

**Statement by Lonny Reisman,  
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**Roundtable on “Medicare Physician Payment Policy:  
Lessons from the Private Sector”**

**Committee on Finance**

**United States Senate**

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**I. Introduction**

Chairman Baucus, Ranking Member Hatch and Members of the Committee, thank you for inviting me to testify before you today. My name is Lonny Reisman. I am the Chief Medical Officer for Aetna Inc.

Aetna views provider collaboration as key to transforming patient care and building a more effective health care system. We believe that aligning incentives and increasing transparency across the health system can improve quality, create efficiency and achieve a better total patient experience. However, we recognize that there is no single model or solution to meet the needs of every health system and patient across the country.

Since 2005, Aetna has invested more than \$2 billion to acquire or build a variety of capabilities to support and enable provider collaboration models by aligning incentives around quality, efficiency, and outcomes.

We meet our provider partners at their current state of readiness with a shared goal of moving towards a more effective and patient-focused health care delivery model. Our partnerships are designed to support all patient populations, qualified providers and insurance payers (not limited to Medicare or Aetna members).

## II. Keys to Successful Provider Collaborations

### Provider payment models that incentivize improvements in quality and cost of care

Our provider collaborations provide a model for health care delivery and payment that ties provider reimbursements to improved population health and reductions in the total cost of care. Our model is unique because, alongside our collaborative payment model, we offer a comprehensive technology suite specifically designed to address the clinical care activities and cost saving activities identified in our contracts as appropriate objectives for population based care. Our Medicare Advantage care management model provides nurse case managers embedded within participating provider groups. Our care managers work in collaboration with physicians and their staff to:

- Develop care plans
- Monitor ongoing symptoms
- Coach patients to manage their conditions
- Help build continuity of care.

Using performance-based compensation, we align incentives and provide the tools and technologies to help providers achieve defined measures around the prevention and management of chronic conditions, improved quality of care, and reductions in avoidable hospital admissions and readmissions.

For example, by collaborating with Aetna, InterMed's Independent Physician Association, NovaHealth in Portland, Maine, averaged 45 percent fewer acute admits, 50 percent fewer acute days, and 56 percent fewer readmissions in 2011 compared to statewide unmanaged, risk-adjusted Medicare populations.

In addition to acute days avoided by quality care and care management we find 99% have office visits at least once a year, and 98% of those with Heart Failure, Diabetes or Chronic Lung Disease at least every six months. 95% of Hospitalized patients have office visits within 30 days of discharge and 99% of Diabetics have HbA1c tests at least annually. We have indeed seen real and measurable impact at the intersection of quality and cost.<sup>1</sup>

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<sup>1</sup> Aetna Analysis and Hostetter. Case Study: Aetna's Embedded Case Managers Seek to Strengthen Primary Care. Quality Matters August 2010: 6-10.

## Providing physicians with access to actionable patient information

New research on medical advances is published frequently. No physician can keep up with it all and relate new findings to patients in his or her practice who are likely to benefit. ActiveHealth Management has a large team of board certified physicians, pharmacists and registered nurses studying the findings of evidence-based research. We then take research from the most reputable sources to develop and maintain the evidence-based rule sets that populate CareEngine<sup>®</sup>, our clinical decision support tool. We alert attending physicians to errors or omissions in care and opportunities to improve health, resulting in better quality care and reduced medical costs.

In a double-blind, randomized study, CareEngine<sup>®</sup> alerts were proven to reduce costs by \$8.07 per member per month, and reduce hospitalizations by 8.4 percent.<sup>2</sup> A follow up analysis published in the Journal of Health Economics found that ActiveHealth Management's technology lowered average charges by 6% compared to a control group. Results also suggested improved quality and that use over a longer period would increase savings to the extent the benefits of correcting missteps spill over into future years.<sup>3</sup>

Through Active CareTeam<sup>SM</sup>, an interactive dashboard workflow tool that enables physicians and other members of the care team to identify the patients that the practice is accountable for who are at risk for disease progression. Using predictive modeling and algorithms, the tool identifies opportunities to provide evidence based care. These interventions are proven to improve quality and reduce cost. By proactively reaching out to the identified patients, care team suite enabled physicians can provide better preventive care and avoid unnecessary health care events.

After just one year of providing disease management, case management, maternity management and lifestyle coaching services for members of the North Carolina State Health Plan for Teachers and State Employees, ActiveHealth Management engaged 81 percent of eligible members in care management programs. Member engagement in these programs can help lead to better health outcomes as members take steps to address health risks identified through the program.

In a study involving a large-scale commercial population of 200,000 members, ActiveHealth disease management achieved a 2.1 percent decrease in the cost trend in members meeting criteria for disease management interventions and an overall

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<sup>2</sup> Javitt JC, et al. Using a Claims Data-based, Sentinel System to Improve Compliance with Clinical Guidelines: Results of a Randomized Prospective Study. Am J Manag Care 2005;11:93-102.

<sup>3</sup> Javitt JC, et al. Information technology and medical missteps: Evidence from a randomized trial. Journal of Health Economics 2008;27 585-602.

reduction in covered charges of \$3.10 per member per month across the entire population.<sup>4</sup>

### **Low-cost technology solutions that create interoperability between providers, patients and health systems**

People with chronic conditions such as diabetes and / or high blood pressure often receive care from many different providers. For these high-risk patients, it is even more crucial that physicians are able to effectively coordinate care. For every 100 Medicare patients, the typical primary care physician must communicate with 99 physicians in 53 practices in order to coordinate care.<sup>5</sup> When these physicians are not able to easily share and act on patient information, patient experience suffers and avoidable health risks can arise.

Aetna's Medicity technology lays the foundation to securely exchange patient health information, which is essential to the success of provider collaborations in optimizing population health. Medicity accomplishes this regardless of which electronic medical record or health information technology they may be using. Applying the ActiveHealth decision support technology to these comprehensive data sets generates the patient-specific care actions needed to optimize clinical outcomes.

For example, Medicity currently connects providers using over 150 unique clinical technology solutions, giving providers timely access to current, accurate and actionable information. With this current information, providers can make better decisions. Medicity currently connects approximately 250,000 providers and 800 hospitals in its seamless communications networks.

Michigan Health Connect (MHC) is a nonprofit corporation founded by health systems to extend provider adoption of electronic health record systems. MHC engaged Medicity to help them tackle the referral process, which was a significant pain point for physicians, involving filling out and faxing forms, as well as numerous phone calls between providers. Medicity proposed using a referrals application running on iNexx™, a free data exchange and application platform that makes it possible for physicians to exchange information securely with other providers and coordinate care for their patients.

MHC was successful in promoting viral adoption of the iNexx™ technology solution throughout its physician population. Within 120 days, MHC rolled out the iNexx™ eReferrals application to 100 practices — including 21 specialties — and is adding

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<sup>4</sup> *ActiveHealth Management*, Study 2004.

<sup>5</sup> *Annals of Internal Medicine*

practices to the eReferral network at a rate of 9 practices per week. These practices are now able to replace the multiple phone calls and fax exchanges with secure, electronic care team networks that enable eReferrals, increase collaboration, and present a coherent picture of a patient's health to all members of the care team.

### **III. Conclusion**

We share the Committee's goal to transform the care delivery system and believe Medicare can benefit from our innovative care solutions. Aetna has achieved positive results through our provider collaborations, using payment models that incentivize improvements in quality and cost of care and low-cost technology solutions to create interoperability between providers, patients, and health systems. We are making it easier to pull meaningful health care information out of silos and act upon it more quickly to improve patient care. We believe that these models can be applied more broadly to improve population health and create a sustainable care delivery system.