DENVER HEALTH
Level One Care for ALL

Reforming the Healthcare System

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Chairman Pallone, Ranking Member Deal, and Members of the Committee, thank you for this opportunity to explain why I strongly support your efforts to achieve health care reform. In giving you my personal reflections, based on long years of observing the difficulties inherent in our current health care industry, I speak primarily as CEO of Denver Health, but also as a member of the National Association of Public Hospitals and Health Systems (NAPH), the national association that represents America's safety net health systems. I came to Denver Health 36 years ago because I believed in its core mission of providing health care to America's most vulnerable people.

I would like to begin by extending my thanks to this Committee, Congress and the Administration, for their historic efforts to reform our nation's health care system. In particular, I support your goal of extending comprehensive health coverage to all Americans.

Health reform is needed now in America to create access for the 46 million Americans who do not benefit from the knowledge and care made possible by the advances in American medicine, but, more importantly, do not even have ready access to basic preventive and primary medical, dental and behavioral health care.

Health reform is needed now because America does not deliver the quality of care that we should expect. The Commonwealth Fund's national and state scorecards show that as a nation we get an overall quality grade of 65 out of 100 and that there is enormous variability across states.

Health reform is needed now because America cannot afford to spend twice as much on health care as other developed countries without our businesses losing global competitiveness and without bankrupting our children.

Your Health Care Reform Draft Proposal addresses many weaknesses that underlie the existing delivery system, including fragmented care, wide disparities in the type and quality of services available to different populations, and workforce training that does not align with our system's needs. The Health Care Reform Draft Proposal acknowledges that true health reform must adequately and broadly address the three issues of access, cost and quality. Both Denver Health and NAPH support Congress's efforts to promote integration and care coordination, to address disparities in care, and to invest in primary care training.

My testimony will briefly describe Denver Health and NAPH, and then will address the following topics:

- Cost reduction
- The role of integrated health systems in health reform, including the use of coordinated care networks
- The need for safety nets in health reform
- Workforce issues

Denver Health and NAPH

Denver Health is the integrated safety net institution for Denver and the Rocky Mountain Region. It includes multiple linked components of a public care delivery system. These are: the 911 paramedic ambulance and trauma system; a Disproportionate Share Hospital which is the busiest hospital in the state with almost

26,000 discharges; all eight of Denver's federally qualified health centers which provide primary medical and dental care; the county public health department; all twelve school-based clinics; a 100 bed non-medical detoxification center; a call center which includes a regional poison center and a nurse advice line; correctional care; and an HMO which serves Medicaid, SCHIP, Medicare and commercial patients. The system is staffed by approximately 5,300 employees including 265 employed physicians. Denver Health is an academic teaching hospital and has a formal affiliation with the University of Colorado Denver School of Medicine. All the physicians have full time academic appointments. Medical and nursing students, interns, residents and a myriad other professional trainees receive clinical training at Denver Health. The system has invested more than $300 million in health information technology, which has resulted in a single imaged electronic medical record with a single patient identifier that links all the patient care components of the system. The facilities are state of the art and have been designed for safety and efficiency.

As do all DSH safety net hospital systems that are members of NAPH, Denver Health focuses on the special needs of the entire population through regional trauma services, regional poison center services, public health, 911 and disaster preparedness. These critical roles will remain after health reform.

It also focuses on the needs of special populations that are largely excluded from health care coverage, and often from any health care at all. These populations rely on the safety net, which is composed of institutions such as DSH hospitals and community health centers. These special populations include the poor, the uninsured and underinsured, minorities, non-English speakers, the homeless, the chronically mentally ill, substance abusers, victims of violence such as rape, victims of infectious disease such as HIV/AIDS, and prisoners.

The care provided to these patients in these systems represents America's national health insurance by default. The volume of this care is staggering in its magnitude. NAPH members include more than 140 of the nation's largest metropolitan area safety net hospitals and health systems. These systems have traditionally served as the primary source of care for Medicaid recipients, patients unable to access insurance, and individuals who find their health coverage inadequate. On average, roughly 60 percent of patients served by NAPH members are enrolled in Medicaid or Medicare, and another 20 percent are uninsured. Although NAPH members account for only two percent of hospitals nationwide, they provide 20 percent of the nation's uncompensated care. The amount of uncompensated care provided by NAPH members has increased significantly in the last year due to the economy, underscoring the need for comprehensive health reform that provides meaningful coverage and access to care to all Americans. In the last quarter of 2008, NAPH members experienced a ten percent increase in uncompensated care costs compared to the same quarter of 2007. In addition, safety net hospitals provide nearly three-fifths of all burn care beds and over 30 percent of all Level 1 Trauma Centers in America's major cities. These disaster care services are critical not only in the event of a major accident, but also during natural disasters and public health crises, such as an influenza epidemic.

Denver Health represents a microcosm of this breadth of care. Forty-six percent of our patients are uninsured, 70 percent are minorities, and 85 percent are below 185% of Federal Poverty Level. Since 1991, we have provided $3.4 billion dollars in uninsured care. Yet we have been in the black every year. The city's payment represents just five percent of our net revenue. The number of uninsured at our door, and the cost for their care, increases every year. In 2007 our uninsured care topped $275 million; last year it was $318 million; and this year is projected to

be $360 million. We are good at cost effective care, but this is unsustainable.

Despite this highly vulnerable population, Denver Health has been able to achieve amazing quality—92 percent of our children are immunized; we have one of the lowest hospital mortality rates in the country with an observed to expected overall mortality of 0.58. Sixty-one percent of our hypertensive patients have their blood pressure under control compared to an average of 34 percent in the country.

While safety nets are there for vulnerable populations, not every American city and town is fortunate enough to have a safety net institution, let alone a comprehensive health care system like Denver Health. The vulnerable populations must not be forgotten in this reform effort. As a safety net physician leader, I see every day that America is failing to meet the health care needs of people in a coordinated, systematic, high quality, low cost way. As a doctor, I ask myself -- why should where you live in America determine if you live? Why should uninsured cancer patients get care if they live in Denver, but not if they live in another Colorado county? This must change. This is why I support meaningful, broad health reform as outlined in the Health Care Reform Draft Proposal.

I believe this Health Care Reform Draft Proposal includes many important reform components. The goal to ensure affordable, quality health care for all is essential.

Reducing Costs

As stated in the Health Care Reform Draft Proposal, costs must be reduced. This is necessary if we are to cover everyone. Costs can be reduced by getting patients to the right place, at the right time, with the right level of care, with the right provider, with the right

outcomes and the right financial incentives. This is not a theoretical construct. For example, our charges per Medicaid day and per Medicaid admission are thirty-two percent below our peer Colorado metropolitan hospitals.

Waste can be removed from our health care delivery systems. Denver Health has adopted Toyota Production Systems or "LEAN" to improve quality by removing waste in all components of our health care system. We have extensively trained 170 employees, including physicians and nurses, in LEAN tools and have realized more than $25 million in financial benefit in less than three years. There are numerous ways to reduce health care costs in our health system without reducing quality. In fact, quality can be enhanced. I offer a number of them here.

1. Develop integrated models of care that provide coordinated care and integration of patient information across the continuum of a patient's life and across the continuum of health and through stages of disease. This will ensure getting the right level of care, at the right place, at the right time, for the right cost.

   Denver Health demonstrates the efficiency and quality of care that can be obtained even among the most vulnerable with this model. Denver Health's charges are lower than the average for metropolitan Denver peer hospitals for all 35 DRGs reported by the Colorado Hospital Association and the lowest in 25 of the 35 (CHA 2007). We are in the top 10 in quality among University Healthsystem Consortium hospitals.

2. Providing incentives to link DSH hospitals, community health centers, school-based clinics and public health departments would aid in this integration. Coordinated Care Networks (CCNs), as proposed by NAPH, have the potential

to serve as a vehicle for transitioning to an integrated system to address the needs of vulnerable patients. Attached to my testimony is a proposal NAPH recently delivered to the Committee. CCNs would be integrated health care delivery systems for low-income populations, voluntarily formed by public and private safety net providers. CCNs would provide support for integrated delivery systems to coordinate the full range of care –primary care to hospital and post-acute care – for low income individuals and families, including Medicaid patients, Medicare beneficiaries (including dual eligibles), the uninsured and those who may be newly covered under health reform. CCNs would focus on improving both quality and efficiency of care for these vulnerable patient populations, and would ensure that their enrollees continue to have a range of necessary "wrap-around" support services that may not be needed by the rest of the population. Given the high-costs associated with treating low-income and other targeted populations, safety net systems, through CCNs, also would be prime testing grounds for incentives to improve quality and efficiency.

3. Provide alternative points of access rather than direct face to face encounters such as Nurse Advice Lines, and other telephone/email management options. This would be particularly valuable for vulnerable populations such as Medicaid and Medicare patients, to whom transportation and co-payments represent a barrier.

   Denver Health created a 24/7 multiple language nurse advice line. The nurse advice line even gives out prescriptions when appropriate. This is especially useful for patients for whom transportation is a barrier. In a published study, we demonstrated that patients frequently choose a lower level of care if they can speak to a nurse. The annual

net dollar savings was more than $300,000 for the then small number of callers (30,000.) (American Journal of Managed Care 2004). Now the line takes nearly 100,000 calls a year.

4. Provide incentives to states to move to Medicaid managed care utilizing high performing systems.

5. Integrate care for mental health, substance abuse and physical health rather than having these services delivered in separate entities, which creates difficulties for patients and their families, and adds cost.

6. Facilitate pharmacy programs so that Medicaid patients who are receiving primary care from 340B provider use that provider for pharmacy services. Community Health Centers and DSH hospitals are 340B providers, and many Medicaid patients already are getting care in these entities. Expand 340B pricing to inpatient services.

   The potential savings is demonstrated in our system. The average price per prescription for our Medicaid patients in the marketplace was $62.73 while at Denver Health it was $27.35 (2007).

   In this regard, we appreciate this Committee's longstanding support for the 340B program, and the expansion of the program included in the Health Care Reform Draft Proposal. Section 340B of the Public Health Service Act enables hospitals and other providers that serve a large volume of low-income and uninsured patients to access significant discounts on pharmaceuticals. We urge you to extend this program to inpatient drugs, ensuring greater access to low income populations and providing savings to safety net hospitals and the Medicaid program. Although the discounts available through the program are approximately 20 – 30

percent of the prices available through other purchasing arrangements, they are only available for drugs used in an outpatient setting. Therefore, 340B hospitals are forced to pay significantly more for inpatient pharmaceuticals, amounting to an average of $1.5 million per hospital in additional costs each year. Moreover, these hospitals must devote significant time and resources to managing their drug inventory to prevent 340B drugs from being used in an inpatient setting. The Safety Net Hospitals for Pharmaceutical Access organization estimates that hospitals participating in 340B would save a combined total of at least $1 billion annually if the program was extended accordingly. These savings would accrue both to the hospitals and the Medicaid program.

The Medicare Modernization Act authorized pharmaceutical manufacturers to voluntarily offer discounted pricing on inpatient drugs to hospitals participating in the 340B program without affecting their Medicaid "best price" and thus the size of the rebates the manufacturers must pay to the entire Medicaid program. Unfortunately, 340B hospitals have been unable to obtain meaningful voluntary inpatient discounts from manufacturers.

Safety Net Health Systems in Healthcare Reform

Enacting comprehensive health reform legislation is a critical step to achieving universal coverage. The Health Care Reform Draft Proposal does not envision full coverage at least until 2013. The health reform initiatives of Massachusetts, Maine, Vermont and others confirm that the process of expanding health coverage to all Americans will take several years. During this time, the role of safety net hospitals likely will expand, rather than contract. In fact, any coverage expansion's success will hinge, in part, on using safety net hospitals and health systems to engage low income and

other hard-to-reach populations, ensuring that these individuals take advantage of the new, affordable coverage opportunities.

During the transitional years, safety net health systems will continue providing high-quality services to all those seeking care, regardless of insurance status. Many people likely will remain uninsured during health reform's initial years, and safety net systems likely will continue treating a disproportionate share of these patients.

Given safety net health systems' uninsured volumes, they also are uniquely positioned to facilitate enrolling the uninsured into new coverage vehicles. Health reform most certainly will use Medicaid as a critical building block for expanded coverage for the poor. States likely will rely on safety net systems to identify newly-eligible patients. Safety net hospitals also will serve as entry points for individuals not eligible for public coverage, but who can enroll in subsidized and unsubsidized private coverage. Given our deep knowledge of our patients' unique needs, safety net health systems will be able to facilitate enrollment in the most suitable plans through the Health Insurance Exchange.

Both Denver Health and NAPH strongly endorse the DSH policy reflected in the Health Care Reform Draft Proposal. Both Medicaid and Medicare DSH payments will continue at their current levels into the foreseeable future, with HHS reporting on both programs by July 1, 2016.

The ongoing need for DSH support is well-illustrated by Massachusetts's experience. Massachusetts paid for its coverage expansion with DSH dollars, assuming that hospitals would recover their costs with the new coverage options. Had payments for the newly-insured been adequate, this assumption may have proven true. Safety net hospitals in Massachusetts suddenly faced significant losses, and the state has been forced to use its economic

stimulus dollars to make sure that its safety net hospitals remain viable.

For that reason, we strongly support the approach to both Medicare and Medicaid DSH outlined in the Health Care Reform Draft Proposal in establishing a thoughtful process by which the DSH programs can be restructured once health reform is fully implemented and only after hospital losses on both the uninsured and Medicaid populations are substantially reduced.

Workforce

The Health Care Reform Draft Proposal's investment in primary care and nurse training, the national health service corps, and scholarships are important and necessary. Without this we will not be able to get patients to the right provider for the right level of care.

As this Committee recognized in the Health Care Reform Draft Proposal, there is no single solution to resolving our workforce issues. We will need to train more physicians. Your proposal takes a step in this direction by redistributing Medicare graduate medical education slots, ensuring that no funded slots remain unused. We will need to attract more medical students to underrepresented specialties, and particularly primary care. Your legislation addresses this issue as well, increasing Medicaid physician primary care payments to Medicare rates and establishing new grant programs for primary care training and preventative medicine.

We also will need to specifically target minority and underserved populations for improved care. Increased funding for the National Health Service Corps is part of the answer, as the program incentivizes new physicians to begin their careers in underserved areas. Denver Health, for example, affiliates with the University of Colorado Denver School of Medicine and trains 3,400 students per

year, including medical students, nursing students, interns, residents and a myriad other professional trainees. Our diverse patient populations ensure that physicians training at our facilities learn to deliver culturally competent care and to treat the specialized needs of minority and other vulnerable populations early in their careers.

Concluding Comments

As a public entity, we believe in the power of the public sector to meet the needs, not only of uninsured patients and patients on public programs, but also of commercially insured patients. We are the major Medicaid provider for the state, a major provider of SCHIP and a Medicare provider, but our HMO also serves private patients. Every mayor of Denver for more than 25 years has been in our health plan. Twenty percent of our net revenue is from private patients. We would welcome the opportunity to be a public plan of choice. Other integrated public safety net systems would also welcome the opportunity to be a public plan of choice for the populations covered under public programs like Medicaid and SCHIP and also for the newly insured populations.

In summary, as a physician and a CEO of a public safety net system, I strongly support and urge you to continue this effort to substantially reform our delivery system, our payment system, and to provide care to all Americans in an affordable, cost efficient, high quality, coordinated true system of care. Not only cannot our current system be sustained, but it should not be sustained. America deserves better. You are to be commended for tackling this difficult issue. I would like to thank you for this opportunity to testify on your Health Care Reform Draft Proposal. It is an historic time for our country. I and NAPH will look forward to working with you in any way we can to help achieve meaningful health care reform.