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**Forum on Advancing Multi-Payer Delivery System Reforms at
the State Level
Lunch Keynote: CMS, State Reform, and Value-Based
Purchasing
Brookings Institution and National Academy for State Health
Policy
October 8, 2008**

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MARK MCCLELLAN: On a happier note, I'm pleased to introduce our lunch speaker. Herb Kuhn is serving now both as the Deputy Administrator at the Centers for Medicare and Medicaid Services and also the Acting Director for the Center for Medicaid and State Operations. So given the topics that we've talked about today, issues in improving Medicaid, issues in how Medicaid can work with other payers to improve care overall, there's nobody who's more in the middle of those issues in government right now than Herb.

In each of these roles, he brings some key leadership to transforming CMS' mission from being just a payer of health services to an active purchaser of quality health care. This is something I have the privilege of seeing firsthand when I worked with Herb at CMS.

He joined CMS as the Director for the Center for Medicare Management in 2004 and from the day he got there, he's played a critical role in leading CMS steps toward value-based purchasing and changes in payment policies to support the kinds of real improvements in care, the real reforms of health care that we spend so much time talking about at this conference.

At CMM, he was instrumental in developing and implementing hospital payment reforms that tied Medicare payment to the severity of a patient's condition more accurately and that pushed forward on quality reporting and

quality improvement activities. He's continued to work on these issues as Deputy Administrator.

On top of all this, he was appointed to be the CMSO, the Medicaid and State Programs Director in April 2008 when he took, so he took charge of overseeing the Medicaid program, the State Children's Health Insurance Programs, a range of other issues including nursing home survey and certification. So he's got some very busy days these days and we're very privileged to have him with us today.

Before his time at CMS, Herb was the Corporate Vice President for Advocacy at Premier, the hospital alliance that's undertaken some leading initiatives on quality improvement. He also served as Vice President for Federal Relations at the American Hospital Association.

Herb, I'm sorry I looked into the technical capabilities and unfortunately we can't cue your entrance with music from one of those washed out 70s rock bands that you like so much. Those are his favorites but nonetheless, we sure are glad to have you here today to help turn the spotlight on the role the federal government in partnering with state efforts to improve care. Herb Kuhn, thank you very much [applause].

HERB KUHN: Well good afternoon and thank you all very much and thank you Mark for that very kind introduction. It's a pleasure to be here to be part of this program. I'm sorry I couldn't have been with you all this morning. I've heard it has

just been outstanding and it doesn't surprise me with something that Mark is at the helm.

I'll just make one observation about Mark McClellan before I get into my remarks here is that I think everybody knows and folks probably here at Brookings really see it now but when I first started at CMS and I got the nod that I was going to come in to be the CMM Director, they were in the transition at that time as well in terms of who was going to be the Administrator.

I heard that, and then soon the news came out that Mark McClellan was going to be the new Administrator and I felt that was like winning the lottery. I had known this man for some time but the opportunity to get the chance to work with him was terrific but then after working for Mark for a while, a lot of people would say well what's it like working at CMS. I said well right now you kind of measure your time in dog years. They said what do you mean by that? I said one year feels like seven [laughter].

This guy worked all the time but as a result, I think we all know the wonderful accomplishments that came after the Medicare Modernization Act and I don't think it could have been anybody but Mark in order to really get us off and get us going. So Mark thank you. It's a pleasure to be here as part of your program.

As I think you've heard during the introduction during my tenure at CMS, it's really been focused on the Medicare side of the ledger but when Dennis Smith left here in April and you're going to hear from Dennis, I think, shortly this afternoon as part of the panel, I had the distinct honor and privilege to now move over to work on the Medicaid side of the program. I will say I've gained a lot of perspective in terms of what's going on in Medicaid.

This program has some outstanding accomplishments when you really thoughtfully sit back and look at it, whether it's some of the innovative waiver programs, whether it's the returning people with disabilities to the community, whether it's some of the value-based purchasing that's going on in Medicaid or whether it's some of the transformation grants, there's some exciting things going on in Medicaid.

Medicaid though, as we all know, and what's going on in the states, has its set of challenges. Some of those challenges are caught up in what is going on with the rest of health care and some of them are Medicaid-specific but what I really want to do today is get a chance to kind of focus a little bit more on Medicaid but, as Mark said, talk a lot about what is going on in value-based purchasing.

But I think in any of this talk, and this is not new information to you all what I'm going to get into but anything like this, you really have to kind of level set and talk about

the elephant in the room and that's finance some of these changes that's going on in health care.

To give you a sense and well to back up just a moment, this is going to be a continuing issue not only for the rest of this administration but to whoever takes over the helm in January as we go forward but to give you a sense of the order and magnitude of the programs that we have at CMS, let me just give you three interesting facts that we'll just kind of noodle on as we all watched the news for the last three weeks.

Loan guarantees for J.P. Morgan in order to purchase Bear Stearns, \$29 billion. That's two and a half weeks of spending for us for Medicare and Medicaid. Along comes the loan package for AIG, \$85 billion. That's six weeks of spending for CMS for Medicare and Medicaid. Of course the big one, the banking industry rescue package, \$700 billion, one year, two weeks. That shows you the size and the scope of Medicare and Medicaid and what's out there as part of that.

Of course, a part of that, again numbers you've heard before, but when you really look at the size of the scope of health care overall in the economy, it's staggering, 1980 we spent \$364 billion in health care, nine-percent of the economy; 2006, it's double that in terms of what we purchase in terms of GDP. We're a little over \$2 trillion now and according to our Office of the Actuaries, in terms of the National Health

Expenditures Report that was put out not long ago, we're going to be at \$4 trillion by 2017.

So again, that gives you the size and the scope of where we are in terms of all this talk in the news of the kind of programs but the size and the scope of health care overall but again, I really want to talk a little bit about kind of the size and the scope of Medicaid as the states think about reform because I know that's what you're talking about here right now.

We project right now in 2009 that Medicaid is going to spend \$207 billion on the federal side. The states are going to kick in another \$157 billion in 2009 alone and 25 years ago, those numbers were \$19 billion and \$16 billion respectively, extraordinary growth in this program as we go forward.

According to NASBO, the National Association of State Budget Officers, one in every five state dollars is spent on Medicaid. Right now, what they projected back in the mid-1980s, about ten-percent of state budgets were in health care. Right now, it's 21-percent. It exceeds what they have in education. According to CBO, it's growing at about eight-percent per year for the next decade.

Just to bring it down just to a little bit more personal level so you can see kind of the things that we think about almost daily over at CMS, the Center for Retirement Research recently noted that the median savings for heads of household was approaching, retirement is only about \$60,000.

This working age population is virtually saving nothing in terms of outside income beyond what they have of that money that's available to them.

Right now when you look at long-term care, we're looking at \$78,000 per year for a private room, \$10,000 less for a semi-private room. Those are the numbers we look at every day when you think about this growth and what's out there. So how do we begin to turn this corner that you're talking about today is some of the innovations that are out there.

That really brings me, what I really want to spend most of my time talking about is value-based purchasing and really what's going on in the state but also a little bit on the Medicare side as well. What I've said over the last couple of years is what I like to call it is this quiet revolution that's going on in health care, a quiet revolution defined by the issue of performance improvement. That's leading to higher quality, more efficient care that's out there.

Quite frankly, I don't think this quiet revolution can come soon enough because when you look at many aspects of our current system, you see a system that rewards volume and episodic care over quality. This translates into an illness-oriented, complaint-based system of care that we have all across this country.

The current system rewards volume at acute care and other institutional services over quality, prevention,

coordination of care, and certainly home and community-based services. We see Medicare and Medicaid expenditures continue to explore but no good evidence that additional spending in those programs are leading to higher quality care.

So what we really need is a system that's going to reward health care providers providing the right care at the right time, a system that supports prevention and ongoing care for the chronically ill and certainly community-based services. Then finally, a system that is definitely more patient-centered where you have patients and providers with better information, better tools in their hands so they can make decisions on the appropriate care every time. This is important to not only people with Medicaid but across all the parts of our system as we go forward.

As Mark said as part of the introduction, part of this quiet revolution is also a major pivot for us as well as states. We need to move, as an organization, to no longer be just a passive payer of health care services kind of like indemnity insurers simply paying the bills when they come through the door but to become an active purchaser of high quality, efficient care and all the states need to move in this direction as well as we go forward.

If you think about what that means for any organization, it's extraordinary to think about an entity, as I talked about, \$700 billion a year basically spending to be able

to pivot, to become an active purchaser where we've been basically passive up until now, is a huge change but it has to come as part of the process. We're on our way in that direction.

When you really look about how far we come, at least when you think about the states and Medicaid, it is pretty remarkable what some of the progress. Let me give you a benchmark here of 2005. At that time, we only had 13 states using national quality measures and publicly reporting those results.

We had few states with aggressive pay-for-performance initiatives, no states were even taking on or considering the issue of never events, very little HIT work, and from CMS, we had no Medicaid or SCHIP quality strategy in place. Well let's fast forward to now 2008.

Now we have 32 states using national performance measures; multi-state neonatal collaboratives using evidence-based guidelines, 30 states with P-for-P initiatives; 20 states have implemented never events. The implementation of the CMS quality strategy came in 2006 and we have a number of multi-state e-health collaboratives. What a change out there.

This is long overdue change but what I really would like to help you even get as better sense of that change is stamp through what we call the six pillars that we've been working on in terms of our quality strategy and give you a

sense of some of that change and where we hope to see some of this going.

The first pillar has to do with the need to promote evidence-based clinical guidelines and performance metrics because after all, if you don't measure, you can't improve and that's what that's all about. We've seen some real progress in this area, first in the area of SCHIP.

We have annual reporting of measures and publicly available data under the SCHIP area, something that really does not exist in Medicaid. In fact, a lot of states do collect some of the data through HEDIS measures that are out there but few report that audited data to the NCQA central database as a result of that. In fact, I think about 25-percent of it even comes that way.

Just last week and I think that was pretty telling, just last week it was revealed that at NCQA press event that of the few majors that are being reported, what we're seeing is little improvement at the state level in terms of care that's being provided to Medicaid beneficiaries.

Among the 52 measures collected from Medicaid plans, only 26, half, showed any increase and most of that increase was very small. The only one that really showed some improvement was childhood immunizations. So again the notion, if you don't measure, you don't improve and we've got to get better at the measurement business.

We also need standardization in the measures. We need to make sure that we have much better transparency of these measures with all the states that are out there as well. We need to know how they're performing and to compare one to another. We also need to look harder at the measurement development process.

Right now, most of the measure development area has been in the area of adults. We need to look at moms and babies. We need to look at long-term care more aggressively, and we need more standardizations for states to have, to stop using the homegrown measures but to really look at standard national measures that are out there. We need to look even harder at childhood obesity as part of this pillar. There's some great work in terms of overweight and obesity guidelines that are out there but we're not measuring that well and we need to do better in this area.

The second pillar involves value-based purchasing. As I noted earlier, this year we have 30 states that are employing value-based purchasing and 20 states have activities under way in terms of the never events. This is one where it's interesting to look what's going on both in the Medicare and Medicaid space in this area and the reaction from the health care community.

What we're basically saying with this policy is we want highly reliable care where there's evidence that the care can

be done right the first time. let's pay for it once. Let's improve the reliability of care. A lot of people don't like that challenge but they're coming along and we're going to get there. We're working both in Medicaid in terms of a state Medicaid Director's letter we issued recently to talk to states even more aggressively about that.

We're taking action in the Medicare side and private employers are getting in the game as well but we're employing also, on the Medicare side, a new tool here that a lot of people haven't paid much attention to. Mostly we've been doing it through the payment formulation in terms of payment in terms of the DRGs, whether it's a more costlier DRG if the condition is acquired after admission but at least on some of the never events, we are now using national coverage determinations to look at some of those to take care of them.

When we use the NCD process for the first time, it brings in the physician payment as well. Up until now, it's only been the hospitals but now we can start to capture not only the particular physician, if it's a surgical procedure, the anesthesiologist and others. We are getting people's attention. Again the whole idea is to drive forward liability in terms of the care out there.

For states in terms of value-based purchasing, it has an added dimension. Not only do states want to pay for high quality, efficient care but also they have to always be

attentive to the fact that their rates are sufficient in order to make sure there's access out there. States have a dual role here more so than any other payer to make sure that quality, the efficiency, but also this second burden in terms of access that they deal with that.

Right now, we're starting to see some pretty good results from some of the states that are out there. Perhaps New York State has the most mature program in terms of pay-for-performance that are out there. They've demonstrated improvements in asthma care, post-partum care, and diabetes control. They're starting to see the differential between the Medicaid population and the commercial population starting to shrink and that's good progress. That's what everybody wants to see.

As part of that also, we're seeing some wonderful validation that this is the way to go in terms of value-based purchasing. A lot of this validation is focused on the Medicare side but I think there's a lot of portability when it comes to Medicaid as well. The Institute of Medicine in terms of their pathways to quality health care reports have opined time and time again that we need to begin linking Medicare and Medicaid payments to outcomes and measurement that's out there.

MEDPAC, the Medicare payment advisory commission, has issued a series of reports to Congress talking about how to tie Medicare payment to value-based purchasing as we go forward.

The President's budgets beginning in '06, '07, '08, and '09 continue to talk about this issue as we go forward.

Congress has certainly gotten into the act many times, we've seen recently whether it's the MMA, the DRA, the Tax Relief and Health Care Act, or most recently MMBA [misspelled?], it's chiming in ever slowly to move us in this direction. The health care community itself has really expressed an interest in and I think some great leadership in trying to move this in this direction towards quality improvement as we go forward.

Importantly, what we're also seeing at some of the Medicare demonstrations, are showing real results, real performance improvement in this area that we find extraordinarily encouraging as we go forward.

The third pillar, health disparities and this is an area where I really want to thank Brookings for their leadership in this area. Through some great collaborative work, Brookings is doing an outstanding, they're doing some assessment of existing data and pulling the best set of best practices on how we can collect, report, and use this data in terms of race and ethnicity.

This is going to culminate next year into a national conference that I think are going to be able to help us identify the gaps, what we can do to address those gaps, and how we can improve. I think a lot of people are looking very

hard at the leadership that Mark and others here at Brookings are leading on this area of racial disparities and how we're going to be able to use that conference next year to continue efforts to close the gap. That will be a key point of our overall quality strategy.

The fourth pillar speaks to utilizing health information technology. Just yesterday, and some of you might have read in some of the press, we held a national e-prescribing conference in Boston to talk about this issue. An exciting thing about what was going on in that conference as well as I think on this whole issue of value-based purchasing is that I think most people are over the realization now or past the point of whether the debate is worth doing.

I think the question has been asked and answered. The debate is over. This is worth doing. It's all about how we go about implementing these programs as we go forward. That's what that conference was about yesterday. Over 1,000 people were there talking about this issue and to hear not only from state leaders, we had the governors from Rhode Island and Massachusetts but other individuals, physicians, pharmacists, others talking about how we're going to move forward to do e-prescribing but more importantly, get HIT into health care as we go forward.

Medicaid has been no different on this. When you look at what we've been able to do with health care transformation

grants, what states have been doing with some of their MMIS systems, they are creating enabling opportunities for providers in those states in order to drive forward in this area.

We also have, under the Medicaid programs, soon a coordinates and a benefits agreement, what we call our COBA agreements that are going to provide, for the first time, state's information on dual eligible Medicare beneficiaries, data that the states have desperately been wanting to help drive and do work in terms of coordination of benefits, a great change that I think that's going to be out there.

I think when more Part D data becomes available, when the new MPA provisions kick in in terms of being able to pay physicians for IT and for e-prescribing opportunities, this is going to be impactful and I think this is going to change.

The fifth pillar talks about the engagement with strategic partnerships. I talked about the one we have with Brookings right now in terms of dealing with health disparities but I think this is going to be an effort where it's going to take a lot of people at the table to continue to drive us in this area if we're going to be successful not only the federal agencies but states, professional organizations and most importantly, consumer groups as part of this effort.

In many cases, these relationships exist now but I think there's going to require to develop new ones as we go forward but as we think about these new relationships think

there's a basic set of principles that CMS needs to bring to the table that everybody can expect and understand how we tend to act or what to act in terms of these new relationships.

First and foremost we need to make sure that we have stakeholder involvement across the board in anything that we do as part of these efforts to drive some of these changes forward. The second thing is we're going to need investigative integrity in everything that we do.

We're going to have to have a great deal of flexibility. I think we're pretty flexible at times, some say less so but I think this is going to challenge us to think about our level of flexibility and what we can do more and better in this area. Above all else, we're going to have to have transparency in all that we do if we're going to be successful in this area.

The other basic principle we're going to need is to make sure that we have good trusted and valued measures that are out there, measures that everybody believes in as we go forward. Again, there's many different measure developers out there. The consensus groups are coming together but we've got to make sure we get that system down or people understand them, they believe them, and they have confidence in them.

Then finally, at every turn, we've got to make sure that all the stakeholders are working together to make sure that we have some good standardization that's out there,

whether it's CMS, the states, or other payers. We need to make sure that we're measuring consistently and to the extent possible, we're putting in place the same kind of payment incentives that go forward.

I think the most destructive things that could happen for this whole movement is that the providers, and we see this somewhat already, are being asked by one set of payers to provide this data in this format this way, another set of providers this data in another format. It's just confusing. It's burdensome. It's not right and we need to move in that direction.

The final sixth pillar is to focus on disseminating innovative state practices. This includes publishing an annual state transparency report for best practices. This includes sponsoring national quality improvement teleconferences that highlight state innovations and it includes hosting promising practices a web page to showcase some of the best practice that are going on in other states.

To be sure this is hard work. This is not only hard work for the innovators, the states, the others that are doing this, this is extraordinary hard work for CMS and new work for us as we move in this direction. As we've been going down this track, we see some common themes from a number of the different groups that we're engaged in that are pretty exciting.

First, is the desire that people see that change needs to be there and they're willing to embrace it and take it on. The other part of that same theme is the fact that what we're trying to do here, I don't think could be ordered. We really need to find the incentives that drive people in this direction through an incentive-based system instead of just trying to order it through conditions of participation or whatever kind of regulatory process that we have.

The second thing that we're starting to see from a lot of the states as they grapple with this is that they are employing the simple but essential kind of engineering change process to all that they're doing. They're identifying the gaps. They're addressing those gaps and they're seeking to improve at every step that they can.

Furthermore, as evidenced by the progress I described in terms of the three short years from 2005 to 2008 with what states are doing, we're seeing the states demonstrate some extraordinarily good innovation out there. One of the things that I'd like to point to in that is what states are doing right now in terms of home and community-based waivers.

If you think back to 2001 when the President launched the New Freedom initiative, it really was a chance to really take those Americans with disabilities and try to get them back in the community, into homes. It was a tremendous effort that started then and then picked up speed with the Deficit

Reduction Act where Congress gave us even new tools in order to help the states through the Medicaid programs to move in that direction.

As a result of that, what we once again saw was the states as the great innovators to move forward in this direction because through this effort now, today, every state has a community alternative to people whose only option before was institutional care.

Thirty-one states and the District of Columbia are not only saving money with the money follows the person demonstration, an effort that Dennis Beck in the back and Mark launched when they were at CMS but they're helping nearly 35,000 individuals with disabilities to rejoin their communities over the life of the program.

We're closer than ever before to kind of a balanced long-term care benefit. In 2007, nearly 40-percent of the payment for long-term care expenditures were invested in community-based services. We've improved even more waivers recently to help young children who have mental disability issues to be able to stay at home to get their service instead of going to institutional cares.

What we're seeing as a result of this is that we're seeing a significant change in terms of the innovations that the states are doing to help people stay in their communities so they can visit friends, go shopping, hold a meaningful job

just like everybody else. Health care is changing and I think that's a good thing.

So in conclusion, let me just wrap up here and say this that as we move forward and particularly looking at the Medicaid program and I think Medicare too, I think there is a bit of cause for optimism, insurgence of some of the changes that we have of value-based purchasing. As noted earlier, it's hard work but there's no doubt it's work that's worth doing. It's evidenced by what we're seeing with the states across the board but particularly in just the example I used in the home and community-based service options.

The states are capable of innovating and innovating quickly to move forward in this direction because right now I think the choices are very clear. The status quo means rising health care costs. The status quo means billions spent to deliver treatments that are often mismatched. The status quo means less focus on preventable conditions or coordination of care.

I think the status quo means a probably looming fight and battle between Congress and the states but with the appropriate share of the Medicaid dollars and who's going to pay what share as we go forward or I think the alternative is how do we go about empowering states, health care professionals, other payers to the extent we can in pursuing the best care at the lowest cost.

I think that what this means is that it's a more of a debate about not how much to spend or not to spend on individual services. It's a debate on how you spend those dollars because that's the incentive that's going to drive the change. That's the incentive that's going to give us higher quality and ultimately that's the incentive that's going to give us more efficient care. So with that, thank you very much and Mark, I'll be happy to take any questions anybody might have [applause].

MARK MCCLELLAN: So Herb thanks for the remarks. You did a nice job of summarizing a lot of initiatives that are taking place at CMS that support state efforts to focus more on getting better care at a lower cost. I was wondering if you could expand a little bit on some of the Medicare sides of these issues.

There have been a few, section 646, so-called demonstrations awarded and some that are under review now including we heard from Allen in North Carolina a little bit earlier this morning. Any further thoughts about, I know it's part of the same thing that you've been talking about of where CMS sees those kinds of initiatives fitting in.

HERB KUHN: Yes, thanks Mark. It's interesting when you think about the whole issue of value-based purchasing. A lot of people think value-based purchasing just means payment changes but I think it means more than just payment and that means a

whole host of things that include a lot of the demonstrations that we're looking at. It means gains sharing. It means payment. It means pay for reporting. It means transparency. It means consumer empowerment.

So many different things are part of that and part of the effort, what we do on the Medicare side, as people know, is to really try to prove a concept and then demonstrations are a chance for us to prove those concepts. Some of those demonstrations have been launched by CMS on our own accord like the Premier demo that Mark talked about earlier.

Some have come as a result of initiatives that Congress have put us down the track and the 646 where it really is looking at true systems changes are ones that we're excited about and I'm glad to hear that you heard about the one in North Carolina. I think that's an exciting one as we go forward.

Beyond that, we're looking at demonstrations that hopefully will get here soon in terms of gains sharing, which I think will really create some new opportunities and some new things to look at. We're looking at a new demonstration that we'll have launched here soon although we've announced it but we'll do site selections soon to call the acute care episode or the ACE demonstration where, for the first time, it really starts to bundle payments together between the hospitals and physicians.

It would be my hope that could be expanded in the future to get into post-acute care as well. We're doing more demonstrations to look at how we can assess patients more than ever before. One of the big problems you see in Medicare but across all parts of health care is the siloed nature of the programs. Medicare Part A, Medicare Part B, and when you get in the post-acute world, it is just unbelievable whether it's long-term care hospitals, rehab facilities, home health, outpatient, you go across the board and we assess for each one of those settings very differently.

We've got a demonstration now to go forward that will help us pull together a single standardized assessment instrument. So we won't be paying by what name is on the door of the facility but really on the patient needs and a site neutral payment system that will drive us in that direction as we go forward.

On the physician side, the physician group practice demonstration is really showing some promise with ten of the largest groups around the country and what we're seeing in terms of greater efficiency that's out there, so a number of these demonstrations that are out there.

Oh, I forgot, on the physician side as well as for chronic care management, we've done since 1999, probably seven different demonstrations to look at chronic care management with about 35 different organizations, continue to evaluate

some of those. Some of those continue and, of course, we have the medical home demonstration that will be launched hopefully by the end of this year as well, a chance to prove the concept.

The real question now is how are we going to take the learnings from those, do the great dissemination of that information and really drive that in programs forward. So lots of good ideas but I think some of us are becoming impatient. It's time to start to turn those demonstrations into actions and the sooner the better. Yes ma'am?

ANN DOSSEY: I'm Ann Dossey [misspelled?] with the [inaudible] and I'll wait for the microphone, even though I do have a booming voice, if I-

HERB KUHN: I could hear you fine.

ANN DOSSEY: I'd like to ask you, you laid out a number of things or a number of exciting initiatives that are under way, but none of them are simple. All of them under the current structure require budget neutrality at some point and the definition of budget neutrality is often an issue. So laying that as one issue out there, are there changes that you and your colleagues at CMS would wish that a new Congress might take that would make your ability to lead and make these changes happen?

HERB KUHN: Sure. As these programs change and if you think about the way the Medicare program changes, sometimes it changes too fast for people or the Medicaid program, sometimes

it changes too slow but if you really think about the evolution of the program, just to get to your point here, is that for the first 20 years, first two decades of the program, we paid unreasonable and customary charges and then everybody realized change needed to occur. Then along came the advent of the perspective payment systems. That's carried us for about two decades as we go forward.

So I think we're kind of at four decades now into the Medicaid program and probably now on the third iteration. it's this whole issue of value-based purchasing and how we're going to go in that direction. It's created a lot of new thinking of how we do things. In particular, we talk about the budget neutrality issue.

I think it's going to force some of us to think a little bit differently in how we can look at those whether our Office of the Actuary, whether CBO, ultimately the Office of the Management and Budget. What really is going to drive a lot of it is the evidence and how we do the evaluation and the work of our evaluation contractors and how we look at that.

For example, I'll give you an example of the quality premier demonstration. If you look at the premier demo and you look at just in the silo that we operate in Medicare right now, the fact that we pay a predetermined rate for a particular DRG notwithstanding that the hospital might be doing some new great engineering things and getting the cost of care down because of

better efficiency of delivering, better adherence to evidence-based guidelines, fewer complication rates, fewer readmissions, all those things that we'd hope that they would be doing.

Someone could say but you're not saving the Medicare program any money. That's not the question we need to be asking.

Does this create a new opportunity for us to look differently in terms of how we price those services and is there a better way to price them that drives greater efficiency out there because you could do a standard evaluation of that program and say it's not showing any change whatsoever when, in fact, it could be fundamental changes as we go forward. So a lot of it's going to be driven in terms of evaluation.

Another thing that I think we're going to have to think differently in terms of budget neutrality is the silos of the program. Take long-term care for example. Long-term care obviously is a benefit driven mostly through the Medicaid program but yet, what goes on in Medicare particularly with the dual eligibles could be very impactful.

So if you look across the enterprise of long-term care of those two programs, you could say that by doing things within the nursing facility might drive more costs on the Medicaid side but you might save on the Medicare side because you've eliminated some perhaps readmissions and then things like that and may ultimately even save money as a result of

that but are we in a position to look across the enterprise?
Are we still going to be stuck in our silos?

So I think part of the budget neutrality is going to force us to think differently, the interactions, how these programs interact, and can we look across the enterprise as we go forward.

I think on a go-forward basis, it's pretty hard for me to get too much here in terms of what to ask for but last November we did a terrific report to Congress on value-based purchasing for hospitals. It was a report that Congress asked us to do. We delivered it up there. I think it really laid it out on the learnings that we have so far and what we have in place of how we could really try to drive greater efficiency and quality in terms of health care.

I would love to see Congress adopt that thing and move forward. They've looked at it pretty hard but I think that's the big wish. Like I said, the debate over whether this is worth doing is over. The question's been asked and answered. Let's move on to implementation and we've given them some tools to go forward. I would love to see them move forward on that one. Yes Allen?

ALLEN DOBSON, JR., M.D., FAAFP: I know in every administration, there's a tendency towards creationism, the world was created the day you arrived and—

HERB KUHN: I thought you were going to start talking about original sin. It's okay.

ALLEN DOBSON, JR., M.D., FAAFP: So we all fall under that trap but when you mentioned the move from payer to purchaser, I think it's fair to say that in states, that discussion's about 15 years ago and what has evolved in the recent period that you refer to is a change in the question of how do you go about it and particularly 15 years ago, the dominant answer was you contract out to managed care entities and now it's more complex and we have multiple options.

We can change payment in a fee-for-service environment. We can direct managed care entities to do differently. We can think about this and one of the things we heard this morning was even those entities that we thought were going to drive change feel very constrained in what they can do.

So my question to you is in Medicare, you face the same dilemma that the state Medicaid agencies do. Part of you is still, a big part of you, is still fee-for-service, and you're doing demonstrations to try to drive change in the system. Part of you is Medicare Advantage and you've privatized or outsourced the notion of transformation.

At the end of the day, we're trying to channel change and the more we fragment, the harder it is for the signals in the delivery system to be consistent. So from the experience you've had on the Medicare and Medicaid side at the national

level, as states and federal government try to work together, how do we integrate these two streams of potential pressure or incentives for improvement in delivery.

HERB KUHN: That's a good question. At least on, and you're right, on the Medicare side when you really think about where we are, we've got about one in five beneficiaries now in MA plans. Four out of five are still in the traditional fee-for-service but that's changed a lot over the last couple of years as MA has grown.

I wouldn't be surprised in the next year or two, we're going to see one in four in MA and we'll continue to see growth there but there's no question we're still going to have a bifurcated system going forward. I think that's pretty clear we're going to have both systems out there.

So the question is really for me of how we start the integration is how do we start to get kind of a road map that looks at how we're going to measure the two so we can make a true value proposition and judgment between the two for Medicare beneficiaries to choose because they do choose.

If you look at the Part D program right now and you look at the number of Medicare beneficiaries and I think it's 80-percent choose something other than the standard option out there. While people say that Medicare beneficiaries aren't choosing, aren't shopping with their feet they indeed are. They

will make informed decisions with some help from some others or on their own.

So when you look at how we measure on the MA side, we're measuring on the health plan level but on the fee-for-service side, we're down to the individual provider level. How we're ultimately going to get the HEDIS measures and then other measures to [inaudible] so we could do some true apples to apples comparisons in the future, I think is really going to be the lynch pin here of how we get that forward.

We thought a lot about that and we're starting to talk to groups about that. We love for people to come in and share with us their thoughts about that but I think that really is kind of the tipping point in the nexus where we kind of get those two together where we can drive forward. So you can see the difference.

People can make the value judgments not only in terms of the quality of care, the efficiency care, but hopefully with caps measures. So they look at satisfaction as well because I think that's a key indicator and driver as well.

That's where I think the change happens and where I think we need a five-year road map that looks at measure development and how we're going to get all of this to sync up and come together.

MERLE GUZNER: Hi. I'm Merle Guzner [misspelled?] with the Center for Science and the Public Interest. I was glad to

hear you mention prevention earlier in your talk. Just out of curiosity, Medicare treats a lot of people with chronic disease but if you're going to do prevention, you have to get them long before, serious prevention, you need to get to them long before Medicare has them as beneficiaries.

So I'm curious about what your thinking is at this point in time, about how you might address that problem. The second question I'd like to get out here because also you talk about value-based purchasing and clinical guideline-based driving decision making and using that.

As somebody who sort of follows some of the micro-decisions that get made at Medicare all the time, I've been recently following the PET scan issue in oncology, which I found instructive but of course, we have the long running issue of ESAs in both oncology and in dialysis, which are major cost factors for Medicare.

What we see is that very often provider interests have very, shall we say, great influence over the guideline writing process, as a result leads to inefficiencies in that particular system. So what do you see Medicare needing to do in order to address, well for lack of a better term, conflicts of interest in the guideline writing system.

HERB KUHN: Let me take the last one first. You're right on the guidelines and particularly the evidence-based measures to make sure that we get ones that are out there that are

appropriate and if the national consensus groups that are out there right now, I think, have been pretty honest brokers in terms of trying to put together the guidelines that come and the measures that come to them and they move that forward.

What we really need to think pretty hard is in terms of what's in the pipeline and the various measure developers out there as we go forward. My biggest fear is kind of what you said is that you might see a measure that comes along that we, as a payer, other payers might say this could be a valuable measure but whatever provider community or whatever special interest sees it, says boy this is going to be hard for us to do.

Let's not let this one go forward. There is an issue there. So I think what we ultimately always have to have is for CMS, while I want us to hit here to the consensus groups out there to always have the opportunity to go through, notice and comment, through regulation, to be able to pull other measures that we think are appropriate that we need to go forward. I think this is going to be very important not only on a quality side but as we start moving more aggressively onto the efficiency side.

So I think that's an option that the agency always has to be able to preserve in order to get at those areas that are going to be tough or where we don't think measure development is as aggressively as we can. People might know, here a year or

two ago, we let a contract with one of our QIOs be a measure developer to help in this process as we go forward.

So I think that will help us as long as we have that opportunity to be out there. To be sure, I have no doubt there's going to be some certain special interests that are going to go to Congress and try to prevent us some day from being able to do that. I have no doubt that that will be something that people will grapple with up there in terms of how that process works but I can see that strain coming. There's no question about it but I think right now, we have a good check and balance in terms of our ability to go through regulation to get measures on our own.

On the issue of prevention, it's really interesting to listen to all the different people debate on that. when you listen to certain public health folks, they really talk about the best thing that you can do is clean water and vaccines and everything else is kind of not really relevant.

Others will argue the complete other side that we've got to get in the prevention game more aggressively than ever before on the Medicare side. Medicare, as we know, the statute limits us to only what Congress identifies in terms of prevention activities that we can do.

I think the statute reads specifically to treat a disease or malformed body part is basically what we can do. We can't get into the prevention business unless Congress

specifically enumerates those opportunities for us. So you see, the prevention opportunities for Medicare are somewhat that's out there but there's no question that, and everybody opines on this, is that we've got to get some of these issues earlier as we go forward.

I think that's part of what I was talking to earlier is the fact that on the Medicaid side, and what we see a lot in the area of the measure development is really kind of on adults. We really need to get to moms and babies.

We need to be thinking about some of these more types of measures that are out there, whether it's asthma control and we're seeing some good measure development in this area, good use by states or some of these other areas where we can really start to focus through the Medicaid program on younger people to start dealing with these issues.

Again if we don't measure, we can't improve. At least that's where my aspect, as a payer, would come from. Obviously from the public health side and there would be a lot of people who could speak to the education, the other kind of things that are out there but it's going to be key for us as we go forward particularly in areas of obesity, etc. This is where I hopefully, we're going to see some more aggressive work by measure developers in the future.

MARK MCLELLAN: One more question.

JIM MAXWELL: Jim Maxwell, John Snow Institute in Boston. I had a question about, I thought your comments were very interesting, about the amount of innovation that's occurring at CMS and also at the state level. You see a lot of this around the long-term care arena.

In New England, we've had the senior care option programs and the disability care options programs but one of the barriers to is all these demonstration programs is that they get the concept out there but then the communities often don't have the resources or the financing really to implement the seed capital or the other resources to sort of spread them widely across a region or across multiple states.

Is there any thought about CMS taking a kind of a next step in value purchasing and being not only an innovator of ideas but perhaps a funder or disseminator, nurturer, or somehow expanding because there's the critical step that you see lacking in a lot of these particularly in the long-term care arena but others as well between the sort of demonstration's successful but then how do you get it out into the field?

HERB KUHN: That's a good question. Obviously most of the tools we have really are kind of payment tools to go forward, really not a grant making agency, although Congress has, at least on the Medicaid side with the transformation grants, have been able to give us some opportunities to get

some seed money in order for states to do some IT investments, etc.

I think this is something that people are going to think about and are there some areas where there might be some opportunities for grants that could be the thing to jumpstart the seed corn, whatever people want to call it, to get these things kind of launched and move forward in certain areas if they think the sustainability is there.

The success on the transformation grant was pretty darn good. I think people could look at the success stories on, perhaps, others but I think that's something that I think the next administration could think about and certainly Congress ought to think about but it's been done and done successfully in the past. So those ought to be the models we ought to look at.

MARK MCCLELLAN: Good. Herb, thank you very much for your comments and time [applause].

HERB KUHN: Thanks Mark.

[END RECORDING]