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CMMI Listening Session 12-10-2010

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TRANSCRIPT

CMMI LISTENING SESSION

DATE: December 10, 2010

TIME: 9:08 a.m. to 11:04 a.m.

LOCATION: Children's Hospital  
Anschutz Medical Campus  
13123 East 16th Avenue  
Mount Oxford Room  
Aurora, CO 80045

REPORTED BY: Suzanne Reid  
Certified Shorthand Reporter, #12549  
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1 LIST OF SPEAKERS (in order of appearance)

2

3 Jim Shmerling, President and CEO,

4 Children's Hospital

5 Jeff Hinson, Regional Administrator,

6 CMS-Denver

7

8 Dr. Rick Gilfillan, Acting Director,

9 Center for Medicare and Medicaid

10 Innovation, Centers for Medicare and

11 Medicaid Services.

12 Dr. Mark Levine, Physician Liaison, CMS

13 Dr. Lynn Parry, CoChair, Judicial

14 Conference, Colorado Medical Society

15

16 Keely CofrinAllen, Ph.D., Director,

17 Office of Health Care Statistics

18 Joseph Stepanek, Retired, USAID,

19 Department of State

20

21 Phil Kalin, Executive Director, CIVHC

22

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1 LIST OF SPEAKERS CONT'D

2 Mary Phillips, President, Colorado Ovarian  
3 Cancer Alliance

4 Diane Livesay, Deputy Regional  
5 Administrator, CMS-Denver

6  
7 Dr. Randolph Fincher, Optometrist,  
8 American Optometric Association

9 Brenda VonStar, FNP, Colorado Nurses  
10 Association

11  
12 Sara Schmidtt, Colorado Rural Health  
13 Center

14 Kelly Stahlman, Parent, Consumer

15  
16 Moe Keller, VP of Public Policy and  
17 Systems Advocacy, Mental Health America  
18 of Colorado

19

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1 LIST OF SPEAKERS CONT'D

2 Jean Nofles, Legislative Advocate, AARP

3 Dr. Doug Ford, Professor of Pediatrics,

4 Director Home Dialysis & Renal

5 Transplantation, Children's Hospital

6 Brenda Hudson, CMS-Baltimore

7 Eric Aakko, Healthy Living Branch Unit

8 Director, Colorado Department of Public

9 Health and the Environment

10 Tiffany Noelle Brown, Ph.D., President,

11 Own Your Own Health

12 Samantha Lippolis, Outreach Coordinator,

13 Children's Hospital-Denver

14 Melissa Field, Director of Policy and

15 Communication, Colorado Association for

16 School-Based Health Care

17 Chris Collins, Executive Director, Alliance

18 Marguerite Salazar, Regional Director,

19 Department of Health and Human Services,

20 Denver

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1 P R O C E E D I N G S

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

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

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

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

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

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

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

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

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

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

22 Most importantly, I'd like to thank you all

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

6 Thank you for taking the time to spend time with us.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 Marie Jones get health care? No.

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

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

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

7           How do we define success? Three-part aim:  
8           as Marie told us, better health, better care,  
9 reduces costs. We think all three are attainable. We  
10 think the way to get there is from continuous  
11 improvement and a system that understands that they  
12 want to accomplish all three at the same time.

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

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

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

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

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

4 Let me talk about that, if I could, for a  
5 moment, specifically established in Section 3021 of the

6 Affordable Care Act: "The purpose of the  
7 center is to test innovative payment and service  
8 delivery models to reduce program expenses while  
9 preserving or enhancing the quality of care."

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

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

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

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

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

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

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

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

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

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

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

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1 is one.

2 The second level, coordinating care models.

3 How do we build coordinating mechanisms -- ACOs,

4 medical homes, whatever you can think of -- that

5 coordinate care across the continuum, across multiple

6 sites of care to provide a seamless care experience

7 that meets our objectives?

8 And third, how do we work at the community

9 population health system level to effect the

10 fundamental determinants of health?

11 So when we are sitting in those offices in

12 D.C. looking at proposals and thinking about proposals,

13 we are thinking about things in this context. Many of

14 them will cross all three. I understand that. We are

15 looking for models that address these levels of care.

16 What does that means in terms of functional

17 activities? Right now at the Center, we are planning

18 and figuring out how the Center should operate. Here

19 are some of the functional activities to think about.

20 We are going to be focused on those three levels at the

21 center of our business model. Okay? We know we are

22 not going to change care from Washington. We know that

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

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

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

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

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

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

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

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

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

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

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

13           Let me skip now to talk briefly about the ACO  
14 shared savings program. This was created under Section  
15 3022 of the Affordable Care Act. We are currently in  
16 rule-making. We are writing the initial draft  
17 regulations for the ACO shared savings model. We are  
18 interested in input. We are interested in hearing more  
19 if you have suggestions about how we should operate and  
20 structure that program. It's scheduled to go live in  
21 January 2012.

22           A lot of the talk about ACOs has been about

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 The first person I saw at the mic was Lynn.

6 (There was a discussion on the  
7 lighting.)

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

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

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

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

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

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

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

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

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

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

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

22 MS. COFFRIN ALLEN: Got to make my presence

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1 known. Anybody here who knows me knows that.

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

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

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

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

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1 MS. COFFRIN ALLEN: It's Keely.

2 DR. GILFILLAN: Thank you, Keely, very much.

3 And thank you for your comments. Can I just ask a  
4 question? Patient identification?

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

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

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

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

20 MS. COFFRIN ALLEN: That is correct.

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

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1 activity?

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

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

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

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

22 MS. COFFRIN ALLEN: Certainly, data from

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

3 DR. GILFILLAN: Say that again?

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

6 DR. GILFILLAN: Yes.

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

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

14 MS. COFFRIN ALLEN: Okay. Thank you.

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

18 MS. COFFRIN ALLEN: Thank you.

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

21 MS. COFFRIN ALLEN: I will.

22 MR. STEPANEK: Thank you very much for this

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

3 MR. LEVINE: Please identify yourself.

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

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

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

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1 ovarian cancer.

2           For patients like Molly who are  
3 hypersensitive or have had severe reactions to ovarian  
4 cancer's first-line drugs, the addition of Avastin  
5 becomes a lifesaving option? For my sister, Avastin  
6 was added to her chemo mix in early November. One  
7 month later, the tumor marker for ovarian cancer, CA-  
8 125, has decreased 50 percent from the high mark in  
9 mid-October of this year.

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

16           Avastin used in treating ovarian cancer is  
17 covered under Medicaid in 46 states, as I understand.  
18 Yet the private contractor for Medicaid's Jurisdiction  
19 4, which includes Colorado, New Mexico, Texas, and  
20 Oklahoma, Trailblazer Health Enterprises based in  
21 Texas, continues to turn down Medicaid coverage for  
22 Avastin use in ovarian cancer.

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

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

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

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

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

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

7 DR. GILFILLAN: Thank you.

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

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

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

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

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

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

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

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

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

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

22           DR. GILFILLAN: Thank you, Phil, for those

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

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

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

22           It's an interesting challenge to providers

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

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

15           MR. LEVINE: Mic in the back row.

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

18           MR. LEVINE: Please identify yourself.

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

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

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

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

22 Ovarian cancer is very deadly. In Colorado,

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1 44 percent of women with ovarian cancer diagnoses do  
2 not make it five years. Avastin offers progression-  
3 free survival by cutting off blood supplies to the  
4 cancer cells.

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

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

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

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

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1 up.

2 MR. LEVINE: Please identify yourself.

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

8 MS. PHILLIPS: Thank you.

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

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

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

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

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

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

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

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1 serving the needs of Medicare beneficiaries.

2 Approximately 14,000 are DME providers.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 DR. GILFILLAN: Okay. Thank you.

21 MR. LEVINE: Back microphone, please.

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

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

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

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

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

22 Nurse practitioners and other advanced

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

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

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

17           Thank you very much.

18           DR. GILFILLAN: Thank you, Brenda.

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

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

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

7 MS. VONSTAR: Thank you.

8 MR. LEVINE: Again, the back microphone.

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

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

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

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

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

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

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

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

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

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

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

17 DR. GILFILLAN: Understood.

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

21 DR. GILFILLAN: Thank you.

22 MS. STAHLMAN: Hello. My name is Kelly

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

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

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

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1 her work --

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

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

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

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

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

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

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

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

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

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

22           Those policies -- the devil is always in the

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

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

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

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

22 MS. STAHLMAN: Thank you.

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

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

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

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

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

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

22 In our conversations about medical home as

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

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

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

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

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

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

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

22           That is one thing that we are doing here in

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

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

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

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

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

3 MR. LEVINE: Explain that term, duals.

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

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

10 DR. GILFILLAN: Right. Thank you.

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

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

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1 through two programmatic areas.

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

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

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

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

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

15           DR. GILFILLAN: The dual eligible?

16           MS. NOFLES: Yes.

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

19           MS. NOFLES: Right.

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

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

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

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

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

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1 health, so forth and so on.

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

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

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

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1 that work.

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

8 MS. NOFLES: Thank you.

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

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

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

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1 possible. We have children in our dialysis program who  
2 live as far away as Spearfish, South Dakota. I have  
3 had patients who I have managed on dialysis that live  
4 40 miles from the Canadian border. The whole intent is  
5 for them to live as normal a life as possible. I think  
6 many of them do very, very well.

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

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

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

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

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

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

17           DR. FORD: Correct.

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

21           DR. FORD: Sure.

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

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1 physician interaction. There are some minimum  
2 requirements with that.

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

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

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

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

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1 folks who are involved in the physician payment policy.

2 Thanks a lot.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 So there is a real directive to get more

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

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

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

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1 MR. AAKKO: Thank you.

2 DR. GILFILLAN: You bet.

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

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

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

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

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

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

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

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

15           DR. GILFILLAN: Thank you, Tiffany.

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

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

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

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

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1 reimbursements?

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

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

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

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

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

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

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

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

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

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

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

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

11 MR. LEVINE: Can you --

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

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1 care.

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

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

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

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

20 MS. FIELD: Thank you.

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

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1 time if I didn't say something.

2 My name is Chris Collins, and I represent  
3 Alliance. And our members provide services and support  
4 to individuals with disabilities, developmental  
5 disabilities primarily, across the state of Colorado.  
6 It is a community-based system. It's been in existence  
7 for over 40 years. It's also what I would call a  
8 consumer-centered system. As a matter of fact, the  
9 names of the programs are called community centers.

10 And that is because we totally come from the community  
11 and the individuals' needs and then reach out within  
12 all the resources within communities, including the  
13 state and federally, to provide our services.

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

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

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

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

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

13 DR. GILFILLAN: Thank you, Chris.

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

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

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

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

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

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

3 Marguerite, please provide us some closing  
4 comments.

5 MS. SALAZAR: Thank you, Dr. Levine.

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

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

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



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2 I, Suzanne Reid, the officer before whom the  
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