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IDENTIFYING OPPORTUNITIES FOR HEALTH CARE DELIVERY SYSTEM REFORM: LESSONS FROM THE FRONT LINE

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED TWELFTH CONGRESS

SECOND SESSION

ON

EXAMINING IDENTIFYING OPPORTUNITIES FOR HEALTH CARE DELIVERY SYSTEM REFORM, FOCUSING ON LESSONS FROM THE FRONT LINE

MAY 16, 2012

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IDENTIFYING OPPORTUNITIES FOR HEALTH CARE DELIVERY SYSTEM REFORM: LESSONS FROM THE FRONT LINE

WEDNESDAY, MAY 16, 2012

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The committee met, pursuant to notice, at 10:03 a.m. in room SD–430, Dirksen Senate Office Building, Hon. Sheldon Whitehouse, presiding.

Present: Senators Whitehouse, Mikulski, Bingaman, and Franken.

OPENING STATEMENT OF SENATOR WHITEHOUSE

Senator WHITEHOUSE. The hearing will come to order.

Let me thank the witnesses for being here. Let me thank Chairman Harkin and Ranking Member Enzi for allowing me the opportunity to chair this particular hearing.

The title of today's hearing is, "Identifying Opportunities for Health Care Delivery System Reform: Lessons from the Front Line." It is part of my continuing effort to raise awareness about the opportunities to reform our health care system through innovation in care delivery. In particular, this hearing is a chance to hear from private sector innovators who have taken this cause to heart and are seeing real world results.

When I talk about delivery system reform, I point to five priority areas: payment reform, primary and preventive care, measuring and reporting quality, administrative simplification, and health information technology. As I expect the experiences shared by today's witnesses will confirm, these priority areas should not, and do not, stand alone and apart from each other. Rather, progress in each area will influence, and be influenced by, progress in the other areas in a manner that can drive virtuous cycles of improvement in care, efficiency in delivery, transparency in information, and reduction in cost.

The potential cost savings in delivery system reform are significant. The President's Council of Economic Advisors estimated that over $700 billion a year can be saved without compromising health outcomes. The Institutes of Medicine put this number at $765 billion annually. The New England Healthcare Institute reported that it is $850 billion annually. And The Lewin Group, and former Bush Treasury Secretary Paul O'Neill, have estimated the delivery system reform savings at $1 trillion a year. We can reduce costs, and

improve quality health outcomes, and patient experiences. It is a true win-win.

My interest in delivery system reform dates back several years. As Attorney General of Rhode Island, I founded the Rhode Island Quality Institute to develop innovative approaches to delivering health care in Rhode Island. I worked to support the inclusion of smart delivery reforms in the Affordable Care Act of 2010, and I recently released a report which assesses the Administration's implementation of the delivery system reform provisions of that law. I submitted this report to the HELP Committee in March.

The report finds that the Administration is working hard to implement the Affordable Care Act, and has moved forward on 25 out of the 45 delivery system provisions in that law.

For example, the Administration is moving forward with programs to move us away from the inefficient fee-for-service model, such as the Hospital Value-Based Purchasing Program and the Hospital Re-Admissions Reduction Program. These are excellent examples of how the Affordable Care Act is helping to realign incentives to focus on the quality of services provided, not the quantity of services provided. It is important to note that a significant portion of the provisions that have not been implemented are stalled, not due to executive inaction, but due to lack of congressional action to ensure adequate funding.

It has been less than 2 months since we released the report, and I am happy to report that progress implementing the Affordable Care Act has continued. Since March, the Administration has: selected the first 27 Accountable Care Organizations in the Medicare Shared Savings Program; selected seven markets to participate in the Comprehensive Primary Care Initiative; announced the first 16 States to participate in the Independence at Home Demonstration project; released the first 26 Health Care Innovation Challenge awards; and increased Medicaid payments for primary care physicians. These recent developments, like others that are well underway, show how the Affordable Care Act is promoting innovation throughout our health care system.

My report largely focuses on the Affordable Care Act's delivery system reforms, but it is important to learn from the efforts of the private sector. While increasing health care costs are the primary driver of our Federal debt and deficit, they are not unique to government health plans. Costs are going up for everyone, whether they are insured by Medicare or Medicaid, the VA or TRICARE, Blue Cross or United Healthcare. We have a systemwide cost problem on our hands, and the solution must be systemwide too. We need to look for best practices across all sectors of our health care system to inform our understanding of what is working on the front lines of reform. That is why I look forward to hearing about the private sector efforts of our first two panelists.

While the Affordable Care Act is pushing the Federal Government toward delivery system reform, the delivery system reform movement has been driven by dedicated providers, payers, employers, and some States that have worked for years to improve the quality, safety, and effectiveness of care. These stakeholders have pioneered new delivery systems that encourage providers to better coordinate care, and reduce waste and inefficiency.

Today's hearing is not an exercise in discussing hypothetical improvements and theoretical cost savings. Our first two witnesses will show how their delivery innovations have resulted in real improvements to quality, real improvements in patient outcomes, and real cost savings.

The advantage of this approach is that it does not rely on shifting costs or cutting benefits. Rolling back Federal health benefits would do little to address the underlying cost problems in our fragmented, inefficient health care system.

Last spring, Gail Wilensky, who ran Medicare and Medicaid under President George H.W. Bush said, "If we do not redesign what we are doing, we cannot just cut unit reimbursement and think we are somehow going to get a better system."

From the private side, George Halvorson, the president and CEO of Kaiser Permanente, joined me at a discussion on the future of health care last year where he said something very similar.

> "There are people right now who want to cut benefits and ration care, and have that be the avenue to cost reduction in this country, and that is wrong. It is so wrong, it is almost criminal. It is an inept way of thinking about health care."

Before I introduce the first witness, I would like to express my deep appreciation for the work and experience that today's panel brings to this discussion. Putting these types of reforms into practice takes guts, vision, and determination. Putting them into practice successfully requires strong leadership and tireless commitment. I hope that today, we can draw from the lessons that you have learned, and I look forward to continuing this conversation with my colleagues in the Senate.

I see that Senator Franken has joined us, and I do not know if the Senator cares to make any opening remarks. If he does, I would be glad to entertain them now, if not, we can proceed with the witnesses.

STATEMENT OF SENATOR FRANKEN

Senator FRANKEN. I would just as soon proceed with the esteemed witnesses, and I am very excited about changing the way we deliver health care.

In our health care system in Minnesota, we tend to do a very good job. I have noticed a number of our systems have decided to become Accountable Care Organizations, and they are very excited about it. They have become pioneer Accountable Care Organizations because they already are doing accountable care, essentially.

Minnesota delivers high value care, relative to the rest of the country, at very low cost. And it is able to do it by already using some of the pieces, some of the parts, of this law that were implemented. I think that Minnesota is a good example of how care organizations can change the way they deliver care, and make it much more, not just more affordable, but actually make it more effective.

I am very happy, for example, about the value index in health reform and I wonder if it should not be extended to hospitals, because the value index is something that will reward high-value health care, like the kind we have in Minnesota. And not just re-

ward Minnesota and pit Minnesota against Texas, or Florida, or those States that do not do as high-value care. Really, it is not about pitting Minnesota against those States. It is about incentivizing those States to do health care more like Minnesota does. I think the value index within the Affordable Care Act is an incredibly important piece of this legislation that is going to bring down the cost of health care delivery and increase the value.

We have already seen in Minnesota, probably the reason Minnesota's care is of such high value compared to other States, is that Minnesota just keeps working on this. We have already seen benefits that have come from this Act that have been implemented in Minnesota that have increased the value of care and that have used resources provided by the Federal Government, including electronic health records, and just doing some simple measures that have reduced the delivery cost of care, reduced the number of rehospitalizations. Incredible success stories that we have already seen under this Act.

So I want to hear from the witnesses.

Senator WHITEHOUSE. Let me thank Senator Franken for that statement.

There are a few of us who are persistent champions of delivery system reform in the Senate. I put myself in that number.

Senator Barbara Mikulski, who is the No. 2 Member in seniority on the committee, the senior Member behind Senator Harkin on the democratic side, helped write the delivery system reform provisions, the quality provisions of the Affordable Care Act, and she is certainly very committed to this.

And Senator Franken, based on the experience of Minnesota and of Mayo, in particular, has been a constant and articulate advocate for focusing our attention here in this area, where there is this win-win of improvement and savings.

Our first witness today is Dr. Al Kurose. Al is the president and CEO of Coastal Medical in Rhode Island. He is a leader in Rhode Island's health care community, and I am really glad to have him here today.

Dr. Kurose has served as president and CEO of Coastal Medical since 2008. Coastal is a physician-owned, medical group that serves 10 percent of Rhode Island's population. More than 90 percent of Coastal's providers practice primary care. Time and again, the Coastal medical organization has led the way in Rhode Island. Coastal Medical was a founding member of the Chronic Care Sustainability Initiative in Rhode Island, joined the Beacon Community's program in 2010, and had 49 of their providers join the Meaningful Use Vanguard as the first physicians in the Nation to achieve meaningful use.

This year, Coastal Medical announced a new contract with Blue Cross of Rhode Island that supports patient-centered medical home practice transformation and shared savings reform, the first of its kind in Rhode Island.

Dr. Kurose is a member of the Steering Committee of the Chronic Care Sustainability Initiative of Rhode Island, the State's all-payer—including Medicare and Medicaid—patient-centered medical home demonstration project. He has been an active member of the Primary Care Physician Advisory Committee to the Rhode Island

director of health, and is also a member of the Health Insurance Advisory Council of our State Health Insurance Commissioner.

He is a graduate of the Washington University School of Medicine in St. Louis, and completed his residency at our own Rhode Island Hospital. He has recently celebrated his 20th year as an adult primary care provider in East Providence, RI.

Dr. Kurose, thank you for coming in from Rhode Island for today's hearing, and please proceed with your testimony.

Dr. KUROSE. Good morning, Senator Whitehouse. Thank you.

Senator WHITEHOUSE. Senator Mikulski, who I was just bragging about, and Senator Bingaman, have both joined us, in addition to Senator Franken.

STATEMENT OF G. ALAN KUROSE, M.D., PRESIDENT AND CEO, COASTAL MEDICAL, INC., PROVIDENCE, RI

Dr. KUROSE. Good morning to all the members of the committee.

As Senator Whitehouse mentioned, my name is Dr. Al Kurose. I am the CEO of Coastal Medical. Again, we have about 70 physicians providing primary care to 100,000 patients in Rhode Island, which is about 10 percent of the population of our State. I am a primary care physician myself. I have had 20 years of experience in community-based office practice of adult internal medicine.

I really appreciate this opportunity to present you with a quick snapshot of our work and to share our viewpoint from the frontlines of the American health care system.

The total health care spend in this country is approaching 18 percent of the Gross Domestic Product. Published estimates suggest that 20 to 30 percent of that entire spend is waste. It seems clear, then, from these figures that the status quo of health care costs and health care delivery is not sustainable.

I am here to share the story of our organization, which I think is fairly unique. It is unique because we are much smaller than the large integrated health care systems like Virginia Mason, like Intermountain, like Humana. But we are much larger than typical small, two or three doctor primary care practices and larger, also, than most group practices and that allows us to have built an infrastructure to support those practices in unique ways. So I think in some ways we may provide a valuable case study of building a progressive primary care organization, really, from the ground up.

We adopted an electronic medical record in 2006. In 2007, as Senator Whitehouse mentioned, we helped start the State's all-payer patient-centered medical home demonstration project, which is also a MAPCP demonstration site. In 2011, all of our offices achieved NCQA Level 3 recognition as advanced primary care homes. And 49 of our providers were amongst the Meaningful Use Vanguard, the first providers in the country to achieve meaningful use of electronic medical records of health information technology.

Federal incentive programs have been very important in our growth and development. Meaningful use fund, regional extension center funds, beacon community funds from the Office of the National Coordinator of Health IT, we have availed ourselves of all those sources of support. And we have applications pending right now for the CMS Innovation Challenge Grant program, the CMS Shared Savings ACO program, and the Advanced Payment Model,

which provides working capital to smaller organizations who are becoming ACO's.

We set standards for ourselves at Coastal to meet the challenge of accountable care new standards. We do not intend to bend the cost curve, but rather, to break it. We set ourselves a very specific goal of reducing the cost of care for our entire population of patients by 5 percent by 2014. Our goal is not to be open more days for our patients, it is to be open every day, to be open 365 days a year with primary care access. And our goal is not to hit most of our quality targets, but every one of them.

Last year, in our Blue Cross contract, we had 20 quality targets. We hit 20 out of 20. Our organization was the first in the Rhode Island Beacon Community to hit every one of its quality targets and much of that success, really I think, goes to the physician culture that we have nurtured over a lot of years.

So when you look at what Federal Government incentive programs have meant to us, it is reasonable to ask: what is the return on investment? The meaningful use dollars that we have accessed, some three quarters of a million dollars, what have we been able to achieve?

Our access to data is limited, but what we have from Blue Cross-Blue Shield of Rhode Island in terms of our commercial and Medicare populations, we can say that our Medicare hospital days per thousand were reduced by 13 percent last year. Our re-admissions on the Blue Cross Medicare side were reduced by 27 percent last year versus the year before. And if you look at the total cost of care for our Blue Cross commercial and Medicare populations, it went up by just 1.5 percentage points last year. Our goal for the future is an outright reduction in the cost of care. If there is 20 to 30 percent waste in the system, we think that we should be able to achieve that.

Does care look different to the patients? It certainly does. As I mentioned, we are going to be starting 365 day a year access to primary care starting in July. Right now, we are at 6 days a week. Already, we have same-day sick visits in every office. Already, we have a new patient-oriented Web site up and running. Already, we have a patient portal through the Internet to our electronic medical records so people can see their own test results and learn the status of their own health. And we already have nurse care managers and clinical pharmacists—key providers—in every office.

So our message from the front lines is that Coastal provides a unique example of a primary care-driven ACO structure, and it may be a model that can be generalized as a mechanism for bringing small practices together to meet the challenge of accountable care.

Patient-centered medical home practice transformation has brought great value, but it is our strong opinion at Coastal that that is just an interim step, and not a final destination for progressive medical organizations.

Our new challenge, the challenge we are grappling with right at this moment, is to understand and manage the total cost of care more effectively for our populations. We do a lot of work in the extended primary care community at Rhode Island, and I can tell you that all of the primary care practices are really starved for data

about utilization of services by their patients about cost of services. If we are going to have a chance to really control the total cost of care, we have to begin with primary care practices having data to understand how the health care dollar is being spent.

Our marketplace also suffers from a relative lack of price transparency. On the commercial side, we have a lot of people who are on high deductible plans now. When they purchase health care, they are pulling out their checkbook and they have scant little information about price or quality of providers. So I think transparency is another piece that I would like to advocate.

I see I have run over. I am looking forward to question and answer. I really appreciate this opportunity to come here and speak to you folks.

Thank you.

[The prepared statement of Dr. Kurose follows:]

PREPARED STATEMENT OF G. ALAN KUROSE, M.D.

SUMMARY

ABOUT COASTAL MEDICAL

Coastal is a physician governed medical group practice based in Providence, RI. More than 90 percent of our 91 providers practice primary care, serving 105,000 patients (10 percent of the Rhode Island population) in 18 offices across the State.

OUR JOURNEY OF TRANSFORMATION AT COASTAL MEDICAL

Coastal Medical formed in 1995 through the merger of seven small private practices, and is a case study of the process of building a progressive medical organization from the ground up. In 2006, Coastal implemented an integrated Electronic Medical Record (EMR). In 2007, Coastal became a founding member of CSI–RI, the State's Patient Centered Medical Home (PCMH) demonstration project. In 2010, Coastal practices joined the RI Beacon Communities Program of the ONC. In 2011, every Coastal practice achieved NCQA level 3 recognition, and 49 of our providers joined the "Meaningful Use Vanguard" of physicians that were first in the Nation to achieve Meaningful Use. The clinical and administrative infrastructure we have built to support our practices is unique in Rhode Island, and has been critical to our success. Coastal is different from other healthcare organizations—smaller by far than integrated systems like Virginia Mason, but larger than most primary care practices.

MEASUREMENT AND REPORTING OF CLINICAL QUALITY AT COASTAL

Our progressively collaborative contracting process with Blue Cross Blue Shield of RI (BCBSRI) began incenting performance on quality metrics long before such performance was required by CSI–RI and the RI Beacon. In 2011, we achieved 20 of 20 BCBSRI clinical quality targets. In the first quarter of 2012, Coastal practices in the aggregate became the first participant in the RI Beacon Community to achieve all clinical quality targets for that program.

THE IMPORTANCE OF FEDERAL INCENTIVE PROGRAMS IN THE EVOLUTION OF COASTAL MEDICAL

The Meaningful Use, Regional Extension Center, and Beacon Communities programs have provided important support to Coastal, helping to fund the infrastructure upgrades needed to advance our work. Our experience with CSI–RI, a MAPCP program, taught us valuable lessons about PCMH implementation. We hope the Medicare Shared Savings ACO and Advanced Payment Model programs will lend crucial support as we embrace accountable care.

At Coastal, we recognize that PCMH practice transformation is just an interim step in the process of evolution toward competency in the delivery of true accountable care. We aim not to "bend the cost curve," but rather to reduce the cost of care for our patient populations by 5 percent by the end of 2014. We will soon offer primary care office visits 365 days a year. Care delivery already looks different to our patients, and our goal is to set new standards of customer service and patient-centered care. Physician culture is our greatest asset as we approach this work, and

aligned financial incentives are also critical. Our experience to date suggests understanding and managing total cost of care will be a formidable challenge for primary care practices that are not part of larger integrated delivery systems. Practices like Coastal will need analytic reports of utilization and cost based on Medicare claims data in order to more effectively manage total cost of care. This may be an area worthy of consideration when contemplating next steps and new programs to drive healthcare system transformation. Transparency of pricing in healthcare will also help both consumers and providers to reduce healthcare costs.

Good morning, Chairman Harkin, Ranking Member Enzi, and members of the committee. Thank you for this opportunity to present a snapshot of our work at Coastal Medical and to share our view from the front lines of the American healthcare system. With the total healthcare spend approaching 18 percent of the GDP, and estimates that 20–30 percent of that spend is waste, the above statements by Atul Gawande and Richard Gilfillan in January at the Care Innovation Summit here in Washington, DC appear to be correct. The status quo of healthcare costs and healthcare delivery is not sustainable.

COASTAL AT A GLANCE

Coastal Medical is a physician-governed medical group practice that was founded 17 years ago in Providence, RI. We employ 91 providers and provide primary care to 105,000 Rhode Islanders, who represent 10 percent of the population of our State. I was one of the founding members of Coastal Medical in 1995, and this is my 4th year as CEO. I stepped away from community-based internal medicine practice at Coastal just 6 months ago, after 20 years of service to patients.

A UNIQUE ORGANIZATION

We believe Coastal Medical represents a fairly unique type of medical organization. Our practice model and organizational structure are very different from that of larger integrated systems such as Intermountain and Virginia Mason. At the same time, we are also very different from small two- and three-doctor primary care practices; and we are different as well from most primary care practice groups, which tend to be smaller in size than Coastal and don't have as much infrastructure in place to support the individual offices.

Coastal Medical is a case study of the process of building a progressive medical organization from the ground up. We began in 1995 with the merger of seven small private practices, and have grown since that time by adding small practices and recruiting residency graduates. In 2006, Coastal made the critically important decision to implement an integrated Electronic Medical Record (EMR), which has enabled much of our practice transformation and clinical quality improvement work. Interestingly, EMR adoption also served to really crystallize our group identity in a manner that we had not anticipated.

In 2007, Coastal became a founding member of CSI–RI, the State's Patient Centered Medical Home (PCMH) demonstration project and a MAPCP demonstration site. Coastal physicians and staff have served in leadership roles at CSI–RI since its inception. In 2009, we embraced PCMH practice transformation at Coastal as the cornerstone of our strategic plan, and in early 2011 every Coastal practice achieved NCQA level 3 recognition. In 2010, Coastal's adult practices joined the RI Beacon Communities program of the ONC. In September 2011, 49 Coastal physicians were amongst the "Meaningful Use Vanguard" group of physicians who were honored as first in the Nation to achieve Meaningful Use. In 2011, the Coastal Medical Board of Directors determined that the provision of accountable care will serve as the singular focus of our organization.

THE IMPORTANCE OF FEDERAL INCENTIVE PROGRAMS IN THE EVOLUTION OF COASTAL MEDICAL

We have received crucial support from Federal incentive programs as our organization has evolved. Coastal's PCMH practice transformation and increasingly sophisticated use of the Electronic Medical Record (EMR) have been driven by incentives made available through the Meaningful Use, Regional Extension Center, and Beacon Communities programs. Those programs helped fund the infrastructure upgrades we needed to do the work of reporting on quality measures, improving performance on quality measures, enhancing our use of the EMR, and changing work flows in our clinical offices.

Our experience with CSI–RI, a Multi-payer Advanced Primary Care Practice (MAPCP) demonstration site, taught us valuable lessons about PCMH implementa-

tion. Very early in the CSI–RI program, it became abundantly clear that the EMR is an essential tool for measuring and reporting the quality of clinical care. Another early lesson was the central role that a Nurse Care Manager can play as a member of the PCMH team, coordinating patient care and engaging patients in managing their own health.

The Medicare Shared Savings ACO and Advanced Payment Model program opportunities are now important drivers of Coastal's strategic decision to embrace accountable care. Our applications to those programs are pending, and we are hoping to be approved for a July 1 start date. An organization of our size will benefit greatly if we are able to access the working capital provided by the Advanced Payment Model. Such funding support will accelerate the delivery system reforms that we intend to accomplish.

COASTAL'S EXPERIENCE WITH BLUE CROSS BLUE SHIELD OF RHODE ISLAND

At Coastal, we recognize accountable care is our future, and are already engaged in a commercial shared savings contract with Blue Cross Blue Shield of Rhode Island (BCBSRI). That contract went into effect January 1, and it is the first of its kind in Rhode Island. Our creative work over the last several years with BCBSRI is a fine example of what can be accomplished in a collaborative relationship between a payer and a provider group that are both committed to meaningful reform. What we are learning very rapidly is that analyzing and understanding the total cost of care for a population is a very complex task that Coastal and BCBSRI need to learn more about together. Just last week, BCBSRI agreed to "embed" a data analyst at Coastal 3 days a week to help us create the level of understanding and reporting of utilization and cost analytics that we will need to create actionable recommendations for our providers.

Our ultimate goal at Coastal is alignment of payment methodology across all payers, including Medicare, for every Coastal patient—so that patient care becomes blind to insurance coverage and every resource is available for every patient in our practices.

SETTING A NEW STANDARD

We reject the status quo in our industry, and aspire to set a new standard for patient experience, access to care, reported clinical quality, and cost efficiency. In the setting of a total medical spend in the United States that is approaching 18 percent of the GDP, and estimates that 20–30 percent of that entire medical spend is waste, we reject goals such as "bending the cost curve." Instead, we have committed ourselves to ***reduce the total cost of care for our populations of patients by 5 percent by the end of 2014***. Already, we can point to significant accomplishments in our efforts to reduce costs, and most of our potential in this endeavor has yet to be realized.

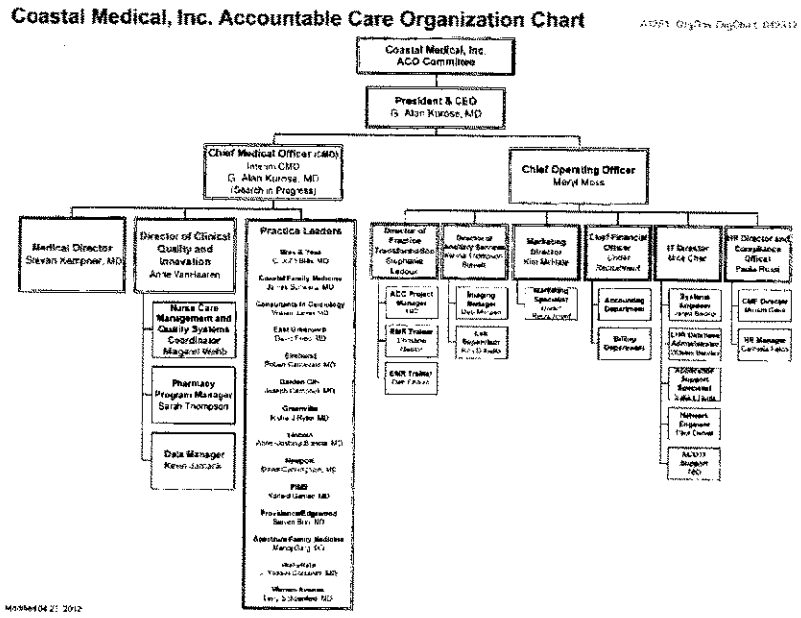
Our new "Coastal 365" campaign will let our patients know that we will now have an office open where they can be seen by a primary care physician 365 days a year. And we will maintain the performance on clinical quality that helped us achieve 20 out of 20 clinical quality targets for our 2011 Blue Cross contract, and made us the first practice in the Rhode Island Beacon Communities Program of the ONC to achieve every clinical quality target for that initiative in the first quarter of 2012.

RETURN ON INVESTMENT

If one examines Coastal as a case study of the process of building a progressive medical organization from the ground up, it is reasonable to consider the investment made by the Federal Government in the form of incentive funding that Coastal has been able to access, and to ask: "What has been built?"; "What are the results to date?"; and "How does the care look different?"

INFRASTRUCTURE DEVELOPMENT

The answer to "What has been built?" is shown in our organization chart below. We believe that we have created a lean but sufficient infrastructure to support successful execution of accountable care. We expect to identify additional modest staffing needs as we progress in our evolution as a primary care-driven ACO. Coastal remains very much a work in progress, as evidenced by the fact that our first Chief Medical Officer and our first Data Manager were both hired within the last month.



PERFORMANCE ON QUALITY

A few highlights of our performance in achieving quality targets are shown in the table below.

Coastal's Performance on Quality Metrics (BCBSRI, CSI–RI, and Beacon)

Quality measure	Coastal performance (In percent)	Target (In percent)
Diabetics with Good Blood Sugar Control	69.8	65
Good BP Control (<140/90)	79.1	68
Tobacco Cessation Intervention	81.4	>80
Fall Risk Screen in Elderly	82.0	>65
Depression Screening	76.9	>50
Pediatric		
Appropriate Rx Upper Respiratory Infxn.	97.5	90
Weight Assessment & Counseling	99.6	60
Adolescent Immunizations	94.3	90
Obtaining Sexual History	100.0	50

PERFORMANCE ON UTILIZATION AND COST

At the moment, Coastal has access to utilization and cost data only for its BCBSRI Commercial and Medicare Advantage populations. All payer utilization data is expected shortly for our two CSI–RI practices. Some highlights of our utilization and cost performance for our BCBSRI populations in 2011:

- **Medicare hospital days/1000 reduced by 13 percent vs. 2010.**
- **Medicare re-admission rate reduced by 27.6 percent vs. 2010.** (Coastal rate is 13.7 percent. RI rate is 20.51 percent (47th in United States). Best State rate in the United States is 13.64 percent).
- **Total cost of care for Coastal's BCBSRI population in 2011 was $6 million less** than if risk-adjusted cost per member were the BCBSRI network average.

• **Total cost of care for all Coastal BCBSRI members increased by just 1.5 percent in 2011.**

PATIENT-CENTERED CARE

Care *does* look different to Coastal patients today versus just a few years ago. Some highlights:

• Every phone call is now answered "Hello, Coastal Medical. Would you like to see a provider today?"
• Pediatric offices are open 7 days a week. Our adult Saturday clinic opened in January 2011. We are opening an adult Sunday and holiday clinic on July 1 (see "Coastal 365" above).
• A completely redesigned patient-oriented Web site went live 2 months ago. Educational links, information about immunization clinics, and health and wellness features are just some of the offerings.
• Our patient portal to the EMR went live in January 2012.
• A Nurse Care Manager works in every Coastal office.
• Clinical Pharmacists rotate through every Coastal office.
• Community-based Nurse Care Managers contact every patient within 2 days of hospital discharge and often see patients during their hospital stay.

OUR MESSAGE FROM THE FRONT LINES

At Coastal Medical, we recognize the status quo of healthcare costs and healthcare delivery is unsustainable. We welcome the challenge of accountable care, and believe that our technologically enabled, physician-governed primary care organization provides an example of a fairly unique primary care-driven ACO model that allows smaller practices to join together and embrace accountability for the Triple Aim goals of a population of patients.

Federal incentive programs have been vitally important to our growth and development to date. Also, RI Health Insurance Commissioner Chris Koller has implemented an "Affordability Standards" mandate which compels commercial payers to increase their primary care spend each year, and this has brought commercial payers to the contract negotiating table with an additional incentive to invest in Coastal's infrastructure development.

We have had much success implementing practice transformation to a Patient Centered Medical Home (PCMH) model of care. Enhanced physician, staff, and patient satisfaction and improved reporting and performance on quality of care have been important benefits of our PCMH work. However, we also recognize that **PCMH practice transformation is an interim step and not a final stage of development for progressive primary care practice groups.** Continuing the work of transforming care delivery and advancing our capability to manage the care of populations will require more sophisticated use of clinical, utilization, and cost data; and new types of interventions based on what that data can tell us.

Understanding and managing the total cost of care for our patient population is our newest challenge, and we are diving into that work at this very moment, upgrading our infrastructure once again to keep pace as our payment and care delivery models continue to rapidly evolve.

Coastal's experience of collaborative work in the Rhode Island primary care community suggests that **there is a widespread need for practices to have access to sophisticated analytic reports regarding utilization of services and cost of different types of care for their patient populations.** Mechanisms to support practices in gaining access to such data and analysis may be a reasonable area to consider for investment in new Federal incentive programs.

There is also little transparency of pricing of healthcare services in the Rhode Island market. This circumstance places both individual consumers (many of whom are now on high deductible health plans) and groups like Coastal at a disadvantage as we attempt to control healthcare costs. Measures to improve **transparency of pricing** appear from our point of view to be another area where new initiatives might help support a rational approach to controlling healthcare costs.

Senator WHITEHOUSE. Dr. Kurose, before I let you go, can you just quickly answer this question? How are your phones answered at Coastal Medical?

Dr. KUROSE. "Coastal Medical, would you like to see a provider today?"

Senator WHITEHOUSE. Today.

Dr. KUROSE. Today. Thank you.

Senator WHITEHOUSE. Next witness is Marcia Guida James. She is the director of Provider Engagement in Humana's National Network organization.

Humana is headquartered in Louisville, KY. It offers health and supplemental benefit plans for employer groups, Government programs, and individuals. It serves 11.8 million medical members and 7.7 million specialty benefit members across the country.

Ms. James leads Humana's Provider Engagement and Payment Reform Division, and developed Humana's Provider Rewards program. Her work at Humana includes leading the organization's work on e-connectivity pilots, and implementing of Humana's first medical home project. Ms. James is a key operational leader on Humana's Accountable Care Organization pilot with the Brookings Institute and the Dartmouth Institute.

The most recent data on the ACO pilot shows improvements in quality, utilization, and physician visits following hospitalization including 8.6 percent improvement for cholesterol management and diabetes, 12.9 percent improvement in appropriate emergency room visits, and 36.6 percent improvement in physician visits within 7 days of discharge.

Ms. James currently serves as co-chair of the E-Health Initiative Accountable Care Council, co-chair of the Implementing Performance Measures Workgroup for the ACO Learning Network, and is Humana's representative on the executive committee of the patient-centered Primary Care Collaborative. She has an M.S. in community health, an MBA in health care management, and is a certified professional coder, which sounds ominous.

Ms. James, I appreciate you coming in today as well. Please proceed with your testimony.

STATEMENT OF MARCIA GUIDA JAMES, MS, MBA, CPC, DIRECTOR OF PROVIDER ENGAGEMENT, HUMANA, LOUISVILLE, KY

Ms. JAMES. Thank you, Mr. Chairman, for convening this hearing to focus attention on transformational delivery system reforms.

Humana appreciates the opportunity to talk about our role in advancing value-based, technology-driven system reforms, including provider collaborations that reward high quality, evidenced-based, efficient care. We believe, like you, that these types of reforms result in better outcomes and lower costs for all Americans.

Today, I will share a few of our unique provider collaborations all of which are driven by best practice health IT arrangements. These initiatives strengthen our Nation's health care system and align with the National Quality Strategy's three aims of better care, healthy people in communities, and affordable care.

Please note that our written testimony contains further details of my testimony today.

Humana's provider engagement initiatives include 25 years' experience with various accountable care models. We are in 52 markets with over 560,000 Medicare Advantage members. These models center on robust exchange of clinical and financial information with provider partners in a variety of flexible reimbursement models.

Our Humana Provider Quality Rewards Program, unlike other pay-for-performance models for primary care physicians, our pro-

gram is designed to meet physicians on their own terms based on their level of practice complexity, as well as to encourage quality improvements.

The program has resulted in a 2 percent improvement in colorectal cancer screenings, a 4 percent increase in spirometry testing, and finally for all of 2011, there was a 7 percent increase in breast cancer screening.

We also partner with the Electronic Health Record vendors to advance our medical home EHR rewards program centered on meaningful use. We want to support the national aim and adoption of EHR's in physician practices.

Addressing the shortfalls in primary care practice and primary care access by expanding primary care and urgent care centers, and workplace wellness sites in 550 point-of-care locations through our new Concentra business division.

We also partner with clinic-based primary care centers to provide coverage in specially designed medical centers to seniors and primarily low income, underserved neighborhoods.

We are partnering with HHS at the Center for Medicare and Medicaid Innovation to promote the Comprehensive Primary Care Initiative in at least two geographies.

We also build information and clinical analytical models in our clinical data systems to enhance care and outcomes. This system integrates clinical guidance based on real-time data, identifies gaps in patient care, and alerts patients and providers to necessary care treatments. In December 2011, our system identified approximately 355,000 actionable gaps in care for our members that generated a multitude of alerts to nurses, providers, members, and our service operations teams.

We created a multi-payer provider health informational network. Along with the Blues of Florida in 2001, Humana co-founded Availity, a health information exchange network that physicians and hospitals use free of charge to help with collecting payments, processing referrals, detecting both potential adverse drug to drug interactions, and prescription drug fraud.

Our partnership with Norton Healthcare System, a Louisville, KY-based not-for-profit integrated delivery system, exemplifies the kind of delivery system advancement and outcomes that can occur when two partner organizations with different, but complementary, expertise come together to serve individuals in a coordinated manner.

Under this Dartmouth and Brookings ACO pilot, we developed a global quality cost payment model where providers are evaluated based on their performance, on specified quality measures including diabetes measures, cancer screening, asthma, and cardiac care. Recently, the Commonwealth Fund highlighted this partnership in a case study and symposium.

Year 2 results from this pilot show a 9.1 percent decrease in unnecessary antibiotic treatment for adults with bronchitis, a 6.1 percent improvement in diabetic testing, an 8.6 percent improvement in cholesterol management for diabetics, additionally, a 36.6 percent improvement in physician visits within 7 days of discharge.

Humana has long support of primary care patient-centered medical homes. Over the years, we have established patient centered

medical homes in 10 States serving over 70,000 Medicare Advantage and over 35,000 commercial members. Our first arrangement began with Wellstar in 2007, an integrated delivery system in Atlanta. This pilot was one of the first in the country and produced a 6 percent improvement in diabetic management and blood pressure management.

Our current relationship with Queen City Physicians in Cincinnati, OH is similarly built on an integrated delivery system, strong data integration, and focused care coordination. We have seen a 34 percent decrease in emergency room visits, improvements in blood pressure control, and improvements in diabetic management.

Let me conclude with some lessons learned. We need to allow for flexibility in payment redesign. This is based on provider group readiness. Adoption of a one-size-fits-all approach will not meet the needs and capabilities of a wide range of provider groups.

Aligning incentives, a major impediment to major practice transformation, is the lack of alignment between traditional payment and value in health care. Humana's efforts represent a progression toward better alignment of initiatives.

Different models are not mutually exclusive. It is not uncommon to see combinations of these models used for the same enrolled populations. Public sector initiatives that build on the promising results observed in the private sector will be best positioned to achieve the goals of the national quality strategy. Alignment and harmonization is critical, better use of data and HIT capabilities to promote information exchange, and finally, continued exploration of additional ways to recognize the role of the patient in achieving desired outcomes.

Thank you, again, for this opportunity.

[The prepared statement of Ms. James follows:]

PREPARED STATEMENT OF MARCIA GUIDA JAMES, MS, MBA, CPC

SUMMARY

Humana, Inc., headquartered in Louisville, KY, appreciates the opportunity to share information about the role we are playing in advancing delivery system reform and rewarding physicians who deliver high quality and efficient care. Like you, we believe there is much promise in delivery system reforms to enhance the overall health care system in America and ultimately, improve patient care.

Humana is committed to strengthening our health care system through partnerships with providers, implementing a variety of new, collaborative delivery system models that seek to achieve the National Quality Strategy's three aims of better care, healthy people/healthy communities, and affordable care.

Highlights of Humana's innovative provider engagement initiatives include:

• Twenty-five years' experience with various accountable care models, including a pilot with Louisville-based Norton Healthcare System that has helped to enhance patient outcomes—decreasing unnecessary visits to emergency rooms as well as adult antibiotic treatment, increasing diabetic testing, and improving the number of physician visits within 7 days of discharge.

• Long-term experience with patient-centered medical homes including, but not limited, to pioneering work with WellStar (an Atlanta, GA-based integrated delivery system) and Cincinnati, OH-based Queen City Physicians. Both arrangements have shown demonstrable improvements in patient health outcomes and patient care, including decreases in emergency room visits; improvement in diabetic management; improvement in blood pressure control; and decrease in patients with uncontrolled blood pressure.

• A unique primary care provider rewards initiative designed to encourage quality and reward physicians that produces discernible results, including significant in-

creases in colorectal cancer screenings and spirometry testing, and marked increases in the number of participating physician practices meeting and/or exceeding patient care measures and in assuring that their patients got needed preventive and chronic care screenings.

• Availity, a cross-health plan, cross-provider, health information technology platform that supports physicians and hospitals, free of charge, and creates a comprehensive, multi-payor electronic patient health record. Additionally, our Care Hub clinical system fed by real-time data from Anvita Health integrates data for physicians, identifying gaps in patient care and generates alerts which can be sent to both patients and providers to inform them of necessary care treatments.

Humana has learned many constructive "lessons" over the course of its experience:

• The importance of allowing for flexibility in payment redesign, based on the readiness of provider groups. Adoption of a one-size-fits-all approach will undermine the ongoing active collaborations to customize arrangements to meet the needs and capabilities of a wide range of provider groups.

• Different models are not mutually exclusive; it is not uncommon to see combinations of these models used for the same enrolled populations.

• Alignment and harmonization of performance measures are important—disparate quality metrics, for example, will spread finite resources too thin, diluting the effectiveness of a National Quality Measurement strategy. Use of a well-established, tested set of performance measures is critical.

• Public sector initiatives that build on the promising results observed in the private sector will be best positioned to achieve the goals of the National Quality Strategy.

Humana appreciates the opportunity to share information about the role we are playing in advancing delivery system reform and rewarding physicians who deliver high quality and efficient care. Like you, we believe there is much promise in delivery system reforms to enhance the overall health care system in America and ultimately, ensure that people receive quality, coordinated health care.

My name is Marcia James. As the company's Director of Provider Engagement, I am responsible for leading Humana's efforts to advance health care delivery system innovations centered on programs that engage providers and health plans through payment reforms and technology-related initiatives. I developed Humana's Provider Rewards program and have served as the company's key operational leader for our Accountable Care Organization pilot collaboration with the Brookings Institute's Engleberg Center for Health Care Reform and the Dartmouth Institute for Health Care Policy and Clinical Practice.

By way of background, Humana Inc., headquartered in Louisville, KY, is a leading health care company that offers a wide range of health and wellness services and health care coverage products that incorporate an integrated approach to lifelong well-being. By leveraging the strengths of its core businesses, Humana believes it can better explore opportunities for existing and emerging adjacencies in health care that can further enhance wellness opportunities for the millions of people across the country the company serves. Humana offers a wide array of health and supplemental benefit plans for employer groups, government programs, and individuals, serving 11.8 million medical members and 7.7 million specialty-benefit members across the country. Humana is also one of the Nation's largest Medicare Advantage contractors with 2.2 million Medicare Advantage beneficiaries. In addition, Humana owns 318 medical centers and has 271 worksite medical facilities.

Humana is committed to strengthening our Nation's health care system through partnerships with providers to implement new models of delivery and payment that seek to achieve the National Quality Strategy's three aims of: better care, healthy people/healthy communities, and affordable care.

Our statement focuses on the following areas:

• Characteristics of the new health care landscape;

• Humana's initiatives in delivery system reform; and

• Lessons learned from these private sector efforts to maximize the opportunity for improvement systemwide.

EVOLUTION OF A NEW HEALTH CARE LANDSCAPE

Historical perspective: The existing gaps in health care quality and variation in clinical practice are well-documented. Often cited is research by the RAND Corporation that found that nearly half of all adult patients fail to receive recommended care. More recent research finds that poor quality continues to plague

our health care system. For example, elderly individuals undergo medical screening tests more frequently than is recommended, putting them at risk for unnecessary, invasive diagnostic followup and complications.[1] Variation in care also continues to exist, with no consistent pattern of care found among even the Nation's top academic medical centers for Medicare patients with advanced cancer.[2] In addition, according to the National Committee for Quality Assurance (NCQA), as many as 91,000 people in the United States die each year because they do not receive recommended evidence-based care for chronic conditions like high blood pressure, diabetes, and heart disease. These are just some of the many examples of the effect our fragmented health care system has on the quality and effectiveness of care. All of this has led to an overwhelming recognition of the need to move from an encounter-based health care system to one that is seamless, coordinated and focused on the full continuum of patient care.

Characteristics of the New Landscape: The private sector, and increasingly the public sector, has implemented a range of different models of care designed to achieve the Nation's goals of improving the quality and value of health care. While health care delivery will continue to evolve as we learn new and better ways to provide safe, effective, and affordable care, there are several key elements common to our new health care landscape that characterize these initiatives.

• *Cooperation/Partnerships:* First and foremost is a renewed sense of cooperation. Recognition on the part of health plans and clinicians alike of the urgent need for practice transformation has resulted in a more collaborative process in identifying priority areas for improvement and performance goals. In fact, a recent study of health plan and provider accountable care partnerships showed a clear trend toward longer term, less adversarial relationships. This same study showed a willingness on the part of both parties to adopt customized arrangements that reflect the different needs and varying levels of capability of the provider groups involved.[3] A better understanding of the strengths each partner brings to these new arrangements leads to increased flexibility in the design of these models and avoids the pitfalls of a one-size-fits-all approach.

• *Improved Performance Standards:* Improved performance standards, many of which emphasize patient outcomes, have enabled health plans and providers to focus on specific areas of care and demonstrate tangible improvements. Goals related to efficiency and value are looked at in concert with quality goals, rather than in isolation, resulting in contract negotiations that have moved beyond merely setting payment rates to identifying achievable quality and efficiency goals. These improved performance standards are supported by an enhanced ability to measure, collect, aggregate and analyze information on provider performance to pinpoint gaps in care and help drive quality improvement.

• *Emphasis on Patient-Centered Care:* Patient engagement in treatment decisions, as well as self-management tools, help patients make informed decisions, better manage their own care, and adhere to treatment plans and wellness programs designed to their specific conditions. Increasingly, value-based benefit designs that promote the utilization of evidence-based health care services, offer patients a role in helping the Nation achieve its health goals by offering patient incentives for making evidence-based health care choices. Health plans implementing new models of care are continuing to explore additional incentives that might be used to further support the patient role in attaining better quality and reduced cost.

• *Use of Health Information Technology (HIT) and Decision Support Tools:* These models rely heavily on the optimal use of HIT and decision support tools—both by the clinician and the patient. Whether through electronic health records, patient registries, or an alternative HIT infrastructure, better use of data and HIT supports population health management, disease and case management, treatment decision support, and performance measurement—activities critical to improving patient outcomes at the point of care and identifying additional opportunities to bridge gaps in care.

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[1] Sima CS, Panageas KS, Schrag D. Cancer screening among patients with advanced cancer. JAMA 2010; 304:1584–91 and Goodwin JS, Singh A, Reddy N, Riall TS, Kuo Y. Overuse of Screening Colonoscopy in the Medicare Population. Arch Intern Med 2011; 171(15):1335–43.

[2] Goodman DC, Fisher ES, et al. Quality of End-of-Life Cancer Care for Medicare Beneficiaries: Regional and Hospital-Specific Analyses, A Report of the Dartmouth Atlas Project. November 16, 2010. *http://www.dartmouthatlas.org/downloads/reports/Cancer_report_11_16_10.pdf.*

[3] Higgins, A. Early Lessons from Accountable Care Models In The Private Sector: Partnerships Between Health Plans And Providers. Health Aff (Millwood). 2011:30(9):1718–27.

HUMANA'S LEADERSHIP IN INNOVATIVE DELIVERY SYSTEM REFORM

Humana has used this new health care landscape as a foundation upon which to build innovative partnerships and models of care with hospitals and physicians that offer better care and better value. To this point, Dr. David Nash, one of Humana's board members and the founding Dean of the Jefferson School of Population Health, compares our current health care system to "an NFL football team that never practices together, but plays games on Sunday"—outcomes in sports and in medical care are going to be better when teammates know each other and work together regularly and cooperatively. For all these reasons, Humana is working with providers on a variety of new, collaborative delivery system models which I will outline below—first generally, and then focusing in on our initiatives around Accountable Care Organizations and Patient-Centered Medical Homes.

Highlights of Humana's innovative provider engagement initiatives include:

• Twenty-five years' experience with various accountable care models with system capabilities that center on robust exchange of clinical and financial information (data transmission and data sharing) with provider partners and engage a variety of flexible reimbursement models.

• Humana's Provider Rewards programs, a primary care provider rewards initiative designed to encourage quality and reward physicians. Unlike other "pay-for-performance" models, Humana's program is designed to help meet physicians on their own terms based on level of practice complexity as well as to encourage quality improvements. During the first 9 months in 2011, the program resulted in such improved health outcomes as a 2 percent improvement in colorectal cancer screenings and a 4 percent increase in spirometry testing. Additionally, over the same time period, there was an over 50 percent increase in the number of participating physician practices meeting and/or exceeding patient care measures and 40 percent increase in assuring that patients got needed preventive and chronic care screenings.

• Partnering with electronic health record (EHR) vendors to advance a Medical Home EHR Rewards Program centered on "meaningful use," aiming to support national adoption of electronic medical records in physician practices with subsidies, among other offerings.

• Addressing the shortfalls in primary care access by expanding primary care and urgent care centers and workplace wellness sites in 550 point-of-care locations through our new Concentra business division.

• Partnering with clinic-based Primary Care Centers to provide coverage in specially designed medical centers to seniors in primarily low income, underserved neighborhoods.

• Partnering with HHS's Center for Medicare and Medicaid Innovation to promote a primary care initiative across two geographies.

• Building information and clinical analytical models under our Anvita Health and CareHub systems to enhance care and health outcomes by integrating clinical guidance based on real-time data for physicians, identifying gaps in patient care and alerting both patients and providers to necessary care treatments. For example, our Anvita rules engine identified approximately 355,000 *actionable* gaps in care for our members that, in turn, generated a multitude of alerts to nurses, providers, members and our service operations teams. As a result, 31 percent of these gaps in care were converted into actions to improve outcomes for those members.

• Teaming initially with Blue Cross/Blue Shield of Florida in 2001 (now expanded to include Health Care Services Corporation, Blue Cross Blue Shield of Minnesota and Wellpoint), Humana co-founded Availity, a cross-health plan, cross-provider, health information technology network that physicians and hospitals use free of charge to help with collecting payments, keeping track of referrals, detecting potential adverse drug-to-drug interaction and prescription drug fraud and abuse and ultimately, creating a comprehensive, multi-payor electronic patient health record. Availity now delivers health information solutions to a growing network that currently includes more than 200,000 physicians and providers of care, 1,000 hospitals, 1,300 health plans and 450 industry partners. Over 1 billion transactions are processed annually.

HUMANA DELIVERY SYSTEM INNOVATIONS IN MORE DETAIL: HUMANA/NORTON ACO AND PATIENT-CENTERED MEDICAL HOMES

Accountable Care Organizations—Humana's partnership with Norton Healthcare System

Our partnership with Norton Healthcare System, a Louisville, KY-based, not-for-profit integrated delivery system, provides an excellent example of the type of delivery system advancement and outcomes that can occur when two partner organiza-

tions with different, but complimentary, expertise come together to serve individuals in a coordinated manner. Under this ACO-type approach, Humana has entered into a pilot with Norton Healthcare, sponsored by the Dartmouth Institute for Health Policy and Clinical Practice and the Engelberg Center for Health Care Reform at the Brookings Institution (Dartmouth-Brookings). Humana brought the opportunity to participate in the pilot to Norton; Norton had an immediate interest. Participation in this pilot has allowed the development of a global quality/cost payment model. Providers are evaluated based on their performance on specified quality measures, such as diabetes measures, cancer screening, asthma care and cardiac care. Recently, the Commonwealth Fund highlighted this partnership in a case study and symposium.[4]

Central to this pilot is accountability of measured outcomes, cost, and patient delivery, focusing on industry-standard performance measures. The partnership is guided by three core principles: (1) integrated care delivery among provider teams; (2) defined patient population to measure; and (3) pay-for-results based on improved outcomes and cost.

Already, the partnership has shown significant results. Our most recent data, based on Year-Two outcomes, showed marked improvement relative to baseline in quality, utilization and physician visits following hospitalization:

- **Quality:** 9.1 percent decrease in unnecessary antibiotic treatment for adults with bronchitis; 6.1 percent improvement for diabetic testing and 8.6 percent improvement for cholesterol management in diabetics;
- **Utilization:** 12.9 percent improvement in appropriate emergency room visits (per 1,000); and
- **Patient Followup:** 36.6 percent improvement in physician visits within 7 days of discharge.

Patient-Centered Medical Homes

Humana has long supported the notion of patient-centered medical homes through various arrangements. Over the years, we have established Patient-Centered Medical Home arrangements in Florida, Ohio, Colorado, Illinois, Michigan, Kentucky, Texas, Tennessee, Missouri and South Dakota—serving over 70,000 Medicare Advantage and over 35,000 commercial health insurance members. Under some of these arrangements, Humana provides financial assistance to help selected physician practices acquire electronic health record (EHR) systems, which can help facilitate enhanced care coordination and allow them to meet Meaningful Use criteria.

In 2008, Humana joined in helping establish the Patient-Centered Primary Care Collaborative, founded by Dr. Paul Grundy—a coalition of more than 900 employers, consumer groups, quality organizations, hospitals and clinicians. The Collaborative is dedicated to advancing patient-centered medical homes that have the following attributes: (1) ongoing relationships with a personal physician; (2) physician-directed medical practice; (3) whole-person orientation; (4) coordinated and integrated care; (5) enhanced access to care; and (6) payment that appropriately recognizes the added value of services provided.

We began our first medical home arrangement in 2007 with WellStar, an integrated delivery system located in Atlanta, GA. This pilot was one of the first in the country. Overall, it produced a 6 percent improvement in diabetic management (A1c levels) and blood pressure management. Additionally, there was a 20 percent improvement in management of "bad" cholesterol levels.

Our current partnership with Cincinnati, OH-based Queen City Physicians similarly is built on a model of integrated care delivery, strong data integration and focused care coordination. This approach has shown demonstrable results:

- 34 percent decrease in emergency room visits;
- 10 percent improvement in diabetic management (A1c levels);
- 15 percent improvement in blood pressure control; and
- 22 percent decrease in patients with uncontrolled blood pressure.

LESSONS LEARNED: MAXIMIZING THE OPPORTUNITY FOR IMPROVING QUALITY AND VALUE SYSTEMWIDE

- It is now widely understood that a major impediment to practice transformation is the lack of alignment between traditional payment and value in health care. Humana's efforts represent a progression toward better alignment of incentives.
- Different models are not mutually exclusive; it is not uncommon to see combinations of these models used for the same enrolled populations.

[4] *Norton Healthcare: A Strong Payer—Provider Partnership for the Journey to Accountable Care,* The Commonwealth Fund, Case Study Series, January 2012.

• Public sector initiatives that build on the promising results observed in the private sector will be best positioned to achieve the goals of the National Quality Strategy. Alignment and harmonization is important—disparate quality metrics, for example, will spread finite resources too thin, diluting the effectiveness of a national quality measurement strategy. Use of a well-established, tested set of performance measures is critical.

• Humana's experience has shown the importance of allowing for flexibility in payment redesign, based on the readiness of provider groups. Adoption of a one-size-fits-all approach will undermine the ongoing active collaborations to customize arrangements to meet the needs and capabilities of a wide range of provider groups.

• Better use of data and HIT capabilities to promote information exchange has proven to be essential to making progress toward quality and resource targets, while continuing to advance the national agenda of connectivity.

• Continued exploration of additional ways to recognize the role of the patient in achieving desired outcomes will be necessary to support the health plan and clinician roles.

Thank you again for holding this hearing to highlight the important role delivery system reform plays in improving both the quality and value of health care and furthering the goals of the National Quality Strategy. We look forward to continuing our work with the committee in pursuit of these goals.

Senator WHITEHOUSE. Thank you very much, Ms. James.

Our final witness is less from the front lines than from the policy side. His name is James Capretta. He is a fellow at the Ethics and Public Policy Center, and a visiting fellow at the American Enterprise Institute. He was an associate director at the White House Office of Management and Budget from 2001 to 2004.

And at the Ethics and Public Policy Center, he studies a wide range of public policy and economic issues with a focus on health care and entitlement reform, U.S. fiscal policy, and global population again. He is also a visiting fellow at the Heritage Foundation.

Earlier in his career, Mr. Capretta served in Congress as a senior analyst for health care issues and for 3 years, he was a budget examiner at OMB. He has an M.A. in public policy studies from Duke University and a B.A. in government from the University of Notre Dame.

Mr. Capretta, welcome.

STATEMENT OF JAMES C. CAPRETTA, FELLOW, ETHICS AND PUBLIC POLICY CENTER, AND VISITING FELLOW, AMERICAN ENTERPRISE INSTITUTE, WASHINGTON, DC

Mr. CAPRETTA. Thank you, Senator Whitehouse. Thank you, members of the committee.

I am very pleased to be here to participate in this very important hearing on health care delivery system reform.

Let me begin with what I think is a point of agreement, which is that Medicare fee-for-service, as the program is currently constituted, is a primary cause of widespread systemic deficiencies in health care delivery that we all want to see addressed.

Why do I think this is a point of agreement? If you look at the 2010 health care law, the key delivery system reforms that are being promoted and pushed, mainly by the Administration, are mainly within the Medicare program itself. Although I am skeptical of the policy prescription, I agree that the changes in Medicare are the right place to start.

Despite the many virtues of American health care, there is no denying that it is all too often highly inefficient. The system is characterized by extreme fragmentation; physicians, hospitals, clinics,

labs, and pharmacies are all autonomous units that are financially independent of one another. They bill separately from the others when they render services to patients. What is worse, there is very little coordination of care among them, which leads to a very high level of duplicative services and low quality care in too many instances.

At the heart of this dysfunction, actually, is the Medicare fee-for-service program. In a June 20, 2009 article in "The New Yorker," Atul Gawande, kind of a very famous article, contrasted the high use, high cost care provided in McAllen, TX to the less costly and higher quality care provided in other cities such as El Paso, TX and also at institutions such as the Mayo Clinic.

Robert Book, however, later pointed out that the real lesson from the Gawande study may be quite different from what most assumed initially. At the time, President Obama and others cited the article as an example of how physician culture and practice patterns have run amok in certain regions of the country, and why bending the cost curve would require addressing these problems.

Yet upon closer inspection, it became clear that the cost differences between McAllen and El Paso were largely confined to Medicare. For the non-Medicare population, the cost differential between the two cities is practically nonexistent. As Book explained, this suggests that Gawande covered a problem with Medicare in McAllen, TX not a problem with medical practice in general in McAllen. Indeed, Gawande's article never really explained who was paying for McAllen's overbuilt system.

It turns out it was largely Medicare fee-for-service with its emphasis on expensive, volume-driven delivery structure. Without Medicare fee-for-service payments for every physician prescribed diagnostic test and surgical procedure, the expensive infrastructure in McAllen would never have been viable.

CBO reports that the average beneficiary—and this is not just located in McAllen—CBO reports that the average beneficiary used 40 percent more physician services in 2005 than they did just 8 years earlier. Spending for physician-administered imaging and other tests was up approximately 40 percent in 2007 compared to 2002, according to MedPAC.

The Administration is trying to address these problems caused by Medicare in the delivery system with initiatives championed by the Centers for Medicare and Medicaid Services. As you probably gather, I am a little bit skeptical that these efforts will solve the problem.

The most prominent delivery reform now being pursued is the effort to move more care delivery into Accountable Care Organizations. Interestingly, a 5-year pilot project on ACO's has already come up short of the high hopes placed upon it.

According to a 2011 story in *The Washington Post*,

> "In 2010 the final year, just four of the ten sites that were part of the study, all long-established groups run by doctors, slowed their Medicare spending enough to qualify for a bonus."

Moreover, the Congressional Budget Office has systematically examined many demonstration initiatives carried out by CMS over the past decade or so, all of which were aimed at carrying out, in various ways, delivery system reform so that costs would moderate

and patient care would improve. The results have been terribly disappointing.

As CBO's director, Douglas Elmendorf, put it,

> "The demonstration projects that Medicare has done in this and other areas are often disappointing. It turns out to be pretty hard to take ideas that seem to work in certain contexts and proliferate that throughout the entire health care system."

I believe there are two reasons to be skeptical about whether or not this is going to be something that can be taken throughout the whole system. First, Medicare fee-for-service looks and operates as it does today for a reason. It is simply much easier for Government-run insurance models to impose across the board payment rate reductions to hit budget targets than it is to make distinctions among providers based on quality and cost data.

This might be thought of as CMS's version of what others have called, and I have called in the past, "the Lake Woebegone effect." Basically to the Government, all providers of medical care are slightly above average. Repeated attempts over the years to steer patients toward preferred physicians or hospitals that have a better record have failed miserably because the political oversight of the program and regulators have never been able to withstand the uproar that comes when some providers are favored over others.

I have other things I would like to cover, and we can do that, I am sure, in the question and answer period.

Thank you very much.

[The prepared statement of Mr. Capretta follows:]

PREPARED STATEMENT OF JAMES C. CAPRETTA

Senator Whitehouse, Ranking Member Enzi, and members of the committee, thank you for the opportunity to participate in this very important hearing on health care delivery system reform.

I would like to make three basic points in my testimony today:

1. The source of many of our problems in health care delivery is the dominant Medicare fee-for-service (FFS) program. It will be nearly impossible to move to a high-value, low-cost delivery system if Medicare FFS continues to operate as it does today.

2. The 2010 health care law's efforts at "delivery system reform"—most of which fall within Medicare—are very unlikely to be the solution people are hoping for because the Federal Government is not good at fostering a high-value, low-cost provider network.

3. A more reliable approach to higher-quality and lower-cost patient care is strong competition in a functioning marketplace.

MEDICARE'S ROLE IN DYSFUNCTIONAL HEALTH CARE DELIVERY

Let me begin with what I think is a point of agreement: Medicare fee-for-service (FFS), as the program is currently constituted, is a primary cause of the systemic deficiencies in health care delivery that we all want to see addressed.

Why do I think this is a point of agreement? By looking at the 2010 health care law. The key "delivery system reforms" that are being pushed and promoted by the Administration are mainly in the Medicare program. In effect, the Administration is hoping to change how health care is delivered for everyone in the United States by changing how Medicare buys services for its enrollees.

Although I am skeptical of the policy prescription, I agree that changes in Medicare are the right place to start.

American health care has many virtues. The system of job-based insurance for working-age people and Medicare for retirees provides ready access to care for most citizens (although access is more problematic for the poor through Medicaid). We have the most advanced network of clinics and inpatient facilities found anywhere

in the world. And U.S. health care is also open to medical innovation in ways that other health systems around the world are not.

But there is no denying that health care in the United States is all too often highly inefficient. The system is characterized by extreme fragmentation. Physicians, hospitals, clinics, labs, and pharmacies are all autonomous units that are financially independent of one another. They bill separately from the others when they render services to patients; what's worse, there's very little coordination of care among them, which leads to a disastrous level of duplicative services and low-quality care in too many instances. The bureaucracy is maddening, the paperwork is burdensome and excessive, and there is very little regard for making the care experience convenient and pleasant for the patient.

At the heart of this dysfunction is Medicare—and more precisely, Medicare's dominant FFS insurance structure.

In a June 2009 article in *The New Yorker*, Atul Gawande contrasted the high-use, high-cost care provided in McAllen, TX, to the less-costly and higher-quality care provided in other cities, such as El Paso, TX, and at institutions such as the Mayo Clinic.[1] However, as Robert Book later pointed out, the real lesson from the Gawande study may be quite different from what most assumed initially.[2] At the time, President Obama and others cited the article as an example of how physician culture and practice patterns have run amok in certain regions of the country and why "bending the cost curve" would require addressing these problems.

Yet upon closer inspection, it became clear that the cost differences between McAllen and El Paso were largely confined to Medicare. For the non-Medicare population, the cost differential between the two cities is practically nonexistent.[3] As Book explained, this suggests that Gawande uncovered a problem with *Medicare* in McAllen, not a problem with medical *practice* in McAllen.

Indeed, Gawande's article never really explained who was paying for McAllen's overbuilt system. It turns out it was Medicare FFS, with its emphasis on an expansive, volume-driven delivery structure. Without Medicare FFS payments for every physician-prescribed diagnostic test and surgical procedure, the expensive infrastructure in McAllen would never have been viable.

Medicare's FFS insurance is the largest and most influential payer in most markets. As the name implies, FFS pays any licensed health care provider when a Medicare patient uses services—no questions asked. Nearly 75 percent of Medicare enrollees—some 37 million people—are in the FFS program.[4] Physicians, hospitals, clinics, and other care organizations most often set up their operations to maximize the revenue they can earn from Medicare FFS payments.

For FFS insurance to make any economic sense at all, the patients must pay some of the cost when they get health care. Otherwise, there is no financial check against the understandable inclination to agree to all of the tests, consultations, and procedures that could be possible, but not guaranteed, steps to better health.

But Medicare's FFS does not have effective cost-sharing at the point of service. Of course, the program requires some cost-sharing, including 20 percent co-insurance to see a physician. But the vast majority of FFS beneficiaries—nearly 90 percent, according to the Medicare Payment Advisory Commission (MedPAC)—have additional insurance, in the form of Medigap coverage, retiree wraparound plans, or Medicaid, which fills in virtually all costs not covered by FFS.[5] Further, Medicare's rules also require providers to accept the Medicare reimbursement rates as payment in full, effectively precluding any additional billing to the patient.

In the vast majority of cases, then, FFS enrollees face no additional cost when they use more services, and health care providers earn more only when service use rises. It is not at all surprising, then, that Medicare has suffered for years from an explosion in volume of services used by FFS participants.

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[1] Atul Gawande, "The Cost Conundrum: What a Texas Town Can Teach Us About Health Care," *The New Yorker*, June 1, 2009, at *http://www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande*.

[2] Robert Book, "Medicare Variation Revisited: Is Something Wrong with McAllen, TX, or Is Something Wrong with Medicare?" The Foundry, December 14, 2010, at *http://blog.heritage.org/2010/12/14/medicare-variation-revisited-is-something-wrong-with-mcallen-texas-or-is-something-wrong-with-Medicare/*.

[3] Luisa Franzini, Osama I. Mikhail, and Jonathan S. Skinner, "McAllen and El Paso Revisited: Medicare Variations Not Always Reflected in the Under-Sixty-Five Population," *Health Affairs*, Volt. 29, No. 12 (December 2010), PP. 2302–09.

[4] *2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Insurance Trust Funds*, April 2012, Table IV.C1.

[5] Joan Sokolovsky, Julie Lee, and Scott Harrison, "Reforming Medicare's Fee-for-Service Benefit Design," Medicare Payment Advisory Commission, February 23, 2011, at *http://www.medpac.gov/transcripts/benefit%20design%20jsjl.pdf*.

CBO reports that the average beneficiary used 40 percent more physician services in 2005 than they did just 8 years earlier.[6] Spending for physician-administered imaging and other tests was up approximately 40 percent in 2007 compared to 2002, according to MedPAC.[7]

Medicare's dominant FFS design also stifles much-needed innovation in service delivery. As Mark McClellan, former Administrator of the Centers for Medicare and Medicaid Services (CMS), put it:

> In traditional FFS Medicare, benefits are determined by statute and cannot easily include many innovative approaches to benefit design, provider payment, care coordination services, and personalized support for beneficiaries. . . . When providers are paid more when patients have more duplicative tests and more preventable complications—as is the case in FFS payment systems—it is more challenging to take steps like adopting health IT or reorganizing practices in other ways to deliver care more effectively.[8]

THE LIMITATIONS OF GOVERNMENT-LED DELIVERY SYSTEM REFORM

The Obama administration is trying to address these problems caused by Medicare in the delivery system with initiatives being championed by the Centers for Medicare and Medicaid Services (CMS). I am very skeptical that these efforts will solve the problem.

The most prominent delivery system reform now being pursued is the effort to move more care delivery into accountable care organizations (ACOs).

An ACO allows doctors and hospitals to join voluntarily with others in new legal entities that are responsible for providing care across institutional and outpatient settings. The idea is to put physicians and hospitals in new organizational arrangements in which they share Medicare revenue and keep the savings if they provide quality care at less cost than FFS Medicare would normally pay. The physicians and hospitals participating in an ACO would keep a substantial portion of the resulting savings. In effect, ACOs are the latest in a long series of efforts to persuade physicians and hospitals to form provider-run—as opposed to insurance-driven—managed care entities.

Interestingly, a 5-year pilot project on ACOs has already come up well short of the high hopes placed upon it. According to a 2011 story in *The Washington Post*,

> "In 2010, the final year, just 4 of the 10 sites, all long-established groups run by doctors, slowed their Medicare spending enough to qualify for a bonus, according to an official evaluation not yet made public."[9]

Moreover, the Congressional Budget Office (CBO) has systematically examined many demonstration initiatives carried out by CMS over the past decade or so, all of which were aimed at carrying out, in various ways, "delivery system reform" so that costs would moderate and patient care would improve.[10] The results have been terribly disappointing. As CBO Director Douglas Elmendorf put it:

> The demonstration projects that Medicare has done in this and other areas are often disappointing. It turns out to be pretty hard to take ideas that seem to work in certain contexts and proliferate that throughout the health care system. The results are discouraging.[11]

I believe there are two reasons to be skeptical that the health care law's efforts will turn out differently. First, Medicare FFS looks and operates as it does for a reason, which is that it is much easier for government-run insurance models to impose across-the-board payment rate cuts than it is to makes distinctions among providers based on quality and cost data. (This might be thought of as the CMS's version of the "Lake Wobegon effect:" to the government, all providers of medical care are "slightly above average.") Repeated attempts over the years to steer patients toward

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[6] Congressional Budget Office, "Factors Underlying the Growth in Medicare's Spending for Physician Services," June 2007, Table 3.

[7] Medicare Payment Advisory Commission, *Healthcare Spending and the Medicare Program: A Data Book*, June 2009, p. 102.

[8] Mark McClellan, testimony before the Committee on the Budget, U.S. House of Representatives, June 28, 2007, at *http://www.allhealth.org/briefingmaterials/mcclellantestimony–818.pdf*.

[9] Amy Goldstein, "Experiment to Lower Medicare Costs Did Not Save Much Money," *The Washington Post*, June 1, 2011, at *http://www.washingtonpost.com/national/experiment-to-lower-Medicare-costs-did-not-save-much-money/2011/05/27/AG9wSnGH_story.html*.

[10] Congressional Budget Office, "Lessons from Medicare's Demonstration Projects on Value-Based Payment," January 2012, at *http://www.cbo.gov/sites/default/files/cbofiles/attachments/WP2012–02_Nelson_Medicare_VBP_Demonstrations.pdf*.

[11] Cited in Merrill Goozner, "Rising Health Care Curve Won't Bend, Even for Obama," *The Fiscal Times*, July 13, 2011, at *http://www.thefiscaltimes.com/Articles/2011/07/13/Rising-Health-Care-Curve-Wont-Bend-Even-for-Obama.aspx*.

preferred physicians or hospitals have failed miserably because politicians and regulators have never been able to withstand the uproar that comes when some providers are favored over others.

The private-sector delivery models that are rightly admired—such as Geisinger, the Cleveland Clinic, and Intermountain Health Care—operate very differently. They do not take just any licensed provider into their fold. They operate highly selective, if not totally closed, networks, which allows them to control the delivery system. Low-quality performers are dropped or avoided altogether, and tight processes are established to streamline care and ensure some level of uniformity. *Most importantly, these models have succeeded despite Medicare's perverse incentives, not because of them.*

A second flaw can be seen clearly in the ACO design. The name Accountable Care Organization begs the key question: accountable to whom? Because in the ACO design the beneficiaries are really not part of the equation. Initially at least, the beneficiaries are to be assigned to ACOs based on their use of physician services. They won't be asked up front if they want to join them. Moreover, the beneficiaries will share in none of the supposed savings from the ACOs. If the ACO effort is found to cut costs, the savings will be shared among the providers and the Government. What incentive do the beneficiaries have to enroll in what will very likely be seen as "managed care?"

In short, the ACO model is built around a flawed understanding of accountability. The ACO will be accountable to the Government with data and other requirements. But the ACO concept is not intended to give the beneficiaries a choice of competing plans and models. This is a very shortsighted way to look at delivery system reform. ACOs will be effective at reducing costs only by becoming more integrated and closed networks of providers who follow data-driven protocols for care. It would be far more effective if beneficiaries voluntarily signed up with such delivery models because it would reduce their costs too. As matters stand, the beneficiaries will have no financial incentive to give up complete autonomy in the choice of providers.

Moreover, for the ACO model to work, some high-cost, low-quality providers must be excluded from the ACO networks. As soon as that becomes evident, and provider revenue is threatened, the Government will come under intense pressure (as it has in the past) to loosen the ACO concept and allow virtually all licensed providers to become "preferred ACO providers." When that happens, the only way to control costs will be the old-fashioned way: with blunt, across-the-board payment rate reductions in Medicare (which is exactly what the 2010 health care law did to hit its budget targets).

RELYING ON A FUNCTIONING MARKETPLACE

The alternative to relying on a CMS-led delivery system reform effort is a functioning marketplace with cost-conscious consumers.

In 2003, Congress built such a marketplace, for the new prescription-drug benefit in Medicare. Two features of the program's design were important to its success. First, there was no incumbent government-run option to distort the marketplace with price controls and cost shifting. All private plans were on a level playing field. They competed with each other based on their ability to get discounts from manufacturers for an array of prescription offerings that are in demand among beneficiaries and their physicians.

Second, the Government's contribution to the cost of drug coverage is fixed and is the same regardless of the specific plan a beneficiary selects. The contribution is calculated based on the enrollment-weighted average of bids by participating plans in a market area. Beneficiaries selecting more expensive plans than the average bid must pay the additional premium out of their own pockets. Those selecting less-expensive plans pay a lower premium. With the incentives aligned properly, participating plans know in advance that the only way to win market share is by offering an attractive product at a competitive price because it is the beneficiaries to whom they must ultimately appeal.

This competitive structure, with a defined contribution fixed independently of the plan chosen by the beneficiary, has worked to keep cost growth much below other parts of Medicare—and below expectations. At the time of enactment, there were many pronouncements that using competition, private plans, and a defined government contribution would never work because insurers would not participate, beneficiaries would be incapable of making choices, and private insurers would not be able to negotiate deeper discounts than the Government could impose by fiat. All of those assumptions were proven wrong.

What actually happened is that robust competition took place, scores of insurers entered the program with aggressive cost-cutting and low premiums, and costs were driven down.

The result has been a strong record of success. In 2012, the average beneficiary premium is just $30 per month for seniors.[12] Over the 6 years that the program has been operating, the monthly premium has gone up an average of about $1 per year.[13] Overall, Federal spending has come in roughly 30–40 percent below expectations.

Similar changes—what might be called a defined contribution approach to reform—must be implemented in the non-drug portion of Medicare, as well as in Medicaid (excluding the disabled and elderly) and employer-provided health care.

In Medicare, that would mean using a competitive bidding system—including bids from the traditional FFS program—to determine the Government's contribution in a region. Beneficiaries could choose to enroll in any qualified plan, including FFS. In some regions, FFS might be less expensive than the competing private plans. But in some places, it almost certainly would not be, and beneficiary premiums would reflect the cost difference. This kind of reform could be implemented on a prospective basis so that those already on the program or nearly so would remain in the program as currently structured.

Moving toward a defined-contribution approach to reform would allow for much greater Federal budgetary control, which is of course a primary objective and tremendously important for the Nation's economy and long-term prosperity. But this isn't just a fiscal reform. It's a crucial step toward better health care too because it would put consumers and patients in the driver's seat, not the Government. With consumers making choices about the kind of coverage they receive as well as the type of "delivery system" through which they get care, the health system would orient itself to delivering the kind of care patients want and expect.

CONCLUSION

I commend the committee for holding this hearing today because it gets to the heart of the matter. To slow the pace of rising costs, we do need delivery system reform. But I do not think the Federal Government has the capacity or wherewithal to make it happen. Like other sectors of our economy, if we want higher productivity and better quality, we are going to need to rely on the power of a functioning marketplace.

Senator WHITEHOUSE. Thank you, Mr. Capretta.

Since this is my hearing and I am going to be here until the end, and to accommodate my colleagues' busy schedules, I am going to defer my questions until the end. I will turn, first, to our first Senator to arrive, Senator Franken.

Senator FRANKEN. Well, I am going to be here until the end, I think, too. So I understand Senator Mikulski——

Senator MIKULSKI. That is OK. Go ahead, Senator Franken.

Senator FRANKEN. OK.

Senator WHITEHOUSE. Good.

Senator FRANKEN. Thank you.

Ms. James, and by the way, it is Louie-ville not Louis-ville, as the Chairman mispronounced it.

Ms. JAMES. Thank you for the correction.

Senator FRANKEN. OK. I have to do that.

Senator WHITEHOUSE. He is this way all the time.

Senator FRANKEN. Well, you know. OK. Let us see. I have a question I wanted to ask that is different, quite different, a little different.

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[12] Department of Health and Human Services, "Medicare Prescription Drug Premiums Will Not Increase, More Seniors Receiving Free Preventive Care, Discounts in the Donut Hole," press release, August 4, 2011, at *http://www.hhs.gov/news/press/2011pres/08/20110804a.html.*

[13] For the average premium in 2006, see Medicare Payment Advisory Commission, "A Data Book: Healthcare Spending and the Medicare Program," June 2007.

We heard some great things that you are doing for your beneficiaries to promote better health care, quality, and lower costs, which is really the definition of delivery system reform.

The Diabetes Prevention Program, DPP, is a structured intervention for people with pre-diabetes. It includes nutritional information and exercise, and the program has been shown to reduce the risks that participants will be diagnosed with Type 2 diabetes by nearly 60 percent. This is the program that Senator Luger and I, actually, put in to the Affordable Care Act. It is one of the many cost reduction pieces that is in here.

It costs $300 for the DPP. It costs over $6,000 to take care of someone with diabetes, and the DPP reduced by nearly 60 percent the number of pre-diabetics who became diabetic. It was successfully piloted by the CDC in St. Paul and in Indianapolis, hence me and Senator Luger, and I authored the bill and he was my chief co-sponsor.

I talked with the CEO of United Health about this program right away, and they decided to cover it. The CEO told me that United Health will save $4 for every $1 they spend on the Diabetes Prevention Program.

Ms. James, do you not think that cost savings interventions like the DPP are a critical part of a delivery system reform?

Ms. JAMES. Yes, I do believe that there are programs out there like that, like the Diabetes Prevention Program that can save significant dollars. I do believe that.

Senator FRANKEN. And if you were diagnosed with pre-diabetes, would you not want to have access to a diabetes program, prevention program, like this one?

Ms. JAMES. Absolutely, and Humana has several diabetes prevention programs in place, as well, to identify patients who are pre-diabetic, and we have our diabetes prevention programming in place.

Senator FRANKEN. OK. Good. And I would urge you to look at ours, and maybe perhaps cover that as well.

Ms. JAMES. I would be happy to bring that information back to Humana, Senator.

Senator FRANKEN. Do you not think it makes sense for Medicare to be covering a program like this, since it saves money?

Ms. JAMES. Well Senator, I cannot answer for Medicare.

Senator FRANKEN. OK, OK. Never mind. I want to go to Dr. Kurose.

In Ms. James' testimony, she writes that a huge problem in our health care system is that we reward volume and not the quality of the care, and Mr. Capretta is basically saying that about fee-for-service. In other words, if you are a physician or a hospital in the current system, you get paid based on how many patients you see, and how many costly procedures you can perform, not whether they get better before or after you see them. So even though Minnesota continues to be a national leader in providing high quality care at low cost, we actually receive extremely low Medicare reimbursements.

Thankfully, the health care law made several changes that will help reward quality rather than quantity. For instance, several of us pushed to make sure that the law included a value index, which

will reward the kind of high quality, low-cost care that physicians in Minnesota and doctors in your practice provide. Unfortunately, the law only applies the value index to physicians and not the hospitals.

Doctor, do you not think that it makes sense to reward high value care in the way we pay hospitals, not just our individual providers?

Dr. KUROSE. Absolutely. I think that the delivery of value on health care has to be redefined at every level in the system.

As somebody who practiced for 20 years and tended to see maybe 18–20 patients a day, spend the time with them, talk to their families, to look across town and see somebody who is doing 40 visits a day, who is just killing it financially, who is really being rewarded. And so looking at my own practice thinking, "Gosh, I am actually being disadvantaged by taking this time to do a good job, to listen to people, to think carefully, to see 18 or 20 patients a day."

That is why we are so excited about accountable care because it is taking that system of perverse incentives, which is all volume-driven, and changing it so that it actually makes a difference whether you do a good job, whether you take good care of people. You put in quality incentives. You put in pay-for-process so that as you build new services for people that is rewarded. And then ultimately, you go to a system that makes payment based on quality and cost, and I think that has to apply at every level of the system.

So absolutely, I think it is something we can all agree about, probably, in this room that the fee-for-service system is a big piece of what got us where we do not want to be, here, today.

Senator FRANKEN. Right.

Dr. KUROSE. If you would indulge me for 1 second, I just have to tell you on the pre-diabetes, we have gone one step further.

We have a pediatric overweight and obesity trial going on called Food, Fitness, and Fun where we are collaborating with kinesiology students from the University of Rhode Island. We are bringing in nutritionists. We have a multidisciplinary pediatric trial working on improving kids who are above a certain percentage of ideal body mass index. That is really where the money is in terms of treating this epidemic of diabetes, and all the medical problems that are related to obesity, is to really start early. So we are excited about that.

Senator FRANKEN. Thank you. I assume we will get to a second round, and we will get into more of this fee-for-service, and that kind of thing.

Thank you, Mr. Chairman.

Senator WHITEHOUSE. Let me now recognize Senator Mikulski, who is the primary author of the quality provisions of the reform bill.

STATEMENT OF SENATOR MIKULSKI

Senator MIKULSKI. Thank you very much, Mr. Chairman or Mr. Acting Chairman for today; chairman du jour.

I really want to thank you for this wonderful report that you put out on the health care delivery system. And I think, perhaps, you have all seen the report because it is a one-stop-shop that essen-

tially tells us what we did and why we did it, and now this hearing asks, "What are we getting out of it?" I would hope that there would be a series of these types of reports and hearings, and that they would be more broadly participated in by both sides of the aisle. I really want to congratulate you on your work.

I would like to ask Dr. Kurose and Ms. James two questions, and then if there is time, two questions to Mr. Capretta.

When Senator Kennedy spoke during the health care debate, he asked there to be three task forces: one on access, one on prevention, one on quality. I was assigned quality, which really goes to prevention, I think. Senator Kennedy, throughout his wonderful career, was focused on access to make sure Americans had access to health care.

My focus as a social worker was what happened after you got access, because I was not convinced that once you had access, it made a difference rather than present a hollow opportunity. Dr. Kurose, you compared access to practices. That is where we got into quality. Let me get to where I am heading.

Our taskforce had very definite proposals. The first was to use technology to help create a kind of virtual medical home, a techno-medical home where the practitioners and clinicians involved with the patient would know the data narrative.

The second was to really use the tools that manage chronic illness, which is why we looked toward the medical home where a primary care doctor could do the best of what medicine offered, but could also call in either other medical specialists or those related to lifestyle and other challenges affecting the patient.

And the third was that if there was hospital admission, how to prevent re-admission using discharge planning, compliance with drug protocols, et cetera.

So now, let me get to you all. What you say in your testimony is stunning. It is exactly what we had envisioned; it is exactly what we wanted. So my question to you is: how did you achieve it? And, how did having a medical home work in practice?

Because, again, one of the things that usually derails everything is the lifestyle of the patient. They say genetics loads the gun, but lifestyle pulls the trigger. So even after brilliant medicine, if someone is a diabetic and they are still having two Coca-Cola's for lunch, two beers for dinner, and pizza as a snack, that patient is in trouble.

How did you do what you did? Is the medical home one of the primary reasons you could do what you did, from a delivery and patient standpoint—not from the bottom line standpoint? Is the medical home the way to go in the same sense?.

Dr. KUROSE. Let me begin by saying I think——

Senator MIKULSKI. It was a long——

Dr. KUROSE. I took some notes, so I think I got it—we are about halfway along our journey. I do not want to create the impression that this is anything but a work in progress because it is absolutely that. To pick up on some of the points that you made.

With technology, the electronic medical records have been a game changer. We are really embracing this team concept of care delivery. It is the primary care physician, but we have learned that there are interactions with patients that are executed better by

nurse care managers. Not just that you are offloading this task from a physician, but the nurse care manager has specialized training, they have more time. You have nurse care managers, you have clinical pharmacists, you have the medical assistant, you have the front desk people, you have the specialty doctors, you have the hospital providers, everybody is caring for this same patient. And the electronic medical record allows us all to be on the same page.

Certainly, in the medical home, we are all on the same page. We are working on interoperability with various hospital systems so that we can get cross talk with their information systems. We have made some really good progress with that, but it still is a work in progress and we are still building our State's health information exchange. It is up and running, but we need more people using it.

The approach to patients with chronic illness is really important; 5 percent of the sickest patients consume up to 50 percent of the health care dollar. Again, the team approach is critical, and we are looking more to reach out to patients, not only in the medical home, but outside of the medical home.

So yes, when they come to our office, they may be seen by multiple people, but we have a nurse care manager who is visiting with patients while they are still in the hospital now, and ensuring that their discharge planning is correct. If that does not happen, we call them within 2 days of discharge.

Our innovation grant proposals have community-based teams that will be going out to peoples' homes including even things like a transportation tech and a vehicle to go pick somebody up. Because we are, honestly, I have seen, you are talking to a patient at 10 a.m., they have no transportation. They are sick. They are elderly. Their kids do not get out of work, their grown kids, until 5 o'clock. You get halfway through the conversation, they get anxious and they say, "Oh, I am just going to call 9–1–1." We could say, "No, we will pick you up in 45 minutes. You will see your doctor within the hour." These are things that we can do to make care so much better.

The whole re-admissions piece, again, I think if we can touch patients in the hospital, it really helps. If we are really focused on transition——

Senator MIKULSKI. Could you come back to the lifestyle?

Dr. KUROSE. Sure, sure.

Senator MIKULSKI. I have not heard about social work, and I have not heard where you intervene in terms of truly helping people with lifestyle issues?

With transportation and so on——

Dr. KUROSE. There's transportation.

Senator MIKULSKI. Do you know what——

Dr. KUROSE. The teams in the grant that we proposed included a behavioral health specialist, a nurse care manager, a community outreach worker, the transportation person, and a clerical support person.

We do have diabetes education programs, but again, that are out of the individual medical homes. It is a work in progress. I met a group of doctors from Ohio that have 10 diabetes classes a week; 10 a week, every week. That is the kind of consistency of execution that, honestly, we are still working on.

We have some offices who are doing great classes, you know, adult male diabetic——

Senator MIKULSKI. My time is——

Ms. James, did you want to comment on what I said?

Ms. JAMES. Yes, absolutely. Thank you.

That is a great question and from the Humana perspective, I want to talk a little bit about the patient-centered medical home and how we support that. I mean, we are very involved on a high level with the patient-centered primary care collaborative with Paul Grundy.

We support, through our programming, health information technology adoption with meaningful use along with our medical home program. But more importantly, I want to talk a little bit about how we assist the practices. You are saying, "How do we get there?" And one way, because we believe strongly in medical home, is to help practices transform. So early on, we assisted practices with gap analysis and helping them to become medical homes.

Another way that we are assisting practices and how we get there with re-admission rates, for example, is that with our medical homes in Ohio, we provide daily census to them on their patients that have been admitted to the hospital. So we all know that sometimes that communication does not always take place. We provide, on a daily basis, census, "Here are your patients who were admitted," so that they can do outreach to those patients immediately.

If you want to talk about lifestyle, the lifestyle piece in our Florida medical homes, again, we have transportation that will take those patients if they do not have a way to get to the physician. We have a division devoted called Humana Cares that has social workers, nurse case managers, and support systems for the patient that assists the practices.

So for practices that do not, or may not, have those essential pieces for the patient, Humana as a health plan can help provide that.

Thank you.

Senator MIKULSKI. Thank you very much, Mr. Chairman. Maybe we could hear the answer to two questions later. First, could they have done this if we had not passed the Affordable Care Act? And second, if we go to a voucher model, would there be support for a National Insurance Commissioner to keep an eye on them?

Senator WHITEHOUSE. Let me now turn to Chairman Bingaman, in addition to being chairman of the Energy Committee, served a unique role during the Affordable Care Act because he sat both on the HELP Committee, this committee and on the Finance Committee, which were the two primary committees that drove this. He was the only person on our side on both committees.

Senator Bingaman.

STATEMENT OF SENATOR BINGAMAN

Senator BINGAMAN. Well, thanks for having this hearing, and all of this work that you have put into it, and your excellent publication here.

Let me ask Mr. Capretta. Your testimony makes the case, or the argument, that what we need to do is to rely more on the market-

place to get efficiencies and cost savings. And you say that the alternative to relying on a CMS-led delivery system reform effort is a functioning marketplace with cost conscious consumers.

Now, one of the things we were trying to do in the Affordable Care Act was to have health insurance exchanges established to get us to that kind of a circumstance where there would be more ability by consumers to choose, and more transparency in what is being offered, and all of that. We cannot get a lot of States to even start down that road; they are very resistant to that.

You cite the substantial success with what was done in 2003 with the prescription drug benefit for Medicare, and how that was designed in a way that allowed for consumer choice and keeping costs down.

Could you give me your thoughts on whether or not an insurance exchange has a value in this process? Is that a crazy idea that we had to try to establish insurance exchanges?

Mr. CAPRETTA. Well, you are putting me on the spot right away, Senator. It is terrific.

Look, the concept of an insurance exchange is not necessarily a faulty concept. I would say that the opponents of it have lots of reasons other than the concept to be against the version that was passed in the health care law.

One thing to understand is that the concept of moving toward something like a premium support model, is taking the Medicare Part D model and extending it to the rest of Medicare. What you would be doing is taking people that are in a fee-for-service structure, moving them out of that, largely, into something where delivery system reform could take place, and the consumer would be much more engaged than they are today.

There is a concern on the other side for the under–65 population that establishing the exchanges the way they were done under the health care law will actually bring more of a regulatory and governmental approach to delivery of health services in that part of the marketplace than exists today.

In other words, when you do it in Medicare, you are pulling people out of a heavily government-driven system. When you do it for the under–65 population, it is more of a mixed bag. Some of the people that will be pulled into the exchanges may actually be in a better system than they will get through the exchanges.

Senator BINGAMAN. But you are going to have 50 million who are in no system at all. An estimated 30 million would wind up with coverage under the Affordable Care Act according to the Congressional Budget Office.

Mr. CAPRETTA. I agree with that. That is certainly what CBO found, and that is an independent question about whether or not the exchange concept is good or bad in that context.

Senator BINGAMAN. But does not the general idea or the structure that we had in mind with an exchange, does it not help consumers to have more choice and get us away from fee-for-service?

I mean, in the sense that if everyone gets coverage, you are going to be under some kind of system of coverage, then you would still have to reform Medicare. You would still have to reform Medicaid, I understand that, to get away from fee-for-service in those government-run programs.

Mr. CAPRETTA. It depends. In the State of Massachusetts, it is true that there is some level of consumer choice that was put together as part of the Connector. But the State also reserved the right, and executed that right, to limit the number of plans that participated in the Connector, and excluded plans that otherwise were licensed providers from actually being offered to the people on the Connector. They did that for, what they thought, were cost control reasons. But I could see California has adopted an exchange concept that allows the State of California to do the same.

So over time, it is quite possible that for the under–65 population with that kind of a design feature, you will actually limit the number of choices and not expand them. I think that is a really—some people say, "Well, you will get more leverage that way. You have these fewer insurers, you will get more leverage."

I think barriers to entry in that regard are really short-term thinking.

Senator BINGAMAN. Well, all I can say is if you have 30 million people who are going to have coverage under the Affordable Care Act that do not have coverage today, presumably a lot of that will be done, I know, some of it will be done through Medicaid, but a lot of it will be done through these exchanges as well.

For those folks who do not have coverage today, you are not limiting choices. You are giving them some coverage. It does not seem to me that the big problem with it is that you are limiting their choices too much.

Let me ask about another problem that Professor Reinhardt—oh, I guess my time is up. Excuse me.

Senator WHITEHOUSE. Go ahead.

Senator BINGAMAN. Let me ask this one other question.

Professor Reinhardt wrote an article in "Health Affairs," which I thought was very interesting, where he basically pointed out that the charge for various procedures varies dramatically from one institution to another. He cited the range of costs for a colonoscopy going from $500 to over $3,500 in one area, I think, in New Jersey where he was looking at it. And he felt that there ought to be some more transparency, and more ability to rationalize this process.

What is the solution to that? Is this health information system that you, Doctor, referred to in Rhode Island, is that going to provide that information? I mean, is this something that we can get away from some way or other? I mean, there is no reason why one provider ought to be charging 7 times what another provider charges for the very same procedure in the same location.

Dr. KUROSE. I think what you are getting at is kind of the heart of where Coastal is really trying to focus right now, and it is very early in the game for us, but understanding utilization of services and cost of services.

Another example is we looked at what, in our population of commercial and Medicare patients, what were the commonest diagnoses for hospitalization? We were surprised to find out that joint replacement is No. 1. So for some of these very sort of discrete procedures—colonoscopy, joint replacement—you should be able to generate reasonable outcomes data. What is the complication rate? In joint replacement, how often are people re-admitted, and how often do they get an infection, et cetera?

I think whenever you talk about price comparisons, you have to be also clear that you are looking at quality at the same time. In fairness to consumers, we would only consider changing our referral patterns if we were referring to somebody who is more cost efficient, but also equal or superior in quality. So I would want to bring quality into the equation. But yes, how we get the price information is difficult.

The way we get it on Blue Cross is sort of reverse engineering off of claims data, and that is complicated and difficult. And various commercial payer contracts have confidentiality clauses in them, so we cannot get that information. It is definitely the case that it would be a game changer if there were price transparency, and I think that that is really important. But quality reporting has to go hand-in-hand with it in a way that is meaningful. And as you move from relatively straightforward procedures to the management of illnesses, the definition of quality becomes a lot more complex.

Senator BINGAMAN. Thank you, Mr. Chairman.

Senator WHITEHOUSE. Thank you.

The one thing I would add to your question, Senator Bingaman, is that in addition to the price for the procedure varying between $500 and $3,500, I suspect what the patient paid for it varied depending on who their insurer was, whether they had coverage, and that could vary by a factor of maybe 3 or 4 times. So the cloud of bad or nontransparent information about price in the health care system is even worse than the Reinhardt report suggests.

But to the extent, I think, that you are beginning to see organizations like Dr. Kurose's take responsibility or an ACO take responsibility like Ms. James does, for a whole episode of care, now they are in a position to demand price transparency in a way that is, I think, more helpful.

One of the things I worry about with Mr. Capretta's theory that you would want a lot of really sensible consumers out there in health care is that, a rough number, that 5 percent of the customers use 50-plus percent of the services, and they tend to be really sick; some of them are even unconscious, and some of them are very, very elderly. And when you are really sick, or elderly, or unconscious, you are not in a really good position to be a very good cost-conscious consumer. It is fine if you are going out for a simple procedure. But in those circumstances—and that is where a lot of the big money is—that is where the system has to support these reforms.

One of the things, Ms. James, that struck me in your testimony was that in some of the areas where you were talking about quality improvement and lowered costs, you were actually talking about providing additional services. And No. 2, that come to mind out of your testimony, you mentioned increases in breast cancer screening, and you mentioned improved or increased physician visits within 7 days after discharge.

So what I understand is, and I will ask you to comment on it, this is not just a question of going to this existing health care system and saying, "We want to have you have less of everything." You are being selective and intelligent about it saying, "There are

some things we want you to have more of because that will improve the care and lower the cost."

Could you elaborate on that point?

Ms. JAMES. Absolutely. In terms of the visits back to the physician within 7 days of discharge, we are absolutely supporting that. So patients can be seen and evaluated by their physician after discharge from the hospital. We all know that when patients are seen after discharge, then there is less of a chance of the patient getting confused with their medications.

And in terms of the breast cancer screening, that is exactly right. We are encouraging more patients getting screened for preventative services and chronic care services.

Senator WHITEHOUSE. So in both cases, it is good for the patient, but in both cases, it is also good for the overall cost. It is good for the bottom line across the board for all of us, correct?

Ms. JAMES. That is exactly right because you look at patients who are seen within 7 days of discharge have less re-admit rates. Patients who get breast cancer screening, you find out earlier.

Senator WHITEHOUSE. You also mentioned in your written testimony your partnership in Cincinnati with Queen City Physicians. You had some pretty amazing results come out of that partnership.

Could you take a moment and just walk us through that?

Ms. JAMES. Yes. Yes, that is with Queen City in Cincinnati. That group, that particular group, and we talked a little bit earlier about electronic medical records. Queen City Physicians has been using their medical record system for over 8 or 9 years. So they had a lot of experience with their EMR system and were able to utilize that system in their patient-centered medical home to get really high, high results on the quality side.

We have a great relationship in terms of providing them with discharge information. That was a piece they did not have previously. So that led to improvements all the way around.

Senator WHITEHOUSE. Your testimony quantifies that a 34 percent decrease in emergency room visits, a 10 percent improvement in diabetes management—Senator Franken's concern—15 percent improvement in blood pressure control, and 22 percent decrease in patients that had uncontrolled blood pressure, all of which is better care at lower cost for patients.

Ms. JAMES. Yes, sir.

Senator WHITEHOUSE. Let me turn to Senator Franken for a second round, but before I do, I would like to put without objection, into the record, a statement of the Boeing Company, which has offered a statement in support of it.

Boeing provides health care coverage to nearly half a million employees, retirees, and dependents in 48 different States. It spends over $2.2 billion providing these benefits.

In 2007, Boeing began testing its intensive outpatient care program to provide customized, quality care at lower cost to individuals with the most complex and expensive conditions. These individuals represent 10 to 20 percent of the population, but account for approximately 80 percent of health care spending.

After piloting the program for 2½ years, the results were impressive. Total annual health care spending per capita for participant was reduced by 20 percent compared to a control group, thanks

largely to reduced emergency room visits and hospitalizations. Additionally, quality improvement metrics showed notable improvements in physical and mental functioning.

Once again, this is from a major corporation on the customer side of the health care system. Their statement will be admitted into the record.

[The information referred to may be found in Additional Material.]

Senator WHITEHOUSE. Senator Franken is recognized.

Senator FRANKEN. Thank you, Mr. Chairman.

Dr. Kurose, I am going to ask you about the work you are doing to prevent diabetes, even in your youngest patients. Diabetes is a huge part of the cost of our care, all chronic diseases are the majority of the cost of our health care, and diabetes is one of the most, if not the most, costly chronic disease. You are doing this preventive work.

As you may know, there is some debate in Congress right now about whether we fund the Prevention and Public Health Fund which, by the way, pays for the Diabetes Prevention Program that I talked about, which reduces by 60 percent those who participate in it from going from pre-diabetes to diabetes.

My colleagues on the other side wanted to use the Prevention and Public Health fund to pay for the bill to keep student loan interest rates low. Whereas, we want to close a loophole for which I can see absolutely no purpose; people in S Corporations not paying FICA on their income because of a reading of the rule.

As a provider, what do you think? Is prevention worth it? Should we keep investing in it?

Dr. KUROSE. I am no expert on policy, but I can tell you this. Diabetes, the effects of that disease in terms of its impact on a typical adult primary care practice is enormous because when you look at all of the complications, the peripheral vascular diseases, the circulatory problems in the legs, the incidence of stroke, the incidence of coronary artery disease and heart attack, the incidence of kidney failure, the incidence of eye problems. This is a disease that consumes a gigantic amount of resources.

The results you spoke of in terms of reducing progression from pre-diabetes to diabetes are impressive. Again as I mentioned earlier, I think that the earlier we can focus on lifestyle issues that lead to somebody becoming a diabetic later in life, the better off we are.

At Coastal, just looking at my notes here, we had 70 percent of diabetics well controlled, meaning that their A1C number was less than 8. Again, I think that is good and it is better than the target we were supposed to hit, but we can do better than that.

I think there is so much room for us to improve, and I think the area of prevention is really fertile ground. It is probably the key to our success in the future in controlling health care costs here because, ultimately, the goal of improving the health of the population is something we really need to keep talking about. Historically, medicine has been focused on one physician-patient encounter at a time.

Senator FRANKEN. Sick care rather than health care.

Dr. KUROSE. Right.

Senator FRANKEN. I want to move on a little bit, and I want to congratulate you on your use of health information technology.

I am proud to say that Minnesota, we consistently rank among the most wired States in health IT. We both know, however, that adopting electronic health records is really just beginning. Being first carries a special responsibility to continue to innovate, and lead, and how to use health IT to transform our health care system.

In Minnesota, the Hennepin County Medical Center reduced medication errors upon hospital discharge by having pharmacists check the medication orders before the patient was discharged. They found that this initiative reduced hospital admissions by half. The Mayo Clinic in Minnesota also implemented a similar intervention using electronic health records with similar success.

A couple of weeks ago, I sent a letter to CMS Administrator Tavener highlighting how this meaningful use of health IT could be part of the Electronic Health Record Incentive Program.

Dr. Kurose, are you familiar with the benefits of having pharmacists look at medication orders before patients are discharged from the hospital?

Dr. KUROSE. I think it is a great idea. We do not have pharmacists in the hospital today. Our clinical pharmacists work in our offices, but it was not even a week ago that I spoke with the director of our clinical pharmacy program to talk about a collaboration with the hospital-based pharmacists. I think that is a terrific idea.

And we also are working with the Community College of Rhode Island and the URI College of Pharmacy to have a training and certification program for medical assistants to do medicine reconciliation to, or at least match up, the pill bottles, match up the lists. But a collaboration with folks in the hospital at the pharmacy end sounds like a very fertile place for us to be working.

Senator FRANKEN. Thank you.

Mr. Chairman, I have run out of my time, and I would be very curious to hear what you have to say, and then come back to me.

Senator WHITEHOUSE. Why do we not continue back and forth?

Senator FRANKEN. I think that is a lovely idea.

Senator WHITEHOUSE. We have a great panel, and I think this is a really good issue.

Let me ask Dr. Kurose two questions. The first is I just want to ask you a little bit about your personal experience as a doctor in the last, let us say, since 2005 about what it is like. How fast has the rate of change been for you? You have used the word "game changer," twice in your oral testimony. I get the impression that we are in a period of real innovation and real almost upheaval in the delivery of care.

Is that something that you experience in your day to day work? Is there something new and different going on out there that you think is noticeable? I am not a doctor. Frankly, the less I see you guys, the better.

Dr. KUROSE. I think the doctors, and the mid-levels, the nurse practitioners and P.A.'s, every member of the staff in the offices feel like the pace of change has been really fast. The sensation of having a fire hose in your face is actually the term that we use around the offices. It has been really brisk.

The adoption of electronic medical records is a painful process when you first start that. It is an incredible amount of work and it is really difficult. But the good news is, I do not think that anybody would turn back. I would say that the physicians would say the electronic medical record has been a distinct improvement.

I think team-based care is really starting to hit the mark now so that physicians feel like their patients are getting better care. And that they are spending more of their time doing only those things that they can do, "working at the top of their license," and having a team of people that can handle some of the other tasks so that overall they do a more consistent job in delivering those services.

Senator WHITEHOUSE. Yes. I hear from our community health centers, from nursing homes, from medical practices, from hospitals the same thing that it was torture going through the electronic health record adoption process, but they would never dream of going back. That once you get through it, it is a real blessing, not only for you, but also for the patients that you are charged with to serve.

One of the issues that we see is the problem of the misalignment that Ms. James spoke about between the payment and the performance that is paid for. I saw this when we started the Rhode Island Quality Institute years ago and we determined that one of the first steps that we would take would be to try to apply the Pronovost Principles that had been first really tried out in Michigan in the hospital intensive care units.

So every hospital in Rhode Island signed up and they went through the Hospital Acquired Infection Reduction Checklist procedures that had been proven out so effectively in Michigan, and we saw similar results. Laura Adams, who runs the Quality Institute, was here in Washington just a couple of days ago and, if I remember correctly, she said that it has been 18 months with virtually zero in hospital-acquired infections in the intensive care units. And, of course, that saves a lot of money.

But I remember the hospital executives coming in when they agreed to do this and saying, "Look. We are totally onboard. We want to serve our patients better, but as long as you are getting into this," I was then the attorney general, "We want to explain something to you; what this will do to our bottom line." And they explained how because they were actually getting reimbursed for the treatment of people who had acquired a hospital-acquired infection. When they eliminated those, they could go back and they could pretty much track what it was going to do to their top line, and that was going to go right through to their bottom line, and this was a time when they were kind of hanging on by their fingernails financially.

So they said,

> "Please, do not ever forget how tough this is and how we do not receive any financial reward, in fact, we receive financial punishment for doing what we know is right for ourselves and for our patients."

And I have never forgotten that message.

In what ways do you see changes happening that encourage you financially in taking the steps that you have taken? And, is there

more that we could be doing? How is that working? Let me ask that of both Dr. Kurose and Ms. James.

Dr. KUROSE. So the incentive for us to take on the challenge of Accountable Care is really important to us. If we were stuck in a strictly fee-for-service paradigm, for us to go through all the work that is necessary for us to understand and try to manage the total cost of care would be incredibly expensive, and we would have no business model to support it.

We have, at Coastal, the Blue Cross contract, which is a shared savings contract that will be very much like the Medicare Shared Savings ACO opportunity and so, that is supporting that work.

Frankly, we are taking a bit of a flyer because we are embracing total cost of care for all of our populations in a setting where we do not yet have a business model to support that. In the last 3 weeks, I have hired a chief medical officer. I have hired a data manager. These are new people with new kinds of expertise that we are going to need.

The Medicare Shared Savings ACO application is still pending. If we do not get that, we are still committed to doing this work, but it is going to be slower and it is going to be more difficult.

Nurse care managers, when you are working in a system where you do not have alignment and harmonization, it is difficult. When we started last year with nurse care managers, the only patients they were allowed to see were Blue Cross patients because they were paid for by Blue Cross. This year, I got United to pay for them. This year, I got my partners to agree: if we do not get any other funding source, we are going to just pony up for the Medicare nurse care managers because we feel so strongly that this is a better way to deliver care that we do not want to have a tiered system of treating patients that looks different depending on what insurance you have.

So we are making that commitment, but having the Federal incentives, having the Medicare ACO Shared Savings opportunity, these things are huge for us. And having a very progressive partner in Rhode Island Blue Cross has really made the difference in pushing us along.

Senator WHITEHOUSE. Yes. Let me give Peter Andruszkiewicz, the new head of Blue Cross, a lot of credit for the way he has operated.

Ms. James.

Ms. JAMES. Thank you.

Humana really wants to be part of the solution in this whole arena, which is why, several years ago, we developed our Rewards Program to improve quality and provide incentives for physicians who do that. But, like Dr. Kurose, there has to be harmonization. Everybody has to be on the same page with the incentives and wanting to align incentives.

But further, our pilot with Norton Hospital System, same thing. It is a big hospital system with physician practices around it. We have developed a shared savings program with that hospital system as part of our Dartmouth and Brookings pilot. But I think that our goal is to see the quality improve and provide incentives for physicians. That is critical. That is going to move the dime.

Senator WHITEHOUSE. Senator Franken, do one last round and then close the hearing.

Senator FRANKEN. OK, if you insist. I like the hearing.

Your story about re-infections or infections in the hospital reminded me of something. I was talking to the president of Mayo, this was about maybe a year ago, and he was talking about ABC News or somebody had come, or the Discovery Channel, had come to do a little 5 minute story or a 4 minute story on how great Mayo was. And he was interviewed, and at one point, they interviewed a housekeeper who was cleaning the hospital room, and disinfecting everything, going through the checklist. She had a checklist.

And the producer from the ABC News organization or Discovery News station said, "Why are you cleaning with this checklist. Why are you doing that?" She said, "Oh, I am not just cleaning the room. I am saving lives."

That is what this is all about. That is prevention and that is just smart. That is Atul Gawande's checklist.

By the way, investing in community-based prevention shows a $5.60 return on $1 investment according to the Trust for America's Health. That is why I think we would be not smart to be paying for the student loan not doubling by paying for it from there.

Mr. Capretta, speaking of Atul Gawande, in his article "The Cost Conundrum," he compares Medicare spending in McAllen, TX with spending in El Paso, TX and Rochester, MN, and he finds the health care spending in McAllen to be much higher than in El Paso or Rochester. The article raised some important questions about the way our current system fails to pay for value.

And then in your written testimony, you argue that Gawande missed the point, and the cost differences between McAllen and El Paso were due to differences in Medicare spending, not spending in private insurance. In support of your argument, you cite an article that found that Medicare spending was significantly different between McAllen and El Paso, but that private insurance spending was, in fact, very similar. So you argue that Medicare must be the problem.

Actually, the article you cite is out of date, and I am wondering if you are aware of that.

Mr. CAPRETTA. It was published in "Health Affairs," in, let me see the citation, I think it was maybe 2 years ago, something like that.

Senator FRANKEN. Well, subsequently, the same author who wrote the article that you cite——

Mr. CAPRETTA. 2010.

Senator FRANKEN. Yes, subsequently Luisa Franzini and many of the other same authors published a more recent, expanded article looking at the State of Texas as a whole to see whether the findings from her first study could be generalized. And this study found that McAllen was an outlier. In this, I mean, you kind of said this was the exception that proved the rule, but in a certain way—well, you used Lake Woebegone, which I always resent when anyone not from Minnesota uses that.

Mr. CAPRETTA. I am sorry.

Senator FRANKEN. OK, that is fine.

Mr. CAPRETTA. I apologize for that.

Senator FRANKEN. But this study which looked at the fuller picture, rather than the situation in an individual town, found that Medicare and private insurance spending was similar across the State.

Here is the conclusion in this piece, "Over the State of Texas, regions of high Medicare spending also tend to be regions of high private insurance spending."

Mr. CAPRETTA. You know, I do not think we need to—I actually agree with you that there is going to be largely a correlation.

My quibble with the original Gawande article was not that, based on these follow-on "Health Affairs" studies, it was really that he never diagnosed Medicare fee-for-service's role in all of this.

That if you look at the cost drivers around the country, if you go around and you talk to people that are practicing care on the ground, I am not a physician. I am not in the business of actually delivering care, but I have been doing policy work for a long time, and invariably they will say, "Medicare fee-for-service is a huge determinant of the organization of the delivery system." It is not the only one. There are other pressures here and there, but if you had to pick one that was dominant it is Medicare fee-for-service, just because of the nature of the volume, and the claims paying process, the——

Senator FRANKEN. Well, I am not in total——

Mr. CAPRETTA. And so, I think we are mainly in agreement.

Senator FRANKEN. Yes.

Mr. CAPRETTA. I guess my point really was that it is not—what was going on in McAllen is very traceable back to Medicare fee-for-service.

Senator FRANKEN. Sure. Would you care to take a few, a couple of extra minutes, since you are cutting it off after this?

Senator WHITEHOUSE. Please.

Senator FRANKEN. Would you agree? I really would love to extend the value index. Again, Minnesota has this very high value care and we get reimbursed like 30 percent less in Medicare per patient than Texas. Now, some of that might be demographic, but it is not all.

Would you like to see, forgetting the Affordable Care Act and maybe your objections to it, would you like to see the value index within that, or that theory, applied to hospitals as well as to individual doctors?

Mr. CAPRETTA. Yes. I worked in the Senate, one of Senator Whitehouse's bio that he read, I worked in the Senate for Senator Domenici for a decade at the Budget Committee. Senator Domenici represented a State that did not quite match Minnesota, but was not too far behind.

And so for a long time, we pursued various reforms that were really not all that different from your concept of the value index. In other words, there are constituents in your State and in other States, namely New Mexico, Oregon, Washington State, frankly Utah——

Senator FRANKEN. Vermont, Wisconsin, the Dakotas.

Mr. CAPRETTA. That are basically low, low cost——

Senator FRANKEN. Rhode Island.

Mr. CAPRETTA. Relatively high—I am not sure Rhode Island is quite there yet, but they are working on it. They are working on it.

Senator FRANKEN. I was trying to get more time.

Mr. CAPRETTA. Yes, my point is, Senator, that this issue of maybe unfairness, frankly, in a lot of the governmental reimbursement systems is traceable back 15 years. It is very difficult to crack.

I think one idea is the value index. Other concepts are to work within the Medicare system so that we do not have such huge cross-subsidies across regions. So I would be open to that. I would have to think a little bit more about the value index in this context.

Senator FRANKEN. OK.

Mr. CAPRETTA. But I am definitely open to the notion that governmental programs have locked in some unfairness.

Senator FRANKEN. OK. Well, thank you. I am way over my time, and I would like to thank all of the witnesses for their testimony and for their service to Senator Domenici, to Humana, to your patients, to the Heritage Foundation.

Senator WHITEHOUSE. Thank you, Senator.

Senator FRANKEN. That was a joke, the last one; just a small one.

Mr. Chairman.

Senator WHITEHOUSE. I just want to comment on Senator Franken's support for the value index. I think that that is a very good idea. Rhode Island does very well on quality. It does not do so well on cost. It is not clear how much of that has to do with demographics.

We are the second most densely populated State, and urban health care seems to be higher cost than rural health care. I do not know whether that is a question of availability, or just the additional stresses of urban life. We also tend to have an older population. And so I think that we would actually do well in a properly adjusted, demographically adjusted value index.

And I think, frankly, even if we did not, it would be an important goal to set out there because a lot of these changes that need to be made to get us moving in the right direction are ones that nobody can do alone. It takes, for instance, the whole community to get together and build a health information exchange so that the electronic health records in different practices and hospitals all talk to each other.

I think that there is a way to begin to force folks in these incredibly low quality, high expense States to have to get together and face their problem, or have there be——

Senator FRANKEN. Can I just say——

Senator WHITEHOUSE. Yes, please.

Senator FRANKEN [continuing]. One last thing. It's just that this is not about pitting Minnesota or New Mexico against Texas or Florida. This is about incentivizing Texas and Florida to become more like Minnesota.

Senator WHITEHOUSE. Yes.

Senator FRANKEN. Thank you.

Senator WHITEHOUSE. Understood.

Let me ask one last question of Dr. Kurose, because when I talk about where we are, the analogy that I often use to compare deliv-

ery system reform to something that people can have a little bit more sense of is the early days of aviation.

You can go from the Wright Brothers and the Wright Flyer to the 747's that are landing right now at Dulles Airport not too far from here, and the principles are pretty much the same. Air moving fast over a curved surface generates lift, a rapidly spinning air screw generates propulsion, and when you bend the wings, you can control your direction. All those things are common from the Wright Flyer at Kitty Hawk to a 747.

What has changed is how well we implement those principles. We have gone from canvas and rope and wood, to steel and even more advanced materials. We have air conditioning, and pressurizing, and most significantly that pilot landing at Dulles comes down an electronic glide slope tube of decision support all the way through, and it does not take away anything from the pilot's autonomy to have that decision support. But it provides the pilot information that they need to know when they need to know it.

If you are closing in on a landing strip and your landing gear is not down, you need to know that, and the aircraft tells you. If you are flying too slow, and you are risking hitting a stall speed, you need to know that, the aircraft tells you. If there is wind shear ahead on the runway, your aircraft will tell you, because that is being broadcast from the airport.

And the decision support that is provided and the advancement which was done by constant innovation, nobody could have taken the Wright Flyer and decreed, "Thou shalt produce a 747." You had to trust innovation and you had to support innovation. And we did it by a lot of military spending, and we did with a lot of subsidies along the way, but we really developed a national industry in this.

And the difference is that if you do not get it right about the aircraft, it reports to you pretty quickly. Down you go. It is a lot harder to know when you are failing and when you are succeeding in health care because it is so hard to pull the information out of the system that tells you.

So if you could just say one word as we close about this data analyst that you just added. You said you hired a chief medical officer and a data analyst.

Talk about the role of data, and why you needed the data analyst, and how important that is to you in providing direction and accountability in your practice.

Dr. KUROSE. I think that is a great topic to touch on.

At Coastal, we believe we need to become a data-driven organization. And when I say "data," I mean data about patient experience, there is patient survey data, data about clinical quality so that sort of typical quality indicators that we all know about. More data about outcomes for patients in various episodes of care, and then we need utilization data and price data.

So if we are really going to execute on the line, improve the health of this population, improve their health care, make their health care more cost efficient, we need all of that information at our fingertips, in a very usable format. So that takes a lot of collaboration between people who are expert in data and people who are expert in clinical care.

There are a couple of other things in the "secret sauce," if you will, at least the way I look at it, in terms of trying to advance the cause here. I think there is a strong element of culture here. I think that I am privileged to represent an organization where there is a real culture of leadership in both management and in physicians, and a real culture of innovation. And I think that as a culture, we have a lot of transformation to do ourselves in the public.

This issue of promoting health as the key to the long-term success of our health care system, I think, that is getting traction, but we have a long way to go in sharing that message. And you can just walk around the mall and look at folks, and see that we have a long way to go.

But I think that data is going to be the key to the way we change things in the future. As in the aviation analogy, technology is also going to be critically important. But personally, I am very optimistic.

Thanks.

Senator WHITEHOUSE. Let me thank all of the witnesses for being here.

And as I said in my opening statement, this is part of a continuing effort to make sure that we are focused in our health care discussions in the Senate and in Washington in this area where I think there are colossal opportunities. And where we really have, let me just say, grim alternatives if we do not get the delivery system reform piece right.

You can look at the health care system as a plumbing problem or you can look at it as a benefits problem. If you do not do anything about improving the plumbing, and if there is a single signal that we need to improve the plumbing, it is that we spend 18 percent of GDP on health care in this country, and the most inefficient other industrialized country in the world is at about 12.

So when the United States of America, the home of innovation and of ability is 50 percent more inefficient than the least efficient competitor that we have, we have a pretty strong signal that there is something that we can do about this. And that the plumbing piece is the way to go.

Your testimony has been important because it has shown that when you go that way, it is a win-win. You are not just taking things away from patients. You are actually giving them better care, you are getting them well sooner, and the overall result is lower cost for all the rest of us. If we do not get this right, then one day we will be facing those benefit cuts.

And to close with the remark that I began with from George Halvorson, who knows a little something about health care as the CEO of Kaiser,

> "There are people right now who want to cut benefits and ration care, and have that be the avenue to cost reduction in this country, and that is wrong. It is so wrong, it is almost criminal. It is an inept way of thinking about health care."

Thank you for showing us the intelligent way of thinking about health care and not only that, going out into the world in your businesses and proving it.

The hearing will remain open for another week for any additional comments that anybody wishes to make.

And I appreciate that everybody participated.
[Additional material follows.]

ADDITIONAL MATERIAL

PREPARED STATEMENT OF THE BOEING COMPANY

INTRODUCTION

The Boeing Company is the world's largest aerospace company, the largest U.S. manufacturing exporter and the leading manufacturer of commercial jetliners and defense, space and security systems. The Boeing Company has more than 170,000 employees in the United States with major operations in 34 States, and offers products and tailored services that include commercial and military aircraft, satellites, weapons, electronic and defense systems, launch systems, advanced information and communication systems, and performance-based logistics and training.

The Boeing Company provides high quality healthcare coverage to approximately 485,000 employees, retirees, and dependents in 48 States, and spends over $2.2 billion annually on health and insurance-related benefits. We view the healthcare benefits we provide as a major component of the total compensation we provide to employees. Importantly, The Boeing Company works diligently to control costs directly and indirectly associated with providing healthcare coverage to our workforce. The ability to provide benefits tailored to our population improves the health of our employees and is crucial in our ability to remain competitive by attracting and retaining the best talent.

The Boeing Company is committed to improving health care delivery for our employees and families, which is the main reason for developing our Intensive Outpatient Care Program ("IOCP"), and we welcome this hearing to examine and identify opportunities for delivery system reform.

INTENSIVE OUTPATIENT CARE PROGRAM

The Boeing Company continually looks for ways to improve the quality and efficiency of health care delivery. In developing the IOCP, the company focused on chronically ill patients who drive a large portion of overall health care costs. First piloted in 2007, IOCP provides services similar to those provided by hospital Intensive Care Units and targets a similar population. IOCP provides intensive outpatient care that utilizes customized plans, a high level of personal attention, different staffing models, and advanced technologies to provide an increased quality of care at lower cost.

IOCP Population

IOCP's target population consists of individuals that represent the most complex and expensive conditions. All have multiple chronic conditions, routinely see several specialists, are participating in ongoing testing, are taking many medications, and have frequent Emergency room visits and hospitalizations.

This target population:

- Represents the most complex and most expensive 10 percent–20 percent of the healthcare population.
- Incurs up to 80 percent of the population's healthcare spending.
- Utilizes the current healthcare system the most yet is the most underserved due to the current healthcare system which is often reactive, fragmented, expensive, and difficult to navigate and access.

The IOCP program participants are identified through an independent and confidential analysis of past health insurance data and through a clinical evaluation conducted by their provider.

IOCP Program Model

IOCP was designed to improve health care delivery for employees and family members who need the most complex health support and care. Boeing worked with three Seattle area medical groups to design and implement the program model. Partnering with these willing medical groups was essential to the success of the program, which represents a completely different model of care than the current healthcare delivery system.

The IOCP model provides customized care delivered by a personal advocacy team to help manage their health issues and navigate the system by using evidence-based medicine to provide high quality and efficient care. Participants were invited to join the pilot program by their current health care provider at no additional cost to the participant.

IOCP clinical sites provided participants with care not typically delivered in the current system. The IOCP program model utilizes:

• Highly customized clinical care, social support and navigation of the healthcare system.
• An intensive intake visit and a customized shared care plan.
• A dedicated team supporting each participant.
• Access to 24/7 care via e-mail, phone and home visits.
• Proactive and reactive evidence-based care deeply integrated with existing providers.
• A very high level of customer service provided to employees and their families.

IOCP Goals

IOCP's main goals are to improve clinical quality, patient satisfaction and the overall health status of the patients, deliver quality healthcare, resulting in lower costs for Boeing, its employees and their families. These goals would be used to expand the model to other Boeing employees and their family members.

Initial IOCP Results

The program tested this new chronic care model for a 2½-year period from early 2007 to July 2009. Patients who enrolled in the Boeing pilot were connected to an IOCP care team that included a dedicated nurse case manager (available in-person) and participating primary care physicians who worked with the patients to implement a mutually agreed-upon clinical improvement plan.

The plan was executed through intensive in-person, telephonic and e-mail contacts, including frequent proactive outreach by a registered nurse, and education in self-management of chronic conditions. The pilot program featured rapid access to care coordinated by the IOCP team, daily care team meetings to plan patient interactions, and direct involvement of specialists in primary care contacts, including behavioral health specialists.

The total cost of care was measured for 276 chronically ill enrollees in the Boeing pilot program and then compared to 276 carefully matched patients who served as the control group. The total annual per capita health care spending per participating patient was reduced by 20 percent compared to the control group. The 20 percent savings was primarily attributable to a reduction in emergency room visits and hospitalizations.

Multiple quality measures and clinical outcomes showed improvement as compared to the baseline for the pilot project patients. Physical functioning scores improved by 14.8 percent, mental functioning scores improved by 16.1 percent, and patients who said they received care "as soon as needed" improved by 17.6 percent. Patients reported a significant decline in missed work days. A high level of staff satisfaction was reported by both the physicians and the nurse case managers working in the program.

CURRENT AND FUTURE IOCP ACTIVITIES

Seattle: The original Boeing IOCP pilot in Seattle was completed in July 2009 with promising results. The 20 percent savings target on annual per member medical expenses was achieved. Regence Blue Cross Blue Shield has adopted the delivery model to their Book of Business for expansion in the Seattle market. The current program in the Seattle market includes three delivery systems (The Everett Clinic, Virginia Mason, and MultiCare) with more expected to launch in the third quarter of 2012. Total program enrollment as of April 2012 was 1,500 members, 590 of which are Boeing members.

St. Louis: United HealthCare Services (UHC) has adopted the model in St. Louis. A partnership was formed with Boeing, UHC and five medical groups in the St. Louis market. The program was launched in the fourth quarter of 2011. Total program enrollment as of April 2012 was 860 members, 300 of which are Boeing members. General Electric and Monsanto are also participating in the St. Louis program.

Southern California: Boeing is working with the Pacific Business Group on Health to lead an expansion into the southern California market. Delivery systems within the Health Care Partners and St. Joseph's networks will be utilized. The California Public Employees' Retirement System is expected to join as a launch participant, with a targeted program launch in fall of 2012.

IOCP MODIFICATIONS

The IOCP program has retained the critical elements and goals that were developed during the original pilot. These include the requirement for dedicated, embedded nurse case managers with a patient panel of less than 200 high risk, medically complex patients, the development of a patient care plan and the continued tracking of clinical and claims based metrics.

While the pilot program utilized a dedicated physician intensivist at each site, study results concluded that dedicated nurse case managers executing coordinated, team medicine is the critical element to the program's success. As a result, the current program has moved away from a dedicated physician intensivist, which was found not crucial or financially viable.

A simplification of the payment model and program evaluation methodology is under consideration.

CONCLUSION

Efforts to improve the quality and efficiency of healthcare in the United States through delivery system reforms are critical to controlling rising health care costs and to ensuring the well-being of Americans. These reforms should be a priority for policymakers, employers, providers and patients. The Boeing Company will continue to support ongoing efforts like the IOCP to positively influence the U.S. health care system.

[Whereupon, at 11:40 a.m., the hearing was adjourned.]

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