(Music)

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

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Happy Groundhog's Day to everyone. Margaret, do you think the groundhog will see its shadow today?

Margaret Flinter: Not if he lives in my yard he won't because first, he would have to get out of that hole and climb through a six foot drift of snow. What an incredible winter it's been, and a little bit of a metaphor for the snowy path it's been for health care reform this month. I don't think things are going to let up anytime soon on either front.

Mark Masselli: I think you are right, stormy it is. And in Florida, US District Judge Roger Vinson struck down the Affordable Care Act asserting that the individual mandate was unconstitutional and therefore the entire act must be thrown out. We have a new word of the day, severability. Margaret, you remember last year, reconciliation was the word of the day but severability is the legal framework that says if one part of the law is found unconstitutional, the entire part is, and this came about because Congress didn't act in putting the severability clause into this piece of legislation so says Judge Vinson.

Margaret Flinter: And while we try not to be too professorial Mark, I think it's really important that people understand and pay attention to these details, that could have pretty far reaching impact. Now, this ruling made an even split. Two judges in the country had previously upheld the law then a Virginia judge remember ruled the individual mandate unconstitutional. But, he didn't go as far as Judge Vinson did in that ruling about the severability.

Mark Masselli: You are right. The Republicans and Democrats in Congress are nearing the split for and against health care reform as well as is the public. It will certainly give Senator McConnell and his colleagues who are pushing to repeal the act in the senate even more momentum.

Margaret Flinter: Well, in addition to the momentum to repeal and to move backwards, there is also the continuing momentum forward particularly around implementing some aspects of the law and specifically looking at innovation. And today, we are focusing on the forward momentum. We are very excited to have Dr. Richard Gilfillan, who is the Acting Director of the New Center for Medicare and Medicaid Innovation at CMS here with us today. You remember that the center was created under the Affordable Care Act with a very specific charge to give people out in the field the opportunity to test out and model up innovations

both in care delivery and in payment reform, strategies that could improve the value and the quality of care and reduce cost at the same time.

Mark Masselli: Speaking of forward momentum, Conversations on Health Care will now be heard in San Marcos, Texas, KTSW FM 89.9 joins a growing list of stations carrying Conversations on Health Care. They broadcast this show at 07:30 a.m. on Monday mornings, good morning Texas.

Margaret Flinter: Welcome to everyone in Texas, and no matter what the story, you can hear all of our shows on our website www.chcradio.com. Subscribe to iTunes and get the show regularly downloaded or if you like to hang on to our every word and read a transcript of one of our shows, come visit us at www.chcradio.com. And you can become a fan of Conversations on Health Care on Facebook and follow us on Twitter and we are also going to be live tweeting the conversations with Dr. Gilfillan. So find us at CHC Radio.

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. Gilfillan, 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. In a much anticipated ruling this week that involved a multi-state lawsuit against President Obama's health care overhaul, US District Judge Roger Vinson in Pensacola, Florida struck down the entire health care law. He narrowed the issue to whether Congress exercised too much power under the commerce clause in the US Constitution to require that all Americans purchase health insurance. He states that because the individual mandate is unconstitutional and not severable, the entire act must be declared void. Florida Attorney General Pam Bondi says the state is thrilled with the ruling.

Pam Bondi: What it does is that this is about liberty, it's not just about health care and that the federal government cannot force us to purchase a product or a good in violation of our sovereign rights as a state.

Loren Bonner: This decision has now produced an even split in federal court rulings so far on the health care law. Two judges had previously upheld the law, both Democratic appointees and Republican appointee US District Judge Henry Hudson in Virginia ruled against the law in December. Judge Vinson's ruling followed the same general reasoning as Judge Hudson's in Virginia but where Hudson's decision would strike down the insurance requirement and leave the rest of the law in place, Judge Vinson took it much farther in validating the entire law and therefore some popular provisions like a change that allows adult children up to age 26 to remain on their parent's coverage. The justice department quickly announced it would appeal the decision and administration

officials declare that for now the federal government in the states would proceed with carrying out the law. The US Supreme Court will most likely take it up and issue the final ruling. Meanwhile, Republican law makers continue their push to repeal the law. Within minutes of the ruling, House and Senate Republicans called once again on senate Democrats to grant an up or down vote on the repeal bill that passed the House in January. The Republicans-led House also began the first committee hearings on health care reform. House Budget Committee Chairman Paul Ryan picked apart the congressional budget office estimate that the law would cut the deficit by $230 billion in 10 years. He made it clear he still thinks the whole law has to go and that repealing it would actually reduce deficit spending not just keep it from getting worse. Instead of financing expanded health coverage, Republicans believe the $500 billion in Medicare cuts in the law can be applied to deficit reduction. Democrats are sharpening their attack mainly through defending the law, the administration says the Affordable Care Act will in fact control cost for consumers and businesses across the board at the same time that it expands access to millions and extends new consumer protections. The newly released 2010 Dietary Guidelines get tough on obesity.

Tom Vilsack: We want to place a greater emphasis on meal patterns that focus on fruits and vegetables and whole grains and low-fat dairy and lean proteins including fish and seafood. We want to move away from our over-reliance in the past on sugar and sodium and saturated fat.

Loren Bonner: That's Agriculture Secretary Tom Vilsack during the unveiling. He says the government's new dietary guidelines should help Americans make healthier food choices. These new and improved dietary recommendations give individuals the information to make thoughtful choices to eat healthier foods in the right portions and to compliment those choices with physical activity.

(Music)

Mark Masselli: This is Conversations on Health Care. Today, we are speaking with Dr. Richard Gilfillan, head of the newly launched Center for Medicare and Medicaid Innovation. The center was created under the Affordable Care Act to test innovative payments in service delivery models, to reduce cost and improve care. Welcome Dr. Gilfillan. You have got an interesting background sort of a mix of both family physician and you were CEO at Geisinger Health Plan which is an integrated health system in Pennsylvania that's nationally recognized as a model for quality health service and delivery. On one had, how does that experience both as a practitioner and somebody who has been engaged in practice re-design shape your thinking as you take on this new role and also tell our listeners a little bit about the Center for Innovation and the tools that Congress has given you to undertake your task.

Dr. Richard Gilfillan: Well, I think the country is at a point where it's clear that we need to find some new ways of delivering care that address kind of the

challenges that we have seen in our health care system which is that it's becoming more and more difficult for people to afford coverage and we have more and more people without coverage, and a significant part of that is because we have not been as efficient as we might be in delivering care. And so I think the Congress through the center charged us with identifying new care models and new ways of paying for care that improve or maintain quality and at the same time impact the overall efficiency of care. And so we are kind of going around the country now trying to find examples of models of care that people have put in place that meet that objective of improving health, improving care, and reducing cost through continuously improving their approach to delivering care. And so it's about finding models that are like that. Many of them are out there today, some of them are in places like Intermountain Healthcare, the Mayo Clinic, some of them are in small practices that I have talked to and met with in Texas where they are doing wonderful things for cancer patients, treating them as outpatients in ways or for conditions that used to require in-patient stays, some of them are innovative ways to deliver skilled nursing care. And Intermountain experience, working in an integrated delivery system, gave me some experience working on models of care like that. So I think the mission is to help providers find those new models of care and there are many institutions around the country that are doing wonderful work in that regard, and our job is to find those examples, support them evaluate them to make sure that we can demonstrate that they are having those outcomes that we desire and then helping Medicare develop new payment mechanisms to support those new models of care.

Margaret Flinter: And congratulations again on your appointment Dr. Gilfillan. We certainly were eagerly awaiting it because we know that so much of delivery system reform really hinges on our ability to do things differently and to do it differently at the level of practice. And I think that's what I have found very intriguing as we look at your website, you are not really looking for the universities to lead with research demonstration projects on this, it seems that you are going to states as a whole bringing together their partners within the state and to individual practices. And I can't help noticing a real emphasis on care coordination, certainly something that Geisinger is known for. Maybe you could tell us a little bit about why would care coordination make a big difference to the beneficiaries that you are particularly concerned about, the Medicaid and the Medicare patients.

Dr. Richard Gilfillan: The coordination across different sites of care is something that's not well done because everyone tends to be focused more on their own kind of place of care or place of service delivery so what is the primary care office, the specialist office. And we have all had the experience of, I mean and we all know for the most part, most people don't have electronic medical records that allow patients experience to be right there in front of you across all sites of care and documenting what's going on in other places. So the system is fragmented and with the system that's fragmented, the people that are most exposed to kind of getting poor outcomes from that are the people who have

ongoing continuing needs overtime and they tend to be elderly folks, they tend to be poor folks, they tend to be the most disadvantaged and vulnerable people in our population. And so our system is, you know if you just need a simple procedure and you are otherwise healthy, you might do okay with a fragmenting care experience but if your health is dependent on being well cared for across different sites of care and overtime, you are most exposed to having a bad result. And we have seen that bad result time and time again. The good news is we have models of care where with more coordination built in explicitly to help people like that, we know that having a nurse in a primary care doctor's office coordinating care more actively can significantly improve people's health and reduce their need to go to the hospital, reduce readmission rates and make the patients and by the way their families much more satisfied with the care experience. So care co-ordination is really important because it addresses the specific gaps that result in the greatest health problems in the most vulnerable populations, and by the way, the most expensive populations.

Mark Masselli: Dr. _____13:18 has said that health care is often fragmented causing confusion, waste and sometimes poor outcomes but he's gone on to sort of talk about primary care that's patient-centered, coordinated and seamless, one that creates health homes as really the foundation that we are going to build this high performing system on. So he's laid out both the problem and the vision. Easier said than done, and as you have indicated, we have got some great examples around the country. But we don't seem to be able to figure out the spread and the sustainability. So where are we going, are we just going in a circle to those providers who aren't able to spread them, they are doing great examples, you are looking at the private sector or are there things within the business community that you might draw on? How is the innovation center really going to be this catalyst for a more comprehensive coordinated system?

Dr. Richard Gilfillan: That's a great question. Let's take the medical home as an example. So what are we doing? We are supporting the development of roughly a thousand medical homes right now in eight different states that will address almost a million Medicare beneficiaries. There are programs that are either in place or coming up or are being developed right now. They involve multiple payers so if you are a primary care physician practice today, you would like to have one program that takes care of all your patients and so our goal is to work with the local insurance companies, local Medicaid plans, the local large employers and so have all the patients, all the practices, patients, be covered under this program. We are going to create a thousand of those medical homes, we are going to support them with additional payments that will allow them to hire case managers, nurses in their offices and provide other services to improve the care of people who typically will have chronic problems and we are going to evaluate that and study it very carefully so that as soon as we can, we are going to know whether or not those models are in fact delivering this better care experience, better health outcomes and reduce cost. And we are going to study them, we are going to have our actuary in Medicare study them, and when we

reach the point of saying, if we do reach the point of demonstrating, that they are indeed delivering those outcomes. Then the nice part of the legislation is it says that the secretary can then change the way we pay primary care physicians and we can take that model of care and take that model of payment and make it the standard way we do business at Medicare for primary care thereby if you will transforming not just a thousand practices but overtime we believe changing how primary care is delivered.

Margaret Flinter: I think you are describing what we call rapid cycle improvement here and rapid's not often a word that we think of when we think about trying to change legislation particularly in such important areas as Medicare and Medicaid so we look forward to seeing that. And I guess a question that goes along with that is, what's the tolerance for innovation, how innovative do you feel like the center can be? Because we look at things like care coordination in the offices to go back to our last question and we say well who can provide that, does it have to be a registered nurse but we know we have a shortage of nursing, is that the only person, can we use social workers, can we use health navigators, can we use _____ 16:55. How broad is the Center willing to look at doing things in a different way not requiring patients to come in and see us in the office if we can do it just as well by phone or by email? I think some of that ties into innovations that people are really asking about.

Dr. Richard Gilfillan: Well I think we can be as innovative as I guess people can conceive of in terms of if someone's got ideas that do the right thing for patients and then improve health, improve care and reduce costs through continuous improvement, we are willing to listen. And obviously there are always state regulations and state licensing issues that one needs to be mindful of. But we are looking for dramatic bold approaches that change the fundamental model of care and whether those come from an individual practice someplace or a small primary care practice that's got a whole new way of doing things, it maybe combines or use nurses in a different way, uses social workers or whether it's because some university medical center has jumped into this and they have some great ideas. We are kind of indifferent to the source. We just know we need to find things that deliver those outcomes for patients and we will go wherever those ideas and opportunities are.

Mark Masselli: This is Conversations on Health Care. Today, we are speaking with Dr. Richard Gilfillan, head of the New Center for Medicare and Medicaid Innovation. I know you have sort of a basket of projects going on around medical home initiatives, the Multi-Payer Advanced Primary Care Practice Demonstration, the Federally Qualified Health Center Advanced Practice and health homes out to states who are focusing on people with a couple of chronic conditions or focusing on one of those, the Multi-Payer Advanced Primary Care Practice Demo. You selected eight states. Tell us a little bit about what you see in those states, why did those states sort of pop up on your radar screen, what were the

best practices and what can other states learn about how do they need to sort of start thinking about being prepared for innovations and transformations.

Richard Gilfillan: Yeah. The MAPCP program is something that has been underway for sometime. There was a solicitation of states, there was a pretty straightforward RFP process and a typical scoring process that went through and so we were looking for multi-payer, we were looking for programs that were well underway because again, we wanted to, and this was coming out of the Office of Research, Development and Information within CMS and wanted to as rapidly as possible kind of get those models into play and support. It's been fascinating and I have heard from a number of folks that the entry of Medicare into that was real important. So they gave it some shot in the arm in some places because things were stalling out a little bit.

Mark Masselli: You know just one side point on sort of the medical homes, you have got this Health Home Initiative that looks very enticing if your state is with some financial problems, CMS is going to pay up to 90% reimbursement for those people, for those states that sort of align their practices in accordance with the model that you have laid out there. Are you seeing a lot of engagement by states in that new initiative?

Dr. Richard Gilfillan: We are. We are getting a lot of questions, a lot of interest, people are excited about it and I think it's going to be a great program. We are trying to make sure while that's being run by our colleagues in the Medicaid area, we want to make sure that there are going to be many opportunities to kind of learn together, spread knowledge across the multiple health home initiatives, medical home initiatives we have out there. So we are working very closely and indeed people are excited about it.

Margaret Flinter: Dr. Gilfillan, innovation in practice of course implies that we are going to have innovation in training so that the health care providers of today and tomorrow are adept in these innovative practices. Tell us a little bit since Medicare also obviously makes a huge contribution through Graduate Medical Education Funds to the training of the next generation of physicians. But both for physicians and other health care professionals, for nurses, and nurse practitioners, social workers, the whole range, how does your center tie to training? Do you have the direct connection to the universities and schools of health professions training or are you just hoping they will come along on this exciting venture?

Dr. Richard Gilfillan: Well I think we recognize a need to do that for sure. It's something that we have talked a lot about internally as well as something that was brought to our attention during our visits to the different cities that we kind of did last month in listening sessions. So it is top of mind here. We have talked with our colleagues within the federal government who are focused on training and supporting the various professions. We are mindful of the opportunity and

indeed the need to do exactly what you describe and see it as a great opportunity going forward. So we will be looking to coordinate with folks in medical education very carefully and that will be part of I think the portfolio once we get out there and start both soliciting and responding to proposals.

Margaret Flinter: Well, lots of exciting work for us to look forward to. Today, we have been speaking with Dr. Richard Gilfillan, the head of the new Center for Medicare and Medicaid Innovation. Dr. Gilfillan, thank you so much for joining us today.

Mark Masselli: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. This week's bright idea focuses on a program that's been improving home care for the elderly and disabled. The Robert Wood Johnson Foundation and the US Department of Health and Human Services teamed up on a pilot program called Cash & Counseling, to give informed Medicaid consumers a choice about their personal assistance services they receive. Traditionally, state Medicaid programs have contracted with home care agencies to provide these services, giving patients little say in who provides care for them let alone when and how services are provided. The program dispenses a set amount of money to participants to use however they choose to pay friends or families that care for them or drive them to appointments or to pay for home renovations, to live more independently. Counselors are available to help participants manage these budgets as well. The program was piloted in New Jersey, Florida and Arkansas and now has spread to a dozen other states due to its success. Similar models are currently being replicated across the country like the Veterans Directed Home and Community Based Services Program, a program that's improving the lives of elderly and disabled by giving them a more active voice in their daily home care. Now that's a bright idea.

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

Mark Masselli: I am Mark Masselli, peace and health.

Conversations on Health Care, broadcast from the campus of Wesleyan University at WESU, streaming live at www.wesufm.org and brought to you by the Community Health Center.