

**CHRONIC ILLNESS: ADDRESSING
PATIENTS' UNMET NEEDS**

HEARING
BEFORE THE
COMMITTEE ON FINANCE
UNITED STATES SENATE
ONE HUNDRED THIRTEENTH CONGRESS
SECOND SESSION

—————
JULY 15, 2014
—————



Printed for the use of the Committee on Finance

—————
U.S. GOVERNMENT PUBLISHING OFFICE

94-614—PDF

WASHINGTON : 2015

For sale by the Superintendent of Documents, U.S. Government Publishing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512-1800; DC area (202) 512-1800
Fax: (202) 512-2104 Mail: Stop IDCC, Washington, DC 20402-0001

COMMITTEE ON FINANCE

RON WYDEN, Oregon, *Chairman*

JOHN D. ROCKEFELLER IV, West Virginia	ORRIN G. HATCH, Utah
CHARLES E. SCHUMER, New York	CHUCK GRASSLEY, Iowa
DEBBIE STABENOW, Michigan	MIKE CRAPO, Idaho
MARIA CANTWELL, Washington	PAT ROBERTS, Kansas
BILL NELSON, Florida	MICHAEL B. ENZI, Wyoming
ROBERT MENENDEZ, New Jersey	JOHN CORNYN, Texas
THOMAS R. CARPER, Delaware	JOHN THUNE, South Dakota
BENJAMIN L. CARDIN, Maryland	RICHARD BURR, North Carolina
SHERROD BROWN, Ohio	JOHNNY ISAKSON, Georgia
MICHAEL F. BENNET, Colorado	ROB PORTMAN, Ohio
ROBERT P. CASEY, Jr., Pennsylvania	PATRICK J. TOOMEY, Pennsylvania
MARK R. WARNER, Virginia	

JOSHUA SHEINKMAN, *Staff Director*
CHRIS CAMPBELL, *Republican Staff Director*

CONTENTS

OPENING STATEMENTS

	Page
Wyden, Hon. Ron, a U.S. Senator from Oregon, chairman, Committee on Finance	1
Hatch, Hon. Orrin G., a U.S. Senator from Utah	3

WITNESSES

Dempsey, Stephanie, patient, Blairsville, GA	6
Lehmann, Mary Margaret, caregiver, Minneapolis, MN	8
Bornstein, Dr. William A., chief quality and medical officer, Emory Health-care, Atlanta, GA	11
DeMars, Cheryl, president and CEO, The Alliance, Fitchburg, WI	13

ALPHABETICAL LISTING AND APPENDIX MATERIAL

Bornstein, Dr. William A.:	
Testimony	11
Prepared statement	33
Responses to questions from committee members	39
Burrell, Chet:	
Prepared statement with attachments	46
Responses to questions from committee members	56
DeMars, Cheryl:	
Testimony	13
Prepared statement	61
Dempsey, Stephanie:	
Testimony	6
Prepared statement	65
Franken, Hon. Al:	
Prepared statement	67
Hatch, Hon. Orrin G.:	
Opening statement	3
Prepared statement	68
Klobuchar, Hon. Amy:	
Prepared statement	71
Lehmann, Mary Margaret:	
Testimony	8
Prepared statement	73
Responses to questions from committee members	76
Wyden, Hon. Ron:	
Opening statement	1
Prepared statement	79

COMMUNICATIONS

American Academy of Family Physicians	81
American Academy of Physician Assistants	85
American College of Clinical Pharmacy (ACCP)	90
American Diabetes Association	93
Diabetes Advocacy Alliance™	98
National Association of Chain Drug Stores (NACDS)	106
National Community Pharmacists Association (NCPA)	109
Special Needs Plan Alliance (SNP)	112

CHRONIC ILLNESS: ADDRESSING PATIENTS' UNMET NEEDS

TUESDAY, JULY 15, 2014

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. Ron Wyden (chairman of the committee) presiding.

Present: Senators Stabenow, Carper, Bennet, Casey, Warner, Hatch, Thune, Isakson, and Toomey.

Also present: Democratic Staff: Michael Evans, General Counsel; Hannah Hawkins, Research Assistant; Elizabeth Jurinka, Chief Health Policy Advisor; Matt Kazan, Health Policy Advisor; Tom Klouda, Senior Domestic Policy Advisor; Jocelyn Moore, Deputy Staff Director; Joshua Sheinkman, Staff Director; and Kelly Tribble Spencer, Detailee. Republican Staff: Erin Dempsey, Health Care Policy Advisor; and Jay Khosla, Chief Health Counsel and Policy Director.

OPENING STATEMENT OF HON. RON WYDEN, A U.S. SENATOR FROM OREGON, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The Finance Committee will come to order.

Today the Finance Committee focuses its attention on what, in my view, is the biggest challenge ahead for Medicare and the future of America's health care system; that is, managing chronic illness.

To understand why this is a growing issue, one need only to look at how Medicare has changed over the years. When the Medicare program began—and in those early days, I was co-director of the Oregon Gray Panthers, with a full head of hair and rugged good looks—Medicare was mostly about caring for seniors who needed to go to the hospital. If a senior slipped on the kitchen floor and broke an ankle, for example, they would head to the hospital, they would get treatment, and they would head home.

In 1970, nearly 70 percent of Medicare spending was for hospital care. Now that number is closer to 40 percent. The change shows how Medicare is very different than it was 4 decades ago. Rather than broken ankles or pneumonia, Medicare is now dominated by chronic conditions such as cancer, diabetes, and heart disease. More than two-thirds of those on Medicare now are dealing with challenging multiple chronic conditions. That care accounts for almost all—93 percent—of Medicare spending.

And we are going to hear today that it is not just seniors who are affected by chronic illness. Half of all American adults have at least one chronic condition. These diseases account for 70 percent of deaths, limit the activities of tens of millions more Americans, and cost the economy billions each year.

The problem is only going to be compounded as chronic illnesses become more common. In fact, there are a number of health care experts who have warned that this generation could be the first in modern times to have shorter life spans than their parents. And this is not just a health issue. The growing prevalence of chronic disease is also a major driver of health care costs that are putting a growing burden on the government, business, and family budgets.

Here is my bottom line: the way health care in America is delivered has to change. And I will repeat that: it has to change. Doctors and hospitals often do not coordinate care or even talk to one another. Patients receive medication for one disease that conflicts with another. Paper medical records force time and energy away from patient care only to be spent on burdensome red tape. There is even data showing that caregivers of those with chronic disease face higher rates of stress and depression and have higher mortality rates. Virtually all Americans get touched by these kinds of issues, and certainly those suffering with chronic diseases are hurt the most by the flaws in American health care.

This morning's hearing is going to look at the problems faced by millions of Americans every day as they try to navigate—navigate—America's chaotic system of treating chronic illness. The committee is going to hear how the tragedy of chronic disease is exemplified by a single mom who, before her 31st birthday, had major heart surgery and can no longer work or even drive a car because of the onslaught of these diseases.

We are going to hear about patients with multiple chronic conditions who are left on their own to shuttle themselves between a whole array of different providers that often are located hours away from each other. We are going to hear a story from a wife struggling to take care of a husband with Alzheimer's, trying to make sure that the doctor appointments are kept, medication is taken, and the marriage is intact.

I think we all understand this is not something that is going to be solved overnight. This chronic care hearing marks the beginning of what will be a bipartisan effort to address the dominant problems in America's health care system that practically everyone over the last decade has managed to ignore.

In the months ahead, the committee can find bipartisan solutions to meet the challenges and strengthen the American health care system. I am very much committed to working with Senators on both sides of the aisle.

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

The CHAIRMAN. Let me recognize Senator Hatch.

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

Senator HATCH. Thank you, Mr. Chairman.

I am pleased that we are finally including a health care hearing today. Frankly, I think this committee should hold more hearings on health care.

We all know the implementation of Obamacare has come under intense scrutiny, and for good reason, in my view. It is imperative that the Senate start exercising proper levels of oversight to determine whether or not the law is working as promised. I do not say this out of politics or partisanship, but because patients, taxpayers, and policymakers deserve honest answers.

That said, today this committee has an opportunity to delve into the very important topic of chronic illness. This is one area where, if we choose to work together, I believe the committee can find real bipartisan solutions that not only improve care coordination and lower overall health care costs, but also give complex patients better tools to more effectively navigate the health care system.

The Medicare Payment Advisory Commission has long said that fee-for-service Medicare creates silos, incentivizing providers to deliver more care, not necessarily higher-quality coordinated care. The successful Medicare Advantage program does give patients the option to receive benefits from private plans that are incentivized to manage care across all settings. However, traditional Medicare fails to meaningfully encourage providers to engage in labor-intensive and time-consuming patient care coordination.

Perhaps this is why in 2013 Medicare Advantage enrollment increased by 9 percent to 14.5 million patients. That number represents 28 percent of all Medicare enrollees. Even with these advances, today's health care system remains fragmented, and there is significant evidence that communication between providers is lacking both in the Medicare program and in the private sector.

The Medicare Payment Advisory Commission estimates that Medicare patients with five or more chronic conditions see an average of 13 physicians and fill an average of 50 prescriptions each year. So it is no surprise that patients with high-cost chronic conditions routinely visit multiple specialists, often repeat medical histories and tests, receive inconsistent medical instructions, do not get health transitioning from one site of care to another, and use more expensive care settings when it may not be necessary.

Today, one remarkably brave patient, as well as a devoted and loving caregiver, will share their personal stories with us. Their testimony will show that the current health care system is not serving all patients well.

But there is hope. We are also going to talk to a medical provider and an employer about the promising efforts underway to address the unique needs of chronic care patients. I applaud these innovative approaches, but we all need to know that there are no easy answers. Developing and implementing policies designed to improve disease management, streamline care coordination, improve quality, and reduce Medicare costs, is a daunting challenge.

Based on past experiences, with the Medicare program in particular, there is still much more work to be done. For more than a decade, the Centers for Medicare and Medicaid Services, or CMS,

has tried numerous demonstration programs to find out what does and does not work to improve care coordination for patients with chronic diseases. These demonstration programs have at best shown mixed results.

According to the Congressional Budget Office, CMS has paid 34 programs in six major demonstrations to provide disease management or care coordination services in traditional Medicare. On average, these 34 programs had little to no effect on hospital admissions or Medicare spending.

In 2010, Obamacare created Accountable Care Organizations, ACOs, which, of course, allow certain providers to work together to coordinate and integrate Medicare services. These provider groups must meet specific quality standards in order to share in any savings they achieve for the Medicare program. The ACO initiative is relatively new. There is no definitive data to prove if ACOs actually improve quality, if they show any promise to save Medicare money, or if they are simply failing.

While the jury is out on whether these ACOs will produce results, Obamacare also gave the Secretary of Health and Human Services broad authority to create and implement new Medicare pilot programs. Through the Center for Medicare and Medicaid Innovation, CMMI, the Obama administration is actively conducting care coordination programs in various Medicare settings. My hope is that the CMMI research will yield results. As we all know, health care costs place enormous strain on the Federal budget. By identifying cost-effective, data-driven ways to improve patient health, policymakers can better target scarce Federal resources to get more value for the dollars spent.

U.S. health care spending grew 3.7 percent in 2012, reaching \$2.8 trillion or \$8,915 per person. In fact, total health care spending consumes 17.2 percent of the Nation's gross domestic product, or GDP. Adding insult to injury, last year the Medicare trustees issued a report showing that the Part A hospital insurance trust fund deficit reached \$23.8 billion and will be exhausted in 2026.

Given the current fiscal reality, we have to find ways to provide high quality care at greater value and lower cost, all without adding to the deficit. So I am glad we are holding this first hearing to understand the problem, but we cannot stop there. I believe this must be the start of a long-term transparent discussion with additional stakeholders, including the administration, CBO, MedPAC, and others that will allow us to work together to identify solutions in an open and transparent way.

Again, thank you, Mr. Chairman, for holding this hearing today. I look forward to hearing from our panel of witnesses. I think it will be very interesting.

The CHAIRMAN. Thank you, Senator Hatch.

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

The CHAIRMAN. Also, let me recognize your years and years of advocacy in terms of trying to come up with fresh, creative approaches for our health care challenges.

For our witnesses, you should know that I am essentially flanked by three, on this side, Senators who have real roots in terms of challenging the status quo and looking at fresh approaches to

chronic disease and health care services, and the same is true on the other side of me. So flanked really by 6 percent of the United States Senate that cares passionately about these issues, and I am very pleased that all of you could be here.

Now, we are going to hear from Stephanie Dempsey, a chronic disease patient from Blairsville, GA. Ms. Dempsey is currently taking on coronary artery disease, Lupus, a seizure disorder, and arthritis. And we very much appreciate your willingness to come, Ms. Dempsey.

Mrs. Mary Margaret Lehmann is here. She is a caregiver for her husband, Ken Lehmann, who is facing Alzheimer's, a disease my mother faced.

Dr. Bill Bornstein comes to us from Emory University. Dr. Bornstein is the chief medical officer and chief quality officer for Emory Health.

Finally, Ms. Cheryl DeMars, the president and chief executive officer for The Alliance, is here. The Alliance is a cooperative of employers who are focused on the delivery of health care benefits.

I also want to note that Chet Burrell, the president and CEO of CareFirst BlueCross BlueShield, was scheduled to testify. Many of us know him and his good work. But as we all know, late last night the skies burst open, and Mr. Burrell is not able to join us.

Senator Isakson, we do have two witnesses from Georgia. You have done a lot of work on these issues, and I appreciate it. Let us have you introduce Ms. Dempsey and Dr. Bornstein to the committee.

Senator Isakson?

Senator ISAKSON. Thank you, Mr. Chairman.

Georgia is very fortunate to have two of our four witnesses today, and I am very pleased to introduce both of them to the committee and to the audience.

First, Stephanie Dempsey. Stephanie is a relatively new citizen of Georgia who lives in Blairsville, GA, which is the capital of the Blue Ridge Mountains of north Georgia and a rural part of our State. She deals with multiple conditions and can talk firsthand about the challenges of having multiple conditions and reaching the services that are necessary in a rural area of the State.

Dr. William Bornstein is a tremendous individual whom you and I have met before, Mr. Chairman, because he was at our rollout, if I am not mistaken, when we first brought the coordinated care bill to the committee. He is the chief quality and medical officer for Emory Healthcare in Atlanta, which is the home of the Emory University Hospital, which is one of the major teaching hospitals in the United States and a major system that provides health care to a significant portion of our 10.2 million citizens in Georgia. He is a nationally recognized leader in the use of health information and technology to drive better outcomes and decisions, and I think the committee will really like hearing from him because he is not somebody who just talks about doing it, he has done it, implementing successful systems throughout the Emory Healthcare system.

We are glad to have Dr. Bornstein here today.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Isakson. And thank you for your good work on these issues. I literally could go around the room and point out the efforts of every Senator who is here, and I very much appreciate your leadership.

Let me also say to our witnesses that your written statements will be included in the record automatically—all that you have put together for your written statement. If you could perhaps summarize your key views for your oral presentation, that would be very welcome.

Let us start with you, Ms. Dempsey.

**STATEMENT OF STEPHANIE DEMPSEY,
PATIENT, BLAIRSVILLE, GA**

Ms. DEMPSEY. Chairman Wyden, Ranking Member Hatch, and the members of the committee, thank you for allowing me the opportunity to testify today. My name is Stephanie Dempsey. I am 44 years old. I live in Blairsville, GA, and I have been battling multiple chronic medical conditions for much of my life.

I have always considered myself a middle-class American. I had a well-paying job, I owned my own home, and I was happily married. Unfortunately, this is not the case today.

The very illnesses that I battle every day have taken that from me. I have lost my independence, my financial security, and, most importantly, my family. I hope my story can help you and those listening today better understand what people with chronic medical conditions face day in and day out, and I hope my story gives you some sense of the challenges that I and so many others go through daily.

I would like to take a few minutes to share my story with you.

I was diagnosed with coronary artery disease at the age of 21. My heart disease is hereditary and has impacted all of the women in my family. My only sister died at the age of 28 from heart disease. My mother, who is 69, underwent quadruple bypass surgery at the age of 48. And my maternal grandmother died at the age of 72 from coronary artery disease.

At the age of 30, I underwent quadruple bypass surgery for severely blocked arteries caused by high cholesterol. Since then, I have had the placement of 27 stints, another bypass surgery, and countless other medical procedures.

I take 15 different medications in the morning and an additional four in the evening, plus a multitude of supplements recommended by my doctors. At times, as you can imagine, it is very difficult to keep track of all my medicines. So I use these different baskets to keep track, and every one is labeled by condition, with my coronary—

The CHAIRMAN. Ms. Dempsey, can I ask a question?

Ms. DEMPSEY. Yes.

The CHAIRMAN. That basket is what you have to navigate through on a daily basis?

Ms. DEMPSEY. Absolutely, every day and every night. They are labeled by condition so that I can stay organized, because there are so many.

In addition to heart disease, I am fighting the effects of Lupus, arthritis, and a seizure disorder, all of which have become debili-

tating. I can no longer work, although I would desperately like to, and I depend on my parents to help care for me.

I always believed—as I am sure some of you have, that you would be taking care of your parents—and I always knew that I would be taking care of my parents as they grew older. Instead, they are taking care of me because I simply had no other choice.

This has been difficult to accept, but this is my reality. Battling a number of complex illnesses has not only taken a toll on me, it has taken a toll on my entire family. As you might imagine, my medical expenses are significant and are becoming more significant by the day.

We fell behind on our mortgage, and we were forced to sell our home. It was difficult to make ends meet. At the time, my first priority was to buy medicine that my son, who is now 20 years old, needed for his own health condition. This required us to scrape money together to make sure that he had the necessary medicine that he required.

Paying for my numerous costly medications was out of the question. Therefore, I was unable to purchase them. As a result, I was hospitalized five times over the course of 6 months, which resulted in five additional stints. As it became more difficult for me to manage my illnesses, the growing burdens became overwhelming for my husband, and, after 21 years of marriage, he decided to walk away.

I had no choice but to move from South Carolina to Georgia to live with my parents. I now live in the rural mountains of Georgia, and, although my primary care physician is nearby, I have had to travel over 2 hours to see my specialists. And because of my seizure disorder, I depend on my parents to take me to my appointments.

In addition to my primary caregiver, I also must see multiple doctors. I have a cardiologist who helps me manage my heart disease, a neurologist and a neurosurgeon who help me manage my seizure disorder, and I have a rheumatologist who helps me manage my Lupus and my arthritis. I interact with countless other health care professionals, such as nurses, physician's assistants, therapists, and others.

Although my doctors are all well-intentioned, they often do not talk with each other or share information about my care. This ultimately leaves me to be my own health care coordinator.

To give you an example, my Lupus disorder keeps my body in a constant state of inflammation for which one of my specialists prescribed me a medication to reduce that symptom. Unfortunately, that medication can cause seizures. He did not remember my seizure disorder, and the medication caused me to have an increase of seizures. After a visit with my neurologist, he took me off the medication, knowing the seizure side effect. Getting this resolved took days, countless phone calls, and much persistence on my part, not including the increase of seizures.

Issues like this happen frequently, and, although I consider myself an educated person, navigating this maze is very difficult and very exhausting, but it is my life at stake, and I do not have a choice but to be engaged.

To give you another example, I recently had to change to a new primary care doctor since my former doctor is now only accepting private-pay patients. This has been a challenge as it will take some time for me to become familiar with my doctor and for her to become familiar with me and my medical history.

In an ideal world, I would want my primary care doctor to manage all of my care, but I have come to realize that this is not realistic because I require specialized physicians.

For a long time, I was privately insured through my employer, and later through my husband's insurance policy. However, when my husband was laid off and his health benefits terminated, I was left without insurance. Fortunately, I was able to qualify for Medicare in 2004 because of the Federal Disability Act. Although it took 2 years of fighting to qualify for Medicare, the program has been extremely helpful. But it still leaves me constantly struggling to pay my portion of my medical bills.

My last surgery in September of 2012 cost \$51,000 for an overnight visit. Medicare covered all but \$1,138 of that fee.

I have encountered countless challenges along this journey, and I am extremely fortunate to be here today to share my story. I am confident that you will not forget me and countless other people who are dealing with chronic illnesses when you develop policies that will help all of us. Our goals are all the same: to live long, healthy, and productive lives.

I sincerely thank you for giving me this opportunity to share my story with you.

The CHAIRMAN. Ms. Dempsey, thank you. You have delivered a powerful and eloquent wake up call here that really speaks to the dimensions of chronic illness, and I want you to know that I think the strongest, richest country on earth can do better by those who have these kinds of chronic conditions. And you ask that you not be forgotten, and you have Senators here, Democrats and Republicans, who are committed to making sure that does not happen, and I thank you for it.

[The prepared statement of Ms. Dempsey appears in the appendix.]

The CHAIRMAN. Mrs. Lehmann, we welcome you from Minneapolis, MN.

**STATEMENT OF MARY MARGARET LEHMANN,
CAREGIVER, MINNEAPOLIS, MN**

Mrs. LEHMANN. Thank you. Good morning, Chairman Wyden, Ranking Member Hatch, and members of the committee.

On behalf of caregivers for individuals living with Alzheimer's disease and other dementias, thank you for the opportunity to testify before you today on the topic of chronic care.

Alzheimer's is a devastating, progressive, and ultimately fatal disease. It currently impacts more than 5 million Americans living with the disease and their 15.5 million caregivers. These men and women living with Alzheimer's are husbands and wives, fathers and mothers, brothers and sisters, business leaders, medical professionals, Republicans, Democrats, and my dear husband of 50 years, Ken, is one of them.

I am honored to be here today to share our story and discuss the issues facing individuals with Alzheimer's and their caregivers. The more we share our story and talk about Alzheimer's, the less of a stigma it will become for others facing this disease.

While Ken is fortunate to have a devoted care partner to advocate for him and, finally, a definitive diagnosis, initially a care plan to ensure that he lives as well as possible with Alzheimer's was not available to us. Our journey to get here was long and difficult. There are many who live with this disease who never get the care and support they need.

Ken's tentative diagnosis came in October of 2009. However, I became aware of changes in his personality and behaviors as far back as 1995. It was then that I began to notice his withdrawing from family, friends, and social situations, having difficulty navigating familiar places, as well as challenges in executive function involving problem-solving and reasoning. His judgment was often compromised, especially in regard to our finances. Ken communicated to me that he was having difficulties at work, particularly learning new computer programs.

We were both patients of a well-known, highly respected internist for 30 years. Over the years, I reported my observations to him. Our internist brushed off my concerns that these signs might be something serious by responding with, "Well, these things can happen," or "It might be just part of his aging."

I would tuck away my fears until the next time and the next time. The wake up call, however, came when my love told me we had to file for bankruptcy. His compromised financial judgment had escalated to financial failure. Subsequently, we lost our home as well.

I was left thinking, how could this ever have happened to us? I encouraged Ken to see another doctor to learn the reasons why. After seeing four neurologists and three internists in a year and a half, Ken was finally diagnosed definitely with Alzheimer's disease in January of 2011. Our story is not unique. Many families struggle to get a definitive diagnosis of Alzheimer's disease just like we did.

Following his diagnosis, his second internist prescribed Aricept and told him to return in a year for a checkup. After receiving the diagnosis, Ken went through what he calls the three Ds—denial, depression, despair. I was devastated and desperate for more answers. We were given the diagnosis, but no information on what to expect or how to deal with the symptoms or how to even manage his atrial flutter along with the Alzheimer's.

After three appointments with three different neurologists, we were finally able to find one with experience in treating people with Alzheimer's. Today, Ken is a patient at the Center for Memory and Aging in St. Paul with Dr. Michael Rosenbloom. And along with the Alzheimer's Association, we have developed a plan not only for Ken to live well, but also for me as his caregiver.

Maria Schriver's HBO documentary "The Alzheimer's Project" reports that 74 percent of caregivers do not survive the persons for whom they are caring. It is not only the person with the disease who needs care and support, but the care partner as well, especially to reduce stress. From our networking with others, we have

also learned that our story, our financial hardship associated with the disease, is not unique.

In many ways, I see my role as Ken's care partner much like that of an operations manager. I try to make sure he can be as independent as can be. We make a concerted effort to engage in social activities, to have a healthy diet, for Ken to exercise his mind and body, and for him to engage in creative expression. I find myself monitoring, monitoring, and monitoring him throughout the day to ensure his safety and well-being.

Dr. Terry Barclay, neuropsychologist at the Center for Memory and Aging, submits that "Living with Alzheimer's can be lengthened 10 percent with medication, but 90 percent by living well, and especially with socialization."

Through our experience, I have learned that there are definite deficiencies in our health system when it comes to dealing with Alzheimer's. Far too many physicians are not familiar with the warning signs of Alzheimer's or how to properly advise patients and their caregivers. Additionally, there is a lack of communication and coordination among physicians. Ken sees an internist, a cardiologist, and a neurologist to deal with various conditions. He carries a list of his 11 medications and supplements to each appointment to ensure that each physician is aware of what his other health providers have prescribed for him. Sadly, this is more often the case than the exception for many individuals with Alzheimer's and their caregivers.

Thank you for the opportunity to testify today. I appreciate the steadfast support of the committee and its focus on chronic care. Alzheimer's is a disease that not only impacts the diagnosed person, but also the lives of their loved ones.

I ask Congress to address chronic care issues around Alzheimer's with the same bipartisan collaboration demonstrated in the passage of the National Alzheimer's Project Act. This focus on quality dementia care will help individuals living with Alzheimer's disease and their caregivers around the country.

An epidemic is well upon us, and too many families are in a situation like ours, facing a fatal brain disease that currently we have no way to prevent, cure, or even slow the progression of, and we are left without a support system to guide us.

As a Nation, we cannot afford to wait until Alzheimer's bankrupts the Nation just as it already has so many hardworking families in Oregon, Utah, and across this country. We must make the smart investment now to realize a better, healthier future for our families and our Nation. Right now all we have is hope.

Thank you.

The CHAIRMAN. Thank you, Mrs. Lehmann. And in addition to hope, we have you, and I sort of see a size 7 halo over there by the witness table. And listening to your story, it also very much exemplifies what my mother dealt with. My mother had Alzheimer's and dementia, she got a master's degree from Yale in the days when no woman got a master's degree, and we saw very much the same evolution of events you did, and I very much appreciate your coming.

[The prepared statement of Mrs. Lehmann appears in the appendix.]

The CHAIRMAN. We have a number of champions here on this committee on both sides of the aisle, Democrats and Republicans, who want to follow up on your Alzheimer reforms, including me. So we thank you.

Mrs. LEHMANN. Thank you.

The CHAIRMAN. Thank you very much for it.

Dr. Bornstein, welcome.

STATEMENT OF DR. WILLIAM A. BORNSTEIN, CHIEF QUALITY AND MEDICAL OFFICER, EMORY HEALTHCARE, ATLANTA, GA

Dr. BORNSTEIN. Thank you, Chairman Wyden, Ranking Member Hatch, and members of the Senate Finance Committee, for inviting me to discuss Emory Healthcare's efforts related to caring for our chronic care patients. I also wish to extend a special thanks to Senator Johnny Isakson, who is Emory's Senator and a good friend and strong supporter of our work.

As the Chief Medical Officer of Emory Healthcare in Atlanta and as a practicing endocrinologist, I know firsthand the challenges faced by our patients with multiple chronic medical conditions, about which you have heard eloquent testimony. Many of my patients have diabetes, and most patients with diabetes have other medical problems: hypertension, coronary disease, kidney disease, and many others. Many of these patients see multiple specialists. They may be seeing me for diabetes, a cardiologist for care of the coronary disease, and a nephrologist for care of the kidney disease. And everything that each of us does, as you have heard already this morning, affects the whole patient.

Many problems, like elevated blood pressure and elevated cholesterol, overlap each of our specialties. Each of us strives to take a patient-centered approach to treating a set of problems, but the challenge is, how do we make sure that all the care is coordinated so that we can take a patient-centered approach to the care of the whole patient?

At Emory, we have a highly sophisticated, single electronic medical record system that spans our hospitals and outpatient clinics so that all providers can see the entire medical record. However, coordination of care requires more than technology and good intentions. It requires reallocation of time, from face-to-face interactions, to time devoted to coordination of efforts among providers, and in non-face-to-face interactions, providing continuous care of patients.

So in addition, we are hiring and training nurse care coordinators. We embed these nurses into primary care practices and feed them data identifying the highest-risk patients, and the care coordinators stay in touch with those patients, helping to make sure that they are doing well and, when they are not, providing them the care they need.

However, as you know, care coordination and technology infrastructure are expensive. When these investments are successful, they help keep our patients out of emergency rooms and hospitals, thus reducing the revenue of our health care system. Under fee-for-service, I am in the awkward position of asking our health system to fund efforts that will reduce our revenue within a context of declining reimbursements like the 2-percent sequester cut and the ever-looming specter of SGR.

To try to deal with these challenges proactively, we have formed a clinically integrated network, the Emory Healthcare Network or EHN, which is our Accountable Care Organization, that provides extensive infrastructure and support for physicians in a collaborative and quality-based environment that drives outstanding performance, improves care coordination, enhances outcomes, and controls costs for our patients and our community. EHN is contracting with payers in ways that liberate us from the constraints of fee-for-service and move us towards better alignment of needs among patients, providers, and payers.

We now have a “shared savings” contract with BlueCross BlueShield and are negotiating similar contracts with other commercial payers. Under shared savings, if we are able to lower the total cost of care and improve quality through better coordination of care, we share in the savings. Shared savings can help offset what would otherwise be negative financial consequences of the investments needed to improve patient care.

It costs in the range of \$6 million to \$10 million annually to run EHN, and that does not fully include the costs incurred by private practices to connect to our Emory Health Information Exchange, which we require for their participation in EHN.

As the leading academic medical center, we care for some of the most complex cases in the country. Emory has been remarkably successful in working within current constraints. Emory is the only health system in America to have more than one hospital ranked among the top 10 academic hospitals in the prestigious University HealthSystem Consortium Quality and Accountability Scorecard. Indeed, both of our eligible hospitals, Emory University Hospital and Emory University Hospital Midtown, have been in the top 10 for the past 2 years and are ranked number 2 and number 3, respectively.

We are proud of this achievement, most importantly because of what it means for our patients. However, we are by no means satisfied. We need to apply and extend these achievements across the continuum to achieve the triple aim of better health, better health care, and lower costs for the population we serve.

We can only achieve this through better coordination of care. Our physicians and staff desperately want to take better care of these patients. That is why we practice medicine. Current structures create frustration among our providers, as well as for our patients. Our primary care teams feel these frustrations most acutely, and these stresses contribute to the relative lack of interest in primary care and other non-procedural specialties. Frankly, it is easier and more profitable to do procedures than to try to coordinate care in our current system.

Our Nation’s capacity to grow its physician workforce is predicated on doctors being able to do what they enter medicine to do—care for all their patients’ needs. American health care should be in a golden age. We have so much to offer patients, and so much more than just a few years ago. To deliver on this promise, we need a new framework that removes barriers and rewards high-quality coordinated care.

Thank you for shining a spotlight on the challenging issue of chronic care. I look forward to answering any questions you may have.

The CHAIRMAN. Doctor, thanks for the help that you have given the committee and also for highlighting how flawed the incentives are in today's system. And we look forward to questions.

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

The CHAIRMAN. Ms. DeMars?

**STATEMENT OF CHERYL DeMARS, PRESIDENT AND CEO,
THE ALLIANCE, FITCHBURG, WI**

Ms. DEMARS. Good morning, Chairman Wyden, Ranking Member Hatch, and members of the committee. I am here today to represent The Alliance, which is a not-for-profit cooperative owned by over 200 employers in Wisconsin, Illinois, and Iowa, who together provide health benefits for over 90,000 employees and their family members. Employers who are members of The Alliance are working to address chronic diseases by creating healthy workplaces, by reducing the financial burden to patients through value-based benefit designs, and by raising the bar on our expectations for health care delivery.

Our efforts in wellness and in benefit design are important, but alone are insufficient to address the cost problems we face in health care. The results of our efforts are too modest and too slow. So simultaneously, we need to use our role as purchasers of health care to make faster progress, and that is the idea behind a new initiative that we are developing called Quality Path.

Through Quality Path, we will move market share to high-value physicians and hospitals and, in doing so, overcome some of the barriers to faster progress; specifically, lack of information to help us understand the performance of individual physicians, and incentives that are misaligned or nonexistent for patients and providers. We are starting with high-cost, schedulable procedures in cardiology and orthopedics, because those are the areas where our members spend the most money.

Here is how the program will work. First, Quality Path will evaluate individual doctor and hospital pairings. Consumers, patients, want and deserve information to help them understand the performance of their doctors. Yet, physician-specific public reporting remains an elusive goal, and the promise of the Physician Compare website is yet to be realized. We will address this unmet consumer need by requiring physicians to disclose their performance on quality measures as part of the Quality Path application process.

Second, Quality Path will set a high bar. We intend to make a real and lasting difference in health care and so have carefully chosen the criteria that we will use to designate Quality Path providers.

We have relied on input from the clinicians who deliver the care and their specialty societies, and have aligned with leading-edge public and private-sector initiatives. The most notable is the CMMI-funded SMARTCare project, which was developed by the

leadership of the Wisconsin chapter of the American College of Cardiology and the Wisconsin Medical Society.

Doctors and hospitals that receive the Quality Path designation will score high on quality measures, will avoid exposing patients to harm associated with the overuse of imaging tests, will consult with patients and respect their preferences when multiple treatment options are available, and will talk with patients about future care needs and document their wishes for end-of-life care as appropriate.

Finally, Quality Path will lower costs for employers and patients. We will be negotiating more aggressive, lower, bundled prices with warranties. This pricing will only be available to employers, our members, who agree to implement substantial financial incentives for their employees to choose Quality Path providers. That way, Quality Path will simultaneously reward patients who seek high-value care and the providers that deliver it.

Quality Path relies on access to data and the flexibility for purchasers to innovate, and that is where the Federal Government can help. Employer organizations like ours and the all-payer claims databases we rely on need access to Medicare data to enhance physician level measurement. We also need the flexibility to design plans that reward high-value care. And we need partners. Market-based efforts like Quality Path will only succeed if there is a significant business case for providers. State and Federal Governments, acting in their role as employers and purchasers, can join with private-sector efforts to amplify our signal strength.

Data-driven innovation holds great promise for improving the value of care, and thank you for letting me share employers' efforts to help make that happen.

The CHAIRMAN. It is very helpful to have that employer input, Ms. DeMars.

[The prepared statement of Ms. DeMars appears in the appendix.]

The CHAIRMAN. Senator Hatch has tried to be in two places at once this morning, and he is very much needed in Judiciary.

So, Senator Hatch, I am pleased to have you start.

Senator HATCH. Well, I am grateful to all of you. Your testimony surely hit home here, and we want to do everything we can to help, and we will see what we can do.

I am sorry that I am split between two committees—and I will go over to Judiciary—but I am very interested in everything you said and everything you have suggested.

So with that, I hope you will forgive me for having this burden of two committees going at the same time.

Thank you.

The CHAIRMAN. Senator Hatch, thank you. You cannot quite be cloned, so it is great to have your leadership.

Let me start with a question that I have been struck by, having kind of watched the odyssey of those with chronic disease over the years, really beginning in those Gray Panther days and then over the years. And what you bump up against first is the staggering burden, the truly staggering burden on patients and families.

They have the disease, and then they have to try to figure out how to make their way through—as you, Ms. Dempsey, said so elo-

quently and you, Mrs. Lehmann—this sort of maze of treatments and medications and appointments. It just strikes me, it is like the system puts this gigantic boulder on your back, this overwhelming burden on your back, when you are trying to deal with chronic disease.

Patients have several physicians. They have this—I always called it a mountain of prescriptions, but I guess I have to rename it now that I see tray after tray over there, Ms. Dempsey, consuming the witness table. They just delivered a phone book the other day to the staff, and people now have medical records the size of phone books.

The first question I would like to see if we can get our arms around as we try to move forward is—and, as I have indicated, there are Senators here who have been really passionately interested in these issues: Senator Stabenow, for example, and Senator Toomey on this Alzheimer's issue, Senator Casey looking at chronic disease for young people, and others—Senator Isakson, teaming up with me.

There are a lot of Senators who care about this issue, and what I am struck by is, at the outset, how valuable to me, kind of by the seat of my pants, it would be to have one individual, one single individual, whether it is a nurse, a physician, another individual from the health care system, who basically would be the go-to person for coordinating the appointments and keeping track of the multiple doctors and making sure that one doctor communicates with another. That was the whole point of the electronic medical record. You did not want Dr. 3 to repeat all the stuff that Dr. 2 and Dr. 1 did, but we are still trying to make sure that interconnection is there.

So let us start with you, Ms. Dempsey, and you, Mrs. Lehmann, to get on the record how valuable it would be to you two to have one single individual. Now, we can have the debate about who it ought to be, but it seems important to have one single individual be that go-to person to coordinate the array of visits and services and the like.

Let us start with you, Ms. Dempsey.

Ms. DEMPSEY. It would be life-changing. It would be absolutely wonderful to be able to, I guess, free up some of my time and maybe even relax enough to know that I do not have to follow a step behind everyone, foot-for-foot, to make sure that things are done and make sure that my care is at the top of the list.

If I had that one person who was the go-to person who would make sure that everything was done correctly and everything was coordinated between everyone else, it would be just invaluable.

The CHAIRMAN. And you, Mrs. Lehmann?

Mrs. LEHMANN. Not only would it be life-changing, it would be life-giving, because most of my time is spent feeling overwhelmed. Where do I call for this? Where do I call for that? We are now facing looking at long-term care. How are we going to do that?

This is a very huge issue. I want to keep Ken at home with me. I want to be his caregiver, but I am going to need help. He weighs considerably more than I, and I am going to need help, and I find this very, very overwhelming.

If I had one person whom I could call and say, "How can we do this, how can you help me," I would so appreciate that.

The CHAIRMAN. Well, thank you both. I am going to have plenty of other questions after I make sure my colleagues get a turn.

But literally, since my Gray Panther days, that struck me as the prerequisite to turning this around. You all have called it life-changing and life-giving. I just would like to take some of that boulder off your shoulders.

When you are dealing with the conditions that you have described this morning, and you have to figure out how to navigate this byzantine health system—I saw it with my mother, and I said to myself at one point, so here I am, I am a U.S. Senator, that is a pretty important position, and everybody in the health care system knew about it, and my mother got a master's degree from Yale, and we were in her hometown where I played basketball, and I said to myself, if it is this hard for somebody like me and my family, what is it like for everybody else who is not starting with that?

That is what we have to turn around.

So let me allow my friends to have at it.

Next is Senator Stabenow. And you should know she has done extraordinary work on Alzheimer's. I do not think a month goes by without Senator Stabenow talking to me about what we ought to be doing on this committee about Alzheimer's.

Senator Stabenow, welcome.

Senator STABENOW. Thank you, Mr. Chairman, for your incredible leadership. And thank you to each of you for the role that you play and the important work that you are doing.

Mrs. Lehmann, thank you, and Ms. Dempsey. And before I ask some questions regarding Alzheimer's, I do want to just start, Mr. Chairman, by saying for the record that, while there are a lot of things that folks want to talk negatively about in the Affordable Care Act, because we have the Affordable Care Act, there are no more preexisting conditions.

So, Ms. Dempsey, at least you are not having to worry about finding insurance, with all the challenges that you have. There are no annual or lifetime limits on the number of treatments that you can receive. So at least you are not also having to battle all of that. And we are in a situation where there are more affordable options for people, and, while we are not doing everything that we can on cost savings, at least we are having the conversation on bundled payments and on coordination and the accountable care groups.

In Michigan, we have seen some real savings to date on this. So there is more to do faster, but at least we are talking about quality of care and what needs to be done. And in my judgment, we have to talk about case management, Mr. Chairman, in a much more real way.

First, let me just say for the record, the number-one cause of death of women in this country is heart disease. People do not realize that. One out of three deaths of women, Mr. Chairman, is because of heart disease. So we need to remind ourselves of that, because doctors do not understand, unfortunately. Women have different symptoms. They are diagnosed differently. Oftentimes, it is said it is stress when it is actually something happening in terms of heart disease.

We have a very important report coming out from the FDA, an amendment that I authored in the FDA Safety and Innovation Act that we passed, that is going to require an action plan for more participation of women in drug clinical trials, because women are different than men and have different reactions.

So we at least want to make sure, Ms. Dempsey, that what you are carrying around in there is actually the best for you to have as a woman. So it is very important, the FDA action plan, Mr. Chairman, that we are waiting on, in August.

Mrs. Lehmann, let me just say that your story emphasizes and reenergizes me to pass something that Senator Collins and I have introduced called the Hope for Alzheimer's Act. We have to get this done.

As you know, this would require comprehensive clinical diagnosis; evaluation for Alzheimer's disease; caregiving plans for newly diagnosed individuals and caregivers about all the options, all the things that you are talking about, to make that available; as well as documentation on the planning going into the medical records and so on—that on top of critical research that we have to continue to do, because there is hope, and we should be doubling down on that health research.

But I am wondering if you could just speak to, if 15 years earlier you had been able to have the tools to diagnose your husband's Alzheimer's symptoms and so on, what difference would that have made to both of you in your lives if you had really known earlier and been able to get the care that you could have had at that time?

Mrs. LEHMANN. It would have been tremendous, just absolutely tremendous. By the grace of God, I am still standing. That is how I feel. This last 15 years has been very, very difficult.

It is the love that we have for each other that has truly sustained us. It is our faith and our family. Without those elements, I cannot imagine having been through this.

Just going to the myriad of doctors and neurologists, whom we expected would know or be knowledgeable about Alzheimer's, but were not, I was hoping at the time, when I was looking for the second neurologist, that there was just a guide in the yellow pages that would say "specializes in Alzheimer's." And the Alzheimer's Association was able to get me a list of doctors who did specialize, but it was later in the process.

Senator STABENOW. And it should not be that hard. It should not have been that hard.

Mrs. LEHMANN. No, it should not. It should not. And if only a doctor—one of the very first doctors we had seen had referred us to the Alzheimer's Association. It was actually a friend in California who called and said, "How are you doing?" And when she heard how I was not doing, she said, "Call the Alzheimer's Association. My dad had Alzheimer's, and they were such a help to me. Maybe they will be a help to you."

So here is another instance of the caregiver help line, which I now refer to as my caregiver lifeline, being the beginning of the change.

Senator STABENOW. That is a wonderful group.

Mr. Chairman, I know you know this, but just for the record, let me say that one out of five Medicare dollars goes to the treatment

of Alzheimer's, one out of five Medicare dollars. This is a huge issue, predominantly of quality of life and life itself, but it is also a huge issue for us in tackling costs.

So I very much appreciate your doing this. And also, again, Ms. Dempsey, thank you for being here. I mean, listening to you, it is overwhelming just listening to you and just unbelievable what you are challenged with. So thank you very much for taking the extra effort to come and share your story.

Ms. DEMPSEY. Thank you for your dedication.

The CHAIRMAN. Thank you, Senator Stabenow.

In addition, Mrs. Lehmann, you should know that Senator Toomey has spoken to us about Alzheimer's, as has Senator Warner, and there will be very strong support in this committee on both sides of the aisle for reforms on Alzheimer's.

Before I recognize Senator Isakson, your Senators, Mrs. Lehmann, Senators Klobuchar and Franken, would like to submit statements for the record.

I ask unanimous consent that the statements be submitted for the record.

Hearing no objection, so ordered.

[The prepared statements of Senators Klobuchar and Franken appear in the appendix.]

The CHAIRMAN. We very much appreciate the good work that Senator Isakson has done in this area. He has been my partner now for many, many months. When you work with Senator Isakson on health reform, you are running with the right crowd. So I am very appreciative.

Senator Isakson, your questions?

Senator ISAKSON. Thank you, Mr. Chairman.

Dr. Bornstein, thank you for your testimony, and thank you for coming to our rollout here. I guess it has been a year ago now since you came up on the coordinated care.

Your testimony was very compelling on one point, and I want to kind of repeat a part of it. Your embedded care—what did you call it: care coordinators or nurses? Is that correct?

Dr. BORNSTEIN. Yes, sir.

Senator ISAKSON. You are not reimbursed through any system for those nurses, are you?

Dr. BORNSTEIN. Correct.

Senator ISAKSON. But you use them to coordinate the care of your patients. Is that correct?

Dr. BORNSTEIN. Yes, sir.

Senator ISAKSON. Which lessens the number of visits on a fee-for-service basis for which you are reimbursed.

Dr. BORNSTEIN. Yes, sir.

Senator ISAKSON. So, in other words, it costs more to do less and less to do more.

Dr. BORNSTEIN. Yes, sir.

Senator ISAKSON. So, if we were doing more care coordination, we would be in much better shape financially as a country, and we would lessen the burden of health care and improve its quality. Is that correct?

Dr. BORNSTEIN. Exactly.

Senator ISAKSON. If Ms. Dempsey was your patient and you had an embedded care coordinator in the practice, would the, not misdiagnosis, but the improper prescription of the drug for rheumatology that affected the seizures have been caught by the care coordinator or by health information technology?

Dr. BORNSTEIN. Well, I think the care coordinator could certainly play a role in that. Our information system would help alert us to that. I also believe in the important role of primary care—as in the earlier discussion—the fact that we need somebody who is kind of captaining the ship and looking at all those pieces.

But I think there is another element, and the dependency on third parties coordinating care, we need to have that built in, but we also need to have all of the individual specialists thinking about care coordination through the process of care.

So, to give you an example, it is very similar to what Ms. Dempsey talked about, and I use a kind of a litmus test for how our system is performing. So, when I take care of a patient with diabetes who might be seeing another specialist, and that specialist considers starting the patient on glucocorticoids, an anti-inflammatory drug that raises the blood sugar, the best thing is for that specialist to coordinate with me and plan around the effects of that medication on the blood sugar, so that is similar to the case of the medication that might increase the risk of seizures.

The question is, how often does that happen, and the answer, in my experience, is almost never. Occasionally, the specialist will ask the patient to let me know about this, putting the burden on the patient to coordinate the care.

So I think we know that most of these individuals are hard-working, well-intended, and care about the entire patient, but the burden of our fee-for-service structure is such that there is relentless pressure to see patients face-to-face and no real provision for the type of activities that need to go on when patients are not there, the conversations that the specialists need to have together that complement having care coordinators and primary care providers as well.

Senator ISAKSON. Well, your testimony affirms what the chairman and I have been talking about, and that is that you can improve quality and lower the cost of improving the quality at the same time by coordinating care for people with multiple chronic illnesses.

Dr. BORNSTEIN. Yes, sir.

Senator ISAKSON. On Alzheimer's, my mother passed away from Alzheimer's, and I was her caregiver for the first 2 years after my father's death, and one of the things I remember that aggravated Alzheimer's was when we would have to take her to a physician or take her to a medical appointment and take her out of her surroundings where she was staying.

Do you experience that, Mrs. Lehmann?

Mrs. LEHMANN. Ken is still early-stage, but I definitely know that that is something that is very common with persons who have Alzheimer's. It can be very difficult, and it can result in behaviors that we do not see on a day-to-day basis necessarily.

Senator ISAKSON. A care coordinator can help avoid the number of visits you have to make to individual physicians, which aggravates Alzheimer's tremendously.

I remember from my mother's situation that she would go from a very docile individual to a very agitated individual because she was outside the surroundings that she was still familiar with when she was in my home.

Mrs. LEHMANN. Exactly, yes.

Senator ISAKSON. Mr. Chairman, the testimony by both Mrs. Lehmann and Dr. Bornstein certifies what you have said all along, and that is, if we can do a better job of incentivizing coordination, the best by-product is better care, but it also is less cost, and I think the testimony we have heard today verifies both of those things.

I want to thank our witnesses for being here today. And welcome to Georgia, Ms. Dempsey. We are glad to have you here. I have a house about two counties over from you, in Rabun County. It is God's country, and we are glad to have you there.

Ms. DEMPSEY. My mother calls it God's country too. Thank you. I appreciate that.

Senator ISAKSON. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. I would just tell our guests that you often see Senators kind of engage in this bouquet-tossing contest where they say nice things about each other, but on the bill, the bipartisan bill that is here in the Senate and in the House—the Better Care, Lower Cost Act—that was Senator Isakson who, from the get-go, really saw that as the frame around which to build.

So we very much thank Senator Isakson for his leadership.

Senator Bennet is next. And I will tell you, Senator Bennet has been running in and out of this room trying to figure out how to juggle meetings and still be here to tackle these issues because he cares very much about it.

Senator Bennet?

Senator BENNET. Thank you, Mr. Chairman.

The nice thing I would like to say about my colleague is "thank you" to Senator Isakson for not using all your time. That never happens around this place. [Laughter.] They should build a statue to you.

Senator ISAKSON. I am just coordinating better. [Laughter.]

Senator BENNET. Mr. Chairman, thanks.

And thank you all for the testimony. It is very, very consistent with what I have heard from patients and others in Colorado. I am delighted that this important topic is before us today.

Dr. Bornstein, I have, I guess, a couple of questions for you. Senator Grassley and I, as well as others on this committee, have been focusing recently on how to improve better care coordination for children with chronic conditions who are often overlooked and suffer tremendously as a result of that.

I am sure you encounter this at your hospital, children with medically complex conditions. I wonder if you could talk a little bit about the challenges that they face and the improvements that you have put in place to deal with our kids.

Dr. BORNSTEIN. Well, care of children at Emory is a separate endeavor, but I know that the same principles apply. Whether you

are a kid or an adult, when you have multiple medical conditions—are on numerous medications, seeing various medical specialists—coordination is not going to occur spontaneously. It requires extra energy and effort. It requires, in particular, the allocation of time to do that.

I think, as we discussed earlier, there has been lots of hope placed on information technology, and I think, given the complexity of the care we now render, information technology is absolutely crucial. It is necessary, but not sufficient. By itself, it will not solve these problems.

Senator BENNET. Our sense is, even beyond just the institution of a hospital, if we could figure out how to create a set of conditions where the children's hospitals across this country were able to work closely—

Dr. BORNSTEIN. I think that is true for adult care as well.

Senator BENNET. Yes.

Dr. BORNSTEIN. While we have our own integrated medical record—and that accomplishes quite a bit—as soon as they see a provider outside of our network, most of that information is invisible to us.

Senator BENNET. You had mentioned in the discussion with Senator Isakson the problematic results that we face because we are enslaved to this fee-for-service system. I wonder if you could talk a little bit about other ways in which the Federal Government and private insurers create incentives that are not only not helpful to you, but drag you in a completely different direction from where you would like to go.

I realize that is a big question, but since you are here and we have the folks who are, in theory, going to be making some of these decisions, think big, do not think small. If you were in the Senate, what are the handful of things you would do to make your life less of a misery?

Dr. BORNSTEIN. Well, let me actually try to address that from two altitudes. It is a big question.

Senator BENNET. I am not implying that your life is a misery, but to the extent that we cause these problems— [Laughter.]

Dr. BORNSTEIN. No, no. Well, let me say at the outset, I think the fact that we are having these conversations is really important, and I have great hope for the future and what is possible.

As I said in my testimony, this should be a wonderful time for patients and for caregivers, given all of the wonderful things we have to offer, and if we can just break through the barriers and improve the structures, I think we can deliver on that promise.

At the granular level, one big concern I have relates to how quality measures are used. So, with every quality measure and with every implementation, there are always unintended consequences. That is just the nature of the universe, more or less. But I think what is particularly important when we think about these quality measures is, what are the unintended consequences and how can we continually improve them?

So, for example, when Ms. DeMars was talking about physician profiling, which I support, we need to make sure that severity adjustment is built into that. So, if I am an endocrinologist at Emory taking care of the most complex patient with diabetes, whose meas-

ures of glucose control may not be as good as some patients with less complex diabetes, how do we account for that, because, if we do not, what we will do is undermine the important efforts that are devoted to those patient groups in need of the most complex types of care.

At the other end of the spectrum, if you would ask me for some thoughts about how we change all this, again, I think the payment structure is a big issue. We desperately need a system in which we have time to put energy and effort into coordination of care and use all of these tools that we are now developing.

So for patients with diabetes, more and more of that care can be delivered when the patient is not there. It needs to be continuous care. So their blood sugars can be transmitted to me if they choose to have that happen, and I can have a more continuous relationship. Within our current structure, if I spend my time doing that, I am going to go out of business and, obviously, no margin, no mission.

I also think there is a way to think about how we develop quality measures that reflect coordination of care. And this may get me in trouble with some of my colleagues, but it is a concept I have kind of thought about that, in a way, is joint and several liability.

So, if a patient has a group of medical problems, my thought is that each of the providers taking care of that patient ought to be responsible for all of the measures of quality that patient needs. So, if they are seeing me for diabetes and an orthopedist for back pain, I ought to have some accountability for the back pain, and the orthopedist ought to have some accountability for the diabetes control, because, after all, what each of us does has an impact on the whole patient.

The CHAIRMAN. Thank you, Senator Bennet. And thank you for all your efforts on this over the years. I look forward to working with you.

Senator Warner is another committee member with a long-standing interest in Alzheimer's and chronic disease. Let us recognize him.

Senator WARNER. Thank you, Mr. Chairman. Thank you for holding this hearing. I know it is just the beginning of a series of hearings on this subject.

I know you raised the issue after hearing Mrs. Lehmann talk, and I think probably all of us have a personal story. My mom had Alzheimer's for 11 years, 9 of which she did not speak. My father was the primary caregiver, along with my sister, a journey that was much harder than anything else I have ever done, and I have enormous respect for both of them for what they did.

That has driven me, from my tenure as Governor and now as Senator—and we keep giving shout-outs to Johnny Isakson, but Johnny Isakson and I have taken another piece of this journey. I know Senator Bennet talked about children. You and Senator Isakson have talked about chronic disease. Senator Isakson and I have talked about and introduced legislation focused on advanced illness and that component of life's journey.

And where I want to start, I think, with Mrs. Lehmann, Dr. Bornstein, and anyone else, is, I think Dr. Bornstein just raised some interesting things about joint and several liability, which is

an interesting concept, an interesting idea. I am sure that some of your colleagues' heads exploded when you just said that.

But prior to that kind of tail-end responsibility, one of the things at the front end is how you set up a care plan. I would like any of you to address this notion of, first of all, how we can do a better job of setting up these care plans to make sure that all of the not only medical providers, but other stakeholders in the individual's life, particularly as we look at advanced illnesses, are engaged, whether that is social workers, hospice, or others, number one.

Then number two, if you could comment on what we from the legislative side, kind of the mirror image, if I am more at the other end of life as Senator Bennet spoke of, what we in Congress can do to advance that goal of having these care plans carry weight.

One of the things that Senator Isakson looked at and I looked at is just having these kind of advanced directives or other tools be recognized across State lines. We heard from our first witness, in her movement from South Carolina to Georgia, the advanced directive she had would not be honored in many instances across those lines.

Mrs. Lehmann, do you want to start—and then other members of the panel—on care plans, both what we can do from kind of the stakeholder standpoint and then from the Congress standpoint?

Mrs. LEHMANN. I have to say that this is a new concept for me. I have been, as I mentioned, the operations manager. I have been the care planner, and I have not gone as far as to make a wish list for what could be, because I am dealing with the day-to-day—

Senator WARNER. Right. You are still living it.

Mrs. LEHMANN. I am indeed living it. But I think it would be so very helpful just to even have someone to coordinate with. I would not mind making the calls if someone would tell me where I should call, whom I should call.

It is a myriad of lots and lots of resources, and I have access to them. I have loads of booklets from the Senior Linkage Line in Minnesota. I have so much wonderful information, and I look at it and I am overwhelmed.

Senator WARNER. Mr. Chairman, one thing I might mention that we started a decade ago, before I was even Governor in Virginia—based upon my own family experience—was, we set up something called *Seniornavigator.com* that answered those kind of questions, but also provided those kind of resources drilled down to zip code level, because so many caregivers or others just do not know where to turn. But that is one of the tools that could be put in the toolkit.

Dr. Bornstein, do you want to address this?

Dr. BORNSTEIN. Yes, sir. Well, I think you put your finger on some very important opportunities.

So, from the standpoint of care plans, I think what we are making good progress on is care plans for diseases. So patients with multiple diseases will have a diabetes care plan, and a coronary artery disease care plan, and so forth.

What we need is a care plan for all of those diseases, an integrated care plan designed for that individual patient that takes into account all of their illnesses.

Again, I think that will not happen without a payment structure that does not solely reward visits. It requires one that will reward those kind of efforts for producing better care.

Senator WARNER. So you do not think it is a rational system where we compensate a medical professional treating someone with advanced illness for repeated tests, but refuse to compensate that same medical professional for sitting down and actually talking through with the family this stage of life.

Dr. BORNSTEIN. Exactly. In fact, we have a very successful palliative care program at Emory, but what they tell us is that the conversations they need to have with patients and families take a long time, and, even under the current palliative care reimbursement codes, they are not able to sustain themselves.

I personally think that there is a great need for more of these conversations to occur outside of health care facilities. You are probably familiar with Ellen Goodman's Conversation Project. These are hard conversations. Even very sophisticated families will often do everything they can to avoid the conversations. But there are tools out there, and we could do a better job of promulgating those tools.

Again, this goes way beyond health care systems. It is kind of a public health opportunity.

Senator WARNER. And one thing I just would mention there. I know my time has expired. But oftentimes the doc may actually be as uncomfortable having the conversation as the family.

Dr. BORNSTEIN. Absolutely. Absolutely. And the different specialists may be on different pages, and they need to have those conversations together as well.

Senator WARNER. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Warner. And our guests should know that, in addition to always raising these important issues, what Senator Warner has described dovetails very well into a very large demonstration project that is going to be beginning shortly and will run through CMS, called Medicare Care Choices. And, for the first time, this would allow patients to have an option between curative care and hospice care, which in the past has not been permitted.

All the applications are in, and they are making the decisions. So this is about to be rolled out shortly, and I think it dovetails well with the important work Senator Warner is talking about.

Senator Casey?

Senator CASEY. Mr. Chairman, thank you very much for the hearing, and I want to thank you as well for sharing your own personal story about your mom.

I left here a couple of moments ago and had a meeting about a whole set of other topics, foreign policy, and the person in the meeting, when I told him where I was going back to, he said, "I have a 94-year-old mother, and she is the equivalent of a concert pianist. And she is 94 and she has Alzheimer's, but she can still play very well, and yet other parts of her life are more complicated."

So it affects so many families. Senator Warner and others have spoken to this over many years.

I will direct my questions not to Ms. Dempsey and Mrs. Lehmann—and I do not do that for any other reason than that I have limited time—but I am especially grateful you are here to provide your own personal testimony. It is not easy to talk about your own lives in a public setting like this, especially something as challenging as this. So we are grateful for your presence and your testimony and the information we derive from it.

I will start with Ms. DeMars. I wanted to talk about the question of MS, in particular. We know—and this is known to medical professionals—that MS is a serious, debilitating disease in which a patient's immune system eats away at the protective covering on the nerves. We know that the treatment for MS is highly individualized, and that is why I ask you the question. Because, even though it is complicated and difficult to deal with, we know that proper management can yield great results in reducing symptoms, slowing disease progression, and improving quality of life.

So I guess the basic question I have for you is, when you look at what plans and employers are doing, how do employers select plans that ensure that patients with MS and other chronic conditions have access to the full range of available therapies? Could you speak to that?

Ms. DEMARS. Sure. Thank you, Senator Casey.

Senator CASEY. And I should say, at a reasonable cost.

Ms. DEMARS. Well, that is a tricky part too.

Our members are self-funded employers. So I will speak from that perspective. We understand that the health of our workforce is directly related to our business results, and so we share an interest in ensuring that our employees and their family members get the right care.

Increasingly, employers are looking to the science, looking to research, to help them understand what they should be covering and at what levels, to ensure optimal health. Value-based benefit design is the nomenclature that is being used to refer to the practice of providing clinically sensitive, clinically nuanced coverage for employees. So the science related to MS would be something that would factor into a self-funded employer's design of their benefit plans to ensure adequate coverage for that condition.

Senator CASEY. Is there anything you would hope we would do to either further incentivize or facilitate this kind of approach to MS, or do you think we are on the right track?

Ms. DEMARS. Well, maybe I could just speak more broadly than specifically to MS. I think the PCORI* research has great promise to help us understand the relative value of tests and treatments that we can begin to factor into how we provide coverage.

Senator CASEY. Thank you very much.

I want to turn to Dr. Bornstein and the question of the socioeconomic status of beneficiaries, which, like everything, has an acronym: SES. There has been a lot of discussion and a lot of recent research on how the socioeconomic status of an individual can affect both outcomes and health.

You know from the work of the committee and from your involvement with these issues that delivery system reform is a huge pri-

*Patient-Centered Outcomes Research Institute.

ority for us and a major topic. Sometimes what is less often discussed is something I am sure you and others have seen as kind of a growing body of research and evidence that racial and ethnic minorities and people with lower average incomes often receive lower quality of care than folks in other income or racial categories.

Can you speak to that in the context of—I guess the basic question is, do you think there is a utility and a need to include these kinds of what might be called socioeconomic status factors when determining health care policy? I know it is kind of a broad question.

Dr. BORNSTEIN. Yes, sir. I think absolutely a critical element of improving health is addressing the socioeconomic disparities. Right now, there is debate going on as we speak around risk adjustment for hospital readmission rates related to socioeconomic status, and I think that kind of illustrates the case very well.

From a hospital standpoint, the hospitals that serve the more disadvantaged populations typically have higher readmission rates. As you know, much of what happens—

Senator CASEY. And they can be penalized because their rates go up, even though they have a more difficult challenge.

Dr. BORNSTEIN. Absolutely. So much of what determines the likelihood of readmission occurs after the patient leaves the hospital. And so their home situation and their access to care and their support structures have a significant impact on that. To penalize those hospitals for things that are very much out of their control would have the unintended consequence of a further deterioration of their economic viability in terms of providing that care.

By the same token, that needs not to fall off the country's radar screen, because this is a problem, and the fact that the disadvantaged have higher readmission rates and worse outcomes does need to be addressed. But the question is, does that need to be addressed by the individual hospital which they are just being discharged from or some other element of society? So I think it is a critical consideration, and we need to never forget about it.

Senator CASEY. Thank you very much.

The CHAIRMAN. Thank you, Senator Casey. And I know you have talked to me about these chronic care issues, particularly in the context of kids, a number of times over the years, and I very much appreciate your advocacy.

We are joined by Pennsylvania's other Senator, Senator Toomey.

Senator TOOMEY. Thank you very much, Mr. Chairman.

I want to thank all the witnesses for being here today.

I direct my question to Mrs. Lehmann. Your story is painfully familiar to so many Americans who are suffering through some variation on that.

I wonder if you could just give us some more thoughts from your perspective on how health care providers might approach care differently: the importance of coordinated care, the importance of whether that is a team or whether that is an individual. Your husband sees multiple physicians. Who should have that responsibility? Do you have any thoughts about how the focus of the care could be different and could be helpful to the patient and the caregiver?

Mrs. LEHMANN. I think among Ken's doctors, our neurologist is our most important person. Alzheimer's is our primary concern. It is fortunate that his atrial flutter is somewhat under control through medication. So he is able to thrive with it.

When someone asks, who is your primary doctor, I always say the neurologist, because in order to live well with Alzheimer's, it begins with him. It begins with how he helps to coordinate the health plan, which he has to a degree.

I think it comes in different portions or different compartments, but what he is looking at in particular is making Ken's life as rich and as powerful as it can be on a day-to-day basis. So he is a very important part of a program that Ken is in, entitled Living Well. It is run by the Alzheimer's Association, by the Wilder Foundation of St. Paul, MN, and by the Jewish Community Center, which has opened its doors to welcome us on their campus every week.

With that Living Well program is associated a caregiver cafe. So Ken and I go together, and this is very, very important. It is not a day program where I drop him off and I do my own thing, which once in a while happens, because they insist that we have some free time, and we all say "but we want to come, we want to be together, we want to have this time together." But we come together, we are a couple, we are supporting each other in this. He goes to his program where they learn about good diet, where they exercise, and where they do a lot of creative expression, which is turning out to be a very, very important part of living well with Alzheimer's.

So Dr. Rosenbloom has been very much a part of that. In fact, he comes to the Living Well program. He is a part of it as far as speaking to the caregivers, speaking to the persons with the disease. Also, the neuropsychologist from our center comes to answer questions about the disease for the caregivers, as well as for the persons with the disease. So that is an aspect which is very, very important in dealing with our daily living.

For me, dealing with finances—and the system—is another issue where I will need help further down the line. That is another triangle or another piece of the pie that I need assistance in, but I am so appreciative of the care plan that we have with our neurologist.

Senator TOOMEY. And does the neurologist sort of take responsibility for anticipating that, for instance, at some point, Ken is less able to communicate a discomfort or a problem that would be an indication of some other problem? So is he the point person for making sure that they are keeping up with what needs to be monitored?

Mrs. LEHMANN. He is. He is. In fact, at our last appointment, he addressed that very issue, just knowing that the disease is progressive and we will be looking at different living situations and so forth. So he has been the point person for that, for which I am very grateful.

Senator TOOMEY. Well, thank you very much. Thank you for coming and testifying today. We appreciate it.

Mrs. LEHMANN. Thank you.

Senator TOOMEY. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Toomey. We have talked about this issue, you and I, a number of times, and I look forward to working very closely with you.

Let me go to the next question. We will involve you in this, Ms. DeMars, as one of the payers and employers. We have talked a lot about Medicare, for example, which I put a special focus on. But chronic disease is often diagnosed well before a patient becomes Medicare-eligible.

In your view, what strategies can the committee pursue, again, in a bipartisan kind of fashion, so that when individuals age into the Medicare program, they are going to be healthier than they would have been otherwise?

Ms. DEMARS. Well, I think the transition to Medicare and the health status of people coming into Medicare, of course, is contingent upon the health care and the lifestyles that they are living prior to Medicare age.

So I am thinking about an answer to your question—how could Congress help promote better health pre-Medicare for people with chronic conditions? For employers, we focus on early detection. As I said earlier, we have a vested interest in the health of our workforce, and so we focus on things like health risk appraisals with biometric screenings, which oftentimes detect or identify undetected—

The CHAIRMAN. You all offer those biometric screenings?

Ms. DEMARS. Yes. Many of our member companies do annual biometric screenings at work, for a couple of reasons. The first is, as an employer, they want to understand the aggregate health of their employee population and use that baseline data as a way to monitor the impact of workplace-based wellness and health promotion programs.

But conducting those biometric screenings also provides individual information, confidential information, to each of the participants and, unfortunately or fortunately, oftentimes people are learning that they have a chronic condition for the first time through that biometric screening.

So early detection is key, and then optimal management once people are diagnosed. One of the things that The Alliance is doing is realigning how we pay physicians based on optimal care of diabetes, a measure that we are using. So that addresses early detection and only begins to address the need to realign financial incentives.

Then there is the complicated question of how we can help people live healthier lifestyles. Employers work on that because they have people there during the workday, but it is a much bigger issue than one that employers can tackle alone.

The CHAIRMAN. I very much would like to follow up with you and am glad you are working on the program, because we clearly want to see if we can come up with some fresh, creative ways to involve employers in this. I think we all understand that many of the underlying challenges patients face when interacting with the health care system are present both in Medicare and the non-Medicare population, and to the extent that we can find a way, as I describe it, to age into Medicare having played offense to the greatest extent possible—as you talked about with biometric screenings and the treatment kind of approaches—I think that makes a lot of sense.

So we are very interested in working with all of you, the employers.

Ms. DEMARS. That is excellent. I think there are great opportunities for alignment between public-sector and commercial employers that share the same interests in promoting health and optimal health care at an affordable cost.

The CHAIRMAN. Let us turn to another topic that is really not for the faint-hearted, but one we have to figure out how to make additional progress on, and that is how we ought to go about using this array of health information technology.

I call it the treasure trove that we now have of all this technology. It is electronic medical records, and ideally this would be good for patients because patients would have this information. It would be good for providers because it is going to help them do a better job of coordinating care.

Also, Ms. DeMars made a point that I am interested in about the Medicare claims data, and how you use that. So why do we not just see if we can bring the four of you into this discussion about the health information technology.

Let us start with you, Ms. Dempsey, and you, Mrs. Lehmann. With respect to your ability to access all this medical information from the various doctors, how is that working out? Is it a useful tool? Is it being shared? Is it hard to figure out whom to go to for what? Tell me your thoughts on that, Ms. Dempsey.

Ms. DEMPSEY. I do not know that it is hard to figure out whom to go to. Once you call the doctor's office and explain to them what you want, you may wait on hold while they try to figure it out, whom they need to get you to and in what hands, but, no, for me, I have not found that that is a problem or a difficulty.

The CHAIRMAN. You are able to get your hands on the information you need.

Ms. DEMPSEY. Not right at the time, but through a process, yes.

The CHAIRMAN. And it is fairly useful?

Ms. DEMPSEY. Yes. Sometimes I do not get exactly what I need that would be useful, but I do eventually.

The CHAIRMAN. And you, Mrs. Lehmann, tell me about your experience. I call it the treasure trove of data. Sometimes you almost wonder if there is too much. Tell me about how your experience is with respect to accessing all this information from your various doctors, and possibly if there are any suggestions you have on how the information could be more useful to patients like yourself, Ms. Dempsey, and others.

Mrs. LEHMANN. We have a binder at home, each one of us has a binder, and after the appointments with the neurologist, we take it home and get the 3-hole punch out and put the new paperwork in the binder. But that is the only medical report that we receive. Ken does not receive anything from the cardiologist, and, if I do not go with him, I have no idea what has transpired other than his relating to me what has transpired, nor do we get any record from the internist, who just makes a follow-up appointment but never gives any specific information from that appointment.

But I so appreciate when I do get that information from the neurologist. I am always there, but I also can review what has transpired, and any referral that he may give us, he puts down the

phone number. So everything that I need is right on those sheets. So that is wonderful.

The CHAIRMAN. So you are doing well with the neurologist. And on the cardiologist front and the internist front, things are coming up a little short.

Mrs. LEHMANN. Exactly.

The CHAIRMAN. Then let us get our providers and our payers into this whole question of health IT. I know, Dr. Bornstein, from being aware of your good work, that you all have put a lot of effort into trying to make health information technology work.

What do you think the big challenges are in terms of how we tackle this, and even apropos of Mrs. Lehmann and Ms. Dempsey? Ms. Dempsey said that she thought it worked okay but that sometimes it was hard to kind of pry it out, and Mrs. Lehmann had some areas where it worked and some where it did not work.

What do you think the next steps are in terms of health IT as it relates to chronic conditions?

Dr. BORNSTEIN. As you say, it is not for the faint of heart, and it is a big topic, but I think, exactly as you heard from Ms. Dempsey and Mrs. Lehmann, America is in a state of transition, and providers are at different points in that transition.

At Emory, we are all connected. We have a patient portal, and so patients can see their lab results. We can communicate with patients about those lab results, and that is a beginning.

Our goal is for the whole record to be available to patients, but it has to be done carefully, because sometimes not everybody wants to read everything that is in there, and that involves some additional research that needs to be done as to how best we use these tools.

But then, when you start moving across systems, there are all kinds of barriers, and while we can see everything that we are doing, frequently a patient will be seeing a specialist outside of our system. The patient may or may not be getting the information from that specialist, and we may or may not be able to get that information. So that is a major barrier. Meaningful use will help move people toward sharing of information, but it is a slow process, and it has had its own unintended consequences.

So I think more than anything, we need more research to understand how best to use this health information technology. Like everything else we have been talking about, there are unintended consequences to all of this. We need to learn how to be smart about it, but I think it is an important tool.

The CHAIRMAN. Thank you. I am struck that you characterized it as a patient portal. Mrs. Lehmann described it as her binder and the like. Obviously, we are going to have to try to figure out ways to make this tool user-friendly for both the patient and the providers.

I continue to hear from providers who describe this like a water torture kind of routine where they are up until 2 a.m. in the morning trying to fill out various and sundry kinds of records, and you just have this picture in your head. What this is all about is, we have providers up in the middle of the night trying to work on their charting. We need them ready to go at the crack of dawn to

give the kind of quality health care services that are so important to our patients and their caregivers.

So we are going to ask you some more questions, Dr. Bornstein, on this.

I was interested by what you said, Ms. DeMars, on this Medicare claims data. And as you know, Senator Grassley and I have been very involved in the initial efforts to make a significant amount of data available.

But what you are interested in doing is also extremely important, because you want to really get it down to the patient level, and we are going to have to figure out a way to make that doable so it protects the patient's privacy and the like.

Tell us, if you could kind of wave your wand as an employer, trying to deal with Medicare claims data down at the individual level, what would you be trying to do?

Ms. DEMARS. Senator Wyden, we are one of the founding members of the Wisconsin Health Information Organization, which is an all-payer claims database to which payers across Wisconsin and self-funded coalitions like The Alliance contribute data.

We are fortunate in that it represents 70 percent of the care for Wisconsin patients. The big hole is Medicare data, and, as Dr. Bornstein commented earlier, the task of getting physician-specific information is tricky and sensitive and critically important, and the more data we have to work with, the better we will be able to do.

In addition, we need clinical information in addition to claims data. We have made a significant investment as a country in health information technology and health information exchange, and we look forward to the day when clinically important indicators can be fed into the administrative claims data to allow us to do a much more sophisticated job of risk-adjusting performance measurements to take into consideration some of the things that Dr. Bornstein mentioned.

The CHAIRMAN. You all have been a terrific panel and have given us a whole host of valuable ideas. I have been scribbling away, as you can see.

Two hours in, let me kind of give you my take with respect to where we are. And I think your testimony has been so valuable, and you could see Senators on both sides of the aisle—nobody talked about what is the Democratic approach to deal with chronic disease, what is the Republican approach to deal with chronic disease. You had Senators on both sides of the aisle saying, let us talk about what is practical, what is fair, how is it going to be user-friendly for patients.

I will tell you, my own judgment is that chronic disease has really gotten short shrift in the debate with respect to health care in America. It has gotten short shrift in the big debates.

I do not think it happened deliberately. I see absolutely no evidence that a Senator got up in the morning and said, I want to be rotten to those with chronic disease or, I do not want to pay any attention to this. I think what happens in the Congress is, you get up and there are a whole host of issues on your plate and off you go for 12 or 14 hours, try to tackle them, and a lot gets lost.

I think what you heard today from Senators, again, on both sides of the aisle is, those days are over. Those days are over when

chronic disease gets short shrift. And you saw determination among Senators to look at both the under-65 population and the over-65 population. I came to this initially in terms of the over-65 population for a variety of reasons, for instance, my background working with the Gray Panthers.

Ms. DeMars, also, Senator Portman and I have introduced something called the Medicare Better Health Rewards Program, to create incentives for those on Medicare to lower their blood pressure and lower their cholesterol and quit smoking and the like.

So that is where I started. But what you heard today from Senators is that they very much understand that link between the under-65 population and the over-65 population and the need to try to put in place what amounts to a seamless web of services so that, in effect, as I touched on with you, Ms. DeMars, when an American ages into Medicare, you will have already begun the heavy lifting.

I could go right down the row with each one of you and thank you for the specific contributions that you have made, and, because I have worked primarily with patients over these years, since before I got elected to Congress, I am leaving with that picture, Ms. Dempsey, of all those trays and trying to imagine what it is like every single day, day in, day out, to make your way through this—and you have been dealing with it for a long time.

To you, Mrs. Lehmann, thank goodness we have caregivers for Alzheimer's patients. My mom got to go to a wonderful, wonderful facility, Channing House in Palo Alto, CA, where they did a great job. I am a Senator and this is the area I specialize in and, my goodness, so many patients do not have what your husband has. So thank goodness for you.

Dr. Bornstein, you have been with us—Senator Isakson and I—since this journey began, and we very much appreciate the good counsel you have given us.

To you, Ms. DeMars, we had not met before today, but you surely account well for the employers. I know Senator Hatch urged us to have you on the panel, and I am surely glad that he did.

So the days when chronic disease got short shrift in the debates about health care in America and in the Congress are now, with this panel, officially over, and you all have been present to get this launch off in the right direction.

So I thank you. God bless. The hearing is adjourned.

[Whereupon, at 12 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD



**Testimony of William A. Bornstein, MD, PhD
Chief Medical Officer and Chief Quality Officer
Emory Healthcare
Emory University, Atlanta, GA
Senate Finance Committee Hearing
“Chronic Illness: Addressing Patients’ Unmet Needs”
July 15, 2014**

Thank you, Chairman Wyden, Ranking Member Hatch, and members of the Senate Finance Committee, for inviting me to discuss Emory Healthcare’s efforts related to caring for our chronic care patients. I also wish to extend a special thanks to Senator Johnny Isakson who is Emory’s Senator. He is a good friend and strong supporter of our work.

As the chief medical officer of Emory Healthcare in Atlanta and as a practicing endocrinologist, I know firsthand the challenges faced by our patients with multiple chronic medical conditions. Let me give you an example that is typical for my diabetes patients. Most patients with diabetes have other medical problems, like hypertension, coronary disease, kidney disease and other often related medical problems. Many of these patients see multiple specialists—they may be seeing me for diabetes care, a cardiologist for their coronary artery disease, a nephrologist for their kidney disease, etc. Everything each of us does affects the whole patient. Many problems, like elevated blood pressure and elevated cholesterol, overlap each of our specialties. The challenge is in how we make sure all the care is coordinated.

Coordination of care requires more than technology and good intentions—it requires re-allocation of time away from face-to-face interactions with patients to devote time to coordinate efforts among providers and allow for more non-face-to-face (phone, email, etc) interactions with patients. At Emory, each of us involved in the care of these patients attempts to address their problems in a patient- and family-centered way. However, the real challenge is coordinating this patient-centered care to take into account the whole patient. Technology, especially the electronic health record, is an important tool. At Emory, we have a highly sophisticated single electronic medical record system spanning our hospitals and

The Robert W. Woodruff Health Science Center
Emory University
1440 Clifton Road NE, Suite 400
Atlanta, Georgia 30322

Tel 404.727.5390
Fax 404.778.3100

An equal opportunity, affirmative action university

outpatient clinics, so all providers can see the entire medical record. Yet, technology alone will not be sufficient to achieve the levels of care coordination we are seeking. So, in addition, we are hiring and training nurse care coordinators. We embed these nurses into primary care practices and feed them data that identifies high-risk patients. These nurses work with those patients who have the greatest risk of a downward spiral of health, based on the types of diseases they have and recent emergency room visits and hospitalizations. The nurse coordinators then stay in touch with those patients and help them get their medical needs taken care of proactively. At the same time, we are helping primary care practices become "medical homes," a practice model in which care coordination is an intrinsic feature.

We have our own patient-centered medical home, the Emory Patient-Centered Primary Care Clinic. This is a practice model that aims to improve the overall health care experience by creating a new care model emphasizing personalized, evidence-based medicine and greater coordination of care. By enhancing access to care, we can reduce expensive and unnecessary utilization and close gaps in care, such as proactively recognizing and treating diseases like diabetes or hypertension before they get out of control. Using a team of healthcare professionals devoted to providing general healthcare needs, the Patient-Centered Primary Care Clinic provides both preventive care and management of ongoing complex illnesses. The goal is coordination of care to keep our patients healthy and mitigate rising risk in those who have early- or mid-stage diseases. We are using the expertise we have developed in building this clinic to help the other practices in our network become equally effective medical homes. In a fee-for-service payment system, the extra costs entailed in care coordination are not reimbursed, and the reduction in face-to-face patient time would result in adverse financial consequences for the provider. In other words, the cost savings that such efforts achieve accrue to the payer at the expense of the provider. We need payment structures that facilitate and reward these activities, rather than those that reward doing more to patients (tests, procedures, etc.) independent of outcome.

Let's take a look at the costs of and reimbursements to our Patient-Centered Primary Care (PCPC) Clinic. EHC's FY2014 projected per-member per-month (PMPM) care coordination fee for the commercial (Emory Aetna plan) enrollee population is \$365,000, with 35,437 total member months. This is the PMPM care coordination fee that Aetna pays (via the Emory self-insured Health Plan) for the PCPC population. In terms of cost for additional resources (i.e. care coordinator, non-fee-for-service activities, etc.) this PMPM is intended to subsidize those resources/time/activities. In FY2014, we are projected to have a positive net operating income of \$134K. Without the \$365K PMPM, EHC would run a loss of approximately \$231K (or ~\$85K loss per provider FTE). For FY2015, EHC is budgeting a PMPM care coordination fee of \$440,000, with 42,718 total member months.

At Emory Healthcare, we care for the most complex patients in Georgia, and as a leading academic health center, we care for some of the most complex cases in the country. We do our best within, and despite, the constraints of the current options. Emory has a large group of patient and family advisors to help us

understand what is important to patients about access to care, how they want their care coordinated, and how to involve their loved ones in decision making. We hear from patients that they want to feel that someone is thinking about them as a whole patient. They know each of the specialists is very focused on the individual diseases they are treating, but they often feel like nobody is thinking about how to put the pieces together in a coordinated fashion. So, our patient and family advisors are routinely invited to sit in on high level, decision-making committees. We want their input to be heard so as to positively affect our value-based care transformation.

At Emory, we have formed a clinically integrated Emory Healthcare Network (EHN), which provides extensive infrastructure and support for physicians in a collaborative and quality-based environment to drive outstanding performance, improve care coordination, enhance quality outcomes, and control costs for our patients and our community. The Emory Healthcare Network includes all of our faculty and employed physicians, as well as high quality private practice physicians, and encompasses our own hospitals, as well as affiliated hospitals. The EHN is our accountable care organization (ACO) through which we are contracting with payers in ways that liberate us from the constraints of fee for service and move us toward better alignment of needs among patients, providers, and payers. We now have a “shared savings” contract with Blue Cross Blue Shield and are negotiating similar contracts with other commercial payers. Under this contract, if we are able to lower the total cost of care through better coordination of care, we share in the savings. This is important because, as noted earlier, better care coordination requires a large and continuing investment and may also reduce revenue to the provider. Shared savings can help offset provider costs invested to improve patient care. A key feature of these contracts is that savings are shared with us if, and only if, we achieve mutually agreed upon quality goals. Running the EHN costs in the range of \$6 million to \$10 million dollars annually. The American Hospital Association has estimated that, for a five-hospital system starting an ACO, the start-up cost is about \$12 million and the annual operating cost is about \$14 million.

Our own medical home (the PCPC clinic) was started as a new practice intentionally designed to manage populations of patients, rather than acute care episodes. However, in our network, we have more than 80 primary care practices that need to learn new population management skills, such as disease registry management and collaborative goal setting. They also need to learn how to move from a physician-centric care delivery system, which focuses mostly on the patients who come to the office, to an entire care team, whose focus is the entire panel of patients whether they come to the office or not. As our evidence-based medical knowledge has exploded, it is now beyond the individual provider's capacity to provide all the services and interventions needed by patients with chronic conditions. A recent study demonstrated that it would require 2 ½ primary care physicians to provide all the care indicated by the medical evidence for health maintenance, care of chronic conditions, and any acute care that their patients may need.

As our network has embarked on value-based contracting, we have an urgent need to manage not just our chronic-care patients but also those of the

highest complexity who have recently been hospitalized, frequently use the emergency department, or otherwise have great needs. To meet their acute needs, we have invested almost \$880,000 for care coordinators in primary care practices. This cost will exceed \$1 million annually as our attributed populations grow from 42,000 to more than 200,000 in the next five years.

So that our other primary care practices develop the skills and expertise to manage populations of patients like our Patient Centered Primary Care practice, we are also spending nearly \$250,000 annually for the next five to seven years in training. In this way, our practices will have the innate capacity themselves to manage more complex patients, rather than relying on the more expensive care coordinators.

Data and analytics are vital tools for effective population management. However, traditional electronic medical records do not effectively aggregate and display population-level reporting with data from disparate sources. As a result, it is necessary for our network to invest more than \$5.6 million over the next six years to gain the capacity to use data generated anywhere across our network to manage our attributed population.

However, we do not know whether new payer alignments will allow organizations such as ours to remain fiscally solvent and able to provide high quality care. This is especially true for organizations that care for patients who are challenged by suboptimal socioeconomics, including dual eligible beneficiaries. These patients often require more intensive, community based, outreach tactics so that care can be delivered in their (sometimes shocking) home environment. Some organizations, like CareMore (now owned by Wellpoint) have excelled in caring for these types of patients, but they have only been able to do within a framework of payer realignment. Some elements of payment reform, which have not been forward-thinking, have threatened such precarious successes. A significant portion of these patients include the aging, baby boomer, Medicare beneficiaries who will begin to suffer from co-morbid neurodegenerative diseases and other brain disorders, such as Alzheimer's, Parkinson's, and depression. Emory is heavily investing in a Brain Health Initiative to innovate the way we care for these patients, both in our own network and as a model to share globally. One of the projects receiving major focus is the dementia medical home, an advanced practice provider-led care model in which geriatric care coordination and caregiver education are central tenets. Our goal is to positively shape this challenging healthcare landscape.

Data sharing among providers is another important element in care coordination. Emory is investing heavily in its own health information exchange (the Emory HIE) to connect the Emory electronic medical record system (EMR) with EMRs in other hospitals and physician practices. Connecting to the Emory HIE is a requirement for participation in the Emory Healthcare Network but entails considerable expense both for Emory and for physician practices in its network. Over the past year, Emory has begun "on-boarding" the EMRs of other private practices in its network to its health information exchange. The goal is for doctors to be able to access current patient records wherever and whenever the patient is

seen, thereby avoiding duplication of testing, providing ready access to the patient's entire medical record, and thereby improving quality of care. The HIE also provides us with better clinical data to drive analytics that we use for continual improvement of quality and cost-effectiveness across the network.

In February, Emory became the first provider to join the Georgia Health Information Network (GaHIN). Now most major provider systems in Georgia have become GaHIN members or are in the queue to connect. This private nonprofit serves as a hub for Georgia providers to share patient data securely with one another. GaHIN connects health-related state agencies, service-area health information exchanges, hospitals, clinics, physician practices, long-term care facilities, payers, labs, pharmacies, and academic health centers, and just recently, a nonprofit, public-private collaborative that operationally supports the national eHealth Exchange. Due in no small part to Emory's efforts, the Centers for Medicare and Medicaid Services recently identified Georgia as one of the leading states in health information exchange.

Our physicians, nurses, and staff make heroic efforts every day but are frustrated by a payment system that is focused on individual encounters and procedures rather than long-term relationships that continue to exist between office visits and hospitalizations. Emory has been remarkably successful in working within the current constraints. As an academic medical center, we take care of the most complex and highest acuity patients and we make major contributions to discovering better treatments and training the caregivers of the future. Emory is the only health system in America to have more than one hospital ranked among the top 10 in the prestigious University HealthSystem Consortium Quality and Accountability Scorecard. Indeed, both of our eligible hospitals, Emory University Hospital and Emory University Hospital Midtown, have been in the top 10 for the past two years and are currently ranked No. 2 and No. 3 respectively. We are proud of this achievement, most importantly because of what this means for our patients. However, we are by no means satisfied. We need to apply and extend these achievements across the continuum to achieve the triple aim—better health, better health care, and lower costs—for the population we serve. We can only achieve this through better coordination of care. It takes significant time and resources to coordinate care and these efforts are not only *not* reimbursed under current payment models but are actually *penalized*. The payment deficit resulting from the current payment system goes beyond stressing our provider capacity to adversely impacting our technology and infrastructure capabilities. On top of this, Medicare provider payment cuts, like the 2% sequester cut, make care coordination even more challenging. The lack of a fix to the current physician payment formula—the Medicare sustainable growth rate—is similarly a major threat that, in the long run, will directly impact Medicare beneficiaries.

Our patients need care plans that encompass all of their medical needs and that are carried out by multi-disciplinary teams, members of which are all operating at the top of their licenses (nurse practitioners and physician assistants applying the full extent of their training, for example). Such plans need to be implemented continuously, not just when patients are physically at our facilities. Fee-for-service

payment models and highly complex regulations create barriers to what we are trying to accomplish. CMS's accountable care models, which are meant to coordinate care, are stymied by the patient attribution method in which providers often do not even know the patients for whose care they are responsible, making it nearly impossible for them to optimize quality care and reduce financial risk.

Our physicians and staff desperately want to take better care of these patients—that's why we practice medicine. Current structures create frustration among our providers as well as our patients. Our primary care teams feel these frustrations most acutely.

The stress felt by our teams is indicative of what is happening nationally. One result has been less interest in the practice of primary care and other non-procedural specialties that serve the needs of those with chronic conditions. Our country's capacity to grow its physician workforce is predicated on the ability of doctors to do what they enter medicine to do—care for their patients in the best way possible.

We need additional innovative structures that encourage the development and implementation of multi-disciplinary care plans for those with chronic illnesses. These patients incur the highest costs, have the greatest needs, and will benefit most from integrated models of care. In fact, our entire healthcare system will benefit from these commonsense approaches. To be successful, chronic care models must recognize and account for what is needed to ensure quality of care—these models must reimburse for the increased costs of technology and, most important, for the time of physicians and other professionals needed to deliver high-quality, high value, coordinated, comprehensive care.

Thank you for shining a spotlight on the challenging issue of chronic care. I look forward to answering any questions you may have.

United States Senate Committee on Finance
Public Hearing
“Chronic Illness: Meeting Patients’ Unmet Needs”
July 15, 2014

Questions Submitted for the Record for Dr. William A. Bornstein

Ranking Member Hatch

Questions for the Witness

1. Dr. Bornstein, we heard Mrs. Lehman share the struggles she and her husband, Ken, endured after doctors diagnosed him with Alzheimer’s disease. The family was given a diagnosis, but were not told what to expect next, how to manage his symptoms, or what support services might be available in the local community. As you well know, patient engagement is a key part of any successful care coordination program. **How does Emory Healthcare engage patients with mental illnesses and dementia?**

Emory Healthcare is very focused on patient and family-centered care. Patient and family-centered care is a centerpiece of our Care Transformation Model (see appendix for attached graphical representation of this model), which is our cultural framework for improving the quality and value of the care we deliver. As part of this initiative, we have numerous patient and family advisors who advise us as how to most effectively engage patients and families. These advisors serve on an enterprise patient and family advisory council but also serve within specialties such as neurology to advise us on how best to meet the engagement needs of specific patient populations. Ms. Lehman also testified that she and her husband eventually found a neurologist who, by her description, effectively coordinates their care. At Emory Healthcare, we have developed a model for a patient-centered medical home for patients with cognitive impairment. We submitted an application to PCORI to fund study of this model. Unfortunately, this application was not funded, but we hope to proceed with studying this model through alternative funding. As I testified, the care coordination activities and other non-face to face care activities are not reimbursed in the traditional fee for service model. New payment models are needed for these sorts of models to expand and flourish. The Lehmans’ situation also raises an additional important point—these models need to allow for capable and willing specialist practices to serve as the “medical homes” or primary care equivalents for patients whose care is dominated by a specific chronic disease. The majority of emerging models insist that the primary care role be played by a “primary care specialty.” Such constraints may impede development of more effective models of care coordination for patients with a dominant chronic illness.

2. Dr. Bornstein, you have testified that the Medicare fee-for-service model does not effectively reimburse providers for care coordination. **We understand its limitations in Medicare, but to what extent is that type of reimbursement still used with health insurance companies?**

Fee-for-service remains the predominant payment structure for commercial insurers—though most are experimenting with or seeking alternative structures that move towards providers sharing risk for the costs of care.

3. Dr. Bornstein, you mention that the Emory Healthcare Network is an Accountable Care Organization. **Is your ACO participating in the Medicare program? If so, how have you viewed the results so far? Have you found substantial differences in how Medicare ACOs work versus the way private health plans you contract with work with you as an ACO? If Emory isn't participating in the Medicare ACO program, do you anticipate that it will want to join the program in the future?**

The Emory Healthcare Network (EHN) is not currently participating in the Medicare ACO program. Even successful participants in the Medicare ACO program have faced financial challenges related to their participation in this program. We believe that details of the risk sharing model are critical to making these models function as “win-win” arrangements for both payers and providers. Our ability to negotiate these details directly with the commercial payers is crucial for the viability of these arrangements. Another critical success factor is the attribution model. It is crucial that we have some concurrent idea of those patients for whom we are at financial risk while we are providing care. This has been a challenge in the Medicare arrangements. All that said, we certainly hope that the details of the Medicare ACO offerings will evolve in such a way that we can participate successfully in the future.

Senator Brown

Questions for the Witness

Alzheimer's Disease (AD)

An estimated 5.2 million Americans currently live with Alzheimer's, and more than 500,000 seniors die each year due to the disease. In addition, Medicare beneficiaries with Alzheimer's disease cost the program three times more than other beneficiaries without dementia. With statistics like this, it is critical that the U.S. do a better job of caring for Alzheimer's patients and supporting their caregivers.

Alzheimer's Disease is by all accounts a long term chronic condition that can be devastating to the individual living with it, family members, and especially those family members who care for the person affected. It is the nation's sixth leading cause of death; one in three seniors die from

Alzheimer's or another type of dementia. In addition, this disease disproportionately affects women—more than two thirds of patients are women, and 60 percent of AD and dementia caregivers are women. Not only does this disease take a toll on our families and loved ones, but it represents a major cost to the nation as well. Each year, AD costs the U.S. more than \$200 billion dollars, including \$150 billion in costs to Medicare and Medicaid. Nearly one in 5 Medicare dollars are spent for patients with AD.

And this disease has many comorbidities. Seventy-four percent of people with AD and other forms of dementia have one or more other chronic conditions, with cardiovascular disease being common. For example, 66 percent have hypertension, 30 percent have heart disease, and 14 percent have had a stroke. And diabetes is diagnosed in about 29 percent of AD sufferers.

Alzheimer's disease is a great example of a complex condition for which we are in dire need of better diagnosis, prevention, treatment, and long term management. I am impressed by the efforts being undertaken at Emory to provide comprehensive care for patients with chronic conditions.

1. **Do you think that providing detailed information about the complexities of AD during the development of a care plan for persons newly diagnosed with Alzheimer's disease could reduce costs for this population in the Medicare program? And more importantly, could this type of information reduce suffering for patients and their families?**

I believe that improving care coordination for this population does have the potential to reduce costs. However, I think that coordinating care requires much more than providing information about complexities. Coordination of care requires ongoing active engagement with patients and families in both face to face and non-face to face continuous interactions. As I testified, this type of care coordination requires investments on the part of providers that are not currently offset within the fee for service framework. To the extent that such investments result in reductions in total cost of care for these patients, the consequent savings accrue to the payer. Therefore, new structures are necessary that provide returns on investments or other incentives for providers to make such investments. While I do believe that improved coordination of care will reduce suffering for patients and their families and will in many cases reduce the total cost of care, I also believe that there is no magic in this and in some situations, better care coordination may not reduce costs. Much like with enhanced preventative care, sometimes costs will increase when care coordination is improved. For patients with AD with or without other chronic comorbidities, an additional important consideration is advance care planning which should be an integral aspect of care coordination and can also reduce suffering and costs of care.

2. **To what degree does Emory engage informal caregivers in the diagnosis, patient education, and treatment planning and management? Are the needs of these caregivers assessed and considered as part of a treatment plan?**

We are beginning to engage informal caregivers within religious and other community structures to provide support for patients and families with chronic diseases. As non-clinicians, we do not anticipate that such individuals will engage in diagnosis or specific clinical decision making. Rather, they should be involved in providing ongoing support to patients and families and this role should be incorporated in the treatment plan.

3. In your experience, what resources for families coping with AD are most lacking?

Given the wide spectrum of severity in the course of cognitive disorders such as AD, I think the answer varies according to stage and severity. In milder, earlier phases, I think the greatest needs that patients and families have is for information and help with planning for the course of the illness and for emotional support. As the cognitive impairment advances, I think these families need more direct help in care, including support for caregivers in the home on at least a part time basis. As is the case for all patients and families dealing with chronic illness, they also need 24 by 7 appropriate health care access for acute situations that is timely, convenient, and doesn't require an Emergency Department visit for a non-catastrophic issue.

4. Outside a national comprehensive electronic health records system, how can medical record documentation improve care coordination for certain populations, such as those with Alzheimer's and other dementias?

As I stated in my testimony, highly functional electronic health record systems (EHRs) that are interoperable are necessary but not sufficient for care coordination. The ease of use, functionality, and interoperability of EHRs need to be dramatically improved. However, even with EHR improvements, physicians and other providers need time during the day that is devoted to care coordination and this requires a reimbursement system that is not built solely around face to face encounters. With time and energy devoted to care coordination, providers can use the functionality of EHRs to improve the coordination of care.

Senator Burr

Questions for the Witness

1. Patients with multiple, common chronic health conditions account for some of the highest health care spending. In your experience, what cost-effective measures improve patient health outcomes and simultaneously lower the cost of care per patient?

We believe that targeting the subset of patients who are at the highest risk of requiring potentially preventable but costly additional care has the highest yield

in terms of improving outcomes and lowering costs. This requires sophisticated analytics that can identify such patients. Preventability is the key here, in that for some “high-cost” patients, the increased costs and resource utilization are not preventable based on current knowledge and tools. We are working on refining such analytics so as to better identify these patients and thereby provide work lists for nurse care coordinators who can then reach out to these patients with interventions aimed at avoiding such costly elements of care as preventable ED visits and hospitalizations.

2. It’s well documented that patient non-adherence to prescribed medications can impact health outcomes, particularly for patients with chronic health conditions. Ensuring that patients with chronic conditions are taking the most effective and medically appropriate medications can help to prevent patients from costly hospital admissions, re-admissions, or needing care in another costly care setting. **In your experience, what role do you believe comprehensive medication management services should play? How can we facilitate better patient engagement so patients understand the benefits and risks of each medication, including interactions with new or other medications they are currently taking? Do you believe that medication management services would be an important improvement to reduce health care costs and improve patient outcomes?**

Particularly for patents with multiple chronic diseases, comprehensive medication management is a key element of care. I think part of this can be achieved through better patient and family education, but this must be done very thoughtfully. For example, lengthy patient package inserts listing every possible side effect and drug interaction are not particularly helpful. A more thoughtful approach involving care coordinators, pharmacists, and other providers with more ongoing continuous relationships is more helpful. However, we also know that even with excellent patient and family education and support and even with waiving or elimination of out of pocket medication expenses, medication adherence is not good. I believe that insights provided through the emerging science of behavioral economics should also play an important role in improving medication management and adherence. At Emory, we are actively exploring these avenues.

Senator Thune

Questions for the Witness

How to Encourage Medication Adherence

1. We have heard a lot about the problem of patient non-adherence to prescribed medications. **For patients with chronic conditions, do you believe that they have the information that they need from their providers to know what medications they should be taking and are having their questions answered about their medications?**

If not, where do you believe this “disconnect” is and do you have any suggestions to fix the problem?

Please see my answer to Senator Burr’s question #2.

Interoperability of HER systems

2. Your testimony mentioned that your system has a single electronic health record vendor. What happens when you need information from a provider who is not in your hospital or outpatient clinic network? Do you feel that electronic health records are sufficiently interoperable to obtain data from an unaffiliated provider?

Our faculty physicians and hospitals do, indeed, utilize a single EHR platform. Affiliated providers who are in the Emory Healthcare Network (EHN) share information across platforms using the Emory Health Information Exchange (HIE). Our HIE is connected to the Georgia HIE, so some limited information sharing occurs beyond the boundaries of the Emory HIE. However, current EHRs are not sufficiently interoperable. Some of this will improve with Meaningful Use adoption. However, in the long run we really need true interoperability that is efficient and highly functional. For example we need to be able to drive decision support across disparate EHR platforms (e.g., drug interaction alerts, care gap alerts, etc.) and we need this to happen without creating additional burdens for provider documentation and workflow. As health care complexity has increased exponentially, we just can’t afford to do otherwise from the standpoints of quality, safety and cost.

Remote Patient Monitoring Can Enhance Patient Care

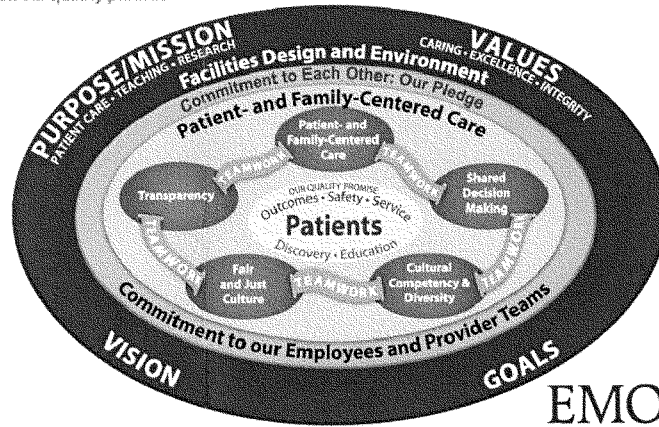
3. How do the nurse coordinators obtain the data needed to identify high-risk patients? Do you use some type of remote patient monitoring?

Currently, we use analytics based primarily on signals from care encounters—e.g., ED visits, hospitalizations, etc. As pointed out in my response to Senator Burr’s question #1, we are working on refining the analytics so as to better identify the cohort of patients who at any given time have the highest degree of modifiable risk factors for deterioration and additional resource consumption. However, we do believe that going forward, such predictive algorithms will be greatly enhanced by signals from remote patient monitoring that may come from “connected” scales, home blood sugar and vital sign monitoring and increasingly from smartphones and “wearables.” We are currently in preliminary discussions with a well-known smartphone design and manufacturing company about potential partnerships in such approaches.

Appendix: Emory Healthcare Care Transformation Model

EHC Care Transformation

To Serve Humanity by Improving Health
Delivering on our quality promise



© October 2013, Emory Healthcare

EMORY
HEALTHCARE

We're all in this together.

Testimony of Chet Burrell

President and CEO, CareFirst BlueCross BlueShield

Chronic Illness: Addressing Patients' Unmet Needs

Senate Committee on Finance

United States Senate

July 15, 2014

Good morning Chairman Wyden, Ranking Member Hatch, and members of the Committee. I am pleased to be here to offer a payer's perspective on strategies to address the unmet needs of patients with multiple chronic conditions.

I would start by saying that chronic conditions are conditions that last a year or more and require ongoing attention. They often limit activities of daily living. They include both physical conditions such as arthritis, cancer, and HIV infection, as well as mental and cognitive disorders, such as ongoing depression, substance addiction, and dementia – often mingled together.

One in four Americans – including one in 15 children and two of three people covered by Medicare – have more than one chronic condition. Chronic conditions often occur in clusters – obesity mixed with hypertension, cardiovascular disease, diabetes, osteoarthritis – compounding the risk of costly breakdowns in health.

These diseases are progressive, typically lifelong and involve multiple specialists with a primary care physician often playing a supporting role. Many people with multiple chronic diseases take 10 or more prescription drugs. It is not uncommon to see people in the under 65 population that we principally serve with 20 or more prescriptions. In the Medicare population, this is even more pronounced.

Since this population also exhibits higher rates of depression and other behavioral health challenges than the rest of the population, we often see non-compliance with medications and other requirements of good care, worsening the chronic diseases involved and deepening the inclination toward depression. This leads, in turn, to a cycle of admission, readmissions and repeated emergency room visits.

A key challenge is that the specialists who treat chronic conditions typically operate in unrelated practices with little or no communication among them. This fragmentation often leads to breakdowns even when each specialist is effectively diagnosing and treating his/her portion of the patient's needs.

Thus, even if each of the specialists is providing outstanding care, the net effect is an uncoordinated jumble of medications and confusing instructions with no one to sort it out. No longitudinal view of the patient's care across settings and over time is ever created and a guide or navigator through the complex health care system is often lacking. If the patient has a primary care physician, they are generally not aware when their patients are hospitalized or when and which specialists see them, making it impossible for them to intervene in a timely way and break the cycle.

The question before us - a great societal problem of our time - is how can we correct the fractured, uncoordinated system I have just described. We have extensive experience with this given that we are now in the fourth year of one of the largest patient centered medical home programs in the country, serving over one million people through over 4,000 primary care providers - all in accordance with one common financial and quality model. After three years of experience, our program has accounted for \$267 million in avoided costs, a 6.4% reduction in hospital admissions, an 8.1% reduction in all-cause readmissions, and improvements in other quality measures. Given national trends downward over the last few years, it would be unfair to attribute these shifts solely to our program, but we believe the PCMH program has had a significantly contributory effect. Here's what we think is working.

Our central focus in this program is to deal more effectively with those who have multiple chronic diseases, who constitute about 10 percent of our subscriber membership and who consume more than a third of all the health care spending we carry out each year. If one were to include those with acute exacerbations of chronic disease and those at high risk for future breakdown, one could safely say that about one quarter of the total number of the 3.4 million people we serve in the greater DC, Maryland and Northern Virginia region consume the clear majority of the nearly \$8 billion in health care spending we incur every year.

The first step toward an effective approach is to accurately identify the people with multiple chronic diseases. We do this based on the comprehensive, detailed claims data we have on each service rendered to each of our members across all care settings over time. To this extensive data, we apply advanced analytical software that can reliably profile those with chronic diseases and conditions. So, this identification process is a critical first step.

Second, we work with an identified chronic care member's primary care physician in our PCMH Program (over 80 percent of PCPs are in the program) to determine if a formal, detailed care plan is called for. If so, a plan is developed by a qualified Registered Nurse who works closely with the PCP and the various specialists involved. The care plan addresses all the pharmacy, behavioral health and medical services needed. The care plan creates a holistic picture of the patient's needs. It is finalized in consultation with and under the direction of the member's PCP. This year, we will complete over 10,000 such plans for people with multiple chronic conditions. We will do 30,000 additional care plans where the conditions involved have reached a more extreme or acute expression. As a result, through the stabilization these plans and their support

provides, we are seeing double digit declines in admission, readmission and ER visit rates for this population.

Third, all care plans are maintained daily and are contained in a single, online system that tracks the care delivered over time and that shows the progress of the patient – or lack thereof. All treating providers, including those providing behavioral health, pharmacy or social services, can see this longitudinal member health record with a few clicks over the web. It also includes a complete pharmacy reconciliation.

Fourth, we have found we had to create a more on-demand capability to offer a majority of the services needed in the home or the community – not in a hospital. The goal is to keep the patient stable at home, using community-based services that are often, themselves, fragmented and under-resourced and un-coordinated.

Fifth, we provided strong financial incentives and rewards to PCPs to allow them to differentially focus on the care of the multi-chronic patient and to encourage them to actively follow these patients carefully through all the care settings and services they receive at the direction of specialists.

At every turn, we have found that we are confronted by the limits in law, rule, policy and custom that thwart the doing of these common sense things, which limit access to needed ongoing services and lead to new levels of noncompliance. For example, Medicare payment rules often do not cover the cost of developing and maintaining care plans. There are limits placed on the circumstances and duration of home based services and so on. We are undertaking a listing of all in current law, rule and policy that thwarts the ability to effectuate the five common sense programmatic elements above.

Historically, Medicare has provided no incentives or additional compensation to PCPs to do the very things that most lead to better outcomes, and we are now participating in a pilot program with Medicare to see if these can be overcome. And, it's not just Medicare. The parts of the tax code governing Health Savings Accounts – the use of which is growing rapidly – do not allow private insurers to provide first-dollar coverage for things to prevent the worsening of chronic disease. We can waive cost-sharing for your ACE inhibitor after you have a heart attack, but not when your doctor is trying to prevent a heart attack.

We have found that primary care providers are eager to take on more of a role in the management of the chronic patient when they fairly compensated for it. We have also found that they respond to financial incentives for achieving better overall outcomes. We have found that they are very focused on understanding gaps in the care of their chronic patients and, in general, are extremely interested in how they are doing on a variety of quality measures. But, we have also found they need extensive supports in data systems, nursing, access to ancillary services such as behavioral health services that we have provided for them. And, they need help in seeing

and assessing with a chronic patient's specialty care givers, the sheer array of drugs their patients are on.

Getting this right based on the experience emerging from models such as ours is critical if we wish to achieve better outcomes and sustained cost restraint.

What I have described is the essence of the CareFirst model. We restructure the care coordination paradigm by setting up the PCP as the quarterback of a patient care team. We equip them with tools to deliver patient-centered care coordination including nursing support and 24/7 access to data, reward them and incentivize patients to further encourage behaviors that promote enhanced quality and a more disciplined stewardship of referrals and other medical services. This is the basis upon which we believe our program has seen its early success. For the third year in a row we have seen costs substantially lower than projected with improvements on key quality measures. And while it is early still in our implementation, we have high expectations for greater, continued quality improvements and savings in the future.

Over the long term, a greater focus on wellness as a sustained, lifelong practice for all Americans is sorely needed and we have placing great emphasis on this with the subscribers we serve. In the meantime, there is much to be done to achieve better cost and quality outcomes for those with chronic diseases or conditions and for those who are at elevated risk of contracting them.

I would be pleased to take any questions you may have or to expand on any aspect of my testimony if you wish me to do so.

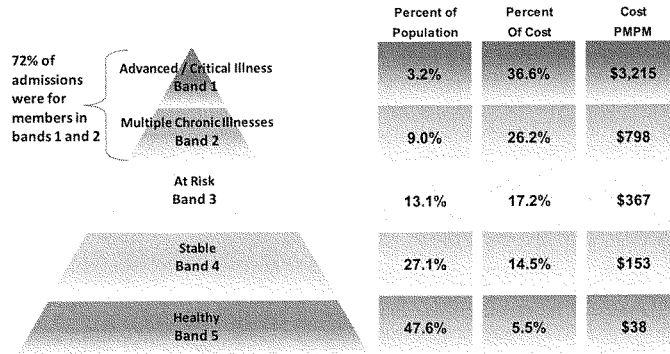


Catalog of Exhibits

Testimony of Chet Burrell
Finance Committee, U.S. Senate

.....
July 15, 2014

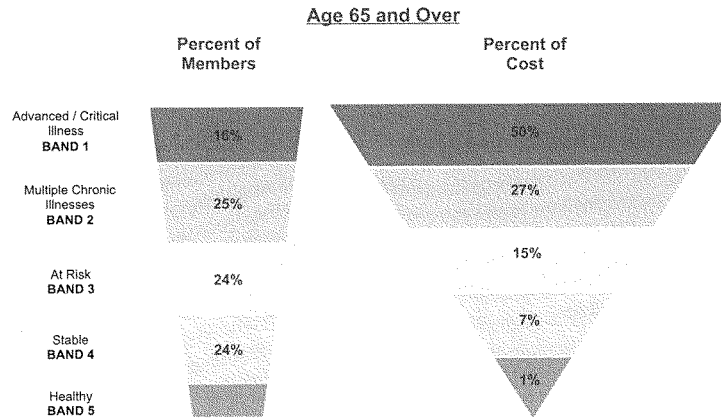
**Illness Pyramid – The Rosetta Stone
Commercial, Under 65 Population**



Source: CareFirst HealthCare Analytics – Commercial, Under 65 Population – 2013

PROPRIETARY AND CONFIDENTIAL

**Illness Pyramid – The Rosetta Stone
Medicare Population**



Source: CareFirst HealthCare Analytics – 2012

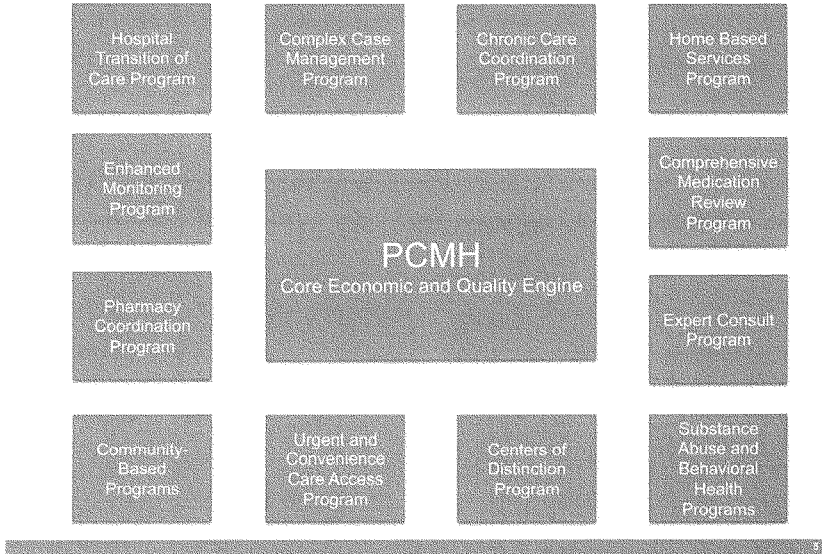
PROPRIETARY AND CONFIDENTIAL

Patient Centered Medical Home (PCMH)**Central Idea**

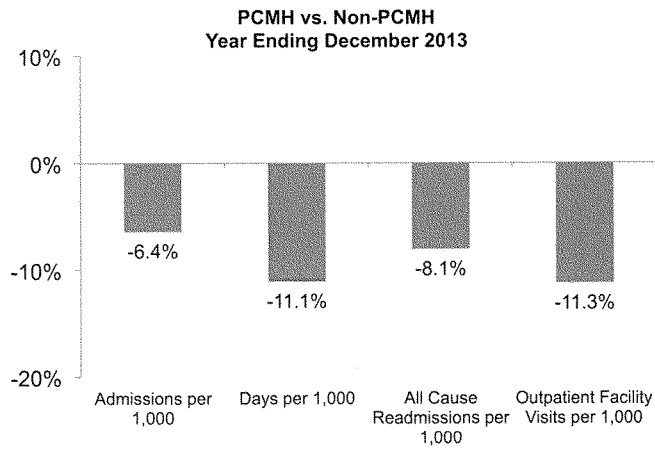
- PCP is the core player
- Total care of patients is to be provided, organized, coordinated and arranged through small Panels of PCPs
- Panels as a team are accountable for aggregate quality and cost outcomes of their pooled population
- Any savings against the Panel's pooled global budget target is shared with them
- Seeks to powerfully incent PCPs as a team to control costs for their pooled patient population and reward savings

If the Panels win, our Members win

PCMH Program At the Core of TCCI



Measures that Matter All Looking Good



Source: CareFirst Health Care Analytics – PCMH population compared to attributed Non-PCMH PCP population. Includes data through EOY 2013, paid through March 2014. Exclusions: Medicare Primary, Catastrophic, TPA, and out of area.

PCMH® AND COA® CERTIFIED

United States Senate Committee on Finance
Public Hearing
“Chronic Illness: Meeting Patients’ Unmet Needs”
July 15, 2014

Questions Submitted for the Record for Chet Burrell

Ranking Member Hatch

Questions for the Witness

1. Mr. Burrell, you have testified that CareFirst has extensive experience with the patient centered medical home model. **Could you please provide more information on how that model actually works for patients? For instance, do patients have to get prior authorization or a referral from their primary care physician before seeing a specialist? What ideas would you have for the Medicare fee-for-service system to set up such a model, keeping in mind that Medicare payment systems are often open to fraud, abuse, and unnecessary utilization?**

Patients with multiple chronic conditions are invited to participate in the program on a voluntary basis, and benefit from a patient-focused approach to care coordination that improves quality and lowers costs. Care Plans that holistically address patients’ medical, pharmacy, and behavioral health needs are developed by a Registered Nurse called a local care coordinator, working closely with the Primary Care Provider. Patients must consent to their Care Plan in order for it to proceed. Approximately 90 percent of patients do.

Patients in PPO or HMO insurance products are not required to obtain prior authorization or referral before seeing a specialist, however, they overwhelmingly follow the referral advice of their primary care provider.

An online hub allows providers, care coordinators, and case managers to connect patients with specific programs and services that best meet their needs. Patients enjoy seamless access to:

- *Home Based Services including home health aides, psycho-social services and other behavioral health services as well as medication management and support in activities of daily living.*
- *Enhanced Monitoring Services provided remotely via mobile and digital capabilities that send a stream of data to a central monitoring station staffed by highly qualified nurses.*
- *Comprehensive Medication Review by a pharmacist working directly with providers on behalf of patients at high risk of drug interaction, overdosing, side effects, etc.*
- *Community Based Services and Supports offered by CareFirst-reviewed providers, and,*
- *Expert Consultation from the top physicians in each specialty or subspecialty (whether or not they are in our network), when a patient or in-network physician needs help with a highly complex treatment plan.*

Lastly, as a special and essential feature of this program, patients who engage in their Care Plan may be entitled to waived cost-sharing for non-hospital based services, as a reward for being a partner in their own health.

Regarding ideas for the Medicare fee-For-Service system, we are keenly interested in changes to Medicare payment rules that lower the barriers to care coordination for Medicare beneficiaries. The proposed payment codes and processes intended to pay physicians for non-face-to-face care coordination are an important first step, as are payment changes that improve team-based care beyond the current "incident to" provisions. Of course, we share your concern that these new payments are not abused.

CareFirst has a number of internal controls to prevent or reduce fraud, waste, and abuse. We are aided in these efforts by primary care providers who see the actual cost of care of all their patients across all settings (e.g., other physicians, hospital care, and pharmacy). Since they are accountable for all costs of care in our program, they have more incentive to watch for fraudulent billing or wasteful spending.

Furthermore, the nature of the small teams that are the organizational building block of the program creates a peer review system, such that many participating physicians are able to see if any one physician's claims are out-of-line. In the model we are testing with the CMS Innovation Center, primary care physicians in panels with Medicare beneficiaries would use these payment codes to develop care plans and review patient progress, as well as provide peer review to claims filed by other PCPs within their panel.

2. Mr. Burrell, in June 2012, CMS awarded CareFirst a new health care innovation grant. It is my understanding that this grant allows you to extend CareFirst's patient centered medical home program design to approximately 35,000 Maryland seniors who are enrolled in fee-for-service Medicare. Over the past decade, both CBO and MedPAC have found that almost all Medicare fee-for-service care coordination demos failed to produce results. **How do you think your program is different? Where will you succeed where others have failed?**

Our program is very different. We received a Health Care Innovation Award from the CMS Innovation Center to test whether our PCMH program that is today very successfully used in the commercial population can be applied to Medicare FFS beneficiaries under one common set of rules.

Because Medicare FFS and CareFirst commercial reimbursements cumulatively account for approximately half of all health care spending in the region, extending the approach through a common model used successfully in the commercial population will provide powerful financial reasons for PCPs and NPs to reduce health spending by improving the health of their patients who are Medicare FFS beneficiaries.

As PCPs and NPs become more involved in and committed to the care management activities that are encouraged and supported by our Patient Centered Medical Home (PCMH) and Total Care and Cost Improvement (TCCI) programs, their effects will grow, accelerate and spread

throughout the health care system. Providing PCPs and NPs with a single, common incentive and accountability model, and the tools to help them focus on their patients with multiple chronic conditions (or those at the greatest risk for chronic illness), will help reduce hospital admissions and readmissions, and otherwise improve the quality of care while lowering costs through improvement. Indeed, this has been the experience of the PCMH/TCCI program.

We agree with the CBO's suggestion to use data to target high-risk enrollees. In fact, the CareFirst PCMH program is very data-centric and uses Medicare data to calculate illness burden scores and otherwise prioritize interventions. Our providers have a global view of patterns of care through a member health record—claims for all clinical services and laboratory data are viewable by any treating provider in real time. We organize and prioritize these data in such a way that providers see beneficiaries at greatest risk of being hospitalized, readmitted, or suffering another type of breakdown in care. We also share data (including admission, discharge, and transfer data) with primary care providers so they are aware of the progress and cost of their patients' care. By providing PCPs with information about the current status, risk, and cost of their patients, they will be better equipped and motivated to provide more coordinated care.

3. Mr. Burrell, care coordination in fee-for-service Medicare must occur in both rural and urban provider settings. **Given the fact that a one-size-fits-all model may not work well in all parts of the country, do you believe the CareFirst model can be easily tailored to fit different delivery system needs? Without a well-developed and well-supported primary care provider system, can the care coordination model you describe be successful in rural and frontier states?**

CareFirst's program is intrinsically local. Each region is divided into sub regions to reflect the unique nature of practice in the community. The program has been equally effective in rural and suburban areas, with perhaps greater success in rural suburban areas, including Western Maryland and the Eastern Shore. Our model could work well in other regions across the country where primary care providers and specialists are similarly scarce, particularly as we look to expand a telemedicine program to allow patients with multiple chronic conditions to receive care and virtually interact with their care team.

Senator Burr

Question for the Witness

1. We know that cardiovascular disease is the leading cause of death in this country, and that in the last decade or more, medical innovation has advanced and improved options and outcomes for patients, which has ultimately lowered the cost of treatment for patients with chronic heart disease. **How can health providers and payers better incentivize the use of the most innovative treatments that have proven to be cost effective ways of treating patients and improving outcomes?**

The top cause of admissions for CareFirst is cardiovascular disease. Whatever innovations we seek, we adopt best practices. The CareFirst PCMH program currently uses industry standard quality measures to identify gaps in care, and always seeks to improve the care of beneficiaries with heart disease and other chronic conditions. We provide PCMH providers with prioritized lists of their patients who are at increased risk for heart disease, metabolic syndrome, and other chronic conditions, as well as data about their patients' medication history, so they can improve care.

It is important to note that heart disease as well as other chronic conditions, is often mingled with other conditions and co-morbidities. In view of this, our program is designed to carefully customize a care plan for each member which is intended to address each condition and stabilize the member at home and avoid further breakdowns. There is constant communication with the member in an organized way by the local care coordinator which results in higher compliance leading to fewer breakdowns and reductions in admissions and readmissions. This high-engagement coordinated care ultimately leads to lower costs and better outcomes.

Reinforcing the constant intervention and communication with the member to monitor and ensure compliance with the care plan is the cost sharing waiver which is an added financial incentive to help ensure compliance and behavioral change. New technology and drug regimens are integrated into the program as they emerge but the key to success of the program is the close monitoring, communication and engagement driven by the local care coordinator.

Senator Thune

Questions for the Witness

Health IT Interoperability

- 1. It seems that a critical component of care coordination is the ability to share data. On a scale of 1-10, with 10 being high, how would you rate the ability for unaffiliated health IT systems to communicate? What do we need to improve interoperability?**

Unaffiliated health information technology systems do not yet communicate well with each other. Though some progress has been made, these systems are not only not interoperable—they communicate poorly with each other, if at all. Many believe we are years away from true interoperability.

The CareFirst PCMH program does not depend on interoperability with other systems. Our providers have 24/7 access to an online global view of patterns of care through a member health record—which shows the record of all clinical services and laboratory data that are available to any treating provider in real time.

Discrimination Claims Can Prevent Effective Wellness Prevention Programs

2. I believe in wellness programs and am concerned that wellness incentive programs are thwarted by overly aggressive action by the HHS Office of Civil Rights. **What can be done to ensure that wellness incentive programs remain strong and effective?**

We agree that there is too much well-meaning concern on avoiding discrimination. Health is a mix of behavior and biology, and though we must never blame people for being sick, we must be able to reward wellness or progress towards wellness. Payers need more flexibility to provide incentives for using preventive services, or for receiving care that prevents illness or worsening of existing disease. We appreciate that there are concerns about the potential for the design of some wellness programs to have a discriminatory impact on some patients but believe those concerns can and should be avoided with careful thoughtful benefit design strategies.

Designing Effective Physician Compensation Programs to Encourage Care Coordination

3. **How do you ensure that the financial incentives you offer physicians to encourage a shift in focus to care coordination are sufficient motivators to move away from a fee-for-service system?**

Fee-for-service is, in essence, the best yardstick to determine the value of any given service and of all services over time. The real challenge is to check the abuses of the fee-for-service system by holding providers accountable through global budgets. It should also be noted that fee for service is a rich source of all data which will be greatly enhanced with ICD-10 in the coming years. Bundled payments, the oft-touted alternative to fee-for-service, are ripe for potential abuse as accountability for any piece of the service rendered is greatly diluted and data is often lost or unavailable.

Our program retains the best elements of the fee-for-service system, and uses them to achieve the goals of capitated population-based payments. Fee-for-service payments—and the cost and use pattern data gleaned from fee-for-service billing—are the foundation of shared savings and gainsharing programs against global budget targets that reflect the illness levels of the patients who are the subject of those budgets. The data gleaned from the fee-for-service system importantly is also used to help physicians understand how their quality and costs rank against other physicians in the area, and to reward behavior change or improvements with powerful financial incentives layered on top of fee-for-service payments.

We recognize the susceptibility of the fee-for-service system to fraud, waste, and abuse, though our panels are able to see all of debits and credits to a patient care account for their attributed members that is maintained constantly. They are accountable for this budget and have incentive to watch for fraudulent billing or wasteful spending.

**Testimony of Cheryl DeMars
President and CEO, The Alliance®
Before the United States Senate Committee on Finance Hearing on
“Chronic Illness: Addressing Patients’ Unmet Needs”**

Thank you Chairman Wyden, Ranking Member Hatch and distinguished members of the Senate Finance Committee for the opportunity to speak with you today. I am Cheryl DeMars, President and CEO of The Alliance, a not-for-profit cooperative owned by over 200 employers that use self-funding to provide health benefits to more than 90,000 employees and their family members in Wisconsin, Illinois and Iowa.

Alliance employers are working to improve health and health care delivery through transparent data that is both comparable and actionable. This data is the linchpin to designing plans that influence care for chronic conditions. Employers have come together through coalitions like The Alliance across the nation, seeking to use their purchasing power to shift the market toward higher value at all levels of the health care system. The Alliance’s latest effort, called *QualityPath™*, aims to shift patients to higher-quality care for high-stakes procedures.

Employers are committed to transforming health care because we understand our business results are closely linked to the health of our work force. We know that employers, in their role as major purchasers of health care, can be catalysts for innovation and improvement. And we know the impact of these efforts is magnified many times when we work in partnership with public sector purchasers like state and federal governments. Our success in these efforts is determined by our access to data that can be used to compare cost and quality, coupled with the flexibility to implement innovative workplace and market-based programs.

The Employer’s Role in Prevention & Early Detection

Preventing avoidable chronic illness makes business sense for employers. According to the CDC¹, 75 percent of our nation’s health care dollars go to treat chronic disease. Yet financial cost is only one measure of the burden of chronic disease on businesses.

Trek Bicycle Corporation in Waterloo, Wis., re-doubled efforts to promote wellness and prevention when a long-time employee died in his sleep of undiagnosed heart disease in 2007. He was 41 years old and left behind a wife, two young daughters and many friends within Trek’s close-knit workforce. Today, Trek gives its 850 employees access to a state-of-the-art wellness center and a network of trails for biking and hiking. The company reduces benefit plan premiums for employees who pursue fitness while remaining tobacco-free.

Many employers offer health risk appraisals that include blood tests for chronic conditions. Our employers say these worksite screenings often reveal previously undiagnosed conditions such as diabetes and hypertension. Colony Brands, a catalog and internet company in Monroe, Wis., encourages health risk appraisals by waiving one month’s insurance premium for participating employees. Sharing test results with clinicians at Colony’s onsite clinic earns another month’s

premium. Webcrafters, a Madison-based book manufacturer and founding member of The Alliance, has offered health risk appraisals to employees since 1996. In 2004, Webcrafters linked participation to a \$50 cash reward and a chance to win a free year of health insurance, which increased participation from 20 percent to 74 percent. Participation jumped to 96 percent when Webcrafters offered a monthly premium reduction of \$20 for individual insurance or \$40 for family coverage.

The Employer's Role in Managing Chronic Conditions & Sharing Information

Once a chronic illness is identified, employers have a number of tools to help employees manage their condition, including value-based insurance designs, worksite clinics and information to compare the quality and cost of services.

Flambeau Inc., a plastics manufacturer in Baraboo, Wis., waives its health plan deductible and co-insurance for screening tests for patients with diabetes or cardiovascular diseases. The use of primary care is encouraged with nominal \$20 co-pays for patients visiting primary care physician offices, nurses or diabetic educators. The same policy applies to patients with diabetes or cardiovascular disease referred to a specialist by Flambeau's onsite clinic.

There is tremendous variation in the cost of caring for chronic illnesses as well as other health services, as established by the Dartmouth Atlas Project. The Alliance helps our members compare the cost of tests and procedures across our provider network. Employers encourage their employees to use this information to make cost-effective decisions. Foremost Farms USA, a milk processing and marketing cooperative in Baraboo, Wis., offers financial incentives to employees who research the cost of care and choose lower-cost providers. Seats Incorporated, a vehicle seating manufacturer in Reedsburg, Wis., shares information about the quality and cost of care through its gain-sharing program. Health savings are shared with employees to reinforce the value of joint efforts by employers and employees.

The Employer's Role in Driving System Improvement

Employers, working together, have an opportunity and obligation to use our role as health care purchasers to create a market that recognizes and rewards better value care. Data reveals that there is well-documented room for improvement in the management of chronic conditions, even in Wisconsin, a state that typically scores well on the AHRQ National Healthcare Quality Report.ⁱⁱ For example, less than half of Wisconsin's diabetic patients are achieving optimal managementⁱⁱⁱ based on data from the Wisconsin Collaborative for Healthcare Quality, a voluntary consortium of Wisconsin providers and insurers. The Alliance is working to accelerate the pace of improvement by aligning financial incentives in our contracts with doctors and hospitals. We use WCHQ measures of management for diabetes, ischemic vascular disease and hypertension to influence physician reimbursement. Delivery systems and physician groups under contract with The Alliance can earn up to 3 percent more for effective management of these chronic conditions.

Moving Market Share to High Value Providers

Despite these programs, progress to improve quality and control costs is too modest and too slow. That spurred The Alliance to develop the *QualityPath* initiative to overcome common barriers to improvement, including gaps in information and misaligned or non-existent financial incentives for providers and consumers. We are developing *QualityPath* in partnership with the Business Health Care Group, a sister coalition serving southeastern Wisconsin.

Beginning January 1, 2015, *QualityPath* will move market share to doctors and hospitals who offer high-quality, fairly-priced health care for high-stakes procedures. We are starting with cardiology and orthopedics because that's where our members spend the most money. *QualityPath* has six key elements.

First, *QualityPath* evaluates individual doctor-and-hospital pairings. Consumers want – and deserve – information about the performance of doctors, yet physician-specific public reporting remains elusive. We will advance this by requiring disclosure of physician-specific information.

Second, *QualityPath* uses nationally recognized outcome measures, many of which are used by CMS. Others are based on the work of physician specialty groups. One insight gained from our *QualityPath* work was that even doctors have difficulty finding out how they compare with peers on outcome measures. For many doctors, the *QualityPath* review process offers the first opportunity to see their own performance data.

Third, *QualityPath* requires doctors and hospitals to adopt three important clinical processes that help ensure care is appropriate and patient-centered. The first process is decision support for high-tech diagnostic imaging, which will help reduce the well-documented overuse of radiology procedures that increase costs while exposing patients to potential harm. Decision support systems are implemented at the site of care to provide real-time feedback to help physicians determine whether an imaging test is needed and the most appropriate test to use. The second, shared decision-making, will give patients a voice in deciding the course of their care when there are multiple, credible treatment alternatives. Finally, advanced care planning will help patients and clinicians discuss, document and share patients' wishes for end-of-life care.

Fourth, *QualityPath* requires the facility and the physician to disclose any conflicts of interest. Policies must either forbid or disclose direct and indirect industry payments to patients.

Fifth, *QualityPath* focuses first on quality and then on cost. Physicians and hospitals that meet quality criteria will be publicly recognized. Then, physicians and hospitals that meet quality criteria can be designated as *QualityPath* providers by agreeing to lower prices in contracts that include provisions for bundled payments and performance guarantees.

Sixth, participating employers will provide incentives for consumers to use *QualityPath* providers. We expect incentives to range from lower out-of-pocket costs to cash rewards, depending on each employer's preferences and plan design.

QualityPath is a collaborative program developed with input and guidance from other purchasers, clinicians and professional and specialty societies. Specifically, we built upon initiatives developed by the Wisconsin Department of Medicaid, Wisconsin Employee Trust Funds, Wisconsin Medical Society and the American College of Cardiology's SMARTCare initiative.

What Employers Need from Public Policymakers

Employers need support from public policymakers to continue to use their purchasing power to improve the health of employees. Employers want to help employees avoid chronic illnesses, when possible, and they want to help them manage chronic illnesses when they occur. When employees need high-stakes care, employers want to help them get high-quality care that improves health outcomes through programs like *QualityPath*. Employers would eagerly welcome the participation of public-sector employees in these initiatives to increase their impact on the marketplace.

Access to data is a common element in all these efforts, but access to data varies significantly from state to state. For example, health data that is available for Wisconsin is lacking in Illinois and Iowa. Since Medicare accounts for more than 20 percent of health care spending, everyone would benefit from greater access to Medicare's broad data. Medicare's Qualified Entity program was designed to share Medicare data with state-level organizations, yet it severely limits how organizations can use this data. We urge you to "free" the data through efforts like the Quality Data, Quality Care Act (S. 1758), which would allow broader use of Medicare data by providers, payers and consumers.

Employers also need clear guidance related to rules and regulations that impact employer-sponsored health benefits. Finally, they need the flexibility to innovate to help more employees make the most of their employer-sponsored health care. Data-driven innovation holds great promise for improving the value and quality of our health care system. Thank you for letting us share employers' efforts to help make that happen.

ⁱ <http://www.cdc.gov/chronicdisease/>

ⁱⁱ http://nhqrnet.ahrq.gov/inhqrdr/Wisconsin/snapshot/summary/All_Measures/All_Topics

ⁱⁱⁱ http://www.wchq.org/reporting/results.php?healthsystem_id=&city_county=&zipcode=&distance=&site_level_flag=0&category_id=0&topic_id=27&providerType=0®ion=0&measure_id=101&sequence_id=5&sort=1

Testimony of Stephanie Dempsey
Volunteer for the American Heart Association
Before the Senate Committee on Finance
Chronic Illness: Addressing Patients' Unmet Needs
Dirksen Senate Office Building, Room 215
July 15, 2014

Chairman Wyden, Ranking Member Hatch, and Members of the Committee, thank you for allowing me the opportunity to testify today.

My name is Stephanie Dempsey. I am 44-years-old; I live in Blairsville, Georgia; and I have been battling multiple, chronic medical conditions for much of my life.

I have always considered myself a middle-class American. I had a well-paying job, I owned my own home and I was happily married. Unfortunately, this is not the case today. The very illnesses that I battle every day have taken that from me. I have lost my independence, my financial security and most importantly, my family.

I hope my story can help you and those listening today better understand what people with chronic medical conditions face day-in and day-out. And I hope my story gives you some sense of the challenges that I, and so many others, go through daily.

I would like to take a few minutes to share my story with you.

I was diagnosed with coronary artery disease at the age of 21. My heart disease is hereditary and has impacted all of the women in my family. My only sister died at the age of 28 from heart disease. My mother, who is 69, underwent quadruple bypass surgery at the age of 48 and my maternal grandmother died at the age of 72 from coronary artery disease.

At the age of 30, I underwent quadruple bypass surgery for severely blocked arteries caused by high cholesterol. Since then, I have had 27 stents, another bypass surgery, and countless other medical procedures. I take 15 different medications in the morning and an additional four in the evening plus multiple supplements recommended by my doctors. At times it can be difficult to keep track of all of my medications, so I use different baskets – labeled by condition – so that I can stay organized.

In addition to heart disease, I am fighting the effects of lupus, arthritis and a seizure disorder – all of which have become debilitating. I can no longer work – although I would desperately like to – and I depend on my parents to help care for me. I always believed, as I am sure some of you have, that I would be taking care of my parents as they grew older. Instead, they are taking care of me because I simply had no other choice. This has been difficult to accept, but this is my reality.

Battling a number of complex illnesses has not only taken a toll on me, it has taken a toll on my entire family. As you might imagine, my medical expenses are significant and are becoming more significant by the day. We fell behind on our mortgage and were forced to sell our home. It was difficult to make ends meet. At that time, my first priority was to buy medicine that my son – who is now 20 years-old – needed for his own health conditions. This required us to scrape money together to make sure that he had the necessary medications. Paying for my numerous

costly medications was out of the question and therefore I was unable to purchase them. As a result, I was hospitalized five times over the course of six months, which resulted in five additional stents. As it became more difficult for me to manage my illnesses, the growing burdens became overwhelming for my husband, and after 21 years of marriage, he decided to walk away.

I had no choice but to move from South Carolina to Georgia to live with my parents. I now live in the rural mountains of Georgia, and although my primary care physician is nearby, I have to travel over two hours to see my specialists. And because of my seizure disorder, I depend on my parents to take me to my appointments.

In addition to my primary care provider, I also must see multiple doctors. I have a cardiologist that helps me manage my heart disease, a neurologist and neurosurgeon who help me manage my seizure disorder, and I have a rheumatologist who helps me manage my lupus and arthritis. I interact with countless other health care professionals such as nurses, physician assistants, therapists, and others.

Although my doctors are all well-intentioned, they often don't talk with each other or share information about my care. This ultimately leaves me to be my own health care coordinator. To give you an example, my Lupus disorder keeps my body in a constant state of inflammation for which one of my specialists prescribed a medication to reduce that symptom. Unfortunately that medication can cause seizures. He did not remember my seizure disorder and the medicine caused me to have an increase of seizures. After a visit with my neurologist, he took me off the medication, knowing the seizure side effect. Getting this resolved took days, countless phone calls and much persistence on my part. Issues like this happen frequently and although I consider myself an educated person, navigating this maze is very difficult and exhausting. But it is my life at stake and I do not have a choice but to be engaged.

To give you another example, I recently had to change to a new primary care doctor, since my former doctor is only accepting private-pay patients. This has been a challenge as it will take some time for me to become familiar with my doctor and for her to become familiar with me and my medical history. In an ideal world, I would want my primary care doctor to manage all of my care, but I have come to realize that this is not realistic, because I require specialized physicians.

For a long time I was privately insured through my employer, and later through my husband's insurance policy. However, when my husband was laid off and his health benefits terminated, I was left without insurance. Fortunately, I was able to qualify for Medicare in 2004 because of the federal disability law. Although it took two years of "fighting" to qualify for Medicare, the program has been extremely helpful but it still leaves me constantly struggling to pay my portion of my medical bills. My last surgery in September 2012 cost \$51,000. Medicare covered all but \$1,138 of the fee.

I have encountered countless challenges along this journey and I'm extremely fortunate to be here today to share my story. I am confident that you will not forget me and countless other people who are dealing with chronic illnesses when you develop policies that will help all of us. Our goals are the same: to live long, healthy and productive lives.

I sincerely thank you for giving me this opportunity to share my story.

**Statement on the Senate Finance Committee Hearing:
“Chronic Illness: Addressing Patients’ Unmet Needs”
Senator Al Franken
July 15, 2014**

I want to take this opportunity to thank Chairman Wyden and Ranking Member Hatch for your commitment to improving care for seniors, and in particular, caring for seniors with chronic illnesses. Preventing chronic illnesses and providing access to home and community-based services for seniors are two issues that I care very much about, which is why I have led legislative efforts in the Senate to improve policy in these areas. I appreciate that you have invited Mary Margaret Lehman, a caregiver from my home state of Minnesota, to testify on this important topic. Thank you as well for the opportunity to share my efforts on behalf of seniors in Minnesota and around the country.

I meet with seniors almost every weekend in Minnesota, and more than anything else, they often tell me that they hope to stay independent and in their homes as long as they can. Home and community-based services help seniors across the country remain independent and keep them out of expensive care settings. Home care is essential not only for individuals with chronic illnesses, but also for their caregivers, many of whom work day and night to care for their loved ones. That’s why I introduced the Home Care Bill of Rights Act, which will strengthen protections for seniors, reaffirm their rights as consumers, and provide assistance to seniors transitioning from nursing homes to home-care settings. The bill also directs the Administration on Aging to develop better tools to help seniors and their families choose high quality home- and community-based services. My legislation has been included in legislation reauthorizing the Older Americans Act, and as a member of the Senate Health, Education, Labor and Pensions Committee, I will continue to work hard to strengthen services for seniors that help them stay independent as long as they can.

I have also worked to prevent chronic illness among seniors, and particularly to prevent type 2 diabetes. In 2009, Republican Senator Richard Lugar and I developed legislation to expand access to the National Diabetes Prevention Program—an evidence-based program to help people at a high risk for type 2 diabetes avoid developing the disease. This program, which was successfully pilot tested in St. Paul, Minnesota and Indianapolis, IN, was shown to reduce by nearly 60 percent the chances of a person at a high risk for type 2 diabetes from being diagnosed with the disease. Our bill, which passed as part of the Affordable Care Act in 2009, established a grant program through the Centers for Disease Control and Prevention to help expand access to the program nationally. In 2012, Senator Lugar and I introduced the Medicare Diabetes Prevention Act to expand access to this effective program for our nation’s seniors, and last year, Senator Collins and I reintroduced the legislation. Our bill is in the Senate Finance Committee’s jurisdiction, and I hope to work with the Chairman, Ranking Member, and my colleagues on the Committee to move it forward.

**STATEMENT OF HON. ORRIN G. HATCH, RANKING MEMBER
U.S. SENATE COMMITTEE ON FINANCE HEARING OF JULY 15, 2014
CHRONIC ILLNESS: ADDRESSING PATIENTS' UNMET NEEDS**

WASHINGTON – U.S. Senator Orrin Hatch (R-Utah), Ranking Member of the Senate Finance Committee, today delivered the following opening statement at a committee hearing on chronic care:

Thank you, Mr. Chairman.

I am pleased that we are finally holding a health care hearing today. Frankly, I think this committee needs to hold more health care hearings.

We all know the implementation of Obamacare has come under intense scrutiny, and for good reason in my view. It is imperative that the Senate start exercising proper levels of oversight to determine whether or not the law is working as promised.

I don't say this out of politics or partisanship, but because patients, taxpayers, and policymakers deserve honest answers.

That said, today this committee has an opportunity to delve into the very important topic of chronic illness. This is one area that – if we choose to work together – I believe the committee can find real, bipartisan solutions that not only improve care coordination and lower overall health care costs, but also give complex patients better tools to more effectively navigate the health care system.

The Medicare Payment Advisory Commission has long said that fee-for-service Medicare creates silos – incentivizing providers to deliver more care, not necessarily higher quality, coordinated care.

The successful Medicare Advantage program does give patients the option to receive benefits from private plans that are incentivized to manage care across all settings. However, traditional Medicare fails to meaningfully encourage providers to engage in labor-intensive and time consuming patient care coordination.

Perhaps this is why, in 2013, Medicare Advantage enrollment increased by nine percent to 14.5 million patients. That number represents 28 percent of all Medicare enrollees. Even with these advances, today's health care system remains fragmented, and there is significant evidence that communication between providers is lacking, both in the Medicare program and in the private sector.

The Medicare Payment Advisory Commission estimates that Medicare patients with five or more chronic conditions see an average of 13 physicians and fill an average of 50

prescriptions each year. So it is no surprise that patients with high-cost chronic conditions routinely visit multiple specialists, often repeat medical histories and tests, receive inconsistent medical instructions, do not get help transitioning from one site of care to another, and use more expensive care settings when it may not be necessary.

Today one remarkably brave patient as well as a devoted and loving caregiver will share their personal stories with us.

Their testimony will show that the current health care system is not serving all patients well.

But there is hope.

We are also going to talk to a medical provider and an employer about the promising efforts underway to address the unique needs of chronic care patients.

I applaud these innovative approaches, but we all need to know that there are no easy answers.

Developing and implementing policies designed to improve disease management, streamline care coordination, improve quality, and reduce Medicare costs is a daunting challenge. Based on past experiences with the Medicare program in particular, there is still much more work to be done.

For more than a decade, the Centers for Medicare and Medicaid Services (CMS) has tried numerous demonstration programs to find out what does and does not work to improve care coordination for patients with chronic diseases.

These demonstration programs have, at best, shown mixed results.

According to the Congressional Budget Office, CMS has paid 34 programs in six major demonstrations to provide disease management or care coordination services in traditional Medicare. On average, these 34 programs had little to no effect on hospital admissions or Medicare spending.

In 2010, Obamacare created Accountable Care Organizations. ACOs allow certain providers to work together to coordinate and integrate Medicare services. These provider groups must meet specific quality standards in order to share in any savings they achieve for the Medicare program.

The ACO initiative is relatively new.

There is no definitive data to prove if ACOs actually improve quality, if they show any promise to save Medicare money, or if they are simply failing.

While the jury is still out on whether these ACOs will produce results, Obamacare also gave the Secretary of Health and Human Services broad authority to create and implement new Medicare pilot programs.

Through the Center for Medicare and Medicaid Innovation (CMMI), the Obama Administration is actively conducting care coordination programs in various Medicare settings. My hope is that the CMMI research will yield results.

As we all know, health care costs place enormous strain on the federal budget. By identifying cost-effective, data-driven ways to improve patient health, policymakers can better target scarce federal resources to get more value for the dollars spent.

U.S. health care spending grew 3.7 percent in 2012 – reaching \$2.8 trillion or \$8,915 per person. In fact, total U.S. health care spending consumes 17.2 percent of the nation’s Gross Domestic Product (GDP).

Adding insult to injury, last year the Medicare Trustees issued a report showing the Part A Hospital Insurance trust fund deficit reached \$23.8 billion and will be exhausted in 2026. Given the current fiscal reality, we have to find ways to provide high quality care at greater value and lower cost – all without adding to the deficit.

So I am glad we are holding this first hearing to understand the problem.

But we can’t stop there.

I believe this must be the start of a long-term, transparent discussion with additional stakeholders including the Administration, CBO, MedPAC, and others, that will allow us to work together to identify solutions in an open and transparent way.

Again, thank you, Chairman Wyden, for holding this hearing today. I look forward to hearing from our panel of witnesses.

###

Senator Klobuchar
Senate Finance Committee Hearing
Chronic Illness: Addressing Patients' Unmet Needs
July 15, 2014

Chairman Wyden and Ranking Member Hatch: Thank you for holding this important hearing today examining the needs of patients with chronic illnesses. I am especially grateful that you have invited Mary Margaret Lehmann to share her story as a caregiver for her husband, Ken, who suffers from Alzheimer's.

Alzheimer's is a devastating disease that exacts a tremendous toll on patients and families. Today, over five million Americans are living with Alzheimer's disease including almost 100,000 people in my home state of Minnesota.

Just as heartbreaking, though, is the burden Alzheimer's places on caregivers like Mrs. Lehmann who dedicate their time to ensure their loved ones are taken care of. Last year, over 15 million family members and friends cared for someone with Alzheimer's disease or another form of dementia. These caregivers sacrifice their time, often at the expense of their own jobs and wellbeing. Caring for a loved one battling Alzheimer's exacts a physical and emotional toll on caregivers that results in a higher incidence of chronic conditions like heart disease, cancer, and depression.

We must do more to support our nation's caregivers. That is why Senator Mikulski and I introduced the Americans Giving Care to Elders Act, or AGE Act. The bill would help caregivers mitigate the financial burden of caring for a family member by providing a tax credit of up to \$6,000 and expanding support for family caregivers offered through the Department of Health and Human Services in partnership with public or non-profit organizations. As the Committee continues its work on tax policy, it is my hope that you will include the AGE Act in those discussions.

Mrs. Lehmann's testimony today also highlights the continued need for medical research. Our country has set a goal to effectively treat or delay Alzheimer's and other dementias by 2025. If we were able to delay the onset of Alzheimer's by just five years we could reduce human suffering and give people valuable extra time with their loved ones. Today the United States spends about \$500 million on Alzheimer's research, far short of the \$2 billion needed to reach our goal of a cure by 2025.

Senator Collins and I introduced a resolution that says the Senate will strive to double the funding the United States spends on Alzheimer's research in 2015 and will develop a plan to meet the target funding goal of \$2 billion a year in research funding over the next five years. I ask my colleagues to recognize the urgency of Alzheimer's disease and commit the needed resources to reach our goal.

Think about the lives that could be improved with better treatments and cures. Think about the days, months, and years we can give back to people like Mary Margaret and Ken Lehmann and the human suffering that could be relieved.

I know the Committee shares these concerns and wants to make life better for those with chronic illnesses and their loved ones, and that is why you are having this hearing today. I look forward to working with the Committee toward accomplishing these shared goals.

United States Senate Committee on Finance
Chronic Illness: Addressing Patients' Unmet Needs

Testimony of Mary Margaret Lehmann

July 15, 2014

Good afternoon Chairman Wyden, Ranking Member Hatch and members of the Committee. On behalf of caregivers for individuals living with Alzheimer's disease and other dementias, thank you for the opportunity to testify before you today on the important topic of chronic care.

Alzheimer's is a devastating, progressive and ultimately fatal disease. It currently impacts more than 5 million Americans living with the disease and their 15.5 million caregivers. These men and women living with Alzheimer's are husbands and wives, mothers and fathers, sisters and brothers, business leaders, medical professionals, Republicans and Democrats. My dear husband Ken is one of them.

I am honored to be here today to share our story and discuss the issues facing individuals living with Alzheimer's and their caregivers. The more we share our story and talk about Alzheimer's, the less of a stigma it will become for others facing this disease. While Ken is fortunate enough to have a devoted care partner to advocate for him and a definitive diagnosis, a care plan to ensure that he lives as well as possible with Alzheimer's was not made available to us and our journey to get here was long and difficult. There are many who live with the disease that never get the care and support they need.

Ken's diagnosis came in October of 2009, however the first signs of Alzheimer's were showing as far back as 1995. It was then that I first began noticing many of the warning signs: becoming withdrawn from friends and social situations, difficulty navigating familiar places, and financial issues. Ken even communicated his frustration over difficulties at work and an inability to learn new computer skills. Since we shared an internist whom we both liked, I would report these signs to him. Our internist brushed off my concerns that these signs may be something more serious, often saying, "these things happen." Not once did we suspect it was Alzheimer's. The wakeup call, however, came when we declared bankruptcy because these symptoms led to the mismanagement of our finances.

We were left thinking, "How could this ever have happened to us?" Finally, I encouraged Ken to see another doctor to learn the reasons behind the changes in his behavior. After seeing a total of four neurologists and three internists, Ken was finally diagnosed with Alzheimer's disease. Our story is not unique. Many families struggle to get a definitive diagnosis of Alzheimer's disease, just like we did. Following his diagnosis, his internist prescribed him Aricept and said he would see him the following year. Ken only shared the news with me, our children and his sister for fear of how others would react. After receiving the diagnosis, he went through what we call The Three D's: denial, depression and despair. We were given the diagnosis, but no information on what to expect, how to deal with symptoms or even how to manage his atrial flutter along with his Alzheimer's. In fact, I took a magazine from the doctor's office that had an article on Alzheimer's, and for a while that was my only resource.

After visiting many neurologists, we were finally able to find one with experience in treating patients with Alzheimer's. Today Ken is a patient of The Center for Memory and Aging in St. Paul and, along with the Alzheimer's Association, we have developed a plan and strategy for not just Ken to live well but also for me as his care partner. Through the Alzheimer's Association we were also able to find new resources for patients and their caregivers and strategies that empower Ken to be independent. From this new network we have also learned that our story of financial hardship associated with the disease is not unique.

In many ways I see my role as his care partner much like that of an operations manager. I try to ensure that Ken is as independent as he can be. We make a concerted effort to engage in social activities and for Ken to exercise his mind and body through creative expression. For me, I have found a wonderful support network through several caregiver support groups where we can share our experiences, trade strategies and find comfort in sharing our burdens. With a disease like Alzheimer's, it is not only the individual who needs care and support, but also their care partners.

Throughout this experience I have learned that there are deficiencies in our health system when it comes to dealing with Alzheimer's. Far too many physicians are not familiar with how to properly advise patients and their caregivers. Additionally, there is a lack of coordination between Ken's various physicians. He sees an internist, cardiologist and neurologist to deal with various conditions. Ken carries a list of his medications to each appointment to ensure that each physician is aware of what his other health care providers have prescribed for him. Sadly this is more the rule than the exception for many individuals with Alzheimer's and their caregivers.

Alzheimer's as a Chronic Condition

Alzheimer's disease is a dramatically under-diagnosed condition, and most of those who have it – diagnosed or not – have at least one additional chronic condition. Detection of cognitive impairment at the earliest stage allows providers to establish the individual's and family's treatment preferences, connect them to community resources, and helps them to plan for the future. This type of planning can prevent confusion and stress for the patient and family, and allow for the best possible quality of their lives. Documenting a diagnosis can also aid in coordinating care, particularly around complex chronic conditions.

Seventy-four percent of people with Alzheimer's disease have at least one other chronic condition. Sixty-six percent have hypertension, thirty percent have heart disease, and twenty-nine percent have diabetes. The management of any chronic condition is challenging; such management in an individual with cognitive impairment is exponentially more difficult. These individuals are less likely – or are often unable – to comply with treatment recommendations and instructions, such as how and when to take medications, keep appointments with providers, and communicate pain or problems. These complications result in more hospitalizations, longer hospital stays, and higher costs than those with the same conditions who do not have Alzheimer's disease. This complex care requires detailed, coordinated care plans organized around the dementia diagnosis.

Once a diagnosis is established, providers can work with the individual and family to establish goals and a treatment plan with the understanding that the individual's dementia may require special measures to effectively treat the other chronic conditions. Providers, individuals, and families should work together to build a care team, accounting for all conditions. Moreover, providers should refer patients and families to appropriate support services, including enrolling in clinical trials. Participating in planning early in the disease process allows individuals with Alzheimer's to create advance directives regarding their care and finances – so that their wishes can be carried out when they are no longer cognitively able to make such decisions, and discuss advanced directives regarding their care and finances so that the patient's wishes can be honored when he or she is no longer cognitively capable of participating in decision making.

Alzheimer's disease also impacts the health and quality of life of those acting as caregivers. The physical and emotional impact of caregiving on Alzheimer's and other dementia caregivers costs an estimated \$9.3 billion annually in increased health costs specifically for the caregivers. Dementia caregivers are also more likely than caregivers of other older people to say that caregiving makes their health worse. Alzheimer's caregivers report higher rates of depression and stress as a result of their caregiving

responsibilities. The chronic stress of caregiving is associated with physiological changes that could increase the risk of developing chronic conditions.

Caring for an individual with Alzheimer's also has a negative effect on employment, income and financial security. More than half of Alzheimer's and dementia caregivers who are employed full or part time report that their caregiving responsibilities cause them to go in late to work, leave work early or take time off. In addition, fifteen percent of Alzheimer's and dementia caregivers take a leave of absence from work, thirteen percent go from working full time to part time and nine percent give up working entirely because of their caregiving duties.

Alzheimer's also presents challenges for those facing the disease without a caregiver nearby or at all. One in seven individuals living with Alzheimer's – nearly 800,000 – live alone and as many as fifty percent do not have a formal caregiver. As a result, their deterioration isn't noticed. These individuals risk a late or missed diagnosis and are also more likely to wander off, fall, and even die compared with people with Alzheimer's who don't live alone. There are an estimated 2.3 million long-distance caregivers for individuals with Alzheimer's disease or a related dementia who live at least one hour away from the care recipient and about one in five long-distance caregivers is a primary caregiver. This makes coordinating the care of the individual with Alzheimer's far more difficult.

Conclusion

Thank you again for the opportunity to testify today. I appreciate the steadfast support of the Committee and its focus on improving chronic care. Alzheimer's is a disease that not only impacts the diagnosed person, but also the lives of their loved ones. I ask Congress to address the chronic care issues around Alzheimer's with the same bipartisan collaboration demonstrated in the passage of the National Alzheimer's Project Act. The most recent update to the *National Plan to Address Alzheimer's Disease*, released in April 2014 by the U.S. Department of Health and Human Services, is starting that process by taking steps to identify and review measures of high quality dementia care in eight areas: 1) diagnosis, treatment, and care; 2) timeliness and accuracy of diagnostic evaluation; 3) patient and caregiver quality of life; 4) evaluation of behavioral symptoms and comorbid conditions; 5) care coordination; 6) assessment and management of caregiver burden; 7) training and provider knowledge; and 8) patient-centered outcomes and goals of care. This focus on quality dementia care will help individuals living with Alzheimer's disease and their caregivers across the country.

An epidemic is well upon us, and too many families are in situations like ours – facing a fatal brain disease that currently has no way to prevent, cure or even slow its progression and left without a support system to guide us. As a nation, we cannot afford to wait until Alzheimer's bankrupts the nation, just as it already has so many hardworking families in Oregon, Utah, and all across this country. We must make the smart investment now to realize a better, healthier future for our families and our nation. Thank you.

United States Senate Committee on Finance
Public Hearing
“Chronic Illness: Meeting Patients’ Unmet Needs”
July 15, 2014

Question Submitted for the Record for Mary Margaret Lehmann

Ranking Member Hatch

Question for the Witness

1. Mrs. Lehmann, you testified that you and your husband, Ken, visited several neurologists before finding a specialist at the Center for Memory and Aging in St. Paul, Minnesota. It sounds like this neurologist has specific training and clinical expertise to treat Alzheimer’s patients. You also talk about a frustrating lack of care coordination between all the other doctors Ken sees to manage different medical conditions. **Does the Center for Memory and Aging employ a nurse or other staff member dedicated to help patients who need additional care coordination services?**

Witness Response

Ranking Member Hatch, yes, indeed my husband and I visited several neurologists before finding a knowledgeable neurologist, with specific training and clinical expertise to treat persons with Alzheimer’s. In addition, I expressed frustration among the other doctors Ken sees to manage different medical conditions.

Your question has prompted me to realize, unfortunately, I as a patient and caregiver, must be more proactive to ensure care coordination takes place, among doctors. It is apparent it not going to happen without my involvement.

Per your question, I called Ken’s internist’s office. I learned it is a private corporation. It has no affiliation with the nearby hospital, which I had assumed, because they share similar names. No print out is given at the end of an appointment regarding basic weight or BP results. If a test of any kind is given, results are mailed in a timely manner. There is no access for medical records/tests/etc. on line and no plan to implement it.

My biggest frustration is that the internist is vocally critical of other doctor’s recommendations regarding Ken’s other health issues. Ken is not bothered by this, but I object, often. Ken likes his internist and is not willing to change doctor’s or health clinics. Problem solving, reasoning and judgment are challenging issues, due to his Alzheimer’s. Ken’s neurologist has offered to talk to his internist.

The internist referred Ken to a heart specialist, in 2010. The heart specialist does send a report to the internist, yearly, but we must make a specific request from the doctor in

order to also get that information. I was never offered that option, therefore I have no results of any visits.

I also called Ken's heart specialist at the University of Minnesota Heart Physicians Clinic. I was referred to a separate number for medical record information. I learned that medical information has not been shared with the patient, in the past, again, unless requested. They subscribed to *My Chart, in May, 2014 so that patients can be apprised of their health conditions/records, on line.

Recently, Ken fell off his bicycle. He tore his rotator cuff and sought medical attention from an orthopedist, specializing in shoulders. The orthopedist recommended surgery. I called his office the next day to explain that he had Alzheimer's and requested physical therapy, as the first response, rather than surgery. Reluctantly, he agreed, but said there was nothing on Ken's medical record that stated he had Alzheimer's. He had been seen by a knee doctor at the same clinic. It had been reported to the knee doctor that Ken has Alzheimer's. It was not noted in his record.

*My experience with My Chart, used by my own internist, is that it is very difficult to navigate and understand. I need a medical dictionary to decipher tests given in order to understand the status of my health. It would be helpful if it included layman's language.

I offered Ken's neurologist, Dr Michael Rosenbloom, from the Center for Memory and Aging, the opportunity to submit procedures of communication among doctors at Health Partners. We are so fortunate to be a patient of Dr Rosenbloom's and Dr Terry Barclay's, neuropsychologist. Dr Rosenbloom's report is also attached.

Thank you, again, for the opportunity, honor and privilege of testifying before the Senate Finance Committee on the topic of chronic disease. Your compassion and dedication for those of us living with Alzheimer's disease and other dementias, is truly heartfelt.

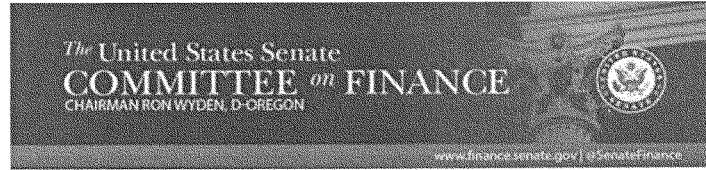
Response of Dr. Michael Rosenbloom

Care coordination is a priority at HealthPartners, and the Center for Memory and Aging recognizes the importance of this service, particularly for aging, memory impaired patients. One of the key members of the Center for Memory and Aging team is a physician assistant who has specialty training in dementia care management, disease education and coordination. This individual provides significant support to the neurology providers within the group and maintains regular contact with patients' primary care providers and geriatricians. The Center for Memory and Aging also holds a clinical diagnostic day four times a month that groups all the appointments for Alzheimer's and dementia patients into one visit. This multidisciplinary approach creates a one-stop shop for patients and caregivers to meet with a neurologist, neuropsychologist, geriatric psychiatrist, physician assistant, social worker and nurse.

The Center is also trying to address issues more relevant to moderate-severe stages of dementia. At this point, the primary concerns of caregivers include behavioral

management, home safety, transitions to structured living environments, and connecting to community resources. To help connect these patients with the appropriate facilities and resources in the community, the Center for Memory and Aging hired a social worker who specializes in Alzheimer's disease. The Center partnered with the local chapter of the Alzheimer's Association and used philanthropic funds to make this service available for all dementia patients seen within the clinic. Unfortunately, although this position has proved to be critical for providing the best care for this population, it's not sustainable based on the current Medicare reimbursement schedule. The Center for Memory and Aging is still trying to find ways to ensure this social worker's position can be sustained in the future.

In addition to work at the Center for Memory and Aging, HealthPartners is trying other models to improve the coordination of care for patients throughout its hospitals and clinics. One example includes a team of care coordinators who call patients after they're discharged from the hospital. During these phone calls, they can make sure the patient understands all the discharge instructions, is taking their medications appropriately, and has scheduled a follow-up visit with their primary care doctor.



Wyden Statement on Addressing the Challenges of Chronic Illness
As Prepared for Delivery

Today the Finance Committee focuses its attention on what, in my view, is the biggest challenge ahead for Medicare and the future of America's health care system: managing chronic illness.

To understand why this is a growing issue, take a look at how Medicare has changed over time. When Medicare started, it was mostly about caring for seniors who needed to go to the hospital. If a senior slipped on the kitchen floor and broke an ankle, for example, they'd head to the hospital, get treatment, and head home. In 1970, nearly 70 percent of Medicare spending was for hospital care. Now, that number is closer to 40 percent.

This change shows that Medicare is very different today than it was four decades ago. Rather than broken ankles or pneumonia, Medicare is now dominated by chronic conditions such as a cancer, diabetes and heart disease. More than two-thirds of Medicare beneficiaries are now dealing with multiple chronic conditions. Their care accounts for almost all – 93 percent – of Medicare spending.

It's not just seniors who are affected by chronic disease. Half of all American adults have at least one chronic condition. These diseases account for 70 percent of deaths, limit the activities of tens of millions more Americans, and cost the economy billions each year. The problem is only getting worse as chronic illnesses become more common. In fact some experts have warned that this generation could be the first in modern times to have shorter lifespans than their parents.

This is not just a health issue. The growing prevalence of chronic disease is also a major driver of rising health care costs that are putting a growing burden on government, business, and family budgets.

The way health care in America is delivered has to change. Let me repeat that – it has to change. Doctors and hospitals often don't coordinate care or even talk to one another. Patients receive medication for one disease that conflicts with another. Paper medical records force time and energy away from patient care only to be spent on burdensome red tape. There is even data showing that caregivers of people with chronic disease face higher rates of stress and depression and have higher mortality rates.

All of us are touched by the American health care system eventually. Those suffering with chronic disease are hurt the most by its flaws. This morning's hearing will look the problems faced by millions of Americans every day as they try to navigate America's chaotic system of treating chronic disease.

The committee will hear how the tragedy of chronic disease is exemplified by a single mother who before her 31st birthday had major heart surgery and can no longer work, or even drive a car, because of the onslaught of disease.

It will hear about patients with multiple chronic conditions who are left on their own to shuttle themselves between a myriad of providers that are often hours away from each other.

It will hear a story from a wife struggling to take care of her husband with Alzheimer's -- to make sure that doctor appointments are kept, medication is taken and their marriage is held intact.

This is a challenge that will not be fixed overnight. This chronic care hearing marks the beginning to addressing the dominant problems in American health care system that practically everyone has managed to ignore.

In the months ahead, this committee can find bipartisan solutions to meet the challenges and strengthen the American health care system, and I'm committed to working with the senators to address it.

###

COMMUNICATIONS



Statement of the American Academy of Family Physicians

Senate Committee on Finance Hearing on “Chronic Illness: Addressing Patients’ Unmet Needs”

July 15, 2014

The American Academy of Family Physicians (AAFP), representing 115,900 family physicians and medical students nationwide, thanks the Committee for holding this important hearing and submits the following statement for the record:

Preliminarily, the AAFP thanks the Committee for its ongoing efforts to repeal the Medicare Sustainable Growth Rate (SGR) formula, and to replace it with a system that encourages physicians to transform their practices away from fee-for-service and toward value-based models such as medical homes. To that end the AAFP has endorsed the bipartisan, bicameral SGR repeal-and-replace package that the Committee unveiled this year, and stands ready to help the Committee see this legislation enacted into law.

Turning to the subject of this hearing, the AAFP shares the Committee’s goals: improving population health in the United States, and at the same time reducing the overall cost of care. We encourage the Committee to continue exploring the notion that addressing the needs of Americans with chronic illness is a promising way to achieve these goals. In addition, the AAFP believes that Family Medicine is uniquely situated to play a key role in the nation’s efforts to prevent and manage chronic illness.

The AAFP Is Dedicated to Achieving Better Population Health at Lower Cost.

The 115,900 members of the AAFP have dedicated their practices and professional lives to delivering high-quality, comprehensive primary care to their patients. The AAFP defines primary care as “health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health settings.”¹ Hence, a core element of Family Medicine is not only diagnosing and treating illness as it arises, but also improving population health through prevention of illness. Family physicians do this by establishing continuing healing relationships with patients and overseeing and managing all of their health needs—often collaborating with other health professionals, and utilizing consultation or referral as appropriate.

Family Medicine as a discipline is also concerned with the overall cost of health care. Beginning with residency, family-medicine training must “incorporate considerations of cost awareness and risk-benefit

¹ American Academy of Family Physicians, “Primary Care,” at <http://www.aafp.org/about/policies/all/primary-care.html>; see also *id.* (Primary-care physicians are “trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern . . . not limited by problem origin . . . organ system, or diagnosis.”).

AAFP Headquarters
11400 Tomahawk Creek Pkwy.
Leawood, KS 66211-2680
800.274.2237 • 913.906.6000
fp@aafp.org

AAFP Washington Office
1133 Connecticut Avenue, NW, Ste. 1100
Washington, DC 20036-1011
202.232.9033 • Fax: 202.232.9044
capito@aafp.org

analysis in patient and/or population-based care as appropriate.² The AAFP also engages in ongoing efforts "to provide public education which emphasizes the responsibility of the individual patient for his/her personal health and for rising health care costs."³ These efforts "emphasize the positive effects of exercise, nutrition, highway safety, and the detriments of drug and substance abuse, obesity, and smoking."⁴ In short, improving health and simultaneously reducing health costs have always been central to the work of Family Medicine.

The AAFP Believes That Actively Managing Chronic Illness Can Improve Health and Reduce Costs.

According to the U.S. Centers for Disease Control and Prevention, 75 percent of the nation's health-care spending is now dedicated to treatment of chronic diseases.⁵ These include persistent and often debilitating conditions like Alzheimer's Disease, arthritis, cancer, chronic obstructive pulmonary disease (COPD), diabetes, end-stage renal disease, heart disease, mental illness, and many others—often occurring in combination with one another. Particularly as scientific advances have allowed us to prevent and cure so many infectious diseases, it is these non-communicable conditions that have now taken center stage in our national debate over achieving better health and controlling costs. Based on this trend, preventing, treating, and managing chronic illnesses before they become unmanageable are essential to improve health and lower costs.

As documented in the July 15 hearing, as well as in recent media reports, private health payers are now acting on this and seeing positive outcomes. For example, the testimony of Chet Burrell, president and CEO of CareFirst BlueCross BlueShield, indicates that under CareFirst's patient-centered medical home (PCMH) program, CareFirst works with primary-care physicians to develop "formal, detailed care plans" that "address all the pharmacy, behavioral health, and medical services needed."⁶ CareFirst's PCMH provides "strong financial incentives and rewards to PCPs [primary care physicians] to allow them to differentially focus on the care of the multi-chronic patient and to encourage them to actively follow these patients carefully through all the care settings and services they receive at the direction of specialists."⁷ Through this effort, CareFirst has documented "\$267 million in avoided costs, a 6.4% reduction in hospital admissions, an 8.1% reduction in all-cause readmissions, and improvements in other quality measures."⁸

² Accreditation Council for Graduate Medical Education, ACGME Program Requirements for Graduate Medical Education in Family Medicine (2014), at 15.

³ American Academy of Family Physicians, "Health Care Costs, Methods for Reducing," at <http://www.aafp.org/about/policies/all/health-costs.html>.

⁴ *Id.*

⁵ See Centers for Disease Control and Prevention, "Chronic Disease Prevention and Health Promotion," at <http://www.cdc.gov/chronicdisease/>.

⁶ Testimony of Chet Burrell, President and CEO, CareFirst BlueCross BlueShield, "Chronic Illness: Addressing Patients' Unmet Needs." Written Testimony before Senate Committee on Finance (July 15, 2014), at 2.

⁷ *Id.* at 3.

⁸ *Id.* at 2.

Further, CareFirst is only one of many BCBS companies that now spend one in five reimbursement dollars in similar programs that pay for quality outcomes rather than volume of services.⁹ In addition, according to *The New York Times*, "Aetna, Cigna, and UnitedHealth Group, among others, are also all exploring similar ways of rewarding doctors and hospitals."¹⁰ These payers recognize that keeping their patient-members well rather than merely treating them when they get sick is a more promising model for their business and for the patients. The AAFP believes that these new payment models (e.g. blended payments for primary care, global payment for defined primary-care services) hold immense promise for both improving care and lowering costs, as well as enhancing the quality of physician practice and the physician-patient relationship. The Finance Committee, with its wide jurisdiction over federal health programs, is well positioned to derive lessons from the experience of these private health payers.

Family Medicine Can and Should Play a Central Role.

Given Family Medicine's focus on comprehensive primary care, including mental health, family doctors can and should be at the center of the nation's collective efforts to prevent and manage complex chronic illness. Indeed, one of the AAFP's stated objectives is to "assume a leadership role in health promotion, disease prevention, and chronic disease management."¹¹

Importantly, Family Medicine, which "encompasses all ages, both sexes, each organ system, and every disease entity,"¹² is the broadest and most general of all medical specialties, and therefore poised to play a prominent role in reforming the delivery of American health care. The work of family physicians—beginning from the first day of residency training—emanates from principles and traditions that value the doctor-patient relationship, and the continuous active management of patients, particularly those with chronic conditions.

First, family medicine training is based on managing a panel of patients over the three-year residency period, rather than reporting to the clinic or hospital and treating cases one at a time as they arrive. Family medicine residents are "primarily responsible for a panel of continuity patients, integrating each patient's care across all settings, including the home, long-term care facilities, the FMP [family medicine practice] site, specialty care facilities, and inpatient care facilities."¹³ Family medicine has led medicine in training doctors in this way, so that physicians are thinking about the whole patient, over a span of time, from the first day of residency. Additionally, "[r]esidents should participate in and assume progressive leadership of appropriate care teams to coordinate and optimize care for a panel of continuity patients."¹⁴ Successfully addressing chronic illness in the United States will necessitate this very type of longitudinal and team-based care.

⁹ Blue Cross Blue Shield Association, "Blue Cross and Blue Shield Companies Direct More Than \$65 Billion in Medical Spending to Value-Based Care Programs" (July 9, 2014), at <http://www.bcbs.com/healthcare-news/bcbsa/bcbs-companies-direct-more-than-65b-in-medical-spending-to-value-based-care-programs.html>.

¹⁰ Reed Abelson, "Health Insurers are Trying New Payment Models, Study Shows." *N.Y. Times*, July 9, 2014.

¹¹ American Academy of Family Physicians, "Vision and Strategic Plan," at <http://www.aafp.org/about/the-aafp/vision.html>

¹² American Academy of Family Physicians, "Family Medicine, Definition of," at <http://www.aafp.org/about/policies/all/family-medicine-definition.html>.

¹³ Accreditation Council for Graduate Medical Education, ACGME Program Requirements for Graduate Medical Education in Family Medicine (2014), at 16.

¹⁴ *Id.*

Second, family-medicine training incorporates mental health to a much greater degree than other primary-care specialties. In fact, to be an accredited family-medicine residency program there "must be faculty members dedicated to the integration of behavioral health into the educational program."¹⁵ This integration of mental health is unique to family medicine. To use just one example of this interaction, chronic illness often leads to depression, and depression and mental illness can lead to other chronic illness. Family physicians are trained to understand these links and treat them.

Lastly, the family-medicine tradition emanates from "a personal doctor-patient relationship" and "*an appreciation for the individual, family, and community connections.*"¹⁶ Family physicians not only treat the whole patient—they also recognize that illness is often connected to events outside the clinic: a woman experiences debilitating depression because her husband is drinking excessively; a man experiences similar depression after the death of a loved one. Family doctors are trained to recognize how the external context of illness can often be instrumental in diagnosing and treating the whole patient.

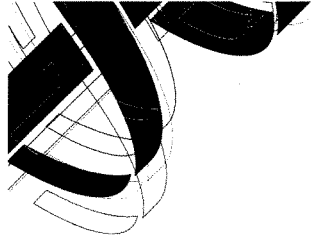
In sum, Family Medicine views the movement toward active management of chronic illness as positive for both patients and health payers. The AAFP urges the Committee to continue pursuing policy solutions in this vein.

* * * * *

Thank you for the opportunity to provide family medicine's views on the evolving efforts to improve health and lower costs. If the Chairman or any committee members have any questions about this statement or about the AAFP, the AAFP encourages them to have their staff contact Andrew Adair, Government Relations Representative, at (202) 232-9033 or aadair@aaafp.org.

¹⁵ *Id.* at 8.

¹⁶ *Id.* at 1 (emphasis added).



**American Academy of
PHYSICIAN ASSISTANTS**

2318 Mill Road, Suite 1300
Alexandria, VA 22314
P 703 836 2272 F 703 684 1924
E aapa@aapa.org
www.aapa.org

Statement of the American Academy of Physician Assistants

for the Hearing Record of the Senate Finance Committee

on

Chronic Illness: Addressing Patients' Unmet Needs
July 15, 2014

On behalf of the more than 95,000 clinically practicing physician assistants (PAs) in the United States, the American Academy of Physician Assistants (AAPA) is pleased to submit comments for the record regarding the Senate Finance Committee's recent hearing, *Chronic Illness: Addressing Patients' Unmet Needs*. AAPA applauds the Committee for directing attention to the need to improve healthcare delivery for the growing number of Medicare beneficiaries with complex, chronic medical conditions. It is the view of the AAPA that increased utilization of complex care coordination holds tremendous benefit for patients, patients' families, and our nation's healthcare system.

PAs are already leaders in chronic care management, and PAs are poised to be leaders in the transition to better and more coordinated care for our patients with complex and on-going needs. PAs are one of three primary care providers along with physicians and NPs. Over the last 50 years, PAs have been providing their patients with access to high-quality care and have seen the benefit of a more coordinated approach to care.

Because of their broad-based medical knowledge, embrace of team-based, patient-centered care, and commitment to patient education and advocacy, PAs are naturally suited to helping coordinate the medical care and on-going needs of patients with chronic conditions. The following case studies highlight several examples of how PAs are working today to provide complex, chronic medical care coordination.

Sickle Cell Unit, Louisiana State University Health Science Center

Most sickle cell patients seek emergent/ immediate treatment for an acute pain crisis. Generally they can be treated with relatively low level interventions – i.e., rest, IV fluids, and IV pain medication

A PA-hematologist team determined that their facility could provide better care for patients with sickle cell disease if treatment for sickle cell pain crisis was coordinated. In August of 2010 they opened a sickle cell day treatment unit; the success was almost immediate. The unit started with three beds and quickly expanded to five. In the first two months, ER visits by sickle cell patients were reduced by 85%. Hospital admissions were also reduced.

The facility is staffed by a PA and RN. The attending physician in the clinic is the consulting physician for the day treatment unit. The PA is the coordinator of the day treatment unit, as well as adult sickle cell services. Additionally, the PA organized a sickle cell orthopedic clinic, the first in the area, and formed a sickle cell support group that meets weekly to discuss various aspects of the disease. The clinic serves as the primary care provider for most of the sickle cell patients. Patients are encouraged to maintain good health through preventive services, which are evaluated and refined on a regular basis.

Metropolitan Nephrology Associates, Metropolitan DC Area, MD and VA

Begun in 1974, Metropolitan Nephrology Associates is a group practice providing expertise in the field of fluid and electrolyte disorders, physiological and pathological conditions affecting kidney function, hypertension, and renal failure. The group includes six nephrologists and one PA. The PA plays an integral role in dialysis treatment, coordinates research grants, and leads the practice's education program for patients facing end stage renal disease.

The PA is responsible for all dialysis patients and covers three hospitals and six dialysis centers in two states. Because of the multiple jurisdictions involved, different hospital systems, and the complex issues that affect nephrology patients, communication and a concentrated effort to improve health care across the care continuum are critically important. The PA uses electronic records and hand-held devices, allowing her to be the principal point of contact with vascular surgeons, physicians, and NPs at other facilities who also care for the nephrology and transplant patients.

Medical Center of Central Georgia/Mercer University School of Medicine Macon, Georgia

A PA runs the house call program for the family medicine residency program at Mercer University School of Medicine, affiliated with the Medical Center of Central Georgia in Macon. Most of her patients are elderly, suffer from multiple chronic diseases and are bed-bound, making an office visit nearly impossible. Advancement in the creation of new technologies allow her to conduct lab studies, EKGs, and other tests in a patient's home. Care is coordinated with medical center specialists, social service agencies, and home support providers.

The in home care coordination provides patients with access to greater emotional support and allows them to benefit from an improved relationship with their healthcare team. In addition, the PA can gather more comprehensive information on the patient, family, and their environment than in the office setting. Daily living activities can be readily assessed, with the opportunity to observe some of them first hand. Bedbound patients and their families avoid stretcher transportation and are more likely to receive timely interventions which can decrease hospitalizations.

Premier Physicians Medical Group in Irvine, California

Premier Physicians Medical Group is a Pioneer ACO in southern California. The lead PA has instituted a coordinated care project for seniors and supervises additional PAs who are care coordinators for patients in the group's five clinics.

The PAs meet with patients, review their healthcare questionnaires, and develop a full picture of the patient's health status and concerns. The PAs are responsible for meeting prevention metrics and assuring appropriate patient education. Each PA is also in charge of a transformation of care project for one metric.

The PA spends one-half day a week in the care coordination role and the rest of the week practicing as a PA in the clinic in which they serve as care coordinator. This allows them to connect with patients in both roles while maintaining their clinical skills and enjoying the variety of coordination and clinical practice. The medical group plans to hire additional PAs to enhance their ACO practice.

These are only a few examples of the many ways PAs are working to improve care for patients with chronic conditions. AAPA supports the Committee's efforts to explore ways to move our health care system towards a more comprehensive approach and to utilize the unique benefit of PAs to realize that goal.

Reforming Medicare to Support Better Coordinated Care

AAPA considers the SGR repeal and reform legislation reported by the Finance Committee, as a solid policy framework upon which to develop policy specific to complex, chronic care. The Committee's SGR legislation laid a strong foundation to address the growing and costly chronic care needs of our nation' aging population by –

- Incenting quality and cost-effectiveness by focusing on value over volume and promoting alternative payment models
- Encouraging complex chronic care coordination by extending codes for complex chronic care management services to physicians, PAs, and nurse practitioners
- Modernizing Medicare to remove barriers so healthcare professionals r can practice at the top of their licensure; including reimbursing PAs for providing and managing hospice care for their patients electing the Medicare hospice benefit, as well as permitting PAs to supervise cardiac and pulmonary rehabilitation services in critical access hospitals.

AAPA supports passage of the Committee's SGR repeal and reform legislation as the first step in addressing complex, chronic medical conditions.

Full Integration of PAs in Complex, Chronic Care Policy

Because PAs are a critical partner in addressing the health needs of our chronically ill patients, we support policy and legislative changes that recognize the full contribution of PAs to the healthcare delivery system. In order to realize the full benefit of the quality medical care and efficiencies offered by PAs, AAPA recommends that PAs be fully and expressly integrated into all healthcare policy designed to encourage the use of complex chronic care coordination. Additionally, as health technology is so integral to care coordination, AAPA encourages Congress to make electronic health records incentives available to PAs in the same way that they are available to physicians and NPs.

PA Profession

The PA profession was created nearly fifty years ago in response to a shortage of primary care physicians. Today, PAs provide high quality, cost-effective medical care in virtually all health care settings and in every medical and surgical specialty. PAs are one of three health care professionals providing primary medical care in the U.S.

All PAs must graduate from PA educational programs accredited by the Accreditation Review Commission on Education for the Physician Assistant. The mean duration of PA educational programs is 26 months. Ninety-one percent of PA educational programs offer a master's degree. PA education includes instruction in core sciences: anatomy, physiology, biochemistry, pharmacology, physical diagnosis, pathophysiology, microbiology, clinical laboratory science, behavioral science, and medical ethics. PAs also complete more than 2,000 hours of clinical rotations, including family medicine, internal medicine, obstetrics and gynecology, pediatrics, general surgery, emergency surgery, and psychiatry.

After graduation, PAs must pass a national certifying examination developed by the National Commission on Certification of Physician Assistants. To maintain certification, PAs must log 100 hours of continuing medical education hours every two years, and they must pass a rigorous recertification exam every ten years. To practice, PAs must hold a state license or, in the case of federally employed PAs, be nationally certified.

PAs practice medicine with a high level of autonomy, developing and managing treatment plans for patients. The PA profession's team-based approach reflects the changing realities of healthcare delivery and fits well into the patient-centered medical home model of care, as well as other integrated models of care management.

PAs have their own patient panels and serve as Medicare beneficiaries' principal healthcare professional. In rural and other medically-underserved communities, a PA may be the only healthcare professional in the community. State laws increasingly allow PAs to own their own medical practices. The Medicare statute recognizes PA-owned rural health clinics. PAs are uniquely flexible in adapting and responding to the evolving needs of the U.S. healthcare system by virtue of comprehensive educational programs that prepare PAs for a career in general medicine and for a team-based approach to providing patient-centered medical care.

Results from the 2013 AAPA Annual Survey indicate that the expanding PA role reflects evolving demands on the healthcare system brought about by new legislation and the ever-changing healthcare market place. The survey reveals –

Every year, a typical PA treats 3,500 patients.

- 80 percent of PAs provide acute care management
- 64 percent of PAs provide chronic disease management (most PAs see patients with multiple chronic diseases).

Thirty-seven percent of PAs work in medically underserved counties in the U.S.

- PA report, on average, 23 percent of their [patients are enrolled in Medicaid and 14 percent are dual eligible
- Additionally, 16 percent of their patients are uninsured.

As noted above, PAs currently provide complex medical care and care coordination for Medicare beneficiaries and the dual eligible population. States are increasingly providing greater authority for PAs to practice at the top of their license (commensurate with their education and experience) and to own their own medical practices.

Conclusion:

In conclusion, we look forward to working together on a bipartisan basis to realize the hope of addressing the unmet needs of our patients with chronic conditions through better coordinated quality health care.

Thank you again for the opportunity to submit a statement to the Finance Committee Hearing Record on *Chronic Illness: Addressing Patients' Unmet Needs*, which took place on July 15, 2014. Should you have any questions, please do not hesitate to contact Sandy Harding, AAPA senior director of federal advocacy, at 571-319-4338, or at sharding@aapa.org.

1455 Pennsylvania Avenue
 Suite 400
 Washington, DC 20004-2514
 202.621.1820
 202.621.1819 [fax]
www.accp.com



C. Edwin Webb, Pharm.D., M.P.H.
 Associate Executive Director

July 14, 2014

The Honorable Ron Wyden Chairman
 The Honorable Orin Hatch, Ranking Member

Senate Committee on Finance
 Attn. Editorial and Document Section
 Rm. SD-219
 Dirksen Senate Office Building
 Washington, DC 20510-6200

Dear Chairman Wyden and Ranking Member Hatch,

On behalf of the American College of Clinical Pharmacy (ACCP), I am writing to thank you for holding the July 15, 2014 hearing entitled "Chronic Illness: Addressing Patients' Unmet Needs."

The American College of Clinical Pharmacy (ACCP) is a professional and scientific society that provides leadership, education, advocacy, and resources enabling clinical pharmacists to achieve excellence in patient care practice and research. ACCP's membership is composed of over 15,000 practitioners, scientists, educators, administrators, students, residents, fellows, and others committed to excellence in clinical pharmacy and patient pharmacotherapy.

ACCP's members are dedicated to advancing a quality-focused, patient-centered, team-based approach to health care delivery that enhances the safety of medication use by patients and ensures that medication-related outcomes are aligned with patients' overall care plans and goals of therapy. Clinical pharmacists, working collaboratively with physicians and other members of the patient's health care team, utilize a consistent process of direct patient care that enhances quality of care, improves clinical outcomes and lowers overall health care costs.

It is well documented that chronic conditions are the leading cause of death and disability in the United States. Seven out of every ten deaths are attributable to chronic disease, and illnesses like heart disease and cancer top the list of most common causes of death. Forty five percent of Americans suffer from one or more chronic conditions and due the demographic reality of our aging population and public health issues such as the growing obesity crisis, the rates of chronic disease are expected to rise dramatically.¹

¹ Partnership to Fight Chronic Disease. 2009 Almanac – The Impact of Chronic Disease on US Health and Prosperity. A collection of Statistics and Commentary. Available at http://www.fightchronicdisease.org/sites/fightchronicdisease.org/files/docs/2009AlmanacofChronicDisease_updated81009.pdf. Accessed July 9, 2014.

Providing Leadership in Clinical Pharmacy Practice and Research

American College of Clinical Pharmacy • 13000 W. 87th St. Parkway • Lenexa KS 66215-4530 • (913) 492-3311
 Michael S. Maddux, Pharm.D., FCCP, Executive Director

The burden of chronic health conditions has far reaching implications for the Medicare program. Over 68% of Medicare beneficiaries have two or more chronic conditions and over 36% have four or more chronic conditions. In terms of Medicare spending, beneficiaries with two or more chronic conditions account for 93% of Medicare spending, and those with four or more chronic conditions account for almost 75% of Medicare spending.²

The importance of medication therapies in the treatment and management of chronic disease – and their role in improving the quality of life for patients who suffer from these conditions – cannot be overstated. Medications are involved in 80 percent of all treatments³ and 60% of seniors are taking three or more discrete prescription or non-prescription medications at any point in time.⁴

Despite these facts, traditional health care practice models and payment policies result in disjointed prescribing and distribution of medications from unconnected professional “silos.” When combined with the continuing growth in the number and categories of medications -- and greater understanding of the genetic and physiologic differences in how people respond to their medications -- the current system consistently fails to deliver the full promise medications can offer.

The too-common result -- particularly in Medicare seniors -- is a range of medication-related problems that frequently are either unrecognized or inadequately addressed:

- dosing “mistakes” that can result in either under treatment or preventable adverse events – or both
- inappropriate, ineffective, or unnecessarily costly medication choices for the established goals of care
- duplicative or interacting medications
- avoidable side effects
- inconsistent adherence or other patient challenges or issues that directly reduce treatment success.

In short, the current medication use “non-system” fails to get the medications right far too often.⁵

Clinical pharmacists use a collaborative, team-based process of care known as comprehensive medication management (CMM) that addresses this unmet need and ensure that patients’ medication use is effectively coordinated, safe, appropriate, and aligned with the patients’ overall care plan.

CMM helps to “get the medications right.” Working in formal collaboration with physicians and other members of the patient’s health care team, qualified clinical pharmacists:

- identify and document medication-related problems of concern to the patient and all members of the care team, using a consistent care process that assures medication appropriateness, effectiveness and safety
- initiate, modify, monitor, and discontinue drug therapy to resolve the identified problems and achieve medication-related outcomes that are aligned with the overall care plan and goals of therapy

² CDC Report - Prevalence of Multiple Chronic Conditions Among Medicare Beneficiaries, United States, 2010. Available at: http://www.cdc.gov/pcd/issues/2013/12_0137.htm. Accessed July 10, 2014.

³ Report to the US Surgeon General 2011. Improving Patient and Health System Outcomes through Advanced Pharmacy Practice. Available at <http://www.usphs.gov/corpslinks/pharmacy/documents/2011AdvancedPharmacyPracticeReporttotheUSSG.pdf>. Accessed July 9, 2014.

⁴ CDC/NCHS Statistical Data Brief. September 2010.

⁵ Parekh, AK et al. The challenge of multiple comorbidity for the US health care system. JAMA 2010;303(13):1303-1304 (April 7, 2010)

- engage and educate patients and families in fully understanding their medication regimen, supporting active patient engagement in the successful use of their medicines to achieve desired health outcomes.

In the emerging environment of patient-centered medical homes (PCMH), the practice of CMM is now recognized as a core strategy to achieve better clinical outcomes and quality. The Patient-Centered Primary Care Collaborative (PCPCC) supports the practice of team-based CMM and has published a resource guide to assist with the integration of this service into clinical practice in the PCMH.⁶ Medicaid programs in North Carolina and Minnesota now support CMM within the practice and service components of their primary care delivery systems.⁷

This service is only rarely available to most Medicare beneficiaries – the patient population most in need and most likely to benefit from the service. In order to address this significant unmet need in the treatment of patients with chronic conditions, ACCP urges Congress to enact legislation that would establish a CMM benefit, delivered by qualified clinical pharmacists, within the Medicare program.

The inclusion of a CMM benefit under Medicare Part B would improve the coordination of care among healthcare providers, patients and other caregivers and help prevent avoidable but costly medication errors, adverse drug reactions, and other medication-related patient safety events.

In “getting the medications right,” CMM also contributes to enhanced productivity for the entire health care team, allowing other team members to be more efficient in their own patient care responsibilities. Team members are freed up to practice at the highest level of their own scopes of practice by fully utilizing the qualified clinical pharmacist’s skills and training to coordinate the medication use process as a full team member.

We thank the Committee for its efforts to analyze and address the issue of unmet needs affecting patients with chronic conditions and we urge you to consider our proposal for the inclusion of comprehensive medication management services within the Part B medical benefit. Please feel free to follow up with us at any time if the College and its members can provide additional information.

Sincerely,



Associate Executive Director

Cc: Michael S. Maddux, Pharm.D. FCCP

⁶ Integrating comprehensive medication management to optimize patient outcomes. PCPCC Resource Guide, Second Edition June 2012. Available at <http://www.pcpcc.org/guide/patient-health-through-medication-management>. Accessed July 9, 2014

⁷ Minnesota statute 256B.0625 Subd. 13h, 2005. Available at www.revisor.mn.gov/statutes/?id=256B.0625. Accessed July 9, 2014

**Statement of the American Diabetes Association
1701 N. Beauregard Street, Alexandria, VA 22311**

**Senate Committee on Finance
"Chronic Illness: Addressing Patients' Unmet Needs"
July 15, 2014**

On behalf of the nearly 30 million individuals living with diabetes and the 86 million individuals with prediabetes, the American Diabetes Association (the Association) is grateful for the opportunity to submit a written statement to the Senate Committee on Finance in response to its hearing on July 15th, 2014 entitled, Chronic Illness: Addressing Patients' Unmet Needs.

Diabetes is a serious, chronic illness that affects children and adults. According to the Centers for Disease Control and Prevention (CDC), one in three adults in our country – one in two among minority populations – will have diabetes in 2050 if present trends continue. The diabetes epidemic will continue to worsen unless something is done to prevent this deadly and disabling disease. Our country cannot afford the growing diabetes epidemic. The nation spent an estimated \$245 billion on diabetes in 2012,¹ an increase of 41 percent in just five years. This includes one out of three Medicare dollars being spent on care for people with diabetes.² The Association would like to call the Committee's attention to the following unmet needs for people with diabetes.

Research

There is no denying the biggest unmet need related to diabetes is there is no cure. This is why federal research funding for the National Institutes of Health (NIH) must be considered a top priority for Congress. Investment in diabetes research moves us closer to a cure as well as better means to treat and prevent diabetes. Federally funded research has led to major breakthroughs including: new drug therapies for type 2 diabetes; ongoing development of the artificial pancreas, a closed looped system combining continuous glucose monitoring with insulin delivery; and the advent of modern treatment regimens that have reduced the risk of costly complications like heart disease, stroke, amputation, blindness and kidney disease. Rates of diabetes-related complications have declined significantly over the last two decades with the largest declines in acute myocardial infarction (-67.8%) and death from hyperglycemic crisis (-64.4%) followed by stroke and amputations which declined by about half.³ New treatments and technologies allow people with diabetes to better manage their disease, reduce their risk of complications, and pave the way to healthier futures.

¹ American Diabetes Association. Economic costs of diabetes in the U.S. in 2012. Diabetes Care, March 2013.

² Centers for Medicare and Medicaid Services. Medicare health support overview. Baltimore (MD): CMS. Online: http://www.cms.gov/ccip/downloads/overview_ketchum_71096.pdf

³ Gregg EW, Li Y, Wang J, Burrows NR, et al. Changes in diabetes-related complications in the united states, 1990-2010. New England Journal of Medicine. April 2014.

Health Disparities

Although all populations are affected by diabetes, members of minority populations are hit the hardest and these disparities need to be addressed. In our country, over 15.9 percent of American Indians and Alaska Natives, 13.2 percent of African Americans, 12.8 percent of Latino Americans, and 9.0 percent of Asian American adults have diabetes compared to 7.6 percent of non-Hispanic whites.⁴ We have to take steps to address the diabetes epidemic, especially in these communities. Passage of the Eliminating Disparities in Diabetes Prevention, Access and Care Act (HR 3322) will help better determine the causes of existing health disparities and ensure minority populations have access to appropriate care. Not only do we need more effective treatment and education in those populations disproportionately affected by diabetes, but we need improved research at NIH, enhanced treatment and prevention programs administered by the Centers for Disease Control and Prevention (CDC), and we need to strengthen the health workforce in underserved areas disproportionately impacted by diabetes.

Disease Management & Care Coordination

Diabetes is a complex, chronic illness requiring continuous medical care. For care of patients with diabetes, treatment must be comprehensive and individualized. The disease impacts individuals differently and successful management requires coordination between the patient and family, the treating physician, and other members of the health care team. As stated in the Association's 2014 Standards of Care, "people with diabetes should receive medical care from a team that may include physicians, nurse practitioners, physician's assistants, nurses, dietitians, pharmacists, and mental health professionals with expertise in diabetes."⁵ A collaborative and integrated team approach provides the individual with diabetes an active role in self-care including in the formulation of a care management plan.

This collaborative team-based approach has the potential to improve diabetes management and care. For instance, while there have been steady improvements in the proportion of people with diabetes achieving recommended goals for glycated hemoglobin, also referred to as A1C (a test reflecting a patient's average blood sugar level for the past three months), blood pressure, and cholesterol in the last 10 years, between 33.4 – 48.7 percent of patients with diabetes still do not meet recommended targets. Team-based care has the potential to reduce health disparities and improve care for specific racial, ethnic and socioeconomic populations who are below average in meeting these targets. While some variation in quality of diabetes care across providers and practice settings is expected, especially for certain patient populations such as those with complex comorbidities, financial or other social hardships, and/or for patients with limited English proficiency, there remains significant potential to improve diabetes care through improved care coordination and disease management.

⁴ Centers for Disease Control and Prevention. National diabetes statistics report: estimates of diabetes and its burden in the united states, 2014. Atlanta, GA: US Department of Health and Human Services; 2014.

⁵ American Diabetes Association. Standards of Medical Care in Diabetes - 2014. Diabetes Care, January 2014. Online: http://care.diabetesjournals.org/content/37/Supplement_1/S14.extract

The Association would like to stress that a major barrier to optimal diabetes care is our fragmented delivery system that lacks clinical information capabilities, often duplicates services, and is poorly designed for the coordinated delivery of chronic care. The Association supports the Chronic Care Model (CCM) because its six core elements for the provision of optimal diabetes care have been shown to be an effective framework for improving the quality of diabetes care. The six elements include: (1) delivery system design (moving from a reactive to a proactive care delivery system where planned visits are coordinated through a team-based approach); (2) self-management support; (3) decision support (basing care on evidence-based, effective care guidelines); (4) clinical information systems (using registries that can provide patient-specific and population-based support to the care team); (5) community resources and policies (identifying or developing resources to support healthy lifestyles); and (6) health systems (to create a quality-oriented culture).⁶ Additionally, new models of team-based chronic care such as the Patient-Centered Medical Home and Accountable Care Organizations show promise to improve outcomes for patients through care coordination and lower costs.

Prevention

More than 11 million individuals over age 65 have diabetes representing approximately 26 percent of that population. Even more startling, 51 percent of those age 65 and older have prediabetes placing them at high risk for developing type 2 diabetes. While the number of seniors with diabetes or at risk of developing the disease continues to grow, we can take action to reverse this trend by promoting evidence-based lifestyle interventions like the National Diabetes Prevention Program (National DPP). The National DPP at the CDC is a partnership consisting of government agencies, private insurers, and community organizations, designed to provide evidence-based community programs to prevent type 2 diabetes in individuals at higher risk – specifically, individuals with prediabetes.

The National DPP originated from the successful Diabetes Prevention Program (DPP) clinical trial carried out by the National Institute of Diabetes and Digestive and Kidney Diseases at the NIH. The clinical trial found individuals with prediabetes can reduce their risk for type 2 diabetes by 58 percent with lifestyle changes including improved nutrition, increased physical activity and weight loss of 5-7 percent. The results were even stronger for seniors. Participants over the age of 60 reduced their risk for type 2 diabetes by 71 percent. Further research translating the clinical trial to a community setting showed the intervention can be replicated in a group setting for a cost of less than \$300 per participant. The National DPP is based on this effective low-cost community model.

The dramatic success achieved by seniors in the original clinical trial and the overall success of the intervention in the community-based setting warrants coverage of this program for our nation's Medicare population. The bipartisan Medicare Diabetes Prevention Act (S. 452/HR 962) would provide the National DPP as a covered benefit for Medicare beneficiaries. Currently, Medicare beneficiaries do not have access to this proven prevention program. Providing

⁶ American Diabetes Association. Standards of medical care in diabetes – 2014. Diabetes Care, January 2014. Online: http://care.diabetesjournals.org/content/37/Supplement_1/S14.extract

coverage of the National DPP through the Medicare program would reduce the number of beneficiaries who develop type 2 diabetes and its dangerous and costly complications, including cardiovascular disease, stroke, blindness, lower-limb amputation and kidney disease. Coverage of the National DPP for seniors would also rein in long term healthcare spending by preventing or delaying the onset of type 2 diabetes and its complications. Avalere Health estimates the legislation would reduce federal spending by \$1.3 billion over the ten year budget window (2015-2024) while at the same time reducing the number of seniors with diabetes.⁷

Access

People with diabetes, and those at risk of developing the disease, require access to the services, tools and education necessary to meet their needs. The Association strongly supports the progress made through the enactment of the Affordable Care Act which, in addition to prohibiting discrimination based on diabetes in coverage and premiums, has increased access to comprehensive health coverage for people with diabetes throughout the country. Unfortunately, more must be done to meet the needs of people with diabetes who have been unable to gain access to health coverage whether it is because of a state's failure to expand Medicaid or the patient's lack of education and awareness about the law.

Absent health coverage, people with diabetes struggle to manage their disease and are more likely to visit emergency rooms and develop costly complications related to diabetes. One example, a woman recently treated in the emergency room with a badly ulcerated area on her foot, got the attention of the attending nurse, an Association volunteer. The patient has lived with type 1 diabetes for more than 40 years, but when she became ineligible for Medicaid in 2011, she was forced to ration her insulin, skip testing her blood sugar, and forego appointments with her doctors. Without health coverage she was unable to appropriately manage her diabetes and a blister from a new pair of shoes ultimately resulted in a severe infection requiring a costly and preventable surgery.

The ACA has broken down barriers people with diabetes faced in accessing adequate and affordable health insurance. Individuals have a new opportunity to access coverage through the Health Insurance Marketplaces, and many qualify for financial assistance to pay for their coverage. As we are in the early stages of implementing major health insurance reforms, there is a continued need to monitor and identify issues individuals face in accessing adequate and affordable coverage. For example, many low-income individuals in the 24 states that have not yet expanded Medicaid continue to lack access to adequate and affordable coverage options.

Improved transparency in health care is another important issue to people with chronic illnesses like diabetes and one that requires the attention of the Committee. Accessible and understandable plan and cost information, as well as information on consumer protections and quality ratings, will help provide individuals with chronic illnesses the tools they need to make informed decisions that will allow them to manage their disease(s). Further improvements are

⁷ Avalere Health. Estimated federal impact of the medicare diabetes prevention act. February 2014. Online: <http://www.diabetes.org/assets/pdfs/avalere/estimated-federal-impact-of.pdf>

also needed in assistance and educational materials for individuals with limited-English proficiency.

Seniors with diabetes also face serious access issues as it relates to managing their disease. The Association is pleased the Affordable Care Act closes the Medicare Part D “donut hole.” However, it won’t be fully eliminated until 2020. In the meantime, some individuals with diabetes continue to be impacted by the donut hole and contact the Association seeking help with their drug costs. In addition, as people with diabetes age into Medicare at age 65, they face a number of serious obstacles that threaten their ability to manage their diabetes. One such issue is that Medicare only covers the use of an insulin pump for a narrowly defined group of individuals. Despite the fact that a person may have been successfully managing diabetes for years with the help of an insulin pump, if he or she does not meet specific and scientifically inappropriate criteria, Medicare will not cover the insulin pump the individual has come to rely on to manage his/her diabetes. This is true even in situations where the pump has allowed that person to have tighter control of blood glucose, reduce the risk for severe hypoglycemia, and reduce wide variations in blood glucose levels. While the Association does not support universal access to technologies like the insulin pump for people with diabetes, we strongly believe Medicare needs to improve access and coverage for certain diabetes services and devices.

Conclusion

Diabetes is a serious epidemic that is affecting more and more Americans and costing our nation hundreds of billions of dollars each year. Addressing unmet needs for people with diabetes is essential if we are to slow the diabetes epidemic and reduce spending on the disease. We look forward to working with the Committee on this important issue and thank you for the opportunity to submit comments. Should members of the Committee and their staff have any questions or need additional information, please do not hesitate to contact Amy Wotring, Associate Director, Federal Government Affairs, 703-299-2087 or awotring@diabetes.org.



Diabetes Advocacy Alliance™
Statement for the Record on
Senate Finance Committee Hearing on
Chronic Illness: Addressing Patients' Unmet Needs
July 15, 2014



July 29, 2014

Senator Ron Wyden
Chairman
U.S. Senate Committee on Finance
United States Senate
Washington, DC 20510

Senator Orrin Hatch
Ranking Member
U.S. Senate Committee on Finance
United States Senate
Washington, DC 20510

Dear Senators Wyden and Hatch:

The undersigned members of the Diabetes Advocacy Alliance™ (DAA) thank you both as the Chairman and Ranking Member, respectively, of the Senate Committee on Finance for convening the July 15, 2014 hearing on "Chronic Illness: Addressing Patients' Unmet Needs."

The DAA is a 20-member coalition that represents a unique cross-section of patient, professional and trade associations, other non-profit organizations, and corporations, all united in the desire to influence change in the US health care system to improve diabetes prevention, detection and care. The undersigned members of the DAA believe that the Committee's recent hearing was both timely and necessary, given that chronic diseases are the leading cause of death and disability in the U.S.¹ and treating people with chronic illnesses consumes nearly 85 percent of the nation's health care budget.² In fact, more than two-thirds of the Medicare population has two or more chronic conditions.³ Almost all Medicare dollars and about 80 percent of Medicaid resources are spent on people with chronic conditions.²

Undoubtedly, chronic illness is a significant public health problem for the nation. **Addressing diabetes, which is a chronic disease we actually know how to prevent, could go a long ways towards ameliorating the human and fiscal toll of chronic illness in America.** Diabetes is a gateway disease, often leading to

complications such as kidney disease, blindness, amputation, and early mortality from cardiovascular and cerebrovascular disease.

Recently, the Centers for Disease Control and Prevention (CDC) released updated statistics for diabetes, painting a picture of a growing epidemic that exacts a significant human toll. Today, more than 29 million Americans have diabetes (up from 26 million just three years ago).⁴ Another 86 million adults have prediabetes, and are at high risk of developing type 2 diabetes, heart disease, and stroke.⁴ Over the past 30 years, the percentage of Americans diagnosed with diabetes has more than doubled; and by 2050, one in three will be living with diabetes.^{5,6} One out of three children born in the year 2000 will develop diabetes during his or her lifetime.⁷

Diabetes wreaks an economic toll on the nation as well. In 2012, diabetes cost the nation \$245 billion, a 41 percent increase from 2007.⁸ People with diabetes have medical costs that are more than two times as high as people without the disease.⁸

As Senator Wyden noted in his remarks, diabetes is one of the leading chronic conditions among the Medicare population.⁹ Based on the new CDC prevalence statistics⁴, it can be estimated that among the nearly 45 million adults in Medicare¹⁰, more than 11 million (or about 1 in 4) have diabetes. One in three Medicare dollars is spent on people with diabetes.¹¹

But we believe that with strong federal leadership and attention on three critical fronts, diabetes is a battle we can win.

1. Better screening for diabetes to identify the undiagnosed and those at risk.

There is an evidence base that shows that more comprehensive screening for diabetes would help with prevention efforts—more effectively finding the undiagnosed and those at risk for developing diabetes so that they can benefit from timely and appropriate intervention to, respectively, prevent complications and prevent diabetes itself. In fact, a body of research shows screening guidelines like those of the American Diabetes Association, which recommend screening based on multiple risk factors, would identify significantly more individuals with diabetes and prediabetes; find people at younger ages so they can live more years disease-free or complication-free; and find more at-risk individuals within minority populations that are disproportionately impacted by diabetes.¹²

Unfortunately, current federal diabetes screening guidelines, promulgated by the United States Preventive Services Task Force (USPSTF), recommend screening based on only one risk factor—hypertension. Under the Affordable Care Act, coverage for clinical preventive services like screening is tied to USPSTF recommendations: services with an A or B recommendation from USPSTF must be fully covered by health plans with no co-

pay. The evidence on diabetes screening is currently under review by USPSTF and we anticipate the release of a new draft guideline in early fall. Our hope is that the new guideline will recommend screening based on multiple risk factors so that more Americans can get screened and detected and receive appropriate treatment and care.

2. Scaling up diabetes prevention programs across the country to provide access and hope for the 86 million Americans with prediabetes.

There is also a strong evidence base for the effectiveness of providing diabetes prevention and lifestyle change intervention through the National Diabetes Prevention Program to help those at risk for diabetes prevent or delay progression to the disease. In 2002, the Diabetes Prevention Program (DPP), a \$200 million clinical trial funded by the National Institutes of Health (NIH) through the National Institute of Diabetes and Digestive and Kidney Diseases, demonstrated that intensive behavioral modification can prevent the progression of prediabetes to type 2 diabetes, reducing the prevalence of type 2 diabetes and by association improving cardiovascular outcomes.¹³ The DPP showed specifically that individuals diagnosed with prediabetes who lost a moderate amount of weight (5 to 7%) and engaged in regular physical activity reduced their chances of developing type 2 diabetes by 58%. Adults aged 60 and over reduced their risk for developing type 2 diabetes by 71%.¹³ The Diabetes Prevention Program Outcomes Study (DPPOS), a 10-year follow-up of the DPP, showed that prevention or delay of diabetes and its complications persisted through the decade.¹⁴ Further research sponsored by the Centers for Disease Control and Prevention's (CDC) Division of Diabetes Translation showed that similar results could be achieved in community-based YMCA settings for approximately \$300 per person.¹⁵

The National Diabetes Prevention Program (National DPP) was established based on the translational, community-based DPP model, and is overseen by the Division of Diabetes Translation at the Centers for Disease Control and Prevention (CDC). Through a unique public-private partnership, YMCA of the USA (Y-USA), the CDC and major insurers like UnitedHealthCare are working together to scale the program nationally and provide insurance coverage for participants. The Y is currently offering the programs in 853 communities in 41 states and the District of Columbia. In addition, Y-USA and the American Medical Association have established a partnership to encourage primary care physicians to refer overweight or obese people with prediabetes to the YMCA's Diabetes Prevention Program. **With adequate federal funding, the National DPP could be scaled to provide access in communities nationwide. Preventing just one person with prediabetes from advancing to full-blown diabetes reduces average annual spending on that adult by 11 percent—and reducing the heart, stroke and kidney complications that might otherwise result reduces spending by an additional 25 percent.¹⁶ Imagine the cost savings if the National DPP were available to the 86 million Americans with prediabetes!**

3. Strong Congressional leadership to advance legislation that most effectively uses federal resources to prevent diabetes and improve the lives of Americans living with the disease.

DAA members are advancing a number of pieces of legislation that we believe have the potential to bend the impact and cost curve of the diabetes epidemic. Many of your colleagues are already cosponsoring or leading this important diabetes legislation, and we commend your efforts in this regard. We would also like to thank the leaders of the Senate Diabetes Caucus, Senator Jeanne Shaheen and Senator Susan Collins.

- **National Diabetes Clinical Care Commission Act (S. 539/H.R. 1074):** Authored by Senators Shaheen and Collins, this legislation would better leverage and streamline the federal government's multiple diabetes programs and policies to reduce the burden of diabetes and its complications. Currently, 35 different federal agencies provide funding for diabetes with little or no coordination among them. This bill would create a commission comprised of diabetes experts, primary care physicians, other health care professionals, and representatives from the federal agencies most involved in diabetes research, prevention and care to review federal diabetes activities, determine which programs are working and which are not, and recommend new approaches to improve diabetes care. The commission will use existing resources to conduct its work within three years and then sunset after submitting a final report to Congress and the Secretary of HHS.
- **Medicare Diabetes Prevention Act of 2013 (S. 452/H.R. 962):** Authored by Senators Franken and Collins, this legislation would provide needed coverage and enable seniors at risk for diabetes to enroll and participate in evidenced-based diabetes prevention programs—rolled out under the National DPP—right in their own communities. Adults aged 65+ have the highest rates of diabetes and prediabetes.⁵ The National DPP is based on proven interventions that have shown that older adults can lower their risk of developing type 2 diabetes by more than 70 percent.¹³ A recent study by the consulting firm Avalere found that providing coverage to Medicare beneficiaries for diabetes prevention programs could save the federal government \$1.3 billion over 10 years and reduce the incidence of diabetes among seniors by 37 percent.¹⁷
- **Gestational Diabetes Act (S. 907/H.R. 1915):** Authored by Senators Shaheen and Collins, this legislation would help fight the trend of rising rates of gestational diabetes through improved detection, research and coordination. About 18% of all pregnancies are impacted by gestational diabetes.¹⁸ Women with gestational diabetes are seven times more likely to develop type 2 diabetes after pregnancy and their babies are at higher risk for both obesity and type 2 diabetes.¹⁹
- **Access to Quality Diabetes Education Act (S. 945/H.R. 1274):** Authored by Senators Shaheen and Collins, this Act would provide federal recognition of

credentialed diabetes educators as Medicare providers for diabetes self-management training services, including telehealth services. Patients who complete diabetes self-management training with diabetes educators improve their care compliance rates by as much as 10 percent, and better management results in fewer costly complications.²⁰

- **Preventing Diabetes in Medicare Act (H.R. 1257):** Authored by House Diabetes Caucus Co-Chairs Representatives DeGette and Whitfield, the legislation would extend Medicare coverage of medical nutrition therapy (MNT) services to people with prediabetes and other risk factors for developing type 2 diabetes as a tool for preventing diabetes. Currently coverage is limited to individuals who are already diagnosed with diabetes.

The DAA believes that the measures and legislation outlined above are critical to addressing the growing epidemic of diabetes—and will ultimately help alter the significant human and economic toll of this disease and chronic disease overall in the U.S. Diabetes is the model for chronic disease prevention and management, and all we need is the political will to make it a national priority. In closing, we thank you for your vision and leadership in focusing on the unmet needs of the millions of Americans suffering from diabetes and other chronic diseases and conditions, and urge you to consider our recommendations as you forge solutions. Please do not hesitate to contact us if you have any questions or we can be of assistance.

Sincerely,

Tricia Brooks
DAA Co-Chair
Sr. Director
Public Policy
Novo Nordisk Inc.

Tekisha Dwan Everette, Ph.D.
DAA Co-chair
Managing Director
Federal Government Affairs
American Diabetes Association

Mary Pat Raimondi
DAA Co-Chair
Vice President
Strategic Policy and
Partnerships
Academy of Nutrition and
Dietetics

References

1 US Centers for Disease Control and Prevention. CDC website: Chronic Disease Prevention and Health Promotion. Available at <http://www.cdc.gov/chronicdisease/overview/>. Accessed July 23, 2014.

2 Robert Wood Johnson Foundation. Chronic Care: Making the Case for Ongoing Care. February 2010. Available at <http://www.rwjf.org/content/dam/farm/reports/reports/2010/rwjf54583>.

- 3 Centers for Medicare and Medicaid Services. Chronic Conditions among Medicare Beneficiaries, Chartbook, 2012 Edition. Baltimore, MD. 2012. Available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf>.
- 4 Centers for Disease Control and Prevention. National Diabetes Statistics Report 2014. Available at: <http://www.cdc.gov/diabetes/pubs/statsreport14/national-diabetes-report-web.pdf>. Accessed July 27, 2014.
- 5 Centers for Disease Control and Prevention. National diabetes fact sheet: national estimates and general information on diabetes and prediabetes in the United States, 2014. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2011.
- 6 Boyle JP, Thompson TJ, Gregg EW, et al. Projection of the year 2050 burden of diabetes in the US adult population: dynamic modeling of incidence, mortality, and prediabetes prevalence. *Population Health Metrics*. 2010;8:29.
- 7 Narayan KMV, Boyle JP, Thompson TJ, Sorensen SW, Williamson DF. Lifetime risk for diabetes mellitus in the United States. *JAMA* 2003 October 8;290(14):1884-1890.
- 8 American Diabetes Association. Economic costs of diabetes in the US in 2012. *Diabetes Care* online ahead of print. March 6, 2013.
- 9 The United States Senate Committee on Finance. Wyden statement on addressing the challenges of chronic illness. July 15, 2014. <http://www.finance.senate.gov/hearings/hearing/?id=ee3a24de-5056-a032-529e-2fc76cca5ae6>. Accessed July 17, 2014.
- 10 Centers for Medicare and Medicaid Services. CMS fast facts overview. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Fast-Facts/>. Accessed July 17, 2014.
- 11 Centers of Medicare and Medicaid Services. (2011). Medicare Healthcare Support Overview. Retrieved from <https://www.cms.gov/CCIP/>
- 12 Dall T et al, Detecting type 2 diabetes and prediabetes among asymptomatic adults in the United States: modeling American Diabetes Association versus US Preventive Services Task Force diabetes screening guidelines. *Population Health Metrics* 2014, 12:12 doi:10.1186/1478-7954-12-12 and Casagrande S, Cowie C, Fradkin J. Utility of the US preventive services task force for screening. *Am J Prev Med*. 2013;45(2): 167-174.
- 13 Diabetes Prevention Program Research Group. Reduction in the Incidence of Type 2 Diabetes with Lifestyle Intervention or Metformin. *New England Journal of Medicine*. 2002;346(6):393-403.
- 14 Diabetes Prevention Program Research Group. 10-year follow up of diabetes incidence and weight loss in the DPPPOS. *Lancet*. 374(9702): 1677-1686, 2009.
- 15 Ackermann RT et al. Translating the DPP into the community: The DEPLOY pilot study. *American Journal of Preventive Medicine*. 35(4): 357-363, 2008.
- 16 Barbara Ormond, Brenda Spillman, and Timothy Waidmann, "Potential State-Level Savings from Primary Prevention," working paper (Washington, DC: Urban Institute, 2009).

- 17 Avalere. Estimated Federal Impact of H.R. 962/ S. 452 "The Medicare Diabetes Prevention Act". Available at <http://www.diabetes.org/assets/pdfs/advocacy/estimated-federal-impact-of.pdf>. Accessed July 28, 2014.
- 18 Mayo Clinic. Gestational Diabetes. Available at <http://www.mayoclinic.com/health/gestationaldiabetes/DS00316/DSECTION=complications>. Accessed July 28, 2014.
- 19 National Diabetes Education Program. Diabetes risk after gestational diabetes. Available at http://ndep.nih.gov/media/fs_post-gdm.pdf. Accessed July 28, 2014.
- 20 Winn A, O'Grady M and Huang ES. The Special Diabetes Program: Impact on federal entitlement program savings. JDRF. Available at <http://advocacy.jdrf.org/wp-content/uploads/sites/111/2013/03/SDP-Impact-on-Federal-Entitlement-Savings3.pdf>. Accessed July 28, 2014.



Statement
Of
The National Association of Chain Drug Stores
For
U.S. Senate
Committee on Finance
Hearing on:
“Chronic Illness: Addressing Patients’ Unmet Needs”
July 15, 2014
10:00 A.M.
215 Dirksen Senate Office Building

National Association of Chain Drug Stores (NACDS)
1776 Wilson Blvd., Suite 200
Arlington, VA 22209
703-549-3001
www.nacds.org

The National Association of Chain Drug Stores (NACDS) thanks the Members of the Committee on Finance for the opportunity to submit the following statement for the record on “Chronic Illness: Addressing Patients’ Unmet Needs.” NACDS and the chain pharmacy industry are committed to partnering with Congress, HHS, patients, and other healthcare providers to improve the quality, affordability, and accessibility of healthcare services.

NACDS represents traditional drug stores, supermarkets and mass merchants with pharmacies. Chains operate more than 40,000 pharmacies, and NACDS’ 125 chain member companies include regional chains, with a minimum of four stores, and national companies. Chains employ more than 3.8 million individuals, including 175,000 pharmacists. They fill over 2.7 billion prescriptions yearly, and help patients use medicines correctly and safely, while offering innovative services that improve patient health and healthcare affordability. NACDS members also include more than 800 supplier partners and nearly 40 international members representing 13 countries. For more information, visit www.NACDS.org.

NACDS supports the *Better Care, Lower Cost* Act, introduced by Chairman Ron Wyden and Senator Johnny Isakson, which would implement the use of Better Care Programs (BCPs) to provide fully-integrated medical care for people with chronic diseases. The bill will promote accountability and better care management for chronically ill patients and provide coordinated items and services under Parts A, B and D with the goal to prevent, delay or minimize the progression of illness or disability associated with chronic conditions. This important legislation would further the goal of ensuring that patient’s needs are met.

We are pleased that the legislation specifically recognizes the contributions provided by pharmacists to improve care to patients with chronic conditions. Community pharmacists play a vital role in advancing the health, safety, and well-being of the American people and in assisting to meet the needs of those suffering from chronic illnesses. As the face of neighborhood healthcare, community retail pharmacies and pharmacists provide access to prescription medications and over-the-counter products, as well as cost-effective health services such as immunizations and disease screenings. Through personal interactions with patients, face-to-face consultations, and convenient access to preventive care services, local pharmacists are helping to shape the healthcare delivery system of tomorrow—in partnership with doctors, nurses, and others.

As the U.S. healthcare system continues on its transformational path, a prevailing issue for public health leaders will be the adequacy of access to affordable, quality healthcare. The national physician shortage coupled with the continued expansion of health insurance coverage will have serious implications for the nation’s healthcare system. Access, quality, cost, and efficiency in healthcare are all critical factors – especially for those with chronic illnesses. Community retail pharmacies are oftentimes the most readily accessible healthcare provider. Research has shown that nearly all Americans (89%) live within five miles of a community retail pharmacy. Such access is vital for those with chronic illnesses, but especially those who are not having their healthcare needs met. From helping patients take their medications effectively and safely, to providing preventive services, pharmacist services help keep people healthier and reduce costs.

Community pharmacists have the education and training to address many of the noted healthcare challenges. Community retail pharmacies stand ready to work with other healthcare providers to

advance patient outcomes and population health. Specifically, community pharmacists are trained and educated to provide comprehensive chronic medication management, health screenings, preventative care, and pharmacogenomics counseling; order and interpret lab tests; initiate and modify medication regimens; provide rapid diagnostic testing (e.g. flu, strep and others); perform physical assessments; and provide immunizations and health and wellness care.

Community retail pharmacies offer innovative care services to reduce hospital readmissions and health outcomes in medical homes, and engage with high risk patients in emerging care models. However, the lack of pharmacist recognition as a provider by third party payors including Medicare and Medicaid has limited the number and types of services pharmacists can provide, even though fully qualified to do so.

Examples of community retail pharmacy's increasing role in providing patient care include medication therapy management (MTM) and expanded immunization services. Congress has recognized the importance of pharmacist-provided services such as MTM by including it as a required offering in the Medicare Part D program. MTM under the Part D program specifically targets beneficiaries with chronic conditions. The experiences of Part D beneficiaries, as well as public and private studies, have confirmed the effectiveness of pharmacist-provided MTM. A 2013 Centers for Medicare and Medicaid Services (CMS) report found that Part D MTM programs consistently and substantially improved medication adherence and quality of prescribing for evidence-based medications for beneficiaries with congestive heart failure, COPD, and diabetes. The study also found significant reductions in hospital costs, particularly when a comprehensive medication review (CMR) was utilized. This included savings of nearly \$400 to \$525 in lower overall hospitalization costs for beneficiaries with diabetes and congestive heart failure. The report also found that MTM can lead to reduced costs in the Part D program as well, showing that the best performing plan reduced Part D costs for diabetes patients by an average of \$45 per patient.

How and where MTM services are provided also impact its effectiveness. A study published in the January 2012 edition of *Health Affairs* identified the key role of community retail pharmacies in providing MTM services. The study found that a community retail pharmacy-based intervention program increased patient adherence for patients with diabetes 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 suggested that interventions such as in-person, face-to-face interaction between the community pharmacist and the patient contributed to improved adherence behavior with a return on investment of 3 to 1.

Since community pharmacists have the proven ability to provide services that lead to better clinical outcomes and lower healthcare costs, allowing them to practice up to their full extent will prove beneficial for all patients, including those suffering from chronic illnesses. Increasing access to community pharmacists will improve health and reduce overall healthcare spending by reduced complications that lead to increased use of expensive medical services and hospitalizations.

NACDS thanks the Committee for consideration of our comments. We look forward to working with policymakers and stakeholders on these important issues.



WWW.NCPANET.ORG

**United States Senate
Committee on Finance
Hearing on "Chronic Illness: Addressing Patients' Unmet Needs"
July 15, 2014**

Chairman Wyden, Ranking Member Hatch, and Members of the Committee, the National Community Pharmacists Association (NCPA) is pleased to submit the following written comments for inclusion in the record of the July 15, 2014 Senate Finance Committee hearing on *Chronic Illness: Addressing Patients' Unmet Needs*. We commend you for holding this important hearing, as the committee considers effective approaches to improving chronic disease management and care quality, while managing skyrocketing health care expenditures. NCPA believes that community pharmacists play a key role in health care delivery, and is committed to working with this committee and Congress to develop policies that will achieve the triple aim of better care, better outcomes, and lower costs.

NCPA represents the interests of pharmacist owners, managers and employees of more than 23,000 independent community pharmacies across the United States. Together they employ over 300,000 full-time employees and dispense nearly half of the nation's retail prescription medicines. Independent community pharmacists are proud to play a vital role in their communities, and are on the front lines of providing medications and related counseling to millions of Americans.

Community pharmacists are a key player on the healthcare team

The perfect storm is brewing in healthcare with an exponential growth in the senior population expected, an influx of newly insured patients gaining health coverage and access to preventative services for the first time under the Patient Protection and Affordable Care Act (PPACA), and an anticipated shortage of primary care providers. As one of the most accessible healthcare providers, community pharmacists are well-positioned and trained to meet the demands of an ever-expanding healthcare system, and to work closely with other healthcare providers in delivering high quality, cost-effective patient care. More than any other segment of the pharmacy industry, independent pharmacies are often located in the underserved and rural areas that are home to many Medicare recipients. In fact, independent pharmacies represent 52% of all rural retail pharmacies and there are over 1,800 independent community pharmacies operating as the only retail pharmacy within their rural communities.¹

In addition to serving as medication experts within the community, pharmacists today work in close collaboration with physicians, and provide a wide array of services such as health and wellness screenings, disease state management, immunizations, long-term and post-acute care, and working with hospitals to ensure safe care transitions to reduce or prevent avoidable hospital readmissions. One example includes the positive impact pharmacists can have in assisting their patients with hypertension management.

In the Hypertension Outcomes Through Blood Pressure Monitoring and Evaluation by Pharmacists (HOME) study, community pharmacists provided patient specific education about hypertension, including: (1) disease process and complications, (2) medication use and adherence, (3) lifestyle modification, and (4) home self-blood

¹ Based on NCPA Analysis of National Council for Prescription Drug Programs (NCPDP) data, Rural Urban Commuting Area (RUCA) Codes, and 2000 U.S. Census data.

100 Daingerfield Road
Alexandria, VA 22314-2888
(703) 683-8200 PHONE
(703) 683-3619 FAX

pressure monitoring techniques.² Hypertensive patients receiving interventions from community pharmacists in the HOME study experienced blood pressure reductions that were clinically meaningful. Four other studies found that blood pressure control improved when community pharmacists assisted with patient education, blood pressure monitoring, drug therapy management and medication adherence.^{3,4,5,6}

Medication Therapy Management (MTM) Services are an effective tool in chronic disease management

NCPA has long supported the efforts of the Centers for Medicare & Medicaid Services (CMS) to promote the MTM benefit to beneficiaries, and we appreciate the agency's recognition of community pharmacists' in the provision of such services. We believe there is encouraging evidence that demonstrates the value of MTM services in the senior population that should be carried over into disease state management programs for all adults, and should be seriously considered in policy deliberations on best practices to address chronic illness. Increasing patient access to these critical services will help achieve the triple aim of better care for patients, improved health in our communities, and reduced costs throughout the healthcare system. As CMS noted, there is growing evidence that MTM services not only improve the quality of care beneficiaries receive, but can also generate medical savings.

NCPA appreciates the analysis CMS has conducted thus far in examining the impact of Part D MTM programs, and recent evidence from both CMS data and the Congressional Budget Office (CBO) confirms the positive impacts associated with comprehensive medication reviews, not only in relation to improved adherence and health outcomes, but also in medical savings.^{7,8} As noted in the CMS interim report, *Medication Therapy Management in a Chronically Ill Population*, not only did Medicare beneficiaries with congestive heart failure and chronic obstructive pulmonary disease (COPD) who were enrolled in MTM programs and received their annual CMR experience significant improvements in the quality of their drug regimens compared to beneficiaries who did not receive any MTM services, but there were also significant cost savings tied to all-cause hospitalizations. In addition to studies conducted by CMS and CBO, additional studies have shown that adherence and MTM services can lead to a reduction in overall healthcare expenditures. MTM can lead to savings through different methods: a comprehensive medication review is an opportunity for a pharmacist to review all a patient's entire medication regimen, and identify potential cost-effective alternatives or eliminate duplicate therapies. MTM is also intended to improve medication adherence, which may increase drug spend through greater utilization, however studies have found that higher rates of medication adherence result in significantly fewer hospitalizations and lower health care costs.⁹

NCPA believes that prevention is the best medicine, and whether it's catching a medication error before it leads to a hospitalization or effective chronic disease management, MTM services present opportunities to improve patient care while providing greater efficiencies within the healthcare system. Broadening access means that more patients will be able to take advantage of an important service to thoroughly review all of their medications to keep patients well, and likely lead to increased productivity through less sick days, and decreased emergency department visits and hospitalizations.

² Zillich AJ, Sutherland JM, Kumbera PA, Carter BL. Hypertension Outcomes Through Blood Pressure Monitoring and Evaluation by Pharmacists (HOME Study). *J Gen Intern Med.* 2005 December; 20(12): 1091–1096.

³ McKenney JM, Slining JM, Henderson HR, Devins D, Barr M. The effect of clinical pharmacy services on patients with essential hypertension. *Circulation.* 1973;48:1104–11.

⁴ McKenney JM. Pharmacy management of hypertensive patients. *J Am Pharm Assoc.* 1974;14:190–5.

⁵ Park JJ, Kelly P, Carter BL, Burgess PP. Comprehensive pharmaceutical care in the chain setting. *J Am Pharm Assoc.* 1996;36:443–51.

⁶ Carter BL, Barnette DJ, Chrischilles E, Mazzotti GI, Asali ZJ. Evaluation of hypertensive patients after care provided by community pharmacists in a rural setting. *Pharmacotherapy.* 1997;17:1274–85.

⁷ CMS Center for Medicare & Medicaid Innovation. Medication Therapy Management in Chronically Ill Populations: Final Report, August 2013.

⁸ Congressional Budget Office. Offsetting Effects of Prescription Drug Use on Medicare's Spending for Medical Services, November 2012.

⁹ M. Christopher Roebuck, Joshua N. Liberman, Marin Gemmill-Toyama and Troyen A Brennan. Medication Adherence Leads To Lower Health Care Use And Costs Despite Increased Drug Spending. *Health Affairs*, 30, no.1 (2011):91-99

Incentives must be aligned in order to provide coordinated care

The current siloed, fee-for-service structure within the Medicare program is not conducive to fostering coordinated care. From an overall payment perspective, there is no connection between Part D spend on medications on better health outcomes, though research has demonstrated the correlation between greater adherence and clinical improvements, which should reduce expenditures in Parts A and B. While this is concerning, we cannot say that we're surprised, due to the structure of the Part D benefit, and the way the MTM program is factored into a plan sponsor's bid. The current structure of considering MTM programs as an administrative cost is actually counterintuitive to promoting better adherence and improved patient outcomes. For these plans, the drug spend is completely segregated from the health spend. As a result, any increases in drug spend, including those resulting from improved medication adherence and expanding MTM programs, adds to the plan's overall costs and consequently increases their bid. As the healthcare payment paradigm shifts from a volume- to value-based system, we would strongly encourage members of the Committee to reconsider innovative payment strategies for medication management services that incentivize quality improvement.

NCPA strongly believes providing patients with greater access to pharmacist services can improve care quality. However, the lack of federal recognition of pharmacists as providers under Medicare Part B presents a barrier as it prevents pharmacists from practicing to the full extent of their licensure. Granting pharmacists provider status has the potential to transform the profession and patient care in a positive way. Consistent with Medicare reimbursement for other non-physician practitioners, pharmacist services would typically be reimbursed at 85% of the physician fee schedule. Pharmacist provider status will enable Medicare beneficiaries access to pharmacist-provided services under Medicare Part B by amending section 1861(s)(2) of the Social Security Act. These services would be reimbursable under Medicare Part B if they are provided in medically underserved communities and consistent with state scope of practice laws.

Effective strategies to improve chronic care for all patients

NCPA is pleased to support the Better Care, Lower Cost Act, introduced by Chairman Wyden and Senator Isakson, as well as Representatives Paulsen (R-Minn.) and Welch (D-Vt.). We believe the bipartisan, bicameral legislation is on target to improve care coordination for Medicare beneficiaries with multiple chronic conditions. NCPA appreciates the expansion of multidisciplinary health teams, and inclusion of pharmacists as an envisioned essential healthcare professional in the Better Care Programs.

We strongly recommend that the Committee examine the findings from the Center for Medicare and Medicaid Innovation called Medication Therapy Management in Chronically Ill Population: Final Report to improve upon the MTM program overall. The study found that the best-performing Part D organizations were able to improve medication adherence and quality of prescribing while keeping health care costs (including drugs) from rising. We encourage the Committee to consider the practices from high-performing MTM programs described in the CMMI report, such as:

- targeting and aggressively recruiting patients to complete a CMR based on information on medical events such as a recent hospital discharge in addition to scanning for the usual MTM eligibility criteria; and
- coordinating care by utilizing trusted community relationships including networks of community pharmacists to recruit MTM eligible candidates, and utilizing existing working relationships between MTM providers (pharmacists) and prescribers to make recommendations and discuss identified problems for patients.

NCPA welcomes the opportunity to work with Congress to improve the care provided for Americans with chronic illness, thank you for the opportunity to submit this statement for the record.

The SNP Alliance

A National Health Policy Group Initiative Working to Change Policy and Practice for High-Risk Beneficiaries

Testimony Submitted to the Record on behalf of the SNP Alliance

Senate Finance Committee Hearing: "Chronic Illness: Addressing Patients' Unmet Needs"

July 15, 2014

SNP Alliance
750 9th Street, NW
Suite 600
Washington, DC 20001

The Special Needs Plan (SNP) Alliance is the only national organization specifically dedicated to representing the needs and interests of Special Needs Plans. Alliance members include all major SNP types, organizational structures and regions of the United States. We also have Medicare-Medicaid Plan (MMP) representation from all states participating in the Financial Alignment Demonstration. Members are also actively involved in states with advanced integration programs functioning outside of national demonstration authority. Our mission is to improve the long-term business viability of SNPs and MMPs. Our goal is to improve total quality and cost performance in serving high-risk beneficiaries. Our work is to advance dual integration efforts and to improve payment methods, health policy, and performance evaluation metrics for high-risk/high-need beneficiaries through legislative and regulatory advocacy.

SNP Alliance members consist of over 300 SNPs in 41 States and the District of Columbia that serve nearly one million beneficiaries. Membership is by invitation only, with members demonstrating high quality performance and commitment to advancing improvements in care for high-risk/high-need subgroups. Two-thirds of our membership is non-profit. All SNPs and MMPs offer specialized benefits and services, as well as comprehensive assessments, interdisciplinary care teams, and individualized care plans for every enrollee. Our members' enrollees have higher rates of chronic and mental illnesses and higher risk scores than Fee for Service (FFS) Medicare beneficiaries. Members also consistently demonstrate lower inpatient usage than for comparable groups in Medicare FFS.

We are pleased to submit this testimony for the record for the Senate Finance Committee's hearing on "Chronic Illness: Addressing Patients' Unmet Needs."

Persons who are frail, disabled, and with complex medical conditions, such as HIV-AIDS and ESRD, are healthcare's most vulnerable, high-cost and fastest growing service group. Approximately two-thirds of all Medicare spending is for those with five or more chronic conditions. In 2013, over \$350 billion was spent on care of persons dually eligible for Medicare and Medicaid, with most costs related to caring for frail elders and for adults with disabilities.

Our current healthcare system was not designed to meet the volatile, complex and ongoing nature of these complex care problems. About two thirds of physicians believe their training did not adequately prepare them to educate patients with chronic illness, coordinate home and community-based services, manage the psychological and social aspects of chronic care, provide effective nutritional guidance or manage chronic pain. (Chart book, G. Anderson, 2010)

To adequately meet the needs of these complex care beneficiaries and control future spending, we must fundamentally change how Medicare and Medicaid finance and regulate the spectrum of primary, acute, pharmacy, behavioral health, and long-term care providers who serve these persons to be more person centered and system-oriented. (See below.)

Person-Centered, System-Oriented Specialized Chronic Care

Current Approach	New Approach
<ul style="list-style-type: none"> • Disease-based, symptom-driven, point-in-time focus • Provider-centric care • Fee-for-service financing (treatment and place specific payment rates) • Component-based performance evaluation • Separate Medicare/Medicaid program for duals 	<ul style="list-style-type: none"> • Population-based, total care, ongoing focus • Person-centric care • Capitated financing (All in, risk adjusted, across care settings and over time.) • Total quality and cost performance evaluation • Integration of Medicare and Medicaid for duals

The growing prevalence and nature of chronic disease and disability has changed the nature of our healthcare problem.

Our current healthcare system works fairly well for people who are relatively healthy and need to see their doctor for a flu virus, broken arm, or to control their cholesterol or high blood pressure. This is not the case for people who are frail, disabled, or those with co-morbid and complex medical conditions.

For most complex care beneficiaries, the full array of primary, acute, pharmacy, behavioral health and long-term care providers are involved. It is not uncommon for any one person to receive care from multiple providers and multiple physicians, who prescribe multiple medications, involving multiple pharmacies. The result is a hodge-podge of providers seeking to address a host of interrelated problems without any sense of how their various interventions relate to one another or how costs accumulate over time.

This fragmented approach to care is in large part driven by a similarly fragmented hodge-podge of financial incentives, program policies, and evaluation metrics focused on financing and regulating specific interventions, prescribed by individual providers, at a particular point in time, for a particular condition or symptom. While all of these disparate requirements involve multiple providers caring for the same person, they in large part ignore the multi-dimensional, interdependent, and ongoing nature of the problem. This is particularly problematic for the 9 million beneficiaries who are dually eligible for Medicare and Medicaid, where each program provides financing for a segment of a person's total care, using different and unrelated incentives, policies, and oversight structures.

In most cases, the confusion, medical complications and costs caused by this fragmentation go without notice as there is no record for what everyone is doing for any given person, and no one is monitoring how much all of these related activities costs or how they affect a person's overall quality of life. It's not that no one cares; it's simply a result of working within the context of structures developed for another time.

When Medicare and Medicaid were established, the primary purpose was to help seniors and poor women and children cover the cost of physician and hospital services. For the most part, government identified specific benefits and services to be covered, with rates and performance standards set for each service. Over time, Medicare included an enriched drug benefit, along with an expanded array of preventive services. Medicaid was expanded beyond coverage of medical care for poor mothers and children to include an array of behavioral health and long-term services and supports. As a result, no one is capable of knowing the total cost of care for any frail elder, adult with disabilities, and person with complex medical conditions, as their condition evolves over time and across care settings. Everyone is focused on specific pieces of care without any sense of the collective cost and quality impact for consumers and government.

People who are frail or disabled and those with severe chronic medical conditions require a systemic approach to financing and oversight.

In the early 80s, Medicare established managed care organizations to address some of these aggregate cost concerns, with primary emphasis given to prevention and early detection and treatment. As time went on, a number of states contracted with managed care companies to help control their Medicaid expenditures. However, neither of these developments fully accounted for the interdependence of care providers in serving the same complex care beneficiaries, nor the accumulation of costs as a person's conditions evolve over time and across care settings. For the most part, managed care companies have multiple provider specific contracts for a segment of a person's total care needs, and manage costs and care piece-by-piece.

If Medicare and Medicaid are to adequately meet the emergent challenges of 21st century care requirements, it's critical for both programs to establish new financing, administration, and oversight structures that mirror the multi-dimensional, interdependent, and ongoing nature of chronic disease and disability. It is critical for them to enable related care providers to work together to optimize *total* quality and cost performance. It's critical for policies and procedures to account for the interdependence of co-morbid illnesses, the relationship between a person's illnesses and their abilities/disabilities, and the influences that a person's history, experience, habits, psychological make-up, education levels and environment have on optimizing total quality and cost performance.

With a major influx of Baby Boomers moving into retirement and a continued decline in average family income and accrued life savings, we can no longer afford to conduct business as usual. We must move from program fragmentation to program integration. We must organize care around the nature of the problem to be addressed rather than the component functions of individual providers and professionals. We must fully embrace the powers of capitated financing to break-through the antiquated incentives of fee-for-service medicine. We must give more focus to strengthening the relationships among related providers and enable managed care companies to redistribute resources to whatever combination of care is most cost effective. We must break through the rigid boundaries of Medicare and Medicaid and integrate related benefits and oversight structures for the dually eligible. We must replace our disease-specific, symptom driven approaches to care with ones that are focused more on improving *total* quality and cost performance for defined population segments, to include frail elders, adults with disabilities, and other persons with late-stage, complex medical conditions.

Special Needs Plans and the Better Care Act provide a foundation for system change.

While Congress has made important progress in advancing care for complex beneficiaries through a variety of initiatives, Special Needs Plans (SNPs) and Medicare-Medicaid Plans (MMPs) established under the Financial Alignment Demonstration are the only major federal initiatives focused on transforming care across the continuum, and including better alignment of Medicare and Medicaid benefits and services.

Today, SNPs serve 2 million special needs individuals. Over 88,000 persons are served by Fully Integrated Dually Eligible Special Needs Plans (FIDESNPs) that offer the full array of Medicare and Medicaid benefits and services, most of which were built on prior national demonstration authority. Under the Financial Alignment Demonstration, ten states are actively engaged in a new round of national integration demonstrations, with over 120,000 enrolled.

Earlier this year, Senator Wyden introduced the Better Care Act to further advance care for complex care beneficiaries through person-centered, system-oriented policies and procedures. However, it's important to keep in mind that our care systems are still deeply rooted in a culture and structures built for another time. To optimize *total* quality and cost performance, Congress, CMS, and States must work together to:

1. **Advance capitated, risk-adjusted financing.** While CMS has made significant progress in risk adjusted financing, existing MA payment methods still do not fully account for all related Medicare and Medicaid costs. They still do not fully account for cost differences in serving frail elders, adults with disabilities, and persons with certain complex and/or co-morbid illnesses or account for the influences of social determinants

of health. They still contain significant payment disparities for serving duals vs. non-duals. SNPs and MMPs should not be penalized for their specialization. CMS should eliminate payment inequities in serving duals and non-duals and eliminate payment penalties for specializing in care of complex care beneficiaries.

2. **Modify program policy.** SNPs and MMPs both are mandated to provide special benefits and services for their targeted population, including providing individual assessments, care plans and interdisciplinary care teams for ALL their enrollees. However, SNPs must also comply with virtually all requirements for general MA plans that serve a healthier group of beneficiaries. For example, with a limited exception for FIDESNPs, SNPs cannot provide supplemental benefits different from those that are also available to Medicare beneficiaries receiving care through traditional MA plans. SNPs must also comply with standard network adequacy requirements that are primarily designed to ensure consumer access to the full array of Medicare benefits and services, without regard to specialty care requirements. This makes it difficult for SNPs to craft benefit and service arrangements of unique importance to those being targeted, to limit network providers to those with special expertise of unique importance to their enrollees, and to forge provider relationships critical to optimizing *total* quality and cost performance, as a person's needs evolve over time and across care settings.
3. **Modify performance metrics.** SNPs must be approved by NCQA based on population-specific models of care (MOC), which are audited by CMS. SNPs also report about 20 HEDIS measures at the plan level, including measures not reported by standard MA plans. In addition, SNPs must report on ALL measures required of MA plans serving a general population. Unfortunately, many MA measures used for Star ratings are misaligned with the needs of key subgroups served by SNPs and unrelated to their specialty care mandate. SNPs were not established to be "super" MA plans; they were established to excel in addressing the needs of a complex care *segment* of the Medicare population. As a result, SNP measurement should be: a) modified to include population relevant measures and eliminate irrelevant and potentially harmful measures; b) risk adjusted or stratified to account for health status, geography, socioeconomic status and other factors independent of health plan interventions; and c) weighted most heavily for population specific measures. Self-reported survey data should be evaluated for validity and reliability for those with cognitive impairments or mental illness.
4. **Fully align Medicare and Medicaid administrative requirements** for plans serving dual beneficiaries. The CMS Medicare-Medicaid Coordination Office, working in collaboration with 10-15 states, is making great progress in aligning Medicare and Medicaid. However, the vast majority of Medicare and Medicaid administrative and oversight policies and procedures are deeply rooted in a bifurcated approach to program management. This causes significant and unnecessary confusion, medical complications, and costs in care of complex care beneficiaries, even for SNPs and MMPs that are fully immersed in advancing dual integration programs. Anticipated cost savings from dual integration programs are not likely to be fully realized without additional alignment of Medicare and Medicaid financing, administration and oversight, inside and outside demonstration authority, with priority attention to integrating eligibility determinations, enrollment, marketing and member materials, program policy, reporting requirements, and contract management.

While reticence for change is understandable, the complex care dilemma is large and growing. The time to act is now.

