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HOW PRIMARY CARE AFFECTS HEALTH CARE COSTS AND OUTCOMES

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED SIXTEENTH CONGRESS

FIRST SESSION

ON

EXAMINING HOW PRIMARY CARE AFFECTS HEALTH CARE COSTS AND OUTCOMES

FEBRUARY 5, 2019

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HOW PRIMARY CARE AFFECTS HEALTH CARE COSTS AND OUTCOMES

Tuesday, February 5, 2019

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

The Committee met, pursuant to notice, at 10 a.m., in room SD–430, Dirksen Senate Office Building, Hon. Lamar Alexander, Chairman of the Committee, presiding.

Present: Senators Alexander [presiding], Murray, Collins, Cassidy, Roberts, Scott, Romney, Braun, Casey, Baldwin, Murphy, Warren, Kaine, Hassan, Jones, and Rosen.

OPENING STATEMENT OF SENATOR ALEXANDER

The CHAIRMAN. Good morning. The Senate Committee on Health, Education, Labor, and Pensions will please come to order. Senator Murray and I will each have an opening statement and then we will introduce the witnesses, and after the witnesses' testimony, Senators will each have a five-minute round of questions.

Dr. Lee Gross of Florida testified last year at this Committee's fifth hearing on the cost of health care. He told us that after 7 years as a primary care doctor, he had an epiphany. Too many Government mandates and insurance companies were getting between doctors and patients, and making primary care more expensive than it needed to be.

In 2010 Dr. Gross created one of the first direct primary care practices. Instead of working with insurance companies and Government programs, his patients pay him a flat monthly fee directly, $60 a month per adult, $25 a month for one child, $10 a month for each additional child.

Dr. Gross is one of more than 300,000 primary care doctors in the United States. Most of us go to see such doctors for our day-to-day medical care, vaccines, flu shots, annual physicals, and managing chronic conditions like diabetes. It is also our entry point to coordinate additional medical care if, for example, we need to get our hip replaced, or an MRI to diagnose a problem. We heard from Dr. Brent James of the National Academies of Medicine on our second hearing that between 30 and 50 percent of what we spend on health care in this country is unnecessary.

I have asked for specific suggestions on what the Federal Government can do to lower the cost of health care for American families, and this year I am committed to passing legislation based on that input to create better outcomes and better experiences at a

lower cost. Senator Murray and I met with Senator Grassley and Senator Wyden, who are the chairman and ranking member of the finance committee, which has a good deal of jurisdiction in the health care area as well, and we are going to see if we can find one or two big things, and several medium-sized or small things, that will help reduce health care costs.

Dr. Gross practice is one of about a 1,000 similar clinics in the United States, and it is a good example of how a primary care doctor can help reduce costs. The first way Dr. Gross does this is by helping with his patients' wellness. For $60 a month, Dr. Gross can do EKGs and cortisone injections, manage chronic conditions like diabetes, asthma, and hypertension, remove minor skin cancers, right in his office.

The second thing he can do to reduce cost is keeping his patients out of the emergency room. For $60 a month, patients have unlimited office visits. They can also email, text, call, use an app to contact his office any time, day or night. So, if you have a stomach pain at 11 p.m., you could text Dr. Gross, who knows that it might just be a side effect of a new medicine that he had prescribed for you.

Third, primary can help reduce health care costs because it is patients' access point to more advanced care. When Dr. Gross refers people for additional care, he is able to provide cost and quality information about the different options, so his patients can choose the best option. For example, one of his patients with rheumatoid arthritis was quoted $1,800 for blood work. Dr. Gross was able to find a laboratory that offered the blood test for under $100.

This echoes what Adam Boehler, who leads the Center for Medicare and Medicaid Innovation, recently told me. He estimated that primary care is only 3 to 7 percent of health care spending, but affects as much as half of all health care spending. And as Dr. Roizen of the Cleveland Clinic has said before this Committee, regular visits to one's primary care doctor along with keeping your immunizations up to date, maintaining at least four measures of good health such as a healthy body mass index and blood pressure, will help avoid chronic disease about 80 percent of the time. This is important because according to Dr. Roizen over 84 percent of all health care spending is on chronic conditions like asthma, diabetes, and heart disease.

I believe we can empower primary care doctors, nurse practitioners, and physicians assistants to go even a step further. At our fourth hearing, we heard about how the cost of health care is in a black box. Patients have no idea how much a particular treatment or test will end up costing. Even if the information on the cost and quality of health care is easily accessible, patients still have trouble comparing different health care options. For example, earlier this year hospitals began to post their prices online as required by the Center for Medicare and Medicaid Services, but to the average consumer, this information has proven to be incomprehensible.

But while the data may be incomprehensible today, it is a ripe opportunity for innovation for private companies, like Healthcare Bluebook, a Tennessee company that testified at our hearing last fall, and non-profit organizations to arrange that data so primary

care doctors, nurse practitioners, and physicians assistants can help their patients have better outcomes and better experiences at lower cost.

There are other ways to lower health care cost through expanded access to primary care. Dr. Gross direct primary care clinic is one example. Another is community health centers, which we talked about at our last hearing. They serve 27 million Americans for their primary care. And employers are increasingly taking an active role in their employees' health and in the cost of health care. One of our new Committee Members, Senator Braun, was an employer of 1,000 people and was aggressive about helping his employees reduce health care costs. Like primary care doctors, more good data could help employers, like Senator Braun, more effectively lower those costs.

Employers are also employing a doctor onsite so employees do not have to take time off work to see a primary care doctor. Onsite primary care makes it easier to keep employees healthy by helping to manage a chronic condition or get a referral to a specialist. Today, I am interested in hearing more about specific recommendations to improve access to affordable, primary care.

Senator Murray.

OPENING STATEMENT OF SENATOR MURRAY

Senator MURRAY. Thank you Mr. Chairman, and thank you to all of our witnesses for joining us as we look at the role primary care can play in addressing skyrocketing health care costs and improving health outcomes.

Families across the country want quality health care to be accessible and affordable no matter where they live, or how much money they make, or what health challenges they indeed face. They want to know that breaking a bone is not going to break the bank, and that a high fever will not come with a high cost. That filling a prescription will not mean emptying a savings account. That managing a chronic illness will not mean having to travel prohibitively long distances or manage exorbitant costs. And when it comes to keeping families healthy and care affordable, how we approach primary care is a key piece of this puzzle.

Experts in Washington State have known this for years, and have been a driving force for models that work to make primary care more accessible, affordable, and effective. Like Dr. Ed Wagner at the MacColl Center in Seattle, who helped advance the idea of the Patients-Centered Medical Home. It is a delivery model where care is coordinated through primary care teams for better efficiency and better health outcomes.

Having these primary care teams quarterback care in this way means giving them a clearer view of the field, a patient's holistic health needs, a roster of their teammates to the patient's other health care providers, and the power actually to call plays, tools for coordinating care or end treatment decisions across the health system. In practice, that means that primary care providers can better understand how to keep all the different specialists and providers on the same page about which treatments, and prescriptions, and approaches are best for a patient's needs, and how to prevent treatments that are redundant, or worse, counterproductive when used

together. And they can better understand what barriers, barriers like cost, or distance, or language, might prevent a patient from getting the care they need and how to overcome them. The result is care that brings down costs, not just by giving patients better, efficient care while they were ill, but also by doing more to keep them healthy.

This promising delivery model was not only advanced in Washington State by the MacColl Center, it was put into practice by one of our state's largest employers, Boeing. Boeing found that by delivering care that was more coordinated and personalized not only lowered costs for patients by one-fifth by preventing expensive care like hospital admissions, they also increased access to care and improved their employees' health outcomes.

Our state has continued to lead the way in implementing new ideas to improve primary care for patients across the country, and I am looking forward to hearing today from Dr. Bennett, who is with the University of Washington, about one of those efforts called Project ECHO for geriatrics, which takes a novel approach to better tailoring care and lowering health care costs for our seniors.

The program sets up a regular teleconference for family medicine residents and others on their team in rural areas to learn from geriatrics experts and consult on issues like which prescriptions are best for elderly patients, how they can help patients manage chronic illness, and what preventative steps can they suggest to patients at risk of dementia or seniors who are concerned about falling. By giving primary care providers access to experts on these issues, this application of Project ECHO helps bring specialized care to seniors who might otherwise have to wait for weeks or months for an appointment. It might even put off getting cured in the first place, if required to travel far from their home. Dr. Bennett, I am very excited to hear more about this work this program is doing and how it leads to better outcomes and lowers costs for seniors across the Northwest.

Of course, while primary care providers can play a critical role in coordinating care and reducing costs, they can only play that role when people have access to care. In fact, when people do not have access to primary care, they do not just miss out on care that could improve their health and drive costs down, this lack of access can actually drive costs higher. Patients go to ER for non-urgent medical care, or worse, without medical care, entirely until non-urgent issues become urgent ones that are more expensive to treat, more debilitating, and more challenging to overcome. So, while innovation and primary care is important, we must absolutely remember to focus on access to it as well, and work to help people overcome barriers like cost, and language, and location.

As we heard last week, community health centers play a critical role in doing that. They provide 27 million people across the country with affordable care close to home. So, I am very glad that Chairman Alexander has joined with me. We are introducing a bipartisan bill to ensure they have stable funding for the next five years. That is a very important step in supporting centers across the country that provide primary care to underserved communities. And so, we continue to focus on the issue of health care costs.

I am hopeful we can find more common ground on issues like how to bring down skyrocketing drug costs so families are not worried about whether they can afford life-saving drugs like insulin, how to address surprise balance billing so patients are not caught off-guard by unexpected and unaffordable price tags for out-of-network care, and how to address President Trump's health care sabotage and lower premiums for families in the country. Democrats have a lot of ideas on how to do all this. We are very eager to make it happen, and I am very—I am actually looking forward to sitting down with Republicans to work with common sense solutions to these health care costs issue we face.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Murray. So the witnesses will know, we have a finance committee meeting today and many of our Members are also on the finance committee so there will be some coming and going. But this is our second hearing on primary care and it is a considerable interest to both the Democratic and Republican Members here, in terms of specific recommendations about what we can do, so we look forward to your testimony.

I thank Senator Murray for the way that she has shown leadership on the community health issue and introducing legislation for five years of stable funding, and this hearing as well. Each witness will have up to five minutes for his or her testimony. I am pleased to welcome our four witnesses.

Senator Roberts, would you like to introduce the first witness?

Senator ROBERTS. Yes, sir. I certainly would. And I would like to say, prior to that introduction, I want to thank the Chairman, I want to thank Senator Murray for your opening comments, more especially with regards to what we can do to help the rural health care delivery system, which is now in pretty rough shape. I do have the privilege of being the chairman of the rural health care caucus. We need to split our membership a bunch to work alongside this Committee, but thank you both.

It is my honor and privilege to introduce Dr. Josh Umbehr before the Senate HELP Committee this morning. Dr. Umbehr is a native Kansan. He was born and raised in Alma, Kansas. Alma, Kansas is the home of the Amish Cheese Factory located on Interstate 70, and you see a lot of cars driving off to Alma and proceeding onward. He attended the Manhattan High School in Manhattan, Kansas. He and his wife Lisa both attended Kansas State University, home of the ever-optimistic and fighting Wildcats, my alma mater, who play the University of Kansas tonight, roughly around the same time we are having the State of the Union—tough choice, but not really.

[Laughter.]

Senator ROBERTS. Dr. Umbehr is reported to be both a fan of the University of Kansas and Kansas State. I do not know how he does that. It is like holding water, sheep, and cattle and everything else you would like to use as an allegory. He majored in human nutritional sciences with a minor in biology.

After graduating from K-State, Dr. Umbehr went on to the University of Kansas School of Medicine, before completing his family medicine residency at Wesley Medical Center in Wichita. Dr. Umbehr is a board-certified family physician. In 2010, he founded

Atlas MD Family Practice, a membership-based, direct primary care practice with two locations in Wichita that has been expanded, as he will talk about later. And to that innovative model, Atlas MD offers its members free home, work, and office visits, unlimited, free telemedicine, free office-based procedures, and a guarantee of no copays.

Atlas MD focuses on building relationships between patients and their doctors through transparent partnerships that prioritize face-to-face care, avoiding unnecessary and burdensome paperwork. Kansas is very fortunate to have Dr. Umbehr and his colleagues at Atlas MD to service a model for how direct primary care can help drive down health care costs, while still delivering high-quality care to patients. Welcome, Dr. Umbehr. We are very interested in your testimony. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Roberts. And I would note that number one, Tennessee plays Missouri at 9 p.m. also tonight. Maybe we can arrange for some sort of split-screen television while——

[Laughter.]

The CHAIRMAN ——watching the State of the Union.

Senator ROBERTS. Would that be on the floor of the Senate, Mr. Chairman?

The CHAIRMAN. Well, I do not know. We will have to discuss that.

[Laughter.]

Senator ROBERTS. Right.

The CHAIRMAN. Next, we will hear from Dr. Sapna Kripalani. She is the primary care physician and assistant professor of clinical medicine at Vanderbilt University Medical Center. Managing more than 2 million patient visits each year, Vanderbilt University Medical Center is one of the largest academic medical centers in the Southeast, and it is the primary resource for specialty and primary care, and hundreds of adult and pediatric specialties for patients throughout Tennessee and the Mid-south.

Senator Murray will introduce our third witness.

Senator MURRAY. Mr. Chairman, joining us today from the University of Washington's School of Medicine is Dr. Katherine Bennett. She has worked tirelessly throughout her career to help make sure seniors across the state have health care providers who understand what they need to stay healthy. She has worked toward that goal as a physician at a senior care clinic in Seattle, as a researcher focused on addressing issues that affect older adults like fall prevention, as an assistant professor at UW where she teaches gerontology and geriatric medicine, as president-elect of the National Association for Geriatric Education, and as the founding medical director of UW's Project ECHO for geriatrics, which she will be talking about today. So, thank you very much, Dr. Bennett, for being here. I am looking forward to your testimony, and everyone's.

The CHAIRMAN. Thank you, Senator Murray. Finally, Ms. Tracy Watts, welcome. She is a partner in Mercer Human Resources Consulting's Washington, DC office. Mercer is a global consulting firm that works with clients in 130 markets around the world,

helping them continue to advance the health, wealth, and performance of their people.

Welcome again to all of our witnesses. Doctor—if you would each summarize your remarks in about five minutes, we will have time for conversations with the Senators after that. Dr. Umbehr.

STATEMENT OF JOSH UMBEHR, M.D., ATLAS MD, WICHITA, KS

Dr. UMBEHR. Good morning, Chairman Alexander, Ranking Member Murray, and distinguished Representatives of the HELP Committee.

As mentioned, my name is Dr. Josh Umbehr, a family physician from Wichita, Kansas, and we are striving to fix health care. We all fundamentally understand that health care is broken for reasons that we agree to, increased bureaucracy, paperwork requirements, reporting, things that raise the burden on physicians while also raising the cost of care and decreasing access for patients. Nobody is necessarily happy with this. Physicians, patients, employers, and even insurance companies are struggling to stand under this increasing weight. But I love the quote, the future is here, it is just not evenly distributed.

Direct primary care is a growing solution across the country, where patients are having that next level version of primary care that is 10X savings. The ability to pay a low monthly membership, based on age only—so no pre-existing conditions matter anymore, all patients are welcome—as low as $10 for kids, $50 for most adults, for again like Senator Roberts mentioned, unlimited home visits, work visits, office visits, telemedicine visits. We have no copays for anything in our office, and any procedure we can do is free of charge. An EKG costs me $0.36. The coffee in the waiting room costs $0.60 a cup. If I do not charge your insurance for the coffee, I probably do not need to charge for the EKG. This is the value we can present to the patient that justifies our membership, because now we are not going through a third party where costs are hidden behind a mountain of paperwork.

We can continue to add to that value proposition with unlimited, free stitching, free lung testing, bone testing, biopsies, joint injections, and basically any procedure a family physician can do in the office, for free in our office. Some physicians will choose to charge a small fee of $5 to cover their, cost of equipment and supplies. But we try to reach out, like Senator and Chairman mentioned, that even though primary care physicians salaries only make up a small portion of the health care spend, we touch almost everything. So, for us to be able to—for the time saved in doing insurance paperwork, we are able to reach out and provide value for our patients. We do this through wholesale medications and labs. Forty-four states allow physicians to dispense medications wholesale to their patients, and actually always have.

A lot of what we have done is not brand new. It is just a new way of using the pieces that have always been on the table. When we go direct to the wholesaler, we can get medications for up to 95 percent less. I can buy a thousand blood pressure pills for $4.90. I cannot buy a thousand rice for $4.90. Insurance is an excellent tool. I support the concept of insurance when used appropriately. Insurance is best managed as a tool for expensive and frequent ex-

penses. Car insurance, home insurance, life insurance all make sense. The way we are utilizing health insurances does not make sense. I think we put the cart before the horse here when we try to do health insurance reform, and unless we bend or break the cost curve of primary care, we will never be able to achieve our goal of more affordable health insurance.

By removing primary care office visits, procedures, copays, and the extension of what else we can do, we decrease the need for as much health insurance. I think often, to the detriment of the movement, we can get type-casted as anti-insurance or anti-government, and that could not be the case. We are pro-efficiency. We want these pieces to move better together so that the patients have the best of both worlds—affordable, accessible primary care, but affordable, meaningful health insurance that does not cost more than their mortgage. We can also go into, we have been able to get breast cancer chemotherapy for $6 a month when the patient was quoted $600 a month with her health insurance, not because we are special but because that is the wholesale price. So essentially, any physician in the system could be doing the same model on their own very easily.

We can extend that reach out into laboratory testing, which is again up to 95 percent cheaper. I can check your blood count for $1.50, your thyroid for $1.60, again see if you are diabetic for $2.25. If you are diabetic, I can treat it with a thousand metformin pills for $11. So, we have a way of getting great access to patients while also decreasing the cost, which often seems counterintuitive. Again, cash is king so this extends into further ancillary services. Thank you.

[The prepared statement of Dr. Umbehr follows:]

PREPARED STATEMENT OF JOSH UMBEHR

INTRODUCTION

Chairman Alexander, Ranking Member Murray, and distinguished members of the HELP committee, I am Josh Umbehr, MD, and I am a board-certified family physician from Wichita Kansas. I appreciate this opportunity to testify on the impact that direct primary care could have on the healthcare costs and outcomes for individuals, families, small businesses and Medicare/Medicaid recipients. Direct care is an insurance free model that makes the patient their primary focus aligns all other incentives for cost and quality care around that centerpiece. Often the focus is about health *insurance* when the primary focus should be on health *care*. We are in agreement that the system is broken and not meeting the needs of its constituents, but we believe that direct primary care is a free market solution which is a 10 X improvement over the status quo. Direct primary care can offer more care, more often, in more ways at a fraction of the cost is available to the masses. Health insurance is the second largest item on nearly every small business budget and is decreasing their ability to grow and be competitive. However common-sense reforms including direct primary care could significantly benefit all patients, physicians, employers and insurance companies.

PERSONAL BACKGROUND

I was born and raised in a small rural town, Alma Kansas, and my parents owned their own trash collection business. They taught us not to accept the status quo and he fought for his First Amendment rights resulting in a 7 – 2 victory at the SCOTUS (https://supreme.justia.com/cases/federal/us/518/668/). This taught us at a young age to challenge the status quo and look for opportunities to create our own path.

In 2001 as an undergraduate at Kansas State University, I worked for a surgeon as his biller encoder and saw the rampant inefficiencies of the insurance-based billing model. The surgeon would work for hours to be reimbursed a fraction of his value because of a broken and bureaucratic reimbursement model. I was encouraged to find physicians practicing outside of the insurance model and found many that were innovating solutions for their patients. Over the next 10 years I watched and learned as physicians explored how they could add more value to their patients without accepting the status quo of health insurance first, care later.

In 2010 along with my cofounder Dr. Doug Nunamaker, we opened Atlas MD Family Practice with the goal of making healthcare affordable for all of our patients. We understood that insurance is a tool that should be used for high risk, low frequency claims and but unnecessary for affordable and predictable primary care. The essential caveat is the ability to decrease the cost of care to the point that insurance is no longer essential for the majority of care. Direct primary care can offer unlimited visits, free telemedicine, no co-pays, free procedures in the office and discounts up to 95% on [wholesale] medications and labs.

We will continue to highly value the ability of health insurance to protect our patients from truly catastrophic risks and expenses but now we are able to utilize it correctly. Direct primary care can decrease the cost of health insurance premiums by 30 – 60% while maximizing access to high-quality care. Simple economics dictates that as the cost of health church goes down, the number of insured families will rise.

DIRECT PRIMARY CARE – How It Works

Memberships: $10-100 per patient per month for

- unlimited free home, work, office visits
- unlimited free telemedicine
- no co-pays ever
- all office-based procedures are included free of charge
  - *including: biopsies, dexa scans, EKGs, holter monitoring, ingrown toenail removal, IUD placements, IUD removals, joint injections, laceration repair, minor surgical procedures, osteopathic manipulations, spirometry, strep throat, trigger point injections, ultrasound, urinalysis… And more*
- wholesale medications for up to 95% savings
- wholesale laboratory testing for up to 95% savings
- pathology services discounted up to 80%
- radiology fees discounted up to 80%
  - *approximately $45 for x-rays, $100 for ultrasounds, $200 for CT scans, $400 for MRIs*
- free or low-cost specialist consultations with telemedicine services like www.rubiconmd.com or www.aristamd.com
- health insurance premiums that are 30 – 60% less for small businesses using partially self-funded models that are ACA compliant

For nearly 2 decades we have been students of other industries, continually learning reading and adapting from how other companies are transforming to provide value for their customers. When Kodak stopped innovating, they were replaced by Instagram. When Blockbuster stopped adapting, they were replaced by Netflix. Purchasing long-distance phone calls by the minute has been replaced by unlimited calls/text/emails.

The membership model of healthcare provides a commonsense solution to several friction points for the consumer. Patients do not know how much care they will need, when they will need it, but when they needed – they want it (now), and they wanted from someone they trust, but they are very worried about the price.

Due to the lack of transparency in the current healthcare model, and perverse incentives in pricing structure offered for the uninsured, out-of-network, and in network patients, the COST of care has become wholly disconnected from the Value of care.

Direct care aims to fix this by offering a previously unprecedented level of transparency and savings direct to the patient. This is possible without any federal or state legislation and is an option for essentially every physician.

The patient and/or their employer can predict with a high level of certainty what the majority of their care will consist of regardless of their pre-existing conditions or frequency of need.

MEMBERSHIPS & HEALTH INSURANCE

Often the direct care model is misunderstood to be anti-insurance or antigovernment which could not be further from the case. We are pro-efficiency.

We understand that for our patients to have lifelong security for both their health and their finances, insurance has a key and critical role to play. We believe that by streamlining 80% of the care provided to most patients, we can drastically decrease the cost of their health insurance while improving access and quality.

In true "hand in glove fashion" the more innovative and cost-effective direct primary care is, the more affordable and more valuable the health insurance becomes. If we can decrease the cost of health insurance by $500-800 per family per month, then we can fully fund the direct care memberships and still have approximately $380-680 per household per month. This level of savings, without sacrificing the level of access or protection, is life-changing for the average household. I believe it could result in an economic boom that would last a generation.

Since 2011 we have been able to work with third-party administrators (TPA) to help small businesses create ACA compatible health insurance plans that have been able to save 30 to 60% on their premiums. Direct care can offer a very broad value proposition (office visits, telemedicine, no co-pays, free procedures, wholesale medications and labs, decreased ER visits, decrease urgent care visits, decreased specialty referrals) which allows the insurance company to lower their premiums to the consumer while broadening access and protection from catastrophic health and financial concerns.

The graphic below demonstrates the amount that an insurance company paid for a small business with about 17 employees/families. Just decreasing the cost of copayments and medications alone could save 60% for businesses similar to this one. Factoring in laboratory savings, improved health, decreased employee absenteeism, this is a win-win scenario for the patient's, the employer, and the insurance company.

Agency Name: **Martin, William J**
Plan Year: **January 2015 through December 2015**

Claim Activity by Service Category

Plan Year To Date	Office Visits	Emergency Room	Outpatient Physician Services	Lab and Diagnostic	Outpatient Hospital	Inpatient Hospital	Prescription Drugs	Other Services	Totals
Claim Count:	89	0	5	1	9	0	86	1	191
Amount Billed:	9,968.13	0.00	11,112.00	5.14	22,550.97	0.00	11,737.13	30.00	55,403.37
Discounts:	3,595.00	0.00	8,236.38	0.00	13,929.31	0.00	5,853.57	0.00	31,614.26
Discount %:	36.1%	0.0%	74.1%	0.0%	61.8%	0.0%	49.9%	0.0%	57.1%
Amounts Not Covered:	55.21	0.00	0.00	0.00	0.00	0.00	55.51	0.00	110.72
Not Covered %:	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.5%	0.0%	0.2%
Member Paid Amount:	1,634.22	0.00	725.10	0.00	5,807.42	0.00	760.00	0.00	8,926.74
Member Paid %:	16.4%	0.0%	6.5%	0.0%	25.8%	0.0%	6.5%	0.0%	16.1%
Plan Paid Amount:	4,683.70	0.00	2,150.52	5.14	2,814.24	0.00	5,068.05	30.00	14,751.65
Plan Paid %:	47.0%	0.0%	19.4%	100.0%	12.5%	0.0%	43.2%	0.0%	26.6%
Average Claim Payment $:	52.63	0.00	430.10	5.14	312.69	0.00	58.93	0.00	77.23
Percent of Total Billed Dollars:	18.0%	0.0%	20.1%	0.0%	40.7%	0.0%	21.2%	0.1%	100.0%
Percent of Total Paid Dollars:	31.8%	0.0%	14.6%	0.0%	19.1%	0.0%	34.4%	0.2%	100.0%

QUESTIONS, CRITIQUES, CONCERNS

In the previous nine years I've had the benefit of speaking publicly to legislative bodies, medical schools, residencies, medical conferences, and countless media outlets. I respected this is a new model that many people have questions and concerns about as they learn how it could affect them and their loved ones. I think one of the most effective ways to address these concerns specific in a Q&A format.

1. Is Direct Care concierge medicine?
    a. No.
        i. Concierge medicine is generally understood to be several thousand dollars per patient per month and may often still build their health insurance in a "fee for noncovered service model"
        ii. Direct primary care is understood the affordable membership model for the masses and never bills health insurance for any services.
2. Is Direct Care just for rich healthy individuals?
    a. No.
        i. Rich and healthy people do not need affordable healthcare.
        ii. In my opinion this model provides the most value for those with the most need. The sicker you are the more medications and labs you need, the more you interact with that working healthcare system, the more life-changing the direct care model could be for you.
        iii. The single mother earning $10/hr at a call center on second shift NEEDS the access and affordability of a Direct Care clinic.
        iv. The patient that doesn't have a car and would have to catch a bus and make 3 connections NEEDs the accessibility of Direct Care with telemedicine.
3. Will Direct Care contribute to the physician shortage?
    a. No.
    b. The American Medical Association predicts that by 2030 there could be a shortage of 130,000 physicians.
        i. https://news.aamc.org/press-releases/article/workforce_report_shortage_04112018/
    c. Where's the American Academy of Family Physicians reports a study showing 22% of the physicians times spent on nonclinical work which is multiplied across the physician workforce would be the equivalent of 165,000 time physicians.
        i. https://www.aafp.org/news/practice-professional-issues/20121016merrittjobsat.html
    d. We have an efficiency issue not a quantitative issue. At his peak, Henry Ford was producing a model T every 24 seconds and I imagine this is because there was no wasted steps in the process. Physicians are burning out in record numbers because of the bureaucratic inefficiencies forced upon the current model.
        i. We can pay for patient care or paperwork but not both.
4. Will Direct Care work for rural communities?
    a. Yes.
    b. Direct primary care will support rural communities because it allows clinics to be profitable without thousands of patients who have desirable health insurance.
    c. The low cost of living and high probability of success will attract and maintain physicians to rural communities.
    d. Telemedicine will also further extend the reach of every physician in every specialty for every patient. Why ask a family with a child with down syndrome to drive a 2 ton vehicle three hours from their rule home to a specialist in the city if they can FaceTime their physician from the comfort of their home.
5. Does direct primary care support mental health?
    a. Yes.

b. I think mental health is a very interesting segment of healthcare considering how difficult we make it for them.
    i. According to www.healthsystemtracker.org - social phobia, avoidant personality disorder, generalized anxiety disorder and panic disorder makeup nearly 20% of all mental health diagnoses. Yet we require them to visit a doctor's office, during office hours, possibly wait a very long time for a very short visit, all while maintaining a stable job that will offer health insurance and reasonable co-pays. This is a system designed for failure by both the patient and the practitioner level.
        1. https://www.healthsystemtracker.org/chart-collection/current-costs-outcomes-related-mental-health-substance-abuse-disorders/#item-eighteen-percent-adults-united-states-mental-behavioral-emotional-disorder
    ii. Providing true quality mental health takes time and flexibility. The direct primary care model allows patients with mental health maximum flexibility to communicate with their doctor over time, by text messages or emails, in a way that is private, convenient, accessible, and useful.
c. Wholesale medications offer patients a level of privacy they may not currently receive if on an employer-sponsored health insurance plan. Employees may be concerned about scheduling multiple visits during office hours or having their medications reported back when (even anonymously) to their employer.
d. Telemedicine continues to be a solution here as well because the patient can find the healthcare provider that is the best fit for their unique needs, personality schedules and budgets with fewer geographic limitations

6. How does Direct Care make medications more affordable?
    a. There are a number of wholesale distributors like www.andameds.com, www.mckesson.com, or www.henryschein.com where physicians can order their medical supplies as well as pharmaceutical wholesale at drastically reduced costs.
        i. This is the same way that most pharmacies have purchased medications for decades.
    b. 44 states make it very easy for physicians to dispense medications, several others have restrictions from 7 – 30 day medication supplies.
    c. No additional federal legislation is necessary
    d. Patients are able to pick up medicine at the time of service and pay on the next invoice cycle
    e. See attachment for rx pricing
7. How does Direct Care make laboratory testing more affordable?
    a. The option for "client billing" is a standard option for most local / regional / national labs
        i. The physician is billed directly for all labs without any requirement for additional paperwork / coding processes
        ii. The physician guarantees payment in exchange for the lowest prices
    b. Represents a significant saving to the patient, employer, and insurance
    c. See attachment for laboratory pricing
8. How does Direct Care make radiology services more affordable?
    a. The option for "client billing" is less familiar in radiology service circles but with the proper education on the legality of the model, many providers are eager to compete to offer cost effective options.
9. How does Direct Care work with small businesses for more affordable insurance?

a. Direct care practices often work with smaller insurance companies / TPAs in combination with small businesses through partially self funded/ ERISA style plans.
b. These plans allow for maximum flexibility so the employer can create a custom plan that is as rich or as lean as their employees desire.
c. The value proposition of Direct Care allows the employer to need much less insurance to manage the risk of catastrophic care.

10. What do insurance companies think of Direct Care?
    a. The initially reaction is to assume that insurance companies would be against 'insurance free practices' like the direct care model.
    b. However, we work with them to show how we can help to manage their risk by providing a very broad value proposition, they are able to:
        i. Ensure patients have maximum access to care
        ii. Lower their premiums
        iii. Attract a larger share of the market
        iv. Decrease their own administrative burden
        v. While increasing their profit margins
11. How does Direct Care affect "Big Pharma"?
    a. For this question, I think its important to make a distinction between large pharmaceutical manufactures (name brand and/or generics) and big retail pharmacies
        i. Manufactures – selling medicines to the wholesaler is their standard business model, so little will change here.
            1. However, if households decrease their insurance premiums and pay the first $ for medications, name brand prices will come down to be competitive with generic options
        ii. Wholesalers – profit margins are higher selling to small groups of dispensing physicians than to large national pharmacy chains – thus direct care is sustainable and profitable for them
        iii. Retail Chain Pharmacies – the source of the large markups (up to 10,000%) and they will have to aggressively adapt to be competitive compared to the dispensing direct care clinic
12. But direct care can't get all medicines cheaper.
    a. Correct.
    b. Some medicines are simply expensive or new or valuable.
        i. The Hepatitis C medicine (Harvoni) is $95,000 for a *CURE* compared to the typical cost of *management* of $140,000/year
    c. HHS is working hard to approve a record number of generic medications which helps Direct Care practices find affordable alternatives for patients
13. But direct care can't treat big things like cancer.
    a. Yes we can treat some cancers.
        i. Medicine is broad and there's a very wide range of complexities for each type of diagnosis.
        ii. Skin cancers are often treated by primary care physicians with biopsies and pathology.
        iii. We can work closely with oncologists to help patients get more affordable medicine.

iv. We helped to save a patient with good commercial insurance 99% of the cost of breast cancer chemotherapy (an estrogen blocker) when the wholesale cost was about $6/mo

v. We helped a patient with a brain tumor who's insurance was going to be billed $26,000 for chemotherapy by finding the exact same medicine – wholesale – for $1900.

b. Often the most the physicians most value commodity is time – the time to look for affordable solutions for their patients.

14. Direct Care is nice – but it can't fix everything.
    a. Correct.
    b. Many patients will always have a need for specialist care, expensive care, expensive (often life saving) procedures. This is the *exact* proper role for insurance.
    c. We want to help provide affordable health CARE to the masses, so that they can feel safe purchasing *less* health insurance, which is more affordable, and more valuable for the big needs in life.
15. How does Direct Care help patients avoid surprise medical bills?
    a. Now the physician is the patients advocate – they are the trained professionals, with the right knowledge, at the right time, to help patients make the best decisions for themselves.
    b. The Direct Care patient expects the doctor to be knowledge about prices and upfront and informative about the cost of services. Otherwise, they'll vote with their feet and go to a Direct Care practice that is more helpful.
    c. The Direct Care practices are working on a regular basis to find the best services at the best prices – so they have their thumb on the pulse of the community – and always have their patients interest in focus.
16. How do you address the concern that cheap care is low quality care?
    a. Direct Care practices spend a great deal of time directly communicating with their patients about the healthcare choices. Often I find that good information, presented in a clear format, helps patients to make very well informed decisions – Especially when they are spending their own dollars first.
    b. The moral hazard is when patients are spending someone else's money and make decisions that are inconsistent with how they'd spend their own dollars
    c. Example: Name Brand Lexapro is $11.97/pill. Generic Lexapro is $0.04/pill. Which would you prefer?
    d.

LEXAPRO 20MG NDC: 00456202001 Item: 310207	TABLET OFF WHT RND FC B AB	ALLERGAN	100	$1,197.27	$11.9727

    e.

BEST PRICE ESCITALOPRAM 20MG NDC: 16729017017 Item: 323400	TABLET WHT/OFF WHT AB	ACCORD	1000	$44.41	$0.0444

        i. The decision becomes pretty easy for patients

f. Direct Care doctors aren't spending 50% of their day doing non clinical paperwork, insurance charting, coding, prior authos – so they can focus on helping the patients with complex medical decisions.

17. If Direct Care places such an emphasize on generic drugs, are they lower quality?
    a. No.
    b. Link below to the FDA's website regarding the generic vs name brand and their relative equivalency.
        i. https://www.fda.gov/drugs/resourcesforyou/consumers/buyingusingmedicinesafely/genericdrugs/ucm167991.htm
            1. A generic drug is a medication created to be the same as an existing approved brand-name drug in dosage form, safety, strength, route of administration, quality, and performance characteristics.
18. Direct Care may be affective for family medicine – but what about other specialties?
    a. An insurance free model is a spectrum from infrequent care (fee for service model) to more chronic care (membership model).
        i. Pathology, radiology and surgical services would continue to work well in a fee for service model
        ii. Dermatology may be mostly fee for service but could have 20% memberships for chronic care.
        iii. Cardiology might be able to offer fee for service visits for certain diagnosis / acute needs – but have a large % of patients on a membership model for their chronic care needs.
        iv. And any chronic care specialty will continue the membership model
19. Have the membership models been used in healthcare before?
    a. Yes.
    b. Professor Christy Ford Chapin, Ph.D – in her book, Ensuring America's Health (The public creation of the corporate health care system), she details the history of "pre-paid' medical clinics in the 20's and 30's before the adoption of employer sponsored health insurance.
    c. http://www.econtalk.org/christy-ford-chapin-on-the-evolution-of-the-american-health-care-system/
20. What regulatory actions can help maximize the growth / adoption of Direct Care models?
    a. We are believers in free markets and the movement is primarily looking for support from employers, state and federal officials.
    b. However, we are looking for legislative or administrative clarity on the HRA, HSA issue for DPC.
        i. Currently it is unclear what the if membership fees are an approved HSA 213(d) expense and that is preventing larger employers from embracing the DPC model.
        ii. IRS 213(d) clearly lists that physicians are approved HSA expense – with no mention of method of payment. The HSA bill was signed in 2003 and although Direct Care memberships were NOT yet widespread – cash for services to many of the medical providers were common place.
            1. Legal fees are an HSA approved expense and lawyers often work on retainer (functionally identical to a membership)
        iii. IRS 502 also makes it very clear that physician services are approved HSA expenses with no mention of method of payment.
            1. Quote: Medical expenses are the costs of diagnosis, cure, mitigation, treatment, or prevention of disease, and for the purpose of affecting any

part or function of the body. These expenses include payments for legal medical services rendered by physicians, surgeons, dentists, and other medical practitioners. They include the costs of equip-ment, supplies, and diagnostic devices needed for these purposes.

c. Clarity on this issue would be a great benefit to the Direct Care Movement.

21. Can Direct Care work for Medicare?
    a. Yes.
    b. Medicare patients can struggle to find physicians accepting new patients in part b/c of the reimbursement issues and the regulatory burden of MACRA, MIPS and the next alphabet soup of documentation requirements.
    c. Medicare patients can expect to pay $7-12k out of pocket for health care depending on their overall health.
        i. https://www.fool.com/retirement/2017/02/05/heres-the-average-americans-annual-medicare-bill.aspx
        ii. This price could be substantially decreased through DPC innovation, unlimited visits, preventive care, administrative efficiencies and more.
    d. Medicare doesn't cover all out patient medicines – one in particular can cost a Medicare patient $66 PER pill at the pharmacy – that Direct Care can get wholesale for $0.15 PER pill.
22. Can Direct Care work for Medicaid?
    a. Yes.
    b. The same cost savings approaches mentioned previously continue to apply to this at risk population – likely even more so.
        i. Although most states would like to cover more patients, most states don't have the budget flexibility to do so. But the direct care value proposition of unlimited visits, no copays, free procedures, wholesale meds/labs for up to 95% savings, decreased ER/UC visits…could VERY conservatively double the purchasing power of the current state budgets. Effectively caring for more people, more often, with the same or fewer resources.
    c. Block Grants – at the federal level there is talk about block granting funds to the states b/c the federal stake holders are seeing that the beurcartic strings are more problematic than they are worth. If this holds true from the federal level, then I presume it holds true from the state to the patient/provider level.
        i. Food stamps are an excellent example of an effective government program that provides funds directly to individuals and allows them to participate freely in the marketplace.
            1. The medical equivalent of food stamps would be piles of paperwork and regulation on expiration dates for milk, calorie counts for cereal boxes, and ICD-10 for produce.
            2. https://fee.org/articles/imagine-if-we-paid-for-food-like-we-do-healthcare/
        ii. Food stamps are the block grant equivalent for at risk individuals to have. I believe Direct Care could function in an equivalent manner for medicine.
23. Are there any pre-existing conditions that can affect membership?
    a. No.
    b. Direct care memberships are most frequently based on age only and not on any pre-existing conditions. We know that some patients might utilize more care based on their diagnoses

than others, but we want to create a system that does not discriminate against patients based on their health.

CONCLUSION

Thank you for the opportunity to testify about how the emerging model of direct primary care/direct care can create a very high value/low cost model for our patients. We strive to create a system where all the incentives are really aligned around the individual patient resulting in maximum transparency and value. Pandora's box of affordable care has been opened and I believe direct primary care has the potential to revolutionize how we deliver healthcare in America. The only way to fix our health insurance system is by first fixing the delivery of healthcare.

I look forward to your questions and to a continuing dialogue on regulatory and legislative changes that can help grow direct primary care into a national solution.

Respectfully submitted,

Josh Umbehr, MD

PRESCRIPTIONS – PRICE LOW TO HIGH

Name	Price
HYDROCHLOROTHIAZIDE 25mg/1	$ 0.006
Ferrous Sulfate (Ferrous) 325mg	$ 0.008
LISINOPRIL 2.5mg/1	$ 0.009
LISINOPRIL 5mg/1	$ 0.009
ACETAMINOPHEN 500mg/1	$ 0.010
FOLIC ACID 1mg/1	$ 0.010
AMLODIPINE BESYLATE 2.5mg/1	$ 0.011
AMLODIPINE BESYLATE 2.5mg/1	$ 0.011
Supplement 20	$ 1.000
AMLODIPINE BESYLATE 5mg/1	$ 0.012
LISINOPRIL 10mg/1	$ 0.012
Metformin HCl 500mg/1	$ 0.013
SIMVASTATIN 10mg/1	$ 0.013
AMLODIPINE BESYLATE 10mg/1	$ 0.014
Diphenhydramine HCL 25mg/1	$ 0.014
Diphenhydramine HCL 25mg/1	$ 0.014
MELOXICAM 7.5mg/1	$ 0.014
AMLODIPINE BESYLATE 10mg/1	$ 0.017
Ecotrin (Aspirin EC) 81mg/1	$ 0.017
LISINOPRIL 20mg/1	$ 0.017
LISINOPRIL 20mg/1	$ 0.017
CYCLOBENZAPRINE HYDROCHLORIDE 10mg/1	$ 0.018
FLUOXETINE HYDROCHLORIDE 20mg/1	$ 0.018
MELOXICAM 15mg/1	$ 0.018
MELOXICAM 15mg/1	$ 0.018
CITALOPRAM HYDROBROMIDE 10mg/1	$ 0.019
TOPIRAMATE 25mg/1	$ 0.019
CARVEDILOL 6.25mg/1	$ 0.020

CYCLOBENZAPRINE HYDROCHLORIDE 10mg/1	$ 0.020
LISINOPRIL; HYDROCHLOROTHIAZIDE 10mg/1; 12.5mg/1	$ 0.020
METFORMIN HYDROCHLORIDE 1000mg/1	$ 0.020
CITALOPRAM HYDROBROMIDE 20mg/1	$ 0.021
METFORMIN HYDROCHLORIDE 850mg/1	$ 0.021
CITALOPRAM HYDROBROMIDE 20mg/1	$ 0.022
FLUOXETINE HYDROCHLORIDE 10mg/1	$ 0.022
Glucometer	$ 0.022
Glucose Meter	$ 0.022
Meclizine 25mg	$ 0.022
CARVEDILOL 25mg/1	$ 0.023
GLIPIZIDE 5mg/1	$ 0.023
LOSARTAN POTASSIUM 25mg/1	$ 0.023
METOPROLOL TARTRATE 100mg/1	$ 0.023
METOPROLOL TARTRATE 100mg/1	$ 0.023
METOPROLOL TARTRATE 25mg/1	$ 0.023
METOPROLOL TARTRATE 50mg/1	$ 0.023
METOPROLOL TARTRATE 50mg/1	$ 0.023
CITALOPRAM HYDROBROMIDE 20mg/1	$ 0.024
GABAPENTIN 100mg/1	$ 0.025
LAMOTRIGINE 25mg/1	$ 0.025
CLONIDINE HYDROCHLORIDE 0.2mg/1	$ 0.028
Iron 65 mg	$ 0.028
CLONIDINE HYDROCHLORIDE 0.2mg/1	$ 0.029
LISINOPRIL; HYDROCHLOROTHIAZIDE 20mg/1; 12.5mg/1	$ 0.029
LOSARTAN POTASSIUM 50mg/1	$ 0.029
CITALOPRAM HYDROBROMIDE 40mg/1	$ 0.030
CITALOPRAM HYDROBROMIDE 40mg/1	$ 0.030
HYDROCHLOROTHIAZIDE 12.5mg/1	$ 0.030
LISINOPRIL 40mg/1	$ 0.030
FAMOTIDINE 20mg/1	$ 0.031
FUROSEMIDE 40mg/1	$ 0.031
Vitamin D3 5000 IU	$ 0.031
CLONIDINE HYDROCHLORIDE 0.3mg/1	$ 0.032
GLIPIZIDE 10mg/1	$ 0.032
GLIPIZIDE 10mg/1	$ 0.032
OMEPRAZOLE 20mg/1	$ 0.032
OMEPRAZOLE 20mg/1	$ 0.032
FUROSEMIDE 20mg/1	$ 0.033
GLIPIZIDE 10mg/1	$ 0.033
HYDROCHLOROTHIAZIDE; LISINOPRIL 25mg/1; 20mg/1	$ 0.033
Pain Reliever Plus (ACETAMINOPHEN; ASPIRIN; CAFFEINE) 250mg/1; 250mg/1; 65mg/1	$ 0.033
RANITIDINE HYDROCHLORIDE 15mg/mL - 473 mL in 1 BOTTLE, PLASTIC (54838-550-80)	$ 0.033
CLONIDINE HYDROCHLORIDE 0.1mg/1	$ 0.035
METOCLOPRAMIDE HYDROCHLORIDE 10mg/1	$ 0.035
PANTOPRAZOLE SODIUM 20mg/1	$ 0.036
RISPERIDONE 1mg/1	$ 0.036
METOPROLOL TARTRATE 100mg/1	$ 0.037
TOPIRAMATE 50mg/1	$ 0.037
TRAZODONE HYDROCHLORIDE 50mg/1	$ 0.037
ATORVASTATIN CALCIUM 10mg/1	$ 0.039
CETIRIZINE HYDROCHLORIDE 10mg/1	$ 0.039
ESCITALOPRAM OXALATE 10mg/1	$ 0.039
SIMVASTATIN 10mg/1	$ 0.039
MONTELUKAST SODIUM 10mg/1	$ 0.040
METFORMIN HYDROCHLORIDE 500mg/1	$ 0.041
SIMVASTATIN 20mg/1	$ 0.041
SIMVASTATIN 20mg/1	$ 0.041
LISINOPRIL 30mg/1	$ 0.042
QUETIAPINE FUMARATE 50mg/1	$ 0.042
DONEPEZIL HYDROCHLORIDE 5mg/1	$ 0.043
TOPIRAMATE 100mg/1	$ 0.043
LORATADINE 10mg/1	$ 0.044

LORATADINE 10mg/1	$ 0.044
PROMETHAZINE HYDROCHLORIDE 25mg/1	$ 0.044
METFORMIN HYDROCHLORIDE ER 500mg/1	$ 0.045
OMEPRAZOLE 40mg/1	$ 0.045
OMEPRAZOLE 40mg/1	$ 0.045
PRAVASTATIN SODIUM 40mg/1	$ 0.045
VERAPAMIL HYDROCHLORIDE 80mg/1	$ 0.045
CETIRIZINE HYDROCHLORIDE 10mg/1	$ 0.046
SERTRALINE HYDROCHLORIDE 100mg/1	$ 0.046
SERTRALINE HYDROCHLORIDE 100mg/1	$ 0.046
PANTOPRAZOLE SODIUM 20mg/1	$ 0.047
PRAMIPEXOLE DIHYDROCHLORIDE 0.5mg/1	$ 0.047
PRAMIPEXOLE DIHYDROCHLORIDE 0.5mg/1	$ 0.047
ESCITALOPRAM OXALATE 20mg/1	$ 0.048
ESCITALOPRAM OXALATE 5mg/1	$ 0.048
ESCITALOPRAM OXALATE 5mg/1	$ 0.048
GABAPENTIN 300mg/1	$ 0.048
GABAPENTIN 300mg/1	$ 0.048
LOSARTAN POTASSIUM 100mg/1	$ 0.048
LOSARTAN POTASSIUM 100mg/1	$ 0.048
RANITIDINE HYDROCHLORIDE 150mg/1	$ 0.048
SERTRALINE HYDROCHLORIDE 25mg/1	$ 0.048
SIMVASTATIN 20mg/1	$ 0.048
ZOLPIDEM TARTRATE 10mg/1	$ 0.048
PROMETHAZINE HYDROCHLORIDE 25mg/1	$ 0.050
QUETIAPINE FUMARATE 100mg/1	$ 0.050
GABAPENTIN 300mg/1	$ 0.051
LOVASTATIN 20mg/1	$ 0.051
PROMETHAZINE HYDROCHLORIDE 25mg/1	$ 0.051
QUETIAPINE FUMARATE 50mg/1	$ 0.051
Calcium & Magnesium	$ 0.052
ROPINIROLE HYDROCHLORIDE 0.25mg/1	$ 0.053
ATENOLOL 25mg/1	$ 0.054
CLONIDINE HYDROCHLORIDE 0.3mg/1	$ 0.054
IBUPROFEN 600mg/1	$ 0.054
PANTOPRAZOLE SODIUM 40mg/1	$ 0.054
HYDROXYZINE HYDROCHLORIDE 25mg/1	$ 0.055
PAROXETINE HYDROCHLORIDE HEMIHYDRATE 20mg/1	$ 0.056
AMOXICILLIN 500mg/1	$ 0.057
SULFAMETHOXAZOLE; TRIMETHOPRIM 800mg/1; 160mg/1	$ 0.057
AMOXICILLIN 500mg/1	$ 0.058
SIMVASTATIN 40mg/1	$ 0.058
SULFAMETHOXAZOLE; TRIMETHOPRIM 800mg/1; 160mg/1	$ 0.058
LOSARTAN POTASSIUM 100mg/1	$ 0.061
ONDANSETRON HYDROCHLORIDE 4mg/1	$ 0.061
SERTRALINE HYDROCHLORIDE 50mg/1	$ 0.061
TOPIRAMATE 100mg/1	$ 0.061
DICLOFENAC SODIUM 75mg/1	$ 0.062
TRAZODONE HYDROCHLORIDE 100mg/1	$ 0.062
ACYCLOVIR 400mg/1	$ 0.064
ACYCLOVIR 400mg/1	$ 0.064
IBUPROFEN 800mg/1	$ 0.064
LOVASTATIN 40mg/1	$ 0.064
ATENOLOL 50mg/1	$ 0.065
FUROSEMIDE 80mg/1	$ 0.065
SIMVASTATIN 40mg/1	$ 0.065
RISPERIDONE 2mg/1	$ 0.066
ATORVASTATIN CALCIUM 20mg/1	$ 0.067
MIRTAZAPINE 15mg/1	$ 0.067
BENAZEPRIL HYDROCHLORIDE 20mg/1	$ 0.068
LAMOTRIGINE 150mg/1	$ 0.070
NORTRIPTYLINE HYDROCHLORIDE 10mg/1	$ 0.070
NORTRIPTYLINE HYDROCHLORIDE 10mg/1	$ 0.070
CLOPIDOGREL BISULFATE 75mg/1	$ 0.072

ONDANSETRON HYDROCHLORIDE 4mg/1	$ 0.072
NAPROXEN 500mg/1	$ 0.073
GABAPENTIN 600mg/1	$ 0.074
INDOMETHACIN 25mg/1	$ 0.074
LAMOTRIGINE 150mg/1	$ 0.074
GABAPENTIN 400mg/1	$ 0.075
NAPROXEN 500mg/1	$ 0.075
FLUOXETINE HYDROCHLORIDE 40mg/1	$ 0.076
LOSARTAN POTASSIUM; HYDROCHLOROTHIAZIDE 100mg/1; 12.5mg/1	$ 0.076
TAMSULOSIN HYDROCHLORIDE 0.4mg/1	$ 0.076
DIVALPROEX SODIUM 250mg/1	$ 0.077
LOSARTAN POTASSIUM; HYDROCHLOROTHIAZIDE 100mg/1; 12.5mg/1	$ 0.078
CLOPIDOGREL BISULFATE 75mg/1	$ 0.080
DIVALPROEX SODIUM 250mg/1	$ 0.081
Biotin	$ 0.083
BUPROPION HYDROCHLORIDE 150mg/1	$ 0.083
TIZANIDINE HYDROCHLORIDE 2mg/1	$ 0.083
CLINDAMYCIN HYDROCHLORIDE 150mg/1	$ 0.084
CLINDAMYCIN HYDROCHLORIDE 150mg/1	$ 0.084
DICLOFENAC SODIUM 75mg/1	$ 0.084
GLIMEPIRIDE 4mg/1	$ 0.084
PRAVASTATIN SODIUM 20mg/1	$ 0.084
SPIRONOLACTONE 25mg/1	$ 0.084
METHIMAZOLE 5mg/1	$ 0.086
GLIMEPIRIDE 4mg/1	$ 0.088
TRIAMTERENE; HYDROCHLOROTHIAZIDE 37.5mg/1; 25mg/1	$ 0.088
CEPHALEXIN 500mg/1	$ 0.089
DICLOFENAC SODIUM 50mg/1	$ 0.090
DICLOFENAC SODIUM 50mg/1	$ 0.090
BENAZEPRIL HYDROCHLORIDE 40mg/1	$ 0.091
LOSARTAN POTASSIUM; HYDROCHLOROTHIAZIDE 100mg/1; 25mg/1	$ 0.091
DICLOFENAC SODIUM 50mg/1	$ 0.094
PIOGLITAZONEHYDROCHLORIDE 15mg/1	$ 0.094
TAMSULOSIN HYDROCHLORIDE 0.4mg/1	$ 0.094
TIZANIDINE HYDROCHLORIDE 4mg/1	$ 0.095
LAMOTRIGINE 200mg/1	$ 0.096
NORTRIPTYLINE HYDROCHLORIDE 25mg/1	$ 0.097
PROPRANOLOL HYDROCHLORIDE 10mg/1	$ 0.097
ISOSORBIDE MONONITRATE 30mg/1	$ 0.099
BUSPIRONE HYDROCHLORIDE 15mg/1	$ 0.100
OLANZAPINE 10mg/1	$ 0.101
ATENOLOL 50mg/1	$ 0.102
ESTRADIOL 0.5mg/1	$ 0.103
WARFARIN SODIUM 1mg/1	$ 0.103
WARFARIN SODIUM 5mg/1	$ 0.105
VENLAFAXINE HYDROCHLORIDE 37.5mg/1	$ 0.106
MEDROXYPROGESTERONE ACETATE 5mg/1	$ 0.110
PIOGLITAZONEHYDROCHLORIDE 30mg/1	$ 0.110
VENLAFAXINE HYDROCHLORIDE 75mg/1	$ 0.110
ATENOLOL 50mg/1	$ 0.113
SULFAMETHOXAZOLE; TRIMETHOPRIM 400mg/1; 80mg/1	$ 0.113
GLIPIZIDE 2.5mg/1	$ 0.116
AMIODARONE HYDROCHLORIDE 200mg/1	$ 0.117
ATORVASTATIN CALCIUM TRIHYDRATE 40mg/1	$ 0.117
ATORVASTATIN CALCIUM TRIHYDRATE 80MG/1	$ 0.117
LEVOCETIRIZINE DIHYDROCHLORIDE 5mg/1	$ 0.117
ATORVASTATIN CALCIUM 40mg/1	$ 0.119
ESTRADIOL 1mg/1	$ 0.119

ESTRADIOL 1mg/1	$ 0.119
MONTELUKAST SODIUM 5mg/1	$ 0.120
ACYCLOVIR 800mg/1	$ 0.121
GLYBURIDE 5mg/1	$ 0.121
PREDNISONE 20mg/1	$ 0.122
TIZANIDINE HYDROCHLORIDE 2mg/1	$ 0.122
NORTRIPTYLINE HYDROCHLORIDE 50mg/1	$ 0.125
NORTRIPTYLINE HYDROCHLORIDE 50mg/1	$ 0.125
ALLOPURINOL 100mg/1	$ 0.127
METHOCARBAMOL 750mg/1	$ 0.129
CARBIDOPA; LEVODOPA 25mg/1; 100mg/1	$ 0.130
BACLOFEN 20mg/1	$ 0.131
TRIAMTERENE; HYDROCHLOROTHIAZIDE 75mg/1; 50mg/1	$ 0.131
FINASTERIDE 5mg/1	$ 0.132
GLIMEPIRIDE 4mg/1	$ 0.134
GUANFACINE HYDROCHLORIDE 2mg/1	$ 0.134
GUANFACINE HYDROCHLORIDE 2mg/1	$ 0.134
METOPROLOL SUCCINATE 25mg/1	$ 0.134
MONTELUKAST SODIUM 4mg/1	$ 0.134
OXCARBAZEPINE 300mg/1	$ 0.135
TERBINAFINE HYDROCHLORIDE 250mg/1	$ 0.135
VERAPAMIL HYDROCHLORIDE 40mg/1	$ 0.139
VERAPAMIL HYDROCHLORIDE 40mg/1	$ 0.139
GEMFIBROZIL 600mg/1	$ 0.140
AMIODARONE HYDROCHLORIDE 200mg/1	$ 0.141
BENZONATATE 200mg/1	$ 0.141
BENZONATATE 200mg/1	$ 0.141
VENLAFAXINE HYDROCHLORIDE 37.5mg/1	$ 0.143
LANSOPRAZOLE 30mg/1	$ 0.145
VENLAFAXINE HYDROCHLORIDE 150mg/1	$ 0.145
GEMFIBROZIL 600mg/1	$ 0.147
DULOXETINE HYDROCHLORIDE 30mg/1	$ 0.151
ROSUVASTATIN CALCIUM 10mg/1	$ 0.152
DULOXETINE HYDROCHLORIDE 60mg/1	$ 0.154
PROPRANOLOL HYDROCHLORIDE 20mg/1	$ 0.160
PROPRANOLOL HYDROCHLORIDE 20mg/1	$ 0.160
SILDENAFIL CITRATE 20mg/1	$ 0.160
NIFEDIPINE 30mg/1	$ 0.163
ROSUVASTATIN CALCIUM 40mg/1	$ 0.165
SILDENAFIL CITRATE 20mg/1	$ 0.169
POTASSIUM CHLORIDE 10meq	$ 0.176
CIPROFLOXACIN HYDROCHLORIDE 250mg/1	$ 0.177
BACLOFEN 20mg/1	$ 0.179
POTASSIUM CHLORIDE 20meq	$ 0.189
Fexofenadine HCl 180mg/1	$ 0.190
Fexofenadine HCl 180mg/1	$ 0.190
DICYCLOMINE HYDROCHLORIDE 20mg/1	$ 0.191
DILTIAZEM HYDROCHLORIDE 60mg/1	$ 0.193
FINASTERIDE 1mg/1	$ 0.194
FLECAINIDE ACETATE 100mg/1	$ 0.195
VITAMIN D (ERGOCALCIFEROL) 1.251/1	$ 0.195
Fluoride 0.25	$ 0.198
NIFEDIPINE 60mg/1	$ 0.198
PROPRANOLOL HYDROCHLORIDE 40mg/1	$ 0.199
ONDANSETRON HYDROCHLORIDE 8mg/1	$ 0.202
Doxycycline Monohydrate (DOXYCYCLINE) 50mg/1	$ 0.205
FENOFIBRATE 54mg/1	$ 0.205
DILTIAZEM HYDROCHLORIDE 60mg/1	$ 0.206
CELECOXIB 200mg/1	$ 0.216
OXYBUTYNIN CHLORIDE 5mg/1	$ 0.216
MINOCYCLINE HYDROCHLORIDE 50mg/1	$ 0.219
CHLORZOXAZONE 500mg/1	$ 0.220
Multi Vitamin	$ 0.240

BACLOFEN 20mg/1	$ 0.223
ALLOPURINOL 300mg/1	$ 0.227
METRONIDAZOLE 500mg/1	$ 0.235
DOXYCYCLINE HYCLATE 100mg/1	$ 0.237
BUPROPION HYDROCHLORIDE 150mg/1	$ 0.241
DIVALPROEX SODIUM 500mg/1	$ 0.248
VALACYCLOVIR HYDROCHLORIDE 500mg/1	$ 0.248
BUPROPION HYDROCHLORIDE 300mg/1	$ 0.255
SUCRALFATE 1g/1	$ 0.265
DULOXETINE HYDROCHLORIDE 60mg/1	$ 0.271
CELECOXIB 200mg/1	$ 0.274
DILTIAZEM HYDROCHLORIDE 180mg/1	$ 0.275
AMOXICILLIN; CLAVULANATE POTASSIUM 875mg/1; 125mg/1	$ 0.281
DILTIAZEM HYDROCHLORIDE 180mg/1	$ 0.290
AMOXICILLIN; CLAVULANATE POTASSIUM 875mg/1; 125mg/1	$ 0.298
PHENYTOIN SODIUM 100mg/1	$ 0.298
L-Carnitine 500MG	$ 0.301
DILTIAZEM HYDROCHLORIDE 120mg/1	$ 0.305
Spironolactone 100mg/1	$ 0.315
METRONIDAZOLE 500mg/1	$ 0.316
ONDANSETRON 4mg/1	$ 0.317
ORPHENADRINE CITRATE 100mg/1	$ 0.325
ARIPIPRAZOLE 5mg/1	$ 0.331
ARIPIPRAZOLE 15mg/1	$ 0.336
HYDROCHLOROTHIAZIDE; BISOPROLOL FUMARATE 6.25mg/1; 5mg/1	$ 0.336
AMOXICILLIN; CLAVULANATE POTASSIUM 500mg/1; 125mg/1	$ 0.360
AMOXICILLIN; CLAVULANATE POTASSIUM 500mg/1; 125mg/1	$ 0.361
AZITHROMYCIN ANHYDROUS 250mg/1	$ 0.376
AMOXICILLIN; CLAVULANATE POTASSIUM 875mg/1; 125mg/1	$ 0.410
DILTIAZEM HYDROCHLORIDE 360mg/1	$ 0.450
nitrofurantoin macrocrystals 50mg/1	$ 0.464
VALACYCLOVIR HYDROCHLORIDE 1000mg/1	$ 0.505
MINOCYCLINE HYDROCHLORIDE 100mg/1	$ 0.536
ONDANSETRON HYDROCHLORIDE 2mg/mL - 25 VIAL, SINGLE-DOSE in 1 CARTON (0409-4755-03) > 2 mL in 1 VIAL, SINGLE-DOSE (0409-4755-18)	$ 0.539
FLUVOXAMINE MALEATE 100mg/1	$ 0.644
BISOPROLOL FUMARATE 5mg/1	$ 0.723
METHOTREXATE SODIUM 2.5mg/1	$ 0.770
Nitrofurantoin (monohydrate/macrocrystals) 75mg/1; 25mg/1	$ 0.793
Scar Gel	$ 0.924
HYDROXOCOBALAMIN ACETATE 1000ug/mL - 1 VIAL, MULTI-DOSE in 1 CARTON (0591-2888-30) > 30 mL in 1 VIAL, MULTI-DOSE	$ 0.950
HYDROXOCOBALAMIN ACETATE 1000ug/mL - 1 VIAL, MULTI-DOSE in 1 CARTON (0591-2888-30) > 30 mL in 1 VIAL, MULTI-DOSE	$ 0.950
HYDROXOCOBALAMIN ACETATE 1000ug/mL - 1 VIAL, MULTI-DOSE in 1 CARTON (0591-2888-30) > 30 mL in 1 VIAL, MULTI-DOSE	$ 0.950
MIDODRINE HYDROCHLORIDE 10mg/1	$ 0.959
DIPHENHYDRAMINE HYDROCHLORIDE 50mg/mL	$ 0.979
AZITHROMYCIN MONOHYDRATE 250mg/1	$ 1.120
FLUCONAZOLE 150mg/1	$ 1.152
CELECOXIB 400mg/1	$ 1.213
IV Administration Set	$ 1.221
PROMETHAZINE HYDROCHLORIDE 25mg/mL	$ 1.388
Nebulizer	$ 1.540
CEFTRIAXONE SODIUM 250mg/1 - 10 VIAL, SINGLE-USE in 1 CARTON (0409-7337-01) > 1 INJECTION, POWDER, FOR SOLUTION in 1 VIAL, SINGLE-USE (0409-7337-11)	$ 1.601

AMOXICILLIN 250mg/5mL - 100 mL in 1 BOTTLE (0143-9889-01)	$ 1.672
ALBUTEROL SULFATE 2.5mg/3mL - 25 VIAL in 1 CARTON (0591-3797-83) > 3 mL in 1 VIAL	$ 2.200
KETOROLAC TROMETHAMINE 60mg/2mL - 25 VIAL, SINGLE-DOSE in 1 TRAY (0409-3796-01) > 2 mL in 1 VIAL, SINGLE-DOSE (0409-3796-19)	$ 2.408
Antifungal (MICONAZOLE NITRATE) 20mg/g - 1 TUBE in 1 CARTON (0472-0735-56) > 28 g in 1 TUBE	$ 2.508
IPRATROPIUM BROMIDE 0.5mg/2.5mL - 1 POUCH in 1 CARTON (0591-3798-83) > 25 VIAL in 1 POUCH > 2.5 mL in 1 VIAL	$ 2.750
UDS	$ 15.000
UDS - UScreen	$ 15.000
SODIUM CHLORIDE 0.9g/100mL - 12 CONTAINER in 1 CASE (0264-7800-09) > 1000 mL in 1 CONTAINER	$ 2.794
Nebulizer mask w/tube child	$ 2.926
Pediatric Micro Mist Nebulizer	$ 2.926
CETIRIZINE HYDROCHLORIDE 5mg/5mL - 120 mL in 1 CARTON (54838-552-40)	$ 3.047
AMOXICILLIN 400mg/5mL - 100 mL in 1 BOTTLE (0143-9887-01)	$ 3.289
AMOXICILLIN 400mg/5mL - 100 mL in 1 BOTTLE (0143-9887-01)	$ 3.344
T Adapter Kit Nebulizer	$ 3.641
MUPIROCIN 20mg/g - 1 TUBE in 1 CARTON (51672-1312-0) > 22 g in 1 TUBE	$ 4.246
Norgestimate and Ethinyl Estradiol	$ 4.391
TOBRAMYCIN 3mg/mL - 1 BOTTLE in 1 CARTON (70069-131-01) > 5 mL in 1 BOTTLE	$ 4.433
In House Testosterone	$ 4.462
TRIAMCINOLONE ACETONIDE 1mg/g - 1 TUBE in 1 CARTON (45802-055-36) > 80 g in 1 TUBE	$ 4.466
SUMATRIPTAN SUCCINATE 100mg/1	$ 4.950
IPRATROPIUM BROMIDE 0.5mg/2.5mL - 1 POUCH in 1 CARTON (0591-3798-30) > 30 VIAL in 1 POUCH > 2.5 mL in 1 VIAL	$ 5.247
TOBRAMYCIN 3mg/mL - 1 BOTTLE in 1 CARTON (70069-131-01) > 5 mL in 1 BOTTLE	$ 5.660
Norgestimate and Ethinyl Estradiol	$ 5.687
SUMATRIPTAN SUCCINATE 50mg/1	$ 5.720
SUMATRIPTAN SUCCINATE 50mg/1	$ 5.742
FLUTICASONE PROPIONATE 50ug/1	$ 6.017
ALENDRONATE SODIUM 70mg/1	$ 6.039
Norgestimate and Ethinyl Estradiol	$ 6.229
Sprintec (Norgestimate and Ethinyl Estradiol)	$ 6.355
Elastic Wrist-Left Larg	$ 6.413
Splint - Elastic Wrist, Left, Large	$ 6.413
wrist elastic left large	$ 6.413
wrist elastic right medium	$ 6.413
TRI-LO-MARZIA (norgestimate and ethinyl estradiol)	$ 6.424
Ear Irrigation Basin	$ 6.644
Junel 21 Day 1mg/1; 20ug/1	$ 7.637
Junel 21 Day 1mg/1; 20ug/1	$ 7.637
Blood drawing kit	$ 8.151
Blood drawing kit	$ 8.151
Junel Fe 28 Day	$ 8.269
Junel Fe 28 Day	$ 8.269
ANTISEPTIC SKIN CLEANSER (CHLORHEXIDINE GLUCONATE) 4g/100mL - 437 mL in 1 BOTTLE, PLASTIC (0116-1061-16)	$ 8.437
Good Sense Cough DM (dextromethorphan polistirex) 30mg/5mL	$ 8.888
MICROGESTIN Fe 1/20	$ 8.971
ERYTHROMYCIN 5mg/g - 1 TUBE in 1 CARTON (24208-910-55) > 3.5 g in 1 TUBE	$ 9.438
Aplisol (TUBERCULIN PURIFIED PROTEIN DERIVATIVE) 5[iU]/.1mL	$ 10.000
CLOTRIMAZOLE; BETAMETHASONE DIPROPIONATE 10mg/g; 0.5mg/g - 1 TUBE in 1 CARTON (0472-0379-45) > 45 g in 1 TUBE	$ 9.823
BreatheRite Spacer	$ 10.087

Cryselle	$ 10.263
KENALOG-40 (TRIAMCINOLONE ACETONIDE) 40mg/mL	$ 10.296
KENALOG-40 (TRIAMCINOLONE ACETONIDE) 40mg/mL	$ 10.296
AZELASTINE HYDROCHLORIDE 137ug/1	$ 10.934
Aplisol (TUBERCULIN PURIFIED PROTEIN DERIVATIVE) 5[iU]/.1mL	$ 10.000
Sling	$ 15.000
POLYMYXIN B SULFATE 500000[USP'U]/1 -	$ 11.737
Universal remover wipes	$ 11.891
Nortrel 28 Day	$ 12.317
Nortrel 28 Day	$ 12.317
BENZOYL PEROXIDE 100mg/mL - 237 mL in 1 BOTTLE (67405-830-08)	$ 12.463
NITROGLYCERIN 0.4mg/1	$ 12.725
ERYTHROMYCIN 5mg/g - 1 TUBE in 1 CARTON (24208-910-55) > 3.5 g in 1 TUBE	$ 13.387
AZELASTINE HYDROCHLORIDE 0.5mg/mL - 1 BOTTLE, PLASTIC in 1 BOX (47335-938-90) > 6 mL in 1 BOTTLE, PLASTIC	$ 13.838
OFLOXACIN 3mg/mL - 1 BOTTLE, DROPPER in 1 CARTON (17478-713-10) > 5 mL in 1 BOTTLE, DROPPER	$ 14.630
Blood Pressure Cuff	$ 16.522
Floating Flange and Tape	$ 16.803
Ammonium Lactate Lotion 12%	$ 16.819
Glucometer test strips	$ 17.765
RIZATRIPTAN BENZOATE 10mg/1	$ 18.216
RIZATRIPTAN BENZOATE 10mg/1	$ 18.216
Medihoney 1.5 oz	$ 18.964
Smart Heart Blood Pressure Monitor	$ 19.657
Nebulizer Tabletop SYstem	$ 19.745
Syringe 1cc	$ 22.990
Drainage Pouch	$ 27.313
Nebulizer COmplete	$ 27.720
CLINDAMYCIN PHOSPHATE 10mg/mL - 60 APPLICATOR in 1 JAR (45802-263-37) > 1 mL in 1 APPLICATOR	$ 29.139
DICLOFENAC SODIUM 10mg/g - 1 TUBE in 1 CARTON (65162-833-66) > 100 g in 1 TUBE	$ 29.524
Detector Strep A	$ 38.368
Medihoney 3.5 oz	$ 44.011
BOOSTRIX 5[iU]/.5mL; 2.5[iU]/.5mL; 8ug/.5mL; 8ug/.5mL; 2.5ug/.5mL	$ 44.055
Testosterone Cypionate 200mgmg/mL	$ 48.974
TIMOLOL MALEATE 5mg/mL - 1 BOTTLE, DROPPER in 1 CARTON (60758-801-10) > 10 mL in 1 BOTTLE, DROPPER	$ 49.500
Slim Barrier Ring	$ 51.348
VENTOLIN HFA (ALBUTEROL SULFATE) 90ug/1 - 1 INHALER in 1 CARTON (0173-0682-20) > 200 AEROSOL, METERED in 1 INHALER	$ 59.125
LIDOCAINE 50mg/g	$ 69.696
Surgical Pathology (Level 4)	$ 72.500

LABORATORY TESTING – PRICING LOW TO HIGH (300 most common tests)

SERVICE NAME	PRICE
GGT	$1.03
UA, MACROSCOPIC	$1.25
URINALYSIS, REFLEX	$1.25
RFL-MICR (INC)	$1.46
UA, MICROSCOPIC	$1.46
SED RATE BY MOD WEST	$1.54
SED RATE MANUAL WEST	$1.54
T-3 UPTAKE	$1.54
T-4 (THYROXINE)	$1.54
CARDIO IQ(TM) CHOL TOT	$2.00
CARDIO IQ(TM) GLUCOSE (S)	$2.00
CARDIO IQ(TM) HDL CHOL	$2.00
CARDIO IQ(TM) TRIGLYC.	$2.00

CHOLESTEROL, TOTAL	$2.00
GRAM STAIN	$2.00
HDL-CHOLESTEROL	$2.00
HGB A1C W/MPG (REFL)	$2.00
HIAA, 5 (U)	$2.00
HIAA, 5-, URINE	$2.00
PRO TIME WITH INR	$2.00
TRIGLYCERIDES	$2.00
TRIGLYCERIDES(REFL)	$2.00
VLDL	$2.00
AMYLASE	$2.05
FOLATE,SERUM	$2.05
IRON, TOTAL	$2.05
LDH, TOTAL	$2.05
MAGNESIUM	$2.05
PSA, TOTAL	$2.05
PSA, TOTAL, 2.5 NG/ML CUT	$2.05
PSA,TOTAL W/REFL	$2.05
CARDIO IQ(TM) INSULIN	$2.50
INSULIN	$2.50
URIC ACID	$2.56
CULT, UA,COMP W/RFL	$2.71
UA, COMPLETE	$2.71
CARDIO IQ(TM) HGB A1C	$3.00
COW'S MILK (F2) IGE	$3.00
CULTURE, GP. A STREP	$3.00
HEMOGLOBIN A1C	$3.00
HEMOGLOBIN A1C W/EAG	$3.00
HEMOGLOBIN A1C W/MPG	$3.00
HEMOGLOBIN A1C W/RFL	$3.00
HEMOGLOBIN A1C W/RFL	$3.00
IMCAP, CODFISH (F3)	$3.00
IMCAP, EGG WHITE (F1)	$3.00
IMCAP, SHRIMP (F24)	$3.00
IMCAP, SOYBEAN (F14)	$3.00
IMCAP, WHEAT (F4)	$3.00
IMMUNOGLOBULIN A	$3.00
*THYROID PANEL	$3.08
*THYROID PANEL (REFL)	$3.08
CARDIO IQ(TM) HS-CRP	$3.08
CK, TOTAL	$3.08

CRP	$3.08
CULT, (U) ROUTINE	$3.08
CULT,(U), SPECIAL	$3.08
HCG TOTAL QL	$3.08
HCG, QUAL,REFL QUANT	$3.08
HCG, TOTAL, QN	$3.08
HS CRP	$3.08
ALBUMIN	$3.13
ALKALINE PHOSPHATASE	$3.13
ALT	$3.13
AST	$3.13
BILIRUBIN, TOTAL	$3.13
BILIRUBIN,DIRECT	$3.13
CALCIUM	$3.13
CARBON DIOXIDE	$3.13
CHLORIDE	$3.13
CREATININE	$3.13
GLUCOSE, SERUM	$3.13
PHOSPHATE (AS PHOS)	$3.13
POTASSIUM	$3.13
POTASSIUM,PLASMA	$3.13
PROTEIN, TOTAL	$3.13
PROTEIN, TOTAL PLASMA	$3.13
SODIUM	$3.13
UREA NITROGEN (BUN)	$3.13
BILIRUBIN,FRAC.	$3.22
BUN/CREAT RATIO	$3.22
PROTEIN, TOT & ALB PLASMA	$3.22
PROTEIN, TOT AND ALB	$3.22
IMMUNOGLOBULIN E	$3.50
HETEROPHILE, MONO	$3.57
ELECTROLYTE PANEL	$3.58
ELECTROLYTE PNL, PLASMA	$3.58
HEPATIC FUNC PNL W/O TP	$3.93
IRON, TOTAL, & IBC	$3.98
*CHOL AND HDL W RATIO	$4.00
*LIP PNL W/O TRIG	$4.00
ABO GROUP	$4.00
CBC(REFL)	$4.00
GLUC, GEST SCRN -135	$4.00
GLUC, GEST SCRN 140	$4.00

GLUCOSE PP (75 GRAM)	$4.00
GLUCOSE, PLASMA	$4.00
GLUCOSE, PP/1 HR	$4.00
GLUCOSE, PP/2 HOUR	$4.00
IMCAP, A. TENUIS (M6)	$4.00
IMCAP, PEANUT (F13)	$4.00
ORG ID 1	$4.00
RH TYPE	$4.00
RPR MONITOR W/REFL	$4.00
RPR(DX)REFL FTA	$4.00
RPR, PREMARITAL,REFL	$4.00
RPR,PM W/REFL	$4.00
CBC(DIFF/PLT)W/SMEAR	$4.10
DRAW FEE, PSC SPEC.	$4.10
HSV 1 HERPESELECT	$4.10
HSV 2 HERPESELECT	$4.10
HSV 2 W/REFL INHIB	$4.10
ORG ID 1	$4.10
ORG ID 1	$4.10
PRESUMPTIVE ID 1	$4.10
PRESUMPTIVE ID 1 M	$4.10
TESTOSTERONE,MALE,IA	$4.10
UA, MICRO (REFL)	$4.10
BASIC METAB PNL W/O CA	$4.11
HEPATIC FUNC PNL	$4.11
HEPATIC FUNC PNL, PLASMA	$4.11
CREATININE,TIMED UR	$4.25
MICROALBUMIN	$4.25
BASIC METAB PNL	$4.29
BASIC METAB PNL, PLASMA	$4.29
IMCAP, C. HERBARUM (M2)	$4.50
IMCAP, CAT DANDER (E1)	$4.50
IMCAP, COCKROACH (I6)	$4.50
IMCAP, D. FARINAE (D2)	$4.50
IMCAP, D. PTERONYSSINUS(D	$4.50
IMCAP, DOG DANDER (E5)	$4.50
IMCAP, WALNUT (F256)	$4.50
ORG ID 1	$4.50
RENAL FUNC PNL	$4.65
HEMATOCRIT	$4.75
HEMOGLOBIN (B)	$4.75

PLATELET COUNT	$4.75
RED BLOOD CELL COUNT	$4.75
WBC	$4.75
HGB & HCT	$4.80
WBC & DIFF	$4.80
HGB INDICES	$4.85
HEMOGRAM	$4.90
CBC(H/H,RBC,WBC,PLT)	$4.95
HEMOGRAM & DIFF	$4.95
CBC (DIFF/PLT)	$5.00
CERULOPLASMIN	$5.00
CMP W/O CO2,ALT	$5.00
FUNGAL STAIN	$5.00
IMCAP, A. FUMIGATUS (M3)	$5.00
IMCAP, ALMOND (F20)	$5.00
IMCAP, BERMUDA GRASS (G2)	$5.00
IMCAP, CLAM (F207)	$5.00
IMCAP, COCONUT (F36)	$5.00
IMCAP, COMMON RAGWEED (W1	$5.00
IMCAP, COTTONWOOD (T14)	$5.00
IMCAP, ELM (T8)	$5.00
IMCAP, MAPLE (T1)	$5.00
IMCAP, MOUNTAIN CEDAR (T6	$5.00
IMCAP, NETTLE (W20)	$5.00
IMCAP, OAK (T7)	$5.00
IMCAP, P. NOTATUM (M1)	$5.00
IMCAP, PECAN NUT (F201)	$5.00
IMCAP, RUSS. THISTLE (W11	$5.00
IMCAP, SCALLOPS (F338)	$5.00
IMCAP, SESAME SEED (F10)	$5.00
IMCAP, SHEEP SORREL (W18)	$5.00
IMCAP, TIMOTHY GRASS (G6)	$5.00
IMCAP, WHITE ASH (T15)	$5.00
IMCAP, WHITE MULBERRY (T7	$5.00
INSULIN, 2 SPEC	$5.00
PREALBUMIN	$5.00
SUSC-1	$5.00
T-3, TOTAL	$5.00
TVAG RNA QL TMA	$5.00
CULTURE, AEROBIC BAC	$5.13
HEP A IGM AB	$5.13

IMCAP, CASHEW NUT (F202)	$5.13
IMCAP, EGG MIX (F245)	$5.13
IMCAP, PISTACHIO (F203)	$5.13
MACADAMIA NUT IGE	$5.13
RETICULOCYTE COUNT	$5.13
SUSC-1	$5.13
CMP W/O ALT	$5.19
COMP METAB PNL	$5.36
COMP METAB PNL, PLASMA	$5.36
COMP METAB W/ADJ CAL PLS	$5.36
*ASCVD RSK PNL W/SCOR	$6.00
*ASCVD RSK PNL/SCORE	$6.00
*CARDIO IQ(TM)LIPID PANEL	$6.00
*LIPID PANEL	$6.00
*LIPID PANEL (REFL)	$6.00
*LIPID PANEL (REFL)	$6.00
*LIPID PANEL WITH RATIOS	$6.00
*LIPID PNL W/RA(REFL)	$6.00
*LIPID PNL W/REF DIR LDL	$6.00
*LIPID PNL W/REFL LDL	$6.00
ASO	$6.00
BILI,DIRECT,PEDI	$6.00
CHOL TOTAL,(REFL)	$6.00
FSH	$6.00
LH	$6.00
PTT, ACTIVATED	$6.00
RHEUMATOID FACTOR	$6.00
RHEUMATOID FCTR, CSF	$6.00
SUSC-1	$6.00
THYROID PEROXID AB	$6.00
TSH	$6.00
TSH W/REFL FT4	$6.00
TSH, PREGNANCY	$6.00
URIC ACID (U)	$6.00
URIC ACID 24HR (U)	$6.00
LIPASE	$6.12
ANA TITER&PATTERN	$6.15
FERRITIN	$6.15
HEP B CORE IGM AB	$6.15
TRANSFERRIN	$6.15
AB SCR RFX ID/TITER	$7.00

ANA IFA W/REFL	$7.00
ANA SC W/REFL DS-DNA	$7.00
ANA SCREEN	$7.00
ANA W/RFX	$7.00
CAMPY CULTURE	$7.00
FECAL LEUKOCYTE STN	$7.00
FRUCTOSAMINE	$7.00
HEP B C AB, TOT (REFL)	$7.00
IMMUNOGLOBULIN G	$7.00
IMMUNOGLOBULIN M	$7.00
LEAD, (B)	$7.00
MALB, RAND UR W/O CR	$7.00
MICROALBUMIN 24HR (U)	$7.00
MICROALBUMIN RAND UR	$7.00
MICROALBUMIN, 24 HR UR	$7.00
MICROALBUMIN, TIMED (U)	$7.00
QT THYROGLOB W/O ATA	$7.00
INSULIN, 3 SPEC	$7.50
*PT W/INR & PTT	$8.00
ABO GRP AND RH TYPE	$8.00
CORD BLOOD ABO/RH	$8.00
GLUC GEST & FAST-135	$8.00
GLUC GEST & FAST-140	$8.00
GLUC,FAST & POST 1HR	$8.00
GLUC,FAST & POST 2HR	$8.00
GTT, 2 SPEC	$8.00
HAPTOGLOBIN	$8.00
ORG ID 2	$8.00
RAST, PENICILLIN G	$8.00
RAST, PENICILLIN V	$8.00
SJOGRENS AB (SS-B)	$8.00
SS A RO AB(IGG)EIA	$8.00
HSV 1/2 HERPESELECT	$8.20
LITHIUM	$8.20
ORG ID 2	$8.20
ORG ID 2	$8.20
PRESUMPTIVE ID 2	$8.20
PRESUMPTIVE ID 2 M	$8.20
T-3, FREE	$8.20
*NAFLD FIBROSIS SCORE	$8.33
IV-PATH,G&M,1SP,PC	$8.46

PROSTATE BIOPSY, 1SP,PC	$8.46
BHL, LDLGGE	$9.00
CT,DIFF SYNOVIAL FL	$9.00
ORG ID 2	$9.00
THYROGLOBULIN AB	$9.00
*THYROID PNL W/TSH	$9.08
METHYLMALONIC ACID	$9.23
SHBG	$9.23
IMCAP, CORN (F8)	$9.76
*LIPID PANEL (REFL)	$10.00
ACTIN ANTIBODY (IGG)	$10.00
ANTI-DSDNA AB, EIA	$10.00
CARDIO IQ(TM) DIRECT LDL	$10.00
DIRECT LDL	$10.00
HBSAG (REFL) W/CONF	$10.00
HEP BE AG	$10.00
INSULIN, 4 SPEC	$10.00
MEASLES IGG	$10.00
RUBELLA IGG AB W/RFL	$10.00
SOYBEAN IGG	$10.00

SUSC-2	$10.00
VITAMIN B12	$10.00
*IRON,TIBC,FER PNL	$10.13
SALM/SHIG, CULTURE	$10.25
SUSC-2	$10.26
*DIAB RSK PNL W/SCORE	$11.00
*DIABETES & ASCVD	$11.00
*HEMOGLOBINOPATHY	$11.00
COMPLEMENT, (CH50)	$11.00
CRYOGLOB EVAL	$11.00
CULTURE, GENITAL	$11.00
CULTURE,SPUTUM/LOWER RESP	$11.00
GASTRIN	$11.00
HBC TOTAL W/REFL IGM	$11.00
HEP B CORE AB, TOTAL	$11.00
HEP B SURF AB QL	$11.00
HEP B SURF AG W/CONF	$11.00
MERCURY (U)	$11.00
MERCURY, 24HR (U)	$11.00
POTASSIUM (U)	$11.00

The CHAIRMAN. Thank you, Dr. Umbehr.

Dr. Kripalani, welcome.

STATEMENT OF SAPNA KRIPALANI, M.D., ASSISTANT PROFESSOR OF CLINICAL MEDICINE, DIVISION OF GENERAL INTERNAL MEDICINE AND PUBLIC HEALTH, VANDERBILT UNIVERSITY MEDICAL CENTER, NASHVILLE, TN

Dr. KRIPALANI. Thank you, Chairman.

Thank you, Chairman Alexander, Ranking Member Murray, the esteemed Members of this Committee for allowing me to be here today to speak with you.

As a primary care physician for the last 17 years, I have had the privilege of sharing in the lives of thousands of patients and helping them navigate a health care system that fails too often, to meet the needs of too many Americans. Let me start by sharing a story with you about a patient that I have come to care deeply about. Jane is a 27-year old woman who I have taken care of for 5 years. She has diabetes, high blood pressure, seizures, and bipolar disorder. She cannot afford healthy food and she often stops taking her insulin because she cannot afford supplies and the medication. She is socially isolated. Although I see her in clinic every one to two weeks, she makes frequent visits to the emergency room and to urgent care clinics several times a month. How can our health care system better support patients like Jane?

As primary care physicians, we are the front line in promoting the health and wellness of our patients. We provide preventive services, diagnose and treat medical conditions, and educate patients about their health risks. We bridge the gap in services that may have limited availability, such as mental health, and we coordinate care with multiple specialists. In this way, the primary care doctor is the quarterback, who makes sure all the players in the health care team are following the outlined plan, including the patient. This vital role is essential in improving the quality of health care and lowering cost. In short, primary care matters.

Unfortunately, primary care is undervalued in the United States. Reimbursements are more robust for treatment of disease rather than prevention. For example, insurers will cover weight loss surgery, but not the lifestyle and behavioral interventions needed to treat obesity. There are numerous ways in which investments in primary care can improve health outcomes in a cost-effective way. I will focus on one, encouraging innovation, two, redirecting spending, and three, investing in the primary care workforce.

First, we should invest in innovative models of health care delivery, and enhance access and convenience, such as home telehealth and shared medical appointments. Home telehealth is an efficient and convenient way to address health needs, and manage chronic illnesses, and gain insight into the home environment. In Tennessee, most payers only cover when they occur in rural health care clinics, but not from home.

A shared medical appointment is a medical consultation that combines peer support in a structured group setting. Since 2017, I have been conducting these visits for diabetics and for exercise counseling. Patients' value sharing their firsthand experiences and health challenges with other patients. These visits can last 90–120

minutes, as opposed to 10–15 minutes for a traditional appointment, and can improve both the patient and physician experience.

Secondly, we must reduce and redirect spending in our health care system. In the U.S., only 6 to 8 percent of health care spending is in primary care. And between 2012 and 2016, spending declined 6 percent in primary care, but increased 31 percent for specialists. I find this statistic alarming.

Internationality nearly every developed country has a higher rate of spending between primary care and sub-specialists, compared to the U.S., and the result is lower cost and higher life expectancy. Studies have shown that greater use of primary care is associated with fewer hospitalizations, fewer ED visits, and lower mortality. Investment in primary care pays for itself by reducing overall health spending and freeing up critical resources for those who truly need them.

Third, we must invest in the primary care workforce. As the baby boomer generation ages and more Medicare beneficiary's access health care, the primary care doctor shortage will worsen. The problem is even more pronounced in rural areas that struggle to attract new physicians. This affects patients with diabetes, seeking a new doctor for refills, the young woman with abdominal pain who cannot get in to see her doctor for several weeks, and the heart failure patient, who is short-breath and needs to see a doctor. We must lessen the gap in salary between sub-specialists and primary care physicians that leads doctors to choose more lucrative careers to offset their educational debts. And we must keep doctors in primary care by eliminating onerous documentation burdens and administrative burdens that disproportionally affect PCPs.

For every hour of face-to-face time we spend on patient care, we spend an additional one to two hours completing administrative tasks. Let us allow physicians to spend more time caring for patients and less time performing tasks that do not improve care.

In returning to our patient Jane, several interventions have proven helpful. She attends our shared medical appointments. She enjoys those interactions. She gets daily phone calls from physicians and nurses from our clinics, and that has reduced the frequency of her ED visits.

Telehealth visits and lifestyle counseling could be helpful if these services were covered, and they could significantly change the health trajectory for Jane. I strongly believe that investments in primary care will help us take better care of patients like Jane and so many other Americans.

Thank you, Senators, for the opportunity to talk about primary health care today, and I welcome your questions.

[The prepared statement of Dr. Kripalani follows:]

PREPARED STATEMENT OF SAPNA KRIPALANI

Thank you, Chairman Alexander, Ranking Member Murray, the Members of this Committee, and their staff for giving me the opportunity to be here today to discuss the role of primary care in shaping our health care and controlling costs as we head into the future. As a primary care physician for the last 17 years, I have had the privilege of sharing in the lives of thousands of patients and helping them navigate a complicated health care system that fails to meet the needs of too many Americans.

I have had the opportunity to work in a variety of health care settings over the years. I attended medical school at Emory University School of Medicine and com-

pleted much of my training at Grady Memorial hospital, which is the largest safety-net hospital in the State of Georgia. I had the privilege of serving our veterans at the Atlanta VA hospital, and worked in the hospital and clinics of Emory University. Through my work in a private primary care clinic in a rural town outside of Atlanta, I witnessed the challenges in accessing specialty care services for patients in a timely manner. These delays placed patients at risk of serious medical consequences. These experiences allowed me to learn about the challenges of health care delivery that transcend socioeconomic classes and affect the cost of health care for all of us. Since 2007, I have been on faculty at Vanderbilt University Medical Center and have been involved in teaching undergraduates, medical students, and residents as they embark on their careers in medicine. I have seen them choose their fellowships in subspecialties rather than a career in primary care in order to avoid the onerous burdens that force primary care doctors to spend more time with documentation and administrative tasks than direct patient care and often lead to physician burnout.

I would like to share a patient story that is all too familiar in our clinics. Jane is a 27-year old woman who has diabetes, hypertension, seizure disorder and bipolar disorder and due to the severity of her mental condition, has not been able to work in years. She is morbidly obese and has a BMI of 45. She cannot afford healthy food and she often stops taking her insulin and other medications when she runs out of money. Due to her seizure disorder and mental health issues, she is socially isolated. Despite all this, she is interested in making healthier choices and taking better care of herself. She calls the office daily with concerns about her blood sugar level or blood pressure. She is seen by me in clinic every 1–2 weeks. Despite these frequent contacts, she visits the walk-in clinic 1–2 times a week and goes to the emergency department 2–3 times a month for various ailments.

How does our current system provide support and assistance for patients like Jane?

How do we control the overwhelming cost of caring for someone like her?

As primary care physicians, we are the front line in promoting the health and wellness of our patients. We help them understand the nuances of their individual health plan and the meaning of terms such as co-pay, co-insurance, deductible and out of/in-network charges. We often personally pick up the phone to speak with administrators of health companies who deny necessary services, so our patients can get the care they need, and we serve to bridge the gap in services that may have limited availability, such as mental health. We educate patients and families about their diseases and counsel them about prevention, vaccines and wellness. We provide them with advice when they see a new medication on TV, hear about a fad diet, or want to try alternative therapies. We help to coordinate visits with subspecialists and make sure they are keeping up with follow-up appointments. In this way, the primary care doctor is the "quarterback" who makes sure all the players in the health care team (including the patient) are following the outlined plan. This vital, albeit time-consuming, role in medicine is essential in improving the quality of health care and lowering cost. In short, primary care matters!

Unfortunately, primary care is undervalued in the U.S. Reimbursements are more robust for the treatment of disease with expensive regimens rather than for prevention. Time spent in educating and counseling about lifestyle modifications is not well reimbursed, and there is little investment in ancillary services by CMS or most insurers. Primary care is the front line for addressing mental health issues and obesity, yet reimbursement is poor for these services. Dietician services are still not covered for people with obesity until they develop diabetes, and insurers will often cover bariatric surgery to treat obesity but will not pay for treatments that target lifestyle and behavioral change.

Health care spending in the U.S. continues to grow. In 2017, we spent an estimated 3.5 billion dollars on health care, which amounts to $10,739 for every man, woman and child in the U.S. This represents 17.9 percent of our GDP which far exceeds the amount spent in other developed countries. This excess spending has not resulted in improved health outcomes compared to other countries. This problem is multifactorial and there will not be a singular solution. There are numerous ways in which investments in primary care can improve health outcomes in a cost-effective way. My testimony will focus on innovation, reducing spending, and investing in the primary care workforce.

(1) **Investment in innovative models of health care delivery.**

This includes coverage for alternative models of care such as home telehealth, which allows patients to receive care in their own home. Advantages include the ability for medical personnel to thoroughly review medications (including over the

counter medicines) that patients take at home, but frequently forget to bring to their doctor's visits, which can help prevent drug interactions, duplication, and other medication errors. Telehealth can enhance the patient history by allowing family members in the home to participate in the visit, when they may not have been able to attend a face-to-face visit. It allows the physician to gain insight into home conditions which may affect the safety or health of the patient. In our clinic, we are preparing to pilot a telehealth program for urgent care needs, but the potential for telehealth in managing chronic diseases such as diabetes, hypertension or behavioral health needs is promising. Imagine the time and cost saved for the patients and the system if the patient and physician could coordinate a time to "log-in" and conduct a visit without the administrative burden, time, cost and inconvenience of an office visit. Telehealth may also increase access to primary care and certain limited-supply resources such as mental health, dermatology, and other subspecialties. Currently, in the State of Tennessee, telehealth visits are only covered by Medicare and Medicaid when patients present to specific rural health care sites. Some commercial insurers will pay for telehealth if the patient presents to a remote health care site, but not from home. This eliminates the numerous advantages and convenience of an at-home visit. I encourage the Committee to support coverage of at-home televisits so that Tennesseans and all Medicare beneficiaries can more easily access the health care they need. Although telehealth will not be appropriate for all situations, I believe primary care doctors would embrace it as an option to enhance patient care.

Another opportunity to improve access is the Shared Medical Appointment (SMA) which is a clinical encounter that allows patients to receive counseling, education, and individualized interventions in group setting. This is a visit in which physicians and facilitators can simultaneously address disease-specific concerns and issues with 8–12 patients in a group setting. In 2017, with the help of our social worker and office staff, I implemented a Shared Medical Appointment program with my diabetic patient population. We conducted monthly visits with this group to set goals, share experiences and provide diabetes-specific education. We later expanded the program in 2018 with a new group of patients who were interested in improving physical activity, called "Healthy Steps." Through collaborative efforts with the Dayani Wellness center at Vanderbilt and a small institutional grant with which we purchased pedometers and supplies, the "Healthy Steps" program has been very successful. A quote from a patient sums it up well . . .

"Thank you for the opportunity to join the excellent Healthy Steps meetings. The information was very valuable. Without the boost of this program I would not have disciplined myself to get more serious about exercising."

With appropriate patient selection, consent forms that address HIPAA policies, and advanced planning, this is a highly successful and innovative way to deliver care and has an additional advantage of creating a support structure for patients who are isolated or feel alone in their disease. Studies have shown potential for enhancement of quality and consistency of care provided as well as improvement in self-management with reduction in cost through use of SMAs. Advantages for patients include reduction in sense of isolation which can improve self-efficacy in managing their chronic illness. Patients learn vicariously about disease management by hearing the perspective of others facing similar challenges in managing their illness. SMAs bring patients together so that those who are managing well can help encourage those who may be struggling.

One memorable moment in a recent shared medical appointment was when a patient-participant provided information to others in the group about the pharmacies that provided the lowest prices on metformin, statins, and blood pressure medications, and which online coupons saved her the most money on her medications. Many of the people in the group were taking the same medications and were delighted to learn how to reduce their monthly medication costs.

The SMA also has advantages for physicians due in part to the ability allocate a longer amount of time with the group than they typically have with patients in a traditional one-on-one model. Typical SMAs last 90–120 minutes (as opposed to 10–15 min for a traditional visit) which allows for a more in-depth exchange of information, allows patients to feel more supported, and can help combat the fatigue that physicians experience as they dash from one room to the next.

By encouraging the implementation of newer methods of delivering primary care, we can improve access and reduce physician burn out while providing cost-saving, high-value care.

(2) **Reduction of excess spending in our health care system.**

This Committee has heard the statistic on many occasions that as much as 1 out of every 3 healthcare dollars is "wasted." It is thought that much of this waste is attributable to excessive or unnecessary testing but defining inappropriate care can be challenging.

However, we do know that patients who have primary care doctors have fewer preventable ED visits which reduces cost. Data have shown that primary care doctors overall use fewer tests, spend less money and provide more high-value care, such as cancer screening, blood pressure testing, diabetes care and counseling on weight loss, smoking cessation and exercise. In lower income populations, primary care use is associated with improved immunization rates, better dental health, lower mortality and higher self-reported quality of life.

Primary care encourages the "right care, right time, right setting" model in which patients can be directed to the most appropriate facility that meets their health care needs. Too often, our emergency departments are filled with patients who present with symptoms that could have been managed in an outpatient clinic. We should seek to divert common non-emergent health care needs to a setting that is better matched economically than the ED. Efforts to identify high health care utilizers and intervene before they seek care can help to reduce the overall cost of health care.

No conversation about healthcare cost is complete without mentioning prescription drugs and the soaring prices of essential medications that lead to significant burden on patients and insurers. This leads to frustrating changes in drug coverage as insurers seek the best deals on medications within a class of drugs. Higher costs lead to higher copays for patients, some of whom must choose between food and rent or their life-saving medications. Medication non-adherence leads to more healthcare costs when that patient ends up in the hospital from poorly controlled hypertension that results in a stroke or other adverse outcomes. We must find a way to control prescription costs so that patients can consistently afford them and avoid higher downstream medical spending.

(3) **Invest in the primary care workforce.**

As the baby-boomer generation continues to age and more Medicare beneficiaries are accessing healthcare, there continues to be growing shortage of primary care doctors nationwide. As a lead physician in my clinic, I have seen new PCPs join our practice and quickly fill their schedules with patients who have been waiting to find a doctor. Within a few weeks, the wait time to see a new provider can quickly climb to several months. This issue is even more prevalent in rural areas which struggle to regularly attract new physicians. While high demand may be good for business, it is not optimal for the patient whose doctor has retired, and refills expire before they can see a doctor. It doesn't help the older patient who cannot get in to see a new doctor after declining health has required her to move in with her daughter. It certainly does not benefit the countless Americans who are unable to find a doctor who accepts new Medicare patients. It is estimated that the United States will face a shortage of between 42,600 and 121,300 physicians by 2030. The declining number of medical students and residents who enter primary care will further aggravate this shortage. Many physicians are discouraged from pursuing primary care due to the relatively low compensation compared to specialists. They recognize the "half the pay, twice the work" penalty of primary care, and with burgeoning educational debts, decide to pursue more lucrative careers. The solution lies in recognizing that primary care is unique from other medical specialties. The emphasis is on disease prevention rather than disease treatment. Primary care physicians, like myself, enter this career in order to develop relationships with patients and families over many years. We share in their joys, sorrow, losses and successes and learn to modify our treatment strategy to meet the unique needs of each individual patient. We thrive in cultivating and nurturing these relationships and in helping patients realize a healthy future.

Unfortunately, Federal regulations such as meaningful use and onerous documentation requirements have been burdensome on primary care doctors, without enhancing the quality of the care provided. Electronic health records have the capability to aid in the identification of deficiencies in care but are not aligned with the work flow of physicians and slow the pace of care in clinic. For every hour of face-to-face patient encounters, we must spend an additional 1–2 hours completing documentation and administrative tasks. This is unsustainable and leads many primary care doctors to leave the workforce. I hope this Committee looks to alleviate this burden so that physicians can spend more time engaging with patients and providing high value care, and less time facing a computer.

In returning to our patient, Jane, several interventions have proven helpful. She has attended our Shared Medical Appointment for diabetes and has enjoyed the per-

sonal interactions and advice from other patients who have been in her situation. She is contacted weekly by the primary care nurse to review her medications. These interventions have reduced the number of ED and urgent care visits she makes. She has successfully lost 50 lbs. and is checking her glucose and blood pressure several times a week. She would be a great candidate for regular telehealth visits, exercise and diet coaching, and medication adherence counseling, if these services were covered by Medicare. Although she has a long road ahead, I believe assistance for patients like Jane could significantly change her health trajectory. I hope future investments in primary care will help us take better care of patients like Jane and many others.

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[SUMMARY STATEMENT OF SAPNA KRIPALANI]

Case: Jane is a 27-year-old woman with diabetes, high blood pressure, seizures and bipolar disorder. She cannot afford healthy food choices, and often stops taking her insulin due to medication and supply costs. She is socially isolated. Although I see her in clinic every 1–2 weeks, she also goes to the walk-in clinics and has expensive emergency department visits several times a month.

How can our healthcare system better support patients like Jane?

How do we control the overwhelming cost of caring for someone like her?

As primary care physicians, we are the front line in promoting health and wellness of our patients. Roles include:

(1) Preventive services such as vaccines, cancer screenings, and healthy lifestyle recommendations

(2) Diagnosing and managing chronic illnesses such as diabetes

(3) Educating patients about medical disease and public health risks

(4) Coordinating care with subspecialists

(5) Bridging the gap in services, such as mental health.

Primary care doctor is the "**quarterback**" who makes sure all the players in the health care team (including the patient) are following the outlined plan. Unfortunately, primary care is undervalued in the U.S. Reimbursements are more robust for the treatment of disease than prevention.

Investments in primary care in the following ways will improve outcomes and reduce cost:

(1) Providing opportunities for innovative models of health care delivery such as home telehealth and shared medical appointments.

a. Increases access

b. Improved convenience

c. Other benefits such as social support

(2) Shifting spending toward improving high-value care such as cancer screening, prevention and chronic disease management which reduces cost.

a. Primary care prevents ED visits and hospitalizations and lowers mortality

b. High prescription cost leads to medication non-adherence

(3) Increasing the primary care workforce to better manage the needs of our population.

a. There is a growing shortage of primary doctors despite an aging population with increasing health care needs.

b. Salary gaps keep doctors from choosing a career in primary care

c. Documentation and administrative burdens lead to physician burn out. For every 1 hour of patient care, we spend 1–2 hours in administrative activity.

The CHAIRMAN. Thank you, Dr. Kripalani.

Dr. Bennett, welcome.

STATEMENT OF KATHERINE A. BENNETT, M.D., ASSISTANT PROFESSOR OF MEDICINE, DIVISION OF GERONTOLOGY AND GERIATRIC MEDICINE, UNIVERSITY OF WASHINGTON SCHOOL OF MEDICINE, SEATTLE, WA

Dr. BENNETT. Thank you. Good morning, Chairman Alexander and Ranking Member Murray, who I am proud to say is my Senator, and distinguished Members of the Committee. Thank you for the opportunity to speak with you today about Project ECHO, its impact on primary care, and my experience using it to improve the care of older adults.

My name is Dr. Katherine Bennett, and I am an Assistant Professor of medicine and geriatrics at the University of Washington where I am the founding Medical Director of Project ECHO-Geriatrics. This hearing topic is of critical national interest and something that I am pleased Congress is working hard to address.

Project ECHO, or the Extension for Community Health Outcomes, was designed by Dr. Sanjeev Arora, at the University of New Mexico. He was a liver disease specialist there, and found that he needed to address the issue of inadequate access to his specialty care, particularly in rural and underserved areas. His Model involved a specialist team, or hub, at an academic medical center and spokes, who were primary care providers at community clinics. Weekly, video-based mentoring sessions included teaching and case consultations. With this model, he was able to reduce the wait times for appointments at his hepatitis C clinic from eight months to two weeks. And the care provided by the ECHO trained primary care providers was equivalent in outcomes to that provided by specialists.

Since then, Project ECHO has been launched throughout the country for many complex conditions. ECHOs have shown impactful outcomes such as reduced hospital readmissions and reductions of physical restraints in nursing homes.

The University of Washington was the first replicator of ECHO outside of the University of New Mexico, and has 10 ECHOs with topics such as hepatitis C, HIV, chronic pain, and my program, geriatrics. In my work as a geriatrician, a specialty in short supply, I see patients who come from areas all throughout the region. Many are on very long lists of medications. Others have dementia that has gone undiagnosed for years. Others have osteoporosis that

has not been treated despite falling and breaking bones again and again. These scenarios are not happening because primary care providers do not care. It is because many have not received geriatrics training. We launched Project ECHO-Geriatrics to address this problem.

Our ECHO is part of our HRSA-funded Geriatrics Workforce Enhancements Program. Our ECHO is unique because our primary audience is physicians in training throughout a regional family medicine residency program—residency network, excuse me. Our specialist panel includes a geriatrician, social worker, psychiatrist, pharmacist, nurse, and Area Agency on Aging staff. Sessions focus on key primary care topics such as dementia, depression, and fall prevention. We have trained over 300 people across several states since our initiation in 2016.

I see a clear improvement in care over time. For example, a young doctor wanted guidance to help a new patient, a woman in her 90's, who was fatigued and having trouble getting around. She was on 36 medications. Months later the same resident presented a different patient. He told us how he had already worked to eliminate medications that could cause confusion or sedation, and was now looking for suggestions to help her remain independent at home. This type of care improves quality of life for older adults and reduces costs by preventable hospital admissions and preventable nursing home placement.

There are currently 10 geriatrics-focused ECHOs throughout the country. Many geriatrics ECHOs do not have patient outcomes data yet, and we need continued funding to obtain this critical information. Knowing that we are moving best practices to the frontline of primary care, and based on what I have seen, I am confident the outcomes are there.

I am grateful to Senators Collins and Casey for introducing the bill to reauthorize the Geriatrics Workforce Enhancement Programs and the Geriatrics Academic Career Awards, which together help us prepare the workforce to meet the unique needs of older adults.

Project ECHO programs need sustained funding to do their work well and to reach more underserved patients. ECHOs are supported through a patchwork of funding mechanisms that are often short-term and unpredictable. Just this month, the Center for Health Care Strategies released a report that reviews a variety of potential sustainability strategies for ECHO. I have included this reference in my written testimony. I am very hopeful that through this Committee, you will enact a strategy to sustain and grow ECHO so that all patients, regardless of where they live, can receive the highest quality health care.

Thank you for this opportunity to speak with you today and I look forward to answering your questions.

[The prepared statement of Dr. Bennett follows:]

PREPARED STATEMENT OF KATHERINE BENNETT

Good morning, Chairman Alexander and Ranking Member Murray—who I am proud to say is my Senator—and distinguished Members of the Committee. Thank you for the opportunity to speak with you today about Project ECHO, its impact on primary care, and my experience using it to improve the care of older adults. My name is Katherine Bennett, and I am an Assistant Professor of Medicine in the Di-

vision of Gerontology and Geriatric Medicine at the University of Washington (UW) and Program Director of the Geriatric Medicine Fellowship. I am the Education Lead for the Northwest Geriatrics Workforce Enhancement Center, which is the University of Washington's HRSA-funded Geriatrics Workforce Enhancement Program (GWEP). In that role I am the founding Medical Director of Project ECHO-Geriatrics. I am also President-Elect of the National Association for Geriatric Education, and a member of the American Geriatrics Society, the Association for Directors of Geriatric Academic Programs, and the Gerontological Society of America. This hearing topic is of critical national interest and something that I am pleased Congress is working hard to address.

Project ECHO was Developed to Improve Access to High Quality Care and Reduce Disparities

Project ECHO, or the Extension for Community Health Outcomes, was designed by Dr. Sanjeev Arora, a liver disease specialist at the University of New Mexico. Dr. Arora had a problem where patients with hepatitis C in New Mexico had to wait up to 8 months to see a specialist for treatment, and many were too sick and/or too far away to feasibly get this specialty care. He sought to address the issue of inadequate access to specialty care, particularly in rural and underserved areas. He launched Project ECHO in 2003 in order to solve this problem. His Model involved a specialist team, or "hub", at an academic medical center and "spokes" who were primary care providers at community clinics. Sessions involved weekly mentoring sessions with teaching and consultations held via secure video conferencing technology. Although everyone is geographically far apart, over time it feels like you are in the same room. With this model, wait times for appointments in the hepatitis C clinic were reduced from 8 months to 2 weeks. Dr. Arora also found that the care provided for hepatitis C by the ECHO-trained primary care providers was just as good, with the same cure rates, as the care from specialists.[1]

Due to this success, Project ECHOs have been launched throughout the country and world to address many complex conditions such as HIV, tuberculosis, and mental illness. There are now over 400 ECHO Programs throughout the country at over 160 locations.[2]

Health Outcomes are Improved With ECHO

Over 100 papers have been published on ECHO. Although many have focused on increased provider confidence for treating common conditions, we have ever increasing evidence that Project ECHO improves important health-systems and patient outcomes. Below are some examples.

- A pain management ECHO for Community Health Centers reduced the use of opioids for chronic pain, reduced inappropriate referrals to surgeons, and increase referrals to physical therapy. This aligns with recommended best practices in pain management.[3] A recent CDC report showed that patients in rural areas are 80 percent more likely to receive opioid prescriptions (vs those in urban areas). ECHO is perfectly suited to reduce this disparity.[4]
- A care transitions ECHO significantly reduced readmission to the hospital from nursing homes, reduced nursing home length of stay (avg. 5-day reduction), and reduce cost (about $2,600 lower per patient).[5]
- An ECHO targeting providers caring for nursing home patients with dementia significantly reduced the use of physical restraints.

A 2016 paper in *Academic Medicine*, "The Impact of Project ECHO on Participant and Patient Outcomes: A Systematic Review" gives a high-quality overview of ECHO outcomes from all ECHOs who have published results.[6]

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[1] S. Arora, et al. "Outcomes of treatment for hepatitis C virus infection by primary care providers." *The New England journal of medicine* 364.23 (2011): 2199–207. Web.

[2] *https://echo.unm.edu/locations-2/*.

[3] D. Anderson, et al. "Improving Pain Care with Project ECHO in Community Health Centers." *Pain medicine* (2017).

[4] Garcia MC et al. Opioid Prescribing Rates in Nonmetropolitan and Metropolitan Counties Among Primary Care Providers Using an Electronic Health Record System—United States, 2014–2017. MMWR Morb Mortal Wkly Rep 2019.

[5] Moore AB, et al. Improving Transitions to Postacute Care for Elderly Patients Using a Novel Video-Conferencing Program: ECHO-Care Transitions. Am J Med. 2017.

[6] Zhou Cet al. The impact of Project ECHO on participant and patient outcomes: A systematic review. Acad Med. 2016.

The University of Washington is a Leader in ECHO Replication

My home institution, under the leadership of Dr. John Scott was the first replicator of ECHO outside of the University of New Mexico. The University of Washington now has 10 active ECHOs addressing a range of complex conditions including Hepatitis C, HIV, Chronic Pain, Heart Failure, and Mental Illness. Given this track record, it was the ideal environment for me to implement an ECHO for Geriatrics.

Many Older Adults Receive Suboptimal Care

As a geriatrician at Harborview Medical Center (a UW-affiliated county safety net hospital, and the only level one trauma center for 5 states), I see patients who come from areas all throughout the five-state region. Many are on very long lists of medications. Others have dementia that has gone undiagnosed for years. Some have never been treated for osteoporosis despite falling and breaking bones again and again. These scenarios are not happening because primary care providers do not care, but because most have received minimal, if any, geriatrics training.[7] Given the critical shortage of geriatricians, and the rapidly growing older adult population, it is the primary care providers of this country who will be caring for the vast majority of older adults.

The field of geriatrics has experienced a rapid advance in the evidence base thanks to the hard work of dedicated researchers. However, the high-quality, cost saving healthcare that is supported by evidence is often not making it to the forefront of care. As a result, older adults suffer from preventable falls; preventable delirium (i.e. confusion) in the hospital; undertreatment of important conditions (such as osteoporosis); and overtreatment with medications and other interventions that do not improve their health, quality of life, or ability to maintain independence. We launched Project ECHO-Geriatrics to address this problem.

Project ECHO-Geriatrics at the University of Washington

Project ECHO-Geriatrics is part of our HRSA-funded Northwest Geriatrics Workforce Enhancements Center, which is the University of Washington's Geriatrics Workforce Enhancement Program (GWEP). The broad goal of the GWEP is to prepare primary care practitioners to provide high quality care for older adults. We do this by training the health care workforce and family caregivers to care for the complex health needs of older Americans. We train them to use the most effective and efficient methods to provide higher quality care and save valuable resources by reducing unnecessary costs, such as unneeded hospitalizations. In the 2016–2017 academic year, GWEPs provided 1,578 unique continuing education courses, including 467 on Alzheimer's disease and related dementia, to 173,078 faculty and practicing professionals from disciplines such as medicine, nursing, health services administration, social work, and psychology.

The University of Washington was pleased to receive funding under HRSAs GWEP Program in July 2015. We launched Project ECHO—Geriatrics in January 2016 under the mentorship of the experienced telehealth team at the UW.

Our ECHO is unique because our primary audience is physicians in training throughout a regional family medicine residency network. We felt that there may be an advantage to training primary care providers *before* they set out into practice. We partnered with many of the residencies in the region, who all agreed that their residents need more geriatrics training. Family medicine residents are required to complete 100 hours (approximately 1 month) of geriatrics training during their three years of residency. However, the great majority of these residencies do not have a geriatrician available to help with this education. Project ECHO—Geriatrics helps fill this need.

Sessions followed the ECHO model of teaching and case presentations. Our specialist panel includes a geriatrician, social worker, psychiatrist, pharmacist, nurse, and Area Agency on Aging staff. Sessions focus on key primary care topics such as dementia, fall prevention, and depression. All didactics (but not case discussions) are archived on our website (nwgwec.org).

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[7] Institute of Medicine Committee on the Future Health Care Workforce for Older Americans. (2008). Retooling for an aging America: Building the health care workforce.

University of Washington's Project ECHO—Geriatrics has Been Successful in Training Future Primary Care Providers

We have thus far trained 300 unique individuals across several states. The majority of participants were physicians training, but also included faculty, nurses, students, and others. We found a significant increase in self-reported knowledge for essential topics in the primary care of older adults, and 70 percent of participants reported that they plan to change their practice as a result of our sessions. These results were published in the *Journal of Graduate Medical Education* in 2018.[8]

More importantly, I see the clear improvement in participants' care over time. For example, a young doctor wanted guidance to help a new patient, a woman in her 90's who was fatigued and having trouble getting around. She was on 36 medications! Months later the same resident presented a different patient. He told us how he had already worked to eliminate medications that are sedating or cause confusion and was now looking for suggestions to help her remain independent at home. This type of care improves quality of life for older adults and reduces costs from preventable hospital admissions and nursing home placement.

Here is a quote from Dr. Braun, a faculty member at the Providence St. Peter Family Medicine Residency Program which has sites in Olympia and Chehalis, WA.

"*We have actively participated regularly for years and have found it invaluable. The program not only helps achieve our hours of required geriatrics training but has transformed the care I see provided by our residents in clinic and across healthcare settings*."

Involvement of the Area Agency on Aging in Project ECHO—Geriatrics is Invaluable

As mentioned, one distinguishing feature of our Project—ECHO is the partnership with the Area Agency on Aging (AAA). The AAAs in King County (where we are based) and in Southwest Washington (who serve a large area including many rural and underserved older adults) were our community partners for our initial application to the Geriatric Workforce Enhancement Program. AAAs coordinate and deliver Federal Older Americans Act (OAA) and other programs to help older Americans and their caregivers get the support needed to help them stay in their homes and communities. We created the position of Primary Care Liaison at these two AAAs as part of our Center. This position aims to decrease the silos between primary care and the community resources that can help keep older adults independent. I invited the AAA Primary Care Liaisons to participate in our ECHO session as panelists, and that ended up being a vital part of our program.

We track the content of our sessions, which are summarized in the Table below:

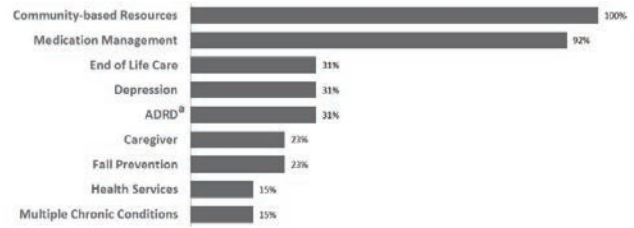

Table: Percentage of Project-ECHO Geriatrics sessions each topic was discussed
[a]Alzheimer's Disease and Related Dementias

As you can see, in every session, we discuss community resources. This is something of vital importance to the health and quality of life for older adults and can help avoid or delay a move to a higher level of care such as in a nursing home. The ECHO learners greatly value the input of the AAA staff, and the AAA staff have said that participating in ECHO helps them have a better understanding of how physicians think through complex cases. It helps us both speak the same language, which is the first essential step in ensuring the highest quality, evidence-based care for older adults.

AAA services save taxpayers money by helping older adults remain independent and healthy in their own homes, helping them stay where they prefer to live, and

[8] K. A. Bennett, et al. "Project ECHO-Geriatrics: Training Future Primary Care Providers to Meet the Needs of Older Adults." *Journal of Graduate Medical Education* (2018).

avoid unnecessary Medicaid and Medicare spending. AAAs have resources that can prevent falls, smooth transitions out of the hospital, help patients learn to manage their chronic diseases, and support family caregivers (just a few examples). The reauthorization of both the GWEP and the *Older American's Act* will help health care and AAAs work *together* to help older adults age successfully in place. I believe this collaboration is critical to improving the health and well-being for older adults and reducing healthcare costs.

The HRSA Geriatrics Workforce Enhancement Program supports geriatrics ECHOs and is essential to improving the care of older adults.

There are currently 10 geriatrics-focused ECHOs throughout the country. The current application cycle for the Geriatrics Workforce Enhancement Program recommended ECHO to all applicants, so we expect more very soon. Many geriatrics ECHOs do not have patient outcomes data quite yet, and we need continued funding to obtain this crucial information. Knowing that we are moving best practices to the front-line of primary care, and based on what I have seen, I am confident the positive outcomes are there.

I would like to take this opportunity to mention the need for reauthorization of the GWEP and the Geriatrics Academic Career Award program (GACA) programs and to thank Senators Collins and Casey who last week introduced the *Geriatrics Workforce Improvement Act* (S. 299). I have included with my written testimony a copy of the National Association for Geriatric Education's letter of support for this important bill. This bipartisan reauthorization and related funding are needed for the continued development of our Nation's primary care workforce. Currently there are only 44 GWEP sites in 29 states. The modest increase in the authorization in the bill (from $40.7 million to $51 million) will have an important impact on training in geriatric care, including the funds authorized for the GACA program which complements the GWEP, and support faculty that will teach and lead geriatrics programs. The GWEP is the only Federal program designed to increase the number of health professionals with the skills and training to care for older people. Nancy Lundebjerg the Chief Executive Officer of the American Geriatrics Society stated it clearly.

"*The GWEP provides support for the current transformation of primary care, while the GACA develops the next generation of innovators to improve care outcomes and care delivery. Together, these platforms play a critical role in developing the workforce we all need as we age*."

The bill will also assist in ensuring that rural and underserved areas will have geriatrics education programs.

ECHOs Need a Steady Funding Source to Have a Greater Impact

Project ECHO programs, in all topics, need sustained funding to do their work well and reach more underserved patients. ECHOs are supported through a patchwork of funding mechanisms that are often short-term and unpredictable. Just this month, the Center for Health Care Strategies released a report that reviews a wide variety of potential sustainability strategies for ECHO.[9] I am very hopeful that through this Committee, you will enact a strategy to sustain and grow ECHO to allow all patients, regardless of where they live, to receive the highest quality health care. Thank you for this opportunity to speak with you today and I look forward to answering your questions.

[9] Project ECHO: Policy Pathways for Sustainability. Center for Health Care Strategies. *https://www.chcs.org/media/Project-ECHO-Policy-Paper*__012019.pdf

NAGE
National Association for Geriatric Education
www.N-AGE.org

NAGEC
National Association of Geriatric Education Centers

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January 25, 2019

The Honorable Susan Collins
Chair
Special Committee on Aging
United States Senate
Washington, D.C. 20510

The Honorable Bob Casey
Ranking Member
Special Committee on Aging
United States Senate
Washington, D.C. 20510

Dear Chairman Collins and Ranking Member Casey:

On behalf of the HRSA Title VII and Title VIII funded Geriatrics Workforce Enhancement Programs (GWEPs) across the country, thank you for your past support of geriatric education and for introducing the *Geriatrics Workforce Improvement Act*. The National Association for Geriatric Education (NAGE) is pleased to offer our support for the *Geriatrics Workforce Improvement Act*, which will reauthorize the GWEP and once again make the Geriatrics Academic Career Award program (GACA) a part of the effort to prepare the geriatrics workforce for the aging of our population. We and the growing numbers of older adults, caregivers, and clinicians caring for elders will urge Congress to move quickly to pass your bill and provide the resources to address our nation's growing demand for geriatric care.

We appreciate the many discussions that your staff facilitated with NAGE, as well as with the Eldercare Workforce Alliance, the American Geriatrics Society, and The Gerontological Society of America during the process of developing this legislation. This authorization and related funding are needed for the development of a health care workforce specifically trained to care for older adults and to support their family caregivers. Currently there are only 44 GWEP sites in 29 states. The modest increase in the authorization in your bill will have an important impact on training in geriatric care. Likewise, the funds you have authorized for the GACA program complement the GWEP, and support faculty that will teach and lead geriatrics programs. The bill will also assist in ensuring that rural and underserved areas will have geriatrics education programs.

NAGE
National Association for Geriatric Education
www.N-AGE.org

NAGEC
National Association of Geriatric Education Centers

geriatrics and gerontology. Our mission is to help America's healthcare workforce be
better prepared to render age-appropriate care to today's older Americans and those of tomorrow.

Thank you for your continued support for geriatric education programs.

Sincerely,

Catherine Carrico, PhD
President NAGE/NAGEC
Associate Director, Wyoming Geriatric Workforce Enhancement Program, Wyoming Center on Aging
Clinical Assistant Professor, College of Health Sciences
University of Wyoming

NAGE is a non-profit membership organization representing GWEP sites, Centers on Aging, and Geriatric Education Centers that provide education and training to health professionals in the areas of

[SUMMARY STATEMENT OF KATHERINE BENNETT]

Good morning, Chairman Alexander, Ranking Member Murray, and distinguished Members of the Committee. Thank you for the opportunity to speak about Project ECHO, its impact on primary care, and my experience using it to improve the care of older adults. I am an Assistant Professor of Medicine and Geriatrics at the University of Washington, where I am the founding Medical Director of Project ECHO-Geriatrics.

Project ECHO, or the Extension for Community Health Outcomes, was designed by Dr. Sanjeev Arora, a liver disease specialist at the University of New Mexico. He sought to address the issue of inadequate access to his specialty care, particularly in rural and underserved areas. His Model involved a specialist team, or "hub", at an academic medical center and "spokes" who were primary care providers at community practices. Weekly video-based mentoring sessions included teaching and case consultations. With this model, wait times for appointments in his hepatitis C clinic were reduced from 8 months to 2 weeks, and the care provided directly by ECHO-trained primary care providers had equivalent outcomes to that provided by specialists.

Since then, Project ECHOs have been launched throughout the country for many complex conditions. ECHOs have shown impactful outcomes such as reduced hospital readmissions and reduction of physical restraints in nursing homes. The University of Washington was the first replicator of ECHO outside of New Mexico and has 10 ECHOs with topics such as hepatitis C, HIV, chronic pain, and my program, geriatrics.

In my work as a geriatrician, a specialty in critically short supply, I see patients who come from throughout the region. Many are on very long lists of medications. Others have dementia that has gone undiagnosed for years. Some have never been treated for osteoporosis despite falling and breaking bones again and again. These scenarios are not happening because primary care providers do not care, but because most have received minimal geriatrics training.

We launched Project ECHO-Geriatrics to address this problem. Our ECHO is part of our HRSA-funded Geriatrics Workforce Enhancement Program (GWEP). Our ECHO is unique because our primary audience is physicians-in-training throughout a regional family medicine residency network. Our specialist panel includes a geriatrician, social worker, psychiatrist, pharmacist, nurse, and Area Agency on Aging staff. Sessions focus on key primary care topics such as dementia, fall prevention, and depression. We have trained over 300 people across several states. I see the clear improvement in their care over time. For example, a young doctor wanted guidance to help a new patient, a woman in her 90's who was fatigued and having trouble getting around. She was on 36 medications! Months later the same resident presented a different patient. He told us how he had already worked to eliminate medications that are sedating or cause confusion and was now looking for suggestions to help her remain independent at home. This type of care improves quality of life for older adults *and* reduces costs from preventable hospital admissions and nursing home placement.

There are currently 10 geriatrics-focused ECHOs throughout the country. Many geriatrics ECHOs do not have patient outcomes data—yet—and we need continued funding to obtain this crucial information. Knowing that we are moving best practices to the front-line of primary care, and based on what I have seen, I am confident the positive outcomes are there. I am grateful to Senators Collins and Casey for introducing a bill to reauthorize Geriatrics Workforce Enhancement Programs and the Geriatric Academic Career Awards, which together will help us prepare the workforce to meet the unique needs of older adults.

Project ECHO programs need sustained funding to do their work well and reach more underserved patients. ECHOs are supported through a patchwork of funding mechanisms that are often short-term and unpredictable. Just this month, the Center for Health Care Strategies released a report that reviews a variety of potential sustainability strategies for ECHO. I have included this reference in my written testimony. I am very hopeful that through this Committee, you will enact a strategy to sustain and grow ECHO to allow all patients, regardless of where they live, to receive the highest quality health care.

Thank you for this opportunity to speak with you today, and I look forward to answering your questions.

The CHAIRMAN. Thank you, Dr. Bennett.

Ms. Watts, welcome.

STATEMENT OF TRACY WATTS, SENIOR PARTNER, NATIONAL LEADER FOR U.S. HEALTHCARE REFORM, MERCER, WASHINGTON, DC

Ms. WATTS. Chairman Alexander, Ranking Member Murray, and Members of the Committee, thank you for the opportunity to discuss how primary care affects healthcare costs and outcomes.

My name is Tracy Watts. I am a Senior Partner and the U.S. Leader for Healthcare Reform at Mercer, and I serve on the Board of the American Benefits Council. Mercer is a business unit of Marsh & McLennan Companies. It is a U.S.-based leading professional services firm with a global network of 65,000 experts in risk, strategy, and people. I have more than 30 years of experience helping Fortune 500 companies design, finance, and administer health care programs to lower costs and improve health.

As you know, 181 million Americans, well over half the population, receive healthcare coverage from their employer. Given the significant role that employers play in the healthcare market, I really appreciate the opportunity to participate in today's hearing. One of the ways that employers are working to improve primary care is through onsite or near-site clinics, as you mentioned Senator Alexander. I would like to share data from Mercer's National Survey of Employer-Sponsored Healthcare Plans to illustrate this point. If you are not familiar with our survey, it includes the responses from more than 2,500 employers and is the oldest, largest, and most comprehensive survey. The results are statistically valid, and they can be projected over U.S. employers with ten or more employees.

Over the past decade, the prevalence of onsite or near-site clinics providing non-occupational health services has increased, particularly among employers with 5,000 or more employees. Only 17 percent had a general medical clinic in 2007. By 2012, the number grew to 24 percent, and in 2018, we are at 31 percent, with another 10 percent of employers of this size considering adding a clinic by 2020.

In a follow-up survey of 121 employers that offer a worksite clinic, 61 percent say that the clinic has been successful in managing costs increases, and 71 percent say it has been successful in improving employee health and wellness. For the 41 percent that completed a financial evaluation, the return on investment ranges 1:1, to a high of $4.00 of return to every $1.00 invested. In my written testimony I included a case study with results of an evaluation we did of PepsiCo's onsite clinics, documenting a financial ROI of 3.1:1, plus increases in employee engagement and productivity.

For years, employers have been pioneering strategies that directly address the biggest cost drivers in the U.S. health care system. Our report, Leading the Way: Employer Innovations in Health Coverage co-authored with the Council, illustrates how employers recognize primary care as the foundation for better health care outcomes and value for their employee. For example, a professional services company contracted with a shared onsite clinic that is open 24/7 and saw a 10 to 30 percent reduction in health care spend over a 4-year period. Princeton University's Health-Coaching

Program helped participants reduce their hemoglobin A1C levels, translating to a 65 percent reduction in cardiovascular risk. 43 percent reduced their value A1C to a target level, and 10 percent to a pre-diabetes level.

In Mesa, Arizona, Boeing launched a direct primary care arrangement. The clinics receive a capitated per-member, per-med fee, providing all primary care required by the enrollee—much of what you have heard about. Boeing pays the fee for that. There is no cost to the employee to participate. Enrollment is optional. In the first nine months of the program, members with chronic conditions have gravitated to the TPC program at a greater rate than expected and with very positive results.

There is also a new front door that promises to change the way primary care is delivered by using more convenient means such as telehealth or even artificial intelligence supported technology that directs consumers to self-care, or triages them to the most efficient and convenient point of care. Eighty percent of employers offer telehealth today, although utilization is slow. Through research done by Oliver Wyman, we know that consumers are growing more comfortable with these technologies and 52 percent are showing a willingness to share personal health data in exchange for services tailored to their needs.

In closing, I would like to share two ways Government policies can support primary care. First, currently onsite medical clinics are included in the Affordable Care Act's Cadillac tax, and as the effective date nears, employers will have to start making tough financial decisions, and we may see some employers decide to walk away from onsite clinics. Full repeal of this tax would encourage expanded use of onsite and near-site clinics. Second, measures to allow more pre-deductible coverage and HSA-qualifying high-deductible health plans for people with chronic conditions, and to permit pre-deductible use of DPC telemedicine services or employer onsite medical clinics without risking HSA eligibility, would also increase the use of primary care services and would improve care adherence.

Thank you for the opportunity to share our employer data and these case studies with the Committee. I will be pleased to answer your questions.

[The prepared statement of Ms. Watts follows:]

PREPARED STATEMENT OF TRACY WATTS

Chairman Alexander, Ranking Member Murray, and Members of the Committee, thank you for the opportunity to discuss how primary care affects healthcare costs and outcomes.

My name is Tracy Watts. I am a Senior Partner and US Healthcare Reform Leader at Mercer, and I serve on the Policy Board of Directors for the American Benefits Council. I have more than 30 years of experience in helping Fortune 500 companies design, finance and administer their healthcare programs to control costs and improve quality of care.

Mercer is a business unit of Marsh & McLennan Companies (MMC), a US-based leading professional services firm with a global network of more than 65,000 experts in risk, strategy, and people. In addition to Mercer, the businesses of MMC, include Marsh, Guy Carpenter and Oliver Wyman, and we employ 25,000 colleagues in the US. Together, we collaborate with our clients to navigate the increasingly complex healthcare marketplace in order to: (i) help individuals, families and employees stay healthy and productive, (ii) enable innovation and (iii) lower their costs.

As you know, more than 181 million Americans—well over half the population—receive healthcare coverage through an employer. (US Census Bureau, Health Insurance Coverage in the United States: 2017). Given the significant role employers play in the healthcare market, I appreciate the opportunity to participate in today's hearing.

Employers, like other healthcare purchasers, have been plagued by ever-increasing healthcare costs. Because employers are frustrated with paying for the volume of healthcare services delivered rather than the value received, they are taking meaningful action to transform the healthcare system. This is the message of Leading the Way: Employer Innovations in Health Coverage, a report co-authored by Mercer and the American Benefits Council (the Council). The report notes that employers have pioneered strategies that directly address the biggest cost drivers in the US healthcare system. Employers recognize that primary care lays the foundation for better outcomes and better value in healthcare, and employer-led innovations have created greater value in healthcare spending by both the private sector and government.

Mercer employs 18 clinicians in our health and benefits consulting practice, including physicians, registered nurses and behavioral health specialists. I have often asked them, "What's the one thing that makes the biggest difference in an employee's health?" They've consistently said, "primary care." Primary care is ideally where care should start, including guided navigation across the confusing healthcare continuum.

Today I will focus my remarks on ways employers are working to improve employee health and manage healthcare costs through onsite clinics and other innovative strategies. I will begin by sharing some important and relevant findings from *Mercer's National Survey of Employer-Sponsored Healthcare Plans*. Then I will share case studies that profile new employer strategies. I will highlight some new technologies that are giving employees a smarter, more convenient "front door" to healthcare and close by suggesting some updates to the rules governing health savings accounts (HSAs) that would better align with these employer innovations.

Continued Growth of Onsite Clinics

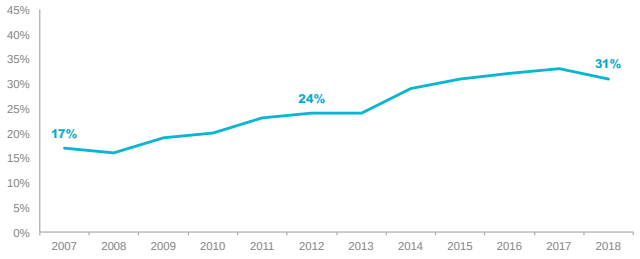
Mercer's National Survey of Employer-Sponsored Healthcare Plans includes responses from more than 2,500 employers and is the oldest, largest and most comprehensive survey of its kind. Its results are statistically valid and projectable to all employers in the US that offer health benefits and have ten or more employees.

Over the past decade, our survey has shown an increase in the prevalence of onsite or near-site clinics providing non-occupational health services, particularly among very large employers. General medical clinics are offered by 31 percent of organizations with 5,000 or more employees (up from 24 percent in 2012 and just 17 percent in 2007), and another 10 percent of employers of this size are considering adding a clinic by 2020.

FIGURE 1

Offerings of Worksite or Near-Site Medical Clinic for Primary Care Services

Among employers with 5,000 or more employees



Mercer National Survey of Employer-Sponsored Health Plans Copyright 2018 Mercer (US) Inc. All Rights Reserved.

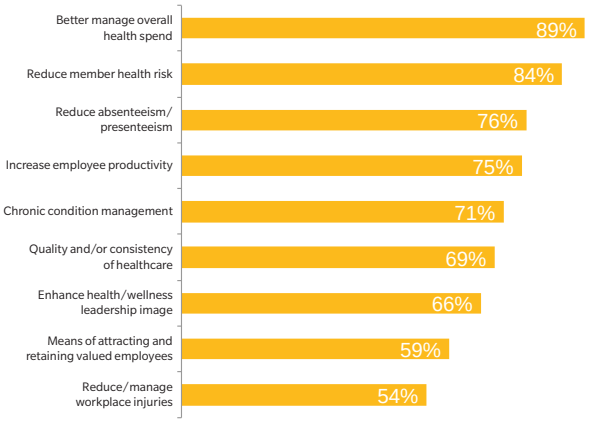
Among employers with 500–4,999 employees, growth has been slower. Though only 17 percent currently provide a general medical clinic, another 10 percent are considering adding one in 2020.

In a follow-up survey of 121 employers that offer a worksite clinic, employers listed their top objectives in establishing worksite clinics as: (i) better managing overall health spend, (ii) reducing member health risk, (iii) reducing absenteeism/presenteeism and (iv) increasing employee productivity and (v) chronic condition management.

FIGURE 2

Important Objectives in Establishing a Worksite Clinic

Percentage of respondents rating objective "Important" or "Very Important" on a five-point scale



When asked about their organization's perception of the financial success of the clinic in terms of reducing health benefit cost trend, 61 percent of respondents believe it has been successful. Respondents were also asked about the clinic's performance in improving employee health and wellness, and 71 percent say it has been successful in this regard. For 41 percent, the return on investment ranges from 1:1 to a high of 4:1.

TABLE 1. Return On Investment (ROI) for the Worksite Clinic in the Most Recent Reporting Period

Majority of respondents (54 percent) don't know or haven't attempted to measure ROI

Return	Percent of respondents
Less than 1.00	7 percent
1.00–1.49	11 percent
1.50–1.99	13 percent
2.00–2.49	8 percent
2.50–2.99	3 percent
3.00–3.99	3 percent
4.00 or more	3 percent

Source: Mercer's Survey of Worksite Clinics 2018

Case Study 1: PepsiCo Offers Onsite Clinics to Improve Employee Engagement and Manage Occupational Injuries

PepsiCo has over 45 onsite clinics throughout the United States that were established to treat and manage occupational injuries and act as an engagement point for employees' health intervention and wellness programs. They asked Mercer to

help them measure the impact of the centers using rigorous, defendable methodology. We used a best practice match cohort approach—which means we matched clinic users to non-users with similar episodes of care and other characteristics and examined multiple outcomes: healthcare, productivity and disability. The onsite clinics have resulted in:

- **Healthcare ROI of 3.1 to 1**. Clinic users had: healthcare savings of $117 per member per month, which was primarily driven by medical spend; lower utilization across all areas (outpatient, specialist, ER, inpatient, diagnostics, Rx); higher engagement in coaching and care management, but lower compliance. The majority of healthcare savings were seen in the first year after the first visit to the clinic.
- **Productivity 3.9 to 1**. Visits completed at the clinic compared to those with community providers generated $9.3 million or 47 Full Time Equivalents in productivity savings over the 3-year period, driven by non-occupational acute care visit savings.
- **No significant impact on disability or Workers' Compensation metrics for overall clinic users**. Among those who sought medical services there were reductions in short-term disability and long-term disability frequency and duration.

The following case studies are from Leading the Way: Employer Innovations in Health Coverage, the report from Mercer and the Council that profiles 15 companies that are implementing cutting edge strategies to manage healthcare costs, drive better quality and personalize the experience for their plan members.

Case Study 2: Professional Services Company Contracted with Shared Onsite/Nearby Primary Care Services Facility to Address Healthcare Cost Trend

A professional services firm provides employees and family members with free 24/7 access to onsite or near-site clinics offering primary care services and generic drug dispensing. The clinic accepts a fixed per-member per-month payment for the service. The reduction in emergency room and urgent care utilization has produced significant savings—from 10–30 percent in actual healthcare spend. Savings have been maintained year-over-year for 4 years.

Despite the positive results, the Affordable Care Act's "Cadillac tax" on high-cost health plans may prompt employers to reduce the types of services provided in onsite and near-site clinics, or close them all together. Currently, onsite medical clinics offering more than "*de minimis*" medical care are included in the excise tax calculation. As the Cadillac tax looms, we've been surprised by employers' continued commitment to onsite clinics. But as the effective date nears, employers will have to start making tough financial decisions—that unwavering support may not hold. This is one of the many reasons we continue to work for repeal of the tax.

Innovative Contracting Strategies

Onsite clinics aren't the only strategy employers are using to enhance the use and effectiveness of primary care. Taking a page from the patient centered medical home care delivery model, where you have a multi-disciplinary team of providers who proactively manage a patient's care, the following case studies illustrate some of the ways employers are incorporating aspects of that model into their own health plans.

Case Study 3: Intel Connected Providers to Focus on Outcomes, Eliminate Waste

Intel found members with chronic conditions needed assistance coordinating their care to avoid wasted spending and achieve improved health outcomes. They contracted with health systems in key markets to create accountable care organizations in which payment reflects performance on cost, quality and patient experience measures. With an emphasis on care coordination, the Connected Care program is achieving higher member satisfaction, lower cost trend and overall lower spending per member.

Case Study 4: Boeing Opens New Doors to Behavioral Health

Boeing is removing barriers to behavioral healthcare. Through an innovative program in one of Boeing's accountable care organizations, primary care doctors can consult directly with a psychiatrist's office during a patient's office visit—a collabo-

rative care model that produces better outcomes. A new program will provide members with same-day telephone or video access to a psychiatrist or doctoral psychologist for free.

Case Study 5: Princeton University Health-Coaching Program Targeted Diabetes

At Princeton University, diabetes was the biggest health plan cost driver with claims averaging $13,000 annually per member. By offering monetary incentives, they doubled participation in their health-coaching program. Sixty-six percent of those program participants reduced their hemoglobin A1c levels—translating to a 65 percent reduction in cardiovascular risk. Of those with high A1c levels prior to entering the program, 43 percent reduced their values to a target level and 10 percent to a pre-diabetes level.

These are just some of the ways employers are working to improve care under a fee-for-service system that does not encourage proactive health management activities by primary care providers, and where individuals only interact with providers when they are ill.

The case studies demonstrate how employer plan sponsors are succeeding at lowering costs and improving the quality of service through innovation. If recognized, scaled and promoted, the innovations highlighted in these studies can serve as a roadmap to fundamentally improve the healthcare system as a whole.

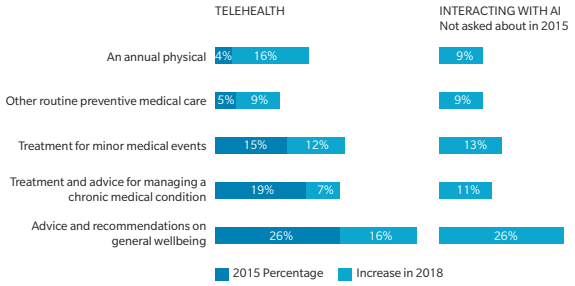
The New "Front Door" to Healthcare

I would be remiss if I didn't address how primary care is being affected by the new "front door" to healthcare. In general, this refers to moving certain types of care out of the emergency room and doctor's office and delivering it through more convenient means such as telehealth and Artificial Intelligence (AI) which helps consumers either direct self-care, or triage them to the most efficient and convenient point of care.

Telehealth has become the norm in employers' plans—it is now offered by 80 percent of employers. But consumer research recently conducted by our sister company Oliver Wyman found that only 10 percent of consumers have used telemedicine services over the past year. The utilization rate for AI was similar. Despite low utilization, openness to telehealth and AI has grown dramatically in the past 3 years. Consumers are growing more comfortable with these technologies and showing a greater willingness to share personal health data (52 percent) to receive services tailored to their situation. (*Oliver Wyman, 2018 Consumer Survey of US Healthcare: Waiting for Consumers*).

FIGURE 3: Openness to the New Front Door Has Grown Dramatically in the Past Three Years

Percentage of respondents who would consider receiving these health and wellness services via telehealth or interacting with AI



While we expect utilization of these services to increase, state licensure laws vary widely, adding complexity and uncertainty to telehealth consultation. There is also a danger that the new front door could further fragment care delivery without effective communication and information sharing back to a patient's primary care physician. Enacting policies that promote interoperability and greater transparency will help guard against fragmentation and support coordinated primary care.

Modernize Health Savings Accounts

In addition to the policy priorities outlined here, modernizing laws and regulations governing Health Savings Accounts (HSAs) would better align this increasingly popular plan design with innovative delivery system reforms that drive more efficient care and better outcomes. HSAs have been used to help make health coverage more affordable, encourage wiser consumption of health services and allow pre-tax spending on a wide range of qualified services. The current regulatory regime, however, has not kept pace with employer innovations.

We encourage Congress to pass legislation that would provide flexibility to allow more pre-deductible coverage in HSA-qualifying high-deductible health plans for people with chronic conditions, and to permit pre-deductible use of telemedicine services or employer onsite medical clinics without risking HSA eligibility. Such legislation should also allow individuals to use HSA funds to pay for "direct primary care service arrangements," a promising strategy being adopted by some major employers. These changes would help decrease overall healthcare spending and improve employees' quality of life.

Thank you for the opportunity to share our employer data and these case studies with the Committee. I'll be pleased to answer your questions.

[SUMMARY STATEMENT OF TRACY WATTS]

Chairman Alexander, Ranking Member Murray, and Members of the Committee, thank you for the opportunity to discuss how primary care affects healthcare costs and outcomes. My name is Tracy Watts. I am a Senior Partner and US Healthcare Reform Leader at Mercer, and I serve on the Policy Board of Directors for the American Benefits Council.

Employers have been plagued by ever-increasing healthcare costs, and they have responded by pioneering strategies that directly address the biggest cost drivers in the US Healthcare System. Employers recognize that primary care lays the foundation for better outcomes and better value in healthcare for their employees.

Some of the ways employers are working to improve primary care is through onsite clinics (offered by 31 percent of organizations with 5,000+ employees), telehealth (offered by 80 percent of employers), improved care coordination and proactive health management. The following case studies demonstrate how employers are lowering costs and improving the quality through innovation.

- PepsiCo's onsite clinics have: an ROI of 3.1:1, increased employee engagement, and generated a productivity savings of 3.9:1.
- A professional services company contracted with a 24/7 shared onsite clinic and saw a 10–30 percent reduction in healthcare spend.
- Intel connected providers to improve care coordination and is achieving higher member satisfaction, lower cost trend and overall lower spending per member.
- Boeing is improving access to behavioral healthcare and seeing better outcomes with their collaborative care model.
- Princeton University's health-coaching program helped 66 percent of participants reduce their hemoglobin A1C levels (translating to a 65 percent reduction in cardiovascular risk). Forty-three percent reduced their A1C to a target level and 10 percent to a pre-diabetes level.

If recognized, scaled and promoted, the innovations highlighted in these studies can serve as a roadmap to fundamentally improve the healthcare system as a whole. The transformation will require the full participation and collaboration of all stakeholders, including the government. Examples of ways in which the government can implement appropriate health policies include:

- Currently, onsite medical clinics offering more than "*de minimis*" medical care are included in the Affordable Care Act's "Cadillac tax." As the effective date nears, employers will have to start making tough financial decisions and we may see some employers decide to walk away from onsite clinics.
- Measures to allow more pre-deductible coverage in HSA-qualifying HDHPs for people with chronic conditions and to permit pre-deductible use of telemedicine services or employer onsite medical clinics without risking HSA eligibility should increase the use of primary care services and improve care adherence.

The CHAIRMAN. Thank you, Ms. Watts, and thanks to all four of you. We will now begin a five-minute round of questions. Dr. Umbehr, you mentioned something that I have been thinking about, which is we have conclusively proven on this Committee and on the Congress that we know how to argue about health insurance and take different positions, so my hope is that over the last year we have moved our focus from just health insurance, or even a portion of it at the individual market, to looking at reducing health care costs because, as you said, we are not going to have less expensive health insurance until we have less expensive health care costs.

Then our testimony last year was that as much as a half of our health care spending is unnecessary, which is a startling figure. And while there are no silver bullets in life, I have learned there are sometimes levers that make a difference, and primary care seems to be a logical, sensible focus for anyone seeking to improve outcomes, improve experiences, and lower costs, as all four of you have said, which is the purpose of this hearing. Now, the direct primary care services that you offer, and you went through an impressive list of lower costs, better experiences, and good outcomes—can you suggest to us two or three barriers to the expansion of what you do that we could do something about?

Dr. UMBEHR. Yes. The key focus that we have is on educating patients and employers, if this is an option, but also broadening the IRS's definition of what an HSA expanse is. Right now, it is a grey area.

The CHAIRMAN. Right.

Dr. UMBEHR. 213(d) says physician——

The CHAIRMAN. I believe that is a bill Senator Cassidy has—Senator Murray and others have. Would that bill make a difference in your opinion in the expansion of direct primary care?

Dr. UMBEHR. I think when that is left broad enough to encompass all types of care, often because we are primary care focused, we mentioned that, but as direct primary care grows, I think we will see an extension of that in direct specialty care.

We have also already launched direct neurology, endocrinology, pediatric endocrinology, cardiology. So, we want to make sure that we are not over-focused on just the value that primary care can give, but cardiologists and endocrinologist are burdened by the same problems in the system. If they had the opportunity for direct care as well, then that will further extend specialty care in the same way that we are extending primary care. So we want a very broad definition of what physician care is allowed for health care—health savings expenses.

The CHAIRMAN. Ms. Watts—let me go to worksite primary care. As I mentioned before he came, Senator Braun has some experience with that in his company in Indiana. In 1987, Senator Romney and I, when we were in the private sector, he in Boston and me in Nashville, each started a company on worksite daycare, which really had no Federal involvement, which grew into a big company when the two companies merged 10 years later. Worksite primary care seems to be an obvious solution to better outcomes, better experience, and lower costs. You have mentioned a couple of barriers to the expansion of worksite primary care. Can you say a

little more about the second one, which was the IRS treatment of health savings accounts and their connection to onsite worksite primary care?

Dr. WATTS. Right. So currently employers that offer an onsite health clinic, if they also have a medical plan that is HSA eligible, for anybody that is enrolled in the HSA eligible plan, they need to charge them the value of that visit so as to not disqualify those HSA contributions. And if that were not the case, those services would probably be provided for free or for a very low dollar copay. And so, it is just an extra layer of paperwork and administrative expense for employers that are offering those.

The CHAIRMAN. I have about 30 seconds left. Dr. Kripalani, telemedicine—what can we do about barriers to more effective use of telemedicine for primary care doctors?

Dr. KRIPALANI. One of the challenges that we experience is that currently in Tennessee those telemedicine services are only offered if the patient presents to a rural health care clinic that is deemed——

The CHAIRMAN. Whose decision is that? Is that state, Federal, or insurance?

Dr. KRIPALANI. I think it is insurance and probably state as well. So, I know right now we are in the process of starting a pilot within Vanderbilt for Vanderbilt insured employees to see about telehealth that is provided from the home to the clinic.

The CHAIRMAN. Thank you.

Senator Murray.

Senator MURRAY. Thank you, Mr. Chairman. Again, thank you to all the panel for excellent testimony. I really appreciate you all being here, and Dr. Bennett especially for flying all the way across the country. I appreciate you coming out here. I want to start with you, and thank you for telling all of us about the important work that you do. As we all know, there is a growing shortage of providers, you mentioned it in your testimony, who can provide appropriate care for seniors. In fact, the Commission of the Department of Health and Human Services estimates that by 2025 there will be a national shortage of nearly 27,000 geriatricians. So, one thing I want to focus on is one of the reasons why I am so interested in the way the University of Washington is using technology and Project ECHO to stretch resources for their—and improve health care quality in particular for patients. And I wanted to ask you how Project ECHO has helped improve patient outcomes, and can you tell us more about what those outcomes are that you hope to improve with this project?

Dr. BENNETT. Thank you, Senator Murray. So as I mentioned, a lot of Project ECHO-Geriatrics programs do not yet have outcomes. A lot of them are quite new. We have outcomes from programs that preceded ours that showed a reduction of physical restraints used in nursing homes by appropriate behavioral care, and also care transitions ECHOs that have reduced readmissions. In our particular program, we are looking at a few outcomes that we hope to move the needle on, some that we base on what we see with the residents, and that includes more appropriate prescribing of medication, reducing medications that can increase the risk of falls or cause cognitive impairment that is reversible because the medica-

tion is causing it. Also looking at whether primary care providers change their behavior, such as doing fall screening or advanced care planning with their patients.

Senator MURRAY. I assume that those improved outcomes would lead to lower health care costs?

Dr. BENNETT. Absolutely. Those are things that we know—preventing falls saves a lot of money. Falls are one of our most costly items in our health care system, more expensive than diabetes. So, if we could prevent some falls, we can save a lot of money.

Senator MURRAY. You said that a critical part of keeping employees is helping in controlling the growth of their insurance premiums. But I wanted to ask you and see if you would comment on another driver of health care costs for employers, and that is the cost of prescription drugs. Data shows that retail drugs alone account for about a fifth of employee health care costs similar to the amount that spend on hospital stays. I want to ask you as a consultant for a number of large employers, which types of drugs are contributing the most to cost increases?

Ms. WATTS. Currently, specialty drugs spend accounts for, on average, about 35 percent of prescription drug cost. But I think the thing to keep in mind is that it is probably going to go to 50 percent within the next couple of years. It is growing at the rate of about 20 percent a year on the——

Senator MURRAY. The specialty drugs?

Ms. WATTS. The specialty drugs spend. Right. And there are more than 300 drugs, specialty drugs, currently in the pipeline that will become available within the next 12 to 18 months. And a lot of these are drugs that are designed to treat orphan situations, so they are not, broad spread therapies. And this is the number one concern of employers as they are contemplating what they need to do to manage their health care spend.

Senator MURRAY. Are there any measures that employers are taking right now to drive down the cost of prescription drugs?

Ms. WATTS. Absolutely, especially with some of these higher cost drugs. They are looking at strategies that address side of care for where the drug is administered, and so in some cases, it is a lot less expensive to have someone administer that drug in the patient's home, which is actually a much nicer place for them to do that. And so, side of care is definitely a strategy. Where the drugs are purchased, some of the larger employers are starting to carve out their specialty drugs purchasing program to leverage lower spend. There is a case study in our white paper on that. So——

Senator MURRAY. What do you mean carve out?

Ms. WATTS. Go to a specialty pharmacy vendor where they can get directly lower pricing for those specialty drugs that enhanced over what we get through their pharmacy benefit manager.

Senator MURRAY. Thank you. And I will yield my time at this point.

The CHAIRMAN. Thank you, Senator Murray.

Senator Roberts.

Senator ROBERTS. Yes, thank you Mr. Chairman. I want to talk about rural health care, and to Dr. Umbehr, to Josh, in your testimony, you mentioned the value that a direct primary care model could bring to rural areas, and as has been said by Senator Murray

and the Chairman, one of the greatest threats to rural providers is the low and steadily diminishing volume of patients. You say that DPC is a valuable solution for rural areas because the model does not rely on a high volume of insured patients. Can you explain more about how your model can help increase access? Senator Murray said, access, access, access, and we all could say that as well, but access to care for rural patients?

Dr. UMBEHR. Absolutely. Thank you for the question. The typical fee-for-service insurance-based primary care office is going to need between 2,000 and 3,000 patients to be viable, 5 to 7 support staff per physician and a healthy mix of high-end, low-end insurers so that the providers can cover the cost of doing business. And in the Direct Care Model, we are able to minimize that. We have one nurse, one full-time equivalent employee for every two physicians. So, that drastically decreases the overhead. We pass those savings along to the patients. This model is very viable at 600 patients, with the physician actually having a slight increase in their income because of those savings on the overhead. We have been able to help over 600 physicians move to clinics like these or start their own clinics in the last few years.

The smallest town is Buena Vista, Colorado with a population of 2,500. I grew up in a town of 900 if you count everybody twice. And these models still work there because now you are going to catch most of that town because you are the only provider in the area anyway, but you can bring jobs to that area. Direct primary care can decrease small business health insurance premiums by up to 60 percent. Health insurance being the largest—second largest item on every employer's budget, and it is driving employees away from rural care. So, if we can bring employers back and decrease the cost of employing them while improving the access to care, this becomes an incredibly viable model.

Then of course telemedicine as well extends that reach so that patients in rural Kansas do not have to drive their farm—gas-guzzling farm vehicle 90 miles to pick up a medicine for $4.00 that should be $0.13. I think everywhere we look at this, it improves significantly.

Senator ROBERTS. Now, you mentioned you are expanding up and down I–70—that is the big interstate that goes through Kansas, and also on 54 over to Dodge City, which I am always interested in, but elaborate on how you are expanding this or how fast this model is really growing?

Dr. UMBEHR. About four years ago when we started doing all the consulting for Free for Physicians—we are movement obsessed. We want to see this movement grow and every time a physician attempts this model and fails it slows the movement. Every time they attempt it and succeed, the movement grows. Doctors are, for better or for worse, very evidence-based, and if the evidence in the model fails, they listen to that and vice versa. So, if we can get good information out to physicians—70 percent of primary care physicians meet criteria for burnout. It is not working well for them or their patients. Then when they believe there is a viable alternative, they start to explore that significantly. When we started, we would convert one or two practices a month. Now, we routinely convert 20 to 30 practices a month. So we are seeing a sig-

nificant increase as the pain of staying in the system, the status quo continues to grow, the incentive to change to a more cost-effective model rises as well.

Senator ROBERTS. Well, thank you for being part of the answer as opposed to the problem. Mr. Chairman, I remember the thrilling days of yesteryear when we passed the Affordable Health Care Act and I got all wound up with the four rationers, iPad, CMII, PCORI, and something called USPSTF, which is a preventive services task force, so I am not going—I cannot do anything with that acronym. So——

[Laughter.]

Senator ROBERTS. Two of those, one is expiring—iPad, there is no longer. I would hope that we could make some more progress on that, but your model does not have to contend with that.

Dr. UMBEHR. Correct. We are free from the paperwork process of scrubbing the chart, doing the paperwork, checking the boxes to make sure we get paid. We are doubling our efforts to show the patients that they are getting a high value for their care. They want preventative care. They want to know that they are meeting guidelines. We have to be overly transparent to say, well, the USTSPF does not find evidence to support testing of prostate cancer in men, but the American Academy of Family Physicians says, have a conversation with your patients, and the American Urology Association says absolutely check all men. So then we have to have a conversation with those patients, see where do you feel you most fit. When it is $1.69 to check, a PSA becomes a much easier conversation, but we still want to be cautious about incidentalomas, where we did something and now we have to do something with it. But we have the time, as my colleague mentioned——

The CHAIRMAN. We have to stay within the 5-minutes——

Dr. UMBEHR. Thank you, sir.

The CHAIRMAN ——if we can, so all the Senators——

Dr. UMBEHR. Yes, sir.

Senator ROBERTS. I led him into that——

The CHAIRMAN. I know you did.

Senator ROBERTS ——into that pasture. I apologize.

Mr. CHAIRMAN. Thank you both for your leadership. Thank you, Senator Roberts. Senator, Kaine.

Senator KAINE. Thank you, Mr. Chairman, and Dr. Umbehr, my dad is from Wamego. I spend a lot of time in Alma. Senator Roberts hates it when I say this. My dad was his fraternity brother at Kansas State.

[Laughter.]

Senator ROBERTS. I was his pledge son.

[Laughter.]

Senator ROBERTS. He comes to me on the floor, Mr. Chairman and says, Al Kaine, says hello, and I say, how do you know Al Kaine? He said, well he is my dad. Boy, to talk about making you feel like going to a critical access hospital.

[Laughter.]

Senator KAINE. He actually called me an epithet, which I am not going to repeat, when I said that.

[Laughter.]

Senator KAINE. But anyway, very good to have you all. I want to ask a quick question about workforce and I want to focus, Dr. Bennett, on ECHO, which I think is fascinating. So on workforce issues, Dr. Kripalani raised them, for the primary care workforce, I assume you all agree that the variety of public service loan forgiveness programs, whether it is National Health Service or others whereby we provide some kind of incentive, for example, loan forgiveness, to have folks go into important specialties like primary care or serve underserved populations, I assume you all agree that is an important component in having the primary care network that we need. Do you do you agree with that?

Just—the reason I want to point out is, if you think there is a way we can do it better. There might be opportunities. We are working on the Higher Education Act Reauthorization, and there are—it is part of the work plan for the Committee over the next couple of years. And so if there are ways to do it better that could more produce the workforce, primary care workforce we need, especially in rural areas, we would love the advice of folks on this panel.

Another—so that is number one. Number two, in Virginia a lot of the primary care workforce, especially in rural Virginia, are immigrant, often born abroad or sometimes born and trained abroad. Is that consistent with your own experience?

Dr. UMBEHR. To answer your first question, yes, I think loan forgiveness is helpful. But the way it is being done now is, I think it perpetuates the status quo. A lot of the times there is that string attached of if you go rural, you are going to accept state Medicaid, Medicare insurance because that is the current model. I mean that is not malicious, but if they were to broaden that as to just provide cost-effective care by whatever yardstick we measure——

Senator KAINE. In those areas.

Dr. UMBEHR. In those areas, I think that would incentivize adoption and innovation, as well as increasing the workforce in rural communities.

Senator KAINE. Any thoughts about the second half of the question dealing with immigration?

Dr. KRIPILANI. Thank you, Senator Kaine. You know, as far as foreign born and foreign trained physicians, I think there is definitely a large number of physicians who are joining the workforce and interested in working in the United States, particularly in rural areas. I know many of them find challenges in finding residency positions.

Senator KAINE. Right.

Dr. KRIPALANI. That is certainly a limitation in increasing that workforce for people who might be interested later on in primary care.

Senator KAINE. Sometimes between getting a residency match in March, and getting your immigration arranged to start in late June, early July that can also be very difficult.

Dr. KRIPALANI. Absolutely.

Senator KAINE. The point that I make in that, and then I want to move to ECHO, is immigration debates seem to be predominately about security, security, security. In my state, immigration is fundamentally about workforce. There are security issues that

are very, very real, but immigration is about workforce, and if we did not have foreign-born or foreign-trained health providers in Virginia, it would hurt our rural parts of the state in a very, very dramatic way. And so, we need to always think about immigration as a workforce issue.

Dr. Bennett, I want to ask you, your ECHO program is based on a national model of ECHO programs, some that focus on geriatrics in Virginia. We have an ECHO program structured in the same model, sort of a hub with telemedicine and other spokes out into the communities. And our focus in Virginia is a multi-university consortium to deal with Opioids and addiction issues using that ECHO model. And I am fascinated with the model. I am fascinated with its application. For example, the school nurses. I mean, I think there are a lot of opportunities to use that model. In particular, talk about your own model in dealing with the issues of dementia. This is an issue that Senator Collins and I, well everyone on this Committee, has focused a lot of attention on. So, Alzheimer's and Dementia care.

Dr. BENNETT. You know, dementia is a condition we are all dealing with. They are a growing number. One in ten older adults has dementia. It is really common and needs an interdisciplinary team to care for these folks. And so, our interdisciplinary panel provides suggestions, models, the interdisciplinary care that is needed for older adults with dementia. And it is not just making the diagnosis or providing medications, it is knowing how to support the caregiver and refer people to community resources. So, we include all of that in our ECHO and model so that the residents leave with those best practices.

Senator KAINE. Right. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Kaine.

Senator Cassidy is not here so, Senator Collins.

Senator COLLINS. Thank you. Mr. Chairman. Miss Watts and Dr. Kripalani, each of you mentioned the importance of patient engagement in the area of diabetes. In the aging committee, which I chair, we had a recent hearing in which Martin's Point, which is a Medicare Advantage Program in Maine, testified about their innovative diabetes program that included care managers who work directly with their members, with their patients, and it includes a weekly telephone call to check compliance with blood sugar readings, with diet, with the exercise. And it has had truly extraordinary results. Emergency room visits have declined by 10 percent for this population. Inpatient admissions have declined by 30 percent. But what they are struggling with is a lot of the work that they do is not reimbursed by Medicare. And Senator Jeanne Shaheen and I, who chaired the diabetes caucus, are trying to change that and to have Medicare, for example, cover diabetes self-management training sessions.

Could you talk about how reimbursement policies of insurers Medicare, Medicaid either impede or facilitate these kinds of interactions directly with the patient, that can try to avoid serious complications that can occur for people who are unable or do not comply? Doctor, we will start with you.

Dr. KRIPALANI. Thank you, Senator Collins. Yes, I agree with you 100 percent that the importance in having frequent check-ins for

patients with diabetes that is poorly controlled, or for patients who are struggling to remain consistent and compliant with their medications, is of utmost importance in adequately managing their diabetes and their chronic conditions that can be results of uncontrolled diabetes. I know in our clinic, we have a designated care coordinator for diabetes who we can call upon if we find that someone is struggling and needs additional resources and contact, and she can independently make phone calls and contact that patient in between visits to make sure that their needs are met, to make sure that they are able to afford their medications, and that there is no other issues that arise in between visits. And that has been extremely valuable in preventing elevated blood glucose causing someone to go to the emergency room to seek treatment.

Senator COLLINS. Thank you.

Miss Watts.

Ms. WATTS. You know, on the employer side, it is not uncommon these days for employers to have specialized programs that target diabetes, that they pay for outside of their traditional insurance program. We call them carve-out programs. And within these specialty programs, there is great technology that exists today, wireless glucometers that keep track of someone's A1C levels, and there is even a newer one that I have seen that can project out your A1C level for the next 12 hours. And think about how powerful that is, especially for childhood diabetics. And so those are the types of things that employers are doing to really push the market for better outcomes, better engagement, and compliance that results in an overall, healthier person. That helps prevent those emergency room visits and other higher costs of care.

Senator COLLINS. Thank you. Dr. Bennett, I appreciated your mentioning the Geriatrics Workforce Improvement Act that I introduced last week with Senator Casey. The statistics are really startling. We only have 7,300 geriatricians who are board certified. We need about 20,000 today and we are going to need 30,000 by the year 2030. In addition to improving health outcomes, could you explain why a geriatric capable workforce would also reduce costs? Unnecessary costs?

Dr. BENNETT. We can prevent falls. We can keep people living independently in their homes by good care of people with dementia, helping support their chronic diseases. Geriatrics is just made to save money.

Senator COLLINS. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Collins.

Senator Hassan.

Senator HASSAN. Thank you, Mr. Chairman and Ranking Member Murray, and thank you guys for this hearing. And count me in as a fan of medical homes and coordinated care. I also just wanted to thank all of you for being here today and for your work helping promote health care in our country and lowering costs. So, Dr. Bennett, I just wanted to follow Senator Collins' question just a little bit more because we know how much our population is aging. I am from New Hampshire where 18 percent of our total population is 65 years or older, and it is among one of the highest senior populations per capita in the country. So, we are in need of more pri-

mary care providers, especially those who specialize in geriatrics. And you have discussed in your testimony that there is a lack of geriatric training that primary care physicians receive. We just talked a little bit about how more expertise in geriatrics can help lower costs, but can you just put it in terms of patients for a second? How will this—how would an increase in geriatricians, and more training for primary care physicians in geriatrics, really help patient outcomes?

Dr. BENNETT. Thank you for that question. In geriatrics, we have a large body of research and a lot of experience knowing how to prevent things like falls, delirium in the hospital, which is very costly. We have learned how to reduce the length of stay and reduce the incidence of delirium, which helps patients live better. And geriatricians really focuses on four primary things. One is, what matters most to the patient. The second one being, making sure that we are screening for cognitive impairment and addressing it when we find it. Helping with mobility, making sure people stay moving around and independent, and preventing falls. And then the final thing is making sure medications and multiple medical conditions are well managed. So all of that complexity is in the geriatrics expertise realm and we have proven cost savings by addressing all of those four issues.

Senator HASSAN. A win, win. Better outcomes for patients——

Dr. BENNETT. Yes, the patients——

Senator HASSAN ——and lower costs.

Dr. BENNETT. The patients get what is most important to them, which is often quality of life and maintaining independence——

Senator HASSAN. Right

Dr. BENNETT ——while we are also saving health care costs.

Senator HASSAN. Terrific. Well, thank you. Dr. Kripalani, I wanted to touch on the issues of integrating behavioral health into primary care. We know that kind of integration can be really critical in addressing a patient's health care needs. But we also know that people across the United States are still struggling to access the behavioral health services they need, including substance use disorder services, which are obviously in great need throughout the country, in places like my state in particular. Congress is taking critical steps to encourage the integration of primary care services and behavioral health services, most recently with the passage of the Support Act. But it is clear we need to do more. So, I am interested in your thoughts about what Congress can do to further improve the integration of primary care and behavioral health services?

Dr. KRIPALANI. Thank you, Senator, for that question. You are absolutely right in that primary care needs more resources to help our patients who are struggling with mental health issues. In primary care, we actually provide a great deal of mental health services as it is, because we are usually the first place patients come to when they need help. However, we are not equipped to handle very complicated and complex cases, and we need ways in which we can easily refer patients to get into behavioral health in a timely fashion for those cases that we feel exceed our abilities. And right now, there is a significant delay in getting new patients in

to see a behavioral health specialist. It can take months, in Tennessee, and that is a big problem.

Senator HASSAN. Okay. Dr. Umbehr, Dr. Bennett, do you have anything to add to that? How can we do better at integrating these services?

Dr. UMBEHR. I think direct primary care encompasses so much. The broader the brush of value we can paint, the more patients we can attract. The ability to be outside of the insurance model allows maximum flexibility for the patient and the provider. Depending on the study, 22 to 75 percent of a physician's day, like you mentioned, is up to 2 hours on paperwork relative to patient care. When we were able to carve out that inefficiency, we get those 2 hours back for patient care. Now, we can extend our behavioral training to the patient.

The use of telemedicine—the depressed or anxious patient does not do the self-care necessary to schedule the appointment to make it during office hours. They are afraid to leave work because they are already anxious and they may be concerned that the employer is watching how many doctor visits they have. If they are up at 2 a.m., and they want to type out a long email to their provider, they should be able to. And be able to extend that conversation with their provider on an ongoing basis, I think, leads to much better outcomes. But also, when we can show that name brand Lexapro is $11.97 a pill, and generic Lexapro is $0.07 a pill, we just maximize the patient's ability to even get the care they might need. So, on all fronts that is very patient obsessed.

Senator HASSAN. Thank you. And I know I asked Dr. Bennett too, but I see I am over time, so can we ask Dr. Bennett to just come in on that quickly?

The CHAIRMAN. Well, let us go to the other Senators. Then you will come back for second round of questions, and we would like to, Senator Hassan.

Senator Romney.

Senator ROMNEY. Thank you, Mr. Chairman. And thank you to each of you for taking time to be with us this morning. Your thoughts and insights are actually quite encouraging and very much appreciated. I am going to begin by talking to Ms. Watts, and just to get your perspective on something. My limited experiences suggested that those places in our economy, in our lives, that are driven by consumers making choices with strong incentives or companies making choices based upon incentives, tend to have the quality go up and the price go down. Almost everything we buy or we use in our country today, the quality keeps getting better and better, the price gets lower and lower in real terms.

The exception to that is in areas where the Government plays a very heavy role, health care, education, the military. With the military, we are not going to have competition. We are not going to find a way to help consumers make those choices, but with regards to education and health care, it seems that incentives are one of the reasons why we are driving the cost up instead of bringing those costs down. You have been associated with Mercer for some time and obviously, do extensive work in the health care arena. Do we have an incentive problem, and is there a way to create incentives like companies that are doing what you are suggesting right now,

which is putting together these clinics at the work site. This seems like a no-brainer for a company to do. To make sure their employees are healthier and lower costs. Do we have an incentive problem in health care, and are there some broad ways that we ought to address those incentives?

Ms. WATTS. Thank you, Senator Romney. There is a theme. There is an underlying theme here where we are trying to make the transition from purchasing based on volume, than the services that are provided. You know, charging for each of those services to paying for delivering a value. So, the direct primary care model is an example of paying for delivering value. And that is definitely a focus of employers. There are a lot of large employers across the U.S. that are direct contracting with accountable care organizations purely for that reason, to get the value of the services. To focus more on, how are you driving the best outcomes, are people healthier once they have completed their treatment, how are we improving the health risk of our population, and so that very much is the focus and it is a big part of what is highlighted in our white paper that we wrote with the Council. But we have only made a little bit of progress. There are still many, many health care services that are fee-for-service that are not based on value, and then on top of that, we have the issue that Senator Murray asked about with regard to specialty pharmacy costs. And so, those are two things that we still have quite a bit of work to do.

Senator ROMNEY. Yes. Thank you. Dr. Umbehr, I am curious as to how it is that a direct primary care model is so much less expensive and requires one assistant for two physicians as opposed to five assistants for one physician. What is the major difference in cost? What is driving such a dramatically lower cost in direct primary care? I presume it is applicable to other sources of direct care for various specialties, and I imagine that some of this has to do with just keeping up with the insurance requirements of all the different insurance companies and so forth. But I presume these direct primary care physicians also have to deal with Medicare and Medicaid, particularly in rural areas where that would be a big share of their reimbursement. How do you get the cost down? How is it you are successful? And how do you deal with Medicaid and Medicare?

Dr. UMBEHR. Excellent. Thank you very much for those questions. I would like to say it is because we are so darn good——

[Laughter.]

Dr. UMBEHR ——but really this is not a proprietary model. This is the free market, like you alluded to. When doctors free themselves up from using 66 percent of their time doing insurance paperwork, they need less staff, they have lower prices, they can provide more value, but they can focus on solutions too. So, to speak to the specialty medicines, Remicade is a medicine we were working with a hospital, or an employer group in Maine. It was being charged $28,000 per month per treatment. The wholesale price is $1,100. I have a patient with brain cancer, 21, at college, and her insurance was charged $26,000 a month for chemotherapy we could get wholesale for $1,900. Same medicine, same supplier, the difference is between the wholesaler and the markup. And that is not to say that those companies are bad. They suffer the same burden

that you alluded to, which is if the primary care doctor has 66 percent of their day spent on paperwork, so does everyone else. And so the more middlemen there are, the higher that price goes up. When a physician is freed from that unnecessary work, they can thrive on what matters and that is finding those prescriptions. And really it is one website. It is a wholesaler. It is easy.

Senator ROMNEY. Thank you.

Dr. UMBEHR. Apologies for not getting to Medicare——

Senator ROMNEY. I could keep going if you let me, Mr. Chairman, but my time is up.

Dr. UMBEHR. I would like to come back to Medicare and Medicaid.

The CHAIRMAN. We can go back to a second round if you would like, but let us—thank you, Senator Romney.

Senator Casey.

Senator CASEY. Thank you, Mr. Chairman. We thank the panel for your testimony, your work in this area. And I know I have missed some of the testimony because of our finance committee hearing, but I will be brief and focus on Dr. Bennett's testimony. Doctor, I was looking at pages 4 and 5 of your, excuse me, your testimony and the interaction or interplay between community agencies and the geriatric workforce. In this case, I was thinking of the area agency, agencies I should say, on aging. We have in Pennsylvania a really robust network of those Area Agencies. And I guess the primary question I want to ask you is, can you share with us how partnerships between the primary care providers and the Aging networks, like Area Agencies, can both bring down spending as well as improve quality?

Dr. BENNETT. Thank you so much for your question, Senator Casey. I am a huge fan of Area Agencies on Aging. And we have partnered with Area Agencies on Aging as part of our Geriatrics Workforce Enhancement Program. Area Agencies on Aging are experts in addressing the social determinants of health, but most primary care providers and clinics do not know about the services of Area Agencies on Aging, so we created a program called the Primary Care Liaisons, where we with our workforce enhancement program funding, funded a position at two different triple A's. And their job was to go to primary care clinics and make sure they were aware of the Area Agencies on Aging resources. And by doing that, they were able to dramatically increase referrals.

The southwest Washington's Area Agencies on Aging just sent me their numbers. They increased referrals by 170 percent with this program. And Area Agencies on Aging have programs that are evidence-based and reduce costs. Examples include their Chronic Care Program, which helps older adults manage their chronic diseases. And that has been proven to save hundreds of Medicare dollars per month. Area Agencies on Aging, with Health Homes Innovation Program in Washington, were able to save 67 million health care dollars over 2 years by providing care coordination in the home. Very simple stuff. Just going to the home, making sure the patient was keeping track of their chronic conditions, and helping coordinate their appointments. And that saved lots of money. So, Area Agencies on Aging are perfect partners, and we need to do more of it.

Senator CASEY. Thanks very much and I will cut my question short. I might submit one for the record. I just note for the record what Senator Collins said. She and I have introduced the Geriatrics Workforce Improvement Act. We hope we can—and you spoke to that in both your testimony and answered her question. Mr. Chairman, thank you very much.

The CHAIRMAN. Thank you, Senator Casey.

Senator Cassidy.

Senator CASSIDY. Thank you. First, I want to know for the record, I think I heard Senator Murray say "y'all", and so I felt like I was back home for just a second. She must be from south Washington State.

[Laughter.]

Senator CASSIDY. Dr. Bennett, I am a big fan of Project ECHO. I have been out to New Mexico where they have used it. I am very aware of the incredible potential there. Ms. Watts, you mentioned that Princeton University is using monetary incentives to get diabetics to go through programs that have given so much benefit. I believe the ACA restricted the ability to lower obesity, clearly the major driver of diabetes. The ACA restricted the ability, I believe, to lower premiums for those who enter a weight loss program. What is the nature of these monetary incentives and how does it interplay with the ACA? And I may have my—I may not remember correctly regarding that, but still what is the nature of these monetary incentives?

Ms. WATTS. It is probably in the form of lower costs for diabetic supplies. Better discounts, lower costs, if you participate in the program, and perhaps that includes the glucometer and other materials, but also personalized coaching to help you deal with questions that you have about managing your condition. Many people, when they are first diagnosed with diabetes——

Senator CASSIDY. But that would not be a monetary incentive, that would just be kind of the general sort of wrap around——

Ms. WATTS. Right.

Senator CASSIDY ——to support somebody.

Ms. WATTS. Right.

Senator CASSIDY. By the way, I am a big fan of onsite clinics. When I was in my previous life, we took immunization programs to children in schools because it turns out working moms have a non-healthcare-related cost of taking their child to the pediatrician. They have to leave work. They have to pick up the child. They have to take the child to the pediatrician, and it is lower income mothers for whom the burden is greatest, because they have to take public transportation, for example. Often times that is the reason the child would not be vaccinated. So, I am totally with you on the onsite. I do think, I do not know, if we have to completely repeal the Cadillac tax, which I would not mind doing, to allow onsite clinics to be exempt from that consideration.

I will go back to the lower income worker disproportionally benefiting as a percent of their income from being a given a flu shot for free, and I do think that is something, although beyond the scope of this clinic—we should do that. It holds down cost and it should not cannibalize someone's HSA. Let me ask as well, you also mentioned using HSA for people with chronic conditions. Now,

theoretically that is what the HSA is for unless you are describing allowing HSAs to be marketed specifically for diabetics, or specifically for hypertensives. What did you mean by that?

Ms. WATTS. Yes. So I think the idea is that in order for a benefit plan to be HSA eligible, all of your expenses have to be applied to the deductible before they can be covered, with the exception of preventive care. And preventive care does not include helping to manage a chronic condition.

Senator CASSIDY. Meaning that you have to use your HSA if you want to go buy a glucometer or you want to see the doctor for that coaching which you described.

Ms. WATTS. Right. You would have to use your HSA dollars or you would need to meet your deductible before the insurance would cover it.

Senator CASSIDY. We could, if you will, come up with HSAs that would allow management of a chronic condition to not be subject to a deductible. I think that is what I am hearing from you.

Ms. WATTS. Yes. Yes, you could change the requirements of a high deductible health plan for HSA eligibility.

Senator CASSIDY. You are saying that you think that would be a positive development because—by the way, we have been talking about that and there are models in South Africa that do that. I think it would be wonderful for us to consider, but I am glad to hear you are endorsing that.

Ms. WATTS. Yes. Well, and I think as well, when you think about the direct primary care model, if we were able to use that, that also definitely benefits those with chronic conditions because all of their primary care is included in that direct primary care model.

Senator CASSIDY. Yes. Be still my heart, you are kind of Nirvana, where I think we should go to empower patients. Dr. Kripalani, you mentioned that you are not allowed to use telehealth, or at least not be reimbursed, unless Medicare or Medicaid—but are you in any capitated arrangements? I would be surprised if there was not an insurance plan by which you are taking the risk that they would not just say, manage the patient however you wish. If you waste money, you lose, but if you have a better outcome and lower cost, you win. Is that not—are these arrangements not allowing telehealth to occur?

Dr. KRIPALANI. Thank you for that question. As far as I know, those arrangements have not been negotiated with my institution. I know that they are through our employer plan. Through Vanderbilt's own plan, they are trying to create an arrangement where we can utilize telehealth, recognizing that will reduce the cost of insuring these patients and provide care in between visits.

Senator CASSIDY. I can see somebody thinking it could be a ruse. You just have some doc, who has lost his license in some faraway state just racking up telehealth, but if you are on a capitated two-sided risk, I can see it working. But you do not know of a legal barrier, rather it is just a question of the contractual relationship. Is that——

Dr. KRIPALANI. That is correct.

Senator CASSIDY. I am out of time. I appreciate it. I yield back.

The CHAIRMAN. Thank you, Senator Cassidy.

Senator Rosen.

Senator ROSEN. Thank you. Thank you, Chairman Alexander, Ranking Member Murray, thank you for being here, for what you do, and how you are improving patient outcomes every day and elevating the conversation of how we need to help, and treat, and expand our education in this area. And so, I think that the community health centers, the teaching health centers, we had a hearing about this just last week, are really important models for integrated health care.

But as we continue to expand those, we are going to have increasing doctor shortages and of course, shortages across the medical workforce support spectrum. So in my home state of Nevada, we actually ranked 48th in terms of a primary care physicians per capita. And if our state's population just remains stagnant, it would take over 2,500 doctors just to bring us up to the national average. And of course geriatrics. Nobody is like—no one is getting any younger, right. We have a rapidly aging population. More Americans are retiring to Nevada each year. And so, this gap, of course, is going to continue to widen over time. And so, to all of our witnesses, however, you want to answer, what are the barriers that we have to redistributing and increasing medical residency slots? Of course, we talk about scholarships, payment, debt, all those kinds of things. That is one part. But how do we do this to empower more physicians? And then also, how do we increase the medical support team for everyone, because doctor or provider—it does not work in a vacuum. You need an X-ray tech, a phlebotomist, etc., etc., etc. So, what ideas do you have to expand that or what challenges do you see to expand the residencies in our medical staffs?

Dr. UMBEHR. I would like to take that first question. Thank you very much, Senator Rosen. I would actually, just for kind of exploration, challenge the assumption that is often held that we are going to experience a physician shortage. If we stay in the current model, we absolutely will have a physician shortage. But the American Academy of Family Physicians has the most conservative estimate of this at 22 percent of a physician's time being spent in nonclinical paperwork during the day. They estimate that if that 22 percent of each physician's time was given back to them—that would be the equivalent of 165,000 full-time equivalent positions added back into the workforce. The most aggressive estimate is that we will have a shortage of 130,000 primary care physicians by 2025. So, it is less of a quantity and more of an efficiency issue.

Senator ROSEN. I want to ask you about the paperwork. Some things only the doctor can dictate. Some things insurance paperwork, we know that you have to labor intensive—you have to hire staff. But what you see it then, is a barrier to just you dictating your reports after that. That is not going to be eliminated, unless you have someone, I suppose in the room, right?

Dr. UMBEHR. Well, we have eliminated it, like, by not accepting any insurance Medicare, Medicaid——

Senator ROSEN. You do not dictate reports? What goes in the H&P, your physicals, all those things?

Dr. UMBEHR. Charting the experience of the visit is fine. Charting it for reimbursement is the issue.

Senator ROSEN. Okay.

Dr. UMBEHR. Making sure you hit MACRA and MIPS, medical decision making, all those things. And if—you could spend 30 minutes with the patient, but if you document it wrong, you will not be reimbursed for that time.

Senator ROSEN. No, I understand.

Dr. UMBEHR. Those are the restrictions. We can pay for patient care or paperwork. We cannot pay for both. If the barriers were removed for reporting, physicians would have more time to see more patients and that would take the burden off the shortage.

Dr. KRIPALANI. Thank you, Senator Rosen. I would like to comment on your mentioning the lack of access and the teamwork approach, which I think we definitely need to invest in, in primary care, in a more robust way. You know, I think that we need to find ways to combine mental health services, behavioral services, all within the structure of the visit when the patient is there. And I think if we can provide those services in real-time that would be much more impactful for the patient in allowing them to make sure when they walk out that door, that they have a full understanding of what their expectations are between then and their next visit.

Senator ROSEN. What barriers do you see to increasing just your workforce, not just physicians', but those that you need on the support team?

Dr. KRIPALANI. Well, currently under the current reimbursement model, those funds to actually employ those additional resources from, sort of more diverse fields, those funds are not there. Our clinics cannot afford to support those additional team members.

Senator ROSEN. Anyone else have anything to add?

Ms. WATTS. The reimbursement impacts what specialty people go into when they are residents. There is a huge debt burden and primary care has lower reimbursement in the current model. So that is a big barrier to more physicians going into primary care.

The CHAIRMAN. Five minutes is up.

Senator ROSEN. Five minutes is up. Thank you very much.

The CHAIRMAN. Thank you, Senator—thank you, Senator Rosen.

Senator Braun.

Senator BRAUN. Thank you, Mr. Chairman, Ranking Member Murray. I was not here for the beginning, but it is true about nine, ten years ago, we took on everything we are talking about here and would want to make the statement that the hardest part to get right was to get the industry to listen to what you are talking about. It was like pulling teeth the day we did it, and all I can tell you is that there is so much room for potential to lower costs if we just get it right. You see, I see here unprecedented transparency and I can see what you are offering is use the tools you have at your disposal, to give that to the folks that become members of your direct primary care. I can tell you that we work real hard to create transparency and I do not know how long it has taking you to get—to be able to peek in and see and get the industry to provide it.

I tried a simple bill in our state legislature that if you are in the business of providing health care services at any level, publish your prices in print or on the web, it was like it was going to blow up the place and I never even got a hearing, and that was in 2015. A lot of strides to make. We finally figured out how—what the for-

mula was. And if we all here wanted to start with something very simple, shed light on the process, let the consumer, like Senator Romney referred to, do all the work and there are ways for the folks that do not, maybe, have the resources to do it. In my company where—and I come from an area where we have not had to address that—you can even incorporate that in. Unprecedented transparency, we ought to focus on that. Skin in the game was the other thing and it was hard to do because people were relying on co-pays. I see here you have no co-pays, which means, I think, that they do not have to spend any money on that because you do not have co-pays.

In our case, we needed to get rid of co-pays to get some involvement in the process of buying health care. And then I had to make sure that I could lower costs enough to make sure they were not getting premium increases, and the tools that we could provide can make this whole thing work. Nine years, we have done it and it is due to the fact that we have done everything you are talking about, and the industry has got to get with it or else, I think, there is going to be a strong case to try other methods. And most of us in the business world, will throw our hands up in the air. That it has just been an industry too tough to break. $10 to $100 per patient, why such a wide range and what is the differentiation between one membership versus the other at that amount?

Dr. UMBEHR. Thank you very much for those questions. That is based on age only. So, kids 0 to 19 are $10 a month.

Senator BRAUN. Okay.

Dr. UMBEHR. $50 for ages 20 to 40. $75 a month, 45 to 65——

Senator BRAUN. Tied into the utilization rate as you age. Okay, that makes sense.

Dr. UMBEHR. Right. The employer rate though is a flat $50 for all adult ages.

Senator BRAUN. Okay. And then when we looked at clinics or direct primary care, first of all, the economy of scale, you mentioned 2,000 to 3,000 patients. It was a 1,000 to 1,500 then, and we would have had to have pooled or associated with other companies to do it. And you do have it to where 600 is a new lower economy of scale where many of your centers survive on that number of members?

Dr. UMBEHR. Thrive at that——

Senator BRAUN. Thrive. That is great. You made big strides there then.

Dr. UMBEHR. Just to hit on that point quickly because it pulls in the shortage issue, if doctors see fewer patients, there will inevitably be a shortage. But back to the efficiency, there are roughly 500,000 primary care providers, 300 million Americans. If each of them saw 1,000, that is 500 million Americans. So, we know somewhere that number is off. But 300 million divided by 500,000 is 600.

Senator BRAUN. Okay.

Dr. UMBEHR. There is the ability there to reach all citizens, especially with the advent of telemedicine.

Senator BRAUN. When we finally found the formula, and I think it is scalable, for what we do through Government, our improving private insurance, there does—there is a need just like in LASIK surgery. I mean that is simply providers and patients coming to-

gether, and that is fallen by 80 to 90 percent just by getting the market to work. Transparency from, what I see, is going to take a law to do it. Could not get it done in Indiana. And if we want to do one simple thing, the people in the business have to show us what they are charging. We do telemedicine, coaching, HSAs because we were at the critical level of being able to self-insure, which was about 300 employees. That enables everything to become consumer-driven. If you get entrepreneurs like yourself, I think there is a chance of taking costs out of the system because we are starting to do a few things that all other industries do.

Dr. UMBEHR. I think the benefit here is that based on the research from large corporate groups, 70 percent of jobs come from small businesses and they do not have enough employees to hire their own, but this essentially lets them do just that. So, they will have the same benefits of hiring a physician, but they can do it for 10 employees.

Senator BRAUN. You are at the leading edge of, I think, maybe the industry getting with it. So, thank you.

Dr. UMBEHR. Thank you.

The CHAIRMAN. Thank you, Senator Braun.

Senator Warren.

Senator WARREN. Thank you, Mr. Chairman. So, I would like to ask today about how to address behavioral health needs through primary care. I know that Senator Hassan asked about this, but I just want to dig in a little bit more on it because I think it is so important. At our Teaching Health Center in Lawrence, Massachusetts, medical residents get unique training in an underserved community, training to help with all of the challenges their patients face including mental health and addiction. All of the medical residents at Greater Lawrence Family Health Center are trained to prescribe medication for addiction treatment, training that not every primary care resident gets. Even so, we have a significant unmet need for services across the state.

A recent survey found that more than half of Massachusetts' adults under 65, who sought behavioral health care, either for mental health or addiction services, struggle to find treatment. Two out of five of them went without the care they needed. One in eight went to an emergency room when they needed treatment. This is not fair to those patients and it is not a cost-effective way to be addressing behavioral health. So, let me ask you, Doctor Kripalani, in Tennessee, how hard is it for your patients to access behavioral health services?

Dr. KRIPALANI. It is a very big problem in Tennessee. Thank you, Senator Warren, for asking that question. It is something we do struggle with every day. Up to 20 percent or more of residents of Tennessee, suffer from some sort of behavioral health disorder for which they need care. And primary care provides a good portion of this, but we are not equipped to deal with complex cases, and it is challenging for us to get patients in to see a provider in an efficient way. And so it is something we struggle with every day.

Senator WARREN. Very helpful to know. Are primary care providers able to provide some of this care or provide appropriate referrals, or do they need more support to be able to do this?

Dr. KRIPALANI. We absolutely need more support. Although we are able to manage a good bit of some of the simpler, more simple depression and anxiety cases, there are some more complicated medical and mental health issues that require specialist care. It can take months to get in. Many of the behavioral health specialists in Tennessee do not accept insurances and they require private pay or cash pay up front. And so, that further limits the patient's ability to get in with them. So, it is a further barrier.

Senate Warren. Yes, thank you. Thank you. That is very useful information. You know, it is clear that providers in primary care settings could also use more guidance on this. Luckily, there are some unique models that we can look to. Dr. Bennett, you have done a lot of work to train primary care physicians in geriatric care through Project ECHO. Can you explain what this program is and how it might be used to meet other needs like general behavioral health needs?

Dr. BENNETT. Thank you for your question, Senator Warren. Project ECHO is really meant to reduce disparities. It helps information that is otherwise monopolized by specialists get to primary care so that patients can get the care directly from their primary care provider. So, through video mentoring and case consultations, these primary care providers, over time, buildup that knowledge base. It is perfectly well suited for shortage areas such as behavioral health, and it has been already successfully used for that. There are behavioral health ECHOs that have trained providers in prescribing those medications for addiction that have been very successful.

Senator WARREN. Good. That is very helpful. You know, in Massachusetts, the Boston Medical Center has an ECHO program that does exactly what you are describing, helping providers in primary care settings across the state provide addiction treatment. There are other unique programs as well at Boston Children's Hospital. The Adolescent Substance Abuse Program partners with primary care practices around the state to get addiction expertise right where it is needed in the local doctor's office. Our health care providers are getting really creative, and they are working hard to provide their patients with the behavioral health care they need, but they need more support and training. I am committed to helping our frontline doctors, nurses, social workers, and other mental health providers get the support that they need. So thank you all for being here today.

The CHAIRMAN. Thank you, Senator Warren.

Senator Baldwin.

Senator BALDWIN. Thank you. So, patients face a number of obstacles when it comes to accessing the care that they need, and it is especially true when it comes to expectant mothers. I worked with my Senator Ryan and colleague Senator Murkowski, to enact recently the Improving Access to Maternity Care Act to help reduce maternity care shortages in rural and underserved communities. It impacts all of our constituents, but I remember hearing from a Wisconsinite, Rachel, who is a mother who lives in Sister Bay in Door County. She had to drive 90 minutes while in labor to the city of Green Bay just to find a doctor who could deliver her baby.

Our recently enacted legislation enables the health resources and services administration, HRSA, to begin collecting data on shortages of maternity care providers, similar to the data that they already collect on primary care provider shortage areas. It is going to allow us to better target our human resources through the National Health Services Corps and enhance patient care. Dr. Bennett, you shared how data has allowed you to advance and monitor improvements in the delivery of care and patient outcomes for our older adults. And so, I wonder if you could describe how existing data from our Federal agencies, including HRSA, has informed the development of the Project ECHO model around the country, and specifically interested in knowing where you have identified gaps in the data that is collected that this Committee should be aware of—that would be helpful for our Nation to collect?

Dr. BENNETT. When we all created our geriatric workforce enhancement programs the first time around, we all did local needs assessments in our areas to see what was needed for the older adults in that region. Most of that aligned across the country. A lot of the data collected has to do with how many people were training and does not really get at outcomes. But this time around, the application for the Geriatrics Workforce Enhancement Program is having us look at outcomes and helping us collect information about, are we moving? Are we increasing referrals to caregiver resources for people with dementia? Are we screening for falls? Are we reducing Opioid—are we addressing Opioid misuse in older adults? And all of these things will help us change the services that we create and change the education we create, in order to improve the care of older adults.

Senator BALDWIN. Excellent. Our family caregivers play an enormous role in a largely unrecognized and largely unkempt, uncompensated fashion, but they so help our Nation's elderly and disabled. The last data collected on family caregivers suggested that 40 million family caregivers provided an estimated $470 billion in uncompensated long-term care in 2013. It is an issue that is personal to me because I was raised by my maternal grandparents, and a much younger woman served as my grandmother's primary caregiver as she grew older and more frail. And it is why I worked with Senator Collins on the Committee to enact our Raise Family Caregivers Act, which more formally recognizes family caregivers.

That bill is just beginning to be implemented, and so Dr. Bennett, I wanted to ask you, given the growing population of older adults and the workforce shortages that you have given voice to, what should we be doing to ensure that our older adults and our loved ones with disabilities receive the highest quality of care in their own homes? And how do you see the need to empower family caregivers?

Dr. BENNETT. Supporting family caregivers is central to the Geriatric Workforce Enhancement Program, and one of the main foci, in addition to improving geriatrics and primary care. And a partnership with the Area Agencies on Aging is essential to solve this problem because they already have fantastic family caregiver support programs that have been proven to delay nursing home placement by up to 2 years. But primary care does not connect as well as it could with triple A's, and that is a huge part of the solution.

Senator BALDWIN. Okay. I am out of time.

The CHAIRMAN. Thank you, Senator Baldwin.

Senator Scott.

Senator SCOTT. Thank you, Mr. Chairman. And thank you to the panel for being here with us this morning. As the greatest provider of health insurance in the country, it makes sense that employers are looking for innovative ways to contain costs while ensuring a high level of care for their employees. A few years ago, Boeing established the Preferred Partnership Program, which allows the company to contract directly with health systems like Roper, St. Francis in Charleston to provide coordinated care specifically tailored to their employees.

The company discovered that they can improve health outcomes and lower costs by integrating primary care with behavioral health, and focusing on the 5 percent of the employees mostly with chronic conditions that produce nearly 50 percent of the costs. Boeing is also one of many employers in my state, including Volvo, BMW, Detyens Shipyard in North Charleston that provide care to their employees. And in some instances, even their families benefit from the care through these onsite clinics. Ms. Watts, what can we do to ensure that employers have the ability to continue to innovate in this space?

Ms. WATTS. Thank you, Senator Scott, for the question and the story that you told about the work that Boeing is doing is also documented in our white paper. We have seen growth in the use of onsite clinics, and I specifically cited survey data for larger employers, but we are actually seeing take up with that with smaller employers as well. We are at a point now where, on your own, you could have an onsite clinic with as few as 500 employees in a location. And there are also instances where several employers will get together and have an onsite or near-site clinic that several of them sponsor.

For all the reasons stated, it does help reinforce the value of primary care, as well as providing very necessary support for chronic conditions. So the things that could help support that would be, first of all addressing the fact that we cannot provide first-dollar coverage for certain services in HSA eligible plans, which has been mentioned. Also onsite clinics, the cost of them are included in the calculation for the Cadillac tax threshold, and even though that continues to be delayed, as that approaches, as the date for that approaches, employers are going to have to look really hard at where they are making their investments and whether or not that will continue to make sense.

Senator SCOTT. Thank you very much. Mr. Chairman, thank you.

The CHAIRMAN. Thank you, Senator Scott.

Senator Jones.

Senator JONES. Thank You, Mr. Chairman. Thanks to all our witnesses for coming here today. And I especially appreciate the testimony regarding telehealth, and ECHO program, and things because I think telehealth is a way that we can really, in today's world, get good quality health care into our rural areas. But when it comes to barriers, we also have a barrier in rural Alabama, in rural America, for lack of broadband. So, I hope that as you continue to advocate for telehealth, you will advocate for Members of

Congress and state legislatures around the country to increase access to broadband, because I think it is very important.

Following on that, Dr. Kripalani, there are a couple of other barriers, and you kind of touched on the fact that it would be great to get more people being seen in their homes, but it seems to me that one of the barriers that we have got is the originating site rules with reimbursements and that sort of thing. And I would like for you to just comment on that and how that might—removing those, might help in this entire area? And you might want to just explain for the record a little bit of what that originating site rule is.

Dr. KRIPALANI. Thank you, Senator Jones. Yes, so the originating site rule states that in order to provide telehealth services, a patient must present to a rural health clinic site that has been deemed an area of a low position coverage, and a—basically a site that is considered rural. And then that clinic site can then communicate via telehealth to a providing site that can then basically connect as a physician-physician or a clinic-to-clinic type of service.

I think this poses a great barrier to patients, because I think a great percentage of patients who would most benefit from telehealth services are those who have limited availability for transportation. And providing a service that will cover clinic-to-clinic coverage does not eliminate the transportation that patient has to provide to get from their home to this clinic site—to this originating site. So, that still continues to provide a major barrier for patients.

Senator JONES. All right, and if we—that just kind of fits into your model about trying to get more people into their homes. And transportation is always a problem, not just the cost, but sometimes just physical transportation is a big deal. Dr. Umbehr, I wanted to—I really appreciate your taking the time to talk to us about the Direct Care Model. One of the concerns that folks have expressed a lot in the last year especially concerns pre-existing conditions, and what protections in your model, the Direct Care Model, do people with direct care memberships have that their membership may not be terminated after they develop some type of time-intensive health care condition?

Dr. UMBEHR. It is a good question. What I would say is, what is the ability of a physician in an insurance accepting model to do the same thing? They have more incentives to see more patients who are less complicated in less time. So the insurance accepting provider is penalized extensively more by spending 30 or 60 minutes with a patient when they should be seeing four, five, six patients per hour. The Direct Care Model is trying to maximize that value.

One, you will have a reputation of not being able to care for sick people, and then essentially that is going to hurt the brand, but also if you can show that you can take care of sick people, then you will develop a reputation and brand for being a good provider and everybody wants to know that their doctor is capable. But also, as we accept patients, we do not know who is going to be sick and who is not, so we accept them all. And yes, some will develop complicated cases, but we develop relationships with these patients, with their employers. I think it would be inconsistent of the physi-

cian oath to just drop a patient because they have become complex. We continue to work with them. We may be able to do all their care. We may be required to work with a specialist. But again, actually, I think it is the current model that incentivizes doctors to accept easier patients over complex patients.

Senator JONES. Right. Well, thank you. Thank you all again for coming here. Mr. Chairman, thank you very much.

The CHAIRMAN. Thank you, Senator Jones.

Senator Murray, you have any other comment?

Senator MURRAY. I would just like to thank all of our panelists. It has been a very interesting focus today and you have all really contributed a lot, and we thank you for that.

The CHAIRMAN. Thank you, Senator Murray. I just have one question, Dr. Umbehr or anyone. I want to make sure I understand this. You are saying that a doctor may buy prescription drugs directly from the wholesaler——

Dr. UMBEHR. Correct.

The CHAIRMAN ——at these remarkably lower prices?

Dr. UMBEHR. Any physician in 44 states can do it.

The CHAIRMAN. State law allows it in 44 states?

Dr. UMBEHR. Yes. Any pharmacist could do it in all 50 states. As an example, of speaking to the cost of diabetic care, a glucometer, brand new, is $0.02.

The CHAIRMAN. Well, what about insulin? We hear a lot about insulin.

Dr. UMBEHR. Insulin does not have a generic and they fight hard against that.

The CHAIRMAN. It is the generic——

Dr. UMBEHR. Well, when there is a generic, there is competition. And so now, you might have four or five generic manufacturers creating a blood pressure medicine. And so now, they do not have a corner on the market, much like we saw with the EpiPen issue. Once they have a corner on the market, the price goes up.

The CHAIRMAN. But most drugs purchased are generic drugs now, right? 85, 90 percent. But, you can go—but the prices you gave are tremendously different prices. Is the price at the wholesaler the list price that the wholesaler paid the manufacturer, or less than that, or more than that?

Dr. UMBEHR. Well, the manufacturer would sell it to the wholesaler. I would assume that a keystone markup of 50 percent, but then the manufacturer does not want to do the legwork of working with individual physicians, pharmacists, hospital——

The CHAIRMAN. Yes, but let me go back, so there is a list price, that is the manufacturer's published list price. What does the wholesaler pay the manufacturer typically?

Dr. UMBEHR. Less than our price.

The CHAIRMAN. Less than your price?

Dr. UMBEHR. The prices are in my testimony——

The CHAIRMAN. The wholesaler must pay a lot less than the list price.

Dr. UMBEHR. Exactly.

The CHAIRMAN. Then charge you some markup.

Dr. UMBEHR. Our exact price from the wholesaler is in our written testimony. We mark everything up 10 percent. That covers the

$0.03 in the label, the $0.10 in the bottle, and the 2 percent in credit card fees, typically. So for us, it is a pass-through—very Costco-esque. It is our way of creating value that helps to justify the——

The CHAIRMAN. Well if any doctor can do that in 44 states, why do not more do that?

Dr. UMBEHR. Most do not know they can. Most pharmacists do not know they can. Most physicians are in a system where they are seeing 30 people a day and doing all the paperwork.

The CHAIRMAN. Wait a minute, they do not know they can go to the wholesaler and buy prescription drugs at that—much less expensively?

Dr. UMBEHR. As the Senator alluded to earlier, just shedding light on this topic would be revolutionary. Most physicians still are surprised to find out what the true wholesale price of medicines are, which is why we try to be so upfront with our data. We are making bold claims and we want to back that up with transparent data to show the true cost of care.

The CHAIRMAN. Well one of the problems with transparency is, as we found out with the Medicaid or Medicare published price, are incomprehensible to most people, but I think, on the other hand, at least it gives some nonprofit, or Bluebook, or somebody a chance to arrange that data in a way that an ordinary primary care physician could figure out what the prices are. Is that true?

Dr. UMBEHR. At our level of transparency, I do not think those things are necessary. The last time I went to Best Buy to buy a TV, the gentleman said we price quote, let me go see if anyone sells it cheaper, and we will match that price. He did not want me to leave the store.

The CHAIRMAN. Well, can you do that? Can you do that with prescription drugs?

Dr. UMBEHR. You cannot do that at the pharmacy because of gag orders.

The CHAIRMAN. But the gag orders we just repelled.

Dr. UMBEHR. Sure, but now it is hard still to shop because the pharmacist is not as interested in getting the lowest price, they are interested in the sales price.

The CHAIRMAN. But you could go to the wholesaler.

Dr. UMBEHR. The physician can, not the patient. So by the physician in this model doing less insurance paperwork, we have more time to fold that service in. So, we can go to the wholesaler for the patient and pass that to them.

The CHAIRMAN. Okay. Let me thank the witnesses. Senator Murray and I were just talking about how useful your testimony has been today and you could see from the large number of Senators who came and asked good questions. We appreciate it. We are looking for specific suggestions, and many of you have given us specific suggestions. In other words, we see the problem and we are beginning to understand it better. So, we need to know exactly, what can we do to help? So the more specific you are, as some of you have already been, the more help it will be to us as we see if we can agree on some steps to take. The hearing record will remain open for 10 days. Members may submit additional information for the record within that time if they would like.

Our Committee will meet again on Tuesday, February 12th at 10 a.m. for a hearing on managing pain during the Opioid Crisis. Thank you for being here today. The Committee will stand adjourned.

[Whereupon, at 12:02 p.m., the hearing was adjourned.]

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