



**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.