



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN SPRING CONFERENCE

Sheraton Baltimore City Hotel, April 20-21, 2010

Verbatim Transcript

Keynote Address - Jonathan D. Blum

Part 1

WELL, THANK YOU, AND THANK YOU

FOR THE KIND WELCOME, AND I

WANT TO THANK THE CMS STAFF,
WHO HAVE PUT SO MUCH HARD WORK

INTO THIS CONFERENCE.

IT'S VERY PLEASING TO ME
TO SEE HOW MANY FOLKS HAVE

DECIDED TO SPEND TWO DAYS
HERE WITH US TO UNDERSTAND OUR

REQUIREMENTS FOR
THE NEXT YEAR.

IT TELLS US THAT THE PART "C"
AND PART "D" PROGRAMS WILL

CONTINUE TO BE STRONG,
THAT INTEREST FROM THE PLAN

COMMUNITY CONTINUES TO BE
STRONG, AND I REALLY WANT TO

THANK YOU, AND I HOPE
THAT YOU'RE GETTING YOUR

QUESTIONS ANSWERED.

IT'S OUR COMMITMENT, AS TIM
HILL TALKED ABOUT YESTERDAY,

THAT WE WANT TO BE AS CLEAR
AS POSSIBLE

WITH OUR REQUIREMENTS.

WE WANT TO BE AS TRANSPARENT

AS POSSIBLE WITH OUR VARIOUS

RULEMAKING ACTIVITIES,
GUIDANCE DOCUMENTS COMING OUT,

AND I'M REALLY PLEASED TO
SEE SO MANY FOLKS HERE THIS

MORNING, AND THANK YOU FOR
SPENDING TWO DAYS WITH US.

TIM HILL YESTERDAY TALKED
ABOUT--KIND OF GAVE SOME

OPENING REMARKS ABOUT THE
NEXT YEAR, AND I WANT TO TALK

ABOUT THE NEXT YEAR BUT
ALSO TALK ABOUT THE NEXT

SEVERAL YEARS.

THE HEALTH REFORM BILL THAT
WAS ENACTED INTO LAW MADE LOTS

OF CHANGES TO THE PART "C"
AND THE PART "D" PROGRAMS.

I KNOW THAT YOU'RE ALL WORKING
TO UNDERSTAND AND WORK TO

IMPLEMENT WITH CMS, BUT I WANT
TO JUST KIND OF OFFER SOME

THOUGHTS AND SOME OBSERVATIONS
BUT SAVE A LITTLE TIME TO

ANSWER ANY QUESTIONS
YOU MAY HAVE.

AND THE WAY THAT I THINK ABOUT
THE HEALTH REFORM LEGISLATION

AND THE CHANGES FOR THE PART
"C" PROGRAM IN PARTICULAR IS

THAT I THINK IT'S GOING
TO MAKE THE PROGRAM AS

STRONG AS EVER.

IT'S GOING TO TRANSFORM THE
PROGRAM, TO ENCOURAGE PLANS TO

COMPETE BASED UPON QUALITY,
BASED UPON THE CARE

COORDINATION VALUE THAT THEY
PROVIDE TO BENEFICIARIES.

I KNOW THERE ARE LOTS OF
CONCERNS REGARDING THE PAYMENT

RATES, BUT I BELIEVE VERY
STRONGLY, AND I WILL ARGUE

VERY STRONGLY, THAT THE
PAYMENT CHANGES THAT CONGRESS

HAS ENACTED WILL IMPROVE THE
PART "C" PROGRAM, WILL MAKE IT

A PROGRAM THAT BEST SERVES OUR
BENEFICIARIES, WILL ENCOURAGE

ALL OF OUR CONTRACTORS TO
COMPETE BASED UPON THE VALUE

THAT THEY PROVIDE
TO BENEFICIARIES.

THE CONGRESS, I WOULD ARGUE,
HAS CREATED THE LARGEST

PAY-FOR-PERFORMANCE
PAYMENT SYSTEM TO DATE.

PLANS STARTING IN 2012 WILL
HAVE THE OPPORTUNITY TO EARN

HIGHER PAYMENTS BASED UPON
THEIR STAR RATINGS, AND TO US

AT CMS AND TO ME, THIS CREATES
A HISTORIC OPPORTUNITY FOR US,

FOR CMS TO PAY PLANS BASED
UPON THEIR QUALITY, BASED UPON

THEIR PERFORMANCE, AND I THINK
THIS BEST SERVES BENEFICIARIES

AND WILL ENCOURAGE ALL OF YOU
TO COMPETE BASED UPON YOUR

QUALITY AND TO MAKE THAT
PROCESS FOR OUR BENEFICIARIES

MORE TRANSPARENT AND WILL
CREATE THE DECISION-MAKING

PROCESS FOR BENEFICIARIES TO
CHOOSE PLANS BASED UPON THEIR

PERFORMANCE AND ALSO WILL GIVE
MUCH STRONGER INCENTIVES THAN

WE HAVE TO DATE FOR PLANS TO
INCREASE VALUE, TO INCREASE

PERFORMANCE TO
OUR BENEFICIARIES.

I KNOW THERE WERE A LOT OF
QUESTIONS YESTERDAY ABOUT HOW

CMS WILL THINK ABOUT THE STAR
RATING SYSTEM GOING FORWARD,

WILL THINK ABOUT CHANGES
TO THE STAR RATING SYSTEM.

WE ARE WORKING VERY HARD TO
IMPLEMENT POTENTIAL CHANGES TO

THE STAR RATING
SYSTEM BY 2012.

IT IS OUR COMMITMENT, AS TIM
TALKED ABOUT, TO MAKE SURE

THAT WE'RE DOING SO IN A VERY
TRANSPARENT WAY, TO BALANCE

THE TENSIONS BETWEEN PLANS
THAT ARE NEW, THAT HAVE

LOW ENROLLMENT.

CMS WILL BE PUTTING OUT,
IN THE NEXT YEAR, MORE

INFORMATION, MORE GUIDANCE
REGARDING THOSE CHANGES,

BUT YOU HAVE OUR COMMITMENT
THAT GIVEN THE IMPORTANCE NOW

OF THE STAR RATING SYSTEM
NOT ONLY FOR BENEFICIARY

DECISION-MAKING BUT ALSO FOR

PAYMENT PURPOSES THAT IT IS

OUR COMMITMENT TO WORK AS
COLLABORATIVELY AS POSSIBLE,

AS TRANSPARENT AS POSSIBLE.

WE WANT TO HEAR YOUR INPUT.

WE WANT TO HEAR
YOUR COMMENTS.

WE'RE GONNA BE WORKING
WITH THE PLAN COMMUNITY,

THE BENEFICIARY COMMUNITY,
OTHER STAKEHOLDERS TO ENSURE

THAT WE ARE CREATING A SYSTEM
THAT CREATES FINANCIAL

INCENTIVES THAT PROMOTE VALUE
BUT ALSO HELP BENEFICIARIES

DECIDE WHAT'S THE BEST
POSSIBLE PLAN FOR THEIR OWN--

FOR THEIR OWN NEEDS.

I ALSO WANT TO TAKE A LITTLE
TIME JUST TO TALK ABOUT SOME

OF THE OTHER CHANGES THAT
WERE IN THE HEALTH REFORM

LEGISLATION THAT WILL BEGIN TO
TAKE EFFECT NEXT YEAR THAT I

DON'T KNOW SO MUCH GO INTO
PAYMENT PURPOSES BUT I THINK

ARE JUST IMPORTANT THINGS
FOR US TO THINK ABOUT.

THE CONGRESS, BOTH IN
THE SENATE AND THE HOUSE,

WERE VERY CONCERNED ABOUT THE
DECISION-MAKING TIME FRAMES

THAT BENEFICIARIES HAVE TO
CHOOSE A PLAN DURING THE OPEN

ENROLLMENT PERIOD.

I KNOW THAT CONGRESS HEARD
A LOT OF CONCERNS FROM

THE BENEFICIARY COMMUNITY.

I CERTAINLY HEARD A LOT OF
CONCERNS FROM THE BENEFICIARY

COMMUNITY REGARDING HOW MUCH
TIME BENEFICIARIES HAVE TO

FIND A PLAN.

SO STARTING NEXT YEAR,
THERE WILL BE SOME CHANGES TO

THE ENROLLMENT PROCESS AS
INCLUDED IN THE HEALTH

REFORM LEGISLATION.

THE FIRST CHANGE IS THAT
CONGRESS HAS CREATED A NEW

45-DAY DISENROLLMENT PERIOD
STARTING IN JANUARY 1,

2011, WHERE BENEFICIARIES WILL
HAVE A 45-DAY PERIOD TO DECIDE

WHETHER OR NOT TO TURN
BACK TO THE TRADITIONAL

FEE-FOR-SERVICE PROGRAM.

THIS--FOR BENEFICIARIES FOR
MAPD PLAN THAT DECIDE TO GO

BACK TO THE TRADITIONAL FEE-
FOR-SERVICE PLAN, THEY WILL

STILL BE GIVEN THE OPTION TO
SIGN UP WITH A STAND-ALONE

PART "D" DRUG PLAN.

I THINK THE OTHER CHANGE,
TOO, TO TALK ABOUT IS THAT

CONGRESS WAS VERY CONCERNED
ABOUT BENEFICIARIES HAVING TO

MAKE A CHOICE FOR WHICH PLAN

TO SELECT FOR THE UPCOMING

YEAR DURING THE
HOLIDAY SEASON.

WE CERTAINLY HEARD THAT
WAS VERY HARD FOR SHIFTS,

FOR EXAMPLE, TO FIELD
VOLUNTEERS DURING THE HOLIDAY

SEASON, SO CONGRESS MADE
SOME CHANGES TO THE ANNUAL

COORDINATED ELECTION PERIOD.

BEGINNING THIS FALL, IN 2011,
THE PERIOD WILL RUN FROM

OCTOBER 15 TO DECEMBER 7 TO
PROVIDE MORE TIME, TO PROVIDE

MORE FLEXIBILITY, PROVIDE MORE
ASSISTANCE TO BENEFICIARIES TO

MAKE THE BEST POSSIBLE CHANGE.

SO WE JUST WANT TO MAKE SURE
EVERYONE IS AWARE OF THESE

TWO CHANGES.

THE GOAL REALLY IS--WHICH I
KNOW IS YOUR GOAL AS WELL--IS

TO MAKE SURE BENEFICIARIES
CHOOSE THE PLAN THAT BEST

SERVES THEIR NEEDS.

FOR ANY BENEFICIARY THAT HAS
DECIDED THAT HE OR SHE MAY

HAVE MADE THE WRONG CHOICE,
THERE IS THIS NEW 45-DAY

PERIOD FOR DISENROLLMENT TO
ENSURE THAT BENEFICIARIES ARE

BEST PROTECTED.

THE OTHER THING THAT I WANT
TO TALK ABOUT QUICKLY IS

THE COST-SHARING CHANGES THAT
WERE IN THE HEALTH-REFORM

LEGISLATION THAT ARE ALSO
VERY CONSISTENT WITH THE CMS

PROGRAMMATIC GOALS TO ENSURE
THAT PLAN BENEFIT DESIGNS ARE

NOT DISCRIMINATORY, THAT
THEY ENSURE TRANSPARENCY

WITH BENEFICIARIES IN BEST
HELPING THEM UNDERSTAND WHAT

THEIR COST-SHARING OBLIGATIONS
WILL BE WHEN THEY GO

INTO A PLAN.

A COUPLE OF CHANGES TO
HIGHLIGHT IS THAT OBVIOUSLY

THE CONGRESS WANTED TO CLOSE
THE DOUGHNUT HOLE, THE PART

"D" DOUGHNUT HOLE, OVER
A 10-YEAR PERIOD.

SO THERE WILL BE CHANGES OVER
TIME TO HOW PLANS HAVE TO

PROVIDE PART "D" BENEFITS.

THAT WILL BE FORTHCOMING IN
MORE GUIDANCE STARTING IN 2011

AND THROUGHOUT
THE NEXT 10 YEARS.

CONGRESS WAS CONCERNED
REGARDING CERTAIN COST-SHARING

BENEFITS THAT COULD BE DEEMED
DISCRIMINATORY, AND FOR SOME

BENEFITS, CONGRESS HARD-WIRED
THE COST-SHARING OBLIGATIONS

TO BE NO HIGHER THAN
THE TRADITIONAL

FEE-FOR-SERVICE PROGRAM.

CONGRESS ALSO GAVE CMS THE
AUTHORITY TO ADD ADDITIONAL

COST-SHARING BENEFITS THAT CMS
WILL BE CONSIDERING FOR FUTURE

YEARS THROUGH
FUTURE RULEMAKING.

CONGRESS WAS ALSO VERY
CONCERNED ABOUT COST-SHARING

FOR PREVENTIVE BENEFITS,
AND THIS YEAR WE ARE ASKING

ALL PLANS TO PROVIDE ZERO
COST-SHARING FOR ALL THOSE

RECOMMENDED BENEFITS THAT
ARE GOING TO BE FREE TO

BENEFICIARIES IN
THE TRADITIONAL

FEE-FOR-SERVICE PROGRAM.

WE UNDERSTAND THAT MOST
PLANS TODAY PROVIDE ZERO

COST-SHARING, BUT FOR 2011,
WE'RE GONNA BE ASKING ALL

PLANS TO PROVIDE ZERO COST-
SHARING FOR NEXT YEAR.

THE OTHER CHANGE THAT'S GOING
TO AFFECT BENEFICIARIES'

OUT-OF-POCKET PAYMENTS IS THE
PART "D" INCOME-RELATED PREMIUM

THAT WILL START NEXT YEAR.

PART "D" ENROLLEES WHO MEET
CERTAIN INCOME THRESHOLDS WILL

BE ASSESSED A HIGHER PART "D"
PREMIUM CONSISTENT WITH HOW

THEY'RE ASSESSED FOR A
HIGHER PART "B" PREMIUM.

WE ARE WORKING VERY HARD WITH
THE SSA TO IMPLEMENT THIS

PROVISION, AND CMS WILL BE
PUTTING OUT MORE GUIDANCE

VERY SOON.

WE EXPECT RIGHT NOW THAT THE
RESPONSIBILITY TO COLLECT

THE HIGHER PART "D" PREMIUM

FOR HIGHER-INCOME
BENEFICIARIES WILL FALL

TO THE SSA AND TO CMS, AND
WE DON'T EXPECT THAT PART "D"

PLANS WILL BE INVOLVED IN
COLLECTING THE HIGHER PART "D"

PREMIUM FOR
HIGHER-INCOME BENEFICIARIES.

Part 2

AND THE LAST POINT
THAT I WANT TO TALK ABOUT

BEFORE OPENING UP TO QUESTIONS

IS ON THE ISSUE OF COMPLIANCE

AND THE ISSUE OF OVERSIGHT
BY THE AGENCY.

I KNOW THAT TIM HILL
TALKED ABOUT THIS YESTERDAY

AND I CAN'T OVEREMPHASIZE
HOW IMPORTANT THIS IS

TO OUR AGENCY.

WE BELIEVE VERY STRONGLY
THAT WE HAVE AN OBLIGATION

TO ENSURE THAT PLANS, BOTH
PART C PLANS AND PART D PLANS,

ARE PROVIDING THE BENEFITS
THEY HAVE CONTRACTED WITH US.

CMS IS VERY CONCERNED

ABOUT PLANS THAT DON'T

MEET THESE OBLIGATIONS,

AND WE WILL BE MAKING SURE
THAT OUR AUDIT RESOURCES,

OUR OVERSIGHT RESOURCES,
OUR COMPLIANCE RESOURCES

ARE POINTED IN A DIRECTION
TO ENSURE

THAT BENEFICIARIES RECEIVE THE
BENEFITS THEY'VE BEEN PROMISED,

THAT THE PAYMENTS ARE ACCURATE,

AND THIS WILL BE A CONTINUED
FOCUS FOR THE AGENCY

THIS YEAR, NEXT YEAR,
AND THROUGHOUT.

WE HAVE A COUPLE OF AREAS
OF CONCERN,

IS ACCESS TO SERVICES
AND PART D DRUGS.

THAT INCLUDES ACCESS TO TIMELY
APPEALS AND GRIEVANCES.

TIM TALKED ABOUT
BENEFICIARY COMMUNICATIONS

TO ENSURE THAT THEY ARE ACCURATE
AND NOT DISCRIMINATORY.

WE STILL HAVE CONCERNS,
THOUGH THE AGENCY

HAS MADE GREAT PROGRESS
TO ENSURE

THAT PLAN MARKETING PRACTICES

AND THE RELATIONSHIP
WITH AGENTS AND BROKERS

ARE FAIR TO BENEFICIARIES, PROVIDE
ACCURATE INFORMATION,

AND DON'T STEER BENEFICIARIES

TO PRODUCTS

THAT THEY DON'T
FULLY UNDERSTAND,

AND I THINK ALSO IS PROVIDING FALSE
AND MISLEADING INFORMATION

TO CMS.

THESE WILL BE PRIORITIES
FOR THE AGENCY GOING FORWARD.

WE WILL MAKE SURE THAT
WE DEDICATE EVERY RESOURCE,

AND THEN AS OUR OBLIGATION
TO MAKE SURE THAT

TAXPAYER RESOURCES
ARE SPENT WISELY

AND BENEFICIARIES ARE PROTECTED

AS THEY NAVIGATE
A VERY COMPLICATED SYSTEM.

WITH THAT, I'LL CLOSE AND OPEN IT UP
FOR A FEW QUESTIONS,

BUT AGAIN, I WANT
TO THANK YOU ALL FOR COMING.

I WANT TO THANK THE CMS STAFF

FOR PUTTING ON
AN EXCELLENT CONFERENCE.

AND WITH THAT, I'LL STOP
AND TAKE ANY QUESTIONS

AND ANYTHING IS FAIR GAME,
AND I SEE MARK

IS GONNA BE, AGAIN,
THE FIRST QUESTION HERE.

JOHN, HI.
TWO DIFFERENT QUESTIONS.

AND PLEASE STATE YOUR NAME
AND YOUR ORGANIZATION
THAT YOU'RE REPRESENTING.

MARK JOFFE ON BEHALF OF
A RANGE OF MEDICARE
ADVANTAGE PLANS.

TWO WEEKS AGO
AT THE PAYMENT
ENROLLMENT CONFERENCE,

TIM HILL CONVEYED
THAT HE WAS--

THAT THE AGENCY
WAS VERY RECEPTIVE

TO CONSIDERING REVISIONS
TO THE STAR RATING SYSTEM,

BUT HE NOTED THAT FOR 2012,

THE CURRENT INTENTION
WAS TO CONTINUE

THE EXISTING SYSTEM
BECAUSE OF--

AND I GUESS FROM
YOUR REMARKS, JOHN,

I COULDN'T QUITE TELL
WHETHER THERE MIGHT BE

SOME RECEPTIVITY
TO CONSIDER CHANGES

FOR PAYMENT YEAR 2012.

SO MY FIRST QUESTION IS,
DOES THE AGENCY

HAVE A POSITION
REGARDING 2012?

Johathan Blum:
I THINK A COUPLE
THOUGHTS TO OFFER.

NUMBER ONE IS THAT WE UNDERSTAND

THAT THE QUALITY--
STAR RATING SYSTEM

WILL BE USED
FOR PAYMENT PURPOSES

FOR THE FIRST TIME IN 2012.

TO DATE, THEY HAVE BEEN USED
FOR BENEFICIARY DECISION TOOLS

AND NOT FOR PAYMENT PURPOSES,

AND SO GIVEN THAT
THE STAR RATING SYSTEM

WILL BE INCORPORATED TO PAYMENT
STARTING IN PLAN YEAR 2012,

I THINK THAT CREATES A SPECIAL
OBLIGATION FOR THE AGENCY

TO TAKE A FRESH LOOK AT
HOW WE ARE CONSIDERING--

HOW WE ARE DEVELOPING
THE STAR RATING SYSTEM

AND TO ENSURE THAT
WE ARE CREATING

THE OPPORTUNITIES FOR PLANS
TO ACHIEVE THE QUALITY
INCENTIVE PAYMENTS

AND THE CHANGE
TO THE BENCHMARKS.

NOW, GIVEN THAT, IT IS ALSO TRUE

THAT THIS IS A VERY
COMPLICATED AREA.

CONGRESS HAS GIVEN THE AGENCY
A SHORT DEADLINE TO IMPLEMENT
THESE CHANGES BY 2012,

AND SO WHILE WE'LL BE
TAKING A FRESH LOOK,

I THINK WE NEED
TO ALSO MAKE SURE

THAT THE AGENCY CAN
IMPLEMENT THE CHANGES

BY JANUARY 12, 2012.

I EXPECT THAT THIS PROCESS
WILL EVOLVE OVER TIME,

AND SO THE STAR RATING SYSTEM
THAT WE HAVE TODAY

WILL LIKELY BE DIFFERENT
FROM THE STAR RATING SYSTEM

THAT WE HAVE IN THE FUTURE.

WE NEED TO MAKE SURE
THAT WE ARE ALWAYS

CREATING THE INCENTIVE
TO INCREASE PERFORMANCE,

TO INCREASE VALUE,

BUT AT THE SAME TIME,
WE WANT TO MAKE SURE

THAT WE ARE
CREATING OPPORTUNITIES

FOR PLANS TO ACHIEVE
THESE INCENTIVE PAYMENTS,

AND SO THAT'S OUR OBLIGATION
AND THAT'S OUR GOAL.

THIS WILL BE A PROCESS
THAT EVOLVES OVER TIME.

I EXPECT THAT WE WILL
BE DOING SO IN A WAY

THAT IS VERY OPEN
AND VERY TRANSPARENT

WITHIN THE LIMITATIONS OF OUR KIND OF
RULEMAKING REQUIREMENTS

AND I THINK THAT'S THE BEST ANSWER
WE CAN GIVE RIGHT NOW,

BUT I DON'T--I THINK TIM WAS GIVING A
VERY ACCURATE STATEMENT

AND--BUT AT THE SAME TIME,
IT'S OUR OBLIGATION

NOW THAT THIS STAR RATING SYSTEM

WILL BE USED
FOR PAYMENT PURPOSES

TO MAKE SURE THAT IT IS
FAIR FOR ALL PLANS.

Mark Joffe:
THANK YOU.
THE SECOND QUESTION--

IS THERE ANYTHING
THAT YOU CAN SHARE

WITH THE AUDIENCE TODAY

WITH REGARD TO
CMS'S INTENTIONS

TO IMPLEMENT
THE DUAL ELIGIBLE

INTEGRATION PROVISIONS
OF THE HEALTH CARE
REFORM LEGISLATION?

Jonathan Blum:
A COUPLE THOUGHTS
TO OFFER THERE.

I THINK IT'S FAIR TO SAY THAT

BOTH THE CONGRESS
AND I KNOW FROM SECRETARY
SEBELIUS'S PERSPECTIVE

AS HEALTH AND HUMAN
SERVICES SECRETARY

AND ALSO AS HER ROLE
AS A FORMER GOVERNOR

THAT ONE OF THE GREATEST
OPPORTUNITIES WE HAVE

TO IMPROVE QUALITY,
TO REDUCE COST

IS TO REALLY THINK ABOUT
THE DUAL ELIGIBLES

AND HOW WE CAN
BETTER COORDINATE CARE

BETWEEN BOTH MEDICARE
AND MEDICAID PROGRAMS.

THE HEALTH REFORM LEGISLATION
REQUIRES THAT CMS

ESTABLISH A OFFICE
FOR DUAL ELIGIBLES.

I THINK THERE WAS A CONCERN
FROM THE CONGRESS

THAT WHENEVER THESE PROGRAMS--
SORRY, THESE INITIATIVES

ARE EITHER HOUSED
ON THE MEDICARE SIDE

OR THEY'RE HOUSED
ON THE MEDICAID SIDE

THAT YOU KIND OF--ONE SIDE
TENDS TO DOMINATE,

AND I THINK THE CONGRESS
BASICALLY SAID

THAT WE NEED TO MAKE SURE
THAT WE'RE THINKING EQUALLY

ABOUT MEDICARE AND MEDICAID

AND TO SET UP A BRAND-NEW OFFICE
WITHIN CMS

THAT CAN FOCUS ON PROGRAMMATIC
CHANGES--INITIATIVES

TO BEST INTEGRATE THE CARE
FOR DUAL ELIGIBLES,

WHICH TO ME IS A VERY--
A VERY RIGHT COURSE.

WE ARE STILL GOING THROUGH
THE PROCESS AT CMS

ON HOW TO IMPLEMENT
AND HOW TO STAFF THAT OFFICE.

THAT IS A TREMENDOUS PRIORITY
FOR THE SECRETARY,

SO I EXPECT THAT IT WILL BE
UP AND RUNNING VERY QUICKLY.

BUT THIS TIME, WE'RE NOT ABLE

TO OFFER PRECISE DETAILS

OR PRECISE POINTS OF CONTACT,

BUT I CAN SAY THAT IT IS
A TREMENDOUS PRIORITY

FOR THE SECRETARY
AND ALL OF CMS.

I THINK IT'S ONE OF
OUR BEST OPPORTUNITIES

TO IMPROVE CARE COORDINATION,
TO IMPROVE VALUE,

AND TO REDUCE OVERALL COST,

BOTH TO MEDICARE
AND TO THE MEDICAID PROGRAMS.