Congressional Briefing Plenary

August 31, 2015

MARTHA ROHERTY: Good morning. Welcome to the HCBS Conference. I'm Martha, the Executive Director of NASUAD and I'm so glad you're all here and you've made it through the registration. I understand there was a line, and I appreciate all of you having such patience. Let me give you a couple of housekeeping announcements before we get started. I hope all of you have downloaded the HCBS app. You'll find the agenda in there. There are interesting polls, there's maps of the conference and a lot of the attendees will be posting and tweeting throughout the conference. If you want to tweet and not using the app, its HCBS2015, I guess hashtag first, because I'm not tweeter, I have to remind myself of that, and that's also the password if you want to use it for the Wi-Fi. The Wi-Fi password is the same, HCBS on the Wi-Fi, should be in lower case, and you're going to look for the Hilton Honors is the website; Hilton Honors meeting is the one you're going to want to go to.

So without further ado, we're going to go on with the show because we have a lot of wonderful intensives. On the right side, we have Rodney Whitlock, Rodney is the Health Director for Senator Grassley. He started out in Congress working for Charlie Norwood, where he managed the Patient Bill of Rights in 1991 and 2001 and he's been instrumental in several critical legislative initiatives such as the CHIP reauthorization and healthcare reform. He's an adjunct professor, which I need to go take one of your classes, because I think you would be amazing, at George Washington University, and he has two kids. To the far left is Matt Kazan, a Professional Staff Member for the Senate Finance Committee. He received his Bachelor's degree from Denver and his Masters of Public Policy from GW. He's worked on three campaigns and he became a Health Policy Associate for the Finance Committee in 2008 and a Health Policy Advisor for the Committee on Finance beginning in 2010.

His expertise is in Medicare and Medicaid and Medicare part C, the healthcare workforce, dual eligible, and medical malpractice. We're going to allow both of them to take a few moments to talk to us about their insights and long-term services and supports and what is going to be happening here in Congress and then we'll field questions from the audience. You can put the questions up on the app and I can read them to them or you can come up to one of the mics, and I'm going to also remind you that this -- whatever they say is off the record, thank you.

RODNEY WHITLOCK: Thank you for having me here today. Forgive me real quick, I need to do this, let's see, okay, camera. When I do a room this size, I always try to take a photo or two because my kids never believe me. How many people were in the room, It was like 3 or 400, 500, something like that, no way, you're lying to us. There we go, so I've convinced them that's the case.

Let's see. I've been away on vacation for a couple of weeks in Iowa, so I'm still getting back into this, but it's a good thing I'm off the record. Martha told me this is being closed captioned and the person doing that job is about to have the most miserable 10 minutes of their life. They're like 6 minutes behind. So let's do a riff on how many community based services and the role this plays in healthcare and/or entitlement programs because out there in America today is a family, and that family is an octogenarian couple with a husband who has Alzheimer's and a wife who is putting herself in the grave keeping him afloat and we have another family out there, in this case it's grandma alone at home, and she's by herself, she's frail, and the family's away, they're not close enough by to give her constant care. Alright . And these are the type of people out there as your government, because we're here to help, we're a large payer for services, pay for the services for these individuals at a point in time where we have the opportunity to make the biggest difference for these individuals, we're missing it, we're missing it badly, and it's because the way our programs are set up. We have Medicare, we have Medicaid and these two programs -- the way they're structured, I'm going to see if I can remember how to do this stuff, I will start with the

Medicare program, right? The Medicare program does not care about those individuals.

Now, that's a bit out there, I admit that, that was hyperbolic and intended to be inflammatory. Medicare is a payer of claims, it's 1965 Blue Cross/Blue Shield at its core, you provide a service, you get a claim paid, the couple can go to their doctor and they see that individual. What does the Medicare program see from that couple? And where Medicare sees expenditures, how does Medicare react? f Medicare sees expenditures, growth and expenditure, Medicare responds by suppressing the expense, let's cut down on the payment, now we've had too much imaging, let's cut the payment, we've got home-based services, lets cut the services on that, home health, pick anything out there, hips and knees, everything, Medicare's approach to it is take whatever we're spending and try to reduce the payment to create the equilibrium, as far as it's concerned, because it's not actually focused on outcomes. I would like to point out that is today, we are clearly working, and trying to fix that. But Medicare doesn't pay for whatever she needs so Medicare doesn't care, they're not looking to expand its expenditures, Medicare does not care. And on the other side, you have a program that desperately cares and that's Medicaid. Medicaid, unfortunately, is stupid. I'm on a roll! Medicaid is stupid. Why do I say that one? Okay. Medicaid does not see them coming. You know, look at any ten individuals out there, okay, that are seniors that could go on Medicaid, okay? Now, if two of them are already on Medicaid, Medicaid does have an attachment to them, they can do things for those individuals but the other 8, Medicaid doesn't see them coming. Medicaid doesn't know where they are, their expenditures, Medicaid desperately wants to try to keep people out of the nursing home? Why? Because once you're institutionalized, your opportunities to reduce costs are over; your opportunities to affect are over, so Medicaid desperately wants to affect things. Medicaid can't. Of those 8 remaining people, 2 are already on, they can do some things with, and how many are they going to get in? 1, 3, 5, 7? Medicaid has no clue. What if Medicaid could come out with a way to figure out okay, we're going

to get these 3, we're going to get these 3 individuals, eventually they're going to be ours, Medicaid has no attachment to them, they're not poor, they're not in the program, we're going to come up with a waiver program and do something with those 3, what's your excuse for not doing the other 5? This is Medicaid, they're clueless, so we file a clean claim, the wife breaks her hip, they both end up in the nursing home, okay? Grandma in her home, you know, she ends up in the nursing home because we can't keep her there, all right?

At the core is this space, you know, home and community-based and a broader set of services that are exclusive of social, ancillary, support, whatever it is, okay, but there are means we have at our disposal if we better organize, what we do and make our payers care we can make them smart. You know, we can affect change, we can change the way we approach that, and if you don't believe that's important, just consider this simple fact, okay, that if we could reduce the average length of stay in a nursing home from 24 to 30 months down to 18 to 24, the amount of money that we would save is tremendous. Just in that, just in reducing it by 6 months through the application of directly timed, appropriate utilization of support services for people in that transitional place, and we can make a big difference. To get there what we need and continue to need is the value of your expertise, particularly your education in helping us, those who do this, understand the value of bringing this to bear. Okay? Right now you're just treated as a woodwork effect, you know, you're just woodwork effect that's all you are, you are unmet demand. If we expand it, we'll get more. What we need is to show the positive impact of these services. Now, we will try, you know, I know that in my office we've tossed in a couple of bills that attempt to at least try to show that this can be of value, that we can make a difference by better aligning services, that consider Meals On Wheels. You know, somebody told me this, so it must be true, it was on Wikipedia I read it, someone told me that if Meals On Wheels was organized as a restaurant, it would be the third largest in America. Think about what we get out of that. A $6 meal with a volunteer goes into a

home, proves that a senior is hydrated, fed, generally okay, on meds, just with that person walking in and checking them out. Okay? Medicare doesn't care to pay for that service; Medicaid didn't know the service was occurring for that the senior. But think of how much value we get for that activity, just that simple action. You know, and that we treat this as a tiny little ancillary program that we may fund or may not and certainly don't care about or integrate into the system. We're a graying population I'm not just speaking of myself, mind you, we're a graying population. I just spent a week in Iowa, we are going to have to find ways to try to be more efficient and effective with our care or it's going to cost us even more.

nd so again, my challenge to you –try to be, you know, where you can, where you meet with your policymakers out there, help them understand the value of your service so that they can commit to trying to make a difference with that, trying to force the fight, to realign these programs to better handle those transitions between people who are perfectly healthy and on their way into institutiosl, which is where this space plays most. Much as I enjoy a good monologue, especially my own, immensely, I will take a break here and look forward to your questions and turn it over to my dear friend, Matt.

[Applause]

RODNEY WHITLOCK: Thank you.

[Applause]

MATTHEW KAZAN: Thanks, Rodney. Will you send me that picture? Great, thank you. My name is Matt Kazan. Thank you for inviting me. My comments are off the record, and are not the opinions of my boss. Our press folks make us say that so we don't get in trouble, and usually I'm on a panel where I'm called stupid, so this is already a heads up.

I think a lot of what Rodney said dovetails into what I wanted to talk about, which is the finance committee's ongoing efforts related to chronic care and chronic disease. Last year, and

then earlier this year, the finance committee held hearings to look at a certain segment of the population in both Medicare and Medicaid that have multiple chronic conditions who often have 5, 6 doctors, 12 prescriptions and try to navigate what often is a chaotic and inefficient system that doesn't work for the patients, doesn't work for the programs and so Senator Widen has started the process of diving into this project and Senator Isakson and Warner have joined a work group in the financial committee to solicit feedback from the healthcare community to figure out what changes we can make to our federal programs to serve this population better. We sent a letter to the healthcare community and received 540 comments back from individuals, organizations, health plans; hospitals, providers, et cetera and we're very pleased with that level of feedback. We've read most of them. We're asking organizations to come in and expand on their comments that they sent to us. That's what the committee's been doing in August and this fall, we hope to introduce legislation based on a lot of that feedback later this year.

A lot of what has been in those comments I think were similar to what Rodney talked about where certain segments of the population with certain health needs are falling through the cracks and certain types of services could either bind the services that we do pay for together better or feed on that need, whether it's Meals On Wheels, whether it's social services. Senator Widen always points to some of the innovative things that Oregon is doing, especially in the social services realm in the Medicaid space. I think their program is often talked about, you know, paying for air conditioners so it's not too hot, to avoid dehydration, to avoid a hospitalization, things like that that are the out of the box that normally a Medicare/Medicaid program is not doing actually saves a lot of money downstream and increases quality immediately.

I think the way Rodney described Medicare is 19656 Blue Cross/Blue Shield is mostly right except I think we have seen a lot of innovation in the last several years after the passage of the Affordable Care Act, whether it be ACOs, health home, the innovation center, we're trying to steer

a very large ship in a very different direction that does care about quality outcomes and doesn't just care about ramping down reimbursement rates to make sure that the entitlement is there for the next cohort of seniors and people with disabilities entering the program.

Now, the next question is in the chronic care realm. Can these new alternative pain models in the service-for-fee program adapt or service folks with chronic diseases well? Can an ARCO? Is it a good fit with folks that have 4 conditions, 8 doctors and 12 prescriptions? Maybe, maybe not. We're testing those models now and we'd like to dive further. On the managed care side, are managed care plans better able to serve a certain segment of this population? Can they serve it better? Better in certain regions of the country? I think that's what we need to figure out, especially on the supplemental services side. Rodney and his boss helped shepherd a bill through the Finance Committee earlier this year that wanted to test an idea to allow certain high-quality Medicare advantage plans to spend their rebate dollars on services that aren't normally allowed to be paid for by Medicare, even on the supplemental side, such thing as Meals On Wheels and other social services that have a good chance of preventing people from spending down to become dual eligible and cost the two programs more money. Because if we can prevent that from happening in the first place, I think everybody wins. And so that legislation has passed the Finance Committee and I believe it may or may not have passed the full Senate or is expected to soon. We think the House is interested and hopefully they will act shortly as well.

I think a challenge on the Medicare Advantage Side is can you distinguish between the plans that are willing and able to do this type of new and innovative services well. And the folks who aren't, and I think CMS has struggled with that and they've cut back a lot on what they've allowed plans to do in the recent past, and for that reason, trying to prevent bad actors from gaming the system one way or the other. So a challenge is really trying to identify who are the good actors, who are the right plans, and who is capable of taking on this more innovative approach and how do

we give them the new tools to care for this particular population and hold their feet to the fire to make sure they're doing it in a highly-quality manner.

So I'll leave it up to questions to go further but I think the chronic disease space and chronic care is very important to our boss, it's broad, there are a lot of things that we can do in this space. I don't know if we'll be able to tackle the whole problem, but the whole committee seems very interested in wanting to produce legislation by the end of this year. And so as Rodney said, I think you all, and organizations like you, your input is very important, so when you meet with folks this week share, tangible, real-life stories about how things that you're doing out in the community that the program should learn about is helpful to create tangible, real fixes to the programs that Congress can make. I think is very helpful to hear and we look forward to your questions.

[Applause]

MARTHA ROHERTY: So with that, I'm going to start asking for your questions, you can send them in through the app or you can come up to the microphone, but I have the first question. That's the right of the Executive Director on the first day!

So one of the things that we've struggled with as an association is the fact that we cannot seem to get Congress to reauthorize the Older American's Act, which provides for a lot of the ancillary services and connect the dots and pays for Meals On Wheels. The Senate has passed it but we can't get traction in the house. Do you have suggestions for us on how we push that forward? And while we're going there, we have not received funding increases for that program in 20 years, while the population is soaring and surging, so any thoughts from either of you on how we can get traction?

RODNEY WHITLOCK: As senate staffers, I think we would say it’s not our fault.

[Laughter]

RODNEY WHITLOCK: I mean, we only passed it just before the last recess or it was a couple

of weeks before that, right? So the House is now under pressure with it having passed the Senate, so that may start to push the envelope. As to funding, I mean, that's the constant challenge around here that is pushing us to reward the value of the services provided. And I know it's not our strongest suit. So the challenge in your space is always trying to educate us as to why it matters. But understand there's competition for resources every day in this place.

MATTHEW KAZAN: I would also add that the current or the more recent challenges regarding funding, especially in discretionary and Congress trying to deal with the sequester, it capped the level of discretionary funding at pretty lower levels. And two years ago I believe Congress temporarily lifted a couple of years of discretionary funding, but has not been paid for, and so not to increase the deficit, so a variety of mandatory programs, Medicare was one of them that were cut to tie to relieve some of that sequester relief, a lot of folks has been wondering if they're going to do that again to provide further relief to discretionary funds. Any time you talk about cutting programs to fund other programs, controversy arise so to as the number of programs available, the number of programs available decreases or folks do not want to fund Medicare or Medicaid. Finding those offsets are difficult, so that's another challenge the Older American's Act and its funding faces.

MARTHA ROHERTY: So I have a question that came in on the app to you, Rodney. If Medicare doesn't care, why from a federal policy's perspective are we so unwilling to allow the states to begin to manage Medicare as well as Medicaid services in a way that can better manage chronic conditions ? You can talk to this, too.

RODNEY WHITLOCK: So let me first sort of follow on with where Matt went, I mean, what Matt said is absolutely true, the Medicare program is undergoing a lot of change to try to get better, it's still very early in the process and it's still trying to -- frankly still trying to overcome the bias of doing things a certain way. And one of those biases is Medicare covers acute services through

CMS setting policy at a federal level, period. And I think that the folks who worked at the CMS office of that duals who tried do some things in that space found very quickly that internal to CMS, there is a very, very strongly-held bias, and that is states keep your grubby little paws off acute service. I mean, that's I think the bias there in CMS. Why? Because it's been their responsibility for 50 years. And no states we're not going to let you do that. And if you look at the projects put together through the office of the duals, that they, you know, were kicking and screaming to get as much as they got out of Medicare and all of the projects were typically, you know, based around states getting, you know – were the states actually able to control the acute service or were they at least participating? I mean, there were some innovative things done, South Carolina, Washington, but not many, and I mean, I sat in on a forum once watching the person who at the time was directing Medicare at CMS basically say hell no. I think that's been the approach to giving states greater acute control.

Now I'm going to step back really quickly just to say I'm not convinced that that's necessarily wrong. That is the question -- I mean, you can go one of two ways if you want to coordinate, oh, and that is giving the federal government a greater role in providing the LTSS side or giving the states greater in acute, and I'm not certain that going to the state's route is the better way to go.

MARTHA ROHERTY: Matt?

MATTHEW KAZAN: I think one thing we consistently hear up here from states is don't press more costs onto us and I think that message resonates with members, of both the Senate and the House. So I think any time you talk about, giving states more responsibilities, giving states more flexibility, there is the, but how much is it going to cost the states or how much fiscal pressure are you pushing on to State Medicaid programs, so I think folks have to be cognizant of that. I think on the duals office and the dual side, there are 9 million duals. So I think the demos have been going

for a while, there really hasn't been a robust analysis of any of them, because their hasn't been enough time elapsed I think, and it's our hope we learn a lot from these demos what we should not do and never try again and what other things we may be able to bring to the larger two programs and try to figure out whether it is payment, quality measurement, whether it's some of the more nitty-gritty issues like appeals alignment and other things, risk adjustment for instance.

But I think it's our hope that the demos -- and we were telling the duals office at the very beginning, make the demos varied enough so that we can test different things and try to figure out what works and what doesn't, and so we'll see if we've done that but I think it's Congress' hope that we ascertain something substantive from these demos because wherever we have duals hearings at least in the finance committee, the poll ticks and members seem interested in tacking this very difficult issue and they get into the substance pretty quickly and there's a frustration there. What can we do here? We want to do something but we don't really know what to do. I think they just need kind of a more robust policy menu to choose from and that was the hope of the duals, to determine who was to give us more options.

MARTHA ROHERTY: Are there questions people want to ask from the floor, if not, I can read more from the app. Go ahead is it or is there a draw maybe?

MARTHA ROHERTY: Is it on, Rodney you started out talking very nicely about the differences between Medicare and Medicaid and Matt, you talked a little bit about chronic care management and in fact, I do believe Medicare has evolved as you have said, we've added a chronic care management code but this idea of making Medicare look more like Medicaid. Rodney maybe you could talk a little bit more about the bill that your boss introduced with Senator Cardin because it does test some interesting ideas and I am wondering if you can also identify other opportunities in Medicare that might for example delay or avert enrollment in Medicaid say a caregiver assessment or other opportunities within the annual wellness visit to support caregivers maybe a caregiver

benefit in Medicare. I mean, I think there are those opportunities but I'd be interested to hear what the two of you have to say about how we can help people stay out of the Medicaid but supporting them through Medicare.

RODNEY WHITLOCK: Our bill is S 704, I actually have no clue what the title is, you know, some bills you think through, you try to come up with the acronym and what it is and this other bill, we have this bill that does pharmacy and I spent Friday with pharmacists in Iowa and they kept introducing the bill to me over and over again by the title and by the end of the day I was sitting there going I wish I had thought of a better title. But the S 704 is what I refer to as our CBI Snip Bill and it looks at ways to benefit the special needs plans. The idea of it is fairly simple, which is you've got these special needs plans which are at risk for the cost of the individual as they are frail at the institutional level and how do you keep them at home, and then what can you do beyond just what is currently allowed within the corners benefit of Medicare to provide statutory services. Now if I toss that question back to you all, we could do a symposium on that for hours, of all of the innovative, creative things that you can do outside the four walls of the benefit, you know. Well, I did the alert devices and grab bars for seniors but the other thing when I was in Iowa, you know, the idea of a talking pill dispenser, which I looked at it and I'm like oh, cool, robot but what it does, it's just a simple device, a few hundred bucks and when it's time for the senior to take their medicine, it says come take your medicine and it dispenses it. And if the senior doesn't come take it after a while, the damn thing starts calling people, no, I'm serious, it starts calling people. I'm like what the hell? This thing -- it's like hooked up into the -- I don't know this shit, you know, how this stuff works but the guy told me it starts calling people, it calls a family member, and then it calls the call center, somebody to go find out why the senior hasn't taken their pill. So these are the types of things that we know we can do, we just don't. And so now pulling it up to bigger picture and where you're going, we're doing it with ACO, we're doing with alternative payment models and it

is generally good. Secretary Burwell has talked about it, ultimately it's the concept of risk and that is increasing the use of cost. Who is in charge of care for an individual, to then use that to drive ultimately the breaking down of the barriers that I talked about in my opener to better align at the moment where seniors are at risk for greatest cost, having people who actually care and want to be smart about it, so our CBI Snip Bill is one way we're testing it with a demo as Matt spoke of 5,000 people, 5,000 amongst the 45 plus Medicare just to see, would this work if we had people thinking this way because that's the type of thing we need to do.

MATTHEW KAZAN: I think another thing we do run into, at least on the Medicare Advantage side, where we could give them more freedom to offer different types of supplemental benefits like the pill robot is we have to think about making sure we're paying plans appropriately for the certain populations that they want to enroll or we want them to enroll because plans have limited supplemental benefits. This is kind of their marketing tool, this is what extra things can I offer to Medicare beneficiaries to entice them to enroll in my plan. A lot them choose lower and cost sharing and that's very attractive because Medicare doesn't have the most attractive benefit package. Let's look at provider drug coverage or other things that are enticing to many of them and so they enroll in that type of plan. Maybe to some beneficiaries, the pill robot is not an enticing reason to enroll in that plan, so plans don't offer that because it's not something that gets their enrollment up and drives revenue and drives those financial incentives. So if Medicare could reimburse plans appropriately to better target the type of people that would benefit from the pill robot and from some of the other types of benefits that target chronic disease and target the types of activities that prevent spend-down and prevent folks from becoming dually eligible, you might see more of the take-up and more enrollment in the type of plans that Rodney was talking about. But I think today, you do see, at least on the risk adjustment side, you see a skew towards reimbursing plans that are slightly healthier than the average and you see an under-reimbursement to plans

whose enroll sicker beneficiaries and much lower reimbursement to plans that enroll fully dual eligible. I'm a health plan and you told me I have to enroll a bunch of complicated very sick individuals and you're going to pay me less than what they probably get paid for in Medicare fee-for-service, that's not a great deal. It makes sense why some of these plans often will target enrollment of healthier non-dually eligible beneficiaries.

MARTHA ROHERTY: Are there more questions from audience or should I read more from the app? Do they have the possibility of ever having full funding and no waiting for eligible people for every HCBS program in every state? So instead of having the -- you know, the reverse of the way it is now with the state plan?

RODNEY WHITLOCK: Yes, um that was sort of a setup, wasn't it? Was I supposed to answer any differently? Yeah, I love the idea. I think we have to constantly substantiate the value. And we're -- Matt was really thoughtful on the talk about the MA plans in that we constantly have to be substantiating the value of what we do. I mean, providing more services just for the sake of proving we can provide more to a government that's $17 trillion in debt is never going to be a winning argument. We constantly have to be able to show and win the battle to show that there's value to what we're providing, there's efficiencies to what we're providing, and so that's always going to be the challenge. We have a bill that's targeted more towards the under 65 disability side, and that's a space where, you know, the development of the support resources is absolutely hampered by the nature of the reimbursement system, that, you know, Medicaid has no incentive, the State Medicaid programs do not have an incentive to go out and develop resources to support individuals who want to be out in the community. Disabled individuals who want to be out in the current, many of which are home-based services, you know, the states get -- the state's don't get anything from Medicaid from their state -- you know, from the federal Medicaid program for developing support resources so if a state goes into let's say wants to use its resources to help

develop the workforce and so they could do things through Community College, they could do things through tax credit. There are all sorts of things they can do to help develop the workforce all of that would be generally speaking state resources. And if the state goes through the process of developing those state resources and then having done that, the Medicaid program then is naturally allowed to do more through the provision of home-based services, and we can show that those services save money. The state has, through the devotion of their resources, saved the federal government half of the double savings, maybe more. Shockingly, states look at that and go okay, if we work really hard, spend our money, we get to save money for the federal government, no. No. No! So while the obvious answer to the question is yes, at least I want you to know why it's too often no.

MARTHA ROHERTY: No, we had a question come in about can you share something about the legislative landscape on some HCBS for children, what does the landscape look like on any of the issues for children?

RODNEY WHITLOCK: Do you want to go first?

MATTHEW KAZAN: No, you go ahead.

RODNEY WHITLOCK: Let's see it's a row of box woods and then maybe a dogwood behind it and then -- come on, it's Monday morning, you want better material please!

[Applause]

[Laughter]

RODNEY WHITLOCK: Thank you. So America is safe today, Congress is out. But unfortunately, that's going to change here in a week or so. When we get back, when Congress gets back and is in session, we have what promises to be a very ugly fall. We're now in a presidential cycle and aptly there's what, three-quarters of the senate running or something like that? Yeah, I mean, it was 12 -- '08 was bad in a lot of respects. This is every bit as bad where you sit around

going why do we only have 63 people here today? But there are just a number of nasty contentious issues waiting in front of us, and it is for professional staff, like Matt and me, a lot of times this is very frustrating, you know, we want to solve, we want it try to solve problems that's what we're employed to do. But we also understand the nature of the place that this is about election, and it's often times about people arguing and yelling and those take precedence over actually doing good public policy some days. I hope this hasn't raised your level of cynicism beyond what it already was. But so we are going to have a difficult fall ahead. We have to fund our government, we have to, you know, deal with our total spending level and how much debt we're able to take on and these are areas where people want to highlight differences in philosophy, and with that, it's going to be a very contentious time. So our challenge in the face of that is going to be to try to find space to do some good policy. So while I suggested you know,a lovely landscape with some box woods and some azaleas and a dogwood, it's probably more of surface of the moon. It's a French field in 1919. It's not always the most productive place to have fertile activity but do know there are people who do care and who are always trying to find open doors to get things done and we do on occasion play a little spy versus spy where we actually talk to each other and, you know, work together. But we're also creatures of the larger political animal here, so that's the best I've got for you on that one.

MATTHEW KAZAN: I'll be slightly more optimistic which won't be much. I don't disagree with anything Rodney said, especially at the higher level things that Congress has to get done that will generate a lot of the press, the funding of the government, the debt limit, presidential politics, but one big thing that happened earlier this year that I think leads to a lot more progress and a lot more accomplishments is Congress finally got rid of the SGR, and that was a problem for Medicare in itself in that every year we'd have to figure out if the doctors were going to take a big cut and if the beneficiaries would have access and we would fund that part of the program 9 months, 12 months

at a time and it was not a good way to run the Medicare program. But it took out the oxygen in the room, however many years we were working to get that problem addressed now it's gone and Rodney and I can go on vacation. It has been quite the opposite, we've been busy on a bunch of other topics and priorities that members have suggested, but it's been bent up because we said we'll get to you when we're done with this SGR, and we can finally do this, they passed 13, 12, relatively small bills, but important bills. Rodney's bill that he spoke of earlier was one of them, the Finance Committee marked up and passed a bill to revamp the Medicare appeals process, other minor healthcare policy bills and I say minor in that it's not Obamacare, not the C this N leading story, subsequent bills that people have wanted to work on for a long time and it's really only happened because we have SGR off our plate. Now we may get sucked into presidential politics and debt limit and is the federal government going to be funded. It's still an important time to cull interest and generate new ideas and start the legislative process and a variety of other things that we haven't been able to do because we've been stuck in SGR land for the last, you know, decade.

MARTHA ROHERTY: Can I ask a question? You both have suggested that we need better tools and evidence to support states getting financing for the Older American Act programming's and all of the other discretionary programs we want to finance. What exactly would be that kind of evidence? What would turn the tide so you would see the evidence that would support that?

RODNEY WHITLOCK: You know, it's beyond anecdotal obviously, for example, in states I look at -- and what we're doing with managed care, and it's the evaluation process that is set to follow all of that which involves, you know, taking the time to look at the data between -- it's outcome-based data and looking at essentially the input of services and the change in the nature of longer-term spending. Because that's ultimately what the Congressional Budget Office, the monster, you know, that's we have to deal with at all times when we make public policy around here. The fact of the matter is they are extraordinarily evidence-based much as I like to joke that

generally I've always presumed CBS scoring to include the entrails of skinned goats, to make that work we've been working on a bill for obesity reduction and CBO goes out and looks at data and what they've found is current data shows that if you are BMI below 30, changes in your weight produce marginal changes in your long-term health spending. In other words, you have to be pretty morbidly obese before you make a difference by losing weight; otherwise, generally speaking, their data shows that if you lose weight it doesn't make that much of a difference. Now, I would like that tell you that intuitively that's stupid, but as much as I say that, you know, they are doing their job, and they're looking at data, and then our challenge is and the folks we've worked with on this bill and who work in the diabetes space as well, other chronic condition, you have to go out and show how the application of supports and services that go to reducing the onset of diabetes and reducing the amount of obesity lead to lower long-term costs well it's the same in this space, so it's the collection of data that show that outcome, those types of outcomes because that is what will motivate us to be able to fund more because it's about -- oh goodness, look at me going into this big return on investment, wow did I say that? I didn't feel comfortable saying it, I just felt icky.

MATTHEW KAZAN: It's peer-reviewed analysis, it makes sense to us that a person with multiple chronic conditions that doesn't take their medicine there is a likelihood they will get hospitalized and that will drive up cost that could have been prevented for a while. CBO didn't recognize that when they scored bills that tried to make it easier for people to take their medication, but after several kind of robust, you know, peer-reviewed analyses that looked at Medicare beneficiaries or I think even non-Medicare beneficiaries if the proper use of medications went up, the services went down. So now CBO as a general rule has within their scores estimates that as Part D prescription use goes up, part A and B spending goes down. That change was only made, you know, after this type of robust analysis was brought to them and they do whatever they do with their chickens or whatever Rodney said. But I think it is, it is, input A leads to outcome B and

outcome B is good and now make sure you have the data to back it up and provide CBO and, have Congress provide to CBO that level of data that they feel comfortable enough making estimates. It's easier to change their tune rather than just, you know, banging against the wall saying we know this works because we've seen it work, you really do need, you know, a robust analysis.

MARTHA ROHERTY: Well, I want to thank you both so much, this has been a really enlightening way to kick off the morning session and very entertaining. So thank you both very much and I hope you have good intensives. You should see some of the comments coming in! I mean, it was good, it was good.

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