That work also needs to be done. That is the next chapter of this book.

We need to stop passing today's healthcare costs for both Medicare and Medicaid down to our children and our grandchildren through debt financing. It is a fiscal and even ethical sin for us to duck the key care delivery cost issues for political reasons and inflict that major burden on our kids and our grandkids when we have functional answers today that can eliminate that intergenerational cost burden and improve care at the same time.

Rationing care is absolutely the wrong answer. We need to reengineer, repackage, and reprice care. For Medicaid, we need to make care better and more accessible so that we can make it cost less. We need to reengineer that care in the context of a cash flow that enables, empowers and rewards reengineering. When that cash flow is put in place, and when it has enough longitudinal stability so that providers can count on it so they can reengineer care around it -- then we can alleviate the burden of those costs to state budgets and we can keep those budgets dollars free to spend the money on streets, roads and schools and appropriate local services.

It is time to improve our skill sets both as purchasers of care and as pure providers of care.

Both are entirely possible to do. We can do that work for our non-governmental markets by using the purchasing models outlined in the prior chapter. We need to buy care by the package, and not by the piece. We need care teams for our patients who consume over 75 percent of the costs of care[260] and really need team care.

We need electronic medical records for all patients and we need tools to connect the data for those patients. We need to make meaningful use of our patient data to improve care, support care, track care and study the results of care.

We should be on the cusp of a golden age for medical research using the new database. As an earlier chapter of this book pointed out, one recent study showed how to cut the death rate for stroke patients nearly in half with one change in procedure.[261] We need that research to

be done and we need tools to get the results of those kinds of research quickly to all relevant caregivers.

All of those goals are entirely achievable. We can use the new tool set for connectivity to provide remote monitoring, in home care, patient care plan coordination and continuously improving care processes. We just need a cash flow for care that encourages use of those tools instead of crippling the use of those tools. Vertically integrated care systems that sell packages of care have the business model needed to use and enhance those tools. So do well-designed Accountable Care Organizations, and well-designed medical homes, and appropriately paid health insurers and health plans who sell care by the package to employers and the government as Medicare Advantage or capitated Medicare programs.

We could be on the cusp of a golden age for care. We also need to be on the cusp of a golden age for health. That is the topic of the final chapter of this book -- improving our total health.

Medicare Advantage has continuously improving quality scores and very high patient satisfaction levels prove the approach model is viable and can get the job done of stabilizing costs and improving both service and quality. A plan to migrate seniors to Medicare Advantage plans -- coupled with a well-designed multi-year SGR-two cap for the annual payment increases for the providers and patients who are not enrolled in those plans -- can easily meet the CBO scoring standards for cost savings. That approach to Medicare funding could remove our dependence on borrowed money to buy Medicare claims in two years. Depending on where Congress sets the annual increase percentage, that blended approach could cut the Medicare cost increases to a fixed three percent each year and save the Medicare trust fund that is now scheduled to go broke in ten years from now. Saving the trust fund can be done. We should be deeply ashamed of ourselves if we don't choose to save the fund when we have the tool kit needed to save it and that tool kit will improve care in the process.