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REFORMING MEDICARE PHYSICIAN PAYMENT: FIXING SGR WHILE IMPROVING CARE

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ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

PARTICIPANTS:

Welcoming Remarks:

MARK McCLELLAN
Senior Fellow and Director, Health Care
Innovation and Value Initiative
Engelberg Center for Health Care Reform

Next Steps on Physician Payment Reform: The CMS Perspective:

PATRICK CONWAY
Deputy Administrator for Innovation and Quality
CMS

Lessons on Physician Payment Reform -- Primary Care and Specialty-Coordinated Care:

BOB BERENSON, Moderator
Institute Fellow, Health Policy Center
Urban Institute

REID BLACKWELDER
Board Chair
AAFP

TOM LEWANDOWSKI
Cardiologist
Appleton Cardiology ThedaCare

ALICE BORRELLI
Director, Global Health and Workforce Policy
Intel Corporation

THOMAS SIMMER
Senior Vice President for Health Care Value &
Provider Affiliation and CMO
BCBS MI

PARTICIPANTS (CONT'D):

Lessons on Physician Payment Reform -- Specialist Care:

MARK McCLELLAN, Moderator
Senior Fellow and Director, Health Care
Innovation and Value Initiative
Engelberg Center for Health Care Reform

JOEL BRILL
Medical Director
FAIR Health Inc.

KELLY CONROY
Chief Executive Officer
Triple Aim Development Group

KEVIN BOZIC
Chair, Department of Surgery and Perioperative Care
Dell Medical School at UT Austin

RANDY KRAKAUER
National Medical Director of Medicare
Aetna

PAM FRENCH
Vice President, Compensation and Benefits
Boeing

How Do We Get It Done? Funding SGR Reform and Overcoming the Remaining Obstacles to Passing a Bill:

MARK McCLELLAN, Moderator
Senior Fellow and Director, Health Care
Innovation and Value Initiative
Engelberg Center for Health Care Reform

PARTICIPANTS (CONT'D):

BILL KRAMER
Executive Director for National Health Policy
PBGH

MIKE CHERNEW
Professor
Harvard Medical School

BOB BERENSON
Institute Fellow, Health Policy Center
Urban Institute

Keynote Closing Address: Members of Congress Policy Context:

CONGRESSMAN MICHAEL BURGESS (R-TX)
U.S. House of Representatives

CONGRESSMAN GENE GREEN (D-TX)
U.S. House of Representatives

Summary and Closing Remarks:

MARK McCLELLAN
Senior Fellow and Director, Health Care
Innovation and Value Initiative
Engelberg Center for Health Care Reform

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P R O C E E D I N G S

MR. MCCLELLAN: Well, again, good morning. I'm Mark McClellan. I'm a senior fellow and director of the Healthcare Innovation and Value Initiatives at the Brookings Institution. I'd like to welcome all of you to the event here today on reforming physician payment, fixing SGR while improving care.

Today's event has been made possible by the Merkin Family Foundation and the Richard Merkin Initiative on Payment Reform and Clinical Leadership. This initiative through Brookings has made possible a growing set of resources for clinicians and policymakers who want to reform care.

We really appreciate you all taking the time and effort to join us today. We're looking forward to a discussion on reforming Medicare physician payment, and how it can support the transition to higher quality, higher value care.

Today's event is not being webcast live, but we are recording the event and supporting materials

along with the event itself will be available soon on the web. For that reason, to ensure the audio quality of the recording we'd like to remind you to turn your cell phones on silent. And also, when you have an opportunity to ask questions or make comments during the latter part of each panel we'll have microphones available for you to use, so please be sure to use them.

Now, as you all know reforming physician payment in Medicare is a bipartisan priority for Congress. The current system is based on the 1997 Balanced Budget Act which attempted to constrain healthcare cost growth through the introduction of the sustainable growth rate or SGR. The SGR sought to make Medicare payments sustainable by adjusting the payment rates to physicians so that total spending would stay roughly in line with the growth of the economy. Unfortunately, it hasn't worked out that way.

Physician related spending has outpaced overall growth in the economy. And to prevent

increasingly large rate cuts Congress has stepped in to head off those rate cuts every year since 2002. Because of this divergence between the spending envisioned in the SGR formula and actual physician spending, legislation that would permanently repeal the SGR has a budgetary cost in the neighborhood of $150 billion or more.

That's a big number. It's the main reason why all of the patches enacted by Congress have just temporarily delayed the payment cuts. It's also why so much is riding on legislation that permanently appeals SGR. This is a once in a generation opportunity to support clinician leadership through effective Medicare payment reform.

Because this has been so hard to do though, we're once again in the legislative version of Groundhog Day with Congress needing to act before April 1st to avoid the scheduled rate cut. Because of the difficulty enacting major physician payment reform, and the resulting long series of short-term patches, physicians and other clinicians that provide

clinical care to Medicare beneficiaries do not have predictability and stability in their payments.

Congress has had to devote significant legislative effort almost every year to pull together enough savings just to provide a temporary patch. Clinicians who are absolutely critical to leading real healthcare reform, and by that I mean new ways of delivering care that improve outcomes and lower costs, those clinicians do not get the financial support they need in doing so.

Last year Congress took a big step toward changing this cycle by coming together behind legislation that would both repeal the SGR and implement major reforms for moving physician payment from a focus on the volume of services to paying for innovative approaches to delivering high-value care. We'll hear from two of the lead sponsors of that legislation later on today.

The bipartisan legislation had two main components in conjunction with repealing the SGR. The first component would shift Medicare's fee for service

payment system further in the direction of linking payment to value. Under current law, Medicare physician fees are adjusted for some quality measures under the Physician Quality Reporting System for the meaningful use of health information technology, and most recently for the value-based payment modifier. The bipartisan legislation would put all these together in a single consolidated payment adjustment system. The merit-based incentive payment system or MIPS, and would make this adjustment to the rates a big larger.

The second component of last year's bipartisan legislation would enable physicians to switch from that payment system to alternative payment models. What's an alternative payment model? Well, it's been largely defined by what it's not. It's not fee for service payments.

Alternative payment models might include partial per member per month payments, like medical homes. Bundle payments for episodes of care like joint replacement surgery, accountable care

organizations in which payment depends, in part, on improving quality and lowering costs for a population of patients, and two-sided risk or partial capitation models.

Why is this important? Well, these payment shifts can further reduce the link between payment and volume, and enable physicians to shift more resources into the particular approaches to care that they think make the most difference for their patients. That might be answering emails or using tele-medicine system or working with nurse practitioners or pharmacists, or other professionals in a care team, or coordinating care better with other physicians. All increasingly important aspects of personalized, preventive, efficient medicine, and all reimbursed poorly, if at all, under fee for service. These models generally come with more accountability for actually improving care in measurable ways as well as reducing costs.

Now under the legislation, physicians who switch a significant enough part of their payments

into alternative payment models would qualify for a 5 percent bonus to help them make the transition. Despite unprecedented bipartisan, bicameral, and tri-committee agreement on these major reform features there was definitely not agreement last year on whether and how to pay for the associated budgetary costs of permanently repealing the SGR.

So here we are, just over two months from the next expiration of the SGR patch, and the question is, is it still Groundhog Day? Now, you all may remember in that movie, although Bill Murray's character had to keep reliving the same day of failure over and over again, each time he got it a bit more right until he finally fixed it. Today's event is about helping to get it right and get it done. It's time for this movie to end.

Our speakers will highlight opportunities for clinicians to improve care, and they will draw on experience with the role of payment reforms in Medicare, and in the private sector to support better care. They'll talk about what clinicians would like

to do and are trying to do to improve care and lower cost, and that how Medicare reform legislation could report and speed those efforts.

They'll talk about what is critical to include in the upcoming legislation. The critical elements that they see as key features to preserve from last year's legislation as well as feasible ways to build on that legislation and make it better. They'll highlight the importance of clinician leadership and supporting clinicians through payment reform. Not only by ending the disruptions of short-term SGR patches, but also be assuring that the new payment methods represent strong, effective linkages between payment and value.

Much of the focus today will be on alternative payment models. We want to move from describing them not as what they shouldn't be, just alternatives to fee for service, but what they should be, payment systems that truly support better care. Now, while describing what's needed in alternative payment models is important it's also important to

keep in mind that for the foreseeable future most Medicare payments will remain in the traditional payment system. So how to do more to support higher value in Medicare's largely fee for service through physician payment reform is also a critical issue.

We're going to start this discussion today, hopefully in just a few minutes, with CMS Deputy Administrator, Patrick Conway, and we'll end with Representatives Michael Burgess and Gene Green. In between those sets we're going to hear from three panels. The focus of the first panel will be in primary care, including care delivered by specialists working effectively with primary care physicians. Better support for high-quality primary care is the cornerstone to most efforts to improve healthcare, and so payment reform must support better primary care services.

I want to emphasize that effective primary care involves not only family practitioners, internists, nurses, and other primary care providers, but also effective coordination with cardiologists,

endocrinologists, gastroenterologists, and many other specialists whose guidance and services are integral to managing chronic disease effectively, especially in more complex patients.

The second panel will focus on healthcare that is primarily led by specialists. Patients who are primarily managed by specialists include most patients with new diagnosis of serious cancers, patients with serious gastrointestinal disorders like inflammatory bowel disease, and patients with advanced heart failure or kidney problems.

Specialists are also in the lead for care decisions around major procedures like joint replacements, heart surgery, colonoscopies, eye procedures and the like. Altogether, specially led care counts for a large part of healthcare, including care for a very diverse range of very serious conditions.

The final panel will draw on examples and ideas presented in the first two panels to tie back to the implications for physician payment reform

legislation. As part of this, we'll discuss a new paper released today by all of the people on that third panel together as well as some other experts who couldn't be here on some specific recommendations for strengthening physician payment reform legislation.

So that's an overview of the day. I would point out that at the back of the room we've copies of a number of these different documents, the agenda for today, the overview of the recommendations, and that paper I just described as well as a number of other materials that I think are relevant to the work that we'll be presenting here today, and that many of the panels will be discussing.

This is intended to be a very discussion oriented session, so you're not going to see slides or long presentations. We've asked each of our panelists to highlight a few key points and a few key issues that they believe are very important, like I said, elements of physician payment reform proposals or elements that should be included in the legislation. All of the experts that we've talked to today have

also written extensively and talked extensively about these reforms, and will try to make it easy for you to get more information on each of these topics that you'd like to pursue in more depth, the things that you hear about today.

So we will be starting in just a few minutes. I think we're still waiting for our first speaker who has also had a busy week. Patrick Conway, I'll go ahead and pre-introduce him. As I mentioned, as the Deputy Administrator for Innovation and Quality at the Centers for Medicare and Medicaid Services. Patrick, in that job, has been the administration's leader in efforts to improve care and reform payments in Medicare along with Marilyn Tavenner who's been working closely with him on these issues.

They have taken a number of steps to not only move forward on previous Congressional legislative proposals intended to support better quality and lower costs, but also have launched a number of creative initiatives through the authorities that Medicare has and the Centers for Medicare and

Medicaid Innovation and its demonstration programs. With the Administrator Tavenner leaving CMS soon I expect Patrick's going to have an even larger role in crafting and implementing CMS initiatives related to improving quality and lowering costs.

Patrick was a driving force behind Monday's announcement at HHS of some explicit targets and timelines over the next several years for shifting Medicare to alternative payment models and for expanding the value-based payment elements in Medicare's traditional payment systems, including the physician payment systems. That announcement also highlighted some plans to work more closely with the private sector, with states, with other collaborators in creating momentum and consistently reinforcing efforts around alternative payment models and payment reforms. That, too, is another reason why the focus that we have today on describing what alternative payment models should be, specifying those characteristics more clearly is really important for helping to support these cross payor efforts, these

system-wide efforts to improve care.

In that announcement earlier this week, CMS highlighted a number of targets that fell into two major categories. One category was movement to alternative payment models where HHS committed to tying 30 percent of traditional or fee for service Medicare -- or moving 30 percent of traditional fee for service Medicare program into alternative payment models by the end of 2016.

Some of the major programs there, that I know you all are familiar with, include the Accountable Care Organization program, Medicare Shared Savings program, which now has over 400 participating ACOs. It includes upwards of 15 percent of the Medicare population. This initiative also includes Medicare's bundled payments for care program which includes a large and growing number of hospital based systems for delivering episodes of care that primarily start in the hospital, and may include not only physician services, but post-acute care and follow-up care as well. So that's 30 percent of traditional

Medicare payments and alternative payment models by the end of 2016, 50 percent by the end of 2018.

Also, in conjunction with this, for all the Medicare providers who are not in alternative payment models CMS aims to tie at least 50 percent of payments in traditional Medicare to quality or value by 2016, and 90 percent by 2018. That is through initiatives like the value-based payment modifiers, the physician quality reporting system, and so forth.

CMS has also announced they're going to launch a healthcare payment learning and action network starting in March to bring together diverse stakeholders to do all this. So Patrick is here to talk to us about, I'm sure these initiatives, but also not only where we are today, but where we're headed, where we should be headed with all these payment reforms.

Patrick, I introduced you as the point person on the administration's efforts to improve care and reform payments in Medicare, and that we expect your role is going to become even more important in

the near future. I'll ask Patrick to make some introductory remarks for a few minutes, and then we'll have a little bit of a discussion about these issues, especially as they relate to physician payments. So, Patrick, please go ahead.

MR. CONWAY: Thanks, Mark. Thanks for the kind introductory, especially I think I'm, like, three minutes late, so thank you for that. But I knew if anyone could share important information with a bit of extra time it would be Dr. McClellan.

I really will keep my remarks very brief because I want to have some discussion and Q&A. A few things. One, I heard Mark talk about the announcement yesterday. You know, obviously, we think a historic announcement. Truly, as you all know, that value and quality, et cetera, I think are bipartisan ideals. I worked for Secretary Leavitt at one point in my career on value-driven healthcare, so very similar concepts. Secretary Leavitt actually put out a very complimentary statement yesterday as well.

Really, the whole point is what we all want.

We're shifting our payment systems to award providers that are willing to take accountability for cost of care and quality of care either for an annual episode or a bundled episode, but a patient population focus in terms of quality and cost.

This was a bit buried in the press, but to share some numbers with you, I was the senior anonymous administration official in the various -- I never know when I'm anonymous or not, alternative payment models, so ACO's bundles, advanced primary care, et cetera, responsible for quality and cost. We were at 0 percent in Medicare fee for service in 2011. We're at approximately 20 percent at the end of 2014, so we made a lot of progress in the last three years, and, obviously, set goals of 30 and 50 to continue that progress.

Statute passed by the Hill has linked increasing percentages, so we're above 80 percent of Medicare fee for service payments now have a link, some linked, to quality or cost. So our various pay for reporting and pay for performance of value-based

purchasing programs like hospital value-based purchasing.

On physicians, a couple things on the proposed legislation, just to call out that we thought were terrific, and the administration has said this, and we're always willing to provide technical assistance. One, as you know, with the SGR reform it would be -- the proposed legislation replaced it with a merit-based incentive payment system. A few things we'd call out from that that we thought were helpful.

One was simplification. So right now we try to, on the back end, align physician value modified, PQRS, meaningful use, and ACO if you're an ACO, this would formally allow them statutorily which we think would be beneficial both for provider burden and for burden on CMS in terms of the systems.

Two, in terms of the level of payment it's interesting, you know, currently if you add up those three main programs, PQRS, physician valued modified, meaningful use we're at 9 percent of payment in 2015 performance period for 2017 payment tied the quality

and value. The construct was in 2018 for it to be 4 percent and then capped at 9 percent. So the only two things, the obvious points I make there is, you know, it would actually lower the percent tied to quality and value in an initial year in 2018 the proposed legislation. And then would set a cap that's about where we are now.

I'd be interested in Mark's views. I think there's some evidence that as you move to double digit regardless of the provider, but especially for physicians, that you're more likely to drive major payment change. I get on the flip side that we've got physicians in this country that are being penalized, many of which are trying to do the right thing, so we have a policy principle for physicians and clinicians who want to report that we make our systems as simple as possible and enable them to report.

Three, we strongly support the emphasis on outcome measures and use of electronic data. We thought that was critical, both EHRs and registries.

A couple other points to call out. The

focus on care coordination and practice improvement. I think, some difficulties there on how you would operationalize that, but I think that focus on clinical improvement activity was critical. Related to that, the ability to reward physicians and clinicians for improvement. So similar to hospital value-based purchasing where you get the best of improvement or attainment, that's how we do hospital value-based purchasing. I think on the physician inclination and the administration's policy is we want to reward improvement. So the ability to reward improvement, I think, is critical.

The funding for measured development, obviously, essential. We've got a diversity of physician and clinician practice in the U.S. A number of you in the room have convinced your specialty societies to make large investments that registers your outcome measures. That's terrific, but I think the federal government needs to be a strong partner there, so the funding to allow the funding government to be a strong partner and fund measure development

certainly was beneficial.

Then, you know, lots of smaller provisions. You know, just to call out one, this low volume threshold issue. In one of our negative payment adjustment files for meaningful use a significant percentage, so greater than a quarter of the physicians that were in the negative payment adjustment files, in quotes, had zero claims. So these could be, for example, pediatricians, like myself, who are in our file but billed zero Medicare claims last year, and will probably bill zero Medicare claims next year.

So, you know, on some level to have a denominator that has physicians and clinicians in it with no volume or very low volume, just to call out one, would seem small, but is actually arguably not small because it just confuses people when they get a letter that says you're going to get a negative payment adjustment. But, by the way, you'll have no claims next year, so it actually means nothing. That is a actually a very confusing communication, and

we've had to answer those calls at our quality and help desk.

Then I think I'm going to stop there in the interest of time, Mark, because I do want to have discussion. But I think overall, thank you for having me here today. I think we are at a real exciting time, and look forward to the Q&A and the discussion. Thank you.

MR. MCCLELLAN: Thanks, Patrick. I appreciate your being here and everyone getting here despite the weather and other challenges.

I would like to stick with the discussion around the SGR legislation, so start with your thoughts or the administration's thoughts, whichever you care to provide, about what --

MR. CONWAY: Oh boy there.

MR. MCCLELLAN: Hopefully they'll align, right. About what you see is the outlook for legislation at this point. The administration has supported the bipartisan bill before. As we were talking about before you arrived, one of the big

challenges has been actually finding the budgetary off-sets to pay for it. A lot of members in Congress, at least, think that those budgetary costs should be addressed. So maybe you could just talk a little bit about the thinking in the Administration on how to get this legislation over the finish line.

MR. CONWAY: So a couple thoughts, and this, you know, will be my opinions, but, I think, aligned with the Administration policy.

I think, one, as you alluded to, we support SGR being fixed. We also, as I tried to outline in my remarks, I think a lot of the concepts in the proposed legislation from last year were very on target. We provide a lot of technical assistance on the Hill and are more than willing to do that again.

You know, on the pay fors, you know, the President's budget is the President's thoughts on budgets and potential savings, so I would defer to that. And, obviously --

MR. MCCLELLAN: That's coming out very soon.

MR. CONWAY: That's coming out soon. Then,

you know, at times, as you well know, people may or may not -- people want to look at different pay fors. So if people wanted to look at pay fors that were not in the President's budget we'd be happy to provide technical assistance there as well.

MR. MCCLELLAN: Great. In terms of the obstacles to legislation though, here we are just a couple more months until the latest patch expires. Still we're going to hear from members of Congress later, but still looks like a way to go to bridge the gaps that ended up blocking legislative action last year.

You talked about a lot of things that the Administration is doing. I'd like to go through a few of them, and maybe push a little bit more on that point that you made about the directional similarity of the Administrative actions you're taking with the legislative proposals, and just maybe talk about what difference the legislation would make or could make.

One of the points, the interesting points that you raised is that you're already getting close

to 85 percent of payments in traditional Medicare for physicians, for hospital, for post-acute care facilities, and home health, and so forth being tied, in part, to quality measurers. If you add up all the programs for physician payment, like you said, we're on track around 9 percent now based on performance this year.

If you look at the numbers in the legislation last year we point out, I think different people count it different ways, give the Congress the benefit of the doubt, be a slightly larger percentage tied to quality. Maybe they weren't quite as aware of all the administrative steps that you announced. Is that the right place to be, and if it's not much of a difference in percentage how much of a difference is the legislation going to make on supporting quality through these payment ties?

MR. CONWAY: I think a few critical pieces that the legislation would have the potential to address. So one is, you know, full alignment in statute of all these programs that have been assigned,

you know, established one-by-one in statute. Which might sound minor, but it's not. I mean, we get letters all the time, especially societies, that say, well, if we report for meaningful use just give us credit for PQRS or vice versa.

We don't have the authority to do that now, including societies who have been around a long time.

MR. MCCLELLAN: Now, you are trying to align the measures across the program?

MR. CONWAY: Right. So what we do on the back-end, exactly, is we have to try to have the same measures, the same reporting mechanism. So it is true, in 2014 you can report once and receive credit for all programs. I'll give you a tangible example of some of the permutations though.

Technically the QCDR legislation is being read as you can only report from a registry as an individual. Obviously, registries often serve big groups of physicians and clinicians, so we've had to, on the back-end, say, you know, from regulatory/statutory construct you're reporting as an

individual, but you can report as a big batch of individuals.

So we go through these permutations on the back-end to align programs that -- and the challenge there is not just on our end. That means that if a physician or clinician well meaning, you know, misses a step or misses a component of one of the programs they can potentially, you know, get credit for one program and not others, so I think the alignment is critical.

The focus on alternative payment models, which we can come back to and the incentives there, obviously, would be aligned with the goals we just announced, and moving physicians and clinicians to alternative payment models. The focus on improvement, I think, is critical.

The last thing I'll mention, you know, meaningful use. We're, obviously, embedding meaningful use in having it become a permanent aligned part of our quality and value programs. It actually moved in CMS and the center that I run a couple months

ago. You know, this legislation, sort of, embedding meaningful use as part of the fabric of transformation also it's aligned in the direction we're going.

MR. MCCLELLAN: I wanted to come back one other area which is the measures and the quality improvement efforts themselves. So payment is one thing, but if we're going to have alternative payment models we need alternatives that those payments will be tied to.

MR. CONWAY: Yup.

MR. MCCLELLAN: You emphasize, and the legislation emphasize, a shift towards outcomes and more flexibility on how --

MR. CONWAY: Yup.

MR. MCCLELLAN: -- providers get there, but providers need not only flexibility, but good support. Data systems, measures, measures that are tied to reports they get from CMS. I know CMS is undertaking a lot of efforts to try to improve that support, but it does seem like an area where the current resources are limited, and where the legislation could make a

big difference.

MR. CONWAY: Thank you for asking that. I do, I think that that part of the legislation would be huge in terms of driving transformation. So we're trying to have more of a focus on getting data out to clinicians, providers, et cetera.

I think -- and in some of our alternative payment models like ACOs, you know, we're increasingly getting more timely data. But the legislation really lays out a framework that essentially that if I'm a provider, if I'm a physician/clinician provider we, CMS, are going to provide you timely actionable data. Which, I think, is where we want to go. It also had funding to move in that direction which we think is beneficial.

You know, ultimately, just once -- sorry to digress slightly.

MR. MCCLELLAN: Go right ahead.

MR. CONWAY: You know, I manage quality and value work for Cincinnati Children's. All of clinicians could literally see a dashboard that was

populating with data daily. And when they made a decision that was outside the evidence base they got an alert, like, tell us why, and we actually updated our guidelines continuously as we learned, you know, from the exceptions, et cetera.

That's hard to replicate on a national scale. I get that. But, you know, if you really want to drive change, you know, it's not data six months later. It's, you know, data that's timely and actionable, so that's where we need to get to.

The last thing I say there, it doesn't always have to be the federal government. I mean, it could be, you know, registries that physicians believe in and have invested in are providing that feedback and reporting to CMS.

MR. MCCLELLAN: Although, even those need some data from CMS and patient follow-up care costs.

MR. CONWAY: Right. So you could think about the linkage point which, I think, is critical.

MR. MCCLELLAN: I would like to open this up to questions and comments from the group. We have a

microphone in the center of the room if anybody wants to go ahead and make the first comment. We've got a few more minutes here with Patrick.

While we're waiting for that, just to keep pushing on the legislative front, so it sounds like all directionally good. Are there any particular areas that you'd call out where if Congress takes a little bit more time to look at this this year, you know, new committee chairs, a bit more process and a chance to review, any significant changes that you think should be there? Maybe around, you know, is 9 percent the right percentage? Is it more support for outcome measures? More support for data? Things like that that we've discussed.

MR. CONWAY: I think certainly more support for outcome measures and data. On the 9 percent I have to be a little careful because we provide technical assistance on the percentage. There is published literature that argues that larger percentages, some of this is from other countries, to be fair, and so there's a question of is it applicable

here, et cetera.

There's also published literature which I see that you all are aware of that, you know, we have to be careful and we need to think about intrinsic motivation, et cetera. So I don't want to overplay this, but I think, you know, from an administration standpoint more flexibility in the percentage over time is beneficial.

The other thing is there's some fairly, like, very directive operational details in the legislation, so, obviously, for an administration perspective when there's that level of complexity it can be hard for us to execute. So a little bit more flexibility on timelines to execute is beneficial.

MR. MCCLELLAN: And as you mentioned, just this whole structure that enables all of the programs that are out there to move more effectively together. You know, we've talked about the physician payment components related to quality. I guess I'd like to push a little bit on some of the other programs.

You mentioned interactions between physician

payment and ACOs, bundle payments. You all are trying to, I think, come up with a comprehensive structure there, but it's difficult with all the different payment systems.

MR. CONWAY: Yeah. And to be fair, just so everyone knows, true value-based purchasing, so adjusting payments on performance. We have in a hospital, physicians, now SNF, skilled nursing facilities, in the legislation to be implemented, and yes, already use a bundle with quality incentive programs, so essentially value-based.

ERFs, L-tax, home health, hospice, et cetera are all pay for reporting. So, you know, that's a legitimate question, which I know Congress has thought about, should some of those start to move towards value-based purchasing and actually adjusting payments based on performance.

This is known publicly, we have 5 percent of home health agencies, historically, who have failed quality reporting. The most common reason is they don't submit a patient experience survey. There's

only a few reasons, which you could imagine, why you don't do that. So, you know, I think a step in the right direction to make agencies report, but I think a value-based purchasing construct in some of these other areas, you know, we would certainly implement if Congress wanted to move in that direction.

MR. MCCLELLAN: And one other issue that I know is important in the announcement earlier this week is collaboration outside of CMS and outside of government in these efforts. That's something that is mentioned in legislative proposals about trying to get to more alignment. Maybe you could say a few words about where you are on that, and how legislation could potentially help.

MR. CONWAY: You know, I think this is critical, the public/private partnership. I think the legislation points to it, which will help, and calls out specific areas which is terrific.

You know, I've been chief medical officer for about four years now, as many of you -- if I make it another year longest ever.

MR. MCCLELLAN: Those are definitely dog years.

MR. CONWAY: You know, soon after I started I started meeting, for example, with all the private plan chief medical officers. There's rules about what we can and can't discuss, but really trying to agree -- trying to talk about and discuss principles and the various programs we have and learn from each other. So I think that public/private alignment is critical.

MR. MCCLELLAN: Great. Well, Patrick, I want to thank you for taking time to be with us today. You've given us a lot to begin today's discussions on how to build on legislative proposals and administrative actions. We'll look forward to continuing to work with you.

We have time for one more question or two if there are any. Please go ahead.

QUESTIONER: (inaudible).

MR. CONWAY: So I think it's a great point. Also, I should have mentioned this, the bill did some flexibility with specialties that see less face to

face, so I know you know that, but we would implement said flexibility.

On the measure maintenance issue, we actually -- so we've had numerous examples, the biggest one is AMA PCPI, you know, as you know, is moving away from measure development. They had a number of measures that were in our program that we committed to the do the maintenance on, so we've had a series of meetings with PCPI. So I think if there are measures that are good, solid, you know, hopefully outcome-oriented measures or intermediate outcome oriented measures or really solid process measurers that drive outcomes, you know, we have a shared interest in the maintaining and programs. Including, we've made the investment, at times, to do measure maintenance for measures that originally were stored by someone else.

MR. MCCLELLAN: That's clearly valuable to the Medicare program, but it's not something that's sort of an explicit push in legislation -- in the law at this point. It is part of -- or could be part of

this legislation.

MR. CONWAY: It certainly could be. I mean, with the example I named, I mean, essentially, you know, we had a choice of paying for measured maintenance or losing a lot of measures that physicians were using, and so we elected to fund measure maintenance, and take over some of the storage.

MR. MCCLELLAN: Any final question for Patrick? Be sure to identify who you are too, Bill.

QUESTIONER: (inaudible)

MR. CONWAY: Yeah, it's a great question, Bill. Bill always asks great questions. So I probably shouldn't comment on the czar concept.

MR. MCCLELLAN: Or you could say something about the cost agencies --

MR. CONWAY: I will. The cost agencies is -- so we actually have a meeting late today on an issue with FDA, the hospital associations and CMS. We probably need to do more of that. You're aware of some examples that I know of where I think sometimes

cross-agency collaboration has worked well. Other times the challenges, we do have different purposes and missions, but we still need to coordinate.

It doesn't actually help a physician if, you know, in the example you gave FDA is sending one signal and CMS is sending an opposite signal. When I was a White House fellow I think one of my major learnings really was this inner-agency collaboration and it's difficult to make happen, but it's critical when you want to drive major change. So I think it's a very fair point.

MR. MCCLELLAN: It's one of the, sort of, related question, and, you know, one of the things that does tend to drive cross-agency actions when there's something that they have to support, something that's in law and policy. We've had a lot of discussion already about alternative payment models, you know, paying not for volume, but paying a movement towards outcomes.

Any thoughts at CMS on how drugs and devices can better fit into that? You know, you've been very

active in overseeing and helping to development the coverage development program there, and some private plans, and especially outside of the U.S. There now are payment models where the driver, the device payment is actually tied into the same outcomes that we've been talking about for clinicians. The kinds of outcomes that matter to patients, and that might be one way to get more alignment between the kinds of drug and device costs and outcome effects that Bill was describing.

MR. CONWAY: Three things to mention one is coverage (inaudible) development. Thank you for mentioning it, I think we have made progress, but that won't solve all the issues. Two, we have a number of specialty models that we've said publicly that we're working on, oncology, that we think will come out very soon which, obviously, has a major focus on appropriate use of medications, et cetera. We're also working on some specialty ambulatory bundles. These are tough, as many of you know.

One thing to put out there. I don't believe

this was any of the proposed legislation, but we've thought about it, and I've talked to a few of you. You know, you could imagine a model where a specialty society meets certain criteria. Such as minimum number of physicians, you know, actuarial assessment that it could save costs and improve quality on the quality side, so a rational for that.

If that society comes forward CMS would still have to review, but it would almost be a fast track to a new payment model, which is a very different construct than our current environment where, you know, we take ideas from everywhere. We go through a process that looks a lot like writing a rule, so quite long. Then eventually we announce a model that people can participate in.

So, you know, I like to think about creatively how you would turn things on their head. I think that's an idea that, you know, if -- I can never ask Congress to do anything, but if Congress or others learned to think about a different model of considering how we fast track some of the specialty

physician/clinician work that would be an example.

MR. MCCLELLAN: Fast tracking alternative payment models sounds like something this group would like to take up. Patrick, I want to thank you for your time today, especially for all your time and effort all those years at CMF. I don't know how you do it, but I know the country appreciates it. Thank you so much for being with us.

All right. I'm going to ask the first panel to come on up to the stage while I introduce them. This panel, as we mentioned, is going to focus on payment reforms affecting primary care and the specialists who work with primary care providers. Our moderator's going to be Bob Berenson, the Institute Fellow at the Health Policy Center at the Urban Institute.

Speaking on the panel we have Reid Blackwelder, the Board Chair of the American Academy of Family Physicians. Tom Lewandowski who is a cardiologist who has led delivery in payment reform efforts at Appleton Cardiology ThedaCare. Alice

Borrelli, the Director of Global Health and Workforce Policy at Intel. As well as Tom Simmer, the Senior Vice President for Healthcare Value and Provide Affiliation, and is the Chief Medical Officer at Blue Cross Blue Shield of Michigan. So, Bob, I'll turn this over to you.

MR. BERENSON: Thank you, Mark. I get to talk later on the later panel, so I'll be very brief right now in my moderator role.

It's easy to -- well, it's not easy. It's hard to find consensus inside the Beltway. Occasionally it's accomplished, as we seem to think it's happening right now with regard to the provisions of the SGR repeal legislation. But it's real important, and that's why this is such an important meeting to, sort of, get perspectives from people outside the Beltway about, you know, the (inaudible) from Washington and are here to help you.

Whether this legislation actually would support the kinds of innovative activities that you're going to hear about from these four speakers or, in

some ways, maybe frustrate those efforts. So the goal of this session is to let four people, very much involved in the real world, with the innovative approaches to increasing value for their patient populations. To have them present very briefly, in like three or four minutes, what they want to say about those initiatives.

Then we're going to have a discussion, which I'll moderate, in which we try to begin to tie those initiatives to the legislation. As Mark emphasized earlier there are, sort of, two basic tools that the legislation is promoting. One is a strong commitment to quality measurement. Patrick reinforced that. He actually defined value-based purchasing as the use of measurement to assess quality.

So quality measurement for individuals as well as groups and alternative payment models that move toward the direction of population-based payment which would involve risks, substantial risk taking by the organization, the provider organization.

So in that discussion I'm going to push a

little bit to try and get some perspectives on these two major tools as it applies to primary care and what sometimes -- Mark talked about this session, the interaction between primary care and specialist, sometimes called the medical neighborhood. The second panel will discuss specialists per say.

You know, we've had seven years of experience with PQRS. We've now had a number of years of development around ACOs, and bundled payments with the Ace's demo and others. You know, any perspectives from the field on how those are proceeding and what's in this SGR, you know, the general approach in the SGR bill. If we run short of time on that discussion I'm quite interested in how the panelists view the need to reform the established fee for service payment systems. Do they promote, in some way, reform that go beyond fee for service or is it, sort of, a distraction to, sort of, focus on the underlying fee schedule? What CMS calls Category 1 payment, basically lacking any value.

So with that I'm done for my intro remarks.

We have a time keeper. I should emphasize we're going to have a discussion, but then we're also going to open for Qs and As for the whole group. The time keeper -- what's your name again? She will keep us on target, and with that we're going to go in the order of Mark's introductions, so starting with Reid, Board Chair of the AFFP. We've got a tough time keeper over there.

MR. BLACKWELDER: I already know. She's threatened me.

MR. BERENSON: Okay.

MR. BLACKWELDER: So three to four minutes to basically cover all of those topics is daunting, even for me. I guess I'll give the short answer, amen, in terms of a lot of the changes.

I mean, we're obviously excited about what's happening right now. There are a lot of things going on in this country that from a family physician's perspective and primary care perspective is where it needs to be. People are saying primary care all the time. Patients that are medical home, these are

acronyms and terms that are being used which creates some challenge because as we were talking earlier words are very important, and how the words are defined, and which buttons get pushed with the words is going to be part of this ongoing discussion.

The moment you had a release of exciting movement toward paying for value and the value of primary care people are often saying this is good, but then they're going, but what does that mean. So we're having to reframe a lot of our thought processes.

I think in many ways this kind of meeting represents an ideal of the patients that are medical home. In the time we had ahead of time you've got folks from different organizations of the medical neighborhood, primary care, specialty, payors, lots of different folks coming together, and all the sudden talking and networking outside of the usual flow of conversation. This is really important because we need to be moving toward conversation, trust, transparency, and being clear about what words we use, what outcomes measures might mean, and be willing to

say this one worked, this one did not. This is going to be a challenging time.

So one of the things I want to do, just tell you where we are, briefly, in terms of primary care up until this very exciting week. Primary care's first contact, continuous continuity and coordinated care in a comprehensive fashion that's undifferentiated by organs or disease or gender. That's a big lift. To do that right you've got to have team-based care. You've got to have other groups working together, and we've got to find ways of making that happen.

Because a PCMH really in and of itself is not one size fits all. It's not always who's in one building. We have to find creative ways. The primary care patients in a collaborative will be releasing a report in a couple of days outlining some exciting outcomes, measures showing improvements in outcomes that are quality of care and lower cost with a lot of the work that's currently being done. Health Affairs has talked about the benefits of managing chronic care.

Then we have two examples of some exciting results from team-based care. One was in Annals of Internal Medicine and one was a family physician in New York, a four person practice using EHRs in the patients that are at home. They showed dramatic improvements, but it wasn't just the electronic record, and it was also different than paper records. It was team-based care.

Then a good friend of mine, Jen Brawl, who's a small town family physician in Kansas she and four other family physicians in Kansas worked together, created a patient centered home before it was cool, several years ago before the acronym was really moving forward. Went in together for an EHR, so they have better operability. They're separate practices. They have shown, in their own outcomes measures, a great example of looking for measures, evaluating those measures, changing them all the time. It's real time data that is improving the care of their community, improving their own personal care through QI measures, so very exciting times happening right now. So we

look forward to further discussion.

MR. LEWANDOWSKI: Cardiologist who can't handle the microphone. I'm Tom Lewandowski. I'll tell you a little bit about myself. I sort of feel, sitting on this panel, a little bit like the PBS when I was a child. One of these things does not fit together.

First of all, I'm a practicing cardiologist in a hospital-owned system. Much of what I'm going to talk about really started as a hobby of something that I was trying to do with the chapter. Since that time it's grown into a physician-led movement that has also led to a Round Two award for our project to move forward. So I have to say that part of what I will be talking about is being supported by the Round Two innovation awards, but what I'm going to say are purely my own feelings on this. I can tell even within the American College of Cardiology I tend to push the edges.

But in essence, our project which we call Smart Care started off as a project where we spoke to

various stakeholders, the payors, the purchasers, the patients, the hospital systems and we really wanted to understand why it seemed like we continued to buy into pitting one specialty against another in placing blame for where healthcare spending is going. Making very rigorous rules and things to jump through in order to get reimbursement, and placing a lot of onerous on people that, frankly, a lot of the decisions are made well above our heads and above our pay grade.

So we really looked at it and said, what is it? We understand what everybody really wants to accomplish, but what is it that we clinicians need to have in our hands to be able to accomplish that work. Subsequently we started looking at all sorts of aspects that Patrick Conway just discussed. So I could basically spend hours talking about any one of those aspects, but in general, what we came up with was a system that is a confluence of all physicians coming together to provide benefit to the patient and to protect the patient's care.

In a way that as we move forward with these

healthcare reforms that not only are we paying attention to the cost, but that the clinicians have the data to understand the changes they made did not adversely effect the outcomes. That's why all the conversations about metrics, registries and stuff are exceedingly important to the physicians out there. I'm telling you here as a clinician, a practicing cardiologist, that cardiologists and all physicians do care about this, and really do want to participate in this activity.

MS. BORRELLI: Thank you. First of all, thanks for inviting Intel as the employer voice to this expert panel. We really appreciate being here. Intel is a U.S. manufacturer. Over half of our employees are right here in the U.S. We care about their health, and we have a different focus than maybe what we had 10 years ago. Our focus at Intel is to have employees who are some of the healthiest on the planet.

It is not about providing a benefit's plan at a fair price. So when you start with that new

focus you start with a new way of providing care. As we talk to our employees we found that they weren't feeling that. We realized very quickly that we did have to change our approach to an ACO.

Within this ACO we have patients in our medical homes that are connected to the specialties and to the providers. We started this new launch in New Mexico. This is where we have a large factory, but it is one of our smaller neighborhoods. We contracted directly with Presbyterian Hospital after doing an RFP.

The decision was made for Intel to get really very involved in the healthcare supplier chain, and to act like the payor that we are. Not simply the benefits provider. We approached this just as we do with any of our contractors who provide all of the materials for our chips. We set up specific requirements, contracts where both the supplier and the payor and the recipient of this new way of doing things would benefit.

So we launched in 2013 and I think maybe one

of the best examples that I can give you of how this is working is through access. Within the first two weeks of the launch, two years ago, one of our employees was diagnosed with cancer. We had set up a system so that any time we had a chronic disease surface like this the interconnected teams went to work. Within two weeks we found the best care for this employee at MD Anderson and he was there getting treatment. This would not have happened otherwise.

But before we started down this road we have five attributes. Let me just tick those off really quickly. The right care, based on evidence-based medicine, right time, so that we were able to get our employees in quickly. The best outcomes, we wanted patient satisfaction rates of over 90 percent. The right price on a per patient per month basis, and the best life, quick return to productivity.

In summary, we met most of those goals. Which ones do you think we didn't meet? That would be the cost. We found out that meeting the goals of the triple AIM is hard. But we were so pleased with the

success on the other metrics, which were also critically important to us, that we launched our second program in Portland this month, Portland, Oregon, which created a new series of challenges because we're working with multiple hospitals and clinics which we have to be connected to through a robust electronic health record system which I'm glad to discuss later since my time is up. Thank you.

MR. SIMMER: Thank you. I'd like to advocate for a particular payment model that I'm calling tiered fees based on practice and population performance. We implemented such a model starting in 2009 in the State of Michigan.

Basically, no physician has been eligible for a fee increase since 2009 unless that physician is participating in a population management organization. About 85 percent of our physicians now do participate in such organizations. We no tier fees for primary care ranging from 100 percent of the base fee to 130 percent, and in specialty care from 100 percent to 110 percent.

What has happened is really remarkable. It no longer operates as a fee for service system. Because under a fee for service system I've got 40,000 physicians working to improve their financial performance by increasing the volume of services delivered. Under this system they no longer think that way. They think how can I perform at a level that can maintain or increase the tier that I'm paid it.

It operates completely differently, so at the beginning of this process our professional fees in Michigan were 2.4 billion. They're now less than 2.2 billion. So there's been an absolutely decrease in the cost of professional services while we've been undertaking this tiered fee arrangement.

It's very interesting because measuring at the population level means that we use the same measures for hospitals, facilities, specialists, and primary care physicians. We see that in these organizations they're now working much more collaboratively and effectively together because

they're all operating under the same measures.

So it's a very interesting thing, but I believe that tiering fees based on population in practice level performance is something that needs a lot more attention because the problem with fee for service isn't just that it's fee for service. It's that it's always the same fee regardless of what you're accomplishing with that service. That's a failing payment model not strictly speaking fee for service.

So I'll conclude with that and I look forward to the discussion.

MR. BERENSON: I guess I'll stand here and ask -- so I'm tempted to simply say I'll use the prerogative to give everybody two more minutes to extend their remarks, but I won't do that. I heard some things I'd like to follow-up on, but first let me ask if any of the panelists have comments about what you heard your fellow panelists make that you'd like to, sort of, get the discussion going. Anybody want to jump in right now?

I will ask then some questions to get things started. First, Alice, could you tell us what about that organization permitted that patient to get to MD Anderson that, it was a he, I believe, he would not have gotten, and, you know, what was it that was different?

MS. BORRELLI: Well, it was the access and the communication between the primary care facility and the patient-centered medical home that he registered in, and that was one of the requirements for choosing this program.

I wanted to say employees had a choice. They could go into this connected care program or they could choose their traditional route, 60 percent of our employees chose this. By registering -- first of all, he was diagnosed, and second of all, we were connecting directly to the specialists with a facilitated appointment schedule. So that the appointments had to be -- I think the requirement was within the next three days, and so it was met.

We had the right people on board to make

that decision. Then there were no limitations either. We wanted to find the very best and the best match for that employee without going through the traditional route of looking at what was local and then, you know, just the referral process. So using evidence-based medicine, knowing what was out there for the alternatives that's what speeded the process along.

MR. BERENSON: Reid, you wanted to comment.

MR. BLACKWELDER: I really did because I love some of what you said earlier and what you were just repeating now in terms of the coordination of care, the communication. Likely some inner operability of the records and ability to make this happen.

But one of the things we've been pushing for, and you reminded me of it when you spoke, is it's all about getting patients to get the right care, and right place, right time, right person, and it sounds like that's an outstanding example of a way of improving outcomes, everybody's satisfaction. You have to lower costs for that kind of efficiency. So I

think that's a great model for things that are possible. Even in the current environment you're finding creative ways of making that work.

MS. BORRELLI: But in the first year we did not lower costs. So maybe first years are not the way to do those measurements because you do invest in making sure that the patients have the primary care facility to go to. That you've got the measurements in place.

I think that's a lesson for us that, you know, you may have to extend that timeframe to reap the benefits.

MR. BERENSON: Or maybe on that need for people who have had good employer sponsored insurance. Go ahead.

MR. LEWANDOWSKI: I have a comment. As we talk about a lot of things and there is a lot we all have learned from each other and that we make use of.

As a cardiologist we're constantly faced with situations where people are always touting the fasted door to balloon time, and from the onset of

pain to the time that the stint's put in. Well, some of the things that we're talking about here we need to get a little bit further down and make it happen at the local level as well.

The reason that I say that is because if we don't find systems and help give the various people doing the work the tools necessary to participate properly then those facilities will not be around locally. So even though we look at various payment systems such as an ACO, yet the policy on how we set up those ACOs quite often drives standard of care in such a way that we cannot afford to keep certain services up to date.

So even though I applaud finding the greatest service somewhere somewhere else. Realize that if we're looking at a cath lab that costs $1,000 a year to maintain, and you do 10 catheterizations a year that means there's $100 of spend just to cover that facility. If we then add $25 for the equipment for that procedure and $25 for the staff, including the physicians, if we now send half of those cases out

to another place without helping locally do this that means now we're down to five cases.

That system, even with the payment not reduced, as everyone's pushing for, only comes to $750. So no matter what the payment system is, including shared savings, we have to look at making sure that we still have the ability to support treatment of patients both locally as well as at centers of excellence.

That is part of what we tried to do with our payment system, and we are a society that in our proposal just applying the tools that we had outlined, just helping the doctors identify what are the things that really will help and what won't on an actuarial basis and going through and checking it. Just for chest pain, the work up of chest pain we could save $3 billion a year for Medicare.

So giving those tools would allow the hospital to still be able to set prices differently, and we'd have to make sure we'd cover those costs because, for me, a helicopter ride from Appleton,

Wisconsin to Cleveland Clinic is still a long time and a lot of money. We still have certain care we have to be able to provide.

So as we move forward with this we really have to look at how do we quickly change when we've got groups of people working together, like primary care and cardiology, to really say, how do we approach this condition differently so that we all start finding areas that we didn't need to do, and pay for that and allow that to happen.

Right now we're putting in the tools and using the money of the grant to do that, but we're dealing with a very large issue of trust in that people have said for a long time the physicians don't want to participate. Here we are. Physicians don't have ideas. Here we were. You won't find a system willing to do it. Here we are. You won't find specialties that will work with you. Here we are.

Yet the one piece that we're still left with is this system, which we said could save $3 billion a year just on the work up of chest pain, has no way to

pay for it. We're using those tools to put -- the money to put the tools in so that we can try and change a system, much like Patrick was describing, where we think we're pretty close to being able to have a self-sustaining model if all the various insurers will do it.

The problem we're having is that now the trust. We're waiting for the payment side to step forward and be able to do it with us. So when I look at things that Intel is doing that is beautiful, and I think it's great. Now we've got to get it down to the local level because we all live in various places, and we don't all live next to a world-class center. We have to help the family practice docs. We have to help the advanced practice clinicians have those same tools, and those cost money which means when I look at it from a standpoint of measurement that is where the registries are so important. Because no one is measuring anything that you don't pay for. So we have to have a mechanism to do that.

MR. BERENSON: There's a lot you said that I

could follow-up on, but I want to engage one thing that Tom Simmer put on the table and get Reid and Tom to talk about it, is the Blue Cross of Michigan's approach to only recognize the medical homes that are within a population management organization.

Most of the work around medical homes are, sort of, standalone medical homes. At least a lot of the demos, a lot of the other insures are not doing it that way. What is, sort of, the trade-offs between requiring that embedding in a larger, let's call it an ACO organization, and trying to promote improved primary care delivery regardless of whether it's embedded in a larger organization. First, go ahead, Tom, and then, Reid, I'd like your perspective.

MR. SIMMER: Well, first I want to build on what Reid said earlier that team-based care and patient center medical home model of practice is a core and foundational element of how we're succeeding with population management. There really isn't a trade-off.

The solo practitioners, the small practices

have all joined these larger, sort of, IPA style physician organizations, and 70 percent of the primary care physicians in the state now have been designated as patient centered medical homes. The smaller the practice the more facilitation that they get from these organizations, so it actually has proven to be something that supports the independent practice model rather than threatens it.

The one thing I'd like to add is that you can't just have a no fee for service system for team-based care and care coordination. It's one thing to tier the fees based on performance. It's another thing to exclude from any payment whatsoever for vital services that contribute to better overall population management. That's what we've done when we have put care coordination and team-based care into the no fee for service system which absolutely kills it.

So in additional to needing tiered fees based on performance we need to directly pay, one way or another, for those services for care coordination and team-based care. Or the incentives alone will be

working with a deficient care model that's not going to be able to deliver the results that we need.

MR. BERENSON: Reid?

MR. BLACKWELDER: I'm really excited to hear what's going on in Michigan, and then your comments because so much of that reflects, I think, a growing recognition of PCMH being more than just a practice here. It has to be the medical neighborhood, but it's also defined by your neighborhood. I think what you're suggesting in terms of the infrastructure support, the support of the local care, but yet taping into a broader picture really makes a lot of your point as well, Tom. What can we do locally? How can we build you up to handle these aspects, but also respect them.

We're going to share goals, share responsibility. We'll provide the support that you need, but we're going to pay you for the kinds of things that keep people out of those long helicopter rides or those global connections. But they're there if you need them.

I think what you're describing is a system that does support the examples I gave earlier. Small practices, single or few physician practices still being able to do what they do. In fact, needing them to do what they do, even better.

MR. BERENSON: The other two have comments on this discussion? All right. Let me ask this question. That, Tom, I think you would then say that a fee schedule needs to be part of payment reform. Paying for activity, of certain kinds, needs to be part of payment reform, and if you agree with that characterization that suggests that we also need to be paying attention to how the existing Medicare fee schedule which most private payors sort of adopt needs -- not maybe as much, but needs attention as well as these new payment models. Would you agree with that?

MR. LEWANDOWSKI: Yes, absolutely. I think that the Medicare payment model remains, primarily, a fee for service model with no differentiation based on performance. The fact that it's a fee for service model I do not feel is the problem. The fact that it

fails to represent any difference in payment based on performance, and I know that's a little bit of an overstatement. We heard that there was 10 percent and this kind of thing, and I know that it's not the intent to keep in that way.

But the fact is that the impact of having a straight fee for service system with no recognition of performance means that you force everybody, as their primary strategy for doing well financially, to reduce the cost of delivering whatever service it happens to be that gets paid, and therefore, you fail to make investments up front in the services that can have a favorable impact down the road.

So that's the story of primary care. Squeeze it until it's literally down to the pulp, and what do you find. Not that you're paying money for primary care, because you're not. But you are paying for your failure to invest in the types of services that do prevent hospitalizations and so forth.

I'm not worried about the hospitalizations that are inappropriate. I'm worried about the

hospitalizations that are appropriate because the condition was allowed to deteriorate due to the lack of attention to a payment model for primary care that would have changed the story.

In our -- we have 4,400 primary care physicians that are patient centered medical homes, and they have a 27 percent lower rate of hospitalization for hospital sensitive condition than the concurrent control of non-patient centered medical home practices. So it's very real that patient centered medical home is managing conditions at a level that produces fewer inpatient admission for hospital sensitive -- this type of ambulatory sensitive condition.

MR. SIMMER: I have a little bit of a comment to that. I think that it can be done with the fee for service system. I think you can do virtual bundles that mimic a bundle or use fee for service built off of it and mimic a bundle with a budget.

I think what we have to be very careful about though is that whether we want to admit it or

not we're trying to go to a value system, and so it's very difficult to create a value system in primary care and leave everybody else in fee for service. Especially when you have services like cardiology where we share patients so much.

So sometimes we're seeing cases where the incentives around primary care medical home sometimes inadvertently in the quest to save money patients do not get care, and in the short term you may see costs go down. Our worry is we are now seeing patients who are much sicker by that time they get to us. So while I agree with everything, and we need to find payments that straddle and don't impeded the primary care physician being able to say I need help. I want to go to these guys because they're doing it in a similar way. We're sharing the same metrics.

So I think what you're saying can be done in fee for service. I think we have to remember that I am an employee, and no matter how I want to do it I'm still being told by my manager what my RVUs are. That is a very dangerous thing for us to have happen to the

physicians.

I know in one of the statement papers you talked about letting systems still deal with fee for service, but that is the reality. So when I see things to help primary care like per member per month bonuses I look at those sometimes and say, does that not lead to people spending less time if we don't cap them? Because that becomes a form of fee for service as well.

So I really want to challenge those who are trying to change things and say, let's look at a paradigm shift here that starts eliminating those fights, starts eliminating those barriers that we're artificially creating so that the primary care physician and the cardiologist can get the patient the care they need as quick as possible, and as efficiently as possible.

MR. BERENSON: Quick response and then.

MR. LEWANDOWSKI: I think that what happens is if you get a per member per month capitation you reduce the incentive to deliver services. I'm not

suggesting that we should do that for the reason that you mentioned. You don't fun into that problem with tiered fees based on population level results.

In order for our specialists to receive any consideration for higher tiered fees they must have implemented patient centered medical neighbor principles as outlined by the American College of Physicians, and be documented by their population management organization for having done so. That theme is intended to help correct some of the issues that you mentioned which are very important issues.

MR. BERENSON: Well, we're just getting started, but I'm -- go Alice, right ahead.

MS. BORRELLI: I just wanted to say, you know, you can't have one metric. You have to have a number of metrics, and you have to have a shared goal by the primary care as well as the specialist, as well as the hospital. That's where we found real unity in the shared goal aspect. I don't know how you do that in fee for service. I think it has to be a dramatic change.

MR. BERENSON: We could go on with this, but I promised that we're going to have some Qs and As. Please line up at the microphone and ask your questions, tell us who you are, and who you're asking your question to. We don't have too much time, so please be brief.

MR. DOHERTY: Bob Doherty, ACP. I talk fast, even though I have a piece of paper here. This is more, sort of, I want to get a reaction to the panel. One of the things that concerns me, and (inaudible) organization that's all on board with supporting value-based payment, supporting medical homes, ACOs, supporting the bipartisan, bicameral bill, and I know we're going to be talking later about whether there should be more risk in that, less risk in the incentives aligned correctly.

My concern is that we are at risk of killing the goose that laid the golden egg, the goose being primary care, and the golden egg being high value of patient centered care. When I talk to physicians around the country, primary care docs, the number one

thing they complain about is administrative burden.

I worry that as we put more measures in without harmonization, prioritization of measures we may be measuring the wrong things. We're going to add more burden to primary care, even more than specialists, making their satisfaction with practice lower and burnout higher. We know all the problems with the EHRs and the ability of EHRs to support the kind of care and clinical documentation that people need.

Primary care just saw their Medicaid payments cut January 1 because Medicaid pay parry wasn't renewed. Their Medicare 10 percent bonus expires at the end of this year, and that's going to be a tough lift. So you have all of these things coming down on them, and I think we really have to look at health policy not just at a macro level of where we want to go, but the micro level of whether the policies we're building to legislation is actually going to make it easier and facilitate good primary care or kill it.

You know, there are things in the medical home that are great concept and we're having great experience, but look at the challenges of that. Taking financial risk is a challenge, the difference certification processes. I could go on and on. So I guess my question to the panel is how do we make sure, as we do the macro policy, we don't kill the goose?

MR. BERENSON: Reid, would you like to start with that one?

MR. BLACKWELDER: Start by saying, first off, Bob, I completely agree these are huge issues and extremely real for all the reasons you identified. When you're talking about things like per member per month there's got to be some balance because there has to be an ability to discuss what's happening truly in primary care without adding the administrative burden. For example the chronic care management fees, that's great. I can be paid for things I promise you I routinely do on my patients, but in order to get paid I have to check certain boxes, spend time documenting. I'm not spending more time documenting which is not

time I'm taking care of patients. I'm taking care of charts.

This is a very real consequence of all. Here's a benefit we're going to pay, but you've got to jump through all these hopes to get there. I think we are at a critical point right now in terms of we're burning out. This has to be part of the ongoing discussion, and you have to look at intended and unintended consequences of trying to do a better thing which we may, indeed, Bob, create more damage to primary care.

MR. BERENSON: Any other comments from the panel?

MR. LEWANDOWSKI: I think the things that you're seeing in primary care are occurring across the whole entire house of medicine. I can tell you that there is a huge war raging right now within the cardiology field around all the maintenance of certification requirements that are being put on top of physicians. It has gotten to the point where between the payment issues, the metric issues,

maintenance of certification; there's no time left to do anything else.

The maintenance of certification is becoming some onerous that it's getting to the point where you can't afford it, let alone keep up with is. So you're absolutely correct and they are all tied together. This meeting today, though, is around the payment portion.

MS. BORRELLI: So Intel has been a big proponent of lean manufacturing, looking at where that access lies and taking it out of the system because we're moving towards a shared goal. We're very fortunate to have some experts in this area move to CMS, so we've had two Intel veterans now at CMS doing the lean process there.

I hear it's really making a difference, but perhaps we need to do more focus and work with the whole community to figure out where to take out these steps that don't need to be made.

MR. BERENSON: Who has another question for the panel? Anybody want to ask? While you're

thinking about it let me then ask. A couple of you explicitly mentioned the importance of having good outcome measures and moving towards recognizing outcomes rather than fee for service or volume, etcetera.

I think Tom Lewandowski you emphasized the importance of having outcomes to protect against potential harm to patients as we move towards powerful payment models that have the potential of creating stinting. We want to make sure that outcomes are not compromised.

How realistic is it that in the new future we can have outcomes? Most of the performance measures are process measurers, and I haven't heard anybody endorsing heavy use of process measurers. What you're going to hear from us a little later is a lot on moving to outcomes. Is this realistic? Do you have experience in the real world that suggests that Medicare could do this on a national basis?

MR. SIMMER: Yeah, Medicare can do it on a national basis, but it's going to be have to done with

the assistance of the physician organizations. You know, we talked about the cost of maintaining registries and stuff like that, but the reality is if we do not have a system to monitor what it is we're doing, and testing whether or not what it is we're monitoring is moving us in the right direction or not we're never going to get there.

So it's really going to have to be an incremental step where we start off with monitoring several things, finding those that point towards the ultimate outcome goals, and then keep watching them and making sure that the ones that point towards it were encouraging people to use it. As we start identifying those that actually are tied to the outcomes then you move them forward.

We haven't put an infrastructure in, and I think we're now getting to that point, especially in some innovative ways, of being able to set up that environment. But it requires that CMS and other payors recognize that that is a service that we need to maintain and has to be supported. Because as we

all start cutting costs it's those things that are not reimbursed that are the first things to go away. So we run the danger of wanting to have all this data, but if we don't send signals that it matters you're going to see it disappear.

MR. BLACKWELDER: Yeah, but the theory of population-based payment, otherwise called capitation, is that the organization will figure out which services make a difference. You're not so --

MR. SIMMER: The problem is that from a clinician standpoint some of the population-based things are very large ideas. And yet, when I'm looking at the population what I see in front of me is a patient. So we have to take this idea of population-based medicine, and we have to boil it down to some tools to help the clinicians identify for that patient what's going to move them in the right direction.

It's going to have to be something that we give the tools to the clinicians to be able to see how they're managing their own population in their own

clinic, let alone, the whole community. So really the concepts that we're all talking about are dead on, spot on. The tools we're giving to the clinicians to do that work have to be actionable, so that they can respond to it.

That's going to require different thinking and more coordination between the various specialties and the various policy levels and everything else. But we have to do it.

MR. BERENSON: Reid?

MR. BLACKWELDER: I think the short answer is, yes, and some will be process measurers, some will be other kinds of measures, but there are a couple of real important concepts. One is you have to have clinician involvement as well as system's involvement to identify the measures. You've got to be willing to recognize you may choose the wrong measure, and so you've got to be able to look at those at times and decide is this actually doing what we think it does.

Going back to Alice's point, where you didn't notice the cost savings in one year, some

things like prevention, I mean, really the foundation of primary care is not something you measure in year, either in terms of outcomes or in savings. So we've also got to look at the timeframe of how we're going to pay attention to that, and not immediately say, oh, it's not working. That's it.

MR. BERENSON: Tom, a quick comment and then we'll have one final question.

MR. LEWANDOWSKI: I think that the actual shift of payment mechanism to include population management results greatly facilitates the process of developing better outcome and process measures. It's one of the essential steps, but we've seen an acceleration of the development of those measures in Michigan since we went to that payment model. But it's still too early to say that we have -- we're ready for outcome measures to fit into our payment model at this time.

MR. BERENSON: Last question.

MR. RICH: Hi, Jeff Rich, Past Present Society of Thoracic Surgeons. I wanted to speak, Bob,

to your comment about outcomes measures. The STS database is full of outcome measures. We've developed pay for performance plans, and the agency data base is full of outcome measures, as well, that are risk adjusted, so the models exist out there.

Rich Prager in Michigan has done a tremendous job with outcomes measures. We, in Virginia, have developed a clinical financial tool for physicians, for cardiac surgeons and hospital administrators to look at outcomes, and look at the impact on costs, and to do cost reduction methodologies and maintaining good outcomes and having quality measures. So it does exist, the models do exist. I would submit that they are alive and Rich is about to -- we're helping Rich put the financial part into your Michigan database.

MR. BERENSON: Thank you for that. I think we're at the end of our panel, so let's give everybody a thanks up here.

(Recess)

MR. MCCLELLAN: While our next panel is

making their way up to the front, which I hope they'll do right now, I do want to thank Bob and the rest of our first panel for that discussion about primary and specialty care, working together as provider networks to support population management. You heard about different models for doing that through accountable care organization population-based support. You heard about models for doing it based on tiered fees, which also are very much based on value, as Tom Simmer emphasized. So different ways for getting there, but all significant movements away from fee-for-service payment.

So I think our panelists are coming up right now. We're now going to move from the focus on primary care and conditions primarily managed by family physicians, internists, and others working in collaboration with specialists to another major component of health care and that is the care that's primarily managed and executed by specialists. So this includes specialists that perform major procedures, surgical operations like joint

replacements, thoracic surgeries you just heard about in the last comment and question, as well as specialists who are the primary provider responsible for patients who have specialized conditions that require complex or specialized services that are not a usual part of primary care. As I mentioned earlier, examples of this might be patients with new diagnoses of serious cancers, patients with serious gastrointestinal chronic diseases, patients with very severe heart failure, or brittle diabetes. Many of these patients are managed primarily by specialists, so it's not just about the major procedures.

So what we want to do now is make sure that we're putting as much emphasis on this part of the practice of medicine as we put on the very important population health and primary care focus services that were part of the last panel.

For this panel, I am joined by Joel Brill who's the Medical Director for FAIR Health, Inc. Joel has a tremendous background as I'm sure you'll hear in gastroenterology and some models of changing care and

supporting it through significant changes away from fee-for-service payment systems.

Kelly Conroy is now or has been the CEO of the Triple Aim Development Group. Kelly's moving to Aledade Health soon. Kelly previous to this has been involved in leading an ACO in Florida that has implemented a number of steps to improve population-based health as well as to improve the effective use of specialty care.

Kevin Bozic is now the Chair of the Department of Surgery and Perioperative Care at the Dell Medical School at UT Austin. I'm sure Kevin will touch on this, but this is really a new medical education and training in care delivery enterprise that's focused very much on new models of care delivery, including for specialty services like orthopedic services where Kevin has a tremendous amount of experience from his previous work at UCSF and elsewhere.

We are also joined by Randy Krakauer, the National Medical Director of Medicare at Aetna. He

has worked on some of their payment reform models in the Medicare Advantage Program and elsewhere.

And from an employer and purchaser perspective, Pam French is the Vice President of Compensation and Benefits at Boeing, which has introduced a number of payment reforms, accountable care organizations, specialty care payment reforms that Pam will talk about as well.

So to get our discussion going, just like the last panel we've asked each of our panelists to spend a few minutes to try to convey some key ideas that they think are critical for these issues related to effective care delivery and financial support for specialty-focused care. So, Joel, I'm going to start with you.

DR. BRILL: Mark, thank you very much and thank you to Brookings and to the invitation and to the support from the American Foundation. So, as Mark mentioned, I'm a gastroenterologist. We're involved in whole-patient care as many of you know. Come on, that was joke! It's early in the morning.

Specialty care is a team sport. It's not just what I do; it's what I and my colleagues do in combination with the care team. So if you think about it, I'm going to talk about two, very simple examples. One example is colorectal cancer screening. We've developed -- we, wearing my American Gastroenterological Association hat -- we've developed a model for colorectal cancer screening and surveillance. Now, we're not saying that everybody has to have a colonoscopy in order to be screened. But if you do, it's a team sport because there's anesthesia involved, there's pathology involved, there's a facility involved, and it's all designed around how we provide the right care in the right setting at the right time. And we tie that into quality measurement, which looks at a process of how we avoid waste and overuse.

In other words, we have peer-reviewed, multi-specialty, multi-stakeholder guidelines developed around the science and evidence of when a patient should come back for follow up based on what

the pathology shows. How do we tie a payment model to doing it right? How do we ensure that the patient has a high-quality, complete examination so that you can assure the patient -- who, by the way, comes in and wants to know did you do the right thing? Did you hurt me? Did you do it in a safe manner? How can we reassure that patient that we did all those things, that we did a complete examination and we brought them back and made a recommendation to come back at the right time?

That's kind of interesting because with colorectal cancer screening, the follow-up intervals change dramatically. If someone has a normal screening, they don't need to come back for 10 years' time. And 10 years is a lifetime and an eternity in the commercial world. That patient may not be in that commercial plan 10 years from now. They may go with the employer group, but they may not be with commercial. But with Medicare, sure, they're still there. But a lot of what we find, polyps or lesions, may require follow up in a two- or three-year period

of time, depending on the pathology, and that's within the commercial world.

So what we've done is try to look at this question, try to develop a model for payment and a model for claims adjudication so that working with the private sector we can say who's in, who's not in. If the patient has a complication, does it get paid as part of the bundle or not part of the bundle? And slowly, but surely, we're finding that in local areas -- because this is a locally driven thing -- people have an interest in bundled payments.

We have another model that actually is a homegrown model that developed in Illinois. One of our large gastroenterology groups approached the large payer, Blue Cross Blue Shield of Illinois, in the area. They had a concept. They said patients with inflammatory bowel disease get hospitalized and a lot of this Medicare information gets triggered when the patient gets hospitalized. But how do we keep the person out of the hospital in the first place? So they created a program called "project sonar." Why?

Because they ping patients weekly. And it's like Ed Koch. Remember the mayor? How ya' doing? Well, that's what sonar is. Sonar pings people every week. How ya' doing? And it involves some very simple, Smartphone-based tools for that patient to answer some quick questions. Now, if the patient answers a question in a way that says "I'm not doing well," it triggers an outreach from the practice to the patient to make sure what do we need to do differently and what's going wrong so that we can avoid that hospitalization, so that we can avoid that ER visit.

By doing that, the preliminary data from the -- albeit it's only about nine months of data -- but the first bit of data shows that we're keeping people out of the ER, out of the hospital. It's a team-based sport. In order to do that we do need more data, more ability to pay for it, and we're going to discuss that more I'm sure in the session to come.

MS. CONROY: I'm going to watch my time and I can speak fast, just like everybody else in the room. I could talk about this subject for probably

about a year. But I would like to thank Mark and Brookings for bringing people like myself. I'm a very boots-on-the-ground, very grassroots efforts in a ACO. I've been working with ACOs since early 2012, so we were an early adopter. The first ACO that I worked with was Palm Beach ACO, and I think they were very unique in their visionary because they were formed with 50 percent primary care physicians and 50 percent specialists. And I think the visionaries were pretty smart back in 2012 to say we should include the specialists. They can help us with this project. So we had about 200 physicians, like I said about 100 primary, 100 specialists, and 78 percent of them were solo practitioners. So this just goes to show you that there was a strong will and a strong belief that physicians could make a difference.

So since then I've traveled around and spoken to about 25 other ACOs. I have seen some really good specialty programs that are working within the confines of an ACO, but I just want to give you a couple of examples. These are ideas that are coming

directly from the doctors themselves. They're not really being driven by anything else other than the goals of the Triple AIM.

One idea that's coming from the physicians is to have the pre-oncology, pre-chemo patient, go back to the primary care physician before they go to chemo to adjust their medications. What they were finding is once a patient was diagnosed with cancer, they never went back to the primary care physician. And the patients never are the same after cancer, but cured, so they really wanted to keep that primary care and that physician and that specialty tied together a little bit better.

Another one that we noticed is as we started as an ACO community doing more annual wellness visits, which really wasn't very well publicized back in 2012, they started identifying patients at risk for falls, a lot more than they thought. And then the big question was, okay, we've identified this group of patients that are at risk for falls. Now what do we do? Typically it was send them to an orthopedic, send them

to a neurologist. So one visionary primary care physician said why don't we send them to a physical therapy company that has a one-time visit that analyzes this fall risk assessment and pretty much gives us a baseline and then sends them back to the primary care physician for the next step? So I thought that was pretty visionary.

Another thing that I have found with ACOs that are working very closely with specialists is that the specialist actually wants the primary care physician to tell them what they want. We all assume that everybody knows that they're talking to each other, and I guess since the world of hospitalists of just not having enough communication in the cafeteria anymore. So we created something called ACO expectations of excellence and we created them for every community stakeholder, but also for specialists. And the specialists actually told us things that they can do to help primary care physicians. For example, an early-stage CKD patient, they'd like to send them to a nephrologist just to get a baseline, get some

ideas about him, and send him back to the primary care physician.

So for me the exciting part has been seeing the primary care and the specialist actually work together, want to work together. I'm sure everybody in this room is well aware that the interoperability that we all thought we had we don't have.

And if I could just make -- I have a whole bunch more things to say, but if I could make one suggestion. I wish that we could make a rule, a law, a legislation, I don't care what it is, that every admit, discharge, and transfer has to be sent to the primary care physician. It's almost criminal that it's not, that the primary care physician does not know that his patient's in the hospital. Everybody else is working on that patient and we think things are communicating. They are so not communicating. So if we could just somehow make a hospital responsible for letting the primary care physician know the patient's there, I think we'd find a lot of things would go much better.

MR. MCCLELLAN: Thanks, Kelly. Kevin?

DR. BOZIC: I want to thank Mark and the Brookings Institution for having us here. I really find this distinction between primary care and specialists and the way this panel's set up and the way the room is divided somewhat interesting. It kind of reminds me as a practicing orthopedist when we refer to our colleagues in primary care or they refer to us as their specialty or surgical colleagues. It kind of reminds of Nancy Pelosi and Mitch McConnell talking about their colleagues on the other side of the aisle. And that's kind of the way this room feels a little bit.

I think that we really need a payment system that incentivizes blurring the lines between different types of providers. And I think that right now, for instance in the ACO world as specialists, we are really on the outside looking in and we are viewed as a cost center rather than a partner in driving value. And I think there's a lot that can be done with the payment system as well as within the physician

community to promote a focus on condition rather than specialty. And some of those things include -- as specialists, we really have expertise in defining appropriateness, for instance. When is it appropriate to get advanced imaging? When is it appropriate to refer to a specialist? When is it appropriate to undergo a surgical procedure or another type of resource-intensive intervention?

There's a lot that could be done with down streaming care in these organizations such that everyone is operating at the top of their license so that we can have some regulatory relief for people to be able to do jobs that may be a little bit outside their comfort zone, but a lot less resource-intensive and allow them to provide the best care to the patient at the right time.

I think that as specialists we have a unique role in defining quality for our specialty and what outcomes are important to us and our patients and helping really measure and understand the value of different types of payment models. And where we see

shining examples of that in the specialty world is in the implementation of registries. We have a cardiologist here. We have the Society for Thoracic Surgeons. We in orthopedics have a fledgling registry right now. But as voluntary registries, these are very difficult to attract hospital participation. We need real clarification on the common rule to help hospitals who want to participate for quality improvement purposes to not be concerned about the Draconian penalties of participating and sharing data and getting patient consent. And we really need some help in terms of making these registry efforts, as was said in some of the early comments by Patrick Conway and others, really available at the point of service to the patients who need them and the providers who need them.

So I'll just wrap up by saying I think as physicians, we are really uniquely positioned to address some of the problems with our health care system and to implement strategies that will improve quality and reduce costs. We know where the bodies

are buried, if you will, but we need a payment system that allows us to focus on those activities that will allow us to create value and work with the other stakeholders in the system. So thanks again for the opportunity.

MR. MCCLELLAN: Thanks, Kevin.

DR. KRAKAUER: Thank you, Mark, and thank you to the Brookings Institution. There's considerable opportunity in specialty care in terms of quality and cost again if we focus on mutually agreed-upon quality or quality value, but as usual, it's not that simple.

We started with ACO-like arrangements, which we call Medicare provider collaboration, about seven or eight years ago. These are simpler than ACOs and, therefore, simpler to implement than most ACOs, but it's not just a contract. It's more complicated than that. We now have about 150 of these, about 100 of them with sufficient membership and time to judge results. Overall, the impact is very good and we're very satisfied with this and we're looking very much

to grow our membership and these arrangements, but it's not just the contract. One of our lessons is that it's really a mutual commitment and not just to the organization per se, but to the physicians themselves involved in the organization and not just necessarily the leadership or for that matter the CEO.

If we look at our good performing groups -- and we like to look best at our good performing groups -- there are several key features that we notice and we're still studying what they are. One is a strong primary care base and strong primary care connectivity. I don't have time to really expound on this, but I have to say that that is of crucial importance.

Also is good physician involvement and good physician engagement in the plan, in the process, and in the implementation. It has to affect what the physician does with the patient in front of him. It's not just the leadership and it's not just a signed contract. The physicians have to be involved themselves in the process.

Effective care management is likewise crucial and not always there at the beginning. It has to be instituted. Sometimes it is there in the beginning. And this is also a frequent point, the failure. Effective care management is sometimes underestimated, the complexity of this and the difficulty of this is sometimes underestimated by experienced clinicians. So here management has to be there, theirs or ours.

There also has to be a robust data environment, involving considerable data sharing and involving us and the physicians both in data sharing. This has to be actionable data, summary data, benchmark data, and basically the results are not their responsibility. The results are our mutual responsibility. We see poor or no results with groups where the physicians are unengaged, case managers are not there or not properly trained or engaged or managed.

I'd like again to talk perhaps about our best groups. In our best groups, and out of 100 of

these that's perhaps 10 or 12 of those, overall we're doing very well, but some are the ones we really like to learn from. We see 50 percent or more reduction in acute days compared to unmanaged Medicare in the same region risk adjusted with cost reductions of 25 percent, 30 percent, or more. The good ones are well engaged and focused, and the MDs are involved. Case managers are well trained and they are embraced by the group, either their case managers or ours. The greatest impacts we see are is it an advanced illness and chronic illness, or a multiple chronic illness? Some chronic illnesses, like diabetes, may require several years to realize the full impact. Others like heart failure the impact may be realized in a much shorter period of time.

But the key that I'd like to leave you with is the focus on value. It is a great opportunity, but it requires clinical engagement, not just dropping a contract and expecting miracles in the short term. We now have more than 50 percent of our members in these types of arrangements and we expect to grow this, but

again it takes work. You need to evaluate the group for potential. You need to provide data, facilitate care management, and occasionally provide care management. Not all will work. We need to learn from those that do work. And we also need to learn from those that don't. But clearly one of the things we have learned is that there is, in fact, considerable opportunity.

MR. MCCLELLAN: Thanks, Randy. Pam?

MS. FRENCH: Thank you, Mark, and good morning, everyone. I appreciate the opportunity to be here as well. This is a really important subject, and I think if we can collectively figure this out, it would make a huge difference in terms of health care delivery in the U.S. and the way patients look at how they navigate the health care system.

So I'm representing the employer perspective, which is the private payer. And then I also think about it from about a half a million employees and their dependents and retirees that receive some sort of health care program from the

Boeing Company. And we have been spending the last several years looking at how we can improve our health care and well-being programs so that we differentiate ourselves from the marketplace. We want people to know if they work for our organization, they're going to get better health care perhaps than if they worked somewhere else.

And so with that in mind, we've looked at how we can give our employees and encourage them to have a better quality of life and how we can have healthier, more productive employees. We apply some of the same principles that we do to the way that we manufacture some of our major products like airplanes. Hopefully, some of you who traveled here flew on one of our products, but it's very complex. If you've ever seen how an airplane is put together, it's an extremely complex approach. And to do it well, you have to be very good at supply chain management. So we are applying some of our principles that we do in our business to the health care industry.

We actually have an initiative called

"partnering for success" that's not geared specifically to health care benefits, but it's more broadly focused on our supplier relationships. And so we're looking for ways at how we can be innovative together. How can we ensure that we are paying for performance and value? And then third, how can we integrate? Oftentimes, we're coordinating many, many suppliers in order to create an airplane. So we want to do that same thing in the health care area.

So some of the areas we've been focused on, one is an ACO-type of model called "preferred partnership." We just launched that in the Puget Sound region, which is where we have our largest population in the U.S. So that is new, but a big part of that was all around ensuring that the specialty care was coordinated well and that our employees had access to care. So if someone finds out they have an issue that needs a specialist, with this new program they can see a specialist within three days.

We've also focused on some other programs. One is the "intensive outpatient care program," which

has been quite a success. Again, it was a pilot in Puget Sound and now we're rolling it out in other locations. And that's focused on those individuals who are the sickest and what we can do about coordinating the care to get them help.

A couple of other things I want to talk about, again to focus more on the specialty care area, are three other programs. One is "urgent care." We are finding about close to a third of our employees were going to the ER for non-urgent services, so things like colds and sore throats. So we offered them an alternative called "urgent care at home" where they can get either a phone visit with a physician, a Webcam, or if their case merits, a home visit. And that has really helped employees get care in a much more appropriate setting and it's very convenient for them. Any of you who've had a child who wakes up at 2:00 in the morning with a terrible sore throat knows it's not fun to go to the ER and sit and wait. So that's one.

A second one is a "cardiac travel program."

This is all around the centers of excellence. We partnered with Cleveland Clinic and the thought here is really around recognizing that there are differences in quality amongst different providers and trying to encourage our employees to use centers of excellence where the likelihood of a positive outcome is higher. This has helped not only our employees, but some of our regional suppliers have kind up upped their game to try to meet those same quality standards.

And then finally, helping people when they have a serious health diagnosis we use a program called “best doctors” and that is to get people to find out if they have the right diagnosis. We’re finding about a third of the time they don’t get the right diagnosis. And then secondly, do they have the right treatment plan? Again, over 50 percent of the time we find that they don’t have the right treatment plan. So this is a group of nationally renowned experts that gets them on the right track.

So those are the kinds of things that we’re

doing. We think that they are things that could be replicated within the Medicare environment.

MR. MCCLELLAN: Thanks, Pam, and I want to thank all of you for covering a broad range of issues related to different aspects, especially care, and how specialists can contribute. As I think several of you mentioned -- Kevin, too -- this really is a team sport.

I would like to push now onto the Medicare legislation. A big part of that, as you know, is around alternative payment models. But I think as we've heard in the first panel and I think your comments have emphasized as well, wanting alternatives is not enough. There are a range of problems that are not being supported well or a range of opportunities for care improvements that are not being supported well in our current payment systems. But just simply saying we don't want fee for service may not be a way to get there. As Tom Simmer emphasized on the last panel, there are ways to make some fairly significant transformations within fee for service as well.

So this is where we get a chance for you all to comment a little bit further about what you'd really like to see in that legislation to make sure when we're talking about moving to alternative payment systems, we're really going to get something that will work for specialists. And just to pick up on a few of the examples that came up, Joel talked about the importance in project sonar for patients that are managed by GI specialists, having an ability to get early and more convenient information using cell phones, Smartphones, something that's not part of current reimbursement systems. I mean it reminds me a lot of what primary care medical homes have tried to do for the chronic patients that they manage, to get better early warnings about problems. Is there sort of an analog, a specialty medical home version, for something like that?

We heard about another example along the same lines from Kelly where in sort of a reverse medical home situation a patient with cancer ends up being primarily managed by the oncologist, but it'd be

nice to have some coordination on maybe there are side issues where the patient is getting treated for cancer and undergoing chemotherapy. But they have other primary care concerns and having an effective way to support that coordination could be important, too.

And Kevin talked a lot about, and others have talked about, bundled payments for colonoscopies, orthopedic conditions.

So what do you want to see in the legislation that would help make sure that the payment section, the alternative payment law that is really the heart of it, does deliver on fulfilling these opportunities that you're seeing outside of Medicare and you'd like to get more support in Medicare to get to better care? What are some key features to think about as the legislation moves forward? I'm willing to start with any of you on that. Pam? Go ahead.

MS. FRENCH: Just a couple of thoughts, one I think we have found that some of our alternative payment methods have worked for us. Again, having that be a key component of where we go I think would

be helpful. I think coordination of care, again I think several of us mentioned that. And then I think having access to cost and quality information is another area that, again, that transparency that drives innovation.

MR. MCCLELLAN: Joel, go ahead and then I think we'll just go on down the line because a lot of people wanted to comment.

DR. BRILL: So, Mark, you bring up some excellent points. This year Medicare started to pay primary care for chronic care coordination for patients who have multiple conditions and that's a great start. I'm an internist. I'm also a specialist. When patients come to a specialist, whether it's an oncologist, cardiologist, gastroenterologist, whatever, sometimes they're seeking specialty-driven care. We have to be able to allow for the care coordination, this payment to the office for coordinating care for the patient during that calendar month, to keep them out of the hospital, to move them to the urgent care, to move them to

extended office hours. We have to be able to do that in specialty care, not just in primary care.

At the same time we have to able to have cross functionality of information so that we do not have EHRs that are all walled gardens. We have to be able to get that information across to all other colleagues because the patient is the circle of care. Everybody's oriented around that patient and how we coordinate collectively to improve things is a critical component and I think would be something that in an alternative payment model forms the foundation of paying for value, not just a race to the bottom.

MS. CONROY: What I would really like to see is for us to go where I don't see anybody going, which is to let the patient know what we're trying to do. I feel like if we could let the patient either choose to be in an ACO or identify themselves, give them some power of engagement, to let them know they're part of an ACO because I think that the patient or the beneficiaries would not let go of this once they started to get it. And I also find that we run into

all kinds of barriers with every community stakeholder of getting information coordinated. So a way to take some of the HIPAA burden off of us is let the patient choose to carry their information around with them, let the patient choose to give the information to everybody.

In the chronic care management codes, while I'm happy to see that we're going to get paid for things that the doctors have already been doing, they're not really well defined. The primary cares are taking it, but the specialists are a big part of it. It should be split with them. If the patient could begin that a little bit, too. They have an $8 co-pay on it, so they're not going to understand it. So I wish we could do some more education with the patient. For some reason we seem to be very hesitant to let the beneficiaries know what's going on and I think that they could help drive our processes, especially as it pertains to a patient care plan. Pushing a button on an electronic health record for a patient care plan is just about the worst thing you

can do. It doesn't even add up or make sense. So we need some way to get the patients more involved in this whole process.

DR. BOZIC: Just to build on that, we have a lot of experience with the BPCI program and bundled payments both in the commercial sector as well as within Medicare. I think it's definitely a step in the right direction towards promoting value, but there's significant shortcomings. The current BPCI program, which I won't go into too much detail on, but one of the major shortcomings in all of these programs is when it's focused on the procedure, we really miss the opportunity to optimize the health of the population. So in other words, the best knee replacement done in the patient who never needed it in the first place is highly incentivized in a bundled payment system. We can set up a system that really optimizes the care for that surgical episode, but we don't get at appropriateness. So if we back up a step from there and tie appropriateness to these bundled payments as well as to putting some financial

incentives in place to optimize the risk factors for that patient who's going to undergo that bundle and engage patients in optimization of those risk factors. For instance, smoking cessation is something that is not -- there's no money in smoking cessation if you're a surgical specialist; however, we have significant influence over the patient at that sort of teachable moment when we can get patients to lose weight, quit smoking, reduce their dependence on opioids, whatever it is. But the incentive is really just to move forward to the procedure and let somebody else worry about those other things, knowing that those are modifiable risk factors that can influence the patient's outcome.

So I think tying the ACO model and the population to health management to these bundles and episodes is an important next step.

MR. MCCLELLAN: Good point. Randy?

DR. KRAKAUER: If you're looking for an opportunity for impact at the intersection of quality and cost in Medicare right now, there's a tremendous

extant opportunity in advanced illness that's just out there. It's about 28 percent of your Medicare cost, about 80 percent of which at least in the last couple of months is acute inpatient, which is of little, if any, clinical or psychosocial value. We and others have already demonstrated that just providing additional support and assistance to this population can produce dramatic effects. In 1 percent of our Medicare population in which we do this, we see an 82 percent hospice election rate, an 82 percent reduction in acute utilization, an 86 percent reduction in ICU. We save $12,900 per engaged member and an extraordinary level of satisfaction. As a matter of fact, it's more gratitude than satisfaction in many cases. In fact, in nine years in 14,000 cases there's not even one single member complaint. Those of you who work in this field know how rather dramatic a statement that actually is. There's nothing we can do that often without a complaint.

Things have definitely improved in the last few years, undoubtedly, but clearly we have more

distance to travel than distance behind us in this field. This should be standard of care, and Medicare has a role in making this standard of care. So if Medicare would facilitate the provision of this type of service -- and this is more than just paying for primary care management. But if we can facilitate the provision of advanced care management assistance to and through every Medicare-participating physician, I think we can have a rather dramatic impact and we will see the results of this if it's done well and it has to be done well. It's not always done well. But if we do this well, we can see the results relatively quickly after it's implemented.

MR. MCCLELLAN: Well, I think you all have emphasized a number of changes in payment that would support the kinds of reforms in care delivery that, Randy, in your example, that's huge savings. Actually all the ones that you mentioned are both lower cost and better outcomes for patients.

But another theme that has recurred through your comments and in the first panel was that this

isn't so simple as just setting up a new payment system and boom, expecting things to change. You need to get the payment system right.

A number of you all have emphasized the importance of supporting data sharing. ADT information, Kelly, the mission discharge and transfer information going back to the primary care providers from specialists or others who might be involved in care.

Kevin and others have talked about the value of registries that have broader participation, include data pulled from hospitals, from specialty care, from payers as well to do more effective patient management.

The legislation does include some support for quality measured developments, some support for data sharing at CMS. I think a lot of what we're hearing is that a lot more needs to be done here. If there are any quick comments on this topic, specific things to look for and to push for in effective physician payment reform legislation, I'd like to hear

some comments on that now. If any of you all want to respond? Kevin?

DR. BOZIC: Well, I think some important things: First of all, funding for measured development. Someone also mentioned maintenance of measures, which is important. Alignment of measures within the CMS programs, which is a big issue right now between PQRS, Meaningful Use, and Value-Based Payment Modifier we can have conflicting incentives and then really a focus on team-based measures. Drilling down to accountability at the individual physician level can sometimes lead to a lot of finger pointing and sort of non-value-added processes. So I think if we can really get some collaboration amongst the specialty societies and to develop true team-based measures that will move the ball forward in terms of improving value, I think that would be helpful.

DR. BRILL: I'll add to that. Measured development needs to be nimble. Organized medicine recently updated some measures. For example, the management of hepatitis C, definitely a primetime

topic, high cost, except that the measures are designed to address a treatment regimen that was so yesterday because we don't use interferon-based regimens anymore. So having a set of quality measures around a treatment that we don't use, that even manufacturers are pulling out of the market, what good is it? So we need to have a very robust and nimble measured development process. We don't need more measures. We need meaningful measures. We don't need to be buried under measure reporting.

MR. MCCLELLAN: Other comments on this topic? Let me just follow up on that one, and then I'm going to turn to comments from those of you who are here participating in the room next, so be ready for that.

But just to follow up, Joel, on your point about needing a nimble process for getting to meaningful measures. Can you or others say a little bit more about how to get there? Is this going to take public support? Is it going to take new mechanisms for, Kevin, for specialties to work

together on moving beyond just a specialty-specific focus? What are the key steps that Congress should be thinking about?

MS. CONROY: I have one little one. It's regarding how the doctors are listed in the PECOS system. I think since we're having so much transparency now, we're finding that most specialists are listed as internal medicine as their first and then their specialty as the second. So they have a profile of a primary physician and they're being held to the quality measures of a primary care physician. So I think that's starting to be uncovered now and people are starting to address their specialty in PECOS so that they can look like who they actually are on paper. And then I think once they actually look like who they are on paper, then we can start to see some more coordination. It's almost no wonder the government couldn't figure out how to do this because it doesn't look the way it is.

MR. MCCLELLAN: Any other comments on this?

DR. BRILL: I will just say one thing.

Measured development has to include the patient, the beneficiary, as part of it. It doesn't make any sense to develop things that aren't meaningful to patients. I know that we incorporate that when we develop measures, but it's a critical thing that sometimes is lost in people.

MR. MCCLELLAN: Great. We'd like to open up to comments and questions from those of you who are here in the room. So please go ahead and head up to the microphone and let us know who you are.

QUESTIONER: Karen Fisher with the Finance Committee. I probably should have asked this to the previous panel as well, but I'm just curious about your thoughts about the role of the patient in Medicare, the beneficiary. And we've heard with the ACOs the level of turnover and churning that goes on and there are a lot of questions about well, if you're marketing really well and you're doing all of these things, the money should be coming back to you. Why are they going off? And I think it was a big surprise to a lot of people when there was so much churning

because I think people thought well, particularly with Medicare beneficiaries, they have their primary care physician and they're not going elsewhere generally. They've been with them for 20 or 30 years and then we find out well, there is all of this information going on.

And so I'm just curious as to the role of the beneficiary. What about cost sharing? Should co-pays be waived? Does that help or should beneficiaries have skin in the game in terms of these new payment models? Just what your experiences are, and I guess if anyone from the previous panel has thoughts on it, too, I'd be interested in it.

MR. MCCLELLAN: Well, several of you made comments about the need for much more patient engagement, so I think this panel has something to say about that. Kelly, you want to go ahead?

MS. CONROY: So the way that Medicare did the attribution in the ACO, I know a lot of people complained about it. I actually love it because the physicians didn't really know how to do population

health management, so they got assigned patients. It's terribly flawed. But they find out a bunch of things, like I said, the PECOS thing. It looks like a specialist is a primary.

MR. MCCLELLAN: PECOS -- for people who don't know -- is method for identifying some basic information about specific physicians.

MS. CONROY: A provider enrollment, right. So it's like a payment, part of the payment mechanism.

The other thing that we found is -- what I loved about the ACO is it brought the walls down of competition between the doctors. It got them to start working together and not seeing each other as competition, and they started sharing best practices. But we noticed that doctors who moonlighted in a skilled nursing facility picked up a patient even though it would have been -- a patient in the ACO -- they picked it up. So Medicare didn't really acknowledge that that was happening. If you're seeing a patient in a nursing home, especially if you're moonlighting, you pick that patient up and the expense

stays with the ACO. So that created a little bit of a competition again between primaries because it really was this doctor's patient, but that doctor got responsible for it. So that's something that Medicare's working out.

And as far as patient engagement, it's nice that now the doctors have a list of who's on their panel and they have a list of who's churning in and out and they're trying to figure out why that is. But if the patients could opt in, if they could make a choice and they knew what we were doing and they could make almost a compact to say that the doctor's going to do this now in an ACO and as a patient I'm going to do that because we hear a lot of issues with the patients not being compliant and you're still responsible for everything there is about them.

And just one thought on the cost sharing. I think if we could waive co-pays for things that are really important for patients like getting to the specialist, getting to the primary, maybe even waiving the co-pay for this chronic care management code, I

think that would get more buy-in on the patient side. And we absolutely -- this whole thing is a heavy, heavy lift. We need the beneficiary's help to help us lift it.

MR. MCCLELLAN: Randy, and then I'll go to Kevin and others. But, Randy, you've got some experience with this in engaging patients in your Medicare Advantage programs you were describing earlier.

DR. KRAKAUER: Yes, thank you, they do. And I would say that engaging patients -- and not just patients, but caregivers and occasionally family members -- is a core function of longitudinal care management. And we do find that when we do this, we get better results. It's not easy, but there are ways to measure the level of patient engagement. So I think this has to be a core feature of the care management process.

You also mentioned co-payments and deductibles. That's value-based insurance design, which is actually another issue that is currently

being studied. In fact, we're involved in studying this. And I believe that there is considerable value in value-based insurance design, particularly in terms of secondary prevention. But, again, not as a standalone, but as a component of an effective care management program that has been very well designed. So eliminating co-payments and deductibles to high value and very necessary services should be associated with good care management, a good adherence program, and other features that will make it more effective.

MR. MCCLELLAN: Pam, and then Kevin and Joel.

MS. FRENCH: Clearly involvement of the patient is really critical for them to get the best care. And if you think about it -- I'll use an example with our intensive outpatient care program. We had the patient and the physician both sign what the treatment plan was going to be and what they were each going to do associated with that. And we found that the people who had not been compliant for many years, because they kind of signed something and

really had a discussion with their physician about it, that helped them follow through on that. So I think the average person doesn't know how to navigate the system. And if you want to get the person the right care at the right time, they need some help with that. Hopefully, they can get that from their primary care physician, but sometimes they go direct and sometimes they don't always connect with the right providers who can best help them. And so I think there's an education component and a shared accountability with the patient and the physician that would help in this case.

DR. BOZIC: I'll just make a brief comment because I see we have other people. As far as having patients have skin in the game, I think it's absolutely essential. If we want to create value-based competition in health care, it's for patients to have skin in the game. I agree with the comments that have been made about preventive services and why it's important to waive co-pays and really actually provide incentives for patients to receive preventive

services. But in the elective care market, we've had some experience in California with reference pricing, which has been very effective in driving down cost of care. I'm not so sure how effective it's been in terms of improving value. So what we want to do is give patients the right -- make information transparent about both costs and outcomes and then make those patients value-conscious shoppers of health care services. And I think we've seen that in certain pockets of the country, but really in the commercial market not in Medicare. It'd be great to have Medicare follow suit.

MR. MCCLELLAN: So an opportunity for patients, not just the providers who are reforming care to share in the savings from it. Joel?

DR. BRILL: So, Karen, Medicare needs to eliminate the bait and switch. What do I mean by that? So in everything commercial -- I mean fee for service, ACO, star measures, colorectal cancer screening, 80x18, 80 percent of the population should be screened by 18. The patient comes to a family

practitioner, to a primary care physician, and says should I be screened? And they say yes, here. Get your FOBT, get your FIT done. It's a free benefit. If it's positive, under Medicare's current definition of screening, that patient no longer is a screening. It's now a diagnostic. Now that patient who thinks that they were getting a service for free as a preventive service, now has an out-of-pocket pay. Medicare needs to fix the bait and switch.

MR. MCCLELLAN: Moving to a bundle would also help with that problem.

DR. BRILL: Yes, it would.

MR. MCCLELLAN: We've got three questions or comments and if we can do these quickly, we can get them all in.

QUESTIONER: I'd like to take the prerogative of being on the former panel and address the issue of electronic health records and patient engagement. We approached this a little differently at Intel. We set the measurements for patient satisfaction, which was one of the five attributes, as

having access to your complete record no matter whether you showed up at the health clinic, Kaiser, or Providence Hospital. So even though we had interoperability language within the contract, the measurement really focused on that. And we let the employee know when you show up, you've got to have access to everything.

So we had eight months to get this in place. We worked with teams representing all three providers and Intel -- and luckily we have experience in this area -- and we were successful. And it is possible to go into the health clinic, for them to ping the hospital, get your electronic health record, have an immediate viewing, and then populate it with real live actionable data rather than shifting PDAs around.

So I just want to let you know it's possible. We can do it if we stay focused.

MR. MCCLELLAN: And make it a core part of the payment reform. Thanks, Alice.

QUESTIONER: Hi, Paul Cotton from NCQA. A fascinating panel and presentation, thank you all.

Two things this morning, one is getting to outcome measures and the other is patient engagement. And I think where these two things come together is the patient-reported outcome measures that people are starting to work on. We're doing one now on depression where I use the PHQ-9 to see where they are, six months later follow up. If they responded to treatment, great; if not, change the treatment. We're getting the patients involved that way. So I just wanted to throw that into the discussion that we need to get the patients involved in the outcome measures themselves.

MR. MCCLELLAN: I think that's pretty important. Kevin and Joel?

DR. BOZIC: In my field in orthopedic surgery, it's critically important that we measure pain and functional status, which is not something that we do routinely. We now have a pretty extensive network in the country to be able to do that, but it's very low on the priority list for providers and hospitals again in terms of voluntary participation.

We've asked for Medicare and others and the commercial payers to sort of step up and really acknowledge how important patient-reported outcomes are so that patients as well as providers understand that putting the infrastructure in place to be able to do that is something that's valuable and will be rewarded.

MR. MCCLELLAN: Joel?

DR. BRILL: Another thing that an APM can fix is that when you use a PHQ-9, the ninth question -- are you suicidal? If that patient answers "yes," that patient goes immediately into behavioral health. And once they go into behavioral health, they can't communicate back with the physician because now it's protected health information. So you have to now have a whole new set of regulations in place to allow that communication to occur. We have over-regulated. We have made it impossible, if not difficult, to do the right thing for patients and we need to fix those things, which we can through alternative payment mechanisms. Otherwise, we're doing PHQ-8s, not -9s.

QUESTIONER: Hi. Jeff Rich again. To be

transparent, as Mark was leaving CMS I was coming because he actually got me the job of running the Medicare fee-for-service program. So I have some of the issues that you came up with and some of the things that Mark worked on and how do you get patients engaged. We actually looked at reducing co-pays for ACO involvement because that was the moral hazard of ACOs. If I was a diabetic and noncompliant, in that ACO which I do not belong to, said they were doing great care with diabetics. I'd just show up there and that ACO would take all the burden of a noncompliant patient.

The other thing was patient knowledge. I think that to get them engaged I'd like to see a payment reform mechanism where patients can actually reduce their co-pays if they learn about their diseases, if they learn about the impacts of their diseases. Give them a test. It's simple. You're a diabetic. What does it mean to keep your glucose under control? And if you can do that, we'll help reduce your co-pays.

But I think there were some really great ideas and I just wanted to reemphasize those, Mark, because you asked for some real practical next steps in the legislation. So we talked about quality measurement and performance measurement. I think there's more than just creating quality measures. There's using quality measures. It doesn't make sense. That was the biggest frustration I had for cardiac surgeons. They all collected these measures, but they did nothing with them. So going from process measures, measuring cholesterol, to actually monitoring the cholesterol level is very important. That's a performance measure that's actionable and shows at least the physician got engaged.

Care coordination, that's where this whole thing broke down. Every time I looked into the payment system, care coordination was the major problem along with the pay for volume. So how do you coordinate care? We now have created the heart team where a patient comes in and sits down with the cardiologist, the anesthesiologist, the cardiac

surgeon, and the social worker, and the advance mid-level practitioners. We talk about their disease and we talk about what their options are together as a team. What I would like to see is some way to pay for that. In an alternative payment system, if we can get providers to sit together in a room and sit together with a patient and their family, that's very valuable. I think that was revolutionary the way the ACC and the SCS put that together. Having been involved in TAVR, transcatheter aortic valve replacement, it's phenomenal what happens with patients.

The bundled payment is important. Rewarding those, Mark, would drive a lot of these payment reforms.

And then for me the Holy Grail is really disease management. So in the state of Virginia now, we're pulling in the Virginia Chapter of the ACC with the cardiac surgeons and the hospitals. We're looking at chronic disease management for coronary artery disease and structural heart disease and valve heart disease. That's a lot of effort and it's unrewarded.

But there's so much reward for the patients for us to sit down as a team within the entire state to make sure there's appropriate use of percutaneous intervention, there's appropriate use of surgical intervention. I think those would be some things that could have some dollars attached to them that would really drive this health care system in the right direction.

MR. MCCLELLAN: Great. Jeff, thank you for the comments and for fleshing out from the standpoint of thoracic surgery and all the specialties and primary care physicians you need to work with how many opportunities there are to improve care.

I also want to thank our panel for pointing out not just practical ways in which care can and is being improved through greater involvement and leadership from specialists, but practical steps to support that through the upcoming physician payment legislation. I think a lot of things that we heard from the first panel as well.

So I want to thank our panelists for their

contributions and we're going to move on to our next panel now.

(Recess)

MR. MCCLELLAN: All right. I'm just going to take a second and get panel three up here to the front. While they're coming up, I do want to emphasize that we'll be continuing some of the themes we've just been discussing in the last couple of panels and this one. This one is focusing on how to get it done.

So, we've heard a lot of ideas about opportunities for care improvement, a lot of ideas about ways in which payments could change and support systems could change to improve it, to support these changes in care delivery. What we'd like to do now is turn to some more specific discussions of what's in the legislation and what might be in the legislation to support better care and lower costs.

So, we've looked at primary care settings in care coordination. We've looked at specially driven

settings. This is on how do we get it done; how do we actually achieve better care through reforming Medicare physical payment. And in this panel, we're hoping to draw on some of the -- well, we're hoping to focus on some of the key policy issues to be addressed in SGR reform, and especially on how practical obstacles to enacting improved bill can be overcome, and on some of these key changes or key features that have been highlighted in the sessions this morning, need to be reflected in any further legislative action.

So, we're going to try to pick up on some of the themes that have come up today, and also, we're going to highlight some of the main points from a set of recommendations that all of the panelists here on this third panel, and some other experts have put together in conjunction with this event. So, the full paper is available on the web. I will be tweeting the links out, as well. And in addition, we're also going to touch on some other related issues, like paying for SGR reform. So, a lot to cover.

I'm going to be moderating this panel discussion again, and on the panel, I'm joined by Bob Berenson, who you saw earlier moderating the first panel. He's the institute fellow at the Health Policy Center at the Urban Institute, and also, by Bill Kramer, the executive director for National Health Policy at the Pacific Business Group on Health.

We were also going to be joined this morning by Mike Chernew, healthcare expert and professor at Harvard Medical School, former vice chair of the Medicare Payment Advisory Committee. Unfortunately, Mike's appearance -- he has become a victim of the snowstorm earlier this week that dumped a couple of feet right on his doorstep near Boston. So, I'm going to be doing my best to channel Mike.

Some of the other authors of the paper that we're releasing today are Arnie Milstein, professor at Stanford University and the leader of a initiative on supporting reforms in medical practice, and David Lansky, the executive director of the Pacific Business Group of Health, and also a leader of the Consumer

Purchaser Alliance.

So, we'd like to begin by building on the morning discussion and highlighting some key areas for payment reform. I'm going to talk about -- we're going to go through three major areas of recommendations, and also, three themes that came up during the discussions this morning.

First, which I'm going to cover on Mike's behalf, are some ideas for assuring that the alternative payment models that are a centerpiece of the Physician Payment Reform legislation really are meaningful and effective reforms to enable clinicians to work together and work with their patients to improve care and lower costs. And I'm going to handle that part, channeling Mike, for the next few minutes.

And then, Bob Berenson is going to talk about some ideas that highlight the importance of not focusing only on alternative payment models, important as they are, but on specific steps to get more value related to physician payments in the traditional Medicare program. Again, that's where most of the

physician payments are and where they will be for the foreseeable future. It's a program that, as you've heard, is embedded in many of the alternative payment models; the basic fee for service payment system.

Third, Bill Kramer is going to talk about another key underpinning for supporting physicians and delivering higher value care throughout the Medicare program and throughout the health system. And that's the importance of strong support for developing and implementing meaningful measures of quality along with strong support for better data for registries and other electronic systems that physicians can use to support their efforts to improve care. It's an underappreciated topic, but one that was not underappreciated in all of the comments this morning, and certainly, a critical one for any substantial effectiveness in shifting payments from volume to payments based on value.

And then, we're going to have a little bit of time for some further discussion of these topics, as well. So, let me move from being moderator to

being Mike for the moment, and I'll sit down over here and join the panel. And I guess somebody can tell me when my time is up, at least (Laughter). We won't need a moderator for that.

So, one major set of issues that have come up today is what constitutes meaningful alternative payment model. And then, the paper that we released today, we highlighted how significant the APM concept is in the legislation. In fact, in the legislation, it's viewed as so important that physicians can get a 5 percent bonus for 5 years if they shift from an alternative payment model from the traditional Medicare fee-for-service payments.

What we highlight in the paper, and I think some of the comments this morning have also illustrated is that not all alternative payment models are created equal, and just simply saying that a payment is not fee-for-service may not be enough to really drive the kinds of improvements that we'd like to see.

For example, consider two possible ways of

qualifying for that 5 percent payment bonus under the law. Maybe one is a group that's moved a lot of their payments into a shared savings ACO. So, say if there's 75 percent, even a hundred percent of their payments, that would certainly qualify. It would be above the minimum threshold for having payments -- could be above the minimum threshold for having payments in an alternative payment model, if we're not careful about how we define alternative payment models.

Contrast that with a physician group that has moved to a fundamentally different payment system; maybe some of the fully bundled approaches that Kevin and others were talking about on the last panel, but it only applies to say, 25 percent of their patient population. Well, even though that second model may actually represent a much more fundamental shift in payments and permit much more movement away from the kinds of services that are encouraged under fee-for-service, and much more support for the kinds of services that aren't paid for at all, that second

model might not qualify under the current legislation.

So, what we wanted to emphasize was building on a lot of the discussion that you've heard and a lot of the work that's going on in different specialties and around the country in implementing the payment reforms, what's really needed in there and how could the legislation encourage alternative payment models that are really likely to work? And we highlighted a few specific lessons for -- or a few specific principles that we think are important for doing this.

One important point is that we think the payment bonus that any physicians receive for moving to alternative payments should not be simply a multiplier on traditional fee-for-service payments. This is important, and it's a way that, to some extent, the payments in Medicare work now. If you have a more meaningful use, if you have a higher score on a value based modifier, all of your fee-for-service payments are multiplied by that amount, which works against the notion of moving away from a focus on volume.

Tom Simmer and Blue Cross of Michigan has highlighted a way to keep a basic fee-for-service structure, but still make sure the math works out, that if you are actually improving care and lowering costs at the population level, then, you get a higher tier payment. But that only happens for providers who are really taking steps to get overall costs down. So, it doesn't end up being a reinforcement of some of the undesirable features of fee-for-service incentives.

Another key point that we believe is important is that whether -- in determining whether an alternative payment model qualifies for a bonus, what matters is the payments to the overall provider organization. This means a flexibility in how the alternative payments and the bonuses on the alternative payments get allocated to physicians and other providers in those organizations.

Also, we highlight the importance of alternative payment models covering multiple services ideally spanning multiple sites of care and providers.

This is something that was emphasized earlier in some of the comments about the need for not only getting care right for say, the gastroenterologist performing the colonoscopy, but also, the anesthesiologist, the facility that's involved in the care.

We heard earlier from Kevin Bozic talking about the importance of working with and having alignment with primary care physicians who might benefit from support from the surgeons, and helping a patient quit smoking or take other steps to change their behavior when they're at a very serious point of engaging the healthcare system with a very serious illness.

Another point that we highlight is that we think APMs, Alternative Payment Models that qualify for the bonus should requires some meaningful shift from unconstrained fee-for-service payment. And that can mean either accepting some downside financial risk or accepting some other steps that move away from the impacts of traditional fee-for-service rates in the say, bundled payments or per member per month

payments, or perhaps a model like Tom had emphasized of still fee-for-service, but where if you don't change practice, you will get less money.

And I think that’s the test to run through. If it’s a new payment system that doesn’t have any impact on your revenues when you shift into it, or has a potted impact on your revenues when you shift into it, that’s probably not enough to drive changes in care. We want to see overall costs go down, if there isn’t any actual change in practice, and you want to provide more incentives for shifting care away from services that currently are low value.

Two other points. One is that to be implemented nationally, we do want to see clear evidence that the alternative payment model can reduce overall spending. Again, the focus here is to get out of the physician payment silo. We're not concerned about savings within physician payment. We are concerned about overall savings.

So, to help assure that happens, evidence is needed. Kevin gave an example of where a bundled

payment reform for orthopedic surgery might do a good job of getting down the cost of individual surgical procedures. But if patients who would actually be better treated through physical therapy, other types of modifications or don't have that serious a condition are getting more surgeries as a result, costs could go up and quality would not go up.

So, it's important to look beyond just the bundle and look at these overall cost impacts. That's not to say that pilots shouldn't be supported under this bonus program to develop that evidence. But before a program goes national, strong evidence is needed.

And finally, something that I think is a general concern is that there needs to be support for better measures, for more meaningful outcome oriented measures that matter to clinicians and to payments. We've heard earlier today that this is hard work to do; to get the data together to develop consensus around what is a meaningful concept to measure and to turn it into something that can be implemented.

And in many of the Medicare payment systems today, there is a bonus for reporting on quality, but it's very much of an on off phenomenon. So, if you need some standards for reporting today under the Physical Quality Reporting Systems, say nine quality measures, you get the same amount of a bonus, regardless of whether these are truly impactful, patient oriented measures, or if they're measures that just get over the goal line.

And similarly, for physicians who want to try to continuously improve on the measures that they are developing and using, they don't get any additional support for going that extra mile. So, having support for physician quality measures that increases with the quality of the measure is an important feature that's not in the law now.

So, we have some examples in the paper of formulas that we think could help do this. We don't know that those need to be actually included in the legislation, but we do think these concepts are very important. So, that ends my effort to channel Mike

Chernew. Now, I'm going to turn to Bob Berenson to switch to the second set of recommendations related to the traditional Medicare fee-for-service payment system.

MR. BERENSON: Thank you. And let me start by gently disagreeing with something that Patrick said right at the beginning today. It’s actually not just Patrick; there’s a consensus inside the beltway that value based purchasing means paying differentially based on an individual’s quality on a particular service.

That may be desirable if we have good measures, but I would also argue that value based purchasing can also -- should include consideration of the kind and mix of services that patients are getting, which can be influenced strongly by how you pay. It also can -- you can change value by affecting how physicians spend their time.

So, a very concrete example of that one -- I'm now on an institute of medicine committee which is looking at the quality issue of diagnostic errors. It

turns out the research shows that virtually anywhere you look in the healthcare system, 10 to 15 percent -- more accurately, 5 to 15 percent of encounters with the healthcare system result in a misdiagnosis or a missed diagnosis.

I think that considering that a lot of doctors, not just primary care doctors feel like they're hamsters on a treadmill and are just trying to survive the day, that if we actually changed how through B -- ultimately, through alternative payment models, but in the short-term through how we construct and pay for services could affect the ability of physicians to actually have more time with their patients.

And one thing that gets no attention, I think, is the ability of physicians to work -- not just physicians, health professionals, but right now, I'll talk about physicians -- to work teamwork -- informal consultations between physicians in different specialties to try to improve that one issue, diagnostic errors, but it can apply across the board.

It's often said that fee-for-service means that doctors get paid for everything they do, and therefore, there's an incentive to generate volume. Well, that's not strictly correct. They get paid for everything that is codified and recognized as a CPT code, and then recognized for payment.

And so, a lot of things that physicians do or should do are not recognized for payment. I think we could -- which is a reason, until we have a full replacement for fee-for-service in a fee schedule, we should be paying attention to the fee schedule, not only because not only because it's sort of there and you have to deal with it, but because there are changes that you can make to improve value, even if it's not specific to measuring an individual's performance on a specific service.

So in fact, there's lots of activities that CMS is engaging in along these lines, but it doesn't get sort of the attention and the priority that this value based payment is getting. More practically, just very concretely, fee-for-service is going to be

with us for a long time. Some believe, and again, Tom Simmer mentioned that, and we had a discussion in panel 1, that maybe there's a definite role for a fee schedule within payment reform. So, it's going to be around.

If you move to blended payments, the values of the individual services is that you're -- I'm sorry, bundling payments, bundled payments become the basis for the bundle. If those individual values are wrong, the bundle is going to be wrong. And even in capitation approaches, the way we typically do population based payment, we sort of add up the RVUs and individual services, and the DRGs and all the other payments, so it just the practical reason why we should be focusing on correcting imperfections in how we pay in existing payment models as we're moving towards alternative payment methods.

So, I want to very quickly tick off three things that we've emphasized in our paper. One is that we should be moving to reducing or eliminating the payment differences for physician services that

are provided in outpatient departments than those provided in physicians' offices. It's often referred to as provider based payment.

Those huge differentials that exist, up to a hundred percent difference, you can be a practice, there's a plaque on your wall that says you're now part of so and so hospital system. You haven't changed anything, but the payment going to the institution is 80 percent or a hundred percent more. There are real, real activities that hospital engage in that deserve extra money.

They do have standby capacity. They do have -- most of them do have EMTALA obligations. And that should be recognized and paid for. But a lot of the services, and MedPAC has done most of the work in this area. They've identified services which really don't differ; where there is no differential cost that the hospitals bear.

So, what's happening now is physician employment by hospitals are often being done for the wrong reasons, not the right ones. We could correct

that. We're recommending a test for prior authorization for high cost discretionary imaging services, initially, but the key point to -- and that's based on the success that many insurers have had with prior authorization for imaging services with apparent good success.

The key thing in the Medicare context is that the focus should be on outliers; not hassling the docs or other health professionals that are never overruled, that know the practice -- evidence based guidelines, that do consult with the radiologist about what to order. The focus should be on what's been documented, and it's the relatively small number of physicians who don't do it right, who generate lots of the unnecessary costs. And so, we would, at this point, call for just a pilot of an approach that would apply this approach that's now in wide use to Medicare.

And then, the final point, and I will be ending, is to focus on an issue that somehow has just become part of the woodwork, without any special

attention, but it is very destructive. And that is, the documentation guidelines for office visits that were put into effect that everybody objected to then. I was actually at CMS at the time, and what happened was, I guess I'll say now reluctantly, a spokesperson sort of defending them, it's now more than a decade later, they have a number of undesirable impacts.

They actually promote up-coding with electronic health records. It's easy to cut and past and get more payment, a higher level of code than you deserve. It distorts the clinical record. Lots of information that's not there to communicate to other physicians, but it's there purely to make the record immutable from audit.

And perhaps, the most significant -- and I've now talked to a number of people in the electronic health records world, is that the vendors who design the software for electronic health records are focused so much on this documentation requirement that the real potential of VHR is to support decision making to deal with the problem I mentioned earlier of

helping make accurate diagnoses, gets short shrift.

And it is time to reconsider eliminating those guidelines, ideally with some modification of the underlying codes. But even if we don't do that, those guidelines have exhausted their usefulness, and we call for a MedPAC study of how well they're working and what the alternative might be. But the point is, real concrete problems in how we pay today -- you heard some in the previous panel by Joel and others about some of the barriers to improving value.

We think as part of moving towards value-based payment, that the current payment system should be part of that discussion and get as much attention and priority as the APMs and the performance measurements.

MR. MCCLELLAN: Thanks. Bill?

MR. KRAMER: Thanks, Mark. Thanks, Bob.

We're on the home stretch here. My focus is going to be on the performance measures to be used in physician payment programs. For those of you unfamiliar on the Pacific Business Group on Health,

our members consist of 60 large purchasers across the country, including Intel and Boeing, whose mission is to transform healthcare; improving quality and affordability.

We do this through innovative. Our members have led the way of the development of ACOs. As you heard earlier, centers of excellence, bundled payments, advanced primary care programs like the IOCP program that Pam described, clinical registries -- one that we work with on Kevin Bozic would be a drug replacement registry. We collaborate with providers and other purchasers, such as CMS, and that has led to our interest in public policy, in Medicare, in particular.

With regard to the current bill, we have supported the direction of the current bill, and I have tremendous admiration for the congressional leaders who have taken on the challenge of putting together a very complex and forward looking bill. We believe it's the right direction, but we believe it could and should be strengthened. In clinical terms,

we think it's the right medication, but we're concerned that the dosage might be insufficient.

So, we have some ideas that we'd like to inject into the debate. The current bill makes great strides in simplifying the performance measures by combining PQRS, meaningful use and the value-based modifier measures under the MIPS program. We think that's good, but could go further.

We think the use of outcome measures, the emphasis on that is great, and the use of registry data, again, we think that's good but could be strengthened. And finally, with regard to measured development selection for use by CMS, bill our first to input for multiple stakeholders. But in our mind, the process is somewhat unclear, and certain types of measures, such as those derived from registries, as well as research use measures are excluded from that process.

In putting together our recommendations, we had three main principles. One was that the right payment incentives depend on getting the right

measures. If we don't have the right measures, then we're building a house on quicksand. We need to have those measures underlying good payment incentives.

Second, in defining value for value-based payment, we think it’s most critical to look at outcomes, both clinical outcomes and patient reported outcomes, as well as patient experience. And that’s fundamentally underlying the third principle, which is, there is a public interest in measures and how they're developed and used.

In clinical care, we talk about putting patients first. Everyone has endorsed that and adopted that. We think putting patients first is also important in the design of payment incentives and measurement, and they need to be part of that process.

I'm going to highlight four major recommendations. One is, we believe that the reporting requirements under MIPS and APMs could be further simplified. We recommend a very discreet core initially of a limited set of outcomes measures and patient experience measures; outcome measures that are

specific to conditions that are relevant to the commissions, and patient experience which is relevant to virtually all providers. We can build up from there, but let's start with a core that everyone can agree to.

Second, we think physicians should be rewarded -- those who use and report on more meaningful measures. In other words, the adoption and use of the reporting of those outcomes measures and patient experience measures -- physicians who do that more quickly should be rewarded.

Third, we think CMS has some significant responsibilities here. One is, they need to drive the rapid development of better measures, including patient reported outcomes. There is money in the bill to do that. CMS should use that wisely.

Second, they should provide more timely and actionable data to physicians. The fourth recommendation is, we think that there should be a robust, independent multi-stakeholder process to select the measures to recommend to CMS for the use

and evaluates payment programs. We do not think there should be exclusions for certain data sources or types of measures. We need to take advantage of all the data that's out there from all the sources to put together the best measures. Thanks.

MR. MCCLELLAN: All right, Bill, thanks for covering all of that. So, if you look at the set of issues that we've tried to address here, it covers making sure that the alternative payment models work as intended and support all of the opportunities in improved care, primary specialty and specialty healthcare providers working together that we've talked about.

Second, some steps -- at least the lesser of steps I think, as Bob mentioned. There are probably others that are important to continue to pay attention to in making sure the Medicare fee-for-service payment system works as well as possible around supporting value. And third, there are some resources in the bill around supporting better quality measures and around supporting physicians and groups who adopt

them. But more support there seems critical for making all of these processes work.

I was going to push these guys on issues like how do you pay for this bill (Laughter), but given the limited amount of time, I'd like to go straight to questions and comments, because the answer to that would be, some of the things that you all have mentioned would have some savings. And they're certainly aligned with the goals of the physician payment reforms. But this does remain a significant issue for passing legislation. So, Kevin, I'll go to you.

DR. BOZIC: Yeah. I just want to follow up on something Bob Berenson said about very practical suggestions for influencing the current payment system as we transition to a value-based system.

So, he talked about CPT codes that are for services that are currently not codified or valued. So, I'll give an example. In my field, I do hip and knee replacement surgery, which is the most common procedure done in the Medicare population; about

600,000 procedures a year at about $30,000 per episode for Medicare.

We have, in our institution, put in place a program to identify modifiable risk factors and refer those patients for smoking cessation, weight loss and opioid tolerance -- reduction on opioid tolerance. We've funded all of those programs ourselves, none of which are revenue. They're all cost centers. None of them generate revenue.

The opioid tolerance -- for instance, we've employed a pharmacist who can't bill for his services, because he's not a physician. So, we employ a pharmacist to help patients reduce their tolerance on opioids. But to back up from that, there are no CPT codes for any of those services, just to refer patients to have those services -- those preventative services.

The financial incentive is heavily based on, well, the primary care doctor did the best they could. Let's just take them to surgery. That's where the money is right now. So, if we could have financial

incentives, just CPT codes for those preventative services, it would have the dual benefit of improving the health of those patients for eternity, not just for that episode, and optimizing those modifiable risk factors leading to a better chance of a good outcome and lower costs over the episode.

MR. MCCLELLAN: Well, thanks, Kevin. Do you want to make a quick comment on that? You don't seem --

QUESTIONER: No.

MR. MCCLELLAN: You hadn’t said --

(Simultaneous discussion)

QUESTIONER: I mean, that’s just one of what I assume would be many recommendations. I don't think all services can be easily paid fee-for-service. I have talked about -- I’ve written about the desirability of all physicians, but I was focusing on primary care physicians engaging in lots more robust communication with their patients after hours through email, through phone calls.

It’s just hard to pay for all of that on a

fee-for-service basis. The transaction costs are sometimes -- would be greater than the actual value of the three minute phone call. The potential for auditing and fraud is there. But I think we should look at opportunities. If it's a discreet service -- I think we've already crossed over the concept that you have to have a patient sitting in front of you.

MR. MCCLELLAN: Okay.

QUESTIONER: We now have a transition care code. We will be doing complex chronic care management. There's some other codes. What you've described, I think, could well be amenable. We'd have to look to see whether it meets a benefit category. I mean, there's all sorts of barriers to doing it, but that's exactly the kind of thing we should be talking about.

Ultimately, if you move towards population based payment and you receive a PMPM, then the organization makes that allocation to the pharmacist. But we will be in a world in which relatively few organizations are doing that, so I think that kind of

suggestions is very useful.

MR. MCCLELLAN: Well, effective alternative payment mechanisms could do that -- could provide that. You know, more population based supports and move resources to where they're most needed, improved outcomes for the patient. But it does seem like there's some steps in improving the first step, the first pass at care coordination measures and payments that CMS has created.

There's time for two more quick questions or comments. Yes?

MS. CANTOR-WEINBERG: Great session. Julie Cantor-Weinberg with the College of American Pathologists. Again, a lot of really good points on you know, focused on patients and outcomes.

I think we have to remember that one size doesn't fit all. The patient experience of care with the pathologist is getting that access to the pathology report quickly. There aren't necessarily universal measures. Sometimes, I hear things about care coordination, which in the case of the

pathologist is delivering the report, or BMI being a universal measure. So we really -- it's absolutely vitally important that the bill last year did this; to recognize differences among specialties.

MR. MCCLELLAN: Great point. Thank you very much.

MR. RICH: Bill Rich, medical director of Health Policy, American (Inaudible) of Opthalmology and (Inaudible) of the Iris Registry.

One of the things is, I couldn't -- first of all, congratulations on the paper. I thought it would terrific, and kudos to all of the authors.

To go, I think Bob's point. Medicare fee-for-service is going to be around. We are still trying to find out what are effective alternative payment models, and we have to have a viable, modified fee-for-service -- strong fee-for-service, because most of the docs, as Bob Dougherty pointed out, are dying with the current meaningful value-based modifier.

Most importantly, I agree totally with Bill

and the need for outcomes measures. We just created 18 outcomes measures across all of the high impact diseases, evidence based, public reported -- patient reported outcomes. But to do that, you have to have measurements.

I would hope in this bill, that you would open up access to data that is closed now from epic and the legacy programs that are EHR systems -- a smile over here from Intel (Laughter). We cannot -- there's not one single data -- Tom Lewandoski can talk about this -- between the two of us, we have 14 million patients in a registry.

There is not one measure that's been calculated in five years from anyone in that system. So, there has to be open access to data from Epic, and we have to do something about -- make that a criteria for certification in State Street. Or if we don't have data, we're not going to get anywhere. Thank you.

MR. MCCLELLAN: Bill, thanks very much for that point. And I want to thank other panelists, the

rest of the authors that contributed to this report. But most of all, all of our panelists today and all of you for the excellent comments, that there clearly are lots of opportunities and a great need for this physician payment reform legislation to be enacted, but also, a lot of good ideas for how it can be used most effectively when enacted, and some key things to pay attention to as we move, hopefully, to that final step.

And like I said earlier today, hopefully, this is the last time we'll be watching this movie. Thank you all very much for joining us. I want to move on to our congressional panel right now. Thank you.

(Applause)

MR. MCCLELLAN: All right. We have Representative Green and Representative Burgess. If you all could come on up.

We wanted to have the final part of today's event, after we've had a chance to hear about all of these ideas, and I know there have been a lot of

congressional staff here, as well as people who have been working hard on issues related to physician payment reform for some time.

I couldn’t think of a better way to end this event than hearing from some of the leaders who have been involved in trying to get physician payment legislation enacted by Congress. So, I'm very pleased to have with us today out of their busy schedules (Laughter) in January, the start of a new session, Representative Michael Burgess, who is a physician and a Republican from Texas, a senior member of the House Energy Commerce Committee who is the lead sponsor of that bipartisan, bicameral tri-committee legislation that we're talking about from the last session.

Also, I'm pleased to have with us our representative, Gene Green, senior member of the Energy and Commerce Committee, the Health Subcommittee, and very much involved in sponsoring moving forward the 2014 bipartisan legislation. Also, a fellow Texan -- you guys, don't reach any conclusion, because I'm a Texan, as well, but I guess

it goes to show something about all of this.

Dr. Burgess, Congressman Green, we were hoping you could start with just a few comments about where we are and where we're headed on physician payment reform legislation this session, and maybe have a little bit of time for discussion before. I know you all have other things to move on to, as well. So, Dr. Burgess, may I start with you?

DR. BURGESS: Well, thank you, Dr. McClellan. Thank you for the invitation. Gene and I do serve on the Energy and Commerce Committee, and it is my fondest hope one day, to walk in to our committee or subcommittee, and there at the witness table will be five doctors to tell us how economists should be paid (Laughter). I'm going to relish that day when it finally occurs.

I also am reminded of when I was in medical school, and of course, the smart kids all sat in the front row, except one kid who wasn’t quite so smart who thought he could sit in the front row. The professors would think he was smart. But then,

unfortunately, he would get asked a question, because he was sitting in the front row. And then he always stopped for a minute and thoughtfully said, do you want the theory or the application (Laughter)? So, I think that was the question that was just asked of me. I mean, you all have heard the theory.

MR. MCCLELLAN: Yeah.

DR. BURGESS: Let me give you the application. It was probably a month before I filed for office in early -- I filed in early 2002, so it was late in 2001 that I first heard the words SGR used together in a sentence. And it was at an AMA, a House delegates meeting out in San Francisco. I was told not to worry about it, because the budgets and surplus after all -- we'll get this taken care of. It's just a blip on the radar screen.

And it has defined (Laughter) my congressional career for the last 12 years. Every year that I have been in Congress, I have been in Congress, I have introduced an SGR repeal bill. Now having ascended somewhat on the Energy and Commerce

Committee, I don't introduce my own bill any longer. I'm trying to work from within the committee structure, and that's where 4015 came from last year.

Some of you recall earlier efforts when I tried to propose offsets to the legislation as it was introduced, and I got to meet a great number of you (Laughter), when I actually offered your world as an offset. And I'm appreciative of the information you conveyed back to me. And that, of course, makes the whole process somewhat more difficult, and that's why offsets have been so contagious.

But I want us just to stop for a minute and just consider where we are. March of last year, the House of Representatives passed in bipartisan fashion, a full repeal of the sustainable growth rate formula on the floor of the House by the middle of March. February 6th of last, year, Committee Chairman and ranking member from the three relevant committees, House and Senate, so bicameral, bipartisan, all agreed on the context of the policy language, setting aside the pay force.

So, these are big milestones that have been accomplished, and it didn't happen in a vacuum. The Energy and Commerce Committee, to their credit with Republicans and Democrats, we took your suggestions to heart. This was not a closed door process where a bunch of us got together in a windowless room over in the Capitol and figured out what life should be like for doctors. We opened the lines of communication up and said, please converse with us.

We set up and email address where people could send information, and they did. And they were sometimes surprised when we responded to the information. I think it was the Society of Thoracic Surgeons. They said, we know you got our stuff because you plagiarized a whole lot of it.

QUESTIONER: But that's not --

DR. BURGESS: I said no, no, that's a derivative and we do that in Washington (Laughter). But it was a collaborative process. It wasn't just something that was done by the committees. Now, the Energy and Commerce Committee did take a lead on the

policy side. And the staff of the Energy and Commerce Committee, my staff -- I mean, I cannot tell you the hours they put into this.

And the democratic staff on the committee was nervous about what we were doing. They wanted to monitor what we were doing. But before you knew it, they were participating in what we were doing, and that was good. I had to leave some things at the door that were very important to me. On the other hand, I got some things that I very much wanted into the final structure of the bill.

We did finally bog down on the offsets, and let me just tell you this: The door is rapidly closing. This bill will be introduced shortly. The language from legislative counsel will largely mirror the language that was left over from the last Congress. Names and dates changed to protect the innocent. But you know, some of the things, quite honestly, changed.

Some of the misvalued code stuff that was actually represented in the bill before got pulled up

and used for the doc fix. That's a shame. That's one of the risks of not getting this done (Laughter), is that you identify something, someone can cart it off and use it for something else. But the language will be substantially the same.

So, the window is closing on any changes that may be made. I will just caution you that if we change too much, then we really need to put this project aside for a little while and begin to work on what's known as the doc fix, because another patch will be required. We're under a time constraint. We've got until March 31st. And as Gene knows very well, we actually go out on recess on March 25th or 26th, so the actual timeline is about 50 days from right now that this has to be done. Fifty calendar days, not 50 legislative days.

Still, your ideas are important to us, and the lines of communication are still open. I just wouldn't look to see great changes in what has happened from last year, other than changing dates and some of those things that were stripped out and used

for other projects in the doc fix and the ABLE Act along the way, where lost some of our ability to offset.

The bill will be offset. And let me just dispel any notion that it's the way I would just offer it up, and add it to the deficit. That will not happen. There are not the votes in the House of Representatives. Even with every Democrat voting in favor, you will not peel off enough Republicans, ehh, because we won so many seats, (Laughter). But you will not peel off Republicans to be able to pass this bill.

So, it will be offset. And what those offsets look like is still very much in the to be determined range. I am waiting to hear from the chairman of the Senate Finance Committee and the new chairman of the Ways and Means Committee before introducing the language. Ways and Means is having their member retreat this weekend, and I expect to hear something from them after that retreat concludes.

But my expectation right now is that the

language will go forward pretty much as you saw at the end of last year. What happens if we don't get it done? Then it's anybody's guess. But the drop dead date is March 31st, and that will not change. I've spoken too long. Let me turn it over to Gene Green.

MR. MCCLELLAN: Thank you.

MR. GREEN: Well, Mark, good to see you again.

MR. MCCLELLAN: Good to see you.

MR. GREEN: And we've worked together over the years. My name is Gene Green, and I represent a very urban district in Houston, east of north Houston. It's an under-served district. We have expanded community based health clinics. We have a lot of physicians in our area who obviously, are impacted by the SGR.

And over the years -- I was here in '97. Mike wasn't. Little did we know that when the Balanced Budget Act passed, we would be fighting over it 15 years later and how we do it. But we need to fix the SGR. There's an opportunity to do it. We're

up against one of those deadlines. But these deadlines, over the last 10 years (Laughter), we've been there.

Mike came to the committee, and you know, as a Democrat, we actually had the SGR fixed in our Affordable Care Act that we passed. It still boggles my mind that there's not one U.S. senator in 2009 that said they wanted to continue the SGR, but we couldn't get the votes in the Senate to be able to fix it and use that House language.

Over the years, we've seen the problems with it. It's cheaper now than it used to be, and we just need to do it as best we can. Like Mike, I can't tell you we won't have to do a short-term fix. The physicians I work with and know, you know, how do you run a practice with not knowing what you're going to get paid in April or May or something like that? So, that's our issue.

But I look forward to working with you. And Mike's force. The pay for its (sic) will be the issue. On my side of the aisle, we don't want to take

any of the benefits Medicare provides now for our seniors to pay for it. So, we need to see how we can find money for it. Maybe more efficiencies, things like that. We can get the CVO to score it that a way (sic) and that's what we want to do.

But you know, we would hope to have that. And Mike, and I -- and I'll end with -- Mike started out with doctors and economists. Mike and I -- I'm a lawyer and Mike's a doctor. So you know, it's almost worse than oil and water (Laughter). But believe me, I would not want doctors to sit with lawyers' pay (Laughter).

But be glad to answer any questions. We're hoping we'll get there. The Congress has changed since last Congress. And although there are bills that are passed without pay forwards, a couple of weeks ago we passed a bill that repealed the 30 hour week and move it to 40 hours, which had a cost issue. That was not pay for, but again, that was the Affordable Care Act.

So, but I understand we need to have a pay

forward, but we need to make it fair and not hurt the beneficiaries that we're trying to make sure doctors could still see.

MR. MCCLELLAN: Thank you for the comments. I would like to, if there are any questions for the members, please head on up to the microphone. Just one, you all have emphasized the importance of getting rid of the SGR. I know you're both committed to using this opportunity to get to better payment systems, too.

And if you want to add any comments about that, since that’s a -- as we’ve been talking about today, a big part of the pill and the challenging part. You know, there’s a lot of work in progress. I'm figuring out better ways to pay and avoiding undesirable consequences.

QUESTIONER: Well, of course, Secretary Butterwell. But I -- some stuff earlier this week that got everyone’s attention, as my deputy chief of staff, Mr. Poliskevich is fond of saying, we agree on the what. We just are worried about the how. And so,

that is still the issue.

The SGR reform, as it passed the House last year, did include some of those things. There's -- as you know, Dr. McClellan, there's plenty of areas where we don't agree. It was important to me leave -- and I was grateful to hear Mr. Berenson refer to them. The fee-for-service part of the Medicare payment schedule needs to remain for right now.

When I go talk to doctor groups, most of them are my age, and as a consequence, that's all they've ever known is a fee-for-service environment. And you may get too hostile, you change too many things at once, and you will see not more physicians delivering for the more patients who are coming in from the Affordable Care Act, but you'll see less.

And while some people think it's good that doctors my age (Laughter) don't continue to participate, I will just tell you, we need those guys and ladies. So, let's not be too hostile to them. I was criticized a lot for the one half of one percent update for five years. One side criticized me for me

(sic). Are you kidding me? That's not nearly enough. We need much more than that.

The other side said, well, what is this, the everybody gets an A bill (Laughter)? Look, it was a compromise. And we're accused of not compromising? That was one of those areas where we compromised. We want to keep doctors continuing to practice medicine.

We recognize that we can't do everything that the house of medicine would want, but we acknowledged that we needed to move a little bit in their direction.

QUESTIONER: I agree with what Mike said, that we're not going to everything. But the bill last Congress was one that should have been passed. But then, over the last 15 years, we've had a lot of would of, could of, should ofs. But we're up against it again, and I -- it would be much more efficient and cheaper for us if we actually came to the full pay for and dealt with it immediately, because the costs will not get any cheaper.

QUESTIONER: And can I just add -- I need to

add to that, because I used to be a student of medical irony when I was in practice. Now, I've become a student of irony writ large (Laughter).

It is irony that we have spent more on patches, short-term fixes and stalemates than we would have spent on repealing this damn thing right from the get go. And we're unfortunately on the precipice of continuing to make that same mistake again.

MR. MCCLELLAN: Similar amount of money, but a lot more congressional time.

QUESTIONER: Yeah.

MR. MCCLELLAN: Yeah. Any comments, questions, please go to the microphone. And if there aren't, I do have one more for you. So, you all have emphasized how there's a lot of agreement on the policy side, on fixing SGR, on some of these important stuffs -- alternative payment systems, improving Medicare fee-for-service and also, better quality measures and better data in support for physicians in practice to actually be able to do well under these reforms. A lot of agreement on all of that.

Pay forwards are tough. Is there any middle ground between just kick the can down the road for just a few more months or a year and the full year 10 year fix? Are there then, some ideas including some that we've talked about, if you might recall, a semi-permanent fix?

So, if there are not enough pay forwards and not enough agreement on enough pay forwards to repeal the law permanently, well, at least there may be enough that could be put together to make this a longer term fix than just a few months. Maybe it's a few years. Maybe it's enough time to get some of these alternative payments and other systems into place at a cost that's in between.

And it's been very tough to deal with these two extremes, just the short-term fix or a very big and costly permanent overhaul. Any other -- are those just the only options out there?

MR. GREEN: Well, we have the experience paying more of the (Inaudible) years than we could have repealed it. And you know, the good intention is

we want to fix it permanently before March 31st. But you know, Congress -- I tell people, if you think Caribbean times are bad, come to Congress time, because even though we have these number of days left, it's going to be very difficult to get something through the House and the Senate when we couldn't do it all of last year. So, we may end up doing that. And I'd like to take baby steps, as we have to do that, too.

But also, that would be part of the pay forwards that we have on a short-term basis. But like Mike and I both agree, we've spent more money in trying to fix it and not permanently fix it, and you know, it makes it harder all the time. Because pay forwards are never easy.

QUESTIONER: As far as the concept of an interim proposal, I mean, I would look at 4015 in that light, also. Because the half percent for five years meant that someone has got to come back and look at how we're doing before that five years is up. And that really means that probably three years in

congressional budget office time.

So, that’s already baked into the cake, to some degree. Could we do a two year doc fix in March? I guess that is theoretically possible, but the reality is, you're probably going to be taking a pretty good look at it in three years, anyway.

Just the other thing I'd mention is, you know, we disagree about the offsets on this. My position was, and the House passed it with an offset that was entirely drawn from the Affordable Care Act (Laughter). We repealed the individual mandate. Not a big deal, but it saved some money, so we might as well use that money for the SGR.

But I want to put this in context. Gene referenced in 2009, the House passed an SGR repeal. It was, in my opinion, awful policy. It was expensive. It wasn’t paid for, but I voted for it, and I was the only Republican who did. And the reason I did was, and I said at the time -- a lot of criticized me and said, oh, you're right base. They're going to just get enflamed because you do

this. I didn't hear a word from them.

But this was the key that gets us through the door that gets us to the next step of the negotiation. Gene's right. The Senate didn't have the courage of its convictions to act on what the House was doing, and unfortunately or fortunately, depending on how you look at it, the issue then died.

But my admonition to Democrats last March, because I wanted to speak to the people who hadn't been here in 2009, recognize this for what it is. It is a step along the way; the key that gets you into the door or in -- the key in the door to get you into a conference committee where actually, you can work this stuff out. So, there has to be the willingness to take that step.

We're going to continue to have -- goodness knows, we'll have fights over the Affordable Care Act. There are plenty to go around there. I think the Affordable Care Act represented a missed opportunity. If you're going to reform healthcare in this country from soup to nuts, what should you do? Well, from a

doctor's perspective, fix the SGR. Give us some liability protection and let us talk to each other about price, if you're going to bug us about cost. Just my humble opinion.

MR. MCCLELLAN: All right, thank you. Kevin?

DR. BOZIC: Yeah. I want to thank both of you for being here today. I know you have busy schedules and all. I just want to say my name is Kevin Bozic, and I'm a soon to be fellow Texan (Laughter) who's relocating to Austin, Texas as the inaugural chair of the Department of Surgery at the Dell Medical School.

MR. MCCLELLAN: That's great.

DR. BOZIC: And so it's nice to hear --

QUESTIONER: Our new medical school.

DR. BOZIC: Yes. It's nice to hear a --

MR. MCCLELLAN: Talk about a missing link. Why was there no medical school in Austin until now?

QUESTIONER: Yeah, that's what my mother always used to ask (Laughter).

DR. BOZIC: Well, it’s nice to hear Dr. Burgess knows that not everybody in Texas talks with a funny accent (Laughter). So, I'm glad to hear that. No offense, Congressman Green (Laughter).

My question for you is, there’s a number of medical professional societies represented here today, practicing physicians, all of whom represent influential people in your communities amongst your constituents. And I think collectively, I don't want to speak on behalf of everybody, we would say that our voice tends to get drowned out by those five, either lawyers or economists that are invited to your hearings.

And so, I'm wondering how we can be more effective advocates for our patients and our members and especially, our societies by -- today, we heard a lot of very constructive ideas about things that are actually being done within the specialty to improve value. But again, sometimes our voice gets drowned out.

So, how can we be more effective advocates

and get our voice heard, when it comes to issues beyond SGR and liability reform, which I understand tend to be our pocketbook issues that we focus on? But we've got a lot of good ideas that can fix some of the other problems, and we're wondering how we can get a bigger voice.

MR. MCCLELLAN: Well, the good news for you is, we fix liability in Texas, so welcome to Austin (Laughter).

QUESTIONER: It's California, so we're used to it (Laughter).

MR. MCCLELLAN: You'll know you're there by when you see your insurance premium (Laughter). I think you do a good job already, and everyone in this room who has interacted with our office, who has interacted with offices on Gene's side or the committee staff offices, you do a good job, I mean, certainly on SGR.

I mean, you sit down next to any member in Congress and say, well, what are you hearing from your docs back home. Oh, can you fix that payment thing?

And I don't even understand it, I don't want to learn about it. Just get it fixed. And that is the attitude of your average member of Congress, so organized medicine, your specialty societies have done their job. People want this off their backs.

The problem is, we haven't gotten it there yet. Now, the good news is that one of the things that was really important to me in the structure of the policy side of the SGR repeal is, one of the things that I think is missing is, you all do such good work from your specialty societies and your registries. Why don't we capture that? Why do we write bills that say the secretary of the Health and Human Services shall determine quality, Section 1311-8, (Inaudible).

Why do we do that? I vote for it, but why is it like that? Why can't it not be constructed that the secretary shall be obligated to evaluate those things which you, yourselves as physician groups have said this is what we need in order to deliver quality to our patients. Here is a measureable impact we can

have on the cost of the care we deliver and the outcomes that we deliver for our patients.

Why shouldn’t the secretary be obligated then to evaluate what you have done and brought to CMS, accompanied by data, and if it will not be one of those things that the secretary says, well, we can accept that, they ought to be able then to give you a reason why they didn’t accept it, and give you an opportunity to remedy whatever the perceived forthcoming is, if you wish, and bring it back again, for another try. And that was part of the quality piece that we tried to build in to the SGR repeal.

Quality can't always be about the bureaucracy. Quality can't always be about the Secretary of Health and Human Services or people who are lifetime employees of CMS. Quality is about what we, as doctors, are delivering to our patients in our respective offices and hospitals.

QUESTIONER: Right. And Mike, I don't disagree with what you said. I would hope that’s what the secretary is doing right now, but as we know

sometimes -- by the way, we work with all of our specialty societies. In fact, in the Houston area, we have huge numbers of them and great advisors, and some of them are long time friends now, we've worked with them for so long.

So, I don't have any problem with that part of your legislation (Laughter). That would be great. Now, I have to admit, you know, coming to Texas, that's why I don't think we need to have liability reform on a national basis. And I would rather states take care of that instead of getting into the mainstays of our problems we have up here (Laughter). Don't add to our plate. Let's see if we can take something away that's not controversial.

MR. MCCLELLAN: And I think that point about the clinicians being information and showing you solutions, showing you how to get better care, lower cost. That clearly carries a lot of weight above and beyond just talking about all of the problems with the SGR. Jeff, last question real quickly. We've only got about one and a half --

MR. RICHEN: Yeah, I'll speak fast. So, Jeff Richen (Laughter), past president of the STS. I testified in front of your community several times --

MR. MCCLELLAN: Right.

MR. RICHEN: -- about repealing SGR, and how do we approve patient reform and create new care delivery miles. But you made an interesting comment, Mike, that you talked to your members, your fellow members, and they say, I don't know anything about this. And we try our best. And Bill and (Inaudible), we try our best to try and educate your members.

Are there other people that we should be talking to? I mean, who are your advisors for this? Is it Shesheido or is it MedPAC, or is it both, or do you -- I mean, who is most of -- your most important advisor? Who do you listen to most? And how do we impact them, if we can't?

QUESTIONER: Well, for -- Pete (Inaudible), Denton Medical Society -- and every time I go over to talk to them, I get blistered (Laughter). We sent you there to fix it. What's taking so long?

MR. MCCLELLAN: Right.

QUESTIONER: You talk to the speaker of the House of Representatives, and he may not understand how it should be fixed. He wants it done. He wants it gone. So, I'm using that as a positive, the fact that you have done your work, you have made people uncomfortable about this as an issue.

I will just tell you, I mean, I would rather spend our committee time talking about vaccination rates than SGR. I'd rather not have another hearing on SGR. We had two great hearings this week, and I appreciate all the participation, but next time, let’s get together and talk about how we deliver better healthcare, not how we pay for something we should have fixed a long time ago.

QUESTIONER: Yeah, no. I mean, I think one of the most fruitful meetings I ever had was actually calling Congressman Stark and asking for a private meeting with him. We spent four hours talking about it in his office in the evening. It was fantasy.

MR. MCCLELLAN: That is really effective.

Extremely effect.

QUESTIONER: I don't know how to continue to do that all the time, and I'm just you know, trying to get some advice from both of you about what is most effective?

MR. MCCLELLAN: Within your specialty society, I mean, I would make that -- I would repeat that story frequently. I did this back in the day when I would call Congress an Army, and there was a patient bill of rights that we were all inflamed about that. And don't try to get a meeting up here, because there's just too much going on during the August recess, during the Memorial Day recess, during the Easter recess.

Everybody knows when those recesses are. It's public knowledge. Call the district office or for a senator or the state office; I'd like to sit down with the Congressman. I'd like to sit down with the senator and go through this. And just to tell you the most effective way to do it, sure, two doctors is going to be impressive with their credentials, but

bring three patients with you and talk about access.

MR. MCCLELLAN: Thanks.

QUESTIONER: And I agree on that. In fact, one of the best lobbyists that I've known; I knew her for a long time -- her and her husband are both anesthesiologists. Obviously, anti-trust issues made no sense. You know? They worked -- now they work at the same network, but before, they couldn't talk. That was just crazy.

But we developed a long-term relationship, friendship. In fact, when my daughter decided -- she was at University of Texas -- she wanted to go to medical school. I called this anesthesiologist and said, okay, tell me about women in medical school and women in practice. She said, it was tough for me -- she's my age (Laughter) -- but she said, and when our daughter went to UT of B, half the class was women.

But you develop that relationship. Now, not every member of Congress is going to -- serves on the health subcommittee of Ways and Means or Energy and Commerce or even add the workforce. But you know,

they all want it fixed. And it's our job to see if we can get at least, our heads together to see how we can fix it. Because I don't know one member in the House who would stand up and say, let's keep the SGR (Laughter). And they haven't said that (Laughter). In fact, even in '97, that probably wasn't easy. (Laughter)

QUESTIONER: So we're like reforming ourselves (Laughter). Half of our trainees are women.

QUESTIONER: All right.

QUESTIONER: Yeah.

QUESTIONER: (Inaudible) sir.

MR. MCCLELLAN: Well, Congressman Burgess, Congressman Green, thank you for our leadership on these issues. It has been a long haul, and for today, covering the theory, the applications, the strategy and the tactics. And I think ending on this last point, and his name came up repeatedly today, is that -- I know physicians often feel very frustrated in the healthcare system, but as you just heard from the members, there's nobody that patients in this country

trust more or ever will.

As a result of that, I think in part, you're always going to have the ear of members of Congress. And what is really impressive with the work that we've heard about today is how much leadership positions are taking in not only calling for repealing the SGR, but really trying to chart the path forward.

This is not going to work. Healthcare reform is not going to work without that kind of physician leadership. So, I want to thank all of you for participating today.

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