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Marianne O'Hare: Welcome to Conversations on Health Care with Mark Masselli and Margaret Flinter, a show where we speak to the top thought leaders in health innovation, health policy, care delivery, and the great minds who are shaping the healthcare of the future.

This week Mark and Margaret speak with Seema Verma, Administrator for the Centers for Medicare and Medicaid Services for the Trump administration. She shares her observations about how swiftly they transitioned their agency's regulations covering health care for more than 130 million vulnerable Americans and seniors. Talking about the hundreds of waivers that were put in place to allow hospitals to continue operations in the pandemic and for telehealth to become more widely adopted to keep people connected to their position and what that will look like going forward.

Lori Robertson also checks in, the Managing Editor of FactCheck.org looks at misstatements spoken about health policy in the public domain, separating the fake from the facts. We end with a bright idea that's improving health and well being in everyday lives.

If you have comments, please e-mail us at chcradio@chc1.com or find us on Facebook, Twitter, or wherever you listen to podcast. You can also hear us by asking Alexa to play the program. Now stay tuned for our interview with CMS Administrator Seema Verma here on Conversations on Health Care.

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Mark Masselli: We are speaking today with Seema Verma, administrator for the Centers for Medicare and Medicaid Services for the Trump administration. She oversees a $1 trillion budget administering health programs for more than 130 million Americans and is a key member of the White House COVID-19 Task Force.

Margaret Flinter: Prior to joining the Trump Administration, Administrator Verma advised a number of states on alternative approaches to the Medicaid expansion created by the Affordable Care Act. She was the architect of the healthy Indiana plan later reworked as HIP 2.0 under then Indiana Governor Mike Pence. She was also the founder and the CEO of SVC, Inc, a health policy consulting firm. Administrator Verma, we welcome you to Conversations on Health Care today.

Seema Verma: Good morning, thank you for having me.

Mark Masselli: Well, administrator, as everyone knows, we're in the midst of this global pandemic, which science is responding as rapidly as it can and yet the virus has exacted a really crushing toll. Almost 200,000 Americans have died and it's been especially rough on the elderly, the

vulnerable populations served by Medicare and Medicaid, the poor underserved and communities of color. HHS and CMS acted swiftly in March to relax some of the restrictions that were governing these 130 million Americans through both programs. I wonder if you could tell our listeners about some of the most significant waivers and changes that were put in place to ensure the health needs of our most vulnerable populations.

Seema Verma: Well, thank you for that question and just to kind of give you a sense of our overall theme, when the pandemic hit, we wanted to do everything we could to support those providers on the front lines. Understanding that many of them were operating in crisis situations, they may be overloaded with a number of people coming in to their emergency rooms and their ICUs and so that was kind of the mentality that we started with. Fortunately, for CMS, we had been on a three-year journey to be working more hand in hand and to increase the dialogue between providers with our Patients over Paperwork initiative. Hats off to the CMS team that worked day and night, I can tell you our team met literally every day for the first two months and trying to get rid of a lot of regulations and they centered around a few areas.

The first one is one that we call hospital without walls, which was sort of understanding that hospitals may be able or may need to be able to provide services outside of their physical capacity or their physical four walls. Allowing them not only to maybe use their different wards like a maternity ward, maybe that got turned over to be able to provide services or maybe they wanted to set up a testing site in the parking lot or maybe they wanted to see patients in another facility. Really giving them a lot of flexibility to provide services out of their walls, that was called hospital without walls. The second area that we were very focused on was regulatory burden. We know that, on a good day most of our providers find a lot of the CMS regulations restrictive. Obviously, they're for a reason, program integrity, quality and safety, but I think we had to think of this in terms of this is crisis level care. And so gave them a lot of flexibility, whether it was simple things like waivers of the Stark Law so that they could provide meals to their medical professionals.

The other thing that we focused on was giving them flexibility around paraprofessionals and augmenting the workforce. There's some restrictions within our policies that say certain kinds of providers can only perform certain types of tasks. We knew in this situation, it had to be all hands on deck, so we relaxed a lot of the requirements for example for nurse in SSS, and that was really important so we can make sure that we were keeping those ICUs open and that they had the appropriate staffing. Telehealth, which I hope we can spend some more time on, that was a big one for us really getting rid of a lot of

regulatory barriers. The other thing we did was provide resources. Not only were the provider relief funds there $175 billion, but even before that early before Congress was able to authorize those funds, we did the accelerated payments program and put out basically giving loans to providers, hospitals and doctor's offices, over $106 billion.

A lot of as you can see a lot of changes, we've put out probably around what we call three interim final rules. Not only we made these changes, we actually can't just make that we have to go through formal rulemaking and so that was an effort. Then the other big piece of it was just a lot of waivers over hundreds of waivers that we put out for the healthcare community. We did that across the nation. We didn't want providers to have to file and ask for permission for every single waiver. Once somebody asked for it and we felt like it was reasonable, we just did blanket waivers. It applied to everybody across the country. I think that's been really helpful as we've seen the virus move to different communities. That way the health system is ready to go, they have the flexibilities that they need.

Margaret Flinter: Well, Administrator Verma, I can tell you that we imagined you were working 24x7 with your team, when we saw the speed at which some of these changes were happening. We do want to talk about telehealth, which we thought was one of the very impactful ones. I think generally been lauded by everybody across the country, in the healthcare industry and good response by consumers as well. I want you to share with our listeners a little more about this rapid expansion of telehealth. What do you think about these changes remaining in place based on the fact that patients are telling us that this really works for them and certainly healthcare leaders are asking for it to remain in place and I also want to quickly just comment on the issue of ensuring pay parity for providers who deliver care via telehealth to their patients as we go forward.

Seema Verma: When it comes to telehealth, again, this was something that fortunately the agency had already been working on before the pandemic had. We had made some adjustments to allow for brief check-ins and recognize that telehealth was in an area. One of our strategic initiatives as fostering innovation and one of the things that we've tried to do is to make sure whether it's in the Medicare program that we're doing everything we can to foster innovation across our country. Telehealth was a great example of this. When the pandemic hit, we tried to do everything we could to expand telehealth. It wasn't just identifying services, we actually increased the number of services, there's now 135 services that can be provided. We also got rid of barriers to make sure that different types of providers could use telehealth and could provide services.

There are also barriers in the program that restrict the number of

visits, so for example, in nursing homes, you could only do one telehealth visit a month. We recognized that obviously it wasn't going to work. We've also made sure that it can be provided in different settings, so again just trying to get rid of all of that red tape around telehealth. As I travel across the country and talk to providers and patients I'm hearing across the board, how valuable people feel telehealth has been. From providers, they're saying, look, this isn't going to replace inpatient care, but it's certainly something that can augment it. Many of them have said, we found some things in telehealth that we didn't quite see or that we wouldn't necessarily been able to accomplish in a face-to-face visit.

One of the examples that I always hear about are medications. People can go retrieve their medicines, they have it all in front of them, and they can actually show the doctor, this is what I'm taking. I heard from a provider in Ohio, who said, she was treating a disabled child and it's very difficult for that family to come in but she was able to see the child in their environment. She was also able to meet some of the other caregivers that participate in the patient's care that don't necessarily come in for a visit. I think we're all recognizing that there's a lot of benefit, certainly convenience. In the case of the pandemic, it's actually protected our patients and protected our healthcare workforce. Going forward I think there's a lot of benefit.

The President is very committed. He's put out an executive order. It's his intent to try to make this a permanent benefit. We will obviously need some help from Congress to make sure we can provide it outside of rural areas. A few areas where I think it's particularly helpful and that's in mental health. As we're seeing more in-person visits return, we're seeing that in the data. You're obviously seeing telehealth go back down but one area where we continue to see many visits is in mental health and a lot of people just feel more comfortable doing that via telehealth. It reduces the stigma and so given some of the pressing mental health issues that we have in this country, we think that it's very important for that service.

The other area, I think, is important, and this is for rural areas but even there's other parts of the countries that just may suffer from not having a workforce there or having access to certain specialists or sub specialists. Telehealth can kind of bridge that gap and make sure across the country that people have access to the type of specialty care that they might need.

In terms of reimbursement, that's a great question and I can tell you that the agency is grappling with that as well. We have to make sure that the reimbursement is adequate and that there's still an incentive to provide the services. If the reimbursement is too low then the providers aren’t going to do it, they're not going to offer this. At the

same time we also need to recognize that there are some things that can only be accomplished in an in-person visit.

There is still a lot of work that goes on behind the scenes with the telehealth visit, getting patient to set up, there's still billing, so we're still trying to study what the difference is. That's something that we're going to continue looking at and I want to make sure that it is adequate enough to ensure that our providers keep offering it.

Mark Masselli: Administrator Verma, you've been a strong proponent of alternative approaches to the administration of Medicaid in your efforts to promote flexibility for individual states, including waivers for such things as work requirements, health savings accounts for Medicaid recipients. We've seen states take many varied approaches to the program, but under the Family First Coronavirus Response Act, states saw their Federal medical assistance percentage go up by 6.2%. That really was an important boost to so many governors and State Medicaid directors who are struggling to meet the needs of the vulnerable population. I think on their mind right now is how long will that last, is this going to be the new floor for Medicaid, and it seems like it's a quick way to get financial support to states. Can you talk a little bit about what your internal thinking is now and how long this additional 6.2% will stay in place?

Seema Verma: Well, that's a great question, and when it comes to the Medicaid program, I've been a strong proponent of state innovation. I've worked with a lot of states before coming to CMS. At the end of the day, from having worked with states and having worked in the Federal Government now almost four years, one of the longest serving administrators, I can tell you that innovation doesn't happen in Washington. It happens on the front lines and providers that are treating patients are really in the best position to think about what's going to work best and the same thing for states. They know their communities better. Every state is different in terms of their delivery system. I think from our standpoint, we need to provide more flexibility for states so that they can design programs that are going to work best for the populations that they serve.

We're trying to move away from a Mother-May-I approach where states are having to come to the Federal Government to ask permission for just routine changes. That being said I think states need to be held accountable around integrity and around accountability for the outcomes they achieve with their programs. This is a very vulnerable population. These individuals have no place to turn and we have to make sure that we fulfill society's commitment to them to make sure that they have high quality care. One of the things that we've done in Medicaid is start a new scorecard so we can actually evaluate state's performance and how is the quality of care,

what kinds of outcomes are they achieving for their Medicaid recipients.

In terms of the FMAP and the increase that is ultimately up to Congress. That being said, I think anytime we're giving money to states, there should always be some accountability and some transparency about how those dollars are used and what they're doing to actually improve the quality of care and the outcomes for these individuals.

Margaret Flinter: Well, Administrator Verma, I'd like to focus a little bit on our nation's nursing homes and assisted living facilities, obviously, an area where there was a devastating toll of the COVID pandemic. You have issued new guidelines for Medicare and Medicaid certified nursing homes to better protect the health of patients and their caregivers. Talk a little bit about some of the new safeguards outlined in the CMS targeted COVID-19 training for frontline nursing home staff program. I think you have some other similar programs aimed at making sure that there's excellent training for healthcare professionals in these settings, so what's changed and what can we look forward to see?

Seema Verma: Sure, so obviously our focus has been on protecting the most vulnerable. In nursing homes, we took very early action, even as early as January and February, putting out guidance to nursing homes and to all healthcare facilities and restricting visitation. That being said, you're right, it's had a devastating impact on our most vulnerable population. From my standpoint, there's been a lot of attention given to hospitals and workers on the front lines in hospitals. But I think it's important to remember that we had a whole nursing home workforce that was under incredible stress. They were not only performing their day to day responsibilities, but they also had to serve as kind of a support system to the residents of nursing homes. It's been particularly challenging for them.

What I would say about our approach just overall is it's been let's push on every lever we can across not only CMS, but working with some of our partners and it's really been unprecedented action. We're shipping in supplies to nursing homes, we're putting point of care tests in there. CMS has issued many different types of regulations, probably more than we've done in the last three years, in terms of the amount of regulations and guidance that we've given nursing homes. I think we also recognize that some of those frontline workers, they may not have time to read pages and pages of CMS regulations and so what we put together was a training. This was intended to help those frontline workers understand those best practices. This was based on all of the investigations and surveys that we did.

One of the things that we did is require all of the states to conduct

surveys of nursing homes in terms of infection control. We've done that over the past few months, almost 99% of nursing homes have been inspected. We've also gone in when we've seen outbreaks and we've worked with the CDC to do these investigations. The training was built on some of the things and some of the lapses that we were seeing around infection control. It's intended to be a resource for nursing homes, assisted living, and really any facility that has congregate care living. It's just routine things like addressing the mental health issues of the residents, hand washing, hygiene, cohorting, so a lot of different topics that we know that the nursing homes were facing.

Mark Masselli: Well, that's such an important program. Congratulations. We're speaking today with Seema Verma, Administrator for the Center for Medicare and Medicaid Services for the Trump administration. She oversees a $1 trillion budget administering health coverage programs for more than 130 million Americans. Administrator, you were talking earlier about you're focusing on rural communities, 57 million Americans, one in five live in sparsely populated regions, and obviously the pandemic has highlighted a lack of direct access of care for so many. In particular, we note the limited broadband access, which hampers the ability of clinicians to deliver telehealth to these populations. I wonder if you could talk a little bit about what the combined strategy of HHS and CMS is to help improve that care to strengthen rural hospitals, rural community health centers and the liken. Tell us a little more about your strategy there?

Seema Verma: Sure, so I think one thing that we've all come to appreciate about the pandemic is that it's exposed all of the issues in our health care system, whether it's just the disparities that we have in terms of our minority communities, but also some of the challenges that rural providers face on a day-to-day basis. Even before the pandemic, we know that we've seen a number of hospital closures across the country and that our rural communities have really been struggling to provide accessible care to their residents. From our standpoint, I think it's trying to really come up with a comprehensive solution. In the past, I think a lot of the approaches are, let's just put more money into it and at the end of the day, that doesn't really solve the underlying problems.

What we've done are a couple things, one we have addressed where there have been very clear financial issues and that's our Medicare reimbursement. The way that it's worked is it kind of pitted urban areas against rural areas. We've seen that there's been growing disparities between Medicare's reimbursement of services in urban areas versus rural areas. We made some sweeping changes to Medicare reimbursement to ensure that rural communities were being appropriately reimbursed. The other area that that we focused

on and we just put out this model and it's called our CHART model. The idea is to actually give some seed money to rural communities, so that they can think about how they can transform their system and it requires them to work together. So it's working not only with Medicaid insurance companies, the hospitals, the clinics, everybody kind of coming together and thinking about what's going to work best here.

In the past, rural communities, I mean, they're just struggling to keep their doors open, they don't necessarily have the time or resources to do this type of planning so that's what these resources are intended to do. The other area that the CHART model allows is that it says that maybe we should be paying our rural providers in a different way. We've all been trying to move away from a fee-for-service system but I think that's more important in rural areas where it's a challenge for them to provide care that's based on volume. They're not going to have the volume. What we've also seen, a lot of times, even when they're providing services, people in their communities will bypass the availability of those services and go to another area or another community to obtain those services. We want to make sure that we are providing some new opportunities to reimbursing rural providers, maybe it's better to pay them on a capitated basis, a bundled payment, predictable income for those rural providers, so that they can actually focus on improving outcomes and keeping people healthy.

There are some opportunities there to change the way we reimburse for services. Then the last area is just giving them more flexibilities. Some of the regulations that we have just don't make sense in a rural community and they need more flexibility, whether it's around telehealth or some bed limits for critical access hospitals or having more flexibility when it comes to what paraprofessionals can do in their community. We're very hopeful that the CHART model will actually lead to some exciting new models that can be replicated across the country.

Margaret Flinter: Well, that's great. I want to give you a chance to talk about something that we saw some good news on in recent days. You've been very focused at CMS on the promotion of value based care models over really several years now, but I understand in one program, the Pathways to Success Program, which is an approach in the Medicare Shared Savings Plan, you've got only 5% of the ACOs in the plan, but realized $2 billion in savings in 2019. I think this is particularly important because there's always the concern that we held back on services in order to save the money, but in this program designed specifically to get greater value without curtailing access to any services. We want to give you a chance to maybe talk about that, and can we expect to see an expansion of that program or that model of

care?

Seema Verma: Sure, I think that it's been an important development in the whole concept of value based care. When I came to the agency, the ACO program in some cases was losing money. There were some providers that were doing well, but there were a lot that were taking all of the CMS waivers and they weren't necessarily producing any results. We took, I would say, kind of a bold initiative, a little bit of a risk to say, look, if you want to stay in this program and you want these flexibilities, then we expect you to take risk. The way Pathways was set up was that it puts providers that are participating in the ACO program on a track to take more and more risk. If they're not willing to do that, then they then they wouldn't be in the program anymore.

I think people were concerned that providers wouldn't want to take risk number one or that they wouldn't be successful and that we actually may deter providers from participating. But we've actually seen the exact opposite been really encouraged with the number of participation with the amount of savings and that we've actually seen, also the quality being maintained and also great results from our physician led practices. They have had tremendous results, we gave them a little bit more flexibility in terms of taking on risk, but I think this really speaks to the fact that in value based care there has to be upside and downside risk for providers. Some skin in the game to produce the types of results that we're all looking for.

Mark Masselli: Administrator, we know we're running out of time but quickly, Operation Warp Speed to accelerate the vaccine deployment is something that's on everyone's mind. There's a really bigger challenge of how we're how are we going to, one, do that safely and make sure the vaccine is developed, but more importantly, how are we going to distribute vaccines at the same time we're doing flu? How are you internally helping provide support to states, local health departments, community health centers, all of those key players out there in terms of making sure that we can really reach every American with both the flu shot and hopefully a vaccine that's safe?

Seema Verma: Well, first of all, I would say there are no shortcuts when it comes to safety and efficacy. There are many levels of review. It's not, even before it goes to the FDA, there's a patient safety board that takes a look at the data that comes from the manufacturers before they even submit it to the FDA. The FDA has a number of advisory committees, external advisory committees, so there's not going to be any compromises when it comes to safety and efficacy. At the same time that these vaccines are being developed, we have a large operation around the distribution of these, that's being handled by the Department of Defense. We are working on sort of building off of what we already do with the flu system in terms of distributing the

vaccine, but also understanding that we're going to need to go beyond that, really working with our retail pharmacies, our traditional clinics.

From the CMS standpoint, we just want to make sure all the reimbursement is in line and that providers in different types of settings can get the appropriate reimbursement. So like I said this is something that with Operation Warp Speed, people are working around the clock. We've already asked states to come up with their plans about how they're going to distribute the vaccine to make sure people in their states can get access to the vaccine.

Margaret Flinter: Great, and administrator Verma, CMS is one of those Federal entities considered an able steward of the public resources and really a beacon of fiscal responsibility with public funds. We have a recent congressional report alleging that you utilized several million dollars in personal expenditures during your tenure as the administrator. Can you comment on this so the public can have a better understanding?

Seema Verma: Number one, I will say that there was an independent Office of the Inspector General report that found that there weren't these types of issues. They review these contracts and they did not find this finding. The report that you're referencing came out from four democratic committees that alleged this. There’s absolutely no evidence of that. The Inspector General didn't find that. Everything that we have done at CMS is to promote the CMS programs. When I came on board, what I wanted to do is sort of change the way CMS was operating. We wanted to make sure that people understood the changes that we were making. We wanted to go beyond just the healthcare community. When we're making changes on interoperability or Medicare Advantage, those are things that require or that we'd want the general public to understand. So we're trying to go beyond the routine, but I would say healthcare industry, to make sure that there was a broader understanding. We've reached out to those journals that reach women, for example. We know that women make a lot of health care decisions, which is why we were trying to reach out to the women's media. The Inspector General didn't find any of this and I think this has just been unfortunately a political attack on public servants, which we would expect previous to an election.

Mark Masselli: We've been speaking today with Seema Verma, Administrator for the Center for Medicare and Medicaid Services for the Trump administration, overseeing health coverage for more than 130 million Americans. You can learn more about their important work by going to www.cms.gov or follow her on Twitter at @SeemaCMS. Administrator Verma, thank you for your commitment to advancing health policy for working to leverage the power of technology as a force multiplier in the care delivery system, and for joining us today

on Conversations on Health Care.

Seema Verma: Thank you.

Margaret Flinter: Thank you so much.

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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 a Labor Day press conference and a rally in North Carolina the following day, President Donald Trump made several unsupported or inaccurate statements about a COVID-19 vaccine. The President claimed “if this were the Obama administration, you wouldn't have that vaccine for three years and you probably wouldn't have it at all.” He has previously made similar claims. It's his opinion that he alone could pull off a vaccine in record time, but it's premature to declare victory and the idea that no other leader could do the same lacks support. The key idea behind Operation Warp Speed is to manufacture a vaccine before it's known to work so that it can more quickly be distributed if it ends up being approved, but that's not new. It was done in 2009 for the H1N1 influenza vaccine. Although the effort this time is much larger given the greater concern of the Coronavirus pandemic, there's no reason to think a different President would not have come up with a similar strategy as other countries and organizations are using the same approach now.

Trump also inaccurately said “we have 30,000 people in just one vaccine right now under test in very, very highly infected areas”, and he said “the numbers are looking unbelievably strong.” As of September 7, the day Trump made his remarks, no trial had met its enrollment target of 30,000 people and no one knows yet how the vaccines are performing. As of September 7th, Pfizer BioNTech was close to that mark. It had enrolled 25,189 volunteers in 39 States. Since the studies are double blind, neither the President nor anyone within the company is working on vaccines or the FDA knows how well the vaccines are performing in the phase three trials so far. The only people privy to that information are those on the data and safety monitoring boards.

Finally, while insisting that he has never said there will definitely be a vaccine in October or November, Trump repeated the idea that it was possible and previously said that such timing was likely. Health officials have said a vaccine is unlikely to be available that soon.

That's my fact check for this week. I'm 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'd like checked, e-mail us at www.chcradio.com, we'll have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

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Margaret Flinter: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. Baltimore, Maryland has one of the highest emergency medical call volumes in the country and it results in a significant number of patients being taken to the ER for conditions that could have been treated outside of the ER. The University of Maryland Medical Center and the Baltimore City Fire Department teamed up in the hopes of reducing unnecessary ambulance trips and hospitalizations. They created a new pilot program which pairs doctors and nurses at the hospital level with paramedics in the field, bringing medicine right into the patient's homes.

Dr. David Marcozzi: 911 low acuity calls, we augment the Baltimore City EMS system, so that we co-dispatch a paramedic and either nurse practitioner or doctor to the scene of low acuity calls and we then enroll them into our program. We then treat them at the scene, discharge them with prescriptions as needed, and then we follow up with them within 24 hours.

Margaret Flinter: Dr. David Marcozzi of the University of Maryland Medical Center says that, this community paramedicine program has a two prong goal. One, reducing unnecessary trips to the ER by delivering right care at the scene, two bringing a coordinated paramedicine team including doctors and nurses into the homes of patients being released from the hospital to ensure that their recovery is supported for better outcomes, thus greatly reducing the risk of re-hospitalization.

Dr. David Marcozzi: It's eye opening to once you understand the challenges when we discharge a patient. People stay just at home to navigate the insurance industry, the multiple providers they're supposed to follow up with, then they follow up back to their primary care. We're exploring, could we do this for longer for THS. Our data demonstrates that the patients who are followed in our program are admitted to the hospital significantly less that translate into lower costs to the system.

Margaret Flinter: But most importantly he says the patient outcomes are markedly

improved. The Mobile Integrated Healthcare Community Paramedicine Program reducing unnecessary emergency room trips, now that's a bright idea.

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Mark Masselli: You've been listening to Conversations on Health Care. I'm Mark Masselli.

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Peace and Health

Marianne O'Hare: Conversations on Health Care is recorded at WESU at Wesleyan University, streaming live at www.chcradio.com, iTunes, or wherever you listen to podcasts. If you have comments, please e-mail us at www.chcradio@chc1.com or find us on Facebook or Twitter. We love hearing from you. This show is brought to you by the Community Health Center.

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