STATEMENT FOR THE RECORD

SUBMITTED TO THE

SENATE HEALTH, EDUCATION, LABOR, AND PENSIONS COMMITTEE

ON

Identifying Opportunities for Health Care Delivery System Reform: Lessons from the Front Line

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

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

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

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

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

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

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

Accountable Care Organizations

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

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

Medical Homes

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

Community Health Teams to Support Medical Homes

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

Independence at Home Demonstration Program

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

Transitional Care

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

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

Home- and Community-Based Services ("HCBS")

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

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

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

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

Comparative Effectiveness Research

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

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

Health Information Technology

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

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

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

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

Reducing Health Care Disparities

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

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

Prevention and Wellness

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

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

Nursing Workforce Issues

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

Elder Care Workforce Issues

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

Genuine Pathway for Generic Biologics

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

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

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

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

Conclusion

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