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Chairman Buchanan, Ranking Member Doggett, and distinguished members of the Subcommittee, thank you for the opportunity to speak with you about the importance of coordinated, patient-centric care which prioritizes patient safety, high-quality care and outcomes, wellness and disease prevention, affordability, and accessibility.

My name is Dr. Michael Hoben, and I serve as the Chief Medical Officer for Population Health Services at Novant Health, an integrated not-for-profit network of more than 900 locations across North Carolina and South Carolina, including 19 hospitals and hundreds of physician clinics, urgent care centers, outpatient facilities, and imaging and pharmacy service locations. In this role, I focus on our health system's ongoing transition to value-based care, including care model innovation, clinical excellence and quality performance improvement, data integration and care innovation, and payor engagement. I also serve as the medical director for one of Novant Health's accountable care organizations (ACOs) participating in the Medicare Shared Savings Program (MSSP) and am an actively practicing family medicine physician at Novant Health Cotswold Medical Clinic in Charlotte, North Carolina.

At Novant Health, our cause is simple: Each of our nearly 42,000 team members is united in a shared commitment to create a healthier future and bring remarkable experiences to life for our patients. I am excited and encouraged to speak today before this esteemed body, which has long demonstrated its commitment to a healthier future for all Americans. Your focus on care coordination is an essential one as we consider policy changes that could have significant impact on our nation's healthcare delivery system.

I am often asked why care coordination should be a primary driver as we create a new vision for healthcare in this country. When policies and practice are designed to enable multifaceted collaboration, affordability, and efficiency, patient well-being can lead, and my colleagues and I can turn back to the heart of why we chose to practice medicine – caring for others.

Care Coordination Defined

Ask four different stakeholders in healthcare to define care coordination and you will get four different answers. Some emphasize the efficient exchange of electronic patient health information among clinicians, facilities, and third-party entities, while others focus on communication and collaboration between clinicians and other care team members. Some prioritize patient navigation through better

discharge planning and more streamlined referrals, while still others think of care coordination in terms of utilization management to better avoid duplicative or unnecessary services. All of these are correct, but each is incomplete.

Care coordination is much more than the exchange of information, the sharing of a discharge summary, or the scheduling of a follow-up appointment. It is more than a prior authorization or an electronic health record (EHR) inbox message between two physicians. Truly coordinated care begins with empathy for and consideration of the whole patient, from their medical conditions and family histories to their behavioral health needs, socioeconomic contexts, and personal goals. It requires a multidisciplinary, team-based approach in which physicians, advanced practice providers (APP), nurses, pharmacists, behavioral health specialists, social workers, patient navigators, community health workers, caregivers, family members, and others have a shared understanding of the care plan and the patient's preferences. And importantly, coordinated care requires active navigation within and across all care settings. We must be able to anticipate our patients' needs and identify their potential risks in real-time to intervene proactively, rather than simply respond to emergencies when they arise. Together, we can transform the healthcare experience from a series of disconnected and reactive encounters focused on problems to one that is simple and intuitive for patients and supports them holistically.

The Value of Health Systems Across the Care Continuum

Value-based care. Novant Health is a case study in how an integrated network of clinicians and facilities can successfully coordinate care for large numbers of patients, offering an example of how to effectively manage population health efforts at scale. As of today, Novant Health clinicians care for approximately 650,000 attributed patients as part of 18 different value-based care programs – about 33% of all Novant Health-attributed primary care patients in North Carolina – across multiple patient populations, including those insured under traditional fee-for-service (FFS) Medicare, Medicare Advantage (MA), Affordable Care Act (ACA) Marketplace plans, and private employer-sponsored plans. Through shared savings, shared risk, pay-for-performance, and care coordination fees, each of these programs reward high-quality, affordable care over simply treating more patients through an alternative payment model (APM) structure.

For example, Novant Health currently participates in the Medicare Shared Savings Program (MSSP) through two accountable care organizations (ACOs), which together cover approximately 75,000 assigned traditional Medicare patients. Each ACO has made the transition to full downside financial risk and participates in the MSSP under the ENHANCED Track. Novant Health's Physician Quality Partners (PQP) ACO ranked 1st in the nation for quality performance in both 2023 and 2024, while our two ACOs have collectively saved Medicare more than $90 million since 2017, even after accounting for earned shared savings.

Clinically integrated network. Our commitment to care coordination also extends beyond our walls. Through our clinically integrated network (CIN), NovaLinc, we partner with independent clinicians and practices across specialties to optimize care, improve population health, and deliver value to patients. Physician-led and dedicated to delivering world-class clinical programs designed by physicians, NovaLinc brings together more than 900 independent clinicians and 4,000 Novant Health clinicians in the belief that we are better together. Independent clinicians maintain autonomy while gaining access to centralized tools and services, while Novant Health clinicians are able to strengthen relationships with

other high-quality clinicians and practices throughout our regions. Starting in April 2025, NovaLinc convenes a Value-based Council for participating primary care clinicians and clinic administrators – both independent and Novant Health – to share best practices and key learnings related to patient care and formulate evidence-based Integrated Care Standards. For example, the Value-based Council recently developed and implemented an Integrated Care Standard to reduce emergency department (ED) utilization and readmissions based on the collective experience and expertise of NovaLinc clinicians.

Population Health. The scalable scaffolding that supports both Novant Health and NovaLinc clinicians in meeting the highest quality and performance measures is an area of work I am proud to lead – Novant Health's Population Health Services Organization (PHSO). Our PHSO team provides the expertise and data to drive:

- *Care management* – Creating quality outcomes through care gap closure, chronic disease management, and continuity of care models.
- *Community care* – Enhancing and maximizing community partnerships for care transitions and patient support.
- *Practice transformation* – Conducting value-based care performance analyses to identify opportunities for improvement, educating clinicians and other care team members, and supporting new team-based care model implementation.
- *Clinical documentation improvement* – Supporting clinician documentation through education, medical chart reviews, and the incorporation of new tools for automation where appropriate.
- *Pharmacy management* – Supporting patient medication adherence and compliance, improving access to and reducing costs for innovative therapies and treatments, and enhancing chronic disease management.
- *Addressing additional factors* – Navigating socioeconomic barriers to patient care, as well as leveraging integrated behavioral health providers, community health workers, and social workers to drive better health outcomes for all patients.
- *Data and analytics* – Securing accurate data sources to analyze and identify opportunities to improve clinical outcomes and reduce costs through point-of-care solutions.

Technology investments. Novant Health has additionally been able to make strategic, patient-centric investments in infrastructure and technology to support patient care and care coordination. For example, we are able to utilize our unified EHR across multiple care settings to ensure patient records, test results, imaging studies, care notes, and treatment plans are seamlessly shared and communicated across our system. As of 2024, approximately 2.6 million of our patients utilize a single source, their EHR patient portal, MyChart, to easily access their own records and connect directly with clinicians and other care team members. Beyond the EHR, we are also able to invest in technologies that enable predictive analytics, clinical registries, and artificial intelligence (AI) to identify high-risk patients and connect with them appropriate clinical interventions to reduce hospitalizations, minimize unnecessary utilization, and improve overall care outcomes.

Evidence-based protocols. Serving as a large, integrated health system also gives us the opportunity to share clinical best practices and adopt standardized protocols across care settings. Evidence-based care pathways help to reduce unwarranted clinical variation and promote patient safety and high-quality care. For example, Novant Health adopted a system-level approach to the early detection and treatment of sepsis in emergency and critical care settings, aligning care protocols across all system facilities with the latest evidence. Novant Health has achieved a more than 40% reduction in sepsis mortality across its hospitals since 2021 due to a coordinated effort to improve early detection and treatment. That means that, as of 2024, an average of 25 patients per month across the health system are overcoming sepsis who were previously predicted not to survive.

Launched in 2024 and updated annually, Novant Health also publishes its HeRO Playbook to support systemwide efforts to continuously strive toward being a high reliability organization (HRO) and foster continuous improvement toward safe, high-quality care for all patients. The HeRO Playbook offers resources for team members to promote evidence-based and common-sense safety behaviors, as well as foster collaborative partnerships across service lines and specialties and facilitate regulatory education and compliance. Additionally, this incredible resource helps to ensure we are all prioritizing the patient experience and a patient-centered culture. For example, team members can learn more about evidence-based Care Imperatives, such as personalized care goals, purposeful rounding, and the "teach back" method of patient education and communication, as well as real-time service recovery and continuous improvement. Since its debut, the HeRO Playbook has become essential reading for all team members as we strive toward truly coordinated care.

Care Beyond the Clinical Walls

Virtual Care Network. Novant Health strives to remain on the leading edge of digital innovations and technological solutions in support of care coordination and patient care. We have a centralized, standardized, and unified Virtual Care Network that supports inpatient care through digitally-enabled rooms, hospital-at-home capabilities, virtual consults, virtual sitters, and tele-intensive care unit (ICU) and tele-stroke services, among others. The Virtual Care Network also supports outpatient care through both scheduled and on-demand video visits, patient portal e-visits, virtual behavioral health services access, and virtual specialty care, such as weight management, sleep care, preventive cardiac care, and more.

In 2024, the Novant Health system had more than 373,000 telehealth encounters of all types, including 332 patients enrolled in remote patient monitoring (RPM). In June 2025 alone, we had nearly 20,000 scheduled video visits, nearly 5,000 medication management video visits, and over 3,000 tele-psychiatry consults. These innovations have directly benefited our patients:

- Virtual clinics significantly improve access at Novant Health, cutting specialty care wait times from 80+ days to less than 30 days.
- 90% of patients experiencing a stroke at a Novant Health hospital are now diagnosed via our tele-stroke program, eliminating critical minutes of wait time from arrival to diagnosis.
- Our Hospital at Home program continues to deliver exceptional patient experience results, earning a 98% satisfaction rate among survey respondents.

- Novant Health's Virtual Menopause Wellness Clinic is transforming care for women in the communities we serve, completing over 1,300 appointments thus far in 2025 and delivering care in over 47 counties across the Carolinas.

Chronic disease management services. Virtual care is also essential for chronic disease management, allowing Novant Health to more widely leverage the expertise of a broader range of clinicians in patient care. Mediful, our chronic disease management service, enables nearly 50 certified clinical pharmacists to virtually support more than 30,000 patients across more than 180 participating Novant Health clinics. Enrolled patients have an initial assessment, participate in follow-up visits, and gain access to a collaborative team of clinical experts on how to best manage their condition and treatment. For Mediful enrollees with diabetes, for example, this approach saw patients' average Hemoglobin A1c levels decline by 2.1 percentage points – approximately twice the improvement seen with medication alone.

Community cruisers. Across the Novant Health footprint, mobile units and their care teams serve neighborhoods, rural regions and other communities that face access challenges and other barriers to preventive care and essential care coordination resources. Seven community health mobile cruisers deliver services such as preventive health screenings, obstetrics and gynecology (OB/GYN) care, adult and pediatric primary care, dental care, and community health education on chronic disease management, nutrition, mental health, and upstream drivers of health. Novant Health clinicians customize unit equipment and care teams to match health system-identified community needs, Community Health Needs Assessments (CHNA), and care priorities from local non-profits and community partners. Depending on community needs, care teams can include clinicians, community health workers, social workers, and medical and other students in training. For example, in 2024, our RemarkableYou Screenings helped 5,886 patients within our communities – including those who are uninsured or underinsured, have no primary care clinician or medical home, or have undiagnosed prediabetes or diabetes – know their vital numbers and identify early risk factors for heart disease, stroke, and diabetes.

An additional six community cruisers have long delivered mobile mammography services in North Carolina. In the Winston-Salem and surrounding Triad region of North Carolina, Novant Health has provided mobile mammography services since 1995. In 2024 alone, the team served over 8,000 patients at local businesses, YMCA facilities, non-profit organizations, churches, and even our own Novant Health clinics in rural areas. Novant Health's latest mobile unit was added to the fleet in 2025 to serve rural Rowan County, and a new cruiser is scheduled to come online in 2026 to expand care in Western North Carolina. Mobile mammography units accept insurance coverage and link patients to Novant Health financial assistance programs as needed.

Community paramedicine. Since 2014, Novant Health New Hanover Regional Medical Center's community paramedic (CP) program has served patients of all ages in Wilmington, NC and communities within a 30-mile radius of the facility without billing patients for its services. Now funded almost entirely by Novant Health, CPs care for patients who:

- Are enrolled in Hospital at Home;
- Do not qualify for Home Health because they are not considered home-bound;

- Lack needed Home Health care because the local Home Health Agency (HHA) does not accept that patient's insurance coverage;
- Are labeled as non-compliant or challenging (often associated with those experiencing behavioral health challenges);
- Are unhoused or their home is not considered safe; and/or
- Are experiencing a substance use disorder and require at-home medication-assisted treatment.

In addition to direct patient care, the CP program works to connect patients to ongoing primary, mental health, and preventive care by working with patients to identify and enroll with a primary care clinician. The program accepts referrals from a wide range of community and government partners and further utilizes telehealth to ensure 24-hour inpatient care at home for those enrolled in Hospital at Home.

Community hubs. Novant Health takes the care of the whole patient and our broader communities very seriously and sees this as an essential part of coordinated care. Our facilities are hubs of their local communities, partnering with community-based organizations and health and wellness groups to empower individuals to adopt healthier lifestyles to reduce the risk of chronic disease, to ensure access to preventive care and essential life-saving treatments and services in rural and underserved areas, and to reduce the total cost of care and promote affordable care options for all patients. We partner with local school districts, recreation centers, churches and faith centers, grocery stores, community coalitions, veterans programs, county health departments, senior centers, and homeless shelters to augment the care provided within the four walls of our hospitals and clinics, ensuring we are meeting patient needs where they are in our communities. For example, two Community Health Educators provided education and care connections to 526 community members in 2024, facilitating group classes on topics like mental health first aid, caregiver support, and diabetes management in locations across our communities.

Correcting for Complexity

As foundational as care coordination is to creating the kind of healthcare system our nation expects and deserves, and as lawmakers and clinicians partner to draft new solutions, we must collectively remain vigilant about also removing complexity from existing public policies. For example, the Novant Health Center for Public Policy Solutions, a patient-focused, clinician-led public policy research center, published a white paper in 2023 that offered solutions to remove regulatory complexities that serve as barriers to comprehensive, common sense annual preventive care and chronic condition management. As the paper outlines, annual wellness visit (AWV) regulations are prescriptive about what can be discussed during a covered, no-cost AWV. When patient questions arise about acute or chronic conditions, these conversations can require the clinician to deploy a patchwork of additional coding – and an unexpected medical bill for the patient often results.

For patients, such unexpected bills or limits on what they can discuss in their time with their clinician are symptoms of a widely complex and often frustrating healthcare system. For clinicians, limits on how they care for patients, combined with a complicated labyrinth of codes, add-on codes, modifiers, and other regulatory requirements, drives burnout and disconnection from the care-focused reasons we entered medicine. While existing regulations were a well-intentioned effort to reward value-based care delivery,

this approach was built with a volume-based Medicare Physician Fee Schedule (PFS) in mind. To promote the coordinated care we are discussing here today, a wholesale reimagining of our nation's primary care coding and delivery system is needed. We must remove unwanted complexity from the system and, consequently, empower patient decision-making, encourage preventive care, and preserve physicians' and other care team members' satisfaction in the practice of medicine.

Conclusion

On behalf of Novant Health, the Novant Health Center for Public Policy Solutions, and myself, thank you again, Chairman Buchanan, Ranking Member Doggett, and distinguished members of the Subcommittee for your consideration and attention today. My teammates and I stand ready to be a resource in your efforts to shape policies that fully enable coordinated care structures, reduce complexity, and create our shared vision of a healthcare system that truly focuses on keeping patients healthy.

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