

IDENTIFYING INNOVATIVE PRACTICES AND TECHNOLOGY IN HEALTH CARE

HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON WAYS AND MEANS U.S. HOUSE OF REPRESENTATIVES ONE HUNDRED FIFTEENTH CONGRESS SECOND SESSION

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IDENTIFYING INNOVATIVE PRACTICES AND TECHNOLOGY IN HEALTH CARE

THURSDAY, APRIL 26, 2018

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:03 a.m. in Room 1100 Longworth House Office Building, the Honorable Peter Roskam [Chairman of the Subcommittee] presiding.
[The advisory announcing the hearing follows:]



WAYS AND MEANS

CHAIRMAN KEVIN BRADY

Chairman Roskam Announces Hearing on Innovation in Health Care

Committee on Ways and Means Subcommittee on Health Chairman Peter Roskam (R-IL) announced today that the Subcommittee will hold a hearing on “Identifying Innovative Practices and Technology in Health Care.” The hearing will focus on innovative practices and technology that physicians, other providers, and various organizations are implementing. The witnesses will speak to groundbreaking models that are changing the landscape of health care and have the potential to modernize our health care system, both through new methods of care and technology. **The hearing will take place on Thursday, April 26, 2018 in 1100 Longworth House Office Building, beginning at 10:00 AM.**

In view of the limited time to hear witnesses, oral testimony at this hearing will be from the invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, <http://waysandmeans.house.gov>, select “Hearings.” Select the hearing for which you would like to make a submission, and click on the link entitled, “Click here to provide a submission for the record.” Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Thursday, May 10, 2018**. For questions, or if you encounter technical problems, please call (202) 225-3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve

the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available at <http://www.waysandmeans.house.gov/>

Chairman ROSKAM. The Subcommittee will come to order. I think it is such an interesting season that we are in right now. First a word to the Members, and then just a general opening statement.

A word to the Members is that so many meetings that I have been involved in over the past several years on health care have sort of a sour tone to them. It is looking out over a landscape that is challenging and difficult, and levels of frustration, and this, that, and the other thing.

I think today we have an opportunity to eclipse that discussion and have a different conversation, and to be a little more forward-leaning, and to be looking at things that are optimistic and buoyant and invitational, as it relates to the health care discussion, and that is the purpose of us coming together today.

Throughout the past couple of decades, we have seen innovation transform the way we look at health care technology and delivery. And in the Medicare program, many of these cutting-edge ideas have failed to be used to their full potential.

In turn, our seniors haven't been able to benefit from greater efficiency, access, and increased positive outcomes in receiving health care. Even worse, while some Americans already have access to these ground-breaking models, they are at risk of losing their path-

way to receiving this care once they turn the age of 65. That is a fact. It is not out of line to say that we are missing an opportunity to save lives with these enhanced treatment methods.

Today's hearing is the second in a series of looking at these innovations in the health care sector. We will hear from witnesses on how they are disrupting the status quo by doing things that haven't been done before. These witnesses appearing before the committee have all in their own way looked at the current state of affairs and have said, "We can do this better" in various fields.

Whether it is providing access to better, more holistic treatments, or increasing efficiencies that inevitably lead to lower costs, I am pleased to hear from our witnesses on how they can help both improve and modernize the Medicare program and, in turn, increase its sustainability.

The lessons we learn here will be on how Congress can help. Can we help both advance and expand upon these front-line advancements, while also leading to a new wave of innovators unleashed on the status quo? In doing so, we can equip our Medicare beneficiaries with the tools to benefit from pioneer ideas.

We need to start implementing policies that open the door to these potentially life-saving medical devices, drugs, and delivery methods in the Medicare program. It is well past time that our Medicare system was brought into this new century. Continuing to fiddle at the edges of an aging health care delivery model can only do so much, and we need to have different conversations about the transformations that are possible. And I think that is what today's hearing and today's discussion is all about.

Now I would like to yield to my friend, the distinguished Ranking Member, Mr. Levin, for the purpose of an opening statement.

Mr. LEVIN. Thank you, Mr. Chairman. Welcome. We are glad you are here, and we are glad we are having this hearing.

As we discuss the issue of innovation, it is important that we not lose sight of the broader context in which we are having this conversation. Innovation should not be a scattershot assortment of new technologies or novel concepts that lack a connection to the overwhelming goal of improving quality and reducing costs.

In order for this to be a worthwhile discussion we have to emphasize a link between the new ideas that we are exploring and actions that will result in real improvements in the health care system.

This is certainly something we had in mind when we developed the Affordable Care Act. Mr. Kind, who is here, Mr. Thompson, who will be joining us, were among those who joined together on this very, very important aspect. The Affordable Care Act was not only a landmark reform of consumer protections, a historic expansion of coverage for tens of millions of Americans, it was also a huge step forward in how we deliver health care.

The law placed a heavy emphasis on innovations that have moved us closer to a payment system that emphasizes value-based care. It facilitated the creation of hundreds of accountable care organizations which have served as the backbone of payment reforms. In the past few years, ACOs and other innovative initiatives established by the ACA have already achieved measurable savings and significant improvements in quality.

The ACA also established the Center for Medicare and Medicaid Innovation, providing us with powerful tools to test delivery system reforms and new ways of paying for care. Under the Obama Administration, the innovation center embarked on a number of initiatives that were reducing inefficiencies and holding providers in a variety of settings accountable for outcomes. This showed that the Administration's commitment to innovation was backed up by meaningful actions and transformative reforms.

However, the same cannot be said of this Administration, in our judgement. Last summer, CMS announced that it was pulling back from an innovation center demonstration that was testing value-based reimbursement for hip and knee replacements and an episodic payment model for cardiac care.

Similarly, the Administration also has abandoned Secretary Burwell's ambitious efforts to tie 90 percent of Medicare payments to value or quality by the end of 2018. And earlier this week, CMS issued a vague request for information seeking feedback on an ill-conceived direct payment contracting experiment that many seniors worry could undermine the Medicare promise.

As we face growing challenges in health care, such as the continued rise in prescription drug costs, it is incumbent upon the Administration and us to show more leadership on these issues. But despite rhetoric and big promises, we have yet to see a focus on real innovation from the Administration, CMS, or the Secretary of HHS. I hope that we can discuss these and other issues in more detail this morning, and begin to explore a new path forward.

Thank you.

Chairman ROSKAM. Thank you, Mr. Levin. I am pleased to introduce today's witnesses.

First, we have Dr. Matthew Philip, who is a physician at the Breakthrough Center in Wheaton, Illinois, and he is joined at the table by Dr. Paul Merrick, the president of the DuPage Medical Group.

Next, we have Dr. Oliver Kharraz, who is the chief executive officer and founder of Zocdoc.

We will hear from Dr. Becki Hafner-Fogarty, who is the vice president for policy and strategy at Zipnosis, Inc.

After that, we have Dan Paoletti, who is the chief executive officer for the Ohio Health Information Partnership.

And finally, we will hear from a familiar face in a different role, and that is Sean Cavanaugh, formerly of CMS, who is here representing the company Aledade as the chief administrative officer.

So Dr. Philip, thank you so much for joining us, and please proceed with your testimony. You are recognized.

STATEMENT OF MATTHEW S. PHILIP, M.D., PHYSICIAN, BREAKTHROUGH CARE CENTER, DUPAGE MEDICAL GROUP, JOINED BY PAUL F. MERRICK, M.D., PRESIDENT, DUPAGE MEDICAL GROUP

Mr. PHILIP. Chairman Roskam, Ranking Member Levin, illustrious Members of this committee, I just want to thank you for this incredible opportunity it is to be with you and share the innovation we are seeing in DuPage Medical Group, and specifically with our intensive outpatient care clinics that we have.

I joined DuPage Medical Group in 2009, after completing my training in Northwestern University and University of Illinois in Chicago, and I initially started taking care of our hospitalized patients and focusing on their quality of care. And what we found is that the same patients over and over were getting hospitalized, re-admitted, and going to the emergency rooms. And we wondered why this was.

And so we looked into the data, and we found data from the Department of Health and Human Services that showed that five percent of patients accounted for a whopping 50 percent of health care costs, and this data was borne true in multiple different research studies.

So we looked around to see what kind of compelling models there were that could address this urgent issue for our patients, and we didn't find anything that was compelling, that could really move the needle on their care. So as an entrepreneurial, independent physician group, we decided to come up with a plan.

And so we put our bottom line aside, and we said, "What can we do for our patients?" And we came up with this model called Intensive Outpatient Care Clinics. And what that entailed was a team of people—physicians, nurse practitioners, nurses, pharmacists, and social workers with resources such as labs, imaging, physical therapy. But more than that, we tried to create a holistic plan, as Chairman Roskam mentioned in his opening testimony, that was tailored to each individual.

See, instead of putting patients into boxes and trying to fit them into a system, which didn't work, we tried to meet patients where they were at and remove some of the obstacles that were holding them back. And what we noticed is, whether it be the opioid crisis or mental health issues or a variety of physical conditions, what we noticed were remarkable turnarounds in patients' health.

Over the past four years we have seen steady improvements in patients' quality, decreasing costs, and patients were happier that they saw this. In fact, last year, we saw up to and even greater than a 50 percent decrease in hospitalizations, hospital re-admission rates, and emergency room visits, which is truly incredible. And this contributed to DMG, which is part of the Illinois Health Partners ACO, which is the fifth-largest ACO in the country, having top 15 percent quality and bottom 28 percent cost.

Now, while those stats may sound remarkable, I think what really brings this home and crystalizes this is actual patient stories. Because when we talk about patients, we are talking about people.

And one of the people that I met with just this past week was Mr. T, who is a 71-year-old patient who is a retired military serviceman. He had been seen in a local area private health system, and he transitioned to our care because he was really struggling. When he brought his records over, I looked through his records, and I noticed that he had seen over 10 doctors. And every two weeks, he was in the emergency room or he was going to the hospital, and despite all of those health interventions and that cost of care, he was progressively getting worse, and his kidney function had progressed to the point of—the stage—right before dialysis.

And when he came to me he was frustrated, he was disappointed, he was ready to give up on the health care profession

and just go on his own, as he said. But what we did is we said, "Let's start over. Let's just meet you where you are at. What is the problem?" And we worked with him to figure out what the root cause of that problem was, and we realized we were way over-complicating it. He was confused. There, they looked at him as just a body, and the solution to treating the body was more pills, more tests, more procedures, and he was frustrated by that.

And what we did is we came up with a plan that was tailored to him. We decreased his medicines, we simplified his care. And what we noticed is he started getting better and better. He started seeing me eight months ago, and over these last five to six months, he hasn't had one emergency room visit, he hasn't had one hospitalization, and he is, more importantly, he is living independently in his own home with his wife. He is feeling better. He is going out to breakfast, and he is more engaged in his community, which is very compelling.

And then, remarkably, his kidney function, which was bordering on dialysis, has started to improve. And his heart function has improved.

And this is just one of many stories that we have to say. And these are real people behind these stories.

Again, as we heard in the opening testimony, there are so many terrible things that happen to people all the time, and we can be a part of the process of getting rid of some of those things, meeting people in the gap, and helping them wherever they are, whether it be with opioids or mental health or their physical mental conditions.

Now, while we are seeing that improvement in quality, we are also seeing the top one percent Press Ganey scores for patient satisfaction, both in our region and nationally. And I would humbly submit to this committee that if we can improve quality while decreasing—improving patient satisfaction, and if we could spend \$.50 on the dollar to do that, why wouldn't we look for opportunities to do that as much as possible?

Thank you so much for your time and for this opportunity.

Chairman ROSKAM. Thank you, Doctor. More questions for you later.

[The prepared statement of Dr. Philip follows:]

Comments for the Record

U.S. House Committee on Ways and Means, Subcommittee on Health

Hearing on

Innovation in Healthcare

Thursday, April 26, 2018

By Mathew Philip, MD

Physician and Member of the Board of Directors

DuPage Medical Group

Mr. Chairman, Ranking Member Neal, members of the Committee, good morning and thank you for inviting me to appear here today to share with you our best practices and innovation in health care delivery. I am Dr. Mat Philip, an internal medicine physician with DuPage Medical Group, one of the largest, independent multi-specialty physician groups in the country located in Suburban Chicago. With more than 700 physicians, 200 advanced practice professionals and 4,900 employees, we see more than 800,000 unique patients annually. I joined DMG in 2009, after finishing my training at Northwestern University Feinberg School of Medicine and University of Illinois in Chicago. DMG is an organization that focuses on delivering the highest quality of care, service and value to the communities we serve. DMG accomplishes this through an integrated outpatient delivery model. I serve on the Board of Directors and my practice is dedicated to caring for fragile seniors.

It is critical that the Committee is seeking to understand this issue. As a physician-owned and directed group, we believe that the power to change health care delivery rests in large part with physicians and the relationship we have with our patients. DMG is constantly looking for ways to innovate and improve health care. As many of you know, an average of 10,000 people each day turn 65, each year, and that

number will increase. Several years ago, it became clear that the most vulnerable patients in our communities were seniors, and they were being underserved by the system. These patients are many times home-bound without any support system around them. Most have co-morbid diseases and lack access to doctors, medications, transportation and in many instances proper nutrition. The main access point to care for these seniors is dialing 911, which leads to a continuous cycle of emergency room visits and numerous hospitalizations. These patients can be hospitalized for the same diagnosis dozens of times per year. Our goal is to help keep these patients at home and out of the hospital. In fact, data from the Department of Health and Human Services noted that approximately 5% of patients account for 50% of healthcare costs among seniors. It was obvious to me and my colleagues that there was a better way to help these patients. Through a physician-driven exercise, we started an intensive team-oriented care model to meet the complicated needs of this fragile population. The model is set up with care teams led by a physician who is supported by advanced practice providers, pharmacists, social workers and health coaches. The results have been nothing less than transformational. Through our high-touch model we reduced admissions, re-admissions and complications for these fragile seniors by as much as 50%.

Last week in my clinic, I saw Mr. R, an 83-year-old with chronic pain. He was a former college football player and drives over an hour and a half to see me in my Intensive Outpatient Clinic (IOP) in Wheaton, because he realized his health was progressively getting worse and he needed help. He saw multiple physicians and specialists who placed him on stronger and stronger medications, such as Percocet (opiate), Hydrocodone (opiate), Lorazepam (anti-anxiety controlled substance), and Restoril (controlled substance that is a sleep aid). The combination of these pills more than doubled his risk of overdose, stroke and heart attack. My team and I developed a treatment plan for him and his wife, who is a nurse, to follow. He is now completely off all opiates and all controlled substances and feels better than he has

in years. He states he felt like he was walking under water before, and now his pain is better and he's able to spend more time with his grandchildren and attend a weekly men's breakfast which brings him a lot of joy.

This is an example of a systematic care delivery model that puts the patient at the center of our decision making. Being physician-owned and directed allows us to create a high-quality, high-value, high-safety environment for our patients to seek care. We utilize a uniform medical record across all of our locations and have built out an infrastructure that meets the needs of our community including immediate care centers, imaging services, ambulatory surgery centers and integrated oncology services - all in a safer environment and lower cost than the traditional system. We are able to reduce redundancy of services and decrease variation leading to increased quality and safety. We take fragmentation out of the system.

Another case that I also saw last week highlights the need of the IOP clinics and the value that DuPage Medical Group delivers, to our patients, and the health care system overall. Mr. T is a 71-year-old retired military serviceman who sought care at a neighboring private health system. He inevitably ended up in the local hospital emergency department, or was hospitalized, every two weeks. He was being cared for by multiple specialists and his primary care physician but would often call his doctor's office and be referred to the emergency department. His kidney function was progressing to the last stage before dialysis. Nobody seemed to be coordinating his care or taking an active role in the management of his chronic conditions. When he joined the IOP clinic eight months ago, we developed a treatment plan with him after understanding his ailments and his goals for improving his health. We realized he had been put on too many medications and was getting confused with his treatment plan. It seemed like every physician told him something different. By removing some of his medications, simplifying his treatments, and seeing him regularly, he hasn't been to the emergency room or the hospital in over six

months! He is also feeling better, and his kidney and heart function have shown significant improvements.

I think patient examples help tell the story of what we are able to achieve. We are improving the quality of life for our patients, keeping them out of the hospital when it is not necessary and improving the health care system. Real outcomes are demonstrated in metrics, and we are very pleased with our ACO results. DuPage Medical Group is part of IHP ACO, the 5th largest ACO in the country. This ACO ranks in the bottom quartile for cost per beneficiary and the top 15% for quality. Our members comprise nearly half of this ACO. We are proud of our results as the top-performing ACO in Illinois.

In closing, we will continue to innovate; it is part of our entrepreneurial nature. I would ask the Committee to examine these key areas to improve care for Medicare recipients:

1. Allow for additional services to be reimbursed in an Ambulatory Surgical Center (ASC) setting. Many services historically have exclusively been done on an inpatient basis and are now routinely done in an ASC setting at a much lower cost. Orthopedic procedures, such as total joint replacement and spine surgeries, are a few examples.
2. Pay for real value. The current ACO system does not recognize the best-performing organizations like DuPage Medical Group. We were the lowest cost ACO in Chicago and did not receive shared savings in the most recent year.
3. Include digital and telehealth services. We have the technology and experience in this area as we have been offering telehealth services for the last four years for patients who are willing to pay for these services. Covering these services would allow for greater access and efficiency for patients and providers. We could do a much better job of avoiding hospital admissions and re-admissions through the deployment of technology.

I want to thank the members of this Committee for the opportunity to share our doctor-directed, patient-focused model, and also thank my fellow panelists in leading the charge to use innovation to improve health care. DuPage Medical Group looks forward to being an active participant as the Committee and Congress work to improve health care delivery for our seniors, and all patients.

Chairman ROSKAM. Dr. Kharraz, thank you. You are recognized.

**STATEMENT OF OLIVER KHARRAZ, M.D., CHIEF EXECUTIVE
OFFICER AND FOUNDER, ZOCDOC**

Mr. KHARRAZ. Chairman Roskam, Ranking Member Levin, and Members of the Subcommittee, thank you for the opportunity to testify today on how Zocdoc leverages technology to improve patients' access to care.

When I founded Zocdoc in 2007, technology was just beginning to modernize the consumer experience across all industries. But health care was being left behind, you know; the doctor directories provided by insurance companies are frequently out of date, and even our best-case scenario, calling down one doctor office after the other, is inefficient and a frustrating experience.

I knew that the status quo wasn't acceptable for patients, so I left my career at McKinsey, and I had the aspiration to create a service that actually delivers on the digital, seamless health care experience that patients expect and, quite frankly, deserve.

You know, most people told me this just could not work. Health care is too antiquated, it is too fragmented, you know, to be improved. But, as a doctor, as a businessman, as a patient, I felt that health care is the challenge of our generation. You know, if we don't fix it, it is going to break our health, it is going to break the bank, or both. And neither of those are acceptable outcomes.

Now, a decade in, Zocdoc's mission is to give power to the patient. Every month, we have six million Americans use the service across the country. In the last year, we served 100,000 Medicare beneficiaries.

Let me tell you how the service works. When a patient comes to Zocdoc.com, or they use our free mobile app, they tell us the reason they want to see a doctor, their location, and their insurance coverage. We then show them in-network nearby doctors that meet their specific criteria. They can read reviews that have been left by other verified Zocdoc patients. And, most importantly, they see real-time availability for this doctor. They can then make a choice between these doctors based on their own preferences and book an appointment with just a few clicks.

This service is completely free for patients. Doctors pay to participate on the Zocdoc marketplace.

Now, the results speak for themselves. On average, it takes in excess of three weeks to see a primary care doctor when you book over the telephone. In contrast, on Zocdoc, the typical appointment

happens within 24 hours of booking. Now, how can we be so much better than the typical health care experience?

Well, what we discovered is that while doctors are booked out several weeks into the future, they actually have near-term availability because of last-minute cancellations and schedule changes. You know, in fact, 20 to 40 percent of doctors' appointment slots go to waste. We can make this hidden supply of health care available and bookable for patients in real time.

Now, that obviously, as discussed, has a massive and dramatic impact on their health care experience, but it also improves systemic inefficiencies. You know, when you can take friction out of accessing health care like this, you actually promote these preventative—important preventative appointments that people just put off too easily.

You also improve or avoid, rather, emergency room utilization. Think of a patient that has a severe flu and can book an appointment for the next morning at 10:00 p.m. at night. That is an avoided emergency room visit right there, and that is the most expensive venue of care you could pick.

Zocdoc is the largest online health marketplace, and you can find appointments for over 50 specialties and nearly 2,000 different procedure types of Zocdoc. We work with private practices of all sizes; we work with large health systems and leading hospitals. And our technology comes with out-of-the-box interoperability with these—with many of the 1,400 different scheduling systems and practice management systems that our providers use to manage their calendars.

Now, our team continues to innovate every day, and I am proud of what we have already achieved. However, we are far from done. Particularly when I look at our provider network, it is very robust in urban settings, but there is still work to do to give access to our members in our rural communities. You know, this is a focus for me personally in the coming month. And we are looking forward to working with the committee to overcome the statutory and regulatory obstacles that prevent doctors in rural communities to participate in the service.

Again, I thank you for the opportunity to testify today. It is an honor.

Chairman ROSKAM. Thank you, Doctor.

[The prepared statement of Dr. Kharraz follows:]



**Statement of Oliver Kharraz, M.D.
Zocdoc founder and CEO
before the
Committee on Ways and Means Health Subcommittee
U.S. House of Representatives

Hearing on Innovation in Health Care**

April 26, 2018

Chairman Roskam, Ranking Member Levin, and members of the Subcommittee, thank you for the opportunity to testify today on how Zocdoc leverages technology to improve patients' access to care.

When I founded Zocdoc in 2007, technology was beginning to modernize the consumer experience across every industry, but healthcare was left behind. Doctor directories provided by insurers are often out of date, and calling one doctor's office after the other is inefficient and frustrating. I knew the status quo was unacceptable for patients.

I left my career at McKinsey & Co. with the aspiration to build a service that delivers the seamless, digital healthcare experience patients both expect and deserve. Most people told me it would never work. They said healthcare was too antiquated and too fragmented to be improved. However, as a doctor, a business man, and a patient, I believe that healthcare is the problem of our generation. If we don't fix it, it will break the bank, our health, or both. Those are unacceptable outcomes.

A decade later, Zocdoc's mission is to give power to the patient. More than six million patients across the country use Zocdoc every month, and last year we served more than 100,000 Medicare beneficiaries. Let me tell you how our service works. When patients come to Zocdoc.com or use our free mobile apps, they enter the reason they want to see a doctor, their location, and their insurance coverage. We surface nearby, in-network providers based on each patient's needs. They can read reviews on doctors – left by verified Zocdoc users – and most importantly, they can see doctors' real-time appointment availability. Patients then select a provider based on their preferences and book with a few simple clicks. Our service is completely free for patients, and providers pay to be part of our marketplace.

The results speak for themselves. National wait times to see a primary care doctor on average exceed three weeks when booked over the phone. In contrast, the typical Zocdoc appointment takes place within just 24 hours. How can we so dramatically improve patients' access to care? We discovered that doctors actually have significant near-term availability due to cancellations and last-minute schedule changes. In fact, 20 to 40 percent of their appointment slots go to waste. We call this the "hidden supply of care."

Our technology makes this hidden appointment inventory available in real-time. This dramatically accelerates patients' access to care and improves systemic inefficiencies. For example, we encourage preventive visits that are all too easy to put off and also prevent unnecessary visits to the emergency room – the most expensive place to receive care. If a patient with severe flu symptoms can book an appointment on Zocdoc at 10:00 at night for the very next morning, an E.R. visit can be avoided.

This might sound easy, but it took years of innovating before we moved from working with a handful of dentists in New York City to serving patients nationwide. Let me give you one example. In our earliest days, a few patients booked open appointment slots only to discover the doctor was out of the office. After personally hand-delivering flowers to a patient to apologize for the fact that their Zocdoc experience did not go as intended, I discovered a root cause of the mix-up. Instead of blocking off the doctor's calendar online, the office manager was using a Post-it note on his monitor to remind himself that the doctor was out of the office.

We had to iterate and leverage technology to detect and proactively address these types of user quirks and behaviors. The Zocdoc experience today is the culmination of thousands of these 0.1 percent improvements.

Today, Zocdoc is the largest online healthcare marketplace, helping patients easily book appointments across more than 50 different specialties and nearly 2,000 procedure types. We partner with private practices of all sizes, as well as leading hospitals and health systems across the country. We have built out-of-the-box integrations with many of the more than 1,400 different practice management systems they use to manage their calendars.

Our team of 500 continually innovates to improve patients' healthcare experience, and I am proud of what we have accomplished. However, I know there are many more problems we need to solve. For example, while our provider network is robust in the major metropolitan areas, I am committed to improving patient access throughout our rural communities. This is among our top priorities in the months to come. We look forward to working with the Committee to overcome statutory and regulatory barriers that prevent rural doctors from participating in our marketplace.

I thank you again for the invitation to testify today. It is an honor.



Chairman ROSKAM. I will now recognize Mr. Paulsen for purposes of an introduction.

Mr. PAULSEN. Well, thank you, Mr. Chairman. And it is my pleasure to welcome with us today from Minnesota Dr. Rebecca Hafner-Fogarty, also known as Dr. Becki to those who work with her. She is the senior vice president for policy and for strategy at Zipnosis, which is headquartered in Minneapolis. She has been in that role since 2013 and has also served previously as its chief medical officer.

Prior to that, she was the chief clinical and medical director at Strategic Alliances at MinuteClinic. I am glad she is here to share some background and perspective and information about the great work that Zipnosis is particularly doing in the telemedicine space.

They started with an idea that if we are going to move forward to a more patient-centered health care delivery system, then we should make it easier for patients to be able to access and use it. And Dr. Hafner-Fogarty and her team at Zipnosis are visionaries who have created a very intuitive platform for doctors to help see patients for a diagnosis quickly, without having to leave their home or leave their business.

I visited Zipnosis several times, and I met with the employees. I have spoken with them about their work and the need for this type of innovative technology. We have seen their growth over the years. They are clearly a definition of a disruptor in innovation.

I want to thank Dr. Fogarty for being with us today, and look forward to hearing her ideas, as well. And I yield back, Mr. Chairman.

Chairman ROSKAM. Thank you.
Doctor, you are recognized.

STATEMENT OF BECKI HAFNER-FOGARTY, M.D., SENIOR VICE PRESIDENT, POLICY AND STRATEGY, ZIPNOSIS, INC.

Ms. HAFNER-FOGARTY. Thank you so much. Chairman Roskam, Ranking Member Levin, and Subcommittee Members, thanks for the opportunity to be here, and good morning. I have submitted written remarks, so I will try to just hit some highlights during this brief time.

I would like to start with a short quote from one of my favorite philosophers, Kermit the Frog. Kermit tells us it is not easy being green. And in Kermitspeak, to be green means to be different.

Kermit is right. It is not easy to be different. However, by departing from the ordinary, all of us sitting at this table are positioned to make a positive impact on health care. In fact, I would argue that thinking differently is necessary to addressing the challenges that characterize today's health care landscape.

Mr. Chair, if there is anything I would like you to remember about my testimony this morning, I hope it is this: Zipnosis is philosophically different from almost every other telemedicine company in the country. As Representative Paulsen said, our goal has been to transform health care for the better.

And it is no accident that we are located in Minnesota. Minnesota has long been a hub of health care innovation, starting a few years ago with two brothers who started a little clinic down in Rochester. Part of that innovative spirit certainly belongs at the

feet of our very enlightened state, local, and Federal Government officials, and I would like to personally take a minute to thank Representative Paulsen. He has been a supporter of Zipnosis since it was about four of us sitting around a table in a coffee shop. So, thank you for your support. Another key supporter of health care innovative has been Senator Amy Klobuchar.

Zipnosis is clinically and technologically different. I won't get into the technical nuts and bolts here, but we are the first virtual care company to offer a truly multi-modal platform. That means you can do an asynchronous store-and-forward visit, you can do a video visit, you can do a chat visit, all on an encrypted, HIPAA-compliant digital platform.

Because we are digital, we can easily track every click that a patient or a provider makes, so it is very easy for us to audit our quality and make sure that the care that is being delivered is truly quality care.

Another thing that makes us different is that we do not provide telemedicine care ourselves. We are a SAS company. We license our technology to health systems. So being a family physician, I think it is important to recognize that if all politics is local, certainly all health care has to have a local base. So we make it easier for those docs to connect to their patients using technology.

We just recently partnered with the American Academy of Family Physicians. This is a really groundbreaking partnership. We are designing a version of our platform that will make it easy for those small and medium-sized family practices, largely located in rural areas, to use the technology to make it easier for patients in their community to get access, to reach out to patients who don't have access in their community.

I want to spend my remaining time saying that there are challenges to being different. Some of our challenges at Zipnosis are related to the fact that a lot of times, because we are chiefly store-and-forward, health care regulators don't know quite what box to put us in.

There are also challenges inherent to telemedicine in general, a fragmented regulatory landscape where every state has multiple definitions of what telemedicine is and what the rules are. Reimbursement is another major factor. The AAFP tells us that that is one of the two major factors impacting the reluctance by physicians to adopt telemedicine is they can't get paid for it.

So that is where folks like you can help folks like me. Hopefully we can work together to improve both the nomenclature and certainly the reimbursement.

Thank you so much for your time, and of course I will be happy to take your questions.

Chairman ROSKAM. Thank you, Doctor.

[The prepared statement of Dr. Hafner-Fogarty follows:]

**HEARING BEFORE THE UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON WAYS AND MEANS SUBCOMMITTEE ON HEALTH**

April 26, 2018

Written Testimony of Dr. Becki Hafner-Fogarty
Senior Vice President for Policy and Strategy, Zipnosis

Chairman Roskam, Ranking Member Levin, and Health subcommittee members, thank you for the opportunity to be with you today to share my ideas on health care innovation. I am honored to share the table with representatives from several other cutting edge companies, in addition to my very own Zipnosis.

Before I introduce myself and Zipnosis, I'd like to share a short quote from one of my favorite philosophers, Kermit the Frog. As Kermit frequently reminded us, "It's not easy being green." And in Kermit speak, being green is not about being environmentally friendly—being green is about being different. The five of us are sitting here because we are different; we have all made a conscious choice to be different—and to do so in ways that we believe will improve healthcare. I'm sure we could all share examples about how it is hard to be different—and it can be hard—but the reason we're here is to share how by being different, we are making health care better for our colleagues, but most importantly for our patients.

With most innovative companies, it is the vision and the DNA of the founders and early leaders that shapes and forms the culture and identity of the organization--so I think that it's important to tell you a little bit about me. I am proud to be a family physician and believe deeply in the notion that continuity of care matters, and that care from clinicians who know you is almost always better than that from a stranger. I also know that this local connection is increasingly difficult for many patients and providers to achieve.

Today's healthcare landscape is characterized by too many patients and not enough physicians and other caregivers to serve them; as well as a culture that seems to value convenience over relationship. Equally important is the changing way we define and create patient-provider relationships. While you and I understand personal and professional relationships by being formed and largely supported by being in physical proximity, our children and our grandchildren completely accept the notion that relationships can be formed and built partially or entirely through the use of technology. Ask any millennial, and they will tell you that their Facebook, Twitter and Instagram "friends" are real.

So, if we are to transform healthcare in the face of these challenges, we must be willing to think differently and to be different. Now I'd like you to meet Zipnosis and hear a little bit about how we are indeed different and why we believe different is a good thing.

Zipnosis is a 10-year-old virtual care company headquartered in Minneapolis. We are proud to follow in the footsteps of a multitude of other MN based innovators--you may have heard of one started by two doctor brothers many years ago in Rochester, MN. Seriously though, from heart valves to HMOs, Minnesota has long been a leader in health care innovation. Our med-tech trade organization has a whopping 495 disruptive members and are known across the country--even around the globe, as strong creative thinkers. Credit for this needs also to be given to current and past state government leaders and policy makers and our congressional delegation--they too have been willing to "be different". I'd especially like to acknowledge Congressman Paulsen, a member of this committee, and Senator Amy Klobuchar for their unwavering support for healthcare innovation. This culture of healthcare innovation helped get Zipnosis off the ground and grow into the innovative company we are today.

Zipnosis was founded with a singular goal of using technology to transform care delivery--making it easier for patients to get care and for clinicians to deliver care--and do it in a way that does not compromise quality. Hence, our mission statement: Innovative access to mainstream medicine. This isn't what sets Zipnosis apart, although it is definitely the genesis of our different take on care delivery.

If there is anything you remember about my testimony today, this is it. **Zipnosis is philosophically different from most every other telemedicine company in the country.** If I may repeat myself, Chairman Roskam, Zipnosis is philosophically different from most every other telemedicine company in the country.

We view virtual care as a tool that can help foster and maintain the patient-physician relationship. Rather than selling services directly to patients, Zipnosis is a software-as-a-service (SaaS) company that licenses our software platform and clinical capabilities to health systems, clinics and physicians. We give *them* the technology to improve access to care for new patients and create stronger relationships with existing patients--and to provide a seamless connection to local care, when and if, patients cannot be safely treated via telemedicine. It is this firm commitment to using virtual care to support local care providers, thus enhancing continuity of care without increasing fragmentation that makes Zipnosis different. One of the results of this philosophical difference is our recently announced partnership with the American Academy of Family Physicians. Together, we are developing a version of the Zipnosis platform especially configured to allow family physicians in small to medium sized practices to offer virtual care in their communities. The importance of this for both physicians and patients cannot be overstated. This means that we've created a platform that allows YOU, Chairman Roskam and members of the committee, to do a virtual visit with YOUR personal physician using a variety of different modalities.

Beyond philosophy, **Zipnosis is technologically different**—a true trailblazer. Most of you sitting in the audience today are members of my generation. That probably means that when you hear the words telemedicine or virtual care, you think about broadband-based video telemedicine that often uses sophisticated equipment to connect specialists to small rural hospitals or PCPs -- a provider-to-provider connection. This 20th century version has much to

offer, and as a matter of policy, I believe that we should continue to strengthen and expand our broadband capabilities. As a native North Dakotan and a former country doctor, I've experienced firsthand the benefits of broadband-based telemedicine.

But Zipnosis is a 21st century virtual care tool. Our platform is built for connection between PATIENTS and providers--a digital platform built for wireless data that enables true flexibility for both patients and providers. According to the Pew Research Center, 77% of the entire US population owns a smartphone; and, according to FCC estimates, 24 million Americans are still without broadband access. In a society where mobile access to care is increasingly expected and even taken for granted, these two data points are evidence that focusing exclusively on broadband-based telemedicine is not the answer.

I must also add that the difference in our technology goes well beyond the internet connection, to include unique features that support our philosophical approach. For example, unlike others in the telemedicine space, Zipnosis explicitly and deliberately uses technology to support locally based healthcare, such as Smart Routing to seamlessly direct patients who are not appropriate for online care into their health system's brick-and-mortar clinics. Plus, we offer a variety of access modalities to community hospital systems to meet disparate patient preferences and clinical needs.

Zipnosis is also structurally different. The heart of our platform is an intelligent, software guided asynchronous adaptive interview. Patients complete a medical history by answering a set of dynamically generated questions--subsequent questions are determined by the patients' answers to the previous questions, often referred to as branching logic -- re-creating the history taking that physicians do in their offices every day. There are many conditions where the medical evidence tells us that it is safe and effective to make a diagnosis and treatment based on a medical history alone. Our platform is deliberately built to create that efficiency for patients and clinicians. Unlike many other telemedicine companies, Zipnosis is not designed around a single modality, so when patients cannot be treated asynchronously, the visit can be converted to a secure, HIPAA-compliant video or chat visit. If a prescription is medically indicated, the physician can easily e-prescribe it; and the patient fills the prescription by choosing the most convenient pharmacy. Because Zipnosis partners with local care providers, we can complete the visit by adding it into the patient's electronic health record.

As I mentioned, I want to share how these differences are positive for the healthcare industry. Our approach and technology uniquely position us to help health systems, providers and their patients address challenges endemic in the healthcare industry, including the imbalance between available providers and patients; geographic and financial healthcare access barriers; the administrative burden placed on providers; the growing healthcare fragmentation fueled by consumer demand for convenience; and the influx of stand-alone retail clinics, urgent care centers, and even juggernaut telemedicine service providers that focus purely on the one-and-done telemedicine transaction. Zipnosis is proud to be different.

Remember, Kermit says, "It's *not* easy being green." While being different comes with a great many benefits, I do want to speak briefly about some of the policy difficulties we encounter--both those that inherent to telemedicine, and those that we encounter because Zipnosis IS different. When we launched Zipnosis back in 2008, nothing like our platform had been seen before. Store-and-forward asynchronous telemedicine was known for its use in clinician-to-clinician specialties such as radiology and dermatology. It definitely wasn't considered a means for collecting patient-generated symptom and health history information for diagnosis and treatment of common, low-acuity conditions. This departure from the norm is one of the reasons for our success, but made it difficult for regulators and others figure out where we fit in the telemedicine landscape. Being different has also magnified some of the other challenges inherent to the virtual care sector. These challenges include:

Fragmented, incoherent regulatory policy. As a long time member and past president of the Minnesota Board of Medical Practice, I accept and understand the need for regulation to protect patient safety and uphold a standard of care. However, as I recently commented to some colleagues at the Federation of State Medical Boards, the current challenge we have is reconciling geographically based professional regulation in an age when both patients and physicians are increasingly unconstrained by geography. It is also universally true that technology develops and changes much more quickly than regulation; this is something we see a great deal in telemedicine. Much of our state based telemedicine policy is a holdover from the late 20th century, when broadband dominated and the internet was first becoming a reality. The result in most states is rather than focusing on language defining and supporting standards of care, i.e. regulating professionals, much ink is devoted to modality specific regulation. This is problematic because the cutting edge modalities of today are already edging toward obsolescence. And because this regulation is geographically based, there are infinite permutations on what modalities are defined as telemedicine and when and how they may be used.

Reimbursement. In this regard, there is room for improvement in most states and at the federal level. One of the biggest barriers to physician adoption of telemedicine is lack of consistent reimbursement. While I believe that some of the reimbursement obstacles may be at least partially remedied as we transform to a value-based reimbursement environment, right now doctors, hospitals and health systems still live in a fee-for-service world. And as with modalities, there are a nearly infinite number of state and federal permutations around telemedicine reimbursement.

If we take the view that telemedicine modalities are some of the current tools that will help us improve quality, cost and outcomes--and I think that we should take that view--then a better answer is to first focus policy and regulatory development on two areas: first, we need to develop common nomenclature and definitions around telemedicine that offers both clarity and flexibility for changing technologies, and second, regulatory policy ought to focus on regulating professionals and professional behavior rather than playing a constant game of catch-up with the technology by regulating specific modalities.

This future-proofing of regulation is critical, because this is where opportunities exist for folks like you to help folks like those of us sitting at the table. Thank you for your time and attention. I'm happy to answer any questions you may have. Additionally, if you are interested in seeing how Zipnosis works, I'd be happy to arrange a demo for you and your staff.

Chairman ROSKAM. Mr. Paoletti, you are recognized.

**STATEMENT OF DAN PAOLETTI, CHIEF EXECUTIVE OFFICER,
THE OHIO HEALTH INFORMATION PARTNERSHIP**

Mr. PAOLETTI. Thank you, Mr. Chair, Members of the Committee. I appreciate the opportunity today. My name is Dan Paoletti, I am the chief executive officer of the Ohio Health Information Partnership, which also manages the CliniSync Health Information Exchange in Ohio.

This testimony isn't as much about technology as it is about community collaboration. We are a non-profit 501(c)(3) organization created in 2009 from the ground up by stakeholders from across the state who really felt that the need for a robust health information exchange infrastructure was key to lowering costs, efficiency, and providing better care.

Ohio is a microcosm of the nation. We have a population of almost 12 million patients; those are 12 million people. Those people occupy farm lands, Appalachia, and multi-cultural urban centers in our major cities.

The challenge of leveling the playing field around the technology first appeared very daunting. But a multi-pronged approach was implemented. We spent many years helping over 6,000 primary care physicians, in collaboration with many community stakeholders, to adopt electronic medical records, while at the same time putting in place the Health Information Exchange CliniSync, which was created in cooperation at first with hospitals throughout the state.

We now have over 157 Ohio hospitals participating, many competing with each other and their environments, which has created an interoperable environment for patient health information in Ohio. This approach has enabled the network to quickly become financially sustainable and resulted in a medical community that now electronically exchanges patient records instead of using paper.

In Dayton, we have partnered with the Wright-Patterson Air Force Base, the Department of Defense, and the Wright-Patterson Medical Center to use the CliniSync services to enhance interoperability to help active-duty members, the troops, their families, and their veterans, and we are currently testing with the VA.

The philosophy in Ohio is that the record should follow the patient. The community health record allows authorized treating physicians to access the patient record, no matter where they had care. To date, almost 13 million individuals have a community health record in Ohio, and the consent policy allows patients to be included unless they choose not to and opt out.

Another important innovation enables notifications to physicians if their patients are admitted to an emergency room or admitted as an inpatient and discharged. These notifications allow for quick follow-up and intervention, if care can be provided outside of a hospital. Since late 2016, almost 7 million notifications have been sent to providers.

An example of notifications, where notifications have helped with intervention, was when one provider received three alerts in the same day on the same patient from three different emergency rooms, indicating the possibility of opioid addiction. These notifications allow for proactive steps for action with that patient.

University hospitals in Cleveland are working with dialysis centers in Cleveland to coordinate care of over 12,000 dialysis patients when they hit the emergency room. An alert is sent to the community nephrologist, they work with the emergency room to reduce some of the tens of thousands of in-patient days that are accounted for by those dialysis patients.

There are lots of stories I could tell you. I could spend a lot of time talking about innovation across the state. But I would like to spend the remaining time with just a few suggestions on where you might be able to help.

When it comes to innovation ideas, and coordination, as CMS moves to alternative payment models, the importance of implementing efficient care and case management is critical. Look for those efforts that are already working. Telehealth and remote monitoring is key and continues to emerge as an important solution to hold the possibility to impact significant challenges such as cost and access.

Quality reporting. In the past, payers have defined quality using multiple different metrics, resulting in a very expensive, burdensome, and unnecessary administrative task. Harmonizing those quality standards across the payers and providers is an important step.

Behavioral health. There is a significant need to revisit rules allowing for data sharing restricted by 42 CFR Part 2. These patients have some of the most significant needs, and if they want their information to be shared, we should allow that.

House Resolution 3545, Overdose Prevention and Patient Safety Act—which I know some of you are involved with—is a very important step forward.

Primary care initiatives. Continuing to fund innovation that puts a primary care provider in the front has allowed innovation in Ohio to really move forward.

And with that, I will pause and allow questions later. Thank you. Chairman ROSKAM. Thank you very much.

[The prepared statement of Mr. Paoletti follows:]



United States House Ways and Means Subcommittee on Health

**Statement of Dan Paoletti, Chief Executive Officer, Ohio Health Information Partnership
and CliniSync Health Information Exchange, Hilliard, Ohio**

Identifying Innovative Practices and Technology in Health Care

April 26, 2018

10 a.m.

My name is Dan Paoletti, and I am Chief Executive Officer of the Ohio Health Information Partnership, which manages the CliniSync Health Information Exchange in Ohio. I want to thank you for the opportunity to comment on *Identifying Innovative Practices and Technology in Health Care*. This testimony focuses on the evolution of health information technology in Ohio over the past decade and the critical role that collaboration and community trust play in sustaining this model.

The Ohio Health Information Partnership is a private, nonprofit organization created in 2009 with HITECH Act funds. Under the direction of the U.S. Department of Health and Human Services, these funds were to be used for the promotion of health information technology to improve the delivery of health care in our state and across the nation. Ohio's success lies in the collaborative creation of this partnership, established from the ground up by medical and healthcare partners who have a vested, critical interest in the successful use of technology and the creation of a robust health information exchange infrastructure.

A COMMUNITY-BASED APPROACH

Our founders include top leadership from the Ohio State Medical Association, Ohio Osteopathic Association and Ohio Hospital Association. The leaders of this partnership serve as the three-member Executive Committee on a 15-member Board of Directors, also made up of business, medical, hospital, long-term care, behavioral health, consumer and health plan leaders. In addition to serving as stewards of the Ohio Health Information Partnership, these champions have garnered the support of other medical, legal and HIT professionals to serve on committees that generated the policies and procedures that govern the organization today.

We extended this grass-roots, collaborative effort to create seven Regional Extension Centers to help guide physicians in the adoption of electronic health records, which would replace manual faxing, phone calls and other antiquated methods of communication. In Ohio and across the country, physicians and hospitals historically had not been able to share electronic patient data with one another to coordinate care for patients treated in disparate healthcare settings.

Because Ohio is a microcosm of the nation, it reflects a diverse population of 11.7 million who share its flattened farmlands, high-poverty Appalachian peaks and the multicultural, urban centers of our major cities. The challenge to level the playing field in technology at first

appeared daunting. While many of the large hospital and health systems already had sophisticated electronic health systems that electronically communicated regionally or within their own systems, our state also had numerous rural and critical access hospitals as well as thousands of independent, one- or two-physician practices that had limited adoption or access to health information technology, often geographically remote from major health systems. Secure electronic access to patient data across multiple care settings over time had the promise to enable effective coordination of patient care that would improve the quality, efficiency and access of care for all.

With the right information at the right time and at their fingertips, physicians and other providers of care could break through the brick and mortar of siloed systems to coordinate and manage the care of their patients with different providers. These breakthroughs would be especially critical for patients with chronic conditions. At no cost to physicians, the regional approach worked well and by 2012, more than 6,000 primary care physicians had adopted electronic health records, the largest population of any singular Regional Extension Center in the nation. The guidance and parameters we received from the U.S. Department of Health and Human Services provided the structure to help these physicians go from paper to electronic health records. We also worked with vendors to create standard interfaces that reduced the cost to practices and provided interoperability among 40 plus integrated vendors.

A TRUSTED EXCHANGE MODEL

Simultaneously, we embarked on the creation of the health information exchange – CliniSync – with cooperation first of the hospitals throughout the state, using HITECH funds to offset the cost of hospital implementation. The level of trust displayed towards CliniSync as a neutral, impartial entity only increased over time and paved the way for 157 hospitals to eventually create an interoperable environment for patient health information in Ohio. This market-based approach enabled the CliniSync network to quickly become financially sustainable with little or no cost to community healthcare providers. We chose Medicity, Inc., as our technology partner since it had much experience with other health information exchanges and large health systems throughout the country.

Back in 2012, Mercy Health St. Rita's Hospital in Lima jumpstarted the effort as the first hospital to connect, and the collaboration broke down the data silos for the greater good of this combined smaller urban and farming community. Shortly after, all hospitals in West Central Ohio went live as a regional effort to communicate. The same trust environment developed in Southeastern Ohio, one of the most impoverished areas of the state and hardest hit by the opioid epidemic. In Portsmouth, the collaborative efforts of Southern Ohio Medical Center (SOMC) and surrounding clinics and physician practices resulted in a technologically savvy medical community that now electronically exchanges patient health records, where previously couriers delivered paper records between the local hospitals and healthcare providers. This effort finally provided the comprehensive access to health records previously unattainable to these rural areas of the state.

By 2013, urban communities and large health systems also began collaborating; this served as a tipping point for broader statewide adoption. University Hospitals in Cleveland became a significant catalyst for comprehensive community sharing of health records in a large urban area. Shortly after, to make sure providers could share information across the Cleveland area, The Cleveland Clinic, MetroHealth, Sisters of Charity Health System and smaller health

systems in Northeastern Ohio all joined. During this time, Mercy Health brought up their Eastern Ohio locations, which also encouraged additional community hospitals to join. In Central Ohio, Mount Carmel Health System joined first, followed by nearby rural hospitals in the area as well as large systems, such as Ohio State University Wexner Medical Center and OhioHealth. Across Ohio, the children's hospitals joined from Akron to Cleveland to Columbus to Dayton.

In the Dayton area, we have partnered with Wright-Patterson Air Force Base, Wright-Patterson Medical Center and the U.S. Department of Defense (DOD) to use ClniSync services, enhancing electronic communication and providing interoperability with neighboring private hospitals and clinicians for active duty troops, veterans and their families. The Veteran's Administration currently is in the testing phase to ultimately better coordinate care with the DOD, giving a more in-depth view of veterans' healthcare needs.

IMPROVED PATIENT CARE COORDINATION

The philosophy behind electronic health records in Ohio is that the records follow the patient. So, a patient's records from Columbus can be shared in Cleveland, in Toledo, or anywhere that specific patient is treated within the community. The Community Health Record allows an authorized, treating physician or staff member to search for a patient, the system matches the patient with accurate identifiers, and the patient's records can be viewed from any hospital encounter, no matter where it occurs in the state. To date, almost 13 million individuals now have Community Health Records. The consent policy allows these patients to be included unless they choose to opt out of having their records accessed by their physicians. Providers can view face sheets, treatment history, hospital encounters, problem lists, allergies, lab results, radiology and other transcribed reports, in many cases directly from their own electronic medical record system (EMR). They can check the latest patient demographic and insurance information captured by other providers and can view, print or download full summaries of care that provide even more comprehensive information. Providers can customize what they want and do not want to view, based on their needs and the care of the patient. This service is extremely helpful in emergency situations when a patient is unconscious or uncommunicative. But it is just as beneficial when staff prepare the physician with information for the next day's patients.

Along with the Community Health Record, an integral solution now enables notifications to physicians if a patient is admitted to or discharged from the Emergency Department or the hospital. Follow-up notifications inform the physician of the patient's status and allow primary care physicians to immediately follow up on hospitalized patients after discharge or when transferred to another facility, such as long-term or rehabilitative care. This notification also allows specialists, dialysis centers and other providers to intervene if care should be given in a different setting than the hospital. Again, once the notification occurs, accountable staff can immediately access additional records on the patient to see what occurred in the hospital, the prescribed medications and after-care instructions. Since late 2016, there have been over 6.7 million notifications sent.

STAKEHOLDER SUCCESSES

An example where the use of notifications identified an avenue of intervention was for an Accountable Care Organization (ACO) that received alerts for a patient from three different emergency rooms on the same day, indicating a possibility for opioid addiction. These notifications allowed the ACO to determine the appropriate steps for action with the patient.

University Hospitals of Cleveland are working with the Cleveland Dialysis Center to coordinate care of over 1,200 dialysis patients. Community nephrologists are notified when one of their patients is admitted to a UH Emergency Department. They are working to coordinate the care of patients to reduce the tens of thousands of inpatient bed days for these patients and move them to a nearby dialysis center. This work, as well as other innovative projects across the state, have tremendous opportunity to provide lower cost high quality of care for patients. For more success stories from leaders in Ohio around Innovative Practices and Technology in Health Care please go to: <http://www.clinisync.org/success-stories>.

The ability to access health information in near real-time gives providers immediate knowledge to diagnose, treat, coordinate care and manage the care of a patient while an event is happening or has just occurred. More than 1,300 ambulatory practices now are now connected, and an estimated 15,000 independent and hospital-employed physicians are part of the network. But the pool of providers who have access to CliniSync has extended well beyond hospitals, primary care physicians and specialists to other healthcare professionals who touch patients' lives every day. More than 500 long-term and post-acute care facilities have access, many using direct, encrypted email messages and the Community Health Record to exchange information. Ohio has 32 behavioral health organizations connected so mental health professionals can access a patient's medical history to better coordinate care. In addition, 29 federally-qualified Community Health Centers are part of the CliniSync Community to help care for patients who are traditionally medically underserved. Of the 157 hospitals connected, 30 are Critical Access Hospitals, who also serve low-income and underserved patient populations. Under a Center for Medicaid and Medicare Services (CMS) End-Stage Renal Disease initiative, dialysis centers now are connecting to health information exchanges across the country to reduce Blood Stream Infections (BSI), and Ohio now has at least 20 centers connected and another 100 in process. In addition, five reference laboratories are in production to send results directly to practices and into the Community Health Record.

INNOVATION ACROSS THE CARE CONTINUUM

Community connectivity has spread into communities in novel and innovative ways. With the addition of two major pharmacy chains and smaller pharmacies, pharmacists can now assist with post-discharge medication management as well as referrals for nutrition, self-care and tobacco cessation programs they offer. With the ability to access the Community Health Record, 16 Emergency Medical Services (EMS) entities and fire departments are now engaged with CliniSync so they can access a patient's records en route to the Emergency Department, and that number is growing each month. And social service and community agencies now are developing "medical neighborhoods" through CliniSync's referral tool. In Central Ohio, 25 physician groups and social service agencies are working together to assist patients with mental health services, self-care management, primary care, medications, transportation, housing, nutrition and other community-based services. Forty-four more organizations in the region want to be involved in this infrastructure.

With payment reform and population health initiatives at the forefront of the healthcare industry, payers and providers collaborated on exchange strategies to improve the cost and quality of care for the communities they serve. To facilitate this in Ohio, a special committee of stakeholders was created to drive these conversations. There are now seven participating health plans, five of which are Medicaid Managed Care Plans. Just as importantly, we have multiple

health systems now also responsible for the care of patient populations. Some examples of how they are using CliniSync include:

- Health plans are notifying pharmacies when their members are discharged so they can initiate post-discharge medication reconciliation.
- Most health plans require hospitals to notify them of an admission within 24 hours. Stakeholders are working together to eliminate manual phone calls and faxes and replace them with a near real-time electronic notification process.
- Health plans are finding benefits in the timeliness of notification data, given that the Medicare and Medicaid populations are often transient. For instance, a health plan could reach an elderly member who had a quick succession of ED visits by leveraging the current address and phone number in the notification, so they could direct the member to less costly, more appropriate services.
- By using a health information exchange, data is more readily available to organizations accountable to that patient. A practice can share a summary of care once to CliniSync, but it would be available to all treating providers and a limited subset would be available to health plans for quality reporting and care.

INTEROPERABILITY ACROSS STATES

To broaden the governance of our organization, a CliniSync Advisory Council was created, made up of hospital, health plan, HIT, physician, behavioral health and other leaders who advise staff on the operations and work in tandem with the Board of Directors on policies and data governance. Under their direction, we are reaching across Ohio borders to work with other states and national initiatives, so data can be shared nationally. Ohio is also working with the Strategic Health Information Exchange Collaborative (SHIEC), an organization striving to enable the secure exchange of patient information to improve the quality, coordination, and cost-effectiveness of healthcare locally, regionally and nationally, representing 60 HIEs that together cover more than 200 million people across the United States. Our CliniSync members include practices and hospitals in bordering states. We are working on a connection to the West Virginia Health Information Exchange and multiple hospitals in Pennsylvania, are making direct connections with the Great Lakes Health Connect and are in discussions with Indiana. As mentioned earlier, there is continued work with the DOD and VA to further connections with those who care for our military personnel and their families.

Ohio is not alone in its innovative use of health information exchange to improve care coordination nor is it the only model that works. Great Lakes Health Connect in Michigan, Colorado Regional Health Information Organization, and the Delaware Health Information Network are great examples of how exchanges can coordinate to improve healthcare delivery. These organizations and many others have been pioneers in collaboration and the development of proven sustainability models. Successful health information exchanges must be supported by community trust and viable market strategies to truly improve healthcare delivery and patient care. This is how successful exchanges have truly excelled.

RECOMMENDED AREAS OF FOCUS

Specific areas where Health and Human Services can facilitate the expanding space of Innovation in Healthcare, is to continue to encourage both financially and from a facilitation perspective, the following areas:

- **Coordination:** Enabling efficient coordination of care is critical for healthcare providers as they take on more financial risk amid the shift toward value-based care, specifically coordinating between those who provide care and those responsible financially for that care. As CMS moves to more alternative payment models, the importance of implementing efficient care and case management coordination processes is critical.
- **Telehealth:** Telehealth continues to emerge as an important solution holding the possibility to significantly impact challenging problems in our healthcare system: access to care, cost and distribution of limited providers.
- **Quality Reporting:** In the past, payers have defined quality using multiple different metrics resulting in overly burdensome and unnecessary administrative tasks. Standardizing a set of measures will create an environment of efficiency, lower costs and a better way to compare care. Harmonizing the quality standards across multiple payers and providers is an important step forward.
- **Behavioral Health:** There is a significant need to revisit new rules and regulations allowing for the sharing of data restricted by 42 CFR Part 2. These patients have some of the most significant needs for care coordination that may be limited because of sharing restrictions. If patients desire their information to be shared, then we should make sure their coordination needs can be met.
- **Primary Care Initiatives:** In Ohio there has been tremendous progress with innovation through programs that put the primary care physician in the forefront of the care. The Comprehensive Primary Care and Chronic Care Management initiatives from Medicare have enabled ongoing innovation for care models in Ohio.
- **Trusted Exchange Framework and Common Agreement (TEFCA):** We feel that this new initiative from the Office of the National Coordinator should focus on resolving issues that affect clinical data transfer and interoperability for treatment purposes. Other aspects of the TEFCA dealing with Healthcare Operations and Payment should then be addressed, such as specific concerns around the HIPAA Minimum Necessary Standard and Privacy Rule.

While the concept of a health information exchange is a technology solution that promotes interoperability, the success of any initiative lies not solely in the technology but in the grass-roots collaboration and trust of all those organizations and professionals who touch a patient's life. Innovation on a regional, statewide level requires an environment in which all stakeholders can come together to generate ideas and to implement those ideas. In Ohio, we would not have accomplished what we have without both stakeholder leadership and the environment to innovate.

Thank you.



Chairman ROSKAM. Mr. Cavanaugh.

**STATEMENT OF SEAN CAVANAUGH, CHIEF ADMINISTRATIVE
OFFICER, ALEDADe**

Mr. CAVANAUGH. Thank you very much for inviting me here today. It is always a pleasure to be in this room. Not many people know, but I actually started my career many years ago as sitting in the back row there for a Member of this Subcommittee. So it is a pleasure to be here.

My name is Sean Cavanaugh, I am the chief administrative and performance officer at Aledade. We are a health care company that partners with independent primary care physicians to help them transition to and thrive under value-based payment models. Prior to joining Aledade last year, I served at CMS for six years, three years at the Innovation Center and three years as deputy administrator and director of the Center for Medicare. In those capacities, I supported the movement toward value-based models, and I am proud to continue that work at Aledade.

Aledade was founded in 2014 to help independent physicians transform health care. We bring together independent practices in a community, practices that are committed to value-based care. We help them form an ACO and join the Medicare shared savings program. Then, we ensure their success as an ACO by providing population health tools, data insights, and practice transformation expertise.

Finally, we negotiate similar ACO contracts with commercial payers, so our physicians can transform care for their entire panel of patients.

Aledade has grown rapidly. We now partner with 1,400 doctors and 247 independent practices, FQHCs, and rural health centers. These doctors are organized into 20 ACOs across 18 states, and they are accountable for 220,000 Medicare beneficiaries and then a Medicare shared savings program, and another 90,000 patients through commercial ACO arrangements.

More than half of our primary care providers are in small practices with fewer than 10 clinicians. And we are on pace to grow significantly next year and in the years to come.

But most importantly, Aledade is producing meaningful results in partnership with our physicians. We have empowered our practices to deliver more primary care, and by delivering more primary care, they have reduced unnecessary hospitalizations across the country, on average, by 10 percent and reducing post-acute care stays, on average, by 22 percent.

And the data shows our results improve the longer our practices work with us. We are committed to using technology and data, practice transformation expertise, and, most important, by emphasizing the relationship between a person and their primary care physician, to improve health care.

Medicare has been critical in this movement to value-based care. As was mentioned by Mr. Levin, the ACA created and funded the Innovation Center to test and design new payment service delivery models. Congress reinforced the importance of the Innovation Center when it passed MACRA on a bipartisan basis. MACRA

incentivizes alternative payment models, and the Innovation Center is the source of those alternative payment models.

But the cornerstone of CMS's value-based payment movement has been ACOs. Nearly 10.5 million Medicare beneficiaries are in the Medicare shared savings program alone, and we have strong evidence now, both from CMS's pioneer evaluation and Harvard researchers, that ACOs reduce costs and improve quality.

Importantly, the evidence also shows that independent, physician-led ACOs achieve greater results than those led by hospital systems.

Congress has done a lot to support value-based care, and we have some recommendations for additional things you can do. There is a longer list in my written testimony. I will emphasize a few important ones.

One, support competition in health care. You can do this by removing incentives for the merger of hospitals and physician practices. These mergers are often incentivized by facility fees for hospitals, where those services can be easily provided in a physician's office. Sometimes those consolidations are incentivized by the 340B program, which we think deserves some review, and we know that Congress is doing that already.

Congress can prohibit anti-competitive behavior such as data blocking. One of the frustrating things for us has been hospitals that aren't willing to notify our PCPs when patients have been discharged from the hospital. We welcome efforts like those in Ohio to make sure that happens.

Specific to the ACO program, I think the two important things you can do and CMS can do is, one, provide more predictability in the benchmarks. The current benchmarking formula that determines whether an ACO has saved money or not is very complex, it is often based national data, rather than local data, and it is done retrospectively. I think you get more ACOs to move to two-sided risk if we move to something more predictable and well-known, something like the Medicare Advantage benchmarks, which are set prospectively.

And then finally, make downside risk less risky. I think many of us would like to see more ACOs move to two-sided risk. CMS created Medicare Track 1+ last year, which calibrates the downside risk to make it strong enough to motivate behavior change, but not so risky to threaten physician practices' solvency.

Thank you very much for inviting me.

[The prepared statement of Mr. Cavanaugh follows:]

Statement of Sean Cavanaugh
Chief Administrative and Performance Officer
Aledade
On
Innovation in Health Care
Before The
U.S. House Ways and Means Committee
Subcommittee on Health
April 26, 2018

U.S. House Ways and Means Committee
Subcommittee on Health
“Innovation in Health Care”
April 26, 2018

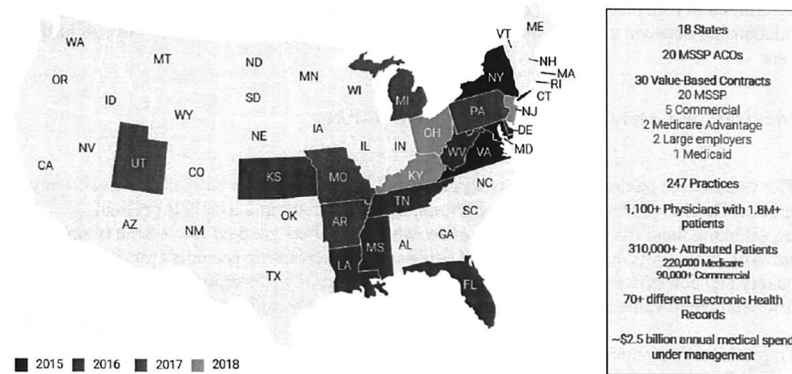
Chairman Roskam, Ranking Member Levin and Members of the Subcommittee, thank you for inviting me to discuss the innovative practices and technology that Aledade is using in partnership with independent physicians across the country to change the landscape of health care.

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

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

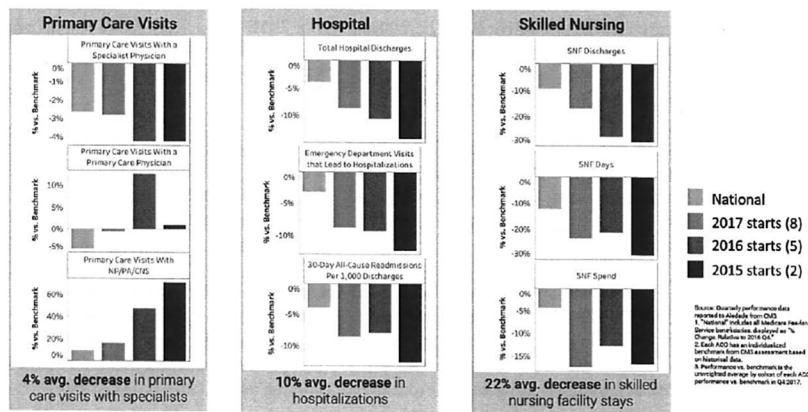
Aledade has grown rapidly and continues to do so. Aledade partners with 247 independent physician practices, Federally Qualified Health Centers and Rural Health Centers in value-based health care. Organized into 20 ACOs across 18 states, these physicians are accountable for 220,000 Medicare beneficiaries through the Medicare Shared Savings Program and an additional 90,000 people (Figure 1) through ACO arrangements with commercial insurers. More than half of our primary care providers are in practices with fewer than ten clinicians.

Figure 1. Summary of Aledade's Footprint.



Aledade is producing meaningful results. We have empowered our practices to deliver more primary care and reduce unnecessary hospitalizations and post-acute care stays, and our results improve the longer our practices work with us (Figure 2).

Figure 2. Summary of Aledade's Results.



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

Medicare as Catalyst for Delivery System Reform

The value-based payment and service delivery movement has been a key pillar of health care reform. This movement has been transforming how physicians and hospitals get paid, transitioning them from fee-for-service under which providers get paid for volume (more services, more procedures, more hospital admissions) to rewarding providers for delivering high quality and cost efficient care and for keeping patients healthy. Changing the financial incentives from volume to value is essential to address the unsustainably high growth of health care costs.

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

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

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

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

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

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

Medicare Shared Savings Program, published by Harvard researchers, have shown CMS' ACO programs have saved Medicare's Trust Funds hundreds of millions of dollars.³

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

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

Guiding Principles for Payment and Delivery System Innovation

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

- *Patient-Centered Care* – A strong primary care physician-patient relationship is the strongest tool available to create more value in health care. This proposition is strongly supported in the health services research literature and in the results of the MSSP.⁴⁵
- *Choice and Competition in the Market* – Congress has taken initial steps to reduce regulatory incentives encouraging the merger of hospitals and physician practices, but more needs to be done. Congress should further eliminate payments for physician practices to merge with hospital systems such as facility fees creating higher payment for the same services and the 340B program making drug pricing uncompetitive in private practice. Congress and CMS should take steps to prevent other anti-competitive behaviors such as data blocking.
- *Provider Choice and Incentives* – Value-based programs that provide a business case for improving care will attract voluntary enrollment by physician practices. These models should, over time, put physician practices at financial risk, but that risk must be proportional to the finances of independent physician practice and not so large as to favor consolidation of practices. Models should provide predictability in benchmarks and move over time to a financial and evaluation structure that includes a comparison to their local market.
- *Benefit Design and Price Transparency* – Price transparency to health care providers and to consumers creates competition by informing the choices of both beneficiaries and referring physicians. Benefit design should incentivize the building of the primary care physician-patient relationship and other cost-saving choices.

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

⁴ <http://www.nejm.org/doi/full/10.1056/NEJMp1709197?query=TOC>

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

Recommendations to Create a Reliable Financial Model to Support Innovation

Limit one-sided risk.

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

CMS Administrator Verma recently expressed her intention to take a close look at the current ACO model “to make sure that they are not driving out smaller practices.” A major driver of provider consolidation has been differential payments for “facility fees” when private practices are purchased and rebadged as hospital outpatient departments (which the 2018 President’s Budget has proposed to eliminate). The Medicare Payment Advisory Commission (MedPAC) has proposed site neutral payment policies to address this issue. But short of practice acquisition, hospitals can use one-sided ACO models as a safe haven for a softer form of consolidation: increasing “in-network utilization” for purposes other than lowering costs. Allowing providers to stay in one-sided risk also decreases savings for Medicare in the long run.

To address these concerns, CMS should continue to limit one-sided MSSP ACOs to two, three-year performance periods – six years total. CMS should not extend one-sided risk for the third MSSP contract.

This could result in some ACOs dropping out of the program; among the most recent cohort ending their initial three-year contract, only 8 out of 65 (12%) voluntarily moved to risk. However, we believe that if two-sided risk is made less risky, and more predictable, then most successful ACOs will be willing to move up the risk continuum. The success of the value-based movement should be measured not only by the number of ACOs, but also by their ability to generate results.

Make downside risk less risky.

The Medicare ACO Track 1+ model, which was unveiled by the CMS Innovation Center in late 2016, took a big step towards creating a two-sided model that is feasible for organizations of differing finances by introducing the concept of revenue-based downside risk. This model qualifies as an AAPM under the “more than nominal risk” test of MACRA, as it provides for penalties of up to 8% of practice revenue for poor performance. For organizations with profit margins of 2–3%, that is certainly sufficient to assuage concerns that ACO waivers could lead to higher costs.

Track 1+ had a strong debut in 2018, with 55 ACOs entering this Innovation Center model. In contrast, only a few ACOs entered the MSSP’s current two-sided models – two in Track 2 and

eight in Track 3. To generate better evidence on the level of risk that yields the best results for the ACO program, CMS should extend revenue-based risk to the MSSP program, and offer additional incentives for organizations that take on more risk.

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

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

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

CMS introduced a regional benchmarking approach last year to account for regional trends, but the complex benchmark calculations conducted between the close of the performance year and the "final reconciliation" are not possible for ACOs to replicate. The regional benchmarking methods also inadvertently introduced a new problem that systematically disadvantages rural ACOs by including their population in the regional comparison group. This policy decision also exacerbated the confounding effects of the approach towards risk adjustment in the ACO program, wherein risk scores for continuously enrolled patients can be reduced, but not increased.

As a result, ACOs are faced with a no-win situation, penalized whether their risk scores decrease or increase. The Next Generation ACO program – an Innovation Center demonstration – has also had shortcomings with respect to the benchmarking methodology, and many of its most promising features are rarely used.

As one recent study of independent ACOs observed, the lag between performance and evaluation, the "black box" of risk adjustment, and benchmarks that are perceived as constantly moving targets, all contribute to a reluctance to move ahead with two-sided risk. Pushing ACOs to take more risk, while creating a more predictable and equitable benchmark can lead to greater savings to the taxpayer without encouraging further provider consolidation.

A radically simpler solution would be for CMS to move all ACO benchmarking towards a methodology based on Medicare Advantage (MA) benchmarks. This approach could also be used to develop an improved version of the Next Generation ACO program that provides an on-ramp for smaller practices. To preserve the existing historical-to-regional transition of MSSP, the

ACO's benchmark could initially be set at their historical percentage of the MA rates in their area (120% or 80%, etc.) during one-sided risk, and then begin the transition towards the actual MA benchmarks as soon as the ACO takes on two-sided risk.

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

Tying ACO benchmarking to MA benchmarks would also have the advantage of giving risk-taking providers greater competence – and confidence – in taking risk for MA patients, and partnering with plans to create more MA options for seniors.

Reward (and simplify) quality.

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

Engage consumers.

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

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

Recommendations to Improve Access to Information

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

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

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

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

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

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

CMS currently sends a monthly batch of 11 different files with claims data to the ACO. Because of the claims lag from provider to CMS, the latest month of data is not very reliable. As a result, we receive reliable claims data for events that happened by the end of April around mid month of May. This six week delay is a barrier to action.

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

Standardize claims feed for commercial payers.

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

Support electronic health record (EHR) interoperability through APIs.

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

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

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

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

Chairman ROSKAM. Well, I want to thank all the witnesses. You have given us great insight, and you all have got great backgrounds. We appreciate your written testimonies very much. And now I am going to invite our Members to inquire. We will start with the gentleman from Texas, Mr. Johnson.

Mr. JOHNSON. Thank you, Mr. Chairman, I appreciate that.

Mr. Paoletti, welcome to the subcommittee. As you know, today many of our military service members receive care at both military and civilian facilities. For example, they may see a military doctor on base for a routine visit but see a civilian doctor for another reason.

I understand that you have been working closely with Wright-Patterson Air Force Base to coordinate care between military and civilian health care providers for active-duty troops, veterans, and their families. As a 29-year Air Force veteran, I commend you for that work, and I want to ask you a couple of questions.

One thing I would like to know more about is whether or not the VA is working to improve their coordination of care with non-military folks like DoD has been doing with your organization. It is an important issue for our troops, veterans, and their families.

Mr. Paoletti, can you tell me if your organization is currently working with the VA on coordination of care? And if so, can you tell me about those efforts and how many VA facilities you are working in?

Mr. PAOLETTI. Yes, Mr. Johnson, an excellent question. And as the only member in my family who has not been in the military—male—it was important to many members that we work on that.

We are currently testing with the VA at the national level. What that means is the interoperability between what we are doing with the private community-based providers and the VA will soon be interoperable. We expect that to be in place in the next two or three months. So the VA, just like Wright-Patterson Air Force Base, will be able to communicate and coordinate with all the local-based providers in the state. We have VA facilities all over the state, in Dayton and Columbus, southern Ohio, Cleveland, and we are using national standards to facilitate that.

Just as a note, we are also working with the different EMR vendors that both the DoD and the VA are looking at and implementing to make sure that the interoperability that we do now with them will carry over once they install their new electronic medical records. But that is critically important to care for our veterans.

Mr. JOHNSON. And you haven't had any difficulty receiving that health care information?

Mr. PAOLETTI. Well, we are not in production yet, but in the testing we have had no problem. And the VA, the folks from the VA we have been working with, have been wonderful and very, very good to work with.

Mr. JOHNSON. Thank you, sir, and I yield back.

Chairman ROSKAM. Mr. Levin.

Mr. LEVIN. Mr. Chairman, you started off by talking about optimism. And I very much share that. I must say that listening to the testimony, especially from a few of you, there is reason to have

been—to be optimistic about the results of recent reforms and recent actions that we took.

Mr. Paoletti, for example, in your efforts did you receive federal funding?

Mr. PAOLETTI. Yes, sir. In 2009 our original funding came from the HITECH Act, as the state-designated entity for health information exchange in Ohio. Since that time, though, we have not taken any more federal funding. But that did get us started.

Mr. LEVIN. The money originally came—I remember well the—what was it, 10—how much money was it that we put aside? Ten million, I think.

Mr. PAOLETTI. The original funding into Ohio was \$14 million.

Mr. LEVIN. Dr. Merrick, you are an ACO?

Mr. MERRICK. Yes, sir.

Mr. LEVIN. And that also was projected through the ACA. It is working?

Mr. MERRICK. Yes. I think the important things that have happened as a consequence of the Affordable Care Act is that health care is a team sport, and it traditionally was much more fragmented. And the move towards transparency of information and data collection to drive higher quality, lower cost has been a very positive thing.

I think one of the challenges that we, as an independent doctor group, have experienced, one of the unintended consequences, is there is such an investment required for EMR, and all these other things that the independent physician is becoming more and more extinct because of the pressures towards consolidation that were referenced by Mr. Cavanaugh.

Our goal is to help physicians remain independent because the data is very clear that when physicians practice outside a hospital employment setting, the quality of care goes up and the cost goes down. And so our goal in being here is—so I am a practicing urologist, I still do surgery and see patients and serve my group.

My father was a 40-year practicing OB/GYN doctor who delivered babies born in Michigan, in Saginaw, and he taught me to be a trusted advisor to our patients. And that is our goal for us, collectively, the 700 doctors of us, to be trusted advisors. And if there is any way that we could serve your committee as a trusted advisor to help Congress help us take care of patients, that is our goal in being here.

Mr. LEVIN. Thanks. I mentioned earlier Mr. Kind and I, sitting here, can recollect how many hours we spent around the table, talking about ACLA [sic] and talking about change from fee-for-service to value-based. It seemed to go on endlessly; it was important.

So Mr. Cavanaugh, let me just ask you. I don't mean to promote undue controversy, but I just don't understand this Administration's position on the innovation fund and, for example, stopping an experiment which seemed to many of us to make so much sense. So why don't you comment on this, because what we did in ACA was to provide some monies to try to cluster payments, right?

So just tell us—you have about less than a minute—what is going on here.

Mr. CAVANAUGH. Well, I appreciate the question. And I would start by saying Secretary Azar and Administrator Verma have said some very positive things about the value-based movement, and we appreciate that.

I think what you are specifically referring to was under the previous Administration we had launched a model that—around some joint replacements and cardiac procedures, there seemed to be a philosophical objection to it because it was mandatory in certain regions of the country.

The purpose of the Innovation Center, though, was to test models and evaluate them. And the reason that was made mandatory was we felt it was necessary for the evaluation, and that you wouldn't get sufficient numbers of participation in different regions unless you had required participation.

So we, personally, were very disappointed that that wasn't continued. I thought it could have been very successful and paved a path for the program. And I am sorry the mandatory part became a stumbling block. But again, I would say that otherwise they have said some very positive things, and we are hopeful they will follow through on them.

Mr. LEVIN. Thank you.

Thank you, Mr. Chairman.

Chairman ROSKAM. Mr. Buchanan.

Mr. BUCHANAN. Thank you, Mr. Chairman. I want to thank you for bringing forth these witnesses here today because in terms of innovation and moving forward, we all talked about delivering quality of care that is more affordable. But I want to focus on costs.

As someone that has been in business for 40 years, 30 years before I got here, and then obviously, being here the last 10, 11 years, I just see costs going up like this. I see it in our area, bankrupting a lot of middle-class families, where they have had to pick up more and more of the tab.

I think of myself when I first 20 years ago paid for everybody's insurance, family, no deductibles. Now the typical business might be picking up 700 in our area, and then the employees are picking up 700. It is 10,000 a year. I had an individual the other day tell me they got an Italian restaurant in our area. For the last 20 years him and his wife, who are in their early 60s are paying \$3,000 a month because things are more age-weighted today. So it is outrageous, what is happening.

So that is why I applaud the chairman holding this hearing, because we have to start looking for ways to be more efficient and bring better care, but we have got to start betting the cost on the cost of care. And we talked about that eight years ago. There is plenty of blame to go around, but I don't see that happening.

What I see is that it is continuing to rise. Even if you got Medicare and Medicare Advantage, that cost continues to go up, in terms of seniors. I am in Sarasota, Florida, so I care about those issues.

But let's start with you, Dr. Philip. You had said that part of what your practice or what you are doing is trying to develop better care, and you thought maybe—taking your quote—\$.50 on the dollar. Just tell me. What are you doing to bend the curve on costs? Is \$.50 on a dollar in terms of the way you are delivering medicine

to patients realistic? Are you really seeing those kind of results? What is your thought, in terms of bending the cost curve?

Mr. PHILIP. Thank you for the question. I think it is actually remarkable, the amount of costs you can take out of the system, especially when the costs are so focused on a small percentage of patients. If we can invest in those patients, those vulnerable patients, we can see huge decreases in the cost to the system.

In the example I gave you—but there are so many more examples of patients that are Medicare patients who were admitted every month with all of these tests done in the hospital, and they come out of the hospital and they said, “Well, they told me it wasn’t this, it wasn’t that, it wasn’t this, but”—I said, “Well, what did they tell you it was?” And they were like they didn’t know, but it wasn’t dangerous.

And I think finding that root cause of the problem and helping people to be well with that holistic approach, there is incredible cost savings.

I had a physician partner of mine take his wife to the emergency room because she was nauseous. And he got IV fluids, IV nausea medicines, and it cost him \$3,000 with his deductible to do that. In our clinic, if we give a bag of IV fluids, it would cost us \$20. We give them that same IV nausea medicine for \$20, and we don’t charge the patient anything. And they get the exact same care for a fraction of the cost. That is why site-of-service is so key. To get the exact same service in the right setting, it dramatically changes the cost—

Mr. BUCHANAN. One other reality in our area that I read in the paper a while back—I share this because it was staggering to me—on the USA Today front page, it said 62 percent of Americans don’t have \$1,000 in the bank. I had to really think about that. And then in our area the deductible average with Blue Cross Blue Shield, 7,000 to 8,000. So how do you have health care?

Dr. Merrick, let me get your thoughts on costs and rising costs. How do we start to bend the curve on costs? You said your father is from Saginaw; I am from Michigan, so I know where Saginaw is. I am from the Detroit area originally. But what have we got to do to start bending the curve on costs?

Mr. MERRICK. The first thing that we did in our group was awareness. And when I came out, if I would do a surgery on a patient, I had no thought or mindfulness about whether or not I did it at the hospital or at the outpatient surgical center. And the cost difference can be up to 65 percent there.

I think identifying the high-risk individuals and preventing hospitalization through Matthew’s program is important. But we have—our sight-of-service strategy extends—what we call immediate care staffed by emergency rooms. We have six sites that have 15,000 visits per site per year at an average cost visit of about \$280. The average cost of an emergency room visit is about \$2,000-plus. And on top of that, roughly half the people who come to the emergency room get admitted, and there is additional cost and risk from that time in the hospital.

So the right service done the right way at the right place is critical.

Mr. BUCHANAN. Thank you, Chairman. I yield back.

Chairman ROSKAM. Mr. Kind.

Mr. KIND. Thank you, Mr. Chairman. Mr. Chairman, let me commend you for holding this hearing. It is kind of fun and inspirational to get a panel of witnesses here telling us what is working within the health care system. We ought to be doing this every week, in my opinion.

But we still face challenges, and we appreciate your feedback here today. I know when Mr. Levin and I and others were working on the Affordable Care Act, it was with the goal of disrupting a health care system that was under-performing and taking us to a bad place.

We were focused on a few key issues. One was fact, a recognition that we were deplorably behind the times when it came to the HIT and the electronic medical record system, and we had to catch up in order to get the data to make good decisions with; we had to disrupt a health care delivery model that wasn't producing great outcomes; and then we needed to try to realign the financial incentives to go to value, quality, outcome, and away from the outdated fee-for-service model. And it is exciting to see a lot of these things starting to gain traction.

But we then delude ourselves in believing it was going to happen overnight. This was going to take a lot of hard work in pushing the boulder up the hill.

Mr. Cavanaugh, welcome back to the Committee. You were situated at the Center on Innovation. In my opinion, I think it was one of the better things that we actually did in the Affordable Care Act, because it did act as a disruptor of delivery system models, new payment models. What really jumped out, in looking over your testimony, both written and oral, was the fact that you are achieving tremendous changes in the post-acute care setting.

Chairman Brady and I have been delving in this world. It is one of the areas I don't think we did a very good job of trying to address reform under the Affordable Care Act. You mentioned that the model that you have right now is reducing post-acute care usage by, what, 22 percent, or are there any highlights or takeaways that we need to be aware of that enabled you to achieve that?

Mr. CAVANAUGH. The first highlight is that it was data-driven, meaning it is not unique to Aledade. When you look at Medicare spending and how much it varies around the country, a significant part of the variation is around post-acute care. And so we knew, as we went into different communities, that that was an opportunity.

But it is also an opportunity because there is better ways to deliver care. The patient would rather be in their home with the right supports. So it is just working—and sometimes in partnership—with skilled nursing facilities and telling them we are not going to send you patients that don't need to be there, and getting them to understand that there is a new paradigm, that it is not about increasing utilization, it is about doing what is best for the patient, so just a relentless focus on what the patient actually needs, and what is best for the patient, and not the routine of just routinely cycling people through institutions.

Mr. KIND. Yes, when we have got time, I would certainly love to personally follow up with you and get more details on how that is working, because I think it works in nicely with what Chairman Brady and I have been kind of focused on here for a while.

But another issue of concern that you raised—and this gets back to HIT and the whole meaningful use and interoperability that we are still having difficulties trying to implement—is the data blocking that you just mentioned. Why is that such a significant problem? And what is needed to overcome that?

Mr. CAVANAUGH. So when I was at CMS, we created a code called transitional care management, because there was evidence, when a patient gets discharged from the hospital, if they are very soon thereafter linked with their primary care physician there is evidence that they are less likely to be readmitted, better health outcomes, lower costs.

So we created a code so the physician could bill for that type of management. And then we saw that the code didn't get used much, and went out to physicians and said, "Why aren't you using it?"

And they said, "Because we don't know when our patient was discharged from the hospital. We don't have the ability." But with health information exchanges, often that is now possible. And that is a part of what Aledade does, is we make sure our practices know: "Your patient was discharged yesterday. Call them today."

But sometimes in some locations there isn't a health information exchange, and we reach out to the hospital directly and say, "We will tap into your system for our data." And it is appalling to me that some hospitals say, "No, we see that data as a competitive advantage, and we are not going to share it with you." When there is evidence that it is better for the patient, better for the beneficiary, they are taking a competitive stance.

Mr. KIND. Yes, we have had to overcome some of those difficulties in Wisconsin with the coalition, the Quality Care Coalition that was formed there.

Mr. CAVANAUGH. Yes. I would—

Mr. KIND. Dr. Becki, if I may—I am running out of time, but first to congratulate you in invoking Kermit the Frog. I think it is the first time in Committee history where we got that philosophy thrown at us. That is great.

But you mentioned in regards to telemedicine that the difficulty of the multiple standards across borders in different states, I am sure licensing plays into that, as well. Are you recommending some type of national standard to apply, or best model that we can move forward on? What exactly can we do to address it?

Ms. HAFNER-FOGARTY. Thank you. Thank you, Representative Kind. You know, I spent about 15 years on the Minnesota Board of Medical Practice, and those medical boards believe strongly that each state is unique, and so each state should have their own definitions. It is job security for me because it just makes interpreting that information difficult.

I truly believe that if we could come to a standard definition of what telemedicine is, what virtual care is, and what telehealth is that could be applied in a regulatory fashion across the country, that would at least get all of us talking the same language. And that would be a huge benefit from a policy standpoint.

Mr. KIND. Thank you.

Thank you, Mr. Chairman.

Chairman ROSKAM. Thank you.

Mr. Smith.

Mr. SMITH OF NEBRASKA. Thank you, Mr. Chairman, and thank you to our witnesses here. I appreciate your insight and input.

One area of Medicare very much in need of innovation is long-term care. And we know that Medicaid is the primary payer on nursing home stays, but Medicare is the primary payer on the large health care costs of this population, such as the tremendous costs associated with trips to the emergency room from skilled nursing facilities. And in fact, on average, 19 percent of hospital transfers originate from skilled nursing facilities. Approximately 1 in 5 patients admitted to a skilled nursing facility are re-admitted to the acute hospital within 30 days.

So studies have found promising results in the use of telehealth to cut down on these massive amounts of ER trips for our most frail Medicare patients and allowing patients to be treated in their homes instead.

Telehealth can allow providers to be with nursing home patients at the time of their emergency. The difference that this would make for patients, especially in rural districts like mine, would obviously be tremendous.

So I am wondering. Would any of you like to speak to the promise of this technology or other technology in long-term care?

Ms. HAFNER-FOGARTY. Thank you, Representative Smith. I think it really is quite critically important in rural areas, because a small long-term care facility may be located many miles from—physically located many miles from the nearest hospital or the nearest clinic.

One of the problems that we tend to encounter is the ability of the care providers to get reimbursed for this care. And I think, as we transition to a value-based care environment, that will become less of a problem because we will be transitioning away from this need to be able to charge on a per-transaction basis.

But I think there is great promise in telehealth. I think the increasing ability of platforms like Zipnosis to link with and to take in objective data by linking with remote monitoring systems will only make that better.

The other thing that is very important in telehealth is the ability to integrate those telehealth visits into the patient's electronic health record so that there is a complete record of what is going on with that patient. A great many telemedicine companies and telehealth companies do not do this. You have increased fragmentation of care; you have got visits floating around out here in the cloud and not connected to the rest of the patient's continuum of care. And so that is something that I think is increasingly important—to make sure that telehealth is part of a whole continuum of care, and not this thing that is sitting out there by itself.

Mr. SMITH OF NEBRASKA. So what would you say is the barrier to moving in a better direction?

Ms. HAFNER-FOGARTY. I think reimbursement is a barrier.

Mr. SMITH OF NEBRASKA. Okay. Mr. Cavanaugh.

Mr. CAVANAUGH. Reimbursement is a barrier. The reason CMS and Congress had such restrictions on telemedicine is the fear that it would be not used wisely, but overused. But if you can get more providers to move to two-sided risk models, meaning they have an incentive not to overspend but to use it appropriately, then CMS can unleash—and they have started to loosen the rules on telemedicine, but only for providers who are under two-sided risk.

So the goal for all of us is to make those two-sided risk models workable for providers so that we can take advantage of these technologies.

Mr. SMITH OF NEBRASKA. Okay. Anyone else?

Mr. Paoletti.

Mr. PAOLETTI. Dr. Becki mentioned something that is very important: remote monitoring.

So remote monitoring, in coordination with telehealth and other technologies, is critically important. So you can monitor remotely EKGs, blood pressure, pulse. You know, instead of having a patient drive 40 miles to the doctor for those routine checkups, that remote monitoring can be very efficient, very cost-effective.

I was talking to the CIO at the Cleveland Clinic yesterday about what they are doing there, some very fascinating things in coordination with telehealth. It holds great possibility.

Mr. SMITH OF NEBRASKA. Very good. Thank you.

I yield back.

Chairman ROSKAM. Mr. Higgins.

Mr. HIGGINS. Thank you, Mr. Chairman. You know, everybody talks about costs, and really, nobody does anything about it, including my party. The Affordable Care Act was a start, but it didn't come close to really cutting the cost curve to the extent that it needs to be cut.

The cost curve is about cutting the rate of inflation on an annualized basis for medical treatment. We still pay more than any other country, and our outcomes are considerably less.

The reason I bring this up is this is not an ideological issue. This is arithmetical. And the fact of the matter is the Federal Government, under Medicare, under the VA, under the Medicaid program, provides health insurance as an insurance provider for 161 million Americans. That is more than 50 percent of the population of the nation. That is a lot of leverage. And in any business, in health care or whatever business you are in, it is all about leverage.

And the biggest mistake in the Affordable Care Act—and I was here, as well—was that there wasn't a public option, because a public option was viewed not as a public takeover of medical services—not one doctor would become part of the public sector versus the private sector; it is all about the insurance—but you needed a public option to provide a countervailing force to private insurance.

For example, Medicare, 2 percent administrative cost versus private insurance, 30 percent administrative cost. That drives up the cost of health care for who? The individual and the Federal Government that is providing the health care. Ninety percent of Medicare patients today have access to a primary care physician and a physician specialist. So there is a wide level of acceptance, regardless of what providers say. They complain about reimbursement rates for Medicare, but they all take it. Why? Because it is a reliable payer.

High satisfaction rate among Republicans, Democrats, and independents for Medicare. High satisfaction rate, over 90 percent.

So why wouldn't we simply use the best public option that already exists—that is the Medicare program—to allow people between the ages of 50 and 64 to buy into Medicare at their own expense, thus realizing great savings? Because we all know, from the most recent iteration of health care advanced by the majority in the House, the most recent iteration, who gets clobbered? The population 50 to 64. Why? Because insurance companies view them as a risk, so they have huge deductibles, huge copays, and huge premiums to the point that they can't afford health insurance.

So there is an incentive for all of us to provide an option to the American people that would allow them to buy in. It wouldn't cost the Federal Government a dime. It wouldn't cost a dime. Just allow them to take advantage of the great leverage that the Federal Government already has.

Mr. Cavanaugh, you are an innovator in the Innovation Center, or used to be, in CMS. Why are we not pursuing aggressively, clearly, and quickly a Medicare buy-in for those between the ages of 50 and 64?

Mr. CAVANAUGH. So, under the Innovation Center statute, it is not clear we could have done that. That was clearly about creating payment and service delivery models.

Mr. HIGGINS. You know what? We are already complicating an already overly-complicated situation. I understand that you can't; that is why we are here. That is why we are here.

You know, as I said at the outset, the Affordable Care Act, Obamacare—call it what you will—was supposed to be a start to health care after 100 failed—100 years of failed attempts by both Republican and Democratic administrations.

So we have the ability—you know, prior to the enactment of Medicare in 1965, less than half of seniors had health insurance in America. There was a very simple reason for that. Private insurance companies didn't want to write a policy for somebody who was older and sicker. A good and generous nation responded to that by creating a Medicare program. Now over 95 percent of seniors have access to health care. The 50-to-64 population today is what the Medicare population was in the 20th century prior to the enactment of Medicare.

So I am sorry to cut you off, but this is not your problem, it is our problem. And, you know, when we over-complicate something that is so really simple, in terms of the leverage points that we have, we defer a solution to a problem that we all have an obligation to solve.

I will yield back.

Chairman ROSKAM. Ms. Jenkins.

Ms. JENKINS. Thank you, Mr. Chairman, and thank you all for being here today.

Mr. Paoletti, I think your remarks offer real hope for the role of technology and improving health care in the United States, if we work with the innovative private sector to find solutions to our common problems. I want to direct your attention to page six of your testimony, where you recommend areas of focus for the Com-

mittee to consider. In particular, you highlight mental health and substance abuse.

I have introduced a piece of legislation—it is H.R. 331—with my colleague, Congresswoman Matsui, that would authorize a demonstration program to provide health IT incentives to behavioral health providers. The legislation would enable psychiatric hospitals, community mental health centers, and methadone clinics to purchase electronic health record systems.

With that as a background, I just have a couple of questions for you. First, can you tell us more about the need to improve care coordination for people with mental illness and addiction disorders? And do you see this technology, such as electronic health records, playing a role in reducing cost, as well as creating better efficiencies in the Medicare space?

Mr. PAOLETTI. Thank you, Congresswoman. It is a critical thing to address. If you look at the cost of care, behavioral health, the activity that occurs in our emergency rooms, and the frequency of which that occurs, and also all the other problems that behavioral health causes in this country, we have to address it.

And technology is important. There are a lot of behavioral health providers, a lot of mental health facilities out there that don't have some of the technology that they need to do the coordination. So I do believe that any assistance provided to them would be incredibly helpful.

But I also want to stress that even if they have the technology, unless we do address the rules around the CFR Part 42 Part 2 restrictions, it is going to limit the coordination that can occur, even if they have the technology. And as I mentioned, there is a resolution in place right now that would address that.

Again, the philosophy should be if the patient wants their information shared, we should allow that. And by bringing the behavioral health community into the fold, I do believe you will see a great impact, not only on cost, but also some of the other tragic events that we see occur across the country.

Ms. JENKINS. Okay, thank you. I am also interested in your views about the role of health IT in battling the opioid crisis. For example, do you believe that e-prescribing can help us both prevent opioid addiction and enhance the quality of medication-assisted treatment?

Mr. PAOLETTI. Yes. E-prescribing is a very critical step. In Ohio, most of our providers are e-prescribing, although we do have a two-factor authentication method in Ohio for that, so it makes it a little more difficult.

But the OARRS database, the prescription-monitoring database that has been implemented in Ohio, and the mandatory use of that system by providers when they are prescribing schedule II drugs, we have seen a dramatic decrease in prescription—schedule II prescriptions in the state. So making it easier for the provider to understand what the patient has been prescribed in the past, making that information more readily available is helping. We are seeing it help now. And it will continue to help in the future.

Ms. JENKINS. Okay, thank you, Mr. Chairman. I will yield back.

Chairman ROSKAM. Ms. Chu.

Ms. CHU. Mr. Cavanaugh, thank you for being here today. For this question, I would like to draw from your prior experience with-
in CMS.

This past weekend I, along with some of my colleagues on the Ways and Means Committee, heard from a number of companies that are working in the precision medicine space about difficulties they face when seeking CMS approval for the use of their products and methodologies in the Medicare system.

I was so impressed by their innovations. They had unique products or treatments that were customizable, based on a patient's genetic makeup, molecular diagnosis, specific imaging, or other aspects of a patient's diagnosis. While many of these precision medicine products are relatively new, they were able to be moved through the FDA's approval process rather swiftly, in some cases because they received a special breakthrough designation.

However, after FDA approval, these same companies are struggling to be approved by CMS. Every one of the companies said they had trouble getting CMS to understand the nature of their innovations. I realize CMS has a very important role in financial accounting, but should there be more expertise in subject matter? And could there be room for improvement in CMS's approval process? Or is there something that Congress could do to improve CMS's approval process?

Mr. CAVANAUGH. Thank you for that question. Even apart from precision medicine, we often ran into questions about why something was approved in FDA and either wasn't approved or took longer for CMS approval. And I would just try to remind folks that the two agencies try to work very closely together, but they do have different guiding statutes and different criteria.

So the first thing is FDA approval is subject to one set of standards. When something gets to CMS, it is really going through three processes: the coverage question, is this something appropriate to Medicare—appropriate, medically necessary for the Medicare population; coding, which is an intricate set of rules, is it unique enough that it deserves its own code; and then what is the level of payment.

So, as far as the precision medicine ones you are talking about, it would be interesting for me to know which part of that coverage coding or payment they are getting held up in.

But your general point is well taken. When I was at CMS, we cared greatly about fostering precision medicine. We tried to work closely with our FDA colleagues. But certainly the agency could always use more expertise and guidance from Congress in this area. It is tied into this theme of this hearing, in that you want to make sure that these are truly innovative, meaning they improve quality of care for beneficiaries and/or reduce costs. I think that is the viewpoint that CMS has long taken.

So I welcome your attention to this point, and I think my former colleagues at CMS would, as well. My sense was they very much support these innovations and would like to see them through the process.

Ms. CHU. So that is why I am thinking if we had more expertise on the review teams, so that there could be better communication—

Mr. CAVANAUGH. Certainly. And, as I said, my colleagues worked very hard to work closely with FDA and make sure they had common understanding of technologies. I am sure that those processes can always be improved, but that we understood that was important.

Ms. CHU. Okay, thank you. And Dr. Kharraz, I was so impressed by what you are doing with Zocdoc. It certainly takes care of the last-minute cancellations and makes doctors' time more efficient.

But my question has to do with language availability. My district in California is one of the most diverse in the country. We have a population that is 26 percent Hispanic and 37 percent Asian. And this diversity is something we are very proud of, but it comes with certain challenges when it comes to health care. Specifically, there is a substantial number of my constituents who are limited English proficient, or LEP. And in the U.S., 25 million individuals are LEP; 26 percent of the total Los Angeles Metro Area is comprised of LEP working-age individuals. Furthermore, 47 percent of adults who speak Asian or Pacific Island languages are limited English proficient.

And so, managing your health care can be difficult enough in your own native language, let alone in the secondary language. Can you talk about the steps Zocdoc is taking to make sure that there is language availability for others for whom English is not their primary language?

Mr. KHARRAZ. Absolutely. Thank you for the question. And as a fellow American whose first language isn't English either, I understand the challenge.

We have taken great care that discoverability of doctors that speak your language as a patient is one of the key features on Zocdoc. And we allow patients to identify doctors that speak 1 of more than 100 different languages, so that they can ideally communicate in their native tongue.

Chairman ROSKAM. Thank you.

Mr. MARCHANT.

Mr. MARCHANT. Thank you, Mr. Chairman. One of the big hospital groups in my district is Baylor Scott and White, and I know Dr. Fogarty at Zipnosis has a relationship with them. Is that correct?

Ms. HAFNER-FOGARTY. It is.

Mr. MARCHANT. Could you explain to me just in a very fundamental way what your relationship is with them? What do you do for them, how do you get paid, and how does a patient know that you are in the process?

Ms. HAFNER-FOGARTY. We have partnered with Baylor Scott and White for going on four years now, and the Texas telemedicine regulatory environment was very challenging when we first entered into partnership with them.

So we started—what we do is we license our software platform to Baylor Scott and White. They create a site within their patient portal called Baylor Scott and White e-visits. So if you are a Baylor Scott and White patient, and you would like to do an e-visit, you can enter through the patient portal and you are given information about the e-visits. We ask you why are you here, what is your prob-

lem, and then you are guided through an asynchronous, adaptive interview.

And that is a lot of adjectives. And what it means is you answer a series of questions that are identical to the questions I would ask you if we were sitting in an exam room together. And the questions change—the software changes the questions based on your answers.

So at the end of this electronic interview your information is submitted to a Baylor Scott and White physician, not a physician sitting on his deck in Malibu, drinking a latte, who happens to have a Texas license. It is a Baylor Scott and White doc who has a practice in your community. And the physician reviews that information, comes back to you, and says, “Here is a diagnosis, here is a treatment plan.”

And if a prescription is indicated, we have a very novel e-prescribing function where all the physician does is enter the prescription, the prescription is actually filled because we allow you to pick the pharmacy that is most convenient for you. You are mobile, you are on your way to work, you are dropping kids off at school or daycare, so you may not want to use the same pharmacy every time.

The record of that e-visit is then deposited within your Baylor Scott and White electronic health record, so the next time you walk through the door of a Baylor Scott and White clinic to see your family physician or your internist, he or she can see, and they can say, “Oh, Mr. Marchant, you had an e-visit here two weeks ago for a sinus infection. How are you doing? Did that clear up for you?” So that is probably more than you ever wanted to know.

Mr. MARCHANT. No, no, it is really very helpful. I am on Medicare. So when does it tell you we can’t help you, or you need to go see the doctor? I mean does it screen your payment method before it gives you any information?

Ms. HAFNER-FOGARTY. We have the ability to—we work with an organization called PokitDok that creates eligibility files. So if you are a Baylor Scott and White employee, you belong to a—what we call a zip group, and that payment and billing is coordinated through PokitDok with the insurance company, there—every single clinical condition that we treat has a number of automatic stop signs.

So if you start a visit for bronchitis and you, in the course of our interview, tell me that you have shortness of breath and crushing chest pain, the software stops the interview right then and there, because you are not medically appropriate to be getting your care by telemedicine. You need an emergency room.

And part of the beauty of our relationship with Baylor Scott and White is we give you the next most appropriate site of care within the Baylor Scott and White system. We don’t just tell you to go away, we say, “Here is the next step,” and we can actually send that information forward.

Mr. MARCHANT. Does Baylor Scott and White use you because they are trying to keep people out of the emergency room? Do they try to drive traffic to this site? Is this a proactive program, or is it a program they just offer?

Ms. HAFNER-FOGARTY. It is a proactive program. And initially, they started with their employees. It might or might not surprise you, but people that work in the health care field are heavy utilizers of health care. And providing care for their employees was costing Baylor Scott and White a lot of money. So they put us in place, first, for their employees, to give their employees a lower-cost option to going to the emergency room or going to urgent care.

And, you know most people just don't like sitting in the emergency room.

Chairman ROSKAM. Mr. Paulsen.

Mr. PAULSEN. Thank you, Mr. Chairman. And thank you also for having Dr. Hafner-Fogarty here with Zipnosis, from a Minnesota perspective. This has been great testimony to hear from all of you.

Dr. Hafner-Fogarty, let me ask you this question. You mentioned Baylor just a little bit ago. But what is the general makeup of the health care systems that Zipnosis supports? Are they big? Are they medium? Are they small? Is it across the gamut? Give a little perspective of that, other than just Baylor.

Ms. HAFNER-FOGARTY. Baylor Scott and White is one of the bigger ones. The smallest system that we have right now is a critical access hospital in central Minnesota that has six doctors and, I think, six nurse practitioners. So we are pretty size-agnostic.

We are really excited about this opportunity with the American Academy of Family Physicians to make a version of our platform available to those docs in two, three, and five-doctor practices, because they need the technology almost probably more than the bigger health systems do.

Mr. PAULSEN. Sure. You know, one of the chief complaints that I hear consistently from the doctors that I speak with on a pretty regular basis is the time they don't get to spend with their patients. They do a ton of paperwork with the compliance costs, and it is just taking away from the doctor-patient relationship.

How does some of the platform and practice work now with Zipnosis? How does it change that, or what does it do with that doctor-patient compliance paperwork component?

Ms. HAFNER-FOGARTY. Normally, if a patient and I are sitting in an exam room, I am doing the data entry and all of the documentation. And I jokingly tell people I went to medical school because I couldn't type worth sour apples, and focusing on a computer keyboard is not why I went into medicine.

What Zipnosis does is we shift the data entry to the patient. The patient creates the information, our software translates that into a physician-friendly, SOAP-style note that all doctors are used to reading. And when the physician makes the diagnosis and the treatment plan, the software creates the documentation. So our physicians literally spend two to three minutes on a telemedicine visit, and it really streamlines and makes them more efficient. And they are not going back for two to three hours at the end of the day doing work after work, which is something my colleagues who are still in practice do complain about.

Mr. PAULSEN. Well, I know we are going to continue to need your advice. You have talked about thinking differently, being green. But clearly, that is going to be necessary if we are going to

address a lot of the health care challenges that we all want to, I think, across the aisle work on.

And health care regulators, as you mentioned, don't know what box that telemedicine may have to be put in, or that Zipnosis or some of the other companies have to be put in. So we have got a very fragmented landscape that is preventing the opportunity—when you are delivering to patients now, once they hit 65, once they hit Medicare, you may not have access, as patients, to a lot of these platforms.

Let me just follow up with Dr. Philip. I want to just ask you a quick question, too, in my time that is remaining. You talked a little bit about sort of the effort you had with an intensive, team-oriented care model that meets some complicated needs in a very fragile population.

I think of Medicare in a chronic care initiative that I had introduced bipartisanship with Senator Wyden and some others a few years ago that we continue to advocate for. And it is this coordinated care. Because I—it sounds like this is a coordinated care model you are using. I think of Medicare having 68 percent of beneficiaries now with two or more chronic conditions, very different than when Medicare was set up in 1965 as an acute care program. And that is consuming 93 percent of all costs.

Is this kind of a similar component or perspective of what you are doing? It is coordinated care, so the physician and the specialist are communicating, they are talking to each other, and they are caring for the patient?

And then, in essence, we have got to transfer in the system, so you are rewarded for hitting benchmarks, or caring for the patient? As opposed to just sick care, it is more well-care health care.

Mr. PHILIP. Exactly. Thank you for the question, Congressman Paulsen. What we find is that when patients are seeing 10 different doctors they are getting 10 different stories. They are getting confused, even if the doctors are seeing what everyone else is saying, they always think their organ system is the most important. You know, there is the old saying if you are a hammer, the world is a nail, you know?

And what we do is we partner with our patients, and we kind of quarterback the situation. We say, okay, that physician-patient relationship is key. Let's create a plan together, and I will interface with each of the different specialists on the case, and we will chart a course together.

And so that coordination of care is absolutely key. Because if there is no vision, what happens is a patient will see one doctor; they will create a plan. The next doctor will change that plan. Patients get completely confused. And as we are adding more and more layers of service, this is critical to streamline and simplify care.

Mr. PAULSEN. Thank you, Mr. Chairman. I yield back.

Chairman ROSKAM. Mr. Kelly.

Mr. KELLY. Thank you, Chairman, and thank you all for being here today.

I thank the chairman and since I have been on this Committee, have had these Jerry Maguire moments where we are asking, "help

us to help you.” And I think today is a really good example of that, and thank you, Chairman, for doing that.

And I am always fascinated when you all come in to talk about something that you know an awful lot about, or you know everything about, and we know so little about, but yet we are going to try to develop policies that we are going to work with you on somehow.

And so I always go back to my private-sector life. I am an automobile dealer, and one of the things I marvel about is the data that we can collect, and the data we can share, and in some cases data that we can't share at all, whether it has a proprietary value to it or there is a privacy issue. I just want to bring this up.

And this is what makes it hard for me to understand. General Motors recalled eight-and-a-half million vehicles because of an ignition problem going back to 1997 and 2014. Now, it amazes me that we can contact sometimes second, third, and fourth-term owners of a vehicle because of a serial number, but we can't talk to each other about private information that may keep people alive.

So in a Jerry Maguire moment—and Mr. Kind and I have something called the Health Care Innovation Caucus, and I think it is great that we have a caucus, but in addition to just having a caucus, I want to have a caucus where we actually talk to the people who know innovation and how innovation could help them to help us develop policies. I think it is nice to have it on your card that you are a Member of that caucus, but I would rather go out of here with not being a Member of a caucus, but actually get something done.

So help us to help you. What could we do, from where we sit, to make it easier for you to do what you are doing right now? I mean you can call a restaurant and make a reservation, say, “I'm sorry, we are booked,” you say, “Well, I really wanted to come,” and they say, “Well, you know, we will put you on the list and if somebody cancels we will call you up.” I have never had a night yet where someone didn't call up and say, “You know what? We got an opening and we need you to fill that table,” because it is all about table turn.

So how can we do this? What can we do? And I don't care, any of you weigh in on it. And if we don't get it done today, keep coming back to us. This chairman is dedicated to the idea that somehow we are going to make a significant difference in the way we deliver our health care, affordable and sustainable health care to the American people.

So any of you want to weigh in? And you all have a depth of knowledge on this.

Mr. KHARRAZ. If I might, thank you so much for the question. I think there are very concrete steps that you all could take to help Americans to go see the doctor when they need them, keep them out of emergency room, and give them access to telemedicine.

One of the things that is holding us back specifically is the Anti-Kickback Statute of 1972 that hasn't been updated to keep pace with technology and what technology can do. And specifically, in order to be compliant, we are limited to charging all providers a flat fee for participating on the Zocdoc platform. That fee can have no relationship to the number of or value of appointments that

they are receiving. And that creates challenges, in particular for rural providers and small practices, because they have to take on an entire economic risk of participating on the platform.

You know, we would like the flexibility to create a pricing model that includes a per-booking charge. This way, we would be able to serve a much broader set of the U.S. population, particularly in rural areas. I recognize that the Anti-Kickback Statute is, of course, important, protective regulations for federal health care programs, but in my view, as long as the patient and not Zocdoc makes the decision for a doctor, these protective provisions can be upheld.

Mr. KELLY. Any of the rest of you? Because you are dealing with this every day.

Dr. Becki.

Ms. HAFNER-FOGARTY. So one of the things that I really feel strongly about is I think we need to streamline especially the Medicare rules around telehealth and telemedicine.

Last week there was a study that came out that said 31 percent of CMS telemedicine visits were improperly billed. Well, you know, if you are a provider and you are trying to take care of patients, and you want to bill Medicare for a telemedicine visit, you have to be in a health profession's shortage area, or you have to be rural, or you have to be a Medicare Advantage ACO, or you have to be a next-gen ACO.

And when they went back and audited all of those, 31 percent of those mis-billed visits, what they found was 90 percent of those mis-billed visits were purely honest mistakes because the doc was a mile too close to a major metropolitan area, and they weren't rural enough; that was a major problem.

So the best thing you could do for telemedicine, in my book, is to remove the originating site restrictions. Those are a holdover from the days when telemedicine was a doc-to-doc consult between a specialist in a metropolitan area and a primary care doc in a rural area. People are using their smartphones. And my 80-year-old neighbor uses her smartphone to do telemedicine visits. So let's make it easy for patients to do it, and let's make it easy for doctors to get paid for doing it when they meet the standard of care.

Mr. KELLY. Yes. Well, my time is up. But real quickly, if you can keep up with us and let us know what it is you think we can do, why you think we should do it, and then how we can do it—that what, why, and how is critical—but keep sending it to us.

Ms. HAFNER-FOGARTY. Thank you.

Mr. KELLY. Thank you.

Chairman ROSKAM. Just a warning to the witnesses. You give them eye contact, he is going to put you in a car you can't afford, but you are going to feel good about it.

[Laughter.]

Chairman ROSKAM. Mr. Meehan.

Mr. MEEHAN. Thank you, Mr. Chairman. I don't know how to top that one.

And thank you for this panel, which is really on the front lines of the innovation, which is such an important area. One of the realities when you are back here on the end is that somebody always

jumps into the question you wanted to ask. But I don't think we really explored it thoroughly enough.

Dr. Kharraz, you mentioned it. We have been working very, very hard in looking at the Anti-Kickback and the Stark Statutes as things which were well-meaning at a particular time in medicine, but we are watching now as you are innovating. We have talked to docs who have in their particular nature of their practice, much of what we are talking about today, is how you are using technology to drive this work towards value-based care and greater innovation.

Can you talk more specifically about how Stark and Anti-Kickback may be impediments to the use of your technologies that would allow us to give greater value-based care at a lower cost?

Mr. KHARRAZ. Yes, great. I think access is one of the key components to make value-based care work. Zocdoc is an access mechanism that is used broadly, you know, for telemedicine and in-person visits today.

The reality is that the Anti-Kickback Statutes are constricting for the type of pricing models that we can put in place to allow our physicians to participate in the system, and open up their schedules to patients. These mechanisms essentially put undue risk on many small practices and rural practices that, quite frankly, don't have the cash flow to make these bets. And we would like to take on this risk for them, and allow them to pay in a more value-based format.

Given the entirety of how the assignment works on Zocdoc is patient-directed, similar to the smartphone example we just heard about, it does not create perverse incentives. It is patient-directed; the patient makes all the decisions. Everything they see is around the patient's preferences. So, we are just enabling the patient to do something that they have done traditionally over the phone. And it is not as if a heavy user of a phone line necessarily has to pay all the future calls up front and take the risk that no one calls.

Mr. MEEHAN. Thank you.

Sean, you have a thought?

Mr. CAVANAUGH. Yes, I just wanted to note that the anti-kickback rules that are referenced, the limitations on telemedicine, these are all artifacts of a fee-for-service system, where, all right, the incentive is to do too much; how do we put guard rails around people doing too much. If you can get health systems, physicians in a value-based model, where they are actually accountable for total cost of care, most of these concerns should fall by the wayside, because they have no incentive to overuse care.

But that is the challenge. How do we get them to be truly accountable for total cost of care? We have many ACOs in one-sided models. And not just ACOs, but we need to transition so that physicians and hospitals are willing to take some downside risk and be accountable. We cannot worry about these antiquated laws.

Mr. MEEHAN. Well, a lot of the times you are talking about when you say two-sided risk, that is where there is going to be a payment and you both work on trying to drive value, so that you can take advantage of whatever efficiencies you can put in there. Is that right?

Mr. CAVANAUGH. That is correct.

Mr. MEEHAN. Okay. Would you talk to me about one other issue that we have got a problem that you have mentioned? It is the proprietary stake everybody seems to have. How do we get beyond this situation where somebody says, "Well, that is really good, but my hospital groups use this information system," and we can't make those two things merge, or we are not willing to make them merge? How do we play a part in moving beyond that?

Mr. CAVANAUGH. I think to do what you—Members of Congress—do best, which is to think about the patient before you think about the hospital and the doctor, what is best for the patient.

And that is why I actually applaud something CMS discussed yesterday. Administrator Verma said some of this data blocking, maybe this should be a condition of participation in Medicare, because it is bad for the health and safety of the patient, for the patient's PCP not to know that you were discharged from the hospital. So yes, you may think this is valuable proprietary data, but it is hurtful to the beneficiaries. So we might make this a condition of being in Medicare.

I think as long as you take a beneficiary perspective, there are ways to get there. It is when you step back and think of these as business models—that is where we get into trouble.

Mr. MEEHAN. Yes, sort of the record follows the patient, and you go from there. Thank you for your work. Thank you for your testimony.

Chairman ROSKAM. Mr. Schweikert.

Mr. SCHWEIKERT. Thank you, Mr. Chairman, and thank you for letting me sit in on the Committee. I am actually not on this one, but I pestered the chairman over and over and over to have a conversation with innovators, though my passion is where is the next level of actual disruption?

Over the next 10 years, two-thirds of all the growth in spending here in Washington is, functionally, Social Security, and mostly Medicare. If you actually look at our 30-year chart, 82 trillion in borrowing—not adjusted for inflation—solely comes from Social Security and Medicare. The rest of the budget is actually in balance. Our Baby Boomers consume everything. And I am one of them. And we seem to have this delusion of math, and the math will always win.

We need a revolution in our health care costs. This morning the Wall Street Journal has an article of some of the new genomic personal-design medicine, a million dollars per cancer patient. So at one time you are starting to develop technologies and mechanisms. I need the next revolution.

How many of you enjoyed your weekend experience at Blockbuster Video? Things change. We need that disruption. And the fact of the matter is my wearable that talks to my phone that I come home, and my pharmaceutical is already there because we see the data on certain algorithmic health from certain types of body sensors being more accurate than a human [sic]. And I know that is uncomfortable.

Forgive me for saying it this way. Dr. Becki, you are the only one who I have actually heard talk about some of the barriers out there. I have a fixation that portable medicine, whether it be the medical records, my in-and-out-, have I been discharged, being

portable with me, but also my telemedicine being in some ways global, and crossing state lines, and breaking jurisdictions if it is going to be efficient and accurate and robust.

What are the barriers that you are coming up, either from licensing boards or medical practices or hospital systems—what do we have to break down to bring that revolution?

Ms. HAFNER-FOGARTY. Thank you, Mr. Schweikert. I have an ongoing conversation with my colleagues at the Federation of State Medical Boards about the need to look at how we regulate the practice of medicine in an era when neither doctors nor patients are constrained by geography any more. And this notion of state-based licensure—and I am committing heresy here by saying it—I think we have to look at making that much more universal and much more uniform across the country.

I think that the tradition that the practice of medicine occurs where the patient is creates great difficulty and limitation if you are a physician who wants to use telehealth to treat patients in multiple states, because then you have to go to the bother and expense of getting multiple state licenses.

I think another significant barrier is the ability to rapidly scale much of the new technology in a way to put it in the hands of lots of patients. Because if you have this cool thing that allows you to take a picture of your kid's eardrum and send it to the doc, unless you have 10 million of those in the hands of the parents of 10 million toddlers, those parents are still taking that child to the ER in the middle of the night. So—

Mr. SCHWEIKERT. And that is part of—

Ms. HAFNER-FOGARTY [continuing]. Scaling new technology is—

Mr. SCHWEIKERT. And that is substantially our fault in the way we compensate and the way we reimburse. You know, when we see data that says 95 percent of emergency room visits were not necessary and there were alternative paths, when we see the material science now saying I have something I can blow into that tells me I have the flu, and I know we only have less than a minute, and this is a brutal question, but for everyone on the panel, what is the technology disruption you see coming that both scares your business model, but you are optimistic for our society? What do we need to see?

Mr. MERRICK. I think versions of telehealth are going to be very important, and home-monitoring, genetic testing, things like that. We are in the process of trying to recruit a very high-tech-savvy individual to help us meet patients in a virtual way. So, you know, the idea of driving from your home—even to a doctor's office, but certainly not a hospital—to receive care, that is going to become antiquated.

And I think, if you fast-forward 10 years from now, about 38 percent of our health care spent is in the hospital environment, and hospitals absolutely, unequivocally need to reinvent themselves. That should not be the point of service and care. It is the most expensive, inefficient delivery model.

Mr. SCHWEIKERT. And a huge debt load.

Dr. Philip.

Mr. PHILIP. I think we also have to marry technology with the patient-physician relationship. I was taught in medical school that 85 percent of diagnoses happen by just listening and talking to patients.

Mr. SCHWEIKERT. What do you see as the technology that you hope does what you need?

Mr. PHILIP. Yes. I am seeing a lot of wearable technology that could potentially help with that. I mean I am seeing people at home, checking their weights with their congestive heart failure that, as their weights are rising, before they realize there is a problem, we will realize there is a problem. And we are seeing that, automatic blood pressure checks. Wearable technology reports their heart arrhythmias, their blood pressure without them even realizing it, and we can prevent it.

Mr. SCHWEIKERT. Excellent.

Mr. KHARRAZ. I think the big challenge for us is going to be discoverability. You know, using the earplug example for a second, patients don't know about this. And as they enter a request, we need to educate them that this is available—telemedicine is something that has high demand on Zocdoc.

However, nearly no one types in telemedicine when looking for this. They look for care the way they have always looked for care. We educate them in the moment that telemedicine is available, and then they can use new modalities.

Ms. HAFNER-FOGARTY. The hospital, as we know it, is obsolete.

Mr. SCHWEIKERT. You can just stop right there.

Ms. HAFNER-FOGARTY. The hospital, as we know it, is obsolete. The ability to use this computer that we call our smartphone to gather objective data about our blood sugar, our cholesterol, and all of that is—

Mr. SCHWEIKERT. The contact lens that does blood glucose.

Ms. HAFNER-FOGARTY. Absolutely. What we need are platforms that organize that raw data into information that the clinician, the physician can use to make clinical decisions about diagnosis and treatment. Because I don't want my patients sending me 50,000 automatic blood pressure readings. It is data overload.

And so, designing the systems that curate that data into usable information is absolutely critical.

Mr. SCHWEIKERT. Okay, the algorithm.

Dan.

Mr. PAOLETTI. This may be a little bit scary, with all the cyber security issues we have had recently, but I believe it is really around data, not so much the technology. Data around the patient is going to initiate proactive case management and intervention and dramatically affect the way that we deliver care.

Mr. SCHWEIKERT. Mr. Cavanaugh.

And once again, Mr. Chairman, thank you for your patience with me.

Mr. CAVANAUGH. We are partly a technology company. All the technologies that have been described are incredibly exciting. I think, though, I would like to bring it home, which is these technologies—I have faith they will be developed. Whether they will be productive or not will depend on whether they are supporting a pa-

tient and a physician, a primary care physician who stays with the patient, maintains a relationship over time, particularly as you said, we have patients in Medicare who have got multiple chronic diseases that are going to be in the program for many years.

So the management of those multiple chronic diseases, and that relationship between a patient and a physician, but augmented by technology, facilitated and made more efficient by technology.

Mr. SCHWEIKERT. Thank you, Mr. Cavanaugh.

Mr. Chairman, look, I don't know if I can own the copyright on it, but I believe we are on the cusp of something we will refer to as digitalceuticals, the algorithm that the wearables, the management, and then platforms that analyze it and then say, "Doctor, you have a patient with this. Patient," you know, "American, you have this; stop eating that."

But if we don't have this disruption, we must understand that we are about to hit a financial cliff, and it is coming at us fast. And I am terrified we are not pushing hard enough for the disruption. Thank you, Mr. Chairman.

Chairman ROSKAM. Well, on that happy note——

[Laughter.]

Chairman ROSKAM. Let me first of all thank each one of you for your testimony today. I have just got a couple of questions to kind of close this out.

Mr. Cavanaugh, you said something that was interesting, and I just want to get a little bit more feedback. In terms of the condition of payment that would precede the sharing of information, what is the best next step on that, do you think?

You know, we are all motivated by different things, and that, as a prelude, changes behavior. What do you think since you have been on this side, you have been in the administration, and you are in the private sector now. What is the best next step for that to happen?

Mr. CAVANAUGH. So, as I said, there was a request for information out of CMS and Administrator Verma yesterday that seemed to indicate that they were entertaining the idea that sharing information about hospital discharges and ED visits would be a condition of participation in Medicare. I think they could do it through regulation.

Chairman ROSKAM. Okay.

Mr. CAVANAUGH. So Congress wouldn't need to do anything.

I think there are some technical questions. If there isn't a health information exchange, how does the hospital do it?

But, you know, thanks to Congress, 95 percent of American hospitals have certified EHR technology. They can do this; it is all a question of will. And, as I said, it is a question of whether they are willing to put the beneficiary first. Because the literature is out there. It is good for patients to have their PCP know they just came out of the hospital.

Chairman ROSKAM. So let me press it a little bit further. Is it good for patients to get the data themselves?

Mr. CAVANAUGH. That would be fine. First of all, yes. I——

Chairman ROSKAM. What would that look like? Is that pie in the sky, in your view? Is that a bridge too far? Or is the tech-

nology—if I am a patient at the DuPage Medical Group—which I am, by the way, violating my own HIPAA situation——

[Laughter.]

Chairman ROSKAM. But if I am a patient at the DuPage Medical Group, and they are pushing to me whatever it happens to be as a condition of payment, that is a good thing.

Mr. CAVANAUGH. Absolutely. And I think at all times the beneficiary owns their medical record and should have access to it in any format that they can take.

Chairman ROSKAM. Right. But your point is that the ownership interest is kind of in name only right now. Yes, you own it, but good luck trying to mine this.

Mr. CAVANAUGH. Yes. And the question is, is it the beneficiary's responsibility—like the caregiver is the hospital, the caregiver is the PCP. They are the ones that should communicate and say, "Your patient was here, and you need to know that."

Chairman ROSKAM. Okay, that is helpful.

Dr. Merrick and Dr. Philip, we spend a lot of time talking about technology, but we are also here talking about practices and the disposition with which you are approaching patients and so forth.

And so, one of the things that made such a strong impression on me when I came to visit you, Dr. Philip, in the practice in Wheaton, was just a different disposition and a different feel to how you were interacting.

One of us said—either you or I—said, "This is like the TV show Cheers, where you come in and people say, 'Norm,' you know, and you know your patients, you are happy to see them." Patients, you were telling me, like stop in and you didn't say it this way, but you can't get rid of these people, because they are finding so much love and energy and joy and so forth.

Can you speak to that? Because that is different. That is unique. I get in and out, as you can imagine, of a lot of medical facilities in this role. And walking in, it felt qualitatively different. There was just a different vibe that was going on at your clinic. And it wasn't all technology, it wasn't all process. There was a different feel to it.

So can you give me a sense of, how it is that the leadership at DuPage Medical Group values this and empowers you and so forth, and what is that like?

Mr. PHILIP. First of all, thank you for the question. That is actually one of the key things that we see. You know, at the risk of sounding, you know, not fancy, or like a simple, you know, physician here, it is the foundation of what we are talking about. This is the wisdom of ages that we see, that caring is good medicine, that compassion actually works, that humility has an impact. When you marry that with research and technology, it is a really powerful combination.

And what we see is, yes, patients do come—there is that kind of trusting interaction, which helps us to wean people off opiates, where they know that we do care about them, and that we are not trying to torture them; we are trying to help them. And then they see, yes, their pain will get better.

We are realizing that research out of Brigham Women's Hospital shows that the number-one factor that increases life expectancy,

the number-one factor, is actually social interaction, and that the variety of social interaction we have is one of the biggest things we can do to increase our quality of life, our length of life, while decreasing our costs.

And we use that. And the resources that people have in their relationships, whether it be their local faith communities, their families, their friends, to say, hey, can we work together on this, instead of just putting all the pressure on patients.

Really, people come in incredibly burdened. Every day, I see people burdened by the weight of health care. I am not here to add more burdens to them, but to take away some of those burdens.

That is powerful. These are things, again—they are not as fancy—married with technology, it is incredibly powerful.

Chairman ROSKAM. And there is a spiritual element in this, right? So if people come in, and they want to be prayed over or they want to pray with someone, you are doing that. Isn't that right?

Mr. PHILIP. What we see is that faith is incredibly important, regardless of your faith. Research shows that even if you are an atheist, that if you have faith in the medical profession, that that creates something called a placebo effect, and we always control for that in all of our studies.

Whatever it is that motivates people and helps them, we want to use that. We don't want to be prejudiced against people's faith or their communities. So if patients come to us and they want prayer, we are happy to pray with them. And we see that it creates a bond, it creates something in both of our relationships on both ends that is really special and valuable.

Chairman ROSKAM. Dr. Merrick, close this out. So you run a big-time physician medical practice that is of significant renown. What was it that came to your attention about this situation where you said, "Hey, we are willing to invest in this"? Because the level of commitment, it seems to me, is pretty significant, in that you are not nickel-and-diming Dr. Philip on what they are doing, and there is a little bit of a throw-the-long-ball feel to this.

How much freedom does he have? And what is the expectation as it comes back to the decisions that you are making, kind of dollar-and-cents sort of things?

Mr. MERRICK. Yes, complete freedom, provided he creates the results that he is doing.

[Laughter.]

Chairman ROSKAM. There you go.

Mr. MERRICK. So, you know, we are a results-oriented group. And the data that we have seen through the Breakthrough Care Center shows that it is a better quality of life for our frail seniors. It is a much lower cost burden to our payer, our government. And when I recruit doctors to our organization, I tell them, "We are going to give you the influence and opportunity to practice great medicine." It looks like Dr. Philip has a nice opportunity here to present his—it will remain to be seen what this influence results in.

But I think our goal in being here is just to share that investing in technology and health care providers, physicians, advanced practitioners, nurses—health care is going to be a people—local busi-

ness forever. And I think one of our biggest barriers currently, as we are seeing the independent doctor, the practitioners, becoming extinct rapidly, that is to the detriment of our patients in the community that we serve.

Every place shows that when physicians work for a hospital versus for their patient, quality goes down and cost goes up. What we ask for is just an opportunity to compete and provide services.

An example is I have two partners trained at the Cleveland Clinic who do robotic cancer urology surgery. And they can't do that in an outpatient setting, which is lower cost and safer, lower infection rate, because it is not reimbursed.

It is illogical to take a healthy person who just happens to have a bad hip and bring them in the petri dish, which is the hospital—there is a role for hospitals: intensive care services, rural areas, teaching institutions. But in many of our communities, there are way too many hospitals that are overbuilt, they compete for services with one another, and they don't bend the cost curve as is required of us.

And so, thankfully, our goal at DuPage Medical Group is really bended to teach physicians the responsibility of stewardship in that, yes, you have to take care of that person and be the trusted advisor on the other side of the exam room, the operating room table, but you have a broader responsibility to the system as a whole, because, quite frankly, you can help support good medicine, but it is our job to fix the system. It is not your job to fix the system. It is your job to support people who can provide answers. And that is our goal.

Chairman ROSKAM. That is great.

Well, for each of you, thank you very much. We really are grateful for your energy and your attention and the ways in which you have encouraged us. Let's continue this dialogue, and I know that we can continue to be the beneficiaries of the wisdom that you have provided, and the backgrounds, and your experience. So thank you.

As a reminder, for the record, any Member wishing to submit a question for the record will have 14 days to do so. And any Members can submit questions after this hearing, and I would ask that the witnesses respond in a timely manner.

With that, the meeting is adjourned.

[Whereupon, at 11:58 a.m., the Subcommittee was adjourned.]

[Member Questions for the Record follow:]

**Response from Zocdoc CEO Oliver Kharraz to Questions for the Record
May 25, 2018**

Hearing on Identifying Innovative Practices and Technology in Health Care
U.S. House Ways and Means Subcommittee on Health

Question from Rep. Adrian Smith:

Dr. Kharraz, you mentioned the Anti-Kickback Statute is a barrier to expanding your service in rural areas. Can you elaborate? What is the barrier today and what needs to be changed to allow rural providers to participate?

Response from Dr. Kharraz:

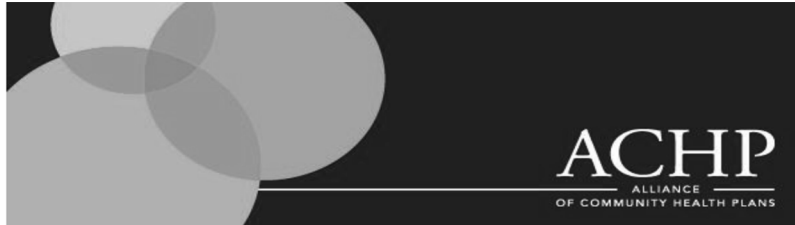
Thank you for the question. As we look to expand our service to rural communities, one of our challenges is out-of-date laws and regulations that have not kept pace with technology, such as the Anti-Kickback Statute of 1972. Although the Anti-Kickback Statute provides important federal health care program protections, it needs to be updated to reflect today's health care environment.

Let me explain how this impacts Zocdoc. In order to comply with the Anti-Kickback Statute's safe harbors, we are limited to charging participating providers a flat fee to be listed in the Zocdoc marketplace, and that fee can have no relationship to the volume or value of the appointments that are booked on our platform. In the major metropolitan areas, we have no trouble recruiting medical providers to participate in our marketplace. But in rural communities and with smaller practices, this flat fee approach is a major barrier that has limited our ability to serve rural communities. As you know, access to care is a significant problem in rural areas. We are confident we can provide the same level of service to rural communities – access to in-network care within 24-48 hours – but it will require more flexibility under the Anti-Kickback Statute in how we charge participating providers.

We would like the flexibility to charge providers a fee only when an appointment is booked with a new patient. Allowing compensation models that include a per-appointment fee will encourage more providers in more geographies and across more specialties to opt-in to participate on the platform; thus increasing provider availability, reducing wait times and systemic inefficiencies, and improving patient access to care. In our view, as long as the patient - not Zocdoc - decides which provider to book, we should have more flexibility under the Anti-Kickback Statute.



[Submissions for the Record follow:]



April 25, 2018

Hon. Peter Roskam, Chairman
House Committee on Ways and Means
Subcommittee on Health
2246 Rayburn House Office Building
Washington, DC 20515

Hon. Sandy Levin, Ranking member
House Committee on Ways and Means
Subcommittee on Health
1236 Longworth House Office Building
Washington, DC 20515

Dear Chairmen Roskam and Ranking Member Levin:

Thank you for holding this important hearing on the barriers to innovation in health care. Our 22 member organizations have long been recognized as leading innovators in the health care space, particularly in chronic care management, care coordination and telehealth. Our plans are committed to addressing social determinants of health and going outside traditional care to provide support for seniors. We are pleased to offer thoughts on one persistent barrier to innovation in Medicare, which your committee can address, the Medicare Advantage Benchmark Cap.

ACHP members are non-profit health plans providing coverage and care for more than 20 million Americans in 32 states and the District of Columbia in all lines of business, including Medicare Advantage. They are deeply invested in their communities and consistently lead government and private ratings on quality and customer service. Member plans have served their communities for decades and, as non-profit organizations, do not enter or exit markets based solely on financial considerations. Plans are characterized by close relationships with providers either through integrated delivery systems or carefully managed networks.

As you know, the federal government rates Medicare Advantage plans using a star rating system evaluating clinical quality, patient satisfaction and other measures. This star rating system serves dual purposes – to assist America's seniors in evaluating the quality of their health care options and to incentivize health plans to work closely with clinicians, coordinate care and improve health outcomes.

In 2010, Congress authorized "Quality Incentive Payments" to not only serve as financial inducements for the highest performing plans, but also to improve benefits for seniors. By law, every dollar rewarded via a Quality Incentive Payment must be returned to beneficiaries in the form of reduced premiums or increased services. Contrary to Congressional intent, due to a flawed interpretation of the benchmark cap, seniors in the highest performing 4- and 5-star plans are missing out on millions of dollars in additional benefits. In 2018, we estimate 11.3 million seniors have not received \$821 million in increased benefits or savings due to the glitch in the benchmark cap.

MAKING HEALTH CARE BETTER

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

Fortunately, there is a bipartisan bill, H.R. 908, introduced by Ways & Means Committee members Rep. Mike Kelly (R-PA) and Rep. Ron Kind (D-WI), which seeks to resolve this problem and allow MA beneficiaries to be served by these innovations in the way Congress intended.

The nearly 2.5 million seniors ACHP member plans serve are missing over \$170 million that would otherwise go directly into their benefits. These funds could go to reduce premiums, sometimes significantly, or offer new benefits such as transportation and gym memberships. In fact, Security Health Plan in Wisconsin has chosen to add for 2017 dental, hearing aid and eyewear benefits. Security believes it would be easier to enhance those and other innovative benefits if the benchmark cap issue was properly implemented. Security also reports that it could reduce MA premiums by as much as \$25 per member per month if its full quality payment was provided.

ACHP member plans have been healthcare innovators for years, and we have the results to show for it, including better performance than our competitors in key categories:

- ✓ 14.7 percent better at controlling high blood pressure
- ✓ 22.6 percent better at diabetes care blood sugar control
- ✓ 8.5 percent better at preventive screenings

ACHP plans are the leaders in Medicare Star Ratings – 97 percent of seniors enrolled in ACHP member Medicare Advantage plans benefit from the care delivered by 4, 4.5 and 5-star rated plans. This is in contrast to non-ACHP member plans which enroll just 72 percent of MA beneficiaries in plans at or above 4 stars.

Given the importance of fiscal responsibility, we are not advocating for elimination of the benchmark cap itself. We are asking for quality to be rewarded as Congress intended so the highest performing health plans in the nation can continue to invest in innovation while returning the benefits of that innovation to Medicare beneficiaries.

Please do not hesitate to contact me if you or your staff have further questions. We are also happy to share the attached additional information:

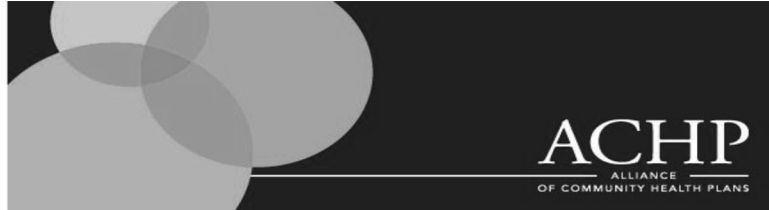
- State-by-state data demonstrating estimated losses – and hence losses to beneficiaries – in each state
- One pager describing this issue
- National heat map of where the benchmark cap impacts counties (we can also provide these maps by state and congressional district).

Sincerely,



Ceci Connolly
President and CEO

Cc: Honorable Members of the House Committee on Ways and Means



Across the US, Seniors in 4- and 5-Star Plans are Missing Millions in Medicare Advantage Benefits

Medicare Advantage was Designed to Reward Superior Performance

- The Medicare Advantage program seeks to improve quality, in part, by offering bonuses to health plans receiving 4 or 5 stars on their quality ratings
- As authorized by Congress, "Quality Incentive Payments" (QIPs) are designed to serve not only as financial incentives for plans to work closely with providers to increase quality, but also to improve benefits for seniors
- Importantly, every dollar rewarded via a QIP must be returned to beneficiaries in the form of reduced premiums or increased services

What Does This Mean for Seniors?

- Seniors are missing out on \$821 million in 2018 of reduced premiums or increased services
- Of note, by statute, QIP funds are prohibited from going to a health plan's bottom line – they must be returned to seniors in the form reduced premiums or increased services.

But Quality is not Being Rewarded and Seniors are Losing Out

- Congress imposed a cap on MA payment benchmarks at the same time QIPs were enacted
- The benchmark cap has, in many cases, disproportionately affected the highest rated plans by including QIPs as under the cap and limiting the payments
- The effect has been to reduce or eliminate QIPs to ACHP's highest-performing MA plans
- The unintended consequence of the benchmark cap provision has been to undermine value-based care, disincentive quality and diminish benefits to seniors

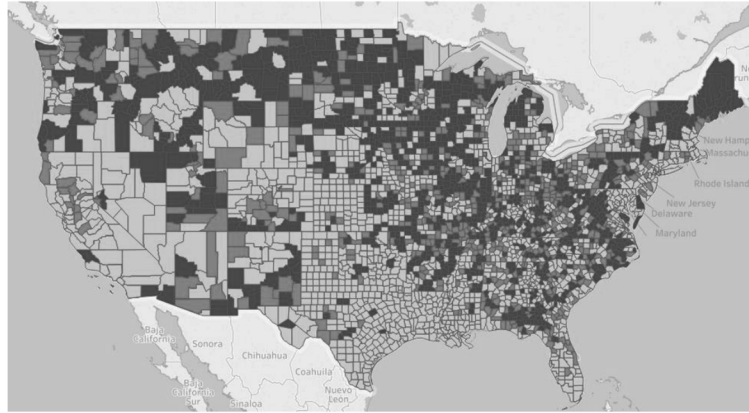
Is there a Solution? Yes, two Options

- Congress can pass bipartisan legislation, H.R. 908, the "Medicare Advantage Quality Payment Relief Act of 2017"
- HHS/CMS can use its administrative authority to address the glitch in the calculation, see below summarized legal opinion.

Who are ACHP Members?

- Members are non-profit, community-based, provider aligned plans active in 30 states and the District of Columbia, providing both private and public coverage and care to more than 19 million Americans, including 2.3 million Medicare beneficiaries.
- Six of the 14 5-star MA/PD plans are ACHP member plans, in addition to two 5-star, MA-only plans.
- 85 percent of enrollment in 5-star plans is in plans offered by ACHP members

2018 QIP Loss Impact



County-Level Benchmark Cap Impact

- No Impact
- Impacts Part of QIP
- Impacts Entire QIP

2018 Estimated MA Benchmark Cap by State and Organization (revenue loss exceeding \$100,000 shown)

STATE	MA Organization	Estimated 2018 Benchmark Cap Revenue Impact	Revenue Loss Attributed to Quality Payment	2017 Enrollment in Capped Plans
	TOTAL U.S. (rounded to millions)	\$923,000,000	\$821,000,000	11,300,000
ALABAMA				
	BlueCross BlueShield of Alabama	\$7,181,000	\$7,181,000	79,992
	UAB Health System	\$5,198,000	\$5,198,000	46,303
	UnitedHealth Group, Inc.	\$2,914,000	\$2,914,000	49,343
	Humana Inc.	\$612,000	\$0	36,540
	Aetna Inc.	\$532,000	\$532,000	3,100
	CIGNA	\$309,000	\$0	46,706
	TOTAL*	\$16,900,000	\$16,000,000	261,984
ARIZONA				
	UnitedHealth Group, Inc.	\$34,529,000	\$31,657,000	206,739
	Anthem Inc.	\$6,375,000	\$6,375,000	12,440
	Humana Inc.	\$5,756,000	\$4,652,000	44,871
	CIGNA	\$1,101,000	\$1,101,000	41,263
	Aetna Inc.	\$450,000	\$450,000	6,390
	Banner Health	\$397,000	\$0	1,370
	Centene Corporation	\$164,000	\$164,000	1,491
	TOTAL*	\$49,400,000	\$44,900,000	368,228
ARKANSAS				
	UnitedHealth Group, Inc.	\$3,457,000	\$829,000	41,736
	Aetna Inc.	\$1,458,000	\$1,458,000	9,314
	USable Mutual Insurance Company	\$1,411,000	\$356,000	19,278
	Humana Inc.	\$1,202,000	\$0	36,427
	WellCare Health Plans, Inc.	\$863,000	\$0	13,902
	CIGNA	\$116,000	\$0	1,752
	TOTAL*	\$8,700,000	\$2,800,000	124,352

*State totals are rounded to the nearest hundred thousand and include all affected plans.

2018 Estimated MA Benchmark Cap by State and Organization (revenue loss exceeding \$100,000 shown)

STATE	MA Organization	Estimated 2018 Benchmark Cap Revenue Impact	Revenue Loss Attributed to Quality Payment	2017 Enrollment in Capped Plans
CALIFORNIA				
	Kaiser Foundation Health Plan, Inc.	\$33,819,000	\$33,819,000	1,069,515
	UnitedHealth Group, Inc.	\$9,111,000	\$9,111,000	132,653
	Centene Corporation	\$2,758,000	\$2,758,000	31,244
	Molina Healthcare, Inc.,	\$291,000	\$0	1,750
	Humana Inc.	\$171,000	\$169,000	8,659
	SCAN Health Plan	\$145,000	\$145,000	26,324
	California Physicians' Service	\$141,000	\$121,000	27,634
	Golden State Medicare Health Plan	\$138,000	\$0	8,134
	TOTAL*	\$47,100,000	\$46,700,000	1,310,298
COLORADO				
	UnitedHealth Group, Inc.	\$3,003,000	\$3,003,000	120,164
	Kaiser Foundation Health Plan, Inc.	\$1,999,000	\$1,999,000	99,883
	Humana Inc.	\$847,000	\$562,000	37,882
	TOTAL*	\$6,000,000	\$5,700,000	259,937
CONNECTICUT				
	UnitedHealth Group, Inc.	\$581,000	\$581,000	52,680
	Anthem Inc.	\$223,000	\$223,000	27,562
	TOTAL*	\$800,000	\$800,000	81,271
DELAWARE				
	UnitedHealth Group, Inc.	\$1,037,000	\$1,037,000	3,223
	Aetna Inc.	\$672,000	\$672,000	6,281
	TOTAL*	\$1,900,000	\$1,900,000	10,708

*State totals are rounded to the nearest hundred thousand and include all affected plans.

2018 Estimated MA Benchmark Cap by State and Organization (revenue loss exceeding \$100,000 shown)

STATE	MA Organization	Estimated 2018 Benchmark Cap Revenue Impact	Revenue Loss Attributed to Quality Payment	2017 Enrollment in Capped Plans
FLORIDA				
	Humana Inc.	\$8,850,000	\$8,679,000	133,644
	UnitedHealth Group, Inc.	\$7,131,000	\$7,131,000	276,561
	Guidewell Mutual Holding Corporation	\$2,594,000	\$2,577,000	87,371
	America's 1st Choice Holdings of Florida, LLC	\$2,575,000	\$2,575,000	66,894
	Health First, Inc.	\$2,085,000	\$2,085,000	37,284
	ULTIMATE HEALTH PLAN, INC.	\$443,000	\$443,000	2,473
	Aetna Inc.	\$344,000	\$344,000	16,993
	TOTAL*	\$24,500,000	\$24,200,000	666,211
GEORGIA				
	UnitedHealth Group, Inc.	\$21,163,000	\$20,766,000	141,055
	Aetna Inc.	\$5,055,000	\$5,024,000	68,659
	Humana Inc.	\$2,822,000	\$0	91,445
	CIGNA	\$1,032,000	\$0	25,782
	TOTAL*	\$30,500,000	\$26,200,000	358,866
HAWAII				
	TOTAL*	\$0	\$0	11,077
IDAHO				
	Blue Cross of Idaho Health Services, Inc.	\$2,991,000	\$2,940,000	21,535
	PacificSource Health Plans	\$764,000	\$0	11,900
	Cambia Health Solutions, Inc.	\$709,000	\$709,000	4,468
	Intermountain Health Care, Inc.	\$623,000	\$0	17,023
	TOTAL*	\$5,300,000	\$3,800,000	60,229
ILLINOIS				
	The Carle Foundation	\$9,294,000	\$9,294,000	18,348
	Aetna Inc.	\$9,227,000	\$9,227,000	44,964
	UnitedHealth Group, Inc.	\$3,198,000	\$3,198,000	61,804
	Humana Inc.	\$2,869,000	\$1,679,000	50,072
	WellCare Health Plans, Inc.	\$228,000	\$0	17,070
	TOTAL*	\$25,100,000	\$23,700,000	209,558

*State totals are rounded to the nearest hundred thousand and include all affected plans.

2018 Estimated MA Benchmark Cap by State and Organization (revenue loss exceeding \$100,000 shown)

STATE	MA Organization	Estimated 2018 Benchmark Cap Revenue Impact	Revenue Loss Attributed to Quality Payment	2017 Enrollment in Capped Plans
INDIANA				
	UnitedHealth Group, Inc.	\$11,725,000	\$11,725,000	96,513
	Humana Inc.	\$5,102,000	\$0	83,872
	Indiana University Health	\$1,912,000	\$1,912,000	15,226
	Aetna Inc.	\$564,000	\$564,000	8,867
	Anthem Inc.	\$280,000	\$29,000	13,433
	CareSource Management Group Co.	\$140,000	\$140,000	1,214
	TOTAL*	\$19,900,000	\$14,500,000	219,144
IOWA				
	UnitedHealth Group, Inc.	\$10,306,000	\$10,306,000	36,917
	Aetna Inc.	\$6,400,000	\$6,400,000	35,771
	Humana Inc.	\$1,437,000	\$0	18,576
	TOTAL*	\$18,300,000	\$16,900,000	91,478
KANSAS				
	Aetna Inc.	\$6,033,000	\$6,033,000	22,701
	Humana Inc.	\$2,322,000	\$1,880,000	16,640
	UnitedHealth Group, Inc.	\$1,952,000	\$1,731,000	9,092
	TOTAL*	\$10,400,000	\$9,700,000	48,433
KENTUCKY				
	UnitedHealth Group, Inc.	\$6,432,000	\$6,146,000	35,048
	Humana Inc.	\$5,727,000	\$59,000	139,555
	Aetna Inc.	\$416,000	\$416,000	3,890
	Anthem Inc.	\$199,000	\$9,000	16,515
	Baptist Healthcare System	\$149,000	\$149,000	1,191
	University Health Care, Inc.	\$101,000	\$101,000	1,977
	TOTAL*	\$13,300,000	\$7,000,000	201,618

*State totals are rounded to the nearest hundred thousand and include all affected plans.

2018 Estimated MA Benchmark Cap by State and Organization (revenue loss exceeding \$100,000 shown)

STATE	MA Organization	Estimated 2018 Benchmark Cap Revenue Impact	Revenue Loss Attributed to Quality Payment	2017 Enrollment in Capped Plans
MAINE				
	Martin's Point Health Care, Inc.	\$9,223,000	\$9,223,000	40,660
	UnitedHealth Group, Inc.	\$3,578,000	\$3,544,000	16,713
	Humana Inc.	\$1,595,000	\$1,595,000	4,840
	WellCare Health Plans, Inc.	\$1,462,000	\$609,000	4,757
	Aetna Inc.	\$887,000	\$887,000	6,885
	Anthem Inc.	\$819,000	\$819,000	3,472
	TOTAL*	\$17,800,000	\$16,900,000	78,624
MARYLAND				
	TOTAL*	\$0	\$0	19,154
MICHIGAN				
	Spectrum Health System	\$18,200,000	\$18,200,000	126,223
	Blue Cross Blue Shield of Michigan Mutual Insurance	\$9,941,000	\$9,941,000	113,698
	Humana Inc.	\$4,170,000	\$2,770,000	54,946
	UnitedHealth Group, Inc.	\$1,653,000	\$1,653,000	10,862
	Aetna Inc.	\$224,000	\$224,000	1,680
	TOTAL*	\$34,700,000	\$33,200,000	348,440
MINNESOTA				
	UCare Minnesota	\$18,140,000	\$17,742,000	89,850
	Medica Holding Company	\$5,043,000	\$5,043,000	11,185
	Humana Inc.	\$2,305,000	\$0	33,061
	Aware Integrated, Inc.	\$2,275,000	\$2,275,000	7,890
	South Country Health Alliance	\$1,571,000	\$1,571,000	2,229
	HealthPartners, Inc.	\$1,022,000	\$1,022,000	3,150
	PrimeWest Rural MN Health Care Access Initiative	\$861,000	\$861,000	2,126
	UnitedHealth Group, Inc.	\$473,000	\$473,000	2,475
	Itasca County Health & Human Services	\$255,000	\$255,000	465
	University of Wisconsin Hospitals and Clinics Authority	\$108,000	\$108,000	630
	TOTAL*	\$32,400,000	\$29,700,000	153,412

*State totals are rounded to the nearest hundred thousand and include all affected plans.

2018 Estimated MA Benchmark Cap by State and Organization (revenue loss exceeding \$100,000 shown)

STATE	MA Organization	Estimated 2018 Benchmark Cap Revenue Impact	Revenue Loss Attributed to Quality Payment	2017 Enrollment in Capped Plans
MISSISSIPPI				
	Humana Inc.	\$499,000	\$0	30,393
	CIGNA	\$244,000	\$0	8,806
	WellCare Health Plans, Inc.	\$187,000	\$0	24,634
	UnitedHealth Group, Inc.	\$122,000	\$122,000	1,819
	TOTAL*	\$1,100,000	\$100,000	65,964
MISSOURI				
	Aetna Inc.	\$10,372,000	\$10,372,000	98,218
	UnitedHealth Group, Inc.	\$7,442,000	\$5,788,000	126,827
	Humana Inc.	\$5,830,000	\$5,114,000	57,813
	Essence Group Holdings Corporation	\$2,787,000	\$2,787,000	52,032
	Anthem Inc.	\$335,000	\$2,000	10,359
	TOTAL*	\$27,000,000	\$24,300,000	345,249
MONTANA				
	Health Care Service Corporation	\$1,888,000	\$0	34,559
	Humana Inc.	\$1,205,000	\$1,079,000	5,463
	UnitedHealth Group, Inc.	\$169,000	\$142,000	700
	TOTAL*	\$3,400,000	\$1,300,000	41,022
NEBRASKA				
	UnitedHealth Group, Inc.	\$1,093,000	\$333,000	20,405
	Aetna Inc.	\$705,000	\$393,000	9,675
	Humana Inc.	\$394,000	\$0	5,488
	TOTAL*	\$2,200,000	\$700,000	35,805
NEVADA				
	UnitedHealth Group, Inc.	\$391,000	\$391,000	6,845
	TOTAL*	\$400,000	\$400,000	15,694
NEW HAMPSHIRE				
	UnitedHealth Group, Inc.	\$1,184,000	\$924,000	15,503
	Humana Inc.	\$214,000	\$214,000	3,456
	Harvard Pilgrim Health Care, Inc.	\$190,000	\$190,000	4,206
	TOTAL*	\$1,700,000	\$1,400,000	24,522

*State totals are rounded to the nearest hundred thousand and include all affected plans.

2018 Estimated MA Benchmark Cap by State and Organization (revenue loss exceeding \$100,000 shown)

STATE	MA Organization	Estimated 2018 Benchmark Cap Revenue Impact	Revenue Loss Attributed to Quality Payment	2017 Enrollment in Capped Plans
NEW JERSEY				
	Aetna Inc.	\$2,067,000	\$2,067,000	37,886
	UnitedHealth Group, Inc.	\$1,304,000	\$1,304,000	100,915
	Horizon Healthcare Services, Inc.	\$715,000	\$715,000	46,399
	TOTAL*	\$4,100,000	\$4,100,000	185,200
NEW MEXICO				
	UnitedHealth Group, Inc.	\$8,393,000	\$8,393,000	16,979
	Molina Healthcare, Inc.,	\$1,117,000	\$1,117,000	4,732
	Humana Inc.	\$959,000	\$0	10,106
	Presbyterian Healthcare Services	\$207,000	\$0	14,801
	Health Care Service Corporation	\$146,000	\$0	19,765
	TOTAL*	\$11,000,000	\$9,700,000	66,996
NEW YORK				
	UnitedHealth Group, Inc.	\$3,569,000	\$1,593,000	247,658
	WellCare Health Plans, Inc.	\$3,175,000	\$2,555,000	46,454
	The New York State Catholic Health Plan, Inc.	\$2,739,000	\$2,739,000	64,985
	MVP Health Care, Inc.	\$2,472,000	\$2,464,000	48,752
	Capital District Physicians' Health Plan, Inc.	\$1,706,000	\$1,706,000	39,816
	Lifetime Healthcare, Inc.	\$1,699,000	\$1,699,000	86,973
	Independent Health Association, Inc.	\$1,535,000	\$1,535,000	73,356
	HealthNow New York Inc.	\$972,000	\$972,000	27,133
	Aetna Inc.	\$620,000	\$620,000	32,108
	Humana Inc.	\$179,000	\$179,000	6,271
	TOTAL*	\$18,900,000	\$16,200,000	676,373

*State totals are rounded to the nearest hundred thousand and include all affected plans.

2018 Estimated MA Benchmark Cap by State and Organization (revenue loss exceeding \$100,000 shown)

STATE	MA Organization	Estimated 2018 Benchmark Cap Revenue Impact	Revenue Loss Attributed to Quality Payment	2017 Enrollment in Capped Plans
NORTH CAROLINA				
	UnitedHealth Group, Inc.	\$29,245,000	\$29,245,000	245,709
	Humana Inc.	\$5,543,000	\$2,631,000	139,608
	Blue Cross and Blue Shield of North Carolina	\$3,362,000	\$0	92,285
	Aetna Inc.	\$1,556,000	\$1,556,000	63,251
	FirstHealth of the Carolinas, Inc.	\$1,548,000	\$1,548,000	6,639
	Gateway Health Plan, LP	\$243,000	\$0	3,184
	TOTAL*	\$42,000,000	\$35,400,000	557,025
NORTH DAKOTA				
	Humana Inc.	\$549,000	\$0	1,575
	TOTAL*	\$700,000	\$100,000	1,826
OHIO				
	Aetna Inc.	\$36,371,000	\$36,363,000	178,578
	Anthem Inc.	\$30,295,000	\$30,295,000	159,540
	UnitedHealth Group, Inc.	\$23,738,000	\$23,738,000	89,428
	Trinity Health	\$14,015,000	\$14,015,000	55,057
	Humana Inc.	\$12,757,000	\$10,533,000	114,150
	Aultman Health Foundation	\$6,624,000	\$6,624,000	20,608
	Summa Health System Community	\$5,563,000	\$5,563,000	24,049
	MEDICAL MUTUAL OF OHIO	\$2,385,000	\$2,377,000	24,780
	Health Plan of the Upper Ohio Valley	\$2,109,000	\$2,109,000	9,236
	Promedica Health System	\$1,160,000	\$1,160,000	13,758
	Premier Health Partners	\$749,000	\$749,000	10,003
	Catholic Health Initiatives	\$323,000	\$323,000	1,116
	TOTAL*	\$137,500,000	\$135,300,000	703,706
OKLAHOMA				
	CommunityCare Managed Healthcare Plans of OK, Inc.	\$2,527,000	\$2,527,000	28,272
	Humana Inc.	\$444,000	\$0	27,616
	Aetna Inc.	\$271,000	\$271,000	4,615
	UnitedHealth Group, Inc.	\$261,000	\$261,000	5,127
	TOTAL*	\$3,600,000	\$3,100,000	76,020

*State totals are rounded to the nearest hundred thousand and include all affected plans.

2018 Estimated MA Benchmark Cap by State and Organization (revenue loss exceeding \$100,000 shown)

STATE	MA Organization	Estimated 2018 Benchmark Cap Revenue Impact	Revenue Loss Attributed to Quality Payment	2017 Enrollment in Capped Plans
OREGON				
	ATRIO Health Plans	\$2,176,000	\$0	10,115
	Cambia Health Solutions, Inc.	\$2,171,000	\$2,171,000	41,873
	UnitedHealth Group, Inc.	\$1,289,000	\$1,289,000	14,974
	Moda, Inc.	\$1,253,000	\$1,253,000	9,360
	Centene Corporation	\$1,027,000	\$622,000	51,950
	Kaiser Foundation Health Plan, Inc.	\$969,000	\$969,000	60,906
	PacificSource Health Plans	\$592,000	\$0	6,727
	Providence Health & Services	\$579,000	\$579,000	44,349
	Humana Inc.	\$538,000	\$379,000	2,391
	Samaritan Health Services	\$119,000	\$0	5,053
	TOTAL*	\$10,900,000	\$7,400,000	249,721
PENNSYLVANIA				
	Geisinger Health System	\$23,509,000	\$23,509,000	84,508
	UPMC Health System	\$19,429,000	\$19,429,000	151,994
	Aetna Inc.	\$19,037,000	\$19,037,000	182,368
	Highmark Health	\$14,180,000	\$14,180,000	112,958
	Capital BlueCross	\$5,046,000	\$5,046,000	22,115
	UnitedHealth Group, Inc.	\$4,461,000	\$4,428,000	51,175
	Humana Inc.	\$1,564,000	\$0	30,116
	Gateway Health Plan, LP	\$654,000	\$0	47,954
	TOTAL*	\$89,000,000	\$86,700,000	687,174
RHODE ISLAND				
	Blue Cross & Blue Shield of Rhode Island	\$7,016,000	\$7,016,000	49,225
	UnitedHealth Group, Inc.	\$3,761,000	\$3,761,000	22,491
	TOTAL*	\$10,900,000	\$10,900,000	71,778

*State totals are rounded to the nearest hundred thousand and include all affected plans.

2018 Estimated MA Benchmark Cap by State and Organization (revenue loss exceeding \$100,000 shown)

STATE	MA Organization	Estimated 2018 Benchmark Cap Revenue Impact	Revenue Loss Attributed to Quality Payment	2017 Enrollment in Capped Plans
SOUTH CAROLINA				
	UnitedHealth Group, Inc.	\$15,090,000	\$15,039,000	114,951
	Humana Inc.	\$1,419,000	\$0	51,034
	Aetna Inc.	\$360,000	\$360,000	2,540
	Horizon Healthcare Services, Inc.	\$131,000	\$131,000	654
	TOTAL*	\$17,300,000	\$15,700,000	183,910
SOUTH DAKOTA				
	Humana Inc.	\$1,193,000	\$0	4,914
	Aetna Inc.	\$963,000	\$963,000	1,941
	UnitedHealth Group, Inc.	\$128,000	\$128,000	212
	TOTAL*	\$2,300,000	\$1,100,000	7,079
TENNESSEE				
	Humana Inc.	\$14,495,000	\$14,024,000	132,102
	BlueCross BlueShield of Tennessee	\$11,970,000	\$11,549,000	124,658
	UnitedHealth Group, Inc.	\$8,630,000	\$6,692,000	92,840
	CIGNA	\$1,547,000	\$0	76,202
	Aetna Inc.	\$218,000	\$218,000	2,068
	Anthem Inc.	\$218,000	\$0	10,359
	WellCare Health Plans, Inc.	\$153,000	\$0	10,875
	TOTAL*	\$37,600,000	\$32,800,000	449,104
TEXAS				
	UnitedHealth Group, Inc.	\$1,905,000	\$1,073,000	130,600
	Humana Inc.	\$1,413,000	\$0	311,530
	Aetna Inc.	\$262,000	\$262,000	10,927
	TOTAL*	\$3,600,000	\$1,400,000	454,154
UTAH				
	UnitedHealth Group, Inc.	\$7,879,000	\$7,879,000	68,711
	Aetna Inc.	\$620,000	\$362,000	10,720
	Cambia Health Solutions, Inc.	\$346,000	\$346,000	6,018
	Intermountain Health Care, Inc.	\$324,000	\$0	23,754
	Molina Healthcare, Inc.,	\$170,000	\$0	6,509
	TOTAL*	\$9,400,000	\$8,700,000	117,366

*State totals are rounded to the nearest hundred thousand and include all affected plans.

2018 Estimated MA Benchmark Cap by State and Organization (revenue loss exceeding \$100,000 shown)

STATE	MA Organization	Estimated 2018 Benchmark Cap Revenue Impact	Revenue Loss Attributed to Quality Payment	2017 Enrollment in Capped Plans
VERMONT				
	UnitedHealth Group, Inc.	\$5,123,000	\$4,716,000	10,050
	MVP Health Care, Inc.	\$1,050,000	\$1,050,000	1,518
	TOTAL*	\$6,300,000	\$5,900,000	11,692
VIRGINIA				
	Humana Inc.	\$6,643,000	\$290,000	89,276
	UnitedHealth Group, Inc.	\$6,515,000	\$5,096,000	44,243
	Aetna Inc.	\$1,965,000	\$1,965,000	9,397
	Piedmont Community Health Plan	\$768,000	\$0	5,000
	Anthem Inc.	\$174,000	\$174,000	6,824
	TOTAL*	\$16,300,000	\$7,700,000	155,365
WASHINGTON				
	Kaiser Foundation Health Plan, Inc.	\$10,155,000	\$10,155,000	79,868
	UnitedHealth Group, Inc.	\$9,854,000	\$9,854,000	102,810
	The Carle Foundation	\$1,590,000	\$1,590,000	6,549
	Catholic Health Initiatives	\$815,000	\$0	23,205
	Cambia Health Solutions, Inc.	\$629,000	\$629,000	10,536
	Aetna Inc.	\$392,000	\$392,000	3,314
	Community Health Plan of Washington	\$205,000	\$0	6,019
	TOTAL*	\$24,000,000	\$22,800,000	252,271
WEST VIRGINIA				
	Humana Inc.	\$7,144,000	\$0	73,021
	Aetna Inc.	\$2,372,000	\$1,789,000	13,843
	Health Plan of the Upper Ohio Valley	\$1,240,000	\$1,240,000	5,167
	UnitedHealth Group, Inc.	\$978,000	\$978,000	4,257
	Stonerise Senior Advantage Holdings, LLC	\$117,000	\$117,000	433
	TOTAL*	\$12,000,000	\$4,200,000	96,721

*State totals are rounded to the nearest hundred thousand and include all affected plans.

2018 Estimated MA Benchmark Cap by State and Organization (revenue loss exceeding \$100,000 shown)

STATE	MA Organization	Estimated 2018 Benchmark Cap Revenue Impact	Revenue Loss Attributed to Quality Payment	2017 Enrollment in Capped Plans
WISCONSIN				
	UnitedHealth Group, Inc.	\$22,690,000	\$22,681,000	145,040
	Marshfield Clinic Health System, Inc.	\$13,267,000	\$12,929,000	37,816
	Humana Inc.	\$7,574,000	\$4,769,000	70,752
	Network Health, Inc.	\$4,683,000	\$4,683,000	63,192
	University of Wisconsin Hospitals and Clinics Autho	\$2,752,000	\$2,752,000	8,162
	Independent Care Health Plan Inc.	\$1,280,000	\$1,280,000	6,843
	Anthem Inc.	\$604,000	\$604,000	5,756
	SSM Healthcare Corporation	\$309,000	\$309,000	2,333
	Aetna Inc.	\$181,000	\$181,000	888
	Care Wisconsin First, Inc.	\$181,000	\$181,000	1,284
	Centene Corporation	\$130,000	\$130,000	920
	TOTAL*	\$54,200,000	\$51,000,000	343,444
WYOMING				
	UnitedHealth Group, Inc.	\$109,000	\$17,000	1,595
	TOTAL*	\$200,000	\$100,000	2,190

*State totals are rounded to the nearest hundred thousand and include all affected plans.



**STATEMENT FOR THE RECORD BY ENCOMPASS HEALTH ON THE
WAYS AND MEANS HEALTH SUBCOMMITTEE HEARING,
“INNOVATION IN HEALTHCARE” (APRIL 26, 2018)**

Encompass Health is America’s largest provider of rehabilitation hospital services and one of the five largest providers of home health care. At the end of 2017, our rehabilitation hospital segment was operating 127 freestanding rehabilitation hospitals in 31 states and Puerto Rico, 42 of which are operated in joint venture partnership structures with other general acute care hospital systems and academic medical centers. During the same period, our home health segment was operating 200 home health agencies and 37 hospice agencies across 28 states. In 2017, our rehabilitation hospitals treated nearly 172,000 patients; our home care agencies treated nearly 125,000 patients; and our hospice agencies have treated nearly 5,000 patients, with the vast majority of these patients being Medicare beneficiaries. We appreciate this opportunity to submit our statement for the record following the hearing “Innovation in Healthcare,” held by the Ways and Means Committee’s Health Subcommittee on April 26, 2018. We welcome the opportunity to engage in further discussions and dialogue with the Health Subcommittee about what steps policymakers could take to encourage more innovation in healthcare delivery and reimbursement.

During last month’s hearing on healthcare innovation, Chairman Roskam framed its purpose as one through which “[t]he lessons we learn here will be on how Congress can help. Can we help both advance and expand upon these front-line advancements while also leading to a new wave of innovators unleashed on the status quo?” While there are many things Congress can do to encourage greater proliferation of healthcare innovation, there are two policy prescriptions that can be immediately helpful and impactful: (1) providing healthcare providers with greater access to healthcare data and information about their patients; and (2) Medicare’s willingness to be more expansive in its experimental efforts with paying and regulating healthcare providers differently. If pursued, these efforts would encourage and expand innovation within the healthcare provider community. The following brief discussion provides additional context around these suggested policy prescriptions.

A. Encompass Health’s Commitment to the Power of Data and Information: the Encompass Health-Cerner Post-Acute Innovation Center

In order to fulfill the potential and promise of the health information technology work and investments that we are undertaking at Encompass Health, patient-level data from Medicare claims is a critical ingredient. But as of now, it is still largely missing. We are highlighting this fact because last year, Encompass Health and Cerner (a leader in healthcare information technology) joined together to form the Post-Acute Innovation Center (for purposes of this statement, the “Encompass Health-Cerner Innovation Center”), a joint entity that combines our medical and clinical expertise in providing post-acute care and services with Cerner’s technical expertise in healthcare data and information technology. One of the primary objectives of the Encompass Health-Cerner Innovation Center is the co-development of advanced analytics and



predictive models that currently do not exist for the purpose of facilitating better management and utilization of PAC services across the healthcare continuum.

This work includes the use of diverse data sets from multiple care settings to develop evidence-based clinical decision support tools that will enhance and improve patient care, care coordination, post-acute utilization and performance, and cost management. The Encompass Health-Cerner Innovation Center is intended to augment and enhance our ability to refine existing care delivery techniques and models and develop new ones. Patient-centeredness and strong evidentiary bases are central components of our approach to developing new patient care models, with sophisticated data and technology platforms designed to improve patients' healthcare outcomes and the efficiency of healthcare delivery playing a key role in all models.

For example, Encompass Health's capabilities to provide and manage PAC services on an episodic basis are built on an enhanced Cerner platform, called "HealtheIntent," which enhances our care coordination and post-acute network management capabilities and thereby increases the likelihood that patient complications are identified and addressed before they become a problem. Just as importantly, it allows for the improvement of patient care and care quality outcomes through the power of predictive analytics. This platform enables our clinical care navigators to access aggregate patient data from existing electronic medical record systems as well as from other healthcare providers to create a continuity of care record across multiple care settings. Encompass Health can use this aggregate, clinical data set, along with other data sources such as claims or open data sources, to evaluate and report on the quality of care being delivered, whether by diagnosis, patient, or particular provider or clinician.

The key to the preceding sentence is, of course, having access to those "other data sources." The Trump Administration has placed considerable focus this year on ensuring that patients, including Medicare beneficiaries, have greater access to their healthcare information in a way that enables that information to be complete, accessible, understandable, and portable across the healthcare continuum. We strongly agree that all patients should have greater access to their healthcare information and data than what they currently have.

It is equally important to ensure that *patients' healthcare providers also have access to data and information* about what is happening with their patients after their treatment or discharge from a healthcare provider's facility or office. The quality improvement programs established under Medicare, as well as the ongoing move toward value-based payment by government and non-government healthcare service payers, necessitates that providers have access to their patients' healthcare data and information *after* they care for them.

Without access to patient-level data, healthcare providers have no concrete way of understanding the post-discharge or post-treatment health service utilization trends attributable to their patients or the quality of the patients' healthcare outcomes. A select group of healthcare providers, such as acute care hospitals, are afforded access to their patients' healthcare information and data that covers what occurred outside of the patient's care episode in the hospital. However, other healthcare providers, including PAC providers, currently have no similar access to our patients' healthcare data and information.



Timely access to patient-level data and information – including claims-based quality data – would provide healthcare providers in the post-acute space with information necessary to identify what occurred after a patient leaves our setting, perform root-causes analyses of adverse events, and determine what could have been done better in a certain case or set of cases. Not only would this benefit a healthcare provider’s understanding of the care it provides, but it could also benefit patients who receive care under programs and protocols that have been designed based on that provider’s refined understanding of the patients it previously treated. Without patient-level data, this approach to quality improvement is unnecessarily hampered. If healthcare providers continue receiving only aggregate annual data on our patients’ quality outcomes – for example, an annual aggregate patient readmission rate – there is no way for us to know which patients fared well and which ones did not, and therefore no way to drill further down and determine what could be done to avoid those situations in the future.

Not only would patient-level data help healthcare providers engage in meaningful quality improvement activities, but it also would enable us to understand in more detail what we need to do to remain engaged, high-quality providers in the eyes of our local acute care and physician partners. Patient-level data would likely also encourage more collaboration among healthcare providers, as we understand the specifics of our patient outcomes and work to improve patient results.

Suggested Policy Prescriptions:

- 1) Congress should proactively encourage CMS to release substantially more data and information, including Medicare fee-for-service and Medicare Advantage data, to all healthcare providers about their patients’ healthcare utilization – including where the services were provided, the reasons (diagnosis) for such services, and the expenditures associated with the services – for a defined period of time, such as for 60 or 90 days, after a patient’s discharge or conclusion of care with the healthcare provider.**
- 2) Congress could amend the Health Information Protection and Accountability Act (“HIPAA”) in a fashion that clarifies that none of its provisions are to be construed or interpreted as preventing the sharing of patients’ healthcare data or information with healthcare providers who have treated the patient, where such sharing is intended to improve care quality and patients’ healthcare outcomes.**

B). Let Healthcare Innovators Innovate; Make “Alternative” Mean Something in APMs

Encompass Health supports efforts aimed at moving the post-acute care (“PAC”) sector away from the site-specific regulatory and reimbursement elements that define PAC providers and Medicare’s reimbursement of our care and services. Ultimately, we see our rehabilitation hospitals and home care agencies functioning in the future as places where patients can receive PAC services in accordance with how they and their medical professionals believe care and services should be provided, without the restrictive effects of site-specific reimbursement policies and regulations that attempt to differentiate PAC providers by levels or intensities of care, or that limit the number and specific types of patients that can or cannot be treated.



Alternative payment models (“APMs”) developed and tested by CMS’ Innovation Center should be voluntary and limited to well-defined control groups or comparison populations. New payment system models should be developed with substantial stakeholder input and involvement and be tested on a voluntary basis. Two key principles should be central to the CMS Innovation Center’s APM and payment reform efforts, including: 1) the models should be developed around reimbursement amounts or rates that are, in fact, an alternative to or different from existing site-specific or level-of-care payment systems; and, 2) the regulatory and policy frameworks that define and govern site-specific or level-of-care service/care delivery and reimbursement need to be substantially modified or dispensed with altogether in accordance with the particular model.

To date many of the major APMs implemented by the CMS Innovation Center affecting hospitals and post-acute care providers have utilized an underlying fee-for-service (“FFS”) structure involving a reduced or discounted “target price” determined through a healthcare provider’s anticipated level of expenditures, based on historical expenditures. “Target prices” are merely historical FFS spending averages for a given treatment. The “target price” is compared against the provider’s actual expenditures incurred during a specified timeframe, with such expenditures being reimbursed and regulated under the typical FFS structure.

This approach disadvantages healthcare providers with truly prospective FFS payment amounts because those amounts are fixed by Medicare and effectively account for the regulatory costs created by the site-specific rules and regulations of that particular payment system. This structure creates a barrier for healthcare providers who want to play a role in a healthcare system that embraces the benefits of market-driven payment models that promote quality and cost efficiency and reward high-performing healthcare providers. Current payment models and systems often subsidize less efficient providers at substantial cost to patients and to the healthcare system.

Without a departure in CMS Innovation Center models from FFS reimbursement amounts and the lack of proportional regulatory modifications and waivers, providers that receive fully prospective payment amounts are “stuck” with a relatively inflexible cost profile, impeding their ability to innovate under APMs. In the absence of truly alternative payment and risk profiles, coupled with adequate regulatory waivers, PAC providers cannot engage in innovative approaches that could unlock the full potential of the effects of care coordination and collaboration, both of which are necessary to APM program success. The regulatory waivers associated with these models to date, particularly for post-acute care providers, have so far been limited to non-existent, with an explicit preference for inpatient post-acute and rehabilitative care to occur in nursing homes via a waiver of the so-called hospital 3-day stay requirement for Skilled Nursing Facilities (“SNFs”).

Finally, policymakers should refrain from relying upon APMs and related healthcare delivery models that essentially treat short-stay acute care hospitals and other non-healthcare provider organizations as the primary microscopes through which PAC utilization and cost parameters are examined and determined. Instead, policymakers should focus more on the beneficiaries consuming the highest amounts of Medicare expenditures and develop models aimed at preventing avoidable hospitalizations in the first place rather than focusing on the Medicare



expenditures consumed after the initial “anchor stay” in the short-stay acute care hospital. The emphasis should instead be on how market-based principles can be harnessed to control costs, promote efficiencies, and improve patients’ care quality. With these principles in mind, technology and data-based, efficient, and high-quality healthcare providers such as Encompass Health are prepared to engage in the analysis of specific pricing and payment models tied to efficiency and quality of outcomes.

Suggested Policy Prescriptions:

- 1) **Congress should encourage CMS’ Innovation Center to test PAC-specific APMs that use reimbursement methodologies that are episodic in nature and not based upon existing site-specific payment policies or systems.**
- 2) **Congress should encourage CMS’ Innovation Center to provide a broader scope of policy and regulatory waivers in PAC-specific models, including regulations that are designed to limit the number and types of patients that PAC providers can treat.**