Mark Masselli: This is Conversations on Health Care. I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well, Margaret, some interesting new recommendations coming out of The White House Conference on aging. The group which convenes once every 10 years has issued new rules governing nursing home care.

Margaret Flinter: So perhaps the most notable change has to do with the proliferation of the use of electronic health records Mark, which were barely in use a decade ago. Now they have a chance to collect meaningful data on patient care in nursing homes and the new rules aim to facilitate better sharing of that data, and also considerable scientific evidence against the overuse of antipsychotic drugs in older patients along with the overuse of antibiotics.

Mark Masselli: The new rules allow for nursing home patients to be able to choose their room mates if at all possible including same sex couples, siblings and long time friends. The idea is that families and near loved ones, should be free to exercise personal choice in these care facilities.

Margaret Flinter: There are concerns from some advocacy groups that the new rules aren't doing enough to address the shortage of nurses in nursing home and long term care facilities and the sheer volume of care can overwhelm nursing staff that is caring for often very complex needs of elderly patients including dementia.

Mark Masselli: And there has been another dramatic shift in recent weeks Margaret, The Center for Medicare and Medicaid has recently announced an agreement with the American Medical Association that would allow for end of life care discussions to be encouraged between patients and providers. This conversation is one that we believe is long overdue. It should be more common protocol that is encouraged.

Margaret Flinter: And CMS is looking to improve the way care is delivered and the way it is paid for and this is something that our guest today knows quite a bit about.

Mark Masselli: Sean Cavanaugh is Deputy Administrator and Director of the center for Medicare at the center for Medicare and Medicaid services.

Margaret Flinter: And Lori Robertson will be stopping by, the managing editor of Factcheck.org. She is always on the hunt for misstatements spoken about health policy in the public domain.

Mark Masselli: But no matter what the topic you can hear all of our shows by going to chcradio.com and it's always if you have comments please e-mail us at

CHCRadio@ chc1.com or find us on and as always, if you have comments, email us at Chcradio.com or find us on Facebook or Twitter, we would love hearing from you.

Margaret Flinter: We will get to our interview with Sean Cavanaugh in just a moment.

Mark Masselli: But first, here is our producer Marianne O'Hare with this week's Headlines News.

Marianne O'Hare: I am Marianne O'Hare with these health care headlines. The recent Supreme Court decision up holding of a gallery of tax subsidies for residents in all states to offset the cost of insurance purchase has let to an interesting phenomenon. Some states that set up exchanges of their own are now focussing on the possibility of a Federal Market Place as an opt out. At least 3 states with their own market places, Minnesota, Vermont and Hawaii have taken steps to switch to The Federal System after their own market places were too much of a financial technical and administrative burden. The court's ruling means they can make that move without disqualifying their residents for subsidies. The White House Council on Aging has issued new guidelines for treating the growing population of America's elderly recommendations were made they would incentivise long term care facilities and nursing homes to provide better living environments for residents, better training in dementia treatment and handling and better use of electronic health data to keep the elderly from frequent admissions. Type 2 diabetes is expected to affect about 75 million Americans by 2-30 and scientist at The University of North Carolina have come up with a much more user friendly tool to keep insulin levels constant. Apparently some 21 million Americans must rely on daily injections or a pump to stabilize insulin; researchers in this study have created a simple patch worn on top of the skin, which releases insulin when it detects a fluctuation and looking to do human trials soon. I am Marianne O'Hare with these health care headlines.

Mark Masselli: We are speaking today with Sean Cavanaugh, Deputy Administrator and Director of The Center for Medicare at The Center for Medicare and Medicaid Services or CMS which is responsible for overseeing regulation and payment of Medicare fee for service private Medicare plans and prescription drug programs. Part of that Mr. Cavanaugh oversaw the development of new payment and service delivery modals as deputy director at the center for Medicare and Medicaid innovation. Previously Mr. Cavanaugh was Director of Healthcare Finance at the United Hospital Fund and also served in senior positions at Lutheran and Healthcare in Brooklyn, New York as well as the New York City's Mayor's Office of Health Insurance. He earned degrees from the University of Pennsylvania and Jones Hopkins School of Hygiene and public health. Mr. Cavanaugh, welcome to Conversations on Health Care.

Sean Cavanaugh: Thanks of having me.

Mark Masselli: Well first of all Happy Birthday. CMS is 50 years old this month and I can't think of any organization that has had such a profound impact on the millions of lives all across America. So you almost, hopefully you are getting little break to celebrate.

Sean Cavanaugh: There are number of celebrations and some assessment of where we have been over the last 50 years and where we are headed. As you said, it's a really terrific history in this program and we're planning for a similar future.

Mark Masselli: The center has also been focusing on innovation and programs as CMS in a way which you are in charge of the idea allowed at the Department of health and human services particularly and many others, can you describe for our listeners that these different programs and what are some of the distinct features as well as how their efforts either can't.

Sean Cavanaugh: A couple of themes have emerged. One is we are really trying to create a variety of pathways to meet the needs of providers. So there is a wide variety of providers out there. So we are trying to create opportunities for all of them to participate in new modals and find ways to improve care. There is also a wide spectrum of where providers are on their ability to transform. Some are leading edge organizations that have been moving to new modals of care for many years and there are others, particularly smaller practices that are just starting to understand areas where they could improve. So we are trying to make sure we can meet the needs of all of them and the work really falls in the 3 categories. One is to create an expectation for improvement so a lot of public reporting about how people are doing on preventing infections and other adverse consequences of healthcare. The second is creating business cases for improvement, so making sure when providers do the things we want them to do and improve the care that they are rewarded under our payment systems and then finally making sure providers have the tools they need for improvement. So we, a couple of months ago and now something called transforming clinical practice. This major investment we are going to make n reaching out in reaching out to small practices around the country trying to find out what their needs are, data needs, and infrastructure needs to improve how they provide care. So I think, as you look across the Government and see the different things we are doing there, all fall into one of those buckets and they work together and hopefully drive improvement.

Margaret Flinter: But I think all of you at CMS would probably are among to first to say that you can't do it alone. That you are always operating in partnership with others around the country and I am particularly being interested in this trend of the interface between public and private entities as a partnership that spurs innovation. Tell us a little bit about why these public and private partnerships are so essential to progress right now?

Sean Cavanaugh: First and foremost are we all acknowledging particularly when it comes to Health System Improvement that we don't have all the answers here. So I think we are reaching out to learn more from what's happening with other payers. Whether they are current full payers, what's happening in the provider community and how we can build upon those successes, probably the best example of that is the innovation center at CMS over the last couple of years has twice solicited what we call healthcare innovation awards and this is where they open the doors and say please send us your best ideas and we will fund your project for 3 years, so that we can study and learn from it and see how it might have lessons for it more broadly. You know we are a large payer for healthcare services but we are certainly not the only payer and if we want to drive change and drive improvement we see a value in working with other payer so that, you know , a physician in his or her office isn't getting 12 different reports from different payers explaining the same thing in different ways, rewarding different behaviors I think to agree, we can all agree on common matrix on what improvement looks like, public private cooperation is supporting and that is essential.

Mark Masselli: Sean prior to taking up your current at CMS, you were a Deputy Director for Program and Policy at the Center for Medicare and Medicaid Innovation. You came up with and have been focusing on the accountable care organization and patient centered medical homes. May be you can tell all this one is about the type or traction you have seen in some of these innovative approaches and what hurdles also have you identified.

Sean Cavanaugh: We are very pleased to see that there is enormous appetite and an enormous willingness among providers around the country to try something different to improve care. You know, as much as people had criticized pay for service medicine, it actually was working financially very well for many providers. And yet we have seen providers step up and understand that pay for service medicine often is not in the best interest of beneficiaries and patients. One area where we tried a lot of thins is an accountable care organization through the innovation center, we can use the pioneer ACO model which was for organizations that were at the leading edge with care coordination and population health management and the other was a program created by Congress called The shared savings program. Between them we have over 400 ACOs providing care to over 7 million Medicare beneficiaries around the country. The great news here is on the quality front, both of those programs have the measurable improvements in the quality of care. They improved care from one year to the next and in areas where there were common quality measures; they outperformed pay for service providers. So already 7 million beneficiaries receiving a higher level of care and if CMS actually has recently issued a report saying that the pioneer shows an addition to generating the quality improvements had also saved the Government over 380 million dollars over 2 years. Another program that got a quick start and some great early results is called Independent

Sit Home. This is a program that is tailored specifically for the free list Medicare beneficiaries who are living in home but have been in and out of hospital and have multiple chronic diseases and physician groups around the country that focuses specifically on these populations and that provide a lot of care in the home and so lot of home visiting. We have recently had a report coming out in just one year and they saved over 3000 dollars per beneficiary for these folks and improved care they got and you are just can't imagine with the home visiting, the beneficiaries are very pleased with the care that they are getting. We also see the secretary (inaudible 11:15) from health and human services. She announced very specific goals for CMS to try to move Medicare towards these new payment modals because the feeling really is that a lot of improvement can be driven by payment so she has talked about making sure we get all of our (inaudible 11:31) systems into value based designs meaning that they are reward improvements in qualities but also to start developing on these alternative payment modals like the ACOs and the independents at home and this was recently reinforced when Congress repealed the SGR formula. They also created a scenario where they are trying to encourage us to create alternative payment modal. So did you see more of this, a lot of openness and willingness on the provider community to work in these environments?

Margaret Flinter: Well it's not always the case and it's not always the case dealing with some of the entrenched larger organizations we have seen this case and point a bit of with the push back against adopting some new technologies, how a cheap protocol certainly meaningful use is something that's just even recently in the (inaudible 12:14) a bit but in another area he has been the adoption of the ICD10 medical billing codes, which The American Medical Association and some other organizations have been pretty ardently opposed to. We understand that CMS has come to some kind of agreement with the AMA and how to move forward with the October 1st deadline this year and make that kind of 20 year overdue upgrade to the ICD10.

Sean Cavanaugh: What I have found is that when they come to us and are concerned about some of the changes we are proposing. It's really important for us to listen and understand where they are coming from and the AMA in particular I think who has been a very strong advocate for the smaller physician practices and so when they speak about the challenges facing these practices and others, we need to understand where they are coming from and see where there is common ground, while the AMA still in fairness I think they have still have some concerns about ICD10 by talking to them about how we would implement it and transition in the coming year. We still need physicians to submit valid ICD10 codes but we gave some reassurances that even if they can't use the most specific ICD10 code, if they are using the right family and are making a good face effort to comply, transitions are hard but as you said I think the move to ICD10 is overdue, it's time, we just have to work together to get through the transition.

Mark Masselli: We are speaking today with Sean Cavanaugh, Deputy Administrator and Director of The Center for Medicare at The Center for Medicare and Medicaid Services. Sean you know, CMS has been releasing a number of rules over, that have led to the slowing down and it's going down over the cost of treating some 50 million American seniors on Medicare and could you tell our listeners about some of the changes CMS has been recommending concerning outpatient reimbursements, I think you were in the New York times on the front page on the telemedicine reimbursement, in home nursing care and end of life care and other approaches to care deliver.

Sean Cavanaugh: Really on a per capita basis, the last few years have been historic low grades of growth in Medicare costs. Low cost growth has allowed a number of things, one of which is it allow Congress to make better policy, with a lot of benefits to lower cost growth and I think --- It's a good point --- As you know we face the challenge of the (inaudible 14:35). We are going to have almost 50% growth in the enrollment in Medicare in the next 15 years and that's why you know, the secretary as I said announced that we are got to try to really move aggressively to new payment modals and why I think congress endorsed that with appealed the SGR, he mentioned specifically tele medicine, I think that's an area that has enormous potential and we are trying new modals in different areas some you know, those are innovational words that I mentioned. We have a number of providers showing how to Telemedicine can be used in innovative ways and will be ruling it out in some of our ACO programs in the next year too as well. So all these technologies, all these innovative ideas, we are going to be testing many of them because we really have a significant challenge before us with the aging of the (inaudible 15:23).

Margaret Flinter: I guess all of our conversations on insurance speaks to the notion that changes hard but it's inevitable and I would add to that and we would like it best when it's happening to somebody else that you should feel that too ourselves but we see such changes happening across the healthcare spectrum and not just at the Federal level but a the state level as well, so I would like to talk a little bit about the state innovation modals or the SIM. 11 states are receiving over 620 million dollars to test out their modals for how they are going to significantly change healthcare in a way that affects the vast majority of the people in the state. What are some of the most interesting innovations that you are seeing in the SIM so far?

Sean Cavanaugh: You know, Medicare at 550 billion dollars and growing plays really large role in the health care system in the United States. When we look at the states we see partners who have many tools themselves, they have policy letter that we don't have but that can help drive change. One they are a large pair themselves through Medicaid and also they have a long history in many of these states with convening providers and working locally to define change and drive change in a way that federal Government doesn't have and you know, with the affordable care act they are also operating in market places in some cases,

so they have a lot of ability to drive change and that the purpose of the state innovation model is to recognize that and build on that momentum and really the value add there is just that, it's much as anything as the convening of bringing people together and reaching consensus on what kind of change works for the payers and providers. One of the exciting modals out of the states comes from the State of Maryland. They have a long history in Maryland, somewhat unique of hospital rate regulation and they came to us and wanted to modernize the way they did it. They thought the modal that they were utilizing was developed in 1970s and they wanted to move toward a more modern approach that looked more globally at hospital costs and they just finished a very successful year where they generated savings at the Federal Government and improved on some quality matrix, I don't think a lot of states will want to go to that very storng regulatory model but I mentioned Maryland because it was a way of working with the Federal Government that's coming to us and they had a plan of what they wanted to and I think, there is going to be a lot more percolating in the State innovation models in the next year or too.

Mark Masselli: Sean there has been an enormous amount of capital being put into hospitals and private practices converting the ARA put in billions of dollars so that we can have this important and dramatic shift from paper records to electronic health records and we have taken a mighty strides in the last year and yet they are still work to be done in terms of interoperability and the health information exchanges and part of the requirement is for practices and organizations to attain meaningful use in health IT and we have seen some practices struggle and there has been a struggle at stage 2 of meaningful use requirements. With kinds of programs are being facilitated by CMS to expedite the adoption of health IT and the ability to use data to effectively improve quality of care and outcomes.

Mark Masselli: Okay I think you are right, which is we have all seen significant strides being made in the use of health information technology but I think it's Universal, to believe that the potential of these technologies is still not fully tapped that there is so much more that could be done particularly to make them interpretable so that there is data sharing. We've tried to balance that in our meaningful use regulations, all the same time understanding the struggles of providers and vendors and keeping up with the change and making sure this works in meaningful ways. One of the things the Federal Government can do is some of the work we are doing that isn't specifically about HIT to the degree that we've reward care that really focusses on positive outcomes and efficiency where implicitly creating a business case for practices to find out a way to make this HIT work in a meaningful way. Not specifically through meaningful use but also just trying to drive towards to the types of cares where interoperable HIIT is indispensable.

Margaret Flinter: We've been speaking today with Sean Cavanaugh, Deputy Administrator and Director of The Center Medicare at The Center for Medicare

and Medicaid Services. You can learn more about their work by going to cms.innovate.gov. Sean thanks you so much for joining us on Conversations on Healthcare today.

Sean Cavanaugh: Well thank you for having me. It's been a great discussion.

Mark Masselli: At Conversations on Health Care, we want our audience to be truly in the know when it comes to the facts about Healthcare Reform and policy. Lori Robertson is an award-winning journalist and managing editor of FactCheck.org, a nonpartisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in U.S. politics. Lori, what have you got for us this week?

Lori Robertson: In the late June the Supreme Court ruled in favor of The Obama Administration in a case challenging the subsidies that are available through federally run insurance market places. The reaction from both sides was swift and in some cases misleading. President Obama said that the ACA made healthcare "A right for all" but the law doesn't achieve universal coverage and it was never expected to. The White House estimates that 16 million uninsured have gained coverage under the law but that's still leaves more than 30 million uninsured and the Congressional Budget office estimates that in 2025, there still will be 27 million uninsured. The law reduces the uninsured but it doesn't cover everybody. On The Republican side a day before the ruling senator Ted Cruise claims that premiums had gone "through the roof" citing at 3000 dollar increase in family employer plans since the law was enacted. The figure is correct but that's actually evidence of relatively low premium growth. Employer premium growth has been slower since the law was enacted compared with the growth before. Premiums have grown more slowly under Obama then they did under President George W. Bush. However, experts say the primary reason isn't The Affordable Care Act instead it's the sluggish economy and that's my fact check for this week I am Lori Robertson, Managing Editor of factcheck.org.

Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact, that you would like checked, e-mail us at Chcradio.com, we will have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

Mark Masselli: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. Of the 6.6 million births per year in this country over a half are unattended and among teens those rates are even higher. Colorado has been conduction an experiment for several years to examine what might happen if sexually active teens and poor women were offered the option of long term birth control such as IUDs or implants. The first question to answer would they take the offer?

Larry Walk: What was so striking was the word of mouth amongst these young women to each other and the network of support that was built amongst these young women to access this program through these clinics to help the thousands of women over the course of 4 to 5 years really did than result in the significant decrease in unintended pregnancies and abortions.

Mark Masselli: Dr. Larry Walk is Medical Director of The Colorado Department of Health and Environment. He says the results were nothing short of astounding.

Larry Walk: The result in decrease is 40% plus or minus in both categories, pregnancy and abortion over these 45 years and those reductions may be even more dramatic when you extend this out over an additional year to more than 50 even approaching 60% reduction.

Mark Masselli: And the results showed not only a dramatic decrease in unintended pregnancies there was a significant economic benefit to the state as well.

Larry Walk: We've seen a significant decrease in the number of young moms and kids applying for and needing public assistance whether that's public insurance whether that's through the WIT program.

Mark Masselli: And in spite of what conventional wisdom might lead one to assume the incidents of sexually transmitted disease has dropped in this population as well.

Larry Walk: Amongst young women 15 to 24, we have seen a decrease in sexually transmitted infections.

Mark Masselli: Many other State Health Departments are already consulting with Colorado on the successful outcome of their experiment. A fee long term contraception program offered to at risk teens and women trying to avoid the economic hardship of unplanned pregnancies leading to a number of positive health and economic outcomes for all involved, now that's a bright idea.

Margaret Flinter: This is Conversations on Health Care. I am Margaret Flinter.

Mark Masselli: And I am Mark Masselli. Peace and health.

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