Nimble Payment Models

Former CMS chief Kerry Weems warns managed care about tougher rate fights

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Nominated for the position of administrator of the Centers for Medicare & Medicaid Services (CMS) by the president in 2007, Kerry Weems, a finance and budget expert, was never officially confirmed. Even so, as acting administrator for more than a year, Weems launched e-prescribing programs, electronic health record pilots, the nursing home quality-comparison Web site, and the CMS do-not-pay list for egregious medical errors.

"When Mike Leavitt, secretary of the Department of Health & Human Services, asked me to be CMS administrator, I said it wasn't going to happen," Weems says. "I'm a career guy. That's the most political job in government. And he persuaded me, and he persuaded the president, and it happened."

The confirmation process for such an official typically includes some partisan wrangling on the Senate floor. With a long list of sensitive healthcare issues under examination—including the debate over the expansion of the State Children's Health Insurance Program (SCHIP) in the summer of 2007—Democratic senators were unwilling to confirm a top healthcare leader nominated by the Bush administration.

As the SCHIP debate heated up, Weems continued on as acting administrator. In the history of the CMS lead position, there have been nearly as many acting administrators as fully confirmed administrators, so Weems' case wasn't unusual. In fact, the agency hasn't operated under a confirmed chief executive since Mark McClellan in October 2006.

Weems was a respected official who was adept at keeping Medicare and Medicaid running efficiently. Not being confirmed was a limiting factor in promoting controversial programs and policies, but he did follow through on the promise he made in his nomination testimony to intensify CMS oversight. He was particularly driven to wring fraudulent activities out of the Medicare and Medicaid payment system.

Now retired from government, Weems continues to influence healthcare's evolution as the senior vice president and general manager for health solutions with global consulting firm Vangent Inc. He remains an advocate of interoperable health records, fraud prevention, comparative effectiveness, value-based purchasing and quality reporting.

"When you leave government after 28 years, you have these notions of what you might want to do," he says. "It really took an entire six or seven month period for me to shed my government skin and decide what I wanted was to work in a health practice and continue moving healthcare in America along to higher quality and lower cost."

The major policy issues haven't changed much since Weems left government. He recently sat down with MHE to assess a few of the industry's biggest challenges.

MHE: How does managed care need to prepare for the near future?

Weems: Be ready for rate fights around every corner. That's the new reality. And you thought it was tough before? It's only just now getting tough on rate fights.

Be prepared to see your populations

expand, especially in Medicaid. There are some great opportunities for managed care expansion in Medicaid. Be prepared for a rate fight constantly there, just given the fiscal conditions of states. The capitation's going to continue to be a real tough fight every year.

The other thing I would say is look at non-traditional populations for capitation. I think those opportunities exist, and information about those populations exists. The key to bringing those populations into a capitated environment is gaining the trust of the state legislatures and gaining the trust of the advocates for those populations.

Those who are very successful with long-term care and the disabled and can assure them that they're going to get better care and have better access in managed care. Those markets are real opportunities. Not easy at all, but real good opportunities.

And thinking ahead two or three years, look at what comes out of comparative effectiveness and how you handle it. In my view, comparative effectiveness as a consumer tool is going to be remarkably effective. Comparative effectiveness as a rate tool, watch it; as a coverage tool, have lots of good lawyers. Using comparative effectiveness for coverage, at least until people are used to it, is going to be a fight, but as a consumer tool, I think it's powerful.

MHE: What will strengthen Medicare? Are you concerned about the sustainable growth rate?

Weems: We've got to throw that away. We've got to find some way of paying physicians that's based on value, not based on the formula. The underlying relative value scale has also skewed the overall physician payment formula away from primary care and into specialties. In addition, the sustainable growth rate on top of that has created literally an unsustainable payment path for physicians. That whole thing needs to be thrown away. We need to take a look at how we can reimburse physicians based on value, not based on the number of procedures that they do.

MHE: What do you think the formula is for reimbursing value?

Weems: I'm not sure it's a formula. We need to look at a number of things, and frankly I think some of the managed care companies are on to it. When you have a risk-based approach and an employed physician, some of those problems go away.

MHE: What about Medicaid? States are cutting Medicaid programs at a time when Americans need them the most.

Weems: In Medicaid, you free up the laboratories of democracy to solve their problems. The thing that I would advocate for is a basic waiver package, similar to what exists for some parts of Medicaid today. That would allow a state to quickly and nimbly readjust payment formulas, readjust coverage formulas, do some things that states have been reluctant to or not allowed to do before—such as have drug formularies in order to get control of their costs—but at the same time make sure that they maintain good, basic coverage for this most vulnerable of populations.

Medicaid right now is unsustainable. Twenty-five years ago at about the time that I started in government, Medicaid was under 10% of state budgets. Today on average, it's 21% of state budgets. On average, states spend more on Medicaid than they spend on primary and secondary education. In some states, they spend more on Medicaid than they spend on primary, secondary and post-secondary education. That is simply unsustainable, because Medicaid is growing faster than any of those other functions.

The states especially have had a real rough time of it, and their revenue gaps are huge. If somebody loses their job and goes on Medicaid, the state also loses the revenue from that person paying state income tax, so they're in pretty tough shape right now.

I think some of the states have good workable solutions. States hold the keys to some of their own help. It would require a change in statute for them to have a sort of 'superwaiver' ability, and Congress would have to craft it carefully to make sure that states were designing programs right, not just attempting to divest themselves of their responsibilities.

MHE: Speaking of responsibilities, do you think more cost is going to be shifted onto consumers?

Weems: Absolutely. We're going to see more and more, especially as the private marketplace understands how to rate providers better and to adjust out-of-pocket based on that.

I think the other thing that we're going to see is a bigger demand on the part of employers and other insurers to have the individuals hold up to their end of the healthcare bargain. That includes some degree of personal responsibility with respect to prevention, and by that I mean maintaining a healthy weight, not smoking, maintaining blood pressure and cholesterol within certain limits.

MHE: Do you think we're going to see any health reform legislation this year?

Weems: I think we'll see some. I think we'll probably see at least a Medicaid expansion. I doubt that we'll see the insurance market reforms. Market reforms don't work without the individual mandate, and a couple of states including Virginia are setting up what could be a very interesting Constitutional challenge to the individual mandate. I'm not a Constitutional scholar, and I'm not an attorney, but the state senate of Virginia passed a bill saying that the state doesn't agree with an individual mandate.

I think that it got too hard at that point. That doesn't mean it's not needed, but I think it just got too hard. And the framework that's been put together

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doesn't work without the individual mandate. You need well, healthy people in the risk pool for it to work, otherwise the costs are unsustainable.

MHE: For a long time, reform initiatives were being done at the state level, and then there was a big federal push. Now it's back to the state level. Do you agree?

Weems: I think it's going to be left to the states, and frankly, they have a lot of work to do. The states need to accept some responsibility for their insurance markets. Some states have made it very difficult to sell individual policies. They need to rethink some of those statutes that make that very difficult.

In a number of ways, the uninsured issue got nationalized, but it's also very much a state issue.

MHE: The American Recovery and Reinvestment Act (ARRA) provides incentives for electronic health records. How far do you think that will go to wire the healthcare system?

Weems: I like the way the administration has done it. First of all, you know this administration put money on the table. The last administration wanted the market to work its magic. That's a slower approach. As part of the stimulus bill, $36 billion came on the table for electronic health records. I think that's going to speed things along.

Also in the rule that the administration created in December, I think they did something really wise, which was for at least the initial round of meaningful use, you get reimbursed. You get your ARRA dollars if you engage in meaningful use with an electronic health record. For at least the first year, they're allowing self attestation for meaningful use rather than building some enormous bureaucratic infrastructure around it. That was smart.

In the second instance what they said was, 'In the next year you have to use an EHR to report meaningful use.' That's going to be harder, but at least they didn't try to, as I said, build a bureaucratic infrastructure around the first year, which was probably the most fragile year for electronic health records.

MHE: Many patients used to believe that there was some big medical record in the sky that contained all their information.

Weems: Right. They just hadn't seen the filing cabinets.

There's a footnote on that, though, and that's privacy. People are going to believe in electronic health records until there's a big records breach—until information for everybody who's been treated for mental illness suddenly becomes public or something like that. So privacy and security are absolutely paramount to this effort, and not just paramount to it technically, but paramount to maintaining the public's trust in the effort. I'm always careful to caution that anybody who works in this field has to understand that while there are penalties for breaches, the biggest penalty for privacy breach is public confidence in the overall effort.

MHE: Congress wants to legislate how private insurers do business. Will providers be asked to start justifying what they charge and how much they're shifting onto the private market? The slice of the pie that the government and public programs pay for is climbing to more than 50%, according to CMS actuaries.

Weems: The National Health Expenditure Report this year said, I believe, by 2012 public spending, which includes the federal and state governments, will be 50% of total health spending, and 50% will be the private sector. The bills that are in Congress are insurance reform, and probably the best way to think about it by analogy is what happened in the state of Massachusetts.

In Massachusetts, they undertook market reform first, and that market reform caused some problems that they saw coming. But they wanted to do market reform first. Frankly the primary care system they had was not prepared for a tsunami of newly insured. So the next year they came back and said, 'Let's do something about primary care. Let's do something about cost rates.'

That's what would have happened if [the Senate] bill had passed. We would have covered everybody first, but then the pressure to reform costs and cost structures would have been insurmountable. We would have come back the next year and done something about delivery system reform and cost reform. You're right, depending on the market, there are huge cross-subsidizations between

Medicare in some cases, Medicaid in others, and private insurers. But for the most part, private insurers are providing the subsidy to Medicaid rates, and in some cases also Medicare rates.

MHE: Medicare is shifting from being a bill payer to being a purchaser of healthcare, looking at quality more often. How well do you think that's going?

Weems: In my view, they're not moving as rapidly as they could, but there are all these institutional barriers. When I started in HHS, [its predecessor] the Health Care Finance Administration was like an indemnity insurer. It paid bills. Over time, the government has been moving from a dumb payer to a smart purchaser. You can see that with the payer reporting efforts and the Physician Quality Reporting Initiative, which is physician-based.

We've probably gathered enough information now that within 24 months, we could put into place a pay-for-performance system that's better than good enough. We could refine it as time goes on, but I think we've gathered enough data. It's now time to quit buying healthcare by the yard and time to start purchasing value in the marketplace.

MHE: The Agency for Healthcare Research & Quality (AHRQ) looks at quality, not cost. Should that change?

Weems: Cost is hard. The problem with cost is it logically ends up in places that politicians don't like to go. It's unsurprising that AHRQ has not been charged with looking at the cost of procedures.

An honest conversation about comparative effectiveness does end up in a conversation about cost. But even if you look at the underlying Medicare statute for coverage, it says that Medicare will cover those things that are reasonable and necessary. It doesn't say reasonable, necessary and cheap. I'm not sure that we have the political means yet to have an intelligent conversation about cost, especially cost of particular procedures or cost of alternative procedures just yet. I'm hopeful that we will, but I don't think we're there yet.

MHE: Talk about your experience with identifying and preventing healthcare fraud. It seems like CMS is getting serious about devoting more resources to it.

Weems: I served in a number of capacities in HHS, including the chief financial officer and CMS administrator. One of the big frustrations I had especially at CMS was getting lacerated by Congress for fraud but not getting the resources that I needed to fight it.

I'm going to try to remember the numbers accurately, but I think Congress failed to provide resources that had been asked for by the president for three of the past four years before I left, to the extent of half a billion cumulative dollars that were not provided for fraud.

Now it's a little inside baseball here, but those dollars were on the discretionary side of the budget, meaning they competed with the National Institutes of Health [NIH], with the Centers for Disease Control and with all of the other health budgets. Your choice in the Appropriations Committee is to give more for bureaucrats to fight fraud or give more to NIH to go cure cancer. As it turns out, that's pretty easy calculus. But fraud continued to grow.

When I left government, I pointed this out loudly and repeatedly. I could not do as much inside government as I could when I got my First Amendment rights back. I'm not sure if that had the effect or not, but at least for the past two years, Congress has provided additional resources. The president's budget promises more. I don't think that they've quite got this problem solved. More money helps. Prepayment review helps, but I think what's needed is a more radical approach to fraud.

MHE: What do you mean by radical?

Weems: CMS cannot be as regular and predictable of a payer as it is. It's literally, kick the machine and money falls out. Most of the fraud business is built up around that regularity. If I bill, they're going to pay. They're going to pay within a certain amount of time. If I can get that money within a certain amount of time, I can be onto my next criminal enterprise before they catch up with me.

So some of that will be stopped with prepayment review. Really the way to manage this—and it's tough on the providers, I understand that—is to make the Medicare payment system a lot less predictable. Most of the fraud regiments today are built on that predictable element of the Medicare payment system.

MHE: You had a great career in public service. Tell me one moment that you will always remember.

Weems: On 9/11, the Department of Health and Human Services did not close. We were there the full work day, rendering aid to the people in New York. The only non-military plane in the sky that night was bringing the pharmaceutical package from the national pharmacy stockpile to New York. That was the only non-military plane in the sky, and it was carrying HHS material. **MHE**