TRANSCRIPT

[00:00:01] John J. Lynch III: I think what scares me the most right now, when you start to ratchet back on the funds that are available for care, and so what do you mean by that, Jack? Well, a 20% increase in my costs and a 2% increase for 55% of my business and the desire by the commercial payer is to reduce what they're paying, the first people that suffer are the underserved. In our community, all you got to do is look at what's going on in Chester and what's going on up near St. Chris. Both hospitals struggling financially and those patients will suffer as a result of it.

[music]

[00:00:40] Voice Over: Welcome to A&M healthcare industry group's *What's Your Moonshot? Podcast Series,* where world-class healthcare leaders seek to solve big problems? Listen as we talk to today's health system CEOs about the journey to achieve their moonshot.

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[00:00:58] Larry Kaiser: Welcome to A&M's, *What's Your Moonshot? Podcast*. I'm Larry Kaiser, Managing Director with Alvarez & Marsal Healthcare Industry Group. I'm joined by my co-host, the ninth Secretary of the Veterans Administration, the Honorable Dr. David Shulkin. We're very pleased to welcome to the podcast today, Jack Lynch, President and Chief Executive Officer of Main Line Health. Jack has served as President and CEO of Main Line Health since 2005.

During his tenure, he and his leadership team have been credited with strengthening the organization's commitment to safety, quality, and equity, while enhancing the technology necessary to support significant advances in these areas. He's also fostered a period of expansion, including the addition of an acute care hospital and six health centers to better serve the Philadelphia mainline and Western Suburban communities, and has also significantly improved the employee experience which has garnered recognition from several independent rating organizations.

Prior to joining Main Line Health, Jack served nearly 20 years as an Executive with the St. Luke's Episcopal Health System in Houston where he advanced to the position of Executive Vice President and Chief Operating Officer for the system, as well as CEO of the systems flagship facility, St. Luke's Episcopal Hospital. Jack, we're looking forward to a great conversation with you today on the podcast.

[00:02:18] Jack: Thanks, Larry. It's great to be with you and David and I look forward to our conversation.

[00:02:24] Dr. David Shulkin: Great. Well, Jack, welcome to the *Western Moonshot Podcast.* A lot of people describe what we're going through now as really unprecedented times and you've been leading Main Line Health now, I can't believe, for 18 years. That's unbelievable. What a great system that is. Would you say that these are really unusual times? Obviously, you're facing a lot of challenges right now. It'd be good to hear you talk about it, but do you think that we're headed back to where things were before the pandemic or do you think that we're in a new normal? If so, how are you planning on dealing with that?

[00:03:08] Jack: We've got about a three-hour podcast here, David.

[laughter]

[00:03:13] Jack: I don't think there will ever be back to normal. I think a lot of things have happened that maybe some are good and some are not so good. I call ourselves being in the post-pandemic period. We all know that there's still people getting the infection, still people getting hospitalized, still people unfortunately dying, but that's not what's really creating the greatest challenges for healthcare leaders today. If you look at the staffing, the great resignation, where did all these people go?

I'm thrilled to tell you that we are back to our pre-pandemic nursing turnover rates, but we've also got a new challenge. The entire support staff, that entry-level and those folks, are now able to get jobs and competing for jobs in lots of industries that used to pay a lot less than healthcare. Whether it's fast food, restaurants, hotels, go down the list of places that now are paying the same thing that most healthcare providers are paying for those entry-level key folks.

By the way, they don't have to be vaccinated. They don't have to wear a mask and the work is different, and so I think we're very challenged in that space. We're in a particular unique challenge in the Philadelphia region because we've seen so many beds closed. Let's start with Hahnemann, and then move up to Jennersville, and Brandywine, and then the changes that have taken place with Taylor, Springfield, and Delaware County, and the decreased services that are available at Crozer.

Those communities are finding care in other providers, whether it's Penn or Mainline, those increased ER visits, increased admissions are creating a real challenge for many of us.

Then you lay on top of that, the inflation. Labor cost have gone up 20%+. Drug cost are up, supply cost are up 20%+. Utilities are up. All of those costs are up yet none of our payers adjust their reimbursement rates for any of those activities.

For 55% of the business at Main Line Health, we got a 2.3% increase for Medicare. When you think about that, coupled with the price increases, the cost increases that I just described for labor supplies, drugs, utilities, it's not sustainable. I'm really proud that we never closed the bed during the pandemic, but we, certainly, paid a premium to make sure that we had the staff to meet the demands that were coming at us.

[00:05:59] David: Jack, it sounds like it can't be business as usual, that the business model just isn't going to add up the way that it did before the pandemic and before these inflationary increases. How do you begin to rethink the way that you do business?

[00:06:16] Jack: I feel like I'm preaching to the choir with the two of you. You, certainly, transformed the Veterans Administration in your tenure and/or tried to make a lot of changes. Certainly, Larry was on the front lines as the President and CEO at the Temple Health System, and so I think some of the challenges that I'm facing today were challenges that both of you, quite frankly, faced earlier, quite frankly, probably pre-pandemic, but I think everything has changed.

We've got a workforce, many of whom want to work from home. The hybrid work-from-home is something we got to contend with. We've got more people that want to be cared for in the home. We've got a lot of conversation going around about hospital at home. I think that's going to be very challenging because it's challenging to staff our home care organization, but when you start to run out of beds because of closures and increased demand and an aging population, you've got to find alternative ways of caring for people.

I also think we got to get really serious about getting to top a license. We can't have professionals working below their license because there aren't going to be enough of them and the staff that are working with those licensed staff are very capable, very competent, but also very difficult to recruit. Tell a quick story. I was at a Country Club and I was having lunch at the bar and I said to the bartender, "How long you been here?" He said, "Two months." "Where'd you work before?" "Bryn Mawr Hospital."

I said, "What did you do?" He said, "I was a patient care tech." I'm like, "Oh my gosh, now I've got to compete for bartenders?" He said the job was really, really hard. Those jobs are hard and those people are really, really important in the delivery of care. We're going to see virtual care that we've never seen before. I think it might improve it. I think there'll be ways that we can take advantage of technology, artificial intelligence. I think things are going to change, but let's face it, healthcare has not been, historically, all that comfortable with change or good at leading that change.

[00:08:29] David: Well, Jack, when you see the headlines, as I'm sure I know you play a big role in national organizations like the Leadership Institute and other national organizations that you participate in. When you see these headlines of health systems losing multibillions of dollars, do you think it's possible to change that quickly or are you concerned about the sustainability of some of our large healthcare systems?

[00:08:58] Jack: I have the privilege of serving on the American Hospital Association Board and we have a lot of conversations about both short-term, mid-term, and long-term things that we need to do as an industry. When we start talking about three to five-year plans, my response is, "Guys, we got to move faster because some of the players will not be here in three to five years." I'm fortunate that I have a fairly strong balance sheet that allows us some time to adjust, but not everybody does.

I think that when you look at the Billion Dollar Club, the folks that are losing a billion dollars. Now, it's difficult for me to understand how much of that billion-dollar loss is from their investment portfolio versus their operating portfolio, but when I look at my own operating performance, we're going to lose over $100 million for the second year in a row. That has nothing to do with the investment portfolio. I tease the Investment Committee that they're supposed to be there when the operation is being challenged. I think a lot of the losses that we're seeing are, in fact, related to operations. A couple of things. One, I think we've got to get funded for the care we're providing. You can't fund Medicare at anywhere from 70 to 80, 85 cents on a dollar, depending on who you ask. I think it's lower.

In my case, I'm funded at around 75 cents on a dollar. Some of the numbers that are being used by others, I think are outdated. When you look at the rising cost and the declining margins in healthcare, I'm convinced that my number's closer to reality. Medicaid, it's 60 cents on a dollar. You know, I look at my colleague Larry, and say, "How in the world could you survive and deliver great care at Temple when most of your payers were government payers"?

[00:10:49] Larry: 85%.

[00:10:50] Jack: Yes. My beef is, why is the government allowed to pay us less than what it costs? David, you'll appreciate this, having served in the administration. Can you picture the Defense Department and the Pentagon's reaction when if they paid their vendors the same way that CMS pays healthcare? The Pentagon gets a bill from Northrop Grumman, and they send them 75 cents on a dollar for the invoice. There's no more technology coming. It's going to stop. Yet for decades, healthcare has tolerated underfunding from government payers because commercial payers made up the difference.

[00:11:35] Larry: I think some would argue that our cost structure is too high also. That's not necessarily the case. You did mention something and I think that it's reasonable to go back to that. Talk a little bit about the use of contract labor. Talk a little bit about what you've done in terms of raising wages. The example, you mentioned about the guy leaving the patient care technician role to go to be a bartender is really significant.

Because as you point out, a number of these other industries have upped their wages and it's an easier job for that matter than being a Patient Care Technician. Yet we need those people badly and a lot of places are suffering not being able to recruit people like that. What are you doing with contract labor before we get into some discussion about equity as well?

[00:12:19] Jack: Yes, it's a great point, Larry. What I would say is that we would all be dead on arrival if we hadn't had the benefit of contract labor. When you look at the spread of COVID and the demand that it put on health systems around the country, initially, regionally, so big burst in New York, contract labor was brought in to deal with it. When you fast forward and look at the fact that there was a big burst across the whole country, we all started drawn from contract labor. The truth was, we, basically, were paying for people to come from other areas because our people were going to other areas.

What we did is we conditioned people, quite frankly, that they could make a lot more money traveling and work less numbers of months a year. How do you begrudge that? My problem and my colleagues' problems with that is that the staff, nurses, and others were not the ones benefiting greatly from that bubble of that increased cost of contract labor, the venture-backed PE-backed firms that own those contract labor companies, saw their margins skyrocket.

I think that's a problem. We did use a lot of contract labor and we have a good contract labor organization that we work with and we've talked a lot about what the rates should be.

We've also built our own more flexible employment opportunities for folks that might be inclined to want to do contract labor. I'll give you a great example. In the State of Pennsylvania, you have to be certified to be a Sterile Processing Tech.

Within the first 18 months of your job, we were paying $70 an hour for a Sterile Processing Tech because we needed to hire contract because we couldn't get them. At the same time, the pay was probably 20, 22, 20 $3 an hour for an employed Sterile Processing Tech. You can picture the conversation in the break room when two or three travelers are telling the guys that are on the team, "Hey, by the way, I'm going to pick a number 40.

I'm just assuming it went from 70 to 40. All of a sudden, you see out migration. The other thing that I can picture and both of you have spent some time in academia, I suspect that if you're one of those academic institutions that teaches the certification, you might be telling your students, "I really encourage you to go work for an agency because you're going to make a lot more money." That's killing us.

The difference between the 20 and the 70, nobody's paying me for that difference. That contract labor has hurt a lot of health systems' bottom line. Quite frankly, we couldn't have done without it, but we've got to get ourselves back into a mode. At the same time, we got to pay people competitively. All of us across the country increased our nursing and other staff salaries over the last two years, much more significantly than we ever would've anticipated.

We did it with the full knowledge that we weren't going to see any increases in reimbursement as a result of it. We did it because if we were going to staff the bed with high-quality, competent, capable people, we had to pay them competitively. As the rates

increase, whether it's through the market or through contract, you're going to lose all your staff if you're not paying competitively.

[00:15:45] Larry: I want to switch gears a little bit here, but it has to do with both workforce as well as taking care of patients. We know that diversity, respect, equity, and inclusion are core values at Main Line Health going along with the discussion that we've just had. Through your moonshot, we know you're working to create equity for all in healthcare. Can you give us a little bit more about your goal of providing safe, high-quality care in a way that is respectful of diversity and equity, and inclusion?

[00:16:14] Jack: Yes, and again, I feel a little bit handicapped. I think about the work that you've done for your career around this space, and I think about the work that David did particularly with veterans and making sure veterans had equitable access to care. I read an article that was put either in *JAMA* or *New England Journa*l in the 1990s, I think it was 1992, that looked at a study at Georgetown.

They looked at the patients that came in with cardiac symptoms into the ED and what happened with them. In 1992, in a very diverse city, Washington D.C., in a very diverse institution with diverse trainees, staff, and attendings, the report, basically, came back and said, "There's a bias in how we take care of people." If you were a White male, you probably got more aggressive and more timely care than if you were a Black female. 1992.

We all know that there is extensive data and evidence to suggest that that and maybe worse is still going on today. The one that really rips my heart out is the racial disparities in internal care. I've asked the question, is it because of the care that's provided in the nine months? Is it because of the care that's provided in the NINE months and then the one to two years of the baby's first life?

The truth is, it has a lot to do also with the one-year, the two years, and the three years prior to the pregnancy. The bottom line is there should not be the gap in mortality and morbidity for a Black woman versus a White woman. We've got to pull out the stops. The frustration is when you talk to Black people about this, they look at you and go, "Where the hell have you been? This has been going on for years."

I accept that, yes, it has been going on for years, but we got to change it. I've often said to people that when I went into this field, and I know that when the two of you went into this field, you didn't get up in the morning and say, "I need to take care of the people that look like me really well." You need to take care of everybody.

My moonshot, quite frankly is that everybody that encounters a caregiver, everybody that encounters a doctor, a nurse, a therapist in the ER, in the doctor's office, in a clinic, gets the same level of care that the three of us enjoy when we encounter. We all know that not everybody gets listened to the same, we all know that not everybody gets access the same. This gets into the whole discussion about, what is healthcare? Is it a right or is it a privilege? It is unconscionable that people that look different than the three of us get different levels of care in this country.

[00:19:13] David: Yes. Now, Jack, this is something that I know that you've believed in a while. I didn't know about your first coming onto this and reading that article back in the '90s. I know well before the pandemic in 2017, you were involved in the Institute for Healthcare Improvements Pursuing Equity Initiative, and you're also involved in something called the Accelerate Health Equity Program. Can you tell us a little bit about how your involvement in these programs and the initiatives that you're undertaking at Main Line Health are beginning to help put that moonshot of yours into action?

[00:19:52] Jack: Yes, David, one of the things that, again, both of you guys know is none of us, particularly White guys have all the answers. All of these organizations, whether it's the Institute for Diversity in Healthcare, whether it's the IHI accelerating or pursuing health equity, whether it's the regional effort around accelerating healthcare. Every single time we get in a conversation with a diverse group of people, LGBTQ, veterans, race, ethnicity, age, gender, or whatever it is.

The more conversations you have with people that look different than the three of us, the more you learn, and the more you understand where you need to put resources or where you need to assist. In the pursuing equity with IHI, it was 12 institutions that IHI selected from across the country some large, some small, some in urban areas, some in rural areas, and I think we all learned something from each other.

One of the things that's really key for us is, we can't talk at Main Line Health about quality and safety without talking about equity. The truth is if you're committed to safety and you're committed to equality, but you're not committed to equity, that's a problem. In our strategic plan, for the last eight years, we've had the word "eliminate disparities of care". For the last three years, two years we've had the word, "understanding that structural racism has contributed to a lack of confidence among many when accessing healthcare," in our strategic plan.

12 years ago, we kicked off our Disparities of Care Colloquium, where Dr. Barry Mann put together a program where we were looking at disparities of care that we thought might be right underneath our roof. The great thing for us is we've been having this conversation for a long time and I think we've made a lot of improvements, but I still hear stories about where someone-- I think what scares me the most right now when you start to ratchet back on the funds that are available for care.

What do you mean by that Jack? A 20% increase in my costs, and a 2% increase for 55% of my business, and the desire by the commercial payers to reduce what they're paying, the first people that suffer are the underserved. In our community all you got to do is look at what's going on in Chester and what's going on up near St. Chris. Both hospitals, struggling financially and those patients will suffer as a result of it. I worry a lot as we look around the country, back to your point, David, where systems are losing lots of money, billions, where are the programs that are going to get cut first?

It's not because they happen to be Black or it's not because they happen to be LGBTQ. It may happen to be it's an underfunded program or it's a program that loses money or it's in a healthcare desert. That's the other scary thing. We're blessed in our region to be able to access three children's hospitals, multiple health systems affiliated with different medical schools great community providers. That's not true everywhere.

[00:23:13] Larry: Just to follow-up a little bit on that Jack this is an issue that obviously we're seeing around the country major cities organizations all grappling with the same issues trying to provide equal and fair healthcare for all. You've mentioned that addressing disparities in healthcare is something that Main Line Health has been particularly concerned about. What are your plans for continuing programs and initiatives aimed at addressing some of these disparities? For that matter what are some of the lessons that you'd share with other leaders who've gone down your journey to achieve your moonshot, in fact, looking at equity and addressing disparities?

[00:23:51] Jack: Larry I think the first thing you have to do is you got to know you got a problem. Let's face it, 25 years ago as CEOs in institutions, no one thought that they were having the number of deaths as a result of safety events because we didn't know. When

they started putting it in front of the three of us as CEOs and all of our colleagues we're like "Oh my gosh we got to do something about it."

We put in scientifically based human factor solutions that reduce the likelihood of an error. Today we're measuring lots of quality and safety metrics, but unless you're measuring those metrics by race, ethnicity, sexual orientation, gender identity, zip code, you don't know there's a difference. In one particular line that I was looking at was, I think it was post C-section complications.

I'm going to use numbers they might not be correct but that's my recall. I think we had a 7%, 6% rate. Might be okay and it might actually be what the national average is. Just assume that it is. When you start looking across the different race and ethnicity it was 14% for Blacks. If you're not looking, you don't find it. The first thing is you got to measure it. Second thing is you got to do something about it. You got to ask questions.

As you guys know, you're a little different than I because you got an MD after your name, but I'm not going to be the one that has the answer to solve that problem. I've got to engage the people that are in the space, show them the data and say, "Guys, gows, what are we going to do about this to address this deficiency?" Committing to the fact that there are disparities of care, I think is the first step.

I said to a colleague of mine 10 years ago, I said, "Do you think your CEO believes there's disparity of care in your ER?" He said, "No." This is a Black colleague, CEO is White. I said, "Do you believe there's disparity of care in your ER?" "He said, "Absolutely." The White CEO is not a bad guy. No one had told him there's disparity of care. I think that's a huge piece. It's hard to argue the topic that people deserve equitable care. Once you get people committed to let's figure out how we address this, the challenging piece is the the economics.

Unfortunately, in some situations the economics are challenging. I have it a difficult time understanding how a Medicaid advantage program payer should be making a lot of money. Because, quite frankly, they're making the money on the backs of the providers doctors and hospitals and on the benefits being provided to the beneficiaries. When the government talks about being committed to eliminating disparities of care how about we start paying Medicaid patients care, the same that we pay commercial or even just Medicare rates.

If you look at where children's healthcare has been challenged they have a different rate structure than what they would have if they were reimbursed the same as a commercial carrier. Unfortunately, some of this disparity of care does come back to the issue around financing and money. Unfortunately, it's not all. I have stories that I've heard from prominent leaders in this community who have showed up in doctor's offices, asked for assistance, have described X or described Y, and just weren't listened to.

We look at the whole uptake on the vaccine for Black and Brown people, and quite frankly, a lot of it was due to a lack of trust. It wasn't a lack of trust because of Tuskegee. It wasn't a lack of trust because of something that happened 50 years ago. It was a lack of trust because three weeks ago when I took my mother into the ER they didn't listen to her. She died the next day. We got to grapple with the fact that this lack of trust is impacting people's care and this underfunding is impacting people's care as well.

[00:28:07] David: I wish that I think this starts by having leaders like you be as passionate about this issue as you are. People do listen to you, Jack, and I think that this is really important. I think we're all trying to figure out the path forward in this. I think you said something very important by us doing this together and sharing ideas, and sharing these commitments and working together in collaboratives, there probably are going to be paths

that people are finding for us to move forward. This is going to be a this is not going to be a quick answer, but it's really important that we continue to struggle with this.

[00:28:53] Jack: Let me go back to Larry's point earlier about cost structure. He suggested accurately that many people feel like the healthcare is too expensive. The first thing I would tell you is that that 65% of my patients that are government pay, may get an invoice or an itemized bill that has nothing to do with what I was paid. Their perception is that they had a $100,000 bill. They don't know that I got paid 15,000. That's not clear to them.

If you're a commercial payer and you're the patient if you're a commercial patient and you get a bill and you see that the invoice or the bills comes out to $25,000 for your care, you may not be paying attention to the explanation of benefits that suggested that the payer had negotiated a rate that was 50% of that and that you're only responsible for maybe 1,500 because of the choice you made when you selected the insurance. I think the big concern we've got to have in front of us right now is the self-insured employers. The self-insured employers are subsidizing the losses that are being curved by providers providing care to government patients. Now, I would agree with Larry, we've got to do something to reduce the cost of care. Main Line took about $130 million out three or four years ago. We're on track to take another $150 million out this year.

I'm not alone. My colleagues around the country, if they're surviving, they're taking costs out, but the perception on the part of the person that is experiencing the health care, for the most part, relates to a bill or the transparency efforts that the government has put in place. If people are looking at my inpatient charges, they're irrelevant. They have nothing to do with what I'm paid.

Now, I think being transparent about our outpatient services is really important and people should know what it's going to cost them before they buy it. Yes, our industry needs to do a better job at bringing costs down. When the Pennsylvania Utility Commission gives the water company, the electric company, the gas company, 7%, 8%, 9% increases, when Social Security increases the checks to their beneficiaries by 9%, and health system providers, including, I don't even know what the doctor's increase was, I think was smaller, get 2.3%, that's a problem.

[00:31:19] Larry: Well, Jack, there have been so many things, so many issues that you discussed today. We could spend the rest of the day, basically-

[00:31:25] David: [chuckles]

[00:31:25] Larry: -talking about this, there's no question.

[00:31:27] Jack: I want solutions from you guys.

[laughter]

[00:31:29] Larry: The challenges that you're facing, at Main Line Health, clearly are challenges that are being faced around the country. The issue of equity and disparities in healthcare is, certainly, something we need to continue to address. It is a sad commentary in a country that have the wealth that this country has, and we still have people who do not have health insurance, or for that matter, they have insurance that doesn't cover what they need, where access is still a problem, and where that unconscious bias and how people are treated is still an issue in this country today.

We need to continue to address it just like you're doing. It's one thing for the C-suite people to be talking about it, we need to get the word out, as I'm sure you're doing throughout your

organization, addressing these issues of equity and clearly disparities in health care. When we see that African American patients, Black patients don't do as well with any number of health issues as White people do, that's a problem needs to be addressed, and, hopefully, we'll continue to address it. Jack, we thank you so much for participating with us today. The comments and the discussion we had really has been incredibly valuable. Thank you very much.

[00:32:36] David: Jack, I am going to leave you with something for you to think about just because you asked for this solution. I'm going to "provocatively" suggest to you that the problem with all of these issues that you're talking about, the disparities in care, the gaps in care, the inequities, all relates back to one thing, and that's the fee-for-service system. Fee-for-service perpetuates many of these things that you're talking about.

If you begin to think about changing our reimbursement system to much more of a bundled approach that begins to start incorporating the socioeconomic determinants in it, I think we could have a system that is much more equitable and much less disparate. That's something that I know that in a future talk, we could talk about what you're doing in Main Line health to create new payment models and to bring your system for so. I couldn't echo Larry's comments and thoughts. Again, thank you for doing what you're doing. Thanks for speaking out, and will continue to enjoy talking to you in the future.

[00:33:59] Jack: Well, thanks. I appreciate the opportunity to be with you guys. I appreciate the opportunity that you are affording others one to talk about the challenges and the solutions, but also to hear about them. I look forward to hear more from more of my colleagues and look forward to solutions that can help ensure that all of us have access to care when we need it.

[music]

[00:34:32] Voice over: Alvarez & Marcel, leadership, action, results.

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[00:34:51] David: Larry, I thought that was a really good conversation with Jack Lynch at Main Line Health. He's been doing this job for a long time and if there's any system that might take a pass or avoid this issue of health disparities and equities, it would be Main Line Health because they're blessed, in general, with being in a very affluent geography. Jack is willing to take this issue head-on. Of course, now that he has expanded his network into areas like Chester County and Delaware County, this is a growing issue that, frankly, as a leader, he has to begin to start tackling.

[00:35:35] Larry: Yes. I was going to say, I mean, the Main Line Health, has for years, always done very well in terms of generating a margin because of the population with which they deal. That is it's mostly insured. Not a huge Medicaid volume, although I think he's seen his Medicaid volume going. The fact that he's willing to address some of these issues and disparities of care and equity within health care, despite the fact that he deals with a fairly homogeneous population, I think really says something a lot about both Jack and the institution that he leads at this point.

I think it's great. I think he was very clear about where Main Line Health sits in terms of their belief in dealing with disparities and dealing with equity and making sure that everyone is afforded the best possibility in dealing with the healthcare system. It's a challenge, there's no question, it's a challenge. As he points out, the reimbursement is such that it makes it a challenge every day to continue to provide the care that, not only they'd like to provide, but the people demand to have.

Yet, the shortfall in the reimbursement for the care we're providing clearly exists. On the other hand, as he points out, we need to look at our own cost structure. As you point out, fee-for-service only encourages more utilization, much of which is not necessary. That's an area we need to deal with. Hopefully, we will deal with as we move more into value-based payment and being paid for quality, not quantity.

[00:37:09] David: Yes. I also think that what Jack is proposing in terms of getting higher reimbursement for the services, is really leading to what we're going to see play out at the national level. Because the problem that the government has is that the Medicare Trust Fund has a finite date in terms of when it's going to be solvent. You're seeing right now with the President's budget, President Biden proposing last week that he extend the life of the Medicare trust fund by raising taxes on affluent people and the Republicans saying that that's not an acceptable answer.

You're going to see this issue play out about whether the system is going to be able to, actually, afford increasing resources into healthcare. Some are, actually, arguing that the Medicare program is more likely to receive additional funds at the expense of the Medicaid program. Of course, Jack is warning against that, that it's really the Medicaid program that's even additionally, underfunded and that's where these disparities are often most seen. What he's talking about is really a national issue whose path is not clear what's going to happen, how it's going to be resolved.

[00:38:36] Larry: Okay. He made an excellent point. Why should Medicaid be paid? Why should we be paying less for Medicaid? Obviously, Medicaid is a state-run program. That's why the distinction, you see some states do very well with their Medicaid program, others don't. Again, it's like, "Well, let's take these people who are underserved, and we'll pay less for them than what we pay for others, even in the Medicare program." There's a real distinction there. Unfortunately, it dates back a number of years, but I think it's, certainly, something that's going to need to be addressed. People deserve to have the benefits of outstanding health care in this country.

[00:39:15] David: Yes. Again, I think it's going to be played out at the national level, even the Medicaid program, most states that have accepted Medicaid expansion are getting 95% matches of federal funds. It's really the federal government that's not providing that level of resource to be able to increase payment in the Medicaid programs. This is still to be determined. It really is going to, unfortunately, get involved in the politics of it all.

[00:39:54] [END OF AUDIO]

ABOUT ALVAREZ & MARSAL

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