NATIONAL QUALITY FORUM

Moderator: Kate Goodrich
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Operator: This is Conference # 95163680

Male: So I'd like you to join me in welcoming an athlete, an artist and all-around best CMS quality standards person, Kate Goodrich.

Kate Goodrich: Good morning, everyone. I didn't know he was actually going to tell that story. It is true. Most of you know me as a policy geek, policy wonk. I did have a former life, I did have moments of glory in athletics and music. So my (best male) swimmer trophy sits on my mantle between my photographs of Gore Vidal and William F. Buckley.

No, it's an honor to be here. I love coming to this meeting every year because I get to see all my friends. I get to see people I haven't seen most of the year, or maybe I'll see at another conference. So lots of great conversations, even so far this morning, lots of hugs, which is really great. So thank you for having me here today.

So I want to talk a little bit today about – so disclaimers, you can read those at your leisure – a couple of topics that I think most of you in this room know very well, have heard me, have heard my boss, Dr. Patrick Conway, talk about numerous times at this conference but elsewhere.

But I really do want to reiterate the importance of the work that we are doing, that you all are doing in partnership with us as a healthcare community around transforming the healthcare system. And I want to talk a little bit about sort of

our latest efforts with the quality payment program, which I know is on many of your minds.

We're in the first year of the program, so we don't really know how it's going yet, because it's just the first performance here, but we want to talk about how that is laid out. And really the foundational importance of the work that NQF does, that many of you do around quality measurements and improvement.

And then finally, I want to end by talking a little bit more about the really critical strategic importance of the partnership between NQF and CMS, actually much of which Shantanu has already talked about this morning and that I want to reinforce.

So you guys have probably all seen these slides and heard us talk about this, but I do want to reinforce that delivery system reform and transforming the healthcare system from a system based on fund volume, to one based on value, is still a strong priority for us at HHS.

We obviously have a new administration on board. We have administrator Seema Verma, who's been with us now for a few weeks. And as we have been working to get her and her team up to speed on the work that CMS is doing, as well as our new secretary, Dr. Price, this has been a really consistent theme around the need to continue to transform -- to pay for value rather than volume.

One thing we should all remember is that certainly MACRA and many of the provisions of previous laws, ACA, PAMA, IMPACT and others, really the provisions around quality and paying for outcomes, paying for good patient experience, is really bipartisan, has quite a bit of support.

And I think that is – that is going to continue; it's really not a partisan issue. And so we still think that in order to focus on driving the healthcare system towards value, to increasing participation in alternative payment models, that we have to focus on the three things that you see here on the screen.

We have to change how we pay providers -- so moving more towards shared savings programs, bundled payments and population based payments, re-stratified population based payments -- is critical to transforming the system.

And that has to come with it an emphasis on outcomes for patients, better healthcare outcomes for patients. And so we have to be incentivizing the right things. Not only do we change the actual payment systems to trying to transition away from the fee-for-service system, but we have to incentivize the right kind of care deliveries.

That means incentives for care coordination, I just heard about shared decision making, which is absolutely critical and foundational as well, that does need to be just how we do business as clinicians and patients together. So it's explicit incentives for those types of care delivery models, for chronic care management and so forth.

And then finally distribution of information and you guys have probably heard me say this before. I think that is as important as the other two areas, right. So clinicians and patients need information in order to be able to provide and receive the best quality of care.

So that means for clinicians to have information about the quality of care, to have data at their fingertips and to understand how to utilize that data at the point of care, when they're taking care of patients. That is a must. And we've made some progress on that front as a community, but so much more needs to be done for clinicians to be able to have data to make informed decisions in a rapid cycle fashion.

And then you've got to have transparency of information, that is so important for patients, families, consumers, to be able to understand the quality of care that is being delivered within their communities, by their clinicians and having that information understandable and accessible to patients in a way that they can actually use it and help them to make better choices.

So those are the three sort of foundational components, that by the way, are not just tenets that are important for us as CMS. There's really a great deal of consensus across the spectrum and with CMS in partnership with commercial

payers on the need for these to be the three focus areas for delivery system reform.

And so what happened several years ago, through an article that was published in JAMA by my boss, Patrick Conway and the former administrator (Cavener), was that we categorized payments into four categories.

Now there are many more than just four categories of payments that are – that are even out there being used now. But these are the four basic categories that are probably most understandable to folks. So first is category one, straight fee-for-service.

As you know, within the CMS system, particularly in the Medicare system, a very, very small minority of payments now are straight fee-for-service with absolutely no tie to quality. Number two is fee-for-service with a link to quality and value.

So whether that's pay for reporting, or pay for performance, such as the new MIPS program or hospital value based purchasing, so where the reimbursement is toggled up or down based upon performance on quality and cost measures.

Now categories three and four is where we want to go, right. That's where we want to have a majority of our payments over time, again, across the public and private sector. So category three is alternative payment models that are built on the fee-for-service architecture, so think the Medicare shared savings program, where you can share in savings at the end of a performance period.

And then category four is really getting to sort of global budgets population based payment. And we have some examples of that through the Maryland all payer system and others as well. So the goal over time is to transform, at least at CMS, but certainly very importantly in partnership with commercial payers, to transition overtime to the latter two categories.

And of course good quality measures that are important to patients and clinicians are foundational to this effort. And so as most of you know, we announced a goal a couple of years ago to get 30 percent of payments into

those categories three and four by the end of 2016 and of course we met that goal actually in early 2016 through a couple of different efforts.

Number one was of course by testing new models and expanding models of care. In order to continue that transition, we'll need to continue to do more of that. But again, I can't emphasize this enough, very importantly, working with many of you, all of our partners in the commercial payer world, but also clinicians and importantly patients and consumers, to share in those goals, to work to align the incentives, to align the quality measures, to align as many aspects as we can of payment, so that clinicians and patients are really targeting the same goals in order to be able to transform their practice.

So that work is ongoing, that work continues, we are doing that now as are many of you and our partners again, in sort of the commercial payer sector are also doing this work as well. And we're seeing some results.

And part of seeing those results is not just around payment levers, but we really believe that we have to use numerous levers, all the levers that are available to us at CMS, in order to truly drive improvement for patients, to truly drive improvement in performance.

So in addition to our efforts related to payment and measurement, we have launched a number of very large scale, action-oriented networks, in order to really spread quality improvement, to identify and spread best practices and quality improvement.

Many of you are probably familiar, certainly with partnership for patients, this audience ought to be really familiar with partnership for patients, because you all were very – and NQF was very, very involved in the launch and spread of that action network.

That has shown some – that along with a lot of the other work that's been done at the local level, at the state level and also through payment levers, has shown results that I'm going to show you in just a minute.

You're probably also very familiar with the quality innovation network, so the QIO's, what we used to call the QIO's and still do. This – these are networks

that are really focused – have traditionally been mostly focused in the hospital world, but also in nursing homes and home health agencies, hospices as well.

Again, very action-oriented networks to give sort of that front line technical assistance to organizations to be able to improve and to generate results. These networks are really focused on generating results. And so to that end, our newest portfolio of networks, if you will, are related to working with front line clinicians, group practices, to be able to transform how care is delivered to provide the best outcome for patients.

So we have a couple of ways we're doing that, well actually three in particular. One is of course through the QIO's, so the QIO's actually are also focused on providing technical assistance primarily to large group practices.

Then we've got the transforming clinical practice initiative, which has a goal of reaching 140,000 clinicians in the United States. I will tell you we're at our targets that we set – our interim targets that we set already.

The goal there is to work with practices that are maybe a little bit more advanced, maybe a little bit more ready to take on financial risk, to help them to be able to make that transformation into advanced alternative payment models, or just into alternative payment models.

And so these are going to be clinicians that are going to be participating in the quality payment program, in the MIPS program maybe initially, but these networks, again, are very action-oriented with clear goals and targets they are trying to reach to help these clinicians transform.

But we also know that there's a large number of clinicians and practices out there that maybe aren't as – haven't participated in quality improvement, or quality measurements, or pay per performance programs before, that are somewhat nervous about the coming landscape related to pay for performance and MACRA and MIPS and so forth.

And so many of these practices are in rural areas, they're in medically under-served areas, or they may be solo or small practices even in urban areas. And so we actually recently announced a set of cooperative agreements for what

we call the SURS contract – the SURS work, which is really related to, again, small, under-served and rural support.

And this was money that was actually part of the MACRA legislation, because Congress recognized that the small, rural and medically under-served regional providers are really at the heart of care delivery in this country. They are absolutely critical and we cannot transform how we pay for care and leave them in the cold, right.

So this technical assistance is focused specifically on that population of providers. So we're really, really excited about that. Most of these awards went to organizations that are deeply rooted in quality improvement and able to hit the ground running and start working with these practices right away.

So I wanted to give you a sense of sort of the overall portfolio – I'm sorry, I left out the end stage renal disease networks. These are networks that work with end stage renal disease patients in dialysis facilities to improve care as well.

So we see this as really as important of a lever for improvement as payment or measurement as well. And we've actually had some good results. You know, I think in the early years of focusing on improvement and measurement and changing how we pay for care, had been primarily focused on the hospital world.

And so these results are what we've seen to date over the last five or six years that is, I would say, in part related to the payment and improvement levers that we've implemented at CMS, but very, very much related also to all of the good quality improvement work that's going on in the front lines within individual hospitals, within local communities, within regions.

So these results were announced last December at our quality conference and what we've seen over a five-year period is a really significant reduction in harm. And these numbers show what that translates to.

So we've seen a 21 percent overall reduction in harm. These are hospital acquired conditions. That translates into 125,000 lives saved, $28 billion in cost savings from harms avoided and 3.1 million fewer harms over five years.

So just stop to think about what that means for patients, for families, for front line providers. This is – this is – these are really quite stunning results. Now, I don't want to overstate the importance of this, because while this is really amazing, there is so much more work to do in a variety of different healthcare settings. And that's where the work that we're doing with all of you and with the National Quality Forum remains just absolutely critically important.

Just briefly I want to talk about the quality payment program. I know it's on a lot of your minds. As I mentioned, we are in the first performance year of the quality payment program. We are working hard on our regulation for the second year of the program, continuing to go out and listen to the patient and consumer community, to the clinician community, to really anybody who wants to talk to us, to understand where we can continue to improve on what we started in this first year.

So the QPP, as we call it, is going to reform Medicare part B payments for about 600,000 clinicians. That number will go up after the third year, because we're able to bring in more clinicians into the program according to how the law was structured with – in the third year of the program.

Clinicians will fall into one of two tracks. We do believe that in the early years of the program, that the majority of clinicians will participate in the merit-based incentive payment system. So this I would put under sort of category two, where you have payments under the fee-for-service system that are tied to performance on four different categories, which I'll go over in a second.

And then you have clinicians who are part of what's called advanced APM's, right. So these are alternative payment models that meet three requirements. One is that clinicians are assessed on quality measures that are comparable to measures that are in MIPS.

Number two is that the providers within these organizations use certified EHR technology. And then number three is that the APM must bear what's called more than nominal risk and we laid out in regulation what more than nominal risk meant.

So when we started this program, we took a step back and said OK, what are we really trying to achieve here, what should our strategy be? And we went out and we talked to front-line clinicians, specialty societies, patient organizations, consumer organizations, to ask them what they wanted out of the program, right, what should our strategic goals be?

And so you see them listed here. We have specific metrics underneath each one of these and each one of these is sort of fleshed out more in our strategic plan, which you can get on our website.

At the end of the day, for all of our work, the number one objective is to improve beneficiary outcomes, that will always be the case, always. Number two and really almost as important, is to improve the clinician experience.

So when we started going out and talking to docs we spent a lot of time talking to our stakeholders, many of you here in the room, including medical professional organizations. But we actually spent a great deal of time literally going out into physician offices, talking to the practice managers, going into the small practices where you know, the spouse of the – of the physician is the one on the weekend working on submitting the quality codes for the CMS programs, right.

So we heard about the pain points, we heard them loud and clear. We heard about the pain points of the electronic health records, how it's not always living up to its promise, after a lot of money has been spent.

And so I will tell you, sometimes it was hard to hear, what people felt about CMS, Shantanu you may remember what that's like. But it was so important to us, it was so important to us to be able to hear this.

And I think it really changed our thinking about how we would go about this program. And again, of course, another major goal is increasing adoption of

advanced APM's, so we have a lot of thoughts about how to do that as well, many of which have come from you.

So our merit-based incentive payment system, or MIPS, essentially assesses clinician performance, or group practice performance, on four categories. Number one is quality, so very similar to the previous programs and we've actually placed the most emphasis on this category. We actually have to weight each of these categories in assessing a total score for clinicians.

The second is cost. Third is improvement activities, this is a new for CMS. I think Congress' thinking there was that clinicians are doing a lot of really great work to really improve care for patients beyond just the day-to-day care of patients.

Bt whether it be through maintenance of certification, or joining a learning collaborative focused on sharing best practices for quality improvement focus on opioid use – or appropriate use of opioids, programs for that, there's a lot of different things that clinicians are already doing that are driving improvement for their patients and they should get credit for that, right.

And then finally, is advancing care information, which is sort of a new term for meaningful use. The law does require that we continue to assess how clinicians use their health IT to improve care for patients.

And the goal is really for all four of these categories to be totally seamless, right, so that what you, as a clinician, are doing to improve care for your diabetic patients, you're reporting on quality measures around outcomes for your diabetic patients, using your EMR to help you be able to track your population of diabetic patients and engaged in specific improvement activities related to those patients, just as an example.

So it should really all be seamless across the board. I do know that we are not there yet. There's no question that this still feels like four distinct, separate categories for clinicians, but I think we are on a very good path through much of the input that we've gotten from our stakeholders, to be able to get to where it is a more seamless program over time.

The other thing we really tried to do was to provide flexibility within these categories, so that it was not so much one size fits all, which our legacy program, which I have to remind myself actually still exists right now, they really do feel like one size fits all. So we really try to provide flexibility within these categories, so that folks can just choose the measures and the activities that are most relevant to their practice.

Alternative payment models, one thing I want to make very clear, this isn't always totally understood. You know, the MACRA legislation did nothing to change the specific incentives and rewards that clinicians can get through participation in APM's. Those remain the same, right.

So if you're in comprehensive primary care plus and you are responding to specific quality measures and specific financial incentives related to being a part of that model, that still exists, that does not change because of MACRA.

However, if you are in comprehensive primary care plus, CPC Plus, or track three of an ACO, or next-gen ACO, not only are you eligible for those financial incentives, but also you are eligible for a 5 percent lump sum bonus, just for being in those advanced APM's, right.

So clearly Congress is trying to incentivize folks to transition into advanced APM's through this financial bonus, which is available every single year for five years, right. So want to make that clear and also folks who are in advanced APM's and see a certain proportion of their patients – their Medicare patients through that advanced APM are not subject to the MIPS program either.

So these are the advanced APM's that are available in 2017. We absolutely heard loud and clear people want to have more choices available to them, particularly for specialists, so we're excited to be working on that with a number of specialty societies, through the work of the PTAC, the physician-focused payment model technical advisory committee, which is a committee that is organized and required by the legislation to review advanced alternative payment models that are suggested to us for expansion.

And then these are some future APM opportunities that we think will be available starting in 2018. I'm not going to go through all of them here. The one I will highlight is ACO track one plus, because one of the things that we heard from a lot of folks is that I'm in – I'm in track one, which is no downside risk and I want to move on to track two, but I can't take on that degree of risk, I'm not ready for that.

And so we heard that and did a lot of, I think, I hope, creative thinking around what a middle ground could look like that would allow people to qualify as part of an advanced APM, but maybe not take on as much risk as was required, or is required, in tracks two and three. So we're excited about that one.

And of course no talk could be complete without me sending you to our fabulous website, qpp.cms.gov. I think when you go to it, you will see that this is a very different government website. I will tell you we've developed some new skills at CMS, one of which has been understanding user-centric design principles.

We brought in some specialists into the agency, from the United States digital service to teach us about Agile development, but also user-centric design processes and those are the principles that we use in figuring out how we communicate with clinicians, not just through our website, but through other means as well.

So this is the future, we think, of our healthcare system. It remains this – you've seen it slide before, we still are making the transition towards value, through the ways that are outlined here. I can't, again, emphasize enough how critical the collaboration between CMS and commercial payers is in order for this to happen and again, focusing on quality and outcomes and qualities measures, again, are fundamental to this effort.

So we have been required under MACRA to develop a quality measurement development plan. I've put this here as part of MACRA because it is, but also the principles that you see here are actually across all the work that we do for all different settings and for health systems.

It – we are required to set priorities for these programs and we've really been focusing on the measurement gap and I heard Shantanu talk a lot about how there are still so many gaps and yet we still have so many measures and we have to be able to manage that and reconcile that.

We – this plan does recommend prioritized approaches to closing gaps and I'll talk through some of those in just a minute. One thing I do want to highlight for you on this is that we do plan to make available technical and subject matter expertise to clinician organizations for measured development.

This is something we heard from a lot of you, a lot of specialty organizations, that they really need. They really need some help in taking the next step to developing measures that are most important for their specialty and for their patients.

So a highlight of some of our priorities for measured development you see here, obviously outcome and patient reported outcome measures remain at the top of our list. There are some specialties that have really significant gaps and it's very important to the Medicare population.

Orthopedics and oncology are two areas where we just don't have enough good outcome measures, also palliative care, we're very excited about the upcoming NQF work related to palliative care. This is something we hear all the time from patients is so important.

Measures of diagnostic accuracy, there was yet another article today in the Washington Post around diagnostic accuracy and the limited percentage of diagnoses that are accurate at the – after the first time a patient has seen the clinician. There's a lot of reasons for that. Capturing that accurately through measurement is difficult, but we are doing some sort of foundational work on that to try and start to get at that.

And then I think we've got to move to different ways of capturing data to measure quality. So we've been hearing from some small, innovative companies about some of the work they're doing to capture patient experience in a real-time fashion with actually very high response rates.

So we're very interested in learning more about what the private sector is doing in this realm and how that can be leveraged for use in payment programs over time. A lot of challenges, Shantanu actually highlighted a number of these challenges.

We would concur with what the challenges are, but I think much of the work that NQF is doing around advancing the science of measurement is going to be critical to breaking through some of these barriers.

Robust feasibility, reliability of validity testing remains a challenge, but actually I think there's some good news on the horizon around the work that NQF is doing with the measure incubator, some of the work we're doing around developing a national testing collaborative to break past this barrier, so that we really can have the most robust measures possible for use in accountability programs.

And the cycle time and cost to develop measurements, to develop measures. So I think everything that Shantanu talked about related to his vision for NQF and what they're going to be sort of experimenting with, I like that word, around the endorsement cycle, I think also applies to what we all need to do as a measured development community around the development cycle as well and to try to integrate those in a – in a – in a feasible way that actually still gets us good quality measures at the end of the day, but at lower cost and reduced cycle time.

So finally, I just want to talk a little bit about the importance of the relationship between NQF and CMS. So some of you may not know this, but Patrick Conway and I both cut our teeth on quality measurement by running the contracts with NQF.

Patrick was actually the original project officer for the contracts that the agency – that actually at the time, HHS, or (ASPI) held with NQF. And then I was the second project officer. And I learned about quality measurement through that experience.

Helen Burstin has probably taught me more about quality measurement than anybody over the years. And so the work with NQF is near and dear to my

heart. It is something that I firmly believe is absolutely critical for the work that the country is doing to change how we deliver and pay for care, because good quality measures and having that broad, multi-stakeholder input, into the use of measures for federal programs, I think is absolutely foundational.

So this is just sort of categories of work that we are doing with NQF. Obviously endorsement and map review are two things that most of you are very familiar with. The development of the measurement science, we get a lot of good ideas from NQF about places that we could work together on advancing the measurement science certainly around attribution, the work around patient reported outcome measures that came out a few – a couple of years ago was very important.

Collaboration on feedback loops, this is something that's been identified time and time again as a need and a gap within the measure endorsement and map input world, which is we all need feedback on how these measures are working out there in the wild, right.

We put measures into programs, we do our own sort of internal analysis on how they're working, both from a quantitative and qualitative standpoint, but that feedback has got to come back to all of you, to the map, to the public, so that we can continue to make better decisions on what the right kinds of measures are for accountability and improvement programs.

So we piloted our first sort of feedback loop with the (MASTA seer) through some of our post-acute care measures. We want to build on that, so we can be doing that across the board in future years.

And then finally, continuous improvement. I think again, what Shantanu said this morning about his vision for NQF, is certainly music to my ears and we've been working with NQF over the last several years on bringing lean principles into our work on working together on how we can make the endorsement and map process more nimble and more meaningful to folks.

Clearly still a lot of work to do there and some of that work is absolutely on us, including the way that we fund NQF as Shantanu mentioned. I think we

need to also be thinking how can we help to make that process more nimble for folks?

The map just brief – I just want to highlight a little bit about the map and the importance of that. Clearly Congress recognized that this approach of getting multi-stakeholder input into measures for programs before the rule making cycle, so what's called pre-rule making, was going to help us really developing consensus around the kinds of measures that needed to be used in public programs.

The map really has taken a coordinated approach to looking across federal programs to see. They help us be able to align measures across programs. If you look at our post-acute care programs for example, there's really tremendous alignment of measures across those programs. It could still be better I am certain.

But a lot of that is because of the work that we've done with NQF and the map to really make that focus very, very intentional. The pre-rule making process, again, allows for sort of that early public preview of potential measures and we've actually tried to think about ways that even before the measures – the map meetings actually happen, that those measures can be publicly available for people to see.

These measures of course are considered prior to rule making, alignment is a key focus there. Endorsement status is definitely considered favorable, it's not required. I will say for us, at CMS, having a measure be NQF endorsed in our programs is very, very valuable, it's highly valuable.

We think that there's – we still need to work together with NQF to make that endorsement process more nimble so that we can more easily include endorsed measures in the process, but I do want you all to hear that for us, having endorsed measures in our programs is absolutely preferable. And then looking at the potential impact of new measures in an actual impact of implemented measures, again, getting back to that feedback loop.

And then finally, I want to emphasize what I said before, which is that continued partnership on continuous improvement is a high priority for us.

You know, it only helps us at CMS, just to be very selfish for a minute, it only helps us as CMS – at CMS, if we have a leaner, more efficient process for measured endorsement.

We certainly hear the concerns that some of you have said to us when we include measures in our programs that have not gone through the endorsement process. We have done that in the past when – particularly when it's a measure of such high priority for the Medicare population in particular and an NQF endorsement may come a little later.

We would far prefer to be able to have measures endorsed in a much more rapid cycle fashion, so that we can always be including those types of measures in our program and we want very much and will be working hard with NQF to help succeed in the vision that Shantanu laid out.

And this goes also for the multi-stakeholder input for the map. One of the things that I think many of you have participated in that process, or have been witness to that process. And there's always been this tension between having measures endorsed and reviewed for accountability program, because and the timing just does not sync up very well.

And so I think we've talked – Helen and I have talked many times and with many of you about the need to really integrate endorsement and approval by the map, or review by the map, in a – in a much more sort of seamless, real-time kind of way.

That will not happen overnight and that is partly on us to work with NQF on how we can get there. But we think that that will be better overall for the measurement community, better overall for the patient community, better for the clinician and payer community as well.

So we are very committed to continuing to work with NQF on those things. And so I just want to thank you, I want to thank NQF for inviting me to come speak today and very nice to see all of you. I hope you have a wonderful meeting and thank you very much.

Female: All right, thank you so much, Kate. Clearly NQF is committed to partnering with CMS on everything that Kate just talked about. So I'm going to invite the panel to come up. My name is Laurel Pickering and I'm the president and CEO of Northeast Business Group on Health.

We're the business coalition in New York City. How many members out there are in New York City metro area? Raise your hand. Oh come on, really? Just a few? So I'm the only board member in the New York City area and I want to let you know, put in a plug, we're going to be hosting a reception for you all to get to meet Dr. Agrawal on May 11th in New York, in the West Village, at WebMD's new headquarters, it's a very cool, funky space.

And I hope that you all will join us, certainly all the members that are in the New York metro area. And if you're not a member, join quickly so that you can join us on May 11th, we're very excited about that.

So now to the panel, we are going to continue the conversation on quality and payment in value innovation. Clearly, as value-based arrangements and alternative payment plans become the new economic model for healthcare, the quality measures underpinning of these programs are increasingly important.

We're fortunate to have Alan Weil, the editor-in-chief of Health Affairs and he is going to be interviewing three experts in quality and payment. I think you all know Health Affairs. To put in another plug, Health Affairs and NQF have recently formed a new journal club, which is an exclusive benefit for NQF members.

And the NQF journal club covers articles of importance to the NQF community, brings authors together with folks that are interested in health economics and quality policy and focuses on very important issues that are covered in health affairs. It's a 60-minute webinar, it's led by Helen Burstin, our chief scientific officer, so I highly encourage you to participate in that program.

Prior to joining Health Affairs, Alan served as the executive director of the National Academy for State Health Policy. He's also an elected member of the National Academy of Medicine, the co-editor of two books, publishes

regularly in peer-reviewed journals and has testified before Congress more than half-a-dozen times and is often called upon major media outlets for his knowledge and analysis. Please join me in welcoming Alan Weil and our next panel.

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