

**PATIENT-FOCUSED CARE: A PRESCRIPTION TO
REDUCE HEALTH CARE COSTS**

HEARING
BEFORE THE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE
ONE HUNDRED FIFTEENTH CONGRESS

SECOND SESSION

WASHINGTON, DC

OCTOBER 3, 2018

Serial No. 115-21

Printed for the use of the Special Committee on Aging



Available via the World Wide Web: <http://www.govinfo.gov>

U.S. GOVERNMENT PUBLISHING OFFICE

35-285 PDF

WASHINGTON : 2019

SPECIAL COMMITTEE ON AGING

SUSAN M. COLLINS, Maine, *Chairman*

ORRIN G. HATCH, Utah
JEFF FLAKE, Arizona
TIM SCOTT, South Carolina
THOM TILLIS, North Carolina
BOB CORKER, Tennessee
RICHARD BURR, North Carolina
MARCO RUBIO, Florida
DEB FISCHER, Nebraska

ROBERT P. CASEY, JR., Pennsylvania
BILL NELSON, Florida
KIRSTEN E. GILLIBRAND, New York
RICHARD BLUMENTHAL, Connecticut
JOE DONNELLY, Indiana
ELIZABETH WARREN, Massachusetts
CATHERINE CORTEZ MASTO, Nevada
DOUG JONES, Alabama

CONTENTS

Opening Statement of Senator Susan M. Collins, Chairman	Page 1
Statement of Senator Robert P. Casey, Jr., Ranking Member	3

PANEL OF WITNESSES

David Howes, M.D., President and Chief Executive Officer, Martin's Point Health Care, Portland, Maine	5
Jeff Micklos, Executive Director, Health Care Transformation Task Force, Washington, DC	7
Sean Cavanaugh, Chief Administrative and Performance Officer, Aledade, Bethesda, Maryland	9
Reverend Sally Jo Snyder, Director of Advocacy and Consumer Engagement, Consumer Health Coalition, Pittsburgh, Pennsylvania	11

APPENDIX

PREPARED WITNESS STATEMENTS

David Howes, M.D., President and Chief Executive Officer, Martin's Point Health Care, Portland, Maine	34
Jeff Micklos, Executive Director, Health Care Transformation Task Force, Washington, DC	64
Sean Cavanaugh, Chief Administrative and Performance Officer, Aledade, Bethesda, Maryland	68
Reverend Sally Jo Snyder, Director of Advocacy and Consumer Engagement, Consumer Health Coalition, Pittsburgh, Pennsylvania	78

ADDITIONAL STATEMENTS FOR THE RECORD

Justice in Aging (formerly the National Senior Citizens Law Center)	92
LeadingAge, an association of nonprofit aging services providers	93

PATIENT-FOCUSED CARE: A PRESCRIPTION TO REDUCE HEALTH CARE COSTS

WEDNESDAY, OCTOBER 3, 2018

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, at 9:30 a.m., in room SD-562, Dirksen Senate Office Building, Hon. Susan M. Collins (Chairman of the Committee) presiding.

Present: Senators Collins, Fischer, Casey, Nelson, Gillibrand, Donnelly, Cortez Masto, and Jones.

OPENING STATEMENT OF SENATOR SUSAN M. COLLINS, CHAIRMAN

The CHAIRMAN. The Committee will come to order. Good morning.

First, let me apologize to our witnesses that we have a bit of a media “circus,” I guess is the right word for it, outside of the hearing room today. But that does not detract from the important work that we are doing inside this hearing room today. And I very much appreciate your patience with getting through the hoards of reporters and protesters and others because the issue that we are focusing on today, like so many issues that are confronting the Senate right now, are extremely important.

According to a recent poll, for more than a year now, Americans have listed health care as the most important issue facing our country. This should come as no surprise. Health care is deeply personal. It is a complex issue that affects each and every one of us. It comprises one-sixth of the American economy. In 2016, we spent \$3.3 trillion on health care. If we want to improve the affordability and accessibility of health care, we simply must get a handle on the cost while also focusing on improving the quality and patient outcomes.

This Committee has already addressed health care costs from several different angles. We have focused on how market failures and a lack of transparency affect the pricing of prescription drugs. For example, we have examined the rising cost of insulin and rheumatoid arthritis drugs, as well as the tangled nature of the relationships among pharmaceutical companies, pharmacy benefit managers, and various other components of the supply chain.

We have also highlighted the need for more investment in medical research in the areas of diabetes, Alzheimer’s disease, and other devastating illnesses, which have significant financial costs for our country.

Today we examine a different aspect of health care costs: How can we better leverage spending on innovations and quality initiatives that help keep patients well? And, critically, what specific actions would help us to succeed in that mission and to help moderate the rising cost of health care?

Health care providers often refer to the “Triple Aim”: improving the patient experience of care, including quality and satisfaction; improving the health of populations; and reducing the per capita cost of health care.

Without a doubt, tremendous opportunities exist for improvement. As Dr. Atul Gawande correctly observes, “The one thing the medical profession is not rewarded for is providing better, higher-value care. . . . In a fee-for-service payment system—a system of paying doctors and hospitals by pill and procedure—we are actually penalized for making the effort to organize and deliver care with the best service, quality, and efficiency we can.”

Part of the solution to bringing down health costs is to emphasize prevention as well as other cost-effective health interventions. According to the Centers for Disease Control, chronic diseases that are avoidable through preventive care services account for 75 percent of the Nation’s health care spending, yet all too often, the incentives are wrong.

For example, colorectal cancer is one of the leading causes of cancer deaths, yet it is also one of the few cancers that can be prevented with proper screening. A recent study finds more than 14,000 colon cancer deaths could be prevented every year if health care providers matched the screening and mortality rates of America’s highest-performing health systems.

We need to learn more from these providers and remove barriers that prevent better performance, but we also need to examine Medicare reimbursement policies. Seniors covered by Medicare are eligible for colorectal cancer screenings without out-of-pocket costs; however, if a physician takes a further preventive action—such as removing a polyp—during the screening while the patient is under anesthesia, the patient is billed as if the procedure were a treatment rather than prevention. This makes no sense to me at all, and I have talked to physicians in Bangor, Maine, where I live, who tell me that when their patients learn this, they will actually cancel the colonoscopy because they are so afraid of being saddled with considerable costs. And that is why I have cosponsored the Removing Barriers to Colorectal Cancer Screenings Act, and I am joining several of my colleagues in sending a letter to CMS encouraging the agency to change its reimbursement and solve this problem. That is just one example.

The care of individuals with diabetes—I know it is an issue of special interest to Dr. Howes—offers another lesson. Medicare will pay for all the serious complications of uncontrolled diabetes—amputations, blindness, heart disease; it affects every system in the body—but the program often reimburses poorly for innovative programs that can help avoid these devastating consequences. Again, that just makes no sense to me. Recently I joined with my Senate Diabetes Caucus Co-Chairman Jeanne Shaheen to expand Medicare coverage for diabetes self-management training sessions, where diabetes educators help train patients on how to manage

their glucose, maintain a healthy weight, eat healthy foods, manage their insulin levels, and improve general care for their diabetes.

On the other end of the spectrum from prevention is the problem of inefficient and wasteful health care spending. According to the Institute of Medicine, spending in the United States on health care waste totaled approximately \$750 billion, or as much as 30 percent of our Nation's health care spending.

Today we will hear from witnesses who bring a variety of very valuable perspectives on how we can successfully achieve better value, lower costs, and higher quality in health care spending. Participating in innovative care models that align payment with quality and value, improving patient engagement and communication efforts, and deploying data to help both clinicians and patients manage chronic conditions are all critical components to improving our health care system and reducing costs.

I want to thank our witnesses for joining us today. I know you have a lot of valuable information to share with the Committee, and I look forward to your statements.

I now would turn to our Ranking Member, Senator Casey, for his opening statement.

**OPENING STATEMENT OF SENATOR ROBERT P. CASEY, JR.,
RANKING MEMBER**

Senator CASEY. Thank you, Chairman Collins, for holding this hearing today.

Every American will interact with our health care system, and we owe every citizen a system that ensures that they can afford the care that they need, no matter what illness or accident that they will endure. We owe taxpayers a system that guarantees federal dollars are spent wisely and efficiently. We owe health care providers a payment system that allows them to focus on what matters most: patient care.

The Affordable Care Act provides individuals, families, taxpayers, and providers all of these benefits. The Affordable Care Act expanded coverage to 20 million Americans. It provides key consumer protections, like protections against being denied coverage or being charged more for coverage due to a pre-existing condition. It invests in proven reforms to our health care delivery system and updated payment models so that providers and patients can work together as partners in shaping their care. These are key improvements to health care in America, enhancing care and reducing costs for patients, providers, and health care systems alike.

The Affordable Care Act is not perfect, and we have more work to do to lower costs—just by way of one example.

Recently, the administration refused to defend the Affordable Care Act's protections for people with pre-existing conditions in a lawsuit led by 20 Republican-led states.

Each of us is one accident or one illness away from joining the millions of Americans with a pre-existing condition. In Pennsylvania, that number is 5.3 million people with a pre-existing condition. Chairman Collins and I agree that we must keep our promise to Americans with pre-existing conditions while working to improve care quality and lower costs.

Congress made a commitment to payment innovation in the Affordable Care Act as well. The law expanded an important program called “Money Follows the Person.” It makes it possible for seniors and people with disabilities to receive the care they need in the very place they most want to be—at home and among those in their community. Alongside Chairman Collins, I am a proud cosponsor of this legislation to extend this essential program. Congress should act to continue Money Follows the Person before the year’s end.

Today the Committee will discuss ways to build upon improvements like Money Follows the Person and other programs made possible by the Affordable Care Act. This is an important conversation.

I look forward to hearing from our witnesses about how we can preserve everything from coverage protections to the innovative programs included in the ACA, but also what more we can do to make our health care system even stronger.

Thank you, and I look forward to today’s discussion.

The CHAIRMAN. Thank you very much, Senator Casey.

I also want to acknowledge two of our colleagues who have joined us. Senator Donnelly and Senator Jones, thank you for being here this morning.

Dr. Howes, we are going to start with you, but I want to give you a proper introduction first.

Our first witness today is Dr. David Howes, the president and CEO of Martin’s Point Health Care, a not-for-profit health care organization headquartered in Portland, Maine. I have known Dr. Howes for many years and have always been so impressed with the innovative approach that he brings. He began his career as a family physician in rural Maine. In fact, he actually served on some of Maine’s islands for a while. That truly is providing health care to a population that otherwise would have great difficulty in accessing it. He brought this background to Martin’s Point, first as a primary care physician and now as the president and CEO.

Martin’s Point is unique in that it provides direct patient care at seven health centers in Maine and New Hampshire, and also offers highly rated Generations Advantage plans to Medicare beneficiaries in Maine and New Hampshire, as well as the U.S. Family Health Plan’s TRICARE Prime to military families in northern New England, New York, and Pennsylvania.

We will then hear from Jeff Micklos, the executive director of the Health Care Transformation Task Force. The Health Care Transformation Task Force is an industry consortium of payers, providers, purchasers, and patients who are committed to accelerating the pace of transforming the health care delivery system. They share a common commitment to transforming their respective businesses and clinical models to deliver person-centered, high-quality care at lower cost through innovation.

Next we will hear from Sean Cavanaugh, a famous name around here these days.

[Laughter.]

The CHAIRMAN. But it is spelled differently, I would note. He is—and this is sheer coincidence—the chief administrative and performance officer at Aledade. Aledade provides value-based care

through physician-led accountable care organizations, ACOs, across the country. Mr. Cavanaugh will discuss his company's successes thus far in reducing spending and improving health care outcomes as well as how accountable care organizations fit into the health innovation landscape. Mr. Cavanaugh previously served as Deputy Director and Administrator of the Centers for Medicare at CMS.

I now will turn to our Ranking Member to introduce our witness from the Commonwealth of Pennsylvania.

Senator CASEY. Thank you, Chairman Collins. I am pleased to introduce Reverend Sally Jo Snyder, a Pittsburgh resident and long-time consumer and patient advocate. Reverend Snyder and I met I guess last year in McKeesport. I did not have a chance to say hello to her personally today. I will do that after the hearing. But thank you for being here.

Reverend Snyder's organization, the Consumer Health Coalition, provides consumer education and health insurance counseling to Pennsylvanians across the state. Among many programs, Reverend Snyder provides trainings to help empower patients to be active participants in their care. These issues are not only at the heart of Reverend Snyder's profession, they are deeply personal. She lost her Mom to what should have been an avoidable hospital-acquired infection. To borrow a phrase from Reverend Snyder, I am confident her testimony will inspire us to "make good ripples" as we work together to transform our Nation's health care system.

Reverend Snyder, thank you for being here, and we look forward to your testimony.

The CHAIRMAN. Thank you very much.

Dr. Howes.

STATEMENT OF DAVID HOWES, M.D., PRESIDENT AND CHIEF EXECUTIVE OFFICER, MARTIN'S POINT HEALTH CARE, PORTLAND, MAINE

Dr. HOWES. Thank you, Senator Collins, Ranking Member Casey, and members of the Committee on Aging for this opportunity to provide testimony regarding the health care landscape for seniors in Maine.

My name is David Howes, and I am the president and CEO of Martin's Point Health Care. We are a not-for-profit integrated health care organization based in Portland, Maine, and we provide care and coverage to about 155,000 people.

In my testimony today, I want to share with you a picture of the health care landscape for seniors in our home state—a landscape shared, I am sure, by many states with significant aging populations in rural areas. I will also tell you what relatively small, but we like to think mighty, health care organization is doing to address the significant needs of this population and how our nonprofit status allows us to go the extra mile in serving both patients and members and improving the health of our communities.

If you would like to learn more, please refer to my testimony for full details on my credentials and background, as well as a number of innovative outcomes that define the high-quality care we provide at Martin's Point.

I would like to start, though, by sharing a personal story from my home State of Maine. This summer my son, Owen, began work

in one of the most physically demanding careers in Maine. He is serving as a sternman on a lobster boat under the tutelage of his boss, “Captain Mike.” I mention this because, to my delight, after he took the job, I discovered that Captain Mike is a Martin’s Point health plan member and a Martin’s Point patient. He comes to one of our health care centers before each lobster season, making the journey from his island home in Vinalhaven to our health care center in Brunswick, some 70 miles south. He comes to have his knees treated for his increasing arthritis—he calls it “getting a grease job”—the result of many years hauling lobster pots. Now at an age when a lot of people are planning retirement, Captain Mike is teaching my son, a member of the new generation, the intricacies of catching lobsters. In the off-season, he returns to the mainland as an art teacher. I think Senator Collins would agree that his career reflects the way many Mainers make a living—doing what they do best, often combining a variety of occupations to add up to a satisfying and sustaining whole. Mike could choose to have his knees worked on closer to home, but he chooses to travel to Martin’s Point because we have earned his trust. By providing both his primary care and his insurance coverage, we are uniquely positioned to consider the full spectrum of his health and support him on land and sea, reliably and affordably.

At Martin’s Point we believe we have much to offer members like Mike and thousands of other rural seniors in Maine, who seek a trusted health care partner who shares their local roots. It is important to remember, though, that for every energetic lobsterman in Maine, there are many more of our members who are confronting the converging effects of chronic illness, forgetfulness, and limited mobility.

Some of the most poignant examples of our provider-patient connections come to me from the nurses who administer our home-based care management programs. They tell me about the little things that they note in their assessments during a home visit, such as the condition of the house, the person’s appearance, and the visible signs of declining self-care.

During a recent visit to conduct medication reconciliation, our nurse arrived at an older man’s home to find that he was storing his medication in various receptacles throughout his home, including spice jars in his kitchen. He had lost track of the number and schedule of his medications. She worked to place all of his pills in one of our organized containers and then reviewed the dosage and frequency with him. The pill box probably cost us less than a dime, but the time spent in conversation and companionship and instruction allowed us to make a full assessment of his circumstances and offer him additional support and monitoring.

As we do this with more and more seniors in Maine, the dime containers represent thousands of dollars per patient in avoided incidents, hospitalizations, and readmissions. I regard our care management programs as some of the best innovation work we are doing at Martin’s Point, and they continue to illustrate to me that the little things, not always medical, make a huge difference.

All in all, we care for a lot of people in Maine, but at the heart of what we do is our “true north”: We are people caring for people—our patients, our members, each other, and our community.

We are very committed to the Triple Aim and score ourselves on the Triple Aim quarterly to see that we are actually making a difference against each of those objectives.

Our care extends to our annual quality metrics that we believe are essential to better health outcomes and form a central part of our organization-wide employee incentive plan. A quarter of our employees' annual incentive is based on a set of quality metrics that are uniform for all 800 employees.

We have dedicated particular attention to the care of chronic conditions such as diabetes and congestive heart failure. We seek great promise in comprehensive home-based care and are seeing promising early returns on our investment in this care model. We have been recognized for our recent work in opioid mitigation, particularly for elders, and we accomplish all that we do through our lean health care management system.

I am pleased to be with you here this morning and would be glad to take your questions on any of the work that we are doing to support our patients and members. Thank you.

The CHAIRMAN. Thank you very much, Dr. Howes.

Mr. Micklos.

**STATEMENT OF JEFF MICKLOS, EXECUTIVE DIRECTOR,
HEALTH CARE TRANSFORMATION TASK FORCE, WASHINGTON, DC**

Mr. MICKLOS. Good morning, Chairman Collins, Ranking Member Casey, and members of the Senate Special Committee on Aging. Thank you for the opportunity to appear before you today to discuss innovative approaches to improving value in the health care system for older Americans. My name is Jeff Micklos, and I am the executive director of the Health Care Transformation Task Force. As Chairman Collins said, we are a diverse group of industry stakeholders across providers, health plans, employers, and consumers. We are looking to accelerate the pace of delivery system transformation. Our payer and provider members aspire to have 75 percent of their business in value-based payment arrangements by 2020.

While the task force supports many types of value-based payment and care delivery models, my testimony this morning will focus on accountable care organizations. ACOs refer to health care organizations that manage the health of their population by tying payment incentives to quality metrics and the cost of care. Last year the task force conducted a study of the 21 highest-performing Medicare ACOs based on 2015 performance data. The most successful ACOs focused on three key elements: one, achieving a high-value culture; two, developing strong population health management programs; and, three, creating structures that can ensure continuous improvement in performance over time.

The highest-performing ACOs first and foremost have a strong commitment to developing a culture that supports innovation and is committed to the mission of improving care delivery. That commitment must be unwavering in the face of multiple obstacles. Changing culture takes time and requires effective leadership at many levels. Most of the successful organizations we profiled had previous experience managing financial risk before implementing

an ACO model, including through commercial payment arrangements with payers. They also had the support and commitment of executive leaders who saw the importance of investing in new models, as well as governance structures that are conducive to fostering a high-value culture.

Organizations with high-value cultures understood the importance of engaging clinicians and care teams to accomplish shared goals and demonstrated a commitment to practice education, support services, and compensation structures that reward continuous improvement. ACOs succeed with truly engaged multidisciplinary care teams committed to understanding how their practice patterns influence the goals of the ACO and serving as champions to help guide their peers.

The crux of any successful payment program is top-notch care delivery. For ACOs, having very strong population health management programs is critical. These programs serve the essential function of identifying at-risk patients with multiple medical conditions and acting swiftly to ensure that these patients receive the best, most personalized care possible to avoid unnecessary hospitalizations.

Effective population health management programs truly put the patient first by using tools and resources that facilitate personalized, proactive care. Vanguard health care providers risk-stratify patients using homegrown analytics models, electronic health record modules, and population health software. These high-tech processes are combined with expert recommendations from physicians on how best to provide treatment that is individualized to patient needs.

Risk stratification practices are key. For example, Atrius Health, a physician-led ACO based in Boston, has taken on risk for its Medicare fee-for-service members for several years, most recently in the Next Gen ACO program. The organization determined that the second-largest opportunity for savings after post-acute care was hospitalization prevention. Atrius built an analytical model that would allow it to proactively identify patients with high clinical risk and assign a score to those individuals based on their likelihood of hospitalization in the next six months. The score is reviewed by a care team to ensure a comprehensive care plan is in place for each patient. A case management team conducts outreach, and high-risk patients are provided with access to additional services such as same-day appointments.

Atrius' approach has resulted in the organization saving Medicare an impressive \$10.4 million in 2016 and \$6.8 million in 2015, while maintaining a quality score of over 95 percent.

The best population health management programs employ interdisciplinary care teams that typically consist of physicians, nurse care managers, pharmacists, social workers, and care guides or navigators. Patient needs inform who from the care team should focus on the patient. For example, a social worker may be best equipped to interact most often with the patients struggling with social factors such as housing or food instability or access to transportation that directly contribute to his or her health status. Strong population health programs also partner with existing community resources and local public health departments to ensure

that all facets of a patient's health challenges are addressed. Today addressing social determinants of health is a concept that gets a lot of attention, and rightfully so, and maturing ACOs are increasingly focused on those factors as a way of caring completely for patients. Partnering with community organizations is important to a comprehensive care regimen for individuals.

Finally, we have found that successful ACOs must have continuous improvement structures in place to drive value once the low-hanging fruit has been plucked. It is simply not enough for health care providers to change their business model in one go and coast. They must constantly reevaluate their performance and business structures. The most sophisticated organizations have dedicated data, actuarial, and performance improvement resources that are constantly looking for new opportunities to increase value.

All organizations should expect to run into challenges on their journeys. That is why participation in shared learning opportunities is critical. The ability to share experiences, compare data with peers, and access to organizations that are more advanced in their value models can be tremendously helpful for budding ACOs. Regional health improvement collaboratives, such as those found in Maine and Pennsylvania, and national consortiums offer outlets for organizations that are interested in learning from peers and cross-industry partners. The task force serves this function for national collaborators.

In closing, changing our health care system is not something that can be accomplished in one fell swoop. Rather, we are rebuilding brick by brick the foundation upon which our care is paid for and delivered. Not all innovation will be an immediate success, and it is incumbent upon all to identify what holds promise and stay the course until sustainable change is achieved. Patience and diligence are absolutely essential.

Chairman Collins, Ranking Member Casey, and members of this Committee, thank you again for the opportunity to testify, and I look forward to your questions.

The CHAIRMAN. Thank you very much for your testimony.

I also want to welcome Senator Cortez Masto and Senator Fischer, who have joined us this morning.

Mr. Cavanaugh.

STATEMENT OF SEAN CAVANAUGH, CHIEF ADMINISTRATIVE AND PERFORMANCE OFFICER, ALEDADE, BETHESDA, MARYLAND

Mr. CAVANAUGH. Chairman Collins, Ranking Member Casey, and members of the Committee, thank you for inviting me today to discuss how Aledade is partnering with independent physicians to provide patient-focused care that reduces costs and improves outcomes.

My name is Sean Cavanaugh. I am the chief administrative officer at Aledade. Prior to joining Aledade, I served at CMS for six years, including a period as Deputy Director of the Innovation Center and three years as the Deputy Administrator and Director of the Center for Medicare, where I supported the movement toward value-based models. I am proud to continue that work at Aledade.

At Aledade, we bring together independent primary care practices who are committed to value-based care. We form them into an ACO and join the Medicare Shared Savings Program. Aledade ensures the success of the ACO by providing data-informed population health tools and transforming how the practices deliver care. We also negotiate value-based contracts with commercial payers, too, so our physicians can transform care for their entire panel of patients.

I am pleased to report to the Committee that value-based payment is working in the Medicare Shared Savings Program. Beneficiaries are getting better care, and Medicare is saving money. In 2017, 10.5 million Medicare beneficiaries were aligned with ACOs in the Shared Savings Program. We now have evidence from the CMS Actuary, from MedPAC, and from Harvard researchers, and the findings among all three are consistent: one, ACOs are saving money for Medicare; two, the savings grow over time, the longer an ACO is in the program; and, three, physician-based ACOs are generating the strongest results.

So, if you think of the three major ways that a beneficiary can receive care in Medicare—traditional fee-for-service, Medicare Advantage, or ACOs—ACOs are the lowest-cost provider of care in Medicare. And, perhaps most important, these savings are the result of Medicare beneficiaries actually receiving better care.

Aledade is proud to be part of the success of the Shared Savings Program. Last year our ACOs saved Medicare over \$40 million. Some of that success was from one of our ACOs in Pennsylvania outside of Philadelphia. We did this by helping independent physicians deliver more primary care, which reduced unnecessary hospitalizations, typically by 10 percent on average, and shortened post-acute-care stays by 22 percent on average. And like the rest of the program, our results improve the longer our practices work with us.

I will give you a very simple example of one of our strategies. We provide our practices with real-time notifications when their patients are discharged from the hospital. This is information that the typical small independent primary care physician would not receive if they were not participating in an ACO and receiving the help of an organization like ours. These practices proactively reach out to the discharged patient and manage that transition to the home. Our physicians ensure that patients comply with follow-up care protocols and, importantly, make sure they understand their medications, why they are taking them, which ones they should be taking. These are simple strategies, but when applied consistently and reliably, they reduce unnecessary readmissions.

Because of our success, Aledade is growing. Next year we will partner with over 2,000 doctors in 350 practices, FQHCs, and rural health centers, organized in 32 ACOs across 24 states. These physicians will be accountable for around 330,000 Medicare beneficiaries and an additional 120,000 commercially insured patients. More than half of our primary care providers are in small practices with fewer than ten clinicians.

Congress has done much to support value-based care, but there is always more you can do. One, we need to reduce the complexity and uncertainty in the Shared Savings Program. It is hard for phy-

sicians to succeed in a complex environment, and some ACOs have been reluctant to move to two-sided risk in the ACO program because of the complicated benchmarking methodology. A simple solution would be for CMS to move all ACO benchmarking methodology toward the methodology used in Medicare Advantage. Those benchmarks are well understood and more predictable.

Two, we can make risk taking less risky, especially for physician-based ACOs. ACOs that do not have access to capital, especially rural ACOs and physician-based ACOs, should not be required to take on potentially crippling levels of risk. The Medicare ACO Track 1+ model took a big step toward creating a two-sided model that is feasible for rural and physician-based ACOs. CMS has proposed to make this a permanent part of the program, and we support that.

Finally, the benchmarking methodology has to be fairer for rural ACOs. Currently an ACO's own performance is included in its regional comparison group, so when that ACO drives down costs, it is making its regional target that much tougher. For most ACOs, it is not a big deal because they have a small percentage of beneficiaries in their region. But a rural ACO could have a majority of the beneficiaries in their county, and this is punishing them for their success.

Thank you for the opportunity to share Aledade's experiences with you, and I look forward to the rest of the hearing.

The CHAIRMAN. Thank you very much for your testimony.

Reverend Snyder.

**STATEMENT OF REVEREND SALLY JO SNYDER, DIRECTOR OF
ADVOCACY AND CONSUMER ENGAGEMENT, CONSUMER
HEALTH COALITION, PITTSBURGH, PENNSYLVANIA**

Reverend SNYDER. To Chairman Collins, Ranking Member Casey, members of the Committee, fellow panelists and persons in attendance, thank you for the opportunity to provide testimony. Furthermore, I want to commend you for realizing the importance of including the perspective of the consumer voice in health care. It has been my experience that the most successful and the most effective policies and programs are initiated with having sought, heard from, listened, and responded to the voice of the consumer.

My name is Reverend Sally Jo Snyder, and I am the director of Advocacy and Consumer Engagement at the Consumer Health Coalition. Our organization educates and activates consumers to be engaged and to take charge of their own health care. We educate our shared community about pertinent health policy issues, and we also enroll eligible Pennsylvanians in public health insurance programs.

I travel across western Pennsylvania performing patient activation trainings. Recently, I conducted a focus group of 125 seniors in southwestern Pennsylvania. The questions asked were: "Who helps you live well?" and, "Who is on your health care team?" With intention, I met with both persons living in high economic areas and with individuals living in poverty and asked the same questions to both groups. Those with resources and financial health answered the questions very succinctly by responding, "My doctor, my

specialist, my therapist.” When pressed, the answer remained the same.

When persons living below or near the poverty line answered the questions, they talked to me for 25 minutes, and they mentioned the bus driver, members of their congregation, their pastor, the social worker, the clerk at the local 7/11, the pharmacist at the CVS, their friends and their family. There is a quote, “We do not heal in isolation, we heal in community.” The more we can broaden a person’s base of connections and increase one’s trust points, we can create better outcomes in physical health, mental health, and overall wellness.

As clergy and advocacy director, I have earned my status as a trust point for the persons our agency serves and journeys. I am trusted because I know their names, I listen, I remember, I pay attention, I am present, and I follow through on what is shared. Providers and care staff must do those same things and become trust points as well.

Being a trust point in the community, I know firsthand how important it is that people of Pennsylvania retain access to affordable health care coverage. The passage of the Affordable Care Act was a watershed moment in our communities, expanding the availability of private insurance coverage as well as Medicaid. Continued threats to these programs undermine community trust and risk the basic health and well-being of Pennsylvanians. This is particularly acute for people with pre-existing conditions, who now worry that the courts will take away the guarantee of health care coverage provided to them by consumer protections in the Affordable Care Act. In fact, it is the threat of persons with pre-existing conditions losing health care coverage that is the most pressing issue of those with whom I educate and advocate.

We provide “Activated Patient Trainings” for seniors. These sessions walk persons through every step of the health care encounter from: finding a provider; communicating with a provider; what to bring to every appointment; questions to ask to understand your diagnosis, including my all-time favorite question in the guide, “Can you explain this to me in a way that I can explain it to the members of my health care team?”; medications; one’s care plan; and that most important question of why. Because these trainings are done in a group setting, persons from these learning communities offer their insights and provide support for their fellow students. In these sessions, additional trust points are formed.

As health care advances, the experience and insight of the patient must be intentional, heard, listened to, and implemented. To fail to involve this perspective from the foundation to the completion is to have a health care system that functions only at half capacity.

A person who fears being able to afford any health care because they lack insurance is not someone who can meaningfully participate in their care and focus on being the most valuable player of their health care team. Patients, providers, and payers are the central players in an effective health care system. All have roles to play, all have responsibilities to fulfill, and all have reasons to work together as a team to build and to bear a health care system that works for all of us.

Thank you, and I welcome your questions.

The CHAIRMAN. Thank you very much. As I was listening to you on the importance of those connections, I was reminded of a previous hearing we held on the impact of prolonged isolation and loneliness on health, and I was astonished to learn that—among seniors, and I was astonished to learn that prolonged isolation and loneliness has the same kind of detrimental impact on health as smoking 15 cigarettes a day. I mean, that is just astonishing. So those connections you talked about are really important, and I think Dr. Howes, in talking about the success of his home health visits, is helping to make those connections as well.

Dr. Howes, I want to turn to another area that you did not have time to get into in your oral statement, and that is the very impressive work that Martin's Point has done in the area of diabetes. Could you tell us what the results have been in terms of reducing emergency department visits, inpatient admissions, and cost reductions, and what you did to achieve those results?

Dr. HOWES. Thank you, Senator Collins. Let me start by just saying that we have had dramatic reductions in both admissions and in total cost of care. As you know, diabetic patients in our system on an annual basis cost about 75 percent more than the general population. And most of them, in fact, two-thirds of them have a second chronic illness. Very seldom does diabetes travel alone as an illness. So you have a second chronic illness, which is very important, and we have very significantly reduced admissions and emergency room visits for this population.

The tool set that we have used is, first of all, to learn about this best, we decided to initiate a special needs plan, a Medicare special needs plan. So we have a diabetes special needs plan. It starts with an analytic infrastructure so that we are able to identify who has diabetes and how do we reach out to them. And we reach out to them initially with relatively simple means, such as mailings and the like, but then call them and urge them to come in. Sometimes we will do that using our own staff. This summer and last summer, we had the pleasure of having interns from local colleges do that, which was really a thrill for them. They were making a real difference for these people and really a positive for the member that was called.

We really focus on meeting these people where they are because not everyone is ready to deal with their diabetes, and we start with a social work conversation or a nurse conversation, which is a motivational interview. What makes it worth you changing the way you are living and improving your diabetes, that when we give you medicine, you will take it; when we ask you to change your diet, you will do it?

We have a multidisciplinary team that lives under that, that works with them and manages medications, diet, and activities. That consists of a physician, a nurse, pharmacist, social worker, dietician. So all of that stuff comes together.

We do meticulous tracking and followup of these people, and where they drop out, we get them back in so that we see them multiple times in the course of a year. And we measure our performance quite carefully and actually feed that performance back to the team.

We reward the team, and the team is rewarded financially, but what I am really struck by is that is much less important to the team that is caring for them than the pride they get in seeing real improvement in these patients. And in the medical field, to an amazing degree, what motivates people is the sense they have done a good job and made a difference in someone's life. And so as this data comes back and they see improvement, it is very self-reinforcing.

So that is really the model that we use for the care of these people. We have many people who are not in our diabetic special needs program, but we extend as much of the same techniques to the community members and non-special needs plan members as we can.

The CHAIRMAN. When you consider that the care of people with diabetes consumes one out of three Medicare dollars, what you are doing is really important in terms of helping to sustain the Medicare program as well as obviously making such an improvement in the lives of these individuals.

Dr. HOWES. The great pleasure for our people, I will tell you, is improving the lives of the people they serve.

The CHAIRMAN. Exactly.

Mr. Cavanaugh, I referred earlier to an Institute of Medicine report that said that the spending in our country on health care, the large percentage, as much as 30 percent, is not useful. And this report found that \$55 billion of the total resulted from missed prevention opportunities or opportunities for preventive care that could have avoided more expensive services in the future.

In your testimony, your written testimony, you specifically mentioned that ACOs are unable to waive co-pays for high-value primary care services and that ACOs are unable to include Medicare beneficiaries in any financial benefit from the cost savings.

Could you elaborate on that and give us some recommendations in that area?

Mr. CAVANAUGH. Sure. A couple things.

One, you are absolutely right and the IOM, of course, is right about prevention, and the core of the Aledade model starts with the annual wellness visit. Our primary care physicians reach out to high-risk patients and get them into the office so they can identify those preventive services that they have not received and do that consistently.

Two, you specifically asked what more could we do to motivate patients on the benefit side. There are some proposals and possibilities to help waive co-payments or encourage certain services. There is much more that could be done. For example, one of the big strategies all of us use is chronic care management, which I think has benefited our patients tremendously. But this is not a service that the beneficiaries see their physician providing, and then they are surprised when they get billed for the co-payment. Transitional care management is the same thing. It is an essential form of care that our physicians provide, and then oftentimes the beneficiary is surprised with a co-payment. You mentioned the problem around colonoscopies.

These are services that are of high value in which the notion of creating a disincentive through co-payment or deductible does not make any sense.

I would suggest one way to get out of this bind—all these co-payments and payment rules were created in a fee-for-service environment where we were worried more about overutilization than underutilization. As ACOs move to two-sided risk where they are truly accountable for the total budget, you do not need to worry about those things as much. If we can encourage policies that move the ACO program to two-sided risk, both CMS and Congress can start looking at these issues and relaxing some of these rules and giving us more flexibility.

The CHAIRMAN. Thank you.

Senator Casey?

Senator CASEY. Thanks very much, Madam Chair, and I was thinking earlier, my staff knows that I have become a little obsessive about these numbers of people that got health care by county in my state. But Senator Nelson was here earlier, and I think when people think of states like Florida and Pennsylvania and Maine, too, people focus on the high percentage of seniors. In our state, depending on the number you look at or the year, the number of people over age 65 approaches 2 million people. And those numbers are big, and the number of people that got health care in our state through the ACA was about 1.1 million people. Just imagine that. More than 60 percent got their health care only because we had Medicaid expansion. But the number that I think a lot of Americans have not thought about until recently is the number of people with pre-existing conditions. Nationally, it is about 130 million. In Pennsylvania, the latest estimate is 5.3 million people. In a state that has a little less than 13 million people, 5.3 million. So I will start with that number.

Reverend Snyder, you have seen not just a big number; you have seen individuals, human beings that have health care and have those protections now and will not have it if the administration's point of view prevails in this litigation. And all the administration has to do is withdraw the argument, just say we are going to make every effort, no matter what, to give people those protections.

So it is pretty clear that we have to make a choice as to whether or not we are going to protect—or I should say maintain the protections for pre-existing conditions.

So I ask you about that in the context of, from your experience dealing with real people, not dealing with numbers in Washington debates, but with those real people, what was their life like before, meaning those with pre-existing conditions, and what is their life like now after having the protections?

Reverend SNYDER. Thank you. I think the deal was in our experience with them, it was kind of a course, and before getting health care coverage, they were afraid. But prior to getting the Affordable Care Act coverage, they would not go to the health care provider because they were afraid. They were afraid to go. They were not feeling well. They were afraid, and I think kind of having a sense of what they had and knowing I am going to go, they are going to diagnose me, this is going to be a label that is going to be attached with me, and then am I going to be able to get health care cov-

erage, and the health care coverage I currently have, if I have it, am I even going to be able to afford it. So there was a lot of fear.

Then the Affordable Care Act comes, and they can get coverage, and it was a big exhale. It was literally like a weight off their shoulders. They definitely exhaled. It was a relief, and they were then going to get care, going to the physician, getting the care they needed, getting on a course of treatment plan, and all going along quite well. And now here they are and there is once again fear. If this is taken away, now what? And that fear is mixed very understandably with anger, and I get that. It is kind of the double ouch: "I did not have it. Now I got it. I was on a course of treatment plan, and now you are going to take that away from me? Seriously." And there is understandable anger and fear, and that is kind of a nasty combination, but it is a very real combination. It is something that the folks now that we are talking with and meeting with, this is issue No. 1, that this needs to be continued and needs to be maintained.

Senator CASEY. As you were talking about that, referencing that weight lifted off the shoulder, at the other end of the state, in southeastern Pennsylvania, we had a meeting a couple weeks ago now where a young woman was speaking about her pre-existing conditions. That is exactly what she said, the language that you just used. She said, after she had all kinds of bouts with cancer at a very young age and all kinds of surgery and ups and down, she literally said exactly what you just said: "A weight lifted off my shoulder." That is what this means.

I know we are running low on time. I will just try to get one more question in. The Money Follows the Person program helps folks who might be a senior or have a disability stay in their community. As of 2016, the program has transitioned over 75,000 people with disabilities and chronic conditions out of institutions. By the end of 2018, this will include 3,500 Pennsylvanians. Can you share why Money Follows the Person is important to older adults and people with disabilities in your experience?

Reverend SNYDER. Sure, absolutely, and starting—you had referenced in your introduction my Mom, and talking from that perspective, my mother was one—and it is kind of the norm in southwestern Pennsylvania. She literally was born in the house where she lived all of her 84 years, literally born, married my Dad, raised her five kids in that house, and rocked numerous grandchildren and neighbors' kids and cousins in her mother's rocking chair. And I share that very personal point of this because home matters. People want to stay in their homes. I could walk down 2nd Street or Avenue or whatever it is in Washington, DC, and ask the first ten people I pass, "Do you want to live in your home or an institution?" And we know what the answer is. "I want to live in my home." Why? It is familiar. It is where they are comfortable. I firmly believe and have evidence that people live longer and recover stronger when they are at their homes. This is absolutely critical for folks to be able to remain in their homes surrounded by family, what they know, what is familiar, surrounded by their own trust points that are very intimate. People know where they live. Meals on Wheels knows this is who I deliver the food to, right? Congregations and support networks know this is where I find this person

is absolutely critical for seniors as well as for persons with disabilities.

Senator CASEY. Thank you, Reverend.

The CHAIRMAN. Thank you, Senator.

Senator Cortez Masto?

Senator CORTEZ MASTO. Thank you. Thank you all for being here today.

You know, I am from Nevada. In Reno, Nevada, we have Renown Health ACO, and it has been in existence since 2014, serving over 18,000 beneficiaries, and there is no doubt it has progressively improved the quality scores and work flows by integrating care that we have all talked about, that you have talked about today. And, in fact, in 2017, Renown also generated \$2.6 million in savings.

However, talking with them—and I do on a regular basis—one of the things that they share with me—and I am curious. I am going to open it up to the panel for what you think. What they said to me is some of the difficulties they have are data sharing at the point of care, and it has been a challenge for them. In Renown, the network includes both rural and urban facilities as well as providers that practice across state lines. And I understand that standardizing the electronic health records within the ACO can be challenging. But I hear from Renown that the full data integration would allow accurate and timely data at the point of care and empower the physicians to make the most informed decisions and eliminate duplicate or unnecessary orders.

So I guess my question for you is: What can the Federal Government do to help data integration or interoperability for ACOs? Is that something that you see as well or an issue or difficulty or challenge that you are dealing with as well? And maybe, Dr. Howes, I can start with you.

Dr. HOWES. Yes, first of all, the lack of data interoperability and data flow between care entities is a real issue, and we are blessed in Maine that we have a health information exchange, which I am not sure is the optimal solution, but it does allow us to get good data on all patient encounters over a period of time. But the need to get data interoperability—and I think this is an opportunity for Congress to push data interoperability between electronic health records and to build really good data warehouses, so that we can understand all of the care that is being delivered in all the locations in which it is being delivered, and intervene in an intelligent way in order to improve the health and avert costs for our patients and members. Very important issue as the health care system evolves forward from really what was an analog system to a digital system and something that has not been sorted out well.

Senator CORTEZ MASTO. Thank you.

Mr. Cavanaugh, do you have something to add?

Mr. Cavanaugh. First of all, you have identified a really complex but important issue, and we fully agree. The better interchange of clinical data would be critical. We spend a lot of money—because all of our physicians have very different EHRs, we spend a lot of Aledade's money just integrating with very different EHRs.

But I will tell you one simple issue that Congress could help with. As I mentioned in my testimony, one of our basic interventions is to tell our physicians when their patient has been dis-

charged from the hospital. The way we do that is we tap into the health information exchange that Dr. Howes referred to. Some states do not have those exchanges. When that happens, we go around to the local hospitals, and we say—you know, at our expense we tap into their systems and just say, “We just want to know when our doctors’ patients are discharged.” And most hospitals are fine with that. They realize it is good for the patient.

We do run into instances where the hospital says, “No, we will not share that data for competitive reasons.” Either we are starting our own ACO and we want your doctor to come to our ACO, or whatever reason. And they are very up front that it is for competitive reasons.

But, you know, if you think of it from the beneficiary perspective, they do not care what corporate entity is benefiting from their data. They want their primary care doctor to know that they have been discharged. And often when our doctor calls the patient, they are startled: “How did you know?” But pleasantly startled. They are glad to hear from their primary care.

So I think Congress and CMS should not allow hospitals to block this. You know, at our expense we are willing to go tap in and just ask, “Tell us when the patient is discharged.” And some hospitals are resistant to that. Not all. Some are more than happy to share the data. But that is something policymakers could help us with.

Senator CORTEZ MASTO. Thank you.

Mr. Micklos?

Mr. MICKLOS. Yes, thank you, Senator, and I would echo what both panelists have already responded. I will add, too, that there continues to just be positive movement in the ability for patients to be able to kind of capture their own information and share it directly, too. And there is a lot of work in the technology arena there that supports that activity. And so that is not going to be a fool-proof solution, but to the extent there have been barriers between proprietary medical—EHR products, the ability to have the beneficiary be the quarterback, as it were, of their information, being able to share that is one solution.

In addition to the clinical data sharing, I think, though, that the opportunities that are out there for ACOs both in the public sphere but also in the commercial sphere is the ability—the greater sharing of claims data and better understanding from an actuarial standpoint where you can manage it. So a provider-led ACO, you see quite a lot of investment now in new experience and expertise with regard to actuarial analysis, and sometimes the data that comes from Medicare is not as complete or as timely as you would like to see. And to Mr. Cavanaugh’s point, you know, you often see in commercial arrangements where there are competitive reasons, and I think we are seeing increasing—and the task force is actually involved in activities where we are trying to further the dialog so that parties who sit across the table from each other can understand better about how they want to use each other’s information to move it forward. So the data sharing is both clinical and also claims data.

Senator CORTEZ MASTO. Thank you. And I know my time is running out. I do not know, Reverend, if you had anything to add.

Reverend SNYDER. Sure, I did. And I appreciate that. I think letting the primary care physician know when someone is being discharged from the hospital is absolutely from the consumer perspective coin of the realm movement, right. It really is, because as you have been in this strange land and you have discharged, now it is trying to get everything in order, and, again, what a moment to have the primary care know and contact you. It is incredible that they know, and then you can help them to get on to this next course of treatment, right?

And with the digital records, with our folks, again and with all of this I would be remiss, representing a consumer voice here, if I did not say from the very get-go involve the voice of the consumer. Tell us what it is. Explain it. Listen to their feedback. Implement that feedback to build this much better system.

Senator CORTEZ MASTO. Thank you.

The CHAIRMAN. Senator Gillibrand.

Senator GILLIBRAND. Thank you, Madam Chairwoman. Thank you, Mr. Ranking Member.

A common theme that we have heard today from your testimony is the importance of preventive care. Studies have repeatedly shown that people who are uninsured are less likely than those with insurance to receive preventive care for major health conditions and chronic disease.

Given that on average an American with multiple chronic conditions will end up spending up to 14 times more on health care services than someone without chronic conditions, it is imperative that these Americans continue to have access to quality, affordable care.

In New York, I am particularly concerned about the more than 1.9 million older adults between the ages of 55 and 64 who have a chronic or pre-existing condition and rely on existing protections in order to access basic health care.

Reverend Snyder, in your testimony you mentioned the uncertainty and worry around the corner of the *Texas v. United States* case that could potentially overturn protections for people with pre-existing conditions and how many of the individuals you work with will have one of these health concerns and fear that they will be unable to access basic quality care.

Can you speak to some of the health and financial challenges that these individuals could face if protections for pre-existing conditions or chronic conditions are lost?

Reverend SNYDER. Sure. Thank you, Senator. First of all, if this is taken away and all the buzz around it, they are automatically going to stop, and they are not going to go. They are not going to get treatment for diabetes. They are not going to get treatment for a chronic health condition. Even worse than that, if it is a cancer diagnosis or they are a cancer survivor, they are not going back because they are scared. And that is problematic, and it impacts not only them but their base and their family on that whole line.

Some of them definitely—and I do not think—well, I will probably say in Pittsburgh, blue-collar Pittsburgh, right? And these are very proud folks, right? And they are not going to be ones who are going to go to a hospital, even knowing they do not have insurance, and, quote-unquote, put that burden on a hospital system. They are not going to do that. They are simply not going to go. And it is hor-

rific. It really is. And, again, I have to emphasize the fact that they had it and were on the—it was an exhale. Kind of they literally got that burden off their shoulders. They kind of stood a little taller and lived a little fuller, which we all should be expected to, and they are simply now dealing with, “I had it and now you are taking it away,” and there is anger and shock with that, and it is the emotional toll of that as well as the physical toll of that. Yes, it is a significant burden that could happen.

Senator GILLIBRAND. Dr. Howes, in your testimony you mentioned that Martin’s Point Health Care’s quality care practices include improving health outcomes through managing chronic conditions, preventive care, and early detection of common cancers. How has access to quality and affordable health care for these patients helped control health care costs?

Dr. HOWES. Both on the acute side and on the chronic side, having good access to primary care is absolutely critical. Small conditions which can become severe quickly are dealt with early, and on the chronic disease side, there are the opportunities to carefully manage people’s medications and all of the other services that they need in order to do what we call advance preventive care, that is, when people have chronic illness, they are at risk, getting in to see the clinician, getting in to see the nurse practitioner who is managing their chronic illness makes an enormous difference in the total cost of care and, consequently, in their access.

Senator GILLIBRAND. Right.

Dr. HOWES. And so I would tell you, that had I written the high-deductible health plan law, I would have made primary care something that could be purchased out of the health savings account because I think we need to lower those barriers. I think it has long-term benefits. I think the same should probably be true in the ACA exchange plans. And I know that we have a couple of plans in your state—Independent Health, led by Dr. Mike Cropp and CDPHP led by Dr. John Bennett—have really worked to reduce barriers to primary care and improve chronic disease care in that way. And it is a win for everybody.

Senator GILLIBRAND. We talked a lot about innovation, and so for Mr. Cavanaugh and Mr. Micklos, given your work with providers and experiences at HHS, could you share with us the importance of patient involvement and consumer education to the success of innovative health care models?

Mr. CAVANAUGH. Certainly. When I was at CMS and we were initially kicking off the whole ACO program, there was a lot of speculation: Well, would ACOs want sick patients or would they want well patients? You know, which way would they select? Now that I am in the ACO business, what I learned is what ACOs want are engaged patients. They do not care if you are sick—the doctor does not care if you are sick or healthy, but if you are engaged, it makes the physician’s job so much easier. So we are constantly looking for ways to engage the patient, working with community organizations, religious organizations, anything that motivates the patient, trying to address issues beyond the medical issues that are really important to the patient, because if they see that their physician practice cares about their life more broadly, they are more likely to be engaged.

Mr. MICKLOS. I agree with that. I would just add to that that as you build a value-based care model, if you cannot engage the patient, it is not worth the investment, right? So in our organization, we do talk about patient activation and how best to reach patients. I think Dr. Howes said earlier in his testimony it is critical that you meet patients where they are and then you engage with them appropriately and move them forward.

I think some of the earlier conversations also talked about in the Medicare population, in particular some of the barriers that still continue to exist from a fee-for-service architecture, where maybe there are not certain services that can be provided in the home, but that patient really needs to be in their home, would benefit from being in their home. So looking at breaking down some of those barriers I think still remains to be an option.

And then to the extent that we can continue to incentivize proper support of preventive medicine, it is very important. And there is increasing flexibility, so we are encouraged there. But more is necessary. We have had members who have contracted with ride-sharing services now that have been able to get people to their appointments, and there is a lot of investment now in public housing and in addressing food deserts.

There have been fraud and abuse laws that have stood in the way of that in the past, and there are still some concerns there, but at least it is going in the right direction. We should encourage this care to be kind of coordinated and integrated across systems and not have some of those last boundaries still stand in the way.

Senator GILLIBRAND. Thank you, Madam Chairwoman.

The CHAIRMAN. Thank you.

Senator Jones?

Senator JONES. Thank you, Chairman Collins, and thank you all for being here on this really interesting and important topic, especially for states like Alabama that are poor and rural and unhealthy, to be honest with you.

I want to focus on a couple of things. One, we have talked about technology, and I think from my perspective telehealth is going to be—we are going to have an increasing role in the coming years. The State of Alabama is trying to put a telehealth clinic in every county health department. The University of Alabama in Birmingham, one of the really world-class medical facilities, has got a program that they are working on.

I would like to just hear from maybe each of you what experience you have had with that, and are there specific models that our states and our communities need to be looking at for telehealth? We will just start down the row, I guess, if anybody wants to chime in on that. I think it is important.

Dr. HOWES. Martin's Point does not have any telehealth capabilities now, but has been looking at it carefully. And there is an enormous benefit in a rural state like Maine where over 50 percent of our population is rural in telehealth. Actually, in parentheses, I started practicing on the island of Deer Isle in 1979, and there had been a telehealth capability out there at that point, which was shut down when we opened our practice. But it really is incredibly valuable for a lot of different populations. On the mental health side, it can be accomplished relatively easy and at low cost. Other spe-

cialties like dermatology, et cetera, are very easy to build telehealth capabilities, and it increases access, it can reduce cost, and it can really benefit the population that we serve.

Our larger issues with putting it in place have been how do we fit it into the larger spectrum of other services that are offered both locally and regionally in a way that optimally benefits the patient and does it at high quality.

Senator JONES. All right. Thank you.

Yes, sir?

Mr. MICKLOS. It is a great question, Senator. I think that there are so many opportunities in this space. I think we have historically thought about it as telehealth. I think there is really just now this broader umbrella of virtual care, and whether it is—it helps with access, that is obviously a critical point, but also for reaching patients where they are. We are talking about from the elderly all the way down to, you know, millennials who want to kind of engage in a different way.

I think there is some really interesting work that the military has done. I heard a presentation just last week about, you know, what the military has done in light of the fact that they have been in theater for 17 years, and there are advancements in how they use it.

It also is a significant way to address the physician shortages, especially in neurology and other areas where there really are some great opportunities to make sure that the consults are ready. And it is a timeliness issue as well. If someone needs that consultation immediately, that is really the way many patients will be able to obtain it.

Senator JONES. Thank you.

Mr. Cavanaugh?

Mr. CAVANAUGH. A lot of our ACOs serve rural areas and are located in rural areas. We are starting an ACO in your state next year, interestingly.

Senator JONES. Good.

Mr. CAVANAUGH. Not many of them participate actively in telehealth, and when you talk to them to find out why, it is because of all the restrictions around the current way it is structured in the Medicare benefit, that it just does not fit the way they practice and it does not fit the way their beneficiaries live. But as Mr. Micklos said, the technology is evolving and our physicians are very excited about it.

Going back to my answer to an earlier question, I think as we move ACOs to being more and more accountable for the total cost of care, all these Medicare regulations that were built around preventing overutilization of services hopefully will fall by the wayside, and we can get more—I think it would work well for many of the beneficiaries that our ACOs treat. I think our doctors would love it. It is just that the way it is currently constructed, it is problematic.

Senator JONES. Yes, sir. Thank you.

Reverend Snyder?

Reverend SNYDER. Thank you for the question, Senator, and I think with this as well is from the get-go, right out of the gate, involve the consumer, the patient, seek their perspective, how it

works, because I think the piece of this is going to be that they understand it, No. 1, how it works, and are going to be concerned about the personal aspect of this. Is that going to be part of it? All the more reason when that occurs to make sure the trust point, the person, you know, with them when they are having that interaction with their provider and setting that up is someone that they absolutely trust. And, again, involve them from the beginning. Share with them, get their feedback in this.

Senator JONES. My time is just about up, but could you, Reverend Snyder—following up on Senator Gillibrand's question, what can we do as Members of Congress to try to help with what I call "health literacy," getting patients to be engaged as you all talked about and understanding? What is it that we might do from the Congress that might help with that program?

Reverend SNYDER. I think the point of that is realizing that we are all involved in this. You can look at it from the economics, and I get that perspective, but as well, I mean, we are all going to be health care consumers and interact with that. And I think becoming available and really listening to these stories of these folks, involving them in this, yes, it is economic, but ultimately it is a person, and it is who they are, and to provide—to gather those stories and listen to them around that piece and be very accessible to hearing those stories and involving them in this piece.

As far as health literacy, again, it really is that, and programs to provide even in your offices, right? And interact with your local community organizations that do that. Honestly, to get people into programs in health literacy as respected trust points and the connection people have with the offices, more than maybe going to get a fishing license or a hunting license, which that is important, too, but as well to have that being a connect point with that office into the broader community I think would be a really good piece as well.

Senator JONES. Great. Well, thank you. Thank you all very much.

The CHAIRMAN. Thank you, Senator.

We are going to do a very brief second round of questions. There are so many issues that have been raised that deserve a little more attention.

Mr. Cavanaugh, I noticed in your testimony that you said you had been able to achieve a 22 percent average decrease in skilled nursing facility stays. That is astonishing for two reasons: one, the difference in cost between home health care and a skilled nursing facility; but, second, as Reverend Snyder said, all of us or virtually all of us would so much rather be able to stay in our own homes. So how did you do it?

Mr. CAVANAUGH. Thank you for the question. I should preface my answer by saying we think we can do a lot more. What we have done so far has been fairly basic. One is having our physicians in our ACOs go out and talk to the local skilled nursing facilities and explain we are now in an ACO, we are now watching, we now care that the right patients come to you, that they stay for the right duration, that they get the right therapies while they are there. There is value in just having that conversation and letting the skilled

nursing facility know that someone now is watching and cares, which has not been true in the past.

In some of our markets, we have created post-acute liaisons, so there is someone in the ACO designated to check in and say, "I see Ms. Smith is still there. What is the plan? When is she getting home? Can we help you plan the discharge so that when she goes home, the services she needs to go home are ready?" So it is almost like augmenting the discharge process for the skilled nursing facility.

There are a series of these things that are really—they are sort of resource-intensive, and that is why—but I think we have just scratched the surface of this.

When I was at CMS and we looked at the variation in spending in Medicare across the country, almost all of it is explained by post-acute-care utilization, how expensive the site of care is. There are just different cultures in different regions, so trying to break out of that and stay focused on the actual needs of the beneficiary.

We have done some basic things and had really remarkable results, but we think there is a lot more potential there.

The CHAIRMAN. That is very encouraging.

Dr. Howes?

Dr. HOWES. We have made some really substantial reductions as well, and one of the very interesting facts that we have learned is that, for example, post-joint replacement, our orthopedists in Maine feel that people do better when they go home than when they go to a skilled nursing facility if they have an adequate rehabilitation plan and they follow it. Their perspective is that their recovery is quicker and more complete. And so that has served as a nice motivator for our teams to get people home as quickly as possible, as much of the time as possible.

The CHAIRMAN. That is absolutely fascinating. I just think this is very exciting.

The final question I want to ask involves the treatment of and the identification of depression and other mental illnesses. And, Dr. Howes, you and I started to have a brief conversation about that. I bring it up because this is the 10-year anniversary of the passage of the Paul Wellstone and Pete Domenici Mental Health Parity Act that was intended to make sure that insurance treated the limits on mental illnesses the same as physical illnesses. And there is a 2016 study that found that a depressed mood, which included symptoms such as anxiety and fatigue, was as strong a predictor of heart disease as well-known risk factors like high cholesterol and obesity.

So, Dr. Howes, what are you doing at Martin's Point to better integrate screening for mental health and substance abuse disorders?

Dr. HOWES. Well, in our population we do the same thing that Mr. Cavanaugh's people do, which is an annual wellness visit, which includes a mental health screen.

The other piece of work that we are doing, which is our home care program adapted from Health Quality Partners in Doylestown, Pennsylvania, is that when our nurses take on a sick, chronically ill patient, they screen very thoroughly for depressive illness and substance abuse, which is both associated with and exacerbates

mental illness. And we are finding a fair amount of treatment need there.

I would also tell you that we find opioid addiction in the elder community is higher than we would like it to be. We are dealing with that, and we actually have now got a zero co-pay for people in our health plans to access opioid treatment for the very reason that it all ties together. Mental illness, substance abuse, and depressive illness are really connected.

The CHAIRMAN. Thank you. That is very helpful.

Senator Casey?

Senator CASEY. Madam Chair, thank you for the second round. I will get to two questions.

Mr. Cavanaugh, I will start with you. You get extra credit because you went to Penn, but that is not why I am asking you the question.

[Laughter.]

Senator CASEY. I want to take you far away from a big city like Philadelphia into rural communities. As you know from your work, you have got a proven track record working in those parts of states like mine. I represent a state that has 48 out of 67 counties are considered rural. That means we have a larger rural population than any other state except maybe three or four, over 3 million people living there. So access to health care in rural areas is a big issue in our state.

People who worry about getting food on the table or figuring out a way to get to their doctors' appointments is a bigger deal when you have great distances to travel, as you know. We know that in our state and in a lot of states the Area Agencies on Aging are critically important.

So I guess in light of your experience with these rural communities and access to care, can you explain the importance of community partners in addressing the social needs of a rural patient?

Mr. CAVANAUGH. Those community partners are absolutely essential, and even more so for a model like ours. Our model is based on the physician practice, and in a rural area, the physician practice is bare bones. It is maybe one or two physicians, maybe one or two staff. So the notion that they are going to personally address the non-medical needs of their patients is just not viable. They need to tap into community resources in a big way. And they do not have the resources of a health plan. So a lot of what we do is try to help them with backup resources, but also help them map out what are the community resources in your community. And the AAA agencies are often the starting point.

I would say one of the hard lessons we have learned both in rural and non-rural communities is a Meals on Wheels program in one community might be the best provider of food services, and then you go one community over, and it is a weaker agency.

So part of it is learning not just what the resources are, but which ones are really worth working with that are really going to deliver, are going to be customer friendly. And, unfortunately, you have to relearn that in every community you work in. We try to stay close with our doctors. They often know this. But often if it is their first time in an ACO, they are doing these sort of functions for the first time, so they are learning.

So I could not agree with you more that tapping into community resources is essential. The aging agencies often are one of the best—not always but often one of the best. So it is a big part of our model.

Senator CASEY. Thank you.

Reverend Snyder, I will go back to you as well for another kind of real-life issue, which is the work that navigators do. It seems like if you had a Ph.D. in health care, you would still need a navigator on some days. But we are grateful for the work that gets done. The navigator grants are critically important. But, unfortunately, the administration has chosen to reduce funding for navigators from \$62.9 million in 2016 to only \$10 million in 2018. So over the course of two years, cutting it by roughly \$53 million. I do not know who the hell thought of that idea. I do not know how the United States of America is better off by taking \$53 million from navigators. But some bright star, I guess, in the administration thought that was a good idea. It is a dumb idea, a really stupid idea.

But I wanted to ask you, what is the value of those navigators and the in-person assistance that they bring?

Reverend SNYDER. Thank you, and I would resonate with not the greatest idea, what they are planning to do. When open enrollment started back in 2013, on October 1, we literally had folks show up at our office asking this question: “OK. I am here for my free health care.” And you are, like, “Well, time out.” And part of that is on us about educating what the Affordable Care Act was. And as that caught its stride, I mean, we have folks coming here and we are a trust point, right? It is confusing. They are intimidated. They are not sure, and to have someone that is with them person to person helping them to navigate it, answering their questions, giving them that comfort, and then the all important followup is absolutely golden. That has been one of the pieces of the Affordable Care Act along with, as we have discussed already, you know, the covering of pre-existing conditions, having the navigators has been absolutely beneficial because folks come in, they are confused, they are intimidated. And we had folks walking in having no idea what a deductible was. So it is meeting them, that person-to-person, that trust point, and helping them to navigate through the system, it was valuable and I think made the Affordable Care Act be the success it has been in a lot of ways.

Senator CASEY. Thank you.

Thank you, Madam Chair.

The CHAIRMAN. Thank you.

Senator Cortez Masto?

Senator CORTEZ MASTO. Thank you. And I want to follow up on the Chair’s latest conversation with all of you on mental illness, but let us turn it to Alzheimer’s and dementia. We have spent a number of hearings, thank you very much, trying to address and understand how those patients and their families dealing with Alzheimer’s and dementia navigate the health care system. Could you talk to us about how you address and work with patients and their families who are navigating your health care system through an ACO that are dealing with either Alzheimer’s or dementia? Maybe,

I do not know, Dr. Cavanaugh, do you mind starting—or, excuse me, Mr. Cavanaugh, do you mind starting?

Mr. CAVANAUGH. You just made my Mom very happy.

[Laughter.]

Mr. CAVANAUGH. Sure, it is one of the great challenges. I hate to keep harping on it, but it starts with the annual wellness visit and making sure you know that the patient has dementia and, you know, screening and just the awareness of the primary care practice and wrapping their arms around the patient. But typically then the practice needs to know who the caregiver is, so it is not just working with the patient, but understanding the patient's support system. And this is, frankly, where traditional American practices have not been well oriented to. But now that you have an ACO model where they see that, it is the type of medicine they want to practice, like this is something physicians want to get involved in, they just have never felt they had the time or that the business case warranted it. You see physicians recognizing the challenge and stepping up to it and saying, "This is how I want to practice. I want to know what this patient is going home to." So a big part of this also is the care manager. Most of our practices, we have embedded care managers if the practice is big enough. It would be not just the physician dealing with the medical side but the care manager dealing with the family side and, again, linking into community resources.

But we do not have any magical clinical programs that solve this problem, but getting the basics right at the outset like that is the important first step.

Senator CORTEZ MASTO. Thank you.

Reverend?

Reverend SNYDER. And I really want to play off of the whole idea of the caregiver in this piece, right? And a lot of times, I mean, the person living with Alzheimer's and dementia, they are scared. They are scared about what they have already lost and what they are going to lose. And the most important thing I think they are scared of is the loss of independence, right?

So one of the things we encourage with the caregiver is a lot of times they will walk in, and a good provider is going to talk directly to the patient, as they should. It is always defend the person's dignity. And they might ask, "How is it going?" And the person might say, "Oh, I am fine. It is well. Everything is good," when the caregiver knows that there have been instances and issues, and maybe there has been falls and what have you. And one of the neat things we recommend is for the caregiver then, before the visit, to either email or call and talk to the provider and share with them, "Hey, look, this has been happening. You might want to address this in the visit," so you are not embarrassing the person who has dementia or Alzheimer's in the visit, saying, "No, that is not true. Things have not been well." It is just another way of defending dignity and involving, again, the caregiver and that whole team—I cannot stress that enough as well—in this whole journey through Alzheimer's and dementia.

Senator CORTEZ MASTO. Thank you.

Yes, Mr. Micklos?

Mr. MICKLOS. I will just add to that that I think the increasing focus on the ability to provide home care services is also very important in that realm. It is really important to be able to meet that patient where they are, and as we talked about, even in a demented state, it is still a better outcome for them to be at home and receiving home care. And so I think we need a greater opportunity to really kind of focus on that.

I think in the Medicare Advantage space and watching the policies around supplemental benefits will also be interesting to watch. There will be opportunities beyond the caregivers, but also potentially for companionship and other opportunities that I know at least from a social work perspective are really important for that patient population.

Senator CORTEZ MASTO. Thank you.

Dr. Howes?

Dr. HOWES. We really are beginning now to scan our claims data base to us who is showing various signs of dementia to try to begin to provide for them services like referrals to dementia daycare, to provide respite for families. In our area we have a wonderful organization called the Southern Maine Area Agency on Aging which has put together a great daycare facility.

But, in addition, we are beginning to figure out what are the social supports that these individuals and their families need. The clinical interventions, while they are making some difference, are not really very effective at this point, and this is really about supporting the patient and supporting the family through this terrible illness and loss.

Senator CORTEZ MASTO. Thank you. Thank you so much. I appreciate the hearing today. Thank you all for being here. Thank you.

The CHAIRMAN. Thank you.

I want to thank all of our witnesses for your compelling testimony today. It is extremely helpful to our Committee as we contribute ideas for moderating health care costs while actually improving the quality of patient satisfaction and outcomes, and the two are not incompatible goals at all, as your experiences clearly demonstrate. In fact, oftentimes the lower-cost interventions, the emphasis on prevention, can prevent more serious illnesses from developing or worsening and increase patient satisfaction and outcomes. I appreciate your sharing your very specific ideas with us. That is very helpful as well.

I also want to thank our staff on both sides of the aisle for working hard on this hearing, which, as I said, I think contributes to the general debate. We have had a lot of focus on the cost of health insurance, which clearly is vital, but we need to focus more on health care costs, which obviously has a direct impact on the cost of health insurance. And I am also concerned about the sustainability of our entitlement programs, and this debate is very important for that as well.

Senator Casey, do you have any closing comment?

Senator CASEY. Just briefly, Madam Chair. Thank you for having this hearing on such an important set of issues.

I also want to thank our witnesses for their testimony, particularly Reverend Snyder, not only because she is from Pennsylvania

but that helped, and I am grateful. And I am really grateful for all of our witnesses who are here today.

Congress, when we passed the Affordable Care Act, took strides to expand coverage and to help make coverage more affordable and transform the health care delivery system. I and I know others will continue to work to keep the promise that our Government made to 130 million Americans and 5.3 million Pennsylvanians with pre-existing conditions. I will also continue to work with Democrats and Republicans to improve the patient and provider experience. We have got a lot of work to do, but I look forward to working with my colleagues in both parties to improve our health care system.

Chairman Collins, thank you very much.

The CHAIRMAN. Thank you.

Committee members will have until Friday, October 12th, to submit questions for the record. If we do receive some, we will be passing them along to you.

Again, my thanks to our outstanding witnesses today, to Ranking Member Casey, and to all the Committee members who participated in today's hearing. Given all else that is going on, I was really delighted that so many members were able to come by for parts of the hearing, and I think that shows their interest in this topic.

This concludes the hearing. My thanks.

[Whereupon, at 11:02 a.m., the Committee was adjourned.]

APPENDIX

Prepared Witness Statements



**David Howes, M.D., President and Chief Executive Officer,
Martin's Point Health Care,
Portland, Maine**

Testimony for Senate Special Committee on Aging
October 3, 2018

Patient Focused Care: A Prescription to Reduce Healthcare Costs

Thank you, Chairman Collins, Ranking Member Casey, and members of the Committee on Aging for this opportunity to provide testimony regarding the health care innovation, quality and transparency for seniors in Maine.

My name is Dr. David Howes, and I am the President and CEO of Martin's Point Health Care based in Portland, Maine. In my testimony today, I want to share with you a picture of the health care landscape for seniors in my home state of Maine (a landscape shared, I'm sure, by many states with significant aging populations in rural areas.) I also will tell you what my relatively small (but mighty) health care organization is doing to address the significant needs of this population.

I earned my medical degree from Dartmouth Medical School in Hanover, New Hampshire, and served residencies at the Dartmouth-Hitchcock Medical Center, the Medical Center Hospital of Vermont in Burlington, and the Eastern Maine Medical Center in Bangor, Maine. I am Board Certified in Family Medicine.

I began my medical career as a family physician serving the rural, island fishing community of Stonington, Maine.

This experience has taught me the power of primary care in improving health outcomes and reducing the cost of care. I brought this philosophy to Martin's Point Health Care in 1989 as a primary care physician and now serve as the President and CEO, a position I have held since 1996. I am deeply committed to the Martin's Point mission of creating a healthier community and have dedicated my career to doing so—both as a physician and as president and CEO.

Martin's Point Health Care is a forward-thinking, not-for-profit organization providing primary care and health insurance plans to the people of Maine and beyond for over 35 years. We own and operate seven primary care health care centers with over 70 health care clinicians in Maine and New Hampshire. We also administer two health plans: Generations Advantage, the largest Medicare Advantage plan in Maine (also offered in New Hampshire), and the US Family Health Plan (TRICARE Prime®) for military families and retirees in Maine, New Hampshire, Vermont, and parts of New York and Pennsylvania. Our Medicare Advantage plans have received the highest quality ratings in Maine by The Centers for Medicare and Medicaid Services and our US Family Health Plan is rated "excellent" by NCQA and is the highest rated plan of its type in the country, based on Consumer assessment of Healthcare Providers and Systems (CAHPS) scores.

As a not-for-profit health care organization serving our local population, offering both primary care and health insurance coverage, we are uniquely positioned to deliver the highest quality care at the lowest cost with the best overall experience for our patients and members. In fact, we are long-standing members of the Alliance of Community Health Plans (ACHP), a national leadership organization based in Washington, DC, advocating for not-for-profit health plans across the country. Members of ACHP are similar to Martin's Point in that they have deep ties to their providers, a dedication to the health of their communities and a commitment to striving for the highest quality ratings. Many Senators serving on the Committee on Aging have ACHP-member health plans operating in their states.

Maine is certainly known for its seafood industry, and this summer my son worked in one of the most physically demanding careers in Maine—he served as an apprentice on a lobster boat, under the tutelage of “Captain Mike.” I mention this because the Captain is a Martin’s Point health plan member as well as a patient at one of our health care centers, and before and after each lobster season he makes the long journey from the island of Vinalhaven to visit our health care center in Brunswick, some 70 miles to the south. He comes to have his knees treated for increasing arthritis, the result of many years hauling and heaving lobster pots. Now at an age when many would be planning retirement, Captain Mike is teaching a new generation the intricacies of catching crustaceans. In the off-season, he returns to the mainland as an art teacher. As Senator Collins well knows, his career reflects the way many Mainers make a living – doing what they do best, often combining a variety of passions to add up to a satisfying and sustaining whole. Mike could choose to have his knees worked on closer to home, but he chooses to travel to Martin’s Point because we have earned his trust. By providing both his primary care and his insurance coverage, we are uniquely positioned to consider the full spectrum of his health and support him on land or sea, reliably and affordably.

At Martin’s Point we believe we have much to offer members like Mike and thousands of other rural seniors in Maine, who seek a trusted health care partner who shares their local roots. All in all, we care for the lives of more than 155,000 patients and plan members. At the heart of all we do, though, is our “true north”— we are people caring for people—our patients, members, each other, and our community.

THE STATE OF MAINE—A SNAPSHOT OF THE HEALTH CARE LANDSCAPE IN AN AGING, RURAL STATE

Maine, as you may know, is a state that is aging rapidly, and by 2020 it is projected those over the age of 65 will outnumber those under 18—a statistic that is 15 years ahead of the national projected date of 2035 (Valigra, 2018). We have the highest median age in the country and roughly 22 percent of our population is over the age of

65 (Amy Newcomb; Julie Iriondo, 2017). By 2040 that number is expected to jump to 28 percent (Qian Cai, University of Virginia, 2017). While this demographic shift is occurring on a national level, Maine is at the forefront and is experiencing this shift ahead of most other states.

In addition, an increasing number of our seniors are chronically ill. Adding to the complexity of this issue, 31 percent of our senior population lives below 200 percent of the poverty line and 51 percent live in rural areas (Cubanski, Casillas, & Damico, 2015).

In short, Maine's senior population is old, chronically ill, poor, and mostly living in rural areas. Lack of access to quality affordable care and community resources, isolation, lack of transportation, and, in many cases, food insecurity, all translate into an ever-growing, vulnerable population living largely in suboptimal circumstances.

In the nation's most rapidly aging state, Maine health care providers are on the frontline of tackling a constellation of senior health care challenges other states will likely face in the years ahead. These challenges demand an innovative and strategic approach to care. Martin's Point is several years into adopting just such an approach, and as an organization offering both direct primary care and health plans (primarily to those over age 65), as well as investing in like-missioned community organizations, we are committed to leveraging our resources to effect tangible improvements in the health of our seniors.

Because many of our senior health plan members also receive care as patients in our practices, we have unique access to both their health record and claims/utilization data. Through the use of clinically oriented data analytics—a cutting-edge function complete with a dedicated team of data scientists and distributed analysts—we glean the information we need to support our chronic disease management and care coordination efforts for our most vulnerable seniors. We then use additional data to drive performance and track overall progress.

Below you will find several examples of innovative programs and methods of care we have developed to support the seniors we serve. At Martin's Point, we believe that by focusing on advanced prevention, we can build care models that allow our patients and members to live longer, healthier lives with a minimum of costly acute interventions. These efforts are our contribution to the steady transformation of health care in our state—improving the health outcomes and the experience while driving down costs for our patients and members, our providers, and our overall health care delivery system.

PROGRAMS AND METHODS OF CARE

Addressing Quality: Annual Quality Metrics

In 2018, Martin's Point implemented a multi-dimensional measure of quality, designed with components we believe are essential to improving health outcomes through managing chronic conditions and early detection of common cancers. For the most reliable data, we set the target group for this measure as those who receive both primary care and health insurance coverage from Martin's Point.

This integrated set of quality measures includes five areas of focus to deliver evidence-based care for adults and seniors:

- Annual physicals
- Diabetes recommended testing (retinopathy screening; nephropathy screening; HbA1c screening 2x/year)
- Breast cancer and colorectal cancer screenings
- Hypertension management
- Medication adherence for cholesterol management

RESULTS

As 2018 is the first year following these measures, we are still in the evaluation phase of these efforts. To date, we have met most targets through the second quarter of 2018 and are on track to meet our third quarter targets.

The combined quality measures are also one-quarter of our annual staff incentive plan, creating motivation and reward for performance of our providers who directly support better health outcomes for our patients and members.

PATIENT EXPERIENCE

In addition to the preventive health benefits of these quality measures, we have also found they create a meaningful touch point with our members. For example, interns from local colleges recently made outreach phone calls to our members overdue for preventive care visits. The simple act of calling and connecting was appreciated by many of our members—showing that someone cared enough to talk with them about their health.

“Ever since I started seeing my Martin’s Point doctor, I have felt confident in my health care.”

“I have had my Martin’s Point doctor for over 20 years, and I credit her with my good health!”

Diabetes Care Management

The Martin’s Point Diabetes Care Management program was created to improve quality of life and health outcomes for our members living with diabetes. Through member engagement, care management, and the removal of barriers, the program works to improve quality, manage disease progression, and reduce costs.

Martin’s Point Health Plan Diabetic Population:

- 21 percent of our 2017 total health plan population have diabetes.
- They account for 32 percent of our health plan medical costs.
- 70 percent of these members have at least one of the following comorbid chronic conditions: chronic obstructive pulmonary disease, congestive heart failure, and coronary artery disease (most notably with CAD present in 32 percent).

2017 Utilization and Cost of Care Data:

- Across all members, 31 percent of ER visits and 36 percent of inpatient admissions were those of diabetic members.
- Those who were readmitted within 30 days of discharge represented 44 percent of all health plan membership readmissions.
- The average fee-for-service cost per diabetic member was 73 percent higher than a member without diabetes in 2017.

INTERVENTIONS

The health plan has three ways it addresses diabetic members' quality and cost of care:

1. **Member Engagement:** We mail a "diabetic scorecard" to members to share their completion/need for annual recommended preventive screenings and tests to help them track progress with their primary care provider (PCP). We follow up with members who are behind on their screenings and tests.

Provider Engagement: Network providers are engaged via regular newsletters and reminders regarding quality-of-care gaps, as well as quality incentive payments, for the diabetic population.

2. **Care Management:** We deploy health plan nurse care managers to assist with individual diabetic members' needs.

Generations Advantage Focus DC (diabetes care) Plan Members: This plan is a Medicare Advantage Chronic Condition Special Needs Plan (C- SNP) targeting care and services to individuals with diabetes. Qualified members are assigned a care management nurse who develops a holistic care plan and coordinates care with their PCP and care team, a pharmacist, medical director, social worker, specialists, and other community providers.

The care plan contains SMART (specific, measurable, achievable, relevant, timebound) goals and interventions that meet the member's needs and provides a framework for monitoring. Care managers use motivational techniques to help members identify barriers and develop interventions, fostering self-management skills enabling members to achieve incremental accomplishments while improving their well-being and health.

An annual interdisciplinary care team (ICT) meeting assesses current state and sets goals. PCPs are in-network, ensuring adherence to nationally-recognized clinical protocols which are used for their care. Social workers assist with an emphasis on addressing behavioral health and social well-being. A clinical pharmacist provides a comprehensive medication reconciliation and review, identifies adherence and cost barriers. The Medical Director is on site and present at the ICT meetings to provide

medical direction, if needed. Members and providers are also invited to join the ICT to promote engagement and alignment.

Other Generations Advantage Plan Members: All Martin's Point Generations Advantage members are eligible for services as part of our Care Management program focused on chronic diseases. Diabetic members can enroll based on their diagnosis, or any other chronic comorbid illness. Care managers work with members, both in their homes and telephonically, to close gaps in care, reduce risk for complications and progression, and decrease ER and hospitalization utilization. These nurses focus on helping members achieve their goals by providing diabetic self-management education, aiding in navigating community resources, and ensuring collaboration between PCP and specialty providers.

3. Removing Barriers to Care:

Access to Care: Better diabetic and preventive care occurs when members have regular visits with their PCP. When data shows these visits have not taken place, or that gaps in care persist after visits, we offer health-plan-sponsored mobile health visits or in-home nurse practitioner visits to provide recommended preventive screenings and tests to members with limited access to care. The visits include point-of-care testing including diabetic eye exams, A1C testing and overall health risk assessments. We always recommend the member return to their PCP for follow-up care.

Medication Adherence: Pharmacy claims data is used to identify members who may not be taking oral diabetic, statin and ACEI/ARB medications as directed. Written and telephonic outreach from pharmacists, pharmacy residents, and senior pharmacy students remind members of the importance of medication adherence and provide guidance in the case of cost or other barriers. Similar outreach and information is shared via mail with diabetic members' provider offices.

RESULTS

Pharmacy Data and Trends:

The three pharmacy outcomes we measure are:

- Non-insulin diabetic medication adherence
- Angiotensin Converting Enzyme Inhibitor(ACEI)/Angiotensin Receptor Blocker (ARB) medication adherence
- Statin use in patients with diabetes

Health plan pharmacy outreach efforts have yielded an average of 2 percent increase in adherence in the above measures on a year-over-year basis following implementation.

Quality Data and Trends:

Key diabetic quality-of-care measures are: rates of retinopathy screening, nephropathy screening, and blood sugar control (measured by A1c < 9). Our 2017 Healthcare Effectiveness Data and Information Set (HEDIS) sample performance data for these are as follows:

- Diabetic eye exam: 86 percent
- Kidney disease monitoring: 95 percent
- Blood sugar controlled: 88 percent

Health plan interventions have yielded positive results on these measures. When the plan launched the diabetic scorecard to engage and educate members, all three measures increased by a range of 2 to 5 percent. Similarly, our efforts to engage members and eye care providers to schedule diabetic exams yielded a 2 percent increase in year-over-year performance.

Care Management Data and Trends:

Diabetic members engaged in care management have shown a greater than 10 percent reduction in 12 month pre- versus post-program enrollment for Emergency Department (ED) visits and ED-specific per member per month (PMPM) cost.

Inpatient admissions rates and inpatient cost reductions have shown similar success with a greater than 30 percent decrease in 12 month pre- versus post-program results.

Home-Based Care: Comprehensive Care Program

In December 2017, Martin's Point launched our Comprehensive Care Program, expanding our capability around home-based care. This program currently serves 159 Generations Advantage plan members with heart failure, diabetes, ischemic heart disease, and/or chronic obstructive pulmonary disease with multiple medications and acute care use. This is a longitudinal program where members receive care and support in their homes and across all care settings from their assigned, community-based registered nurse. The program aims to help seniors improve and maintain overall health and independence, thereby reducing unnecessary ER/inpatient utilization. This is accomplished through symptom-response planning, patient education, regular medication reconciliation, and addressing psychosocial determinants of health.

The program, implemented through our partnership with Health Quality Partners based in Doylestown, PA, focuses on all factors that may be impacting seniors' health—physical, emotional, social, and environmental—including key factors that lead to unnecessary medical interventions and hospitalizations like untreated depression, loneliness, food insecurity, beginning dementia, errors in the use or prescribing of medication, unsafe home environments, alcohol use, or neglect. There is no end date to the program—building on the consistent relationship with the community-based registered nurse, enrollment is lifelong or until the member terminates their relationship with Martin's Point.

INTERVENTIONS

Comprehensive Care Program nurses are community-based and trained to the advanced preventive model developed at Health Quality Partners. They are part of the members' care team, sharing insight into the member's home environment dynamics, close communication with their primary care provider, and providing advanced preventive care, including medication reconciliation, symptom monitoring, and timely communication to the care team. Based on the needs of the individual, a nurse may:

- Provide personalized health assessments, education, and support
- Teach the individual to manage their chronic health conditions

- Encourage the individual to receive preventive care and services to lower the risk of complications
- Monitor and work with the member's doctors as needed
- Visit the member at home or wherever they receive care (rehab, hospital)
- Go with the member to doctors' visits and coordinate follow-up care
- Help to manage medications and treatment plans
- Provide an individualized action plan based on the member's goals to stay healthy
- Assist with long-term planning to help the member stay as independent as possible

RESULTS

Exceeding expectations, 54 percent of invited members are accepting our nurses into their home for the first visit and then inviting them back again and again.

Embedded Nurses: Integrated Care Connection Program

Another way we care for our senior population is by embedding nurse managers in our primary care practices to help manage complex care, advocate for our patients and doctors, and help patients navigate an increasingly complex healthcare system. In 2016 we launched our Integrated Care Connection (ICC) Program, which is designed to improve the coordination of care for Martin's Point patients with chronic conditions. Through this program we identify patients with chronic conditions and ER/Inpatient utilization in the past year. We then conduct a comprehensive office visit with the patient, PCP, and ICC nurse care manager to develop a care plan designed to meet the patient's health goals. Throughout the program we provide ongoing access and support, including both face-to-face and phone outreach, customized to meet the patient's needs and preferences. Participants are provided with the direct phone number of their nurse care manager, supporting continuity of care and avoidance of redundant efforts.

INTERVENTIONS

ICC nurse care managers partner directly with participants and their health care providers to ensure participants get the best care possible from everyone who is involved in delivering care. ICC nurse care managers work to promote participant well-being in a number of ways, including:

- Working to develop realistic health goals

- Coordinating care by sharing participant health information with other providers or facilities in the community
- Helping to manage medications
- Supporting participants, and their families/support systems, as they manage their medical conditions
- Identifying and reducing barriers to getting the care needed
- Facilitating and conducting advance care planning and end-of-life discussions
- Closing gaps in care and promoting preventive health care

The trusting relationship formed between participant and nurse care manager is a core component of the program. Many patients face social barriers, including isolation and loneliness. The nurse care manager focuses on building both autonomy and community connections, while honoring the participant's personal goals.

Program Components

- Collaborative office visit with patient, PCP, ICC nurse care manager
- Access through face-to-face and telephonic support
- Core components to guide conversations and educate
- ICC nurse care manager and patient develop patient-defined goals and action planning

Topics of Discussion Between Nurses and Their Patients

- Symptom-response plans
- ER use and inpatient hospital services
- Monitoring health at home
- Meal planning
- Adding activity
- Managing medications
- Recommended testing and follow-up appointments
- Emotional health
- Advance care planning
- Smoking and substance use
- Barriers to care
- Support systems

RESULTS

- 59 percent of those invited agreed to participate
- Up to 65 percent decrease in emergency room utilization
- A significant decrease in hospitalizations, number of inpatient days, and no readmissions for our graduated group

PATIENT EXPERIENCE

"I just feel so spoiled and attended to! It's almost like 40 years ago when the doctor knew you and insurance companies didn't rule a physician's practice. My ICC nurse care manager makes a BIG difference. I KNOW how big the practices are and I don't expect this sort of attention. I LIKE it but I don't expect it."

"Thank you so much for being such an important part of my Mom's health care. I don't know what we would do without you!"

PROVIDER EXPERIENCE

"Pt successful in remaining tobacco free for 8 months, despite smoking since an early age of 13. Has also recently lost weight. He has done well with an established trusted practice contact and ongoing support (by ICC nurse care manager)."

"With (ICC nurse care manager's) diligent and compassionate care our mutual patients have done SO VERY WELL!!!"

"The ICC nurse care manager researches the patient and prepares the visit so well that they are now well cared for during and between visits."

"The ICC nurse care manager helps the patients feel engaged. Patients love her and the extra attention."

Reflections from our ICC nurse care manager, Christina:

"One of the unfortunate realities of modern medicine is that care is often fragmented.

Patients receive care from multiple providers, from different systems, including the VA, using different medical records that do not connect to each other. Our patients are often taking multiple medications from different prescribers. It is often overwhelming, especially to those who are ill. As a nurse care manager integrated in the primary care provider's office, we are able to communicate with the different specialists and systems, identify discrepancies, coordinate care, and advocate for the patient.

Medication errors are one of the leading causes of adverse events and readmissions. As part of the Integrated Care Connection (ICC) program, we can reconcile medication lists from various providers, review what the patient is actually taking, remedy errors, and help with cost issues. We then provide the patient with a corrected medication list, ensure they understand it, and empower them to carry it with them and advocate for themselves.

We are able to facilitate care and help patients and families navigate the medical system. For example, I was able to help a veteran and his family, who were overwhelmed, contact the VA and coordinate extra help so he could remain safely at home while his wife had extensive surgery with an extended rehabilitation stay.

We are fortunate to have the time to develop relationships with patients and families, get to know them as people, understand their goals, concerns and questions, and facilitate communication with the health care team.

Staying on Top of Trends: Congestive Heart Failure Pilot Program

At Martin's Point, we leverage our data to analyze trends in our members' health and make plans to address them. In the summer of 2017, we saw an increase in recurrent hospitalizations in the Portsmouth, NH region where we largely serve military retiree and dependent members covered by our US Family Health Plan. We have a primary care practice that also serves many of those members in the same area. As we drilled down into the data, we found there was a cohort of patients, most of whom with a diagnosis of congestive heart failure (CHF), who were being admitted to a local hospital and then readmitted within 30 days to the same or a different hospital.

While representing only 3 percent of the total health plan population, members with CHF accounted for 28 percent of the total health plan inpatient hospitalizations in 2017. This represented the highest hospitalization rate of any of the plan's chronically ill population, including those with CAD, COPD, diabetes and asthma. In addition to having the highest hospitalization rate of any chronically ill cohort, the CHF population experienced the most rapid month-over-month increase in hospitalizations, averaging a 5 percent month-over-month hospitalization rate increase from 2015–2018.

The hospital costs on the health plan side were unusually high. In 2017, the average health plan medical cost of a 65+ year-old member with CHF was over three times that of a similar member without CHF. Even more striking were the stories of human suffering—patients not understanding their conditions or triggers and, as a result, being displaced from their homes when hospitalized, sent to an unfamiliar rehabilitation unit

and then back home only to end up returning to the hospital. The situation was a revolving door of confusing and disruptive moves.

In response, we pulled a multidisciplinary team of leaders and technical experts together to perform a root-cause analysis. The group was led by senior clinical staff (medical directors from plans and practices, nurse and nurse practitioners, embedded care managers from the practices, pharmacist leaders, primary care physicians and a cardiologist). The team focused on creating goals to decrease hospitalization, reduce medical expense, and improve quality of life.

Leveraging the in-home assessment/care team model we had initiated through our association with Health Quality Partners, we obtained more information about this at-risk Portsmouth CHF population. We ensured that:

- Each member would have at least one in-home assessment
- A full medication reconciliation would be completed while in the home
- Each member would be offered telemonitoring devices
- Each member would receive a CHF educational packet

The CHF Pilot Program launched in December 2017. Originally 63 members in the Portsmouth, NH area were identified by their primary care providers. Of those, 42 engaged with the program and received an in-home visit. Currently we have 34 members enrolled. (Those no longer in the program left for a variety of reasons. Some transitioned to hospice, were admitted to long term care or assisted living, a few passed away and one disenrolled from the health plan.) The pilot will continue, at least, until the end of December 2018.

INTERVENTIONS

Starting in December 2017, two nurse case managers from the Martin's Point health plan visited each member in their home. While the home visit was focused primarily on the above-stated goals, the case manager also completed an in-home evaluation including assessing caregiver burden, fall risk, and home safety. Subsequent contact was primarily telephonic, with additional home visits depending on individual need. The case managers also had frequent contact with the PCPs and clinical staff at our

Portsmouth health care center and collaborated with the on-site pharmacy team for full medication review and reconciliation.

After six months, the CHF pilot team from the delivery system and the health plan met to review preliminary outcomes, discuss success stories and opportunities. The decision was made to extend the pilot program.

Through this combined effort, we learned that most of our patients and members were lacking basic information on their health conditions, use of their medications, and the triggers for their conditions. Most importantly for them is developing a “symptom response plan” that allows them to act earlier and more effectively to prevent an acute worsening of their condition. We checked in with them more frequently—by phone and in-person. We arranged closer follow up with their doctors.

RESULTS

Our program’s approach had yielded improvements in members’ medication adherence, and decreased hospital admissions and readmissions. Preliminary outcomes included:

Medication Adherence

- 3 Months pre-engagement: 69.7 percent
- During engagement: 86.2 percent (23.6 percent improvement)

Admits/1000

- 3 Months pre-engagement: 126
- During engagement: 115 (8.7 percent improvement)

Readmits/1000

- 3 Months pre-engagement: 63
- During engagement: 20 (68.2 percent improvement)

ER Visits Per 1000

- 3 Months pre-engagement: 81
- During engagement: 115

While we did not see a large reduction in use of the emergency room, we did find a significant reduction in hospitalization rate. We are able to intervene earlier and provide participants with a better quality of life while also keeping them in their home. With these preliminary findings in mind, our two case managers did additional home visits in August 2018 for those members who visited the emergency room. The objective of these visits was to:

- Provide additional education about the disease process
- Complete a full medication reconciliation and collaborate with the PCP and pharmacist, as needed
- Provide information on urgent care centers and walk-in clinics in the Portsmouth area

We have identified that not all emergency room visits for these members are related to CHF. This has underscored the need to understand individual members' barriers to primary and urgent care, and to educate members on their care options during and after normal business hours.

The in-home component of the pilot was extremely helpful for the case manager, especially in identifying safety concerns, allowing a first-hand view of the member and how they function in their environment. This built additional trust with the member and provided a strong opportunity for the nurse to gain additional understanding of how their social needs impact their overall health.

Another key finding in this work was our recognition that many patients with advanced heart failure had not had conversations about advance directives and few, if any, had conversations about palliative approaches as they near the end of their lives. As a result, we are now piloting a palliative care program that will support those conversations and allow patients to understand all the options available to them.

In-Home Telemonitoring: Congestive Heart Failure

For our health plan members with congestive heart failure, we offer an in-home telemonitoring program. This program encourages members to be active participants in their health care by promoting self-management and reinforcing positive behavior, increasing their ability to stay independent in their home. It provides both the member and family peace of mind, knowing they are being monitored and that their health care providers are promptly informed of changes.

We implemented this program in 2014 and have enrolled 711 members to date—an average of 16 new members per month. In 2017, we averaged 280 members per month and in 2018 that number has jumped to 293 members per month.

Promoting Medicare Benefit and Clinical Strategy Alignment: Opioid Management

The Senate Special Committee on Aging dedicated a hearing earlier this year to opioid use among seniors. Addiction, whether opioid, alcohol, or others, is quite common among the senior population and is an issue we are confronting directly at Martin's Point. The states located in the Martin's Point Medicare Advantage service area—Maine and New Hampshire—are among the ten states with the highest drug-overdose mortality rates in the nation.¹ As recently as 2012, nearly all counties in our service area were in the top quartile of opioid prescribing rates, including a designation as a national hotspot.² While opioid prescribing rates have been following national downward trends, the effects of high opioid-prescribing rates continue to affect our population. In fact, Maine reported a significant increase in opioid overdose Emergency Department visits from 2016 to 2017.³ Decreased access to providers who treat mental health and substance use disorders has only exacerbated the issue, especially in our rural communities. Martin's Point recognizes that a wide array of stakeholders is involved in tackling the opioid crisis through many modalities, and thus the organization is focused

¹National Center for Health Statistics, Centers for Disease Control and Prevention, Drug Overdose Mortality by State. https://www.cdc.gov/nchs/pressroom/sosmap/drug_poisoning_mortality/drug_poisoning.htm

²Centers for Disease Control and Prevention, Opioid Overdose Data: U.S. Opioid Prescribing Rate Maps. <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html>

³CDC's Enhanced State Opioid Overdose Surveillance (ESOOS) Program, 16 states reporting percent changes from July 2016 through September 2017.

on innovative ways health plans can provide cooperative and complementary benefits and clinical programs.

Comprehensive Opioid Management Strategy

Martin's Point's approach to opioid management has long been rooted in the education and engagement of members, providers, and pharmacy partners. At the core, pharmacy management and care coordination activities, including those listed below, have driven our opioid management strategy.

- Formulary design and management that promote appropriate utilization
- Drug utilization review, both at the time of filling a prescription and retrospectively by pharmacists at Martin's Point
- Care coordination by care managers and social workers working with physicians and other health care professionals
- Providing access to medication-assisted treatment (MAT)
- Data collection and analysis to assist in conversations with health care providers and identify populations and/or geographies where action is needed

Using these opioid strategy elements, Martin's Point saw over a 10 percent decrease in opioid utilization from 2016 to 2017 and continues to see decreased utilization into 2018.

Leveraging Medical Benefit Design

As we continue to look at opportunities to assist our population in the management of opioid utilization and opioid use disorder, one key consideration is how to align medical benefits and offerings with the clinical needs of the population. The Centers for Medicare & Medicaid Services (CMS) recently updated guidance for Medicare Advantage plans in order to promote value-oriented medical (Part C) benefit strategies. In 2019, Martin's Point will be taking full advantage of the new CMS guidance, in conjunction with our overall opioid management strategy, to better care for our beneficiaries affected by or at risk of opioid use disorder.

To remove barriers to prevent and alleviate opioid overuse, we are reducing member costs and adding additional supplemental benefits. For plans that do not already have \$0 cost sharing, Martin's Point is eliminating the member cost share for individual and group mental health, psychiatric, and substance use disorder therapies for members

with opioid use disorder. All our plans currently cover acupuncture, fitness services, and naturopathic services members can use for alternative pain management. For members with opioid use disorder and chronic pain syndrome, we are adding coverage for additional acupuncture coverage and therapeutic massage as part of a non-opioid pain management care plan.

Most importantly, the new clinically-nuanced benefits require member participation in a plan-sponsored wellness or care management program to incentivize and facilitate member engagement in their care plan and supportive activities. Program components include a behavioral health focus, care coordination, addressing social determinants of health, and member-driven goals and activities for non-opioid pain management.

Opioid Strategy: Looking Forward

Martin's Point is dedicated to living out the organization's mission to create a healthier community. We are striving to improve the collection and use of information to better enhance the care of our community, including information that will help us better address social determinants of health and other opioid use disorder risk factors. We will continue to grow our community partnerships and multidisciplinary stakeholder engagement so we are positioned to amplify the impact we have in our community in an environment of limited resources. Finally, Martin's Point remains open to novel ways to address the opioid crisis.

LEAN JOURNEY: CREATING CUSTOMER VALUE THROUGH AN ALIGNED ORGANIZATION

Our success in serving seniors, and all our customers, is directly attributed to our management system. We drew inspiration from the lean health care principles advanced by Dr. John Toussaint in his book *Management on the Mend*, with each component of the management system contributing to an aligned organization. At Martin's Point, our management system acts as our central nervous system, pulsing with ways to solve problems, eliminate waste, and create value. Our management system enables us to align focus throughout our organization, to identify problems, and to work together—in real time—to solve them. There a variety are reasons why some

organizations function better than others. In our organization, it's the intentionality behind how we work together as framed by our management system. Our management system components include:

- Developing People
- Deploying strategy
- Managing visually
- Following up
- Standardizing work

In his book *Management on the Mend*, Dr. Toussaint describes the management system as a "cultural transformation," not an operational project. The expansive nature of this effort requires involvement from every part of the organization. Our senior leaders are actively engaged in the application of lean concepts in health care, and our story was featured in a May 2018 white paper by the lean health care network and research group Catalysis. As a not-for-profit team of experts, Catalysis is dedicated to helping leaders improve their health care systems, change organizational behaviors, and enhance delivery of patient care while lowering its cost.

Martin's Point is in the eighth year of our lean transformation journey. Our current focus is to make lean principles management driven, supporting the implementation of our strategy while also contributing to the success of our ongoing business results. In this phase, lean principles are well integrated into the management system, and improvements are driven by customer needs and wants. If you were to stop by the Martin's Point campus on the third week of each month, you would find our entire senior leadership team in a room displaying key operating indicators, with red or green status flags illustrating current performance. Any red indicators need to be addressed by a problem-solving and improvement discussion. The discipline of measuring these items month over month helps us improve through the intentional conversations of our top-most leadership around problem solving. In addition to our internal discussions, we regularly visit other organizations who are leading the way in lean health care, including UMass Memorial Health Care of Massachusetts and Intermountain Healthcare of Utah.

Leaders throughout Martin's Point have also invested time in defining "standard work," in the context of 10 competencies. The core set of competencies for all employees includes:

- Customer focus
- Business acumen
- Learning on the fly
- Process improvement
- Driving for results
- Dealing with ambiguity

In addition to the core set, Martin's Point leaders are expected to be proficient in four additional competencies: creating vision, strategic agility, managerial courage, and developing high-performing teams. Leader standard work is intended to document the recurring actions needed to demonstrate these competencies, the expressions of which will vary according to a leader's role in the organization.

For our patients and members, the results of our investment in a lean management system have allowed us to improve the ways we fill prescriptions, schedule patient appointments, and verify accuracy of medical coding. We have not only realized improvements in our day-to-day work, but have also received high marks in recent evaluations from CMS and the Defense Health Agency. For our employees, we believe our management system contributes to increased connection and engagement. Our data shows that 89 percent of our employees say they understand how their work connects to our strategic initiatives and goals, which means the daily experience of the majority of our employees drives our "true north" of serving our patients, members, each other, and our community. And in 2017, Martin's Point was named to the list of Best Places to Work in Health Care and Biopharma by the Great Place to Work Institute. We believe the positive experience of our employees better enables them to provide an enhanced experience for our patients and members.

IN CLOSING

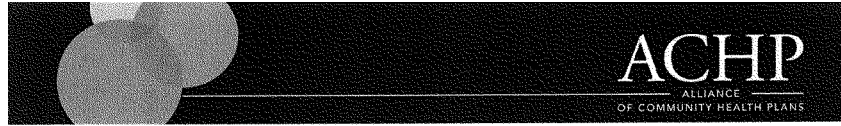
In all we do at Martin's Point, we retain a core connection to our community. Not too long ago, a bus pulled up in front of our Health Care Center in Scarborough, just a few

miles south of Portland, Maine. A crowd of 50 seniors emerged from the bus and made their way inside. At first glance, it may have looked like we had overbooked for medical appointments—but this gathering was to receive a different kind of care. These seniors were coming to the Community Center at Martin's Point to attend a Fire and Fall Prevention session offered by the Scarborough Fire Department. The Community Center is a senior-centered gathering place we intentionally included in our floor plans when we designed our new state-of-the-art facility in Scarborough, with the intent of partnering with the Town of Scarborough, the Southern Maine Agency on Aging and the Southern Maine Strong Balance Center to offer programming for the local senior community. The presentation was one of a full slate of programs offered at the Center, ranging from educational and social to health and wellness. The activities include: senior yoga, balance classes, Tai Chi, bingo, senior movie night and a weekly lunch program. The Center's programs are offered Monday through Friday and are an important way to offset senior loneliness and isolation year-round. We are able to do this because we are a not-for-profit organization. The return on our investment in this dynamic and vibrant space is measured in the smiles and great reviews that we receive, and in knowing that we are fulfilling our mission as we create a healthier community through authentic relationships, one person at a time.

Works Cited

- Amy Newcomb; Julie Iriondo. (2017, June 22). *The Nation's Older Population Is Still Growing, Census Bureau Reports*. Retrieved from <https://www.census.gov/newsroom/press-releases/2017/cb17-100.html>
- Cubanski, Casillas, & Damico. (2015). *Poverty Among Seniors: An Updated Analysis of National and State Level Poverty Rates Under the Official and Supplemental Poverty Measures*. Retrieved from Kaiser Family Foundation: <http://files.kff.org/attachment/issue-brief-poverty-among-seniors-an-updated-analysis-of-national-and-state-level-poverty-rates-under-the-official-and-supplemental-poverty-measures>
- Qian Cai, University of Virginia . (2017). *National Population Projections*. Retrieved from Weldon Cooper Center for Public Service: <https://demographics.coopercenter.org/national-population-projections/>
- Valigra, L. (2018, March 14). *Maine projected to have more old than young people by 2020*. Retrieved from Bangor Daily News : <https://bangordailynews.com/2018/03/14/news/state/maine-projected-to-have-more-old-than-young-people-by-2020/>

Note: Supplementary information follows statement.



About ACHP

The Alliance of Community Health Plans (ACHP) is a national leadership organization bringing together innovative health plans and provider groups that are among America's best at delivering affordable, high-quality coverage and care. ACHP's member health plans provide coverage and care for more than 20 million Americans. These organizations focus on improving the health of the communities they serve and are on the leading edge of innovations in affordability and quality of care, including primary care redesign, payment reforms, accountable health care delivery and use of information technology.

Our Mission

ACHP and its members improve the health of the communities we serve and actively lead the transformation of health care to promote high-quality, affordable care and superior consumer experience.

We realize our mission by:

- Providing a forum to solve our members' most pressing challenges
- Advocating for better health and health care
- Developing quantitative and qualitative tools to improve performance and meet marketplace challenges
- Building the evidence base for health care improvement

ACHP Members Are

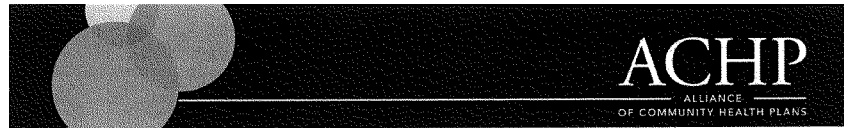
- Not-for-profit health plans or subsidiaries of not-for-profit health systems, or provider groups associated with health plans. Member organizations are located primarily in mid-sized and smaller markets and have deep roots in their communities.
- National leaders in health care quality that annually rank among the top-performing health plans in the nation.
- Innovators in delivering affordable, coordinated, multidisciplinary care, and pioneers in the use of electronic health records.
- Role models for other health plans in innovating to achieve the industry's Triple Aim – better health, better care, at a lower cost.

Our History

The Alliance of Community Health Plans was founded in 1984 as The HMO Group to help independent health maintenance organizations identify and share best practices. The group changed its name, appointed new leadership and moved from New Jersey to Washington, D.C., in 2001. ACHP continues to help high-performing health plans and provider groups improve coverage and care and to advocate for policies that improve health and health care quality and affordability.

MAKING HEALTH CARE BETTER

1825 Eye Street, NW, Suite 401 | Washington, DC 20006 | p: 202.785.2247 | f: 202.785.4060 | www.achp.org



ACHP Member Organizations

AultCare Health Plans
Canton, Ohio
www.aultcare.com



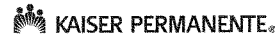
Independent Health
Buffalo, New York
www.independenthealth.com



AvMed
Miami, Florida
www.avmed.org



Kaiser Foundation Health Plan, Inc. and
The Permanente Federation
Oakland, California
www.kp.org



Capital District Physicians'
Health Plan
Albany, New York
www.cdphp.com



Martin's Point Health Care
Portland, Maine
www.martinspoint.org



Dean Health Plan
Madison, Wisconsin
www.deanhealthplan.com



PacificSource
Springfield, Oregon
www.pacificsource.com



Geisinger Health Plan
Danville, Pennsylvania
www.thehealthplan.com



Presbyterian Health Plan
Albuquerque, New Mexico
www.phs.org



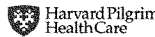
Group Health Cooperative of
South Central Wisconsin
Madison, Wisconsin
www.ghcscw.com



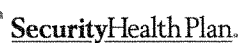
Priority Health
Grand Rapids, Michigan
www.priorityhealth.com



Harvard Pilgrim Health Care
Wellesley, Massachusetts
www.hphc.org



Security Health Plan
Marshfield, Wisconsin
www.securityhealth.org



Health Alliance
Urbana, Illinois
www.healthalliance.org



SelectHealth
Salt Lake City, Utah
www.selecthealth.org



Health Alliance Plan
Detroit, Michigan
www.hap.org



UCare
Minneapolis, Minnesota
www.ucare.org



HealthPartners
Minneapolis, Minnesota
www.healthpartners.com



UPMC Health Plan
Pittsburgh, Pennsylvania
www.upmchealthplan.com



MAKING HEALTH CARE BETTER

1825 Eye Street, NW, Suite 401 | Washington, DC 20006 | p: 202.785.2247 | f: 202.785.4060 | www.achp.org



Community health plans play a unique role in the American health care system. As nonprofit organizations, our mission is to improve the health of the communities we serve. Our member organizations are:

Rooted in the Community

It's more than location: ACHP member plans are a part of their communities.

On average, our plans have served their community for 40 years.

Our member organizations work to improve the health of the entire community, not just their members by educating the public about opioids, providing mental health resources and offering free screenings.

And they are committed even when things get tough. That's why **17 of our 21 member** plans still offer coverage on the individual market, providing neighbors access to affordable coverage and care.



Mission driven, not profit driven

We focus on the health of our communities, not the bottom line.

Our plans work with doctors and health systems to create new payment models, improve outcomes and care delivery, generating savings.



As nonprofit plans, ACHP members:

- Don't answer to Wall Street.
- Focus on patients, not profit.
- Reinvest in care delivery and the community.

@ACHP

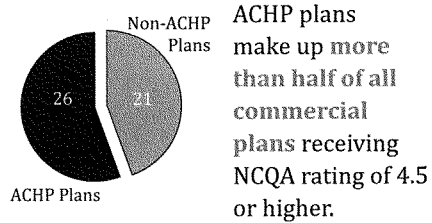
MAKING HEALTH CARE BETTER

achp.org

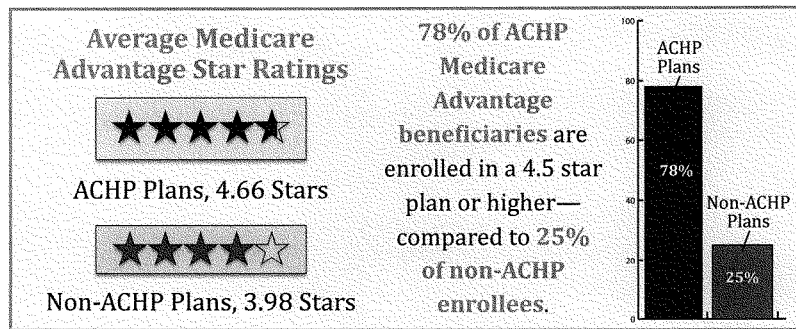


Quality at our Core

Our plans are consistently tops in national quality and consumer satisfaction ratings year after year.



11 ACHP Plans are the top ranking plans in their region, according to J.D. Power.



About ACHP

The Alliance of Community Health Plans is a national leadership organization representing nonprofit, community-based health plans and provider organizations. Our members provide coverage and care for more than 21 million Americans in 32 states and the District of Columbia.

@ACHP

MAKING HEALTH CARE BETTER

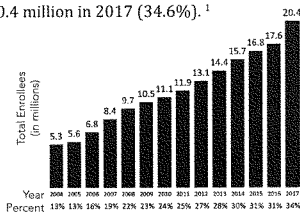
achp.org

The Value of Medicare Advantage

Medicare Advantage (MA) offers quality, affordability and ease, with enhanced benefits to more than 20 million Medicare beneficiaries across the country.

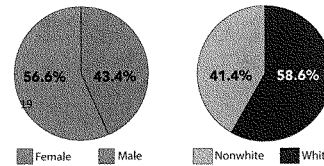
More than 1/3 of all Medicare beneficiaries choose MA

Since 2004, the number of MA enrollees has more than tripled from 5.3 million (13%) to 20.4 million in 2017 (34.6%).¹



By 2025, the CBO predicts 30 million Americans will be enrolled in MA.²

Serves a wide population with diverse health care needs³



More for every health care dollar

More than 97% of MA plans offer at least a vision, hearing, or dental benefit—and half offer all three.⁴



These and other benefits are included in the premium. MA plans coordinate care and focus on keeping seniors healthy.

Easy to navigate

Enrollees pay one premium for access to hospitals, physicians and other services. Combined MA/Part D plans cover Rx drugs, too.



Lower out-of-pocket costs



MA plans are required to limit out-of-pocket spending for services covered under Medicare Parts A and B to no more than \$6,700. In 2017, the average out-of-pocket limit for MA enrollees was \$5,219.⁵

Sources:

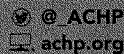
1. "Medicare Enrollment Dashboard." CMS, March 2018. Includes MSAs, cost plans, demonstration plans, and Special Needs Plans as well as other Medicare Advantage plans. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/Medicare-Enrollment/Enrollment%20Dashboard.html>

2. Congressional Budget Office, March 2015 Baseline, March 9, 2015.

3. "2016 CMS Statistics." CMS, March 2017, p.6.

4. CMS data, 2015.

5. Jacobson, et al. P.4.



The Value of Medicare Advantage

Higher standards for better care

The CMS Star Ratings system incentivizes high quality, effective care by measuring and publicly reporting plan performance.



Star Ratings in MA are driving improvements in quality:

- 71% of enrollees are in plans earning at least 4 (out of 5) Stars⁶
- 91% of beneficiaries are satisfied with their coverage⁷

Transforming health care

MA Plans work with doctors and health systems to create new

payment models, improve outcomes and care delivery, generating savings.



ACHP's nonprofit, community-based health plans provide the highest quality MA coverage to seniors nationwide.

Leading the way on quality

ACHP plans are focused on getting the right care to the right patient at the right time. That's why ACHP plans top national rankings year after year, improving outcomes and providing a superior patient experience.

8 of 16
5-Star contracts
nationwide were
operated by ACHP plans⁸

34
ACHP Medicare
Advantage contracts
received 5, 4.5 and 4 Stars⁹

Tops in customer experience

ACHP MA plans have some of the highest retention rates, with many plans retaining **more than 90%** of beneficiaries from year to year.

Driving innovation

Through benefit design, telehealth, and home-based care, ACHP plans are creating innovative approaches that encourage high-value treatment and patient experience.



6. CMS 2016 Star Rating data, 2015.

7. "Patient Survey on Medicare Advantage," Better Medicare Alliance, The Winston Group, February 24-26, 2015.

8. "Community Health Plans Again Top CMS Quality Ratings," Alliance of Community Health Plans, October 13, 2016, <http://www.achp.org/achp-news/community-health-plans-top-cms-quality-ratings/>.

9. Ibid.





**Jeff Micklos, Executive Director
Health Care Transformation Task Force, Washington, DC**

**Hearing before the Senate Special Committee on Aging
“Patient-Focused Care: A Prescription to Reduce Health Care Costs”**

Chairman Collins, Ranking Member Casey, and Members of the Senate Special Committee on Aging: thank you for the opportunity to provide written testimony on innovative approaches to improving value in the health care system for older Americans.

The Health Care Transformation Task Force (“Task Force”) is a diverse group of over 40 private sector stakeholders across the industry – including providers, health plans, employers, and consumers – that support accelerating the pace of delivery system transformation. Together Task Force members share a common commitment to transform their respective businesses and clinical models to deliver better health through high quality care at reduced cost and aspire to have 75 percent of their business in value-based payment arrangements by 2020.

My commentary today focuses on how organizations are using effective and innovative strategies to improve care and lower costs for aging Americans, with a particular focus on Accountable Care Organizations.

First, I’d like to offer some background on value models. You may be familiar with the term Accountable Care Organization, or ACO for short – this refers to a health care organization that ties payments to quality metrics and the cost of care. ACOs have grown in popularity among health care organizations over the past several years, supported by programs that have been offered by the Center for Medicare and Medicaid Services and commercial insurers. ACOs remain the most prolific vehicle for value-based payments to-date: in 2017, there were more than 923 public and private ACOs covering approximately 32.4 million lives across the country.¹ In 2018, there are 656 Medicare ACOs that cover almost one-third of the entire Medicare Fee-for-Service population.²

¹ Muehlstein, D. et al. Growth of ACOs And Alternative Payment Models in 2017. *Health Affairs*. Available at: <https://www.healthaffairs.org/doi/10.1377/hblog20170628.060719/full/>

² MedPAC June 2018 Report. Chapter 8: Medicare accountable care organization models: Recent performance and long-term issues. Available at: http://www.medpac.gov/docs/default-source/reports/jun18_ch8_medpacreport_sec.pdf?sfvrsn=0

There is strong evidence to support that ACOs have had a meaningful impact on lowering costs. Recently released 2017 data from the Medicare Shared Savings Program, the primary program for Medicare ACOs, demonstrates that the federal government has generated \$314 million in net savings – *after* bonuses were paid out to participants. Gross savings to the program totaled \$1.1 billion. The 2017 results also confirm in practice what the industry has known to be true – that organizations which committed to the program early on are more likely to generate shared savings than their more junior peers. For example, ACOs that started the MSSP program in 2012 or 2013 created net savings of \$205 million, while ACOs that started in 2016 or 2017 generated \$68 million in losses.³ These results show that with most good innovations, it takes time to realize potential.

ACOs have also had a significant impact on health care quality. A June 2018 report by MedPAC indicated that over 90 percent of risk-bearing Medicare ACOs met or exceeded quality standards. These ACOs also had strong patient experience scores and high-performing readmissions results.⁴ A 2017 Office of Inspector General report indicated that ACOs outperformed fee-for-service providers on 81 percent of key measures such as screening for depression and risk of falling.⁵

Late last year, the Task Force conducted a study⁶ of the 21 highest performing Medicare ACOs based on 2015 performance data. Among the most successful ACOs, we found that organizations focused on three key elements: 1) achieving a high-value culture; 2) developing strong population health management programs; and, 3) creating structures that can ensure continuous improvement in performance over time.

We found that the highest-performing ACOs first and foremost have a strong commitment to developing a culture that supports innovation and is committed to the mission of improving care delivery. That commitment must be unwavering in the face of multiple obstacles; changing culture takes time and requires effective leadership at many levels. Most of the successful organizations we profiled had previous experience managing financial risk before implementing an ACO model. They also had the support and commitment of executive leaders who saw the importance of investing in new models, as well as governance structures that are conducive to fostering a high-value culture (such as encouragement of innovation and feedback).

Organizations with high-value cultures understood the importance of engaging clinicians and care teams to accomplish shared goals, and demonstrated a commitment to practice education, support services, and compensation structures that reward continuous improvement. ACOs simply cannot succeed without truly engaged physicians and other health care practitioners who are committed to understanding how their practice patterns influence the goals of the ACO and serving as champions to help guide their peers. The delicate balance of aligning incentives is critical to getting all stakeholders on the same page driving toward success.

³ <https://www.naacos.com/press-release--more-medicare-acos-achieve-quality-and-cost-goals-in-2017>

⁴ MedPAC June 2018 report.

⁵ OIG. Medicare Shared Savings Program Accountable Care Organizations Have Shown Potential for Reducing Spending and Improving Quality. Available at: <https://oig.hhs.gov/oei/reports/oei-02-15-00450.asp>

⁶ Health Care Transformation Task Force. Levers of Successful ACOs. 2017. Available at: <http://hcttf.org/2017-11-8-levers-of-successful-acos/>

In our research, we have seen that the most successful Medicare ACOs are those that have been in the program over the course of multiple years and have had time to learn how to manage risk. They may have started with similar commercial insurance agreements that gave them the experience and confidence necessary to effectively manage a shared savings program.

As I'm sure this Committee will appreciate, the crux of any successful payment program is top-notch care delivery. For ACOs, having very strong population health management programs is critical. These programs serve the essential function of identifying patients who are at-risk for or already have challenging or multiple medical conditions and acting swiftly to ensure that these patients receive the best, most personalized care possible to avoid unnecessary hospitalizations.

Effective population health management programs truly put the patient first by using tools and resources that facilitate personalized, proactive care. Vanguard health care providers risk-stratify patients using homegrown analytics models, electronic health record modules, and population health software; these high-tech processes are combined with expert recommendations from physicians on how best to provide treatment that is individualized to patient needs.

One example of how risk stratification works in practice is an ACO that organizes patients into four categories, from least to most intensive. Thirty-five percent of patients receive wellness and preventive care prompts, such as cancer screenings and vaccine outreach. About forty percent receive early disease management in response to emerging symptoms of chronic disease, such as Type 2 diabetes. The next twenty percent of patients are more frequent hospital emergency department utilizers; these patients are assigned to patient navigators who assist in discharge planning and complex care management for chronic illness. The remaining five percent of patients receive hospice or palliative care for late-stage illness.

The best population health management programs employ interdisciplinary care teams that typically consist of physicians, nurse care managers, pharmacists, social workers, and care guides or navigators. These structures are often flexible to best accommodate patient needs. In some instances, a social worker may be best equipped to interact most often with the patient, especially if the patient is struggling with social factors such as housing instability or access to transportation that directly contribute to his or her health status. Strong population health programs also partner with existing community resources and local public health departments to ensure that all facets of a patient's health challenges are addressed. Today, addressing social determinants of health is a concept that gets a lot of attention and rightly so, and maturing ACOs are increasingly focused on those factors as a way of caring completely for patients. Partnering with community organizations is critical to a comprehensive care regimen for individuals.

Many high-performing ACOs and providers have specific programs and resources that are geared toward chronic illness. The most ubiquitous programs focus on four primary chronic conditions: diabetes, congestive heart failure, chronic obstructive pulmonary disease (COPD), and chronic kidney disease. These conditions disproportionately affect aging and low-income Americans. Effective ACO-administered chronic disease programs rely not only on evidence-based disease treatment protocols, but also empower patients through education, clinical support, and assistive tools such as remote monitoring to help manage their own health.

Finally, we found that successful ACOs must have continuous improvement structures in place to drive value once the “low-hanging fruit” has been plucked. It is simply not enough for health care providers to change their business model in one go and coast. They must constantly reevaluate their performance and business structures. The most sophisticated organizations have dedicated data, actuarial, and performance improvement resources that are constantly managing change and looking for new opportunities to increase value. They partner with clinical leaders to address variation and inefficiencies in clinical workflow and patient outcomes, and find ways to reduce duplication in areas such as quality reporting that can contribute to physician burnout.

Successful organizations also tie performance to compensation. This is an area that is still in testing. Many health systems and physician groups are experimenting with how best to tie provider quality performance back to compensation. Some ACOs directly pass on shared savings to each participating provider through gainsharing arrangements. Challenges and complications can arise, however, as there is generally a lag in shared savings payments to the organization and when providers expect to be compensated for their performance.

All organizations should expect to run into challenges along the road to value. That’s why participation in shared learning opportunities is critical. The ability to share notes/compare data with peers, and access to organizations that are more advanced in their value models, can be tremendously helpful as ACOs and others navigate regulatory, financial, and cultural challenges. Shared learning collaboratives can also provide organizations with a better understanding of their performance relative to their peers. Regional quality collaboratives, such as the Wisconsin Collaborative for Healthcare Quality, and national consortiums, offer outlets for organizations that are interested in learning from peers and cross-industry partners. The Task Force serves this function for national collaborators.

In reality, there is no one-size-fits all approach to value-based health care. Yet, through our analysis of ACOs and our ongoing work to promote new value-based payment models, we’ve discovered that the key themes I just described are essential for organizations to successfully transition away from volume-driven, fee-for-service medicine.

To all of us in this room, we must remember that changing our health care system is not something that can be accomplished in one fell swoop. Rather, we are rebuilding brick by brick the foundation upon which our care is paid for and delivered. Not all innovation will be an immediate success, and it is incumbent upon on all to identify what holds promise and stay the course until meaningful change is achieved. The Task Force stands as a reminder of what can be accomplished when like-minded organizations reach across the negotiating table and work with their fellow health care stakeholders to develop and commit to implement new answers to old problems.

Chairman Collins, Ranking Member Casey, and members of the committee, thank you again for the opportunity to testify before you today. I welcome your questions.

**Statement of Sean Cavanaugh
Chief Administrative and Performance Officer, Aledade**

“Patient-Focused Care: A Prescription to Reduce Health Care Costs”

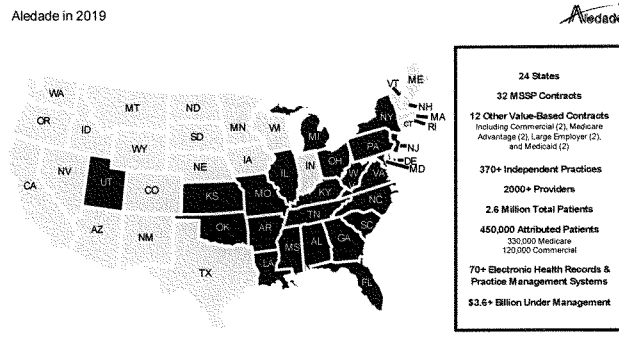
Before The
U.S. Senate Special Committee on Aging
October 3, 2018

Chairman Collins, Ranking Member Casey and members of the Committee, thank you for inviting me to discuss the innovative practices and technology that Aledade is using in partnership with independent physicians across the country to change the landscape of health care.

My name is Sean Cavanaugh, Chief Administrative and Performance Officer for Aledade, a health care company that partners with independent primary care physicians to help them transition to and thrive under value-based payment models. Prior to joining Aledade last year, I served at the Centers for Medicare and Medicaid Services (CMS) for six years including a period as the Deputy Director of the Center for Medicare and Medicaid Innovation (CMMI) and three years as Deputy CMS Administrator and Director of the Center for Medicare. In those capacities, I supported the movement toward value-based payment and service delivery models in Medicare and Medicaid and I'm proud to continue that work in the private sector.

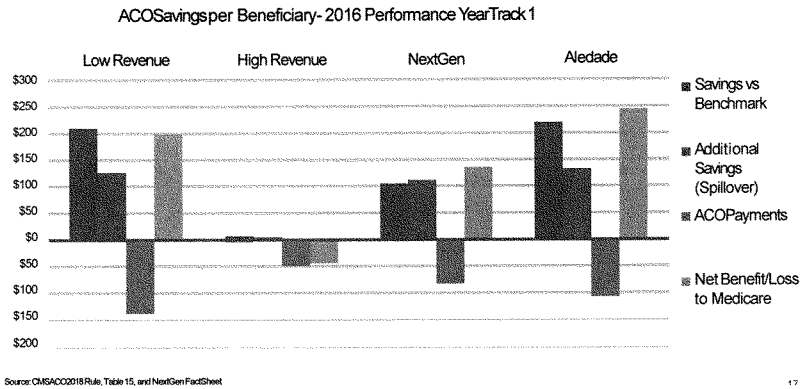
Aledade was founded in 2014 to help independent physicians thrive in value - based programs. We bring together independent primary care practices who are committed to value-based care, join the Medicare Shared Savings Program, and negotiate similar accountable care organization (ACO) arrangements with commercial payers, provide data-informed population health workflow tools, and transform how our practices deliver care.

Aledade has grown rapidly and continues to do so. Next year, Aledade will be partnering with over 370 independent physician practices, Federally Qualified Health Centers and Rural Health Centers in value-based health care. Organized into 32 ACOs across 24 states, these physicians are accountable for close to half a million people, including 330,000 Medicare beneficiaries through the Medicare Shared Savings Program and 120,000 people (Figure 1) through ACO arrangements with commercial insurers. More than half of our primary care providers are in practices with fewer than ten clinicians.

Figure 1. Summary of Aledade's Footprint.

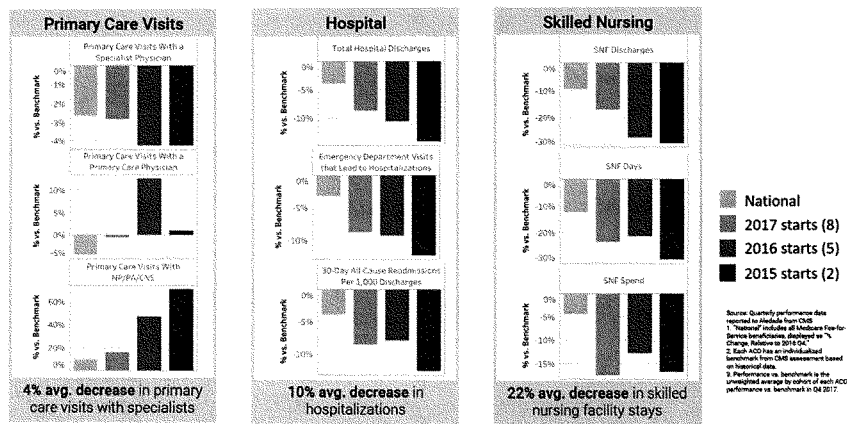
Aledade is producing meaningful results. Last year, our ACOs saved Medicare over \$40 million. But Aledade is not alone in succeeding in the Medicare Shared Savings Program. Our analysis of CMS data shows that physician-sponsored ACOs are generating outstanding results (Figure 2). CMS data indicate that “low revenue” (i.e., physician-led ACOs generated about \$200 in savings per beneficiary in 2016 saving \$499 million for Medicare in 2016. By comparison, “high revenue” (i.e., hospital-led ACOs) generated a net loss to Medicare. The Next Generation ACO model also produced positive results. On average, Aledade ACOs outperformed both Next Generation ACOs and other physician-led ACOs.

Figure 2. 2016 MSSP ACO Performance

"Low Revenue" Physician Led ACOs Outperform All Other ACOs

These savings were generated through real improvements in the care received by Medicare beneficiaries. We have empowered our practices to deliver more primary care and reduce unnecessary hospitalizations and post-acute care stays, and our results improve the longer our practices work with us (Figure 2).

Figure 2. Summary of Aledade's Results.



We are committed to outcome-based approaches to determine the value of health care. We are committed to using technology, data, practice transformation expertise and, most important, the relationship between a person and their primary care physician to improve the value of health care.

Medicare as Catalyst for Delivery System Reform

Our physician partners could not have made these positive changes without a transformation in how physicians and hospitals get paid, one that allows them to transition from fee-for-service under which providers get paid for volume (more services, more procedures, more hospital admissions) to value-based payment that rewards providers for delivering high quality and cost efficient care and for keeping patients healthy. Changing the financial incentives from volume to value is essential to address the unsustainably high growth of health care costs.

This value-based payment movement has accelerated over the past 8 years thanks to the Affordable Care Act (ACA). The ACA created and funded CMS' Innovation Center to design and test new payment and service delivery models to reduce program expenditures while improving the quality of care for beneficiaries. Under these models, CMS rewards value, tests these ideas in the real world, rigorously and independently evaluates them to learn what works and what does not, and scales the ones that do work. The Innovation Center's portfolio spans ACOs, patient-centered medical homes, episodes of care, and even state and community-led innovation efforts.

Congress reinforced the importance of the work of the Innovation Center when it passed the bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). MACRA, as you know, incentivizes practitioners in Medicare to participate in Advanced Alternative Payment Models (AAPMs). The Innovation Center is the arm of CMS that has the authority to test and expand alternative payment models in Medicare.

CMS has been a catalyst to move from fee-for-service to rewarding value. In 2011, almost none of Medicare's payments were significantly tied to value; as of 2016, over 30% of Medicare payments are made under value-based payment models.¹ Additionally, private insurance companies and state Medicaid programs are increasingly joining the movement and becoming leaders in their own right.

The cornerstone of CMS' value-based payment movement has been ACOs. In 2017, it is estimated that there were 923 ACOs in the country covering more than 32 million people, nearly 1 in every 10 Americans, including 10.5 million Americans in the Medicare Shared Savings Program alone.² We have strong evidence that ACOs do indeed reduce cost and improve quality.

¹ <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-03-2.html>

² <https://www.healthaffairs.org/doi/10.1377/hblog20170628.060719/full/>

CMS' independent evaluation reports of the Pioneer ACO model, as well as studies of the Medicare Shared Savings Program, published by Harvard researchers, have shown CMS' ACO programs have saved Medicare's Trust Funds hundreds of millions of dollars.³ These cost reductions mean that MSSP is currently the most efficient way to deliver Medicare benefits to the American people, cheaper than traditional Medicare and cheaper to the taxpayer than Medicare Advantage.

In particular, the evidence shows independent physician-led ACOs achieved greater savings than those led by hospital systems. This makes intuitive sense - independent physicians are not conflicted with needing to preserve unnecessary inpatient admissions or high cost procedures to fund a hospital's budget. Independent physicians play a critical role to improving quality, reducing costs, and fostering competition to ever-consolidating health systems. However, independent physicians often lack the financial and technical resources available to hospital systems to join the value-based payment movement. Aledade addresses just that - we help independent physicians transition to and thrive under value-based programs.

It is from this perspective that I offer my assessment on the guiding principles for continued payment and delivery system innovation and policy recommendations to strengthen the financial incentive to support innovation, increases access to necessary information, and increasing the actionability on information.

Guiding Principles for Payment and Delivery System Innovation

As federal policy seeks to encourage payment and delivery system innovation, I offer these guiding principles.

- *Patient-Centered Care* – A strong primary care physician-patient relationship is the strongest tool available to create more value in health care. This proposition is strongly supported in the health services research literature and in the results of the MSSP.⁴⁵
- *Choice and Competition in the Market* – We applaud the initial steps Congress has taken to reduce regulatory incentives encouraging the merger of hospitals and physician practices and we encourage Congress continue to focus on anti-competitive behavior of all health care entities. Congress and CMS should also take steps to prevent other anti-competitive behaviors such as data blocking.
- *Provider Choice and Incentives* – Value-based programs that provide a business case for improving care will attract voluntary enrollment by physician practices. Models can attract participation through three principles:
 - *Predictable benchmarking* – Reducing uncertainty enables investment and risk taking.
 - *Long-Term Structure* – A clear path over the next 10 years that moves over time to a financial and evaluation structure that includes local market comparison as well as historical performance includes comparison to their local market, not just past performance supports fundamental change in practice patterns.

³ <http://www.nejm.org/doi/full/10.1056/NEJMsa1600142>; <http://annals.org/aim/article-abstract/2566329/savings-from-acos-building-early-success>; <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2601418>

⁴ <http://www.nejm.org/doi/full/10.1056/NEJMmp1709197?query=TOC>

⁵ <http://www.nejm.org/doi/full/10.1056/NEJMsa1600142#t=article>

- *Risk Taking* – A reliable benchmark with an obvious long term future allows for the taking of financial risk, but that risk must be proportional to the finances of independent physician practice and not so large as to favor consolidation of practices.
- *Benefit Design and Price Transparency* – Price transparency to health care providers and to consumers creates competition by informing the choices of both beneficiaries and referring physicians. Benefit design should incentivize the building of the primary care physician-patient relationship and other cost-saving choices.

Recommendations to Create a Reliable Financial Model to Support Innovation

Limit one-sided risk.

Today the vast majority of Medicare ACOs (460 of 561, or 82%) are still in one-sided risk models. The Track 1 MSSP model undeniably serves as a critical on-ramp for providers to gain experience with total cost of care models, particularly for the physician-only group of ACOs that have demonstrated the greatest ability to generate savings for Medicare. However, upside-only models do not force organizations to make a commitment to a new business model centered on value and outcomes, rather than volume and market power.

CMS recently proposed numerous changes to the Medicare Shared Savings Program, including shortening the time an ACO can stay in one-sided risk. Because the data show that performance of different types of ACOs varies tremendously, CMS is right to look at strengthening the business case to save on health care costs. Moving to two-sided risk does strengthen the business case, particularly for underperforming high-revenue ACOs for whom the current shared savings incentives are least attractive.

We believe that if two-sided risk is made less risky, and more predictable, then most successful ACOs will be willing to move up the risk continuum in return for greater up-side from CMS. The success of the value-based movement should be measured not only by the number of ACOs, but also by their ability to generate results.

Make downside risk less risky.

The Medicare ACO Track 1+ model, which was unveiled by the CMS Innovation Center in late 2016, took a big step towards creating a two-sided model that is feasible for organizations of differing finances by introducing the concept of revenue-based downside risk. For the first time ACOs of all types could take the same level of risk, rather than a high revenue ACO risking 5-10% of their Medicare revenue and a low revenue ACO having to risk 50-100% of their Medicare revenue.⁶ Combine this “right-sizing” of risk with the MACRA bonus associated with qualifying as an AAPM under the “more than nominal risk” test of MACRA, physicians and

⁶ <https://www.ajmc.com/contributor/travis-broome/2016/03/changing-stop-loss-formula-can-drive-interest-in-risk-based-models?p=1>

hospitals alike can both move to risk over time. As organizations with profit margins of 2–3%, CMS is then assuaged its concerns that ACO waivers could lead to higher costs.

Track 1+ had a strong debut in 2018, with 55 ACOs entering this Innovation Center model. In contrast, only a few ACOs entered the MSSP's current two-sided models – two in Track 2 and eight in Track 3. This debut highlights that it is as much getting the policy right as it is provider willingness that determines participation in two-sided risk models. We strongly support CMS' recent proposal to make revenue-based risk a permanent part of the MSSP.

Make the benchmark more predictable and strengthen the link to Medicare Advantage.

The original ACO financial benchmarking methodology was an attempt to move money from regions with high per-capita Medicare spending to regions with lower spending, while still rewarding efficiency. It has proven unsuccessful at both. High cost ACOs receive slightly more shared savings than low cost ACOs⁷. It is time to create a better measure of whether an ACO actually generates savings to the Medicare program compared to the alternatives.

One of the major hesitations that ACOs have about entering into two-sided risk is the complexity and unpredictability of the program's current benchmarking methodology. Sophisticated statistical analysis by Harvard Medical School Department of Health Care Policy researchers has shown that the current benchmarks do not accurately share savings based on a given ACO's activities because they do not account for local variations in cost trends. As a consequence, some ACOs generate "savings" against a benchmark that was not attributable to their actions, while other ACOs are told that they did not generate any savings, even as they have worked hard to improve patient outcomes and reduce hospital and emergency department utilization. Both scenarios sap provider confidence to take on two-sided risk, and reduce the program's ability to reduce costs.

CMS introduced a regional benchmarking approach last year to account for regional trends, and this year CMS has proposed to accelerate the transition to regional trends. Unfortunately, the complex benchmark calculations conducted between the close of the performance year and the "final reconciliation" are not possible for ACOs to replicate creating uncertainty all the way to the final settlement and discouraging additional investment. The regional benchmarking methods also inadvertently introduced a new problem that systematically disadvantages rural ACOs by including their population in the regional comparison group. Without fixes, the benchmark methodology will continue to favor urban ACOs with high historical costs.

As one recent study of independent ACOs observed, the lag between performance and evaluation, the "black box" of risk adjustment, and benchmarks that are perceived as constantly moving targets, all contribute to a reluctance to move ahead with two-sided risk.⁸ Pushing ACOs to take more risk while creating a more predictable and equitable can lead to greater savings to the taxpayer without encouraging further provider consolidation. CMS's proposed rule moves in this direction, but we believe more can be done and most importantly must be done as a package. We cannot move ACOs to risk without improving the model.

⁷ <https://www.healthaffairs.org/doi/10.1377/hblog20171120.211043/full/>

⁸ https://www.naacos.com/press-release-may-2-2018#_ftn1

A radically simpler solution would be for CMS to move all ACO benchmarking towards a methodology based on Medicare Advantage (MA) benchmarks. This approach could also be used to develop an improved version of the Next Generation ACO program that provides an on-ramp for smaller practices. To preserve the existing historical cos-to-regional cost transition of MSSP, the ACO's benchmark could initially be set at their historical percentage of the MA rates in their area (120% or 80%, etc.) during one-sided risk, and then begin the transition towards the actual MA benchmarks as soon as the ACO takes on two-sided risk. This transition encourages participation by both ACOs with high cost history and ACOs with low cost history.

The processes for establishing these MA benchmarks are well understood, and the benchmarks themselves are much more predictable. The rates are set prospectively, and do not require extensive analysis of cost trends months after the conclusion of the performance years. Improving the timeliness and predictability of benchmarks would greatly benefit ACOs at no loss to CMS; in fact, it would greatly reduce the cost and complexity of administering the ACO program for Medicare, since the MA program has already invested in the policy and analytic tools for solving many of the technical problems that ACO benchmarking faces.

Tying ACO benchmarking to MA benchmarks would also have the advantage of giving risk-taking providers greater competence – and confidence – in taking risk for MA patients, and partnering with plans to create more MA options for seniors. By allowing providers and investors to focus on one rate setting methodology, we could see more private investment in both MSSP and MA.

Reward (and simplify) quality.

Currently, ACO quality scores appear to be uncorrelated with savings against benchmark. It is reassuring that the savings are not coming at the expense of patient care, and there is no evidence ACOs are stinting on needed health care. However, there is an opportunity to incentivize improved patient experience and quality outcomes in addition to savings, similar to the MA program. A simplifying approach aligned with the Patients Over Paperwork initiative would be for CMS to use identical clinical and utilization measures for the ACO programs and the MA STAR rating program, evolving both towards more meaningful outcomes and patient-reported measures over time. Such an approach would reward quality through increases in the benchmark, reduce administrative burden for CMS and providers, allow consumers to make informed choices between ACOs and MA, and provide an opportunity for making improvements in both.

Engage consumers.

ACOs face limitations in using benefit design to align financial incentives with beneficiaries as in MA. For example, currently ACOs are unable to waive copays for high value primary care services. Similarly, ACOs are unable to include Medicare beneficiaries in any financial benefit from cost savings. Just as financial incentives are powerful mechanisms to change providers' behaviors, they can be effective to drive positive consumer behavior change.

Greater flexibility should be given for ACOs to engage consumers as long as it does not come at the cost of greater administrative burden, such as requiring each patient to fill out additional paperwork. Such flexibility may be provided through legislation or through increased guidance and clarity on the use of waivers to anti-kickback and associated rules that have largely been unused by ACOs.

Recommendations to Improve Access to Information

Include admission, discharge and transfer data feeds as a condition of participation in Medicare for hospitals.

There is much more information available than simply claims data. One of the most available and powerful pieces of information is known as admission, discharge and transfer data (ADT) feeds. These are notifications when a person is admitted to a facility, discharged from it and transferred within it. For facilities with certified electronic health record -- which includes over 95% of hospitals -- there are not technical barriers to sharing this information. We have successfully built a link between our ACO and a hospital in 30 minutes once the business and policy issues were settled. However, we still see hospitals that will not share this information with primary care physicians. In some cases, this is for business reasons where they see the information as a competitive edge. In other cases, they are unwilling to make even the minimal investments on the technology side to make this change.

We have reached an inflection point with ADT data. It is time for sharing facility notifications with physicians for common patients to no longer be considered an aspirational goal, but a quality and safety requirement. We believe that it should become part of the Medicare conditions of participation.

Direct CMS to make all available data available to ACOs through API style interfaces to improve the ability to take action on the data and its security.

One of the keys to successful population health is to use data to inform accountable physicians about the health care the patient is receiving from others. From admissions to the hospital to whether a referral was completed to whether a prescription was filled, the sharing of data can greatly reduce the burden on the patient and health care provider alike to remember to share information with each other. MSSP has been an exemplary standard in providing claims data, transaction data that details a patient's each encounter with the health care system - which provider they saw or which hospital they were admitted to, for what diagnosis, and what services were furnished or procedures performed.

However, other sources of CMS data remain unavailable to ACOs. For example, when a physician practice queries Medicare for eligibility they receive back a host of information beyond simply whether the person enrolled in Medicare. They receive the last date of several preventative services and the due date of preventative services. Not only could CMS make this query available to ACOs, but they could enhance the information provided. For example, they could include which physician a Medicare beneficiary is attributed to an ACO model if any.

The methods for claims data can also be improved. CMS currently sends a monthly batch of 11 different files with claims data to the ACO. Because of the claims lag from provider to CMS, the

latest month of data is not very reliable. As a result, we receive reliable claims data for events that happened by the end of April around mid month of May. This six week delay is a barrier to action.

CMS is currently experimenting with an API interface that would allow a beneficiary to give an ACO permission to access claims data every day. Rather than waiting until next month's file, an ACO's data would improve every day. CMS should move the entire claims information distribution to an interface basis. Not only is it faster, but it is more secure as there would no longer be static files just sitting on a website, a secure website to be sure, but still a static one where millions of Medicare claims sit for 30 days.

Availability and Standardization of claims feed for commercial payers.

Commercial plans are even more challenging as there is not a uniform structure for providing claims data. Commercial data differs in both content and structure from Medicare and other commercial plans. An effort to standardize the claims feed – just as the claims forms themselves have been standardized - would reduce barriers to access of information.

The other barrier to claims data from commercial payers is the concern that disclosing pricing information raises anti-competitive concerns. This concern varies from commercial payer to commercial payer. Some payers will not disclose any prices, others list prices, others the price sent by the provider, but not the price paid, still others the actual price paid. We would encourage the Department of Justice and the Federal Trade Commission to provide additional guidance to commercial payers about the appropriateness of price disclosure in claims feed used for population health to bring more standardization to the feeds.

Support electronic health record (EHR) interoperability through APIs.

Clinical data housed in EHRs is also very informative. This clinical data includes patient's medical history, patient's state of health (e.g., existing conditions, test results), and physicians' care plans going forward. However, it is also the hardest to access across providers. With the proliferation of ACOs where the providers themselves are responsible for total cost of care, a provider-led business case for sharing clinical data has emerged.

At Aledade, we interface with 70 different versions of EHRs. The key to such proliferation is determination as the ACO will not be successful without the information. We also do not let the perfect be the enemy of the good. An interface that cannot support sharing notes but can share lab results is better than no interface at all.

CMS and the Office of the National Coordinator (ONC) are currently moving towards FHIR based APIs. These hold a lot of promise, especially if we abide by the principle of not letting the perfect be the enemy of the good. We should not prevent an EHR API from sharing lab data just because it cannot share notes. Our experience is that once any data is flowing, it will get better, faster and more comprehensive over time. The key is to get some data flowing.

Thank you for the opportunity to share Aledade's experiences with you. I look forward to continuing to engage with Members of the Subcommittee as you consider these important questions, and I am happy to answer any questions you may have.

Statement of Reverend Sally Jo Snyder, Director of Advocacy and Consumer Engagement, Consumer Health Coalition, Pittsburgh, Pennsylvania

To Chairman Collins, Ranking Member Casey, members of the committee, fellow panelists and persons in attendance, thank you for the opportunity to provide testimony. Furthermore, I want to commend you for realizing the importance of including the perspective of the consumer voice in health care. It has been my experience that the most successful and effective policies and programs are initiated with having sought, heard from, listened and responded to the voice of the consumer.

My name is Reverend Sally Jo Snyder and I am the Director of Advocacy and Consumer Engagement at Consumer Health Coalition (CHC). CHC educates and activates consumers to be engaged and to take charge of their own health care. We educate our shared community about pertinent health policy issues including the social determinants of health and engage in systemic advocacy. CHC enrolls eligible Pennsylvanians in public health insurance programs. We believe that access to quality, affordable health care, and ultimately good health and wellness, are critical to a person's ability to reach his or her potential. We also know that people experience disparate 'starting points' or access to resources that are unfortunately correlated with socioeconomic status, racial or ethnic background and disability status.

Personally, the lessons I taught and the lessons I learned from the consumers trained me well as I served as a caregiver to my mother during her illness and her passing on

from a hospital-acquired infection. Along with my four siblings, extended family, colleagues and connections in the field, we too struggled at times with keeping communications lines open and flowing between my mom's medical providers which happened to be from competing health care systems; we worked to understand the changes in medications and what was no longer being prescribed and made certain that various medications supported one another; we sought to learn the course of treatment for her illness and always kept my mom informed and encouraged her to ask questions of her providers. Unfortunately, we weren't diligent enough as our mom contracted a hospital-acquired infection and then we learned the lessons of persistence, asking questions and demanding answers. The most powerful lesson was the need to be constant and present 24-7 as advocate, record keeper and defender. What I learned and lived has fueled my instruction to others.

Healing in Community

In my work, I travel across Western Pennsylvania performing patient activation trainings. Recently, I conducted a focus group of 125 seniors in Southwestern, Pennsylvania. The questions asked were "Who helps you live well?" and, "Who is on your health care team?" With intention, I met with both persons living in high-economic areas and individuals living in poverty and asked the same questions to both groups. Those with resources and financial health answered the questions very succinctly by responding, 'My doctor, my specialist, my therapist.' When pressed, the answer remained the same.

When persons living below or near the poverty line answered the questions, they talked to me for 25 minutes and mentioned the bus driver, members of their congregation, their pastor, the social worker, the clerk at the local 7/11, the pharmacist at the CVS, their friends and their family. There is a quote, *"We do not heal in isolation, we heal in community."* The more we can broaden a person's base of connections and increase one's trust points, we can create better outcomes in physical health, mental health and in overall wellness.

The Importance of Trust Points

As clergy and Advocacy Director, I have earned my status as a trust point for the persons our agency serves and journeys. Like anyone who earns another's trust, this happens through knowing another's name, listening well and remembering, paying attention, being present and following through on what is offered. For a successful health care experience, providers and care staff must become these trust points. From obtaining coverage to finding a provider, making the most of every health care encounter can easily leave one feeling unsettled, unsure and unmoored. Having others *"in it with you,"* learning how to navigate, what to bring, questions to ask and pointers to make, make the sojourn in and through the system of care a successful one for both patient and provider.

Being a trust point in the community, I know firsthand how important it is that people of Pennsylvania retain access to affordable health coverage. The passage of the Affordable Care Act was a watershed moment in our communities, expanding the

availability of private insurance coverage as well as Medicaid. Continued threats to these programs undermine community trust and risk the basic health and well-being of Pennsylvanians. This is particularly acute for people with pre-existing conditions, who now worry that the courts will take away the guarantee of health coverage provided to them by consumer protections in the Affordable Care Act. In fact, it is the threat of persons with pre-existing conditions losing health care coverage that is the most pressing issue of those with whom I educate and advocate.

Activated Patient Trainings

We provide "Activated Patient Trainings" for seniors. These sessions walk persons through every step of the health care encounter from:

- Finding a provider
- Making the matter of transportation the second most important question asked at the time of making an appointment
- What to ask the provider on the initial visit
- Being prepared and directing the appointment so as to make the most of those 15 minutes
- If a longer appointment is needed, to ask for the first or last appointment of the day
- What to bring to every appointment
- Understanding your medications
- What to ask if a test is suggested
- Understanding options if surgery is proposed
- The importance of following-up
- Evaluation of the visit

Because these trainings are done in a group setting, persons from these learning communities offer their insights and provide support for their fellow students. In these sessions, additional trust points are formed.

We stress that whenever a test or a new medicine is suggested or surgery is proposed, the initial response must be **“Why?”** and that from that question mutual dialogue can and must occur.

My favorite question in the guide is **“Can you explain this to me in a way that I can explain it to others?”** This question makes certain that the patient both understands one's diagnosis and treatment plan and is able to share this information with their team of trust points.

We strongly emphasize having someone accompany a person on their health care visits and created the acronym B.U.D.D.Y. to assist in selecting the right individual or “Visit Buddy”:

B = Back, they've got yours

U = Understand their role to support and take notes

D = Disciplined and will stay focused on you and the visit

D = Details person

Y = You are the focus of the medical appointment.

We open each training by asking, "Who is on your health care team?" We want seniors to realize that they are the Most Valuable Player, the MVP, of their health care team. A successful health care system works when, as in any relationship, there is mutuality, honesty and accountability between patient and provider. We ask them to list the **name**, **contact information** and **role** of every member of their health care team and to keep this list updated and kept on file with the medical provider and brought by them to every medical appointment.

Trainings in Action

Technology can be a valuable asset. First, we must work to make sure it is available for every patient, even more to persons living in poverty and isolation, and that education on how to use the technology is provided. Congregations, community centers, YMCA, beauty parlors, barber shops and coffee houses are known trust points that can be utilized as training sites and in doing so broaden the base of who's involved in one's care. A useful model for my work is the Community Health Workers model that operates from the foundation of being a trust point and assisting persons in preparing for a medical visit. They help a senior to update one's personal health profile and medications list, make certain the individual's health care team roster is updated and work to prepare the "What I Need to Now" questions for the provider visit. This information can then be emailed to the provider a day prior to the visit. These encounters make for a more productive health care visit because both the patient and the provider are prepared and literally on the same page.

We encourage patients that after each medical appointment, the person complete the “Doctor Visit Checklist” that asks an equal number of questions of both patient and provider. Copies of the checklist are left with the provider to be kept on file and with the patient for their records. Our consumer advocates report this creates both mutual accountability and another way to communicate, check-in and follow through.

Using Patient Activation to Prevent Hospital Readmissions

The success of our “Activated Patient Trainings” has led to a series of focus groups and trainings on Reducing Hospital Re-Admissions. We worked in concert with a professor from the University of Pittsburgh’s Graduate School of Public Health and the model we developed and used was the “**Four C’s of Readmission Reduction**” which are:

- Communication
- Comprehension
- Course of Treatment
- Coordination of Care

For example, when a person is being discharged from the hospital, the attending nurse will ask a series of questions from a Discharge Checklist. We teach persons that there are “*no checks without chats*” and to make certain the care plan, follow-up care and medications are understood. We also stress the person have a family member or other trust point present during this time.

Conclusion

As health care advances, the experience and insight of the patient must be intentional, heard, listened to and implemented. For the all-important relationship of Provider and Patient, we must make a priority to listen to and learn from the individuals whose lives are most impacted by the new treatment, the course of care and the new advances in medicine. To fail to involve this perspective from the foundation to the completion is to have a health care system that functions at half capacity.

Thank you for this opportunity. I look forward to answering any questions and continuing the dialogue. For the Patient and Provider relationship to work, we must include the patient perspective, yet we must also make sure that patients can access the system—affordable coverage is a key part of that foundation.

A person who fears being able to afford any health care because they lack insurance is not someone who can meaningfully participate in their care and focus on being the MVP! Patients, providers and payers are the central players in an effective health care system. All have roles to play, responsibilities to fulfill and reasons to work together as a team to build and to bear a health care system that works for all.

Respectfully submitted,

The Reverend Sally Jo Snyder, Director of Advocacy and Consumer Engagement

Note: Supplementary information follows statement.

Proactive Patients Have Better Outcomes

by Stacey Shannon

For decades, the medical community has conducted studies finding that patients who are involved in making decisions for their care and treatment have better outcomes and spend less money on medical care than those who don't. But for IC patients going from one medical provider to the next and perhaps even being told their symptoms are all in their head, being proactive in their care can be tough and require energy they are lacking.

However, being a proactive patient is vital in finding treatments that work and managing a chronic and painful condition like IC.

Talk with your doctor

Just like in any good relationship, communication is the foundation of a good patient/provider relationship. Rev. Sally Jo Snyder, director of advocacy and consumer engagement for the Consumer Health Coalition in Pittsburgh, PA, said preparing for your appointment is the start. She tells patients to come prepared with three questions for their doctor.

"Communication is the best medicine," Snyder said.

Communication is so important, in fact, that the Consumer Health Coalition has its patients complete a form after each appointment assessing how well they communicated their needs and how well their medical provider listened and responded. She recalled one instance where a patient said her doctor didn't have

time to answer questions. The doctor read the assessment and called the patient at home that evening to talk further with an apology and explanation about having had an emergency in the morning and been running late the rest of the day.

Patients who are involved in making decisions for their care and treatment have better outcomes and spend less money on medical care than those who don't.



"We need to work to build a system where that's the norm that we would expect that," Snyder said.

Unfortunately, it isn't the norm. In most situations, doctors aren't given patient feedback in any way other than through discussion at appointments. That's why Snyder said patients should do their best to prepare ahead of time and know what they want to discuss with their providers.

"Really be in charge of the appointment," she said. *"Direct why you're there and where you need to go."*

Toni Rutherford, a 65-year-old IC patient living in Texas who was diagnosed in 2001, has learned firsthand the importance of doing her own research and communicating with

her medical providers. She starts with basic questions when working with new providers.

"When I am speaking to clinicians, I first have to make sure they know what IC is — many don't," she said. "When some of the doctors I have seen basically told me to suck it up, I just shut up and never went back to that doctor."

She remembers one urologist in particular who gave her a hard time about flinching every time he tried to put a scope in her urethra. Rutherford had already been through several hours of testing on her urinary tract and was sore and sensitive. She couldn't believe he didn't understand why that hurt her. Another time she saw a pain management doctor who wanted her to try a TENS unit before prescribing drugs. She had the trial unit surgically implanted and had no relief.

"I began to learn at that point that no one knows a whole lot about IC and that it was best to listen to my own body and do what I think is right," Rutherford said.

Fortunately, she has a helpful family physician who listens to her and has helped her throughout her IC journey. She also learned to keep charts and track her symptoms and treatments so she had solid information to share with her doctors.

"At this point in my life, I don't chart my symptoms anymore," Rutherford said. *"I kept charts on everything in the early years of IC. I researched and read everything I could on the subject."*

Rebecca Bailey, a 21-year-old IC patient in Auckland, New Zealand who was diagnosed in 2014, has also learned the importance of doing her own research.

"I have done a lot of research myself," she said. *"In fact, I have been suggesting things to my urologist to try next for the last few years."*

Bailey said she's been fortunate in that she's never had a medical professional minimize her symptoms, though she has had quite a few who didn't know what IC was until she told them. She's found having a family member along with her at appointments is helpful in communicating

with her doctors.

"I take my family along to say things along the lines of, 'Well, that's not good enough; you can't leave a 21-year-old like this. Surely there is something else to try,'" she said. *"[This helps] because I always feel so defeated during doctors' appointments and usually forget what I want to talk about."*

Snyder said that feeling is common, so she encourages her clients to write down their questions, psych themselves up and, just like Bailey does, bring a support person along. She also encourages patients to talk candidly with their doctors by asking lots of questions — especially at the first appointment — like whether the doctor is familiar with IC, how much he supports any alternative treatments that have been working and even whether he's supportive of the patient's faith. She also said patients shouldn't be afraid to ask why.

"When you're there and the doctor says he wants to run a test, ask why," Snyder said. *"[Say to him], 'Talk to me. Why do I need this?' Have that dialogue."*

The purpose isn't to question the doctor just for questioning's sake but for the patient to really understand what's going on with their care.

Snyder said patients should also keep track of their care.

"We encourage everyone to...have that notebook or folder where you're keeping track of the appointments and tests you've had," she said, pointing out that taking notes at an appointment is a good idea.

While communication between patients and doctors is important, the way they communicate is also important. Bailey, for example, has forged a good relationship with her doctor and can present some of her own research in a respectful way. Snyder said it's important to form a relationship in which doctors and patients can be open with one another.

"You want yourself to present an open, willing dialogue — not arrogant," she said. *"At the same time, I don't want my provider to be arrogant either."*

Sometimes the relationship just

doesn't work for whatever reason, just like happened with Rutherford with the doctor who continually minimized her pain. Snyder said sometimes patients just have to move on to another doctor, and that's OK. She pointed out that even though providers can have bad days sometimes, a doctor who continually doesn't listen or has other issues isn't one to keep going to.

"The best advice I can give to a newly diagnosed patient would be to trust their body and their instincts," Rutherford said. *"It is OK not to take the advice that some doctors give and it is OK to change doctors until they find one that suits them."*

Take care of yourself

While having open lines of communication with a doctor you can trust is a big part of being a proactive patient, self-care is also important for IC patients to manage their condition. That can include things like following the IC diet, reducing stress and resting when necessary.

"The hardest thing for me to give up was coffee, but I stayed off of it because I had to function at work."

—Toni Rutherford

Rutherford said in her early days with IC, she stayed strictly on the IC diet, in spite of some challenges.

"The hardest thing for me to give up was coffee, but I stayed off of it because I had to function at work," she said. *"I stayed on a strict IC diet and it did work. I didn't track it; I just remembered things that triggered symptoms."*

Bailey has also been aware of diet when it comes to her IC symptoms, but she has been more prone to splurging on food that can irritate her bladder.

"There are a couple things I avoid completely...but am flexible with everything else," she said.

Bailey will have binge days where she eats a few foods that irritate her bladder in one day using the theory that if she's going to be extra sore, she wants to enjoy herself. When she is in a flare, though, she sticks with the IC diet strictly.

Along with being proactive about the IC diet, patients have also found they have to be proactive in managing their stress levels. Rutherford said anxiety is her biggest trigger for an IC flare, so she reduces her stress as much as possible. She works with her doctors and psychiatrist to maintain her lifestyle and keep going.

"Since I have learned that anxiety is my worst trigger, I have been able to manage my pain much better," she said.

Along with doing her best to reduce stress, Bailey said she also follows her body's cues.

"If I want to stay in bed...I will just stay in bed," she said. "You need to listen to your body. Thankfully when I've had a day in bed, I go a little stir crazy, and I tend to have to do more the next day to get out of my head. Some days you can do more than others and those days spent in bed make me stronger to work or study or see friends, which is also important."

Create your own support network

Along with finding and managing good relationships with doctors and themselves, patients need a support group around them to be proactive in managing their health. Support networks come in all different ways from family to friends to medical advocates.

Bailey said her family has been supportive and have gone with her to appointments. She's tried to help them understand that living life with IC is like, even though it's a challenge.

"I don't think my family understands," she said. "I don't believe anyone who doesn't have IC can ever really understand."

She said the most helpful tool she's found in describing life with a chronic illness is a blog post by Christine Miserandino, a lupus patient.

"It's about how everything you do requires spoons (energy), and some days you wake up with more spoons than other days so [you're] forced to choose wisely and not do so many things," Bailey explained. *"I think it is a powerful message standing for all of those with invisible illnesses."*

Rutherford gave her family members a printout about IC when she was first diagnosed to help them understand.

"Everyone was supportive, except for my husband when it came to sex," she said. "It was a very important part of my life to lose, and my husband never really did understand it."

Snyder said a support network is vital for patients. She herself has a variety of friends she can go to for different things. For example, one friend is a good listener, another is a good motivator, another is a nurturer and so on. They all fill various roles and needs.

"I really think it comes to support systems that are broader than the relationship you have with your [medical] provider," she said.

And sometimes that can mean seeking out professional help, which could be a psychotherapist for counseling in dealing with life with chronic pain or finding a medical advocate to help navigate doctors' appointments and insurance issues.

Keep going

In the end, the best way for patients to be proactive about their healthcare is to just keep going and fighting for their best outcome. Sometimes that can be talking to numerous people at an insurance company until someone clears a needed procedure or sometimes that can be finding the strength and fortitude to get out of bed on the hard days.

"My proactivity has mainly stemmed from not giving up, even when the urol-

ogist has said there is nothing else to try," Bailey said. "I have learned some things to make me feel better and some that make me worse."

Rutherford is the same way and remains determined to not let IC rule her life.

"I have always been motivated to stay active," she said. "And I refused to lose that part of my life."

Another component is to remember sometimes a negative answer doesn't mean to stop the fight. For example, according to the Social Security Administration, 34.8 percent of applicants were awarded with disability in 2010, but 31 percent were denied for technical issues. An estimated 70 percent of claims are denied the first time around. However, the appeals process often changes that decision.

Patience is definitely a part of the process. Trying and finding the right treatments takes time, but the end result is worth it when patients end up with a better quality of life.

"This can be managed, but you've got to be proactive in it," Snyder said.

Bailey added: *"It's a slow process, but you will eventually figure out what works best for you. Think about what you can do to keep stress levels lower, and make sure you have support networks in place. It's a battle, but what doesn't kill us makes us strong."*

Suggested Reading

Snyder's Guide, "Being a Proactive Patient: A Guide to Person-Centered Care"
<http://consumerhealthcoalition.org/programs/health-committee-for-people-with-disabilities/being-a-proactive-patient/>

Find a medical advocate for hire:
<http://www.aphadvocates.org/>
<http://nahac.memberlodge.com/>
<http://www.patientadvocate.org/>

Doctor Visit Checklist**DID I**

- Arrive early for my appointment? ☐
- Complete my personal health profile? ☐
- Bring a current medications list? ☐
- Know my weight, blood pressure? ☐
- Understand my condition and the course of treatment/care? ☐
- Make my needs clear and ask questions? ☐
- Have visit shared with other doctors and make follow-up appointments? ☐

DID THE DOCTOR

- Spend enough time with me? ☐
- Really listen and respond to my questions? ☐
- Answer in terms I understood? ☐
- Show respect for me? ☐
- Make me feel comfortable? ☐
- Address the health concerns I came with? ☐
- Make clear my medications and what and when and how to take? ☐

Words of wisdom to the Providers

- ☆ Listen to me
- ☆ Talk with me, not at me
- ☆ You and me in a mutual dialogue
- ☆ Don't just hand me a prescription
- ☆ Remember, we are a team, and I am the MVP!
- ☆ Relationships matter --- ours is a very important one
- ☆ Don't rush...slow down
- ☆ Let me be the focus for the 15 minutes
- ☆ Take a seat, let me see you at my level
- ☆ Involve me, include me
- ☆ Remember: We are both part of a much larger community
- ☆ Alternative treatment is a good thing
- ☆ Don't take me for granted
- ☆ Mutual respect
- ☆ Talk to me in a way I understand
- ☆ Show me what you mean
- ☆ I am a person
- ☆ Person first not my condition
- ☆ Encourage me
- ☆ Believe
- ☆ Answer my questions

Additional Statements for the Record

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

Statement for the Record Submitted to the Senate Special Committee on Aging on

“Patient-Focused Care: A Prescription to Reduce Health Care Costs”

October 3, 2018

Justice in Aging is writing to express our support for the EMPOWER Care Act (S.2227), which would extend the Medicaid Money Follows the Person Program (MFP). Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income beneficiaries and populations that have traditionally lacked legal protection such as women, people of color, LGBT individuals, and people with limited English proficiency.

We greatly appreciate that the Aging Committee is examining MFP, a critical program that has helped more than 88,000 older adults and people with disabilities in 47 states move out of institutions and into the community. MFP is a common-sense way to fund Medicaid Home and Community-Based Services that help older adults age in place and improve their quality of life, while saving money that the federal government and states would otherwise spend on more costly institutions.

We would like to share the story of a California resident whose life was transformed by the MFP program:

Freddie has significant physical and some cognitive impairments resulting from having polio as a child. In 2002, Freddie was attending adult day health care and living independently in the community with the help of a caregiver when her caregiver physically abused her to the point where she almost died. She was in the hospital for three months, and the assault caused a seizure disorder. She was transferred to a skilled nursing facility where she lived for the next six years. When a local organization received a funding contract for MFP and a case list, Freddie was first on the list to transition back to her community. California Community Transitions, the name of the MFP program, was able to find housing for Freddie and arrange support services. Freddie has been living in the community now for over eight years. That is eight years of independence – getting to eat when she wants to eat, get up when she wants to get up, watch what she wants to watch on television, keep the temperature at the temperature she wants.

As you know, federal funding for this successful program expired September 30, 2016, and states are already having to scale back their MFP programs. Without additional federal funding, most states will be forced to completely eliminate their programs.

Justice in Aging appreciates that both Chairman Collins and Ranking Member Casey are cosponsors of the EMPOWER Care Act and are continuing to bring attention to this important issue through this hearing. We are grateful for the House Energy & Commerce Committee’s passage of a 1-year extension of the MFP program (H.R. 5306), and ask that the Senate support a longer 5-year extension, as included in S. 2227.

WASHINGTON

1444 Eye Street, NW, Suite 1100
Washington, DC 20005
202-289-6976

LOS ANGELES

3660 Wilshire Boulevard, Suite 718
Los Angeles, CA 90010
213-639-0930

OAKLAND

1330 Broadway, Suite 525
Oakland, CA 94612
510-663-1055



LeadingAge Statement for the Record

Patient-Focused Care: A Prescription to Reduce Health Care Costs

Senate Special Committee on Aging

October 12, 2018

LeadingAge, an association of not-for-profit aging services providers, appreciates the opportunity to submit a Statement for the Record for the October 3, 2018, hearing on, "Patient-Focused Care: A Prescription to Reduce Health Care Costs." We are pleased the Committee examined how insurers, health care providers, and patients are approaching this challenge, specifically by identifying innovative efforts currently under way to moderate health costs while improving health outcomes and satisfaction in the process.

The mission of LeadingAge is to expand the world of possibilities for aging. Our membership has a service footprint of 4.5 million and includes a community of 6,000 members representing the entire field of aging services, including not-for-profit organizations, state partners, and hundreds of businesses, consumer groups, foundations and research partners.

LeadingAge "Patient-Focused Care" Telehealth Demonstrations

LeadingAge applauds efforts that promote opportunities to implement patient-focused care, and ultimately reduce health care costs. The LeadingAge Center for Aging Services Technologies (CAST) has a number of ideas for new models that test market-driven reforms that empower Medicare beneficiaries as consumers, provide price transparency, increase choices and competition to drive quality, reduce costs and improve outcomes. These initiatives have been submitted to the Centers for Medicare and Medicaid Services (CMS), Center for Medicare and Medicaid Innovation (CMMI), since the models are closely aligned with many of the guiding principles outlined in the Request for Information on the Innovation Center's future direction.

The LeadingAge telehealth demonstrations would waive certain statutory Medicare telehealth requirements, such as rural and originating site restrictions included in section 834(m) of the Social Security Act. The demonstrations would also allow the patient's home – which may include their home in the community or retirement community, and independent living unit, senior housing apartment or an assisted living unit – to be an eligible originating site.

Additionally, under the statutory Medicare telehealth requirements, asynchronous remote patient monitoring (RPM) has generally not been eligible for reimbursement (except in Hawaii and Alaska); this was recently changed to allow physicians and physician assistants to bill only for chronic care and complex chronic care management in the community. The LeadingAge

demonstrations would allow additional LTSS providers to bill for chronic care and complex chronic care management in broader segments of the Medicare population, such as those who provide services within retirement communities, senior housing and congregate settings.

Additionally, the demonstrations would modify the existing telehealth requirements and allow SNFs to receive increased facilities fees. This would ensure SNFs using telehealth and RPM technologies can support the costs associated with including infrastructure, hardware, software and the qualified nursing staff using telehealth and RPM technologies.

Most important the LeadingAge telehealth demonstrations would allow LTSS providers to implement innovative efforts that explicitly encourage the use of telehealth and remote monitoring technologies, and moderate health costs while improving health outcomes and satisfaction in the process. By focusing on older adults in the community and by waiving certain Medicare telehealth requirements that impact care, there is a greater opportunity to avoid high-cost settings, and ultimately reduce hospitalizations and hospital readmissions of nursing home residents.

Chronic Care Management in the Community Demonstration

The “Chronic Care Management in the Community Demonstration” would be aimed at Medicare beneficiaries 60 years or older with two or more of five chronic conditions (diabetes, heart failure, hypertension, chronic obstructive pulmonary disease and asthma). Participants would be living in the community in home-based settings – which includes their own homes, independent living, senior housing, affordable housing, assisted living communities, and continuing care retirement communities, which are also referred to as life plan communities.

The demonstration would test and evaluate the cost-effectiveness of a payment model similar to the payment methodology used in the Independence at Home Demonstration, where CMMI works with medical practices to test the effectiveness of delivering comprehensive primary care services at home and if doing so improves care for Medicare beneficiaries with multiple chronic conditions. Providers could bill for services such as: monitoring, educating, triaging, and managing participants’ health.

The demonstration would also allow LTSS providers to coordinate with primary care or specialty providers when needed for additional interventions, like medication titration, change of medications, ordering laboratory tests, or modifying any other part of the care plan.

Reducing Hospitalizations and Hospital Readmissions of Nursing Home Residents

The “Reducing Hospitalizations and Hospital Readmissions of Nursing Home Residents Demonstration” would be led by skilled nursing facilities and life plan communities. The demonstration would be aimed at testing and evaluating the cost-effectiveness of a payment system that would provide financial incentives to SNFs (and the skilled level of LPCs).

Participating providers would receive annual incentive payments based on a percentage of the Medicare savings (Parts A, B and D). The savings would be achieved as a result of using two-way video conferencing telemedicine and telehealth services to connect with physicians, hospitalists, psychiatrists, and other specialists to help older adults residing in SNFs reduce unnecessary hospitalizations and hospital readmissions. The demonstration would also improve health outcomes and coordinate with hospitals and physicians if/when hospitalization or readmission is necessary.

The payment model should allow SNFs to bill for services, such as assisting physicians in triaging, stabilizing and managing participants' health. Additionally, they would also coordinate with physicians and hospitals when needed for additional interventions, like medication titration, change of medications, ordering laboratory tests, modifying any other part of the care plan, or transferring to a hospital. The eligibility for payment should not be limited to rural areas.

Conclusion

In conclusion, LeadingAge would like to thank the Senate Aging Committee for examining how health care providers can promote patient-centered care. As we have stated, by focusing on older adults in the community and by waiving certain Medicare telehealth requirements, there is greater opportunity to avoid unnecessary high-cost settings. Launching the identified demonstrations would moderate health costs in eligible nursing facilities while improving health outcomes among Medicare beneficiaries and satisfaction in the process.

