TRANSCRIPT

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LIST OF SPEAKERS (in order of appearance)

Jim Shmerling, President and CEO,
Children's Hospital
Jeff Hinson, Regional Administrator,
CMS-Denver

Dr. Rick Gilfillan, Acting Director,
Center for Medicare and Medicaid
Innovation, Centers for Medicare and
Medicaid Services.
Dr. Mark Levine, Physician Liaison, CMS
Dr. Lynn Parry, CoChair, Judicial
Conference, Colorado Medical Society

Keely CofrinAllen, Ph.D., Director,
Office of Health Care Statistics
Joseph Stepanek, Retired, USAID,
Department of State

Phil Kalin, Executive Director, CIVHC

LIST OF SPEAKERS CONT'D

Mary Phillips, President, Colorado Ovarian Cancer Alliance

Diane Livesay, Deputy Regional Administrator, CMS-Denver

Dr. Randolph Fincher, Optometrist, American Optometric Association

Brenda VonStar, FNP, Colorado Nurses Association

Sara Schmidtt, Colorado Rural Health Center

Kelly Stahlman, Parent, Consumer

Moe Keller, VP of Public Policy and Systems Advocacy, Mental Health America of Colorado

LIST OF SPEAKERS CONT'D

Jean Nofles, Legislative Advocate, AARP
Dr. Doug Ford, Professor of Pediatrics, Director Home Dialysis & Renal Transplantation, Children's Hospital
Brenda Hudson, CMS-Baltimore
Eric Aakko, Healthy Living Branch Unit Director, Colorado Department of Public Health and the Environment
Tiffany Noelle Brown, Ph.D., President, Own Your Own Health
Samantha Lippolis, Outreach Coordinator, Children's Hospital-Denver
Melissa Field, Director of Policy and Communication, Colorado Association for School-Based Health Care
Chris Collins, Executive Director, Alliance
Marguerite Salazar, Regional Director, Department of Health and Human Services, Denver

P R O C E E D I N G S

MR. SHMERLING: Good morning. I'm Jim Shmerling, president and CEO of the Children's Hospital. I welcome all of you here this morning. I thank Dr. Gilfillan for being here to speak with us. Dr. Gilfillan is the new director of the Center for Medicare and Medicaid Innovation.

Innovation is something we all know about on this campus. We have a number of initiatives, being on this campus: The Children's Hospital, the University Hospital, the School of Medicine. With the development of biosciences on this campus, there is a tremendous of innovation occurring here.

With the leadership of our dean, Richard Krugman, who is here this morning, we have begun an initiative with the School of Medicine and the hospitals around quality, quality and excellence through structural integration.

There are a number of grants that are supporting medical education. We are including, as we go forward, medical students and residents, how to integrate quality and safety in our work here. I know

that in the new legislation, there is a provision for innovation for pediatric delivery. For those of us who are in pediatrics and all of us on this campus, we are really looking forward to hearing the coming comments.

So with that, I'd like to have Jeff Hinson from the Centers for Medicare and Medicaid Services come up and make the introductions.

MR. HINSON: Good morning. My name is Jeff Hinson. I'm the regional administrator for CMS here in Denver, Region 8. So first, I'd like to thank Jim for hosting us. It's a wonderful facility and a great place for us to talk and listen.

Real importantly, his staff has been instrumental in helping us get started. Debbie Roseth and Heidi Baskfield were instrumental. The folks around here, my staff, are actually helping out things.

I'd like to thank Amy here. She is our sign language interpreter.

Dr. Levine, if you don't mind standing up. He is going to be our MC for the day. We are trying to get done.

Most importantly, I'd like to thank you all

for coming out and spending your valuable time to help listen and give us feedback on where we go in the field of medicine. We have consumers, clinicians, employers, hospital health systems, state representatives, and health care experts and others around our region. Thank you for taking the time to spend time with us.

What we want is the highest quality care system possible, a system that coordinates and integrates care, eliminates waste, and encourages the prevention of illnesses. We have new provisions in the Affordable Care Act that give more opportunities than ever before to work with public and private partnerships and sectors to make real improvements in our nation's health care delivery system.

Let's face it. The current health care system is broken. We pay a lot of money for systems that are fragmented, disorganized, and fail to meet the patients' needs.

The problems are generated from a health care delivery system that is set up to pay for piece by -- pay by piecemeal, not care that is delivered to us and coordinated. Patients want high quality, timely and

efficient care. They want to get treated as individuals. They want their doctors to take into account their values and their wishes.

Our health care professionals want to provide health care. That is why they got into the health care field in the first place. We know that our health care professionals work hard every single day to provide the best quality care. We want to help them out and make this a more better and more efficient health care system. Our current health care system doesn't offer or provide patients with the care that they should receive. It doesn't support the health care professionals providing that care.

Today you are going to have an opportunity -- this is a listening session for CMS. We want to hear your opinions. We are going to highlight three areas that I've laid out in the Affordable Care

Act: Accountable Care Organization shared savings program, the CMS Innovation Center, and the Federal Coordinated Health Care Office. We look forward to working with you over the next couple weeks, next couple of months, next couple of years, actually.

Without further delay, I'd like to introduce Dr. Rick Gilfillan, who is now the acting director of the Center for Medicare and Medicaid Innovation in the Centers for Medicare and Medicaid Services. That is a mouthful. Rick joined us in July of 2010 where he was originally working on programs that improve and update the nation's health care system and overseeing the Accountable Care Organizations and value-based initiatives.

Before coming here, he was the CEO of Geisinger in Pennsylvania, the senior vice president of National Network Management at Coventry Health Care, the general manager of IBC's AmeriHealth, and the chief medical officer for Independence Blue Cross.

Dr. Gilfillan, would you like to come up. I'm going to turn this over to you. I appreciate you coming out.

DR. GILFILLAN: Thank you. Thanks very much, Jeff. Can you hear me okay out there? Let me first echo those words of thanks to all you for being out here today, Jim and Mike for getting this together for us. Thanks to Marguerite Salazar, Diane Livesay, and

particularly to Mark Levine for actually going to the trouble of picking me up last night and shuttling me about town this morning. Thank you to the CMS and HHS regional staff for getting this meeting together.

I should correct one note on the introduction. Jeff, thanks for the promotion. I was the CEO for Geisinger Health Plans. There is a guy who is the CEO of Geisinger Health System, Glenn Steele, who does a fabulous job. Many of the people here know him.

It really is a pleasure to be here with you all today. As Jeff said, we are going to talk about three topics: the Innovation Center at the Center for Medicare and Medicaid Services. We'll talk a little bit about Accountable Care Organizations. And we'll talk a little bit about the Federal Coordinated Health Care Office. But what this is most about is hearing from you all and having an exchange and learning, getting your thoughts about these three areas of activity for CMS. I'm looking forward to a great exchange as we talk about these three areas.

I want to start with a thank-you. Thank you

for doing the hard work that I know people at Denver Health were doing this morning, when we were here this morning at 7 a.m. on their campus as people at Children's Hospital are doing right now, and as many of you health care providers do every day. I think it's important for us to begin every conversation about delivery system reform with a recognition that the delivery system is doing extraordinary work already -- every doctor, nurse, other caregivers, ancillary folks, hospital administrators. There is a ton of excellent work being done every day by these people. We want to start off by recognizing that that is the case. And in many instances, in children's hospitals like this, we know that incredible work is done on behalf of children and families. So we understand that is there.

We understand that when we say delivery system reform and change, we are asking for folks to change the way they provide care, even as they are providing care for thousands of people every day. It is a daunting challenge and one that we at CMS want to be your partners in. If there is one message to take away today, it is that we understand that challenge for

you all, and we want to be your partners in finding a way to do even better work than you are already doing today.

The reality is, the system is unsustainable. You have all seen slides that demonstrate this and talk about it in all sorts of ways. Typically, it's a line graph that shows escalating costs going up at an unsustainable rate. This was a different one. I decided that for nothing else but my own entertainment, I'd put a different slide up. This shows a pie chart that says that in 2030, right now at the current projections, that Medicare and Medicaid will consume 30 percent of the federal budget. That is not sustainable. If you extend that out to 2050, it starts looking like the entire budget.

It's clear that notwithstanding the excellent work we have all done in health care delivery, the system as it's operating today is unsustainable.

Having said that, it's intellectually interesting and it's quantitatively fascinating to think about all aspects of that. But at the end of the day, this is about patients. And we want to make sure

that we anchor everything we think about and talk about and plan from the reality of patients' experiences.

This is a patient from northeast Pennsylvania. Her name is Marie Jones. You can find the story that she tells on the New York Times Web site. She is an older woman who has a series of chronic medical conditions. Most notably, she has trouble breathing. She has COPD. She has had a tough times over the years with frequent ER visits, hospitalizations for exacerbations of her underlying illness.

And here, she is shown with her case manager that works in the medical home that we created awhile back out there for her in her primary care physician's office. We put nurses in that office, one nurse for every 800 Medicare patients. These nurses develop relationships with the doctors, other nurses, with office staff, and really put together a new model of care. They went right at helping people like Marie do better. We put a line in, a hot line, so that when Marie has a problem or her family has a problem, she can call that nurse directly. She can find out what

she should do to trigger the use of her rescue kit for her medical condition or medicine because she's starting to have a tough time.

As Marie said, the idea of the program is to "keep me healthy, keep me out of the hospital, and keep costs down. I don't think I would still be here without this program. It's been my lifeline."

That is what the delivery system reform is about. It's not about more money for insurance companies or simply saving money for CMS; it's recognizing that we can actually do a better job for people like Marie and make the system sustainable. That is what we want to talk about. That is the goal.

So how do we conceptualize that when we move from one patient to a broader system? Jeff mentioned fragmented care. We think that the need is to move from that fragmented care system to a seamless coordinated care system, a system today that we support. We support fragmented care very well. We have inpatient payment mechanisms, outpatient payment mechanisms, RBRVS, other prospective payment systems. But can we find a way to pay for that nurse to help

Marie Jones get health care? No.

We want to change our payment mechanism at CMS from those that support a fragmented care system to those that can support a seamless coordinated system. So that gives us a mission. CMS wants to be a constructive force and a trustworthy partner for continual improvement of health and health care for all Americans. That is Don's message about what he wants CMS to be. That is not our parents' CMS. That is not our CMS from a year ago. That is one CMS trying to find a way to work as a partner in creating continuous improvement in the health care system, thereby improving health and health care for all Americans.

All Americans. We can't do this alone. We can't do it just with Medicare and Medicaid. We need to do it for all. The delivery system -- the doctors, nurses, the hospitals -- are taking care of all Americans. We can't offer one business model, one fragmented system for some 50 percent of the business and then seamless care and expectations for 50 percent of the business. We need to find a way to work together across the entire health care industry to

offer one seamless care system, one set of objectives for health care providers. And that means we want to be shoulder-to-shoulder with other payers, with providers, with other stakeholders to create, if you will, that transition from the fragmented system to a seamless system.

How do we define success? Three-part aim:

as Marie told us, better health, better care, reduces costs. We think all three are attainable. We think the way to get there is from continuous improvement and a system that understands that they want to accomplish all three at the same time.

So our strategy, from a transition standpoint for CMS -- and by the way, going from here to here is a transition in all aspects and for all segments of the industry. And in every piece of our business, we need to think about the reality of that transition. It's not a no-brainer. There are clinical issues. How do we actually move from here to here? How do we do that?

Financially, how do we as an organization, as a university hospital or children's hospital, have a business model that operates very well with a

fragmented care approach to a seamless care business model that allows us to be successful in doing both? And how do we and other payers move from fragmented payment systems to systems that support value-adding coordinated care in that new environment? So we have to think about our transition strategy as you do.

We have, by the way, a lot of payments -- a lot of levers to help with that transition. We have to spend $800 billion a year, about a third of everything that's spent in health care. It seems like for saying that much, we ought to be able to be influential about getting outcomes that the American people need and want. So we have payments, obviously. We have transparency tools. We have a new value-based payment system, which we are building as a result of the Affordable Care Act. We have much more in the way of program integrity activity, which are important. We have COP efforts to look at what are the terms for engagement with Medicare and Medicaid are. Maybe we need to revisit what those conditions of this patient are for providers and understand that we have a set that fits fragmented care. Now we need a set of

conditions that fit seamless care. We have a whole host of Affordable Care Act provisions, and we have a new set of Medicare and Medicaid innovations.

Let me talk about that, if I could, for a moment, specifically established in Section 3021 of the Affordable Care Act: "The purpose of the center is to test innovative payment and service delivery models to reduce program expenses while preserving or enhancing the quality of care."

So if you are the team running the Innovation Center, you say, "Well, what is my mission? What am I supposed to be doing? How do I think about that charge in the legislation?"

We think about -- there are three ways we can meet that. We can identify new ways of providing care that provides the same quality at a lower cost. We can find some new models of care that provide better care at the same cost, although note we can't live there.

The Center for Innovation has a specific mission around reducing program expenditures. So it's nice for people to say, "We have a great idea for a quality improvement activity. It's going to cost a

little bit more, but we think the quality piece is good." That is great, but that is not our charge. Our charge is to do both. Okay? So we need to think very concretely about that opportunity.

And the third framing of that is to say better quality, lower cost, just like what we said. We think that's feasible. We think it's doable. It's real. There is not a tradeoff. If anything, there is a direct connection between doing more efficient and effective care and improving the quality of outcome.

So what do we have to do that? Ten billion dollars in funding between 2010 and 2019. We have some nice liberalization of the context within the operation of the federal government around expectations for budget neutrality and paperwork reduction.

Here is the key. Here is the key. We get new payment provisions within the Affordable Care Act. But what the Center for Innovation can do in conjunction with the Centers for Medicare and Medicaid is to find new models of care, find new models of payment that take us from here to here. If we can demonstrate to the satisfaction of the actuary that

indeed it does reduce program expenditures, then the secretary can redefine Medicare payment policies without going through congressional legislation. Okay?

So we have a static set, if you will, of payment mechanisms. This gives us a dynamic set of payment mechanisms. In the context of the health care system looking to continuously improve, this is the dynamic capability that allows it to continually improve. It supports you all in new ways of providing care.

The mission, then, for the Innovation Center is to identify and validate new models of care of payment that improve health and health care and reduce the total cost. That is the mission. We think very concretely about patient care models. We are thinking -- I'm trying to give you an idea now of how we are thinking of looking at proposals and things you may have.

We are thinking of looking at this at three levels of care. Patient care model: How do we deliver the best OB care. How do we deliver the best hip surgery care? Acute episodes of care, et cetera. That

is one.

The second level, coordinating care models. How do we build coordinating mechanisms -- ACOs, medical homes, whatever you can think of -- that coordinate care across the continuum, across multiple sites of care to provide a seamless care experience that meets our objectives?

And third, how do we work at the community population health system level to effect the fundamental determinants of health?

So when we are sitting in those offices in D.C. looking at proposals and thinking about proposals, we are thinking about things in this context. Many of them will cross all three. I understand that. We are looking for models that address these levels of care.

What does that means in terms of functional activities? Right now at the Center, we are planning and figuring out how the Center should operate. Here are some of the functional activities to think about. We are going to be focused on those three levels at the center of our business model. Okay? We know we are not going to change care from Washington. We know that

care is going to be changed at local communities where care is different, institutions are different, arrangements are different, and challenges are different. So we are going to have folks very much focused on understanding proposals, new models, et cetera, that come out of those three levels. That is going to be the core of what we do.

And every time we have a decision to make in our organization about where we should pay attention, where we should focus, our default position is going to be you taking care of patients in the community. We want to understand that and build off that. We will have diffusion in learning systems as a critical piece of collaboratives. We will have other ways of interacting with regional. We are not sure exactly how that is going to work, but we know we need that capability. We know we need an innovation cycle, a management process. We need ways of getting ideas from you.

And by the way, we think many of these ideas are already out there right now, maybe 70-30. There are great systems of care. There are great models of care

that exists in pockets that we think can be diffused more broadly. We need to check them out, validate them, and make sure they work, et cetera, as I said. But they are out there. We are not thinking that all of the ideas are going to fall from the sky or be created by an individual thinking great thoughts someplace. We are going to have some of that. We will look at technology further. But we also want to mine and diffuse what is out there already.

The other thing that is going to be different about this. Remember that last step; right? The actuary needs to say, "Yes. This is good. This works." That creates evaluation of new models of care as a central function in our business model. We need rapid cycle evaluation. We need to find a way to much more rapidly demonstrate that new models make a difference.

Here is where we are. We opened our doors. We are building our team. We are recruiting and looking for great people who are interested in working with us in Baltimore at this point. We are building an operating plan right now. Part of being out here is to

hear from you about what you think about innovation, what you think, how you think we should operate, what you think our priorities should be, and really make sure we get that input as we build our operating model.

We want ideas. We have a Web site up. It doesn't have quite the capture capability for input that we would like. We are building that out now. Stay tuned for that. We are beginning our work with a couple of initiatives. One is the Multi-Payer Advanced Primary Care Practices model. This is being done out of ORDI. It's about a $100 million investment supporting medical homes in eight states. And we think we will help support about 1000 medical homes for about a million Medicare beneficiaries. We have announced the Medicaid Health Home State Plan Option, which provides 90 percent matching funding from the federal trust fund for the first few years of any state-based Medicaid health home model.

We have put out a proposal for medical homes in Federally Qualified Health Centers which we think will be supporting probably 500 FQHC sites. It will be supporting care for about 200,000 patients.

And finally, we announced the state grants through the Federal Coordinated Health Care Office to evaluate new ways of dealing with the dual-eligible population. I'll come back to that in a moment.

It's about partnership, as I have said repeatedly. We understand that we need to simplify expectations for providers in the delivery system. We know we want to work with other local payers, large employers, and providers to develop simplified sets of expectations, because at the end of the day, they need to have a rational environment within which to drive that so that all patients can benefit.

Let me skip now to talk briefly about the ACO shared savings program. This was created under Section 3022 of the Affordable Care Act. We are currently in rule-making. We are writing the initial draft regulations for the ACO shared savings model. We are interested in input. We are interested in hearing more if you have suggestions about how we should operate and structure that program. It's scheduled to go live in January 2012.

A lot of the talk about ACOs has been about

financing. Back to Marie. It's about new ways of delivering care. We want to make sure we focus on new ways of delivering care. That is high on our radar screen as we think about those proposed regulations. Multiple types of providers are clearly defined in the legislation. Patient-centered criteria is very important. We need to be mindful of that as we think about structuring the regs. There is a requirement to meet a quality threshold.

We think it's important and need to think about and reflect on and develop systems that recognize that this is going to be very data-rich. Its success is going to be determined by its ability to use data to inform its care processes and evaluate its strength. If you want continuous improvement, you can only do that with regular data and timely data.

We want to reinforce the notion of the seamless care experience. And if you think about that, if you think about the prerequisites to a -- if you are operating a health care system to a patient moving across it and not dealing with transitions or having it be as smooth as possible, what are the implications of

that when you think about what an ACO should deliver? And finally, we need to be a continuous learning organization.

Lastly, I would like to speak about the Federal Coordinated Health Care Office. Why the focus on dual eligibility? When I went to D.C., I honestly did not have enough knowledge to really deal with this and answer this question. Melanie Bella is the new director of this office. And she is a dynamo, a great person, with incredible commitment to this population.

But here is the deal: Nine million individuals, accounting for a ballpark 40 percent of Medicare and Medicaid expenses, more than 80 percent are fully eligible for Medicaid. They are more likely to have challenges in their daily living, multiple chronic conditions. And there is a tremendous opportunity to improve care and outcomes for this population, a population who really are the most needy in our country.

And yet, there are these bizarre dynamics that exist between Medicaid and Medicare, state interests, federal interests, how the dollars flow,

that keep everybody fragmenting the care experience nicely. They are really good at it. Here is a whole office set up to do one thing: Take us from here to here for that population. That is what it's about.

We are looking for ways to solve that conundrum of the Medicaid people thinking, "Do I want that person is in a skilled nursing facility to stay there? Do I want him to go back to the hospital?" And the Medicare people are thinking just the opposite. It's a wild ride for people who are dual-eligible and at the end of the day need that nurse support more than anybody, yet we can't find a way to get it for them. That is what this office will be about.

The focus will be on beneficiary in person-centered care and service delivery and finding new models of care, new models of payment that coordinate that care.

Melanie has set the department up in two sections. She has gone a long way already in getting great information together. Think about that data for these people. Where is it set? The Medicare piece is in one place; the Medicaid data, in another place. If

you really want to understand this population, how would you put that data together? It's fragmented. It's in different places. In this case, they're actually in antagonistic places from an objective standpoint. They are in antagonistic places. We need to put data together and begin that analysis. She has started doing that.

We are also looking for ways to then come to states and say give us some ideas. Give us your best suggestions how we can actually provide a rational integrated care, coordinated care experience, for these folks.

So as I mentioned, Melanie has been appointed. She is hiring folks. She has established it in a couple of communities that goes across the federal structure. She is interacting with folks federally. And we are looking and have -- I'm sorry -- we are actually looking for states to give us suggestions as we announce our intent to make 15 awards of approximately a million dollars to states to make proposals to us -- that would be the first stage -- telling us what they want to do. We'll go through a

selection process, understand what exactly they are proposing, and then go to a second stage of supporting the development of a more specific approach.

We can do this. We believe we can do it. We think the system is -- people are waiting out there who would love the opportunity to do this. It's just incumbent upon us to figure out how. One of the ways is to be here with you today and hear what your thoughts are about how we can work together to get to this new seamless care system.

So thank you very much for the opportunity to be with you today. I am looking forward to your questions, suggestions, conversation.

MR. LEVINE: I am Mark Levine. Thank you very much, Rick, in helping us at least understand the challenge we are all facing. And you'll notice Rick did not give us a lot of answers. The answers are actually out there. And we are here, actually, not to tell you what the future is going to be but to hear your comments and suggestions about what it is that -- to take advantage of these opportunities that we have as we move the health system forward.

Everybody should have received some information about the Center for Innovation and Integration Center as you walked in. Please also take note of the Web site, which is innovations.CMS.gov. There, by the way, you can sign up to receive announcements and happenings and things that are going on there so that you can keep in touch with the different activities that are going on.

Now it's time for us to open up the mics. There are two mics there. People who can't get to the mic, raise your hand. We have traveling mics that will move to you if you are not able to do that.

As you start to talk, please identify yourself by name and by prospective, for instance, whom you represent or what you are doing. Please try to keep your remarks brief. I don't think we have so many people here that we won't have time to hear everyone say everything they want. We will put a ten-minute limit. Brenda in the front row will be holding up time cards as time goes on if you do happen to go that long.

Remember, Dr. Gilfillan spotlighted three particular areas that we are soliciting comments on.

But don't restrict your comments necessarily to the Accountable Care Organizations, the Innovation Center itself, and the new Federal Coordinated Health Care Office for dual-eligibles.

The first person I saw at the mic was Lynn.

(There was a discussion on the lighting.)

MS. PARRY: My name is Lynn Parry. I'm cochair for the judicial conference for the Colorado Medical Society, the first CMS.

The question is -- Don Berwick has been very eloquent about the need to deliver more efficient and effective care. But he also describes that in the change from inefficient care to more affordable and more effective care, there is this little bump where increased price, increased the need to set up, basically, the infrastructure to select the data to look at your outcomes. How are you incorporating that as you look at the programs for delivering new models of care?

DR. GILFILLAN: Well, I think we understand our role. In some instances, it will be to help folks

put infrastructure in place or provide support for some of those activities. We see that and understand that. And there are times we should -- obviously, it's not going to get changed overnight. We are not going to suddenly see those care costs go down. At the same time, we have to make an investment.

But we do think that overall we should be able to see in the proposals, a plan or an expectation that is tightly tied back to what is happening with patients and an overall decrease in total costs.

We think it's important -- and Don says this often: It's important for us to commit up front to reduce costs. So we will be mindful of that need to investigate. And one of our roles is to be a vehicle that supports people as they build infrastructure to make that change. We can't support it in every way or for everyone. But that is part of our modeling -- part of our evaluation model, what we expect to see.

MS. COFFRIN ALLEN: Morning. Thank you for inviting us. My name is Keely Cofrin Allen. I'm the director of the Office of Health Care Statistics in the Utah Department of Health. I want to tell you a little

about a resource that we have called the Utah All Payers Claims Database. There are now six all-payer claims databases across the country and another ten in various states of exploration and start-up. Colorado is one of them. I won't presume to speak for Phil Kalin, who is here. But I would like to make a plea on behalf of all of the states who collect all-payer claims.

Utah is the first state in the country to have an all-payer claims database that can analyze episodes of care from a statewide perspective, across payers, across health insurance claims, including pharmacy enrollment and medical claims.

The Utah APCP is capable of performing comparisons of health care cost efficiencies and effectiveness statewide for both cross-sectional as well as a longitudinally based disease progression perspective. This is where the Medicare database comes in. When we look at -- and I've prepared a handout.

DR. GILFILLAN: It's always good to have a handout.

MS. COFFRIN ALLEN: Got to make my presence

known. Anybody here who knows me knows that.

When we look at disease progression in Utah across the age-perspective data, of course, we don't have adequate data for people who have aged into Medicare. We need the data to create transparency. If care isn't going to be performed in D.C., then the data can't stay in D.C.

With Medicare data, we can begin to examine this important part of the population. With identified Medicare data, we can track people into Medicare as well as track dual-eligible enrollees that you spoke about before.

So to put the data together, the states -- and as I said, I speak -- I'm taking liberty in speaking on behalf of the other all-payer claims databases to say we need the Medicare data in order to create a complete picture of care in our individual states. Once we are able to do that, I think we can greatly inform the federal government on health care reform efforts at the national level as well. Thank you.

DR. GILFILLAN: I'm sorry. Is it Kiley?

MS. COFFRIN ALLEN: It's Keely.

DR. GILFILLAN: Thank you, Keely, very much. And thank you for your comments. Can I just ask a question? Patient identification?

MS. COFFRIN ALLEN: Yes. We have -- in Utah, we have patient identifiers that are secured and encrypted. But we are able to track people across care delivery systems as well as across payers.

One of the reasons that we fought so hard to get identified data in Utah is because we were given the mandate to create episodes of care. And without the ability to create complete episodes, particularly for people who change plans in the middle of the year because of an episode, or someone with chronic conditions in 12 months, we needed those identifiers.

So yes, we do have them. All the data are identified. We do have that identified database.

DR. GILFILLAN: But they are encrypted in a consistent way so that you can track them?

MS. COFFRIN ALLEN: That is correct.

DR. GILFILLAN: But you are not using them, for instance, for registries or care intervention

activity?

MS. COFFRIN ALLEN: No. We are not currently using them for that.

DR. GILFILLAN: Right. You are -- what are you asking -- I just want to make sure I understand. There are provisions within the Affordable Care Act to release more data, Section 3022. And the regulations on that are also going through a process right now.

I think there is -- we expect the health care system to be data-rich, not just the ACOs. We know that there are ways to try and support the very activities you are talking about. There is a big issue of patient identifiable data that needs to be paid attention to and is something that is being addressed and considered.

But we want to be there with you in terms of being able to create those episodes, understand the performance of health care systems. And I think as we move down this road, Keely, hopefully you'll give us feedback, and we can find a way to be your partner on the data side as well.

MS. COFFRIN ALLEN: Certainly, data from

Medicare that was identified within Medicare would be very useful, and we can do a lot with that.

DR. GILFILLAN: Say that again?

MS. COFFRIN ALLEN: Data that are identified within Medicare.

DR. GILFILLAN: Yes.

MS. COFFRIN ALLEN: But obviously, to track people as they age into Medicare in Utah would require identifiers.

DR. GILFILLAN: I understand. I'm not familiar with the conversations that have gone on around that specific issue, but I understand your point.

MS. COFFRIN ALLEN: Okay. Thank you.

DR. GILFILLAN: People are very interested in getting there. Folks are working very hard to try to find a way to make sure we are an effective partner.

MS. COFFRIN ALLEN: Thank you.

DR. GILFILLAN: Please give me the handout, if you will.

MS. COFFRIN ALLEN: I will.

MR. STEPANEK: Thank you very much for this

opportunity. It's a pleasure to learn about CMS innovation in Washington.

MR. LEVINE: Please identify yourself.

MR. STEPANEK: My name is Joe Stepanek from Boulder, Colorado. I live at 720 11th Street. I'm here to address chemotherapy drug use in the treatment of ovarian cancer. I recently lost my mother to ovarian cancer. I'm now here to speak on behalf of a dear friend, my sister in Albuquerque, Molly, who is fighting for her life from this dreaded disease.

Molly and I served together overseas with the American Aid Program, first in Pakistan, Bangladesh, Indonesia, and now Kenya -- most recently in Kenya. I'm here to speak on behalf of Molly's plight.

A relatively new drug, Avastin, is currently FDA-approved in a variety of cancer treatments. It still awaits FDA approval for its use in ovarian cancer. However, Avastin is being used for ovarian cancer treatment all over the U.S., based on three or four accepted pharmaceutical compendia and numerous clinical studies. These compendia and studies all support Avastin as a safe and effective treatment for

ovarian cancer.

For patients like Molly who are hypersensitive or have had severe reactions to ovarian cancer's first-line drugs, the addition of Avastin becomes a lifesaving option? For my sister, Avastin was added to her chemo mix in early November. One month later, the tumor marker for ovarian cancer, CA-125, has decreased 50 percent from the high mark in mid-October of this year.

At first, sir, I thought I was speaking off topic. It just occurred to me that for Molly and thousands of people like her, if we can help Molly stay home and be well and not be in the hospital, it will save Molly and the entire system a great deal of money. For this reason alone, I welcome the CMS initiative.

Avastin used in treating ovarian cancer is covered under Medicaid in 46 states, as I understand. Yet the private contractor for Medicaid's Jurisdiction 4, which includes Colorado, New Mexico, Texas, and Oklahoma, Trailblazer Health Enterprises based in Texas, continues to turn down Medicaid coverage for Avastin use in ovarian cancer.

In October of '09, 30 congressmen from this region, Jurisdiction 4, sent a letter to Medicaid and to Trailblazer. Yet there has been no action or correction in this inconsistent policy coverage.

I'm personally saddened and outraged that Molly and I have returned from decades of work overseas to come home and find a brick wall facing us. We kindly ask that anybody that can help Molly help us address the coverage in this region, coverage that is available to women in almost all of our states but not in this region, please contact me after this session.

Again, I greatly appreciate having the chance to speak. Thank you.

DR. GILFILLAN: Joe, thank you for that. I'm sorry for the loss of your mother; and your sister, the challenges she is facing. If you would, be sure and give your contact information to the CMS folks. We will get information and follow up. I appreciate your bringing this to our attention.

MR. STEPANEK: And again, I think it's worth repeating, that coverage, as you rightly pointed out, begins at home, individual responsibility at home. So

for a topic that appears off topic, it's really the heart of the matter. All of us have to take responsibility and take care of ourselves at home with the help of a marvelous system. But the system needs to start at home. I salute your innovative work, sir. Thank you.

DR. GILFILLAN: Thank you.

MR. KALIN: Good morning. I'm Phil Kalin from the Center for Improving Value in Health Care, CIVHC, as it's known. Thank you for coming out to Colorado.

I wanted to follow up, actually, on one point that Keely Cofrin Allen over in Utah made regarding the health care database and expand that theme for a second.

In Colorado, CIVHC's role is to try to bring together all the major stakeholders and try to improve value in health care. And it varies dramatically and is in line with what you are doing in terms of cost and quality.

One of our first major initiatives is launching an all-payer claims database. And like Keely

described, we are trying to bring Medicare and Medicaid data in as part of that, as part of our overall database.

One of the themes that I just wanted to touch on was, part of -- as I look at the rapid cycle and innovation concepts you are talking about, as we look at bringing in Medicaid and Medicare data in the system, you find we have to go up two different lines within CMS in order to start doing. One of the themes -- and Keely made the point very well about the importance of identifying data in the system. But to even get the speed going in terms of what we are trying to do, if we can find one way to get high enough in the CMS structure so that as we are trying to get that data, we don't have to go up two different lines to get that. It would be very, very helpful so that we could be high enough in CMS so that decisions could be made and get the data into our system without pursuing a Medicaid track and a Medicare track, if that makes sense.

And then, just using that theme about trying to break down some of the barriers, part of it is, as

we bring people together in Colorado representing all the providers, payers, et cetera, there really are a lot of good ideas and, surprisingly enough, a lot of unanimity in terms of the kinds of solutions we need to be following.

And as we talk about bringing people together -- medical homes, different payment methodologies -- one of the first things we run into -- and I know it's not new to you, but it's certainly something that to the sense we can begin working together on would be helpful -- is payers, providers say we want to work together. But then we start to get into FTC concerns and that sort of thing.

The degree to which we can -- given there is a desire and understanding to move along the direction that you and Dr. Berwick have outlined, the degree to which we can lower the barriers that are preventing people from feeling comfortable in sitting down and having frank discussions and negotiations to create innovative models of payment and delivery, that would be a huge service. Thank you.

DR. GILFILLAN: Thank you, Phil, for those

suggestions. And I think we need to follow up internally and talk to CMS to be sure and get a plan as to how to do that on the data side. That would be great.

Just so you know, there has been a great deal of energy and time put into trying to resolve and trying to understand the constraints that exist today from the FTC or other places in D.C. We have got -- like everything else, we've got a fragmented regulatory approach that works real well, and we know we need to get a regulatory system that works. We have to be mindful of the concerns that people have. And they are very real.

There is an interesting challenge that faces the broader industry, this challenge that other payers are saying, "Wait a minute. I'm already having a hard time negotiating effective rates with a lot of providers, and now you are talking about systems that are going to make those people more powerful and give them more leverage. I'm concerned it's going to cause rates to rise further."

It's an interesting challenge to providers

and payers in the commercial world, I think, to say that there is a problem here. You need to sit down and figure out a way to deal with that, because that is a significant reality. As these people think about finding ways to make it easy for folks to come together, they are doing it in a context where the commercial side is saying, "Whoa, we are concerned already."

So we are sincerely interested in finding an approach, and we are working on a way do to that, to make it easier. But it's also not any kind of unbridled, open door. To the extent the industry can come together and find ways to mitigate those concerns, that would be very helpful.

MR. LEVINE: Mic in the back row.

MS. PHILLIPS: I'm going to follow up on what the gentleman in the third row was talking about.

MR. LEVINE: Please identify yourself.

MS. PHILLIPS: My name is Mary Phillips. I'm the president of the Colorado Ovarian Cancer Alliance. I'm a five-year survivor of metastasized ovarian cancer. So far so good for me, but not so much for

most women with this disease. For two years, COCA -- we call ourselves COCA -- has been fighting against Trailblazer Health Enterprises on this issue of the lack of coverage for Avastin in Colorado, as well as the other three states that Trailblazer takes care of.

We think it's unfair that in 46 states, reimbursement or Avastin is possible, but not in our local state of Colorado. We are involved with the letter also from the 30 legislators, but that didn't seem to make a dent.

As the gentleman said, Avastin is covered for ovarian cancer in CMS-approved compendium. This strongly, to our mind, indicates that Trailblazer Health Enterprises is erroneously denying coverage. We believe there is no reasonable basis for local determinations for anticancer drugs. Cancer does not respect state boundaries. It isn't fair, in our minds, to allow Avastin to women with ovarian cancer in 46 states but not 4. This is not equal treatment. Women with enough money can and do go to other states to get Avastin treatment. This doesn't make any sense.

Ovarian cancer is very deadly. In Colorado,

44 percent of women with ovarian cancer diagnoses do not make it five years. Avastin offers progression-free survival by cutting off blood supplies to the cancer cells.

We are asking CMS to consider our request for equal treatment for women in Colorado and in Texas, New Mexico, and Oklahoma. We believe there is no good reason for Medicare to allow contract administrators to discriminate in reimbursement of anticancer drugs among states.

I have my contact information here in case anyone would like more elaboration on what COCA has done, along with our partner organization in Washington, the Ovarian Cancer National Alliance. Thank you.

DR. GILFILLAN: Mary, thank you very much. I'm not familiar with all issues here, obviously. I'm sure our colleagues will look into this and have a response.

MS. LIVESAY: Mary, I can take that information. I'm thinking it sounds like it's a local carrier determination of some sort. But we will follow

up.

MR. LEVINE: Please identify yourself.

MS. LIVESAY: I'm Diane from CMS here in Denver. Let me look into it, and I'll follow up. I'm unaware of the letters that have gone forth and stuff like that. Thank you for making us aware of the situation.

MS. PHILLIPS: Thank you.

DR. GILFILLAN: Thanks, Mary. Continued good health. And it was great to hear your story. Thank you for providing it.

DR. FINCHER: Good morning. My name is Dr. Randolph Fincher. I'm a doctor of optometry in practice in a multidoctor optometry practice in the cities of Aurora and Centennial.

MR. LEVINE: Please speak closer to the microphone. This is being recorded.

DR. FINCHER: Excuse me. This is not an advertisement for my offices, but I do want to make one comment about Avastin, which is not what I'm here to talk about. It is a very innovative drug. I don't know if you are aware of this, but it's continually

used off label for macular degeneration and diabetic retinopathy in Colorado. It is effective at one-tenth of the cost of other injectable drugs for those diseases. So it's an area -- there is a lot of areas -- a lot of drugs that can be used across other areas that can save CMS a lot of money. And I applaud you for making your stand.

I'm here today as a concerned citizen and a physician who provides primary eye care in the community. In addition, I'm proud to represent hundreds of my colleagues of the Colorado Optometric Association, tens of thousands across the country who are members of the American Optometric Association. On behalf of optometry and the millions of patients we serve, thank you for offering us this opportunity to share our thoughts on health care delivery and reform.

To provide a bit of background, doctors of optometry serve patients in nearly 6500 communities nationwide. In 3500 of these communities, optometry is the only eye doctor available. Medicare beneficiaries and approximately -- I'm sorry -- approximately 34,000 optometrists are currently enrolled as physicians

serving the needs of Medicare beneficiaries. Approximately 14,000 are DME providers.

Additionally, optometrists provide the majority of eye care and vision care services received by Medicare and Medicaid beneficiaries. Optometrists also play key roles in essential eye and vision care services which America's children need to learn and grow beginning in the first year of their life through the critical school age development, and into healthy productive adults.

The AOA is particularly proud that the Affordable Care Act recognized pediatric vision care as an essential benefit for plans opting with the new system of insurance exchanges. We look forward to working with HHS to ensure that this benefit is fully defined as a direct access to an annual comprehensive eye care exam beginning in the first year of life.

HHS Secretary Kathleen Sebelius recently spoke at the American Optometric Association, and she referenced a recent OIG report which found that in nine states, 75 percent of all children didn't receive the required medical, vision, or hearing screenings. She

explained that the Affordable Health Care Act begins to tackle those problems by making a comprehensive eye exam an essential health benefit.

At the same time, the AOA is actively involved in encouraging the exploration of new health care delivery models to improve health outcomes and lower overall health care costs. We believe that we bring a unique perspective in that optometrists are primary care providers for those essential primary vision and health services that tie directly to reducing the need for many Medicare expensive procedures and costs, mainly hypertension and diabetes.

Like other health care experts, we believe that the ACO concept is an important direction for CMS to explore. We continue to have great hopes for the promise of ACOs. But we share concerns of CMS and others that old biases and misplaced motivations contain the lofty goals of ACOs. In particular, Congress chose to narrowly define an ACO professional as a doctor of medicine or osteopathy. Where is podiatry? Where is optometry? Where is dentistry? They all provide care too. We believe that Congress

used a limited definition, not to discriminate against optometrists and other physicians, but to make sure that the ACO was accountable for comprehensive care for a minimal number of Medicare beneficiaries.

Nevertheless, we believe serious access to care issues could arise if CMS does not take decisive actions to ensure the access of all physicians to maintain -- that all physicians is maintained for Medicare patients through the ACO.

Elsewhere in the Affordable Care Act, in Section 1201 entitled Nondiscrimination In Health Care, Congress outlawed discrimination against optometrists and other physicians solely based on their license. This provision was a critical important piece of this act which reverses the decade-long practice of health care insurers restricting patient access to specific types of providers based on their license at whole.

For patients, provider discrimination has proven detrimental to their health. For the care delivery system, this type of discrimination has led to higher costs and far less competition. Yet Congress seemingly violated this key nondiscrimination principle

in the definition of an ACO professional. We fully believe that the lawmakers inserted this restriction, which is foreign to the ACO concept in general, to prevent Medicare from providing rewards to groups of providers who might not actually cause a reduction in cost.

DR. GILFILLAN: Excuse me. You've got a big line of people behind you. I think it's important to try -- we hear a lot of your points and understand them.

DR. FINCHER: So are we denied the ten-minute rule?

DR. GILFILLAN: I think we are getting close to it, if I'm not mistaken.

DR. FINCHER: Well, I'm getting dried up here too.

My point here today is that there are many types of physicians that currently serve Medicare patients. And as the group I directly represent, optometry, I would like to make sure that CMS understands that we want to be included in all provisions of the law. Thank you.

DR. GILFILLAN: Understood. Let me just, if I could, address your point, at least point out to you that the language you refer to in terms of ACOs and the definitions of physicians has to do with assignment or aligning of patients with ACOs.

The ACO provision is about finding new ways to provide outstanding care to folks within the context of people served by Medicare. It's not about -- the challenge there is being able to do that and maintaining the freedom of access to get the care they believe they need.

So I just wanted to point out to you that I hear your concerns, but I also think it's important for people to realize that the ACO provision is about providing these services in the context of human services and Medicare.

DR. FINCHER: Well, there are conflicts within the legislation, and I think they need to be resolved.

DR. GILFILLAN: Okay. Thank you.

MR. LEVINE: Back microphone, please.

MS. VONSTAR: My name is Brenda VonStar. I'm

a member of ANA, American Nurses Association, and a member of the Colorado Nurses Association. I'm also an advanced practice nurse. I've been a family nurse practitioner for over 30 years. There are a couple of things -- I know that the ANA has given their comments to CMS in regards to this, but a couple of things. Number one, I was very happy to hear you say nurses. And nurses are --

DR. GILFILLAN: My sister is a nurse. I had no choice.

MS. VONSTAR: Nurses are the backbone of the health care system. We are the ones that have, all of our lives, done coordination of care. And I'd like to see nurses be in the leadership roles in those areas.

My other area is nurse practitioners or other advanced practice nurses. In Medicare, we have to bill under Incident 2. Therefore, the data doesn't really reflect how much nurse practitioners are giving care. Nurse practitioners and other advanced practice nurses should be able to practice at the full extent of their license rather than being relegated to a lower cost.

Nurse practitioners and other advanced

practice nurses should get equal pay for equal work rather than only getting 70 percent of the fee.

Also, in regard to ACOs, I really do believe that nurse practitioners and other advanced practice nurses should be able to be considered primary care providers. I have worked in the field for 30 years, and I believe I have provided primary care to many, many people. And frequently, advanced practice nurses work in areas that are not covered well by physicians.

So when we talk about health care providers, I would like that to be included as all providers of health care, including nurse practitioners and psychiatric nurses as primary care providers. Again, I think in leadership of ACOs and participation that nurse practitioners and advanced practice nurses should be part of that leadership.

Thank you very much.

DR. GILFILLAN: Thank you, Brenda.

We are very mindful of -- the legislation was pretty explicit about the need -- we are mindful of the opportunity to find ways to address your concerns. We know the outstanding work that nurse practitioners do

and that in many ways, they provide important primary care every day.

We have heard nationally from folks with a similar perspective. I would urge you to stay close and keep us well informed of what you are thinking about the issue along the way.

MS. VONSTAR: Thank you.

MR. LEVINE: Again, the back microphone.

MS. SCHMITT: Good morning. My name is Sara Schmitt, and I am representing the Colorado Rural Health Center. We are a nonprofit organization that serves through the state Office of Rural Health here in Colorado. I'm also representing ClinicNet, which is an alliance of community-funded safety net clinics.

I have one brief comment. We are very encouraged that you are looking to engage with a broad range of providers in these new models and systems, including the safety net providers, such as federally funded eye health centers, since they do provide essential services in rural and underserved areas.

We just ask that rural health clinics, critical access hospitals, as well as nondesignated

community-funded safety net clinical also be included in these programs and that they also be considered as members of the safety net serving the rural and underserved areas. Thank you.

DR. GILFILLAN: Thank you. I should also say that I think, Sara, to you and the institutions you represent and to the audience that at the end of the day, much of what we will looking for is creative ideas from you all. I hope that you are thinking that way. And I'm sure we will get a lot of proposals from a lot of folks. So I think it will be important.

At times, we will be asking for specifics, and at times, we will be responding to brilliant ideas that come to us unsolicited. We want to make sure that we encourage everyone to think creatively.

In that regard, I want to go back to what we talked about before. Think about a patient. Think about a patient's needs. Think about a program that will meet that patient's needs and address that patient's needs better. Think about that population of patients with those needs. Think about how what you do will demonstrate change along the dimensions of better

care, better health, lower costs. And tell us in those proposals a story that goes back to that patient and that population.

So it's important to think about it like -- around the patient population, I think, and not necessarily start just with the institutional perspective.

Sara, not specifically you, but just in general, we would like to see things come at us from that sort of perspective, around everything we are doing in understanding the patients and people and personal needs, if you will, as we start this.

MS. SCHMITT: And I think certainly for rural citizens and residents in Colorado, they often have to rely on the rural health clinic. That may be the only provider in 200 miles.

DR. GILFILLAN: Understood.

MS. SCHMITT: We would love -- and this is from our residents as well. They would like their providers to have access to these programs too.

DR. GILFILLAN: Thank you.

MS. STAHLMAN: Hello. My name is Kelly

Stahlman. Thank you for that segue. I'm a parent. In my favorite phrase, "I'm just a mom." I come from a Fortune 500 background in sales and marketing. My husband is a chief financial officer. We have twin sons that were born at two pounds and are now 18. We are in the midst of transitioning from the pediatric world to the adult world. I have had the opportunity through this -- our two favorite quotes: "Necessity is the mother of invention" and "Facts do not cease to exist because they are ignored."

The first is, through the learning of this life, I have become a consumer member on the Division of Insurance Consumer Council. I am fairly well-versed in the DIC. I have learned the Medicaid system from the home- and community-based perspective with PSDT, periodic screening for diagnosis and treatment. And as the kids are growing from 18 to 21, I'm learning what happens when they hit 21.

In the process, I am a consumer representative on CIVHC, and I have been on multiple health -- consumer councils. I'd also like to give you major kudos for putting Melanie Bella in this position,

her work --

DR. GILFILLAN: That wasn't me; that was Don.

MS. STAHLMAN: -- on dual eligibles and on the disability care coordination model. Colorado is one of 14 or 15 states that has that model. I actually work for CAHI. The board is 51 percent consumers or their family members, and the majority of their staff are consumers or family members.

So coming at it from a person's perspective and a patient's perspective and what is happening is twofold. You have this bubble of Medicare eligibles. The baby boomers are aging into Medicare at a rapid rate. But not only are they aging and having their own needs, a vast majority of them are caregivers for adult children with disabilities. So you are getting a double whammy that I don't believe is being fully recognized in the policies being implemented.

And we still have the separation of public and private funds. My hope for Melanie's group in Innovation is to also focus on exchanges. Not only do we have to integrate Medicare and Medicare, in my case, the kids are 21. We have invested in their K-12

education through special ed, and we've raised them with the expectation to have lives. And to some extent, there is a sense, depending on the day, that we really should have raised them to watch TV and drool, because what we see coming is a cut in benefits, a cut in services, a cut in home- and community-based access.

Medicare does home health. You must be homebound to be eligible. Medicaid does not have that, and yet the home health care agencies are beginning to implement it. Whether it's policy, whether it's suggestions, however it's working, people are falling off a cliff at the same time that they are aging into Medicare and developing their own disabilities. There are almost three generations that need to be looked at at the same time.

My hope for the Center for Innovation is to -- one of the things that you got rid of was the financial hits, if you will, done in the Deficit Reduction Act of '05 with the CPAP coverage. Kudos for that. But we went back to targeted populations so that you have waivers for those -- I look at it, in the kid world, it's cerebral palsy and autism. In the adult

world, elder care, it is stroke and Alzheimer's.

We need to have life span policies and life span access that looks at more than -- it needs to be based on individual needs. There do need to be requirements for eligibility. But then once that has been determined, rather than giving a list of things that you can have and nothing else is available, because that is in that waiver over here and not in this waiver over here, the benefits need to be the benefits, and the access to those benefits shouldn't be by targeted population. We need to be looking at the whole person.

We are looking -- at the all-payer claims database, you are looking at the whole system, public and private, with the exchanges in the Medicaid infrastructure. You are looking at Medicaid buy-ins. Now we need to be looking at the whole person and not split up mental health from physical health from -- mental health from traumatic brain injury or mental from development disability or physical health from mental health.

Those policies -- the devil is always in the

details. Those policies are a great way to reduce costs by denying care. But it's more expensive because it pushes everybody into crisis. Thank you.

DR. GILFILLAN: Kelly, thank you very much. I know Melanie is very knowledgeable about these issues. And I can tell you we have talked about them to -- probably not to the level of depth to educate me enough to make me understand all the points you are making, to be very honest, but I know that we are working at that, along with Cindy Mann.

We understand that there is a great opportunity here to do much better, and we are just beginning to explore how to do that. I can assure you we are working together. And you know Melanie, so you probably know that she is not going to let us not address this.

Keep us informed and posted. If there are specific proposals that any one of you are involved with wants to make, as we come live and into a position to accept those specific proposals, we certainly are open to that.

MS. STAHLMAN: Thank you.

DR. GILFILLAN: A lot of folks are trying to explore how to do the right thing.

MS. STAHLMAN: Thank you. And that is one of the most encouraging things, that there are a lot of people involved trying to figure this out.

And just to clarify, regarding Melanie, I know her. She doesn't know me. She has met me several times, but there is no reason that she would.

DR. GILFILLAN: All right. I'm surprised, given your eloquence on the topic. Thank you.

MS. KELLER: Good morning. I'm Moe Keller. I represent Mental Health America of Colorado. We are a nonprofit, and we advocate for individuals with mental health problems. Our biggest issue, of course, is integration of care, which has been addressed by Kelly. I appreciate that.

We want to make sure that an individual can have their mental health needs addressed at the same time their physical needs are addressed. I understand that mental health care is an issue you're addressing as well.

In our conversations about medical home as

well in the ACO concept, we are running into a couple of roadblocks in terms of how to integrate that care between the providers. And one is HIPAA compliance. Everyone is pretty cautious about that, and we want to be able to work on HIPAA compliance directly. The other is the billing piece, which you've addressed and Phil from CIVHC spoke about.

How does a provider in a psychiatric situation bill in a general practitioner's office, and how does the general practitioner take care of the physical needs without including the psychiatric piece? SAMSHA has rules on billing codes. The billing codes are different. Health providers can better work together to be able to be recompensed for their combined efforts and how that piece works out.

That we are finding is somewhat of a difficult thing because Medicaid is so restrictive in billing, and so are some of the rules from SAMSHA regarding mental health in terms of drug and alcohol use. That is one piece.

In terms of an idea, the current governor of Colorado set up a couple years ago the formation of

councils because we recognized that individuals who have Medicaid wind up in a number of departments of the state. They cross systems. They wind up in emergency rooms in hospitals. They wind up in child welfare, in juvenile justice. They wind up in the prisons. The money is not being best used in terms of following the individual across those systems because we do silo funding. They go from department to that department.

So we found that we have a subgroup that has recently identified 299 individuals who have crossed six different departments in the state of Colorado. And their costs are huge.

So we are looking at that date and saying we have to find a way for the state, when the states are looking at this across the country -- every state has to be -- how do we get early intervention so that we can identify that individual and have the money follow that individual rather than the silo funding that we are doing at this stage -- the level where the departments are not communicating with each other about the individual and the services they receive.

That is one thing that we are doing here in

the state of Colorado to try to identify these folks and be able to lower the costs. That might be something we might look at in terms of how Medicaid or Medicare looks at this in terms of service delivery in the state organizations.

DR. GILFILLAN: Is that something -- is there some work you all have done that is documented that you can kind of provide to us? We face similar kinds of cross-cutting issues, and obviously, the dual-eligible problem is one of them, being in multiple places and not seeing them.

It's interesting to think about. Suppose you had a public health care system that actually saw patients and didn't see programs, a seamless public policy. Maybe we need to think about that in a way -- in a creative way where we do see people, right, and we don't see programs.

And that is an interesting -- it's something we struggle with. I'd be interested in any guidance you have about how you are thinking about and how you are proceeding. And actually, it's kind of an interesting topic to take up with Melanie, that group,

and look for an opportunity. Maybe there is a proposal there. Maybe there is a model there for the duals.

MR. LEVINE: Explain that term, duals.

DR. GILFILLAN: For people who are covered by Medicare and Medicaid and who have -- they are probably the people that are crossing those multiple programs.

MS. KELLER: And certainly, individuals who have a mental health condition cross those a lot. We see them every day. We do have that data.

DR. GILFILLAN: Right. Thank you.

MS. NOFLES: I'm Jean Nofles. I'm a former -- I retired from Centers for Medicaid and Medicare seven years ago. I am a legislative advocate for AARP right now, and I sit on the Consumer Insurance Council.

What I want to talk to you about is, I know it is difficult to find programmatic success when that success is dependent on conflicting rules, regulations, legislation policies. So I'm glad to see that there is an initiative to have legislative alignment. I think that is very good, and it also puts the issue far enough up in CMS -- as I think the gentleman from CIVHC said -- so that it would eliminate the problem going up

through two programmatic areas.

And my question is, is there a public forum or mechanism for the public, either individually or organizationally, to have input into the legislative alignment?

DR. GILFILLAN: And I did not get your name.

MS. NOFLES: Oh, Jean, J-e-a-n, Nofles.

DR. GILFILLAN: Jean, I'm not sure I understand what you are characterizing as legislative alignment. Can you just --

MS. NOFLES: The legislative analysis and alignment that you talked about as part of the integration. It was under the -- I believe the woman's name was Melanie.

DR. GILFILLAN: The dual eligible?

MS. NOFLES: Yes.

DR. GILFILLAN: Is there a process for you all to have input?

MS. NOFLES: Right.

DR. GILFILLAN: Well, one, we have all tried to maintain as much as we can. Well, we all try to maintain, in fact, that kind of access to people who

want to come in and talk and provide input. There is certainly that.

I'm trying to think about where the office is right now in terms of establishing advisory panels. And I'm not sure. I would need to get back to you exactly where that is going to end up. She has solicited and will be soliciting proposals from states. And those proposals will be, basically, give us ideas about how you would structure a program in an innovative way to provide services that are integrated and coordinated for a dual-eligible population.

So at the state level, having the conversation at the state level might very well be a vehicle for having that input. And certainly, if you come from the National AARP perspective, we would be happy to sit down at some point and have a conversation about ideas you have if you want to formulate a proposal.

MS. NOFLES: All right. One other thing, though, as other people have testified, the problem isn't just with the dual eligible. The problem is that conflicting legislation applies to the disabled, mental

health, so forth and so on.

DR. GILFILLAN: Yes. I hear that. That is a broader issue. There are lots of people who know a lot about legislation and how to change it. I think -- going back to how the Innovation Center works, we are in a position to find new models of care that can work in spite of it, right, and find ways to work in spite of some of the ways Medicare pays.

I think I would go back and say think about the patients and think about a way for us to interact with you all in a way that is different from the way it is. Think about the contract you, as an organization, would have ideally in 2013 with Medicare or Medicaid. Think about what that contract looks like. If you have an idea as a provider about a contract or arrangement that actually meets the objectives, that is -- those are the kinds of proposals we are interested in hearing about.

So I would think about -- I would make it more specific. We are not in the legislation business. We are in the care model business. I would love to hear specific proposals on populations where we can do

that work.

Let me be clear on one thing. We are open to meeting with and talking with people from all sorts of organizations. We have pretty much an open-door, although our list is a little backlogged in terms of getting those people in. But we are open to having those conversations. Thank you.

MS. NOFLES: Thank you.

DR. FORD: Good morning. My name is Doug Ford. I'm the pediatric nephrologist. I'm the medical director of the home dialysis program here at Children's and also the medical director of the transplant program.

I have a couple questions and perhaps a comment about the interpretation of reimbursement for ESRD care for children. When Trailblazers became the coordinator for our billing, they interpreted it that each child who was on home dialysis, or any patient, adult patients as well, had to be seen on a monthly basis for physician reimbursement.

Children who are home dialysis, the whole point is to try to have them live as normal a life as

possible. We have children in our dialysis program who live as far away as Spearfish, South Dakota. I have had patients who I have managed on dialysis that live 40 miles from the Canadian border. The whole intent is for them to live as normal a life as possible. I think many of them do very, very well.

When the interpretation came that we had to see the children every single month -- even though we provide ongoing care on a day-by-day basis, interacting with the families. We have meetings twice a month where we review their care. It is very closely managed. But when the interpretation came that we had to see the patients monthly, parents have expressed concern about that. I have children who, in school, now have to miss nine extra school days per year because they have to come in and see me for me to be reimbursed for the care that I give them on an ongoing basis.

Quite frankly, I'm really uncomfortable telling the families that they have to come in and see me simply so I can be paid for the work that I do as their nephrologist. So I have been telling the

families, that's fine. You don't have to come in. We will continue to manage you on an outpatient basis, because it makes me feel mercenary, quite frankly. But it is important that these children continue to get care.

And I guess my question is, is that an appropriate interpretation of the CMS rules for reimbursement for ESRD care, that the children literally have to come into the building every single month?

DR. GILFILLAN: It doesn't sound like it, but I don't know the answer.

MS. HUDSON: My name is Brenda Hudson, and I am from the central office in Baltimore. I didn't actually work on that policy, that is the physician payment policy.

DR. FORD: Correct.

MS. HUDSON: That is the correct interpretation. It was really put in for patient protection --

DR. FORD: Sure.

MS. HUDSON: -- that there are face-to-face

physician interaction. There are some minimum requirements with that.

DR. FORD: All right. I do thank you.

I would point out that parents have repeatedly expressed to me that they prefer not to. So they now -- literally, children have nine more days of school absences because they come in to see me. And it does make me feel badly saying, "I have to see you for me to be reimbursed for the care." I'm sure you know, as a ESRD physician, we are providing care on almost a continuous basis, making adjustments in the children's care.

I do thank you for that clarification. You might consider that because of the impact on the families' lives -- we have patients who live hundreds of miles away and have to travel in the winter. And they are not thrilled to do that. But I do thank you for that clarification.

MS. HUDSON: I do recall seeing comments that have mentioned that before. Especially in rural areas, I know it can be a challenge for the patients to get in. I would be happy to pass that concern along to the

folks who are involved in the physician payment policy. Thanks a lot.

MR. AAKKO: Good morning. My name is Eric Aakko. I'm the physical activity and nutrition director for the Colorado Department of Public Health and Environment. And I applaud your efforts to look at population-based approaches to address obesity, smoking, and increasing exercise. I had a comment and a question.

The comment is, I'm just curious as to what direction you folks may be looking at to address obesity and increasing exercise. My comment relates to some of the work that we are doing here in Colorado to address increasing physical activity and decreasing obesity. We are finding some success in partnerships around the state to increase improvements to the built environment so that people can actually walk and bike to school, that they can have safe playgrounds to play in.

We are finding that it's not only a way to prevent disease, but it's also a treatment for disease in particular, making improvements to school nutrition

and community gardens, that sort of thing. When people can get out and actually grow vegetables, even in areas of high poverty where we are having community gardens put in, that's a positive benefit for the community and for the folks to be out there getting physical activity growing vegetables and increasing their consumption of fresh fruits and vegetables.

The other piece that I'll be happy to give you more information on is, here in Colorado we have a great model for increasing breast-feeding in the health care system. It is called "Colorado Can Do 5." It's the five best practices to increase breast-feeding.

Just as you are looking forward to innovative approaches, I think one area that has had great success in literature and in practicality is the policies surrounding increasing breast-feeding in the whole population.

Thanks so much. I'd appreciate hearing any efforts that you folks are looking at around obesity and increasing exercise.

DR. GILFILLAN: Thank you, Eric. It's early in the game for us in terms of getting specific. And

some of the things we are looking at -- I should say that we have been alive legally for two and a half or three weeks now. So we are getting there. We are building our team and trying to get the budget approved, et cetera. But we know that there are some areas we are interested in overall. Let me comment on those.

We talked about the ACO issues, a big one. We are very interested in patient safety issues around hospital care. We think there is great opportunity, and we are interested in hearing from people about patient safety right now.

We are interested in medical homes, because it's one of the key opportunities, we think, to make a big difference, because we have the opportunity to support patient safety and also improve the efficiency of the actual delivery of care.

We are talking a lot about the ABCs with the CDC folks, on the population front, as kind of a point of focus. But it's very early. As we think about metrics and quality metrics, for instance, for ACOs and medical homes, we are thinking about population health

and thinking about the ABCs, if you will, because of the opportunity to have a direct impact on lives.

In that population space, that third level, if you will, we know a lot of the work -- we know that the most important work long-term is done -- if you think about the determinants of health for a population, 10 percent of it is about how health care is delivered and 90 percent of it is about those determinants of health.

Having said that, we also say that in terms of the total cost of care, 80 percent of the difference there is about who and how the care is delivered as opposed to underlying determinants of health. It's a funny way of thinking about the broader look.

One of the reasons that we cannot meet all of Kelly's expectations and other people's expectations is because we spend so much money doing regular care efficiently, we don't have the resources to do the other things that would be ideal, like support people in their homes or provide the extra services that states and individuals need covered.

So there is a real directive to get more

efficient in those levels of care soon and being able to afford these other services. In a lot of states, this is by schools, education, or health care, Medicaid. So that is really important.

I say all that by way of saying, we know we need to be in that space. We know we need to think about it on those public health issues in terms of health. We are not going to spend the majority of our resources. There are other people to do that. What we are thinking is -- we are looking for opportunities to double-down on other things that are being done already in the community, using the capabilities that we have in the first two levels and making those initiatives more effective.

What that translates into in terms of programs, we are not sure yet. We are just beginning to think about it. We are open to suggestions and ideas. I think we are going to find that it's very important for us to look for leveraging synergistic interventions, if you will, that make use of our other capabilities where we can bring something additional to things that are already being pursued in this area.

MR. AAKKO: Thank you.

DR. GILFILLAN: You bet.

By the way, I would be really interested in opportunities that did that. Right. I should bounce this back to you guys. That is how we think about it. Think about that when you came to us with ideas.

MS. BROWN: Good morning. I'm Tiffany Noelle Brown. My background is, I was a medical sociologist. Today, I'm here as a consumer representing Own Your Own Health and the Campaign for Better Care. Both organizations want to improve care, especially for people who are the heaviest users of health care and have the poorest outcomes and the highest costs. I think everybody in this room is concerned with that population.

My organization is also incredibly concerned about the general population and how we are socializing and teaching people how to act in these new models of care. One thing I would add to the efforts that you are doing as I straddle in my own world, is helping patients and families to learn what their new role is as we start developing these new systems.

We thank you very much for reaching out to us as advocates in the state and for hosting this listening session. We really appreciate the work from the new Center of Innovation and the Accountable Care Organizations, including the Shared Savings Program, and the Federal Coordinated Health Care Office. We applaud your commitment in working on this. It's great to hear other people's ideas.

The new models for delivering care to patients under our program, the Accountable Care Organizations, and others that will be tested by the Center for Innovation have tremendous potential to improve the quality and coordination of health care, as well as containing costs. But the stakes are really high. We all know this. It is critically important that these new models focus as much on improving the health of our population and health care delivery systems as they do on reducing costs.

To make certain that these key delivery system reforms are implemented in a way that is truly patient-centered, we urge you to build it right, by ensuring strong consumer patient involvement in the

process, which I hear that you are doing, and by making sure that new models meet patient needs; ensure real accountability to ensure that there is quality improvement, patient safety, and cost containment; design models and initiatives in a way that moves providers and care systems toward seamless, coordinated care, better health, and lower costs; facilitate the partnerships and alignment these models need to succeed.

And I know that there are other people who want to talk, so I won't go into other specifics. I do want to say that having this consumer voice is really important, and we greatly appreciate having all of you here to help hear us. Thank you.

DR. GILFILLAN: Thank you, Tiffany.

It's very interesting. We are really -- if you look at the legislation, it says that the ACO must meet patient-centered criteria established by section. Right? It's a very interesting question. And coming up with those criteria has been a very interesting process and one that we are continuing to work on. It could probably benefit from more input on it. We will

be interested to see specific guidance that folks have around making that very concrete. Thanks for your comments. I appreciate any input that you have.

MS. LIPPOLIS: I'm Samantha Lippolis with Children's Hospital. I work in the areas of coordination of our regional clinics in Wyoming, Montana, and rural Colorado and also with our telemedicine initiative. And I know the American Telemedicine Association has been very excited for the Center of Innovation to come on board. And as you know, there are models in the VA, the Department of Defense, for using telemedicine. At the Children's Hospital, we certainly reach out with pediatric subspecialties.

And although many delivery systems and specialties are efficacious with telemedicine, certainly, payment is still a big barrier. I'm just wondering how you see the Center of Innovation helping us get some of these codes that could be recognized for telemedicine. Like the nephrologist said, a face-to-face visit is required. Well, maybe some of that could be done via video consult, and that could count for

reimbursements?

DR. GILFILLAN: Great question. And what I would say is, I'm looking for you to come to us and say here is a model. Here is a new care model. It involves telemedicine in a big way. These are the patients we are talking about, kids in rural areas that have renal disease or something else that makes sense. Here is the number of them. Here is the way we deliver care today. I don't know whether this goes back to the ESRD question or not. Maybe it does. Here is the way we care for them today. Here is the way we'd like to care for them tomorrow, using this whole new way of doing this.

And then here is what it costs today. Here is what it will cost tomorrow. Here is the quality of the improvement. Maybe there needs to be quality of educational exposure and family life and home stuff in there, you know, and disruption for parents leaving work. I don't know what is in there. I think if you get creative and think about a way to build that kind of a proposal, it would be a very interesting model for us to consider.

MR. LEVINE: We will take the last two comments. I'd like you to keep them short, please. We would like to finish up soon.

MS. FIELD: My name is Melissa Field. I'm the director of policy and communication for the Colorado Association for School-Based Health Care, and I'm here to advocate for this model. So bear with me while I briefly describe, as some of you don't know.

The school-based health center provides preventative and primary care to students in facilities located in schools or on school grounds. They are staffed by multidisciplinary team of medical and mental health providers. And sometimes they include dental health professionals. It provides services such comprehensive exams, immunizations, diagnosis and treatment of injury and illness, management of chronic conditions, mental health service, substance-abuse counseling, health education, and preventative care.

Colorado opened its first school-based health care in 1978 and now has 48 operating throughout the state, including serving those rural areas that have limited access to medical services. The state

recognized the school-based health centers as essential community providers because we serve low-income and publicly insured and uninsured populations and do not restrict their care based on the family's ability to pay.

School-based health centers provide an invaluable safety net for children and youth who otherwise have difficulty accessing primary care and preventive care. Studies show that school-based health centers also reduce health care costs by reducing inappropriate emergency visits, hospitalizations, overall medication intervention, reducing the cost for preventive care.

We believe that the school-based health center is an ideal location for qualified families to enroll in Medicaid and CHP Plus because regardless of income, language acquisition, ethnicity, or cultural values children attend school.

Effective outreach efforts at school-based health centers take a comprehensive approach by identifying eligible children, assisting them with enrollment and retention, and ensuring that the

children can access care in which they enrolled. The parents know where the child's school is located. They are familiar with the transportation routes to and from school and generally trust school personnel. Schools can address the parents' language barriers and lack of reading skills by providing application assistance for the students.

In addition, school-based health center staff know which families need medical services. They are a trusted source of health-related information.

MR. LEVINE: Can you --

MS. FIELD: So basically, we are just advocating on behalf of the school-based health center model. We think it's very effective, and it's cost-effective, delivers excellent care. Currently, over 2 million students nationwide are served by this model. But the model has a difficult time being sustainable because only 21 percent of the revenue comes from patient revenue. We are highly dependent on grant funding and donations and that kind of thing. We'd like to ask you for a more sustainable reimbursement model and recognition of this effective delivery of

care.

And I brought a short brochure which provides some personal stories from students and anything you would want to know about school-based health.

DR. GILFILLAN: Thank you. I want to make sure. If there is something here -- I understand the Medicaid situation varies by state. I assume for Medicare -- I don't know that there is something that -- is there anything I'm missing in terms of Medicare? I'm assuming there is not a lot there. It would be more of a private payer.

MS. FIELD: The issue we have with Medicare is primarily with the dental and the mental health services, getting reimbursement for those services. So basically, we have dental professionals come in and provide sealants and fluoride treatments to the children.

DR. GILFILLAN: That is still Medicaid. I just wanted to make sure I wasn't missing something.

MS. FIELD: Thank you.

MS. COLLINS: I will be very brief. I thought that maybe Mark Levine might give me a hard

time if I didn't say something.

My name is Chris Collins, and I represent Alliance. And our members provide services and support to individuals with disabilities, developmental disabilities primarily, across the state of Colorado. It is a community-based system. It's been in existence for over 40 years. It's also what I would call a consumer-centered system. As a matter of fact, the names of the programs are called community centers. And that is because we totally come from the community and the individuals' needs and then reach out within all the resources within communities, including the state and federally, to provide our services.

One recommendation I'd like to have for you to consider is, be sure that the long-term care system is in the dialogue. I know a lot of our talk is around acute care and how that works. We want to make sure that that not-for-profit voice -- and these are all not-for-profits -- has a voice in this dialogue. We'd appreciate that.

We will certainly want to provide some proposals around innovation. Some of the things I

heard alluded to, which I think are positive, were that a bundled rate setting is much better and more consumer friendly than fee for service which is out of control and not very cost-effective.

I'd also like to emphasize that we believe that outcome-based metrics need to be developed. We are struggling with that. And we would like to partner with others across the country to come up with better outcome-based measures for community and individually based long term-care.

We also support technology. We think that is going a long way. Thank you for the opportunity.

DR. GILFILLAN: Thank you, Chris.

As I said, it is a population of folks that we are thinking about a lot and are very interested in getting innovative proposals around once we are open and ready to react. Thank you.

MR. LEVINE: Now it's time for us to conclude. I want to thank all of you for this wonderful and broad-ranging look. We will find it very helpful as we continue with the very difficult but important job of crafting programs.

I'm going to, in a moment, turn the microphone over to our regional director for HHS, Marguerite Salazar. Before I do that, I just want to underscore the Web site where you can go. It is innovations, with an S, .cms.gov. There, in the next few weeks, you will find a transcript of this session, thanks to the people who have been transcribing this today.

It is now my honor and privilege to introduce to you Marguerite Salazar, who was appointed by President Obama this spring to be the regional director for the Department of Health and Human Services here in Denver. Marguerite has been a visionary health care leader in Colorado for many years. Many of you know her from her work as president and CEO of Valleywide Health Systems, a large community health center in rural Colorado.

Governor Bill Ritter has called her a brilliant leader and one of the most remarkable people who understands the challenges of serving the un- and underinsured. In her role as HSS regional director, Marguerite is the eyes and ears of Secretary Sebelius.

In that role, one of her primary jobs is to assist in the implementation of the Affordable Care Act.

Marguerite, please provide us some closing comments.

MS. SALAZAR: Thank you, Dr. Levine.

You'll be happy to hear that that introduction is longer than what my remarks are going to be.

I want to take a few sentences to say that I thank you so much. Thank you all for being here today and providing input to Dr. Gilfillan. We have really concentrated on what the community has to say. Health reform is such a huge undertaking that it is not going to happen without input from the consumers, from the communities, and from providers especially.

When Secretary Sebelius asked me about taking on this position, she emphasized that the Affordable Care Act is about the states doing what works for the states. So these meetings and these listening sessions are truly a part of what she meant when she told me that. She said that this is not something that is going to happen at the federal level completely. Every

state is going to have tremendous flexibility.

So in order to get that information and to help the states know what is going to work for them, we need to hear from you. That is what is happening today.

The President and Congress have set a beautiful table for us as far as trying to look at what we are going to do in the future for health reform. But the meeting today is really the meat, the potatoes, the vegetables, and the fruit. We are putting that all together.

Once again, your input will be taken. I know that we have already seen some changes and modifications to the law because of the input that people like you have provided. I know that is going to continue to happen. Please don't feel that your words are not going to be taken seriously. They will be taken to the White House and everywhere else. Thank you again for being here. I think this concludes our session for today. Thank you.

(Meeting concluded at 11:04 a.m.)

CERTIFICATE OF NOTARY PUBLIC

I, Suzanne Reid, the officer before whom the foregoing hearing was taken, do hereby certify that the witness whose testimony appears in the foregoing pages was recorded by me and thereafter reduced to typewriting under my direction; that said hearing is a true record of the proceedings; that I am neither counsel for, related to, nor employed by and of the parties to the action in which this hearing was taken; and, further, that I am not a relative or employee of an counsel or attorney employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

Suzanne Reid
Notary Public in and for the
State of Colorado

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