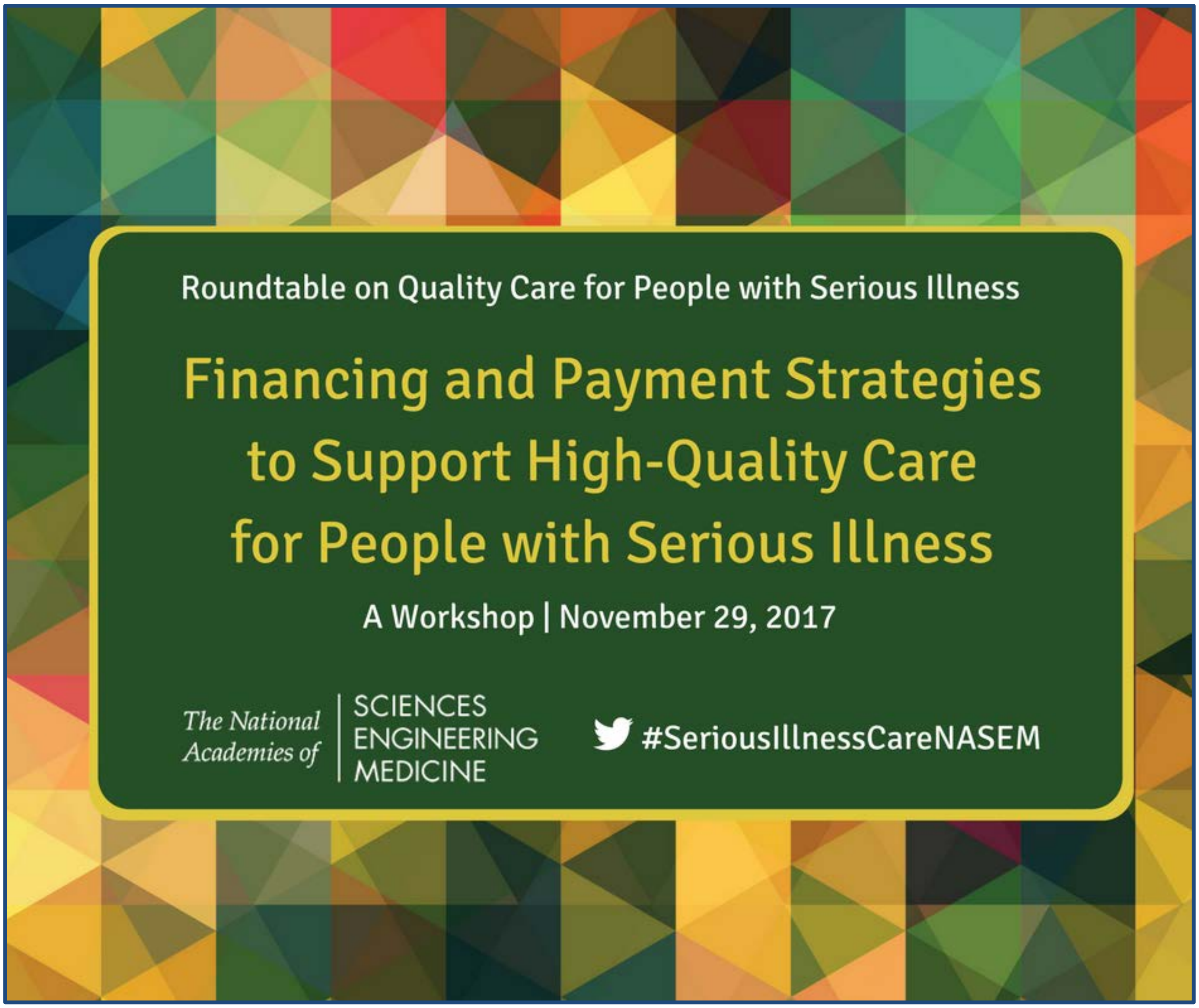


Roundtable on Quality Care for People with Serious Illness

Financing and Payment Strategies to Support High-Quality Care for People with Serious Illness

A Workshop | November 29, 2017

The National Academies of SCIENCES ENGINEERING MEDICINE

#SeriousIllnessCareNASEM

Keck Center of the National Academies
500 Fifth Street, NW
Room 100
Washington, DC 20001

The National Academies of SCIENCES ENGINEERING MEDICINE

The National Academies of
SCIENCES · ENGINEERING · MEDICINE

Roundtable on Quality Care for People with Serious Illness

November 29, 2017

Dear Colleagues:

We would like to welcome you to the third in a series of public workshops sponsored by the Roundtable on Quality Care for People with Serious Illness at the National Academies of Sciences, Engineering, and Medicine.

The focus of this workshop is on *Financing and Payment Strategies to Support High-Quality Care for People with Serious Illness*. The goal of this workshop is to explore some of the innovations in financing and payment in fee-for-service, value-based payment, and global budgeting arrangements across a range of settings and patient populations. The workshop also includes a session focused on the evolving policy landscape as it relates to the financing and payment of serious illness care.

We hope you will find the presentations informative, thought-provoking, and inspiring and that you will be able to incorporate the lessons learned here today into your vital work caring for people living with serious illness and their families.

Each workshop session includes a question and answer period and we encourage you to participate actively in workshop discussions. Proceedings of this workshop will be published by the National Academies Press and may incorporate your comments and ideas. In addition, the workshop will be webcast, and a video archive will be available at: http://www.nationalacademies.org/hmd/Activities/HealthServices/QualityCareforSeriousIllnessRoundtable/2017-NOV-29.aspx

We invite you to share your insights throughout the workshop using the Twitter hashtag: **#SeriousIllnessCareNASEM**.

Thank you for participating in this workshop.

Sincerely,

Haiden Huskamp

Haiden Huskamp

30th Anniversary Professor of Health Care Policy
Harvard Medical School
Workshop Planning Committee Co-Chair

Mark B. Ganz

Mark Ganz

President and CEO
Cambia Health Solutions
Workshop Planning Committee Co-Chair

The National Academies of
SCIENCES · ENGINEERING · MEDICINE

Roundtable on Quality Care for People with Serious Illness

WORKSHOP NOTES

- This workshop is being recorded. Please identify your name and affiliation prior to asking questions at the microphone.

- A live webcast of this workshop is available online at: http://www.nationalacademies.org/hmd/Activities/HealthServices/QualityCareforSeriousIllnessRoundtable/2017-NOV-29.aspx

- Please use the hashtag #SeriousIllnessCareNASEM to tweet about the workshop.

- An archive of the video webcast and presentation slides will be available at: http://www.nationalacademies.org/hmd/Activities/HealthServices/QualityCareforSeriousIllnessRoundtable/2017-NOV-29.aspx

- Proceedings of the workshop will be published following National Academies procedures. Rapporteurs will compose the proceedings from the workshop transcript, and external reviewers will examine the proceedings to make sure it accurately reflects workshop discussions and conforms to institutional policies.

- Interested in receiving updates from the Roundtable on Quality Care for People with Serious Illness or the National Academies of Sciences, Engineering, and Medicine's Health and Medicine Division?

  Sign up for the **Roundtable** listserv at: https://www.nationalacademies.org/hmd/Activities/HealthServices/Quality CareforSeriousIllnessRoundtable.aspx

  Like **NASEM Health and Medicine Division** on Facebook: www.facebook.com/NASEMhealth

  Follow **NASEM Health and Medicine Division** on Twitter: @NASEM_Health

  Follow **NASEM Health and Medicine Division** on LinkedIn: http://www.linkedin.com/company/nasemhealth

Agenda

The National Academies of
SCIENCES · ENGINEERING · MEDICINE

Roundtable on Quality Care for People with Serious Illness

Financing and Payment Strategies to Support High-Quality Care for People with Serious Illness: A Workshop

WORKSHOP AGENDA

The Keck Center of the National Academies
500 Fifth Street, NW - Room 100
Washington, DC 20001
November 29, 2017

Workshop Objectives

- Explore innovative financing and payment strategies across a range of settings for people of all ages facing serious illness
- Identify existing barriers to scale and spread of financing and payment innovations
- Examine potential policy actions to address barriers to innovation

Wednesday, November 29, 2017	
8:00 am	**Registration and Breakfast**
8:30 am	**Welcome from the Roundtable on Quality Care for People with Serious Illness** Leonard D. Schaeffer (Chair) and James Tulsky (Vice Chair) **Overview of the Workshop** Mark Ganz and Haiden Huskamp, Planning Committee Co-Chairs
8:40 am	**Session 1: Financing High-Quality Care for People with Serious Illness** *Moderator: Haiden Huskamp, PhD, 30th Anniversary Professor of Health Care Policy, Harvard Medical School* **Session 1A: Patient-Caregiver-Clinician Perspective** Interview with a patient/family caregiver and his clinician *Interviewer: Patricia Bomba, MD, VP & Medical Director, Geriatrics, Excellus BlueCross BlueShield* Speakers: – Ralph Bencivenga, Patient/Family Caregiver Perspective – Bethann Scarborough, MD, Associate Director of Ambulatory Services and Assistant Professor of Palliative Medicine, Icahn School of Medicine at Mount Sinai, Clinician Perspective
9:20 am	**Session 1B: Framing the Challenges and Opportunities for Financing and Payment Innovation** Overview of the current financing landscape for care for people with serious illness, including the gaps, challenges and opportunities; overarching framework of different payment models for people of all ages, all stages of serious illness. *Moderator: Haiden Huskamp*

	Speakers: – David Stevenson, PhD, Associate Professor of Health Policy, Vanderbilt University School of Medicine – Diane Meier, MD, Director, Center to Advance Palliative Care **Audience Q & A**
10:15 am	**Break**
10:30 am	**Session 2: Financing and Payment Innovations: Challenges, Impact, and Lessons Learned from Fee-for-Service and Value-Based Payment Arrangements** This session will explore examples of challenges and opportunities for innovation in fee-for-service and value-based payment systems across a range of settings and patient populations. Speakers will discuss lessons learned from their efforts to implement innovative financing and payment arrangements and identify the key barriers to such innovation. *Moderator: Harold L. Paz, MD, Executive Vice President & Chief Medical Officer, Aetna* Speakers: – Richard Popiel, MD, Executive Vice President and Chief Medical Officer, Cambia Health Solutions – Jeanne Chirico, MPA, Vice President of Community Services for Lifetime Care and Director, Excellus BlueCross BlueShield CompassionNET Program – David DeBono, MD, Medical Director, Oncology, Anthem, Inc. – Shari Ling, MD, Deputy Chief Medical Officer, Center for Clinical Standards and Quality, Centers for Medicare & Medicaid Services – Robert L. Fine, MD, Clinical Director, Office of Clinical Ethics and Palliative Care, Baylor Scott & White Health **Panel Discussion/Audience Q & A**
12:15 pm	**Luncheon Keynote Speakers** 12:15 pm—1:00 pm Members of Congress have been invited to discuss the legislative and policy environment related to care for people with serious illness. **U.S. Senator Ron Wyden (D-OR)** Ranking Member, Senate Committee on Finance **U.S. Representative Phil Roe (R-TN)** Chairman, House Committee on Veterans' Affairs **Buffet Lunch 1:00 pm —1:40 pm**
1:45 pm	**Session 3: Financing and Payment Innovations: Challenges, Impact, and Lessons Learned in Global Budgeting Arrangements** This session will explore examples of challenges and opportunities for innovation in global budgeting arrangements across a range of settings and patient populations. Speakers will discuss lessons learned from their efforts to implement innovative financing and payment arrangements, and identify the key barriers to such innovation.

	Moderator: Cheryl Phillips, MD, President and CEO, SNP Alliance, Inc. Speakers: – Susan E. Wang, MD, Regional Lead, Shared Decision-Making, Southern California Permanente Medical Group, Kaiser Permanente – Anna Gosline, MPH, Senior Director of Health Policy and Strategic Initiatives, Blue Cross Blue Shield of Massachusetts – Vicki Jackson, MD, Chief, Division of Palliative Care and Geriatric Medicine, Massachusetts General Hospital – Gregory James, DO, Senior Medical Director, OptumCare **Panel Discussion /Audience Q & A**
3:15 pm	**Break**
3:30 pm	**Session 4A: Regulatory and Policy Changes to Ensure High-Quality Care for People of All Ages with Serious Illness** *Moderator: Mark Ganz, President and CEO, Cambia Health Solutions* *Keynote Presentation*: – Patrick Conway, MD, President and CEO-elect, Blue Cross Blue Shield of North Carolina Dr. Conway will share his insights and perspectives on policy and regulatory changes to ensure high-quality care for people with serious illness.
3:50 pm	**Session 4B: Next Steps** This session will focus on policy changes necessary at the federal and state levels to address barriers to financing and payment innovation to support high-quality care for people with serious illness. Speakers: – Edo Banach, JD, President and CEO, National Hospice and Palliative Care Organization – Julian Harris, MD, MBA, President, CareAllies – Rodney L. Whitlock, PhD, Vice President, Health Policy, ML Strategies *Moderator and Discussant: Patrick Conway* **Panel Discussion /Audience Q & A**
5:15 pm	**Wrap-up and Adjourn** Mark Ganz and Haiden Huskamp

Rosters

The National Academies of
SCIENCES • ENGINEERING • MEDICINE

Roundtable on Quality Care for People with Serious Illness

*Financing and Payment Strategies to Support High-Quality Care for People with Serious Illness:
A Workshop*

WORKSHOP PLANNING COMMITTEE ROSTER

Haiden Huskamp, PhD (Co-Chair)
30th Anniversary Professor of Health Care Policy
Harvard Medical School

Mark B. Ganz (Co-Chair)
President and Chief Executive Officer
Cambia Health Solutions

Robert A. Bergamini, MD
Medical Director, Palliative Care Services
Mercy Clinic Children's Cancer and Hematology
Representing the Supportive Care Coalition

Patricia A. Bomba, MD, FACP
Vice President & Medical Director,
Geriatrics
Excellus BlueCross BlueShield
Chair, MOLST Statewide Implementation
Team & eMOLST Program Director
Chair, National Healthcare Decisions Day
NYS Coalition

Stephen Friedhoff, MD
SVP, Clinical Strategy and Programs
Anthem, Inc.

Lee Goldberg, JD, MA
Director, Improving End-of-Life Care
Project
The Pew Charitable Trusts

Anna Gosline, MPH
Senior Director of Health Policy and Strategic
Initiatives
BlueCross BlueShield of Massachusetts

Ziad Haydar, MD, MBA
Senior Vice President and Chief Clinical Officer
Ascension Health

Joanne Lynn, MD
Director, Center for Elder Care and Advanced
Illness
Altarum Institute

James Mittelberger, MD, MPH
Director and Chief Medical Officer
Optum Center for Palliative and Supportive
Care UnitedHealth Group
(through July 2017)

Leonard D. Schaeffer
Judge Robert Maclay Widney Chair
and Professor
University of Southern California

Sharon Scribner Pearce
Vice President, Policy
National Hospice and Palliative Care
Organization

Allison Silvers, MBA
Vice President for Payment and Policy
Center to Advance Palliative Care

The National Academies of
SCIENCES · ENGINEERING · MEDICINE

Roundtable on Quality Care for People with Serious Illness

Financing and Payment Strategies to Support High-Quality Care for People with Serious Illness:
A Workshop

SPEAKERS AND MODERATORS ROSTER

Edo Banach, JD
President & CEO
National Hospice and Palliative Care Organization

Ralph Bencivenga
Patient-Caregiver
New York, NY

Patricia A. Bomba, M.D., FACP
Vice President & Medical Director, Geriatrics
Excellus BlueCross BlueShield
Chair, MOLST Statewide Implementation Team & eMOLST Program Director
Chair, National Healthcare Decisions Day NYS Coalition

Jeanne Chirico, MPA
Vice President, Community Services
Lifetime Care

Patrick Conway, MD
President and CEO-elect
Blue Cross and Blue Shield of North Carolina

David J. Debono, MD
National Medical Director, Oncology
Anthem, Inc.

Robert L. Fine, MD, FACP, FAAHPM
Clinical Director, Office of Clinical Ethics and Palliative Care
Baylor Scott and White Health

Mark B. Ganz
President and Chief Executive Officer
Cambia Health Solutions

Anna Gosline, MPH
Senior Director of Health Policy and Strategic Initiatives
Blue Cross Blue Shield of Massachusetts

Julian Harris, MD, MBA
President
CareAllies

Haiden Huskamp, PhD
30th Anniversary Professor of Health Care Policy
Harvard Medical School

Vicki Jackson, MD, MPH
Chief, Division of Palliative Care and Geriatric Medicine
Massachusetts General Hospital
Co-Director HMS Center for Palliative Care
Associate Professor of Medicine
Harvard Medical School

Gregory James, DO, MPH, CMD
Senior Medical Director
OptumCare
Central-West Region

Shari M. Ling, MD
Deputy Chief Medical Officer
Centers for Medicare & Medicaid Services

Diane E. Meier, MD, FACP
Director, Center to Advance Palliative Care
Gaisman Professor of Medical Ethics
Vice Chair for Public Policy and Professor
Department of Geriatrics and Palliative Medicine
Department of Medicine
Icahn School of Medicine at Mount Sinai

Harold L. Paz, MD, MS
Executive Vice President and
Chief Medical Officer
Aetna

Cheryl Phillips, MD
President and CEO
SNP Alliance, Inc.

Richard Popiel, MD
Executive Vice President and
Chief Medical Officer
Cambia Health Solutions

Representative Phil Roe, MD
(R-Tennessee)
Chairman, House Committee on Veterans Affairs

Bethann Scarborough, MD
Associate Director of Ambulatory Services
Assistant Professor of Palliative Medicine
Brookdale Department of Geriatrics and Palliative Medicine
Icahn School of Medicine at Mount Sinai

David G. Stevenson, PhD
Associate Professor of Health Policy
Department of Health Policy
Vanderbilt University School of Medicine

Susan Elizabeth Wang, MD
WLA Chief, Department of Geriatrics, Palliative & Continuing Care
Fellowship Director, Palliative Medicine
Regional Lead, Shared Decision-Making and Advance Care Planning
Southern California Permanente Medical Group
Kaiser Permanente

Rodney Whitlock, PhD
Vice President, Health Policy
ML Strategies

Senator Ron Wyden, JD
(D-Oregon)
Ranking Member, Senate Committee on Finance

Roundtable Sponsors

The National Academies of

SCIENCES • ENGINEERING • MEDICINE

Roundtable on Quality Care for People with Serious Illness

Sponsor Organizations

- Aetna
- Altarum Institute
- American Academy of Hospice and Palliative Medicine
- American Cancer Society
- American Geriatrics Society
- Anthem
- Ascension Health
- Association of Professional Chaplains
- Association of Rehabilitation Nurses
- Blue Cross Blue Shield Association
- Blue Cross Blue Shield of Massachusetts
- The California State University Institute for Palliative Care
- Cambia Health Solutions
- Cedars-Sinai Health System
- Center to Advance Palliative Care
- Centers for Medicare & Medicaid Services
- Coalition to Transform Advanced Care
- Common Practice
- Dignity Health
- Excellus BlueCross BlueShield
- Federation of American Hospitals
- The Greenwall Foundation
- The John A. Hartford Foundation
- Hospice and Palliative Nurses Association
- Gordon and Betty Moore Foundation
- Kaiser Permanente
- Susan G. Komen
- National Academy of Medicine
- National Coalition for Hospice and Palliative Care
- National Hospice and Palliative Care Organization
- National Institute of Nursing Research
- National Palliative Care Research Center
- National Patient Advocate Foundation
- National Quality Forum
- Oncology Nursing Society
- Patient-Centered Outcomes Research Institute
- Sentara Healthcare
- Social Work Hospice and Palliative Care Network
- Supportive Care Coalition
- UnitedHealth Group

Roundtable Overview

The National Academies of
SCIENCES • ENGINEERING • MEDICINE

Roundtable on Quality Care for People with Serious Illness

The National Academies of Sciences, Engineering, and Medicine (the Academies) has established a *Roundtable on Quality Care for People with Serious Illness*. Through meetings, public workshops, and background papers, the Roundtable fosters an ongoing dialogue about critical policy and research issues to accelerate and sustain progress in care for people of all ages with serious illness. Inspired by previous work at the Academies, including the 2014 Institute of Medicine report *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life*, the roundtable convenes key stakeholders to focus on five priority areas:

- Delivery of person-centered, family-oriented care, including mechanisms to reduce multiple transitions between care settings during serious illness and in the final phase of life; recognition and support for the role of family caregivers; and efforts to ensure that critically ill individuals and their families understand the benefits of, and have access to, palliative care.
- Communication and advance care planning, including clinician-initiated conversations with individuals and loved ones about end-of-life care values, goals, and preferences; policies to support and incentivize such conversations; and methods to record individual preferences and ensure that they are honored.
- Professional education and development, including attention to palliative care in medical and nursing school curricula; reducing educational siloes to improve the development of inter-professional teams; and health care providers' communication skills.
- Policies and payment systems, including policies to reduce payment siloes and incentives that will result in use of helpful services; scale-up of successful programs that integrate health care and long-term social services; policies to incentivize the provision of comprehensive palliative care; and the development of quality standards and measures.
- Public education and engagement, including strategies to promote informed understanding of advanced care and end-of-life care issues among diverse groups; efforts to motivate health care consumers to seek high-quality care for themselves and their loved ones; and efforts to normalize conversations about death and dying through storytelling and advocacy at multiple levels.

The Roundtable is limited to a three-year term in order to focus its activities on tangible, short-term goals. Roundtable activities include expert meetings, public workshops and webinars, summary publications, and targeted communications and community engagement activities. Roundtable membership includes federal agencies, health insurers, advocates, patients, health care providers, foundations, academics, and others interested in the topic.

Laurie Graig
202-334-1484
lgraig@nas.edu

Sharyl J. Nass
202-334-2320
snass@nas.edu

Andrew M. Pope
202-334-1739
apope@nas.edu

The National Academies of
SCIENCES • ENGINEERING • MEDICINE

Roundtable on Quality Care for People with Serious Illness

Roundtable Membership

Leonard D. Schaeffer (Chair)
University of Southern California

James A. Tulsky, MD (Vice Chair)
Dana-Farber Cancer Institute
Harvard Medical School

Jennifer Ballentine
The California State Institute for Palliative Care

Robert A. Bergamini, MD
Supportive Care Coalition

Amy J. Berman, RN, BSN, LHD
The John A. Hartford Foundation

Patricia A. Bomba, MD, FACP
Excellus BlueCross BlueShield

Susan Brown
Susan G. Koman

Grace B. Campbell, PHD, MSW, RN, CRRN
Association of Rehabilitation Nurses

Steve Clauser, PhD, MPA
Patient-Centered Outcomes Research Institute

Jeff Cohn, MD, MHCM
Common Practice

Janet Corrigan, PhD, MBA
Gordon and Betty Moore Foundation

Andrew Dreyfus
BlueCross BlueShield of Massachusetts

Carole Redding Flamm, MD, MPH
BlueCross BlueShield Association

Stephen Friedhoff, MD
Anthem, Inc.

Mark B. Ganz, JD
Cambia Health Solutions

Ziad Haydar, MD, MBA
Ascension Health

Pamela S. Hinds, RN, PhD, FAAN
Children's National Health System

Haiden Huskamp, PhD
Harvard Medical School

Kimberly Johnson, MD
Duke University School of Medicine

Charles N. Kahn, III, MPH
Federation of American Hospitals

Rebecca A. Kirch, JD
National Patient Advocate Foundation

Tom Koutsoumpas
Coalition to Transform Advanced Care

Shari Ling, MD
Centers for Medicare & Medicaid Services

Bernard Lo, MD
The Greenwall Foundation

Joanne Lynn, MD
Altarum Institute

Diane E. Meier, MD
Center to Advance Palliative Care

Amy Melnick, MPA
National Coalition for Hospice and Palliative Care

Jeri L. Miller, PhD
National Institute of Nursing Research, NIH

R. Sean Morrison, MD
National Palliative Care Research Center

Murali Naidu, MD, FACS
Sentara Healthcare

Brenda Nevidjon, RN, MSN, FAAN
Oncology Nursing Society

Harold L. Paz, MD, MS
Aetna

Sharon Scribner Pearce
National Hospice and Palliative Care Organization

Judith R. Peres, LCSW-C
Social Work Hospice and Palliative Care Network

Philip A. Pizzo, MD
Stanford University School of Medicine

Wendy Prins, MPH, MPT
National Quality Forum

Thomas M. Priselac, MPH
Cedars-Sinai Health System

JoAnne Reifsnyder, PhD, ACHPN
Hospice and Palliative Nurses Association

Judith A. Salerno, MD, MS
New York Academy of Medicine

Katrina M. Scott, MDiv
Association of Professional Chaplains

Katherine Sharpe, MTS
American Cancer Society

Joseph W. Shega, MD
American Geriatrics Society

Christian Sinclair, MD
American Academy of Hospice and Palliative Medicine

Tanya Stewart, MD, MBA, FAAHPM
UnitedHealthcare Retiree Solutions

Susan Elizabeth Wang, MD
Kaiser Permanente

The National Academies of
SCIENCES • ENGINEERING • MEDICINE
HEALTH AND MEDICINE DIVISION

Roundtable on Quality Care for People with Serious Illness

Staff Roster

Laurie Graig, MA
Director, Roundtable on Quality Care for People with Serious Illness
202-334-1484
lgraig@nas.edu

Sharyl Nass, PhD
Director, Board on Health Care Services
Director, National Cancer Policy Forum
202-334-2320
snass@nas.edu

Andrew Pope, PhD
Director, Board on Health Sciences Policy
202-334-1739
apope@nas.edu

Sylara Marie Cruz
Research Assistant
202-334-2822
scruz@nas.edu

ABOUT US

THE HEALTH AND MEDICINE DIVISION

We ask and answer the nation's most pressing questions about health and health care.

The Health and Medicine Division (HMD)—an operating unit of the National Academies of Sciences, Engineering, and Medicine (National Academies)—helps those in government and the private sector make informed health decisions by providing evidence upon which they can rely.

Through our consensus studies, we offer straightforward answers to questions of national importance. Our convening activities bring together actors from across the health care spectrum to explore complex topics and work toward shared understanding on critical health issues.

Each year, more than 3,000 of the world's leading experts in industry, academia, and the health care sector volunteer their time, knowledge, and expertise with HMD. They work through committees composed to ensure the needed expertise and to avoid conflicts of interest. With the assistance of approximately 150 HMD staff members, their contributions help to advance health.

Our advice is steeped in science and led by evidence. For millions of people across the United States and around the globe, improving health is not merely an academic exercise; it is a matter of daily survival and well-being. In all we do to improve health policy and decision making, HMD is ever mindful of the impact of our work on the lives and health of individuals, families, communities, and nations.

As of March 2016, the Health and Medicine division continues the consensus studies and convening activities previously undertaken by the Institute of Medicine.

OUR WORK

From alerting the public to the widespread problem of medical errors to setting the blueprint for the future of nursing to emphasizing the importance of end-of-life care preferences, our consensus studies provide independent, evidence-based advice on pressing issues in health and health care.

Many of the studies that HMD undertakes are requested by federal agencies and independent organizations; others begin as specific mandates from Congress. Before any National Academies report is released, it undergoes extensive peer review by a second group of experts, whose identities remain anonymous to the authoring committee until the study is published. For decades, this process has resulted in sound publications providing policy makers, the health professions, and the American people with objective advice grounded in evidence.

While our consensus committees are vital to our advisory role, HMD also convenes a series of forums, roundtables, and standing committees. These activities facilitate discussion; discovery; and critical, cross-disciplinary thinking, and when required can quickly gather experts to address matters of urgent importance, such as emerging infectious diseases and health-related disaster preparedness.

OUR NAME

As of March 2016, the Health and Medicine division continues the consensus studies and convening activities previously undertaken by the Institute of Medicine. With this change, HMD is now fully integrated into the broader work of the National Academies, which is facilitating more collaborative and interdisciplinary approaches to the most pressing challenges facing the nation and the world.

Learn more at
nationalacademies.org/HMD

The National Academies are private, nonprofit institutions that provide independent, objective analysis and advice to the nation and conduct other activities to solve complex problems and inform public policy decisions related to science, technology, and medicine. The National Academies operate under an 1863 congressional charter to the National Academy of Sciences, signed by President Lincoln.

✉ **HMD_NASEM@nas.edu**
@NASEM_Health
facebook.com/NASEMHealth

The National Academies of
SCIENCES · ENGINEERING · MEDICINE

The nation turns to the National Academies of Sciences, Engineering, and Medicine for independent, objective advice on issues that affect people's lives worldwide.
www.national-academies.org

Upcoming Roundtable Workshop

The National Academies of
SCIENCES · ENGINEERING · MEDICINE

Roundtable on Quality Care for People with Serious Illness

Implementation of Quality Measures for Community-based Care Programs for Serious Illness: A Workshop

The Keck Center of the National Academies
500 Fifth Street, NW - Room 100
Washington, DC 20001
April 17, 2018

An ad hoc committee will plan and host a one-day public workshop to examine strategies, approaches, and key challenges to implementation of quality measures for community-based care programs for serious illness.

The workshop will feature invited presentations and panel discussions on topics that may include:

- An overview of the role of patient experience and shared decision-making in defining quality across a range of evolving care settings, including community-based organizations and home-based care
- Model programs such as those developed by BlueCross BlueShield of Massachusetts and the Veteran's Health Administration, as well as international efforts such as the Harvard Global Equity Initiative on Pain Control
- The roles of key stakeholders driving implementation of quality measures, including: private and public payers; accreditation organizations; and NQF's National Quality Partners
- Potential tools and mechanisms for implementation, such as public report cards (i.e., CMS, state-based) and quality improvement efforts undertaken by care programs for serious illness
- Challenges and opportunities for using potential data sources, including: electronic health records; claims; registries; patient-reported data; and crowdsourcing
- Ways to develop a feasible approach and timeline for implementing quality measures

The committee will develop the agenda for the workshop sessions, select and invite speakers and discussants, and moderate the discussions. A proceedings of the presentations and discussions at the workshop will be prepared by a designated rapporteur in accordance with institutional guidelines.

The National Academies of
SCIENCES · ENGINEERING · MEDICINE

Roundtable on Quality Care for People with Serious Illness

Planning Committee Roster

Amy Kelley, MD, MSHS (Co-Chair)
Associate Professor
Brookdale Department of Geriatrics and Palliative Medicine
Icahn School of Medicine at Mount Sinai

Amy Melnick, MPA (Co-Chair)
Executive Director
National Coalition for Hospice and Palliative Care

Steve Clauser PhD, MPA
Program Director, Improving Healthcare Systems
Patient-Centered Outcomes Research Institute

Laura Hanson, MD, MPH
Professor, Geriatric Medicine
Co-Director, Palliative Care Program
University of North Carolina School of Medicine

Pamela S. Hinds, RN, PhD, FAAN
Director and Professor
Conway Chair in Nursing Research
Director, Nursing Research and Quality Outcomes
Children's National Health System

Rebecca A. Kirch, JD
Executive Vice President of Healthcare Quality and Value
National Patient Advocate Foundation

Murali N. Naidu, MD, FACSVP
Chief Clinical Officer
Sentara Healthcare

Wendy Prins, MPH, MPT
Senior Advisor, Quality Innovation
National Quality Forum

Joan Teno, MD, MS
Professor, Medicine
University of Washington School of Public Health

Christine Ritchie, MD, MSPH, FACP, FAAHPM
Harris Fishbon Distinguished Professor
Clinical Translational Research and Aging, Division of Geriatrics, Department of Medicine
University of California San Francisco

Program Descriptions

Cambia Health Solutions is a total health solutions company headquartered in Portland, Oregon, that serves as a catalyst to a person-focused and economically sustainable health care system. We seek to change the way people experience health care through personalized, compassionate guidance and consumer empowerment. For people and families facing serious illness, our goal is palliative care everywhere -- in the hospital, in the community, in the home – depending on the patient's preferences. We have heavily invested in palliative care as one of signature efforts to transform people's journey through the healthcare system because it puts the patient and the family at the center at a time when it is most needed and provides a model of care for the rest of the system.

Our approach

We've created a holistic approach to palliative care across our Foundation, health plans, strategic investments and technology innovations. All of these efforts focus on changing the experience of people with serious illness by empowering them and shifting the paradigm. When designing products and services and choosing philanthropic investments, Cambia evaluates whether the initiative:

- Makes the path through serious illness smoother and easier
- Focuses on what matters to patients rather than on what's the matter with them
- Involves shared decision-making that helps patients feel in control of their experience
- Provides an extra layer of support for patients and families

Our actions

Since its inception in 2007, **the Cambia Health Foundation** has made purposeful philanthropic investments totaling more than $30 million to advance the field of palliative care. Our initial grants provided seed money to regional hospitals to plan and implement sustainable palliative care services. Thereafter, we funded consumer awareness campaigns through CAPC and The Conversation Project. More recently, consistent with the Institute of Medicine's finding in the landmark 2014 *Dying in America* report that we must "increase training in palliative care so that more clinicians know how to compassionately and effectively treat patients who want to be made comfortable but avoid extensive medical procedures," the Foundation has made significant investments in workforce and leadership development, including:

- A signature $10 million grant to the University of Washington to launch the Cambia Palliative Care Center of Excellence at the University of Washington.
- Investments in the End-of-Life Nursing Education Consortium (ELNEC) to train the trainer, improve quality and integrate palliative care into health care systems.
- A $4 million grant to Doernbecher Children's Hospital to establish "The Cambia Health Foundation Endowed Chair in Pediatric Palliative Care" and "The Cambia Health Foundation Innovation Fund in Pediatric Palliative Care."

- Finally, the Cambia Health Foundation identifies, cultivates and advances the next generation of palliative care leaders through its Sojourns Scholar Leadership Program. Each year, the Foundation selects up to 12 scholars and supports their work and leadership development with a 2-year $180,000 grant.

With our regional health plans, we have created what has been called the most comprehensive palliative care program in the nation. We believe we are the only health plan in the United States with support in place for the entire palliative care spectrum, from birth – and even before birth - until natural completion of life. Our Personalized Care support program includes:

- A palliative care benefit that covers Advance Care Planning, Home Health Medical, Home Health Psycho-Social, Specialized Care Management and Caregiver Support.
- First-in-nation perinatal and neonatal hospice support and remission support.
- Partnerships with local provider and consumer organizations to pilot innovative new palliative care models.

The response and uptake have exceeded expectations. In the first year alone, palliative care managers served 1,753 individual members and their caregivers. Health plan members have expressed a high level of satisfaction with the program.

Through Echo Health Ventures, a collaboration between Cambia and BlueCross BlueShield of North Carolina, we have invested in building and growing innovative solutions that address the issues of aging, caregiving and coordinated care.

- Echo portfolio company GNS Healthcare provides an Advanced Illness solution that allows health plans and health systems to identify members who are most appropriate for advanced illness interventions, such as palliative care, within the next year.

Writing the next chapter, together

We are deeply committed to helping more Americans take charge of their health care and empower them to live with dignity and a sense of control, especially when facing a serious illness. Cambia believes that palliative care is deeply personal and fundamentally rooted in a deep respect for a patient's wishes. Most importantly, as Cambia's CEO Mark Ganz stated in the keynote panel of the 2016 AAHPM and HPNA Annual Assembly, investments in palliative care are a return on humanity – not a return on investment.

Peggy Maguire
Senior Vice President Corporate Accountability and Performance, Cambia Health Solutions
President, Cambia Health Foundation

CompassionNet
Surrounding families with support

Excellus
A nonprofit independent licensee of the Blue Cross Blue Shield Association

Description:
CompassionNet is a community-based pediatric and perinatal palliative care program originally sponsored by the Lifetime Healthcare Companies, including Excellus BlueCross BlueShield. CompassionNet provides support to families caring for a child with a potentially life-threatening illness as well as families expecting the birth of a child with a serious medical condition. Often starting at the time of diagnosis, the interdisciplinary team collaborates with other providers to address physical, emotional, social, and spiritual needs of the children and families'. Some children are discharged from CompassionNet when their condition improves, while others remain on the program as they continue to receive treatment. If a child's condition worsens, the CompassionNet team is available to support, train, and collaborate with the direct care providers who may need the expertise of the pediatric palliative care specialists. Through collaboration with community organizations and other resources, CompassionNet extends the "net" of support to reach beyond the physical needs of the child to the unmet needs of all family members.

Team Members:
The CompassionNet team includes case managers, nurse practitioners, child life specialists, social workers, physicians, nurses, a chaplain, and volunteers. CompassionNet considers the child, all family, educational providers, and treatment team part of the team for treatment plans, goal setting and communication.

Eligibility Criteria
A child under the age of 21 who has an Excellus or Univera insurance plan and has been diagnosed with:

- A medical condition for which curative treatment is possible but may fail
- A medical condition which is progressive and treatment is comfort oriented only
- A potential life-limiting condition whereby the child is experiencing a progression or exacerbation of the disease which may be evidenced by increased frequency or duration of acute care intervention; and/or requiring intensive pain and symptom management
- A condition involving severe, nonprogressive disability during a time of extreme medical fragility placing the child at risk to die,

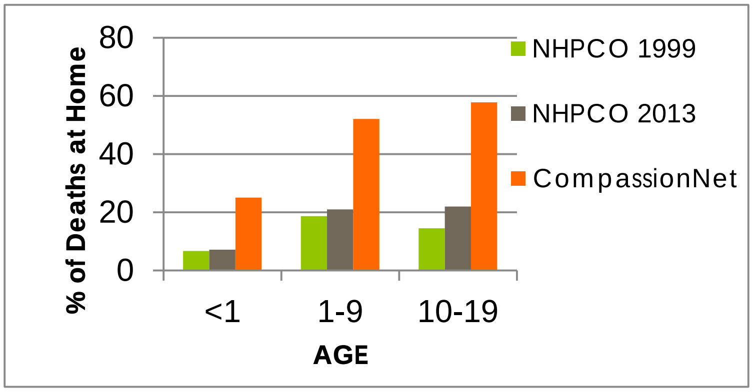
Or Families expecting the birth of a child with a serious medical condition

Support Offered As Needed

- Collaboration and coordination among home care, primary physicians, and hospital teams involved in the child's care
- Facilitation of difficult conversations about goals of care
- Consultation for pain and symptom management
- Assistance with providing developmentally- appropriate medical information
- Access to home-based services, such as child life, art, music and massage therapies
- Access to bereavement services when needed for up to 3 years following the death
- Services to meet the needs of siblings and other family members

Results:

1. **Average annual per child fully loaded CompassionNet expense $6995**
2. **Increased proportion of children dying at home against National Standards**



3. **Decreased Overall Expense per child according to payer claims data**

Table 2

Cost and Location of Death at 5 Moments in the Last Year of Life

Children/Adolescents	**Year**	**Median Total Costs** **6 months**	**3 months**	**1 month**	**Last week**
Hospital (*n*=84)	$197,069	$113,110	$67,561	$45,615	$29,169
Home (*n*=74)	$116,708	$57,295	$24,521	$6,173	$1,213
Mann-Whitney U (*p*)	2269 (.003)	2031 (<.001)	1648 (<.001)	1149 (<.001)	729 (<.001)
Infants					
Hospital (*n*=51)	$111,876	$111,876	$111,876	$94,025	$78,442
Home (*n*= 14)	$94,009	$77,406	$23,375	$12,508	$2,288
Mann-Whitney U (*p*)	302 (.38)	240 (.06)	137 (<.001)	86 (<.001)	65 (<.001)

Note: *p* values are based on two-tailed tests

For more information please contact Jeanne Chirico at Jeanne.chirico@lifetimecare.org

Anthem is a health benefits company. Its purpose is: "Together we are transforming health care with trusted and caring solutions". Its vision is "To be American's valued health partner". Its values are to be accountable, caring, easy to do business with, innovative and trustworthy.

Anthem has medical plan enrollment of 40.3 million members with annual revenue of 88 billion dollars. Fully insured members number 15.3 million and 25 million are in self-funded plans. There are 8 million members enrolled in Medicare and Medicaid plans.

Anthem recognizes that the care of the seriously ill patient is important. Under ideal circumstances, patients with incurable advanced illness are treated by a palliative care team early in the course of their disease, and preferably in the outpatient setting (either clinic or home based). During these visits, the patients can receive a formal symptom assessment and an evaluation of their psychosocial needs. However, the availability of outpatient palliative care is severely limited by a shortage of practitioners and a poorly defined financial model.

Anthem has chosen to address the palliative care needs of its patients in two ways: 1) Our Enhanced Personal Health Care Program, and 2) Our Advanced Illness Support Program.

Enhanced Personal Health Care Program (EHPC)

The EHPC is a value-based payment model designed to provide resources to provider practices to encourage the move from the fee-for-service environment to a value-based payment model. The EPHC began in 2012 and after three years included 54,000 participating providers caring for 4.6 million members in Anthem plans. Anthem has developed transformation teams to assist practices in transformation of their practice and has positioned clinical liaisons to help practices interpret data, develop care management skills and help in identifying and managing high risk patients.

The EPHC is designed to achieve three main goals:

1) Support the transformation of care delivery through collaboration with providers that have varying levels of experience with risk-based contracting.

2) Improve patients' quality and experience of care and their health status and outcomes.

3) Slow the growth of total cost of care in order to ensure the affordability of high-value coverage.

The EPHC achieves these goals through flexible infrastructure design that can serve the needs of solo practitioners all the way up to large ACO organizations. Participating providers receive upfront clinical coordination payments to offset the costs of care coordination and program implementation. Subsequently, providers are eligible to share in savings (30-35%) if attributed members have a lower cost of care than projected and also are eligible for enhanced reimbursement if quality measures improve. Conditions of participation in the program are as follows:

1) Provide 24/7 access to members through extended hours and/or call coverage.
2) Have a dedicated position in the practice that supports participation in EPHC and practice transformation.
3) Regularly participate in collaborative learning sessions and use support tools, such as hot-spotting reports, to identify gaps in care.
4) Use a disease registry to manage care for patients with certain chronic conditions and engage in care planning for high risk populations.
5) Use generic prescription drugs when clinically appropriate.
6) Engage in quality and performance measurement, and meet appropriate performance standards on nationally endorsed quality measures.

Initial analysis of EPHC in 2013-2014, demonstrated 7.8% fewer acute inpatient admissions, 5.1% decrease in outpatient surgery costs, 5.7% fewer inpatient days, 7.4% decrease in acute admissions and an increase in outpatient visits for high risk patients with chronic comorbidities, and finally a 3.5% decrease in ER costs. Overall net savings from the program over this time period was $6.62 per attributed member per month as compared to members not enrolled in the program. Care coordination quality metrics and patient satisfaction scores were also significantly improved.

A significant part of the EPHC is the sharing of actionable data. There is a clinical application, Provider Care Management Solutions, which provides practices with real time data to determine which patients require attention. Data feeds also include longitudinal member records, hot-spotter reports and gaps in care reports designed to help providers target their care management efforts. These interventions are particularly important for the care of the seriously ill.

Advanced Illness Support Program

Delivering palliative care in the community is limited by three major barriers. The first is the Medicare Hospice Benefit which effectively requires patients to stop disease-modifying therapy to enter hospice care. The second is the shortage of palliative care practitioners and the third is a reimbursement structure that impairs the development of a stable financial model. Anthem is currently formulating solutions to these limitations.

The Advanced Illness Support Program is a combination of two initiatives. The first is an expanded hospice benefit program. The plan is to offer hospice benefits to commercially insured/Medicaid members with an anticipated prognosis of 6-12 months. They would be allowed to continue to receive disease-modifying therapy like chemotherapy and transfusions. It is hoped that as the patient and their family become comfortable with their hospice team, that advance care planning discussions are completed, goals of care are ascertained, and ultimately, late aggressive care will be avoided. It is anticipated that there will be significant cost of care savings.

The second initiative is an investment in palliative care assets to develop a home-based palliative care program. Our strategy is centered on three programs: 1) A home-based telehealth program to offer home-based palliative care, 2) A home-based multidisciplinary palliative care team making home visits, and 3) The potential for clinic-based palliative care embedded in practitioners' clinics (i.e. – oncology clinics). It is expected that these programs will more effectively disseminate palliative care to our members, will provide members 24/7 access to a palliative care team, and provide highly-trained palliative care professionals to our members.

The Innovation Center was established by section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act). Congress created the Innovation Center for the purpose of testing "innovative payment and service delivery models to reduce program expenditures …while preserving or enhancing the quality of care" for those individuals who receive Medicare, Medicaid, or Children's Health Insurance Program (CHIP) benefits. Congress provided the Secretary of Health and Human Services (HHS) with the authority to expand the scope and duration of a model being tested through rulemaking, including the option of testing on a nationwide basis. In order for the Secretary to exercise this authority, a model must either reduce spending without reducing the quality of care, or improve the quality of care without increasing spending, and must not deny or limit the coverage or provision of any benefits. These determinations are made based on evaluations performed by the Centers for Medicare & Medicaid Services (CMS) and the certification of CMS's Chief Actuary with respect to spending. An update will be provided on the following Models:

Independence at Home Demonstration: Home-based primary care allows health care providers to spend more time with their patients, perform assessments in a patient's home environment, and assume greater accountability for all aspects of the patient's care. This focus on timely and appropriate care is designed to improve overall quality of care and quality of life for patients served, while lowering health care costs by forestalling the need for care in institutional settings. The Independence at Home Demonstration will build on these existing benefits by providing chronically ill patients with a complete range of primary care services in the home setting. Medical practices led by physicians or nurse practitioners will provide primary care home visits tailored to the needs of beneficiaries with multiple chronic conditions and functional limitations. The Independence at Home Demonstration also will test whether home-based care can reduce the need for hospitalization, improve patient and caregiver satisfaction, and lead to better health and lower costs to Medicare. Selected primary care practices will provide home-based primary care to targeted chronically ill beneficiaries for a three-year period. Participating practices will make in-home visits tailored to an individual patient's needs and coordinate their care. CMS will track the beneficiary's care experience through quality measures. Practices that succeed in meeting these quality measures while generating Medicare savings will have an opportunity to receive incentive payments after meeting a minimum savings requirement. Participation in this home-based care demonstration is voluntary for Medicare beneficiaries.

Medicare Care Choices Model: Under current payment rules, Medicare and dually eligible beneficiaries are required to forgo curative care in order to receive services under the Medicare or Medicaid Hospice Benefit. Fewer than half of eligible Medicare beneficiaries use hospice care and most only for a short period of time. Through the Medicare Care Choices Model, the Centers for Medicare & Medicaid Services (CMS) will provide a new option for Medicare beneficiaries to receive hospice-like support services from certain hospice providers while concurrently receiving services provided by their curative care providers. CMS will evaluate whether providing these supportive services can improve the quality of life and care received by Medicare beneficiaries, increase patient satisfaction, and reduce Medicare expenditures. The model is designed to 1) increase access to supportive care services provided by hospice;2) Improve quality of life and patient/family satisfaction; and 3) Inform new payment systems for the Medicare and Medicaid programs.

CPC-Plus: CPC+ is a unique public-private partnership, in which practices are supported by 54 aligned payers in 14 regions (PDF) in Round 1, and seven payers in four regions (PDF) in CPC+ Round 2. This partnership gives practices additional financial resources and flexibility to make investments, improve quality of care, and reduce the number of unnecessary services their patients receive. CPC+ seeks to improve quality, access, and efficiency of primary care. Practices in both tracks will make changes in the way they deliver care, centered on key Comprehensive Primary Care Functions: (1) Access and Continuity; (2) Care Management; (3) Comprehensiveness and Coordination; (4) Patient and Caregiver Engagement; and (5) Planned Care and Population Health.

CPC+ provides practices with a robust learning system, as well as actionable data feedback to guide their decision making. The care delivery redesign ensures practices have the infrastructure to deliver better care, resulting in a healthier patient population. CPC+ Round 1 supports 2,850 primary care practices, comprising 13,090 clinicians and serving more than 1.76 million Medicare beneficiaries. Practices of all sizes and structures are located in each of the 14 CPC+ regions: Arkansas, Colorado, Hawaii, Greater Kansas City Region of Kansas and Missouri, Michigan, Montana, North Hudson-Capital Region of New York, New Jersey, Ohio and Northern Kentucky Region, Oklahoma, Oregon, Greater Philadelphia Region of Pennsylvania, Rhode Island, and Tennessee. Starting in January 2018, CMS expects to select up to 1,000 primary care practices in CPC+ Round 2: Louisiana, Nebraska, North Dakota, and the Greater Buffalo Region of New York.

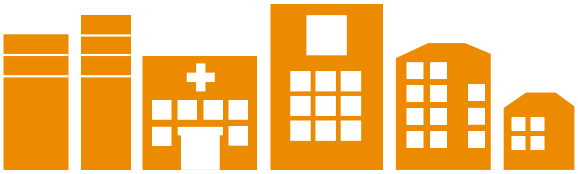
BaylorScott&White
HEALTH

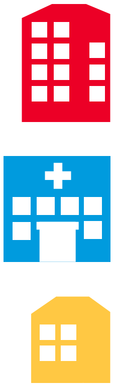
CHANGING HEALTH CARE. FOR LIFE.®

Baylor Scott & White Health is the largest not-for-profit healthcare system in Texas, and one of the largest in the United States. Baylor Scott & White was born from the 2013 merger of Baylor Health Care System serving North Texas and Scott & White Healthcare serving Central Texas. After years of thoughtful deliberation, the leaders of Baylor Health Care System and Scott & White Healthcare decided to combine the strengths of the two and create a new model system able to meet the demands of healthcare reform, the changing needs of patients and extraordinary recent advances in clinical care.

With a commitment to and a track record of innovation, collaboration, integrity and compassion for the patient, Baylor Scott & White stands to be one of the nation's exemplary healthcare organizations.

48 HOSPITALS





496 SPECIALTY CARE CLINICS

163 PRIMARY CARE CLINICS

161 SATELLITE OUTPATIENT CLINICS

25 AMBULATORY SURGERY CENTERS

6 URGENT CARE CLINICS

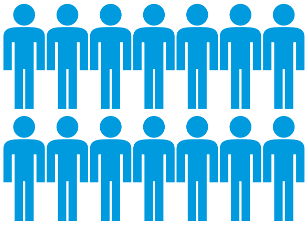
4 SENIOR HEALTH CENTERS

$8.4 BILLION
TOTAL OPERATING REVENUE

$10.8 BILLION
TOTAL ASSETS

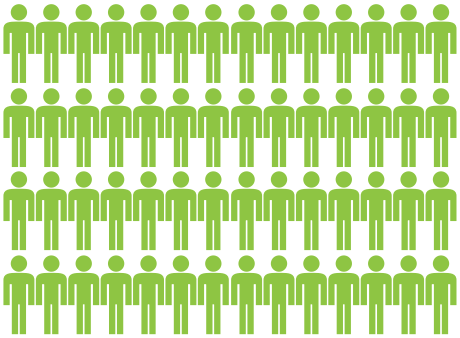
$754+ MILLION
2016 COMMUNITY BENEFIT

48,000+ EMPLOYEES

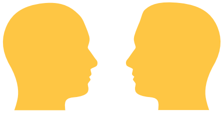


9,600+ PHYSICIANS

548,000+ COVERED LIVES



5.8+ MILLION
PATIENT ENCOUNTERS ANNUALLY



5,385
LICENSED BEDS

3.6 MILLION
OUTPATIENT REGISTRATIONS

Statistics for hospitals, specialty care clinics, primary care clinics, satellite outpatient clinics, ambulatory surgery centers, urgent care clinics, employees, physicians and licensed beds as of 3/31/2017.

Statistics for patient encounters, outpatient registrations, total operating revenue, total assets and community benefit as of 6/30/2016.

9/19/2017

BSWH Supportive and Palliative Care Overview

Two components: Specialty palliative care and primary palliative care. We refer to our specialty program as **Supportive and Palliative Care (SPC)**. SPC supports patients and families facing serious illness and seeks to lessen suffering (physical, emotional, social and spiritual) associated with serious illness.

- 14 hospitals (100+ non-OB beds) with CAPC model/TJC certifiable model specialty SPC programs.
    - 2 academic tertiary care campuses (1000 bed BUMC – Dallas, and 650 bed SW – Temple)
    - 5 outpatient clinics, more on the way.
    - 3 programs Joint Commission Certified (BUMC 1st 10 in nation), more on the way
    - AHA Circle of Life Award 2014, best system wide program
- SPC teams – 5 core professionals: MD/DO, APRN, Pastoral Care, SW, Child Life Specialists (CLS)
    - 19 FTE PM certified physicians, 17 FTE APPs, growth plan driven by metrics
    - 4 facilities with full time social work and pastoral care members, other facilities with shared social work and pastoral care members
    - 6 Child Life Specialists serving children of seriously ill adults (100% philanthropy funded)
    - In-kind services from Speech, Occupational, Physical, Music, and Art therapists. Nutrition services, volunteers.
- Selected data (FY17)
    - Percent non-obstetric admissions served 5.1% (range 1.8% - 11.6%)
    - Inpatient consults 6358, Inpatient follow-ups 16211, Outpatient visits 1800
    - Consult location: Floor 62.7%, ICU 35.1% (range 10.6 – 49.3%), ED 2.2% (range 0 – 5.8%)
    - Families with children of seriously ill adults served by CLS: 1392
    - Children of seriously ill adults served by CLS: 2521
    - Leading diagnoses: Cancer 35.6%, Cardiac (mostly heart failure) 22.3%
    - Consult activities: Care Planning 92.4%, Pain 48.5%, Other Symptoms 39.8%
    - Pain improvement 95.3% (range 91 – 100%)
    - Code status change 51.1%, One or more new Adv. Directives 39.5% (range 11.9 – 66.1%)
    - Live discharges 81.7% (range 23.3 – 100%), Live discharge with hospice 34.1%
    - Hospital Deaths seen by SPC 28.6% (range 3 – 76%)
- Time factors (impacts direct cost savings – shorter time better)
    - Admission to consult: Median Days 3 (range 2 - 5), Mean Days 4.96 (range 3.25 - 7.69)
    - Consult to discharge: Median Days 4 (range 2 - 6), Mean Days 6.18 (range 3.87 - 9.12)

Current primary palliative care focus is on enhancing the communication and care planning skills of non-palliative care physicians who see seriously ill patients, utilizing the Serious Illness Conversation Program (SICP) developed by Drs. Susan Block and Atul Gawande. We are only one year into a multiyear initial training program accompanied by perpetual training as new clinicians join our system.

- Total physicians trained: 52
- Total APPs trained: 20
- Serious Illness Conversations Documented to date: 242
- New Advance Directives Associated with SICP to date: 87

KAISER PERMANENTE®

One-Page Summary of the Structure and Organization of Kaiser

What is Kaiser Permanente?

There is no legal entity called "Kaiser Permanente" or "KP." It is a trade name that references certain legal entities contracting with each other in each KP region. There are eight different KP regions and a national division called "Program Office" or "PO".

- In regions other than KP-Washington, "KP" consists of three contracting KP entities: a regional Kaiser health plan (HP), Kaiser Foundation Hospitals (KFH) and a regional Permanente Medical Group (PMG).
- In the KP-Washington region, "KP" consists of two contracting KP entities: HP and PMG. KFH has a very limited role.

In all regions, HP contracts with PMG to provide professional services to HP's members. The HPs are considered dedicated group model HMOs because the contracts between HP and PMG are mutually exclusive.

The KP regions include: Colorado, Georgia, Hawaii, Mid-Atlantic States (VA, DC, and MD), Northern California, Northwest (OR and Southwestern WA), Southern California, and Washington. The Regional Health Plans offer health maintenance organization (HMO) and exclusive provider organization (EPO) plans.

Corporate Structure of KP Entities

All the regional health plans and KFH are nonprofit, tax-exempt 501(c)(3) charitable organizations. All the PMGs are for profit medical groups. Seven PMGs are professional corporations and one PMG (Southern Cal) is a partnership

MASSACHUSETTS

AQC

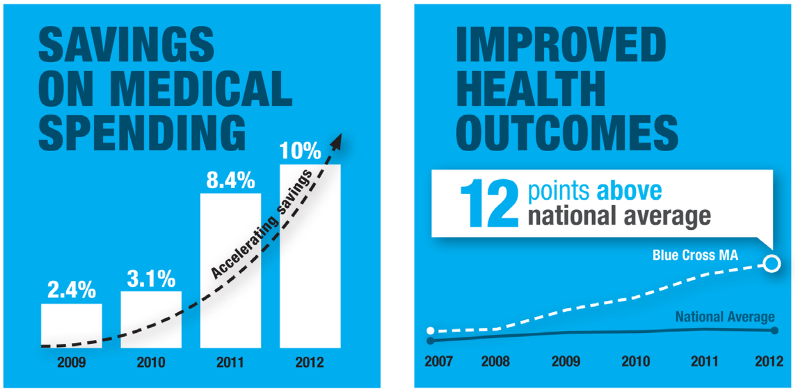
Harvard Study Shows Blue Cross Blue Shield of Massachusetts AQC Continues to Lower Medical Spending and Improve Quality

New findings by Harvard Medical School demonstrate that the Alternative Quality Contract (AQC) model is achieving its goals of improving the quality of patient care while slowing growth in medical spending, finding accelerating savings over four years of analysis. The AQC combines a global population-based budget with performance-incentive payments tied to nationally accepted, clinically important measures of quality, outcomes, and patient experience.

> "This rigorous evaluation of four years of data demonstrates that the AQC is achieving its twin goals of lower costs and better care for our members. These great results would not have been possible without the incredible effort, commitment and leadership of our physician and hospital partners."
>
> – Andrew Dreyfus, President and CEO,
> Blue Cross Blue Shield of Massachusetts

The Alternative Quality Contract (AQC), one of the largest private payment reform initiatives in the United States, is an innovative way to pay for care that focuses on promoting quality and rewards positive health outcomes. Introduced in 2008, it is a crucial component of our agenda to make quality health care affordable for our members and employer customers and is our predominant contract model with our network physicians and hospitals.

The *New England Journal of Medicine* study finds Blue Cross Blue Shield of Massachusetts' innovative payment model is improving patient care and lowering costs.



New Payment Model Redefining Health Care

The results from this multi-year study, published in The New England Journal of Medicine in October 2014, show even greater improvements in both cost and quality of patient care than was reported in the first years. Two earlier studies, conducted by the same Harvard team, found that, compared with a well-defined control group, AQC groups reduced medical spending by two percent in the first year and by more than three percent in the second. The 2014 study finds that the AQC gained even more momentum relative to a control group in years three and four, with savings accelerating to 10 percent by the last year (2012). The importance of the study design is that by having a control group, the study is able to isolate the effects that are uniquely due to the AQC from those that occurred in the environment overall. In other words, while trends locally and nationally were down, the AQC produced an additional effect—lower cost trends by an additional two percent in the first year and increasing to 10 percent in the fourth year. The study examined claims data from members whose primary care providers were in the AQC in Massachusetts compared to a control group of commercially-insured individuals across eight northeastern states (Connecticut, Maine, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island and Vermont).

Highlights of the Harvard Medical School study include the following:

- Cost savings among AQC groups grew from 2.4 percent in the first year to 10 percent by year four.
- Savings were concentrated in the outpatient setting and explained by both providers' increased use of lower-cost settings and their reduced use of unneeded tests, procedures and imaging.
- AQC groups' performance on quality and outcome measures increased over the study period, even as national average scores stagnated.
- AQC groups showed particular success at achieving positive health outcomes for patients with three of the most prevalent chronic conditions—diabetes, cardiovascular disease, and hypertension.

On a Path Toward Success

As of December 2014, our total AQC membership participation is 680,000 (87 percent of instate HMO members) with total AQC doctor participation at 5,547 primary care providers (88 percent of the in-state network) and 15,810 (89 percent of the in-state network) specialists.

> "The AQC has been transformative. It has allowed us to innovate because it enables us to think like a system rather than as an individual doctor or a small individual practice. It allows us to do things more efficiently and gives us the resources to implement programs that would be very difficult for small practices to do."
>
> – Leslie Sebba, MD, Medical Director,
> Northeast Physician Hospital Organization

For more information or a copy of the study, visit **www.bluecrossma.com**.

BRINGING THE CLINIC TO YOU AND YOUR FAMILY

Patients are often able to manage complex illness well over a period of years. Eventually it becomes more difficult to leave the house to see your doctors. Symptoms such as fatigue, breathlessness and pain increase. The ELEOS Program can help. An ELEOS Nurse Practitioner and/or Doctor can come to your home and, working closely with your regular doctors, help them continue to care for you at home even as your care becomes increasingly complex.

The right care,
At the right time,
In the right place.

ELEOS works in concert with primary care and subspecialty physicians to provide comprehensive, interdisciplinary care to patients and their families coping with advanced complex illness—in the care setting that many patients feel best meets their goals and values.

Ask your doctor if you would benefit from enrollment in the **ELEOS Program: a collaborative effort between Primary Care and Palliative Medicine.**

CONTACTING US

*An **Extra Layer of Support***
for you and your care team

For questions about the ELEOS program or to change the time of a previously scheduled visit by an ELEOS provider, please call our Administrative Office: **617.724.3344**

For all urgent medical questions or medical emergencies, please call your regular physician.

Subspecialty Palliative Medicine is covered by most insurance plans.

A FOUNDING MEMBER OF PARTNERS® HEALTHCARE

MASSACHUSETTS GENERAL HOSPITAL
PALLIATIVE CARE

The ELEOS Program

AN EXTRA LAYER OF SUPPORT FOR YOU AND YOUR CARE TEAM

ABOUT THE ELEOS PROGRAM

As common medical problems such as heart, lung or kidney disease, dementia or cancer become more advanced they become more difficult to manage. The future becomes less certain. Patient's goals change. Treatment options and benefits become more limited.

In these situations, patients and their doctors may benefit from the involvement of an ELEOS Advanced Practice Nurse Practitioner and/or Doctor certified in Palliative Medicine.

Specially trained to help care for patients with advanced illness and complex medical management needs, ELEOS clinicians work closely with your doctors and care team in creating the best care plan for you and your family.

And we do it all at home.

> *"All things are difficult before they are easy."*
>
> ~Thomas Fuller
> *(1608 - 1661)*

HOW WE CAN HELP BOTH YOU AND YOUR CARE TEAM AT HOME

- Improve your quality of life through advanced pain and symptom management.
- Clarify the complex benefits and burdens of the treatment options your doctors are able to offer and how they align with your goals and values.
- Develop a care plan that allows you to avoid exhausting hospital and emergency room visits.

WHAT TO EXPECT FROM ELEOS

Your doctor may ask us to visit you when it becomes more difficult for you to get to clinic, when your symptoms become more burdensome, or when the best plan of care at home becomes less certain.

Under the direction of your doctor, ELEOS clinicians provide clinical assessment and support to you and your family through our specialized home visit program. During our visits we assess pain and symptom management and clarify questions you may have regarding what to expect as your disease progresses. We can also help to coordinate your care among your different providers and help to communicate your goals and wishes for care to your family or other health professionals.

SNP Alliance

OCTOBER 2017

SNP Alliance Profile Briefing

Health Plans Specializing in the Care of High-Risk/High-Need Beneficiaries across the Nation

The SNP Alliance is a national membership organization dedicated to improving policy and practice of MA Special Needs Plans (SNPs) and Medicare-Medicaid Plans (MMPs). The SNP Alliance's 26 members serve over 1.3 million special needs individuals in 36 States and the District of Columbia.

SNPs

SNPs are a subset of Medicare Advantage (MA) plans specifically authorized and designed to meet special care needs of Medicare beneficiary sub-groups. The plan types and subgroups include:

- ***Chronic condition SNPs*** (C-SNPs): serving persons with certain severe or disabling chronic conditions (e.g., HIV-AIDS, chronic heart failure, COPD, mental illness, etc.).
- ***Institutional SNPs*** (I-SNPs): serving persons residing in nursing homes or with comparable care needs in the community.
- ***Dual eligible SNPs*** (D-SNPs): serving persons covered by both Medicare and Medicaid.
- ***Fully Integrated Dual Eligible SNPs*** (FIDESNPs) and ***Medicare-Medicaid Plans*** (MMPs) – which are a specific type of D-SNP and provide both Medicare and Medicaid benefits, including long-term services and support.

While SNPS are regulated, evaluated, and paid on the same basis as other MA plans, they are required to provide additional benefits and services to their target populations and to implement tailored care management according to unique Models of Care that serve every enrollee.

Since authorized by the *Medicare Modernization Act* of 2003, SNPs have grown substantially in number and enrollment. As of October 2017, a total of 583 SNPs had an enrollment of over 2.4 million beneficiaries. Total SNP enrollment has grown over 60% since 2010.

National SNP Plan # and Enrollment, October, 2017

SNP Type	# of Contracts	# of Plans	Enrollment
Chronic Condition SNPs	52	123	347,333
Dual Eligible SNPs (All types)	191	377	2,060,825
Institutional SNPs	41	83	68,255
TOTAL	**284**	**583**	**2,476,413**

Source: CMS SNP Comprehensive Report, October 2017

Plans working with states to integrate Medicare-Medicaid benefits for dually-eligible beneficiaries

SNP member plans provide extensive service to those who are dually-eligible for both Medicare and Medicaid.

These individuals may require community long- term services and supports, behavioral health services, and other assistance in order to have their complex needs addressed. The health plan works to integrate and coordinate the two separate programs — Medicare and Medicaid — each with different rules governing how plans and providers may interact with the beneficiary.

Profile of SNP Alliance

Each year, the SNP Alliance conducts an annual survey of its membership.[1] Respondents to the most recent survey represented three-fourths of Alliance members and about 1.1 million SNP enrollees (N=20).

There were 7 C-SNPs, 11 D-SNPs, 10 FIDE-SNPs, 6 I-SNPs, and 9 MMPs represented in the results. Key findings of this report indicate:

---

[1] 2016 SNP Alliance Survey data analysis by SNP Alliance, March, 2017.

- **Member SNPs serve unique subgroups of beneficiaries with more complex health and social issues:**
  - ***HCCs-*** looking at high cost, complex chronic conditions, SNP enrolled populations show a high rate of chronic conditions.
  - ***Risk Scores -*** Beneficiaries enrolled in these SNP plans had higher risk scores than in the general Medicare population.

SURVEY DATA POINTS ☑

- **D-SNPs** collectively reported **69%** of enrolled population had 1 or more HCCs and **33%** had 3 or more HCCs
- **C-SNPs** reported that **84%** of enrolled population had 1 or more HCCs and **40%** had 3 or more HCCs
- **D-SNPs** collectively reported **1.40** average risk score, while **FIDE-SNPs** reported **1.63** and **I-SNPs** reported **2.26** suggesting greater

  - ***Behavioral health/mental health conditions***- The enrolled population of the SNPs had much higher rates of behavioral and mental health conditions than the beneficiaries enrolled within all Medicare Advantage health plan products.[2]

SURVEY DATA POINTS ☑

- **38.8%** of the **I-SNP** enrollees in member plans had a major depressive, bipolar, or paranoid disorder compared to just **8.7%** of enrollees overall in MA plans (including SNPs)
- **7.6%** of enrollees in **C-SNPs** had drug or alcohol dependence compared to **2.2%** overall in MA plans (including SNPs).

  - ***Wide age variability-*** SNPs disproportionately serve the <u>*under 65*</u> Medicare subgroup population—individuals who are eligible for Medicare given their disability. For example, **43.9%** of the D-SNP plan enrollment was under 65, compared to just **16%** of all Medicare beneficiaries nationally.

Nationally about 18% of the Medicare population is dually-eligible for both Medicare & Medicaid. Most (70%) of these individuals are not in MA plans, but receive care through fee-for-service payments. However, within these member SNPs, from **33%** (C-SNPs) to **100%** (FIDE-SNPs) were dually-eligible.

- **SNP health plans are managing care despite having populations with high complexity and risk scores -- the great majority of whom are dually-eligible.**
  - Inpatient admissions were below expected, as compared to fee-for-service beneficiaries who are also dually-eligible.

- **SNP health plans observe significant social risk issues in their populations.**
  - Health plan care managers who conduct health risk assessments for individuals enrolled identified the top 5 social risk factors they observe:
    1. Low health literacy
    2. Poverty/low income status
    3. Lack of mental health services and supports to assist the member
    4. Lives alone or has few social supports
    5. Housing instability

One care manager explained:

> *A high proportion of our enrollees have mental health diagnoses. They are vulnerable to crises, especially when not compliant with medications--and one of the common indicators is they become difficult to reach - they are evicted from their apartment, kicked out or move out of a friend/family home, are confused or in a state of panic and their situation is unstable.*

- **SNP health plans noted challenges with the existing performance measures which are skewed to a healthier population (those without extensive social risk factors or behavioral health issues). Top concerns were:**
  1. Measures are not risk adjusted for socioeconomic status and social determinant of health risk factors, which are prevalent in the SNP population.
  2. Existing self-report surveys of beneficiaries are not translated (other than into Chinese and Spanish), nor do these survey methods accommodate those without access to a stable address or communication technology—therefore many individuals are left out of the survey sample.
  3. Measures are misaligned across providers and health plan—quality improvement is hampered.

---

[2] MedPAC June 2016 Data Book; Section 9 "Medicare Advantage." Figures include SNPs in calculations, therefore true comparison with general MA enrollment (non-SNP) would show even greater differences.

Bios

WORKSHOP SPEAKERS, MODERATORS, AND PLANNING COMMITTEE MEMBERS

Edo Banach, JD
National Hospice and Palliative Care Organization

Edo Banach is the president and CEO of National Hospice and Palliative Care Organization, the nation's oldest and largest, non-profit leadership organization working on behalf of hospice and palliative care providers and professionals.

Prior to joining NHPCO, Mr. Banach was a partner in the firm of Gallagher, Evelius & Jones in Baltimore, Maryland. Previously, he served as the Deputy Director of the Medicare-Medicaid Coordination Office at the Centers for Medicare & Medicaid Services. Before his leadership role at CMS, he served as Associate General Counsel at the Visiting Nurse Service of New York.

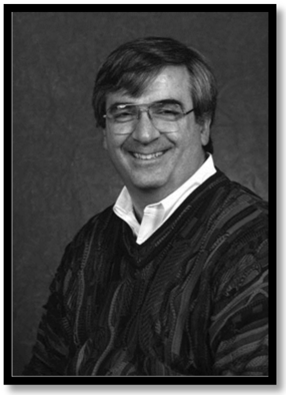
Mr. Banach holds a B.A. from Binghamton University and a J.D. from the University of Pennsylvania Law School. Before attending law school, Banach worked for the New York City Department of Homeless Services and Mayor's Office of Operations. Additional professional experience includes time as General Counsel at the Medicare Rights Center.

He was born in Israel, raised in New York City, and currently resides in Maryland with his wife and two children.

Ralph Bencivenga
Patient Caregiver Voice

Ralph P. Bencivenga served as help desk manager and education coordinator of Kramer Levin Naftalis & Frankel LLP in New York City from 2003 to 2008. In that position, he assisted the attorneys in the firm with the numerous work tickets assigned to cases and trained employees in his department. From 1968 to 2003, Ralph was the associate director of the Office of Technology of Merrill Lynch & Co, where he managed the help desk and desktop support. He received a BS degree from The City University of New York – Brooklyn College. He currently resides in New York City. Ralph was the sole caregiver to his wife Patricia while he himself simultaneously faced the challenges of serious illness.

Robert A. Bergamini, MD
Mercy Clinic Children's Cancer and Hematology
Supportive Care Coalition



Robert A. Bergamini has spent most of his 35-year career as a pediatric hematologist-oncologist, and from the beginning, included palliative care as a priority of his practice before the field was formally defined. This approach to whole person care provided a firm foundation for his current role as Mercy's ministry-level Medical Director for Palliative Care, which serves 39 hospitals and outpatient facilities/clinics across Missouri, Oklahoma, Arkansas and Kansas. He was appointed in 2013 to the Supportive Care Coalition's Board of Directors and is a member of the Coalition's Executive Committee. Following his Fellowship in Pediatric Hematology Oncology at St. Louis Children's Hospital, Washington University Department of Pediatrics, and serving as Clinical Instructor in Pediatrics at Washington University, in 1985 Dr. Bergamini entered private practice at Mercy St. Louis. Dr. Bergamini and his team established the first support group in the St. Louis area for siblings of children with cancer, and an educational support and intervention program to provide supplemental educational assistance and diagnostic testing. With the help of patients and staff, Friends of Kids with Cancer, a local charity was founded. Under Dr. Bergamini's leadership as Mercy's medical director of palliative care services, programs have started in three new communities and a pilot program is under way for palliative care and hospice care via telemedicine to meet the ministry's large rural population where density is less than six people per square mile. Mercy is in the final stages of obtaining accreditation for a palliative care fellowship and effective July 1, 2017, will have two positions available. Dr. Bergamini serves as the medical liaison to local faith-based communities. Initiatives include providing palliative care education for the Diocese of Little Rock and the Archdiocese of St. Louis. Dr. Bergamini is working with the Diocese of Little Rock on introduction of POLST legislation during the next session of the Arkansas legislature.

Pat Bomba, MD, FACP
Excellus BlueCross BlueShield

Patricia Bomba is a nationally-recognized expert who currently serves as the Vice President and Medical Director, Geriatrics for Excellus Health Plan, Inc. and subsidiaries of The Lifetime Healthcare Companies. In her current role, she serves as a geriatric consultant on projects and program development affecting seniors. She is a nationally recognized palliative care and end-of-life expert who designs and oversees the implementation of community projects. Prior to her work at Excellus Health Plan, Inc., she was engaged in private practice in Internal Medicine and Geriatrics in Rochester, New York. Dr. Bomba is New York State's representative on the National POLST Paradigm Task Force, a multistate collaborative. In addition to serving as a New York State Delegate to the White House Conference on Aging, she served as a member of the Review Committee of the National Quality

Forum's "Framework and Preferred Practices for a Palliative and Hospice Care Quality" project, chairs the BlueCross and BlueShield Association National Medical Management Forum and is a member of the Medical Society of the State of New York Ethics Committee. Dr. Bomba is passionately focused on educating the medical community, the public at large with a goal of improving the quality of life for seniors and their families. She has spoken extensively regionally, statewide and nationally to professionals, community groups and professional organizations on issues related to Palliative Care, Pain Management, Advance Care Planning, End-of-Life Care, Elder Abuse and Wellness and Healthy Living for the Older Adult. Dr. Bomba is author of several articles on issues related to palliative care, elder abuse and end-of-life concerns. She authors a bimonthly electronic newsletter dedicated to raising awareness of elder abuse and palliative care. Dr. Bomba earned a Bachelors degree from Immaculata College and graduated from the University of Virginia School Of Medicine. She completed her residency in Internal Medicine at the University of Rochester. Dr. Bomba holds board certification in Internal Medicine, with Added Qualifications in Geriatric Medicine. She attended the Executive Development Program at the Wharton Business School.

Jeanne Chirico, MPA
Lifetime Care

Jeanne Chirico, MPA is the Vice President of Community Services for Lifetime Care the region's largest Home Care and Hospice organization. Lifetime Care is leading the way in quality home care, Care Transitions, Hospice, and cutting edge telemedicine. Ms. Chirico is the Administrator responsible for the Lifetime Care Hospice and Palliative care program within Monroe, Wayne, and Seneca Counties as well as being the administrator for Home Care Plus, the Licensed Agency serving 19 counties in Upstate NY. Ms Chirico is also responsible for the implementation, management, and expansion of Care Transitions program sponsored by the Excellus BlueCross and BlueShield Company throughout Upstate NY and delivered to the RRHS patients carrying Excellus, Medicare Fee For Service or MVP insurance products to prevent 30-day readmissions. Ms Chirico has extensive experience in program development and assisted Rochester General Hospital in the design and implementation of the CHF Transitional Care program delivered within the hospital setting and continued at home and with physician coordination. Ms. Chirico has led many grass-root community initiatives including a major undertaking leading to the creation of a nationally recognized pediatric palliative care program CompassionNet.

Patrick Conway, MD
Blue Cross and Blue Shield of North Carolina

Patrick Conway, MD, MSc, joined Blue Cross and Blue Shield of North Carolina as president and CEO-elect on Oct. 1, 2017. He will succeed Brad Wilson as CEO at Wilson's retirement by the end of 2017.

Conway most recently served as Deputy Administrator for Innovation and Quality at the federal Centers for Medicare and Medicaid Services (CMS). In this role he also held the position of Director of the Center for Medicare and Medicaid Innovation (CMMI). As the most senior non-political leader at

CMS, he worked in both Republican and Democratic administrations and is considered one of the driving forces behind the national movement to value-based care, with health care payments tied to quality and innovation.
At Blue Cross NC, Conway is continuing that commitment to delivering the best health outcomes and best service experience at the lowest cost for customers. The company is a leader in improving North Carolina's health care system, making health care more affordable and working with doctors, hospitals and others to improve quality and value. Blue Cross NC strives to be a model health plan and health solutions company.

Conway joined CMS in 2011 as the agency's Chief Medical Officer and served as Principal Deputy Administrator and Acting Administrator. A respected leader, innovator and clinician, he was elected to the National Academy of Medicine (NAM) in 2014. Election to the NAM is considered one of the highest honors in the fields of health and medicine, recognizing individuals who have demonstrated outstanding professional achievement.

He is a practicing pediatric hospitalist and was selected as a master of hospital medicine from the Society of Hospital Medicine. Before joining CMS, he oversaw clinical operations and quality improvement at Cincinnati Children's Hospital Medical Center, with a focus on improving patient outcomes across the entire multi-billion dollar health system.

Conway completed his pediatrics residency at Harvard Medical School's Children's Hospital Boston, graduated with high honors from Baylor College of Medicine, and graduated summa cum laude from Texas A&M University. Additional honors include Presidential Rank Award, Distinguished Executive (president's highest executive honor), Health and Human Services Secretary's Award for Distinguished Service, White House Fellow, and Robert Wood Johnson Clinical Scholar.

David Debono, MD
Anthem, Inc.

David Debono completed internal medicine and hematology/oncology training at Indiana University in 1996. He practiced hematology/oncology at Presence St. Mary's Hospital in Kankakee, Illinois for 12 years. During that time, he was a hospice medical director and became board certified in Hospice and Palliative Medicine in 2003. For the past seven years he has practiced palliative medicine in an academic setting: the last three years at Karmanos Cancer Center: an NCI-designated comprehensive cancer center in Detroit, Michigan. Since 6/1/17, he has been the National Medical Director of Oncology for Anthem. He advocates for the Cancer Care Quality Program and is also closely involved in developing programs in palliative care for Anthem members.

Robert Fine, MD, FACP, FAAHPM
Baylor Scott & White Health

Robert Fine is the founder and leader of both the Clinical Ethics Service (1985) and the AHA award winning Supportive/Palliative Care Service (2004) at Baylor Scott and White Health, the largest not-for-profit health care system in Texas. He is a member of the Editorial Board of the Journal of Pain and Symptom Management and co-chairs the Policy Subcommittee of the Texas Palliative Care Interdisciplinary Advisory Committee. He has previously served on the National Quality Forum Committee on Palliative and End of Life Care, the Ethics Committee of AAHPM, the Corporate Ethics Committee of VITAS Hospice, and the Steering Committee on Palliative Care for the Coalition to Transform Advanced Care (C-TAC). He served as the lead physician author of the Texas Advance Directives Act (1999) and is the recipient of numerous civic leadership awards in Texas.

Stephen Friedhoff, MD
Anthem, Inc.

Stephen G. Friedhoff is the Senior Vice President of the Clinical Strategy and Programs Department for Anthem. Prior to his current position, Dr. Friedhoff held a similar role with Amerigroup Corporation prior to Amerigroup's acquisition by Anthem. He has held several clinical and administrative positions over the course of his career. At Independence Blue Cross/AmeriHealth-New Jersey in Philadelphia, Pa., he assumed progressive responsibility including senior/regional medical director. He was also medical director with Health Net of the Northeast (formerly Qualmed Health Plans) in Philadelphia, Pa. and clinical faculty and medical director in the Virtua Family Medicine Residency Program, at Virtua Memorial Hospital in Mount Holly, N.J. He continued to practice Family Medicine in NJ part time until 2014. Dr. Friedhoff obtained his undergraduate degree at Rensselaer Polytechnic Institute in Troy, N.Y., summa cum laude, and his medical degree at the Rutgers–New Jersey Medical School in Newark, N.J. He completed his family medicine residency at Virtua Memorial Hospital in Mount Holly, N.J., where he served as chief resident and was the recipient of the New Jersey Resident of the Year Award by the New Jersey Academy of Family Physicians. Dr. Friedhoff is a certified health insurance executive through America's Health Insurance Plans, a diplomat of the American Academy of Family Physicians and board certified by the American Board of Family Medicine. He holds active medical licenses in New Jersey, Florida, Kansas, Iowa and Louisiana. Dr. Friedhoff has also served on the board of trustees of Samaritan Hospice in Marlton, N.J. and was a recipient of the "Home Care Physician of The Year" award in southern New Jersey.

Mark Ganz
Cambia Health Solutions

Mark B. Ganz, is President and Chief Executive Officer of Cambia Health Solutions. Mark has been a change agent in the ever-evolving health care community his entire life, and health care system transformation has become his personal passion and professional cause. The son of a Spokane, Washington, physician, Mark spent many childhood afternoons at his father's family practice learning the importance of service, community and family. Transforming the way people experience health care is the cornerstone of his vision for the industry and Cambia. Since taking the top post in 2003, he has guided the company along a path of re-imagining and reshaping the health care system to one that is accountable to individuals and families. Mark has led the charge to make the system more affordable, understandable, and economically sustainable. At Cambia, that means nourishing game-changing companies such as HealthSparq, while delivering on the promise built over 95 years as a trusted health plan. Mark has an extraordinary record of involvement regionally and on the national stage, including as chairman of the board for America's Health Insurance Plans. Mark also serves on the board of directors for the following organizations: Portland General Electric Company; Oregon Business Council (also executive committee member); Greater Portland Inc, a regional economic development corporation; Blue Cross and Blue Shield Association; University of Portland Board of Regents; Boy Scouts of America-Cascade Pacific Council; Jesuit High School; and The Conversation Project. In 2013, he was honored with a Governors' Gold Award for his lifetime contributions to the state of Oregon in the areas of health care, economic development and leadership through community service. Mark's commitment to community was also recognized when he was inducted into the Gonzaga Preparatory School Hall of Fame along with his brothers, Rick and Bill. In 2015, the National Eagle Scout Association awarded Mark the Distinguished Eagle Scout Award (DESA) for his tremendous commitment and leadership within the community and health care industry. Recognition of Mark's groundbreaking work to personalize health care led Portland Business Journal to name him Healthcare CEO of the Year for 2014. Mark earned both his undergraduate and law degrees from Georgetown University in Washington, D.C. While an undergraduate, he was a staff member for U.S. Senator Henry M. "Scoop" Jackson (D-Wash).

Lee Goldberg, JD
The Pew Charitable Trusts

Lee Goldberg is Project Director, Improving End-of-Life Care Project, at The Pew Charitable Trusts. Lee Goldberg works to advance policies that help people receive high-quality health care near the end of their lives. Before coming to Pew, Goldberg was vice president for health policy at the National Academy of Social Insurance, where he wrote extensively on options for addressing the financing of long-term supports and services, the development of health insurance exchanges under the Affordable Care Act, and the impact of hospital consolidation on health care markets. Goldberg received a master's degree in international economics and international relations from Johns Hopkins

University's School of Advanced International Studies and a law degree from George Washington University. He is a member of the California bar.

Anna Gosline, MPH
Blue Cross Blue Shield of Massachusetts

Anna Gosline serves as the Senior Director of Health Policy and Strategic Initiatives in the Executive Office of Blue Cross Blue Shield of Massachusetts. She manages and coordinates policy and communications projects, including those on payment and delivery system reform, health coverage reform, and health care cost containment. She also manages the development of company initiatives on serious illness and palliative care. Previously, Anna was the Director of Policy and Research at the Blue Cross Blue Shield of Massachusetts Foundation where she oversaw the Foundation's policy and research project portfolio. Before joining the Foundation, she managed a large-scale health system study for the state of Vermont. In a previous life, Anna was a health care journalist in the UK and Canada. Anna holds a master's degree in health policy and management from the Harvard School of Public Health, a graduate certificate in science writing from the University of California, Santa Cruz and a bachelor's degree from the University of Toronto.

Julian Harris, MD, MBA
CareAllies

Julian Harris is President of CareAllies, a Cigna Company and a Fellow with the Harvard Kennedy School Healthcare Policy Program. CareAllies is an innovative population health management services company focused on helping physician groups and delivery systems navigate the transition to value-based care. Dr. Harris joined Cigna in 2015 as Senior Vice President of Strategic Operations to optimize the company's approach to multi-year planning and internal investments and to accelerate the company's delivery of value-based solutions in local markets. He launched and became President of CareAllies in 2016.

Prior to Cigna, Dr. Harris served as the Associate Director for Health in the White House Office of Management and Budget (OMB). As the federal government's chief health care budget official, he oversaw $1 trillion in spending and policy for a range of coverage programs, including Medicare, Medicaid, Marketplaces, and the CMS Innovation Center. Dr. Harris led OMB's engagement and oversight of agencies on initiatives as diverse as developing new CMS Medicare ACO and bundled payment models, replacing the SGR with MACRA, and launching the President's precision medicine initiative.

During his time as the chief executive of the then $11 billion Medicaid program in Massachusetts, Dr. Harris led the development of a primary care-centered ACO program and built value-based payment into the country's first Medicare-Medicaid duals demonstration. He has also advised providers and investors on innovative approaches to navigating and supporting the transition to value-based payment.

Dr. Harris trained in internal medicine and primary care at Harvard Medical School's Brigham & Women's Hospital, and he worked as a hospitalist at Cambridge Health Alliance. He graduated with a bachelor's degree in Health Policy & Medical Ethics from Duke University, and he holds a Master of Science degree from Oxford University, where he studied as a Rhodes Scholar. He is also a graduate of the Health Care Management MBA Program at the Wharton School of Business and the School of Medicine at University of Pennsylvania.

Ziad Haydar, MD, MBA
Ascension Health

Ziad R. Haydar is Ascension Health Senior Vice President and Chief Clinical Officer. Dr. Haydar leads all care excellence operations towards the quadruple aim of ideal clinical outcomes, ideal patient experience, ideal provider experience, at lowest possible cost. In addition, DR Haydar has the responsibility for the creation and the performance of Ascension Medical Group, a physician and provider organization that comprises around 7,000 providers. Dr. Haydar has served in Ascension Health since 2010 when he started as Vice President for Clinical Excellence and Physician Integration. His role changed to Chief Medical Officer in 2012, and to Chief Clinical Officer in 2015. Prior to 2010, Dr. Haydar was an executive with Baylor Health Care System in Dallas Texas. He received his M.D. degree from American University in Beirut, trained in Family Medicine at the Medical University of South Carolina, completed a fellowship in Geriatrics and Gerontology at Johns Hopkins University School of Medicine, and obtained an MBA from the Cox School of Business at the Southern Methodist University.

Haiden Huskamp, PhD
Harvard Medical School

Haiden Huskamp is a health economist and 30th Anniversary Professor of Health Care Policy at Harvard Medical School. Dr. Huskamp has three primary areas of research: 1) the financing and utilization of end-of-life care services; 2) mental health and substance use disorder policy; and 3) prescription drug policy. Dr. Huskamp's research on end-of-life care has examined the changing characteristics of the hospice industry and the effects of industry changes on the provision of end-of-life care, the timing of discussions about hospice care that occur between physicians and patients, and patient-level variation in hospice costs. She served on the Centers for Medicare and Medicaid Services Technical Expert Panel for Hospice Payment Reform and on the Institute of Medicine Committee on Care for Children Who Die and Their Families. Dr. Huskamp recently authored a paper on the financing of end-of-life care services published in the Institute of Medicine report "Dying in America."

Vicki Jackson, MD, MPH
Massachusetts General Hospital

Vicki Jackson is the Chief, Division of Palliative Care and Geriatric Medicine at Massachusetts General Hospital and Associate Professor, Department of Medicine, Harvard Medical School. She also serves as the Co-Director of the Harvard Medical School Center for Palliative Care. She was the former Fellowship Director for the Harvard Palliative Medicine Fellowship. She completed residency and chief residency in Internal Medicine at The Cambridge Hospital, Harvard Medical School. She pursued training in research methods through the Harvard General Medicine Fellowship and completed a Master's in Public Health at The Harvard School of Public Health. She completed training in palliative care at The Dana-Farber Cancer Institute and Brigham and Women's Hospital. She joined the faculty of Massachusetts General Hospital in 2002. She pursued further research training in the Program for Cancer Outcomes Training. She was selected in 2003 for the Harvard Academy Education Fellowship where her work focused on the development of end of life medical and communication curriculum which was the basis for the curriculum for the Harvard Palliative Medicine Fellowship. In 2009, she was selected as the Rabkin Fellow in Medical Education at The Beth Israel Hospital.

Currently, she is the Palliative Care lead investigator and mentor on several studies funded through NIH, NCI, and NCCN investigating the effect of early ambulatory palliative care for patients with advanced cancer. In 2015, she worked with hospital leadership to develop the Palliative Care Continuum Project which seeks to disseminate excellent palliative care for seriously ill patients at MGH through patient engagement, comprehensive advance care planning, and primary palliative care education for clinicians. Nationally she served as Co-Chair for an innovative 3 year academic leadership training program for junior palliative medicine faculty and currently serves as member of the Board for the American Academy of Hospice and Palliative Medicine. She also served as the Co-Editor for a series devoted to the clinician-educator in The Journal of Palliative Medicine. She is the co-author of the book Living with Cancer: A step by step guide to coping medically and emotionally with a serious diagnosis published by Johns Hopkins University Press. Her work has been featured in the New York Times, Boston Globe, and on National Public Radio, and ABC World News Tonight.

Gregory James, DO, MPH, CMD
OptumCare

Gregory James is the Senior Medical Director for OPTUMCare for the Central Region of the United States. This position has clinical and quality oversight responsibility for Post-Acute and Long Term Care (Nursing Home) Patients enrolled with UnitedHealthcare Plans in six states. He has been in this position since the Fall of 2016. He had been the Senior Medical Director for the State of Florida for OPTUMCare for seven years prior to that.

Dr. James was a finalist for the Medical Director of the Year for National AMDA in March 2014. He is board certified and recertified in Family Medicine, Geriatrics, in Post-Acute and Long Term Care for Nursing Facility Patients (ABPLM).

Dr. James had been the Director of the Family Medicine Residency Program at St. Petersburg General Hospital (St. Petersburg, FL), for five years, and the Director of the Sun Coast Hospital Family Medicine Residency (Largo, FL) for eight years prior to that.

Dr. James has been a Director and an Officer, for the American Osteopathic Board of Family Physicians (AOBFP), the certification board for Osteopathic Family Physicians. He currently serves the American Osteopathic Association (AOA) as a Florida member to the annual House of Delegates, and has done so for the last 15 consecutive years. He has previously served the AOA on their Council on Post-Doctoral Training (COPT) and Commission on Osteopathic College Accreditation (COCA). In 2006, he was voted Educator of the Year by the Florida Society of the ACOFP; and in 2013, the Educator of the Year for the National ACOFP. At Sun Coast Hospital, he received the Outstanding Clinical Instructor Award three times and the Outstanding Lecturer Award twice. Dr James is a Distinguished Fellow for the ACOFP.

Dr. James received his Doctor of Osteopathic Medicine (DO), as well as his Masters in Public Health (MPH), from the Nova Southeastern University, College of Osteopathic Medicine in Ft Lauderdale, FL. He served NSU/COM as their Alumni President in 2007, and was voted the Alumnus of the Year in 2004. That same year he was also a finalist for the outstanding Alumnus Award for all of Nova Southeastern University.

Dr James completed a three-year residency in Family Medicine at Sun Coast Hospital in Largo, FL. He is a recent Past President of the Florida Osteopathic Medical Association (FOMA).
This organization represents all Osteopathic Physicians (DO’s), in the state of Florida.

Shari Ling, MD
Centers for Medicare & Medicaid Services

Dr. Shari M. Ling is currently the Centers for Medicare & Medicaid Services (CMS), Deputy Chief Medical Officer serving in the Center for Clinical Standards and Quality (CCSQ), responsible for assisting the CMS Chief Medical Officer in the Agency's pursuit of higher quality health care, healthier populations, and lower cost through quality improvement. Dr. Ling long-standing focus is on the achievement of meaningful health outcomes through delivery of high quality beneficiary-centered care across all care settings, with a special interest in the care of persons with multiple chronic conditions and functional limitations, and reducing health disparities. Dr. Ling has served as the lead coordinator and facilitator of the CCSQ Measures Forum. Dr. Ling represents CMS on the Health and Human Services (HHS) Multiple Chronic Conditions workgroup, and the National Quality Forum Measures Application Partnership Post-acute Care/Long-term Care workgroup, and chairs the Measures and Data sources sub-workgroup for the HHS Action Plan for Healthcare Associated Infection (HAI) Prevention in Long-term Care facilities. Dr. Ling also serves as the clinical sub-group lead for the HHS National Alzheimer's Project Act.

Dr. Ling is a Geriatrician and Rheumatologist who received her medical training at Georgetown University School of Medicine where she graduated as a member of the Alpha Omega Alpha Honor Society. Dr. Ling received her clinical training in Internal Medicine and Rheumatology at Georgetown University Medical Center, and completed Geriatric Medicine studies at Johns Hopkins University. She remained on faculty at Johns Hopkins for 5 years, after which she joined the Intramural Research Program of the National Institutes of Health at the National Institute on Aging as a Staff Clinician for 8 years studying human aging and age-associated chronic diseases with attention to musculoskeletal conditions and mobility function. Dr. Ling continues to serve as a part-time faculty member in the Division of Geriatric Medicine and Gerontology at Johns Hopkins University School of Medicine, and in the Division of Rheumatology, Allergy and Clinical Immunology at the University of Maryland. Dr. Ling volunteers at the Veterans Administration Medical Center in Baltimore. She is a Gerontologist who received her training in Direct Service from the Ethel Percy Andrus Gerontology Center, at the University of Southern California, and served as the co-director of the Andrus Older Adult Counseling Center.

Joanne Lynn, MD, MA, MS
Altarum Institute

Joanne Lynn is Director of Altarum Institute's Center for Elder Care and Advanced Illness, which aims to ensure that frail elderly Americans can live meaningfully and comfortably at sustainable costs. She is a geriatrician, hospice physician, health services researchers, quality improvement advisor and coach, and policy advocate. The work includes implementing and measuring care plans, developing methods for counties and cities to monitor and manage frail elder care, coaching counties and cities, and developing support for caregivers. The reform model comes together as MediCaring Communities, summarized in a book available on Amazon. As part of engineering reform, the Center for Elder Care and Advanced Illness has led a project to get caregiver issues onto party platforms in both parties in all of the states, with substantial success, and also worked with many groups to gather a Forum just after the election to move along the process of demanding improvements. Dr. Lynn has been a tenured professor at Dartmouth and George Washington University, a staff member at CMS, the Bureau Chief for Cancer and Chronic Disease for Washington (DC), a researcher at RAND, and on IHI's quality improvement faculty. She is a member of the Institute of Medicine, a Master of the American College of Physicians, a Fellow of the Hastings Institute, and an author of more than 280 peer-reviewed publications, 80 books and chapters, and a dozen amicus briefs and publications for public commissions. Her book, Handbook for Mortals, is widely used to guide patients and families through serious illness and death.

Diane E. Meier, MD, FACP
Center to Advance Palliative Care
Icahn School of Medicine at Mount Sinai

Dr. Diane E. Meier is Director of the Center to Advance Palliative Care (CAPC), a national organization devoted to increasing the number and quality of palliative care programs in the United States. Under her leadership the number of palliative care programs in U.S. hospitals has more than tripled in the last 10 years. She is also Vice-Chair for Public Policy and Professor of Geriatrics and Palliative Medicine; Catherine Gaisman Professor of Medical Ethics; and was the founder and Director of the Hertzberg Palliative Care Institute from 1997-2011, all at the Icahn School of Medicine at Mount Sinai in New York City. Dr. Meier is the recipient of numerous awards, including the 2008 MacArthur Fellowship. She was named one of 20 People Who Make Healthcare Better in the U.S. by *HealthLeaders Media* 2010 and received an Honorary Doctorate of Science from Oberlin College in 2010. In 2012, she was awarded American Cancer Society's Medal of Honor for Cancer Control in recognition of her pioneering leadership of the effort to bring non-hospice palliative care into mainstream medicine. Other honors include the Open Society Institute Faculty Scholar's Award of the Project on Death in America, the Founders Award of the National Hospice and Palliative Care Organization 2007, AARP's 50th Anniversary Social Impact Award 2008, Castle Connelly's Physician of the Year Award 2009 and the American Academy of Hospice and Palliative Medicine Lifetime Achievement Award 2009. Dr. Meier served as one of Columbia University's Health and Aging Policy Fellows in Washington, DC during the 2009-2010 academic year, working both on the Senate's HELP Committee and the Department of Health and Human Services. Dr. Meier has published more than 200 original peer review papers, and several books. Her most recent book, *Meeting the Needs of Older Adults with Serious Illness: Challenges and Opportunities in the Age of Health Care Reform*, was published by Humana in 2014. She edited the first textbook on geriatric palliative care, as well as four editions of *Geriatric Medicine*. Diane E. Meier received her BA from Oberlin College and her MD from Northwestern University Medical School. She completed her residency and fellowship training at Oregon Health Sciences University in Portland. She has been on the faculty of the Department of Geriatrics and Palliative Medicine and Department of Medicine at Mount Sinai since 1983. She lives in New York City.

James Mittelberger, MD, MPH, FACP, FAAHPM
Optum UnitedHealth Group

James Mittelberger, M.D., M.P.H., FACP, FAAHPM, was Director and Chief Medical Officer for the Optum Center for Palliative and Supportive Care through July 2017, responsible for guiding development of programs to improve serious illness care across Optum. Previously Dr. Mittelberger was national CMO at Optum Palliative and Hospice Care and West Region CMO at UnitedHealth Group/Ovations. Prior to UnitedHealth Group, Dr. Mittelberger spent more than 20 years as a geriatrician, palliative care physician and educator as Chief of the Division of Geriatrics (and Palliative Care) at the Alameda County Medical Center and as medical director of the Over 60s Clinic, a community health center. Selected leadership roles include founding board member and chair of a Public HMO (The Alameda

Alliance for Health,) Chair of California state POLST Task force, co-founder and president of a multi-specialty medical group (OakCare Medical Group,) and President of the California Association for Long Term Care Medicine. Dr. Mittelberger is board certified in internal medicine, geriatrics, and hospice and palliative medicine. He completed his BA at Brown University, MD at UC San Diego School of Medicine, Internal Medicine residency at the University of Washington, a faculty development fellowship in ethics and quality improvement, MPH at the University of Washington School of Public Health, and a health care leadership fellowship at the California HealthCare Foundation. He is a Clinical Professor of Medicine at the UCSF School of Medicine.

Harold Paz, MD, MS
Aetna

Harold L. Paz, M.D., M.S., is executive vice president and chief medical officer for Aetna. He leads clinical strategy and policy at the intersection of all of Aetna's domestic and global businesses. He is responsible for driving clinical innovation to improve member experience, quality and cost in all areas of the health care delivery system. Reporting to Aetna's Chairman and CEO, he is a member of the company's executive committee.

Before joining Aetna in 2014, Dr. Paz served as chief executive officer of Penn State Hershey Medical Center and Health System, senior vice president for Health Affairs for Penn State University, dean of its College of Medicine and professor of medicine and public health sciences for eight years. His vision for health care transformation at Penn State led to the formation of an integrated healthcare system of four hospitals, 64 ambulatory care practices and 18 affiliated hospitals focused on population health across central Pennsylvania. Prior to his appointment to Penn State, he spent 11 years as dean of the Robert Wood Johnson Medical School and chief executive officer of Robert Wood Johnson University Medical Group, the largest multispecialty group practice in New Jersey where he was professor of medicine.

Dr. Paz has focused his research and teaching on clinical outcomes, health care effectiveness and personalized health. A pioneer in the field of quality management, Dr. Paz was among the first to study clinical outcomes in the intensive care unit. From this early work, he recognized the need to formally train physicians in quality, and in 1993 he started the first fellowship of its kind in quality management. Currently, he is professor adjunct of internal medicine at Yale University School of Medicine and remains clinically active in pulmonary medicine at the West Haven Veterans Administration Hospital. He serves on the National Academy of Medicine (NAM) Leadership Consortium and the NAM Roundtable on Quality Care for People with Advanced Illness.

A fellow of the American College of Physicians and the American College of Chest Physicians, Dr. Paz is currently on the boards of Select Medical Corporation, United Surgical Partners International, Research!America and the National Health Council. Dr. Paz is past chair of the Board of Directors of the Association of Academic Health Centers and a former member of the Association of American Medical Colleges (AAMC) and the University Health System Consortium boards of directors. He previously was chair of the AAMC Council of Deans administrative board and has served on the AAMC executive council, in addition to corporate and scientific advisory boards in the biotechnology field. He has authored over 100 publications, including peer-reviewed research and quality articles, chapters, commentaries and abstracts. He is the recipient of numerous awards and an honorary degree.

Dr. Paz received his bachelor's degree from the University of Rochester, a master of science in life science engineering from Tufts University, and his medical degree from the University of Rochester School of Medicine and Dentistry. He completed his residency at Northwestern University, where he served as chief medical resident and instructor in clinical medicine. He was a Eudowood Fellow in pulmonary and critical care medicine at Johns Hopkins Medical School. In addition, he was a post-doctoral fellow in environmental health science at Johns Hopkins School of Hygiene and Public Health.

Sharon Scribner Pearce
National Hospice and Palliative Care Organization

Sharon Scribner Pearce has served as the Vice President for Public Policy at the National Hospice and Palliative Care Organization (NHPCO) since 2015. In that role, Sharon serves as the primary liaison between Capitol Hill and the NHPCO leadership and membership; manages the day-to-day operations of the NHPCO Hospice Action Network (HAN); leads a dynamic team of policy professionals; and coordinates advocacy and policy work across the department and organization. Sharon arrived at NHPCO with almost 20 years of health policy experience, including six years advising members of Congress on Capitol Hill, five years as a hired-gun lobbyist at a large K Street firm, and seven years as in-house lobbyists at the National PACE Association and Girl Scouts of the USA.

Cheryl Phillips, MD
SNP Alliance, Inc.

Cheryl Phillips, is President and Chief Executive Officer for the SNP Alliance, a national non-profit association of special needs and managed Medicaid plans to serve vulnerable adults with complex care needs. Prior to this she served as the Senior Vice President for Public Policy and Health Services at LeadingAge in Washington, DC. Dr. Phillips was the Chief Medical Officer of On Lok Lifeways, the originator of the PACE (Program of All-Inclusive care for the Elderly) model based in San Francisco, California from 2007 – 2011. She has also served as the Medical Director for Senior Services and Chronic Disease Management for the Sutter Health System, a network of doctors, hospitals and other health providers in Northern California. Dr. Phillips is a past President of the American Geriatrics Society, the organization representing health care professionals committed to improving the health of America's seniors; and is also a past President of the American Medical Directors Association, the physician organization for long-term care.

In addition to serving on The SCAN Foundation Board, Dr. Phillips serves on the Board of Directors for Ascension Senior Living. She has also served on multiple national boards and advisory groups for chronic care including the CMS Quality Assurance and Process Improvement (QAPI) Technical

Expert Panel in Long Term Care, the National Quality Forum MAP Coordinating Committee, several Expert Panels for Long Term Service and Support Measures, and has provided multiple testimonies to the U.S. Senate Special Committee on Aging. She served as a primary care health policy Fellow under Secretary Tommy Thompson, and was appointed by the Governor as a California Commissioner on Aging and appointed to the Olmstead Advisory Committee for California. Dr. Phillips is a past Co-Chair of Advancing Excellence, the campaign for quality improvement in nursing homes.

Richard Popiel, MD
Cambia Health Solutions

Dr. Richard Popiel serves as Executive Vice President and Chief Medical Officer for Cambia Health Solutions. As a member of the company's senior executive leadership team, he is responsible for the company's clinical strategy with the goal to improve members outcomes and the experience they have as health care consumers. Dr. Popiel's responsibilities include oversight for all medical, pharmacy and network activities, as well as all cost stewardship activities. Dr. Popiel is a nationally recognized health care delivery expert and thought leader coming to Cambia from Horizon Healthcare Innovations, a Horizon Blue Cross Blue Shield of New Jersey company, where he was President and Chief Operating Officer. Prior to that, he served as Horizon's Vice President and Chief Medical Officer and as Vice President/Senior Medical Director for The Permanente Company, a subsidiary of Kaiser Permanente.

Active in professional organizations advancing consumer-focused health care issues, Dr. Popiel chairs the National Council of Physician and Pharmacy Executives, a Blue Cross and Blue Shield Association council comprising chief medical and chief pharmacy officers. He also leads the Chief Medical Officer Leadership Group at America's Health Insurance Plans (AHIP) and serves on the AHIP board of directors. Additionally, Dr. Popiel serves as a member of the Board of Directors of The George Washington University's Medical Faculty Associates. Previously he served as a member of the Board of Advisors of The George Washington University's School of Medicine. His philanthropic activities include board membership for the George Washington University Alumni, where he has also been honored as an Outstanding Alumnus. In addition, he is currently the Vice Chair of the Classic Wine Auction, supporting five non-profit partners benefitting children and families.

Dr. Popiel earned a B.S. in biology and his M.D. at The George Washington University in Washington, D.C. He completed residency training at both the George Washington University Hospital and the Georgetown University Hospital in Internal Medicine and Emergency Medicine. He completed a toxicology fellowship at the University of Illinois. He is board certified in Internal Medicine. Dr. Popiel also holds a Master of Business Administration from Northwestern University Kellogg School of Management.

Phil Roe, MD
Chairman, House Committee on Veterans Affairs

Phil Roe represents the First Congressional District of Tennessee. A resident of Johnson City serving his fifth term in Congress, Phil has a strong work ethic and is committed to working on behalf of the First District, Tennessee and our nation.

A native of Tennessee, Phil was born on July 21, 1945 in Clarksville. He earned a degree in Biology with a minor in Chemistry from Austin Peay State University in 1967 and went on and to earn his Medical Degree from the University of Tennessee in 1970. Upon graduation, he served two years in the United States Army Medical Corps.

Congressman Roe is Chairman of the House Committee on Veterans' Affairs. Additionally, he serves on the House Education and Workforce Committee.

As a physician, Congressman Roe has become an active player in the effort to reform our nation's health care system. He is the co-chair of the House GOP Doctors Caucus and a member of the Health Caucus.

Prior to serving in Congress, Phil served as the Mayor of Johnson City from 2007 to 2009 and Vice Mayor from 2003 to 2007. He ran a successful medical practice in Johnson City for 31 years, delivering close to 5,000 babies. Phil has three children - David C. Roe, John Roe, and Whitney Larkin - and is a proud grandfather. He is a member of Munsey United Methodist Church.

Bethann Scarborough, MD
Icahn School of Medicine at Mount Sinai

Bethann Scarborough, is an Assistant Professor of Palliative Medicine and Associate Director Ambulatory Palliative Care at Mount Sinai. She received her undergraduate degree from the Pennsylvania State University and medical degree from the University of Virginia School of Medicine. She completed a residency in Internal Medicine at Yale New Haven Hospital and went on to complete a Palliative Medicine fellowship at the Mount Sinai School of Medicine.

As Associate Director of Ambulatory Services, she oversees the administrative and operational aspects of the outpatient palliative medicine practices at Mount Sinai, and has spoken nationally on process of creating a successful outpatient palliative medicine practice. Her clinical work focuses on providing palliative care concurrently with oncologic care within the Tisch Cancer Institute at Mount Sinai, where she built a robust outpatient embedded Supportive Oncology practice. She is particularly interested in fostering relationships that promote co-management of patients with serious illnesses while providing the framework needed for ongoing, interdisciplinary advanced care planning discussions.

Leonard D. Schaeffer
University of Southern California
Chair, Roundtable on Quality Care for People with Serious Illness

Leonard D. Schaeffer is the founding Chairman & CEO of WellPoint, the nation's largest health benefits company by membership. WellPoint (now Anthem) serves nearly 39 million medical members and has annualized revenues of $78.4 billion. He is currently the Judge Robert Maclay Widney Chair and Professor at the University of Southern California and is a Senior Advisor to TPG Capital, a private equity firm. Schaeffer was Chairman & CEO of WellPoint from 1992 through 2004 and continued to serve as Chairman through 2005. Under his leadership, WellPoint was selected by FORTUNE magazine as America's "Most Admired Health Care Company" for six consecutive years; named by BusinessWeek as one of the 50 best performing public companies for three consecutive years; and identified by Forbes magazine as America's best large health insurance company. Schaeffer was selected by BusinessWeek magazine as one of the "Top 25 Managers of the Year" and by Worth magazine as one of the "50 Best CEOs in America." In 1986, Schaeffer was recruited as CEO to WellPoint's predecessor company, Blue Cross of California, when it was near bankruptcy. He managed the turnaround of Blue Cross of California and the IPO creating WellPoint in 1993. During his tenure, WellPoint made 17 acquisitions and endowed four charitable foundations with assets of over $6 billion. Under Schaeffer's leadership, WellPoint's value grew from $11 million to over $49 billion. In 2009, Schaeffer established a new research center at USC. The *Schaeffer Center for Health Policy and Economics* emphasizes an interdisciplinary approach to research and analysis to promote health and value in health care delivery and to support evidence-based health policy. He has also endowed chairs in health care financing and policy at The Brookings Institution, Harvard Medical School, the National Academy of Medicine, U.C. Berkeley and USC.

Previously, Schaeffer was President and CEO of Group Health, Inc. of Minnesota, a staff model HMO. Schaeffer was also EVP and COO of the Student Loan Marketing Association, the national secondary market for student loans and earlier was a Vice President of Citibank and a consultant specializing in design and installation of large scale financial and management information systems. In the federal government, he served as Administrator of the Health Care Financing Administration (now CMS) and was responsible for the U.S. Medicare and Medicaid programs. He was also the Assistant Secretary for Management and Budget of the federal Department of Health and Human Services. Previously, Schaeffer was Director of the Bureau of the Budget for the State of Illinois and also served as Chairman of the Illinois Capital Development Board and as Deputy Director for Management, Illinois Department of Mental Health and Developmental Disabilities. Schaeffer is active on the boards of numerous businesses, philanthropic and professional organizations. He was awarded a Doctor of Humane Letters (Hon) from USC and received the inaugural USC Sol Price Award for his lifetime achievements as a business leader, policy expert and philanthropist. He was the Regent's Lecturer at the University of California at Berkeley, a Gilbert Fellow at Princeton, and a Williams Fellow at RAND. He is a member of the National Academy of Medicine (NAM) of the National Academies. A native of Evanston, Illinois, he is a graduate of Princeton University.

Allison Silvers, MBA
Centers to Advance Palliative Care

Allison Silvers is Vice President for Payment and Policy at the Center to Advance Palliative Care (CAPC). In this role, Ms. Silvers educates health plans, policymakers, and health systems on the value of palliative care and strategies for ensuring access for people with serious illness. She leads the development of CAPC's new "Payment Accelerator" to support palliative care programs as they pursue value-based payment, and works with national health plan leadership to define best practices in palliative care access and payment.

Prior to joining CAPC, she served as the Chief Strategy Officer for VillageCare, where she oversaw a CMS Innovation Award to improve treatment adherence for people living with HIV/AIDS, along with leading a Medicare Bundled Payment for Care Improvement initiative for post-acute services. In previous roles at VillageCare, she secured Patient-Centered Medical Home (PCMH) Level III accreditation for a primary care center and directed community case management programs that aimed to reduce morbidity and disability among isolated seniors.

Ms. Silvers has also helped launch two health insurance programs: a Medicaid managed long-term care plan and a start-up commercial plan offered on the New York State marketplace. She has served as the long-term care subject matter expert for a New York State Commission, and directed a Medicare Coordinated Care Demonstration.

Ms. Silvers holds an MBA from Yale University and a BS in Economics from the Wharton School, University of Pennsylvania.

David Stevenson, PhD
Vanderbilt University School of Medicine

David Stevenson is currently an Associate Professor of Health Policy in the Department of Health Policy at Vanderbilt University School of Medicine. Dr. Stevenson's primary research interests are long-term care and end of life care. His previous work has focused on a broad range of topics in these areas, including the evolution of Medicare's hospice benefit, end-of-life care for Medicare Advantage enrollees, long-term-care financing options for the future, and the impact of Medicare Part D in the nursing home pharmacy sector. He has worked in various research and policy settings, including the U.S. Public Health Service, the University of Washington School of Public Health, the Urban Institute, the Visiting Nurse Service of New York, and Medstat.

Dr. Stevenson received a B.A. in religion from Oberlin College, a S.M. in health policy and management from the Harvard School of Public Health, and a Ph.D. in Health Policy from Harvard University. His previous faculty appointment was in the Department of Health Care Policy at Harvard Medical School, from 2004-2013.

Susan Elizabeth Wang, MD
Kaiser Permanente

Susan Elizabeth Wang, M.D., is the Regional Lead for Shared Decision-Making and Advance Care Planning for the Southern California Permanente Medical Group. She created and directs the Kaiser Permanente Los Angeles Hospice and Palliative Medicine Fellowship. Dr. Wang is the Chief of the Department of West Los Angeles Geriatrics & Palliative Medicine. She is triple board certified in internal medicine, geriatric medicine, and palliative medicine. Dr. Wang joined Kaiser Permanente from the clinical faculty of UCLA in 2006.

Rodney Whitlock, PhD
ML Strategies

Rodney Whitlock is a veteran health care policy professional with more than 20 years of experience working with the US Congress, where he served as health policy advisor and as Acting Health Policy Director for Finance Committee Chairman Chuck Grassley of Iowa and, earlier, on the staff of former US Representative Charlie Norwood of Georgia.

During his years with Representative Norwood, Rodney managed the Patients' Bill of Rights, which passed the House in 1999 and 2001. In February 2005, Rodney left the office of Congressman Norwood to join the Finance Committee Staff as a health policy advisor to Chairman Grassley. In that capacity, he was lead Senate staffer for the Medicaid provisions of the Deficit Reduction Act of 2005 and the Tax Relief and Health Care Act of 2006.

In 2007, Rodney worked on the Children's Health Insurance Program Reauthorization Act, which passed Congress twice and was subsequently vetoed twice by President George W. Bush. Rodney spent 2009 and 2010 deeply engaged in health care reform legislation. Late in 2010, he became the Acting Health Policy Director for Senator Grassley, and shepherded the Medicare and Medicaid Extenders Act of 2010 into law. Following his tenure in Senator Grassley's Congressional office, Rodney served as Health Policy Director in the Senator's personal office.

Ron Wyden, JD
Ranking Member, Senate Committee on Finance

As the Senate's leading voice for health care as Ranking Member of the Senate Finance Committee, Senator Ron Wyden has a long history of working to find commonsense, bipartisan solutions to the major issues effecting working Americans. He has sought common ground for innovative policy approaches to some of the nation's most entrenched issues, from comprehensive tax reform to improving Medicare and ensuring that every American has access to quality, affordable health care.

Health care has been the hallmark of Wyden's career and he continues his long-time work in Congress to forge solutions that improve care while lowering costs. He has championed proposals to improve care for people in Medicare with chronic diseases and written legislation included in the Affordable Care Act to empower innovative states to design an individual market that works best for them while still providing quality, affordable health coverage. Wyden is also committed to tackling the challenge of rising prescription drug costs.

Wyden was first elected to Congress in 1980 to represent Oregon's 3rd District. In 1996, he was elected to the U.S. Senate in a special election. Prior to his service in Congress, Wyden co-founded the Oregon chapter of the Gray Panthers, an advocacy group for the elderly. He also served as the director of Oregon Legal Services for the Elderly from 1977 to 1979.