

**PROGRESS IN HEALTH CARE DELIVERY:
INNOVATIONS FROM THE FIELD**

HEARING

BEFORE THE

**COMMITTEE ON FINANCE
UNITED STATES SENATE
ONE HUNDRED TWELFTH CONGRESS**

SECOND SESSION

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MAY 23, 2012
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PROGRESS IN HEALTH CARE DELIVERY: INNOVATIONS FROM THE FIELD

WEDNESDAY, MAY 23, 2012

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:08 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Rockefeller, Bingaman, Wyden, Nelson, Menendez, Carper, Cardin, Hatch, Snowe, and Thune.

Also present: Democratic Staff: Russ Sullivan, Staff Director; David Schwartz, Chief Health Counsel; Sara Harshman, Research Assistant; Tony Clapsis, Professional Staff; Karen Fisher, Professional Staff; and David Sklar, Fellow. Republican Staff: Chris Campbell, Staff Director; and Kristin Welsh, Health Policy Advisor.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will come to order.

Albert Einstein once said, “If you always do what you always did, you will always get what you always got.” As health care premiums were doubling from 2000 to 2010, it was clear we could no longer do what we always did. We could no longer tolerate what we always got when it came to our Nation’s health care. We all have common goals: to reduce health care costs and improve health care quality. How do we do that? Innovation plays a key role. That is the focus of our hearing today.

It is not the type of innovation we normally think about in the health care industry; it is not developing a new drug or device in a laboratory. The innovation we are talking about transforms the way providers deliver care to patients. This innovation means patients spend more time with their doctors rather than talking to the insurance companies. This innovation encourages doctors and nurses to communicate more with their patients and with each other about patient care, and it makes us spend our scarce health care dollars more wisely.

The private sector has always been at the forefront in creating innovative ideas. They have to. Now the entire health care community is involved. Employers, health plans, Medicare, and Medicaid are committed to innovation, and providers of all kinds are engaged to improve the way health care is delivered.

We will hear about this innovation from our four witnesses today. We will hear about how they are working individually and working together to lower costs and improve quality.

Health reform encouraged this innovation, and we must continue to build on the progress. Medicare and private payers are together sending one message to providers: from now on we will pay for quality, not quantity. It is a message that providers have already begun to hear and respond to.

Starting in October, Medicare will start paying hospitals more money when they produce better results for patients. Hospitals that produce poor outcomes will get less. For the first time, hospitals will be penalized if patients are readmitted too often. Almost 1 in 5 Medicare beneficiaries is readmitted to a hospital within 30 days of discharge. We need to encourage providers to do the job right the first time.

I am encouraged to see the private sector aligning with this effort. This year the insurance company Wellpoint will require all hospitals it contracts with to be subject to similar programs. These incentives provide a common-sense foundation to change behavior. The private sector cannot do it alone, nor can Medicare and Medicaid do it alone. The only path forward is through partnerships between the public and private sectors.

That is why we created the Centers for Medicare and Medicaid Innovation, known as the Innovation Center. Medicare and Medicaid are now engaged on the front lines and working with the private sector to find new models of payment in delivery of care.

The concept is simple: find the best ideas and test them. If they work, expand them. If they do not, move on to new ideas. Already the Innovation Center has launched more than a dozen new projects. These projects involve more than 50,000 providers in almost every State in the country. They try out new payment models to reduce costs and make patients healthier. We know that there cannot be a one-size-fits-all solution. Health care in Missoula, MT is different from health care in McAllen, TX.

I look forward to hearing about the innovative models our four witnesses are developing. Their experience in pioneering new approaches and partnering with Medicare and Medicaid should be instructive to us all. So let us embrace innovation as an opportunity to change things for the better. Let us encourage public-private partnerships. Let us do this to lower health care costs for consumers and for taxpayers. Let us do it to improve patient care and, as Mr. Einstein advised, let us not always do what we always did.

[The prepared statement of Chairman Baucus appears in the appendix.]

The CHAIRMAN. Senator Hatch?

**OPENING STATEMENT OF HON. ORRIN G. HATCH,
A U.S. SENATOR FROM UTAH**

Senator HATCH. Well, thank you, Mr. Chairman. I want to thank Chairman Baucus for convening today's hearing.

Americans are looking for areas of agreement between our two parties on health care, and I have been very clear about my opposition to Obamacare, the President's health care law. This deeply flawed law spends too much, it taxes too much, and it does really

nothing to address the fundamental challenge of rising health care costs.

However, the chairman and I agree on the need for providers and payers to work together to provide higher quality, better-coordinated care to patients. Our witnesses this morning all have tried innovative methods to achieve that shared goal. According to the Medicare Payment Advisory Commission's most recent report, last year Medicare spent over \$229 billion on inpatient hospital and post-acute care for Medicare beneficiaries. Now, this represents 43 percent of total Medicare spending.

Meanwhile, the population of Medicare beneficiaries is exploding. Last year, the first Baby Boomer became eligible for Medicare. By 2031, it is projected that 80 million people will be Medicare-eligible. As these retirees enroll in Medicare, government spending is bound to mushroom.

As most health care providers will tell you, in addition to an aging population, we face a growing number of patients with chronic illnesses such as diabetes or heart disease. These patients are sicker and more expensive to treat. While providers are doing their best to manage these patients, too often our health care system is not structured for easily coordinated care.

Currently, we have a system of silos. Patients are seen in a variety of settings: doctors' offices, hospitals, or nursing homes, and it is not uncommon for a health care provider to have an incomplete picture of all the care a patient is receiving.

Furthermore, a fee-for-service system provides little financial incentive to manage care properly. Instead, the incentive is to increase the volume of services. Reducing costs will require that patients receive the right care in the right place at the right time.

Increasingly it is private payers, on behalf of employers, who pressure providers to reduce costs, providing better care and better health outcomes. Patients deserve and demand better care. In my own home State of Utah, we are privileged to have some of the Nation's best, most efficient health care providers, but not all providers are created equal. Much of our health care system is fragmented, and often the right hand does not know what the left hand is doing.

Unfortunately, the patient is caught in the middle, with very little coordinated care. We know from our witnesses today, as well as other health care leaders, that there is a needed focus on care transitions. Many errors can be avoided when health care providers keep this focus.

Of late, much attention has been focused on the Center for Medicare and Medicaid Innovation, CMMI, and the flourish of activity it has created. Like many of my colleagues, I remain concerned that CMMI has an enormous budget and very little accountability.

It is more than a little ironic that an organization touting quick, innovative change and efficiency took over 5 months to respond to my request for very basic information on its strategic plan and an accounting of how it is spending \$10 billion of taxpayer money.

In addition to continued oversight of CMMI, I intend to ensure that the pilots and programs they develop actually work for our seniors. For example, when CMMI unveiled the Accountable Care Organization, or ACO, pilot, most providers felt it simply would not

work, was unnecessarily burdensome, and did nothing to advance the cause of higher quality, lower costs, and more efficient care.

Many of our witnesses today have very interesting stories to tell about how they are transforming care within their communities. They identified a problem, knew a solution was needed, and did not wait for the government to tell them how to best fix the problem. I would have to say innovation has happened in every community and in all sizes, and no one knows better the needs of the community than the caregivers on the ground.

I know this is not easy and often takes years to develop, but I congratulate all of you for the great work that you all are doing every day. I look forward to hearing from our witnesses and learning about how others can hopefully adopt some of these great ideas and achieve positive results in their own communities, and I appreciate you holding this hearing, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

[The prepared statement of Senator Hatch appears in the appendix.]

The CHAIRMAN. I would like now to introduce our witnesses. First is Dr. Richard Migliori, executive vice president of Health Services, UnitedHealth Group. Doctor, thank you very much for taking the time to come and for your testimony.

Second is Dr. Lee Sacks, executive vice president and chief medical officer of Advocate Health Care. Dr. Sacks, thank you for your time here.

Dr. Marc Malloy is chief executive officer of Renaissance Medical Management Company. You too, sir; thanks very much for being here today.

And Mr. Paul Diaz is chief executive officer of Kindred Healthcare. Mr. Diaz, thank you too.

So let us begin. You know our procedure. You may each speak for about 5, 6 minutes, whatever seems most appropriate. Your statements are automatically included in the record.

This is a very important subject, so just tell us what you think and make the best use of this hearing. Thank you very much.

Dr. Migliori?

STATEMENT OF RICHARD MIGLIORI, M.D., EXECUTIVE VICE PRESIDENT OF HEALTH SERVICES, UNITEDHEALTH GROUP, MINNETONKA, MN

Dr. MIGLIORI. Thank you, Chairman Baucus and Ranking Member Hatch, for holding this important hearing and for the opportunity to share UnitedHealth Group's recommendations on improving the health care system.

At UnitedHealth Group, I focus on innovations focused on improving care delivery through technology and health services. UnitedHealth Group is a diversified health and well-being company based in Minnetonka, MN. We serve over 75 million Americans through contractual partnerships with more than 85 percent of America's hospitals and physicians. That activity generates more than \$300 billion in annual health expenditures and, as I will explain, it is also a rich source of information that helps us improve the system.

UnitedHealth Group has the privilege of partnering already with approximately 300 Federal and State government agencies. We are the country's largest provider of Medicare Advantage plans and Medicaid managed care plans. We are honored to have recently been awarded the Department of Defense Tri-Care contract to manage health care services for beneficiaries in the West region. We administer large-scale databases for CMS and the Office of Personnel Management. We are also proud to partner with CMS on various demonstration initiatives, including the ACOs.

To create sustainable access, however, to high-quality, affordable health care, we must address variations in the quality of care, increases in the prevalence of chronic diseases, and fragmentation of existing information, as you both noted in your introductory comments.

With our partners, UnitedHealth Group addresses these challenges by embracing wellness and prevention programs that foster behavioral changes, by empowering consumers with decision support tools through transparency initiatives, and finally by aligning incentives and driving better outcomes through data analytics and payment reform for the health care delivery system.

These innovative approaches are deployed in the private marketplace today at full scale, but they are not as widely available in the government health programs. Broader adoption of these kinds of programs would lead to better quality outcomes at lower costs for Federal and State governments, and most importantly for the American people.

In short, we believe better information leads to better decisions, resulting in better health. To help us achieve those goals, we invest \$2 billion annually just in technology. UnitedHealth Group's prevention programs use technology to identify and mitigate risk of disease by fostering behavioral changes.

To prevent the onset of diabetes, we partnered with the CDC and the Y to develop the Diabetes Prevention Program. This diet and exercise program helps create healthy lifestyles for people on the cusp of developing diabetes. The results confirm that this program works, and we estimate that, if Medicare fully embraced and reimbursed programs like it, the Federal Government could save about \$70 billion over 10 years.

Enhancing transparency is also critical to modernizing the health care system. UnitedHealth Group's decision support tools empower people to be better health care consumers and decision-makers. Our treatment cost estimator provides a comprehensive view of quality and cost differences among providers. It delivers personalized cost estimates for treatment options for hundreds of diseases, including surgical procedures and tests, giving consumers more control of the quality and cost of their care.

Lastly, effective delivery system reform requires aligning incentives in driving better outcomes through broader adoption of pay-for-performance programs and data analytics. We measure to ensure that care delivery achieves quality and efficiency. When physicians deliver high-quality, efficient care, we can offer a variety of value-based reimbursement structures that reinforce optimal results.

Our premium designation program is a comprehensive tool for physician performance assessment. We assess care quality as defined by specialty societies and other independent credible medical experts. High-performing doctors are designated in our online and mobile directories, but, most importantly, premium physicians deliver care that is 14 percent lower in cost on the basis of better decisions and fewer complications. Importantly, the program has received positive feedback and engagement from physicians and medical societies.

Public-private collaboration on delivery system reform will produce better results for the American people. We are eager to partner with the Federal Government to bring our resources, best practices, and innovations to the public marketplace.

Together, we can use existing information to improve health, to create transparency, and to improve the health care delivery system so Medicare and Medicaid patients will experience higher quality and more affordable care.

We look forward to continuing to be a resource to the committee, and thank you for your leadership on this important issue.

The CHAIRMAN. Thank you, Doctor.

[The prepared statement of Dr. Migliori appears in the appendix.]

The CHAIRMAN. Dr. Sacks, you are next.

STATEMENT OF LEE SACKS, M.D., EXECUTIVE VICE PRESIDENT AND CHIEF MEDICAL OFFICER, ADVOCATE HEALTH CARE, OAK BROOK, IL

Dr. SACKS. Chairman Baucus, Ranking Member Hatch, and members of the committee, thank you for inviting me to testify before you today. My name is Dr. Lee Sacks. I am the chief medical officer of Advocate Health Care and the CEO for Advocate Physician Partners.

Since a picture is worth a thousand words and I just have 5 minutes, my understanding is the staff has given you five slides to follow along with my comments.

The CHAIRMAN. All right.

Dr. SACKS. Advocate Health Care is a faith-based not-for-profit integrated delivery system with roots that go back over 100 years in metropolitan Chicago. We have everything from academic medical centers down to a 25-bed critical access hospital in Eureka, IL, as we have been in central Illinois the last 3 years.

Advocate has been very focused on engaging physicians, because they are the key to our success, and has a pluralistic physician platform. Today we have over 6,000 physicians on the collective medical staffs; about 4,000 are partnered in Advocate Physician Partners.

Within the 4,000, we have 3,000 who are in independent practice, mostly solos, 2-, and 3-person practices, and another 1,000 who are employed in our two large medical groups, Advocate Medical Group, or AMG, and our Dreyer Clinic.

Advocate Physician Partners has a 17-year history that started off doing capitated managed care. Today, we have 230,000 capitated lives, and we have 245,000 attributable lives in a commercial ACO-like arrangement that started in 2011.

APP has been recognized for our clinical integration program, which has created value for our patients, for employers, and for payers. We liken it to an umbrella over our local physician hospital organizations and medical groups, each of which has a medical director who continues to be a practicing physician in the local community, respected by his peers, supported by staff and by a local board which create accountability and drive results. This has created value for the communities that we serve.

Clinical integration is a difficult term to understand, so my last slide is a schematic to help picture what this means. Take a patient, Jane Smith, in her 50s with diabetes. Jane sees a primary care physician. She gets prescriptions filled, she has lab tests periodically, she checks in with an endocrinologist regarding diabetes, she has a screening mammogram according to guidelines, and she sees an OB/GYN for female issues. For all of those encounters, data goes into the APP Data Warehouse and populates our disease registries.

The disease registries—we have 10 chronic disease registries, starting with conditions that are high-cost and have an opportunity to create value, such as diabetes and congestive heart failure. We also have registries for wellness: adult wellness, screening for breast cancer and colon cancer, pediatric wellness, tracking immunizations.

The registries are an opportunity to assure evidence-based care and best practices by all of our clinicians. So, whenever Jane or another patient sees one of our physicians, they have access to the registry. If they use electronic records, it populates the record automatically.

If they are on paper, they can access the registry through a web-based browser. It guides them to assure that every one of the patients in the registry gets evidence-based care and that we work to optimize their results. It takes a team of physicians supported by other clinicians to provide optimal results in those chronic diseases.

What I consider to be the critical success factor for our performance is that we have been physician-driven. We use the same metrics across all payers. Additional dollars in our pay-for-performance program recognize that it takes work that is not paid for in traditional fee-for-service to accomplish managing chronic disease, and we provide infrastructure to our independent physicians to surround them with resources so that they can perform like a large multi-specialty group.

That includes governance, technology like the disease registry, practice redesign coaches, patient outreach programs, office manager training, and physician education through our e-university. In 2011, we entered into a shared savings contract with Blue Cross of Illinois that covers 245,000 attributable lives and 150,000 HMO lives.

Results to date have achieved what both Blue Cross and Advocate set out to accomplish: we have bent the cost curve while maintaining our market-leading outcomes in service and safety. We have applied to participate in the Medicare Shared Savings Program to start July 1, and have been told that we will have over 150,000 assigned lives.

In conclusion, we realize that the current fee-for-service system is not sustainable and have focused on innovative changes that enhance value. Despite the challenges, this is an exciting time to be a leader in health care with an opportunity to make a difference.

I look forward to your questions.

The CHAIRMAN. Thank you, Dr. Sacks.

[The prepared statement of Dr. Sacks appears in the appendix.]

The CHAIRMAN. Mr. Malloy?

STATEMENT OF MARC MALLOY, PRESIDENT AND CHIEF EXECUTIVE OFFICER, RENAISSANCE MEDICAL MANAGEMENT COMPANY, WAYNE, PA

Mr. MALLOY. Chairman Baucus, Ranking Member Hatch, and distinguished members of the committee, thank you for the opportunity to be here today. My name is Marc Malloy. I serve as the president and chief executive officer of Renaissance Medical Management Company. I am honored to be asked to share with you our experience as an industry leader driving innovation in health care delivery.

Renaissance is a physician-owned network of 230 primary care physicians located in the suburban market of Philadelphia. It is one of the 32 pioneer ACOs chosen by CMMI.

Since 1999, Renaissance has been focused on improving patient outcomes, improving quality of care for the population served, and lowering medical costs. We exist to support our patients through the practice of high-quality medicine in an economically sustainable way. We have never shied away from the challenge of improving our patients' well-being, delivering high-quality care, and controlling cost. Renaissance has invested in people, processes, and technologies to achieve results.

From a practical perspective, the physicians understand that the best way to improve quality and lower costs is to focus on three primary areas. First, keep people healthy. At the root of our success is the commitment of our physicians whose daily efforts ensure that we focus on prevention and wellness.

We do this by making sure that our patients get health screenings that they are supposed to receive and by making available to patients up-to-date information and tools to become active, engaged partners in promoting their health. In addition to the obvious benefit of patients staying healthy, if we can prevent patients from developing a medical condition, we can completely avoid the costs associated with that care.

Second is mitigating the health risk factors. In order to improve the health and well-being of the people we serve, it is critically important that we ensure that the individuals understand how their family history and lifestyle affect their well-being and how to mitigate their health risks. Our physicians regularly screen the patients to identify patients with emerging conditions so that they can effectively treat any of the emergent issues before they become more serious.

Once we identify the risk, we work with the patients to create personalized goals and target appropriate, proven interventions, such as tobacco cessation, stress management, nutritional coun-

seling, physical activity, and others to help the patients mitigate the identified health risk.

When I think about the efforts in this area, it reminds me of a phrase I learned from my mom, Sylvie Marceau, who passed away this past October. She always spoke about the importance of early entry to care. In her work as the CEO of the Healthy Start Coalition in St. Lucie County, FL, she dedicated her life to reducing infant morbidity and mortality. Her work demonstrated that getting expectant mothers into care early in their pregnancy provided the best opportunity for healthy moms and babies. Likewise, the identification of and early entry into care for patients with medical conditions typically results in lower costs of care as well as better outcomes when the condition can be managed before it becomes more significant.

Lastly, ensuring the provision of coordinated care is a very important aspect of what we do. When a patient already has a serious acute or chronic condition, our ability to improve well-being and reduce costs comes from our commitment to delivering an evidence-based plan of care that is coordinated across the patient's entire care team. We deploy nurses to perform patient risk assessments, establish clinical goals for the patient, educate the patient or the caregivers on how best to manage that disease state, monitor the progress, and feed all that information back to the primary care physician.

The combination of the various resources developed and deployed by the physicians has produced some pretty impressive results. We have achieved some of the highest quality measures in the Nation. We have demonstrated medical cost savings over several years. It is because of our success in these areas that Renaissance applied for, and was selected as, a pioneer ACO.

Every innovation that Renaissance has made over the years has essentially been based on adapting to the ecosystem within which we operate. With the passage of PPACA, the environment continues to change, and Renaissance is working with its partners to adapt the people, processes, and technologies to continue its mission to improve patient well-being, improve the overall quality of care, and lower costs for the population served.

Thank you for the honor and privilege to report on our work in the Philadelphia marketplace.

The CHAIRMAN. Thank you, sir. Thank you, Mr. Malloy, very much.

[The prepared statement of Mr. Malloy appears in the appendix.]

The CHAIRMAN. Mr. Diaz?

STATEMENT OF PAUL DIAZ, PRESIDENT AND CHIEF EXECUTIVE OFFICER, KINDRED HEALTHCARE, LOUISVILLE, KY

Mr. DIAZ. Good morning. My name is Paul Diaz, and I am the chief executive officer of Kindred Healthcare. I want to thank you, Mr. Chairman and Ranking Member Hatch, and all the members of the Finance Committee, for holding this hearing today.

I am honored to share our experiences about the significant amount of private sector activity around delivery system changes occurring in the field and the critical role that post-acute care plays

in reshaping our delivery system into one that is more patient-centered, outcome-driven, and cost-effective.

Your decision to have this hearing today is timely. Providers and payers, as you have heard, across the country are actively engaged in efforts to improve care and reduce cost. Because Kindred provides care to patients in over 40 States and has developed a significant presence in 20 large health care markets, as well as many small communities, we have been able to participate in a wide range of efforts and test new models of care delivery.

Before I share our experiences, I would like to emphasize two things that we think are very important for the committee to consider. First, reshaping our health care system will require teamwork, cooperation, and trust between those charged with delivering care and those paying for it. This will not be easy, but with change comes opportunity.

But change also brings uncertainty and fear, and there is a great deal of that out in the health care environment today. So the only way to transform our system, as we see it, is to take concrete and measurable steps to create incremental reforms and establish a path for the future.

Second, post-acute care is a critical part of the solution we have talked about today. Today, there are over 47 million Medicare beneficiaries, and an estimated 7,000 individuals join the program every day. Thirty-five percent of these patients need post-acute care following a hospital stay.

More and more of our patients have chronic conditions such as diabetes and heart disease, as you spoke of, Mr. Chairman, and it makes them very expensive to care for as they cycle through our health care system, with multiple hospitalizations and rehospitalizations. We have to do a better job of coordinating care for these patients to improve quality and reduce cost.

But tremendous opportunities exist as they leave hospitals and enter post-acute care settings and transition homes. Several years ago, Kindred and other providers began to develop the capabilities to meet the needs of patients through their entire episode of care to begin to address the shortcomings of the current silo-based system.

So we set out to build capabilities to deliver integrated post-acute care in local communities. This includes medically complex care in our long-term acute care hospitals, intensive rehabilitation services in our inpatient rehabilitation facilities, restorative rehabilitation and nursing care in our skilled nursing centers and home care—where patients really want to be—and palliative hospice services.

But this is not a goal that any provider, in our view, can achieve on their own. Instead, we are working with acute care hospitals and managed care organizations, physicians, care managers, and others to integrate care and services in a more patient-centered way and into the broader health care delivery system at a local level to achieve the shared goals of clinical patient satisfaction and financial goals.

We have found that there are certain key capabilities that have been spoken of today that are critical across a patient episode. First, as Dr. Sacks talked about: achieving clinical integration. We do this through Joint Operating Committees with our partners to

establish systems and clinical practices to coordinate and improve care.

We established dozens of these committees throughout the country, with hospitals and physicians, payers, and private and public ACOs. This type of clinical integration builds trust and has produced measurable results in clinical outcomes and patient satisfaction, while reducing rehospitalization rates in our system by over 8 percent since 2008.

It also is essential to establish partnerships and trusts with the physicians in order to achieve the care integration across settings. Today, physicians oversee care within health care settings, but all too often do not follow their patients across settings to oversee care in a seamless way.

So we are testing different models that enable physicians, nurse practitioners, and other coordinators to continue the care throughout a patient care episode. In one community, staff physicians employed by our acute hospital partners follow their patients into our post-acute care settings, which helps to provide a seamless transition from hospital to home. The point here is that physicians and other practitioners under their supervision must be at the center of efforts to better coordinate care.

Another key enabler of teamwork and coordination is the availability of electronic health records. The ability to have information for our clinical teams within our care settings, and to transmit information across sites of care with our partners is a critical element for effective care management over an episode.

At Kindred, we have a 5-year plan to install and link electronic health records across our care settings, and we are doing this as we are also piloting and testing linking these systems with the electronic health records of our partners.

We would be happy to share the details of these pilots with the committee, but I caution the committee that these activities are time-consuming, technically challenging, and an expensive process.

All of these integrated pilots are designed to eventually support the kinds of changes that have been spoken of today for the payment system to improve quality and reduce cost. It is tempting to say that we should immediately pay for a fixed cost or a full episode of care, commonly known as bundling or capitation, but I would caution the committee that comprehensive reform of delivery and payment systems will take time. But incremental changes can produce immediate results while we build the infrastructure for a fully integrated system.

We are testing different pay-for-performance models to align interests and build trust with our partners. These pilots can help build a bridge from today's pay-for-volume-based fee-for-service to tomorrow's value-based system. These pay-for-performance pilots build into payment rates incentives to lower costs and improve care, such as paying for reduced length of stay, reduced rehospitalizations, and improved clinical outcomes, so that folks can develop the confidence to take financial risk.

In closing, it is important for the committee to understand that providers are committed to transforming our health care system through innovation, as has been spoken of today, but this is difficult to do in an environment of uncertainty and payment cuts.

As you know well, providers were subject to many payment cuts over the last few years, as Congress, CMS, and private payers understandably deal with a deficit imperative. But I urge the committee to consider the impact of additional payment cuts, including the pending 2-percent sequestration cuts to Medicare payments, on our ability to continue to improve quality, meet the growing demand for health care services, and continue to invest in the innovations you have heard about today.

We believe we can reduce costs and overall spending and reshape our delivery system. And investing in electronic health records, investing in care management, and improving quality have long-term rewards, but achieving these requires investments in the short term.

A good place to start is rehospitalizations that you have heard about today. Today, post-acute providers are not rewarded or penalized for rehospitalization rates, so I urge the committee to consider ideas about ways that the payment system can encourage reduced hospitalization on the one hand, and discourage high rates of rehospitalizations on the other.

Acute care hospitals are already incentivized by the payment system to do this, as Chairman Baucus noted, and I see no reason why physicians and post-acute providers should not have skin in the game so that our interests are aligned in this effort as well.

At the end, again, thank you. I am an optimist. I believe we can take the important steps here to change our system, but we need to do so over time in a manner that preserves patient access and rewards quality and outcomes. And we do need stability and alignment in our current payment and regulatory system to foster collaboration and teamwork and establish a path to a more rational and integrated system.

Thank you, sir.

The CHAIRMAN. Thank you, Mr. Diaz, very much.

[The prepared statement of Mr. Diaz appears in the appendix.]

The CHAIRMAN. In the spirit of Mr. Einstein, we are going to do things a little bit differently, and have done things a little bit differently. Number one, usually in a hearing like this we would have CMS up here, and so on and so forth. I thought it would make more sense not to have CMS, but rather to have the private sector here. You can tell us what you are doing and what is working, what is not working, and we will get it straight from the horse's mouth rather than having to go through a Federal agency.

There is something else I am going to do differently, and that is this. I am going to ask a few questions—let me back up. The traditional practice in this committee is for each Senator to be allotted 5 minutes to ask questions on the basis of arrival to the committee. It is sort of the early bird system. So whenever a Senator arrives early, he or she is in queue ahead of those who arrive later.

But I am just going to upset the apple cart a little bit this morning. I will ask a few questions, and then I will tell my colleagues, it is just open to all of you. It is kind of like the Supreme Court. You just ask questions. Just jump in at any time if you have a question you want to ask on a certain subject.

I know we will all respect each other's time and respect each other, and so forth. So, in the spirit of the search for the truth,

what works, and being kind of efficient about this and not getting siloed ourselves in 5-minute segments, I am going to attempt this experiment.

So, I will start, and then anybody else jump in anytime he or she wants.

Here we have post-acute sector riders and the insurance industry and so forth. I would just like you to tell us—and I am assuming that we all want to move much more toward reimbursement based on quality as opposed to quantity. I am assuming that you all agree with that. If you do not, you had better speak up, but I am assuming that.

And we have passed this law. We have innovation centers and so forth. If you were a little more bold in each of your areas and how we integrate across the board, or even just generally, whether it is ACOs, bundling, or whatever it is, and working with the Innovation Center—I did not hear you talk much about the Innovation Center, any of you—how do we get there more quickly? How will we know when we get there?

By “getting there,” I mean we pretty much change the system so we are reimbursing based on quality outcomes, not quantity, and we are getting better care for less cost. So how are we going to kind of know when we are there? But the earlier question is, I want each of you to be a little more bold and just suggest an idea that maybe together we might pursue. I will start with you, Dr. Migliori.

Dr. MIGLIORI. Thank you, Mr. Chairman. Innovation is core to improving. We are pushed to innovation by our current client base, the employees across America, as well as the government agencies we serve. We compete on our ability to demonstrate innovation.

The areas of innovation that we focus most on are three. One is tools of innovation to get people healthy. By getting people healthy, they not only can avoid and prevent the progression of chronic disease, but we can also lessen demand on an already over-taxed health care system—I mean overburdened health care system. The delivery of health care is going to be challenged by the fact that we are going to be some 45,000 primary care physicians in deficit as a result of the increasing need, as well as the increasing—

The CHAIRMAN. But how do you work with providers? Because I think your company does a pretty good job of burrowing down, finding the cost, and reducing costs. I mean, you mentioned the diabetes prevention program of yours. But how well do you work with providers, the doctors over there, on the outcome side?

Dr. MIGLIORI. Yes, Senator. In fact, what you are describing is the whole reason why we built our services wing of our organization, a discrete business that has as its clientele 240,000 physician practices, over 54,000 hospitals, 66,000 pharmacies. The purpose of that business is to do two things.

Number one is, to better link those health care delivery systems together so that they can look more like each of the organizations that are also on the panel today, but then to use the information that we collect on a regular basis to inform them about health care activity within their practices and the people they serve.

The CHAIRMAN. Let me ask Dr. Sacks or Mr. Malloy. I mean, are insurance companies working with you, the providers? Are you working with them?

Dr. SACKS. Senator, I will say “yes.” I mentioned our program with Blue Cross of Illinois that started in 2011. It really was the first time that we created some alignment of incentives, because it used to be an “us” or “them” situation. If one side did well, usually the other side was disadvantaged.

But I think in terms of answering your question, we need alignment of incentives, and we need to think about it across the whole continuum of care. I firmly believe that if we are going to succeed in managing costs and creating value—and I use “value” rather than “quality” because value is quality and efficiency, and we have to have both.

They generally go hand-in-hand, but you want to make sure about that. Then you have to look at systems of care. It is one of the reasons we have not focused on bundled payments in some of the small innovation grants, because they are all very small fragments of the system. With that, virtually everybody in the Medicare population has more than one condition, and patients with chronic conditions—diabetes, heart failure, coronary artery disease—you cannot split that apart and just focus on diabetes, or you cannot just focus on taking care of the knee replacement without managing the other chronic conditions.

So we have focused on populations over time. We are thinking that, as we do this in the commercial population, our population is going to age into Medicare very quickly. Hopefully the investment we have made in them while they have been employed and insured commercially, if we can continue with similar alignment, will pay dividends and let them live healthier lives and create more value in the Medicare population.

The CHAIRMAN. So the Innovation Center will not allow you to apply for larger grants to get more diseases coordinated?

Dr. SACKS. Well, the pioneer program was an example. As I said, we applied for the Medicare Shared Savings that will start July 1st. That is to manage a population of 150,000. It will be a challenge, but it is a real opportunity to create alignment across the whole continuum with that. We need to move quickly. We do not have the luxury of 10 or 20 years to figure this out because everybody knows what is going on with the cost curve.

I think another opportunity to learn from the private sector—large employers, in conjunction with their benefits consultants and health plans, have redesigned benefit plans to create alignment with their employees so that they are focused on the things that they can manage, because individual behavior plays a role in a lot of our health care expenses.

I hear it every day from physicians who get frustrated, and my answer has been, we need to figure out how to engage our patients, but it certainly helps when the benefit plan incents that.

So, an example. At Advocate Health Care, over the last 5 years, we have gone from having patients voluntarily filling out health questionnaires to raise their awareness to providing an \$800-a-year credit towards their out-of-pocket expense to get a health screening, with parameters like blood pressure, weight, body mass index,

glucose, and cholesterol. If their parameters do not meet the criteria for being healthy, to get the money, they have to go through six coaching sessions.

The CHAIRMAN. Well, I appreciate this. I would invite my colleagues to jump in here. I am going to keep asking questions until somebody jumps in.

Senator HATCH. I will be happy to ask a couple of questions.

Dr. Sacks, I understand that Advocate spent several years working through the appropriate channels at the Federal Trade Commission to ensure that the ACO set up with Illinois Blue Cross was legal and did not run afoul of the FTC laws.

Now, considering the ground work laid by your organization, how long should other groups plan on devoting to this type of a process, and has the FTC streamlined their review cycle, or are you critical of it?

Dr. SACKS. Senator, that is correct. Between 2002 and our consent decree in 2007, it was a long time, and there were some unique circumstances. I think part of that was, we were pioneering and helping to clarify what clinical integration was. Since then, the FTC has really used us as an example, along with other organizations. I have participated in several workshops that they have put on.

My understanding is that, if an organization is looking to clarify whether or not they are within the safe harbor of clinical integration, it can be done within a matter of months. There are hundreds of organizations today that either have clarified that or are moving down that road, so it is moving a lot quicker.

Senator HATCH. Well, your organization spent almost a decade on clinical integration, and you have a very successful model as a result, as I see it.

Now, can you tell us a little bit about the cultural changes needed to ensure that you have the necessary buy-in from the physician community?

Dr. SACKS. That is an important question. We have had the luxury of evolving. We started in 1995. We had 90,000 capitated lives and about 2,000 physicians, and we grew, initially just focused on capitation. I recognize that is a loaded word today, with a lot of negativity attached to it, but it does allow you to align incentives and focus on the population and manage outcomes. We grew to over 400,000 capitated lives.

One of my colleagues has a saying similar to the Einstein saying: "There is nothing better than playing with live ammunition." You learn very quickly, as opposed to dabbling with small numbers. When physicians are taking the risks for financial performance, they self-correct and take the difficult steps, discipline each other, and move forward.

The discipline of being under the scrutiny of the Federal Trade Commission also helped create more alignment within the organization because there was a resolve that we were going to continue to be successful, create value, and demonstrate that to the marketplace.

When new physicians come in, there is an intense orientation. There is an orientation for our governance. I think we are at a point now where we are self-perpetuating and can pass this on, but

I do not want to minimize the challenges. You cannot just flip the light switch and go from being in the pay-for-volume paradigm to doing something like we have and expect that it will come off seamlessly.

Senator HATCH. As a medical liability defense lawyer many years ago, I had some experience in this field. Let me just ask all four of you, how do you prepare for and handle medical liability concerns, and what is the percentage of cost of doing business that is caused by many of these suits?

I remember when I was trying those cases, I estimate about 95 percent of them were brought to get settlement of what it cost for attorneys' fees. A lot of them were frivolous. The explosion started when they changed the law from the standard of practice in the community to the doctrine of informed consent, which meant every case went to the jury.

How do you plan for, prepare for, and handle medical liability concerns? Dr. Migliori, we can start with you. How serious are they in your planning purposes, and so forth?

Dr. MIGLIORI. Senator, I cannot provide specific facts and figures as to how much of health care costs are dedicated to defensive medicine or practice. What we do understand, though, is that the most effective tools, we think, in improving the health care system and lowering costs really have to do with the adoption of a better use of automation tools, as you have heard from the other panelists, but also data that we can provide them so that the physician has more awareness of what is happening with the patient and they can take specific action and share that information with the patient. If we are going to get into how much of what we see in terms of utilization is driven by fear, I think we would have to engage some of our actuaries to come up with a more learned response.

The CHAIRMAN. Let me ask just your gut impression on that. To what degree does moving toward quality affect defensive medicine?

Dr. MIGLIORI. I think that with the—

The CHAIRMAN. Anybody can answer that question.

Dr. MIGLIORI. I think with the very visible impact and the efforts around the table and around the health system on quality and the pursuit of quality, my anticipation is that the quality of care will go up and the whole issue around defensive medicine will become much more mitigated.

Senator HATCH. What percentage of money do you set aside for possible medical liability litigation?

Dr. SACKS. I will give you some examples, Senators.

Senator HATCH. Yes.

Dr. SACKS. I am responsible for risk management and insurance and patient safety. We have been recognized as leaders in patient safety. Yes, it makes things better, but we still make mistakes. There are system failures. In 2011, our organization covering the hospitals and the employed physicians spent \$90 million on liability costs, both accruals based on the actuaries and actual payouts.

As you probably know, tort reform was overturned by the Illinois Supreme Court in February, 2½ years ago. So for 2012, our actuaries have said that we need to budget \$190 million because of the increase in lawsuits. So, in spite of having fewer patient safety events and much more transparency and disclosure, that is an

extra \$100 million that is not being reinvested in patient care in our organization. So, it is real.

Senator HATCH. Is it the same for you other folks?

Mr. DIAZ. Yes. Let me echo that.

Senator HATCH. Mr. Diaz?

Mr. DIAZ. Approximately \$70 million on \$6.5 billion of revenue, equal to our profits last year. So it is a—

The CHAIRMAN. That figure again?

Mr. DIAZ. So our profits, Chairman Baucus, we operate on a net margin of 1.2 percent, about equal to the total medical malpractice cost in our company. So that does a lot to take away from the IT budget and the other innovation budgets that we have.

Now, as Dr. Sacks was saying, within those claims there are errors and mistakes. We learn from that. We have a pretty comprehensive risk management process. But there is no doubt that those dollars, from a societal perspective, are better invested in the innovations that we talked about today and advancing our health care system.

I am optimistic, though, to echo the points that the convergence of focus on wellness and health care, bringing physicians into this, makes them act less defensive and more patient-centric and should have the dual impact of bringing some of this down. But there is no question that there is a significant inefficiency when a company like Kindred Health Care's net profits are equal to the malpractice reserves that we take every year. There is something wrong with that.

Senator HATCH. My time is up. I am happy to relinquish.

The CHAIRMAN. Senator Rockefeller?

Senator ROCKEFELLER. As I am listening, Mr. Diaz is the one who is sort of talking about the future. Do you not all pretty much practice managed care?

Mr. DIAZ. We are more on the provider side.

Senator ROCKEFELLER. The other three answer. Do you not sort of practice managed care?

Mr. MALLOY. I think from the perspective of managed care, we are a provider organization and we operate within an environment of managed care, so certainly a lot of the innovations that we—

Senator ROCKEFELLER. All right. Well, just taking your answer gives me great concern. The States like to practice managed care because it is so safe and predictable. There is no evidence really, unless you can produce it for this committee, that managed care works, that it increases quality or that it lowers costs. Higher forms of managed care are more wasteful, in my judgment. What concerns me greatly is the medical community's inability to try new things that they have not tried in the hopes that they might work.

Now, I am just going to give you a couple of examples. To me, the most important thing in what Senator Hatch, running for office, calls "Obamacare," is the Independent Payment Advisory Board. What I like about that is, that will do more to cause the treatment of Medicare to be scrutinized than anything else and will save a lot of money without reducing benefits or payments to doctors, because that is written into the accountable health care law.

What worries me is that all the attention—and I would just like each of you to comment on this—is on Medicare. When Medicaid

and CHIP, for example—the Children’s Health Insurance Program—went through either CMMI or CMS, through rules which were a terrible mistake, they sort of concentrated on Medicare but not on Medicaid and Children’s Health Insurance Programs. Medicaid is, what, 70 million people? It is by far the largest amount of money, but there is no focus on new ways of working with Medicaid and CHIP. I worry about this in terms of the national quality, strategy, and all the rest of it.

So what I would like to hear from each of you is, do you agree with that, and what thoughts do you have about applying some of the thoughts that are put to Medicare to Medicaid and CHIP? I am assuming that the law is going to stand and that, even if part of it does not, that the Independent Payment Advisory Board will. But it has not yet been formed, as you know.

I will start with you, Mr. Diaz.

Mr. DIAZ. Thank you, Senator. Well, I think at the core of all the things that you heard today, those same innovations extend to the dual-eligibles. We care for hundreds of thousands of dual-eligibles every day, and principally Medicaid folks, so we have great experience with this.

We share some of your concerns, given some of the chronic under-funding of Medicaid that is going on right now in many States. But I would say that my optimism comes from the fact that the same learnings on managing wellness and managing chronic conditions that we focus on in terms of the Medicare business will extend to those same patients, particularly the dual-eligibles. So, I mean, I think that these same innovations show promise in terms of outcome.

Senator ROCKEFELLER. I do not accept that. Tell me why you think you are right on that. In other words, if something does not work with the dual-eligibles, Medicaid, CHIP, or whatever, then the hospital committee gets together and says, well, we made a mistake there, so we are going to change and do it this way.

Mr. DIAZ. The alternative—because my doctors and nurses do not see patients through a Medicare, Medicaid, or a united lens, they just see a patient. So, when we talk about clinical innovation for electronic health records to improve the coordination of care, it is not through a payment lens, it is through a patient lens.

The opportunity we talked about today is allowing our clinicians to do that. So again, I just do not think they see it as a Medicaid patient or a Medicare patient, they see it as a patient who is ill, who has chronic disease, and we can do a better job of coordinating their care.

Senator ROCKEFELLER. I will stop with this. My time will run out. But the fact that there are so many people, 70 million people, in Medicaid, and millions and millions of children in the Children’s Health Insurance Program, the fact that that is not given weight formally in the CMMI experimentation or approach to experimentation, you think will solve itself?

Mr. DIAZ. I will turn it over to the other panelists. But our lessons learned and the innovations that we are participating in, I think, have implications for all of our patients, regardless of their payer source. I will let the other folks comment on it.

Mr. MALLOY. Senator, I would say that, with the innovations that we have deployed within our population, in similar vein, we have developed technology tools that our physicians use. Our hope is that, as the payment environment continues to change, it will encourage the alignment of incentives to do this across the board.

The same thing—we do not change the way we treat patients from room to room to room as the physicians move from one patient to the next. The issue really comes down to whether or not we can create the environment to align the incentives to achieve what is necessary.

I spent a number of my years within the health care world on the health plan side. I ran a small Medicaid plan in Maryland as well. It used to infuriate me that we could not get to the point where we understood exactly where we were with respect to our quality measures.

When I came to Renaissance and discovered that physicians, within their own environment, 230 independent physicians scattered across the Philadelphia marketplace, had invested their time, energy, and money into making new tools, new capabilities, and care plans that would treat the patients, I was very excited about that, and it felt to me like there was an opportunity to take those same capabilities and begin to move those across the country.

So we created a company, and we started to do exactly that. Our first prospective client became a client. It is a health plan that is using all the same tools and capabilities that we have today, and they are doing that to advance improved quality within their marketplace.

Our results: we have some of the highest quality measures in the Nation with respect to Healthcare Effectiveness Data and Information Set (HEDIS) measures. We also have a demonstrated medical cost savings over the same time period. Most of our savings come from reduced event-driven care, so fewer emergency room visits, fewer readmissions into the hospital. I think those are all applicable, regardless of who the payer is. I would love to see these types of capabilities expand across the entire spectrum so that physicians are using these for all their patients, not just subsets or segments of them.

Senator ROCKEFELLER. I thank you. My time is up.

Senator WYDEN. Mr. Chairman?

The CHAIRMAN. Senator Wyden?

Senator WYDEN. Mr. Chairman and colleagues, I think I have heard the words “aligning incentives” about 5 times in the last 15 minutes. I certainly support that. We always hear about it in the context of providers, insurers. Those are usually the two. But almost invariably the patient is kind of an after-thought, particularly with Medicare and senior citizens.

I think, for example, that real behavioral change, particularly in this program with 50 million people that a lot of us see as sacred ground—I mean, I remember working on Medicare reforms when I was director of the Gray Panthers. We were passing petitions around for what Senator Rockefeller was working for back in those days. So this is really sacred ground.

Senator Portman and I have introduced the first bill to really start trying to come up with some fresh thinking in terms of cre-

ating behavioral changes, particularly for seniors: lowering blood pressure, cholesterol, and all that kind of thing.

Mr. Malloy, what do you think about just the concept? Let us set aside any bills and the like. But what do you think about that concept? Because I think it is really an after-thought that the senior, the beneficiary, really is not much part of this discussion of aligning incentives.

Mr. MALLOY. I completely agree. I personally had some experience with this within the Medicaid plans that we serve that Senator Rockefeller talked about, and we found that incentives for encouraging patients to see their primary care physician and have preventive care screenings were incredibly effective. I think it would be fantastic to continue to expand that into other marketplaces.

The new organization that I have recently become affiliated with, Health Ways, has a lot of programs that are along those same lines, to incent and align incentives for patients, to have them focus more on their own health care and improving their own health status. I think it is important. I think incentives matter throughout the health care spectrum, whether it is the patients, the providers, or hospitals.

I think, as we think about payment reform, those are the areas that we have to focus on to encourage the—

Senator WYDEN. We have appreciated your support, your endorsement for the legislation, the Health Ways Group. Let me take the other side of the coin then if I could, for you, Dr. Migliori, with this question of incentives and particularly for us to create a new approach to getting the patient involved. You have been talking about the transparency efforts United has put in to try to get more data and to try to particularly get comparative data.

Senator Grassley and I have introduced legislation to open up the Medicare database so that people could really see what the data was, again, on an important program with 50 million people.

Now, some States have gone beyond that. Colorado, for example, has been talking about an all-payer database so that you could get Medicare information, Medicaid information, and private payer information. I gather that you all would like to see these kinds of approaches that get a great deal more data out there, and particularly comparative kinds of approaches. Is that correct? I do not want to put words in your mouth; just tell me how you see this.

Dr. MIGLIORI. Senator, that is correct. Our perspective is that health care improves when the participants in health care—the doctors, the patients, the hospitals—are connected and then informed to take action by the data they are generating themselves.

You can go beyond that to the other point that you raised earlier, which is to then provide meaningful changes in reimbursement so hospitals do not take it on the chin when people get healthier, but at the same time providing incentives and fostering encouragement to get patient engagement, just as Dr. Sacks was saying earlier. Getting patients engaged, taking the information that comes out of the health care system, analyzing it, understanding what it is saying, and pushing it back to the health care system, is the best way for us to create higher quality, better health, and lower costs.

Senator WYDEN. I appreciate that.

Mr. Chairman, thank you for that. I think what the witnesses are highlighting is that, with a lot of these decisions, particularly that last point by you, Dr. Migliori, we are making some decisions in the dark. I mean, to really not have this kind of information so that people can have it to make choices just seems to me to be a big gap in this.

I want to see us align incentives, and that is what we have been talking about. Let us make sure, first and foremost, that we recognize that behavioral change starts with people, with individuals, and we ought to at least have some incentives there. I think what you all are trying to do with data, Dr. Migliori, is very helpful, and I thank you, Mr. Chairman.

Senator NELSON. Mr. Chairman?

The CHAIRMAN. Senator Cardin, I know you have been anxiously looking for recognition, but I must say that Senator Nelson has been even more anxiously, and earlier, looking for recognition.

Senator NELSON. Well, with a star-studded panel like this, it is a good opportunity to try to point out, as we ease in to the new health care bill, some of the misunderstandings and confusion about the bill that this panel can help us understand. So I just want to ask questions in two areas: Long-Term Acute Care facilities and Accountable Care Organizations.

So Mr. Diaz—

Mr. DIAZ. I guess I will do LTACs.

Senator NELSON. I think you will do LTACs. How do you think the post-acute care that you are familiar with can reduce the cost and improve quality, and what are some of the other ways that we can improve that post-acute care? And just lace her in, because I want to get to ACOs before my time runs out.

Mr. DIAZ. Well, I will tie that back to Chairman Baucus's question too about how we can get more aggressive and how we can drive behavior, allocate human capital, financial capital, to move these things faster. I think those challenges are different in Dillon, MT than they are in Chicago. The problem, as we talk to physicians—and our leadership team just yesterday—is the uncertainty. What we need is some certainty on one side of CMS at the same time that we are trying to drive innovation on the other side. Those two activities need to be coordinated.

The CHAIRMAN. They are not now?

Mr. DIAZ. I think we are making progress. I think that there has been improved dialogue about understanding that you cannot advance the Innovation Center if there are conflicting things going on on the regulatory and payment side.

So I think things like advancing the LTAC legislation to clarify further that only the most clinically appropriate patients belong in LTACs, that can save money in the Medicare system. It is just sort of foundational so that we can move forward to the real problem, which is, we ought to be focusing on wellness behavior.

If we want to reduce costs, we need to reduce utilization across the board, and we need to measure our progress in reducing that with a limited set of clinical outcome measures and patient satisfaction measures to guardrail against pushing length of stay down in acute care hospitals, or LTACs, with things like rehospitalization policy.

So to tie those two together, I think if we can bring—and I hear fear in our physician groups all the time—some stability on the regulatory side and then focus on a narrow set of measurable clinical outcomes and patient satisfaction outcomes and reduced utilization, length of stay, and guardrail it with things like penalties on rehospitalizations, then I think we can deploy human and financial capital in a much more aggressive way.

Senator NELSON. That is true. And also bundle payments so that you are looking for the outcome. Instead of paying every little thing that happens, you get cheaper and you get better outcomes.

All right. Let us take Mr. Diaz's answer, and the rest of you, take it to Accountable Care Organizations in the private sector, not in Medicare. What do you think?

Mr. MALLOY. I think the Accountable Care Organization concept is something—we have been operating in that environment long before it really had that title, from our perspective. We have been focusing on improving quality on one end and making sure that we have gotten patients into early entry to care. I think, as we look into the future, we will see more of that. There is certainly an ever-increasing drift in that direction, and I think that is appropriate.

From our vantage point, as I mentioned in some of my opening remarks, a lot of it comes down to making sure that you are operating within the environment that you serve. So, to the extent that payment reform and payment changes within the commercial market begin to take hold, change, and move more toward gain share or risk type of arrangements and so forth, then we necessarily will adapt our model to that. So we assess where we are within the environment, and we adapt to whatever that environment is. I think that is probably true for the other panelists as well, but I will let them speak on their behalf.

Dr. SACKS. Yes, Senator Nelson. As I said earlier, we have been engaged, so we are in the 6th quarter of commercial accountable care with 150,000 HMO lives under risk-adjusted capitation and 245,000 PPO lives, which is the first time we have been able to align incentives for the PPO.

What I think has jumped out is, one, it is a recognition that an organized delivery system can make a difference. Two, it is alignment of the incentives, both between the payer and the delivery system, and then within the delivery system between physician specialists, primary care, and possibly—

Senator NELSON. Let me ask you this. You are a PPO and an HMO. How do you see the new ACO, Accountable Care Organization, as different from what you do?

Dr. SACKS. The ACO is like what we are doing with the PPO, or Preferred Provider Organization, population. Similar to Medicare, these patients have a benefit plan that provides access anywhere that you can use a Blue Cross card, which is virtually anywhere.

Our incentive is to provide superior service and outcomes so that they will want to get all of their care within our network where we can better manage it, but we have the financial accountability for out-performing the market on the trend in the cost of care.

I think the exciting thing is, with results through the third quarter of our first year, we have out-performed the market by nearly

5 percent, showing that there is an opportunity for real savings and getting the rate of health care inflation down to a level of CPI.

I think to be honest, 2 years ago, if somebody had said we would get it to CPI, we would have been very skeptical. We set out to do that for 2014, thinking that, if there are going to be insurance exchanges, we had to have a product that would be price-competitive, and we have accomplished that in the first year.

I think it is a grand opportunity, and yet I have no illusions. It is probably a transition vehicle, and shared savings and out-performing the market will not go on forever. As the marketplace changes and those who compete with us in the Illinois market start to engage in what we are doing, our ability to out-perform them will disappear, but it will probably migrate to some type of global budget.

Several of you have referenced bundled payments, and I think what you have talked about is bundles for a discrete episode of care, such as a joint replacement or cardiac surgery. Think about it: a global budget is the grandest bundled payment. It is a bundled payment for a population over a period of time. I think that is where we need to move to, and that creates the alignment of everybody providing care within that system.

Senator NELSON. I know my time is gone, but I would just ask rhetorically of the committee: is his success in Illinois a result of the new health care law, his PPO, or both? Since my time has run out—

The CHAIRMAN. You are right. That is a good rhetorical question. [Laughter.]

Senator Cardin?

Senator CARDIN. Mr. Chairman, thank you very much. There are a lot of good things that are happening out there. You all are coming up with ways to make our system more accountable and give better results at less cost. You can point to a lot of examples, and you have already done that.

But I want to get back to reality. You all are facing additional cuts in the Medicaid programs in every State in this Nation. This year, we are going to be looking at a significant reduction in Medicare cost over baseline. It is not what we think is right but what gets scored around here that we are going to have to end up doing.

So what I find very frustrating—and I can give you chapter and verse—we have a program in Maryland that has used technology to bring down costs for diabetes: WellDoc. It started, by the way, in 2004, when cell phone technology was not what it is today. It has demonstrated, in a 7-year study, that it has brought down diabetes care by 10 percent. That has never been scored for the 10-percent savings, so now we have achieved that, but we do not get credit for it.

So we have spent a lot of time on delivery system reform, and the Affordable Care Act, with the ACOs, is clearly in that direction. We do talk about bundling, because bundling is a way that we can sometimes get scoring.

But I think our challenge is, how do we put into the code a scoring mechanism that captures the practices that you all have instituted so that we can get credit for it through the process that we have to follow here in Congress? Because I tell you, we are running

against a cliff that is going to come up very soon as to how we deal with the sequestration, how we deal with the SGR system for Medicare, how we deal with the Bush tax cut issues.

All of that is going to come up soon, and part of that is going to have to have scored spending savings, and a large part of that is being looked upon as to how we get that out of the health care system. We think, many of us, that we have already gotten a lot of that out of the health care system, and we will demonstrate that in the years ahead because of what we have passed, but it does not get scored.

So now we have to put something in the code that gets scored that you all have confidence in, that is not just another round of cuts to providers, because, if we just continue to do that, you are not going to be in business. So what do we do? How do we resolve this issue to allow these good practices that you all put in place on delivery system reform to show the savings, and therefore allow us to get the credit for it?

Mr. DIAZ. If I may, Senator, I think your concern is well-placed. I mean, I see innovation and investment in technology in our company coming to a screeching halt as a consequence of the sequestration cuts. It is just unavoidable. There are only so many years we can freeze wage rates for nurses and cut without affecting patient care. So we are living that struggle today.

I think what we need to do is pick five things. As we all talked about, let us pick the five things that we think move the dial the most. Maybe some of them are penalties, like rehospitalizations. But things like reducing length of stay should be something that we are all championing, because, if we are getting patients home faster, there should be incentives for that.

So providers that are accomplishing those things above the baseline and are showing superior outcomes should be rewarded, and providers that are not should be held accountable. That is one of the greatest frustrations in Kindred Healthcare: we are outperforming on all these measures, but it does not really matter at the end of the day in terms of our sustainability from a financial perspective.

The reward systems within our organizations are hard to sustain too, which are around people, quality, and clinical outcomes, as well as financial metrics like rehospitalizations and lower length of stay.

Senator CARDIN. The challenge is, it is so difficult to put that into code where you are reducing, in your case, reimbursements to hospitals based upon admissions and rewarding long-term care providers based upon results.

You are not going to have the same confidence level from the hospital community that you would from the long-term care community. But you are absolutely right. I mean, that is what we do. The cost centers are exactly where you said they are. We are achieving some of those savings, and they do not get scored.

Mr. MALLOY. In our example, what we did not have is—we compare our population to a comparable cohort using a third-party actuary to assess our savings. It is more difficult when you try to get into the individual initiatives that you have undertaken to say how much is associated with a very particular piece, but certainly our

integrated program that we have deployed has been proven to be effective.

But we have similar challenges about, well, how much of that was really associated with coordinated care versus the preventive activities and the wellness that we have done? It is a challenge. But I think if there were a way to look at it in terms of total programs that have been deployed and compare those to a comparable cohort, that may be a financial—

Senator CARDIN. I will just make one last observation. That is, we know that we are going to reduce costs and hospital infection rates. We know that. We have been able to demonstrate that. There is study after study that shows that. We did not get the scoring for it, even though we know that it is going to take place. It seems to me that there is some way that we could put in an enforcement mechanism to make sure hospitals obtain what we know they should obtain in hospital infection rates so that that can get scored, and again a reward for those who exceed expectations.

That is within one area of health care costs. I think we need to look for more of those examples where we can demonstrate savings, put some enforcement mechanism that gets scored, hospitals or providers that meet the standards or exceed them, they get rewards, and, if they do not, there is a penalty.

Thank you, Mr. Chairman.

The CHAIRMAN. You are welcome.

In the spirit of bipartisanship, Senator Thune?

Senator THUNE. Thank you, Mr. Chairman. I am glad you are not forgetting about us over here.

The CHAIRMAN. You are there, alive and well.

Senator THUNE. Yes. [Laughter.] Yes, that is right.

Well, I appreciate the hearing, and I thank you all for your thoughtful observations.

I have a question that has to do with this whole issue of interoperability and how advanced we are, what we might be able to achieve in the form of savings. If I twist my knee in Colorado and have to go to the emergency room, and they want to find out what prescriptions they can give me and that sort of thing, or how to treat me and to be able to know who treats me in South Dakota, what my medical history is, that sort of thing, or for example, you have long-term acute care, acute care—you have all these various ways in which people access the health care system in this country—how integrated are we?

How interoperable are we in terms of electronic medical records and that sort of thing, say on a scale of 1 to 10? Then, what sort of savings could we achieve—and I am sure that is a very difficult thing to quantify, but if you could at least in general terms talk about what that might mean in terms of avoiding redundancy, avoiding duplication and over-utilization because of tests and all sorts of things that might be available if you had access to a medical record for a patient?

Dr. MIGLIORI. Senator, if I may, interoperability is something that is not at a level that it should be. If I was to score it using your 1 to 10, it is probably a 3, for two reasons. Number one, it has been the slow adoption of electronic health records and other

automated clinical systems. The groups to my left here are exceptions to the rule.

The second, though, is that, even when you have integrated systems or electronic systems, trying to move between systems is very poor, and I think it represents a threat to safety, as well as an issue around efficiency—how much efficiency and the ability to provide a specific number. I suspect we could come up with some estimates. But certainly, in a society that expects choice and is full of mobility, to have a system that silos its information really is counter-current to their intent.

Mr. DIAZ. Let me just give an echo, an example. So we have a Joint Operating Committee with the Cleveland Clinic. I mentioned in my testimony we have a lot of folks, and we are very focused on rehospitalizations in that Joint Operating Committee. The number-one issue of all of those clinicians was, how do we get information to manage these patients? So we built an interface with EPIC, which is the clinical information system that the clinic uses.

Now the Cleveland Clinic doctors can access EPIC, and we have linked it to ProTouch, our medical record. So when they follow the patient from the clinic to our long-term acute care hospital or our sub-acute facility, they can go backwards into the EPIC system, or they can move forward into our system, as we have built that interface.

That is a 1 percent on the 10 percent chart that you said. I mean, it is just not happening fast enough. And urinary tract infections, rehospitalizations caused by that and other things, have dropped like 30, 40 percent, by letting our clinicians have the information to manage patients across these care sites.

Mr. MALLOY. I would just build on that and say that getting information to physicians is very difficult at this point. One of the major aspects of how we can improve quality and lower cost is through a transitional care program that we have within our organization, trying to make sure that, when a patient is discharged from the hospital, we know everything about what happened there so that, as they move into the home environment, we can make sure that we are carrying that care through so they are not readmitted into the hospital later.

I think a big part of this is additional investments into the Health Information Exchange models. In Pennsylvania, there is a project under way, and it is at the State level. It is very complex. It looks like it is going to take some time to get in place. In Delaware, to our south, we found that they have the Delaware Health Information Network, which is the backbone of health information which allows physicians and hospitals to sort of plug in and get that information out.

But to your question, if something is happening across the country, that information just is not there. It really is an issue of patient safety, it is an issue of making sure that you have timely information in the clinicians' hands so that they can actually effect change when they need to. We are still a long way from that. I would not even give it a score as high as 3, as my colleague down at the end of the table did.

Senator THUNE. By and large, that is a resource issue, I mean, to make that happen. But to create those standards of interoper-

ability, we have always talked about that, but it does not sound like that is happening out there.

I guess my last question is, as my time is out, how do we incentivize that?

Dr. SACKS. Senator, right now the incentives are to continue to build infrastructure. I agree with what my three colleagues have said. We are one of the more advanced systems with electronic health records. All of our Chicago-area hospitals achieved Meaningful Use Stage 1 last year. We have four prime vendors.

While they all meet Meaningful Use and are “interoperable,” unless you set the systems up with the same data definitions and the same fields, you realize that you are talking theory, but in the real world I cannot exchange your prescription from the medical group system to the hospital system, and it creates a host of safety issues.

It is much more complicated than banking because you do not just have to deal with 10 digits and putting them in the right boxes. We are moving in that direction. It needs to be encouraged and incented, but ultimately there needs to be standardization of the definitions so that, when we record a blood count in my office system, it is the same as a blood count in South Dakota or in the hospital so that it moves seamlessly, and that is one of the practical challenges. To be honest, the vendors do not have an incentive to do that. They want to try to be a 1-brand solution and keep you as a customer of their total solution.

The CHAIRMAN. Well, how do we solve that? I mean, did the stimulus bill not provide about \$20 billion for health IT? I mean, the first question is, was that spent wisely? Second, I know all these different vendors are competing for business. It seems to me that they are just going to keep competing and we are not going to have this interoperability that everybody talks about. But do you fellows not have some ideas on how to solve that?

Mr. MALLOY. Sure. I think with respect to the investment in EMR, I think that has been hugely successful, at least within our realm. About 85 percent of our physicians are currently on an EMR system. We expect to be at about 95 percent by the end of the year. But EMR, in and of itself, does not really solve the issue. It allows you to track the records of the individual patient, but it really does not allow you to do sort of the population management type things that need to be done.

The CHAIRMAN. Right.

Mr. MALLOY. It also does not allow us to exchange information back and forth.

The CHAIRMAN. So what do we do?

Mr. MALLOY. I think it is a matter of understanding some of those core pieces. To Dr. Sacks’s point, there are some practical issues where EMRs do not really talk well to each other. If somebody puts information in a text field versus in an empirical specific data element field, it is hard to clean that up. It is really a matter of having sort of clinicians opine on what is really necessary in order to make those talk, and of establishing some standards.

The CHAIRMAN. Senator Carper has been very patient over there. Senator Carper?

Senator CARPER. Thanks so much.

We have also been patient in Delaware, and I just want to follow up on something Mr. Malloy said. Fifteen years ago, when I was Governor, we signed into law the notion of creating a Delaware Health Information Network, and we have nurtured it for 15 years.

Last week, we celebrated its 5th anniversary of being live online. For the last 5 years, we have been able to sign up more of our hospitals, more of our nursing homes, more of our providers. Last week we were at 100 percent of hospitals, 100 percent of nursing homes, 92 percent of providers.

This is technology that is enabling us to provide better quality health care, save lives, and also save money. We are very proud of what we have done. I know it is not the whole solution, the whole answer, but hopefully it is something that others can look at. We made plenty of mistakes along the way, and others can learn from our mistakes and be able to perhaps replicate some of our successes.

Senator Thune just walked out. He is a great athlete. We had a 5-K race last week that a bunch of people participated in, including Dick Lugar at the tender age of 80, and he has run in about, I think, 30 of the races here on Capitol Hill. We are just very proud of him. And Thune is a great athlete. I call him Thune. But Senator Baucus over here is a great athlete as well. He does not run 5-Ks or 10-Ks, this guy has run like 50-mile races and so forth, and probably still does it.

I like to—ever since I was a Naval flight officer, an ensign, down in Pensacola, FL—try to work out just about every day, and I do not miss many days. I do not remember the last time I missed a day's work from sickness. I talk to other people who work out regularly, exercise regularly, and watch what they eat, and a lot of them say the same thing. They just frankly do not get sick very much, and, if they do, it tends to go away.

Not everybody is as crazy as guys like me, and maybe Senator Thune, maybe our Chairman, in terms of exercising. But I am convinced if we could somehow motivate people to do that more often, as well as to watch what they eat, we would all be a lot better off, and frankly a lot better off fiscally as we look at the squeeze on Medicaid, Medicare, and all.

When we were working on health care reform legislation, former Senator Ensign of Nevada and I offered legislation adopted by the committee, signed into law, that enables providers to provide premium discounts of as much as 30 percent to employees who, if they are overweight, bring it down and keep it down; if they use tobacco, stop smoking, stop using tobacco and continue to stop smoking; if they have high blood pressure, high cholesterol, bring it down and keep it down. It can actually go up as high as 50 percent.

But that is an effort on our part to incentivize people to do what they know they ought to be doing anyway, and, if they do those things, not only will they be better off, the group will be better off, and also the taxpayers will be better off.

Could you just talk to us a little bit from your perspective as to what you are mindful of that we are doing to incentivize people to assume personal responsibility for their own health?

Dr. MIGLIORI. Senator, that has been core to our business. In fact, perhaps the fastest-growing area of our business at United

Health Group has been the growth in employer-incented programs that incent engagement.

We have over 40 large employers with now over 2 million people who are on programs that require them to do their biometric testing, the simple things—blood sugar, cholesterol, body mass index, and blood pressure—and, if they are out of whack, to get engaged into programs, much the way Lee had said earlier.

And with doing those activities, there are some modest financial contributions made in a variety of ways for health care and other things, such as deposits made into the health spending accounts and the like.

The important thing about these programs, with each one of them, we have seen an increase in people getting engaged. We did it for our own. The first client that we used was ourselves, with 136,000 UnitedHealthcare employees that we put through a system of doing that.

What we found is that we had diabetics whom we did not know of. Ten percent of our diabetics did not know they had it. They engaged in weight programs. Half of them lost over 9 pounds in weight. We had a 12-percent reduction in cardiac disease. We had 10 fewer heart attacks that year, and we also had diabetes costs fall dramatically, like 19.6 percent.

What we have done beyond that is to make it simpler to do. We have gone to the point now of building mobile applications for your smart phone that will connect to commercially available things like Fitbit, so that people can record into their cell phone and then transmit to their personal health record and their health coach, at their discretion, their activity. So that way we can start building the linkages for people to do that and, as they take on this responsibility, to effect change.

The important thing is, what you are going after is that 50 percent of American's premature deaths are the result of lifestyle choices, and those are the choices that have to change.

Senator CARPER. Thank you.

Dr. SACKS. From my vantage point, going back to my days as a practicing family physician, some of the most frustrating times were when I would encounter a patient, and their lifestyle was the barrier. No matter how I would try to educate them that you need to exercise, you need to lose weight, you can control your blood pressure without medication, my success rate was probably in the low double digits.

When you get alignment with family reinforcing it, when you get financial incentives, when you get the employer, when you change the food in the cafeteria at work, when you set up exercise programs, you can get the success rate up into the 50-, 60-, 70-percent range. It takes the whole community to get this done.

As I said earlier, we have been doing this with our own workforce over the last 5 years, and every year we have seen improvement. It has bent our cost curve, which was the biggest driver of inflation on the cost side for our organization, and it has given us a healthier workforce which is more productive.

I think we all have creative ideas of how that can be driven deeper and farther across this country, because it has typically been the

large commercial employers that are self-insured that have been innovative because they are paying for it.

Senator CARPER. Could the last two witnesses just briefly respond?

The CHAIRMAN. Sure.

Senator CARPER. Mr. Chairman, thank you.

Please, Mr. Malloy.

Mr. MALLOY. In similar fashion, I tend to agree. I think we are now beginning to meet the member where they are at so that they can really focus on improving their health care. I think a lot of times they feel as if it is a little overwhelming, and, if they have the proper tools and the proper incentives there and begin to understand that small changes can really make a difference, I think that is very important.

Health Ways has been doing that for their employees for a number of years, also with the plans and members that they serve. New mobile apps and those types of things are certainly important, being able to track and trend where you are with respect to how you are performing against those things. The Fitbit idea is something that has really been phenomenal.

It makes it easy for people to kind of link together what they are doing and report it back to their health records, track it, and then to share it socially, because we do know from the science that there are a lot of positive effects from the social interactions of family and friends and the impact that that has on changing behavior. So, I think there is a general movement that seems to be happening in a number of different areas that will reinforce that.

Senator CARPER. Thank you.

Mr. Diaz, just briefly. Mr. Diaz, could you comment, please?

Mr. DIAZ. We have 77,000 employees across the country and have embarked on some of the same things. I mean, it is amazing the frustration I have sometimes going into the break room to see nurses who are caring for patients on ventilators who are having a cigarette and a regular Coke.

Senator CARPER. Did you say cigarette and a rum and Coke? [Laughter.]

Mr. DIAZ. And so we have redesigned programs. We have really tried to foster a much more active lifestyle within our support center. I think we are sort of just at the beginning of that, but I think there are clearly signs of change happening in employer-based systems. I think the bigger challenge, as Senator Wyden said, is how do we accelerate that in Medicare beneficiaries, the dual-eligibles in Medicaid, where some of the lifestyle things are more entrenched because of socioeconomic issues and other things.

Senator CARPER. All right. Thank you.

Mr. Chairman, you have been very generous. Could I just add one last quick P.S.?

The CHAIRMAN. All right.

Senator CARPER. Later this year, part of the health care law that we passed will go into effect in States across the country. It is a provision that Senator Harkin, Senator Murkowski, and I worked on, with good support from our committee. It provides that people who walk into a chain restaurant later this fall will look up on the

menu board and see, for the item being served, cost and calories. If they do not have a menu board, they will have a menu.

Chain restaurants across the country that have a sit-down menu, you open it up, and for the item being served, you see price and calories. The restaurants have to provide, upon demand, upon request, additional information as to sodium, fats, trans-fats, cholesterol, a variety of other things. That is just one more tool to help people, encourage people, enable people to take personal responsibility. Thank you.

The CHAIRMAN. No question, it all helps. It all adds up. Senator Menendez?

Senator MENENDEZ. Thank you, Mr. Chairman.

I want to thank Senator Carper for his focus in this regard. His example has made me go to the gym more and order Egg Beaters when I head for breakfast.

I thank you all for your testimony. Mr. Diaz, in your testimony you highlight the important issue of increasing coordination and integration as a means to improve care and reduce unnecessary costs, something that we clearly want to achieve. Kindred is in a unique position to provide this high level of coordination as the operator of so many post-acute facilities. However, that can be difficult when those post-acute care sites are not under one roof.

In New Jersey, to address this issue, health care facilities, home care providers, and other stakeholders worked with State officials to create and implement what we call a mandatory Universal Transfer Form. The use of this form will, we believe, ensure that providers across the continuum of care have the access to patient history and information that will help improve care.

So my question is, do you see that as a way to more effectively and accurately coordinate care for patients transferring into post-acute settings, and do you think something like a Universal Transfer Form can be an effective tool to improve provider coordination?

Mr. DIAZ. I do, whether it is in the ACO examples that we have talked about or other collaborations. We talked about a lot of capabilities, and I mentioned building trust, breaking down silos, things like IT to enable that, are critical.

In each community, there is going to be a role for large integrated providers and individual providers. I think what it is going to require is that these networks, as we set them up, have people to deliver on the value proposition, whether they are large or small. So we have to allow for that.

People have to come at it from a collaborative perspective. I think the challenge is, if we continue to approach things in a sort of "I win, you lose" fashion, we are never going to get anywhere. It is going to require everyone giving a little bit in terms of breaking down these silos that we are in.

Senator MENENDEZ. And I would assume that that sharing of information at the end of the day is critical, (1) for the patient, and (2) also for savings.

Mr. DIAZ. Without question. As you have heard today, and we have seen examples of in our pilots, there are just tremendous patient opportunities and tremendous opportunities to reduce costs when we can give clinicians information to manage patients over

an episode as opposed to aligning incentives around the short-term acute care hospital, as has been spoken to.

Senator MENENDEZ. Finally, I know that earlier you mentioned in your testimony, legislation that Mr. Nelson and Mr. Roberts are sponsoring, that I am co-sponsoring, with reference to long-term care hospital improvements, which outlines specific criteria to better identify long-term care hospitals and their role within the continuum of care. Why are such specific criteria needed, and what would having such criteria in place actually accomplish?

Mr. DIAZ. Well, long-term acute care hospitals, like inpatient rehabilitation hospitals, like skilled nursing facilities, play a unique role in the delivery system. Right now there is a lack of regulatory clarity there. I think what that would do, what the criteria would do, would enable not only public payers, but the private payers here, to all understand better what that role is, what the outcomes are that can be generated, and what the costs are. I think that just enables us to be more efficient in getting patients to the most clinically appropriate setting as quickly as possible. Long-term acute care hospitals do not have that clarity in the way that other sectors do today.

Senator MENENDEZ. Thank you.

The CHAIRMAN. Thank you.

Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman. Mr. Chairman, I think this has been an excellent hearing, and I appreciate the way you are doing it.

I want to kind of see if I can sort of summarize how I have come to see this. I mean, you all have appropriately characterized what we are dealing with in America as largely a sick care system. We have not put the focus on behavioral changes for individuals. We are now talking about trying to change those incentives, so, when we align incentives, it is not just providers and insurance companies, but it is individuals. That is what Senator Portman and I are trying to do with the Medicare program. I think you have given us a number of good comments.

But the question also has to be, for us, in the delivery system: what do you do when people have serious illnesses, and particularly what some have characterized as essentially a silver tsunami that is going to land at your doorstep, Mr. Diaz, in terms of long-term care?

What I wanted to ask for just a minute is your thoughts about what could be characterized, at least in Washington, as a long-term care Accountable Care Organization. Now, in my part of the world—Chairman Baucus knows this—when people heard the words “Accountable Care Organizations,” they would kind of smile and say, that is what we have been doing for 25 years. That is Group Health up in Seattle, that is Providence in Portland, and the like.

But I think in something resembling English, this is integrating services. If you are not a senior, it is integrating the kinds of services that Dr. Migliori is talking about with employers and unions and others. But for older people, I am particularly interested in it because, what I remember from my days working with seniors is

watching seniors get bounced from provider to provider to provider, particularly in the long-term care kind of setting.

What would you think, Mr. Diaz—since you all live and breathe this 24/7—about that kind of concept here and having people in long-term care who would essentially look at that continuum of services, obviously trying to keep people at home to the greatest extent possible, but also having the institutional kind of services as well, and for this committee and the Congress to start thinking about, probably in the lingo of Washington, DC, it would be called a Long-Term Care Accountable Care Organization?

I would see it—from my Gray Panther days—as something that puts it all in one place for the seniors so they do not get jostled around from place to place. What do you think of the idea?

Mr. DIAZ. Well, I think we talked about some of the success stories that many of us have had. At the core of that, particularly for seniors—30 or 40 percent of whom have some cognitive impairments and do not have champions within their household—it is about having a physician-directed care manager, someone who can really attend to the drug regime, attend to the discharge, prevent that rehospitalization. So I mean, I think at the core there has to be a care manager.

If we take the 5 percent of Medicare beneficiaries with those chronic diseases who are consuming 50 percent of the costs, going back to Chairman Baucus's question, and we focus on them having a care manager, I think we can bend the cost curve and create a lot of value for those beneficiaries. I mean, I know probably everyone here has a personal story of the difficulty in navigating the system when you are a senior and how we have to jump into this for parents.

So I think that is one of the highest returns we could get to the system. It has been proven in many of the physician practices that when you can really get a nurse practitioner or a care manager who is following the patient and owning that medical record, I think a lot can be accomplished.

Senator WYDEN. I would like to continue that discussion, particularly with people in the long-term care industry, because we are seeing, in the Affordable Care Act, one of the provisions—and Chairman Baucus was very supportive of it—was independence at home. Oregon just has been able to receive one of the first demonstration projects for a wonderful program called House Calls.

What we have been pointing to is the VA—for the sickest people, people you all speak about with these co-morbidities, having a very sick population—saving upwards of 20 percent on that population by caring for them at home. That is the kind of model I would like to see, where someone like yourself—and I think you characterize it correctly—a care manager, a physician, a nurse practitioner, would have this array of options. I am interested in following that up with all of you in the industry.

Dr. Migliori, did you want to add anything?

Dr. MIGLIORI. Yes. I fully agree with you. That is the right kind of model, where you are expanding the responsibilities and capabilities of fully licensed clinicians to do those kinds of things, such as nurse practitioners. We serve about 9 million people who are Medicare-eligible through a variety of programs. We have 1 million

people who are both Medicare- and Medicaid-eligible. For many of those people, we actually conduct house calls.

We have built tablet-based electronic health records so we can go in the home to make sure that the primary care physician's orders are understood and they are able to be fulfilled. We go to the point of actually looking at their medicine bottles to see whether or not there is a pill, there is a bottle corresponding to the prescription, and that the pills are being taken. We will make sure that they have access to nutrition, to whatever therapies, whatever equipment they need. When we have done that, we have reduced readmissions 28 percent. Those readmission rates are impacted even more for our non-white clientele.

Senator WYDEN. Could you get me that information? I would like to see it. I am also interested in following up with you and Mr. Diaz, those of you who are working with this, on what the implications are in other areas, particularly with respect to medical monitoring equipment. We have as our large private employer in our part of the country Intel, and they have been very interested in this, doing very good work, and I would like to follow up with you. Thank you for the time, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

You know, for what it is worth, I know a lot of you are talking to a lot of very smart people in the social networking sphere, new start-ups. Smart phones are going to be so smart and do so much. It is not just financial services, banking and so forth, but health care. I know you are doing this already, but, just off the top of my head, I would just urge you to spend a lot of time and go out to Silicon Valley, or go up to New York to something called Silicon Alley, and just pick their brains. They will surely pick yours to try to find a way to make money.

Second, thank you very much for all that you are doing here. We depend on you. You are the private sector. You know what works, what does not work. You have a bottom line to meet, you have payroll to meet. So I would just urge you, as I did earlier, just be aggressive. Be bold. Take a flier, let us know what might be better, work better, as we proceed. You will get great reception from this committee. I know you will elsewhere too, but certainly with us, and I would just urge you to keep it up.

I have a question that Senator Hatch wanted me to ask, and I will just ask it. It is for you, Mr. Diaz. You do not have to answer. The answer could be for the record.

The question is, I have been hearing of some innovations in managing the dialysis population, a population that is only 1 to 2 percent of the Medicare population but takes up to 8 percent of Medicare spending. Can you tell me what the dialysis industry is doing to manage this chronic problem? Do you have a short answer? Go ahead.

Mr. DIAZ. I have a very short answer. It is a very complex population that also has the same rehospitalization trends, and I think a lot of good work is happening. I am on the board of a company called DaVita. It is one of the leading dialysis companies. I know there is a great commitment there to clinical outcomes and to focusing on integrated health, so I think there is a firm commitment

in that industry to be part of the solution to managing a very unique population.

The CHAIRMAN. Yes. All right.

Thank you all very much. Remember, I said to let us know what other ideas you have. Just give us anything. All right? Thank you very much. Thanks for taking the time. You have come great distances. We appreciate it.

The hearing is adjourned.

[Whereupon, at 11:58 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

**Hearing Statement of Senator Max Baucus (D-Mont.)
Regarding Progress in Health Care Delivery and Innovations from the Field**
As prepared for delivery

Albert Einstein once said "If you always do what you always did, you will always get what you always got."

As health care premiums were doubling from 2000 to 2010, it was clear we could no longer do what we always did. We could no longer tolerate what we always got when it came to our nation's health care.

We all have common goals: to reduce health care costs and improve health care quality. How do we do that? Innovation plays a key role. That's the focus of our hearing today.

It's not the type of innovation we normally think about in the health care industry. It's not developing a new drug or device in a laboratory.

The innovation we're talking about transforms the way providers deliver care to patients. This innovation means patients spend more time with their doctors, rather than talking to insurance companies.

This innovation encourages doctors and nurses to communicate more with their patients and with each other about patient care. And it makes us spend our scarce health care dollars more wisely.

The private sector has always been at the forefront creating innovative ideas, and now the entire health care community is involved. Employers, health plans, Medicare and Medicaid are committed to innovation, and providers of all kinds are engaged to improve the way health care is delivered.

We'll hear about this innovation from our four witnesses today. We will hear about how they are working individually and working together to lower costs and improve quality.

Health reform encouraged this innovation, and we must continue to build on this progress.

Medicare and private payers are together sending one message to providers: From now on, we will pay for quality, not quantity. It is a message that providers have already begun to hear and respond to.

Starting in October, Medicare will start paying hospitals more money when they produce better results for patients. Hospitals that produce poor outcomes will get less money.

And, for the first time, hospitals will be penalized if patients are readmitted too often. Almost one in five Medicare beneficiaries is readmitted to a hospital within 30 days of discharge. We need to encourage providers to do the job right the first time.

I am encouraged to see the private sector aligning with this effort. This year, the insurance company WellPoint will require all hospitals it contracts with to be subject to similar programs. These incentives provide a common-sense foundation to change behavior.

The private sector cannot do it alone, nor can Medicare and Medicaid. The only path forward is through partnerships between the public and private sectors.

That's why we created the Center for Medicare and Medicaid Innovation, known as the Innovation Center. Medicare and Medicaid are now engaged on the front lines and working with the private sector to find new models of payment and delivery of care.

The concept is simple: Find the best ideas. Test them. If they work, expand them. If they don't, move on to new ideas.

Already, the Innovation Center has launched more than a dozen new projects. These projects involve more than 50,000 providers and almost every state in the country. They try out new payment models to reduce costs and make patients healthier.

We know there can't be a one-size-fits-all solution. Health care in Missoula, Montana is different than health care in McAllen, Texas.

I look forward to hearing about the innovative models our four witnesses are developing. Their experience pioneering new approaches, and in partnering with Medicare and Medicaid, should be instructive to all of us.

So let us embrace innovation as an opportunity to change things for the better. Let us encourage public private partnerships. Let us do this to lower health care costs for consumers and for taxpayers. Let us do this to improve patient care. And as Mr. Einstein advised, let us not always do what we always did.

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**Statement of Paul J. Diaz
CEO, Kindred Healthcare**

**Senate Finance Committee Hearing
Progress in Health Care Delivery: Innovations from the Field
Washington, D.C.
May 23, 2012**

Kindred Healthcare is pleased to submit these comments for the Senate Finance Committee's hearing on "Progress in Health Care Delivery: Innovations from the Field." Kindred is honored to participate in the hearing and share our experiences about the critical role that post-acute care plays in transforming our delivery system into one that is more patient-centered, outcome-driven and integrated. In particular, we commend the Chairman, the Ranking Member and the entire Committee for seeking input from those of us in the field who are testing new models to improve care and reduce costs through the many collaborative innovations in care delivery.

The Committee's decision to hold this hearing on delivery system reform is very timely. Hospitals, health systems, managed care organizations, physician groups, post-acute providers and others across the country are actively engaged in efforts to transform our nation's healthcare system through private sector and publicly supported initiatives. There is a growing recognition that our current healthcare delivery system must be changed. Kindred has a national vantage point to offer in these discussions since we operate in over 40 states and are participating in a range of reform efforts in local healthcare communities throughout the country. As a provider of diversified post-acute services caring for our nation's sickest and most expensive patients, Kindred is actively working with private and public Accountable Care Organizations (ACOs), hospitals, health systems, physicians and managed care organizations on innovative ways to deliver integrated care, improve quality, restore wellness and reduce costs.

At the outset I want to emphasize that transforming our healthcare system requires building trust, collaboration, cooperation and aligned incentives between providers, payers, patients, and policymakers. It won't be easy, and in our experience systemic change will require incremental reforms, but without a culture of cooperation, teamwork and trust between those charged with delivering and paying for care, I fear we will remain stuck in our current silos, state of inefficiency and unsustainable cost growth. I will emphasize this theme throughout my comments.

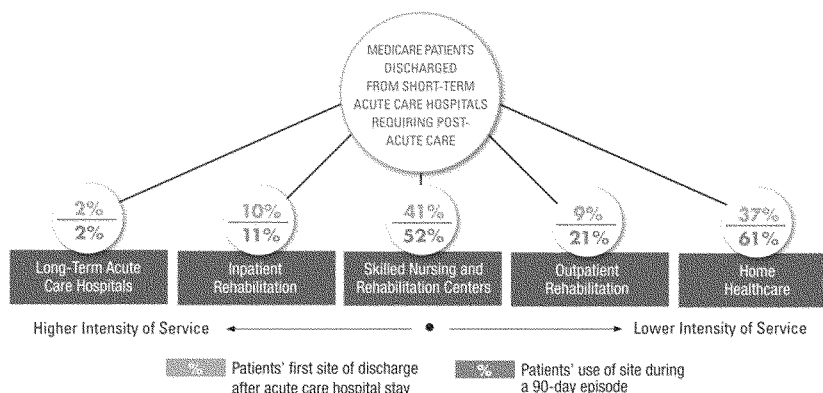
Why is Care Delivery Reform Needed and Why is Post-Acute Care Important?

Before sharing with the Committee some examples of new care delivery models we are testing with our partners in the field, I would like to provide some context as to why we are engaged in these activities and why post-acute care is so important to delivery system reform.

As you know, the existing fee-for-service system, which pays for volume rather than value, has produced a fragmented delivery model that does not serve patients well and contributes to unsustainable cost growth. This problem also exists in “post-acute” care, where a growing number of chronically ill and medically complex patients require care after a short hospital stay. Today, there are over 47 million Medicare beneficiaries and an estimated 7,000 individuals added to the program every day.¹ A growing number of these people have chronic conditions such as diabetes and heart disease and represent the most expensive patients to care for as they cycle through our system with acute care hospitalizations, re-hospitalizations, and consumption of other health care services. The following chart from a CMS-sponsored study illustrates this point and also highlights the critical role that post-acute care can play in coordinating care and lowering healthcare costs: 35% of all Medicare beneficiaries who have been admitted to an acute care hospital require some form of post-acute care following their hospital stay. These same patients often require care in more than one post-acute setting to meet their needs.

Tremendous Opportunities Exist to Better Manage Patient Care for Patients Discharged From Acute Care Hospitals

35% OF MEDICARE BENEFICIARIES ARE DISCHARGED FROM ACUTE HOSPITALS TO POST-ACUTE CARE.⁽¹⁾



(1) RTI, 2009: Examining Post-Acute Care Relationships in an Integrated Hospital System

The problem from a care perspective is that as patients move from the acute care hospital to multiple post-acute settings there isn't anyone, particularly physicians, who are responsible for coordinating care and driving the outcomes throughout the patient's entire episode. This results in a lack of coordination among providers, confusion about how to transition patients, when to transition, what is the most appropriate setting and how to continue the care in a seamless way from provider to provider. This “silo-based” delivery system does not make the most efficient use of healthcare services based on individual patient need. Worse, it is not “patient-centered” in terms of achieving the

¹ Kaiser Family Foundation, 2011 and AARP 2011 projections

patient's goal of getting well and home more quickly. And it results in fragmented care including unnecessary hospitalizations, a major focus of policymakers and providers.

This system is also not ideal from a payment perspective. Because providers are paid each time the patient has an encounter with the healthcare system, there is little incentive for coordination of care and this system can produce redundancy in services and higher than necessary costs.

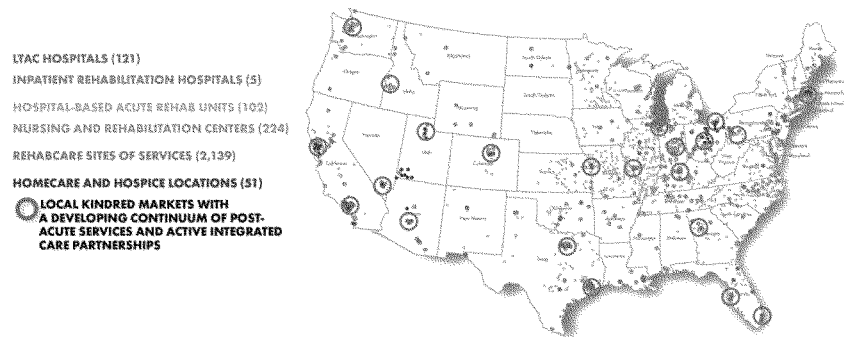
The Need for Coordinated, Cost-Effective Post-Acute Care

Several years ago Kindred as well as many other post-acute providers embarked upon an effort to develop the capabilities to meet the needs of patients throughout their entire episode of post-acute care-- from hospital to home-- to begin to address the shortcomings of the silo-based system described above. The goal is to become a post-acute "continuum of care" provider so that we can be part of the solution for patients and payers in a future healthcare system that will be more integrated. As I noted at the beginning of my comments, this is not a goal that post-acute providers can achieve on our own. Instead, we are working with acute hospitals, health systems, managed care organizations, physicians, care managers and others to "integrate" post-acute care into the broader healthcare delivery system to achieve our shared goals. Our motivation for doing so was well summarized by MedPAC in their 2007 Report to Congress: "Effective coordination of care between acute and post-acute settings has benefits for patients and providers. Such coordination can reduce hospital readmissions—thereby reducing spending and improving patient experiences."

Today, Kindred is the largest provider of diversified post-acute care in the nation, operating in over 40 states. Within these 40 states we are focused on approximately 20 local healthcare communities where we are building the capacity to develop the service lines that span the entire post-acute spectrum so that we can partner with others in the delivery system to better coordinate care. We have 121 Long Term Acute Care Hospitals (LTACs) serving the most critically ill patients, 5 free-standing and 102 hospital-based Inpatient Rehabilitation Facilities (IRFs) providing intensive rehabilitation services to restore functional ability, 224 Skilled Nursing and Rehabilitation Centers (SNFs) providing restorative, rehabilitative and long term care services, and 51 Home Health and Hospice sites providing in-home services and palliative hospice care. We are also the largest provider of rehabilitation services in the nation, with 2,100 sites of service providing physical, speech, and occupational therapy to about 500,000 patients a year.

But our size and national scale is less important than our efforts to be able to provide a continuum of post-acute care in local healthcare communities. The following map shows Kindred's sites of service throughout the country and highlights those communities where we have or are developing the capacity to deliver a continuum of integrated post-acute care.

Advancing Integrated Care: Kindred is developing the capacity to deliver the full continuum of post-acute care in local healthcare markets



Innovations in the Field: Key Capabilities Needed to Provide Integrated Acute and Post-Acute Care

Kindred's growing capacity to deliver the continuum of post-acute care in local communities has provided us with a good opportunity to test different models of integrated care with our hospital and managed care partners to improve quality and reduce costs. We have discovered in testing these models that no one approach will fit every situation and every community. The adage that "all health care is local" is especially true when considering how to transform the system and make care and payment more integrated. Still, we have learned that there are certain key capabilities that are needed to integrate care across a patient episode, and we have focused on these key capabilities in our new care model pilots.

Clinical Integration Between Acute and Post-Acute Care, and Between Post-acute Providers

As I noted earlier, trust and collaboration among a team of physicians, nurses, therapists, and other post-acute and acute providers is crucial to reforming our delivery system. We have learned that a critical first step is to achieve clinical integration with our hospitals and managed care organizations. We do this through establishing "Joint Operating Committees" (JOCs) with our partners to establish a formal mechanism to identify shared goals and strategies to coordinate and improve quality care. These JOCs have a formal charter, include clinical, care management and operational representatives from each of our organizations, meet regularly and use structured agendas to identify specific clinical outcome, patient satisfaction and efficiency goals, and collect and analyze data to measure progress and identify areas for improvement.

Kindred has established dozens of JOCs throughout the country with hospitals, health systems, physicians, managed care payers, and private and public ACOs. This type of clinical integration can yield significant and immediate results even under the current fee-for-service payment system. As a result of our efforts in collaboration with our acute hospital partners, Kindred has reduced re-hospitalization rates by over 8% in our LTACs and Skilled Nursing and Rehabilitation Centers since 2008.

A specific case study can demonstrate the power of collaboration and communication to improve quality and reduce costs immediately. A Joint Operating Committee between Kindred and a prestigious Academic Medical Center in Cleveland, Ohio focused on higher than acceptable re-hospitalization rates. The Joint Operating Committee analyzed the data and found that a significant number of re-hospitalizations from Kindred post-acute settings involved patients with urinary tract infections (“UTI”). To examine the issue further, patients were screened prior to post-acute admission and it was discovered that many patients had actually acquired the UTI in the acute care hospital, prior to post-acute admission, but before clinical symptoms had appeared. The intervention chosen was to more actively screen and treat patients prior to discharge from the acute care hospital. The result was a significant decrease in re-hospitalization rates.

We have achieved similar declines in re-hospitalization rates with Managed Care Organization (“MCO”) partners, but MCOs are also interested in reducing lengths of stay over episodes of care since they are paid on the basis of capitation. A Joint Operating Committee with a Physician-led managed care organization in Las Vegas, Nevada has focused on appropriate length of stay for the multiple Kindred post-acute service lines in that market—LTAC, hospital-based subacute, and free-standing skilled nursing and rehabilitation services. Based on appropriate use of each of these services lines, and a relentless focus on appropriate length of stay across an episode of care, post-acute length of stay has been significantly reduced. Kindred and other acute and post-acute providers have achieved similar results nationwide: Between 2008 and 2011 patient length of stay has dropped at Kindred LTACs and Skilled Nursing and Rehabilitation Centers by 12% and 27% respectively. This is better for patients as they are able to return home sooner and it also lowers cost to the system by reducing length of stay.

Physician Participation in Care Management Across Settings

A very important part of achieving care integration across settings is the role of physicians in participating in decision-making and overseeing care across multiple service sites. Under the current fragmented system, physicians typically oversee patient care *within* settings, but rarely follow patients from acute, to post-acute, to home to make sure that the care is coordinated and seamless *across* settings. The movement towards “medical homes” and other arrangements to engage physicians in population health management are encouraging, but we have found that more is needed in the short-term to better coordinate post-acute care.

The models of physician care oversight vary significantly from community to community. As a result, Kindred and our partners are testing a range of models to achieve the goal of active physician engagement in care management across an episode of care. In Indianapolis, where Kindred has the full range of post-acute services, we are working with a large health system who has been selected as a “Pioneer ACO.” We also have an affiliation with an independent physician practice group whose practice privileges include the acute hospital system as well as Kindred’s post-acute service offerings. Our coordination with both the hospital system and the physician group enables treating physicians to follow their patients throughout an entire episode of care. This increases the likelihood of care being better coordinated and also reduces the risk of re-hospitalization.

In Denver and other markets, the absence of an independent physician practice group with the capacity to follow patients from acute to post-acute sites requires a different approach. In these markets, we are testing a “Hospitalist” model in affiliation with a national organization that provides Hospitalist services to both acute and post-acute providers. Under this approach, we have identified Hospitalists who treat patients in acute care hospitals and are willing to follow those patients into Kindred post-acute settings to ensure smooth transitions in care and to better integrate care across settings.

In a growing number of markets across the country it is increasingly common for physicians to become employed by hospitals, health systems, and managed care payers. In fact, over 50% of physicians are now employed by hospitals and a decreasing number are choosing independent practice. The challenge for post-acute care providers is the availability of enough physicians to provide care, particularly integrated care across our sites of service. To respond to this trend, in markets such as Cleveland where most physicians are employed by hospitals, we have established an agreement with the hospital system to have hospital-employed physicians follow their patients into our post-acute settings. The example given above about the reduction of re-hospitalizations attributable to urinary tract infections was made possible because staff physicians from the acute hospital system not only follow their patients to Kindred post-acute sites of care, but also actively participate in our Joint Operating Committee.

The Importance of Information Technology, Electronic Health Records and Interoperability as a Key Enabler for Care Integration

In addition to clinical integration and physician coverage across sites of care, a key enabler for care integration is the availability of Electronic Health Records and information technology. The ability to collect and retrieve patient information accurately and efficiently *within* healthcare settings can improve quality care and reduce costs. The ability to transmit this information *across* sites of care is a critical element to effective care management over an episode of care.

While few providers across the country have achieved full adoption of electronic health records, there is some progress being made and Kindred is piloting different approaches. We have a Kindred-specific 5-year I-T plan, costing millions of dollars, to install health information technology within each of our service lines and currently have an electronic health record in our LTACs. At the same time that we are working on installing electronic health records within Kindred service lines, we are also testing ways to create “interoperability” with our acute care partners.

In Cleveland, for example, we have established an I-T linkage between the EPIC Electronic Health Record system used by our acute hospital system partner and our own LTAC electronic health record. This enables physician access to electronic patient records in both settings and includes information from both the acute hospital and post-acute stay. We are in the process of creating a similar linkage with the records in our hospital-based sub-acute service line as well as our free-standing Skilled Nursing and Rehabilitation facility. This interoperability has produced a high level of physician and patient satisfaction, enabled improved integration of care, and in the future will be a key enabler to support a more integrated delivery system.

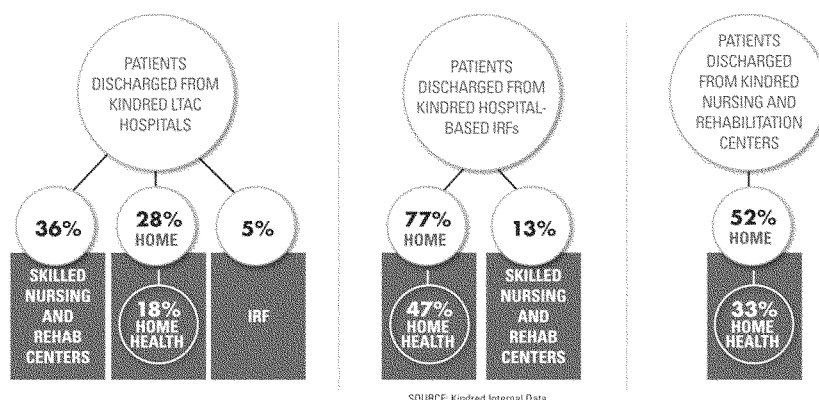
But I would be remiss in not pointing out that achieving even modest levels of interoperability is technically very difficult and expensive. And while a growing number of hospitals and physician practices are investing in electronic health records because of government financial support, only a tiny portion of the billions of dollars available for health information technology in the Stimulus Package was made available to post-acute providers, so the investment in HIT for the post-acute sector will lag other healthcare sectors, as documented in a recent Health Affairs article.²

Clinical Criteria for Post-Acute Levels of Care and Care Management Capabilities

Another key enabler for care integration between acute and post-acute sites of care is clinical criteria for post-acute levels of care and the use of clinical care managers across an episode of care. This is a particularly important strategic initiative for Kindred since, as noted above, patients often need multiple post-acute services to meet their needs and it is vital to coordinate these services to achieve care integration for the patient and cost savings for the system. The following chart shows the number of Kindred patients who are discharged from our own settings to other post-acute settings which demonstrates two key points: The number of patients returning home from all sites of Kindred post-acute care is increasing; and it is important to coordinate care between settings to achieve quality and cost control objectives.

² “Electronic Health Records: Hospitals Ineligible For Federal Meaningful-Use Incentives Have Dismally Low Rates Of Adoption Of Electronic Health Records” Health Affairs March 2012 31-3505-513. Larry Wolf, Jennie Harvell and Ashish K. Jha.

Kindred Is Working Towards Determining the Most Appropriate Care Setting For Patients as they Continue Their Care Throughout a Post-Acute Episode



We are piloting several different initiatives across the country aimed at achieving these goals, including: centralized admissions for all Kindred post-acute sites of care to help discharge planners determine the appropriate site of care based on clinical criteria and patient need; clinical programs in Kindred post-acute settings that are tailored to meet the needs of acute hospitals in the market to promote coordinated care; care management strategies that focus not just on appropriate site of care upon hospital discharge but also throughout a patient's entire episode of care, including the post-acute episode; clinical criteria to help determine when patients are ready to transition to another site of care, including home, without increasing the risk of quality problems or re-hospitalization; and direct admissions to post-acute sites of care (including developing urgent care centers) to avoid costly acute hospitalizations.

As noted above, communication between sites of care is key, as is the ability to transmit patient information across an episode of care electronically. But there is no substitute for clinical care managers on the ground to ensure smooth transitions for patients throughout the healthcare system and helping to determine which clinical setting is appropriate based on patient need and when transitions can safely occur. In addition to physician coverage across sites of care, Kindred is also testing models of nurse practitioner and other clinical nurse specialists serving as "care managers" to help manage a clinical episode of care.

We are also testing models of integrated care targeted at getting patients home faster and in a way that prevents re-hospitalizations. In Dayton, Ohio, for example, we are piloting a program where Kindred's home health care managers conduct pre-discharge assessments of patients in Kindred Skilled Nursing and Rehabilitation Centers

to make sure transitions home are smooth. Part of this assessment includes an evaluation of the continued need for physical, speech and occupational therapy at home. Since Kindred's RehabCare therapists provide therapy in both settings, the functional gains achieved at the skilled nursing and rehab setting, which enables the patient to return home, can be continued in a seamless way, both to continue functional improvement as well as reduce the risk of re-hospitalization.

Quality Measures that Transcend Sites of Care

As noted by MedPAC, providers, payers and regulators need quality measures to coordinate care between settings, to achieve quality improvements, and to reduce costs. Likewise, consumers need access to understandable information to be part of care decision-making. In post-acute care, it is vital to have quality measures that transcend sites of care and for there to be a high level of transparency on these performance measures. Currently, the post-acute space lacks a common set of quality indicators to evaluate care outcomes as patients move across sites of service. This lack of common quality measures impedes effective care management across an episode of care.

While policymakers test different ways to produce common quality metrics such as through the recently released CMS study, "PostAcute Care Payment Reform Demonstration" ("PAC-PRD"), Kindred has several innovation pilots underway. For example, we are pilot testing use of a "Functional Outcome Measure" (which measures functional improvement produced by a course of rehab) across an entire episode of care, including the acute hospital and post-acute stay. These measures are collected and displayed on an IPAD so that both clinicians and patients can see, in real time, where they are in their recovery cycle. Collecting and using this common measure across both the acute and post-acute episode promotes continuity of care as the treatment protocols used, and the functional gains achieved, can be continued from setting to setting. Again, since Kindred therapists provide care across all settings, this also promotes continuity of care and efficient delivery of services.

Aligned Payment Incentives Between Payers and Providers

All of the key enablers described above that promote care integration will also be needed to support a payment system that is more integrated. As noted, the current fee-for-service payment model contributes to a fragmented delivery system and payment inefficiency. It also discourages aligned incentives between providers and between payers and providers. Today, there are separate payment systems for each post-acute provider and insufficient criteria to guide appropriate patient placement. Today, payment systems do not encourage post-acute providers to reduce lengths of stay. In fact, providers who reduce lengths of stay are penalized because patient care costs are front-loaded and payment systems do not recognize this fact and can produce payments below costs for very short lengths of stay. Today, post-acute providers are not rewarded or penalized for re-hospitalization rates. And today, post-acute providers are not paid based on the quality outcomes achieved.

The Committee should recognize that it will take time to transform our current payment system into one that pays for value, rather than volume. In the meantime, I wanted to share a few Kindred pilots with managed care payers that can help shed light on how the payment system might be designed for the future. For example, Kindred has developed with one physician-led managed care organization a pricing model that reflects different levels of care based on patient characteristics for multiple post-acute services. The levels of care are determined both by patient characteristics and the services needed in each post-acute setting. The pricing agreement is supported by a centralized admission infrastructure as well as physician-led care management used to assess level of care, appropriate length of stay, and movement between sites of care.

We are also in the process of developing “pay for performance” payment adjustments to this and other contracts with managed care organizations to promote alignment of interests between payer and post-acute provider. These payment adjustments include, among others, shared risk and gain around: 1) reductions in lengths of stay; 2) reduced re-hospitalizations; 3) quality improvements, including patient experience measures; and 4) discharge rates home. As discussed below, we view “pay for performance” payment adjustments as a critical bridge to a fully integrated payment system, including the concept of payment of a fixed cost for a full episode of care.

Towards Delivery System Reform and Integrated Care: Barriers and Opportunities

In some ways Kindred is uniquely situated to support delivery system reform through integrated care because of the diversity of our post-acute service lines and our national scope which has provided us an opportunity to work together with our partners in the field to test new models of integrated care that are tailored to the needs of local communities. But we are by no means unique. Many post-acute providers—LTACs, IRFs, SNFs, Home Health, Hospice providers—are likewise expanding their capacity to meet the diverse needs of patients, establishing closer linkages with hospitals, health systems, ACOs and managed care payers, making investments in health information technology and developing care management capabilities to prepare for a more integrated system.

And all providers face the same challenges in making progress towards these shared goals, some of which I would like to highlight for the Committee. I would also like to share a few ideas for incremental progress as we work together towards comprehensive reform.

Payment Instability under the Current System

Kindred recognizes our shared obligation to reduce costs and have supported efforts to stem the rise in healthcare expenditures as part of our nation’s debt reduction imperative. Over the last several years, all healthcare providers have been subject to tremendous reimbursement pressures as Congress, CMS and private payers have been forced to reduce provider payments to address this national crisis. At the same time, I urge the Committee to consider the impact of additional payment cuts—including the

impending 2% sequestration cut to Medicare payments beginning in January 2013 and continuing for 10 years—on our ability to continue the kinds of innovation pilots I have described today. Innovation requires stability, and more payment cuts will cause a level of instability that I fear will prevent the kind of innovation needed to transform our healthcare system.

We can reduce costs and overall spending by reforming our delivery and payment system – through reduced lengths of stay, reduced hospitalizations, investments in electronic health records, investing in care management, and improvements in quality. But achieving these long term goals will require investments in the short-term, and making these investments requires a measure of stability and confidence in the current payment systems. As noted by a prominent policy expert: “Before provider payments are reduced, our payment system must be reformed to encourage the more efficient delivery of care... so that new delivery models can gain traction.”³

Address FFS Payment Rules that are Inconsistent with Integrated Care

As we work together towards a more integrated delivery and payment system, I urge the Committee to consider incremental reforms to the current fee-for-service payment systems that inhibit innovation and progress towards a more rational system in the future. There are many examples that I would be happy to discuss with the Committee, but I would like to mention two specific ideas in the time that I have.

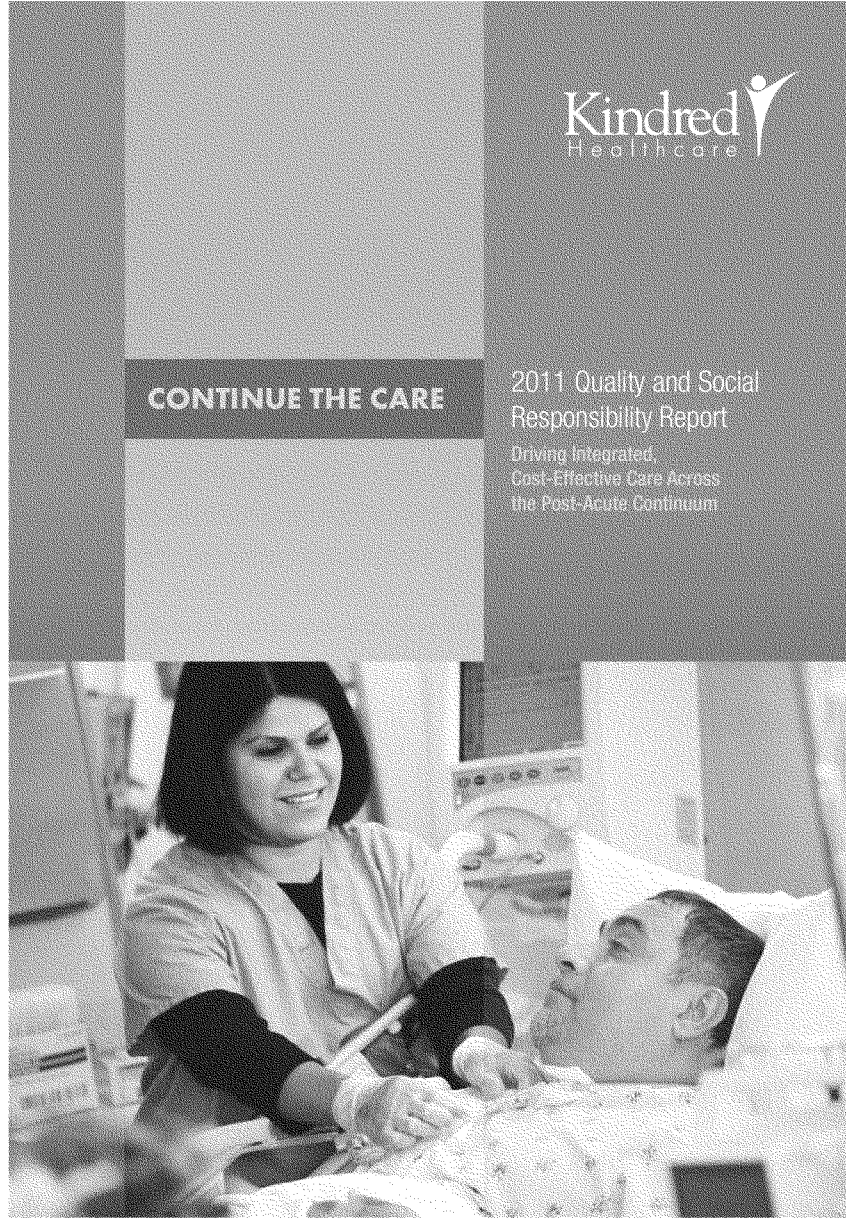
First, as I have mentioned, it is important that acute and post-acute providers and payers have aligned incentives to achieve the shared goals of improved care and lower costs. An immediate focus on reducing re-hospitalizations is an area where providers and payers can be aligned. I urge the Committee to consider ideas from post-acute providers and others about ways that the payment system can encourage reduced hospitalizations on the one hand, and discourage high rates of re-hospitalizations on the other. Acute hospitals are already incentivized by the payment system to address this important issue. I see no reason why post-acute providers should not also have “skin in the game” so that interests are aligned.

Second, there are changes to the current fee-for-service payment system that can encourage appropriate patient placement into post-acute settings based on patient needs and align Medicare payments more closely with patient characteristics and care needs. For example, the so-called “IRF 60%” rule, which defines appropriate patient criteria for admission to an IRF, has had the effect of stemming growth in overall IRF spending and encouraging appropriate use of this post-acute setting. Likewise, I commend Senators Roberts and Nelson, both members of this Committee as well as several Committee co-sponsors, for introducing last session S. 1486, The Long Term Care Hospital Improvement Act. This legislation, like the “IRF 60% Rule,” would more clearly define the role of LTACs in the healthcare continuum as treating the nation’s most medically complex patients. It would also reduce Medicare spending by ensuring only patients who

³ Mechanic, Robert E.; Altman, Stuart H. “Payment Reform Options: Episode Payment is a Good Place to Start.” *Health Affairs – Web Exclusive* (2009): 262.271.

require the intensive services provided by LTACs are admitted and treated in that post-acute setting. These types of incremental reforms to current fee-for-service payment systems are a helpful and necessary bridge to a fully integrated delivery and payment system.

On behalf of Kindred, I would like to thank the Chairman and the Ranking Member again for the opportunity to share our perspective on delivery system reform and some of the innovative projects we are pursuing with our partners in the field. I started my comments by emphasizing the need for collaboration, trust and teamwork between providers, payers, and policymakers to achieve delivery system reform. I would like to close my comments by re-emphasizing this point and committing to the Chairman, the ranking Member and the entire Committee that providers stand ready to work with you and others in the healthcare community to transform our healthcare system, beginning with incremental reforms that can produce immediate results. Our ability to do so will depend critically on some measure of payment stability and confidence in the short-term and incremental reform of our current payment system to enable and promote the type of innovation that needs to occur to transform our system in the long term.



YEAR IN REVIEW:

Delivering on Quality, Value and Innovation in Patient Care Delivery

498,000

patients and residents were cared for by Kindred in settings across the post-acute continuum.

Kindred Long-Term Acute Care and Rehabilitation Hospitals, Skilled Nursing and Rehabilitation Centers and PeopleFirst Homecare and Hospice continued to **improve in key quality indicators** and

OUTPERFORM NATIONAL QUALITY BENCHMARKS

throughout 2011.

In 2011, Kindred's Long-Term Acute Care Hospitals treated the sickest, most medically complex patients, discharging nearly

70%

of patients home or to a lower level of care after an average length of stay of 28 days.

Customer **satisfaction** high with

92%

of our patients, residents and families indicating they would recommend Kindred again.

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RehabCare
 Kindred's RehabCare Division is the
**LARGEST PROVIDER OF
 REHABILITATION SERVICES**
 in the United States with 2,139 sites of service.

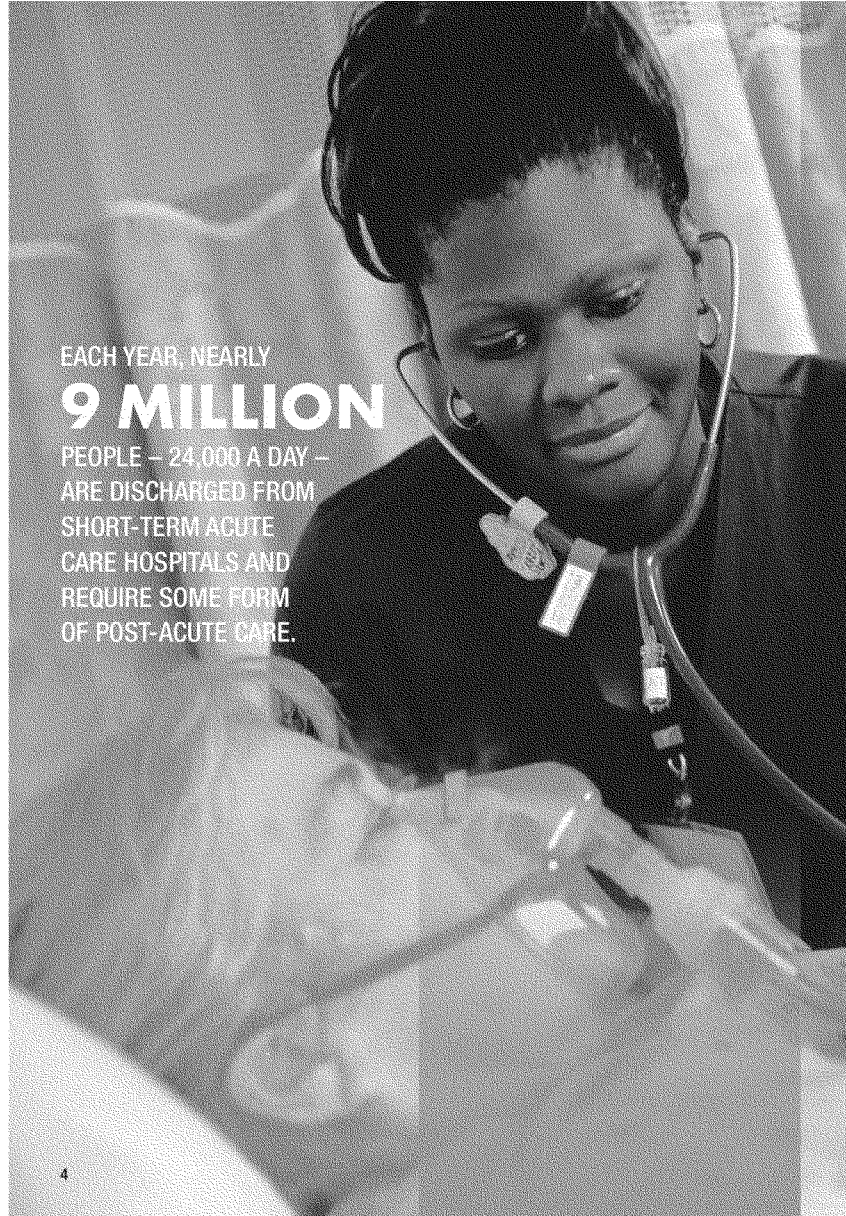
Since 2008, Kindred Nursing and Rehabilitation Centers discharged
16% MORE PATIENTS HOME
 ~ with 52% of patients discharged home in 2011 after an
AVERAGE STAY OF 32 DAYS.

RehabCare therapists helped 471,000 patients and residents achieve an average of
MORE THAN 76% IMPROVED FUNCTION
 and independence from what they were able to do prior to illness or injury.

From 2008 to 2011, we have
REDUCED THE TOTAL AVERAGE LENGTH OF STAY
 in our hospitals by 12% and in our nursing and rehabilitation centers by 27%.

Kindred Long-Term Acute Care Hospitals and Nursing and Rehabilitation Centers
REDUCED REHOSPITALIZATION RATES BY OVER 8%
 from 2008 to 2011.

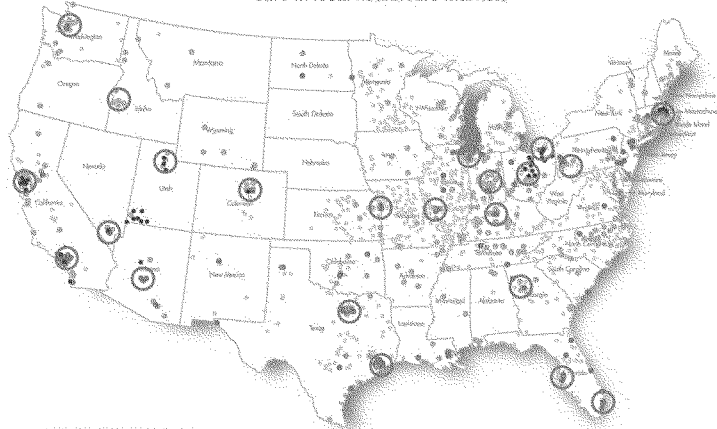
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EACH YEAR, NEARLY
9 MILLION
PEOPLE – 24,000 A DAY –
ARE DISCHARGED FROM
SHORT-TERM ACUTE
CARE HOSPITALS AND
REQUIRE SOME FORM
OF POST-ACUTE CARE.

ADVANCING INTEGRATED POST-ACUTE CARE

Kindred is developing the capacity to deliver the full continuum of post-acute care in local healthcare markets



LTAC HOSPITALS (121)

INPATIENT REHABILITATION HOSPITALS (5)

HOSPITAL-BASED ACUTE REHAB UNITS (102)

NURSING AND REHABILITATION CENTERS (224)

REHABCARE SITES OF SERVICES (2,139)

HOME CARE AND HOSPICE LOCATIONS (51)

LOCAL KINDRED MARKETS WITH A DEVELOPING CONTINUUM OF POST-ACUTE SERVICES AND ACTIVE INTEGRATED CARE PARTNERSHIPS

Kindred Healthcare is

77,800

dedicated employees taking care of

53,500

patients and residents every day in over

2,200

locations in

46

states.

OUR MISSION

Kindred Healthcare's mission is to promote healing, provide hope, preserve dignity and produce value for each patient, resident, family member, customer, employee and shareholder we serve.

OUR MANAGEMENT PHILOSOPHY

Kindred Healthcare's management philosophy is to focus on our people, on quality and customer service, and our business results will follow.

In local healthcare delivery systems throughout the country, Kindred is
AN ACTIVE PARTNER
 in advancing integrated care and new payment models.

CONTINUE THE CARE

Transforming Post-Acute Care

Our nation's healthcare delivery system is changing to require coordination and collaboration among providers with the goal of improved quality and better patient outcomes while reducing costs. While post-acute care historically has been an afterthought in healthcare, it now plays an important role in effective integrated care strategies.

Every year, more than 34 million patients are discharged from inpatient hospital care. For many of these patients a quick recovery is impossible. They require specialized medical and rehabilitative care after a short stay in a traditional hospital – they need post-acute care – in order to recover and regain independence. The goal of post-acute care is to provide recovery, help patients regain function and ensure an independent lifestyle.

Kindred is uniquely positioned to deliver quality medical care and rehabilitative services across the entire post-acute continuum. Our team of physicians, clinicians, therapists and dedicated support staff enables us to more successfully and seamlessly transition patients and effectively manage their entire episode of care across multiple settings – this is how we **Continue the Care**. We make recovery possible at sites of service in local communities nationwide, including

long-term acute care (LTAC) hospitals, acute rehabilitation units, inpatient rehabilitation hospitals (IRHs), sub-acute units, transitional care centers, skilled nursing and rehabilitation centers, homecare, hospice and through contract rehabilitation services provided in acute and post-acute settings.

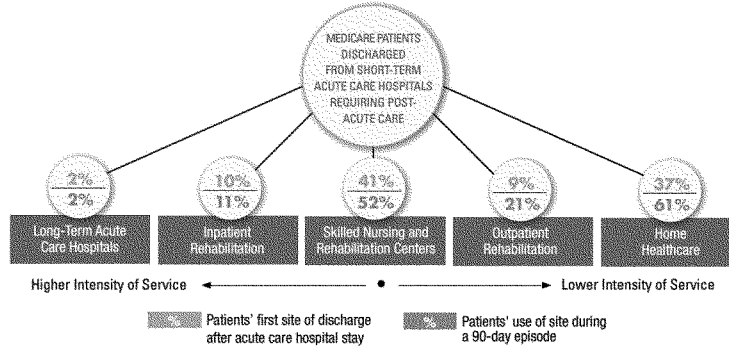
Through partnerships with physicians, health systems, managed care organizations, and acute care hospitals in local markets, Kindred is increasingly able to break down silos of care, better manage episodes of care and deliver on our promise of high-quality, person-centered healthcare.

Kindred's committed approach has led to a proven track record of success with superior clinical outcomes, high customer satisfaction and quality care.



CURRENTLY THERE ARE 47.6 MILLION MEDICARE BENEFICIARIES WITH AN ESTIMATED 7,000 INDIVIDUALS ADDED TO THE PROGRAM EACH DAY.*

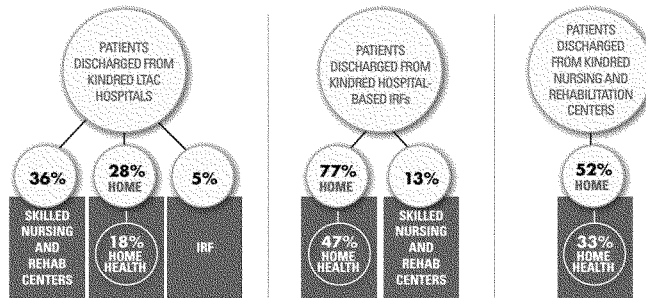
35% OF MEDICARE BENEFICIARIES ARE DISCHARGED FROM ACUTE HOSPITALS TO POST-ACUTE CARE.⁽¹⁾



(1) RTI, 2009: Examining Post-Acute Care Relationships in an Integrated Hospital System

Following an acute hospital stay, a growing number of Medicare patients need post-acute care – often in multiple care settings. Kindred is expanding its capacity to deliver a full continuum of post-acute care in local markets nationwide, in response to this need.

In order to best provide care from hospital to home, our integrated and interdisciplinary care management teams focus on a patient's individual needs. Transitioning patients home more quickly provides superior clinical outcomes and lowers costs by reducing lengths of stay – while reducing unnecessary rehospitalizations.



SOURCE: Kindred Internal Data

*Kaiser Family Foundation, 2011 stateswithfacts.org, and AARP 2011 projections.

“Effective coordination of care between acute and post-acute settings has benefits for patients and providers. Such coordination can reduce hospital readmissions – thereby reducing spending and **IMPROVING PATIENT EXPERIENCES.**”

Medicare Payment Advisory Commission (MedPAC) June 2007 Report

Driving Innovations in Care Coordination

Our nation's healthcare system is undergoing a transformation that emphasizes Accountable Care Organizations, bundled payment systems and private sector initiatives; all of which share the goal of better care coordination across settings, improved quality outcomes and lower costs. In local healthcare delivery systems throughout the country, Kindred is an active partner in advancing new integrated care and payment models.

Throughout 2011, Kindred built upon its significant and ongoing efforts to improve care coordination and management throughout an entire patient episode of care by increasing partnerships with physicians, care networks, managed care organizations, acute care hospitals and payors. Developing these relationships has led to active communication, enabling a better understanding of patient needs, better care transitions, improved care outcomes and more patients discharged home.

Kindred is proud to be participating in a number of innovative integrated care projects, including participating in bundling demonstrations, applying for Innovation Grants, and partnering with recently announced **Accountable Care Organization (ACO) Pioneers**.

Representing our network of diverse post-acute services in local healthcare delivery markets in hospital **Joint Operating Committees (JOCs)**, and utilizing our internal interdisciplinary team approach has resulted in improved patient care and streamlined transitions between care settings. In addition to JOCs, our partnerships benefit all involved – patients, payors and providers alike – through IT linkages, mechanisms to track and share key data, integrated physician leadership across settings and alignment of financial and clinical goals.

Transitional Care and Homecare Pilot

Our approach to integration and coordination is to break down the silos of care and focus on the unique needs of

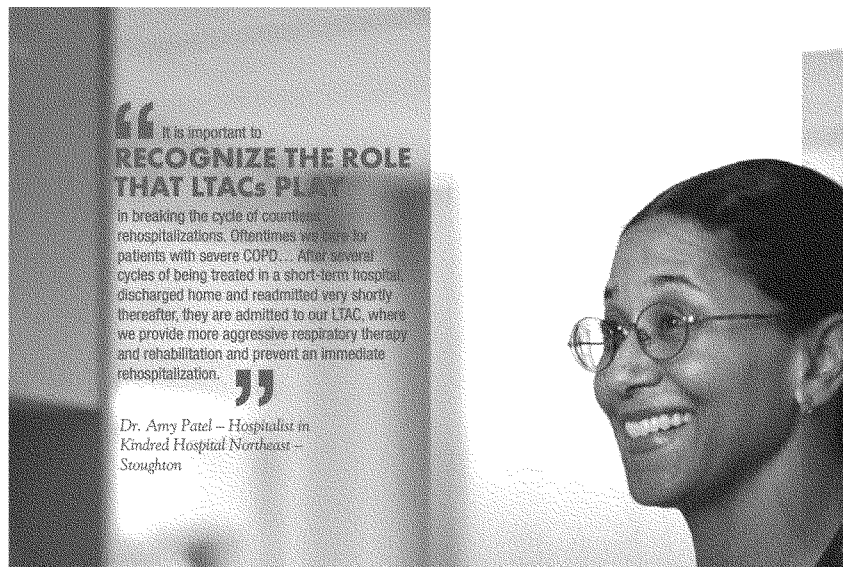
each patient. One pilot that illustrates this approach is in our Columbus, Ohio, market. Upon admission to our skilled nursing and rehabilitation centers in the area, patients are assessed as to whether they may require homecare after discharge for a full recovery and independence. A Clinical Integration Specialist (CIS) from Kindred's homecare agency attends all care conferences and understands all aspects of the patient's care, improvement and progression toward discharge. During this time, the CIS is an advocate for the patient and a trusted advisor to the patient and family who works to ensure everyone is prepared for the transition to homecare.

The goal is to ensure a seamless transition to the home, a more rapid return to the community and reduce rates of post-discharge rehospitalization.

Innovations in Technology

Kindred has recognized and invested in the development of information technologies including electronic health records (EHRs) in order to improve clinical delivery, capture real-time documentation, track patient outcomes, and better serve our business partners.

We are committed to invest in and enhance our internally developed ProTouch system that is used in all our LTAC hospitals. Recent upgrades to this system establish alerts to a patient's change in condition or medication management; enable clearer communication between physicians, nurses and case managers; and provide improved data analytics.



Additionally, in the Cleveland, Ohio, market we have established an electronic linkage with our acute care partner's health record, EPIC, within our local LTAC hospital.

In 2011, we began the process of implementing the Point Click Care web-based EHR in our Nursing Center Division, beginning with our Transitional Care Centers. This tool will improve the accuracy of documentation, streamline processes and increase operating efficiencies – all contributing to improved quality care.

Throughout our **RehabCare Division**, our therapists in the field rely on handheld technologies and applications that provide the highest levels of productivity and efficiency. Enhanced technology initiatives drive improved clinical and operational results throughout the division. In 2011, we added the ability to track and trend treatment data, which provides the ability to identify and implement best practices, target clinical advancements and provide improved patient outcomes.

Innovations in Reduced Rehospitalizations

Kindred continues its focus on innovative strategies to reduce rehospitalizations from post-acute care settings through a collaborative project with Dr. Andrew Kramer, a noted expert in this area. 2011 witnessed the development

and first pilot test of an application that identifies patients at highest risk of hospitalization in a single cluster market so that clinicians can most appropriately tailor care interventions and reduce the risk of rehospitalization.

The pilot test demonstrated the potential of the web application to identify patient risk, and to identify sites with elevated readmission rates for Kindred LTAC hospitals and nursing and rehabilitation centers. Equally important, the tool identifies the specific factors that increase the risk of hospitalization so that colleagues can take action to reduce the risk.

Innovations in Physician Engagement

At Kindred we recognize that physicians are a key element of integrated and coordinated care. Throughout 2011, we engaged in several initiatives to foster improved physician alignment which resulted in physicians increasingly following patients from the acute hospital to a variety of Kindred post-acute settings. Additionally, physicians are an integral part of the medical leadership team at our facilities. To promote training of physicians in post-acute care, Kindred facilities are used as academic sites for residents, medical students and allied health clinicians.



Long-Term Acute Care Hospitals

Research indicates that only five percent of our nation's population accounts for nearly half of overall healthcare spending.* As healthcare struggles to deliver quality care at a lower cost for the sickest patients, LTAC hospitals play a vital role in caring for and stabilizing the most medically complex patients, and improving function so that they may go to a lower, less costly setting of care without being rehospitalized.

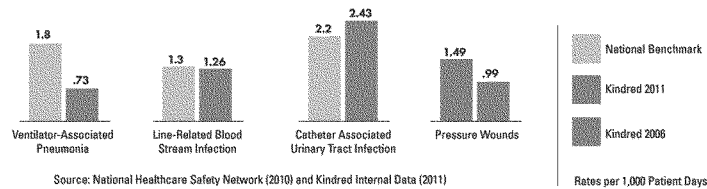
Our patients are critically ill with few care options left. They come to our hospitals because they require aggressive and specialized care with an extended recovery time that conventional short-term acute care hospitals are not equipped to provide. Kindred LTAC Hospitals offer expert interdisciplinary care and services tailored to the medically complex patient including 24-hour physician support, special care units, telemetry units with on-site laboratory and radiology services and operating rooms.

Kindred LTAC Hospitals are accredited by the Joint Commission, meet all conditions of participation for the Medicare program as overseen by the national Centers for Medicare and Medicaid Services and are licensed and inspected by state regulatory authorities.

Who Are Our Patients

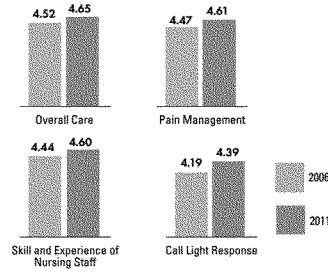
The physicians and clinical teams in Kindred LTAC Hospitals treat the very sickest patients who require the most intense and life-saving medical interventions. Our LTAC patients have three to six concurrent active diagnoses and have suffered an acute episode on top of several chronic illnesses. We use patient screening criteria to evaluate the appropriateness of patients admitted to our hospitals to ensure that those patients requiring less-intense services receive care and rehabilitation in alternate settings best suited for their needs. The criteria dictate that our long-term acute care is comparable to a traditional acute hospital level of care and address the patient's needs for high intensity of service because of an intense severity of illness.

KINDRED'S QUALITY EXCEEDS NATIONAL BENCHMARKS ON MANY KEY INDICATORS

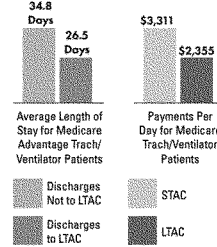


10 *Source: AHRQ, Research in Action, June 2008

PATIENT/FAMILY SATISFACTION SCORES
(1 = Poor, 5 = Excellent)



LOWERING THE COST OF CARING AND THE AVERAGE LENGTH OF STAY FOR THE MOST MEDICALLY COMPLEX MEDICARE AND MEDICARE ADVANTAGE PATIENTS



Source: MedPar (2010)

Interdisciplinary Care Coordination

In each LTAC hospital we use Interdisciplinary Care Coordination Teams to best treat the patient by planning for his or her unique clinical needs, focusing on any barriers to discharging the individual to the next level of care. The expertise of every team member is critical in the collaborative process in order to achieve Kindred's standard of quality patient care. Many disciplines contribute to the team including nursing, physicians, respiratory care, case management, pharmacy, nutrition, infection control, Chief Clinical Officers and wound care specialists.

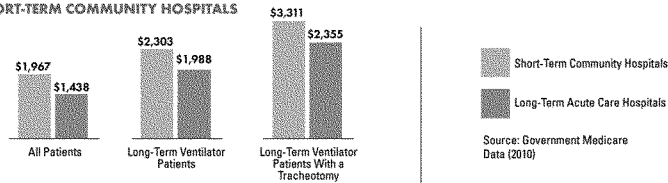
Subacute Units

Situated within our LTAC hospitals, our subacute units – licensed as skilled nursing facilities – provide medical care and rehabilitation for those patients who no longer require the very intense and aggressive medical care provided in a long-term acute care hospital. Being co-located enables care and treatment by the same physicians, therapists and care professionals ensuring a coordinated transition and improved outcomes.

“ For patients with tracheostomies, Medicare spending for the episode of care was **LOWER** for those who used a [long-term acute care hospital] than for those who did not. ”

MedPAC, March 2011 Report to Congress

LONG-TERM ACUTE CARE HOSPITALS COST SIGNIFICANTLY LESS PER DAY THAN SHORT-TERM COMMUNITY HOSPITALS



Source: Government Medicare Data (2010)

There has been an **8.2%**
IMPROVEMENT
 in Kindred Nursing and Rehabilitation
 Centers' Rehospitalization rate in the
 first 30 days from 2008 to 2011.

Nursing and Rehabilitation Centers

Skilled nursing and rehabilitation centers have emerged as essential components of an effective integrated care delivery system providing intensive nursing care and rehabilitation therapies in a very cost-efficient setting. Acute providers and managed care payors increasingly recognize the value of today's nursing and rehabilitation centers to manage episodes of care, reduce rehospitalizations and transition patients home sooner.

In 2011, the patients served in our nursing and rehabilitation centers continued to be more medically and clinically complex with growing nursing and therapy needs. Despite challenging reimbursement and regulatory pressures, Kindred invested additional clinical resources, including an **11% increase in nursing hours per patient day since 2004**, to meet the growing patient needs. This investment has resulted in an increase in patients discharged home, a decrease in the average length of stay and a reduction of hospital readmissions.

Outcomes Excellence

We demonstrate our dedication to quality care and performance improvement through the outcomes data that we measure and report. Kindred is leading the industry in outcomes tracking, providing robust reports which include rehospitalization rates, length of stay, discharge disposition, functional outcome measures and customer satisfaction. We use this data to improve our quality and build post-acute care relationships that establish appropriate patient goals and create plans of care for a successful return to home.

Specialized Clinical Programs

To meet the needs of the communities we serve, our centers have developed additional expertise in the clinical areas of cardiac, pulmonary, renal, orthopedic, stroke recovery and wound care. Through 2011, nearly 200 programs have been implemented in Kindred centers nationwide. Through these programs, patients benefit from specialty physician involvement, an interdisciplinary team with advanced training for the conditions they treat and specific protocols

and equipment to best meet their needs. While all Kindred centers care for a variety of conditions, these programs offer additional and advanced capabilities to care for patients with more complex therapy needs.

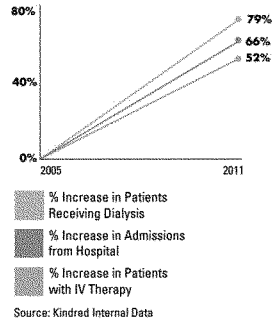
Transitional Care – Short-Term Rehabilitation

As patients have become more medically and clinically complex, we specialize in providing services to meet their unique and changing needs. Our transitional care centers are shaping the future of our nursing and rehabilitation centers. These centers focus on patients who require aggressive short-term rehabilitative and medically complex care. Generally they are recuperating from joint surgery, strokes or other procedures and need an intensive, supervised rehabilitation regimen. Rehabilitation services include physical, occupational and speech-language therapies. These services are dedicated to restoring patients and residents to 75 – 100% of their prior level of function.

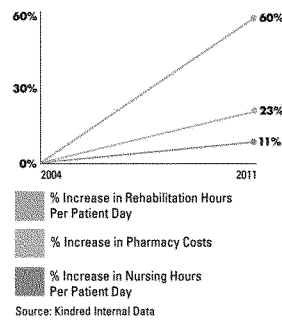
Alzheimer's and Dementia Care

Many of our patients go home within a few weeks, and for those residents who are unable to return home, we provide safe, compassionate care in an environment that fosters independence and dignity. We care for a great number of residents with some sort of dementia, including Alzheimer's disease. Many of our nursing and rehabilitation centers specialize in providing interventions to best manage the unique challenges facing these residents and offer a supportive and safe environment for the resident, and peace of mind for their families.

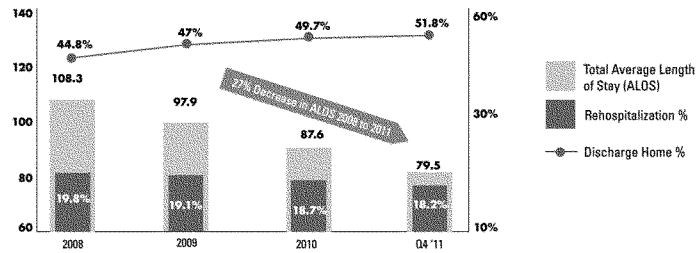
KINDRED IS CARING FOR MORE AND SICKER PATIENTS...



AND IN TURN HAS INVESTED IN ADDITIONAL CLINICAL RESOURCES...

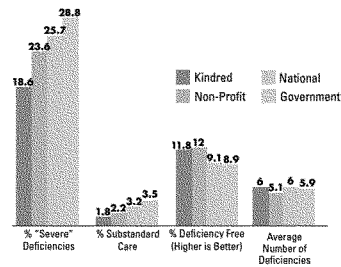


RESULTING IN FEWER REHOSPITALIZATIONS AND MORE PATIENTS GOING HOME SOONER...

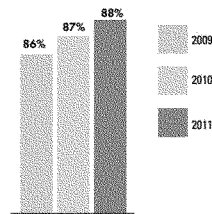


KINDRED'S SURVEY QUALITY PERFORMANCE EXCEEDS NATIONAL AND PEER BENCHMARKS

Source: CMS-Maintained OSCAR Database, November 2011



CUSTOMER SATISFACTION IMPROVING - % PATIENTS AND RESIDENTS WHO WOULD RECOMMEND OUR NURSING AND REHABILITATION CENTERS FOR CARE



Research indicates that higher-intensity therapy leads to **SHORTER LENGTHS OF STAY.**



The provision of rehabilitative therapies – including physical, occupational and speech-language – across all settings of post-acute care is integral to the goal of improving the functional ability of patients, shortening lengths of stay and driving down costs. RehabCare therapists treat patients across the Kindred continuum, enabling effective care coordination and management of patient episodes.

Throughout the entire post-acute care delivery system, a primary goal is to improve the well-being and physical abilities of each patient so that he or she may enjoy the highest quality of life possible. Regardless of the setting in which care is delivered, rehabilitative therapies are an essential component in delivering improved patient outcomes. As well as serving Kindred facilities, our RehabCare therapists provide contract rehabilitation services in unaffiliated hospitals, inpatient rehabilitation facilities, skilled nursing facilities and through home health agencies nationwide.

RehabCare therapists provided intense physical, occupational and speech-language therapies in **2,139 sites of service in 2011, helping 471,000 patients and residents** achieve improved function and independence.

There is a growing body of research that illustrates that higher-intensity therapy interventions result in shorter lengths of stay in post-acute care settings and improved recovery. Additionally, evidence suggests that rehabilitative therapies are also critical in reducing rehospitalization rates.

Recovery Through Rehabilitation

In 2011, the rehabilitation provided by our RehabCare physical and occupational therapists enabled patients and residents to **regain 76.5% of their function** as compared to what they were able to do prior to illness or injury. As well, our rehabilitation interventions in Kindred

and unaffiliated skilled nursing facilities led to the ability of **39.8% of treated patients and residents to return to home or community.**

Clinical Training for Outstanding Rehabilitation

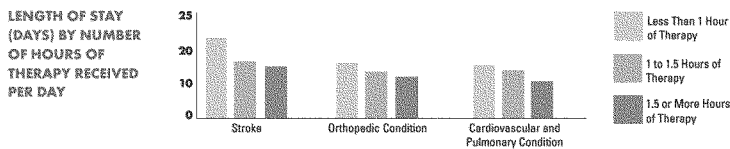
RehabCare focuses on the clinical development of our therapists. Our rehabilitation teams are educated and trained on the latest technology, surgical approaches, protocols and precautions and will develop, follow and modify a rehabilitation plan that is unique to each patient's needs, goals and progress toward the goal of functional independence for a safe return home.

We provide ongoing clinical training related to falls management, cognitive retraining, pain management, seating and positioning, low vision and bariatric care, among many others.

Inpatient Rehabilitation Hospitals and Hospital-Based Acute Rehabilitation Units

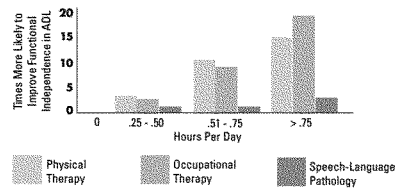
Through expert, intense and aggressive interdisciplinary therapy care our Inpatient Rehabilitation Hospitals (certified by Medicare as inpatient rehabilitation facilities (IRFs)) provide rapid recovery and improved function for patients who can tolerate at least three hours of rehabilitation therapy each day.

In 2011, we cared for approximately 42,400 patients in 102 hospital-based acute rehabilitation units. More than 76% were discharged to home or community after an average length of stay of just over 12 days.



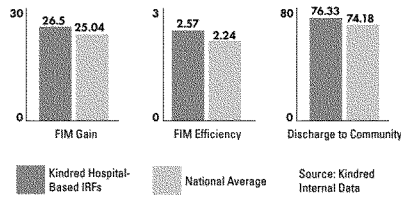
14 Source: Dianne Jette, et al (2008), Archives of Physical Medicine and Rehabilitation

STROKE PATIENTS' ODDS OF IMPROVING ADL FUNCTIONAL INDEPENDENCE OVER NO THERAPY INTERVENTION, BY PATIENT THERAPY HOURS PER DAY, 2002



Source: DU Jette, et al. "The Relation Between Therapy Intensity and Outcomes of Rehabilitation in Skilled Nursing Facilities." Archives of Physical Medicine and Rehabilitation

KINDRED IRFS OUTPERFORM NATIONAL IRF PERFORMANCE IN KEY QUALITY MEASURES



Source: Kindred Internal Data

Earlier rehabilitation admission, higher-level activities early in the rehabilitation process, tube feeding and newer medications are associated with

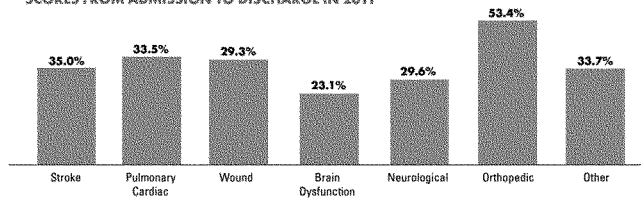
BETTER

stroke rehabilitation

OUTCOMES.

Hess et al. Archives of Physical Medicine and Rehabilitation Vol 86, December 2005

REHABCARE'S INCREASE (%) IN FUNCTIONAL OUTCOME MEASUREMENT SCORES FROM ADMISSION TO DISCHARGE IN 2011



Source: Kindred Internal Data, Using Modified "Functional Outcome Measures" (FOMS)

Homecare is a **COST-EFFECTIVE** service for individuals recuperating from a hospital stay.



As the lowest cost post-acute provider, homecare enables patients to return home sooner. Through the effective uses of rehabilitation and clinical care, patients gain the abilities and improved health to live independently and prevent new hospital admissions.

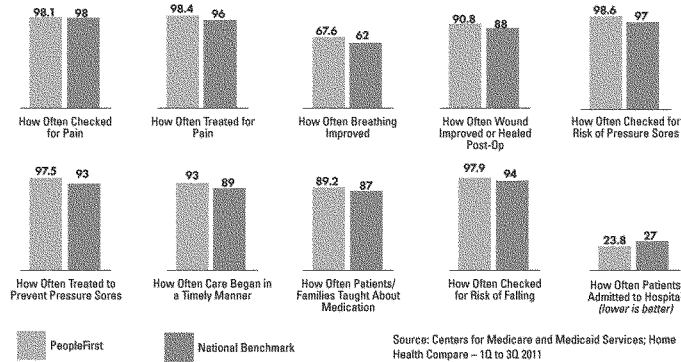
Kindred's homecare and hospice division, **PeopleFirst**, includes 2,300 caring employees serving 4,800 individuals on a daily basis – providing home-based medical and rehabilitative care as well as a comfortable and supportive environment for end of life care.

2011 saw significant growth and development for PeopleFirst Homecare and Hospice. This additional expertise and expanded capability ensures our ability to continue the care for patients, residents and clients across the entire post-acute spectrum. These capabilities allow us to provide care and services in an individual's most-preferred

location – their home or place of residence. Our homecare professionals are able to provide the most cost-effective critical nursing and rehabilitative services that alleviate the need for a hospital admission or emergency room visit in the least expensive setting.

The ability to discharge patients from LTAC hospitals, IRFs or skilled nursing and rehabilitation centers to our home health services ensures a greater coordination of care, with quicker transfers home and fewer post-discharge rehospitalizations – all at significant savings to the healthcare system.

PEOPLEFIRST HOMECARE EXCEEDS NATIONAL PERFORMANCE ON THESE KEY QUALITY MEASURES



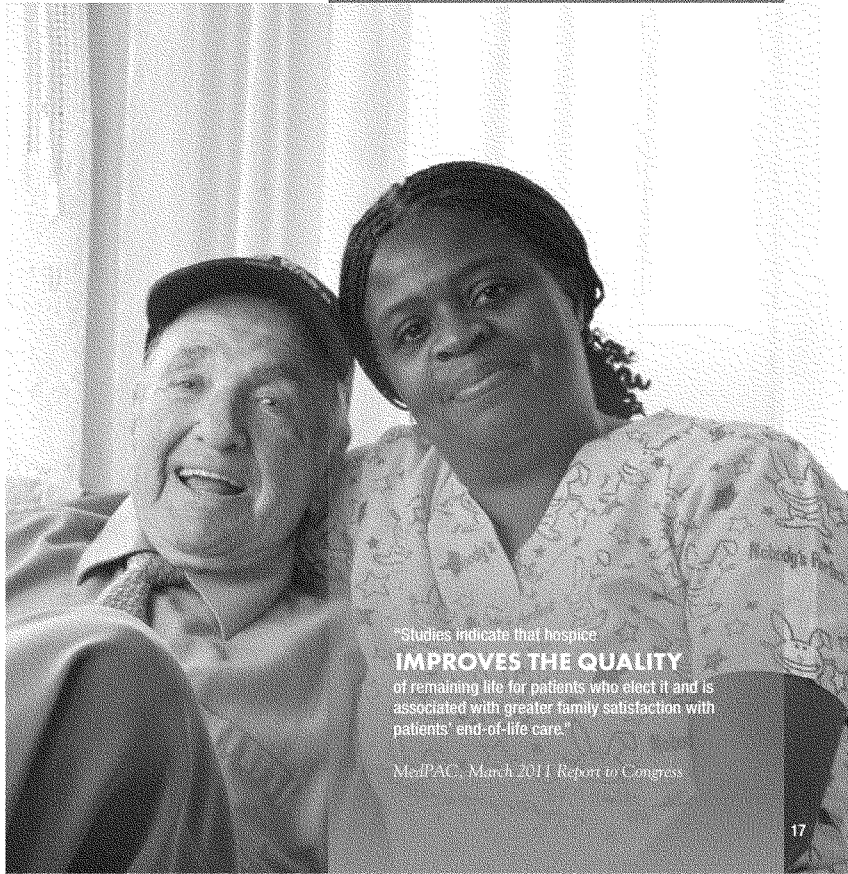
In 2011, all PeopleFirst Hospice locations completed implementation of the National Hospice & Palliative Care Organization's Family Evaluation of Hospice Care Survey, which will provide the ability for each location to benchmark against State and National data moving forward.

“ [Home health] patients often need help adjusting to or recovering from a recent acute health condition, and in-home nursing visits permits beneficiaries to

SHORTEN OR AVOID POST-ACUTE STAYS

at skilled nursing facilities and other higher cost post-acute care providers.”

MedPAC, March 2011 Report to Congress



“Studies indicate that hospice **IMPROVES THE QUALITY** of remaining life for patients who elect it and is associated with greater family satisfaction with patients' end-of-life care.”

MedPAC, March 2011 Report to Congress

Investing in Our People, Communities and Economy

Investment in Employees

Kindred recognizes that our greatest strength is the nearly 78,000 dedicated and compassionate employees who create our dynamic culture of caring. Every day they deliver on our mission of hope, healing and recovery. In order to equip our employees to provide high-quality medical care and rehabilitation across the continuum, we invest in ongoing education, leadership training, the proper tools and resources, as well as a commitment to their health and well-being.

Our goal is to attract, develop and retain outstanding talent and to provide the opportunities to ensure clinical excellence and expertise and to grow professionally.

Leadership and Professional Development

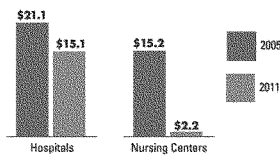
Kindred offers a series of leadership development programs designed to bring out the best among our colleagues including our Executive Fellowship, Nurse Leadership and Rehab Manager-in-Training programs. These are designed to provide hands-on field experience, practical tools and resources to help prepare employees for challenges they may face. As well, our Rising Stars program mentors and assists individuals for officer leadership positions.

In late 2011, Kindred held its third annual Clinical Impact Symposium – Cardio-Pulmonary Rehabilitation Across the Continuum. By bringing together 350 professionals from many different disciplines throughout Kindred, we furthered our commitment to provide the best in interdisciplinary care for our patients and customers, and to expand our clinical expertise.

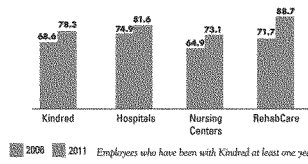
Providing HOPE

The HOPE fund (Helping Others Persevere through Emergencies) provides much needed assistance. Since 2005, almost \$4.4 million has been donated to provide hope and financial assistance to 2,800 employees. In 2011, employees donated the equivalent of \$254,000 to fellow employees encountering emergency situations.

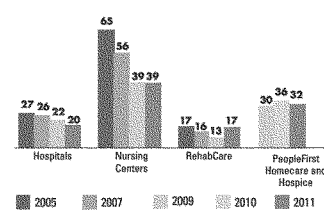
REDUCTION IN CONTRACT LABOR (\$ in millions) – IMPROVING THE CONSISTENCY OF THE PATIENT/CAREGIVER RELATIONSHIP



EMPLOYEE RETENTION (%)



TURNOVER RATES (%)



OUR PEOPLE

OVER 61,000

employees and dependents were covered under Kindred's medical plan in 2011 – an increase of 46% from 2004.

In 2011,

OVER 28,000

employees and dependents completed a Health Risk Assessment for 2012. This is approximately a 28% increase over 2010. Employees who engage in wellness programs have the opportunity to reduce their contributions for medical insurance.

The Kindred workforce is a team of **DIVERSE INDIVIDUALS** who share the common goal of providing the highest quality care for our patients and residents. In 2011, Kindred's compassionate workforce was composed of more than **81%** women and approximately **39%** minorities.

ALMOST \$450 MILLION

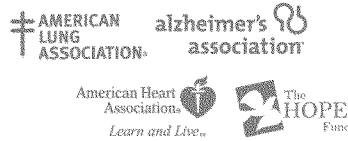
was invested in our employees in 2011 including: **\$34.7 million** in employee training • approximately **\$152 million** to our employee healthcare plan • **\$2.4 million** to employees in tuition reimbursement • over **\$30 million** invested in employee recognition and bonus programs for non-management employees throughout the year.



THE COMMUNITY

On behalf of those patients and residents we serve each day we raise awareness and critical funding for the diseases and conditions that most affect them and their loved ones. We are proud to provide increased local community support by providing matching donations to the funds raised by employees.

Through ongoing support by the Kindred Foundation, we have created strong national and regional partnerships with the Alzheimer's Association, the American Heart Association and the American Lung Association.



THE ECONOMY

In 2011, at a time when unemployment and job losses remain a national concern, **KINDRED INCREASED THE NUMBER OF NET CLINICAL EMPLOYEES BY OVER 3,000**, including 900 new RNs, 330 LPNs, 1,115 CNAs and 675 physical, occupational and speech-language therapists.

Kindred is the **102nd** LARGEST NON-GOVERNMENT EMPLOYER IN THE UNITED STATES AND IN 2011 PAID OVER \$2.7 BILLION IN SALARIES AND LABOR COSTS • ALMOST \$105 MILLION IN EMPLOYEE STATE INCOME TAXES • APPROXIMATELY \$152 MILLION IN COMPANY-PAID HEALTH INSURANCE • OVER \$157 MILLION IN PROVIDER, PROPERTY AND INCOME TAXES • OVER \$644 MILLION IN PRODUCTS AND SERVICES FROM VENDORS.



680 South Fourth Street
Louisville, Kentucky 40202
www.kindredhealthcare.com

Learn more about patient and employee experiences with
Kindred by following us on Facebook and Twitter.



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**STATEMENT OF HON. ORRIN G. HATCH, RANKING MEMBER
U.S. SENATE COMMITTEE ON FINANCE HEARING OF MAY 23, 2012
PROGRESS IN HEALTH CARE DELIVERY: INNOVATIONS FROM THE FIELD**

WASHINGTON – U.S. Senator Orrin Hatch (R-Utah), Ranking Member of the Senate Finance Committee, today delivered the following remarks at a committee hearing examining the progress of health care delivery in the nation:

I want to thank Chairman Baucus for convening today's hearing. Americans are looking for areas of agreement between our two parties on health care. I have been very clear about my opposition to Obamacare, the President's health care law. This deeply flawed law spends too much, taxes too much and does nothing to address the fundamental challenge of rising health care costs. However, the Chairman and I agree on the need for providers and payers to work together to provide higher-quality, better coordinated care to patients. Our witnesses this morning all have tried innovative methods to achieve that shared goal.

According to the Medicare Payment Advisory Commission's most recent report, last year Medicare spent over \$229 billion on inpatient hospital and post-acute care for Medicare beneficiaries. This represents 43 percent of total Medicare spending.

Meanwhile, the population of Medicare beneficiaries is exploding. Last year the first baby boomer became eligible for Medicare. By 2031, it is projected that 80 million people will be Medicare eligible. As these retirees enroll in Medicare, government spending will mushroom.

As most health care providers will tell you, in addition to an aging population, we face a growing number of patients with chronic illnesses, such as diabetes or heart disease. These patients are sicker and more expensive to treat. And while providers are doing their best to manage these patients, too often our health care system is not structured for easily coordinated care.

Currently, we have a system of silos. Patients are seen in a variety of settings — doctors' offices, hospitals, or nursing homes — and it is not uncommon for a health care provider to have an incomplete picture of all the care a patient is receiving.

Furthermore, our fee-for-service system provides little financial incentive to manage care properly. Instead, the incentive is to increase the volume of services. Reducing costs will require that patients receive the right care, in the right place, at the right time. Increasingly, it is private payers — on behalf of employers — who pressure providers to reduce costs, providing better care and better health outcomes.

Patients deserve and demand better care. In my own state of Utah, we are privileged to have some of the nation's best, most efficient health care providers. But not all providers are created equal. Much of our health care system is fragmented, and often the right hand does

not know what the left hand is doing. Unfortunately, the patient is caught in the middle with very little coordinated care. We know from our witnesses today, as well as other health care leaders that there is a needed focus on care transitions. Many errors can be avoided when health care providers keep this focus.

Of late, much attention has been focused on the Center for Medicare and Medicaid Innovation — CMMI — and the flourish of activity it has created. Like many of my colleagues, I remain concerned that CMMI has an enormous budget and very little accountability. It is more than a little ironic that an organization touting quick, innovative change and efficiency took over five months to respond to my request for very basic information on its strategic plan and an accounting of how it is spending \$10 billion of taxpayer money.

In addition to continued oversight of CMMI, I intend to ensure that the pilots and programs they develop actually work for our seniors. For example, when CMMI unveiled the Accountable Care Organization — or ACO — pilot, most providers felt it simply would not work, was unnecessarily burdensome, and did nothing to advance the cause of higher quality, lower cost, more efficient care.

Many of our witnesses today have very interesting stories to tell about how they are transforming care within their communities. They identified a problem, knew a solution was needed, and did not wait for the government to tell them how to best fix the problem. Innovations happen in every community and in all sizes, and no one knows better the needs of a community, than the caregivers on the ground. I know this is not easy and often takes years to develop, but I congratulate all of you for the great work that you are doing every day.

I look forward to hearing from our witnesses and learning about how others can hopefully adopt some of these great ideas and achieve positive results in their own communities.

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**Testimony of Marc Malloy
President and Chief Executive Officer
Renaissance Medical Management Company**

**United States Senate, Committee on Finance
“Progress in Health Care Delivery: Innovations from the Field”**

May 23, 2012

Chairman Baucus, Ranking Member Hatch and other distinguished Members of the Committee:

Thank you for the opportunity to be here today. My name is Marc Malloy. I serve as President and Chief Executive Officer of Renaissance Medical Management Company. I am honored to be asked to share with you today our experience as an industry leader driving innovation in health care delivery.

Renaissance is a physician-owned network of 230 primary care physicians located in the suburban market of Philadelphia and is one of the thirty-two Pioneer Accountable Care Organizations (ACO) chosen by CMMI. Since 1999, Renaissance has been focused on improving patient outcomes, improving quality of care for the population served and lowering medical costs. We exist to support our patients through the practice of high quality medicine in an economically sustainable way.

We have never shied away from the challenge of improving our patients' well-being, delivering high quality care and controlling costs. Renaissance has invested in people, processes and technology to achieve results. From a practical perspective, the physicians understand that the best way to improve quality and lower costs is to focus on three primary areas:

Keep Healthy People Healthy

At the root of our success is the commitment of our physicians whose daily efforts ensure that we are focused on prevention and wellness. We do this by making sure that our patients get the health screenings they are supposed to receive and by making available to patients up-to-date information and tools to become active, engaged partners in promoting their health. In addition to the obvious benefit to the patient of staying healthy, if we can prevent people from developing a medical condition, we can completely avoid the costs associated with care.

Mitigate Health Risk Factors

In order to improve the health and well-being of the people we serve, it is critically important to ensure that individuals understand how their family history and lifestyle affect their well-being, and how to mitigate their health risks. Our physicians regularly screen patients to identify patients with emerging conditions so that they can effectively treat any emergent issues before they become more serious. Once we identify risks, we work with patients to create personalized goals and target appropriate, proven interventions such as tobacco cessation, stress management, nutrition counseling, physical activity and others to help patients mitigate identified health risks.

When I think about our efforts in this area, it reminds me of a phrase I learned from my mom, Sylvie Marceau who passed away this past October. She always spoke of the importance of "early entry to care." In her work as the CEO of the Healthy Start Coalition in St. Lucie County Florida, she dedicated her life to reducing infant morbidity and mortality. Her work showed empirically that getting expectant mothers into care early in their pregnancy provided the best opportunity for healthy moms and babies. Likewise, early identification of health risks and early entry to care for patients with medical conditions typically results in a lower cost of care and better outcomes when a condition can be managed before it becomes more significant.

Ensure the Provision of Coordinated, Evidence-Based Care

When a patient already has a serious acute or chronic condition, our ability to improve well-being and reduce costs comes from our commitment to delivering an evidence-based plan of care that is well-coordinated across the patient's entire care team. We deploy nurses to perform patient risk assessments, establish clinical goals for the patient, educate the patient and or caregivers on how best to manage the disease state, monitor progress and report findings and progress to the primary care physician.

The combination of the various resources developed and deployed by the physicians has produced some impressive results. We have achieved some of the highest quality measures in the nation, and demonstrated medical cost savings over several years. It is because of our success in these areas that Renaissance applied for and was selected as a Pioneer ACO.

Every innovation that Renaissance has made over the years has been based on adapting to the ecosystem within we have operated. With the passage of PPACA, the environment continues to change. Renaissance has entered into a strategic relationship with Healthways that will bring new capabilities to our ACO for things like predictive modeling to identify patients likely to need additional care management services. In turn Healthways expects to deploy the tools and capabilities developed by Renaissance into other parts of the country as part of its physician driven population management strategy.

Renaissance is working with its partners to adapt the people, processes and technology to continue its mission to improve patient well-being, improve the overall quality of care and lower costs for the population served. In addition, we have entered into new discussions with hospitals and payers alike to establish high performance networks, which is to say, hospitals and physicians aligned in ways to collaborate on providing the best care at the lowest costs. We believe that these smaller but higher performing networks of providers will provide a basis for new products and services for the consumer market, and the health insurance exchange.

The clinical leadership within Renaissance has concluded that vertical and horizontal integration are inevitable, as such we have entered into discussions with potential partners to drive a deliberate and contemplative approach to advance our clinical quality objectives but to also provide better information sharing, greater transparency in quality and costs, and better delivery of care to patients. Our goal is to be the architects of these arrangements.

The world of health care delivery is changing and the changes will certainly be disruptive, but we think that organizations willing to innovate and adapt have an opportunity to fundamentally improve the delivery of health care in America.

Thank you for the honor and privilege to report on our work in the Philadelphia marketplace. I would be pleased to answer any questions.

United States Senate Committee on Finance
“Progress in Health Care Delivery: Innovations from the Field”
Testimony of Richard Migliori, MD
Executive Vice President for Health Services
UnitedHealth Group
May 23, 2012

Thank you Chairman Baucus and Ranking Member Hatch for holding this important and timely hearing and allowing UnitedHealth Group to provide you with our perspective on how to improve the health care delivery system. My name is Dr. Richard Migliori, and I am the Executive Vice President for Health Services at UnitedHealth Group, a diversified health and well-being company based in Minnetonka, Minnesota. UnitedHealth Group serves more than 75 million people through its health benefits and health services businesses and operates in all 50 states. The company has the unique ability to engage in all aspects of the health care delivery system and apply lessons learned at full-scale in the marketplace. As a result, we view health care delivery and benefit design through multiple lenses. Our findings are informed by our experience with:

- 16,000 physicians, nurses, and clinical practitioners on our staff;
- Direct relationships with 754,000 health professionals, 5,400 hospitals, 66,000 pharmacies, 900 labs, 400 life science organizations, 300 commercial insurance companies and health plans, and 300 government agencies;
- Managing more than \$300 billion in health care annually;
- Processing 80 billion transactions a year, including 750 million transactions through our Web portals and mobility devices;
- Processing more than 2 million claims and more than 1 million calls per day;
- Operating Health Information Exchanges for eleven states; and
- Managing over 24 million Personal Health Records.

I. Challenges and Opportunities in the Current Health Care Marketplace

Sustainable access for Americans to high quality, affordable health care is put at risk by factors that will persist until the health system is modernized. These factors include:

1. Variation in Quality of Care and Resource Consumption: Though our health system is remarkably talented, its outcomes and resource utilization performance can vary greatly across regions, among physicians and institutions, and across specialties. This results in measurable evidence of overuse, underuse and misuse of medical treatments across the system.
2. Fragmentation of Information: Much of American medicine is practiced in small groups of physicians, and the adoption of automated clinical and administrative systems has been comparatively slow. Even with broader adoption of enterprise Electronic Health Record (EHR) systems, interoperability to enable inter-institutional information exchange is suboptimal. As a result, the level of adoption of automated information within health care lags behind other sectors of our economy. This fragmentation and suboptimal information may interfere with a physician's ability to gather information during the evaluation and treatment of a patient, increase administrative costs, and slow the adoption of new innovations in care.
3. Increasing Burden of Chronic Disease: The changes in American lifestyle behaviors have contributed to the more than doubling of obesity rates since the early 1990's. It is well established that the prevalence of many chronic diseases, such as diabetes and its

complications – coronary artery disease, osteoarthritis, and hypertension, increase as a function of body mass index. These increased prevalence rates place an additional burden on the health system that is already facing challenges of capacity – a burden that can be relieved by modification of lifestyle behaviors.

These factors and their consequences contribute to a health care experience that is inconsistent in its quality, create waste that leads to ongoing cost trends that threaten its sustainability, and result in a care experience for its consumers and providers that is less than its full potential.

In our role as one of the nation's largest payers for health care, managing and coordinating care for 75 million people across a vast network of physicians, hospitals and other health care entities, we have had the privilege of being able to measure and document these trends and to introduce innovative approaches to improve access to high quality and affordable care. Over the last 18 years, we have worked to foster a health system that is more connected, better informed, and better aligned in its objectives and incentives to continuously improve the safety, timeliness, effectiveness, efficiency, equality, and patient focus of the health system. Our approach leverages health data and analytics, technology, shared accountability, cost saving measures, and collaboration among providers, payers and patients across the health care delivery spectrum.

The challenge to modernize the health system that provides for better health and higher quality of care at an affordable cost is evident to those who seek care and those that provide it –

the system's patients and physicians. Through a national survey we recently conducted, we found that only a quarter of physicians (26%), around a third of consumers (38%), and half of hospitals (50%) believe that – absent new action – their local health care community is on course to becoming more sustainable. As result, UnitedHealth Group is working with partners in both the private and public sectors to address the following identified key challenges:

1. The Health Challenge: While doctors think that patients always or often receive needed preventative health care 50% of the time, patients believe they receive it one third (33%) of the time. Although this shows that both doctors and patients suspect that more preventative care could be delivered, patients are more skeptical and believe they are not receiving the full breadth and scope of the preventative care they could benefit from.
2. The Quality Challenge: 47% of consumers said they believe there are significant differences in the quality of care provided by doctors in their local area, while 64% of providers said that was the case. Clearly, there is a transparency gap between what patients believe and their physicians know.
3. The Cost Challenge: U.S. adults believe that health care costs in their community could be cut by between a quarter and a third (29%) without having a negative impact on quality. This shows consumers, who would normally be apprehensive about cutting health care budgets, know there is room for reform in the system.

This information guides us on how we engage with the health system, the investments we make and the innovations we bring to the marketplace. We identify ideas we think might work, test them and, if they are demonstrated to work, we bring them to full-scale in the marketplace. We rely on the market feedback loop to learn. There are times when our investments don't work, but when they do, we can transform how health care is delivered and see powerful results in the areas of quality, care coordination, and maximizing the system's potential.

The opportunities that exist today are core to our mission to help people live healthier lives through our benefits business platform – UnitedHealthcare – and to help the health system work better through our services business platform – Optum. We need to increase care coordination in the U.S. health system as consumers, doctors, and hospitals are increasingly finding that the health care delivered in their communities is not coordinated. There is an opportunity to increase the use of technology and leverage its capabilities better. Today, fewer than half of the Electronic Medical Records in use allow doctors to share their patients' medical records electronically with hospitals, and only a third of physicians report having a computerized system in place to track patients with chronic conditions and ensure appropriate monitoring and follow-up care. We need to align incentives and create a more transparent system for physicians and patients.

Delivery System Reform must incorporate the tools to empower consumers and providers to achieve a common goal: transparency so informed decisions can be made and alignment of incentives so the system can reach its full potential. These tools will not only improve health outcomes but also reduce costs.

UnitedHealth Group's health care delivery efforts are targeted to address the core challenges and opportunities of the health system outlined above. We do this by:

- Embracing wellness and prevention programs and fostering behavioral changes to improve the health status of the entire population by preventing avoidable diseases and the complications that result from the progression of these diseases;
- Empowering health care consumers with decision support tools through various transparency initiatives to help those that need to access the health system so they can do so with greater insight and make informed decisions; and
- Aligning incentives and driving outcomes through the use of data analytics and payment reform to empower health care providers with the technology and services they need, enabling them to better serve their patients.

Underlying all of these capabilities is our proficiency in gathering, protecting and analyzing diverse forms of health data and sharing our insights with participants in the health system – those who seek, deliver, regulate, and finance health care. Through our investment of over \$2 billion annually in technology, including new development, we collect, dissect, analyze, and apply data to predict health care needs, identify areas of improvement, and protect program integrity.

Through our health services business, Optum, we provide services to 60 million individuals. Optum's customers include hospitals, physicians, health plans and their members (UnitedHealthcare and others), and other health care stakeholders. Over the past 15 years, Optum has created products and services which provide consumers and clients with complete solutions for a modern and evolving health care marketplace. We help physicians achieve greater consistency in their clinical performance and patient outcomes, build stronger individual consumer engagement and better health for people, drive down unnecessary costs, adapt to quality-focused compliance mandates, and help the alignment of participants across the health industry make the transition to new funding and payment arrangements.

Our benefits business, UnitedHealthcare, serves 26.4 million Americans, including employer-sponsored health plans, of which 3 million workers and their families are sponsored by small business health plans; 8.9 million seniors; and more than 3.6 million Medicaid beneficiaries (including 2 million children in 24 states and Washington, D.C. in acute and long-term care Medicaid plans). UnitedHealthcare utilizes innovations, strategies, and resources to steadily transform the way health care is delivered and financed. As a result, we offer consumers a simpler, more affordable health care experience that serves their needs through every stage of life. We are looking forward to providing benefits administration and services for 2.9 million active duty and retired military service members and their families in the TRICARE West Region starting in 2013, and bringing many of our innovative best practices and approaches to the TRICARE Program.

Our deep clinical expertise across these broad populations, exemplified by our robust medical management programs which apply evidence-based medicine, has led to reduced hospital readmissions, length of stays, and inappropriate emergency room utilization. We have enhanced quality while managing the cost trend. Improvement in quality outcomes for our UnitedHealthcare plans is exemplified by a dramatic reduction in readmission rates of 7.1% for our Medicare Advantage members in the past 2 years, and a 15% conversion of unnecessary hospitalizations into outpatient observation status. Preventing unnecessary admissions and readmissions helps to reduce waste in the system and deliver better outcomes for consumers.

We appreciate the opportunity to provide the Committee with our insights regarding what has worked for us in meeting the needs of our customers and individuals across the health care system and our recommendations for application of these innovations to Medicare and Medicaid as areas for potential collaboration and partnership. The tools and innovations I will outline are not currently broadly available in the Medicare and Medicaid programs. That is where the greatest opportunity lays for the Federal Government to change the health care delivery system and prepare it for today and tomorrow's consumers and health care participants. While not comprehensive, below are some of the best performing and highly successful tools and innovations we are deploying today to address various health care challenges and create an innovative, efficient, high quality, consumer-responsive, and provider-supportive health care system.

II. Embracing Prevention Programs and Fostering Behavioral Changes

The vast information and knowledge we have collected has helped us to learn more about who is consuming health care, why they are consuming it, where they are consuming it, and how their care may vary from published evidentiary standards of best medical practices. These insights are clinically significant and also have an economic impact. We have learned that gaps in the system exist and there are often significant differences between the care people receive and the care they should have received based on the published clinical guidelines and evidence. Informing the consumer of these gaps, educating them and making them a smarter and more empowered health care consumer is critical to creating opportunities to improve care delivery.

The benefit of using this data is seen in our wellness programs, where we work to identify the risk of disease in its earliest stages and to inform lifestyle modification programs that reduce the likelihood of disease. It helps us engage people with established chronic diseases in programs that address and potentially reverse the progression of that chronic disease.

We are proud of the investments we have made in these programs and the results we are achieving in decreasing the prevalence of chronic diseases. I'd like to touch on a few specific UnitedHealth Group initiatives:

Preventing the Onset of Chronic Diseases Such as Diabetes:

Working in partnership with the Centers for Disease Control and with nontraditional providers such as the Y-USA to deliver the Diabetes Prevention Program (DPP), we work to help delay the onset of diabetes. Our results from the DPP include a 5% mean weight loss for

participants, an average of 13 sessions attended out of the 16 sessions, and nearly 75% of the participants that attend at least one session will go on to complete the program. With 50% of seniors entering the Medicare program with pre-diabetes, we estimate that the Medicare program could save \$67 billion over ten years by reimbursing for programs like the DPP. We have two specific programs designed for those who are already combating Diabetes. Our Diabetes Control Program (DCP) partners with pharmacies like Albertsons, Kroger, Rite Aid and Walgreens to provide private one-on-one consultations with local pharmacists to increase compliance with medications and care plans. Our expectations from the DCP include increased compliance with the American Diabetes Association's guidelines, 75% compliance for A1c, and an increase in Rx compliance while slowing the progression of the disease. Our commercial business, UnitedHealthcare, has designed the Diabetes Health Plan to help consumers manage their diabetes while reducing their out-of-pocket expenses by as much as \$500 annually through enhanced benefits in exchange for compliance with preventive care guidelines.

The Diabetes Health Plan is an example of a value-based benefit that incents consumers to practice healthier behavior. Consumers receive richer benefits, or lower out-of-pocket costs, if they commit to fulfilling the American Diabetes Guidelines such as receiving blood sugar tests at least twice annually or diabetic retinal exams once annually. In exchange, they receive lower out-of-pocket costs, such as no copays for their diabetes, hypertension or cholesterol –lowering drugs.

Considering the high costs associated with managing chronic diseases, investments in prevention are worthwhile for all parties involved. Working with the Federal Government on

ways to increase medication and care plan compliance and preventing the onset of Diabetes will be key to addressing this chronic disease.

Implementing Employer-Sponsored Healthy Rewards Programs:

The CDC estimates that roughly 50 percent of a person's overall health stems from daily lifestyle choices. To encourage healthier lifestyles and behaviors, we have developed UnitedHealth Personal Rewards, a program that rewards people for making healthy choices in their daily routine. Created by UnitedHealth Group in 2010 and adopted by over 40 large employers, the program serves more than 2 million people. The program has led to greater awareness of an individual's health, better care seeking behaviors such as wellness program enrollment, a reduction in Emergency Room use, an increase in PCP wellness exams, and weight loss. We saw a 19.6% reduction in diabetes-related complications, a 12.3% decrease in coronary artery disease costs, a 3.3% reduction in hospital admissions, and a 5% reduction in Emergency Room use. The investment in the health of our employees helps us keep a productive workforce and helps our employees and their families live high quality lives. As we look to modernize the Medicare and Medicaid systems, we should consider how we can incent the population, similar to what employers are doing in the private marketplace, to make the right behavioral changes and informed care decisions.

Leveraging Telehealth Capabilities to Increase Access to Primary Care:

Through enhanced models of telemedicine, we are working to expand access to America's health system and increase the use of preventative services and ensure individuals get the care they need when they need it. The NowClinic, a telehealth program established by UnitedHealth Group to meet the lifestyle needs of today's consumers, is an online tool that

provides patients with real-time access to licensed physicians in their state and facilitates through secure, live conversations between patients and physicians. Available in 18 states (Arizona, California, Connecticut, Illinois, Kansas, Kentucky, Michigan, Minnesota, Missouri, Nebraska, New Mexico, New York, North Carolina, Ohio, Pennsylvania, Utah, Wisconsin, and Wyoming), people can log into myNowClinic.com and get access to physicians, and, in select states, our nurses, regardless of insurance coverage. This capability brings primary care to the individual's home or office, removing yet another obstacle to accessing a physician.

As individuals' lifestyles continue to change and access to providers becomes even more difficult because of demands on the system, the Federal Government can play a role in encouraging innovative care delivery that leverages technology and is an efficient use of providers' time.

Leveraging Technology and Mobile Apps to Increase Care Compliance:

Our Medicaid benefits business, UnitedHealthcare Community and State, recently launched an initiative – Baby Blocks – designed to engage pregnant women with an online mobile tool to drive the understanding of appropriate pre-natal and post-partum care and well-baby care. By using email reminders for scheduled appointments and offering an incentive program to encourage engagement in their care and the care of their babies, we believe that women will experience fewer complications and that their babies will be healthier. If proven effective, compliance with this program should result in Medicaid savings to the State and Federal Governments.

III. Empowering Health Care Consumers Through Transparency and Decision Support

Tools:

UnitedHealth Group has been at the forefront of developing transparency tools and decision support services that help people make better decisions as they access the health system. Examples of the most important and effective tools include:

Transparency on Costs:

UnitedHealthcare's Health Treatment Cost Estimator provides our consumers a comprehensive view of how treatment costs differ from doctor to doctor. The tool delivers personalized cost estimates for various treatment options. It covers a broad range of care options, provides cost and quality data for more than 400 geographic areas covering 116 diseases, 90 different types of surgeries and procedures, 500 individual services, lab tests, and radiology tests, and more than 3,000 medications. Utilizing significant amounts of data from a variety of sources, including our own in-network fee schedules and data licensed from the independent not-for-profit FAIR Health, this tool equips our consumers with personalized information to make informed decisions on where to seek care. Empowering consumers with this information allows them to be more confident about the quality of their care and in control of the economics surrounding it.

Creating Customized Health Care Tools:

Optum has taken the concept of providing the right care at the right time to the right people even further with the creation of our eSync Platform. This powerful technology helps build a detailed health portrait of each patient and then delivers customized health care management tools to individuals directly and via their care providers. By combining, in a

HIPAA compliant manner, a wide range of health data such as medical claims, health and lifestyle choices, and demographic factors, UnitedHealth Group can turn this information into a practical blueprint for effective, personalized plans based on a member's actual health care needs. Through a combination of outreach by Optum's nurse, direct mail, mobile applications and Health eNotes, our consumers receive information about an upcoming medical procedure, or a reminder to schedule an annual exam, or tips on starting an exercise plan, all based on their personal needs. Optum's eSync also powers the ability to proactively reach out to high-risk customers and offer them the opportunity to participate in programs specifically designed to help them reduce their health risks.

For nurses, clinicians, health coaches, physicians, and others, the eSync platform also provides enhanced visibility into a patient's medical history and real-time medical profile which can result in better health management and potentially significant savings for individuals, their employers, and the health care system as a whole. Medical care designed for the individual is critical to creating an efficient, effective, and consumer-friendly health care system.

Adoption of technology in a manner that allows communication across the health care system, regardless of payor or provider, and is critical to reforming the health care delivery system in a manner that decreases costs without impacting quality. In addition, it provides an opportunity to empower both consumers and providers with the information they are seeking to improve outcomes. The Federal Government's role in requiring the adoption of Health Information Technology is critical to increasing its widespread use.

IV. Aligning Incentives and Driving Outcomes Through Technology and Payment**Reforms:**

Our data analytics allows us to serve the important needs of physicians and institutions that care for consumers, customers, and their patients – providing insights into everything from physician practice patterns, to gaps in care, to the full cost of specific care episodes. Our technology and investments enable us to provide tools and solutions to more than 250,000 physician practices of varying sizes and more than 5,400 hospitals. In addition, we partner with the provider community through Accountable Care Organizations and Medical Homes. In addition to the eSync platform I discussed earlier, we are working with the hospital and provider community to develop new ways to deliver health analytics directly to the point of care, aligned with physicians' regular workflow, to enable better, real-time decision making between physicians and patients. Optum developed the Optum Care Suite for patients, physicians, and other health professionals to access essential health intelligence and collaborate in making medical care decisions to improve health outcomes. Managed via Cloud technology, in a secure environment that protects patient privacy, Optum Care Suite marries clinical data from electronic medical records with related health claims, patient-reported outcomes, and Optum's powerful analytics. Pilots conducted with small group primary care practices in Arizona have demonstrated that sharing of information bi-directionally with physicians, measuring clinical outcomes, and moderate financial incentives that are reimbursed effective to their ability to close the gap in care, led to a ten-fold increase in the rate at which the evidence-based medicine gaps were closed.

Creating Meaningful Use to Securely Share Information:

Our investments include operating Health Information Exchanges in more than 11 state-wide programs, multiple regional programs, and several hospital-specific health systems. The connectivity established across these health systems is further enhanced with administrative - and clinical – information based decision support systems. Optum’s Axolotl Discover Program delivers powerful analytics to the Health Information Exchange, converting vast amounts of raw data, almost instantly, into critical health insights for physicians and other care providers who participate in the Exchange. The Quality Health Network (QHN) and Optum partner together to deliver a Health Information Exchange in Colorado. Using Optum’s Elysium Exchange platform deployed by QHN, the independent hospitals and physicians of Aspen and Montrose counties are electronically connected to each other and with other independent hospitals and physicians in Grand Junction, Colorado. The real time clinical messaging infrastructure allows authorized physicians to share clinical data at the point of care between and among disparate hospital and Electronic Medical Record (EMR) systems. The Exchange has been identified as a model for quality improvement and cost efficiency.

Innovative Program Designs:

Our commitment to being a leader in modernizing America’s health care system is also evident in our program designs and our leveraging of nurse practitioners. Utilizing appropriate, evidence-based clinical interventions through our Evercare Program and the Senior Care Options Program in Massachusetts, Medicare and Medicaid Eligibles have experienced:

- A greater than 50% reduction in inpatient utilization;

- A 26% bed-day reduction over a three year period;
- A 64% reduction in Medicare inpatient admits;
- A 52% reduction in Medicare costs; and
- A 60% reduction in emergency room visits.

In our Medicare Advantage programs, with the use of high-risk case management, advanced illness transitional care, and post-acute transition programs, seniors experience:

- 30% fewer hospital readmissions than Fee-for-Service;
- 50% fewer hospital readmissions in institutional settings;
- A reduced length of stay in the Skilled Nursing Facilities by 2 – 4 days, resulting in over \$1,000 in savings per case; and
- Savings of \$2,400 a year per member through the use of high risk management tools.

We all benefit when care is delivered in the right setting, when gaps in care are narrowed, and complications are identified earlier and treated effectively.

Innovative Payment Reforms:

Payment is another important method in aligning incentives and driving quality outcomes. We have a strong commitment to modernized reimbursement systems with physicians and hospitals that pursue evidence-based care when conventional Fee for Service systems could create ineffective outcomes. The UnitedHealth Premium Physician Designation Program empowers our members across the Country to make physician selection choices based

on quality and cost efficiency. Started eight years ago, our Premium Designation Program is perhaps the nation's broadest and deepest transparency tool for physician performance and assessment. This program provides physicians with valuable feedback on their performance while at the same time enabling patients to make informed health care decisions. We use the extensive data we have from claims, pharmacy, laboratory and other administrative data sources, and analyze care patterns using sophisticated episode-grouper analytic software. This approach analyzes patient care by condition across settings and time, thus representing a more patient-centered view of care.

Our program is grounded in the principle that performance measures should be developed by expert physicians in each specialty area and approved by nationally-accredited bodies. As such, we incorporate performance measures that have been reviewed and endorsed by the National Quality Forum and the National Committee for Quality Assurance, as well as performance measures developed in collaboration with medical specialty societies and reviewed by committees of practicing physicians. The Premium Designation Program evaluates physician performance on quality and efficiency across 21 different areas – including primary care and specialties such as cardiology and orthopedics.

The Premium Designation Program analyzes the performance of physicians against both quality and efficiency benchmarks. Quality is measured first and only those physicians who meet or exceed quality benchmarks are then evaluated for cost-efficiency. Quality is assessed using more than 300 national standards and metrics developed by physician specialty societies. Efficiency is measured using more than 230 measures and benchmarks that are risk-adjusted and

tailored to each physician's specialty and geographic area to account for differences in average costs. On both dimensions, performance is measured relative to other physicians. Results are displayed in our provider directories using a "star" format, with one star for quality and another for efficiency. This online system has been well-received, with positive feedback from physicians and medical societies. Key outcomes associated with our Premium Designation Program include:

- For all 21 physician specialties in the Program, the incremental savings between Premium Designated Physicians and non-designated physicians is 14%;
- Cardiologists who earn a quality designation have 55% fewer redo procedures and 55% lower complication rates for stent placement procedures than cardiologists who did not receive the quality designation; and
- Orthopedic surgeons who earn a quality designation have 46% fewer redo procedures and a 62% lower complication rate for knee arthroscopy surgeries than other orthopedic surgeons who did not receive the quality designation.

Another example of a unique provider reimbursement model is our Cancer Care Reimbursement Model which reimburses oncologists up-front for an entire cancer treatment program, as well as for the margin between their costs of purchasing medication and the retail price charged. By paying medical oncologists for a patient's total cycle of treatment rather than

a number of visits and the amount of chemotherapy drugs given, this new program promotes more patient-centric, evidence-based care with minimal loss of revenue for the physician.

Payment reform is an important tool to create greater efficiency and high quality outcomes in the health care system. The Federal Government should look to adopt payment models that align incentives and reward high quality medical outcomes.

Collaboration with Providers:

Working closely with various health care providers in local markets and communities, our business and effectiveness is driven by the recognition that care delivery needs to promote a collaborative network aligned around the concept of total population health management and outcomes-based reimbursement. In close coordination with local integrated care delivery systems, we deploy a core set of technology, risk management, analytical and clinical capabilities and tools to assist physicians in delivering high-quality care across the populations they serve. Our coordinated post-acute care services augment primary care physicians to deliver services outside of hospitals to vulnerable, chronically ill populations. Specifically, two of the systems Optum partners with, Monarch HealthCare and AppleCare Medical Group, both in California, are currently taking part in CMS' ACO demonstrations and initiatives.

V. Opportunity for Public-Private Partnerships:

UnitedHealth Group partners with federal and state governments in a variety of ways. We serve approximately 300 federal and state government agencies. Currently, we administer the Multi-Payer Claims Database for CMS and the Data Warehouse for the Office of Personnel

Management. We are in the final discussions with CMMI to participate in its Comprehensive Primary Care Initiative in Colorado and Ohio. In addition to serving as the largest provider of Medicare Advantage Plans and Medicaid Managed Care Plans in the country, we are proud of our partnerships with the Federal Government in the following capacities:

- Federal Employee Health Benefits Program, Office of Personnel Management;
- TRICARE West Region (*awarded in 2012, for Contract Beginning in 2013*);
- A Blue Button participant with HHS and the Department of Veterans Affairs;
- Community-Based Care Transitions Program for CMS;
- Development and testing of imaging efficiency measures for CMS;
- Contract with TRICARE's North Region on predictive modeling;
- Reserve Health Readiness Program for the Department of Defense; and
- Clinical disability exams for Military Veterans for the Department of Veterans Affairs.

We continue to look for ways to partner with the government and bring our private sector innovations to the public marketplace. Delivery System Reform is a ripe opportunity for collaboration.

As the Senate Finance Committee and Congress continue to evaluate how to implement Delivery System Reforms and create a high quality health care system that is efficient and responsive to consumers' needs, I urge you to invest in the application of Health Information Technology, leverage existing data and information capabilities in the health system today, and apply those private sector best practices that are proven and delivering results, to federal and

state health programs so that Medicare and Medicaid beneficiaries have the benefit of what is available and working in the broader marketplace. The innovations I have outlined for you today are examples of these best practices. They are proven and operating at full-scale in the marketplace today, yet Medicare and Medicaid beneficiaries generally don't have access to them. Medicare and Medicaid modernization is a tremendous opportunity for our nation and addressing the dually-eligible Medicare and Medicaid population will be critical to addressing some of our greatest health care challenges. UnitedHealth Group appreciates the opportunity to testify today and the Committee's recognition that Delivery System Reform is needed to truly modernize America's health care system. We look forward to continuing to be a resource to the Committee.

Thank you for your leadership on this important issue.



Senate Finance Committee Hearing

Progress in Health Care Delivery: Innovations from the Field

May 23, 2012

**Lee Sacks, M.D.
Chief Medical Officer
Advocate Health Care**

Chairman Baucus, Ranking Member Hatch and Members of the Committee, thank you for inviting me to testify before you today. My name is Dr. Lee Sacks, and I am the Chief Medical Officer for Advocate Health Care and the Chief Executive Officer for Advocate Physician Partners. Advocate is pleased to have been recently named one of the nation's top health systems, based on clinical performance in 2011 by Thompson Reuters. We are the largest health system in Illinois and one of the largest health care providers in the Midwest, operating more than 250 sites of care, including 10 acute care hospitals, two integrated children's hospitals, five Level I trauma centers (the state's highest designation in trauma care), two Level II trauma centers, one of the area's largest home health care companies, and one of the region's largest medical groups.

Advocate Physician Partners (APP) drives improvement in health outcomes, care coordination and value creation through an innovative and collaborative partnership with our physicians and the Advocate System, with a physician network that includes more than 1,100 primary care physicians and 2,900 specialist physicians.

APP's nationally-recognized clinically-integrated approach to patient care utilizes best practices in evidence-based medicine, advanced technology and quality improvement techniques. Through its focus on prevention, the early detection and treatment of diseases and the coordination of care across the continuum, APP continually provides value and reduces avoidable costs. We have fostered widespread adoption of evidence-based practices in independent private practice physician offices and in large integrated medical groups. We have demonstrated value to the community through improved health outcomes and significant cost savings for employers, payers, and patients.

APP's Clinical Integration Program (Program) began in 2004, with 36 measures directed largely at primary care physicians. This sophisticated pay-for-performance program has grown to include 159 measures in five domains, including clinical effectiveness, efficiency, patient safety and patient experience. The number of measures has grown by adding measures for physicians in specific specialties, measures which align physician and hospital outcomes goals and measures requested by private payers and employers. The Program's use of a single consistent set of measures and goals across all payers is an ideal approach to facilitate participation by physicians.

APP maintains clinically-integrated PPO contracts with all major commercial insurance companies in the market and has provided commercial payers and private employers with consistent quality improvement and cost savings over the eight years of the Program's existence. Incentive payment structures vary based on the needs of the individual payer. Funding for both hospitals and physicians in these contracts depends upon attainment of high performance. By

design, approximately 15 percent of incentive funds remain unearned by physicians in any given year, because of the rigor APP uses in setting performance targets.

APP's Clinical Integration Program has demonstrated that through shared accountability and transparency, a physician-hospital organization with more than 4,000 physicians, including 2,900 independently practicing physicians, in over 900 separate practice sites, can improve health outcomes and patient satisfaction while reducing costs. Through private sector innovation, the Program has overcome three challenges addressed in health reform: the limitations of fee-for-service reimbursement; the need for infrastructure to improve outcomes in small single-specialty physician groups (the country's dominant mode of practice); and the barriers to physician and hospital collaboration necessary for improving patient outcomes. The Program has received national recognition for both the quality of its outcomes and its operational efficiency and forms the framework upon which Advocate based its first accountable care organization (ACO)-like contract with Blue Cross Blue Shield of Illinois (Blue Cross).

FTC Identifies APP as a Model Organization

APP is one of a comparatively few organizations whose contracting practices and Clinical Integration Program have been reviewed by the Federal Trade Commission (FTC). Following a multi-year review, beginning with an inquiry in 2002 and ending with its Consent Decree in 2007, the FTC made the determination to allow APP to continue operating its clinically integrated program.

As a result of its experiences with the FTC, APP instituted an annual review of its governance program and conducts mandatory annual workshops on fiduciary duty for all physicians and associates who participate in the governance program. This focus on governance supports APP's commitment to its ethical responsibility to conduct itself in a manner that creates value for society—in the form of better health outcomes at sustainable costs—through the collaborative efforts of clinicians and health care administrative professionals. In addition, over the course of the past two years, the FTC has invited APP to participate in its workshops on antitrust and clinical integration, including Clinical Integration in Health Care: A Check Up in May 2008, the FTC, DOJ, and CMS-sponsored workshop in October 2010 and the May 2011 workshop focusing on potential ACO antitrust issues. We have appreciated these opportunities to share our experiences and lessons learned and continue to stand-at-the-ready to be a resource to policymakers, as well as those in the private and non-profit sectors, seeking to adopt the types of changes and practices we have to improve outcomes and reduce costs.

APP's Relationship with Blue Cross Improves Health Care Quality

When Advocate and Blue Cross began contract renewal discussions in 2010, both parties agreed that bending the health care cost trend was a critical step to ensure employers could continue to provide health insurance as an employee benefit and for publicly-funded programs to remain solvent. The passage of the Patient Protection and Affordable Care Act (PPACA) provided a framework for innovations in both the private and public health care sectors, with the overarching goal of supporting innovation and partnership throughout the health care system in a way that encourages and rewards organizations that are able to reduce the cost of care while improving quality and patient safety.

The negotiations resulted in the creation of one of the nation's largest ACO-like commercial shared savings PPO contracts between Advocate and Blue Cross, covering more than 245,000 attributed PPO lives. The negotiations also led to a contract for Blue Cross HMO products under which APP is responsible for the total cost of care for 180,000 lives. APP and its member physicians also provide care for an additional 400,000 PPO patients who are not part of a shared savings contract and 60,000 patients covered under other HMO contracts. The agreement also includes a rigorous set of performance measures on outcomes, safety and patient satisfaction.

After the first year, the shared savings program has achieved the goals that APP and Blue Cross laid out. It has bent the cost curve, decreasing inpatient days per thousand by 12.5% compared to the non-APP rate of 7.5%, with a trend in the cost of care on a risk-adjusted basis that has been 4.6% below the market trend through the first three quarters of 2011. All of this was achieved while maintaining the outstanding outcomes, safety, and patient satisfaction results for which the APP network has been recognized.

Advocate Health Care—A Leader in Innovation

Advocate recognized that in order to bend the cost curve and be successful under these new arrangements, the organization would need to attain the optimal convergence between the three interdependent drivers of value: population health, patient experience and total cost per capita (the Triple Aim). Advocate made a strategic decision to align the entire organization through a transformational approach to care delivery called AdvocateCare. The goals of AdvocateCare relate to: improving care coordination across the continuum; developing lifelong relationships

with patients; and, improving access to appropriate care. This approach will reduce unnecessary utilization resulting from poor care coordination, poor communication and poor transitions from one site of care to another, all of which also contribute to increases in avoidable hospital admissions and readmissions and overuse of outpatient services.

Seventy dedicated outpatient care managers—principally registered nurses, advanced practice nurses and social workers—work closely with APP’s 1,100 primary care physicians to address the needs of the sickest three to five percent of patients assigned to APP physicians in its PPO shared savings and HMO risk arrangements with Blue Cross. The care managers focus on enhancing patient knowledge, increasing patient adoption of behaviors to further self-management of the condition and providing assistance to patient and caregivers to navigate the health care system. Although financially feasible in shared savings and capitation models of care, these care management services are not reimbursed under fee-for-service models. Specific payment models like those specified in the PPACA and like the shared savings program developed in conjunction with Blue Cross are necessary in order for health care organizations to provide these valuable services in the fee-for-service sector, the dominant mode of payment in the country.

Medicare Shared Savings Program Participation

APP understands that the current health care delivery model and the associated payment system are not economically sustainable. As such, we have launched innovative partnerships, like the one with Blue Cross, in order to test new health care delivery models to improve health care quality. Given its size and experience with financial and clinical integration, APP recognizes its

duty and responsibility to be at the forefront of developing new and innovative care delivery and payment models. Programs such as the Medicare shared-savings program (MSSP) help promote new models of care delivery and care coordination that will enable the delivery of high quality, affordable care to Medicare beneficiaries.

APP views participation in MSSP as a critical step in its evolution, and a key means to achieve the critical mass needed to transform its operations and the practices of its member physicians and hospitals. If selected to participate in MSSP, APP would fully embrace the opportunity to expand its existing ACO model to include Medicare beneficiaries. APP looks forward to its partnership with CMS and the opportunity to transform health care delivery—improving outcomes and reducing costs.

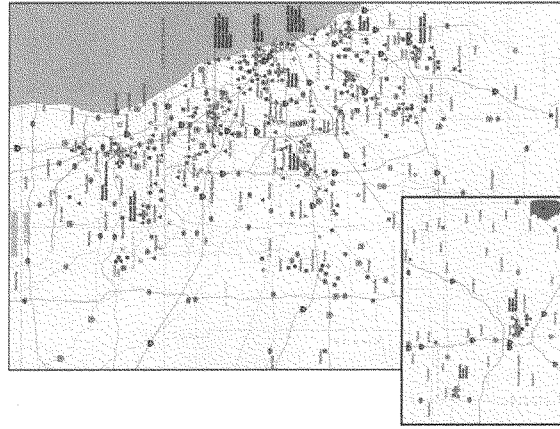
Conclusion

APP's Clinical Integration Program fosters collaboration among payers and patients, as well as physicians and hospitals, creating the framework by which it has evolved into an ACO.

Advocate firmly believes that organizations like APP must be at the center of any lasting solution to improve—and sustain—the current health care system. Sustainable, system-wide solutions will necessitate changes to health care delivery, performance measurement and provider reimbursement. Organizations such as APP, as evidenced by its seventeen-year history, have the ability to implement these changes and drive significant improvements in health outcomes and the patient experience while also reducing costs.

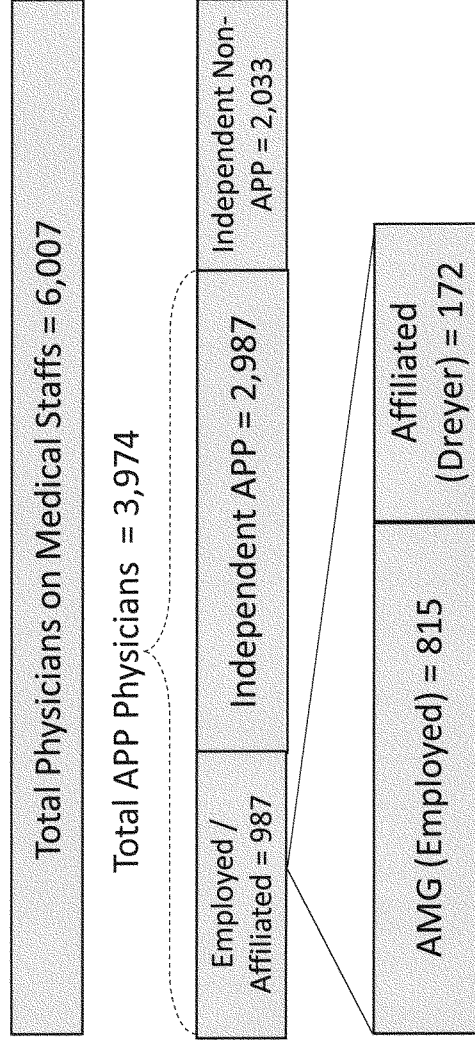
Thank you for the opportunity to testify before you today. Advocate Health Care and Advocate Physician Partners stand ready to serve as a resource and work with this Committee and all Members of Congress to improve the quality and efficiency of health care in this country. I would be happy to answer any questions you may have.

Advocate Health Care

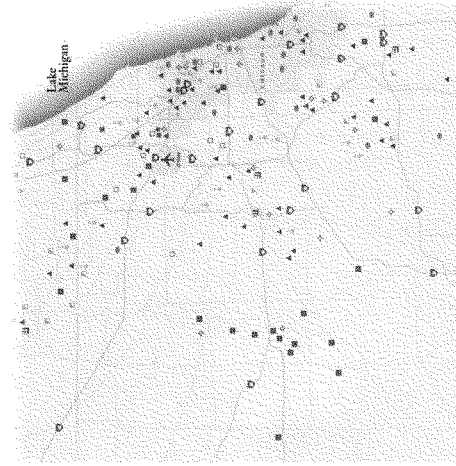


- \$4.7 Billion Annual Revenue
- AA Rated
- 12 Acute Care Hospitals
 - 2 Children’s Hospitals
 - 5 Level 1 Trauma Centers
 - 4 Major Teaching Hospitals
 - 4 Magnet Designations
- Over 250 Sites of Care
 - Advocate Medical Group
 - Dreyer Medical Clinic
 - Occupational Health
 - Imaging Centers
 - Immediate Care Centers
 - Surgery Centers
 - Home Health / Hospice

Advocate's Physician Platform

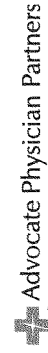


Advocate Physician Partners



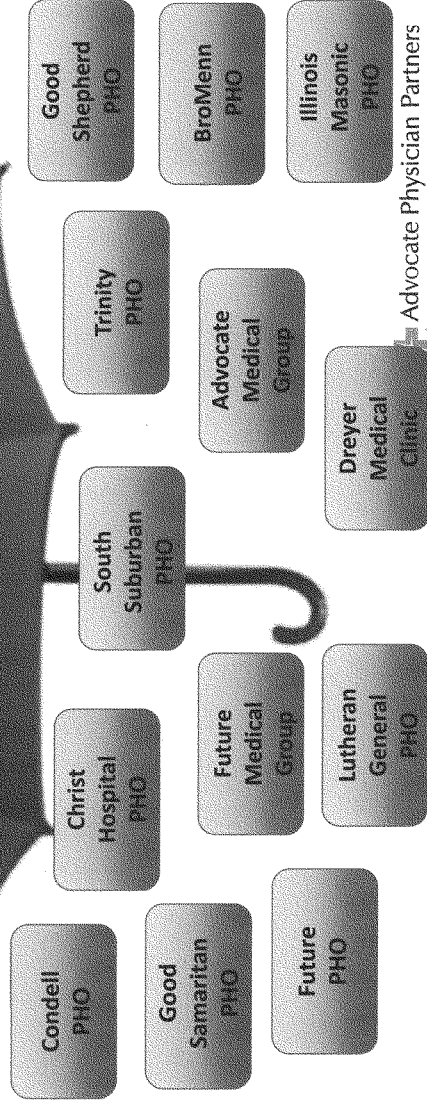
Advocate Physician Partners delivers services throughout Chicagoland and Downstate Illinois.

- Physician Membership
 - 1,085 Primary Care Physicians
 - 2,889 Specialist Physicians
 - Total Membership Includes 987 Advocate-Employed Physicians
- 10 Acute Care Hospitals and 2 Children's Hospitals
- Central Verification Office Certified by NCQA
- 230,000 Capitated Lives/700,000 PPO Lives
- 215,000 "Attributable Lives"

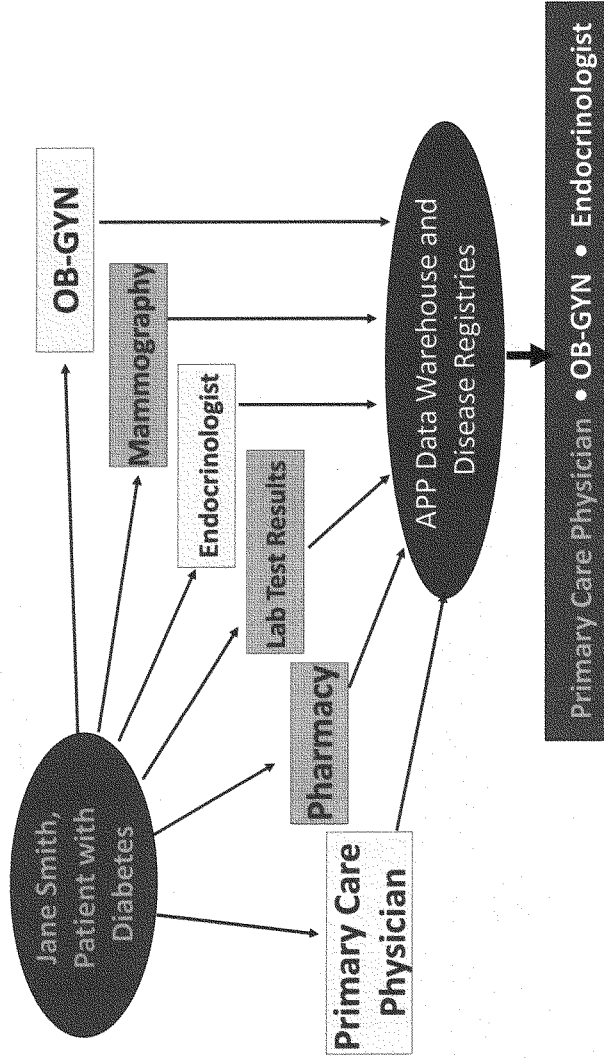


Advocate Physician Partners

To drive improvement in health outcomes, care coordination and value creation through an innovative and collaborative partnership with our physicians and the Advocate system.



What Clinical Integration Looks Like



COMMUNICATIONS



**STATEMENT FOR THE RECORD
SUBMITTED TO THE
SENATE FINANCE COMMITTEE
ON**

Progress in Health Care Delivery: Innovations from the field

May 23, 2012

**AARP
601 E Street, N.W.
WASHINGTON, D.C. 20049**

**For further information, contact:
Ariel A. Gonzalez
(202) 434-3770
Federal Health & Family Team
Government Affairs**

AARP appreciates the opportunity to share with the Committee our thoughts on delivery system reforms that hold promise for improving the quality, of care, safety and efficiency of services throughout the health care system. Our goal is to ensure every American has access to adequate, affordable health coverage that offers services of high quality, and is delivered in an efficient, person-focused manner.

For most Americans, health care is uncoordinated, quality is uneven, and the cost of care increasingly unaffordable. The prevailing method for paying clinicians (i.e., fee-for-service) encourages fragmentation and offers little incentive for clinicians or health plans to improve, coordinate, or integrate care. Cost is an issue for employers as well. Individuals and families with employer-based insurance often experience discontinuity due to coverage changes their employers make in search of lower premiums. Such churning makes it difficult for people to receive continuous care, develop meaningful clinician/patient communication, or establish trusting relationships with their clinicians.

One out of every six dollars in our economy is for health care; we spend a far greater share of GDP on health care than any other nation. There is widespread agreement that the continuing escalation of health care costs is not sustainable and that there is great urgency to transform health care to reign in excess cost growth. Moreover, there is also substantial evidence that the quality of care provided in the U.S. does not produce better results for the dollars we spend. Thus, we face the enormous challenge of trying to reduce health care spending as we improve service delivery and quality.

The Affordable Care Act ("ACA") included a number of important reforms to improve health care delivery that should help us make significant progress toward improving the health care system in this US. Proper implementation of these delivery system reforms are needed in order to transform our health care system to achieve the goals we have described. The status quo is simply not acceptable.

We also must focus more efforts on cost savings in addition to delivery reforms. Unfortunately in our current system, fraud is too prevalent and is the cause of wasted resources that could be used for other productive purposes. Further legislative action is required to eliminate waste, fraud, and abuse in the U.S. healthcare system, and there are a number of pending bipartisan bills that will help in this effort.

Delivery reform accomplished through adoption and implementation of new models of care -- such as Accountable Care Organizations ("ACOs"), Medical Homes, and Independence at Home Demonstration Program -- will present a major departure from the way most primary care practices now provide services (where care continues to be fragmented and siloed). But these new approaches hold great promise as the foundation for a person-centered delivery system. A family caregiver may also often act as the care coordinator or help provide services, especially for someone with multiple chronic conditions, cognitive impairment, or other needs for long-term services and supports. Interdisciplinary care teams, working with other team members with the individual and their family caregiver at the center of the care team, is an important approach in reforming the delivery system.

Below, we provide a brief discussion of innovative delivery system reforms we believe may lead to improved, more efficient care.

Accountable Care Organizations

Accountable Care Organizations (“ACOs”) are a new model of care that consists of a group of providers who accept responsibility for the cost and quality of care a population of individuals receives. The ACA outlines how Medicare will pay ACOs in the traditional Medicare program and identifies how they will be formed, organized, and paid. ACOs that are able to improve quality and reduce health care costs will be eligible to share some of the savings accrued to the Medicare program. In the ACO model, entities will be jointly accountable for the care they provide, thus reducing the incentive to provide unnecessary testing and procedures. HHS estimates that ACOs could save Medicare nearly \$1 billion in the first three years.

ACOs will also be developed in the private sector. Several pilot programs are underway to test various ways to organize ACOs. These will provide valuable insights into best practices.

Medical Homes

“Medical homes” are intended to lead to higher-quality, more cost-effective care through better coordination of services and support for patients that is culturally appropriate, interactive, and respectful. This model is inherently patient-centric and embodies a “whole-person” approach to improving care through enhanced access, coordination, and support for patient self-management.

Community Health Teams to Support Medical Homes

In an effort to establish policies that encourage all payers to improve care coordination and provide transitional care, the Affordable Care Act authorized Interdisciplinary Community Health Teams to collaborate with and support Medical Homes. These teams would target patients with chronic conditions, including children, regardless of payor type. Community Health Teams would contract to provide supportive services to patient-centered medical homes and qualified primary care providers who will receive capitation payments for each enrollee. Expansion of the Community Health Teams have the potential to improve the efficiency and quality of care coordination and transitional care by developing best practices and specializing in these services within designated geographic areas.

Independence at Home Demonstration Program

The Independence at Home (“IAH”) model offers the potential to improve the delivery of care for high-risk individuals with multiple chronic conditions who need help with daily activities (such as eating, bathing and dressing), as well as better address their high costs. This model uses physician or nurse practitioner directed home-based primary care teams designed to improve health outcomes and reduce expenditures. It is a demonstration program in the ACA and similar models have shown promising results.

Transitional Care

Almost one fifth of Medicare patients discharged from a hospital were readmitted within 30 days; these readmissions cost Medicare \$17.4 billion in 2004. These hospital stays, many of which are preventable, pose a major concern—from both a health quality and financial perspective. Transitions from hospital to home or other settings can be complicated and risky, especially for individuals with multiple chronic illnesses. Patients frequently report difficulty remembering clinical instructions, confusion over correct use of medications, and uncertainty over their prognosis. And in cases where multiple providers are involved, patients often get conflicting instructions from different providers. Family caregivers often act as care coordinators for their loved ones, but they face challenges in coordinating care, especially as individuals transition from one setting to another.

AARP was pleased to see that as part of the ACA, several provisions addressed transitional care, including the Community-Based Care Transitions Program and Community Health Teams. The Community-Based Care Transitions Program authorizes HHS to make grants available to hospitals with high readmission rates in partnership with community-based organizations. As this program is implemented, we urge Congress to consider expanding this program.

Home- and Community-Based Services (“HCBS”)

Individuals prefer to live in their homes and communities, and an AARP study found that 9 out of 10 Americans age 50+ want to stay in their current residence for as long as possible. Receiving services in such settings is also cost effective, as on average, Medicaid can provide home and community-based services to three people for the cost of serving one person in a nursing home. Helping individuals live in their homes and communities can help delay or prevent unnecessary and more costly stays in nursing homes or other institutional settings.

Unfortunately, when states are forced to cut Medicaid long-term services and supports spending, they often target home and community services (“HCBS”), since these are defined as “optional services” under Medicaid law (even though they are critical services for many people). Cutting HCBS could result in more people having to go to nursing homes – generally more costly than HCBS – and their care being paid for by Medicaid. Research shows that states that invest in HCBS, over time, slow their rate of Medicaid spending growth, compared to states that remain reliant on nursing homes. The ACA contained a number of important provisions both in Medicaid and outside of Medicaid, including the Community Living Assistance Services and Supports (“CLASS”) program, to help give people more options to receive services to help them live in their homes and communities.

Family support is a key driver in remaining in one’s home and in the community. The estimated economic value of family caregivers’ unpaid contributions was about \$450 billion in 2009, more than the total spending on Medicaid that year. Family caregivers who take on this unpaid role risk the stress, physical strain, competing demands, and financial hardship of caregiving, and thus are vulnerable themselves. Recognizing

family caregivers and supporting them in their caregiving roles in the health and long-term services and supports ("LTSS") systems is vital, including assessing and addressing their needs.

Comparative Effectiveness Research

AARP strongly believes that a fundamental building block of a reformed health care system is the availability of better evidence on which to base care decisions. According to some estimates, less than half of all medical care is based on or supported by adequate evidence about its effectiveness. Research is needed that is scientifically valid, objective, and that will produce comparative information about treatment options and guidance about when to use particular interventions and for whom. Independent, objective comparative effectiveness research ("CER") has the potential to greatly improve health care quality and patient outcomes by helping to ensure that consumers and clinicians receive valid information upon which to base their decisions. This research can ensure that the resources expended by patients and payers (including government health programs) result in the delivery of quality, evidence-based and high value healthcare that is appropriate for the individual patient. Well-designed comparative effectiveness research will seek to identify specific subpopulations of patients for whom one intervention might be more appropriate than another intervention. As a result, such studies often enable physicians to make better decisions based on specific patient characteristics, applying the scientific information elicited in evaluating various treatment options.

For years, AARP advocated for the establishment of an entity to conduct or oversee independent, objective research to inform clinical and patient decisions and we were pleased to see the creation of the Patient-Centered Outcomes Research Institute ("PCORI") included as part of the Affordable Care Act. We applaud and support PCORI's mission to help people make informed health care decisions by producing and promoting high integrity, evidence-based information derived from research that has been guided by consumers, families, and the broader health care community.

Health Information Technology

Health Information Technology ("HIT") is a critical tool that can enhance quality improvement efforts. HIT can promote and facilitate data collection, storage, and retrieval; reduce errors; foster coordination; support clinical and patient decisions; and reduce unnecessary duplication. The many advantages of HIT and data exchange include:

- Reduction of medical errors by helping to eliminate mistakes that arise from poor handwriting or lack of complete medical records;
- Decision support for clinicians and patients through access to information, prompts for best practices, educational information, etc;
- Facilitation of information-sharing at critical times in non-emergent situations to enhance opportunities for care coordination and integration across settings and between and among providers;

- Reduction of duplicate tests and procedures that are now commonly performed because records are not available when they are needed;
- Facilitation of data collection to measure performance and accelerate the development of interventions to address identified problems;
- Facilitation of data collection on race, ethnicity, and other patient characteristics that give rise to health care disparities. Without data, it will be impossible to assure equitable care for all;
- Support for public health initiatives by providing access to data to help avert public health threats;
- Elimination of redundant paperwork and the need for patients to repeat medical history and demographic data;
- Greater consumer engagement by giving patients and family caregivers access to information they need to support self-management; and
- Access to a wide array of technologies that help people stay in their own homes and out of institutions and also allow them to access needed health care services remotely through non face-to-face encounters with clinicians and other medical personnel.

CBO estimates that these changes in utilization will reduce Medicare spending by \$4.4 billion over the 2011-2019 period.

Reducing Health Care Disparities

There is ample documentation of disparities in health care that arise among certain population groups (e.g., racial and ethnic minorities), or based on age, gender, geography, or sexual orientation. As we move forward to improving the quality of the health care system, we must take steps to eliminate disparities so all Americans receive high quality care in a manner that reflects their cultural and linguistic and personal preferences. Efforts to address health disparities over the last decade have been hampered by a lack of data. For example, data on racial and ethnic groups must be routinely collected in standardized formats if we are to be able to focus efforts on eliminating the reasons for disparate care. Similarly, unless we include women and older persons in clinical trials and other research, we will not have the knowledge to address reasons for differences in care they experience.

AARP is deeply concerned about the unique health challenges that many minority populations face. We commend the important steps taken by the passage of the Affordable Care Act and the development of data collection standards by HHS to ensure that these challenges can be better addressed. Under the ACA, many of the previously underserved will have affordable coverage for the first time. However, we must ensure that this coverage is truly accessible. It is essential that all providers, whether insurers participating in the Exchange or publicly-funded programs like Medicare or Medicaid, offer linguistically and culturally competent care. Without trained interpreters and providers who can recognize cultural differences and alter their services accordingly, these communities will have coverage but not access.

Prevention and Wellness

AARP believes that wellness and prevention efforts, including changes in personal behavior such as diet and exercise, should be a top national priority. The ACA made achieving healthy living a goal by establishing the Prevention and Public Health Fund, which provides much-needed funding to support initiatives such as community-based tobacco cessation and prevention programs, efforts to reduce diabetes and heart disease, breast and colon cancer screenings and adult vaccine programs. A focus on prevention will not only lead to better health for Americans, but will also help reduce health care costs. Seventy-five percent of all health care costs in our country are spent on the treatment of chronic diseases, many of which could be easily prevented. Investing in public health initiatives will reduce the need for more costly treatment and intervention of these chronic diseases.

AARP strongly supports investments in disease prevention and health promotion because they can save lives, reduce chronic illness and the spread of infectious disease and help slow the growth of health care costs.

Nursing Workforce Issues

AARP recognizes that in order to achieve these important reforms in health care delivery, we must have the appropriate mix and number of highly skilled health professionals. For example, to deliver more primary care, better coordinate care and increase our focus on wellness and prevention, our nation needs more advanced practice registered nurses and nurses at all levels. As recognized by the 2010 landmark Institute of Medicine ("IOM") report on the Future of Nursing, advancing nursing education and leadership while allowing nurses to practice to the full extent of education training can improve health care quality, access and efficiency. AARP strongly supports investments in nursing education and promotion of innovative delivery models that take full advantage of the skills, experience and leadership of nurses.

Elder Care Workforce Issues

AARP also believes that it is important to have a competent and trained workforce that is able to meet the unique health and LTSS needs of older adults. There is a shortage of individuals at many levels with the appropriate competencies and training to meet the needs of the current, as well as the growing, aging population. The ACA took some important steps in this area, such as training for direct care workers, geriatric education and training, additional training opportunities for family caregivers, and a demonstration project to develop training and certification programs for personal or home care aides, to name a few. However, it is important and more needs to be done to make sure that there is a sufficient and adequately prepared workforce at all levels to address the needs of the growing aging population.

Genuine Pathway for Generic Biologics

Biologics are used to treat many diseases – such as multiple sclerosis, arthritis, cancer and others – that often affect older populations. The daily costs associated with

biologics are approximately 22 times higher than the daily costs associated with small-molecule drugs; annual costs for biologic drugs can reach as high as \$400,000. Underinsured and uninsured persons who are prescribed biologic drugs—particularly those with chronic conditions who require such treatment indefinitely—may find the drugs unaffordable and decide to forgo them completely. Biologic treatments may also be too expensive for individuals fortunate enough to have health insurance; even the well-insured may face high co-insurance amounts. The costs associated with biologic drugs are also a large and growing burden for employers, state governments, and federal programs like Medicare and Medicaid.

Increasing the availability of generic versions of biologics is a critical element of a health care cost containment strategy. In the last Congress, AARP endorsed bipartisan legislation entitled the “Promoting Innovation and Access to Life-Saving Medicine Act.” This legislation, H.R. 1427 introduced by Representatives Henry Waxman (D-CA) and Nathan Deal (R-GA) and S. 726 introduced by Senators Charles Schumer (D-NY) and Susan Collins (R-ME), would have created a five-year period of market exclusivity. However, despite the Federal Trade Commission (“FTC”) finding that biologic manufacturers did not need any exclusivity beyond the term of their patent, biologic manufacturers were ultimately granted twelve years of market exclusivity by the Affordable Care Act.

Were the exclusivity period reduced from even twelve years to seven (and the Administration has previously urged 5 years), there would be a \$2.3-\$3.5 billion savings over ten years. These savings could be further increased if the unnecessary market exclusivity period provided by the ACA were eliminated entirely

Conclusion

On behalf of our millions of members and all older Americans, we thank you for the opportunity to share with you our views on the important role of health care delivery system reform in improving quality and lowering costs. AARP is committed to tackling high costs throughout the health care system, as well as ensuring that every American has access to adequate, quality affordable health coverage that is delivered in an efficient, person-focused manner.



Senate Finance Committee
Hearing on
Progress in Health Care Delivery: Innovations from the Field
May 23, 2012

Statement Prepared by
American Medical Rehabilitation Providers Association
1710 N Street, NW
Washington, DC 20036

The American Medical Rehabilitation Providers Association (AMRPA) is pleased to submit a statement for the record to the Senate Finance Committee in connection with the hearing on “Progress in Health Care Delivery: Innovations from the Field.”

AMRPA is the national trade association representing medical rehabilitation providers. In addition to inpatient hospital level medical rehabilitation hospitals and units (IRH/Us), AMRPA represents a large number of outpatient rehabilitation service providers associated with hospital members. Additionally, AMRPA represents comprehensive outpatient rehabilitation facilities (CORFs), rehabilitation agencies, and the outpatient practices in skilled nursing facilities (SNFs). Inpatient rehabilitation hospitals and units (IRH/Us) serve more than 550,000 patients per year. AMRPA members work with patients to maximize their health, functional skills, independence, and participation in society so they are able to return to home, work, or an active retirement.

Post acute medical and rehabilitation care is often critical to the treatment and recovery of patients after discharge from the hospital. Today, such care is provided by various providers, including IRH/Us, long-term care hospitals (LTCHs), and hospital-based skilled nursing facilities (HSNFs). With this array of providers, there is confusion about what care is clinically necessary and effective and what value is being received by patients and payers. Medicare’s payment systems and regulations make referring and treating patients among these different care settings difficult and costly, especially if a patient needs more than one level of care during his or her recovery. These factors point to a need to improve the post acute care delivery system by moving from facility-centered to patient-centered care and improving care coordination.

Inpatient rehabilitation hospitals and units have recognized the need for improvement in America’s health care system and have embraced innovative care models that will improve the coordination and continuity of care for patients who need post acute care. We firmly believe that public-private partnerships can transform the health care delivery system. To that end, AMRPA, in particular, has been a leader in developing innovative care models, such as the Continuing Care Hospital (CCH). The Continuing Care Hospital Pilot was authorized in Sections 3023 and 10308 of the Affordable Care Act of 2010 (ACA), Public Law (P.L.) 111-148.¹ AMRPA strongly supported its inclusion in the health care reform legislation. We are disappointed, however, that to date the Department of Health and Human Services (HHS) and the Center for Medicare and Medicaid Innovation (CMMI) have not moved forward to partner with the post acute care sector to implement the CCH mandate.

The CCH model organizes care around the patient instead of the provider. A key feature of the CCH is that it would enhance quality of care by eliminating regulatory boundaries among the

¹ 42 U.S.C. 1395cc-4 (authorized the Continuing Care Hospital model as a bundling pilot) and 42 U.S.C. 1315a (allows the Department of Health and Human Services Secretary to test the Continuing Care Hospital model through the Center for Medicare and Medicaid Innovation).

current hospital-based post-acute care (PAC) providers by creating a new type of provider with the characteristics of all three of those mentioned above (IRH/Us, LTCHs, HSNFS). It would test new payment methods, quality standards, outcome measures, and foster long-term accountability for care provided. It would result in reduced costs and increased efficiency of providing post acute care services. In addition, it would leave the clinical decision making about needed services to patients and their doctors, not regulators or payers.

The Continuing Care Hospital would be an amalgam of the care settings currently described as LTCHs, IRH/Us, and hospital-based SNFs that are organized, in part, to deliver rehabilitation therapy programs, as well as medical care. The CCH could be an actual building (a hospital offering some or all three levels of care) or a virtual entity (an organization that provides under common management most or all of the three levels of care in more than one building or unit). CCHs could operate distinct units or distinct levels of service that encompass the current three levels of service referenced in the authorizing statute. A physician would make the admission decision regarding whether a patient should receive care within the CCH and also determine the intensity of services the patient would need. Payment would be determined by the patient's clinical and functional characteristics, plus non-patient related adjusters. The episode of care would be the stay in the CCH plus the first 30 days following discharge from the CCH. Hence, this model centers admission, treatment, and payment decisions on the needs of the patient, rather than concentrating on the type of the provider of care.

Creation and use of performance and outcome measures would be a critical component of the model. The CCH model would increase quality of care while reducing costs. The CCH model will improve quality by: (1) allowing for appropriate care based on the patient, not provider type or financial incentives; (2) removing barriers to access caused by the current provider requirements and payment systems; (3) measuring care and outcomes in order to provide disincentives for inadequate care; and (4) promoting collaboration among HSNFs, IRH/Us and LTCHs to streamline the field and the care provided. The CCH model will decrease costs by: (1) streamlining care delivery and eliminating regulatory and administrative costs to the payor and providers; (2) avoiding confusing, if not conflicting, post acute care requirements that can lead to re-hospitalization; and (3) eliminating the costs of multiple admissions and discharges associated with transferring patients to multiple post acute care entities.

AMRPA is eager and committed to working constructively with HHS to implement the CCH model to ensure the right care is delivered at the right time for patients in need of post acute care services. We encourage the Senate Finance Committee to continue to highlight the contributions of the private sector in adopting innovations that improve health outcomes and lower costs. One thing is clear: maintaining the current system of conflicting incentives, chaotic decision making and placement decisions, restricted access, quality of care risks, and economic jeopardy for patients and providers is untenable. We must all work toward improving the current health care system in a deliberate and visionary manner with the needs of patients first in mind.



Statement
of
The National Association of Chain Drug Stores
for
U.S. Senate
Committee on Finance
Hearing on
**Progress in Health Care Delivery:
Innovations from the Field**
May 23, 2012
10:00 a.m.
215 Dirksen Senate Office Building

National Association of Chain Drug Stores (NACDS)
413 North Lee Street
Alexandria, VA 22314
703-549-3001
www.nacds.org

The National Association of Chain Drug Stores (NACDS) thanks the Members of the Senate Finance Committee for consideration of our statement for the hearing on “Progress in Health Care Delivery: Innovations from the Field.” NACDS and the chain pharmacy industry are committed to partnering with policy makers and others to improve quality and lower costs in the healthcare delivery system.

NACDS represents traditional drug stores, supermarkets, and mass merchants with pharmacies – from regional chains with four stores to national companies. Chains operate more than 40,000 pharmacies and employ more than 3.5 million employees, including 130,000 pharmacists. They fill over 2.6 billion prescriptions annually, which is more than 72 percent of annual prescriptions in the United States.

Community Pharmacies – Improving Patient Care and Reducing Healthcare Costs

Community retail pharmacies are at the front line in the healthcare system, interacting with patients on a daily basis. In recent years, retail community pharmacies have played an increasingly important role in providing patient care with services such as health screenings provided by pharmacists to help educate patients and give them a better understanding of their health status and potential needs. Additionally, pharmacist-provided immunizations and medication therapy management (MTM) services have been proven to improve patient health and prevent unnecessary hospitalizations, physician visits, and other higher cost interventions.

MTM services have also been shown to improve medication adherence. An estimated one-third to one-half of all patients in the United States do not take their medication as prescribed. There are many reasons. Many simply fail to pick up their medications from their pharmacy. Others fail to take their medication correctly, stop taking it altogether, or never take it in the first place. These circumstances seriously undermine quality of life and quality of care, patient outcomes, and the value of healthcare dollars spent. Poor medication adherence costs the U.S. approximately \$290 billion annually¹ – 13% of total healthcare expenditures. Clearly, steps need to be taken to address the issue of lack of adherence with medication therapy. This is one reason we are so devoted to ensuring that patients adhere to their prescription drug treatment regimens.

Community pharmacists are uniquely qualified through their comprehensive education and training to significantly reduce the problem of poor medication adherence. As medication use experts, pharmacists assist patients in achieving positive outcomes from their medication therapy. Pharmacists help patients every day by counseling on proper use of medications, checking for possible side effects, drug interactions or allergies, and helping to coordinate insurance benefits. All these activities help ensure patients receive maximum therapeutic benefit

¹ New England Healthcare Institute, *Thinking Outside the Pillbox: A System-wide Approach to Improving Patient Medication Adherence for Chronic Disease*, August 2009, available at http://www.nehi.net/publications/44/thinking_outside_the_pillbox_a_systemwide_approach_to_improving_patient_medication_adherence_for_chronic_disease (last accessed March 5, 2010).

from their medication therapy. When patients adhere to their medication therapy, it will reduce costs from higher-cost medical care, such as emergency room visits and catastrophic care.

Medication Therapy Management (MTM) – Better Outcomes and Lower Costs

NACDS believes that increasing access to pharmacist-provided MTM will produce better health outcomes while reducing overall healthcare costs. MTM consists of services such as complete medication reviews and professional counseling services offered by qualified pharmacists. MTM prevents medication errors, ensures medication compliance, and gets patients more involved in their medication therapy. Pharmacists are the most highly trained professionals in medication management. They receive a minimum of six years and in many cases eight years of college, with four years enrolled in a College of Pharmacy where they study medication uses, dosing, side effects, interactions, and patient care. As highly trained and accessible healthcare providers, pharmacists are uniquely positioned to play an expanded role in ensuring patients take their medications as prescribed.

Evidence shows that MTM improves patient outcomes and reduces unnecessary medical spending. In the North Carolina “Checkmeds” program, MTM helped 31,000 seniors save \$34 million in one year – a return on investment of nearly 14 to 1. The January 2011 edition of *Health Affairs* found that better medication adherence produced annual savings of \$7,823 for patients with congestive heart failure, \$3,908 for those with hypertension and \$3,756 for diabetic patients. In addition, a comprehensive medication review program by one major pharmacy chain showed a nearly 3-to-1 return on investment, with Medicare Part D savings of over \$36 per member per month for seniors in the program. A recent study published in the January 2012 edition of *Health Affairs* demonstrated the key role retail pharmacies play in providing MTM services to beneficiaries with diabetes. The study found that a pharmacy-based intervention program increased beneficiary adherence and that the benefits were greater for those who received counseling in a retail, face-to-face setting as opposed to a phone call from a mail order pharmacist. The study also suggested that the interventions, including in-person, face-to-face interaction between the retail pharmacist and the beneficiary, contributed to improved behavior with a return on investment of 3 to 1. MTM services provided by Minnesota pharmacists to Blue Cross Blue Shield beneficiaries in collaboration with primary care providers increased the percentage of patients achieving their goals of therapy and reduced healthcare expenditures from \$11,965 to \$8,197 per person with a return on investment of more than 12 to 1.

We appreciate that Congress has recognized on a bipartisan basis the important contribution that MTM makes to improved outcomes and reduced costs. The Medicare Modernization Act of 2003, which created the Medicare Part D drug benefit, specifically included MTM as a required offering. The Patient Protection and Affordable Care Act of 2010 also made improvements to the Part D MTM benefit and established grant programs for MTM in treating chronic diseases and in care provided in the new “medical home” model. While these steps are welcome, more needs to be done to control the huge costs associated with medication non-adherence and to improve seniors’ access to MTM services.

We are convinced that MTM is a key way to vastly improve health outcomes and reduce costs by ensuring that individuals receive the maximum health benefit from their prescription medicine. As noted above, currently the Medicare Part D program includes an MTM benefit, but the requirements are vague, and have resulted in inconsistent availability to beneficiaries. To ensure that individuals receiving prescription medications through Medicare Part D are provided with all the tools they need to improve their healthcare outcomes and reduce overall program expenditures, NACDS supports S. 274, the Medication Therapy Management Empowerment Act of 2011 sponsored by Senator Kay Hagan (D-NC). The Act strengthens the Medicare Part D MTM program requirements including services such as an annual comprehensive medication review for eligible beneficiaries and expands eligibility standards to include beneficiaries with only one chronic disease, dual eligible beneficiaries enrolling in Medicare for the first time, and beneficiaries in transitions of care, such as those recently discharged from a hospital or other institutional setting. Such beneficiaries are likely to have new medications, and would benefit from a targeted intervention by a pharmacist. We urge members to co-sponsor S. 274.

In addition to strengthening the Part D MTM program, we urge Members to also consider ways to expand such services and benefits from MTM in other areas as well, such as the TRICARE program and the Qualified Health Plans that will begin operating under the Health Insurance Exchanges in 2014.

Expand Coverage of Vaccines in Medicare Part D

Neighborhood retail pharmacies have played an integral role in recent years in providing vaccinations and immunizations against illnesses such as flu, pneumonia, and shingles. Despite the availability of effective immunizations, many Americans remain unvaccinated and susceptible to vaccine-preventable diseases. An Institute of Medicine Report estimates that more than 50,000 adults and 300 children in the United States die each year from vaccine-preventable diseases or their complications.² However, the United States Department of Health and Human Services has found that immunizations, including those administered by pharmacists, help prevent 14 million cases of disease and 33,000 deaths yearly.³

Expanding pharmacists' vaccination authority can also lead to decreased healthcare costs. In a final rule expanding the portfolio of vaccines that TRICARE beneficiaries may obtain from community pharmacies, the Department of Defense noted significant savings were achieved under the TRICARE program when the program was first implemented to allow beneficiaries to obtain flu and pneumococcal vaccines from retail pharmacies.

Notably, the Department not only allows its beneficiaries to obtain vaccinations at local network pharmacies, but by encouraging beneficiaries to obtain vaccinations at local pharmacies and waiving cost sharing when pharmacies are used for immunizations, the Department estimates it

² Institute of Medicine Report, *Shaping the Future For Health – Calling the Shots – Immunization Finance Policies and Practice*, available at http://books.nap.edu/html/calling_the_shots/reportbrief.pdf.

³ Department of Health and Human Services, Fiscal Year 2008, Centers for Disease Control and Prevention, *Justification of Estimates for Appropriation Committees*, available at http://www.317coalition.org/documents/cdc_fy2008budget_immunization.pdf.

saved nearly \$1.5 million in administration costs. Additionally, it was estimated that the Department had a savings of over \$600,000 annually through avoiding medical costs that would have been incurred in treating influenza but were not because increased availability of the flu vaccine led to more beneficiaries being vaccinated (Fed. Register Vol. 76, No. 134, p. 41064).

Currently all 50 states allow pharmacists to provide certain immunizations. Encouraging Medicare beneficiaries and others to obtain vaccinations at their neighborhood pharmacy is a cost effective and convenient way to prevent illness and reduce healthcare costs. In order to create a streamlined, consistent, and more cost effective vaccine policy, NACDS believes Part B vaccines should also be available under Medicare Part D. We believe this policy would increase immunization rates in target populations since pharmacists are the most accessible healthcare provider. The Medicare program would also benefit from the efficient, electronic-based processing of vaccine claims, which occurs in Part D. This will help move the system toward greater use of health information technology, a proven cost saver.

Increase the Utilization of Generic Drugs

Pharmacists are also leaders in promoting cost savings, helping educate consumers and providers about affordable alternatives like generic drugs and over-the-counter remedies. Pharmacies have long promoted generic drugs as safe, cost-effective alternatives for many patients. Community pharmacy has a higher rate of generic dispensing – 73% – than any other practice setting.

Substituting generic pharmaceuticals for their brand-name equivalents is an effective way to achieve significant savings in public and private healthcare programs. For example, in the Medicaid program, we estimate that for every 1% increase in generic utilization, approximately \$809 million in federal and state dollars would be saved. NACDS has endorsed S. 1356, The Affordable Medicines Utilization Act, which would encourage states to increase Medicaid generic dispensing rates.

Conclusion

NACDS thanks the Committee for allowing us to share our comments on the role of community pharmacies in improving patient care and reducing healthcare costs through health care delivery system reform.

WISCONSIN HOSPITAL ASSOCIATION, INC.

Wisconsin Hospital Association
5510 Research Park Drive
Madison, WI 53711



Written Testimony Submitted to the
United States Senate Committee on Finance
for the hearing record on
Progress in Health Care Delivery: Innovations from the Field
Wednesday, May 23, 2012, 10:00 AM

At exactly the same time the United States Senate Committee on Finance was hearing testimony about innovations in health care delivery, Wisconsin hospitals and health systems were testifying in Madison, Wisconsin before the State Assembly Committee on Health at a hearing entitled, "Transforming Health Care in Wisconsin Through Better Quality, Better Outcomes and Better Value." Invited speakers at this hearing were from Aurora Health Care of Milwaukee, Bellin Health System of Green Bay, Gundersen Lutheran Health System of La Crosse, and the Wisconsin Hospital Association (WHA) of Madison. Each testifier discussed how hospital and health systems are reforming health care in Wisconsin by refocusing on delivering higher quality, patient-centered, outcomes-focused care with the goal of achieving better value for each health care dollar. The testimony on the following pages was provided by WHA Executive Vice President Eric Borgerding to the Assembly Committee on Health at that hearing. We believe it gives excellent insight into Wisconsin's commitment to driving health care value and provides important information for the Senate Committee on Finance regarding its hearing on the same subject matter.

*Testimony Before the Wisconsin State Assembly Committee on Health
Eric Borgerding, Executive Vice President, Wisconsin Hospital Association
May 23, 2012*

Chairman Stone, ranking member Richards, members of the committee, my name is Eric Borgerding, I'm Executive Vice President of the Wisconsin Hospital Association. I'm joined by WHA's chief quality officer, Kelly Court. I have just a few general remarks and then will turn it over to Kelly.

First, I want to thank you for holding this hearing and providing this venue for discussion about some very positive trends and developments in Wisconsin health care that warrant more attention.

In many ways Wisconsin is a leader in a national transformation, an effort to repurpose and retool the structures of health care delivery and financing away from volume driven, fee-for-service

reimbursement, and instead towards a system that must both demand and reward better quality and better outcomes and that will ultimately produce more value for our health care dollars.

Indeed, improving quality and value is health care reform ... reform that began in Wisconsin prior to the passage of the Affordable Care Act, and that will continue regardless of how the Supreme Court rules next month.

This reform, as defined by increased focus on quality and value, is being hastened, if not dictated, by the combined forces of deficit reduction and, as importantly, the need for employer health care cost containment in a national and globally competitive economy. Reform here means increasingly engaged payers, coupled with integrated systems of providers aligned toward a common goal—producing better quality, outcomes and value for employer and employee health care dollars.

WHA believes this type of health care reform can set Wisconsin apart from other states. Here's why:

- **Wisconsin remains the home of national leaders and pioneering organizations in the quality and value movement.** The ThedaCare Center for Healthcare Value, the Wisconsin Health Information Organization (WHIO), the Wisconsin Collaborative for Health Care Quality (two of which's founding members you will hear from today), MetaStar, the Partnership for Health Care Payment Reform, headed up by former Wisconsin Department of Health Services Secretary Karen Timberlake, and a host of other Wisconsin business and health leaders are not only nationally recognized catalysts, but continue to push providers, insurers and patients to seek superior quality and value and, importantly, accelerate the pace of change in Wisconsin.
- **Wisconsin has a strong presence of integrated hospital and health systems that include employed physicians, and align towards a common goal—better outcomes.** At least two-thirds of Wisconsin's practicing physicians are employees of hospitals or growing integrated systems. That means more care is being delivered "under one roof", aligned, and within a shared philosophy and goal of achieving superior outcomes.
- **You cannot improve what you cannot measure, and Wisconsin hospital and health systems have a long history of commitment to improving care and transparent reporting of results.** We are a national leader in ongoing, measurable quality improvement, including WHA's CheckPoint and the Wisconsin Collaborative for Health Care Quality – pioneering efforts bringing providers and payers together to develop and publicly report health care performance.
- **Wisconsin is a leader in adopting electronic health records.** In 2012, Wisconsin hospitals ranked second in the nation in adoption of certified electronic health records (EHR) technology. Further, Wisconsin is ahead of nearly all of its Midwest neighbors in the adoption of more advanced EHRs.

Capitalizing on alignment and connectivity, Wisconsin providers are developing accountable models of care responsible for improving quality, reducing costs and better managing the health of their patients. Hand-in-hand with this delivery system change, the payment model in health care is also changing, moving away from unit pricing, fee-for-service and volume, and towards outcomes, total cost of care and value. There are several examples across the state of these "accountable care" models —three of which you will hear from today.

- **Wisconsin hospitals are taking a page from the manufacturing sector's book and increasingly adopting LEAN and other efficiency initiatives that focus on reengineering processes to reduce waste and improve quality, and we are seeing growing evidence that these initiatives are bearing fruit:**
 - A 2011 study by Milliman and Mercer, conducted for the Greater Milwaukee Business Foundation on Health, showed that from 2003-10 hospital operating expenses in SE Wisconsin increased by 17 percent compared to a 28 percent increase in the Hospital PPI and 37 percent increase in the Hospital Market basket index for the same period.
 - And Lean is not limited to large organizations. I spent all day last Friday at Prairie du Chien Memorial hospital – a small 25 bed hospital adopting lean management principles that are quantifiably reducing cost. Lean is more than a process, is it a culture change that involves employees at all levels and even facility design. In fact, Prairie du Chien is in the process of replacing their 62 year old facility and designing it with Lean principles in mind.
 - Further, Wisconsin hospital supply costs per discharge are now nearly 19 percent lower than the national median.
 - And according to recent data from CMS and Kaiser, Wisconsin hospitals cost less per Medicare patient than national averages. In fact, 88% of Wisconsin hospitals cost Medicare less per patient than the national average.
- **And hospital commercial payments are also reflecting improvements in efficiency and quality. For example:**
 - From 2003-10, commercial payments to hospitals in SE Wisconsin increased 40 percent less than the Hospital CPI over the same period. Health care costs are a component of labor costs and effect Wisconsin's competitiveness, and with over one-third of all Wisconsin jobs located in the seven county SE Wisconsin region, the impact of these cost and price improvements should be significant.
 - Statewide hospital rate increases are moving downward, declining from 7.4 percent in 2002 to 4.8 percent in 2012. Still high, but certainly trending in the right direction.

These are just a few examples, and in the interest of time I've distributed a packet containing several more illustrations of Wisconsin's high marks in national rankings and ongoing efforts to improve quality and value.

These are promising trends, indicators of progress and glimpses of solutions to our massive health care challenges. It is a direction in which we are heading, but not a place we have arrived. Health care still consumes too much of our GDP, our federal budget, our state budget, our personal budgets and employers' budgets. Some in the health care and the business communities are critical of the pace of improvement in health care. They are not wrong, but we believe, for our part, things can change.

There is a good story taking shape in Wisconsin, and we should start telling it. Health care can be an economic and competitive advantage for this state. Access to quality and efficient care should be as much a part of our economic infrastructure as roads and utilities.

Regardless of how the Supreme Court rules on the Affordable Care Act, Wisconsin must, and we are confident, will accelerate down the "reform" path. Few other states are as well positioned, or committed to succeed, if not thrive, in this emerging health care value dynamic—that is a Wisconsin strength that we believe can transform into Wisconsin advantage.

Thank you again for this opportunity to speak. We are very committed to and passionate about the future of health care, and helping our members succeed in a necessarily changing, value focused world.

As WHA's testimony demonstrates, Wisconsin hospitals and health systems are committed to moving forward with value-based care. The result of these efforts has been documented in research from other organizations like the Dartmouth *Atlas*, Kaiser Family Foundation and *The Commonwealth Fund*.

For example, the Dartmouth *Atlas* reports that high value states like Wisconsin cost the Medicare program far less than other states, and a recent *Commonwealth Fund* report ranked all of Wisconsin's communities in the top quartile of the nation in health care system performance. Most recently, Kaiser analyzed the Centers for Medicare and Medicaid Services "hospital efficiency" data and found that 88% of Wisconsin's hospitals are better than the national average in hospital efficiency.

However, improving cost efficiency is one of only two important goals when pursuing value. The other goal is towards continual quality improvement. In 2004, the WHA launched its voluntary hospital quality reporting program – CheckPoint (www.WiCheckPoint.org). **CheckPoint was the first statewide, voluntary hospital quality reporting initiative in the country.** It was designed to meet growing stakeholder demand for information on the quality of care provided by community hospitals. Consumers, providers and employers are able to view quality and error prevention information on every Wisconsin hospital. Wisconsin remains the only state in the country to voluntarily report more than 60 measures of quality and safety.

This culture of quality improvement is why in 2012 a full 98% of Wisconsin hospitals are also voluntarily participating in the largest quality improvement initiative WHA has launched in a decade: **Partners for Patients**. The ambitious goals of the *Partners for Patients* initiative are to reduce inpatient health care associated complications by 40 percent and readmissions by 20 percent over a three-year period in 10 key areas.

We believe these examples demonstrate that Wisconsin hospitals and providers take seriously their commitment to health care value through improved quality and reduced costs. On behalf of our hospitals and health systems, we appreciate the opportunity to relay this information to the Senate Committee on Finance.

Find out more about what Wisconsin is innovatively doing to drive health care value at www.wha.org.

