(Music)

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

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Margaret, today we are going to focus in on practice redesign and payment reform but also at the heart of these transformations it's a focus in on prevention. The health reform legislation requires that all new health plans cover recommended preventative services like mammograms and vaccines with no deductibles or co-payments eliminating financial barriers for people to get these services.

Margaret Flinter: And Mark, the White House is making sure that the country knows about it. Prevention is near and dear to the hearts of this administration and finds its way into almost all aspects of health reform. Secretary Sebelius, Surgeon General Regina Benjamin and Nancy-Ann DeParle from the White House hosted two back-to-back national call and conference calls to talk about the preventive service change for the health plans and also how it specifically affects women and girls just a continuing thrust to involve people in the changes and in the positive ways that can impact America's health.

Mark Masselli: And today we are going to hear from somebody from CMS who is going to tell us a little bit about not only the private health plans but the new directions that CMS is headed. We have with us Dr. Bill Kassler who is the Chief Medical Officer for the New England Region of the Centers for Medicare and Medicaid Services. Dr. Kassler also serves on the board of the Foundation for Healthy Communities which is helping to improve health and health care in New Hampshire.

Margaret Flinter: New Hampshire being one of the states that's really doing some very innovative work. And no matter what the story you can hear all of our shows on our website www.chcradio.com. Subscribe to iTunes and get our show regularly downloaded or if you would like to hang on to our every word and read a transcript of the show, come visit us at www.chcradio.com.

Mark Masselli: And as always, if you have feedback, Email us at www.chcradio.com we would love to hear from you. Before we speak with Dr. Kassler let's check in with our producer Loren Bonner with Headline News.

(Music)

Loren Bonner: I am Loren Bonner with this week's Headline News. The Obama Administration rolled out another benefit under health care reform that give patients the right to appeal health plan decisions like insurance claims denials.

Last week, the administration issued rules for new health plans in every state that guarantee a consumer the right to appeal a denial to the insurance company and then to an external board if necessary at the same time many consumers don't know that they can appeal on insurer's decision, determinations like claims denials and rescissions made by their health plans. In addition to the new regulations, the administration is providing $30 million and grants to states to strengthen consumer assistance offices. President Obama also wants to regulate any erroneous government spending from Medicare and Medicaid. Last week, he signed the Improper Payments Elimination and Recovery Act that requires agencies to spend at least one million dollars on audits to identify potential overpayments, produce plans to cut such overpayment errors and set penalties for agencies that fail to comply.

Obama: We have begun an unprecedented effort to put an end to a problem known as improper payments which is the purpose of the bill that I am signing into law today. Now, these are payments sent by the government to the wrong person or for the wrong reasons or in the wrong amount.

Loren Bonner: The Office of Management and Budget says the majority of improper payments come from Medicare and Medicaid.

Nancy Pelosi: We will have what we need to hold the insurance companies accountable. I contend that whatever we have coming out of this bill will hold them accountable and they will be crying out for a public option one of these days.

Loren Bonner: That was speaker of the house Nancy Pelosi talking about the public option during the health care debate last year. The subject is back on the table. More than 120 democrats in the house are pushing a new bill to reintroduce the debate arguing that it would help reduce federal spending. Democrats say that the CVO estimates that the public option could save the government $68 billion between 2014 and 2020. It was a contentious issue in the health care debate leading up to the reform legislation and the potential bill has a slim chance of passing in this Congress. In any case democrats wanted to remain a viable option down the road.

This week on Conversations on Health Care, we are exploring the patient-centered medical home concept. The current and planned medical home pilot projects around the country are designed to make primary care practices more effective, more efficient and more satisfying for both patients and providers alike and perhaps even more cost effective. Right now the National Committee for Quality Assurance or NCQA is the primary vehicle for practices and providers to be recognized as medical homes. The NCQA in collaboration with a number of professional groups such as the American College of Physicians have defined the criteria with practices able to achieve certain levels based on the degree to which they meet the criteria. These include making sure that a patient has a

personal relationship with a specific provider, the use of guidelines and reminders for chronic and preventative care, extended hours and ways to communicate electronically between patient and provider. Practices that qualify must have an effective way to manage health information both in practice and when the patient receives care outside of the practice. Ideally, this would be an electronic health record but in cases where a full EMR is not available, practices might use a registry for chronic disease and an electronic prescribing system. Contrary to popular belief, practices in poor neighborhoods with a high percentage of racial and ethnic minorities are more likely than others to have a medical home structure in place. A recent Commonwealth Fund study that surveyed around 300 primary care practices in Massachusetts that serve poor neighborhoods found that these practices were more likely than others in the state to qualify as medical homes. They were significantly more likely than others to have onsite language interpreters, clinicians who spoke multiple languages, frequently used multi-functional electronic health records, staff who assisted patients in self-managing chronic illnesses and physicians who were aware of the patients' rating of their health care experiences. Transforming primary care practices require substantially large investments in time, money and technological support. In some ways, this study gives hope to what is possible as we strive to make the patient-centered medical home a standard for delivering care. Let's turn now to our interview with Dr. Bill Kassler who can tell us more about one of these medical home pilot projects, the multi-payer demonstration project as well as some other innovation highlights from CMS around health care delivery.

Mark Masselli: This is Conversations on Health care. Today, we are speaking with Dr. William Kassler, Chief Medical Officer for the New England region of the Centers for Medicare and Medicaid Services. Welcome Dr. Kassler.

Dr. William Kassler: Thank you.

Mark Masselli: The appointment of Dr. Don Berwick to head CMS is a very significant move forward both because CMS has been without a head since 2006 and because Dr. Berwick's stature as a physician leader in driving change in health care. There has been a widespread support in the health care community for his appointment but also a recognition that CMS is an enormous agency and creating and driving change, the hallmarks of his career since he founded the Institute for Health Care Improvement will be easy at CMS. What do you think the immediately challenges will be for Dr. Berwick in assuming to fill this long unfilled position?

Dr. William Kassler: Well, Dr. Berwick is going to have to hit the ground running. We have a number of responsibilities at CMS given the implementation of the hi-tech aspects of the stimulus plan. We have a tremendous amount of work to do to make sure that the doctors and hospitals get the incentives that they need for a meaningful use of health information technology. And then of course right on the heels of the stimulus was the Affordable Care Act called Health Care Reform

and that's such a massive act and there are so many responsibilities that we have to implement so many provisions of that act and we will certainly look forward to his leadership in terms of making sure that CMS implements that well.

Margaret Flinter: Dr. Kassler, you have spent most of your career in public health, seven years as State Medical Director for New Hampshire, 17 years as an officer in the Public Health Service at CDC. And it seems from what we have read about your work that a lot of your efforts have focused on collaboration within communities, integrating population based public health strategies and preventative services into clinical care and making a priority of doing that with the public health insurances Medicare and Medicaid. And it seems to me in Medicare over the last few years we have seen a move in the direction of preventative services for sure but we need to do more. What are the prevention priorities for CMS now from your viewpoint and what innovations and prevention might we see in the coming years?

Dr. William Kassler: We are in a very fortunate position with respect to Medicare being able to take on more preventative services. And with the recent legislation, we are now authorized to give not only preventative services that 10:31_____ those really work but we are also authorized to do that in a way that doesn't have beneficiary have a co-pay associated with it. So we are really looking forward I think to the golden age of prevention in Medicare.

Mark Masselli: It's been only a few weeks since Congress voted a reprieve on the scheduled cuts in Medicare fees to physicians. We understand the history about this legislation and I think everyone expected the late reprieve but it creates an uproar every time that scheduled cut comes around mostly around fears that physicians will ould drop out of the Medicare program. What's CMS doing to ensure that physicians continue to enroll as Medicare providers?

Dr. William Kassler: Well, first and foremost, the cuts that you are referring to, the so-called sustainable growth rate, is an active Congress and CMS has absolutely no authority to change that. So the so-called Doc Fix must happen at the legislative level, Congress and the senate needs to act and CMS can't. What we can do is we can make sure that every time that this expired and that the doctors were threatened with a cut, we can try that 10 claims, full claims, wait until congress acts and then of course retroactively make docs hold if Congress does that. In terms of what we can do overall to make Medicare more provider-friendly, we have to do a better job in terms of making sure that we have good customer service, that we are not an awful bureaucracy to deal with.

Margaret Flinter: Dr. Kassler, let me talk about the next generation of health care professionals for a minute. Today, as our listeners probably know, physicians complete their residency training in a specialty area whether that's family medicine or neurosurgery in a hospital based residency program funded by something called GME or Graduate Medical Education legislation that sets

forward a payment mechanism by Medicare to pay hospitals for the cost of their training. Now there have been so many calls for changes in the way GME is set to prioritize primary care, increase diversity to recognize the importance of training outside of the hospital where most care takes place. What do you see that's innovative coming up either in terms of changes to GME or just training the next generation of health professionals in general in the United States?

Dr. William Kassler: Once again, GME is a creature of Congress so I don't think CMS is going to on its own change the way in which we pass through federal funds to support medical education. I think medical education is a very conservative beast. It takes a long time for these sorts of trends to percolate down into the medical school and residency program. But I do think that some of the areas in which we are working on in CMS might help. In particular we are standing up a whole center for innovation in which we are going to be looking at innovative ways, at demonstration projects, at creative ways in which we can pay docs, in which we can align incentives for physicians to deliver higher quality, more effective and more efficient care. And finally, I think one of the most exciting innovations on the horizon is what's called the Medical Home Concept. And I am happy to talk about that more if you want but I think that's where the innovation is and that's where the national efforts are to reinforce and help save primary care.

Mark Masselli: Today, we are speaking with Dr. William Kassler, Chief Medical Officer of the New England region of CMS. I think we share the same belief about the importance of community to build healthy infrastructures and support systems for health. You practice in a community health center yourself in New Hampshire and you also currently serve on the board of the Foundation for Healthy Communities which is helping to improve health care in New Hampshire. At our health center we believe that every state in America represents a laboratory for innovation. What are some of the advances in innovations that New Hampshire has made?

Dr. William Kassler: Well I think you are correct. I think that the federal government being so large can only do so much but I think the states really are _____15:12 for innovation. Particularly in New England, some of the small states I think have the ability to be very, very creative in ways that larger states that may be more stuck in political rivalries can't do. In the state in which I live in, New Hampshire, there have been number of innovations. First of all the state works together with every single health plan and payer including Medicaid in New Hampshire to come up with a medical home project in which primary care docs are paid more for counseling and for coordinating care and for more effectively serving the needs of patients. As well, the State of New Hampshire through what's called the Citizens Health Initiative is developing another model called an Accountable Care Organization in which groups of doctors and other providers stand together and are accountable for the outcomes that we care about such as better quality, more efficient care, lower cost and better patient outcomes.

Margaret Flinter: And Dr. Kassler I am going to take you up on the offer to talk a little bit more about the patient-centered medical home or health care home as some call it. It strikes me that I can hardly remember a development in health care delivery that's gotten more across the board support as a concept than this concept. And so the advanced primary care practice or the patient-centered medical home concept, and I think those are being used somewhat interchangeably, now has a major champion in Medicare through the new demonstration project, the Multi-payer Advanced Primary Care Practice Demonstration if I have said that long title correctly. Can you tell us what really drove this for CMS? This is really CMS getting involved in a level of care delivery on the ground that's a little bit unusual in our experience. So tell us more about CMS's goal for this project.

Dr. William Kassler: Well first of all this is a project that is really developed and advocated by the providers, by the family docs, by the pediatricians, by the primary care internals. So what the medical home model says is that patients do best when they have a medical home, when they have a primary care doctor who serves basically as a conductor of this very, very complicated orchestra and that primary care doctor can refer to a specialty care, can do the counseling, can do the care coordination and deliver high quality cost effective care. But the payment system has to change. So rather than simply being reimbursed for procedure and the more procedures one indulge, the more money one gets, this demonstration project, this concept will reimburse doctors extra for coordinating care, for having the technologies in place to do preventive services, having better hours, being more patient centered, having health records that reduce medical errors. So docs will be paid for performance, they will be paid for counseling and for care coordination things that typically now they are not.

Mark Masselli: That's quite interesting. It seems like there is this intersection of practice redesign and payment reform that's going on and New England seems to be leading the way certainly. You have the group that you are working with in New Hampshire, the Foundation for Healthy Communities and you have got Vermont Blueprint for Health and also you have got in Hanover Dartmouth and they are very engaged in their many initiatives, the clinical microsystems. Tell me though outside of being in New England what needs to be in place for states who want to implement medical home models or payment redesigns. Is there sort of a ____ 19 11 going on here that they have to have before they take this leap?

Dr. William Kassler: Well first of all I want to point out in your neck of the woods, the Middlesex Health Care System is one of those innovators as well. They have been involved for quite a while in our primary care demo and have really demonstrated high quality cost effective care through innovation and through some of these techniques that we are talking about. So don't discount what's in your own backyard

Mark Masselli: It's still New England though, I am trying to--

Dr. William Kassler: There you go. So that being said, I do think that the successes in Maine, New Hampshire, Vermont, Massachusetts around some of these projects have to do with putting aside the differences and bringing all the stakeholders to the table, bringing the competing health plan, Medicare, Medicaid, the different doctors and hospitals and the different systems that they represent to get together to figure this out. And so states that are successful really try to transcend this very vulcanized and fractured system and develop a vision across all the players.

Margaret Flinter: Dr. Kassler, we all recognize that how we pay providers needs to change and that's part of that concept of the patient centered medical home. But I think HHS Secretary Kathleen Sebelius said it thoroughly when she said that advanced primary care practices are the most promising model for bringing down health care costs across the country and certainly CMS will be monitoring this very closely in terms of cost. What is the potential for saving cost with the patient centered medical home or the advanced primary care practice model and what are you looking for in terms of cost savings, what are the areas where you think that really can be accomplished?

Dr. William Kassler: One of the ways is using technology to reduce medical errors. Apart of being a medical home and getting paid that extra amount is that an office and a practice has to develop transformed set of standards, they have to adhere to a higher level of practice and a higher level of standards than previously in order to qualify for these extra payments. So that generally means having patient registry so that they can keep track of who is getting the preventive services and who is not and can reach out to those who aren't getting the preventive services, they have health information technology that can effectively share information and reduce the redundancy across all the different specialty systems, they have electronic health records that can reduce medication error and clearly document all of the various different tests involving patients from provider to provider.

Mark Masselli: Dr. Kassler, when you look around the country and the world what do you see in terms of innovation and who should our listeners of Conversations be keeping an eye out for?

Dr. William Kassler: We have to have innovation around how health care gets delivered at the system level, how it gets financed and paid for, what are the disparities. And frankly the next step really needs to be at the policy and political level in order to be able to diffuse all that wonderful biomedical research out into the public. I mean right now we have areas of the country and certain populations that aren't benefiting from all of the wonderful health care that we have and we need to develop those systems in order to make sure everybody benefits.

Margaret Flinter: Today, we have been speaking with Dr. William Kassler, Chief Medical Officer for the New England region of CMS. Dr. Kassler, thank you so much joining us today.

Mark Masselli: Each week Conversations highlights a bright idea about how to make wellness a part of our communities into everyday lives.

Speaker: This week's bright idea focuses on a new program called Open Notes which is seeking to increase access to doctors' notes on patients medical records. According to the 1996 federal Health Insurance Portability and Accountability Act, patients are legally permitted to view doctors' notes but they rarely do. The creators of the Open Notes program want to change that. The program is still in its pilot stage with about a 100 primary care doctors currently signed up for a 12 month trial period in Massachusetts, Maryland, and Washington State. Participating patients will be able to access their medical records and doctors' notes on a secure online portal. Researchers will interview these patients and their doctors both before and after the trial to track the program's success. The Open Notes Initiative is part of a larger movement to increase access to medical information by creating digital reserves of medical records online. Proponents hope that the increased availability of this information will strengthen doctor-patient communication, reduce medical errors and improve overall quality of care. Although patients are excited about the project's potential, not all doctors feel the same way. They worry that access to their notes will lead to an increase in patient questioning, they will overwhelm their already busy schedules. However, experts are hopeful that these possible challenges will motivate doctors to find solutions that will further improve doctor patient communication. For example, rather than using confusing shorthand terminology such as anorexia to mean reduced appetite, doctors will be encouraged to clarify their notes or include a guide to abbreviations and terms. Improvement such as these will actually save doctors' and patients' time since patients medical records and doctors notes on them will eventually be available online, patients will simply look up information such as their latest cholesterol level or blood pressure reading instead of calling their doctor's office to ask. By streamlining the process through which patients access their medical records and doctors' notes, Open Notes is helping to improve doctor-patient relationships and cut down on time consuming communication problems. 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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