

MACRA AND ALTERNATIVE PAYMENT MODELS: DEVELOPING OPTIONS FOR VALUE-BASED CARE

HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED FIFTEENTH CONGRESS FIRST SESSION

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MACRA AND ALTERNATIVE PAYMENT MODELS: DEVELOPING OPTIONS FOR VALUE-BASED CARE

WEDNESDAY, NOVEMBER 8, 2017

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:02 a.m., in room 2123, Rayburn House Office Building, Hon. Michael Burgess (chairman of the subcommittee) presiding.

Members present: Representatives Burgess, Guthrie, Barton, Shimkus, Blackburn, Lance, Griffith, Bilirakis, Long, Bucshon, Brooks, Mullin, Hudson, Collins, Carter, Green, Engel, Butterfield, Matsui, Castor, Sarbanes, Schrader, Kennedy, Eshoo, DeGette, and Pallone (ex officio).

Also present: Representative Ruiz.

Staff present: Adam Buckalew, Professional Staff Member, Health; Jordan Davis, Director of Policy and External Affairs; Paul Edattel, Chief Counsel, Health; Adam Fromm, Director of Outreach and Coalitions; Caleb Graff, Professional Staff Member, Health; Jay Gulshen, Legislative Clerk, Health; Alex Miller, Video Production Aide and Press Assistant; James Paluskiewicz, Professional Staff Member, Health; Jennifer Sherman, Press Secretary; Hamlin Wade, Special Advisor for External Affairs; Jeff Carroll, Minority Staff Director; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Una Lee, Minority Senior Health Counsel; Samantha Satchell, Minority Policy Analyst; and C.J. Young, Minority Press Secretary.

Mr. BURGESS. The Subcommittee on Health will now come to order, and I will recognize myself 5 minutes for the purpose of an opening statement.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Today marks the Health Subcommittee's third oversight hearing to examine the implementation of the Medicare Access and CHIP Reauthorization Act. Personally, for me, the Medicare Access and CHIP Reauthorization Act was a significant milestone because repealing the Sustainable Growth Rate formula was one of my highest priorities coming to Congress.

The Medicare Access and CHIP Reauthorization Act represents a fundamental change in a healthcare payment system that had re-

mained static for many years and had created uncertainty for providers. Before the passage of this bill, Congress delayed cuts to Medicare reimbursements for doctors a total of 17 times.

Through the hard work and steadfast leadership of the Energy and Commerce Committee and the unwavering commitment from the medical community, this bipartisan effort led to policies that sought to put power back in the hands of those who actually provide the care. That way, doctors will give shape to the healthcare payment of the future.

So it is critically important that the Medicare Access and CHIP Reauthorization Act succeeds and I am glad that the committee remains dedicated to ensuring that we get payment reform right. It does continue to be one of my top priorities.

Today, we will convene two panels of witnesses.

And I want to welcome Dr. Jeffrey Bailet, the chairperson of the Physician-Focused Payment Model Technical Advisory Committee—we will call it PTAC for short—and Ms. Elizabeth Mitchell who is the vice chairperson of PTAC. I want to welcome you to our subcommittee this morning.

The next panel, we will hear from physicians representing key stakeholder groups that have either already had, have an alternative payment model, or have one in the pipeline with the PTAC or the Center for Medicare and Medicare information. With that I want to take a moment also to welcome Dr. Daniel Varga from the Texas Health Resources Presbyterian Hospital where I did part of my residency, which provides care for many of my constituents in the north Texas area. It is good to have you in person today, Dr. Varga.

The focus of today's hearing will be on the Alternative Payment Models which is one of two options that eligible professionals can be reimbursed under MACRA. The other option is a Merit-based Incentive Payment System which also deserves our full attention and will be the subject of an additional hearing in the very near future.

One of the many goals of the Medicare Access and CHIP Reauthorization Act was to encourage and engage in care delivery models that drive quality while reducing healthcare costs. This movement towards alternative payment methods has allowed providers greater flexibility to innovate and try a delivery system that better aligns with their unique practice needs and allows them to produce better patient outcomes and offers an opportunity to share in the savings. I am encouraged by figures that indicate an estimated 50 percent of Medicare payments will be tied to these alternative payment methods next year.

We may have heard of some of these models before. The Medicare Shared Saving Program through Accountable Care Organizations, the Next Generation ACO Model, the Comprehensive Primary Care Plus model, and the Oncology Care Model. It is safe to say we will likely hear of them and similar hybrids in the near future. It is notable and important these efforts are physician-directed and physician-led. This is not necessarily the easiest path, but it is the correct one.

A recurring theme that we will hear this morning is that physicians are best suited to provide the determinants of quality. Pa-

tients are counting on us. Not congressmen, but doctors. They are counting on us to get this right. It has been 2½ years since the Medicare Access and CHIP Reauthorization Act became law.

I believe the true potential of this act has yet to be met, but I believe the law has already begun proving a success of delivering better care to beneficiaries, savings to the Medicare program, certainty for our doctors. It is important to hear the positive impact this law has had so far from everyone here today. Finally, it is critical that what we accomplish today follows the same open, transparent, and bipartisan structure that helped us get this act signed into law.

I again want to welcome all of our witnesses. Thank you for being here today. Thank you for giving us your time. I look forward to your testimony. And I will yield the balance of my time to Mrs. Blackburn from Tennessee for a statement.

[The prepared statement of Mr. Burgess follows:]

PREPARED STATEMENT OF HON. MICHAEL C. BURGESS

Today marks the Health Subcommittee's third oversight hearing to examine the implementation of the Medicare Access and CHIP Reauthorization Act since its enactment. Personally, MACRA was a significant milestone because repealing the Sustainable Growth Rate was one of my driving forces soon after I came to Congress. MACRA represents a fundamental change in a health care payment system that had remained static for many years and had created tremendous amount of uncertainty for providers since 2003. Before MACRA, Congress delayed cuts to Medicare reimbursements for physician services a total of 17 times! Through the hard work and steadfast leadership of the Energy and Commerce Committee and unwavering commitment of the medical community, this bipartisan effort led to policies that sought to put power back in the hands of those who actually provide care. That way, doctors will give shape to the health care payment systems of the future. So, it is critically important that MACRA succeeds, and I am glad that the committee remains dedicated to ensuring we get payment reform right. This continues to be one of my priorities.

Today we will convene two panels of witnesses. First, I want to welcome Dr. Jeffrey Bailet, chairperson of the Physician-Focused Payment Model Technical Advisory Committee (PTAC), and Ms. Elizabeth Mitchell, vice chairperson of PTAC to our subcommittee this morning. Later, we will hear from physicians representing key stakeholder groups that either already have an Alternative Payment Model (APM) or have one in the pipeline with PTAC or the Center for Medicare and Medicaid Innovation (CMMI). With that, I want to take a moment to also welcome Dr. Daniel Varga from the Texas Health Resources, which provides care for many of my constituents in the North Texas area.

The focus of today's hearing will be on Alternative Payment Models (APMs), which is one of two options eligible professionals can be reimbursed under MACRA. The other option is the Merit-based Incentive Payment System (MIPS), which also deserves our full attention and will be the subject of an additional hearing in the near future.

One of the many goals of MACRA was to encourage and engage in care delivery models that drive quality while reducing healthcare costs. This movement towards APMs has allowed providers greater flexibility to innovate and try a delivery system that better aligns with their unique practice needs, produce better patient outcomes, and offer them an opportunity to share in significant savings. I am encouraged by figures that indicate an estimated 50 percent of Medicare payments will be tied to APMs next year. We may have heard some of these models before: the Medicare Shared Savings Program through Accountable Care Organizations, the Next Generation ACO Model, the Comprehensive Primary Care Plus Model, and the Oncology Care Model. It is safe to say we will likely hear of them and similar hybrids much more in the future.

It is notable and important that these efforts are physician directed and physician led. This not necessarily the easiest path, but it is the correct one. A recurring theme we hear this morning is that physicians are best suited to provide the determinants of quality. Patients are counting on us—the doctors—to get this right.

It has been 2½ years since MACRA became law. I believe the true potential of MACRA has yet to be met, but I believe the law has already been proven a success in delivering better care to beneficiaries, savings to the Medicare program, and certainty to doctors. It is important to hear the positive impact this law has had so far from everyone here today. Finally, it is critical that what we accomplish today follows the same open, transparent, and bipartisan structure that helped get MACRA signed into law.

I again want to welcome all of our witnesses and thank you for being here. I look forward to your testimony.

I would like to yield the balance of my time to Ms. Blackburn of Tennessee, for a statement.

Mrs. BLACKBURN. Thank you, Mr. Chairman. And I am so pleased that we are doing this hearing today. And I was one of those that joined you in being a vocal opponent of kicking the can on the SGR. There were things that needed to be done and it is our responsibility to address those issues and to find solutions and of course getting MACRA to the President's desk was a solution.

The old system of short-term fixes does not work, didn't work, and I am looking forward to hearing how the law's Alternative Payment Models are being designed and implemented and improving patient treatment and outcomes in a variety of settings. Being from the Nashville, Tennessee area, we have a lot of health care that is headquartered there and the steps that are being taken are important to them, to our constituents. And I yield back.

Mr. BURGESS. The Chair thanks the gentlelady. The gentlelady yields back. The Chair recognizes the subcommittee ranking member, Mr. Green of Texas, 5 minutes for an opening statement, please.

**OPENING STATEMENT OF HON. GENE GREEN, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. GREEN. Thank you, Mr. Chairman. And I want to thank you for calling this hearing. I know we were both concerned over those 17 years that how we were going to fix the SGR and we did come to a bipartisan solution. And my concern and with this hearing we don't want to recreate the SGR and have Congress go through that so as nimble as Congress can be on our feet we need to make sure we catch it before we have to deal with it for 17 years.

The Sustainable Growth Rate was the scourge of Medicare and doctors who treat Medicare patients for more than a decade and acted as part of the Balanced Budget Act of 1997. The SGR calculations led to a reduction of physician payments starting in 2002 and had to be patched annually, as you said, for 17 years. In 2014, this committee along with other committees of jurisdiction finally came together and introduced a bipartisan bill to permanently repeal the SGR and replace it with a system that rewards value over volume and incentives for quality care.

Finally, in 2015, an agreement on offsets was reached in H.R. 2 that was Medicare Access and CHIP Reauthorization Act or MACRA overwhelmingly passed both chambers and was signed into law. MACRA did more than just repeal the flawed SGR formula. It was designed to overhaul and realign payment incentives for Medicare and transition of our health system to one that rewards value instead of just volume of care. It provided stability in Medicare payments for providers for immediately following years

and made it easy for providers to report on and deliver high-quality care, streamlining Medicare's multiple quality reporting systems, and over time consolidating them into one.

Critically, MACRA encourages providers to move away from fee-for-service and partake in a new delivery model that will reduce costs while increasing quality. Under the law, physicians who treat Medicare beneficiaries have a choice between participating in the Merit-based Incentive Payment System, MIPS, or the Advanced Alternative Payment Models, APMs, to make the shift from fee-for-service and volume-based payment system to a value-based payment system.

The focus of today's hearing is in the implementation of these two tracks, the Alternative Payment Models. Alternative Payment Models generally are an approach to provide provider payment that offers incentive to quality, cost-effective care in specific circumstances for specific patient populations or episodes of treatment. Advanced APMs created under MACRA go a step further and under these models physicians accept some amount of financial risk for the quality of the care and ultimate outcomes of their patients. Participants in Advanced APMs accept this risk in exchange for greater rewards when they succeed.

Starting next year, qualifying APM participants can receive a 5 percent bonus in their reimbursement annually. Centers for Medicare and Medicaid Innovation center has developed and piloted APMs since its inception. Many of these now qualify as Advanced APMs under MACRA including certain Accountable Care Organizations, Patient-Centered Medical Homes and the Comprehensive Primary Care Plus model.

I want to note that one of the most successful ACOs in the country is Memorial Hermann Accountable Care organization created and operated by leaders of the Memorial Hermann Health System in Houston, a 16-hospital integrated health system based in Houston. The Memorial Hermann ACO has been number one in Shared Savings Program ACO in the country for several years running, and by 2016 has generated nearly 200 million in savings across 3 years of participation in the program. Today we hear witnesses from these payment models, models that are currently underway and physicians participating in them in which are generating savings to Medicare and improved patient outcomes.

Staunch oversight of MACRA is critical. We must avoid the pitfalls of what we did since 1997, and I am pleased we are having this hearing today and hope this committee engages in more oversight and dialogue as the major reforms of MACRA are fully implemented. And I yield back the balance of my time.

Oh, sorry. For the record, I would like to insert a letter from the American Academy of Family Physicians.

Mr. BURGESS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. BURGESS. The Chair thanks the gentleman. The gentleman yields back. The chairman of the full committee has been detained on a conference call. We will recognize him for an opening statement upon his arrival. But pending that, I would like to recognize the gentleman from New Jersey, Mr. Pallone, the ranking member of the full committee, 5 minutes for an opening statement, please.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Mr. Chairman, for holding this important hearing and thank the witnesses for being here today. We are meeting today to discuss one of the great bipartisan success stories of this committee, the Medicare Access and CHIP Reauthorization Act of 2015 or MACRA.

MACRA built upon the successes of the Affordable Care Act to improve the quality and efficiency of the Medicare program and of our healthcare system more broadly. Prior to the ACA, healthcare services in the Medicare program were predominantly reimbursed on a fee-for-service payment model which rewarded providers for the number of tests or procedures they performed instead of the quality of medical care provided. And the ACA took major steps towards improving the quality of our healthcare system by creating new models of healthcare delivery within the Medicare program.

These new payment and delivery models focused on transforming clinical care and shifting from a volume- to a value-based care model such as Accountable Care Organizations or ACOs and Patient-Centered Medical Homes. These models prioritize the patient with the goal of improving care coordination and patient outcomes by simultaneously lowering costs and they have reduced hospitalizations, emergency department visits, and have improved both the quality of care and access to care. There are additional opportunities to refine these models and increase savings, for example, by better targeting the riskiest and costliest patients for interventions.

But I want to take a moment to recognize that while we continue to face challenges, the transformation to a value-based healthcare system is well underway. With MACRA we are entering the next phase of delivery system reform and further shifting the paradigm away from a volume-based to a value-based healthcare system.

MACRA builds on these healthcare delivery systems reform efforts by offering opportunities and financial incentives for physicians to transition to new payment models known as Advanced Alternative Payment Models or AAPMs. And AAPMs must meet a number of criteria and require clinicians to accept some financial risk for the quality and cost outcomes of their patients. Physicians can join existing and successful models that qualify as AAPMs such as ACOs and the Comprehensive Primary Care Plus or CPC+ model which we will hear about today. They can also develop their own models known as Physician-Focused Payment Models.

A number of physician organizations have already submitted applications for approval by the Physician-Focused Payment Model Technical Advisory Committee or PTAC, and PTAC has been accepting and reviewing applications for Physician-Focused Payment Models over the last year and has approved several for testing, including the ACS-Brandeis Model which we will hear about today from the American College of Surgeons.

I look forward to hearing from PTAC about the application process, the way these efforts fit within the broader context of delivery system reforms, how these submitted models have been evaluated, and how models may be implemented going forward.

Our second panel of witnesses practice in a variety of settings across the country and represent diverse expertise and training. They each have a unique perspective to share with us regarding the implementation of MACRA and how it has encouraged a focus on quality and efficient health care. And I want to thank you all for your commitments to delivery system reform. It is only through sustained commitment of the leading physician organizations and clinicians such as yourselves that we can hope to bend the cost curve.

So I look forward to discussing the tools and best practices providers are already using, some of the challenges and opportunities they have faced as well as future efforts that can be employed to help make MACRA work effectively for all, so I thank you.

I don't think anybody on my side wants the time, Mr. Chairman, so I yield back.

[The prepared statement of Mr. Pallone follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

Good morning. Thank you Mr. Chairman for holding this important hearing, and thank you to the witnesses for being here today.

We're meeting today to discuss one of the great bipartisan success stories of this committee, the Medicare Access and CHIP Reauthorization Act of 2015, or MACRA. MACRA built upon the successes of the Affordable Care Act to improve the quality and efficiency of the Medicare program, and of our healthcare system more broadly.

Prior to the ACA, healthcare services in the Medicare program were predominantly reimbursed on a fee-for-service payment model, which rewarded providers for the number of tests or procedures they performed instead of the quality of medical care provided. The ACA took major steps towards improving the quality of our healthcare system by creating new models of healthcare delivery within the Medicare program. These new payment and delivery models focused on transforming clinical care and shifting from a volume- to a value-based care model, such as Accountable Care Organizations or ACOs and Patient Centered Medical Homes.

These models prioritize the patient, with the goal of improving care coordination and patient outcomes while simultaneously lowering costs. They have reduced hospitalizations, emergency department visits, and have improved both the quality of care and access to care. There are additional opportunities to refine these models and increase savings, for example, by better targeting the riskiest and costliest patients for interventions. But I want to take a moment to recognize that while we continue to face challenges, the transformation to a value-based healthcare system is well underway.

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commitment to delivery system reform—it is only through the sustained commitment of the leading physician organizations and clinicians such as yourselves that we can hope to bend the cost curve.

I look forward to discussing the tools and best practices providers are already using, some of the challenges and opportunities they have faced, as well as future efforts that can be employed to help make MACRA work effectively for all.

Thank you, I yield back the remainder of my time.

Mr. BURGESS. The gentleman yields back. The Chair thanks the gentleman. The Chair would remind Members that, pursuant to committee rules, all Members' opening statements will be made part of the record.

And we do want to thank our witnesses for being here today on both panels. We thank them for taking their time to testify before the subcommittee. Each witness will have the opportunity to give an opening statement followed by questions from Members.

Today we will hear from Dr. Jeffrey Bailet, the chairperson of the Physician-Focused Payment Model Technical Advisory Committee, and Ms. Elizabeth Mitchell, vice chairperson, Physician-Focused Payment Model Technical Advisory Committee. That is a mouthful.

We appreciate you being here today.

And, Dr. Bailet, you are now recognized for 5 minutes for an opening statement, please.

STATEMENTS OF JEFFREY BAILET, M.D., CHAIR, AND ELIZABETH MITCHELL, VICE CHAIR, PHYSICIAN-FOCUSED PAYMENT TECHNICAL MODEL ADVISORY COMMITTEE

STATEMENT OF JEFFREY BAILET

Dr. BAILET. Thank you. Chairman Burgess, Ranking Member Green, and distinguished members of the Energy and Commerce Subcommittee on Health, thank you for the opportunity to testify on behalf of the chair and vice chair of the Physician-Focused Payment Model Technical Advisory Committee or PTAC. We are Jeffrey Bailet, executive vice president of Health Care Quality and Affordability at Blue Shield of California—we insure 4.1 million members, we are nonprofit, and the third largest health plan in California—and Elizabeth Mitchell, my vice chair, CEO of the Network for Regional Health Improvement, a national network of multi-stakeholder Regional Health Improvement Collaboratives with over 30 members across the U.S.

As an otolaryngologist—head and neck surgeon—and as a Blue Shield executive vice president, I am responsible for leading all medically related activities for the health plan, including quality medical management, provider contracting, and our Accountable Care Organization strategy, and I also serve as the chair of PTAC. Thank you for extending this opportunity for us to speak on the important topic of Medicare payment reform and PTAC's role supporting physicians and technicians as they transition to value-based care delivery.

Even before the inception of MACRA there was considerable agreement that the current fee-for-service model based on paying for the volume and intensity of services is unsustainable and needs to change to a model that is value-based, patient-centered, and accountable. However, we need to transform the care delivery system

and change the trajectory of spending in a way that maintains the vibrancy of the institutions and professionals that have dedicated their lives to preserving health and caring for the sick, injured, and dying in the U.S.

MACRA and Alternative Payment Models have the potential to address the fundamental drivers of cost and quality and ensure that we have a high-value health system, the backbone of which is providers who want to change care delivery and give better care to patients.

As the largest purchaser of health care in the world, Medicare has considerable influence on payment and, through the development of Alternative Payment Models, drive market change, and the PTAC plays an important role in accelerating model development. The PTAC is an 11-member advisory committee established to consider physicians and other clinical stakeholders' proposals for new payment models that foster high-quality, high-value health care.

PTAC members are a diverse, highly talented group that have deep expertise in clinical care and technical expertise in the areas of measurement, payment, and care delivery reform. The committee includes a balance of physicians and non-physicians who are highly committed to ensure that proposals are critically, thoroughly, and expeditiously evaluated.

We have sought to establish high-integrity relationships with the clinical and broader stakeholder communities across the country, some of which you will hear today. We are inviting comments, questions, or concerns prior to and during public meetings when models are evaluated. Furthermore, PTAC is keenly interested in all types of models including those emanating from single specialty, primary care, small and rural practices, sophisticated health systems, and multispecialty group practices.

PTAC's disciplined and collaborative efforts have garnered tremendous interest in creativity from stakeholders, receiving 33 letters of intent and 20 full proposals spanning many specialties, payment types, and practice sizes. To date, the PTAC has held 9 days of public meetings, we have deliberated on six proposals, we have voted on five with submitted reports to the secretary, and we have 14 proposals under active review. It is our belief that the interest in and work of PTAC confirms Congress' direction and intent for MACRA to transition U.S. health care to a high-value system delivering better care at lower cost.

Lastly, PTAC works collaboratively with CMS and CMMI to garner input about specific proposals especially if they have previously evaluated to any capacity by CMS or CMMI. To date, the models PTAC has sent to the secretary for potential limited-scale testing have not been approved.

In addition, we are unclear whether because of the extensive review process already provided by the PTAC, submitters can undergo a more expedited review and evaluation process. Our concern is that if we are not able to support our recommendations or work to fix any shortfalls in our analyses, the value of PTAC's process will not be fully realized. We believe that closer coordination between PTAC and CMS and CMMI will enable greater efficiency, greater capacity to implement more innovative models, and greater clarity for applicants seeking to understand the process of submission and

approval and look forward to continued partnership with CMS and CMMI.

In closing, PTAC is an incredibly important forum to identify innovative models from the field to expand Medicare's payment model portfolio. Transforming care delivery, including implementing innovative payment policy, is complicated; therefore an open public process that includes the stakeholders and also educates stakeholders and the public is likely the best way forward. We believe the PTAC is well suited for this purpose.

We commend Congress for its vision and we thank you for the opportunity to be part of such important work. Thank you.

Mr. BURGESS. The Chair thanks the gentleman.

Ms. Mitchell, you are recognized for 5 minutes, please.

STATEMENT OF ELIZABETH MITCHELL

Ms. MITCHELL. Thank you Chairman Burgess, Ranking Member Green, and distinguished members of the committee. Thank you again for the opportunity to be here today and for your leadership on these critically important issues.

As president and CEO of the Network for Regional Health Improvement, my members and I work at the community level with all stakeholders, employers, providers, health plans, patients, and others, and I can assure you that healthcare quality and affordability are of primary concern. The urgency to reduce healthcare costs while improving quality cannot be overstated. This is impacting families, employers, State governments, and our overall economy.

MACRA addresses the fundamental drivers and by reforming care and payment we have truly the opportunity to achieve better care at lower cost and this is an incredible opportunity for the U.S. Dr. Bailet has shared the innovation and leadership that we have seen from the physician community and their readiness to lead these changes. This is an opportunity that we cannot squander.

Despite the exceptional interest in PTAC as evidenced by the number of proposals and letters of intent, there are still barriers that physicians face in transitioning to these new models. Providers who are ready and willing to lead change continue to face barriers and need additional support. The PTAC took the time to think about some of the key barriers that we have seen from the submitters over the first year and we have identified three priority areas for your consideration. These include the need for technical assistance to providers, greater access to shared data, and the opportunity for limited-scale testing of innovative models.

PTAC believes that there is a material need for technical assistance for providers to develop and implement Physician-Focused Payment Models and APMs. Most physicians, they have experience changing care delivery but they have not been trained in the development of incentives, payment models, or risk management. Recent surveys of high-performing health systems and medical groups demonstrate the growing willingness to support and assume risk, but these organizations have made considerable investments in the infrastructure to successfully participate in APMs.

And while large health systems may have the resources and expertise to develop and implement these models, such small and

rural practices are at greatest risk of not being able to afford the technical support to design and implement the payment and care changes needed to succeed under risk-based models. This threatens to leave these small and rural practices out of the transition to value-based care.

Congress should identify ways to enable the provision of technical assistance to providers seeking to develop and implement APMs in a way that does not exacerbate resource differentials among providers and that helps move all providers forward towards value-based care. Although MACRA does not authorize PTAC to provide such technical assistance, many members of our committee believe that PTAC should be able to do so, or at a minimum PTAC can provide valuable insights related to what types of technical assistance would be most helpful.

The PTAC supports deployment of HHS resources to provide access to analytic, technical, and quality improvement support. We also believe that there is a need for greater access to shared data. This is a common barrier identified by submitters. PTAC, too, has observed common weaknesses among some of the submitted proposals. Specifically, applicants need communitywide, all-payer claims and clinical data sharing across communities to successfully implement models. Providers cannot manage risk, care, or cost without timely, comprehensive data.

Most of the proposals PTAC has received require coordination of care across practices, providers, and communities, but if data is not shared effectively participants cannot coordinate patient care across episodes or populations. Data blocking, lack of interoperability, and other limits on data access continue to be a major barrier to care improvement on behalf of patients. The move to APMs as required by MACRA has made this an urgent issue. We ultimately must address the barriers to communitywide data access in order to enable the successful transition to APMs.

Finally, limited-scale testing of innovative models is necessary before we scale models for national implementation. This is the committee's third priority and we believe that innovation in any industry requires the opportunity for small-scale testing. PTAC has identified limited testing of models as an important phase of development and implementation as it is unknown how key elements of the model will clinically and financially perform until the model functions in a testing environment.

Given the diversity of markets across the United States, regional testing will also identify aspects of the models that may require flexibility and implementation. We do not expect a one-size-fits-all approach to reform and we believe limited-scale testing of these important innovations will allow successful transitions to Alternative Payment Models.

In closing, I want to underscore what my chair has said. We are seeing excitement and innovation and enthusiasm from the field. We see clinicians who are ready to lead the transformation in care and payment, and we think this is an incredibly important opportunity to support the move to alternative-based payment models for a high-value health system. Thank you.

[The joint prepared statement of Dr. Bailet and Ms. Mitchell follows:]

Statement of

Jeffrey Bailet, MD

Chair - Physician-Focused Payment Technical Advisory Committee

And

Elizabeth Mitchell

Vice Chair – Physician-Focused Payment Technical Advisory Committee

**on
Medicare Access and CHIP Reauthorization Act of 2015: Examining Physician Efforts to
Prepare for Medicare Payment Reforms
before the
Subcommittee on Health
of the
Committee on Energy and Commerce of the U.S. House of Representatives
November 8, 2017**

Chairman Burgess, Ranking Member Green and distinguished members of the Energy and Commerce Subcommittee on Health, thank you for the opportunity to testify on behalf of the Chair and Vice Chair of the Physician Focused Payment Technical Advisory Committee (PTAC). We are Jeffrey Bailet, Executive Vice President of Health Care Quality and Affordability at Blue Shield of California (BSC), the third largest nonprofit health plan in California, insuring 4.1 million members and Elizabeth Mitchell, CEO of the Network for Regional Health Improvement (NRHI), a national network of multi-stakeholder Regional Health Improvement Collaboratives with over 30 members across the US. As an Otolaryngologist - Head & Neck surgeon and as a BSC Executive Vice President, I am responsible for leading all medically related activities for the health plan including quality, medical and network management, provider contracting and relations and our Accountable Care Organization (ACO) strategy. As the CEO of NRHI, I am responsible for leading our members and state-affiliated partners working at the state and regional level to transform care and payment toward the goals

of better health, better care and lower costs. Together we are privileged to provide leadership support to the PTAC, the committee established by Congress in the Medicare Access and Chip Reauthorization Act of 2015 (MACRA), to evaluate and recommend Physician Focused Payment Models (PFPs).

Thank you for extending this opportunity for us to speak on the important topic of Medicare payment reform and the PTAC's role supporting physicians and clinicians as they transition away from fee-for-service to value-based care delivery. We appreciate the opportunity to speak to this noteworthy policy achievement and we are pleased to be leaders in the transition toward a value-based Medicare payment system as Chair and Vice Chair of PTAC. The PTAC was created by Congress in MACRA as an advisory committee appointed by the Comptroller General to consider physicians' and other clinical stakeholders' proposals for new payment models that foster high quality, high value health care. After thorough evaluation with extensive public input, the PTAC will then advise the Secretary of Health and Human Services (HHS) regarding what payment models we believe are likely to meet HHS' goals of better health and smarter spending.

Even before the inception of MACRA, considerable agreement existed that the current fee-for-service model based on paying for the volume and intensity of services is unsustainable and needs to change to a model that is value-based, patient-centered and accountable. Given the demographic realities related to the aging of the baby boomers accelerating their need for healthcare services and the history of healthcare cost escalations in excess of inflation, the urgency for change from all stakeholders has grown. At the same time, we need to transform the

care delivery system and change the trajectory of spending in a way that maintains the vibrancy of the institutions and professionals that have dedicated their lives to preserving health and caring for the sick, injured and dying in the US.

Healthcare quality and affordability are of critical importance to families, communities and public and private payers. MACRA and alternative payment models (APMs) have the potential to address the fundamental drivers of cost and quality and ensure that we have a high value health system, the backbone of which is providers who want to change care delivery and give better care to patients. As the largest purchaser of healthcare in the world, Medicare has considerable influence on payment and can drive innovation by providers. Through the development of APMs, Medicare is driving market change and the PTAC plays an essential role in accelerating model development.

Since PTAC was chartered on January 11, 2016, PTAC leadership, in collaboration with the entirety of the committee, have worked tirelessly to establish PTAC as a credible, trusted, transparent body that supports and enables leaders from the field to bring innovative proposals to expand the Medicare payment model portfolio. PTAC members are a diverse, highly talented group that have deep expertise in clinical care, and technical expertise in the areas of measurement, payment and care delivery reform. As designed by Congress, the committee includes a balance of physicians and non-physicians. Members are committed to the effort as demonstrated by the countless hours of volunteered time devoted to evaluating models and serving on the Committee. PTAC members partner with the dedicated and highly skilled Assistant Secretary for Planning and Evaluation (ASPE) staff to ensure the PTAC remains responsive and evaluations are complete, clearly written, evaluated expeditiously, accurately

reflect the points of view expressed during deliberations, and communications to stakeholders, submitters and the Secretary are transmitted in a timely way. We have sought to establish high integrity relationships with the clinical and broader stakeholder communities and critically evaluate proposed models, often engaging in extensive dialogue with proposers to better understand the clinical and financial nuances of their proposals. As part of our evaluation process we elicit input from independent clinical experts and invite clinical stakeholders from across the country to provide comments, questions or concerns prior to and during public meetings when models are evaluated. We are committed to transparency and relentlessly ensure potential conflicts of interest and/or questions of partiality are disclosed and addressed when evaluating proposals to avoid limiting the effectiveness of our recommendations. Furthermore, PTAC is keenly interested in all types of models including those emanating from single specialty, primary care, community based groups, small and rural practices, sophisticated health systems or multispecialty group practices, and unconventional care delivery models such as Hospital at Home. We welcome and invite ideas from all stakeholders to best reflect input from leaders in the field seeking to transform care on behalf of patients.

PTAC's disciplined and collaborative efforts have garnered tremendous interest and creativity from stakeholders who believe in the Committee's value. This is exemplified by the Committee receiving 33 letters of intent and 20 full proposals spanning many specialties, payment types and practice sizes since starting to accept submissions on December 1 of 2016. Submitter types include specialty medical associations, health systems and academic medical centers, individual or small physician groups, larger groups of greater than 100 physicians, and Health Care Innovation Awards (HICA) awardees. Emanating from all areas of the country, models reflect nineteen different specialties and three payment model types: bundled payment, care

management, and capitation. Since release of the final rule by the Secretary one year ago, PTAC has held 9 days of public meetings, deliberated on 6 proposals, voted on 5 with submitted reports to the Secretary and has 14 proposals under active review. This level of interest and activity reflects a readiness and demand for change from leaders across the physician community and beyond, including a willingness to participate in alternative payment models and to accept some form of risk, either two-sided risk for total cost of care, variants of capitation, and risk for achieving quality outcomes. The Committee's thorough and deliberative processes reflect the commitment of committee members to honor the leadership and innovation from the field to make care better for all Medicare beneficiaries. It is our belief that the interest in and work of PTAC affirms Congress' direction and intent for MACRA to transition US healthcare to a high-value system delivering better care at lower cost.

However, providers who are ready and willing to lead change continue to face obstacles to transforming care and payment and need additional support. In our first year of evaluating proposals, three common barriers have been identified repeatedly and warrant further consideration by Congress to fully achieve the potential of MACRA and alternative payment models. The committee has prioritized three high impact changes that would accelerate progress and enable providers to improve care and value. These include the need for:

- technical assistance;
- greater access to shared data; and
- limited scale testing of innovative models.

Technical Assistance: PTAC believes there is a material need for technical assistance for providers to develop and implement physician focused payment models (PFPMs) and APMs.

Most physicians have experience changing care delivery but have not been trained in the development of incentives, payment models or risk management. Recent surveys of high performing health systems and medical groups demonstrate growing support to assume risk, and these organizations have made considerable infrastructure and human capital investments to successfully participate in APMs.

While large health systems may have the resources and expertise to develop and implement these models that address both the clinical and payment elements—such as determination of payment amounts, risk sharing and risk adjustment—small and rural practices are at greatest risk of not being able to afford the technical support to redesign care and payment or the infrastructure and human capital investments needed to successfully assume risk and participate in alternative payment models. This threatens to leave these small and rural practices out of the transition to value-based care. Many of these smaller, potentially less sophisticated practices need to participate in APMs if we are going to successfully transform care delivery by enhancing quality and lowering costs. The PTAC plays an important role in working with these clinical stakeholders as we evaluate models that these practices could participate in. Congress should identify ways to enable the provision of technical assistance to providers seeking to develop and implement APMs in a way that does not exacerbate resource differentials among providers and that move all providers towards value based care.

Although MACRA does not authorize PTAC to provide such technical assistance, many members of the Committee believe PTAC should be able to do so. At a minimum PTAC can provide valuable insights related to what types of technical assistance would be helpful to sharpen models and make them more likely to be recommended—and later implemented—based on the trends and learnings garnered through evaluations of proposals. The PTAC supports

deployment of HHS resources to provide access to analytic, technical, and quality improvement support and believes that this assistance would promote a more diverse and stronger pool of submitted PFPs, and greater success implementing PFPs, benefitting HHS and those it serves.

Greater Access to Shared Data: PTAC submitters have consistently identified data access as another major barrier to developing and implementing PFPs and APMs. PTAC too has observed common weaknesses across submitted proposals. These include inadequacies in the data presented in submitted models, inadequate measurement, and limited strategies for sharing data and information across sites to better manage care. Submitters need better and more timely access to clinical and claims data to identify areas of improvement, design and implement innovative models, and then track quality and resource use to ensure that care innovation is occurring.

Specifically, applicants need community wide all-payer claims and clinical data sharing across communities to successfully implement models. Providers cannot manage risk, care, or cost without timely, comprehensive data. Most of the proposals PTAC has received require coordination of care across practices, providers, and across communities, but if data is not shared effectively, participants cannot coordinate patient care across episodes or populations. Data blocking, lack of interoperability, and other limits on data access continue to be a major barrier to care improvement on behalf of patients. The move to APMs as required by MACRA has made this an urgent issue. We ultimately must address barriers to community wide data access in order to enable the transition to APMs and enable success under MACRA.

Limited Scale Testing of Innovative Models: Our third priority change is the need for small scale testing. Like any innovation, promising PFPs are likely to require testing in the field to fully understand implementation barriers and unintended consequences before being nationally scaled. PTAC has identified limited testing of models as an important phase of development and implementation as it is unknown how key elements of the model will clinically and financially perform until the model functions in a testing environment. Given the diversity of markets across the US, regional testing will also identify aspects of the models that may require flexibility in implementation or specific attributes that are responsive to local needs instead of a ‘one size fits all’ approach. Enabling small scale testing of promising models will enable identification and understanding of necessary changes to the model before widespread adoption. PTAC created the recommendation category of “recommended for limited-scale testing” in support of implementation on a limited scale to generate clarifying data and information.

Lastly, submitters and other clinical stakeholders have shared their need for greater clarity as to what happens after PTAC has made its recommendations to the Secretary. While we understand the review process is new, the sooner submitters and our Committee gain greater insights into the post PTAC portion of the review process and how PTAC recommendations are considered, the higher likelihood of maintaining engagement and an excited willingness to move forward. PTAC works collaboratively with CMS & CMMI to garner input about specific proposals, especially if they have been previously evaluated in any capacity by CMS or CMMI, if similar models exist that have previously been considered, or obvious challenges CMS or CMMI identifies that may limit the ability for a specific model to be successfully tested or implemented. In the spirit of collaboration and transparency, detailed strengths and weaknesses within proposals are incorporated within the reports to the Secretary allowing for their continued

downstream evaluation by CMMI and CMS. Also, included in model evaluations are areas where unintended incentives exist for providing unnecessary or inappropriate care. These potential shortfalls are discussed with submitters for clarification and persistent concerns are included in the written recommendation to the Secretary. To date, the models PTAC have sent to the Secretary for potential limited scale testing have not been approved. In addition, we are unclear whether, because of the extensive review process already provided by the PTAC, submitters can undergo a more expedited review and evaluation process. Our concern is that if we are not able to support our recommendations or work to fix any shortfalls in our analysis the value of the PTAC process will not be realized. We believe that closer coordination between PTAC and CMS and CMMI will enable greater efficiency, greater capacity to implement more innovative models, and greater clarity for applicants seeking to understand the process of submission and approval and look forward to continued partnership with CMS and CMMI.

In closing, PTAC is an increasingly important forum to identify innovative models from the field to expand Medicare's payment model portfolio and increase opportunities for physicians to transform care and payment. PTAC is receiving innovative proposals from providers about ways to make care better, reflecting leadership and readiness for change. Medicare is leading payment reform and can catalyze private sector participation in multi-payer models to accelerate this transformation. Payment change can reduce burden on physicians and clinicians enabling them to provide optimal care by removing barriers. The good news is that changes have already been made and are showing signs of success – both in terms of cost savings and quality improvement. Some complain that the changes are not big enough or fast enough, but this critique should be viewed through the lens that shifting our payment system from fee-for-service to one based on value must be done right if it is to be sustainable. Transforming care delivery,

including implementing innovative payment policy, is complicated. Therefore, an open public process that includes all stakeholders and simultaneously works to achieve consensus whenever possible, and which also educates stakeholders and the public in the process, is likely the best way forward even if deliberative. We believe the PTAC is well suited for this purpose, we commend Congress for its vision, and we thank you for the opportunity to be part of such important work.

Mr. BURGESS. The Chair thanks both of our witnesses for their testimony this morning. We will move to the question portion of the hearing and I am going to recognize myself for 5 minutes for the first round of questions.

And Dr. Bailet, it is my understanding that during the summer you communicated with the Department of Health and Human Services identifying a number of opportunities where your group can provide or improve payment model development and I think I heard in Ms. Mitchell's testimony the answer to this question, but I am going to ask you.

Does PTAC need authority to specifically authorize its ability to provide technical assistance through the APM development process?

Dr. BAILET. Under the statute, MACRA remains silent on whether it gave the PTAC the authorization to provide technical assistance. As we said in our testimony, there are significant interests by PTAC members to provide technical assistance. As I said earlier, there is some very skilled, highly talented folks who really understand how to build these models both clinically and also on the financial business side and the measurement side to make them successful.

We also understand that the PTAC has a role to play relative to evaluating models and providing technical assistance does cause potential conflicts. If you think downstream, supporting particular stakeholders and we then at the same time evaluate their models, depending on how that turns out you can see that there could be some downstream complications. Despite those challenges, we still believe at a minimum that we should because of our exposure and the insights that we gain from working with clinical stakeholders, we think we can be at a minimum a beacon to cast the light on particular areas that submitters are struggling with or are challenged that the global stakeholder community can learn from. And I think that is at a minimum a role the PTAC should play.

I do think to answer your question directly that this question of can the PTAC provide technical assistance that needs to be answered definitively and so we would look to you for clarity on that.

Mr. BURGESS. And are you free to disclose your communications with the Department of Health and Human Services this summer? Were they positive in their comments toward you or—

Dr. BAILET. Yes. Yes. We sent Secretary Price a letter. We have had private conversations with him as well. Very supportive, understands the importance of technical assistance. Again we have spent a year before we accepted our first proposal standing up the committee, building in a process. We want these models to be successful, but stakeholders, depending on their level of sophistication and experience and the infrastructure investments, they come at it from different places. This is new and we are all learning.

So I think it is absolutely paramount that technical assistance be delivered. I believe the word we got back—and I will let my colleague speak as well that the receptivity for technical assistance exists. I think the mechanics of how it would be distributed, how it would be identified, and how it would go out to the stakeholders that remains an open question.

Mr. BURGESS. Very well.

Ms. Mitchell, did you have something to add to that?

Ms. MITCHELL. I would only underscore the demand we are hearing from across the country. Again physicians understand clinical care delivery, but a lot of this work in incentive design risk management is new. PTAC has recognized the urgency of this. We do not have clear authority to address it. We think that somewhere HHS needs to find a way to meet the needs of providers so that they will be successful.

Mr. BURGESS. OK, thank you. Thank you for that observation and the acknowledgment that it may require legislative activity not just administrative activity.

So I am going to ask you a question. I mean it comes up all the time, the hiring freeze that the administration has imposed across all levels of the Federal Government. Is your PTAC, is it currently subject to a hiring freeze?

Ms. MITCHELL. It is our understanding that they are subject to a hiring freeze. I think it is also important to note the volume of activity which I think is an indicator of success of PTAC, but it has also been more than we have anticipated in terms of time demands. This is again also highly technical, complex work, and I think having the right staff is critical. We have had excellent staff support. We just think that given the demand there is need for additional support.

Mr. BURGESS. Very well. We previously asked the administration to evaluate an exemption for PTAC and we will continue to communicate with them.

Just to my last few seconds, I just want to make the observation. I downloaded the application form and, man, it is lengthy. I was actually going to provide a little technical advice that there ought to be a worksheet or a checklist. Actually there is one, but it is way, way deep in the weeds here. Maybe that ought to be advanced to right after the table of contents.

Ms. MITCHELL. Well, we appreciate the concern and we recognize that it is lengthy. However, the committee really felt that it was our job to make the instructions as clear as possible and as complete as possible, so we are hopeful that this is actually a helpful document. You will note that there is even visuals in there to explain the process.

Mr. BURGESS. Right.

Ms. MITCHELL. Again this is meant as a tool for assistance to submitters. Dr. Bailet?

Dr. BAILET. I think the only other comment is as we design this we really put ourselves in the eyes of the stakeholders.

Mr. BURGESS. Sure.

Dr. BAILET. And we were thinking this is new, our process is new. We wanted to be entirely transparent. And if you look at the document, it is constructed—there is a lot of definitions. Every 10, all 10 of the criteria are spelled out through the lens of the committee what is it that the criteria is trying to accomplish, what is the committee looking for to see in these proposals, because again I will go back to my earlier comment. We want these proposals to be successful.

We also are taking feedback from the clinical stakeholders about our process. They have provided input and we have revised our

process based on that input and we will continue to do so and we will take this comment under advisement as well.

Mr. BURGESS. I am sure we will have continued conversations. My time has long since expired. I will recognize Mr. Green 5 minutes for questions, please.

Mr. GREEN. Thank you, Mr. Chairman. I think we would be happy to work with you to see what we can do. We don't want to have this process fail because we don't have staff or quality staff or that you can't provide assistance. That just seems silly. But we will be glad to work with you on that to see how we can do.

Dr. Bailet and Ms. Mitchell, thank you for being here today and your insights. I would like to ask about PTAC's mission and what you have set out to accomplish. From my perspective, PTAC and the PTAC process, evaluating Physician-Focused Payment Models is uniquely in the delivery system reform context because it is driven primarily from the ground up by providers. Now does PTAC fit within the broader delivery system reform efforts?

Ms. MITCHELL. Thank you. I think what one of the consistent themes that we hear from submitters, and we have experienced in our day jobs, is that there are many clinical improvements that providers know could be made that would make care better for patients, and the current payment system is actually a barrier to making those changes. Many physicians will tell you they will lose money trying to do the right thing in many cases. The pay-for-service system often incents duplication, redundancy, overuse.

So this is actually a forum, in my view, where clinicians can bring models for better care and hopefully have a payment system that supports those changes.

Mr. GREEN. Well, and that's what I hear from my physicians that they are concerned about the end result so they want to have the input. And the unique benefits and challenges does have a model or, you know, challenge.

But from my understanding PTAC is comprised of 11 members appointed by the Comptroller General. Each of these members are nationally recognized for their expertise in payment and reform and Alternative Payment Models. PTAC's members include both physicians and non-physicians.

I know it has been official for having both physicians and non-physicians there because they can get the process moving, how does your review process engage stakeholders and the public along each step of the way?

Dr. BAILET. So we have a multistep process and if you will indulge me I will walk the committee through it as quickly and efficiently as possible.

So working with the ASPI staff using our primer on how to submit a model, the model is submitted to the committee formally after a letter of intent is sent 30 days in advance. And the only reason the letter of intent, it is non-binding, but it just helps us staff appropriately. We need to know how many models are out there and potentially coming in and that was the purpose of that letter of intent.

When the proposal is submitted, the ASPI staff check it for completeness to make sure that all of the appendices and the references in the document is complete. At that point the model is

transitioned to a review committee which is comprised of at least one physician and two other members of the committee to review the contents of the proposal and then they go about working with the stakeholders, the submitters directly. There is a question and answer. Typically it is at least one pass, if not two or more, in writing, an exchange for clarity on particular points in the model and then we have, we host a call with the submitters for additional clarity.

During this entire process the proposal is published for the entire stakeholder community nationally to see. We get comments from the stakeholder community globally either in writing, we also have them come to our deliberative meetings in public and make public statements about their concerns, questions, or support for the models.

Following the exchange between the stakeholder submitter and the PTAC review team, we then go to the national expert clinician. We have, if it is on renal disease we will speak with a qualified renal nephrologist to get their perspective on the elements of the model and it helps sharpen our focus and answer our questions that we still may have about the model and the proposal and how does it work in the real clinical environment, if you will.

All of this time, the full committee does not deliberate. As a FACA committee all of our deliberations have to be done in public. So the proposal review team creates a document after all of their work on their recommendation based against the criteria of the secretary. It is non-binding, but it is directionally helpful for the full committee when we sit down for the first time in our public session to then deliberate and review.

And if I could, that particular session how it starts is the review team reviews the model for the committee, we then invite the stakeholders up to the table. They either, so far they have been all coming in public. They have been coming to the public meeting. They then have an exchange. That typically can go on for an hour where we talk with them about questions that we have or sharpen our focus on the model before we deliberate because we want to make sure we understand the nuances of these models.

We also have public comments come before we start to deliberate, so then the public comes up, they provide their input, and at that time the committee goes into the deliberative mode. We discuss the model amongst ourselves and then we vote against the 10 criteria on an individual basis. So it is, we support it—well, we don't support it, it doesn't meet the criteria, it meets the criteria, or it meets the criteria with priority. We do that through all of the criteria and then we vote on the model in general at making the recommendation to the Secretary to support, to support with high priority, or to support it with limited testing.

That is the process, and it is exhaustive. And we are really happy to be part of it, but it takes a lot of energy to get it done.

Mr. GREEN. Thank you, Mr. Chairman. I know I ran over, but these are issues that again we don't want to come here 5 years from now and have to see what we didn't do now.

Dr. BAILET. Right, thank you.

Mr. GREEN. So I appreciate your explaining the process.

Mr. BURGESS. The Chair thanks the gentleman. The gentleman yields back. The Chair now recognizes the gentlelady from Tennessee, 5 minutes for questions, please.

Mrs. BLACKBURN. Thank you, Mr. Chairman. And I want to stay kind of in that same vein where Mr. Green is, because one of the things I think many times we will do is something gets passed, it gets on the books, it takes forever to get it straightened out. And when we are looking at the APMs and the utilization of technology in this process, it changes so quickly that there has to be a nimbleness that we have not seen before. And I assume that each of you agree with that because you are shaking your heads in the affirmative.

But let's stay right with you, Dr. Bailet, and let me have you talk a little bit more about timeline, a little bit more about process. And Ms. Mitchell, I want you to weigh in on how we are, when you have this integration, if you will, the physician, which is an incredibly important component of this, and the other two stakeholders that are involved in this process, talk to me about how that relates to our rural and underserved areas.

Dr. BAILET. So I will start with the timeline and the process. We are very sensitive and acutely aware of the need to get these models in the field. Physicians are being measured as we speak today for payment that will impact them a year and a half, 2 years downstream, so we did not want to be a rate-limiting step as these models came forward. We measure our, as we move through that process that I described those measurements are done in weeks. It typically takes about 2 weeks for us to get back to the stakeholders with a series of questions.

Mrs. BLACKBURN. So basically you are doing an expedited process in approving as you go?

Dr. BAILET. Yes. We don't—well, because of our public schedule because we can't deliberate in private—

Mrs. BLACKBURN. OK.

Dr. BAILET [continuing]. The deliberation, we batch them. So we have a meeting next month. We have seven proposals. We are going to go through 3 days of public meetings.

Mrs. BLACKBURN. All right. And then let me stop you right there.

Ms. Mitchell, talk about this as it relates to the rural and underserved areas and how you are feeding in that data, because data is essential to this.

Ms. MITCHELL. Certainly I will try. I think it has been very important that there is a balance on the committee of physicians and non-physicians and I am one of the non-physicians. My background is actually working with multi-stakeholder groups at the community level for transforming care and payment.

I am from Maine. I am highly sensitive to the small and rural issues. I think what we are—because we are receiving proposals from the field, we are receiving proposals from small practices. I believe you will hear that on the next panel. We are, I think, as a group we are a diverse group. We are committed to ensuring that everyone can succeed under this model and that is actually one of the reasons that we are particularly urging technical assistance so that it isn't just the well-resourced health systems that can afford these changes.

Mrs. BLACKBURN. So you are deliberate and intentional in having individuals from these rural and underserved areas?

Ms. MITCHELL. We don't actually control who comes to the committee, we respond to the proposals that we receive. However, we are certainly trying to promote the opportunity and we certainly welcome and weigh the issues of small and rural practices to the extent possible.

Mrs. BLACKBURN. OK. And let's look at the high-performing hospital or health systems and medical groups and just a couple of comments quickly—I have a minute left—on how you characterize those groups' interest in risk assumption.

Dr. BAILET. The larger, more sophisticated integrated systems they have already made the infrastructure investments whether it is electronic health record, they have the modeling, they have the data analytics, the population health tools that really help them be successful in an Alternative Payment Model environment.

And so they are very much, they are ready and willing, and some of them, many of them across the country, are already in alternative or Advanced Alternative Payment Models, so they are sort of leading the way, if you will. That said, I would be remiss if I didn't mention that the smaller practices have a high degree of nimbleness that the larger practices don't necessarily have, and can move very quickly, but they also need help with the infrastructure.

Ms. MITCHELL. And if I might just add to that, the small and rural practices may be providing exceptional care. We think that this might provide greater flexibility to them so that it isn't again the one-size-fits-all approach because we recognize that care will be delivered differently in different communities and in different sized practices.

Mrs. BLACKBURN. Right. And that is the nimbleness that I think we are wanting to see and the flexibility that we want to see on this. And we are not going to be hesitant to continue to do oversight and to pull it back if we think it needs adjustment.

I yield back, Mr. Chairman. Thank you.

Mr. BURGESS. The Chair thanks the gentlelady. The gentlelady yields back. The Chair will make the observation that is the third time the word "nimble" has been used. I don't recall that ever happening in a committee hearing before.

Mr. GREEN. It is tough for Members of Congress to be nimble.

Mr. BURGESS. The Chair recognizes the gentlelady from California, Ms. Matsui, for 5 minutes, please.

Ms. MATSUI. Thank you, Mr. Chairman, and I will try to be nimble. So thank you very much for holding this hearing and thank the witnesses for being here today. You know, as you know we came together in a bipartisan way on this committee to fix the broken SGR and replace it with a MACRA, and I am pleased that you are making progress with the goals set forth by MACRA to truly transition our Medicare payment system from value to volume.

As you state in your testimony, Medicare has considerable influence on payment and that can drive innovation. That is what I would like to focus on today. Every witness here is testifying to the hard work providers are putting in to update their systems of care and develop payment models that adequately reflect that. We are

hearing about care coordination, patient-centered care, and better management of chronic diseases.

I believe that technology whether in the form of data systems, measuring quality, interoperable electronic health records, care delivered remotely, or conditions monitored remotely will be integral to our success in achieving our goals of higher quality and reduced costs. Thank you, Dr. Bailet and Ms. Mitchell, for your leadership on PTAC and I appreciate the dedication you bring to your work.

I would like to focus on this issue of telehealth and health IT. The 10th criterion for judging APMs is to encourage a use of health information technology. Either one of you or both of you, can you expand upon that? How does the PTAC ensure that models are encouraging the use of health IT?

Dr. BAILET. I will start. It absolutely is essential, especially when you realize the diversity of the care that is delivered across the country and the shortages in particular areas where certain specialty services, for example, are not available. So leveraging technology is absolutely essential.

You mentioned telehealth, making sure that patients, members have access to high-quality specialists through telehealth. There is a lot now with technology with your smart phone and a lot of diagnoses can be made using your smart phone, for example. So we need to leverage that technology and we embrace the submitters who put technology in front, embed that in the model.

There are some challenges with that and the Secretary has commented about proprietary technology, because that obviously limits the deployment and the implementation of these models, but the notion of leveraging technology to drive care into the communities is absolutely essential.

Ms. MATSUI. OK.

Dr. BAILET. Getting everyone on a health information platform and, as you know, being from California, my organization with also Blue Cross—

Ms. MATSUI. Sure.

Dr. BAILET [continuing]. We have built an HIT platform with over 25 million records. So we—

Ms. MATSUI. Can I ask you this, then? So I assume health IT, electronic health records, devices that remotely monitor, clinical decision support software, software that helps clinicians on a team communicate securely and to allow providers to deliver care remotely, it includes all of this. So are there experts on the PTAC that specialize in health IT or have extensive experience with it? Does PTAC consult with such experts? Because I know you have a balance of people on there, physicians and non-physicians.

Ms. MITCHELL. I think to your point, there is a range of expertise, users of EHRs and other health IT and some of us who have been working around data sharing. I would like to emphasize our deliberations on this criteria. Technology is important but it is also insufficient. This is really about sharing the data freely and effectively across sites and many of the barriers to doing that are not technology barriers, they are business or otherwise.

So I think it will be very important particularly as we move to measures of population health and also to reduce the burden on

providers that this data be shared effectively regardless of the technology.

Ms. MATSUI. So you have, of the 20 or so models you have under review can you provide some examples of those that are leveraging technologies, and have the providers come up with creative solutions?

Dr. BAILET. So there are several that have been highlighted that we have reviewed already. There is one specifically around looking at five different cancers and accuracy of diagnoses—lung, colorectal, breast. It is a bundled payment model. It comes from the Hackensack Meridian Health. They have a special technology that looks at the biopsies themselves and is able to do genetic analyses and helps tailor the treatments to the specific characteristics of that particular tumor type. We talked about the proprietary nature of that technology and they have assured us that other systems can adopt either that technology or a sister technology like that. But that is just one example.

Ms. MATSUI. Sure.

Dr. BAILET. There are several others.

Ms. MATSUI. No.

Mr. BURGESS. The gentlelady's time has expired.

Ms. MATSUI. Thank you. I yield back.

Mr. BARTON [presiding]. The gentlelady yields back. The Chair recognizes himself for 5 minutes. I want to say at the beginning of my question period that I am not an expert on this, and I didn't hear the opening statements, so if this were an energy hearing I would be in good shape. But talking about MACRAS is, as I told Gene Green, a little out of my depth.

My first question is just a basic question. We wanted to change the payment system because the old one was so complicated. Are any of these new systems actually being used right now, or are you just thinking about it? Either one of you.

Ms. MITCHELL. The models that we have received, several of them we have recommended for further testing, but then it is up to CMS and the Secretary when and if to implement those. So—

Mr. BARTON. As we speak, all the payments are still being made under the old system; is that correct?

Ms. MITCHELL. Well, there are demonstration projects that CMS has implemented over the last several years that do change payment, but the Physician-Focused Payment Models that we have evaluated have not yet been implemented at least through CMS.

Mr. BARTON. All right. And Dr. Burgess told me that you have actually voted on five alternative systems; is that correct?

Dr. BAILET. Yes, five. We have deliberated on six, voted on five, with recommendations to the Secretary.

Mr. BARTON. OK. Now these five all passed, so to speak, so they have been forwarded to the Secretary, or did you vote down any of them?

Dr. BAILET. We voted two down. And then the reason we deliberated on six, the sixth submitter retracted their proposal after hearing the point of view of the committee. They are—resubmitted it for after they have modified it, but the others were either recommended for small-scale limited testing or implementation.

Mr. BARTON. So you forwarded five to the Secretary—

Dr. BAILET. Yes.

Mr. BARTON [continuing]. Which we don't have right now.

Dr. BAILET. That is correct.

Mr. BARTON. But there is somebody active, I guess. The Secretary or his or her designee decides if these systems that you voted on are acceptable for the marketplace; is that correct? And then if he passes it then it comes back and doctors pick which one they want to use. Is that how it works?

Dr. BAILET. Well, that is part of our challenge is we see this, we want to be a value-add to the system. We are upstream of CMS and CMMI. We want to make sure that the process and evaluation and the analysis that we are providing sharpens these models so that when they get downstream to CMS and CMMI it helps them do the work they need to do relative to analysis and figuring out how to actually stand up these models within the current Medicare system.

Mr. BARTON. Well, to me that seems overly complicated. Now it may not be, but I want to try again. Somebody is going to—your doctor groups have voted on systems that they want to use, right?

Dr. BAILET. Right.

Mr. BARTON. You have forwarded those to the Secretary of Health and Human Services. The Secretary of Health and Human Services and the bureaucracy decides which of those are acceptable; isn't that right?

Dr. BAILET. That is right.

Mr. BARTON. If they say, "We have the HHS stamp of approval," it comes back, and who decides which of those to use once they are approved?

Ms. MITCHELL. The only requirement is that the Secretary post a public response to our recommendations. It is then up to the Secretary and CMS if and when to implement.

Dr. BAILET. Our charge is to advise the Secretary, work with the stakeholders, make a recommendation, provide that advice.

Mr. BARTON. I got that and you have done it.

Dr. BAILET. Yes, sir.

Mr. BARTON. You are waiting on the Mt. Olympus approval, right? Sooner or later some of these are going to be approved. My question is once they are approved—I guess I will rephrase it. How are they implemented once approved?

Dr. BAILET. And again, that is, we need more clarity on how that is going to happen. That is not under our purview. We are ready, willing, and able to partner with CMS and CMMI.

Mr. BARTON. Well, who is the decision maker?

Dr. BAILET. The Secretary and HHS.

Mr. BARTON. OK, I am saying they have approved it. I mean at some point in time somebody in the system, a doctor who is seeing patients—

Dr. BAILET. I get it. OK.

Mr. BARTON [continuing]. Says OK, we are going to switch from this old system to this new system A.

Dr. BAILET. Right.

Mr. BARTON. And I am assuming since we are trying to be inclusive that is a hospital, a region, a State, somebody says yes, we are going to use alternative system A.

Dr. BAILET. Right. So that is where just like in CPC+ or some of the other models, the Alternative Payment Models that have already been deployed, the Oncology Care Model, for example, that is what CMS will do. They will take our recommendations. They will look at these proposals. They will refine the model and figure out how do we build this model with these concepts and be able to implement it within the Medicare payment system. They will put it out there, I believe.

I don't want to speak for them, but my guess would be that they will take these models, put them out there for the physician——

Mr. BARTON. They. They being——

Dr. BAILET. CMS and Medicare, put in Alternative Payment Models saying——

Mr. BARTON. So CMS is the one who chooses which model to use?

Ms. MITCHELL. We don't have the authority to direct CMS to do that. We can make recommendations.

Mr. BARTON. So they are going to tell you which model to use.

Dr. BAILET. Or not.

Mr. BARTON. See, I had it all wrong. I assumed the doctor groups, the providers would choose which one they want, but you are saying CMS is going to say, "We like this one."

Dr. BAILET. Well, CMS will make the models available for the stakeholders to then sign up to deploy. So they will, just like the Oncology Care Model, it is out there and practices will sign up to participate.

Mr. BARTON. And they can make more than one model available?

Ms. MITCHELL. Yes.

Dr. BAILET. Yes.

Mr. BARTON. OK, because I thought the whole point of this was to give doctors or—I keep saying doctors—to give providers——

Mr. BUCSHON. Will the gentleman yield?

Mr. BARTON. I would be happy to yield.

Mr. BUCSHON. I think what you are trying to get at, if you don't—if there is an Alternative Payment Model that has been approved and you don't participate in that, then you are in MIPS.

Dr. BAILET. Right.

Mr. BUCSHON. So you can at that point it seems to me you are not necessarily forced to accept the Alternative Payment Model, but if you don't you have to participate in MIPS. Is that——

Mr. BARTON. What is MIPS?

Mr. BUCSHON. That is the overall reporting system that assesses quality, value.

Mr. BARTON. The current system?

Mr. BUCSHON. Well, no. It was put in place under MACRA.

Mr. BARTON. So it is a new one too.

Mr. BUCSHON. It is a consolidation of three separate evaluation systems that were previous MACRA.

Mr. BARTON. I am glad I have clarified this situation.

Mr. BUCSHON. So the point is I think, Chairman, is that a physician if they don't participate in the Alternative Payment Model they will have to be in the MIPS. And you might comment on that. I yield back.

Mr. BARTON. This is the last because our time has expired. So answer Dr. Bucshon's question and then we will go to Ms. Castor.

Mr. GREEN. I just want to say, Mr. Chairman, you and I could talk energy all the time.

Mr. BARTON. Yes. Energy policy is simple compared to this.

Would you like to comment on—

Ms. MITCHELL. Yes. That is correct. PTAC is actually, I think our role is to expand the options for participation so that CMS has a broader portfolio that is representative of what physicians think would be better models. So we can recommend those for inclusion in the Medicare portfolio, but again it is not up to us who participates or if they are implemented.

Mr. BARTON. We thank and we yield to the gentlelady from Florida for 5 minutes.

Ms. CASTOR. Well, thank you. And I want to thank you, Mr. Chairman, for calling this much needed hearing. And thank Dr. Bailet and Ms. Mitchell for your work on the Physician-Focused Payment Model Technical Advisory panel and to all of the doctors and medical professionals that have also been engaged in this and taking this on.

I am very gratified to see the progress on transitioning to value rather than volume, at the same time while we improve patient care, allow doctors to practice medicine, and do everything we can to help lower the cost. I hear you talking about the difficulty now with submissions and approvals and you need answers from CMS and CMMI. Would you say that the progress has stalled on your work?

Dr. BAILET. I am not sure I would use the word stalled. I think we are new. We are new at the game. And then I don't mean game in a negative way, but I mean this is a new process. We have only sent two sort of series of recommendations to the Secretary and, as you know, we have an interim Secretary, so I think that people are finding their way.

We are in dialogue with CMS and CMMI. It is a constant, you know, it is a constant partnership. We are trying to work with them. They are providing insight—

Ms. CASTOR. So they, really, it would be helpful if the committee held a follow-on hearing with CMS and the folks that are working on this to get some of the answers that Mr. Barton asked and Mr. Green and others.

In order to most effectively review the proposals submitted to PTAC, MACRA required the Secretary to establish a set of Physician-Focused Payment Model criteria for evaluating the proposals. MACRA also required PTAC to then review proposals submitted based upon these criteria when making recommendations to the Secretary.

So there are 10 criteria, including the extent to which proposals provide value over volume, increase care coordination, improve quality, all factors that PTAC considers when evaluating a proposal. Ms. Mitchell, can you describe the 10 criteria established by the Secretary, particularly the criteria designated by PTAC as high-priority criteria?

Ms. MITCHELL. Certainly. And if I might just respond very briefly to your last question, I think it is very important. We are not seeing any sort of slowdown in number of submissions to the committee. In fact, it is the opposite. We have more proposals than we

even had anticipated. I think the question about what happens next is really the open one.

Ms. CASTOR. Thank you for clarifying that.

Ms. MITCHELL. Yes. And in terms of the high-priority criteria, we are evaluating each proposal against every criteria, but there were certain criteria that the committee thought carried, you know, particular weight. So as an example, scope is a high-priority criteria. We don't think that it is optimal to identify a model that only one or two or just a handful of practices can participate in, we are really looking for more transformative models. So scope, as an example, meant that we would have greater participation if it was a high-value payment model.

The high-priority criteria, quality and cost, obviously the point of payment reform is not to change payment, it is to get better care at lower cost. So how are we determining if these changes are actually giving better patient care at a more affordable rate? So that seemed extremely important in the entire undertaking.

And then, finally, payment methodology, if Dr. Berenson was here he would tell you we are not just looking for an addition of a new code. We are talking about meaningful changes in the methodology of payment, and that is what we are seeing. We have had some proposals that do not meet that criteria. They could be fixed differently, the barriers. We are really looking at models of payment that are currently not supported and require a new payment methodology.

Ms. CASTOR. So, Dr. Bailet, you talked about you have seen some innovative proposals. Give us some hope here. What is innovative that you have seen? What has been difficult? What has been a little less challenging?

Dr. BAILET. So there was a lot of energy in our last public meeting when we looked at hospital at home. So typically patients today show up in the emergency room, they need admission. They have criteria to meet admission. And this model has the sophistication for select patients to actually treat them as if they were hospitalized but to provide that care in the home. That is tremendously innovative. It is also allowing patients to—

Ms. CASTOR. Is that because the medical professionals go there? I mean—

Dr. BAILET. There is a team that is deployed, there is training. But the point is that hospitals are not places—you don't, you know, I am a surgeon and I would tell my patients you want to be in the hospital no more than 1 second longer than you need to be. Bad things happen to you in the hospital.

And so this allows patients with the patient and the family to make a decision to get that care, but get it at home, safely. We think that model shows tremendous promise. There is some economics obviously, but it also is very beneficial when you match it against the criteria. It helps the patients specifically and their family to be able to get that care at home. That is just one example of several of the models that we have looked at.

Ms. CASTOR. So out of these models what has been particularly difficult?

Dr. BAILET. Physicians and stakeholders are very, they are much clearer on the clinical side of the model. Where we are challenged

is on the payment side, getting the data to be able to model for the committee to say, “Here is what the data is showing us, here is where the dollars are, and here is how the model will impact the dollars.” That is an area of technical assistance that could help.

I think Elizabeth wanted to make a comment.

Ms. MITCHELL. I would just add, several of the models we have seen are communitywide. As an example, how do we bring in hospice care, transportation, other services that patients actually need? And there is a major barrier of sharing data and information effectively in a timely way.

So that—and a provider has said that that is their primary barrier to implementing the models that they are bringing—so that continues to be just a priority area that we have got to solve.

Ms. CASTOR. Great. Thank you again for your work.

Dr. BAILET. Thank you.

Mr. BURGESS [presiding]. The Chair thanks the gentlelady. The gentlelady yields back. The Chair recognizes the gentleman from Illinois, Mr. Shimkus, 5 minutes for questions, please.

Mr. SHIMKUS. Thank you, Mr. Chairman. And I appreciate my colleague from Florida, because that was one of the questions I was going to ask and she picked it up, was highlighting a specific example. And I think you outlined a pretty good example of where you can be helpful. I am interested in this is because, you know, I was here in '97 when we passed the SGR to spend my career postponing it to the point where then we got to MACRA and MIPS and all this other position where we are today.

Being a competitive market Republican and understanding competition and how that improves, you always get a little—I am concerned. The Government is such a big payer in the healthcare arena, whether it is Medicare or Medicaid, that we really do drive that reimbursement. And we drive the reimbursement because I mean, actuarially, those two are mandatory spending programs that are actuarially challenged.

So then we, how do we look at trying to save the money, but we know docs want to get paid, right? We know docs want to get paid well if they can, so I think this is an interesting debate because doctors still want to be compensated for their training, their loans, and the like while we are trying to drive efficiency and lower costs.

And that is your challenge that and you are an advisory committee or commission and you are advising the Federal Government on how we might be able to do that. And you gave us an example of one just in the last testimony, but I am concerned about the—you talk about telemedicine, sharing data, part of that is proprietary information. Part of it is going to be patient records. Part of it is going to be specific care models that practitioners may want to say, “This is how I can financially do it. This will drive patients to me, but it gives me a competitive advantage,” right?

So how are you doing this? I mean how are you, or just let's do it in a big data framework, big data, and thank you for helping me remember the word, an algorithm. I mean how do—and we are going to have these big discussions on the algorithms and transparent, how do you do transparency on algorithms when someone feels that that is a proprietary nature that they have come up with?

So those are the questions that I am interested in hearing as you are trying to provide advice and counsel, because some of this stuff might require either proposals from HHS or maybe legislative changes. Can you guys—Ms. Mitchell, do you want to say anything based upon my little diatribe?

Ms. MITCHELL. I will try. We have actually had proposals that do include proprietary elements, and I think we have been clear with submitters that anything that is included in a proposal for Medicare they won't have proprietary elements that couldn't be shared more broadly. Again this is an entirely voluntary process. They could do this without Medicare as well. I think it would be helpful probably to ask the next panel about some of their experience with that.

And I think it is going to be a balance of interests. I think given the massive investment that we put into our healthcare system and the value for patients we are trying to achieve, I think there is just going to have to be a balance of obviously preserving the interests of all. I also think that there are success stories around the country—Oklahoma, Oregon, others—where there are sharing data across the community in a way that protects privacy. They are clearly effective stewards of that data. But it also allows physicians and others to have a full picture of population health and patient care and, frankly, it helps with patient safety. If a patient is admitted from one hospital to another and those records can be quickly transferred, that actually helps patient safety as well.

So there are ways that this is being done around the country now that could be emulated and scaled.

Mr. SHIMKUS. And I appreciate it. And I think also just in the—and I am going to close with this brief statement is I mean there is a national debate about how we pay for health care and will it be a one-payer system or will it be a competitive market model that helps bring clarity and efficiencies?

So good luck, I am not sure how it is all going to turn out. I yield back the balance of my time.

Mr. BURGESS. The Chair thanks the gentleman. The gentleman yields back. The Chair appreciates the gentleman's request for good luck. The Chair recognizes the gentlelady from California, Ms. Eshoo, 5 minutes for questions, please.

Ms. ESHOO. Thank you, Mr. Chairman.

Dr. Bailet, it is wonderful to see you. And thank you, Ms. Mitchell. I have really enjoyed the questions of Members and your responses because you keep deepening and broadening what you are doing.

Several of my questions have already been posed, but I want to pick up on what Congresswoman Castor said and recommend to the chairman that we have another hearing both with the stakeholders and with HHS, because I think it is important to bring that—to strengthen the linkage.

Since you are dependent upon what, I mean you are doing so much work and then it goes someplace else and it seems to me that there is a question mark around it. So I am not suggesting, I am not impugning the agency, it just seems to me that I don't have a sense of how welcoming they are, especially if the model that you

are recommending to them is going to cost more, because there is a constant push on the agencies not to spend as much.

So which takes me to a question. You know the area that I represent. It is known as the innovation capital of our country. Most people think of it as just in terms of technology, but we have many, many of biotechnology companies that are creating really innovative technologies. Stanford Medical Center, I think, is doing important and exciting work around telehealth and telemedicine for the treatment of other health conditions such as stroke.

Specifically, how are new and innovative technologies being integrated into the APMs?

Dr. BAILET. We have had several proposals that have proprietary technology that are embedded, and I gave one example relative to the genetic ability to screen the tumor types for personalized medicine, and I believe Stanford is trying to do that work as well. There are other information systems, population health systems, that are able to look at the entire cohort. If you are in, for example, renal disease, look at your patient population and find elements to help sharpen the care and offer patients treatments before they start dialysis to improve the outcomes and decrease the chances for complications.

I am trying to remember, I have all of the 20 in front of me.

Ms. ESHOO. Well, no. That gives me a flavor. Do you know what the cost of a particular application is after you have reviewed it?

Dr. BAILET. No, we don't. And that—no, we don't.

Ms. ESHOO. So that is up to the agency to cost it out.

Dr. BAILET. Right, yes.

Ms. ESHOO. And are providers—I mean money drives everything in the world I am sorry to say, but it does. I don't know what the incentive on the part of physicians would be—well, maybe some that are highly idealistic, but people have to live, to move away from fee-for-service. I think doctors would say, and what do I get out of this? And I don't think that that is a selfish question.

So do you see in the models that have been submitted to your commission that—I don't know how to put it. Are they based, if you put your fingers on the scales is it with anticipation that there will be a better system with better money? Maybe that is the best way to put it.

Dr. BAILET. Physicians they want to do the right things for their patients. They want to get recognized appropriately for the work they are doing. There are certain limitations in the fee-for-service system that doesn't recognize those efforts, and despite those challenges physicians continue to do it anyways.

These models reframe the way care is delivered. It recognizes their efforts. It pays for nurse coordinators. It pays for home care. It pays for things that the traditional system doesn't recognize that are incredibly valuable to drive outcomes and lower cost. So that is why—that is certainly why I am energized to be in this work, and I think my colleagues on the committee would echo that, and you will hear that from the stakeholders who are behind me.

Physicians, again, and clinicians, they want to do the right thing for their patients. And yes, their economics have to work, but there also has to be, you have to do the right thing for your patients and

it can't be completely driven by the economics. But we also have to be realistic about that.

Ms. ESHOO. Thank you very much for important work.

Ms. MITCHELL. May I just—

Ms. ESHOO. It is up to the chairman. You can answer. I can't talk.

Mr. BURGESS. Please answer.

Ms. MITCHELL. I would just add that I think all the research including recently from the National Academy of Medicine show that about 30 percent of health spending do nothing to improve patient outcomes, so there is waste in the system that could be addressed through better, more effective utilization that does not in any way create barriers for physicians.

Physicians are trying to navigate those barriers right now. I think there is huge opportunity. I think there was a recent GAO report that showed we are spending about \$40,000 per physician per year on performance measurement. There are opportunities for savings that actually enable physicians to have more flexibility to give the right care at the right time.

Ms. ESHOO. Thank you very much.

Thank you, Mr. Chairman.

Mr. BURGESS. The Chair thanks the gentlelady. The gentlelady yields back. The Chair recognizes the gentleman from Missouri, Mr. Billy Long, 5 minutes for questions, please.

Mr. LONG. Thank you, Mr. Chairman.

And my questions are for both of you. And, Ms. Mitchell, I will start with you. And this first one might sound like an oxymoron, but can you each elaborate on why it is important that physicians not overassume risk in models they may be approaching for the first time while at the same time keep pushing forward in their drive for physicians to assume risk?

Ms. MITCHELL. Well, certainly, I think if Mr. Miller were here again representing the committee—I don't think risk is magic in any way. I don't think the assumption of risk will suddenly change care delivery, but I think it is a move towards greater accountability and ownership for outcomes. I think what we are trying to do is find models that appropriately enable risk and accountability certainly without putting a burden that is not manageable or sustainable on physicians, so I think it is a very important balance.

I don't know if that answers your question, but we think it moves them towards value.

Mr. LONG. OK, Dr. Bailet?

Dr. BAILET. So to follow on with Elizabeth's comments, there are unintended consequences. These models have elements that are new. Many of them have not been field-tested, if you will, so the intent is good, but until you actually deploy the model in the field, you are not exactly sure what are the outcomes. Are you going to get the outcomes that the model is established to accomplish, which is why the committee felt strongly and continues to feel that some limited testing is necessary for some models where the elements are uncertain or unclear.

So we need to strike a balance between encouraging physicians and clinicians to take risk and to be held accountable and to be recognized for outcomes and paid accordingly, but we also know that

in the world of in the past with managed care if you push too fast too far and you outstrip the sophistication of the clinicians and their ability to perform, those are also unintended consequences that we need to be careful about making sure that we don't do anything that is so disruptive that it impugns these organizations.

And I used the word "vibrancy" earlier, and I used that specifically. I hear a lot of things about well, we want to keep our practice viable. I used to run a practice of nearly 2,000 physicians in Wisconsin. I don't think viable is what is top of mind for patients who are seeking care. We want physicians and clinicians to have vibrant practices, to be able to provide the highest quality care with the best outcomes.

And that is where if you outstrip your ability to do well in risk you can have an economic consequence that could impugn your practice. And when these small hospitals and rural practices go out of business, your ability to repair them or replace them are incredibly hindered. And so that is where I want to make sure that as we go forward we are very thoughtful about implementing at the right pace in the right way. And there needs to be flexibility. Elizabeth said it is not a one-size-fits-all solution that we are talking about here.

Mr. LONG. OK. And since your microphone is still on I will start with you on my next question and then we will move to Ms. Mitchell. I would like for both of you to answer this one. But do you believe CMS's approach in the short term should be more focused on ensuring providers are ready to transition to qualified Alternative Payment Models or in simply getting more providers into value-based payment arrangements?

Dr. BAILET. You told me earlier that you were going to give me a tough question.

Mr. LONG. No, I didn't. You said I was, I just agreed with you.

Dr. BAILET. Well, I think, and I am not being evasive, I think it is both. I think physicians, as I said physicians are in different—and clinicians—are in different states of readiness, and so they need to get in. They need to move away from fee-for-service. Whether they get in on the Merit-based Incentive Program, which has value elements, or they are sophisticated enough or willing to get into an Alternative Payment Model, I think physicians have to get on the playing field, clinicians have to get on the playing field and get in the game. And the fee-for-service model is not sustainable and so this, I think this legislation these efforts compel physicians and clinicians to get on the field.

Elizabeth?

Ms. MITCHELL. I would just add that what we are seeing in PTAC is the early adopters, the leaders and the innovators who are ready to go. And I think by creating that opportunity by allowing them to go first with appropriate technical assistance, flexibility, and small-scale testing, we will learn a lot and that will enable some of the practices who are less ready to actually, I think, succeed as they move forward.

Mr. LONG. So do you agree with the doctor that both are important?

Ms. MITCHELL. Both are important, yes.

Mr. LONG. OK, thank you. I have got a really, really tough question for my next one, but you all are lucky I am out of time so I am going to yield back.

Mr. BURGESS. The gentleman's time has expired. The Chair recognizes the gentleman from Maryland, Mr. Sarbanes.

Mr. SARBANES. Thanks, Mr. Chairman. Thank you to the panel for being here. A lot of the motivation for the Affordable Care Act was to begin to kind of turn our healthcare system towards prevention, primary care, shift the kind of caregiver world to the prevention side of the spectrum, et cetera.

MACRA was passed separately from the Affordable Care Act, but I am curious if you perceive that there is alignment there between the goals of the Affordable Care Act and the goals of the new kinds of payment methodologies that MACRA is pursuing.

Ms. MITCHELL. Well, I guess I would say that to the extent that the goals of both legislation were affordable care, I think there is alignment in the intent. Obviously the Affordable Care Act focuses more on insurance and I think MACRA focuses more, and appropriately so, on the fundamentals of care and payment. I don't think you will have affordable insurance until you have affordable care and it is going to be these payment and care delivery reforms that actually enable that.

Mr. SARBANES. Thank you. The other question I had is, it gets to sort of how—and a number of Members have spoken to this—but how the physician community in particular is receiving these new models. And I don't know if you are the right witnesses to describe this, but I am interested in whether kind of the next generation of physicians coming along whether you are seeing that there is, first of all, more facility with the concepts, maybe more eagerness to try them. Are medical schools beginning to assimilate some of these models into the conversations they are having with the next generation of providers? Is there a symmetry with how certain cohorts within the physician community are responding to these things?

Dr. BAILET. I think it is highly variable. I mean, I am hoping that my colleagues, when they come up and testify, that you will hear some specific answers to those questions relative to training and the receptivity for the next generation of physicians and clinicians to embrace these models in care delivery.

I think—and I don't want to speak for the committee, but from my own personal experience—I think there is an appetite for new medical trainees who are coming and entering into the clinical practice, I think there is an appetite for them to provide the value which is the high quality and affordable care. I think they understand the economics that these folks are coming out of school, for example, with hundreds of thousands of dollars of loans.

So I think that they understand that there is an economic consequence if their current employer or their practice is not successful. So I believe that the economic piece is there. I think the clinical piece is there as well relative to innovation and training and I think there is a willingness to try. I think one of our biggest challenges is there is still the unknown. We don't know how some of these models are going to impact outcomes. And so I guess I would leave it at that.

Mr. SARBANES. Do you feel as though the provider community gets that they are living in a new world, if you think they are living in a new world or not yet?

Dr. BAILET. I think there is probably some vestiges of remnants of folks in the provider community that still harken back for the fee-for-service environment. And I am not saying that fee-for-service there is not a place for that model in the new world, but I think that also there is a high degree of recognition that the value, paying for outcomes, being able to track it, and being able to actually deliver on the commitment to provide outcomes is one of the things that is in front of us that actually can bend the cost curve.

So I do think that that is where the collective thinking around the provider community is today. As I go around the country I don't hear a lot of debates about, well, we need to go back to just pure fee-for-service. I am not hearing that. I think people are now focused on what does it look like, how do we get there, and at what pace do we move from fee-for-service to value and how do we do it while we are basically practicing in both worlds. How do we navigate risk in one and fee-for-service in the other, for example.

Mr. SARBANES. OK, thank you. I yield back.

Mr. BURGESS. The gentleman's time has expired. The gentleman yields back. And speaking for the vestige, the Chair recognizes the gentleman from Indiana, Dr. Bucshon.

Mr. BUCSHON. Thank you, Mr. Chairman.

I would first like to, I would like to comment on what Ms. Mitchell said about the cost of care coming down as the key to affordable insurance. I completely agree on that. That is a big issue. And to do that more transparency in the healthcare marketplace as well as more active consumer participation in their healthcare decisions, including the cost of what they are being provided, is really key.

As a former cardiothoracic surgeon I know my organization that I participate in, the Society of Thoracic Surgeons, they have been really pioneers in quality measurement for the last 25 years with the STS database. And, Mr. Chairman, I would like to ask unanimous consent to submit their comments on this hearing to the record.

Mr. BURGESS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. BUCSHON. I would like to highlight the STS has designed a quality-based payment program specifically related to cardiothoracic disease including coronary bypass, grafting, valve repair, replacement procedures, and as well as treatments for lung cancer, relying on this database and I would encourage CMS and Congress to take a look at that, as they already have. And they are actively pursuing partnerships, looking forward to bringing, you know, fruition of payment model that could help provide quality incentives and efficiencies to really one of the largest cost centers that we have in the Medicare program.

Ms. Mitchell, according to CMS, only, currently, 5 percent of physicians are in Alternative Payment Models. And I have heard from a number of physician specialty organizations that there are some Stark Law barriers potentially to participating and succeeding in an APM because it prohibits practices from financially

incentivizing their physicians to follow treatment pathways that are related to value that might improve the system.

Do you think there is any problems there legally in that that are preventing some people from participating in APMs?

Ms. MITCHELL. I am not an attorney and would not want to pretend to be, so I would not be able to answer that question with any authority. Perhaps Dr. Bailet has insights.

Dr. BAILET. No.

Mr. BUCSHON. Maybe I will ask that for—

Dr. BAILET. Played one on TV, right?

Mr. BUCSHON [continuing]. The next panel. Just there are some barriers out there. I am not a lawyer either. I don't, but we are going to be working on trying to decrease the barriers for physician participation in APMs.

Maybe any one of you can discuss the importance of engaging in the specialty community in developing APMs. That can be some of the more difficult APMs to work to get together. And can you elaborate on where you see growth potential in the future for specialists playing a bigger role in these new care delivery models? Dr. Bailet?

Dr. BAILET. Well, we have garnered a lot of interest from the specialists, single specialty societies. You are going to hear from my colleague Dr. Opelka about his ACS model. So there is tremendous interest and we have a number of specialty-specific models that we are evaluating right now. So I think that our interaction with the specialty community actually is pretty robust, but again I think you will hear that as you get to the next panel.

Mr. BUCSHON. I suspect that is true. Do you think it is more difficult to put together APMs as it relates to the specialists versus primary care or no?

Dr. BAILET. I haven't seen that.

Ms. MITCHELL. I haven't seen that, either.

Mr. BUCSHON. Not really?

Dr. BAILET. No.

Mr. BUCSHON. OK, good. The other area, and I have a minute and 30 seconds to address MACRA, is it will require significance guidance by CMS's physician participation in multiple APMs. Obviously we want physicians to be able to experiment with different approaches to improving their practices while also recognizing that many APMs being developed by stakeholders are somewhat narrow, centered around a specific disease or condition.

Can each of you speak to why it is important to allow physicians to experiment with different quality-based payments and have you thought about this facet of the program as you review the proposals?

Ms. MITCHELL. So I will try to answer that. I actually think it could be very important to participate in more than one model. I think at the community level you are trying to align models and incentives and not carve out certain groups over here and others over there.

So I think the ability to, as an example, have episodes within a capitated payment or an ACO, I think, is an important innovation to test. I think there are regulatory barriers right now to doing

that and I think that is something that warrants further exploration.

Dr. BAILET. I agree.

Mr. BUCSHON. Do you have any comments?

Dr. BAILET. No, no.

Mr. BUCSHON. I yield back.

Mr. BURGESS. The Chair thanks the gentleman. The gentleman yields back. The Chair recognizes the gentleman from Massachusetts, Mr. Kennedy, 5 minutes for questions, please.

Mr. KENNEDY. Thank you to the chairman. Thank you to the witnesses. Thank you for answering the questions and educating the discussion.

I wanted to get your opinion on a couple of things and build off a little bit of the conversation from our colleagues. There are different, I guess, excuse me, a variety of Alternative Payment Models that have now been put forth and authorized by CMMI. In your assessment if you had any ideas or suggestions for us, how does CMMI evaluate those different models?

Are there factors there that should be taken into account differently or aspects there that perhaps Congress should be looking at that should be accentuated that aren't fully contemplated there? Do you have any suggestions as to how those models or other models might be put together to address the themes that you have talked about so far today?

Ms. MITCHELL. I hope this answers your question. I think that there are a lot of lessons from the demonstrations to date. I will point to sort of CPC and CPC+, initially, because we have seen, I think, real success in some communities because you have aligned payers so you have alignment of incentives and measures. So it is not just noise, it is everyone is going in the same direction. It is a primary care-based model and it requires data sharing across the community.

I think those examples point to successes that could be replicated. I think there are some elements of the CMS evaluation approach that I don't know that we get information soon enough so that we can apply it and sort of rapidly learn and improve and I think there are ways to really take lessons earlier and share them more effectively to benefit all of the new models and implementers.

Jeff, would you add anything?

Dr. BAILET. No, I think that is well said.

Mr. KENNEDY. Building on that for a second, and one of the areas that I have focused on here is the—well, mental behavioral health and the integration thereof in primary care. So particularly for that model then we have seen issues around the absorption of electronic medical records for the mental health practitioners, the sharing of that information between primary care and mental health practitioners and obviously concerns about some of the dissemination around mental health records.

What if there is some things that CMS might be able to do there, there is some issues there that might actually require a legal change. I don't know if you have any suggestions for us to look at given at least in my concerns about the lack of adequacy on a comprehensive care system set up to address those patients that are suffering from medical illness across the country particularly with

regards to Medicaid. And so I don't know if you have any comments on that but would welcome them.

Ms. MITCHELL. I would personally just state for the record I think that is one of the highest priority areas in the country. I think that if we don't address mental behavioral health we are missing just a huge need, and integrating that into primary care is a very important strategy.

I think there are very real limits and barriers, some regulatory and legal, that keep us from sharing information adequately and I think there are also examples around the country where we have done that effectively, responsibly, and protecting patient privacy but actually getting the information to people who need it for better care.

I am happy to follow up with you on some of those models—

Mr. KENNEDY. I appreciate that.

Ms. MITCHELL [continuing]. Because you are exactly right. We have to address that.

Mr. KENNEDY. Doctor, anything else?

Dr. BAILET. No. I agree.

Mr. KENNEDY. So one of the great things about representing Massachusetts is, I am kind of preaching to the converted here, but being able to visit particularly those community health centers that are on the front lines of some of these issues from, you know, partnering with farmer's markets in doctors writing scrips to farmer's markets to make sure that their patients are getting access to fresh fruits and vegetables to the absorption of medical and adoption of medical-legal partnerships, so that when a patient potentially comes in with an asthma issue that if there is mold in an apartment, yes, you can give them an inhaler, but you are not going to address the concern because there is mold and an inhaler doesn't cure mold.

Are there other systemic, you are talking about alignment incentives, what should we be focused on when we start to look at issues? You mentioned transportation before which is obviously critical. Are there other kind of one-offs here that you think we should keep in mind as we try to think of the opportunities and challenges of actually trying to reach out to patients and then wrap them in this continuum of care so you can get to them and reduce the cost of delivery?

Dr. BAILET. I think there are lots of opportunities, palliative care, for example. I mean I think that the data where, you know, you follow the economics. So we consume a tremendous amount of resource relative to folks who are at their end of life. We have been able to, I have seen models out there where we have been able to get the uptick, the average length of stay, for example, in hospice which is, I think, nationally, somewhere between 16 and 18 days. There needs to be a more concerted effort that should be measured in months, not days, if we are doing the good work and want the outcomes we would want for that cohort of patients.

So I think there is tremendous opportunity and, again, I used palliative care as an example, but there are others that you also raised.

Ms. MITCHELL. And you are exactly right. That is where the opportunity is to really improve health and reduce costs. We have ex-

amples by members around the country. There are partnerships with the criminal justice system and hospitals to actually identify much more effective interventions than, you know, another ER visit.

And by doing that coordination, finding out what people's real needs are, typically—housing, transportation, the real upstream social determinants—that is where you are going to really impact health. And connecting those services, the providers and that information, I think, is a very big opportunity.

Mr. KENNEDY. Thank you. I appreciate it.

Mr. GUTHRIE [presiding]. Thank you. The gentleman yields back, and I will now recognize myself for 5 minutes for questions.

Dr. Bailet, in your testimony you mentioned how Medicare is driving market change through the development of APMs. What are these trends and what are you seeing the impact is on other players, or payers? I am sorry.

Dr. BAILET. Well, I can speak for my organization that I currently work with, the Blue Shield. We are moving the commercial side of the business to value-based pay-for-value. It is one of our top priorities in the organization and MACRA actually allows—in 2019—allows the commercial payers to partner with Medicare and put these models in the field.

So, again, the economics going from fee-for-service to value, paying for outcomes, it not only is the right thing to do clinically, but it is also the right thing economically. And as one of the largest payers in the State of California contracted with over 50,000 physicians and over 400 hospitals, we are very activated to get these practices of the future, if you will, out in the field and we want to do it with the stakeholder community, not to them.

And that is one of the things that that is a tenet of the PTAC, which is why we are so transparent. We want to make sure that we are right there, lock arms with our stakeholders, and I hope you hear that from the folks who are going to come behind us. But it is driving market change.

Mr. GUTHRIE. Do you believe our patients are being affected in a positive way with this?

Dr. BAILET. I do. Again, yes. I do.

Mr. GUTHRIE. Thanks. I have another question. So it appears that many are already responding to practice transformation efforts in commercial markets. Can you speak to the ideal way Medicare can both learn from these private sector efforts and harmonize with them to smooth practice modernization?

Ms. MITCHELL. So I guess I would just say I don't think providers think about their patients based on who pays their care, so to the extent that private and public payers can align that will enable providers to actually give optimal care across their patient population. To the extent that there are innovations in the commercial sector, I would hope that they would share those.

Often it is very hard to get information on the outcomes of those changes. I think they could inform Medicare, and I think Medicare coming to the table and joining multi-payer efforts is really an optimal way to accelerate change.

Mr. GUTHRIE. OK, thank you. And can you comment to the interests of PTAC in the diversity of models, but also those who have

reached out to you? Do they include large and small rural and urban as well as primary and specialty interests?

Dr. BAILET. Yes.

Mr. GUTHRIE. Specialty interests, not special interests.

Dr. BAILET. Yes. And so I think you will hear we have a small rheumatology practice that has submitted a model before us that we have not evaluated it, it is under evaluation. So we have a broad array of medical stakeholders again from the range of small and rural practice to sophisticated systems and specialty societies like American College of Surgeons, for example.

Mr. GUTHRIE. OK, thank you.

I will yield back and recognize Dr. Ruiz for 5 minutes for questions.

Mr. RUIZ. Thank you very much, Mr. Chairman. And thank you for allowing me to waive on to this subcommittee.

When we passed MACRA in 2015, one of the goals was to increase quality of care and stabilize payments, moving towards payment models that reward high-quality care. One of the options under MACRA is for providers to participate in an Advanced Alternative Payment Model under which the physicians accept some of the financial risk. However, in just over a year since its creation, the Physician-Focused Payment Model Technical Advisory Panel which reviews the proposed APMs has received only 19 proposals that we have discussed earlier for consideration and deliberated on just five of those. So I am concerned we are not seeing enough to really make a smart decision on what is going to be the best model.

And speaking to different physician specialty organizations, I have learned that one of the greatest barriers to developing APMs are laws that prohibit many of these physician practices from coordinating, collaborating with other specialties while they are trying to develop an APM, much like what Dr. Bucshon mentioned, so this means that the groups are not able to test out their model to see if it will work in practice. And while these laws are important and serve an important purpose, in this instance they are restricting the development of these payment models, stunting movement towards fully achieving the goals of MACRA.

What are some of these barriers in general that have inhibited different practices and organizations from developing APMs? If you can name me the top two barriers and then I want you to name the—if you were to recommend us, how would we resolve those top two barriers?

I will start with Mr. Bailet and then I will go to Ms. Mitchell.

Dr. BAILET. I guess what I would say, I would turn to the second row of testimony behind us, the folks who are actually out there trying to create these models for our consideration, to answer your question relative to those two barriers.

Mr. RUIZ. OK.

Ms. Mitchell, do you have an answer or an idea? Because I will ask them and I have been speaking with them.

Dr. BAILET. Yes.

Mr. RUIZ. But, you know, I wanted to get your perspective in being involved as well.

Ms. MITCHELL. Absolutely. In my testimony I shared that the barriers that we have heard most frequently in our first year are

access to data and technical assistance to design the models and opportunity for small-scale testing. So I think those are three issues and we have actually asked for congressional consideration on each of those.

So I do think that there are barriers, but I do also think that the panel, the next panel will be able to share how they have overcome them.

Mr. RUIZ. So the MACRA required the Secretary to establish a set of Physician-Focused Payment Model criteria for evaluating proposals. MACRA also required PTAC to then review the proposals submitted based on these criteria when making recommendations to the Secretary. These 10 criterion including the extent to which proposals provide value over volume, increase care coordination, improve quality, et cetera, can you describe the 10 criteria established by the Secretary, particularly the criteria designed by the PTAC as, quote, high-priority criteria?

Dr. BAILET. Yes, we reviewed that earlier but we can go back again.

Mr. RUIZ. Give me the top two, please.

Dr. BAILET. There is three.

Mr. RUIZ. Give me the top two.

Dr. BAILET. Scope, cost, and quality.

Mr. RUIZ. Scope, cost, and quality. And in the proposals that you have reviewed in scope, cost, and quality, what are the easiest criteria for most proposals to attain?

Ms. MITCHELL. Well, I think all of the proposals that we have seen have recognized that we are looking for models that improve quality without increasing cost and they have all brought forward models that will—

Mr. RUIZ. So everybody has been able to meet all 10 criteria easily?

Dr. BAILET. No.

Ms. MITCHELL. No.

Mr. RUIZ. All right, so which are the difficult criteria for the organizations to meet?

Ms. MITCHELL. Well, I think one of the challenges is sometimes that it is not a payment methodology that is actually different enough to require an Alternative Payment Model. As an example they may just need a tweak in codes or something, a much more minor intervention, so it might not qualify as an Alternative Payment Model. That is one example.

Dr. BAILET. I would say another example that we have found as a committee is the care coordination, the ability for physicians and clinicians to work with each other across communities, across disciplines, sharing data that we talked about. Those are all contributors to make—

Mr. RUIZ. Is it more of a technical difficulty with the electronic medical records issues or is it a cultural, a difficulty within different institutions?

Ms. MITCHELL. I don't believe it is a technical barrier. I think it is more often a business or a cultural barrier. I think that it is certainly possible to share data across platforms and—

Mr. RUIZ. What would you recommend we do to improve collaboration across the different institutions and specialties so that we can get better models?

Ms. MITCHELL. I think that we are seeing that. I think that the proposals that are coming forward are actually laying out ways to collaborate more effectively. I think that there can be incentives for data sharing. You can have data standards so that it is possible to share data across platforms, and you could actually ask the vendors to ensure that there is no data blocking so that data can effectively be shared.

Mr. RUIZ. OK. If the barrier is a business model then I think we have to look at what are the business incentives for them to work together during these APMs, because they also have business needs in the short term as well.

Ms. MITCHELL. Absolutely. And I think that by changing some of the incentives that we are actually helping them to find viable business models for the right care.

Mr. BURGESS [presiding]. The gentleman's time has expired. The Chair recognizes the gentleman from Oklahoma, Mr. Mullin, 5 minutes for questions, please.

Mr. MULLIN. Thank you, Mr. Chairman. Thank you for both of you all being here. As you guys have, you know, been sharing the same questions, my question line will be the same too. And I really appreciate you all's patience. As you can tell, the committee is really looking into this. This isn't something that we are looking to stand in the way, we are looking to help to improve and so we appreciate you all being here.

I represent a very rural district, very, very rural district, and our constituents obviously receive care, many of them, from critical access hospitals. Do you think it is time that we explore, target value-based payment models for critical access hospitals that recognize the unique needs of rural areas?

Dr. BAILET. I think, yes, I would agree with that.

Mr. MULLIN. Ma'am?

Ms. MITCHELL. Yes, I think so. I think there can be some very innovative practices in rural areas, and in many cases some of these models may actually allow small rural practices to succeed by creating more flexibility and really evaluate—

Mr. MULLIN. Which models specifically would you think?

Ms. MITCHELL. In terms of the models that we have received?

Mr. MULLIN. Well, and if you are talking about ways to look at the value-based payment structure how would that look like? What would we be needed to push from this point of view to make it?

Dr. BAILET. Well, my experience with critical access hospitals in small rural communities, my former practice was in Wisconsin, getting specialty care to these small hospitals, allowing patients to get the care they need at home or in their local community rather than have to travel great distances. So using technology, telehealth, telepsych, for example, psychiatry, behavioral health at the bedside, neurology, it is often difficult to get those services, the actual practitioner, on the campus of these smaller hospitals.

Mr. MULLIN. Right.

Dr. BAILET. But if you can leverage technology like teleneurology where they can actually be at the bedside with cameras and do the

analysis that they need for patients who are having a stroke whether they are going to administer treatment there or transfer the patient, those are the kinds of things that these models will support, will stand up and recognize and pay for.

Mr. MULLIN. Have you looked at what Alaska is doing within the IHS? You know, they are extremely, obviously, rural and IHS has their own issues, their own problems, which, you know, we are working through that on a task force. Being Cherokee myself, I understand, you know, very well. But Alaska has seemed to be ahead of telemedicine, where, I mean, they just don't have that access to the care, that it is not reasonably for them to be able to get into and a lot of dynamics play into, factors play into this when you start talking about having to fly people in and out.

And so they don't have a choice. They have been forced to do it, but they have been successful at it. Are you familiar with it? Have you looked at it at all?

Ms. MITCHELL. Not in any detail.

Dr. BAILET. No. No.

Mr. MULLIN. Maybe we—I suggest you maybe taking a look at that. Another question, what is PTAC doing to encourage applications in rural and underserved areas?

Dr. BAILET. So we are again reliant on the proposals that are submitted, but I will say, in the first year before the Secretary's criteria were finalized, we had several public meetings with stakeholders across the country and we were very clear and we continue to be very clear that we are encouraging small and rural practices to submit proposals, that we are receptive to receiving proposals.

We see that as a significant area of need and we are trying to foster everything that we can do relative to our process to make sure that we are open and willing and we make it as seamless as possible for these smaller practices to compete and build these models for our evaluation.

Mr. MULLIN. So what are some of the barriers? And once again we are looking to work with you.

Dr. BAILET. Right.

Mr. MULLIN. So what are some barriers that is standing in your way from this side? I mean because I am assuming if there were barriers that you could already take care of you would have already done that so there must be something that we are keeping that from happening.

Ms. MITCHELL. Well, again one of the barriers that again keeps coming up is the need for technical assistance particularly among small and rural practices who might not have the resources. I think we do need to find a way to offer that. I think some of the measurement systems in some of these models could actually be beneficial for small and rural practices or critical access hospitals which often have higher patient experience scores.

They are actually, they might be recognized for the things that they are already doing well. So I think looking at measures and technical assistance and again the data needs for these practices. They can't necessarily build analytic teams nor should they need to. So how can we make it easier, reduce provider burden to actually just have the information they need to give the care that they are giving.

Mr. MULLIN. And just to make a point on when you said a patient's experience which we put, you know, high value on that which I agree is about customer service, but it is also about care too. A lot of times the reason why you see that, in my opinion, is these rural providers they are personally connected to the individual.

Ms. MITCHELL. Absolutely.

Mr. MULLIN. When my father had a major heart attack and actually coded he was right at the hospital. And the guy that was working there who is a good friend of ours knew my dad well and when he couldn't speak, he couldn't say anything, knowing the personality that my dad typically had, immediately recognized it and it saved his life. But I think that we take it more personal, but we are getting farther and farther behind.

And we as a committee really want to help with that and as personally as a Member I want to work with you. If you have ideas, if there is something that we can do, if you recognize areas that we can push on this committee, please use our office. Use me as a resource because I am going to be using you as a resource. Thank you. And I yield back.

Mr. BURGESS. The Chair thanks the gentleman. The gentleman yields back. The Chair recognizes the gentleman from North Carolina, Mr. Butterfield, 5 minutes for questions, please.

Mr. BUTTERFIELD. Thank you very much, Mr. Chairman. Thank you for convening this hearing today.

Dr. Bailet, let me just direct one or two questions to you and then we will see how much time we have left after that.

Dr. BAILET. All right.

Mr. BUTTERFIELD. But first of all, thank you so very much for your testimony. Like the gentleman from Oklahoma, I represent a small rural community in eastern North Carolina and so I am very interested in your comments to him and to others about the challenges facing small rural providers in taking advantage of the APMs. And so, I guess, question one would be what proportion, what proportion of the 32 letters of intent and the 20 full proposals are from small and rural practices?

Dr. BAILET. I don't have the number available. It is more than one.

Mr. BUTTERFIELD. You just don't have it with you?

Dr. BAILET. I don't have it with me.

Mr. BUTTERFIELD. But you do collect the data?

Dr. BAILET. Yes, we do. Absolutely.

Mr. BUTTERFIELD. All right. Number two, has PTAC observed differences in applications from large practices and small and rural practices? Do you discern any differences between the applications?

Dr. BAILET. Well, the applications are highly variable from application to application. And I think—

Mr. BUTTERFIELD. In terms of quality?

Dr. BAILET. Right.

Mr. BUTTERFIELD. Quality?

Dr. BAILET. In terms of sophistication and how they are built. So there is clinical sophistication and then there is the policy, payment policy sophistication, and both components need to be present for our recommendation to carry weight and to garner our support.

The area of technical assistance, I don't want to—I think I would be—I don't want to say that the smaller practices are the ones that are needing more technical assistance compared to the larger, more sophisticated practices. I am not saying that.

But we have found in both arenas, in both practice cohorts that there have been challenges with their model. More so on the payment side and the data side, not so much on the clinical side.

Mr. BUTTERFIELD. But you do acknowledge that there is room for improvement in many of the applications?

Dr. BAILET. Absolutely, yes.

Mr. BUTTERFIELD. From the large practices to the small practices?

Dr. BAILET. That is correct.

Mr. BUTTERFIELD. But wouldn't you acknowledge at least that the weight of those, the majority of those are more toward the rural practices because of the lack of expertise? I mean we hear that every day up here where disadvantaged groups just don't have the expertise to present the quality of proposals that you would want.

Do you communicate directly with the small and rural practices about the benefits of technical assistance? Do you let them know that it is there for the asking?

Ms. MITCHELL. Actually one of our key challenges is that we are not at this point allowed to offer technical assistance. We have made available the resources that we do have, so to the extent that the committee can organize data for applicants we are doing that. But so far we are limited from what—

Mr. BUTTERFIELD. You can't proactively go out and advertise that it is available?

Ms. MITCHELL. Currently not.

Mr. BUTTERFIELD. I didn't know that.

Dr. BAILET. We are charged to evaluate the models as they stand. We cannot provide guidance. We cannot make recommendations on how the models should be reconstructed. That is not in the purview of the PTAC and we are careful not to go into the area at this point.

Mr. BUTTERFIELD. All right. Let me try it this way then. Have you worked with Health and Human Services to share your experiences with applications and make recommendations about how to deploy resources and technical assistance, at least has HHS been made aware of this?

Ms. MITCHELL. Yes. And the committee sent a letter to Secretary Price naming technical assistance as a key need for applicants. So we certainly weighed in on that need.

Mr. BUTTERFIELD. Right. I am about to run out of time, let me move to a different subject.

Dr. Bailet, I am acutely aware of many of the health disparities that affect African American citizens today. Several of the approved APMs deal with chronic disease management like ESRD that disproportionately affects minorities. Can you discuss with me some of the APMs that are being considered that would disproportionately affect African American and other minorities?

Dr. BAILET. We are currently evaluating a model for hepatitis C, which I would think, I believe, I don't have the numbers specifi-

cally in front of me, the demographics, but I believe that that is another health challenge that just like end-stage renal disease with the African American community. So those are two that come to mind.

Mr. BUTTERFIELD. We are out of time.

Mr. BURGESS. The gentleman's time has expired. The Chair would inform the gentleman that I am getting a copy of the letter that the Physician Technical Advisory Committee sent to the Secretary in August and I will make that available to you so that you will know the communication that occurred from this group back to the agency.

The Chair now recognizes the gentleman from Florida, Mr. Bilirakis, 5 minutes for questions, please.

Mr. BILIRAKIS. Thank you, Mr. Chairman, I appreciate it so very much and I thank the panel as well.

I have a few questions for both of you. Can both of you discuss your experiences in transitioning to value-based care outside of your work on the Physician-Focused Technical Advisory Committee and how that has influenced your view on what Advanced Alternative Payments Models can deliver? Now I know that some of these things have been covered, but if you could respond I would appreciate it.

Ms. MITCHELL. Sure. Well, I will speak to my experience which is quite different from Jeff's, but I actually used to work in a very large health system so I had some experience there as they were trying to transition their practices. But more recently I have worked in multi-stakeholder groups in various communities from Hawaii to Maine where they are bringing together employers, health plans, providers, patients, State governments, others, to try to come up with payment changes that actually meet all the stakeholders' needs.

So is it getting value for the money, is it improving patient outcomes, and are clinicians actually happier providing this care and is it better suited, are the barriers being removed, it is actually that multi-stakeholder alignment that enables the transition. So that is, and we have tried various models, ACOs, bundles, Patient-Centered Medical Homes, and implemented those in different communities.

Mr. BILIRAKIS. Thank you.

Dr. BAILET. In my experience supporting large physician practices, multispecialty group practices, there is a tremendous amount of inertia to work with the physicians and the clinicians to get them to change their practice styles and move away from fee-for-service, volume-driven practices to focus more on outcomes. The models I have deployed in my former leadership roles relative to supporting physicians and clinicians, paying them for quality outcomes, paying them for collaboration with their colleagues, paying for their utilization of electronic health record. There has been and I think there continues to be some challenges with galvanizing the level of interest.

There is challenges with the data that typically we hear from the physicians that as they move away from volume, you know, does the data that you are sharing with me that you are now going to pay me for accurately reflect the work that I am doing? So there

is—I think it is washing out—but there was obviously on the front end of moving from volume to value a healthy dose of skepticism from the physicians. Well, you are going to pay me differently, but am I actually going to get paid for the work I am doing?

So it is very challenging, but I think right now what I am seeing is that the mindset of the physician and the clinician is they know they need to do it. They know they need to move away from the fee-for-service environment and pure fee-for-service, and the question is how do we do it, and at what pace do we do it, and what tools are you going to provide me so that you are not overburdening my practice?

Elizabeth talked about the \$40,000 per physician just to monitor and track quality, but I would also argue there is another 750 hours I believe that was in that same study that each physician has to devote to monitoring and managing and measuring and reporting quality. I am here to say that as a health plan we had 188 quality metrics that we were holding our physician community accountable for. I don't want to get into the weeds, but I am sure you think that that is not optimal.

Yesterday, the board of Blue Shield approved moving to an integrated healthcare association set of metrics, 34, and we are going to lead the way in the State and try and get a standardized set of metrics, 34 metrics—it is not boiling the ocean—to actually have and change outcomes and drive this value and try and take the burden away from the practitioners.

Ms. MITCHELL. And could I just add, I think that that is absolutely essential to not only reducing burden and cost, but allowing physicians to accelerate improvement. And the other element of that report is that there was only 5 percent overlap in commercial plans for using the same measures. If they could do what Blue Shield of California did and agree to use a common set, that makes life easier for physicians and it can lead to better care at lower cost. I think it is just an exemplary move and one that could easily be replicated around the country if folks were willing to do that.

Mr. BILIRAKIS. Very good. We will take a hard look at that and I will submit my questions for the record because I don't have time. Thank you, Mr. Chairman, appreciate it.

Mr. BURGESS. The Chair thanks the gentleman. The gentleman yields back. The Chair recognizes Mr. Green of Texas for any concluding thoughts that he might have.

Mr. GREEN. Mr. Chairman, my concluding thoughts, I want to thank you for the work you are doing and I think we just see we have a long way to go and we will do what we can to get you some resources so we can move it. Again my biggest fear is we are going to end up 17 years from now doing what we did with the SGR and medical practice is more important than that. So we will hopefully get some stability there. And thank you for your work and keep in touch with us and let us know what we may be able to do.

Dr. BAILET. Thank you for your support. Thank you.

Ms. MITCHELL. Thank you.

Mr. BURGESS. And I will just recognize myself briefly.

Dr. Bailet, I do want to, I think it is important to note that you all were chartered January of 2016. It took some time to organize and staff up, so it has really just been a little over a year that you

have been at work on this and as someone else pointed out you do have day jobs as well.

So it is, I mean I picked up perhaps on some criticism that you weren't active enough or doing enough. I am actually pleased with the work product that is coming through the PTAC right now and I believe that we—and then I think I heard your testimony that there is more, it appears there is more activity in submissions and I think that is good and I think that is important. I think we all recognize that there is a tremendous amount of work ahead of us on this.

One of the things that I do feel obligated to mention, when this concept for the Physician's Technical Advisory Committee came up, when the legislation to repeal the Sustainable Growth Rate formula was being contemplated, some of us are less enthusiastic about all aspects of the Affordable Care Act and there are portions of the Affordable Care Act that to me are disagreeable because of the coercive nature of the Affordable Care Act. So the individual mandate would be one of those things and I am well on the record about that in this committee.

But the Center for Medicare and Medicare Innovation, CMMI, which had the ability late on a Thursday or Friday afternoon to simply roll out a demonstration product that was going to be pushed out to the entire country with no cost-benefit analysis, with no randomized clinical trial, I mean this was a problem that I saw that we were careening towards. And the Physician's Technical Advisory Committee in part was created to help us offset what I saw was an impending disaster with CMMI.

Now I think it is very helpful that Ms. Mitchell has pointed out the small-scale testing. It might be reasonable to find out if something works before we require every practice in the country to behave that way. CMMI was set up differently. Your model is, I think, the correct one because, yes, I was integral in setting it up, but still I think your model is the correct one.

And we acknowledge there are elements of the unknown. This is new territory. There are going to be things that we encounter that we did not expect. And unlike the Affordable Care Act that it was perfect when it was passed and has required no adjustments, this I recognize may require adjustments going forward and this committee is going to be nimble about accepting those and providing you with the legislative backdrop that you need to do your jobs and we thank you for doing your jobs.

Thank you for being here today. It has been a very informative panel, and you are now excused and we will transition to our second panel.

Again we will thank our second panel of witnesses in advance for being here today and taking the time to testify before the subcommittee. Each will have an opportunity to give an opening statement followed by questions from Members. And let me give you a moment to get seated, and we will proceed with the introductions.

Mr. GREEN. Mr. Chairman, before our witnesses leave, I would offer again if you want to sit down and work on how we can agree to, 7 years later, on the Affordable Care Act, we would be glad to do that.

Mr. BURGESS. I have always been available to you.

Very good. Again we are going to have each of you after your introductions an opportunity to give an opening statements followed by questions from Members.

So today we are going to hear from Dr. Louis Friedman, the American College of Physicians; Dr. Daniel Varga, chief clinical officer, Texas Health Resources; Dr. Bill Wulf, CEO of Central Ohio Primary Care Physicians; Colin Edgerton, American College of Rheumatology; Dr. Brian Kavanagh, chair for the American Society of Radiation Oncology; and, Dr. Frank Opelka, medical director of Quality Health Policy for the American College of Surgeons. We appreciate each of you being here today.

And Dr. Friedman, you are now recognized for 5 minutes for an opening statement, please.

STATEMENTS OF LOUIS A. FRIEDMAN, D.O., FELLOW, AMERICAN COLLEGE OF PHYSICIANS; DANIEL VARGA, M.D., CHIEF CLINICAL OFFICER, TEXAS HEALTH RESOURCES; J. WILLIAM WULF, M.D., CHIEF EXECUTIVE OFFICER, CENTRAL OHIO PRIMARY CARE PHYSICIANS, ON BEHALF OF CAPG; COLIN C. EDGERTON, M.D., ALTERNATE DELEGATE, AMERICAN COLLEGE OF RHEUMATOLOGY; BRIAN KAVANAGH, M.D., CHAIRMAN, AMERICAN SOCIETY FOR RADIATION ONCOLOGY; AND FRANK OPELKA, M.D., MEDICAL DIRECTOR, QUALITY AND HEALTH POLICY, AMERICAN COLLEGE OF SURGEONS

STATEMENT OF LOUIS A. FRIEDMAN

Dr. FRIEDMAN. My name is Louis Friedman. I am pleased to share with this committee my perspective and that of my national organization, the American College of Physicians, on Alternative Payment Models under MACRA, specifically a Comprehensive Primary Care Plus program. On behalf of the college, I wish to express our appreciation to Chairman Burgess and Ranking Member Green for convening this hearing, for allowing us on the front lines of patient care to share our experiences in the transition to value-based care.

ACP is the Nation's largest medical specialty organization, representing 152,000 internal medicine physicians who specialize in primary care and comprehensive care of adolescents and adults, internal medicine subspecialists, and medical students who are considering a career in internal medicine. I am board certified in internal medicine and am a fellow of the American College of Physicians. Since 2001, I have been in private practice at Woodbridge Medical Associates in New Jersey which has been NCQA-certified as a Patient-Centered Medical Home Level 3 since 2008.

Our practice is small with just four physicians and one physician assistant. In the 3 years since our practice started participating in the CPCI program and now 1 year into the CPC+ program Track 2, we have gained significant knowledge with the benefits and challenges of the program. I would like to share my experiences with all of you today. Under CPC+ we have expanded our ability to analyze and deliver care and our patients have benefited in many ways.

With the added financial support that the CPC+ program provides, we have been able to offer self-management programs such

as nutrition classes and dietician visits. These are available free of charge to patients and have been well received by many who need them. For example, I have had one patient who was six-feet three inches tall, weighed 442 pounds, he had a high blood pressure and terrible venous insufficiency of the legs, which causes massive chronic swelling. He enrolled in our 8-week class and by the end had lost 31 pounds. He dropped another 10 pounds in the next 2 months and his swelling has improved.

Now this is an extreme example but shows that we can induce positive lifestyle changes which in turn can help prevent disease. Feedback data from CMS is another tool that we did not have access to previously, but now do as a result of our participation in CPC+. Often, patients simply are not aware that many medical issues such as upper respiratory infections, rashes, minor cuts and bruises, can be easily treated in less expensive urgent care settings or office setting often for a shorter wait time for the patient.

Now we can review the number of patients, our patients per quarter who are admitted to the hospital, seen in the emergency room, or seen in urgent care centers. Once identified, we hope to better educate these patients as to when and when not to seek emergency room care. Prior to CPC+ we didn't have this ability and thus had no idea how many unnecessary emergency room visits there were.

Pre-visit planning by ancillary staff and effective monitoring within the EHR have helped us to improve our rates of vaccination, screening procedures for mammograms, and diabetic eye exams. Screening tools for early detection of dementia have helped us and at-risk families better prepare to care for their loved ones, and the CPC+ reimbursement for managing these patients with this diagnosis has been helpful for targeting this effort.

On a practice management level, regulations issued by CMS requiring EHR vendors to obtain health information technology certification made it possible to track patient parameters more effectively. Prior to enacting these regulations, EHR vendors had no incentive to create effective dashboards with which we can track patient measures such as blood pressure, blood sugar measurements, et cetera. Without this ability there would be no way that a practice could hope to report the necessary measures to the program.

If this committee and Federal agencies look to improve upon this program in the future, I would like to offer some suggestions. First, there is a need to simplify the reporting requirements under CPC+. As more private payers enter the APM market, one option would be to streamline specific metrics across the proposed CMS and private payer models. This would be in line with ACP's Patients Before Paperwork initiative and the ideas that the college has laid out for how to address excessive administrative tasks as well as with the administration's new Patients over Paperwork and Meaningful Measures initiatives.

Another suggestion would be efforts should be made to encourage interoperability among EHR software vendors which would lead to better electronic communication between medical offices and hospitals. And I would be remiss if I did not acknowledge that there is a financial incentive as well to participation. This is needed for the practice to maintain the appropriate staff and computer sys-

tems. However, I believe we must continue to move forward with value-based coordinated care such as been found in programs like CPC+, the Medical Home, and other APMs away from fee-for-service system.

Given the time and effort our practice has invested over the past few years to this end as well as the significant and incremental improvements we have experienced, we plan to continue with this model and not return to a purely fee-for-service structure.

In closing, I would like to note that since 2016, practice participation among ACP members and advanced payment delivery models is increasing, and many more have noted that they are making changes to prepare for successful participation in the QPP overall. This is the case for both the ACP primary care and subspecialist members. Therefore, we in the physician community appreciate the opportunity to offer our input on how these models are impacting our practices and both in patient care, both now and throughout transition. We very much want to be part of this process and provide feedback whenever needed.

[The prepared statement of Dr. Friedman follows:]

**Statement for the Record****American College of Physicians****Hearing before the Energy and Commerce Health Subcommittee****On****MACRA and Alternative Payment Models: Developing Options for Value-based Care****November 8, 2017**

My name is Louis Friedman. I represent the American College of Physicians (ACP), the nation's largest medical specialty organization, representing 152,000 internal medicine physicians who specialize in primary and comprehensive care of adolescents and adults, internal medicine subspecialists, and medical students who are considering a career in internal medicine. I am board certified in internal medicine and am a Fellow in the American College of Physicians. Since 2001, I have been in private practice at Woodbridge Medical Associates, Woodbridge, New Jersey, which has been NCQA-certified as a patient centered medical home, level 3, since 2008. My practice participated in the Comprehensive Primary Care Initiative (CPCi) for three years and is now enrolled in the Comprehensive Primary Care Plus (CPC+) program, track two.

On behalf of the College, I would like to express our appreciation to Chairman Burgess and Ranking Member Green for convening this hearing and for allowing those of us on the front lines of patient care to share our experiences in the transition to value-based care, not only through existing Alternative Payment Models (APMs) but through new ones as well. Thank you for your shared efforts in wanting to ensure that these models improve health outcomes while reducing costs, as intended under the Medicare Access and CHIP Reauthorization Act (MACRA).

Today, I am pleased to have this opportunity to share ACP's perspective on MACRA and its ongoing implementation, specifically with respect to Alternative Payment Models (APMs), including their

impact on ACP member physicians, but also my own practice experiences in having worked within the Comprehensive Primary Care Plus (CPC+) program.

OVERVIEW OF ACP's VIEWS ON MACRA

ACP has been a strong supporter of MACRA and embraces its shift from a volume-based payment and delivery system, as was the case under the preceding fee-for-service system with yearly adjustments based on Medicare's Sustainable Growth Rate (SGR) formula, to one of value, accountability, and patient-centered care. ACP has been active in providing feedback on the implementation of the Quality Payment Program (QPP) as established by MACRA via its letters on both the 2017 and 2018 proposed rules, as well as on the Measure Development Plan and other requests for information and feedback from the Agency.

Repeal of the SGR was a priority of ACP's, and nearly all of medicine, for more than a decade. Thanks to the passage of MACRA, physicians and their patients no longer have to be concerned with impending yearly payment cuts as a result of the flawed SGR formula. However, as noted earlier, MACRA not only repealed the SGR, it also has led to a true shift in the Medicare program from a volume-based payment and delivery system to one of value, accountability, and patient-centered care—an approach the College strongly embraces. In a recent paper outlining its forward-looking priorities, ACP recognizes the importance of MACRA in helping to ignite movement by Medicare toward these aims, and then calls for even further acceleration of the transition from fee-for-service (FFS) payment systems to bundled and risk-adjusted capitation payments, hybrid FFS + bundled/capitated payments, and other payment systems that incentivize value rather than volume.

Alternative Payment Models (APMs) and Advanced APMs

To achieve this acceleration, ACP believes that all public and private payers should transition their payment systems to support innovative payment and delivery models linked to the value of the care provided. This should be accomplished by testing a variety of APMs, such as accountable care organizations (ACOs), Patient-Centered Medical Home (PCMH) and Patient-Centered Specialty Practice

models, bundled payments, capitated payments, and others. These models should include risk adjustments, including adjustments for socioeconomic status, to the extent possible. The College also has recommended that the Centers for Medicare and Medicaid Services (CMS) work to ensure patients, families, and the relationship of patients and families with their physicians are at the forefront of the Agency's thinking in the implementation of APMs and the advanced APM pathway within the QPP, including as part of the development and implementation of the performance measures to be used within these models.

In recognition that all clinicians are not willing or able to move directly into models with significant payment at risk, there should be pathways to help clinicians transition to models with increasing levels of risk at stake. ACP particularly believes that the PCMH model has been shown to improve quality and patient and physician satisfaction, reduce health care disparities, and reduce costs—and therefore has repeatedly recommended that CMS provide multiple pathways for medical homes to be included in the advanced APM pathway within the QPP, even in some cases without bearing more than nominal financial risk (particularly if it is a medical home that meets criteria comparable to medical homes expanded under section 1115A(c)).

The College further believes that APM development and implementation for clinicians who currently lack opportunities—such as specialists/subspecialists; clinicians who are unable to participate in current models, such as those in regions where models are not being tested; and those who are unable to participate due to limitations in the model design—should be prioritized. In particular, this should include testing of the patient-centered specialty practice model as a potential Advanced APM.

Importance of the CMMI and PTAC

The College strongly supports the Center for Medicare and Medicaid Innovation (CMMI) and its essential role in developing, financing, implementing, evaluating, and expanding innovative physician-led Advanced APMs, as authorized by MACRA, as well as in the broader context of value-based payment and delivery system reform. Along these lines, ACP has encouraged CMS to fully use its authority under the CMMI and the Physician-Focused Payment Model Technical Advisory Committee

(PTAC) process to expand the availability of Advanced APMs and other models, as noted earlier. In order to accelerate the movement toward value-based payments, ACP believes there should be an expedited process for CMMI to develop, test, and expand APMs. This should include a clear pathway for testing models recommended by PTAC, as well as models from other payers including Medicaid and private payers. The creation of additional APMs would provide more opportunities for practices to transition from traditional FFS to more valued-oriented payment approaches. It is also imperative that the CMMI continues to have adequate funding to support its critical role in MACRA/QPP and the movement toward value-based payment. Further, the College looks forward to providing robust feedback to the CMMI per its recent “New Direction” Request for Information (RFI).

ACP also believes that CMS should make technical assistance available to stakeholders who are developing APMs for PTAC review. Organizations that seek to propose models through the PTAC often lack sufficient expertise in at least a few areas that are needed to fully develop proposals for review, causing changes to be made throughout the PTAC process. The CMMI could provide this technical assistance to organizations as needed throughout the development process based on expertise gained in the design and testing of other models. This would not only enable the stakeholders to submit a proposal to the PTAC that is more comprehensive, but also allow the PTAC to conduct a more thorough review and recommendation to CMS. It also could make it easier for the CMMI to take steps to test models recommended by the PTAC if the CMMI aided in development of components that are required for implementation.

ACP Views on the Comprehensive Primary Care Initiative (CPCi) and the Comprehensive Primary Care Plus (CPC+) Programs

The College was a strong supporter of the CPCi program and remains supportive of and encouraged by the ongoing CPC+ program, the only medical home model that is specifically identified as an advanced APM in the QPP (for those in practices with 50 or fewer clinicians). ACP believes that CPC+ offers the potential of greatly strengthening the ability of internists and other primary care clinicians, in thousands of practices nationwide, to deliver high value, high performing, effective, and accessible primary care to millions of their patients. The success of this program will depend on Medicare and

other payers providing physicians and their practices with the sustained financial support needed for them to meet the goal of providing comprehensive, high value, accessible, and patient-centered care, with realistic and achievable ways to assess each practices' impact on patient care. The College is committed to working with CMS on the ongoing implementation of this program to ensure that it is truly able to meet such requirements of success.

It is with this in mind, that I share my perspective as an internal medicine physician practicing in a participating CPC+—and former CPCi—practice.

PERSPECTIVES OF A PARTICIPATING CPC+/ADVANCED APM PRACTICE

In the three years since our practice started participating in the CPC initiative and now, one year into the CPC+ program, track 2, we have gained significant knowledge of the benefits and challenges of the program.

Benefits of the CPC+ Program

The addition of care coordination staff has enabled us to better track our patients who have been discharged from the hospital, reach out to them within 48 hours of discharge, and review medications and determine whether further ancillary services are needed. Follow up visits are also arranged at that time, which has helped to limit confusion on the patient's part and we anticipate this will lead to a decrease in readmissions.

We have expanded our ability to analyze and deliver care and our patients have benefitted in many ways. With the added financial support that the CPC+ program provides, we have been able to offer self-management programs such as nutrition classes and dietitian visits. These are available free of charge to patients, and have been well received by many who need them. Gaining a patient's commitment to attend these classes on a regular basis, however, can be inconsistent. That being said, I had one patient who was six foot three inches tall and weighed 442 pounds. He had high blood pressure and terrible venous insufficiency of the legs which causes massive chronic swelling. He enrolled in our eight week class and by the end of it had lost 31 pounds. He dropped another 10

pounds in the next two months and his swelling improved. This is an extreme example, but shows that we can induce positive lifestyle changes which in turn can help prevent disease.

Feedback data from CMS is another tool that we did not have access to previously, but now do as a result of our participation in CPC+. Often patients simply are not aware that many medical issues such as upper respiratory infections, rashes and minor cuts and bruises can be easily treated in a less expensive urgent care or office setting (often with a shorter wait for the patient). Now we can review the number of our patients per quarter who were admitted to the hospital, seen in the emergency room or seen in urgent care centers. Once identified, we hope to better educate these patients as to when and when not to seek emergency room care. Prior to CPC+, we did not have this ability and thus had no idea how many unnecessary emergency room visits there were.

Pre-visit planning by ancillary staff and effective monitoring within the EHR have helped us to improve our rates of vaccination, screening procedures for mammograms, and diabetic eye exams. Screening tools for early detection of dementia have helped at-risk families better prepare to care for their loved ones. The CPC+ reimbursement for managing patients with this diagnosis has been helpful with targeting this effort.

On a practice management level, regulations issued by CMS and the Office of the National Coordinator (ONC) requiring EHR vendors to obtain health information technology certification, as part of the EHR Incentive Programs, has made it possible to track patient parameters more effectively. Bear in mind that there are many EHR vendors out there, large and small, and many of them simply had not been powerful or sophisticated enough for a practice to track and report the measures required by the program. Prior to enactment of these regulations, EHR vendors had no incentive to create effective dashboards with which we can track patient measures (blood pressure, blood sugar measurements, screenings such as mammograms and eye exams). Without this ability, there would be no way that a practice could hope to report the necessary measures for the program.

Challenges of the CPC+ Program

While my experience overall with CPC+ has largely been positive, we have noted challenges with the program as well. There is an administrative component to CPC+ that cannot be overlooked, which

necessitates having a strong administrative team in place to truly allow the physicians to concentrate on clinical practice. Physicians are trained and motivated to take care of patients, and are not naturally inclined to deal with software problems and other administrative tasks. Our practice structure is organized so that doctors' hours are focused on addressing clinical issues, although we routinely review performance measures at practice meetings. While the physicians are seeing patients, a multitude of other activities occur related to the CPC+ and other quality improvement programs. These include team meetings with our medical assistants, front desk and care coordination staff, as well as communication with our EHR vendor to determine how best to help the practice track and meet the milestones. This all requires careful choreography so that high risk and recently discharged patients are contacted in a timely fashion, appointments are arranged and assessments are made the day before a visit so that nothing is missed during the visit. All this happens in the background of a medical office where the more typical activities such as patient check-in, insurance issues are resolved, medical assistants and physicians are evaluating patients and in-office procedures are done as needed. We are fortunate to have effective administrative talent in our office to handle these tasks, however many practices of our size or smaller lack the resources and the ability to attract the needed staff. Employing a full-time trained accountant and/or project manager who can design a budget and analyze the constant flow of data is not feasible for most small practices, but there is a need for that in a CPC+ practice. Many physicians have needed to outsource these tasks, thus adding to overhead.

In addition, computer software, hardware and information technology support are fundamental for any practice hoping to excel in CPC+. Once again, keeping our EHR and related hardware up to date and running smoothly requires appropriate staff and constant communication with a software vendor, who is also a CPC+ stakeholder.

Office staff requirements have changed overall as a result of our participation in CPC+. As previously mentioned, administrative staff needs to have experience in accounting, project management and computer hardware, unless these are outsourced, in order to meet the demands of a CPC+ practice. We also have found a need for specialized staff who have knowledge and understanding of a given health care demographic or population. For example, population care coordinators are now needed in our practice, which is a new position that we, as well as other practices, have had difficulty finding and

retaining. Furthermore, meeting the demands of this type of practice also requires someone with a clinical background, extensive telephone communication skills, and the ability to analyze spreadsheets of patient information. These care coordinators can help follow through on the physician's treatment plan to make sure it happens. Coordinators can make sure patients get the procedure they need scheduled, the medications they need covered and filled and filter out those that are no longer needed. They can help direct patients to behavioral health centers, home health agencies and rehabilitation programs and work to ensure the implementation of their care plan. The ideal candidate would be a nurse, yet most nurses prefer face-to-face clinical contact. I believe this job description is evolving and, for our practice, currently requires the work of multiple employees.

Future Options for Improvement under the CPC+ Program

I would be remiss if I did not acknowledge that there is a financial incentive to participation. However, this is needed for the practice to maintain the appropriate staff and computer systems. An increased financial incentive would make the program more attractive to prospective practices as well as provide the financial resource to improve their infrastructure.

Overall, I believe that our patient care has improved since participating in this program. With that, I would like to offer to this committee and to Congress ideas for improvement to the program. Looking to the future, there is a need to simplify the reporting requirements under CPC+. As more private payers enter the APM market, one option would be to streamline specific metrics across both CMS and the private payer models. Reporting measures should be realistically achievable with the understanding that the physician can guide patients but ultimately, parameters such as BMI, blood pressure and blood sugar control are as much about patient engagement as they are about the expertise of the clinician. In addition, efforts should be made to encourage interoperability among EHR software vendors. This would lead to better electronic communication between medical offices and hospitals.

The Need to Stay the Course and Move Away from a Fee-for-Service System

As I reflect on the changes that have occurred in the practice of medicine, payment for medical care has changed a great deal since my father started his general practice in the early 1960s. At that time,

care was reactive in practice rather than the proactive approach that has become the current standard. Among the vast differences, chronic diseases such as diabetes and high blood pressure were not as prevalent, and preventive care was not recognized as a priority. A simple fee-for-service model worked well then, but simply is not as effective in addressing chronic disease management. We must continue to move forward with value-based, coordinated care, such as can be found in programs like CPC+, the medical home, and other APMs, and away from the fee-for-service system. Given the time and effort our practice has invested over the past few years toward this end, as well the significant and incremental improvements we have experienced, we plan to continue with this model and not return to a purely fee-for-service structure.

VIEWS FROM THE BROADER ACP MEMBERSHIP ON MACRA, APMs, and CPC+

As noted earlier, ACP's membership is made up of 152,000 internal medicine physicians, related subspecialists, and medical students—just over half of its post-training members identify themselves as primary care physicians. ACP members who provide care directly to patients are in a variety of different practice sizes and settings, ranging from small independent practices to being employed within large health systems. A recent survey of a random sample of ACP members indicates that, since 2016, practice participation in advanced payment and delivery models is increasing—and a large percentage of the respondents noted that they are making changes to prepare for successful participation in the QPP overall. Beyond these survey data, however, the feedback coming from ACP members through their chapters and up to ACP National is that they want to participate in APMs and are eager to have more opportunities available in their area and/or that are relevant for their specialty.

ACP members who are primary care internists are hearing from their colleagues like me about the improved bottom line from having been in CPCi and now CPC+ participating practices, and more importantly, about the changes we have been able to make in terms of infrastructure, staffing, and technology to truly improve patient care. And they want in! At a recent meeting of one of ACP's policy committees, a member stated that she simply cannot figure out how to sustain her rural, primary care practice on fee-for-service alone—"It's killing me," she said. And the impact of fee-for-service alone on an internist's practice goes beyond ensuring they keep their doors open in order to maintain an accessible source of care, to impacting their ability to provide the high quality and patient-centered

care they would like to provide to their patients. This is why the drumbeat of interest is growing, particularly since the passage of MACRA.

Another factor driving the interest of ACP members in pursuing alternative payment models is the excessive administrative burden they face, particularly within a strictly fee-for-service environment. This is why ACP launched its "Patients Before Paperwork" initiative in 2015 in order to develop and maintain related policy, participate in various efforts to work to alleviate specific regulatory and insurance requirements, and identify opportunities to eliminate other unessential tasks that detract from patient care and contribute to physician "burn-out." Ideas for how to address excessive administrative tasks are outlined in detail within its policy paper "Putting Patients First by Reducing Administrative Tasks in Health Care," which was published in the *Annals of Internal Medicine* in March 2017 and was recently supported by the American College of Obstetricians and Gynecologists. Therefore, ACP is pleased with the new initiatives recently announced by CMS to put "Patients Over Paperwork" and to ensure that the agency is using "Meaningful Measures" in all of its programs, including the Quality Payment Program—and have offered to actively engage with the Administration to address these issues.

Interest in APMs is not limited to primary care internists and to current models like CPC+, but is also shared by ACP's internal medicine subspecialist members. This is why the College is such a strong advocate for testing and implementing models built around the patient-centered specialty practice approach, as initially outlined in its "Patient-Centered Medical Home Neighbor" paper in 2010. ACP members regularly reach out for any information or assistance the College can provide to help them to help prepare for participation in APMs or even to develop new ideas for subspecialty-relevant APMs, noting the importance that these models be able to interact successfully with the PCMH/CPC+ model, as well as other models being implemented now, in order to ensure true population health management and care coordination.

CONCLUSION

The College would again like to sincerely thank Chairman Burgess and Ranking Member Green for convening this hearing and for your continued desire to see that the value-based system, as established under MACRA, is successfully implemented. We in the physician community appreciate this opportunity to offer our input on how these models are impacting our practices and patient care, both now and throughout the transition. We very much want to be part of this process and to provide feedback whenever needed.

Mr. BURGESS. The Chair thanks the gentleman.

Dr. Varga, you are recognized for 5 minutes, please, for an opening statement.

STATEMENT OF DANIEL VARGA

Dr. VARGA. Thank you, Mr. Chairman. Thank you to the members of the committee. My name is Dan Varga. I am the chief clinical officer and senior executive vice president for Texas Health Resources and the senior executive officer of the Southwestern Health Resources ACO, also speaking as a participant in Premier's Population Health Collaborative.

I would like to make three points to the committee. First, our decision to move to a two-sided risk, Next Generation ACO was a direct result of the incentives included in MACRA and the fact that these Alternative Payment Models, in our opinion, are working. We believe in a value-based healthcare system where incentives for all providers can be aligned and where healthcare providers are able to collaborate using an integrated infrastructure and transparent data on quality and utilization to deliver better outcomes for our patients.

This is even more critical in North Texas. Because of North Texas' strong economic and population growth, more than 40 percent of practicing physicians do not participate in the Medicare fee-for-service program or severely limit their availability to fee-for-service beneficiaries. Thus, by participating in the Next Gen ACO, Southwestern Health Resources ACO has been able to keep almost 3,000 physicians in the fee-for-service model. And this includes faculty, employed, independent PCPs, specialists, urban and rural physicians.

Moreover, because of our participation in a Next Gen ACO we have waivers that allow us to partner with doctors to reduce the CMS reporting burden for our clinicians by reporting those measures for them as a group, earn bonuses by participating in the ACO which creates important incentives to physicians to move to this new care model, have access to comprehensive data on utilization for our 67,000 beneficiaries, allowing us to better direct our care management activity to areas where it can create the most value.

I can't point out enough that this data transparency for integrated providers is priceless and also allows us to clinically integrate within a set of safe harbors. In our experience, these models are working. In our experience with our 67,000 beneficiaries, we are among the top 10 Medicare ACOs in 2015 and 2016, saving 30 million in '15 and 37 million in 2016.

We have been able to garner and retain top talent including 600 primary care physicians—40 percent employed, 60 percent independent—as well as another 2,300 participating providers; budget in 2017 and '18 to distribute over \$22 million in incentives and gain sharing to independent PCPs alone, make investments in infrastructure to support coordinated patient-centered care with a budget of 70 million in 2018 to go along with over \$100 million in investments since the institution of our ACO program; to tighten our network of providers to create better outcomes for our patients based on objective clinical and efficiency metrics; and to better manage our ED and acute care utilization.

We additionally have the benefit of participating in Premier's Population Health Collaborative. Since 2012, about 50 percent of the Premier ACOs have achieved shared savings, better than the approximately 31 percent experienced by the rest, while also outperforming on quality metrics. In 2016, a hundred percent of the Collaborative's Pioneer and Next Gen ACOs achieved savings versus 50 percent otherwise.

And we also have the advantage, again referencing data, of sharing data, not just on our beneficiaries but on hundreds of thousands of Medicare beneficiaries and the ability to learn from our peers on how their markets are performing and how tactics in those markets can be deployed in ours. Share these results to demonstrate that while there has been concerns that APMs are not delivering real savings, it is clear that with a balanced and planned approach and effective execution, these models can work.

The second point is that these value-based care and payment models are a significant departure from the past, changing 50 years of culture and habit. There is a number of implications to that. First, the changes are obviously long overdue as we move from a fragmented fee-for-service system where providers are incented to do more services to one where competition will be driven by high-value networks that deliver differentiated outcomes.

This work to better organize the healthcare market into high-value networks is necessary and desirable and we would urge that folks make a differentiation between consolidation to create excessive market power and integration of providers in the market to create a high-value network. Policymakers should also be careful not to tilt the playing field to the advantage of one provider group over another and maintain a level playing field.

And finally, while significant progress has been made to move to a value-based payment and delivery model, this Congress and administration should continue to build on these positive steps as have already been mentioned with needed change as we believe more organizations will move to and succeed in APMs, and I encourage you to review the listed areas' reform in my written testimony and those in Premier's Delivery System Transformation Roadmap.

Thank you again for the opportunity to testify before this committee. You have made a vital and lasting impact on our Nation's healthcare system with the design and enactment of MACRA and I urge you to continue to build on this successful work. Thank you.

[The prepared statement of Dr. Varga follows:]



**HOUSE ENERGY AND COMMERCE COMMITTEE
SUBCOMMITTEE ON HEALTH**

**"MACRA AND ALTERNATIVE PAYMENT MODELS: DEVELOPING
OPTIONS FOR VALUE-BASED CARE"
NOVEMBER 8, 2017**

Good morning, Chairman Burgess, Vice Chair Guthrie, Ranking Member Green and members of the Committee. My name is Dr. Daniel Varga. I am the Chief Clinical Officer and Senior Executive Vice President for Texas Health Resources, one of the nation's largest faith-based, nonprofit healthcare systems with more than 350 points of access throughout North Texas. I am board certified in internal medicine and have more than 27 years of combined experience in patient practice, medical education and health care administration. I am speaking today as the clinical leader of the Texas Health Resources accountable care organization (ACO) as well as a participant in Premier Inc., an organization of which we are both an owner and member. We participate in many Premier performance improvement collaboratives, including its Population Health Management Collaborative. I will be sharing the results of both our organization and the Premier collaborative.

I have three points I would like to make to the Committee.

First, our decision to move to a two-sided risk, Next Generation ACO model was a direct result of the incentives included in the Medicare Access and CHIP Reauthorization Act (MACRA) and the fact that these alternative payment models are working. Each of the lawmakers on this Committee should be proud of your work and leadership in passing this important legislation.



I cannot stress enough how pivotal MACRA has been and the long-term, positive impact it will have for our nation. Health care providers have been trapped in a micro-managing, fragmented Medicare fee-for-service system. This system has stifled innovation, left providers to manage the challenges of perverse incentives, caused a focus on sickness rather than wellness, incited a duplication of services, undermined coordinated care, driven providers to focus on throughput and speed rather than patient-centered care, and ultimately led to increased health care spending. What's more, because Medicare is the dominant and most stable health care payer, it has become the template on which our health care system is built and private insurers follow.

In North Texas, we have an additional dilemma. While the Medicare fee-for-service program represents the dominant payer in many markets, because of North Texas's strong economic and population growth, more than 40% of practicing physicians do not participate in the Medicare fee-for-service program or severely limit their availability to fee-for-service beneficiaries. Thus, by creating for 2017 the only qualifying Advanced Alternative Payment Model within the area through our participation in the Next Generation ACO model, Texas Health Resources has been able to keep almost 3,000 physicians in the fee-for-service model. Therefore, the incentives that were created by MACRA are essential in order for us to maintain access to high quality physicians and the care they provide in our community.

Moreover, because of our participation in a Next Generation ACO, we have waivers from some of the constraining Medicare requirements. This enables us to work with our clinicians to innovate the care delivery process. We are also able to reduce the Centers for Medicare & Medicaid Service (CMS) reporting burden for our clinicians by reporting those measures for them as a group. Finally, the ability to earn bonuses by participating in the ACO has created an



additional incentive to move to this new care model. These are important reasons why MACRA is an essential building block in building a better health care system.

We have unquestionably seen this innovation and improvement in our Next Generation ACO. Our experience has allowed Texas Health Resources to:

- Be among the top ten Medicare ACOs in achieving shared savings. Specifically, we achieved savings of \$29,958,600 in 2015 and \$37,268,130 in 2016;
- Care for 67,000 beneficiaries through a value-based delivery model;
- Garner and retain top talent, including 600 primary care physicians (40% employed, 60% independent), and 2,300 participating physicians - with our employed physicians covering two-thirds of our beneficiaries;
- Facilitate a model of care where independent physicians and employed physicians both perform well and are held to the same standards of performance;
- Provide an integrated information technology platform for both independent and employed physicians;
- Make big investments in advancing compliance, clinical integration, patient experience, quality, and coordination of care standards with an ACO budget of more than \$70 million for 2018;
- Build the necessary infrastructure to allow both independent and employed physicians to assume financial risk for the patients they manage and to succeed in that environment knowing that most independent physicians could not afford the investment or the risk on their own;



- Tighten our network of providers to create better outcomes for patients, including preferred relationships with Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, and Home Health Agencies based on objective clinical and efficiency metrics;
- Create an effective primary care management model with ongoing success in post-acute care and specialist utilization efficiency, which is essential to managing costs overall; and
- Increase our cost reduction efforts in Medicare Part A by focusing on appropriate hospitalizations.

While we are pleased with the progress we are making, we know we are not unique. Because we participate in Premier's Population Health Management Collaborative, we both learn from and see the remarkable successes of many other organizations. As part of Premier's Population Health Management Collaborative, we are able to analyze and benchmark clinical and claims data with peers; receive clinical and strategic support from national experts; as well as learn from and share insights and best practices with many other organizations participating in alternative payment models to improve performance. This collaborative, as well as other Premier collaboratives, have an impressive record of consistently outperforming other health care providers in delivering improved outcomes in both public and private payment models.

The Medicare ACOs in Premier's collaborative have comprised approximately 6% of the total number of Medicare ACOs since the inception of the Pioneer ACO Model and Medicare Share Savings Program (MSSP) in 2012, and now the Next Generation ACOs. Yet, year over year, these ACOs have consistently performed better than other ACOs in the Medicare program,



despite the fact that the average benchmark for these ACOs is lower than the national average.

Specifically:

- Since 2012, each year about 50% of the Premier ACOs have achieved shared savings, better than the approximately 31% experienced by the rest. They have also outperformed on quality metrics compared to non-Premier ACO participants.
- Since 2012, Premier Medicare ACOs have delivered at least twice the amount of shared savings than the other ACOs, and thus increased savings to Medicare. In other words, had all ACOs performed at the same level as those in Premier's collaborative, Medicare could have potentially saved twice what it has so far with these programs.
- Since 2012, the 6% of Medicare ACOs in Premier's collaborative have generated 20% of the nation's savings.
- In 2016, the Pioneer and Next Generation ACOs comprised 19% of the total number of ACOs, yet delivered 33% of the nation's savings to Medicare. Moreover, 100% of these two-sided model participants in the Premier collaborative achieved shared savings compared to a little over 50% for the rest of the participants.
- Further, Premier collaborative members outperform in other alternative payment arrangements, such as bundled payment. In the Comprehensive Care for Joint Replacement (CJR) model, participants in Premier's Bundled Payment Collaborative performed 35% better than the national average in the first two quarters of performance year 1.

I share these results to demonstrate that, while there has been concern that alternative payment models are not delivering real savings for the nation, it is clear that with a planned approach and effective execution, these models can and are working.



My second point is that these value-based care and payment changes are a significant departure from the past, changing 50 years of culture and habit. This has a number of implications.

For one, you may hear anxiety and complaints from some providers. As we all know, change is hard, but the fee-for-service system has also been generous to many providers and suppliers. However, these changes are long overdue. They began in the early 2000s and should continue, as they are leading an important revolution in health care that will benefit our population and our economy.

It is essential that lawmakers and policymakers understand the consequences of this change and view the developments in our health care system from the vantage point of where we are headed and not from where we have been. There is a lot of talk in Washington about health care consolidation with the concern that it will drive up health care spending.

What is occurring, however, is that we are moving from a fragmented, fee-for-service system where providers are engaged in "coopertition" to deliver more services (both competing with and referring more business to other providers) to one where competition will be driven by high value networks that deliver differentiated outcomes.

As illustrated earlier, Texas Health Resources both works with independent clinicians and employed physicians, and we believe that this pluralistic model is vital to the success of our ACO. We do not want to simply employ physicians. We do, however, want to create a high-value network in which providers are aligned and have a shared objective to deliver high-quality,



cost-effective healthcare across ambulatory, behavioral, acute and post-acute providers, as well as with community partners. To achieve this Texas Health Resources has created a clinically integrated network of both employed and independent physicians, and other providers working to engage and satisfy patients, deliver better outcomes and manage spending. Our goal is to deliver care in the right setting, avoid duplicating services and achieve high-quality outcomes.

Our Dallas market is gradually being defined by providers organizing themselves into competing high value networks. Insurers have attempted to build these networks in the past, but we believe they will never truly succeed because they are simply not at the front line of care, engaging regularly with the patients they serve and embedded in the community. In fact, in many areas of care delivery, insurers simply create a conflicting and duplicative layer of excess in the healthcare system. Moreover, they are not in a position to identify breakthrough innovations that can delight consumers with service and convenience, as well as deliver better health outcomes.

Therefore, much of this work to better organize the health care market into high value networks is both necessary and desirable. Policymakers need to differentiate between consolidations to create excessive market power from organization of the market into a high value network. Moreover, policymakers must be careful not to tilt the playing field to the advantage of one provider group over another. If, for instance, payment models create an unequal advantage for physician- versus hospital-led models, it will only lead to hospitals acting to protect themselves by hiring more physicians.

My final point is that while significant progress has been made to move the micro-managing Medicare fee-for-service system to a value-based payment and delivery system, this Congress and administration must continue to build on the positive steps that have been made. There



remain significant problems with the structure of and rules that govern these programs. With needed changes, we believe more organizations will move to and succeed in these alternative payment models, benefitting both Americans and our nation. Some of the areas of greatest need include:

- Removing regulatory barriers that impede integration of health care providers and undermine efforts to reduce costs and improve quality;
- Modernizing the legal framework that was created in the Medicare fee-for-service program to allow ACOs to tailor care practices which ensure they are providing the right care to the right patient at the right time;
- Increasing flexibilities for ACOs to design their own programs, such as establishing networks and altering benefit designs;
- Exempting Medicare ACOs' shared savings from the sequestration cuts to avoid the double hit that ACOs now incur;
- Specifically for the Medicare Shared Savings Program, we recommend:
 - Allowing providers to choose prospective assignment in all ACO models;
 - Better risk adjustment for the acuity of ACOs' patient population;
 - Creating a quality bonus system that rewards rather than penalizes high performers;
 - Allow an ACO to assume greater risk by moving to a higher risk track annually;
- Creating new voluntary alternative payment models, including bundled payment models where the health system can be conveners; and



- Modernizing a 40-year old confidentiality law that blocks providers' access to substance use information on their patients, impeding their ability to provide proper care coordination and presenting a serious threat to patient safety.

Many of these needed changes are laid out in "Premier's Delivery System Transformation Roadmap," which offers a number of thoughtful recommendations to move our nation's health care system to one that rewards value over volume. I strongly suggest the Committee review this Roadmap, of which the recommendations were derived both from organizations like Texas Health Resources and the collective experience of Premier's collaboratives.

Thank you for the opportunity to testify before this important Committee. You have made a vital and lasting positive impact on our nation's health care system with the design and enactment of MACRA. This has been pivotal progress that is working to benefit our patients, communities and our nation. I commend you for this accomplishment and urge you to build on this successful work.

Mr. BURGESS. The Chair thanks you for your testimony. The Chair would make an observation that it has been long a goal of mine to have a panel with five or six physicians before this subcommittee. This may be one of the first times this has happened in my experience. I wasn't really planning on talking about this aspect. I wanted to get five or six doctors in here to tell us how much economists should be paid.

Dr. Wulf, you are recognized for 5 minutes.

STATEMENT OF J. WILLIAM WULF

Dr. WULF. Thank you, Chairman Burgess, Ranking Member Green, and members of the Health Subcommittee for inviting me to testify today. I am pleased to be here to share with you how the move to Alternative Payment Models is working to transform the delivery of health care.

I am testifying today on behalf of CAPG. CAPG is the largest association in the country representing capitated physician organizations participating in coordinated care. CAPG members include over 300 medical groups and independent practices in 44 States, Washington, DC, and Puerto Rico. CAPG members have proven that APM-type models of payment and care delivery can lead to lower cost and higher quality.

I also address you today as a physician and the CEO of Central Ohio Primary Care Physicians. Our group consists of 370 physicians, 200 adult primary care physicians, 60 pediatricians, 75 hospitalists, and 25 specialists. COPC is the largest physician-owned primary care group in the country.

Let me begin by emphasizing a single point: The value movement is working. To underscore that point I will share with you our organization's journey into value-based payments and why being in an APM matters to primary care. We were formed in 1996 when 33 of us got together from 11 practices. Beginning in 2006 through 2014, we reported for PQRS when it was still PQRI, we deployed an EHR and we are now on our second generation EHR. All of our eligible providers met meaningful use. We too became Level 3 Patient-Centered Medical Homes.

All of these initiatives, every one of them, made being a PCP less satisfying in a fee-for-service world. In 2014, we entered into shared savings contracts with both commercial and Medicare Advantage payers. We sought contracting structures that reward PCPs for things that do not happen. If you are a primary care physician taking care of 1,500 patients and no one has colon cancer because they have all had their colonoscopies, you have created value. Value heretofore unrecognized by the primary care physician, but recognized by the employer or the payer.

We developed programs to improve care. This meant expanding our hospitalists program, developing transition of care nursing, hiring care coordinators, having visiting physicians who see only two patients in crisis a day, and having an ER intervention program where our nurses intercept our patients in the emergency room. In 2016, we earned \$12 million in shared savings for our primary care physicians that was returned to them. Our Medicare readmission rate on 4,000 Medicare admissions in 2016 was 7 percent. The national average is over 18 percent.

The ability to reward primary care physicians for high quality and lower cost is crucial to the preservation of primary care. In 2017, we desire to be in a Medicare APM. We qualified for CPC+ Track 2. CPC+ payment model allowed us with prepayment to expand our existing care coordination, move towards capitated payment because of the hybrid model, and receive quality payments. In 2018, we will move to prepaid contracts with downside risk on 25,000 Medicare Advantage lives.

Clearly, MACRA's incentives for advanced APM participation is the latest program driving us into new models of payment. Past programs have discouraged fee-for-service volume and APMs are now rewarding value and creating value. We are thrilled to see that last week CMS announced its intention to create an advanced APM demonstration in Medicare Advantage. With one-third of all Medicare lives in Medicare Advantage, it is crucial that it be rewarded like fee-for-service Medicare. In the MACRA final rule the agency states that participants in such demo will qualify as an APM. This is a crucial step forward and we thank the Members of Congress including those present at today's hearing and we encourage CMS to move forward.

Thank you for the opportunity to testify. I hope it has been helpful and I am pleased to answer questions.

[The prepared statement of Dr. Wulf follows:]



The Voice of Accountable Physician Groups

**Statement of Dr. J. William Wulf
CAPG – the Voice of Accountable Physician Groups
Before the House of Representatives Energy and Commerce Subcommittee on Health
November 8, 2017**

Thank you Chairman Burgess, Ranking Member Green, and Members of the Health Subcommittee for inviting me to testify today. I am pleased to be here today to share with you how the move to alternative payment models is working to transform the delivery of healthcare in our country to a model that is better for patients and physicians.

I am testifying today on behalf of CAPG. CAPG is the largest association in the country representing capitated physician organizations practicing coordinated care. CAPG members include nearly 300 medical groups and independent practice associations (IPAs) in 44 states, Washington, DC and Puerto Rico. CAPG believes that APMs are essential to building a delivery system that can meet the demographic and financial challenges facing the nation. CAPG members have decades of experience with APMs, including those that are risk based or capitated, and have proven that these models of payment and care delivery can lead to lower cost, higher quality care.

I also address you today as a physician and the Chief Executive Officer of Central Ohio Primary Care (COPC). Our group consists of 370 physicians, including 200 adult primary care providers, 60 pediatricians, 75 hospitalists and 25 specialists. COPC is the largest physician-owned primary care practice in the country. Our physicians provide care to over 350,000 patients in 65 offices across central Ohio.

915 Wilshire Boulevard, Suite 1620
Los Angeles, CA 90017
Telephone: 213-624-2274
FAX: 213-683-0032
www.capg.org

Let me begin by emphasizing a single point: the value movement is working. To underscore that point, I will share COPC's own journey into APMs with traditional Medicare and Medicare Advantage (MA) plans.

COPC's Value Journey

Like many primary care practices across the country, we started our movement toward value-based care delivery in the patient-centered medical home model (PCMH). At the time, we were looking for a way to organize our own physicians across different offices, in order to improve quality and access. We worked with the health plans in our local market to organize our doctors around a common set of clinical measures, bringing the clinical team together to focus on specific, aligned goals. Our local payers made a financial commitment to the model and as a result, we began to build the infrastructure that is necessary to move to risk-bearing payment models. We quickly saw that the PCMH model was both improving quality and bending the cost curve. We also recognized that PCMH was a stepping stone or building permit to move into shared savings and risk.

Based on PCMH results, we negotiated a shared savings arrangement with the health plans that would allow us to share in some of the cost savings that we were achieving for employers, patients as well as payers. We also entered a shared savings arrangement with our contracted Medicare Advantage (MA) plans for our 25,000 MA beneficiaries. To date, these arrangements have been upside only (we share in the savings but are not at risk for financial losses). In 2018, we will transition into downside risk and delegation for our Medicare Advantage lives.

As you know, in 2015, Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA). The law provided additional incentives to move into advanced APMs for our traditional Medicare population. Because of the incentives in the law and our successful

experience with APMs with other payers, we decided to move into Comprehensive Primary Care Plus (CPC+) in 2017. CPC+ is a multi-payer advanced medical home model that qualifies as an advanced APM under MACRA.

We knew that we wanted to be in the advanced APM track under MACRA and we had evaluated the model options available for our group. We believe that CPC+ would give us an opportunity to bring successful care management tools developed for our MA population to our fee-for-service population. This year we have 26,000 traditional Medicare beneficiaries and 180 physicians in CPC+. The model has several design elements that made it an attractive choice for our organization.

First, CPC+ reforms payment for our practice. Rather than relying solely on a flawed, volume-driven fee-for-service payment methodology, CPC+ combines prepaid, per-beneficiary-per-month payments with modified fee-for-service payments. We receive a care management fee calculated on a per-member-per-month basis. In addition, in CPC+, our fee-for-service payments are reduced. The withheld amount is instead paid to the group in lump sums on a quarterly basis. The pre-payment of funds allows us to invest in the infrastructure that we need to coordinate and manage care for our population. It has enabled us to bring successful care management models, like Transitions of Care (described below) to our fee-for-service population, resulting in better care at a lower cost.

Second, CPC+ uses robust performance based incentives that examine how well the practice performs on clinical quality, utilization, and patient experience. We know that performance measurement and accountability are essential in the movement from volume to value. CPC+ makes an upfront incentive payment for performance which is later reconciled against actual performance. If a participant falls below the performance standards, funds must

be repaid to the government. We believe that this is a critical element in a successful APM and will safeguard against concerns that may arise from the transition to advanced APMs.

Finally, the CPC+ program requires that its participants continue to build on the core competencies of population health management and improvement. For example, in the model, we identify and stratify our patient population. This means using data to identify the sickest patients and then tailoring our care processes and resources toward those patients. These patients often represent the most significant opportunity to improve care, reduce costs, and enhance quality. CPC+ provides the data and infrastructure for our FFS population to allow us to identify patients most in need and tailor services to those patients, to get them healthy and keep them healthy.

We are still relatively new to the CPC+ program, with this being the first year of implementation. What we already know is that this program provides the funding and payment model to allow us to bring our care management processes and tools to the FFS Medicare population.

Examples of Success with APMs: COPC Transitions of Care Program

Our Transitions of Care (TOC) nursing program is designed to create smooth transitions for patients who leave the hospital. When a COPC patient goes to the hospital, a TOC nurse will see the patient. From that point on the, TOC nurse will stay connected to that patient, through the time the patient leaves the hospital. The TOC nurse electronically schedules an appointment with the patient's primary care physician before the patient leaves the hospital. The nurse will also contact the patient 48 hours post discharge to check on the patient's health status, reconcile medications, and remind the patient about the follow up appointment. If the patient misses the appointment, the nurse will follow up with the patient and ensure the patient sees the primary care physician.

We know that this follow up appointment and the surrounding care coordination services work. The program has enabled us to keep our Medicare readmission rate to seven percent (as compared to a Medicare national average readmission rate of roughly 18 percent). The TOC program coupled with an expanded hospitalist program, care coordinators, visiting physicians and an expanded quality staff generated \$12 million in shared savings in 2016.

But, perhaps more importantly, this program has real life impact on our patients. In a fee-for-service system, a patient discharged from the hospital has little post-discharge planning. The patient may leave the hospital with instructions to call her physician, but there are few if any supports in place to ensure that visit happens. As a result, fee-for-service patients typically begin a vicious cycle of emergency room visits followed by post-discharge complications, landing the patient back in the hospital multiple times. Our TOC model, powered by the infrastructure of our APM participation, breaks this cycle.

The Importance of Advanced Alternative Payment Models

COPC physicians are committed to APMs because we see what they can achieve for patients and for the healthcare system as a whole. We are working, across payer types, to move away from fee-for-service payment and ultimately, toward pre-paid, capitated models. We know that these models offer better quality for patients at a lower cost. Importantly for groups like COPC, we also know that these models will save the practice of primary care, by getting our primary care physicians off the treadmill of fee-for-service and enabling them to spend the time with patients that need the most attention and to be paid for keeping their patients healthy.

First, APMs are demonstrated to improve quality and reduce cost. A recent study by the Integrated Healthcare Association (IHA) examined the health care quality and cost across the state of California. Looking at results for 24 million patients, IHA found that:

- Capitated commercial contracts outperform fee-for-service commercial products on cost and quality. The capitated model outperformed the fee-for-service model on five of six quality measures and cost, on average, \$200 less per patient annually;
- Statewide emergency department visits, all cause readmissions, and inpatient bed days were all between 50 percent and 75 percent higher in fee-for-service than in capitated, coordinated Medicare Advantage;
- A coordinated care delivery system is a key factor in the success of capitated payment models.¹

A recent study in the American Journal of Managed Care compared two physician organizations in Medicare Advantage, one where the MA plan paid its downstream physicians with fee-for-service, the second where the MA plan paid its downstream physician organization a capitated payment. The capitated group had higher quality and generated cost savings.

Specifically, the patients in the capitated (advanced APM) group had a six percent better survival rate and a 32.8 percent lower risk of dying as compared to the FFS group. The capitated group reduced emergency department visits and inpatient hospital admissions by 11.2 percent and 11.9 percent respectively. The reduction in ED visits resulted in an estimated savings of \$100,915. The reduction in inpatient admissions resulted in a savings of \$1,756,869.

In our view, these improvements to quality and patient experience flow from a payment and delivery model that encourages physicians and other care team members to focus on providing the right care for their population. In APMs, incentives are re-aligned toward team-based care, a focus on preventing illness and disease progression, and providing care in the right

¹ Integrated Healthcare Association, Benchmarking California Health Care Quality and Cost Performance (2016), available at <http://www.ihc.org/sites/default/files/resources/issue-brief-cost-atlas-2016.pdf>.

place at the right time. Participating in models like CPC+ brings us one step closer to this ultimate end-goal.

It is no secret that the healthcare system faces serious challenges in the years to come. Baby boomers are aging into Medicare at a rate of about 10,000 per day, seniors are living longer, and often with multiple chronic conditions. These demographic shifts necessitate a more robust primary care work force. I believe that our country is already facing a crisis in primary care and that these challenges could exacerbate the problem.

Along with other policy changes, the shift to advanced APMs can help save primary care. In a fee-for-service payment model, physicians are on a treadmill of sorts. Over the last 6-8 years programs such as PCMH, PQRS and Meaningful use have slowed the delivery of care due to increased documentation requirements. The electronic health record you have incentivized is a better record but it is much more difficult to complete a visit. Current delivery models have already curtailed volume so it is imperative we continue to move forward and pay for value. Without pay for value the only way a primary care physician can maintain their compensation is to see more patients. This can lead to burnout, frustration, and a feeling that the physician does not have time to have meaningful interactions with patients.

APMs can get our doctors off that treadmill. We pay our doctors to keep their patients healthy, we reward our physicians for their performance on quality and efficiency metrics, not the volume of services provided. The result is two-fold, they are less focused on volume, to be sure. But our physicians also see that their patients are getting the care they need and are healthier as a result. In all, we believe that APMs are key to a more satisfying, sustainable way to practice medicine. We think that APMs are one piece of the puzzle for saving primary care in this country.

Medicare Advantage APMs

Clearly, MACRA's incentives for advanced APM participation have played a role in driving us into new models in advanced APMs. This is true for other CAPG members as well. We believe it is equally important to have these incentives for risk contracting (advanced APM participation) in Medicare Advantage as well. As you know, a third of all seniors are enrolled in Medicare Advantage. In some parts of the country, more than half of the senior population is enrolled in an MA plan. MA has reached a size and strength where its role in delivery system and payment reform simply cannot be ignored.

We were thrilled to see that CMS announced its intent to create an advanced APM demonstration in MA. In the MACRA final rule for 2018, the agency says that participants in such a demo can qualify as advanced APM participants for 2018 through 2024. This is a crucial step forward that will allow additional doctors to participate in advanced APMs and will also align incentives across Medicare. We thank all the Members of Congress, including those present at today's hearing who encourage CMS to move forward with this important policy change.

Conclusion

Thank you for the opportunity to testify today. I hope this testimony has been helpful as you consider the status of the value movement and the role MACRA has played to accelerate delivery system transformation. I am pleased to answer any questions.

Mr. BURGESS. The Chair thanks the gentleman.

The Chair recognizes Dr. Edgerton 5 minutes for your opening statement, please.

STATEMENT OF COLIN C. EDGERTON

Dr. EDGERTON. Chairman Burgess, Ranking Member Green, Chairman Walden, Ranking Member Pallone, and distinguished members of the Health Subcommittee, thank you for the opportunity to speak before you today.

My name is Dr. Colin Edgerton and I am rheumatologist in a small private practice at Low Country Rheumatology in Charleston, South Carolina. I am one of seven rheumatologists in a single specialty group. Our practice is a typical rheumatology practice with around 50 percent of our patients being in Medicare along with a significant number of TRICARE patients and a smaller group of Medicaid patients. The remaining group of patients are in the commercial segment.

Because South Carolina, like most areas of the country, suffers from a shortage of rheumatologists, our patients may travel long distances, commonly 1½ to 2 hours, to see us and receive treatment. As a result, we see a mix of urban, suburban, and rural populations. In addition to my work as a rheumatologist, I am also privileged to be involved with the American College of Rheumatology, where I currently chair the committee on rheumatologic care. The ACR represents approximately 9,500 rheumatologists and rheumatology health professionals.

Community physicians including rheumatologists are keenly aware of the opportunities created by MACRA for developing models to promote value-based care. Before MACRA there really was no meaningful way for small specialties and small practices to participate in Alternative Payment Models. As rheumatologists, we did not have the opportunity to engage in APMs. Our specialty simply did not fit into the previously existing value-based products.

Coming from a community practice setting, even just a few years ago I would not have considered myself someone who could get involved in an APM. But with the repeal of the SGR formula, an institution of MACRA, rheumatologists saw for the first time a structured opportunity to participate in value-based medicine.

There are several reasons that I and also the ACR have been excited to get involved in creating APMs under MACRA. Most notably, we immediately saw the benefits of APMs, recognizing that certain aspects of care provided by rheumatologists as cognitive specialists are undervalued in the current system. In many instances, the value of training and expertise provided by rheumatologists is not recognized in payment outside of innovative models. Additionally, non-face-to-face care and chronic disease care coordination with other providers are critically important but not reimbursed services provided by rheumatologists every day. And like other specialists that are developing APMs, rheumatologists know that these valuable services prevent costly or unnecessary procedures and lower overall costs.

My early foray into value-based medicine involved reaching out to leaders in the AMA initially who had experience with value-based projects through CMS. This finally led me to the Physician-

Focused Payment Model Technical Advisory Committee, PTAC, whose members have been generous with their time, listening to my ideas, and guiding my progress. The ACR simultaneously has begun developing an APM and I have been fortunate to participate as a representative of the community of rheumatologists.

The ACR's APM is approaching its testing phase and my partners and I are eager to be a pilot site. The ACR's APM addresses the treatment of rheumatoid arthritis, a lifelong condition whose care depends on the stage of the disease. The APM reflects the varied involvement of the rheumatologist during these distinct stages of care, splitting payment into an initial stage for diagnosis, including, for example, communication with primary care physicians followed by ongoing care stratified by the disease severity and other illnesses that complicate disease treatment. This model aligns payment with physician work and reimburses services that have traditionally been undervalued.

Quality measures are built into the APM to ensure treatment adheres to best practices. Rheumatologists as a specialty are energized by the opportunity to provide our patients value-based care through this framework. We look forward to participating with more physician participation in APMs. Specifically, smaller practices are eager to participate in APMs as well, and allowing some of the downside risk to be covered could help those practices get involved.

Regarding timelines, as soon as MACRA was codified many specialties began to look at APMs, and I am hearing that a reduction in the qualification thresholds could allow these eager physicians to utilize the APM framework.

We appreciate the committee's work to get us to this point and we look forward to continuing to develop and implement innovative new payment models that offer the opportunity to provide better patient care aligning payment with highly valued services. Thank you again for inviting me and I am happy to address any questions the committee may have.

[The prepared statement of Dr. Edgerton follows:]

Colin C. Edgerton, MD, FACP, FACR, RhMSUS

Testimony – Committee on Energy and Commerce

Subcommittee on Health

Wednesday, November 8, 2017

Chairman Burgess, Ranking Member Green, Chairman Walden, Ranking Member Pallone, and distinguished members of the Health Subcommittee, thank you for opportunity to speak before you today. My name is Dr. Colin Edgerton, and I am a rheumatologist in a small private practice at Low Country Rheumatology in Charleston, South Carolina, where I am one of seven rheumatologists in a single-specialty group.

Our practice is a typical rheumatology practice, with around 50 percent of our patients being in Medicare, along with a significant number of Tri-care patients and a smaller group of Medicaid patients. The remaining group of commercial patients makes up approximately 40 percent of our patient population. As rheumatologists, many of the diseases we treat affect the Medicare population, although autoimmune diseases do also strike younger Americans as well.

Because South Carolina, like most areas of the country, suffers from a shortage of rheumatologists, our patients may travel long distances (commonly 1.5 to 2 hours) to see us and receive treatment. As a result, we see a mix of urban, suburban, and rural populations in our practice. In addition to my work as a rheumatologist caring for patients with rheumatic disease in our small private practice, I am also privileged to be involved as a volunteer with the American College of Rheumatology (ACR), where I currently chair the Committee on Rheumatologic Care. The ACR represents approximately 9,500 rheumatologists and rheumatology health professionals.

Community physicians including rheumatologists are keenly aware of the opportunities created by the Medicare Access and CHIP Reauthorization Act (MACRA) for developing models to promote

value-based care. Before MACRA there really was no meaningful way for small specialties or small practices to participate in alternative payment models (APMs). As rheumatologists we did not have the opportunity to engage in early APMs because our specialty did not fit into the previously existing value-based projects. Looking back just a few years, I recognize that, coming from a community practice setting, I would not have considered myself someone who could get involved in an APM. But with the repeal of sustainable growth formula (SGR) and institution of MACRA, rheumatologists saw for the first time a structured opportunity to participate in value-based medicine.

There are several reasons that I and also the ACR have been excited to get involved in creating APMs under MACRA. Most notably, we immediately saw the benefits of APMs, recognizing that certain aspects of care provided by rheumatologists as cognitive specialists are undervalued in the current system. We are trained to recognize and diagnose rheumatologic diseases and other illnesses that complicate treatment, and to communicate with patients, their family and their doctors to maximize the treatment plan. Yet in many instances, the value of the training and expertise provided by rheumatologists is not always recognized in payment outside of innovative models. Services such as non-face-to-face care and chronic disease care coordination with other providers are examples of critically important but non-reimbursed services provided by rheumatologists every day. And, like other specialists that are developing APMs, rheumatologists know that these valuable services prevent costly or unnecessary procedures and lower overall costs.

My early foray into value-based medicine involved reaching out to leaders in the AMA who had experience with value-based projects at the Centers for Medicare and Medicaid Services (CMS). This led me to the Physician-Focused Payment Model Technical Advisory Committee, or PTAC, whose members have been generous with their time listening to my ideas and guiding my progress. The ACR simultaneously began developing an APM and I have been fortunate to participate in this process as a

representative of community rheumatologists. The ACR's APM is approaching its testing phase, and back home my partners and I are eager to be a pilot site and to help "work out the kinks."

The ACR's APM addresses the treatment of rheumatoid arthritis (RA), a life-long condition whose care depends on the stage of the disease. The ACR's APM reflects the varied involvement of the rheumatologist during these distinct stages of care, splitting payment into an initial stage for diagnosis (including, for example, communication with primary care physicians), followed by ongoing care stratified by the disease severity and the other illnesses that complicate treatment. This model aligns payment with physician work and reimburses for services that have traditionally been undervalued. Quality measures are built into the APM to ensure treatment adheres to best practices.

One of the most important components of MACRA is its emphasis on physician-generated value-based initiatives. In support of that emphasis, the PTAC has been created and it is obvious that it is made up of people who are committed to "beating the bushes" around the country to engage physicians at the grass-roots level, and providing guidance even before an APM is formally submitted. The feedback that PTAC provides to organizations developing and submitting APMs has been enormously helpful.

Rheumatologists as a specialty are energized by the opportunity to provide our patients value-based care through this framework, and we look forward to more physician participation in APMs. Smaller practices are eager to participate in APMs, and allowing some of the downside risk to be covered could help those practices get involved. Regarding timelines, as soon as MACRA was codified many specialties developed APMs, and I am hearing that a reduction of the qualification thresholds could allow these eager physicians to utilize the APM framework.

We appreciate the Committee's work to get us to this point and we look forward to continuing to develop and implement innovative new payment models that offer the opportunity to provide better patient care-- aligning payment with highly value services. Thank you again for accepting this testimony and I am happy to address any questions the Committee may have.

Mr. BURGESS. The Chair thanks the gentleman.

Dr. Kavanagh, you are now recognized for 5 minutes, please, for an opening statement.

STATEMENT OF BRIAN KAVANAGH

Dr. KAVANAGH. Thank you, Chairman Burgess, Ranking Member Green, and members of the Health Subcommittee. I am a radiation oncologist at the University of Colorado. I treat cancer patients there. I serve as the chair of the board of directors for the American Society for Radiation Oncology, also known as ASTRO.

ASTRO represents more than 10,000 individuals striving to give cancer patients the best possible care. ASTRO's membership includes radiation oncologists, nurses, cancer biologists, medical physicists, and other healthcare professionals. Close to 60 percent of all cancer patients will receive radiation therapy and ASTRO's members treat more than one million cancer patients each year.

Radiation therapy is a safe and effective treatment for cancer. It works by damaging a cancer cell's genetic material thus stopping its growth. When the injured cancer cells die the body's natural healing processes remove them. Most treatments are given as outpatient procedures and so patients can maintain a high quality of life while receiving treatment. Of the million patients treated annually with radiation therapy, about 60 percent receive care in hospital outpatient departments and the other 40 percent receive care in freestanding community-based centers.

Radiation oncology centers have extremely high fixed costs. The minimum capital to build one is approximately 5½ million dollars. Radiation oncology reimbursement rates have had cumulative payment cuts totaling approximately 20 percent for freestanding community-based centers in recent years. These payment cuts created instability throughout the profession, jeopardizing the viability of these centers and patient access to care.

ASTRO very much appreciates Congress' longstanding support of radiation oncology, perhaps best exemplified by the bipartisan passage of the Patient Access and Medicare Protection Act of 2015 or PAMPA. However, PAMPA is not a permanent solution and it only stabilizes radiation oncology payments temporarily through the end of 2018. We believe it is critical that radiation oncologists have an Advanced Alternative Payment Model before PAMPA expires.

The Medicare Access and CHIP Reauthorization Act, MACRA, has provided ASTRO with an opportunity to pursue an APM that promotes high-quality care and moves us beyond the prior era of uncertainty. Recently, the Center for Medicare and Medicaid Innovation, CMMI, released a report to Congress which outlined design considerations for implementing an advanced APM in radiation oncology. ASTRO has proposed a Radiation Oncology Alternative Payment Model, the ROAPM, and we are pleased to see that our proposal is concordant with the concepts for an advanced APM in the CMMI report.

Currently, there is only one oncology-focused advanced APM, the Oncology Care Model, the OCM. However, ASTRO is concerned that this model does not adequately address the needs of patients who need radiation therapy and ROAPM is needed to fully realize the benefit of multidisciplinary care for patients. And we believe

that the ROAPM would complement and build upon the foundation set forth by the OCM.

The ROAPM is designed to incentivize the appropriate use of cancer treatments that result in the highest quality of care and best patient outcomes. The model applies to a comprehensive list of cancer disease sites that account for more than 90 percent of Medicare spending on radiation therapy and include breast, lung, prostate, colorectal, and head and neck cancers.

The ROAPM uses care episodes that are clearly defined by billing codes that punctuate the beginning and end of a treatment course and the 90-day period thereafter. An episodic payment rate will enable practitioners to focus on high-value patient care. The model features a two-sided risk corridor with an opportunity for shared savings but also accountability for excess resource utilization. Throughout the episode, physicians must adhere to strict clinical practice guidelines.

These guidelines help to ensure that patient care is appropriate and of the highest quality without over or undertreating patients. In addition, the model rewards participation in a robust practice accreditation program and measures performance on accepted quality measures to promote safe, high-quality care. The ROAPM also rewards shared decision making with patients, efficient communication with other providers caring for the patient, and survivorship planning.

In summary, ASTRO would like to thank Congress very much once more for repealing the SGR with the MACRA legislation. MACRA has ended the significant instability associated with the SGR and created a forward-looking framework for the advancement of value-based care. ASTRO fully embraces the spirit and goals of MACRA and is committed to ensuring that radiation oncology can fully participate in advanced APMs to drive higher quality, cost effective cancer care.

The proposed ROAPM incentivizes the use of appropriate cancer treatments that produce the best possible outcomes for patients, helps rein in Medicare spending, can stand on its own or dovetail with other APMs, uses well-established guidelines, and contains key patient engagement components. After experiencing significant payment cuts under Medicare fee-for-service in recent years, the field of radiation oncology needs long-term payment stability and predictability to secure patient access to care. ASTRO is committed to moving full speed ahead to ensure that radiation oncology can participate in advanced APMs under MACRA that drive greater value in cancer care. The next step is implementation of the ROAPM before December 31st, 2018.

Thank you for the chance to speak with the committee.

[The prepared statement of Dr. Kavanagh follows:]

U.S. House of Representatives

Committee on Energy and Commerce

Subcommittee on Health

Hearing titled, "MACRA and Alternative Payment Models:

Developing Options for Value-based Care"

Testimony of:

Brian Kavanagh, MD, MPH, FASTRO

Chairman, American Society for Radiation Oncology (ASTRO)

November 8, 2017

The American Society for Radiation Oncology (ASTRO) represents more than 10,000 people who strive to give cancer patients the best possible care and to advance the science of oncology.

ASTRO's membership includes radiation oncologists, nurses, cancer biologists, medical physicists, and other health care professionals who specialize in treating patients with radiation therapy. ASTRO's members work in various clinical settings including hospitals, freestanding community-based radiation oncology centers, and academic research institutes. Together, they make up the radiation therapy treatment teams that are critical in the fight against cancer. Of the estimated 1.7 million people diagnosed with cancer each year, ASTRO's medical professionals will treat more than one million of them, as close to 60 percent of all cancer patients will receive some form of radiation therapy as part of their treatment program. As the leading organization in radiation oncology, ASTRO is dedicated to improving patient care through professional education and training, support for clinical practice and health policy standards, the advancement of research, and advocacy.

Radiation Therapy

Radiation therapy, or radiotherapy, is the use of ionizing radiation to treat cancer and certain other diseases. Radiation therapy is proven to be safe and effective across a broad spectrum of cancer types. Radiation therapy works by disrupting the genetic material that drives cancer cells to grow and spread. When these damaged cancer cells die, the body's natural healing processes remove them. Normal tissues are also affected by radiation, but they are able to repair themselves in ways that cancer cells cannot. Radiation therapy has many benefits, including allowing patients to maintain their quality of life during treatment. Almost

all radiation therapy treatments are delivered as out-patient procedures; thus, patients receive treatment without the need to be hospitalized.

Modern cancer care requires the coordination of multiple cancer disciplines and specialists who contribute to the overall care and well-being of the patient. For each patient, radiation oncologists develop and operationalize a multi-step, customized plan to deliver the radiation therapy exclusively to the tumor-bearing area while protecting the surrounding normal tissue to the maximum extent possible. Radiation therapy can be delivered in numerous ways: externally, internally, and through surface application. During external beam radiation therapy, the radiation oncology team uses a machine to direct high-energy x-rays or particle beams toward the cancer. Internal or surface radiation therapy, also called “brachytherapy,” involves placing radioactive material (i.e., radioactive seeds) inside the patient or on the surface of their body. Depending on patient-specific considerations, the total radiation dose prescribed for the patient may be given in one session or over the course of multiple sessions. Systemic therapies, such as chemotherapy or immunotherapy, are often strategically combined with radiation therapy to provide synergistic benefits for patients with certain types of cancer. Radiation therapy is used in some cases as the only modality directed locally to the tumor, and in other cases it is given pre- or post- surgery to maximize the chance of the complete eradication of a primary tumor.

Access to Radiation Oncology Care

ASTRO is committed to always putting patients first and believes that moving away from fee-for-service to value-based health care will help patients and drive greater value in cancer care. The Society applauded the repeal of the Sustainable Growth Rate (SGR), which created

years of instability and uncertainty in health care, and supported the development of a new value-based Medicare physician payment system in the Medicare Access and CHIP Reauthorization Act (MACRA).

Radiation oncology centers differ from most other specialty centers in that they have extremely high fixed costs. The minimum total capital required to build a freestanding radiation oncology center is approximately \$5.5 million. These facilities require an additional minimum \$2 million in annual operating and personnel expenses. A linear accelerator is the primary machine used to provide radiation treatment, and it stands about nine feet tall and 15 feet long and weighs more than nine tons. The machine must be housed in a specially shielded room with thick concrete walls. As a result, it requires millions of dollars to install the basic machinery before the first patient exam room is even added. This substantial upfront capital investment, combined with required machine maintenance contracts and salaries for highly skilled technical staff, means that fixed costs in radiation oncology are significant. About 60 percent of patients treated with radiation therapy receive care in hospital outpatient departments, and the other 40 percent receive care in freestanding community-based centers. Radiation oncology reimbursement rates have sustained significant cuts in recent years, resulting in cumulative payment reductions totaling approximately 20 percent for freestanding community-based radiation oncology centers. The payment cuts created immense instability throughout the field, jeopardizing the continued viability of these centers and patient access to the high-level care the centers provide.

The onslaught of recent reimbursement reductions and future uncertainty is putting the profession at risk. ASTRO urges Congress to prevent any additional Medicare payment cuts to

community-based radiation oncology centers and preserve access to these critical services for the more than 400,000 cancer patients who are treated annually in community-based centers.

Patient Access and Medicare Protection Act (PAMPA)

ASTRO and the radiation oncology community remain extremely grateful for the bipartisan, unanimous passage of the Patient Access and Medicare Protection Act of 2015 (PAMPA), which temporarily halted cuts to Medicare payments for radiation oncology through the end of 2018. PAMPA created a more stable environment for ASTRO to work with the Centers for Medicare and Medicaid Services (CMS) on an alternative payment model (APM) and valuation issues involving key radiation treatment delivery and image guidance codes. However, it is not a permanent solution, and time is running out. Fortunately, MACRA has provided the radiation oncology specialty with an exciting opportunity to pursue an APM that could achieve the goal of incentivizing high-quality, high-value care while also offering a long-term solution to this instability. ASTRO has used the temporary stability provided by the payment freeze in PAMPA to enthusiastically pursue a Radiation Oncology Alternative Payment Model (RO-APM). It is critical that radiation oncologists have an opportunity to participate in an APM to realize the goals of MACRA.

PAMPA also included a mandate for the Center for Medicare & Medicaid Innovation (CMMI) to research and develop a report on an alternative payment model for radiation oncology. On November 3, 2017, CMMI released their report to Congress, "Episodic Alternative Payment Model for Radiation Therapy Services." The CMMI report outlined important payment model design considerations for implementing an Advanced APM in radiation oncology. The report describes the delivery of radiation therapy services, why Medicare beneficiaries may

need radiation therapy services, and how Medicare pays for these services. The report also described several APM design considerations: the rationale for such a model, expectations of clinical practice transformation, the potential scale and alignment with other initiatives, and the measurement of improved clinical quality and patient experience. The report also noted that the model could address many of the challenges with the current payment systems and that it has the potential to provide stability in radiation therapy payments.

ASTRO appreciates that the CMMI report identifies the key model design elements and provides a viable path forward to ensure the field of radiation oncology can be at the forefront of efforts to improve the patient experience, elevate treatment quality, and lower overall costs for cancer patients. ASTRO was pleased that the report aligned with the ASTRO-proposed RO-APM. We believe the RO-APM will incentivize the appropriate use of cancer treatments that result in the highest quality of care and best patient outcomes. In addition to the enhanced patient experience, ASTRO supports the sentiments expressed in the report aimed at providing stability in radiation therapy payments by creating the RO-APM to address the unique needs of the profession.

Radiation Oncology Alternative Payment Model (RO-APM)

Currently, there is only one oncology-focused model in the Advanced APM portfolio: the Oncology Care Model (OCM). While the OCM is a step in the right direction, there is a risk that it could inadvertently discourage optimal multidisciplinary care coordination. The OCM's potential unintended consequence is to incentivize an overly minimalist approach. As a result, practices may be rewarded for excluding certain therapies, including radiation therapy, within each six-month episode of care. ASTRO believes that the RO-APM will complement and build

upon the foundation set forth by the OCM and encourage the interdisciplinary coordination of care for cancer patients' overall well-being.

ASTRO embraces the spirit and goals of MACRA and is committed to ensuring that radiation oncology can fully participate in an APM that drives greater value in cancer care. ASTRO has been working with stakeholders to develop the RO-APM in a form consistent with the goals of MACRA. The Society believes the recent report from CMMI validates the collaborative process and diligent efforts that were undertaken to construct the RO-APM.

The RO-APM would provide the field of radiation oncology with a meaningful and viable opportunity to participate in the evolving world of health care payment reform as initiated by MACRA. The model has three primary goals:

1. To reward radiation oncologists for participation and performance in quality initiatives that improve the value of health care for patients.
2. To ensure fair, predictable payment for the radiation oncologist in both hospital and freestanding community-based cancer centers to protect cancer patients' access to care in all settings.
3. To incentivize the appropriate use of cancer treatments that result in the highest quality of care and best patient outcomes.

Stakeholders involved in the development of the RO-APM include leading members of the radiation oncology community who practice in hospital and/or freestanding community-based radiation oncology centers. In addition to engaging key stakeholders, ASTRO has closely monitored the activities of the Physician-Focused Payment Model Technical Advisory Committee (PTAC). ASTRO also met with the CMS Innovation Center on multiple occasions to

solicit advice and guidance from agency experts regarding the development of Advanced APMs. It is ASTRO's goal to provide stability to the delivery of radiation therapy for patients, and the radiation oncologists who treat them, by attaining implementation of the RO-APM before January 1, 2019.

The American Cancer Society estimates there were 1.7 million new cancer cases in 2016. Among these cancer patients, 250,000 were diagnosed with breast cancer; 225,000 were diagnosed with lung cancer; 181,000 were diagnosed with prostate cancer; 95,000 were diagnosed with colorectal cancer; and 72,100 were diagnosed with head and neck cancer. Medicare SEER data analysis indicates that, of the Medicare patients receiving radiation therapy, 83 percent had one of the five primary disease sites, accounting for 93 percent of the total Medicare spend on radiation therapy services between 2007 and 2012.

The RO-APM applies to the five primary disease sites: breast, lung, prostate, colorectal, and head and neck. Individual disease sites are not divided further for the purposes of payment (e.g., all breast cancer cases have the same modeled payment). The model also applies to two secondary disease sites: bone metastases and brain metastases. The primary disease sites usually involve curative treatment, while the secondary disease sites typically involve symptom-relieving palliative intent. The RO-APM replaces fee-for-service payment with an episode-based payment that remains the same regardless of the course, modality, or length of treatment. Through this structure, the RO-APM meets the goal of replacing volume-based care with value-based patient care. With many hurdles along the way, ASTRO believes that technical assistance from PTAC, and data sharing from CMS, would be beneficial for all organizations looking to create an APM, as access to CMS data was critical in creating the RO-APM.

According to the RO-APM, when a patient has an International Classification of Diseases (ICD-10) diagnosis code corresponding to one of the seven disease sites included in the model, eligibility is established. After the patient gives informed consent to be treated with radiation therapy, an episode is triggered by one of three distinct radiation therapy treatment planning codes: Current Procedural Terminology (CPT) codes 77261, 77262, or 77263. The episode of care begins at this time and concludes 90 days after the last radiation therapy treatment. Throughout the episode, participating physicians must adhere to well-vetted clinical practice guidelines, including ASTRO guidelines, where applicable, and the National Comprehensive Cancer Network (NCCN) guidelines. ASTRO believes that the requirement for guideline adherence is a major strength of the RO-APM. These guidelines help to ensure that patient care is appropriate and of the highest quality without over- or under-treating patients who need radiation therapy.

Medicare claims data from a specific reference period will be used to determine payments per episode within a disease site. A participating provider's target rate will be based on a blended average of his or her own practice's historical reimbursement rate, along with regional and national benchmark rates for the same episode of care. The provider will be paid a portion of the target rate once an episode is triggered and a portion of the target rate at the completion of the episode. The model features a two-sided risk corridor, in which a provider may share in savings if spending is lower than the target. However, providers who exceed the target would be responsible for any overpayment up to a specific amount. These tenets are part of the built-in guardrails to ensure that appropriate care is being provided throughout the treatment delivery process.

The quality component of the RO-APM is comprehensive. It begins with a patient engagement component that involves shared decision making, nurse care management, care plan development, specialty care communication, and survivorship planning. ASTRO has established the Accreditation Program for Excellence (APEX), and to achieve APEX certification requires meeting or exceeding a series of standards relating to the quality performance of a radiation oncology practice. To be recognized for the highest level of quality in the RO-APM, APEX accreditation or accreditation through a similarly rigorous program is necessary. Additional quality measures based on guidelines that are disease-site-specific will be layered on top of accreditation. The purpose of these quality measures is to track how frequently participating practices are adhering to the specific guidelines identified as part of the model. Adherence to clinical guidelines can improve the quality, outcomes and cost effectiveness of health care. After a pay-for-reporting period to establish a benchmark for quality data, a pay-for-performance mechanism will be implemented. This mechanism will modify payment in future years based on quality performance. Similar to the Bundled Payments for Care Improvement (BPCI) model, the base rate discount will be modified in future years based on quality measures' performance in a prior year.

We believe the RO-APM is consistent with Advanced APM characteristics stated in the Quality Payment Program (QPP). We are further encouraged by the recent CMMI report to Congress endorsing that physicians should assume accountability for controlling the total cost of Medicare spending related to the treatment of cancer with radiation therapy, as well as the total cost of Medicare spending on all services the patient receives during the episode of care.

Conclusion

ASTRO appreciates Congress' longstanding strong support of radiation oncology, which has contributed substantially to better cancer outcomes while protecting access to care. The Society has devoted significant resources to the development of the RO-APM and is committed to ensuring that radiation oncology can meaningfully and fully participate in Advanced APMs to drive greater value in cancer care. ASTRO believes that the RO-APM:

- Incentivizes the use of appropriate cancer treatments that produce the highest quality and best outcomes.
- Helps physicians assume accountability for controlling the total cost of Medicare spending related to cancer during the episode of care.
- Can stand on its own or dovetail with other oncology alternative payment models.
- Requires adherence to nationally recognized clinical guidelines.
- Contains patient engagement components including shared decision-making, nurse care management, care plan development, specialty care communication, and survivorship planning.

After experiencing significant payment cuts under Medicare fee-for-service in recent years, the field of radiation oncology needs long-term payment stability and predictability to secure patient access to care. It is critical that there is an Advanced APM option available to radiation oncologists before the PAMPA payment freeze expires December 31, 2018. ASTRO believes the RO-APM is a smarter way to pay for radiation oncology services and will lead to better value for Medicare and patients. ASTRO looks forward to continued opportunities to work with Congress and CMMI to refine and implement this model.

Mr. BURGESS. The Chair thanks the gentleman.

And Dr. Opelka, you are recognized for 5 minutes for an opening statement, please.

STATEMENT OF FRANK OPELKA

Dr. OPELKA. Mr. Chairman, Ranking Member Green, distinguished members of the committee, we thank you for the opportunity, the privilege to come before you today on behalf of the 84,000 members of the fellows who are members of the American College of Surgeons.

MACRA, to us, created a unique opportunity for physicians to lead in the development of APMs. When you think about it, since the inception of fee-for-service over a half a century ago, clinical care has become increasingly more complex. We have many more medications and technologies upon which to treat patients. And the only way to succeed has been for us to form teams, teams of care around patients for which these patients suffer.

So we have come together in thinking about Alternative Payment Models in team-based episodes of care to add to the library of Alternative Payment Models to be considered. We lacked the opportunity to build business models or payment models around team-based care until MACRA came along with the advanced APM opportunity. When you consider what has to go forth in building that APM model there are five general principles that I think that would be helpful to think about as you do this.

First is the clinical care model, something we as clinicians are all expert at, and those are those complex models of team-based care that have changed today. Second are the quality measures that assure that those models are effective. Third, what are the payment models the insurer has? That is that technical component that makes it difficult to build the APM. We as clinicians are not those who have the technical skills of building the payment model aspects.

Fourth is changing our business operations from fee-for-service into these alternative risk-based models. And fifth, the actual structure of risk, what is involved? There are all sorts of aspects to risk. There is insurance risk. There is clinical risk. There is operational risk of having the right team ready to meet those clinical risks.

The PTAC has been a wonderful experience for us. We learned with them. They were hypercritical of our model and helped us in framing the model and making necessary adjustments and corrections to the model. There was an enormous back and forth between our team, the American College of Surgeons, and our partner Brandeis University in building the APM model. We partnered with Brandeis because of their knowledge in the Medicare cost measurement system and their role in developing the CMS Episode Grouper that is used by Medicare to frame the actual cost structure of different episodes.

The Episode Grouper allowed us to provide risk-adjusted, patient-individualized, significant target prices. Not a bundle, but a patient episode price, extremely granular information that allowed us to create an operational model for national scaling of an implementation of an APM. When we come about the quality aspect of

this, the ACS has a centurylong experience in multiple registries that we use worldwide in defining, measuring, and improving quality of care.

Our ACS optimal resource for surgical quality and care and safety division runs things like the National Surgery Quality Improvement Program. These gave us a framework upon which to build an episode-based measure framework. Stop measuring physicians and measure patients. How did the patient do? If the patient did well, reward the team. If the patient didn't do well, it is time to penalize the team.

So let's measure patients and what they do and not the individual physicians and make us all have shared accountability because that is what patients expect us to do. We have added to this the ability to put in the phases of care across the episode. For example, in surgery there is a preop phase, an intraop phase, a postop phase, post-discharge phase. We have also put in patient-reported outcomes which we think create meaningful measures. So instead of measuring here and there across a surgeon's experience, we are measuring the episode for the patient. We think that is critically important. The episode-based measure framework coupled with the EGM allows us to create quality cost measures with teams of providers to influence the patient experience and outcome.

Assigning risk—this is the difficult part. Asymmetric risk, we don't think symmetric risk, same upside-downside risk really draws in what we need. We think you need asymmetric risk, more upside to bring people out of fee-for-service into the model and significant enough downside to protect the patients and the payer as well.

So that is the nuts and bolts of what we put forward. The PTAC process has given us considerable experience and input. And moving forward now, we have gone through PTAC in December all the way through March with approval in April. That went to the Secretary, and within a couple months we heard back from the Secretary giving us further direction, further clarification, testing and piloting with CMS and CMMI. We have been working with them almost on a weekly basis since then in walking forward in workgroups to deal with intellectual property, refinement of validity and reliability of the modeling, further questions about how the EGM grouper is used in the model, and the quality and the risk adjustment aspects of the overall model.

Once again, Mr. Chairman, we thank you and your committee for all your efforts in this regard, and we look forward to your questions.

[The prepared statement of Dr. Opelka follows:]



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**AMERICAN COLLEGE
OF SURGEONS**

*Inspiring Quality:
Highest Standards,
Better Outcomes*

**Statement of the
American College of Surgeons**

Presented by

Frank Opelka, MD, FACS

**Before the
Subcommittee on Health of the
Committee on Energy and Commerce
United States House of Representatives**

**RE: MACRA and Alternative Payment Models:
Developing Options for Value-Based Care**

November 8, 2017

Chairman Burgess, Ranking Member Green, and Members of the Committee, on behalf of the more than 80,000 members of the American College of Surgeons (ACS), I wish to thank you for inviting the ACS to participate in this hearing. We have been very active in working to improve the value of care, both through our longstanding commitment to continuous quality improvement as well as our more recent endeavor to develop the ACS-Brandeis Advanced Alternative Payment Model (A-APM) proposal.

MACRA and the Decision to Develop an APM

In the weeks following the enactment of the *Medicare Access and CHIP Reauthorization Act* (MACRA), our advocacy and policy team began the work of reviewing our analysis of the bill with implementation in mind. As part of this, the ACS took stock of the existing alternative payment models that were available for surgeons, and decided that part of our MACRA implementation strategy would need to involve the development of new options for participation for surgeons consistent with modern surgical practice in team-based episodes of care. The payment structure and incentives in the law make it clear that over time the surest way to succeed will be to transition into new payment models designed to provide additional flexibility in care design to those willing to take on financial risk.

While opportunities to meaningfully participate in such models were limited for surgeons (due to geography, specialty, practice style, etc.) the law also created a

new pathway for creation of APMs, the Physician-focused Payment Model Technical Advisory Committee, or PTAC.

The ACS takes its responsibility in contributing to improved health care quality seriously. As some of you may remember, a little more than five years ago our Executive Director, Dr. David Hoyt testified before this panel on our efforts at that time to develop innovative payment strategies as part of a replacement for the sustainable growth rate (SGR). With the passage of MACRA and the creation of the PTAC we saw an opportunity to refocus our efforts toward creation of an APM that would meet the requirements under MACRA, meet the needs of surgeons, and provide new tools for participants to improve care for our patients.

In developing a new payment model, there are at least five important elements which need to be considered. These include:

Clinical care model: What changes can be made to the way we do things to improve the quality of care to the patient and clinical outcomes?

Quality measurement: What processes, outcomes and patient reported experiences are worth keeping track of and how do you use that information to adjust payments?

Payment model: How should we change the way we pay for health care to incentivize appropriate, high quality, efficient team-based care? For example, we intend to seek payment models tied to increased quality and reduced utilization through a novel shared savings framework.

Business model: How do you structure participation so that the necessary team of physicians would join together with APM entities, or form them, in order to create shared accountability for the patients for whom the team provides care? And how could the models attract private payers? What is the value proposition for the involved stakeholders?

Risk structure: Transferring risks from insurers to providers requires careful consideration. There is a difference between clinical risks that providers can reasonably assume and insurance risks that providers should avoid. How are risks structured within the constraints of behavioral economics to offer enough upside risk to attract participants and adequate downside risks to protect patients and the goals for optimal care? What limitations do you place on downside risk for cost overruns or not maintaining quality so that you meet MACRA advanced APM requirements while limiting potentially catastrophic losses?

For physicians and those deeply engaged in patient care, it is a natural tendency to begin from the clinical care model and subsequently add the other elements of quality, risk, and alternative payment models folded into new business operations. Starting by building multiple clinical models, each with its own underlying payment model would, however, be administratively difficult for participants and payers to implement and scale across the nation.

In contrast, we chose to partner with a team at Brandeis University who had in-depth knowledge of Medicare cost measurement and analysis. Our partners at Brandeis had developed software known as the CMS Episode Grouper for Medicare or EGM.

This software represents years of work and provides an in-depth, objective view of how care is currently provided. A combination of painstakingly developed clinical episode definitions and complex algorithms allow the software to automatically assign relevant charges to a team-based episode and assign providers to clinical roles in the episode based on which services they provide to the patient.

The EGM also looks at the patient's other current and historical episodes, both to provide risk adjustment and to ensure that each dollar spent is counted only once. This allows our model to produce risk adjusted, patient specific target prices for each episode. It also allows us to show extremely granular information on the causes of variation. And, this model allows for all physicians and all payers to share a common operational model in order to assist in a national scale for implementation.

Quality

The ACS has over a century of experience in defining, measuring and improving quality. The ACS has long believed that the current approach to quality measurement is narrow, complex, costly and slow to adapt to changing care patterns. We see MACRA, and particularly APMs, as an opportunity to propose and implement new measurement strategies. Currently available measures are frequently irrelevant to surgical care and in fact in some reporting options providers may be scored for quality based on care they played no role in providing.

Our recently-published "Optimal Resources for Surgical Quality and Safety" is designed to be a valuable resource for surgeons as they work to improve the quality of care they provide and to improve patient safety. While our knowledge is primarily

in surgical care, the lessons learned have helped us to create an environment of continuous quality improvement and patient-centered care that can be easily adapted to a wide range of health care with the participation and clinical expertise of the wider physician community.

Phases of Care

Surgical care, and in fact all health care, occurs in phases. The ACS believes that registry-based quality measures that encompass the phases of care, along with care coordination and incorporation of patient reported outcome measures (PROs), will be meaningful and important to both surgeons and surgical patients. For example, measuring quality across the phases of surgical care (those being preoperative, perioperative, intraoperative, postoperative, and post-discharge) may include items such as documenting the surgical plan and patient's goals of care, screening the patient for things that could affect outcomes such as frailty and tobacco use and helping them to prepare for surgery, taking time out to review safety checklists, documenting a post-operative care plan and communicating that plan with the patient, his or her family and their primary care provider and measuring success in preventing infections, readmissions and reoperations. Adding in PROs provides a patient perspective and further validates the value and success of the process measures. The measures described are broadly applicable to many surgeries but can be customized for individual specialties or procedures to reflect the most pertinent processes and outcomes for a given episode.

Measuring quality in this way has the added benefit of lining up well with cost measurement to paint a much more detailed picture of the value of care provided. In the ACS-Brandeis model, performance in what we refer to as an episode-based measure framework is used to adjust payments, providing maximum incentives to those providing the highest value care.

Team-based Nature of Patient-centered Care

The model that we have developed is broadly applicable to the full range of health care providers. As noted in the ACS' recently updated joint statement on physician-led team-based surgical care, "optimal care is best provided by a coordinated multidisciplinary team recognizing each member's expertise. Coordinated surgical care provides best outcomes, lowers costs, and increases patient satisfaction."¹ Our episode-based measurement framework coupled with the EGM allows for quality and cost measurement designed around the patient and the full team of providers who have influence over the patient's experience and outcomes.

Sometimes the highest value surgery for a patient is no surgery at all. The capabilities of the EGM allow the ACS-Brandeis model to incentivize the avoidance of unnecessary care through appropriate interventions. The model contains both treatment episodes and condition episodes. Related treatment episodes can be nested within condition episodes in a way that appropriately apportions costs and avoids double counting of Medicare dollars.

¹ <http://bulletin.facs.org/2016/08/statement-on-physician-led-team-based-surgical-care/>

Ultimately with the further development of additional treatment and condition episodes and the analysis of participant data, this model could allow sophisticated health systems to take on global risk for a patient population or risk for the care of specific clinical chapters.

Recruiting Clinical Expertise

Once it became apparent that our model was suitable for (and in fact hinged on) participation of the entire team involved in providing care to the patient, we began building a community. We first reached out to other surgical societies to fill them in on the early details of the model, but we soon expanded to other groups involved in caring for surgical patients and have welcomed participation and input from any interested groups whether they care for surgical patients or not. We leveraged this community to help further validate the clinical content and have leaned on them for their expertise in quality measurement around the care they provide.

Over the next several months, we held a series of in-person meetings and webinars to educate interested parties on the model and exchange ideas. The model has greatly benefited from this participation. Since our model does not mandate narrow clinical pathways, there are significant opportunities for innovation for the clinical experts. It is our intent that the ACS-Brandeis model will provide the tools, structure and incentives for these ideas to flourish.

The PTAC Experience

Soon after the PTAC announced its process for accepting new models we submitted our letter of intent and began the work of organizing our materials into the mandated structure based on the ten required criteria. We were the first organization to submit a proposal in December of 2016. Given the newness of the PTAC and the broad scope of our proposal I think it is fair to say that it has been a learning experience on both sides, with many practical questions being addressed as they arose.

Between December 2016 and March 2017, ACS and Brandeis staff were kept busy with a series of questions and requests for clarification and additional information from the three-member preliminary review team assigned to our model. While we had intentionally designed the model to be flexible, these questions challenged us and helped us to refine various aspects of the model.

The ACS-Brandeis A-APM was one of the first three models considered by the PTAC at its April meeting and was one of two that were voted on favorably at that meeting, after much deliberation and with strong support from the community of organizations that had participated in the model's development or followed its progress.

This victory was followed by an eight-week period in which we recovered from the previous months' flurry of activity and waited patiently for the PTAC's formal report and recommendation which was transmitted to the Secretary in early June. We then experienced a slightly more nerve-racking period of anticipation while we waited for the Secretary's response. Since our model was again among the first to reach

this milestone, we had no idea of what to expect next or when to expect it. In fact, we were told that “there is no required timeline for the Secretary’s response to PTAC’s comments and recommendations.” In the interim, we spent a great deal of time working to educate interested organizations and potential partners and have been contacted by several other organizations interested both in our model, and in gleaned advice in navigating the PTAC process and developing physician focused models of their own.

It was another three months until we received the Secretary’s positive response and were contacted by representatives from CMS and CMMI to begin the next phase of refining and validating the model in preparation for testing. This is work that we are currently engaged in.

Overall, our experience in navigating the pathway for physician-focused payment models created by MACRA has been a time consuming and complex yet rewarding experience. We have taken the long view in development of our model, shooting for a model that will ultimately serve the needs of our patients and provide meaningful APM participation options for the broadest range of our members and other providers.

I, and the ACS appreciate the chance offered by the Chairman and the committee to share our story and experience in developing our APM proposal. While we are closely monitoring and regularly weighing in with CMS on all aspects of the implementation of MACRA, it is this opportunity for payment and care model design and development that we find most promising. This process is unprecedented in its

transparency, and leans heavily on the expertise of medical providers and it is for these reasons that we believe it will succeed. We look forward to keeping you informed of our continued progress as our model moves forward with refinement, testing, and hopefully implementation.

Mr. BURGESS. The Chair thanks the gentleman and thanks to all of our witnesses for participating today. We will move to the question and answer portion of the second panel and I will recognize Dr. Bucshon from Indiana for 5 minutes, please.

Mr. BUCSHON. Thank you, Mr. Chairman. Thanks, everybody, for being here. I was a cardiothoracic surgeon before I was in Congress so I also reiterate what the chairman said about how great it is to have an entire panel of physicians here at the Health Subcommittee.

A couple of quick things. The American College of Surgeons, Dr. Opelka and others, proper risk, and this is a little off the beaten path, but proper risk stratification of patients and assessing patient outcome and how important that is, I mentioned in the previous panel the STS database and other, you mentioned some databases.

I mean one of the things I have always been concerned about as a physician when we are trying to design what is quality of care, how important is, I think, individual specialties assessing the risk stratification in the patient group that is in their area. How important do you think that is?

Dr. OPELKA. So if we are rewarding based on outcomes, there is nothing more important than actually having accurate risk adjustment and that comes ideally from clinical data. So we have worked on this modeling with folks like STS. How do we use the STS database to validate the current risk adjustment and how do we use future versions of STS in this modeling to make enhancements? We think that is the kind of work that needs to be done so that you get proper risk-adjusted pricing as well as proper risk-adjusted quality measurement.

Mr. BUCSHON. Anyone else? Dr. Wulf?

Dr. WULF. Two comments. I think data is useful, not only for risk adjustment to identify your high-risk patients, but we as primary care need accurate data to identify value in our specialists. Historically, a primary care physician refers to a specialist based on either knowing them and their kids play soccer together, they trained together. We think of specialists as quality, but data is so important as we in primary care seek value for our patients and we can identify that through data.

Mr. BUCSHON. Dr. Varga?

Dr. VARGA. Yes, sir. And we would agree. Further, probably the biggest issue for us is having adequate data as mentioned to be able to do risk stratification. But it is not just simply to get the right pricing, it is actually to understand the level of care that the patient requires at any point in the continuum and then understand how to match resources to that level of risk stratification. It is critical whether you are talking about a primary care scenario or whether you are talking about a complex cardiovascular surgery case.

Mr. BUCSHON. Anybody else have a—

Dr. EDGERTON. I would agree. From the rheumatology perspective we know that our patients with rheumatoid arthritis suffer from other comorbidities that have a massive impact on their outcomes, but that is also important when we are looking at the cost of their care. We have struggled to extract that data from our

EHRs despite the fact that we spend large amounts of time entering data into the EHRs. We have designed a clinical data registry called a RISE Registry as a college to help us do that, to extract some of that data, but it continues to be a struggle.

Mr. BUCSHON. Yes. I agree with everything everybody said because I think Government agencies tend to maybe think if you give a couple of little, a couple data points in health care like overall morbidity or overall mortality without getting a bigger, deeper dive, especially specific deeper dive, you can, these things don't work out that well because it is just not specific enough.

Dr. Wulf, you probably know I read, I co-led the letter to CMS about certain payment arrangements between Medicare Advantage plans and physicians as advanced APMs under MACRA. And I understand, you mentioned CMS has come out and said that a new MACRA rule that they would be initiating a demonstration project to test the approach, and I know CAPG has been a leading voice in pushing this.

So can you talk about the importance of APMs in a little more depth than you did in your testimony as it relates to Medicare Advantage and why CMS should move quickly along with this demo?

Dr. WULF. Yes, and thank you for that effort, Dr. Bucshon. Just like as we entered into shared savings and now risk with Medicare Advantage, we were able to provide for that subgroup of our seniors certain benefits that we were able to pay for with a per-member, per-month payment. Through CPC+ we were able to expand those benefits to all of our seniors.

So just as we are now with APMs recognizing and providing programs for Medicare, it would be unfair to exclude the one-third of patients in Medicare Advantage from those type of fundings that all medical groups use to create coordinated care. So I think it is important that all programs are for all seniors, fee-for-service Medicare and Medicare Advantage and I think this is a step in that direction.

Mr. BUCSHON. OK, thank you.

I yield back, Mr. Chairman.

Mr. BURGESS. The Chair thanks the gentleman. The gentleman yields back. The Chair recognizes the gentleman from Texas, Mr. Green, ranking member of the subcommittee, 5 minutes for questions, please.

Mr. GREEN. Thank you, Mr. Chairman. I want to thank our whole panel for joining us today.

Dr. Varga, I understand that transitioning from a healthcare organization to an Alternative Payment Model can be challenging and there are a lot of moving parts to consider. In your testimony you discuss how MACRA encouraged Texas Health Resources to participate in the Next Gen ACO model. Can you speak a little more about what it is like at Texas Health Resources before implementing the Next Gen ACO model and why this model was the best fit for your organization as opposed to an APM?

Dr. VARGA. Yes, sir, happy to respond. As I pointed out in my oral testimony, first and foremost for Texas Health Resources and for the Southwestern Health Resources ACO, this was an issue of access to care. With a large percentage of the doctors in North Texas not participating in fee-for-service Medicare program there is

a very difficult scenario for folks who are aging out of commercial insurance and aging into Medicare actually finding a primary care doctor and in some situations a specialist who actually accepts patients in the fee-for-service model.

A bit of workforce constraint as well in the Medicare Advantage program there as well, one of the things we really wanted to make sure we did with this is by offering the incentive programs that come through the Next Gen Alternative Payment Model, we are able to actually incent physicians to participate and continue to see Medicare fee-for-service patients.

I think the other thing that we are experiencing in this is the ability to really coordinate care across the full continuum with our physicians, whether it is specialists or primary care. We have already shown that we can generate savings in the model. We already started to demonstrate that we can actually, in very targeted areas with adequate data, start to decrease, which in North Texas is a big issue which is overutilization of post-acute services whether it be rehab, skilled nursing facilities, or home health.

So the program has made an incredible impact on us, and we, like Dr. Wulf's group, believe that we can extend that into the Medicare Advantage program as well as move forward.

Mr. GREEN. How did MACRA and the opportunities it created hasten this decision to engage in a delivery system reform and participate in the Next Gen ACO model?

Dr. VARGA. I think probably the reason that MACRA accelerated this is in the MSSP Track 1 program that we have historically participated in, the cap on upsides really created a model that, in terms of looking at what sort of benefits we could return to physicians in that model, was relatively limited. The other piece of the Track 1 model that was very different from Next Gen is some of the waivers we get in Next Gen to be able to more aggressively coordinate care across the full continuum and actually take in different sorts or adopt different payment models like advanced care coordination fees, sub-capitation, actually full cap, really creates a model where we can actually get our group of folks to manage these patients across the full continuum.

The ability to create value, both for the patients and for the physicians in the network, is far superior to the model we had in Track 1.

Mr. GREEN. What was the challenge to get your providers to get comfortable with the level of financial risk posed by the Next Gen's ACO model?

Dr. VARGA. Well, that is one of the reasons we believe in this integrated model is that as it was mentioned earlier, the concept of asymmetric risk is one that is tolerated in this. So given that the health system and the Part A expense of the model is usually the most expensive piece of this, the health system provider can absorb upfront the bulk of the risk, both the risk incurred by building infrastructure, but also the potential for downside risk and the ability to help physicians manage that piece as they went forward.

So we really had very little resistance to the providers stepping in to a two-way risk model.

Mr. GREEN. And what type of infrastructure changes in provider education did Health Resources require to implement that Next Generation ACO?

Dr. VARGA. The biggest change above the MSSP Track 1, which we had been in for the last 3 years, was really a far more aggressive care coordination model for mostly the post-acute world. That is really in our ACO where the data points us. We had already undertaken a fairly significant investment that allowed us to help our doctors get onto a common electronic health record platform with us, a common disease registry platform to point out gaps in care, and a common analytics platform for reporting. The biggest issue was actually in putting the technology and bodies in place to be able to do the post-acute care coordination model.

Mr. GREEN. Mr. Chairman, normally as a lawyer I have plenty of lawyers in the room, today we have plenty of physicians. And I think that is what is important, to make sure you are comfortable with what we are doing and again not recreating an SGR that goes 17 years and really hurts medical practice and your patients. So thank you for having the hearing.

Mr. BURGESS. The gentleman yields back. The Chair thanks the gentleman.

And Dr. Friedman, Ranking Member Green brings up an excellent point. And as I was talking to you before the hearing convened, I can remember a morning probably 2005 or 2006 when I had to face a roomful of your participants all sitting around little round tables down in a room in the basement of this building, and it was significantly stressful. I thought everyone was going to be eager to hear what my thoughts were on repealing the SGR, but nobody wanted to hear what they were. They just wanted it done, and they wanted it done last week.

So I felt the anxiety. It only took us 13, 14 years to get to this point, but it was largely your group, that group of doctors that morning, that really provided the, you know, the lift and the thrust to get this thing done. Do your doctors ever talk about that now? Are they grateful the SGR is gone or have we just moved on and now we are at the next thing?

Dr. FRIEDMAN. Sorry. So just repeat that last part of the question.

Mr. BURGESS. Well, are your doctors, do they talk about things like that now? Are they grateful the SGR is gone or are they just worried about the next phase?

Dr. FRIEDMAN. I think it is a mix. You know, I think, you know, I spent a fair amount of time polling my colleagues in the office before I came to do this and I get mixed remarks. From the standpoint of patient care we have seen some big benefits. Care coordination has improved and outreach to patient has improved. We don't go to the hospital anymore. We are just strictly outpatient doctors, so we are in the office. And from that standpoint we have gotten very good at retrieving the information and getting the patients into the office so there is continuity of care.

So things have been great. And I have to say that, you know, the fee-for-service model was not working for us. I mean we, had we not embraced this model, had we not embraced CPCI and Patient-Centered Medical Home early on and now CPC+, we would have

sold our practice to a larger system. So I think they would all acknowledge that.

That being said, I think the administrative burden that we see in the office, the physicians' administrative burden, and also my administrator's, the amount of work that she has to do has increased, and that is a bone of contention.

Mr. BURGESS. Very good.

Dr. Varga, you in your testimony talking about that Premier doesn't simply want to employ physicians, you want to create those high-value networks so you have doctors who are basically private practice doctors who are working within your network; is that correct?

Dr. VARGA. We do.

Mr. BURGESS. And kind of a 60/40 split on that between employed physicians and independent physicians?

Dr. VARGA. With the 60 being the independent PCPs.

Mr. BURGESS. How do you allow them to maintain their own independent practices and at the same time conforming to the measures that you are requiring to improve outcomes?

Dr. VARGA. It is a good question. I think the biggest issue for us as we started was actually getting everyone to commit to a pluralistic physician model where in large part we are largely agnostic to the physician economic relationship with the health system.

So as we said we have faculty, we have employed, and we have independent PCPs. We also have independent specialists who participate with our ACO in a nonexclusive fashion through a series of structures that we have built inside the ACO. I think the common thread, Mr. Chairman, is simply that, independent of the economic relationship folks have with this, we all have aligned incentives, we all work off of a common infrastructure, and we are all held accountable to the same clinical performance metrics.

And we really believe that it is highly valuable to have that pluralistic model in play because an employed-only model really tends to drive you to one sort of structure. It can work, but you don't really learn from the independent practice proposition. You also don't learn from folks who are nonexclusive to your network as well.

Mr. BURGESS. So you also talk about the anxiety and complaints. How is that part of it going?

Dr. VARGA. You know, it has actually gone fairly well. You know, we are fortunate in North Texas that the economics of the two-way risk ACOs are actually a little bit better than they are in some other areas of the country, so we have been able to produce shared savings at a fairly hefty rate for the last 2 or 3 years. We still have complaints, and I think one of the things that we will start to really encounter as we go forward is we have not yet had to really, really drive the narrowness of the network in terms of—

Mr. BURGESS. Have not.

Dr. VARGA. We have not, in large part because the physicians have largely performed to the set of standards that we have set in predominantly a one-way risk model. As you get into a much more aggressive two-way risk model, as you get into Medicare Advantage, the importance of really, really high-performing physicians becomes absolutely critical.

Mr. BURGESS. And Dr. Edgerton, your practice would, you know, of all of the different types of practices that I worried about as we were doing this, your highly specialized, small office, I mean that was the one that I thought was going to have the most difficult time with any sort of adjustment along these lines, but you have done it. Is that right?

Dr. EDGERTON. That is correct. And we are approaching now that pilot phase. One of the real benefits has been the interaction with PTAC. Interestingly enough, because they can't reach out to us directly, it was largely looking at the PTAC Web site and the way that they are so transparent. In studying the feedback they had given to different models that were similar to what we were thinking about and being able to learn, it is sort of like a university of APMs if you spend enough time on their Web site and see the comments that come both from PTAC and from other stakeholders.

So that has really been useful in moving us along, not only as a small office but also as a small specialty.

Mr. BURGESS. Very good. And I do need to observe that we have a vote on and I do want to recognize Mr. Guthrie for his questions.

Dr. Bucshon, we probably won't have time to go to a second round if that is OK with you.

Mr. GUTHRIE. Do you want me to yield to you? Do you have any more questions?

Mr. BURGESS. No. I will yield to you and please go ahead with your questions.

Mr. GUTHRIE. Hey, Larry, I will ask one quick one if you want to go into—OK.

Dr. Varga, since joining an APM what have you been able to accomplish and what do you hope to accomplish in the future with regard to patient outcomes?

Dr. VARGA. So I think the first thing we have been able to accomplish—and I can't emphasize this enough to the committee—is, number one, we have for the first time I think in history had comprehensive data on the population of Medicare beneficiaries that we are managing, which opens up a world of opportunity. As folks who are physicians would tell you, if you give doctors useful, reliable, timely data, 99 times out of 100 they will make the right decisions off of that data. And so it starts with that.

I think the second piece is we have been able to align incentives with our physicians, our hospital providers and our post-acute providers to really take a patient-centric, patient-oriented approach around quality and efficiency and be able to really drive that care model. I think we are excited about the savings we have generated. We are also very proud of the quality metrics we have generated within the program as well.

And I think the last thing that I would say in that is it has really turned the culture. We think far more in an ACO-centric way than we do in a hospital-centric way now, because our lives live in the ACO and we coordinate care in the ACO. The hospital is one very small—

Mr. GUTHRIE. Thanks. I want to—now I have a couple of physician friends here that have practiced under this and they may have a different perspective. I want to make sure they have a chance to ask what they want to ask.

So Dr. Bucshon, I will yield.

Mr. BUCSHON. Thank you, I appreciate that.

I mean this is more on a personal level. I mean, I think for those of you who are in an APM, do you think participation in an APM has affected positively the quality of life of physicians in all of your practices and do you in the job satisfaction amongst physicians, because I think all of us know that there has been a decreasing job satisfaction amongst physicians in all specialties over maybe the last 20 or 30 years, and our ability to recruit quality people to go into all of our specialties maybe has become a little more difficult. So do you think participating in these APMs and the way we are redoing the system maybe will improve those circumstances? Anyone want to comment?

Mr. GUTHRIE. I am noticing my time. We probably just have time for one answer and then we are going to have to go vote.

So go ahead, Dr. Wulf.

Dr. WULF. I would comment from a primary care standpoint, absolutely. That we are able to get to a payment model that rewards quality instead of volume, and this does that, makes all the difference. And I have been asked before what is the tipping point for this and it actually is not financial. The tipping point is physicians understanding that you can get them into a contract model that will pay for quality and pay for value. And so absolutely it is these type of payer contracting relationships have changed our physicians' lives and made a very difficult clinical life much more palatable.

Mr. GUTHRIE. Thanks. I wish I had more time for everyone else, but we are called to the floor. So I will yield back my time to the Chair.

Mr. BURGESS. And the gentleman yields back. The Chair appreciates that. We have a series of votes on the floor that is going to consume some time, so I think we can conclude the hearing and dismiss you all and not have to reconvene after votes. But I do want to thank all of you for being here today.

We have received outside feedback from a number of organizations and I would like to submit their statements for the record: The American Association of Nurse Anesthetists, the American Society of Anesthesiologists, the American Medical Association, the American Physical Therapy Association, Healthcare Leadership Council, American Society of Clinical Oncology, AHIP, the HSSR Coalition, American Hospital Association, American Association of Nurse Practitioners, the Society of Thoracic Surgeons, the American Academy of Orthopaedic Surgeons, and without objection, so ordered. Those will be made part of the record.

Pursuant to committee rules, I remind Members they have 10 business days to submit additional questions for the record. I ask witnesses to submit their response within 10 business days upon receipt of the questions. And without objection, thanks again. The subcommittee is adjourned.

[Whereupon, at 1:09 p.m., the subcommittee is adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. GREG WALDEN

I thank Chairman Burgess for his continued leadership on MACRA, as well as Ranking Member Pallone, for the bipartisan slate of witnesses we have before us today.

Today marks our third hearing since the passage of MACRA. Just as this committee led the effort to find a solution to SGR and other issues then, we continue our oversight over the bipartisan law and remain committed to its successful implementation.

As my colleagues know well, we worked over many years to address the problems associated with the SGR and impending yearly payment cuts to doctors that inevitably were avoided thanks to short-term, temporary patches—17 in all. It seems like this was so long ago, but we must not lose perspective of what we have accomplished. Particularly now as we continue to move forward on the implementation of this important law.

MACRA is up and running and today we will hear about the most forward looking aspect of the law—Alternative Payment Models (APMs). Today, they are already delivering better outcomes for Medicare beneficiaries and returning savings to the Medicare program. This is not a hypothetical—the transition to value is real, and very much underway and delivering results.

MACRA has already proved to be a success. It has acted as an accelerant on doctors being able to enter into new team based arrangements, to think about their patient populations through payments that reward outcomes, and to take what they knew worked in the private sector and carry it over to the Medicare program.

Most importantly, APMs finally reward providers for all the things they have always wanted to engage with patients on, but instead were forced to simply “do more” to be able to afford to stay in the Medicare program. MACRA delivered that change.

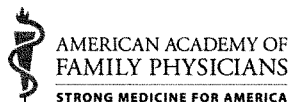
Physicians in qualified APMs will receive a 5 percent bonus from 2019–2024. Technical support is provided for smaller practices to help them participate in APMs. We will hear from the Physician Technical Advisory Committee (PTAC), another successfully implemented element of MACRA, that is further helping physicians create models that are data driven with physicians in the driver’s seat.

We are still in the early stages of moving away from traditional fee for service, but these efforts continue to be embraced by the physician community who are eager to assume the risk if it means being put back in the charge within an APM to best direct care for their patients and to be judged on outcomes.

We expect to hear today from our witnesses who come from diverse backgrounds. They train and practice across the country, in rural and urban settings. Each are practicing physicians, in different arrangements and all have worked with their organizations to provide tools and best practices that other physicians can utilize and learn from to be better positioned to succeed under MACRA.

This committee stands with the physician community in our united goal of a successfully implemented MACRA and we will continue to work with you in a bipartisan fashion to see that the law delivers on its promises.

That said, I think we should all be very excited by the work already underway by our witnesses to make tangible differences to the care delivered to the country’s Medicare beneficiaries. I look forward to hearing more about their efforts and continuing to work toward a successful implementation of MACRA.



**AAFP Statement for the Record to the
Energy and Commerce Committee,
Health Subcommittee**

**“MACRA and Alternative Payment Models: Developing Options for Value-based Care”
November 9, 2017**

On behalf of the American Academy of Family Physicians (AAFP), representing 129,000 family physicians and medical students, thank you for the opportunity to submit this Statement for the Record for the U.S. House Energy and Commerce Committee Health Subcommittee regarding the implementation of the Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA) and the development of new alternative payment models (APMs) called for in MACRA.

The AAFP supported MACRA's passage and the movement away from fee-for-service to value-based physician payment delivery and payment models. With implementation of MACRA, the development of new APMs, including physician-focused payment models, is accelerating. While some of these models may deliver comprehensive, longitudinal care, many run the risk of perpetuating (or even exacerbating) the fragmented care many patients receive under the current fee for service (FFS) system. It is our overall assessment that there needs to be a greater focus on the development of comprehensive, longitudinal APMs and the pace of development needs to increase significantly.

Strengthening Primary Care

Evaluating MACRA's effectiveness and the strength of APMs should first recognize the central role of primary care physician, and family medicine's role in the health care ecosystem.

Family physicians are the largest primary care specialty and the most visited, especially for individuals in underserved areas. One of five US office visits are conducted with a family physician. This represents 123 million visits annually, 48 percent more than the next-highest medical specialty.¹ Family physicians also provide more care in rural and underserved areas than any other medical specialty.² The complexity of care provided by family physicians is unparalleled in medicine. Family physicians address more diagnoses and offer more treatment plans per visit than any other medical specialty. Furthermore, the number and complexity of conditions, complaints, and diseases seen in visits with family physicians is far greater than those seen by any other physician specialty.³

There is an emerging consensus that strengthening primary care is imperative to improving individual and population health outcomes, as well as to restraining the growth of health care spending.⁴ Strengthening primary care is critical to driving better value for patients, payers, and communities. Health systems built with primary care as the foundation have positive impacts on quality, access, and costs. Transformation cannot be overly complex or burdensome to operationalize. In addition, it must be recognized that there is no one-size-fits-all solution, as patient panels, populations, and primary care practices vary. Finding the proper balance between flexibility and simplicity remains elusive.

AAFP Headquarters
11400 Tomahawk Creek Pkwy.
Leawood, KS 66211-2680
800.274.2237 • 913.906.6000
fp@aafp.org

AAFP Washington Office
1133 Connecticut Avenue, NW, Ste. 1100
Washington, DC 20036-1011
202.232.9033 • Fax: 202.232.9044
capitol@aafp.org

CMS and private payers must make new investments in primary care to truly capture and realize the value proposition of family medicine and primary care. Though primary care oriented Advanced Alternative Payment Models (AAPMs) will continue to clinically coordinate with other payment models, primary care AAPMs must be kept distinct from bundled payment models to maximize support for the delivery of continuous, longitudinal, and comprehensive care across settings and providers. Including primary care in bundled payments will not provide the support our health system needs to increase value and strengthen primary care.

The American Academy of Family Physicians (AAFP) is fully supportive of the Physician-Focused Payment Model Technical Advisory Committee's (PTAC) role in evaluating physician-focused payment models (PFPs) and making subsequent recommendations about those models to the U.S. Department of Health and Human Services (HHS). The AAFP has developed an Advanced Primary Care Alternative Payment Model (APC-APM), which has been submitted to the PTAC to quicken the migration of family physicians away from the current inefficient FFS payment system. The APC-APM is a foundational model for delivering patient-centered, longitudinal, and coordinated care to Medicare beneficiaries – and establishes a payment structure that will begin to appropriately compensate family physicians for delivering this type of care.

Principles for Evaluating APMs

The AAFP also developed the following set of principles to guide the ongoing evaluation of proposed models to ensure that they are patient-centered. In our view, any APM implemented should meet these criteria:

Longitudinal, Comprehensive Care. Primarily, APMs should support the delivery of team-based, comprehensive care, which includes all acute, chronic, and preventive services, not just episodic care. They should provide continuous, coordinated, and connected longitudinal care in the most cost-effective setting. APMs should not fragment care across clinicians and settings for patients since fragmentation weakens clinician accountability for outcomes and/or costs, and negatively impacts patient experience and outcomes. Primary care APMs should be based on the core functions of the Patient-Centered Medical Home (PCMH) as articulated through the Joint Principles of the Patient-Centered Medical Home and CPC+ Initiative, which focuses on care coordination, population health, care management, patient and caregiver engagement, and comprehensive and coordinated care.

Improving Quality, Access, and Health Outcomes. Approved APMs must demonstrate how they will contribute to improvements in access to high quality of care and increase positive health outcomes for all patients. New models should use the core measure sets developed by the multi-stakeholder Core Quality Measure Collaborative to ensure alignment, harmonization, and the avoidance of competing quality measures among payers in an effort to reduce administrative burden. APM payments should be appropriately risk adjusted to ensure accurate assessment of provider performance and accountability.

APMs Should Coordinate with Primary Care Team. It is our strong belief that APMs should not fragment care across clinicians and settings for patients since fragmentation weakens clinician accountability for outcomes and/or costs, and negatively impacts patient experience and outcomes. Furthermore, we believe that a health care system built on and around longitudinal and comprehensive primary care can reduce the frequency and overall utilization of specialty care, for some patients. In the event that condition-focused APMs are approved, they should be required to contact and coordinate care with a patient's primary care physician and team (or primary care clinicians serving Medicare patients in a given geographic area). This will allow patients receiving care through a specialty- or disease-focused APM to also benefit from coordination with a primary care physician and team that will provide longitudinal care, in addition to treatment of a particular episode or condition. APMs should

include agreements with primary care physicians (reimbursed through separate, primary care APM) to enhance the working relationship between the specialty- or disease-focused physicians and the primary care physician and team.

APMs Should Promote Evidence-based Care. APMs should incent or require use of evidence-based recommendations to treat acute and chronic conditions and to provide preventive services. New models of care should be physician-led, team-based, and primary care oriented to ensure they are patient centered. Patient centeredness requires an ongoing, active partnership with a personal primary care physician who leads a team of professionals dedicated to providing proactive, preventive, and chronic care management through all stages of life. This ensures that complex care management and care coordination issues are continually addressed.

APMs Should be Multi-payer in Design. Approved APMs should be multi-payer in design to ensure that all patients—regardless of payer—have access to promising care models that can improve their health outcomes and care, and reduce costs. Payment models should be multi-payer in their design to allow the CMS and other health care payer programs to leverage investments and learning in payment and delivery system reform. Payments for primary care should be made mainly on a per patient basis through the combination of a global payment for direct patient care services and a global care management fee. APMs should attempt to avoid reliance on FFS payments.

The 2018 Final Quality Payment Program (QPP) Regulation

While physicians transition away from fee-for-service to APMs, it is important to examine how those systems are working. The following are the AAFP's observations for the Merit-based Incentive Payment System (MIPS).

Low Volume Threshold - CMS is raising the low volume threshold in 2018 to exclude those who care for less than or equal to 200 Medicare Part B beneficiaries, or receive less than or equal to \$90,000 in Medicare Part B payments. Raising the low volume threshold should exclude more small practices from MIPS. The AAFP advocates for an opt-in option so that anyone who wishes to participate might be able to do so.

Virtual Groups – The AAFP is discouraged with the manner in which the virtual group policy has been developed and implemented. While we are somewhat pleased that Virtual Groups will begin in 2018, we are concerned that they will not benefit solo and small group practices in a manner consistent with legislative intent. We believe that the virtual group policy will be a key contributor to assisting solo and small group practices transition away from fee-for-service, yet remain independent. Overall, we believe there is much work to be done to ensure that this policy achieves its original goals.

Performance Period - Quality and cost will both be measured for an entire year in 2018. Increasing the quality reporting from "Pick Your Pace" to full year reporting is a bigger step than many are ready to take. Along with this, the data completeness criteria increased to 60%. We appreciate the 5 bonus points added to the final score for small practices. However, this was only finalized for one year. We would like to see this extended into future years of the program.

MIPS APMs – AAFP remains steadfastly opposed to the entire MIPS APM category. This entire category was created outside of the statutory requirements and introduces an unnecessary level of complexity to an already complex program. The AAFP strongly encourages consistency and equal reporting standards among all MIPS-eligible clinicians. Concurrently, we are concerned that eligible clinicians may intentionally remain in MIPS APMs, given the scoring advantage they have been given,

instead of progressing towards AAPMs, which is the intent of the QPP. We urge CMS to closely monitor participants who may be intentionally avoiding the progression to AAPMs.

Level Playing Field – AAFP believes all specialists and subspecialists should be required to meet the same program expectations as other MIPS participants. In the same vein, AAFP is concerned that using dual-eligible status as an indicator of patient complexity may severely underestimate the number of truly complex patients, not to mention the fact that not all states have expanded Medicaid. Dual eligibility cannot be consistently applied and would not be an accurate indicator of patient complexity and thus creates an uneven playing field from state to state.

Risk – The AAFP adamantly opposes putting APM entities and their eligible clinicians at financial risk for anything beyond their own performance. AAFP believes it is appropriate for primary care physicians in Medical Home Models to accept performance risk—not financial risk—based on the original MACRA statute, which reflects Congressional intent regarding the qualification of Medical Home Models as AAPMs. The AAFP strongly recommends that Congress require CMS to remove the Medical Home Model financial standard in its entirety and reiterates our strong belief that medical homes should not be subject to any financial risk. We object to the application of a nominal amount standard to Medical Home Models. Further, the AAFP does not understand CMS' logic in creating separate risk standards for AAPMs and Other Payer AAPMs. The risk standard should be the same for all AAPMs, except for Medical Home Models.

Conclusion

Thank you for the opportunity to comment on the implementation of MACRA. As policy makers evaluate MACRA's impacts, we urge you to remain focused on changes that will strengthen primary care and its role in bolstering system-wide reforms.

For more information, please contact the AAFP's Government Relations Department at 202-232-9033.

¹ AAFP, Family Medicine Specialty, <http://www.aafp.org/about/the-aafp/family-medicine-specialty.html>

² AAFP, Rural Practice, <http://www.aafp.org/about/policies/all/rural-practice-paper.html>

³ Complexity of ambulatory care visits of patients with diabetes as reflected by diagnoses per visit

Moore, Miranda et al. Primary Care Diabetes, Volume 10, Issue 4, 281 - 286

⁴ Macinko J, Starfield B, Shi L. Quantifying the health benefits of primary care physician supply in the United States. *Int J Health Serv.* 2007;37(1):111-26.

**Statement for the Record
to the
House Committee on Energy and Commerce
Subcommittee on Health**

**MACRA and Alternative Payment Models:
Developing Options for Value-based Care**

**Bruce A. Weiner, DNP, MSNA, CRNA
President, American Association of Nurse Anesthetists**

8 November 2017

Introduction

Chairman Burgess, Ranking Member Green, and Members of the Committee, thank you for the opportunity to offer this statement for the record. The American Association of Nurse Anesthetists (AANA) is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists, with membership that includes more than 52,000 CRNAs and student nurse anesthetists representing over 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who personally administer more than 43 million anesthetics to patients each year in the United States. CRNAs provide acute, chronic, and interventional pain management services. In some states, CRNAs are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities.

The House Energy and Commerce Subcommittee on Health's hearing, entitled "MACRA and Alternative Payment Models: Developing Options for Value-based Care" comes at an important time. As you know, the Centers for Medicare & Medicaid Services' (CMS) Innovation Center is currently seeking feedback on a new direction to promote patient-centered care and test market-driven reforms that empower beneficiaries as consumers, provide price transparency, increase choices and competition to drive quality, reduce costs, and improve outcomes. Certainly, the Committee will be influential in providing guidance for this new direction.

Ensure Equal Treatment of CRNAs and APRNs in Models

The AANA urges the Committee to ensure that CRNAs and other APRNs are treated on par with physicians in models, including physician specialty models and advanced alternative payment models. These healthcare providers are core to improved access to high quality, cost-effective care. Furthermore, the National Academy of Medicine (NAM) recommends that government policy expand opportunities for nurses to lead collaborative healthcare improvement efforts, and prepare and enable nurses to lead changes that advance health.¹ Increasingly, the healthcare industry is recognizing APRNs for their leadership role in clinical, educational and academic, executive, board, legislative, and regulatory domains. In addition to their roles as expert healthcare professionals, APRNs are CEOs of hospitals and health systems, chief nursing officers, chairs of regulatory bodies and advisory committees, and have taken many other positions with wide spans of responsibility.

In particular, the AANA expects that CRNAs should automatically be included in models when anesthesiologists are mentioned. As CMS develops the new direction of the Innovation Center, we urge the Committee to ensure that CRNAs will not face professional discrimination based solely on licensure in these efforts.

Require the Strategic Use of Anesthesia Services

¹ NAM (National Academy of Medicine). The Future of Nursing: Leading Change, Advancing Health (Washington, DC: The National Academies Press, 2011), see Recommendation #2: Expand opportunities for nurses to lead and diffuse collaborative improvement efforts, p.11 and Recommendation #7: Prepare and enable nurses to lead change to advance health, p. 14.

Anesthesia professionals, such as CRNAs, can play an integral role in episodes of care that involve anesthesia as proper anesthesia services management can improve patient flow, advance patient safety, and ultimately yield cost savings.² Conversely, research shows that suboptimal care in the preoperative, intraoperative, or postoperative phases of surgery may compromise care, resulting in poor patient outcomes³ that increase healthcare costs. The AANA urges the Committee to consider the role of anesthesia delivery that is safe and cost-efficient in itself and encourages the use of techniques such as Enhanced Recovery After Surgery (ERAS) programs,⁴ which help reduce costs and improve patient outcomes.⁵

Furthermore, we recommend that the Committee promote cost-efficient anesthesia delivery models. All models of anesthesia delivery being equally safe according to extensive published research, the most cost-effective anesthesia care delivery model is the CRNA non-medically directed model, and we recommend that the Committee promote its use in this regard.

In demonstrating the costs of various modes of anesthesia delivery, suppose that there are four identical cases: (a) has anesthesia delivered by a non-medically directed CRNA; (b) has anesthesia delivered by an anesthesia care team where a CRNA medically directed at a 4:1 ratio by a physician overseeing four simultaneous cases and attesting fulfillment of the seven conditions of medical direction in each; (c) has anesthesia delivered by an anesthesia care team where CRNA medically directed at a 2:1 ratio; and (d) has anesthesia delivered by a physician personally performing the anesthesia service. (There are instances where more than one anesthesia professional is warranted; however, neither patient acuity nor case complexity is a part of the regulatory determination for medically directed services. The literature demonstrates that the quality of medically directed vs. non-medically directed CRNA services is indistinguishable in terms of patient outcomes, quality and safety.) Further suppose that the annual pay of the anesthesia professionals approximate national market conditions, \$170,000 for the CRNA⁶ and \$540,314 for the anesthesiologist⁷. Under the Medicare program, practice modalities (a), (b), (c) and (d) are reimbursed the same. Moreover, the literature indicates the quality of medically directed vs. non-medically directed CRNA services is indistinguishable.

² See for example Rice AN, Muckler VC, Miller WR, Vacchiano CA. Fast-tracking ambulatory surgery patients following anesthesia. *J Perianesth Nurs*. Apr 2015;30(2):124-133 and Kimbrough CW et al. Improved Operating Room Efficiency via Constraint Management: Experience of a Tertiary-Care Academic Medical Center. *Journal of the American College of Surgeons* 2015; 221: 154-162.

³ Miller TE, Roche AM, Mythen M. Fluid Management and Goal-Directed Therapy as an Adjunct to Enhanced Recovery After Surgery (ERAS). *Canadian Journal of Anesthesia* 2015; 62 (2)" 158-168.

⁴ American Association of Nurse Anesthetists, "Enhanced Recovery After Surgery: Considerations for Pathway Development and Implementation," July 2017, available at: <http://www.aana.com/myaana/Advocacy/fedgovtaffairs/Documents/20160902-aana-comment-on-opioid-analgesic-prescriber-education-rfi-final.pdf>.

⁵ See for example Boulind CE, Yeo M, Burkill C, et al. Factors predicting deviation from an enhanced recovery programme and delayed discharge after laparoscopic colorectal surgery *Colorectal Dis*. 2011;14:103-110; Miller TE, Thacker JK, White WD, et al. Reduced length of hospital stay in colorectal surgery after implementation of an enhanced recovery protocol. *Anesth Analg*. May 2014;118(5):1052-1061; and Enhanced recovery care pathway. A better journey for patients seven days a week and better deal for the NHS. National Health Service 2012-2013. <http://www.nhs.uk/resource/research/publications/enhanced-recovery-care-pathwayreview.aspx>. Accessed February 25, 2015.

⁶ AANA member survey, 2014

⁷ MGMA Physician Compensation and Production Survey, 2014. www.mgma.com

However, the annualized labor costs (excluding benefits) for each modality vary widely. The annualized cost of practice modality (a) equals \$170,000 per year. For case (b), it is $(\$170,000 + (0.25 \times \$540,314))$ or \$305,079 per year. For case (c) it is $(\$170,000 + (0.50 \times \$540,314))$ or \$440,157 per year. Finally, for case (d), the annualized cost equals \$540,314 per year.

Anesthesia Payment Model	FTEs / Case	Clinician costs per year / FTE
(a) CRNA Non-medically Directed	1.00	\$170,000
(b) Medical Direction 1:4	1.25	\$305,079
(c) Medical Direction 1:2	1.50	\$440,157
(d) Anesthesiologist Only	1.00	\$540,314
<i>Anesthesiologist mean annual pay</i>	<i>\$540,314</i>	<i>MGMA, 2014</i>
<i>CRNA mean annual pay</i>	<i>\$170,000</i>	<i>AANA, 2014</i>

Under the more costly anesthesia models, hospitals and other facilities – not to mention patients and employers paying for commercial health plan coverage – are bearing the additional costs. Therefore, we recommend that the Committee should consider direction incentives for high value care that include the use of cost-effective anesthesia care.

Promote Full Scope of Practice and Remove Barriers to Care

The AANA believes the Committee should spur models that support and encourage APRNs, including CRNAs, to practice to their full professional education, skills, and scope of practice. Our policy recommendation corresponds with a recommendation from the NAM's report titled *The Future of Nursing: Leading Change, Advancing Health*, which outlines several paths by which patient access to care may be expanded, quality preserved or improved, and costs controlled through greater use of APRNs, including CRNAs.⁸ The NAM report specifically recommends that, "advanced practice registered nurses should be able to practice to the full extent of their education and training."⁹ Moreover, the NAM states with regard to one type of APM, the accountable care organizations (ACOs), that "ACOs that use APRNs and other nurses to the full extent of their education and training in such roles as health coaching, chronic disease management, transitional care, prevention activities, and quality improvement will most likely benefit from providing high-value and more accessible care that patients will find to be in their best interest."¹⁰

We also recommend that the Committee encourage payment models that do not impose unnecessary physician supervision requirements.¹¹ Waiving unnecessary supervision requirements is consistent with Medicare policy reimbursing CRNA services in alignment with their state scope of practice,¹² and with the NAM's recommendation, "Advanced practice registered nurses should be able to practice to the full extent of their education and training."¹³

⁸ IOM op. cit. p. 69.

⁹ IOM op. cit. p. 7-8.

¹⁰ IOM op. cit. p. 3-41.

¹¹ See 42 CFR §§ 482.52, 482.639, 416.42.

¹² 42 CFR §410.69(b), 77 Fed. Reg. 68892, November 16, 2012.

¹³ Institute of Medicine (IOM). *The future of nursing: leading change, advancing health*. Washington, DC: The National Academies Press, p. 3-13 (pdf p. 108) 2011.

There is no evidence that physician supervision of CRNAs improves patient safety or quality of care. In fact, there is strong and compelling data showing that physician supervision does not have any impact on quality, and may restrict access and increase cost. Studies have repeatedly demonstrated the high quality of nurse anesthesia care, and a 2010 study published in *Health Affairs*¹⁴ led researchers to recommend that costly and duplicative supervision requirements for CRNAs be eliminated. Examining Medicare records from 1999-2005, the study compared anesthesia outcomes in 14 states that opted-out of the Medicare physician supervision requirement for CRNAs with those that did not opt out. (To date, 17 states have opted-out.) The researchers found that anesthesia has continued to become safer in opt-out and non-opt-out states alike. In reviewing the study, the *New York Times* stated, "In the long run, there could also be savings to the health care system if nurses delivered more of the care."¹⁵ Most recently, a study published in *Medical Care* June 2016 found no measurable impact in anesthesia complications from nurse anesthetist scope of practice or practice restrictions.¹⁶

CRNA safety in anesthesia is further evidenced by the significant decrease in liability premiums witnessed in recent decades. In 2015, self-employed CRNAs paid 33 percent less for malpractice premiums nationwide when compared to the average cost in 1988. When adjusted for inflation through 2015, the reduction in CRNA liability premiums is an astounding 65 percent less than approximately 25 years ago according to Anesthesia Insurance Services, Inc. According to a May/June 2010 study published in the journal of *Nursing Economics*, CRNAs acting as the sole anesthesia provider are the most cost-effective model for anesthesia delivery without any measurable difference in the quality of care between CRNAs and other anesthesia providers or by anesthesia delivery model.¹⁷

The evidence also demonstrates that the supervision requirement is costly. Though Medicare requires supervision of CRNAs (except in opt-out states) by an operating practitioner or by an anesthesiologist who is immediately available if needed, hospitals and healthcare facilities often misinterpret this requirement to be a quality standard rather than a condition of participation. The AANA receives reports from the field that anesthesiologists suggest erroneously that supervision is some type of quality standard, an assertion bearing potential financial benefit for anesthesiologists marketing their medical direction services as a way to comply with the supervision condition of participation. When this ideology is established, anesthesiologist supervision adds substantial costs to healthcare by requiring duplication of services where none is necessary. Further, the Medicare agency has clearly stated that medical direction is a condition for payment of anesthesiologist services and not a quality standard.¹⁸ But there are even bigger costs involved if the hospital administrator believes that CRNAs are required to have anesthesiologist supervision.

According to a nationwide survey of anesthesiology group subsidies,¹⁹ hospitals pay an average of \$160,096 per anesthetizing location to anesthesiology groups, an increase of 13 percent since

¹⁴ Dulisse, op. cit.

¹⁵ Who should provide anesthesia care? (Editorial) *New York Times*, Sept. 6, 2010.

¹⁶ Negrusa B et al. op. cit.

¹⁷ Paul F. Hogan et. al, "Cost Effectiveness Analysis of Anesthesia Providers." *Nursing Economics*. 2010; 28:159-169.

¹⁸ 63 FR 58813, November 2, 1998.

¹⁹ Healthcare Performance Strategies. Anesthesia Subsidy Survey 2012.

the previous survey in 2008. An astounding 98.8 percent of responding hospitals in this national survey reported that they paid an anesthesiology group subsidy. Translated into concrete terms, a hospital with 20 operating rooms pays an average of \$3.2 million in anesthesiology subsidies. Anesthesiology groups receive this payment from hospitals in addition to their direct professional billing.

As independently licensed professionals, CRNAs are responsible and accountable for judgments made and actions taken in his or her professional practice.²⁰ The scope of practice of the CRNA addresses the responsibilities associated with anesthesia practice and pain management that are performed by the nurse anesthetist as a member of inter-professional teams. The same principles are used to determine liability for surgeons for negligence of anesthesiologists or nurse anesthetists. The laws' tradition of basing surgeon liability on control predates the discovery of anesthesia and continues today regardless of whether the surgeon is working with an anesthesiologist or a nurse anesthetist.²¹

There is strong evidence in the literature that anesthesiologist supervision fails to comply with federal requirements, either the Part A conditions of participation or Part B conditions for coverage. Lapses in anesthesiologist supervision are common even when an anesthesiologist is medically directing as few as two CRNAs, according to a 2012 study published in the journal *Anesthesiology*,²² the professional journal of the American Society of Anesthesiologists. The authors reviewed over 15,000 anesthesia records in one leading U.S. hospital, and found supervision lapses in 50 percent of the cases involving anesthesiologist supervision of two concurrent CRNA cases, and in more than 90 percent of cases involving anesthesiologist supervision of three concurrent CRNA cases. This is consistent with over ten years of AANA membership survey data. Moreover, the American Society of Anesthesiologists *ASA Relative Value Guide 2013* newly suggests loosening further the requirements that anesthesiologists must meet to be "immediately available," stating that it is "impossible to define a specific time or distance for physical proximity." This newer *ASA Relative Value Guide* definition marginalizes any relationship that the "supervisor" has with the patient and is inconsistent with the Medicare CoPs and CfCs, and with the Medicare interpretive guidelines for those conditions, which require anesthesiologists claiming to fulfill the role of "supervising" CRNA services be physically present in the operating room or suite.

If a regulatory requirement is meaningless in practice, contributes to greater healthcare costs, and is contrary to existing evidence regarding patient safety and access to care, we recommend that the Committee discourages the development of models that impose unnecessary supervision requirements.

Promote Access to Care in Rural Areas

²⁰ American Association of Nurse Anesthetists. Code of Ethics for the Certified Registered Nurse Anesthetist. Adopted 1986, Revised 2005.

²¹ Blumenreich, G. Another article on the surgeon's liability for anesthesia negligence. *AANA Journal*. April 2007.

²² Epstein R, Dexter F. Influence of Supervision Ratios by Anesthesiologists on First-case Starts and Critical Portions of Anesthetics. *Anesth*. 2012;116(3): 683-691.

As CRNAs provide anesthesia for a wide variety of surgical cases and in some states are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities, it vital that the Committee promote access to the use of CRNA anesthesia services in rural America. Furthermore, the Committee should ensure models do not create unintended barriers to the use of CRNA services and that CRNA are practicing at their full professional education, skills, and scope of practice. CRNAs play an essential role in assuring that rural America has access to critical anesthesia services, often serving as the sole anesthesia provider in rural hospitals, affording these facilities the capability to provide many necessary procedures. The importance of CRNA services in rural areas was highlighted in a recent study which examined the relationship between socioeconomic factors related to geography and insurance type and the distribution of anesthesia provider type.²³ The study correlated CRNAs with lower-income populations and correlated anesthesiologist services with higher-income populations. Of particular importance to the implementation of public benefit programs in the U.S., the study also showed that compared with anesthesiologists, CRNAs are more likely to work in areas with lower median incomes and larger populations of citizens who are unemployed, uninsured, and/or Medicaid beneficiaries.²⁴

Promote Multi-modal Pain Management in an Effort to Reduce the Need for and Reliance on Opioids

The AANA recommends that the Committee promote multi-modal pain management in models as a way to help curb the opioid epidemic. Likewise, the Committee should ensure that models do not limit the use of medically necessary CRNA pain management services. The AANA is concerned in the increase in opioid drug use, abuse and deaths and is committed to collaboratively working toward a common solution to help curb the opioid epidemic in the US. As a main provider of pain management services and as APRNs, CRNAs are uniquely skilled to provide both acute and chronic pain management in a patient centered, compassionate and holistic manner in all clinical settings (e.g., hospitals, ambulatory surgical centers, offices, and pain management clinics).²⁵ Furthermore, the holistic approach that CRNA pain management practitioners employ when treating their chronic pain patients may reduce the reliance on opioids as a primary pain management modality, thus aiding in the reduction of potential adverse drug events related to opioids. According to a recent AANA position statement, *A Holistic Approach to Pain Management: Integrated, Multimodal, and Interdisciplinary Treatment*, “CRNAs integrate multimodal pain management as an element of enhanced recovery after surgery (ERAS) protocols to manage pain. Management begins pre-procedure and continues after discharge by using opioid sparing techniques such as regional anesthesia, peripheral nerve blocks, non-pharmacological approaches, and non-opioid based pharmacologic measures. Careful assessment and treatment of acute pain, which may include appropriate opioid

²³ Liao CJ, Quraishi JA, Jordan, LM. Geographical Imbalance of Anesthesia Providers and its Impact on the Uninsured and Vulnerable Populations. *Nurs Econ.* 2015;33(5):263-270.
<http://www.aana.com/resources2/research/Pages/NursingEconomics2015.aspx>

²⁴ Liao, op cit.

²⁵ AANA Chronic Pain Management Guidelines, September 2014, available at:
<http://www.aana.com/resources2/professionalpractice/Pages/Chronic-Pain-Management-Guidelines.aspx>.

prescribing, can decrease the risk of acute pain transitioning to chronic pain or the development of opioid dependency and abuse.”²⁶

In developing the plan of care for the patient, CRNAs obtain patient history, evaluate the patient, order and review necessary diagnostic testing, and assess the patient’s psychological and emotional state. Non-pharmacologic pain mitigation techniques are often employed in the treatment of chronic pain and considered as part of the care plan. These techniques may include patient education regarding behavioral changes that can decrease pain, such as weight loss, smoking cessation, daily exercise, stretching, and physical or chiropractic therapy. Such therapies may not be sufficient when used alone, but they have significant benefit when they are used in a complementary manner with other therapies.

The Committee should ensure that models do not limit the use of these medically necessary CRNA pain management services. Leading physician subspecialty organizations in pain management research, practice guideline development, and education are known to use economic and advocacy means to exclude other members of the pain management team, such as CRNAs, from educational and practice opportunities, thereby limiting patient access to care, diagnosis, treatment, and ultimately improved patient quality of life.

Conclusion

A report issued in April 2015 by the Federal Trade Commission (FTC), “Competition and the Regulation of Advanced Practice Registered Nurses,” underscores the point that for CRNAs and other APRNs, “even well intentioned laws and regulations may impose unnecessary, unintended, or overbroad restrictions on competition, thereby depriving health care consumers of the benefits of vigorous competition.”²⁷ The AANA hopes the Committee will be cognizant of these barriers and require that models do not impose barriers that limit a CRNA’s ability to provide comprehensive care.

CRNAs are proven to be safe, high-quality and cost-effective healthcare providers. As the Committee examines MACRA and other APMs for ways to develop value-based care, the ANNA encourages the Committee to recognize that CRNAs are vital to resolving the challenges facing the nation’s healthcare system.

²⁶ See AANA Position Statement, “A Holistic Approach to Pain Management: Integrated, Multimodal, and Interdisciplinary Treatment, July 2016, available at: www.aana.com/HolisticPainMgmt.

²⁷ Federal Trade Commission. Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses, March 2014, p. 1.

November 8, 2017

The Honorable Greg Walden, Chairman
The Honorable Frank Pallone, Ranking Member
House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington D.C. 20515

Dear Chairman Walden and Ranking Member Pallone,

On behalf of the more than 52,000 members of the American Society of Anesthesiologists (ASA), I am writing to thank the House Energy and Commerce Committee for scheduling the November 8, 2017 hearing, "MACRA and Alternative Payment Models: Developing Options for Value-based Care."

ASA has invested heavily in initiatives aimed at improving the safety, quality and efficiency of care for the surgical patient. We have developed a clinical registry, operated by the Anesthesia Quality Institute (AQI), that contains detailed files on millions of anesthetic administrations by thousands of physician anesthesiologists in hundreds of care settings. These data have led to dozens of published reviews to inform the safe practice of anesthesia.

We have sponsored the Perioperative Surgical Home (PSH) Collaboratives in almost 60 large and small health care institutions. PSH is a patient-centered delivery system that aligns with the National Quality Strategy (NQS) to achieve the triple aim of improving health, improving the delivery of healthcare and reducing costs. These goals are met through shared decision-making and seamless continuity of care for the surgical patient, from the moment surgery is made, all the way through recovery, discharge and beyond. In these collaboratives, care redesign exercises have improved outcomes and reduced cost. We are about to launch an expanded series of demonstrations for physician anesthesiologists to further develop the key concepts of care coordination for the surgical patient and maximize the benefits to be derived from these opportunities. Physician anesthesiologists represent the common pathway for nearly all surgical and procedural care patients and can contribute to improved quality and more cost-effective care.

In these efforts and others, ASA has embraced the underlying goals of MACRA.

The Role of the Physician Anesthesiologists and Alternative Payment Models

Our submitted comments today address the role of the physician anesthesiologist as part of the larger community of clinicians, patients, and other stakeholder in the transition of the Medicare system from volume-based to a value-based system through the development of alternative payment models. We believe physician anesthesiologists can play a vital and critical role in this transition. Our comments address three issues:

- Pathways for the Perioperative Surgical Home in the Development and Implementation of APMs
- Role of the Physician Anesthesiologist in Addressing Substance Abuse in an APM Environment
- Recognizing and Integrating Specialists within the APM Environment

Pathways for the Perioperative Surgical Home (PSH) in the Development and Implementation of APMs

As part of our shared vision with CMS of shifting healthcare delivery from volume to value, and as mentioned in the introduction to this letter, ASA has been organizing and partnering with other medical specialties to implement the PSH care delivery model in healthcare organizations across this country. The PSH is a patient-centered, physician-led, interdisciplinary and team-based system of coordinated patient care, which spans the entire experience from decision of the need for any invasive procedure—surgical, diagnostic, or therapeutic—to discharge from the acute-care facility and beyond. The PSH strives to achieve the triple aim of better patient experience, better healthcare, and reduced expenditures for all patients undergoing surgery and invasive procedures.

ASA has been assessing the PSH's core strengths within this new Advanced APM landscape. Since the PSH is a multi-disciplinary approach to patient care, it has several unique qualities that position it well to have a varied and robust impact on physicians who will be reporting under both the MIPS and the Advanced APM pathways. Several of these strengths are listed below:

- Team-based and physician-focused: Physicians across the care spectrum can participate.
- Proven track record of cost and care: Data collected from organizations participating in the PSH Collaborative have shown consistent improvement in both patient care and cost reduction.
- Flexibility with current payment initiatives: The PSH payor-agnostic framework aligns well with several of the existing and emerging value-based payment models under CMS and private payor payment initiatives.
- Flexibility for practitioners: As an integrated care delivery model, the breadth and depth of clinical settings and patient subgroups can be considered through a tailored approach to care.

PSH was developed initially as a care model, but ASA believes that it can fit under and help enhance existing payment models or promote new payment models. We request that Congress encourage CMS to consider three pathways for the integration of PSH within their efforts towards value-based care and the development of Advanced APMs.

Care Model

PSH integrated into any system or model

- Provides a systematic approach that embeds measurable quality metrics and enhances patient care.

Plug & Play

PSH embedded into an existing Advanced APM

- Provides a care pathway for existing MIPS APMs and Advanced APMs.
- Allows greater participation in Advanced APMs by specialists that currently do not participate.
- Recognizes the impact of acute care episodes on population health improvement.

Independent APM*Integrate the PSH care model with a financial risk model*

- This model will be designed to meet all three of the criteria for an Advanced APM (financial risk, quality and HIT).
- Expands opportunities for APMs that are physician-led and covers various sites of service including inpatient, outpatient and ambulatory surgical centers.

Role of the Physician Anesthesiologist in Addressing Substance Abuse in an APM Environment

Numerous recent reports have found that current opioid epidemic is the deadliest drug crisis in American history. Last month President Trump declared the opioid crisis a public health emergency. Combating this epidemic will require a multi-pronged strategy – a critical element of this fight will be the design of a system that promotes the appropriate prescribing of opioids to patients by addressing inappropriate financial incentives for providers and implementing evidence-based practice standards that reduce opioid use and deter the inappropriate prescriptions of opioids. The significant extent of this crisis compels us to enact such strategies as part of the implementation for all payment models where opioid prescriptions are relevant.

Anesthesiologists, as general anesthesiologists and as pain specialists, along with many other physician specialties have been working diligently to address issues of over-prescribing of opioids. ASA has been leading efforts to support their physician members and the patients they service in this area. We ask Congress to urge CMS to consider the strategies described below in payment model development, taking into account the important role of anesthesiologists.

- Taking a unique approach to tackling this epidemic, ASA is partnering with Premier Inc., and its network of hospitals, on a **national opioid safety pilot** to reduce patient harm from opioid misuse, dependence and addiction. The six-month pilot, which began in September, is geared at addressing opioid misuse and abuse, through implementation of evidence-based practices and education provided by ASA physician members, aimed at improving pain management and reducing opioid prescriptions after surgery. We believe this is one way to reduce the number of medications in America's households and prevent them from getting into the wrong hands, a large contributing factor to this epidemic.
- ASA released a statement for long-term opioid use in chronic, non-cancer pain conditions which provides a guide to management of opioid use for chronic non-cancer pain. This document provides a comprehensive set of considerations including patient evaluation, communication, use of quality metrics, consideration of multimodal treatment options, assessment of risk of dependence and addiction among other considerations. The statement can be found here: <https://www.asahq.org/resources/resources-from-asa-committees/considerations-for-long-term-opioid-use>
- ASA collaborated with the CDC on the **Guideline for Prescribing Opioids for Chronic Pain**, which provides recommendations for primary care providers on opioid prescribing, including when to initiate or continue opioids for chronic pain; follow-up and discontinuation; and addresses risk and harm of opioid use. Because of ASA's involvement, the CDC modified the guideline's recommendation on acute pain.

- ASA has collaborated with other pain societies, through the *Pain Care Coalition (PCC)* — comprised of the American Academy of Pain Medicine, American Pain Society, and ASA. The coalition works together to support policies to further responsible pain care. Most recently, the PCC submitted comments to the White House Opioid Commission, in response to the commission's interim report.

Taken together ASA believes that the integration of these strategies; some that are led by anesthesiologists and others that are examples of anesthesiologists working with primary care physicians, surgeons or other providers; into payment models can be an effective means to address the opioid epidemic, enhance the quality of care provided to patients and as a result also produce overall cost savings to the system.

Recognizing and Integrating Specialists within the APM Environment

ASA, along with other procedure-focused medical specialties, remains concerned with the lack of alternative payment models which are applicable to the services we provide. As the Quality Payment Program (QPP) approaches its second year of implementation, the need for expanding opportunities for procedure-based specialists to fully participate becomes even more critically important to ensure that the Program offers opportunities for payment reform to a wide range of physicians participating in the Medicare program. To address this comprehensively, ASA believes this issue must be addressed on two levels.

Firstly, greater efforts must be made to recognize the contributions that anesthesiologists can make to the success of broad-based population health oriented APMs. Actively managing and coordinating the care of patients undergoing surgical procedures is often overlooked, yet can yield substantial improvements in cost and quality, contributing to the success of population health management programs. Key to the success of the PSH model is the active management of patients at the time of transitions in care—pre-procedure to procedure and procedure to post-procedure—and in care setting—e.g., institution to home. Use of measures that capture these contributions and integration of care models such as PSH can help CMS and other payors better understand the impact of anesthesiologists and other specialists on the cost and quality of healthcare provided to Medicare beneficiaries.

On a parallel track we believe greater efforts and resources must be committed to the development of APMs that more directly capture the contributions of a wide range of specialists. Similar to the situation for many other specialties, currently there are few, if any, opportunities for physician anesthesiologists to participate in Advanced APMs. Nor do we see a significant change to this situation in the near future. The scarcity of Advanced APM opportunities means it is highly unlikely that any of our members, or many specialists in general, will be eligible to participate in models that may have the greatest impact on advancing the triple aim.

We urge Congress to encourage CMS to develop models that capture the contributions of specialists across the spectrum of care. We are eager to work with the Agency and other stakeholders to turn these desirable goals into a reality. We remain committed to identifying and nurturing payment solutions to ensure a diversity of provider types have options under the Advanced APM track of the QPP. We look forward to working alongside CMS to achieve this aim.

We appreciate the House Energy and Commerce Committee's consideration of how Alternative Payment Models can advance payment reforms to Medicare, and this opportunity to share how the ASA's Perioperative Surgical Home delivers value, patient satisfaction and reduced costs. Please contact Manuel Bonilla, Chief Advocacy Officer, at: m.bonilla@asahq.org or 202-289-2222 should you have any questions.

Sincerely,

A black rectangular box redacting the signature of James D. Grant.

James D. Grant, M.D., M.B.A., FASA
President
American Society of Anesthesiologists



STATEMENT

of the

American Medical Association

for the Record

**U.S. House of Representatives Committee on Energy and
Commerce
Subcommittee on Health**

**RE: MACRA and Alternative Payment Models:
Developing Options for Value-Based Care**

November 8, 2017

**Division of Legislative Counsel
(202) 789-7426**

Statement
For the Record
of the
American Medical Association
to the
U.S. House of Representatives Committee on Energy and Commerce
Subcommittee on Health
Re: MACRA and Alternative Payment Models:
Developing Options for Value-Based Care

November 8, 2017

The American Medical Association (AMA) appreciates the opportunity to present our views to the U.S. House of Representatives Committee on Energy and Commerce concerning the Medicare Access and CHIP Reauthorization Act (MACRA) and Alternative Payment Models (APMs). The AMA believes APMs can provide significant opportunities for physicians to improve the quality and outcomes of their patients' care in ways that also lower growth in health care spending. That is why we have hosted workshops, convened meetings, and produced educational materials to support efforts by physicians in all specialties to develop APMs that will eliminate barriers to better care delivery in their practices and communities.

This year, the AMA convened two workshops on physician-focused APMs attended by hundreds of highly engaged physician leaders and medical society staff. We heard many good ideas from workshop participants who are on the cutting edge of APM design, and we want to use these concepts to help develop a more robust APM pathway under MACRA and increase physician participation in APMs.

For example, we heard from an osteopathic physician who has been participating in the Comprehensive Primary Care model in Oklahoma. The extra support available through this model allowed his practice to develop a team-based approach to care, focus on care improvements like preventing falls, provide same-day appointments for more severely ill patients, and implement patient registries that helped improve management of the practice's patients with chronic conditions like diabetes.

We also heard from a cardiologist participating in the Bundled Payments for Care Initiative in Illinois. The model has allowed his team to significantly reduce skilled nursing facility lengths of stay and hospital readmissions for heart failure patients.

Today, however, most physicians still do not have the option of participating in APMs under MACRA. Last year's final rule indicated that about five percent of clinicians would be qualified APM participants in 2017, and the forecast for 2018 is similar.

Submissions to the Physician-focused Payment Model Technical Advisory Committee (PTAC) signal that many specialty societies are developing physician-focused APMs. A number of these APMs focus on better managing chronic diseases and preventing exacerbations, improving the speed

and accuracy of diagnoses for symptoms or conditions, improving the process of selecting treatment plans, and engaging patients in helping to better manage their conditions at home. These improvements in care delivery can lead to fewer emergency visits and hospital admissions and better outcomes for patients. Several physician-focused APMs have been implemented on a small scale with support from private payers or with grants from the Centers for Medicare & Medicaid Services (CMS), while others are still being designed and have not yet been tested.

Examples of Physician-Focused APMs

COME HOME: In New Mexico, oncologist and AMA President-elect Dr. Barbara McAneny designed a specialty medical home for patients with cancer which she called the COME HOME model. With grant funding from a CMS program, the model significantly reduced the complication rates for patients receiving chemotherapy, such as dehydration, which in turn reduced their emergency visits and hospital admissions. The model also helped reduce duplicative diagnostic testing and improve symptom management. Now Dr. McAneny's practice is participating in the Medicare Oncology Care Model, and she is also working with a private payer in New Mexico to implement an APM developed by the American Society of Clinical Oncology that builds upon the experience and lessons learned from the COME HOME model.

SonarMD: An Illinois gastroenterologist, Dr. Lawrence Kosinski, developed a specialty medical home model for patients with Crohn's disease and ulcerative colitis with support from Illinois Blue Cross Blue Shield. He called it Sonar because his patients were like underwater submarines and he needed a way to find out if his patients were having a problem before they surfaced in a hospital. The model grew out of data that the payer provided to him showing that, of the more than 50 percent of Crohn's disease patients hospitalized with complications of their disease, less than one third had seen any physician within the 30 days preceding their hospital admission. Interviews with the patients revealed that the symptoms of their disease had come to seem normal to them over time, so they had no way of knowing that a change needed to be made in their treatment plan to avoid a developing emergency. Under the Sonar model, participating gastroenterologists receive funding support for proactive outreach to patients by nurse care managers. Each patient receives a "ping" via text message, email or phone each month with a few structured questions. The nurses are able to use the patients' responses to these questions, called Sonar scores, to alert the gastroenterologists if they need to see the patient or adjust their medication regimen. The Sonar model has cut the rate of hospitalizations in half, and was the first APM recommended by the PTAC to the Secretary of Health and Human Services. Recently, the AMA participated in a meeting of Dr. Kosinski and CMS to discuss how to potentially implement this model for Medicare patients with an array of chronic conditions that would benefit from this type of intensive physician-nurse-patient engagement.

Bridges to Care: A team led by Dr. Jennifer Wiler, an emergency physician in Colorado, used grant funds to test a physician-focused APM focused on patients who utilize the emergency department multiple times per year and are insured by Medicaid. Their CMS award supported up to eight home visits within 60 days of an emergency department visit or hospital discharge by a team that provided intensive medical, behavioral health, and social care coordination services. As described in a paper published last month in *Health Affairs*, the model was able to substantially reduce the number of emergency visits by people who had been coming to the emergency department more than three times a year, and more than double their number of visits to primary care physicians.

Value-Based Total Joint Arthroplasty (TJA): With support from Horizon Blue Cross and Blue Shield of New Jersey, Dr. Stephen Zabinski led the design and implementation of a TJA APM that supports the provision of intensive pre-operative care focused on risks that the patient can modify before surgery, such as their weight, anemia, diabetes control, and smoking. This improvement in

the patients' preoperative functioning makes them less likely to experience postoperative complications and allows their rehabilitation to proceed more quickly and at lower cost. Within a few years, the APM achieved very significant reductions in length of stay and inpatient complication rates, more than doubled the percentage of patients discharged to their home instead of a rehabilitation or skilled nursing facility, lowered costs and achieved high rates of patient satisfaction with their care.

Patient-Centered Opioid Addiction Treatment: As a component of our efforts to help bring an end to the epidemic of opioid overdose deaths, the AMA has been working closely with the American Society of Addiction Medicine to develop a physician-focused APM for managing the treatment of opioid use disorder. As the Members of this Committee know, the opioid epidemic is widespread, growing rapidly, and has overtaken many other leading causes of death. The treatment model for opioid use disorder requires interventions that address its medical, psychological and social components, including medication-assisted treatment. The model aims to broaden coordinated delivery of the full spectrum of services needed for treatment, improve transitions to outpatient care for patients discharged from more intensive levels of care, and reduce the number of avoidable emergency department visits and hospitalizations. Payments under the model would support an evaluation, diagnosis, treatment planning, and treatment induction phase, followed by a maintenance phase. Patient-centered, comprehensive and collaborative treatment plans would cover care from induction through stabilization, treatment, and long-term recovery. It would also support more intensive management when warranted by special circumstances such as a relapse, comorbidities, or a patient choosing to discontinue the medication. Payments under the model would be adjusted based on performance on outcome measures.

Other Specialist Models: Under the Medicare physician fee schedule, physicians treating patients with chronic diseases, such as rheumatoid arthritis, asthma, headaches, and diabetes, are paid primarily based on the number of times the patient comes to the physician's office. There is no payment for many high-value services, such as phone calls to respond to patient setbacks or complications and consultation with other physicians to improve diagnosis, treatment planning, and care coordination. Payments are often inadequate to support the additional time and services needed by patients with difficult-to-diagnose or difficult-to-treat conditions. As a result, patients may be inaccurately diagnosed or inappropriately treated, experience continued symptoms of their disease or side effects of medications that could have been avoided, and be hospitalized or seen in an emergency department for problems that could have been prevented. A number of specialty societies are designing physician-focused APMs to improve diagnosis and management of chronic diseases, including the American Academy of Neurology, American College of Rheumatology, American College of Allergy, Asthma & Immunology, American Association of Clinical Endocrinologists and others. Several of these models include elements in common, such as: a one-time payment to support a comprehensive diagnostic work-up, testing, and development of an initial treatment plan; monthly payments to cover the treatment and care management needed to get the condition under good control; payments to cover ongoing care, either by a primary care physician for patients whose conditions are well-controlled or continued care by a specialty team for patients with more difficult-to-control conditions or complex comorbidities; and support for collaboration between specialists and primary care physicians during diagnosis and treatment planning and when needed due to disease progression or other issues.

PTAC Technical Assistance

The PTAC reports to the HHS Secretary of May 31, 2017 on Project Sonar and on the COPD and Asthma Monitoring Project included the statement, "Because PTAC has been advised that it may not provide technical assistance, the Committee is hopeful that the Secretary would consider options for

providing technical assistance to this and other submitters.” The AMA urges Congress to clarify the MACRA statute to ensure that the PTAC can provide data and technical assistance to individuals and organizations developing APM proposals.

One of the greatest barriers physicians face in designing and implementing new approaches to care delivery and payment that will reduce Medicare spending is their inability to obtain data on the full range of services their patients are receiving today. Most of the savings from improved care delivery come from lower spending on services such as hospital admissions and post-acute care that are not delivered directly by physicians, and some of the biggest opportunities for improved care coordination come from avoiding duplication and conflicts with services delivered by other providers. Physicians do not have access to information about the other services their patients are receiving that would enable them to identify and quantify opportunities for savings or take action to achieve these savings. If the PTAC could provide these types of data to those developing APM proposals, we believe it would significantly enhance the quality of the submitted proposals and greatly increase the likelihood of their testing and implementation.

APM developers also need assistance with technical issues such as risk stratification. The risk adjustment methodologies used in the Medicare and Medicaid programs to date are designed to address differences in patient needs among large populations associated with a health plan or hospital. These methods cannot be appropriately transferred for use in risk stratifying patients associated with a medical practice or those with a particular condition. Current risk adjustment methods, for example, do not take into account patients’ stage of disease, functional status, and whether they have a caregiver at home. Factors like these can have a significant effect on treatment plans, adherence, and patient outcomes. The PTAC report to HHS on “The COPD and Asthma Monitoring Project” describes questions about the project’s proposed risk adjustment methodology and indicates that the proposal would benefit from technical assistance on this and other issues, but notes that “PTAC has been advised that it may not provide technical assistance.”

Policy Recommendations

Recently the AMA applauded an announcement by the CMS Administrator regarding a new direction for the Center for Medicaid and Medicare Innovation. We were extremely pleased that this announcement sought comments on how CMS can help develop APMs for specialists, engage in limited scale model tests, adopt behavioral health APMs, test models involving direct contracting with patients, and expand opportunities for participation in Advanced APMs under MACRA. The AMA will be making a number of recommendations to CMS in response to this Request for Information.

The AMA is also extremely pleased that Medicare has finalized coverage of remote patient monitoring in the fee-for-service program subject to a number of coverage requirements. This is an important bridge for physicians being paid through the Medicare fee schedule to transition into APMs as remote patient monitoring provides new tools that will help patients and physicians actively manage chronic conditions and improve population health.

Several of the key challenges facing APM participants and developers are highlighted below, along with our policy recommendations to address them.

Need for a True Innovation Lab: The internal CMS process for developing each model that it wants to test takes 18-24 months. Although Congress established the PTAC to review APMs proposed by stakeholders, there is no real pathway for these stakeholder-developed APMs to be tested and implemented. The AMA recommends that CMS encourage physicians to develop an array of

approaches that make sense for the patients they treat in the specific environment where they practice. CMS should then be ready to quickly test multiple approaches to see which ones work, instead of trying to decide on one single best approach before any testing is done. In addition, the process needs to be speeded up. We are about to enter the second MACRA performance period with only about five percent of clinicians in Advanced APMs. Other industries have methods for rapid prototyping and CMS should develop a similar approach to testing APMs. CMS and the PTAC also should better integrate their processes.

Do Not Tie Financial Risk to Total Spending: Physicians participating in an APM can appropriately take accountability, including financial risk, for aspects of their patients' care that they can control or influence. These include decisions on the appropriateness of tests they order, procedures they perform, medications they administer, whether patients are discharged to their homes or to expensive facilities. Physicians should not be expected to take risk for the prices of drugs and biologics or the severity of their patients' conditions and their functional status. Most Medicare spending does not go to physician services, so increasing physicians' financial risk for Medicare spending on hospitals and drugs will be a major barrier to increasing their participation in APMs.

Lessen Administrative Burdens: Many of the concerns that we hear from physicians about the current payment system have more to do with administrative and regulatory burdens than with payment rates. Prior authorization, certification, documentation and reporting requirements, and electronic health record systems that do more to hinder than support patient care are enormously burdensome. In developing APMs, CMS should take maximum advantage of opportunities to lessen these burdens by waiving Medicare and other payer requirements. This could allow for new pilot programs using telehealth, for example. In addition, when APMs require any type of reporting or documentation, payment rates should be adequate to cover physician costs associated with these tasks.

The AMA strongly supports efforts to reduce barriers to higher quality care and lower costs in current payment systems through the development of APMs. We appreciate the opportunity to provide our comments on this matter and look forward to working with Congress and CMS on developing options for value-based care.



1111 North Fairfax Street
Alexandria, VA 22314-1486
703/684-2782
www.apta.org

**Comments of the
American Physical Therapy Association
Health Subcommittee of the Committee on Energy and Commerce**

Wednesday, November 8, 2017

For a hearing titled

"MACRA and Alternative Payment Models: Developing Options for Value-based Care."

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) appreciates the opportunity to submit comments to the Health Subcommittee of the House Energy and Commerce Committee as it considers the development and use of alternative payment models (APMs).

APTA's goal is to improve the health and quality of life of adults and children in our society by advancing physical therapist practice, education, and research and by increasing the awareness and understanding of physical therapy's role in the nation's health care system. APTA is committed to being a vested partner with the Centers for Medicare and Medicaid Services (CMS) as it moves swiftly toward its goal of shifting from Medicare payment based solely on fee-for-service to a value-based payment system.

To that end, APTA urges the committee and Congress to ensure that physical therapists can participate fully in the development and use of APMs moving forward. As Congress continues to explore the future of APMs, APTA is pleased to make the following recommendations:

Recommendations

Expand Focus of APMs to Include Rehabilitation

Physical therapists are central to the quality of care throughout the health care continuum, and they work cohesively as members of the health care team to ensure the success of innovative delivery models such as bundled payments and accountable care organizations. The success of APMs in improving the quality of care and reducing costs will depend on the collective efforts of all providers throughout the health care spectrum, including physical therapists in private practice, home health agencies, rehabilitation agencies, inpatient rehabilitation facilities, skilled nursing facilities, hospitals, and other provider settings. The care provided by physical therapists is critical to improving patients' function and successfully transitioning patients from one setting to the next. For these reasons, the physical therapy profession is well-positioned to be a key player in innovative models.

However, there are significant hurdles that impede physical therapists from fully participating in APMs. Current Advanced APMs bar specialty and nonphysician providers from participation. To accelerate the adoption and use of Medicare (and Medicaid) APMs, CMS should undertake a stronger effort to promote payment models that are accessible to all providers, including physical therapists. We recommend that CMS apply significantly more time and resources toward developing rehabilitation-inclusive APMs. Greater action must be taken to integrate rehabilitation services into payment models. Further, as the development of APMs continues onward and APM engagement grows, we strongly recommend that CMS provide additional guidance, technical assistance, and other support to providers who have not yet participated in APMs. As illustrated by the current approved list of Advanced APMs and throughout the current roster of projects under way by the Center for Medicare and Medicaid Innovation (CMMI), rehabilitation has not been a focus, and, therefore, the participation of physical therapists in APMs has not been as robust as that of primary care physicians and hospitals.

The true potential to reduce costs and improve the health of individuals and populations will not be fully realized until CMS takes meaningful steps to include physical therapists and other rehabilitation providers within APMs, including Advanced APMs. **APTA urges Congress to promote the inclusion of physical therapy in APMs as it continues oversee implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).**

Develop APM Pathways for Nonphysician Providers

Empowering physical therapists to develop and lead APMs will result in expanded access to medically necessary rehabilitative care for Medicare beneficiaries, leading to improved outcomes and higher quality of life. Numerous physical therapy practices and rehabilitation entities are at the forefront of innovation, and these entities should be able to become key players in health care transformation. **APTA urges Congress to**

direct CMS to create APM pathways under CMMI and through the Physician-Focused Payment Model Technical Advisory Committee that allow physical therapy practices, rehabilitation agencies, and other therapy providers to be the main conveners of approved APMs.

We also recommend that the agency solicit input from small practices when creating future payment models to ensure that a key demographic of providers is adequately represented. This will help to ensure that current challenges associated with APMs are resolved in future model iterations. Moreover, CMS should not advance any new payment model until it can ensure that the model would not perpetuate or intensify patient access issues. Further, implementation of any new model should not occur until CMS can confirm that all stakeholders are adequately prepared to participate in the model.

Promote Quality and Outcome Measures to Ensure APM Success

As previously stated, rehabilitation services such as physical therapy are integral components of APMs. Unfortunately, many of the metrics that have been developed to assess progress are exclusive of nonphysician specialties, including physical therapy. Additionally, some metrics are not attributed to nonphysician specialties due to the measure attribution methodologies; this includes cost metrics and metrics for readmissions at the provider level. APTA believes that both team-based metrics and specialty-specific metrics are important to the delivery of high-quality care.

As CMS undertakes the development of new APMs, we urge the agency to include quantitative and qualitative metrics, including meaningful performance-based and patient-reported outcome measures, by which CMS can ensure that coordinated, patient-specific, outcome-based care is being delivered safely by properly qualified professionals. The variety of measures included within APMs must include measures applicable to multiple types of clinicians. Specialty sets should be developed and adopted for nonphysician providers, including physical therapists. Such measures should contribute to coordinated care, be correlated to positive health outcomes, and not impose an undue burden on providers. The types of measures that we recommend CMS develop and adopt are measures that monitor and track patient outcomes, provider performance, and changes in utilization of services. Including a robust set of quality measures within APMs will help to show the positive effects of nonphysician providers' interventions on patient outcomes.

To ensure that APMs are multidisciplinary, we recommend that CMS mandate the inclusion of functional measure items within APMs that show the value of providers who traditionally have been excluded from APM participation. It is critical that new models include appropriate measures that address function and illustrate the value of each provider to the APM patient population. **To assist Congress and CMS in its efforts, APTA welcomes the opportunity to serve as a resource to CMS and share data results at the**

clinician, practice, and national levels for the measures included in APTA's Qualified Clinical Data Registry (QCDR).

Advance Registry as Integral to Future Success of Models

It is important for CMS to continue to support the development and success of professional registries as we move toward outcomes-based payment and advanced quality reporting structures that will rely heavily on electronic data submission. CMS must look beyond claims to create an affordable, accessible health care system that puts patients first. In recent years, clinical data registries have evolved and are now embraced by more than 20 professional associations. Development of these registries has been spurred by the need to create meaningful quality measures to assist providers in the shift to value-based payment and models of care. These registries will be critical to the success of innovative payment models in the future, as they have the ability to deliver real-time data to providers for monitoring, assessing, and responding to new and dynamic models of care delivery.

QCDRs, such as the Physical Therapy Outcomes Registry, capture relevant data from electronic health records (EHRs) and billing information, and transform this data into meaningful, intuitive, and actionable feedback for providers on the frontline of patient care. New models of care will require providers to have access to real-time data so they can successfully identify and modify care design to maximize patient outcomes. The use of real-time data will allow for better coordination throughout the continuum of care and can be used to break down traditional silos of care. We believe the use of real-time data should be a guiding principle for these future models. Additionally, we encourage CMS to look for ways to incorporate real-time patient data, such as patient-reported outcomes, and other patient-generated data, such as from wearable devices, into innovative models. **APTA asks Congress to direct CMS to incorporate the use of data from registries into future care models.**

Encourage CMS to Address Lack of EHR Standards for Nonphysician Providers

To facilitate an increase in the number of eligible clinicians choosing to participate in Advanced APMs, CMS should establish a policy that permits physical therapy EHR vendors to have certified EHR technology (CEHRT). No physical therapy EHR vendors have certified EHR technology (CEHRT), and the US Department of Health and Human Services (HHS) has not yet addressed how these vendors would meet the CEHRT requirements. While the Office of the National Coordinator of Health Information Technology (ONC) certification process has established standards and other criteria for structured data that EHRs must use, there is no standard certification criteria for EHRs for physical therapists. **APTA urges Congress to direct CMS and ONC to work together to develop standardized certification criteria for EHRs for physical therapists and other rehabilitation providers.**

As CMS moves to establish guidance for physical therapy CEHRT, APTA recommends that CMS implement a temporary waiver for physical therapists and other specialty

providers not yet included in meaningful use. Physical therapists have been exempt from EHR meaningful use and have not been afforded the same resources as physicians and hospitals for health information technology adoption. This waiver would permit physical therapists and similar specialty service providers to participate in Advanced APMs until CMS has adopted a policy for physical therapy-specific CEHRT. **Once a policy has been adopted, we request that Congress direct CMS to provide appropriate resources and support, including implementation assistance and/or consultant support, to physical therapists and other nonphysician providers as they adopt certified EHRs, to better enable small practices, such as physical therapy practices, to participate in these new models of care.**

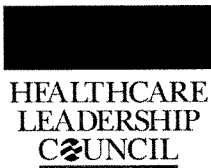
Create Incentives for Collaborative, Coordinated Care

To enhance the quality and safety of patient care, we encourage HHS to consider revising current regulations so that different disciplines—including physical therapists, occupational therapists, speech-language pathologists, physicians, nurses, physical therapist assistants, occupational therapy assistants, social workers, psychologists, psychiatrists, and nutritionists—are encouraged to work as a unified care team across the care continuum. HHS should incentivize health professionals to work as an interdisciplinary team to not only increase communication and cooperation among providers but also improve the effectiveness of care delivered to patients. Cohesive teamwork across disciplines will lead to improved patient outcomes.

Unfortunately, current Medicare policies fail to effectively promote interdisciplinary collaboration; as such, there is limited communication among providers across settings. Accordingly, APTA recommends that to improve patient outcomes and quality of care, CMS more effectively encourage coordination and communication between health care professionals in such a manner that does not create an increased financial or administrative burden on health care providers. **APTA strongly believes that the success of APMs in improving the quality of care and decreasing costs depends on the collective efforts of all health care providers throughout the health care spectrum.**

Finally, we recommend that Congress direct CMMI to better support the creation of models that no longer rely on the fee-for-service structure, as it will become increasingly difficult to make the appropriate cost adjustments using these types of retrospective cost-setting methodologies in the future.

Should you have any questions regarding our comments, please contact Kara Gainer, Director, Regulatory Affairs, at karagainer@apta.org or 703/706-8547. Thank you for your consideration of these comments from the APTA.



November 8, 2017

The Honorable Greg Walden
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Walden:

On behalf of the Healthcare Leadership Council (HLC), I am writing to thank you for your commitment to advancing reform of the nation's healthcare delivery system.

HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century health system that makes affordable, high-quality care accessible for all Americans. Members of HLC – hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, laboratories, biotech firms, health product distributors, pharmacies, post-acute care providers, and information technology companies – advocate for measures to increase the quality and efficiency of healthcare through a patient-centered approach.

HLC has long supported a shift away from fee-for-service healthcare toward a system based on providing better value for healthcare consumers. Our member organizations have been proponents of delivery system innovations that are value-based, patient-centered and reward improved quality and cost-effective care.

HLC strongly supported the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) and is pleased to provide feedback that we expect will strengthen the broader transition to a payment system that emphasizes value. As providers in the delivery system transition to a new payment system that emphasizes value, we encourage prioritizing consumer feedback and outreach, provider feasibility and minimizing new administrative burdens. We have been pleased to see significant action on key recommendations provided by HLC in previous years. In particular,

- HLC encourages Congress and the Administration to continue to push forward with its efforts to facilitate the movement of organizations to pay-for-performance and Advanced Alternative Payment Models (AAPMs). A critical element of this

effort will be incorporating complementary value-based arrangements (such as Medicare Advantage) into AAPM MACRA thresholds as soon as possible.

- HLC appreciates CMS allowing Merit-based Incentive Payment System (MIPS) eligible physicians the opportunity to “pick their pace” by submitting data from a 90-day performance period, rather than a full year.
- HLC is pleased to see and strongly supports efforts to reduce the quality measure reporting burden on clinicians. HLC continues to stress that these and other flexibilities are necessary as it may be difficult – particularly in the initial years – to design APMs that meet the financial risk standards and are attractive to a variety of providers. The federal government must ensure, however, that these flexibilities do not lessen important incentives for provider participation.
- HLC supports proposals in the Quality Payment Program (QPP) designed to address the challenge of attracting providers without prior risk-bearing experience into new alternative payment arrangements (such as the virtual groups proposal). We encourage the federal government to continue to implement these proposals in a way that acknowledges the wide range of technological and reporting capabilities of providers, including the provision of regular outreach, training, and education to allow for wider adoption.
- HLC supports the creation of a new improvement activity for clinician leadership in clinical trials, research alliances, or community-based participatory research (CBPR) – especially around minimizing disparities in healthcare access. HLC supports this effort to improve clinical trial enrollment and encourages the federal government to consider including other physicians or even a counseling service payment to incentivize providers to provide information on clinical trials.

As shared in previous correspondence, HLC would like to continue to emphasize several broader priorities that we believe are critical for the overall success of value-based care programs.

Congress should adopt changes to modernize the federal fraud and abuse legal framework to facilitate stronger provider performance in MIPS measurement categories and facilitate growth into full AAPMs. Modernization of the current legal framework is needed to make it more compatible with healthcare delivery system transformation while retaining appropriate protections against fraud and abuse. Congress should amend Anti-Kickback Statute and Stark Law to allow waivers for stakeholders engaged in alternative payment arrangements (both AAPMs and MIPS-reporting APMs) that meet certain conditions. (An unpredictable and burdensome system of “one-off” waivers is not sufficient for alternative payment goals). Congress should also extend existing Anti-Kickback Statute and Stark Law exceptions for

donation and financial support of electronic health information products that facilitate care coordination, cyber security protection, and compliance with Advancing Care Information performance category goals.

Congress and CMS must plan now to implement a strategy that will facilitate the introduction of innovative private-sector alternative payment arrangements when permitted in 2021. HLC believes that MA plans, commercial health plans, Medicaid managed care organizations (MCOs), and other appropriate entities should be eligible for consideration as Other Payer Advanced APMs. It is critical that the federal government offer clear and consistent guidance over the next several years as these entities prepare to participate in the program. Including other payers as Advanced APMs would help advance the movement toward value-based care. Making the Other Payer Advanced APM category as broad and as flexible as possible will help move the entire health system toward care focused on value and optimal patient outcomes. HLC encourages CMS to be transparent, flexible, and consistent regarding the criteria for APM “eligibility” for advanced model consideration. It is equally important for CMS to consider the sensitivity of patient and proprietary contractual information to ensure that transparency efforts are also protective of disclosure. Similarly, the Other Payer certification process and timelines will need to reflect the realities of the market, and would be best supported by a flexible, rolling AAPM certification process.

CMS should focus on the alignment of measurement across all programs to ensure current incentives (such as MA benchmark calculations) facilitate the transition to Other Payer Advanced APM arrangements. CMS should recognize that MA plans forming Other Payer Advanced APM arrangements will need to adjust their bids to account for increased risk and the requirements of other value-based initiatives; and the benchmarks must be adjusted accordingly.

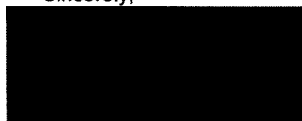
One approach to facilitating a strategy for Other Payer Advanced APMs would be using the Center for Medicare and Medicaid Innovation (CMMI) demonstration projects (under 1115A waiver authority). Treating providers who contract with private sector alternative payment arrangements and who meet requirements regarding EHR usage, quality, and financial risk as participating AAPMs would allow for consistent application of APM requirements across the Medicare program while reducing provider burden. A voluntary demonstration project designed to test risk contracts between health plans and other stakeholders for inclusion as Other Payer Advanced APMs would allow both CMS and the private sector time to perfect the rules for MA and other programs to become a qualifying MACRA AAPM. A CMMI demonstration could also allow for experimentation in harmonizing performance measures across programs. HLC members believe the inclusion of MA plans would create a meaningful path for clinicians to pursue the five percent MACRA bonus.

Quality measurement should better incorporate socioeconomic status adjustments to incentivize alternative payment arrangements in areas of high need. It is critical that all efforts to move to outcome-based payment properly account for both complexities of patients as well as the socioeconomic challenges that providers face in caring for patients. Without these adjustments, efforts to reward higher performing providers may result in lower funding for those serving the most vulnerable. To ensure appropriate payment and risk-adjustment, quality programs under MACRA should include a reasonable number of measures that truly capture variance in patient populations. We support the use of a limited number of standard, vetted measures and urge CMS to synchronize measures, expectations, and reporting requirements with existing efforts in the private sector. By working closely with experts in the private sector, a system that appropriately reflects health system challenges – such as the social and economic status of consumers – can create a more accurate payment system.

It is imperative that Congress and CMS continue to work closely with private-sector health leaders during MACRA implementation. The law provides CMS with an unprecedented ability to transform healthcare delivery through incentives. These changes, which will have far-reaching and significant effects on consumers nationwide, should be validated by healthcare experts across the healthcare system. These changes must be deliberate, transparent, and allow for meaningful collaborative effort. Similarly, we urge the federal government to provide clear, concise, and actionable feedback on a timely and regular basis to allow providers to improve the quality of care delivered to patients and enhance program performance.

HLC appreciates the opportunity to comment on the proposed rule. Please contact Tina Grande, SVP for Policy, at tgrande@hlc.org or 202-449-3433 with any questions.

Sincerely,



Mary R. Grealy
President

Bruce Johnson, MD, FASCO
President
American Society of Clinical Oncology

Statement prepared for:
House Energy & Commerce Committee
Subcommittee on Health

MACRA and Alternative Payment Models: Developing Options for Value-based Care

November 8, 2017

The American Society of Clinical Oncology (ASCO) is pleased to submit this statement for the record of the hearing entitled, “MACRA and Alternative Payment Models: Developing Options for Value-based Care.” ASCO appreciates the work of the Energy & Commerce Committee, specifically this subcommittee, in shepherding passage of the *Medicare Access and CHIP Reauthorization Act* of 2015, which repealed the flawed sustainable growth rate formula and established a path for the development of alternative payment models (APMs) that recognize the delivery of high quality, high value care.

ASCO is the national organization representing more than 42,000 physicians and other healthcare professionals specializing in cancer treatment, diagnosis and prevention. Medicare beneficiaries over the age of 65 account for 54% of all new cancer care cases. With that in mind, we offer our strong support for the development of additional alternative payment models tailored to oncology care.

Congress passed MACRA, in part, to move the Medicare program from traditional fee for service to a system that pays for high quality care delivery. Two years since passage, the Center for Medicare and Medicaid Services (CMS) has taken some important steps forward, but accomplishing this transition requires the availability of a menu of APMs for physicians. To date CMS has approved one alternative payment model in the oncology care space – the Oncology Care Model (OCM). ASCO looks forward to continued work with CMS and the Physician Technical Advisory Committee (PTAC) to implement additional oncology-focused APMs, such as the Patient-Centered Oncology Payment (PCOP) model, to provide flexibility to oncologists to choose the best option for their patients and their practices.

Need for Multiple Oncology Specific APMs

Given the significant morbidity, mortality and financial expenditures arising from cancer in the Medicare population, CMS should avoid a narrow approach that fails to test more than one oncology-focused APM option to meet the needs of the diverse Medicare population. CMS should embrace oncology-focused Advanced APMs that differ from the OCM, and CMS should remain open to implementing additional oncology-focused models on a timely basis through the Physician Focused Payment Model pathway created by Congress.

Multiple oncology-specific APMs are needed to enable oncologists to select the optimal approach for their patients and their practices to survive in a value-based payment environment and to facilitate the

oncology community's transition out of the Merit-Based Incentive Payment System (MIPS). The OCM, which is currently in place through the Innovation Center, is certainly one such approach that has drawn participation from a large number of practices. This is a testament to the willingness that cancer care providers have to move from the current fee for service system.

Medicare's need for additional oncology APMs is critical, since cancer is extraordinarily complex. Additional APMs could be one tool in dealing with specialty drug costs in the rapidly changing environment of personalized cancer care. It would be a waste of the opportunity created by Congress if only one model were to be tested. Therefore, additional approaches to reforming oncology payment are needed and should be tested by the Innovation Center.

ASCO's Patient-Centered Oncology Payment (PCOP) Model

ASCO's PCOP model will soon be under consideration by the PTAC. Congress created the PTAC as an advisory board and we encourage CMS to take seriously the recommendations of PTAC. Our membership is engaged and eager to participate in testing innovative models that lead to better care. We anticipate continuing to revise both our reporting requirements as well as the details of our one- and two-sided risk financial components to meet the needs of all constituents. The PCOP model positions eligible clinicians to move into monthly payments upon demonstrating their ability to succeed in this care management and payment environment.

PCOP Model Overview

The PCOP Model is the product of an ASCO volunteer work group comprised of leading medical oncologists, seasoned practice administrators, and experts in physician payment and business analysis. It has benefitted from extensive feedback by ASCO members, policymakers and a wide range of stakeholders across the oncology community, including patient advocates.

The basic PCOP model provides supplemental, non-visit-based payments to oncology practices to support diagnosis, treatment planning, and care management. Oncology practices would be able to bill payers for four new service codes:

1. New Patient Treatment Planning
2. Care Management during Treatment
3. Care Management during Active Monitoring
4. Participation in Clinical Trials

Practices would continue to be paid as they are today for services currently billable under the Medicare Physician Fee Schedule, including Evaluation & Management services, delivery of chemotherapy and immunotherapy, and drugs administered or provided to patients by the practice.

PCOP introduces two-sided risk in a way that engages eligible clinicians while not putting financial viability of physician practices at risk. It requires robust reporting of quality measures and treatment pathway compliance to ensure quality of care.

Goal of the PCOP Model

The goal of the PCOP model is to better support for services critical to high value, high quality care. Oncology practices would receive payment for care management, including management of toxicities and other supportive care patients with cancer need—and that avoid costly hospitalizations and emergency department visits. Payments would be made in a way that allows practices the flexibility to provide this care in a way that meets the unique circumstances of their staffing, their care delivery environment and, most important, unique needs of the patient. It also enhances quality without increasing financial burdens on patients.

Expected Participants

All patients who have a cancer diagnosis requiring chemotherapy or immunotherapy are eligible to participate in the PCOP model. ASCO has engaged a wide range of oncologists from across the country in the development of PCOP, indicating its broad support and their willingness to participate. Additionally, one practice and payer have already implemented PCOP, showing its viability. We expect participation from medical oncology practices at diverse practice sites, including small independent practices, wherever PCOP is available.

PCOP differs from the OCM by supporting the full range of resources necessary for oncology providers to plan, coordinate and manage cancer treatments, while focusing on efficient utilization of resources, avoidance of ineffective spending, and reduction in unnecessary hospital visits. The PCOP model also offers the opportunity for practices and payers to transition to bundled payments once proficiency has been demonstrated in the fee for service model. We will continue to dialogue with the Innovation Center regarding implementation of PCOP to provide an alternative pathway for oncology APM participation. Congress should use its continued oversight authority to encourage such conversations that will further the goals of MACRA.

ASCO thanks the subcommittee for its bipartisan commitment to strengthening the Medicare program. If you have questions about this or any issue affecting cancer care, feel free to reach out to Amanda Schwartz at Amanda.schwartz@asco.org or 571-483-1647.



STATEMENT FOR THE RECORD

**Submitted to the
House Energy and Commerce Committee
Subcommittee on Health**

***“MACRA and Alternative Payment Models:
Developing Options for Value-based Care”***

November 8, 2017

America's Health Insurance Plans
601 Pennsylvania Avenue, NW
Suite 500, South Building
Washington, D.C. 20004

America's Health Insurance Plans (AHIP) is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for the American people.

Value-Based Agreements Improve Health Care for Medicare Beneficiaries

We thank the committee for focusing on the role of Alternative Payment Models (APMs) in providing incentives for high quality, cost-effective patient care under the "Medicare Access and CHIP Reauthorization Act of 2015" (MACRA).

Through their participation in the Medicare Advantage (MA) program, our members are strongly committed to serving Medicare beneficiaries. MA health plans have a long track record in emphasizing prevention, providing access to disease management services for chronic conditions, and offering systems of coordinated care for ensuring that beneficiaries receive the health care services they need.

Unlike the traditional Medicare program, MA plans often offer additional, comprehensive benefits such as vision, dental, and hearing coverage, as well as a cap on out-of-pocket spending, and many plans offer drug coverage with no additional cost to beneficiaries. In addition, in comparison to the traditional Medicare program, MA has been shown to reduce hospital readmissions¹ and institutional post-acute care admissions², and increase rates of annual preventive care visits³ and screenings.⁴ As a result, the MA program has a beneficiary satisfaction rate of 90 percent.⁵

Value-based agreements are an important strategy used by MA plans to improve health care for Medicare beneficiaries. These agreements are designed to ensure that patients receive the greatest possible value for every dollar spent on their care. Through them, doctors, health care institutions,

¹ Lemieux, Jeff, Sennett, Cary, Wang, Ray, Mulligan, Teresa, Bumbaugh, Jon. Hospital readmission rates in Medicare Advantage plans. *American Journal of Managed Care* 18(2): 96-104. February 2012.

² Huckfeldt, Peter J., Escarce, Jose J., Rabideau, Brendan, Karaca-Mandic, Pinar, Sood, Neeraj. Less intense post-acute care, better outcomes for enrollees in Medicare Advantage than those in fee-for-service. *Health Affairs* 36(1): 91-100. January 2017.

³ Sukyung, Chung, Lesser, Lenard I., Lauderdale, Diane S. et al. Medicare annual preventive care visits: Use increased among fee-for-service patients, but many do not participate. *Health Affairs* 34(1): 11-20. January 2015.

⁴ Ayanian, John Z., Landon, Bruce E., Zaslavsky, Alan M., et al. Medicare beneficiaries more likely to receive appropriate ambulatory services in HMOs than in traditional Medicare. *Health Affairs* 32(7): 1228-1235. July 2013.

⁵ Morning Consult National Tracking Poll. March 11-16, 2016.

and health insurance providers come together to focus on one goal: helping the patient achieve their best health for the long term.

A recent study, published in February 2017 by the *American Journal of Managed Care*, found that these initiatives have been successful. By delivering care in ways that focus on value, MA plans have increased the use of preventive health care services, increased physician office visits, reduced both emergency department visits and inpatient hospital admissions, and increased the lifespan for MA enrollees.⁶

Specifically, for beneficiaries who received care from providers in value-based agreements:

- Beneficiaries were almost 3 times more likely to undergo preventive care visits;
- Women age 74 and younger were 28 percent more likely to undergo screening mammography;
- Emergency department visits were reduced by 11.2 percent and inpatient hospital admissions were reduced by 11.9 percent; and
- The overall survival rate was 6 percent higher than for other beneficiaries and the hazard of dying was 32.8 percent lower.

The benefits of providers contracting with MA plans are further demonstrated by a study published by *Health Affairs* in September 2016. This study presented data showing that the innovative techniques employed by MA plans have a spillover effect that has contributed to the recent slowdown in national Medicare FFS spending.⁷ Specifically, the study shows that in counties with high baseline MA penetration rates, each 10 percentage point increase in MA penetration was associated with a decrease in per capita FFS spending of \$154 annually (nearly 2 percent).

⁶ Mandal, Alok K., Tagomori, Gene K., Felix, Randell V., Howell, Scott C. Value-based contracting innovated Medicare Advantage healthcare delivery and improved survival. *American Journal of Managed Care* 23(2): e41-e49. February 2017.

⁷ Johnson, Garret, Figuero, Jose F., Zhou, Xiner, Orav, E. John, Jha, Ashish K. Recent growth in Medicare Advantage enrollment associated with decreased fee-for-service spending in certain US counties. *Health Affairs* 35(9):1707-1715. September 2016.

MA Plans Can Provide Value as Advanced APMs

As Congress examines the implementation of MACRA and the role of APMs, AHIP supports a demonstration that would allow clinicians to receive credit under the Medicare Advanced APM rules for participating in financial risk-based arrangements with MA plans.

In a final rule on MACRA issued last week, the Centers for Medicare & Medicaid Services (CMS) signaled its intention to test the effect such a demonstration would have in expanding incentives for eligible clinicians. We applaud CMS for taking this approach, and we look forward to working with the agency to design and implement the demonstration.

In August 2017, AHIP addressed the attached letter to CMS outlining our guiding principles for designing a voluntary MA Advanced APM Incentive Demonstration Program. Our principles focus on: (1) establishing the basic structure of the demonstration; (2) supporting the infrastructure that is needed to transition to risk-based payment arrangements; (3) designing a demonstration that is budget neutral and also enhances quality; (4) developing an attestation process through which clinicians could indicate the percent of payments, or patients, associated with qualifying MA payment arrangements; and (5) preserving Medicare's non-interference clause to ensure that CMS cannot dictate pricing or contract terms between MA plans and their network providers.

These principles, as discussed in our comment letter, are essential for ensuring that the CMS demonstration program effectively levels the playing field to provide equal incentives for providers under both the MA and FFS programs. Such a demonstration would recognize and reward the successful, innovative practices that MA plans and providers have already developed together to better serve their patients. It also would ensure that the MA program continues to deliver better care, improved health, and lower costs for Medicare beneficiaries.

We thank the committee for considering our perspectives on the merits of establishing an MA Advanced APM Incentive Demonstration Program. We look forward to working with you as Congress continues its oversight of MACRA and other Medicare issues.

**America's Health
Insurance Plans**

601 Pennsylvania Avenue, NW
South Building
Suite Five Hundred
Washington, DC 20004

202.778.3200
www.ahip.org



August 21, 2017

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Hubert H. Humphrey Building
200 Independence Ave., S.W. Room 445-G
Washington, DC 20201

Submitted electronically via <http://www.regulations.gov>

Medicare Program; CY 2018 Updates to the Quality Payment Program

Dear Administrator Verma:

America's Health Insurance Plans (AHIP) is writing on behalf of our members in response to the Centers for Medicare & Medicaid Services' (CMS) Notice of Proposed Rulemaking for the Medicare Program; CY 2018 Updates to the Quality Payment Program (QPP). AHIP is the national trade association representing health insurance plans. Our members provide health and supplemental benefits through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation.

AHIP appreciates CMS' efforts to solicit feedback on the proposed changes for year two of the QPP. In general, AHIP is supportive of efforts to alleviate administrative burden to encourage clinician participation in the Merit-based Incentive Payment System (MIPS) and a transition path to Advanced APMs. We also strongly support CMS' consideration of a demonstration that would allow clinicians to receive credit under the Medicare Advanced APM rules for financial risk based arrangements with Medicare Advantage (MA) plans. Our recommendations concerning such a demonstration and select proposals in the Notice of Proposed Rulemaking are below. We look forward to working with CMS to develop the demonstration.

I. MIPS in QPP Year 2

Low Volume Threshold for MIPS Eligibility

In the current year, or 2017 transition year, of the MIPS program, clinicians with less than or equal to \$30,000 in Part B allowed charges or who provide care for 100 or fewer Part B beneficiaries are excluded from MIPS. CMS has stated that any clinicians or groups who are excluded from MIPS may still voluntarily participate in MIPS and are not subject to the MIPS payment adjustment. Beginning with the 2018 performance year, CMS is proposing to increase this low-volume threshold to allowed charges of less than or equal to \$90,000 or 200 or fewer Part B beneficiaries. CMS believes this will likely exclude 134,000 additional clinicians from MIPS from the approximately 700,000 clinicians that would have been eligible based on the low-volume threshold that was finalized in the CY 2017 QPP final rule.

Comments:

AHIP supports CMS' continued focus on the creation of pathways for small group practices to successfully participate in MIPS. We believe some of the proposed changes described below will help continue to move the program in the right direction.

AHIP, for example, supports modification to the low volume threshold to exclude small groups, rural practices and practices in Health Professional Shortage Areas (HPSAs) from MIPS, but still allow them to voluntarily participate in MIPS without being subject to potential negative payment adjustment.

Although AHIP supports the public dissemination of MIPS data, it is important that the information be released in a form that is convenient and simple to understand for all health care stakeholders. To that end, we encourage CMS to work closely with stakeholders to develop templates, draft language, etc. to ensure the public at-large can easily decipher, digest, and use this important information. Additionally, performance data must be presented in a format that is understandable by the provider. For example, CMS could consider developing standardized summary reports and delivering them to providers along with detailed supporting data.

Additionally, we are supportive of the proposal that allows clinicians and groups who might otherwise be excluded from MIPS based on not meeting either the threshold for Part B allowed charges or attributed Medicare patients, but who exceed one of these low-volume thresholds, to still choose to

participate in MIPS and be subject to the MIPS payment adjustments. Given the change in low volume threshold in year two, we suggest CMS allow providers who exceed both thresholds to still voluntarily participate in MIPS and be subject to the MIPS payment adjustment.

Virtual Groups

CMS is proposing that beginning in 2018 small provider groups would have the option to report as “virtual groups” for year 2 and beyond. Additionally, CMS has more specifically defined a virtual group as a combination of two or more TINs composed of a solo practitioner or a group with 10 or fewer eligible clinicians under the TIN that elects to form a virtual group with at least one other such solo practitioner or group for a performance period for a year. CMS states that providing these additional flexibilities and reduction in barriers will further enhance the ability of small practices to participate successfully in the QPP.

Comments:

AHIP supports the implementation of virtual groups as a way to accommodate small practices and practices in rural or HPSAs, and agrees with the proposal to define a virtual group as a solo practitioner or a group with 10 or fewer eligible clinicians under the TIN that elects to form a virtual group with at least one other such solo practitioner or group for a performance period for a year. This will allow small practices to more easily form a virtual group and begin MIPS participation.

We suggest CMS provide additional information regarding reporting requirements for virtual groups. Specifically, we suggest CMS require all members of a virtual group to report on the same measure set, which would allow CMS to more easily calculate performance against measures.

We also continue to support the idea of providing technical assistance to MIPS eligible clinicians in small practices, rural areas, or to clinicians practicing in HPSAs, as this will help them be successful in MIPS.

Performance Period

In the 2017 transition year, CMS is requiring a minimum 90-day performance period for the categories of Quality, Advancing Care Information, and Improvement Activities. The Cost category is currently measured on a 12-month performance period. CMS is proposing to require a 12-month performance

period for the Quality and Cost categories and continue the 90-day performance period for Advancing Care Information and Improvement Activities.

Comments:

AHIP supports the proposal for the 12-month performance period for the Quality category, as we believe the current 90-day performance period is not sufficient for clinical practices to thoroughly diagnose performance, make practice improvements and re-assess to gauge effectiveness of improvement activities. CMS should consider a longer performance period for the Improvement Activities category as well, given that a key MIPS strategic goal is process implementation that drives movement toward delivery system reform and continued quality improvement.

Additionally, we encourage CMS to look for ways to narrow the gap between the performance period and the payment period for the QPP program. By more closely coupling reporting to payment periods, e.g. instituting a 6-month gap, CMS will allow physicians to better understand the performance and payment link as well as implement the necessary steps to improve processes based on more recent information about their performance.

Performance Threshold

In the 2017 transition year, CMS requires a minimum of 3 points be achieved for clinical practices participating in MIPS to avoid a negative payment adjustment. CMS also requires practices achieve between 4 and 69 points to achieve a positive adjustment and 70 or greater points to be eligible for an exceptional performance bonus. For year 2 of the QPP, CMS is proposing to increase the performance threshold from 3 points to 15 points, while keeping the additional (exceptional) performance threshold at 70 points. CMS believes moving the performance threshold to 15 points represents a meaningful increase in the performance threshold that will drive quality improvement while maintaining flexibility for MIPS eligible clinicians in the pathways available to achieve this performance threshold.

For example, clinical practices can achieve 15 points by:

- Reporting all required improvement activities.
- Meeting the advancing care information base score and submit 1 quality measure that meets data completeness.
- Meeting the advancing care information base score, by reporting the 5 base measures, and submit one medium weighted improvement activity.
- Submitting 6 quality measures that meet data completeness criteria.

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Comments:

AHIP supports the change in performance threshold.

Facility Based Measurement

As a new proposal for year two of the QPP, CMS is proposing to implement a voluntary facility-based scoring mechanism, which would be based on the current Hospital Value Based Purchasing Program and be available to facility-based clinicians who have at least 75% of their covered professional services supplied in the inpatient hospital setting or emergency department. The facility-based measurement option will convert a facility Total Performance Score into a MIPS Quality performance and Cost performance score.

Comments:

AHIP supports the proposal, as this will allow clinicians who mainly treat patients in a facility setting to still be eligible to participate in the QPP.

Quality Performance Category

Under the 2017 QPP final rule, for the 2019 payment year, CMS requires a 50% data completeness for quality measures, with measures that do not meet the data completeness criteria receiving a maximum of 3 points. The final rule also provided that the data completeness threshold would increase to 60% for the 2018 MIPS performance period. In addition, CMS is not currently incorporating a performance improvement (year over year) factor.

CMS is proposing to delay the increase in the data completeness threshold. Under the proposal, the 50% threshold would apply to the 2018 performance year and not increase to 60% until the 2019 performance year. Additionally, for the 2018 performance year CMS is proposing that any measures that fail data completeness receive only 1 point instead of 3 points, with the exception of small practices, which will continue to receive 3 points. Finally, an improvement in quality performance would be incorporated into the scoring in the 2018 performance year.

Comments:

AHIP supports these proposed changes. In addition, we continue to encourage CMS to adopt more outcome measures, including patient-reported outcomes, and medication adherence measures beyond those that are currently included in PQRS, VM and EHR Incentive Program.

Cost/Resource Use Performance Category

Under the 2017 QPP final rule, the Cost performance category counts for 0% of the final score in the 2017 performance period/2019 payment year, but will count for 10% in the 2018 performance period/2020 payment year and 30% in the 2019 performance period/2021 payment year. For 2017, this performance category includes the total per capita costs for all attributed beneficiaries measure, the Medicare Spending Per Beneficiary (MSPB) measure, and ten episode-based measures, with no incorporation of a performance improvement factor.

CMS is proposing that the Cost performance category remain at 0% of the final score in the 2018 performance period/2020 payment year (rather than increase to 10%) before going up to 30% in the 2019 performance period/2021 payment year. Additionally, CMS is proposing to keep the total per capita costs and MSPB measures but not use the original ten episode-based measures for the 2018 performance period. CMS instead will work on developing new episode-based measures with clinician input for future performance periods. Lastly, CMS is considering including an improvement factor in the cost performance category.

Comments:

AHIP continues to support the measurement and assessment of clinician performance on Cost / resource use and we recommend CMS increase weighting and emphasis on performance in this category, as we believe that such an emphasis is critical to driving value and affordability of healthcare. Requiring the transitioning from a weight of 0% to a weight of 30% over the course of just one year is extreme, would present an additional challenge for physicians, and would help accomplish the goal of encouraging providers towards Advanced APMs, where understanding cost and risk is a critical component.

Additionally, AHIP recommends consideration be given to cost measures that go beyond assessing whether there is waste in the system, and that seek to promote clinically-appropriate utilization of healthcare services, including for those clinicians who serve a significant portion of the frail and elderly population.

Lastly, we ask CMS to consider episode groupers for chronic conditions that do not have an inpatient trigger, so that costs for chronic conditions can be included even if an inpatient stay does not occur (i.e., management of diabetes).

Improvement Activities Performance Category

CMS is not proposing changes to the weighting or number of activities required to achieve full credit for the Improvement Activities category. However, CMS is proposing to add activities clinicians can choose from, including consulting Appropriate Use Criteria (AUC) through a qualified clinical decision support mechanism when ordering advanced diagnostic imaging services.

Comments:

AHIP continues to support the use of AUC for advanced diagnostic imaging services in the Medicare program. We continue to support CMS' intent to establish standards for clinical decision support mechanisms (CDSMs) that focus on the functionalities that a qualified CDSM should be able to perform, allowing for growth and innovation and promoting choices that fit into physician workflows and build on existing CDS infrastructures.

Advancing Care Information Performance Category

In the final 2017 QPP rule, the Advancing Care Information performance category counts for 25% of the total score. In addition, clinicians are permitted to use either the 2014 or 2015 Certified Electronic Health Record Technology (CEHRT) Edition for the 2017 transition year but are required to use 2015 CEHRT Edition for 2018.

Although CMS is not proposing changes to the weighting of this performance category, they are proposing to allow clinicians to use either 2014 or 2015 CEHRT Edition for 2018. Additionally, CMS would grant a bonus to clinicians for using 2015 CEHRT Edition. CMS is also proposing to add a significant hardship exception for MIPS-eligible clinicians in small practices.

Comment:

AHIP supports CMS in its proposal to afford practices additional flexibility in the use of 2014 CEHRT given the time and resources required for practices to upgrade. We also support the additional consideration being given to MIPS-eligible clinicians in small practices.

However, for future performance years, CMS should consider increasing the overall weighting and strengthening the requirements of this category by emphasizing patient outcomes, patient engagement, and care coordination.

Finally, we encourage CMS to continue their work with the Office of the National Coordinator for Health IT (ONC) on interoperability, with the ultimate goal of requiring all clinicians to use the same Edition Health IT Certification Criteria in order to improve interoperability, consistency of reporting, and consistency across providers.

Final Score Bonus for Small Groups

CMS is proposing to add a bonus of five points to the final score for MIPS eligible clinicians who participate in MIPS for the 2018 MIPS performance period and are in small practices or in a virtual group or an APM entity with 15 or fewer clinicians (the entire virtual group or APM entity combined must include 15 or fewer clinicians to qualify for the bonus). CMS has indicated that a bonus of 5 points is appropriate to acknowledge the challenges small practices face in participating in MIPS and to help them achieve the performance threshold of 15 points for the 2020 MIPS payment year.

Comments:

AHIP supports CMS in considering small practices and allowing for a pathway for these practices to participate in MIPS. However, offering numerous and overlapping bonuses complicates an already complex program and reduces the significance of a bonus. Instead of offering a bonus to incentivize participation, the needs of clinicians, particularly those in small practices, are better served by technical assistance that promotes movement to value and accountability, as well as thoughtful evaluation and adjustment.

CMS may wish to employ a "small group" performance benchmark for applicable performance categories, as an alternative way to provide considerations for small groups, as this will allow for points to be awarded based on performance rather than practice characteristics.

II. Advanced APMs in QPP Year 2

Clinician Cap for Medical Home Advanced APMs

Under the CY 2017 final rule, beginning in 2018, the Medical Home Model Advanced APM financial risk standard does not apply for APM Entities that are owned and operated by organizations with more than 50 eligible clinicians. CMS is proposing to exempt Round 1 participants in the CPC+ Model from the 50-eligible clinician cap since the clinician cap was finalized after CPC+ Round 1 participants had signed agreements with CMS.

Comments:

We understand the need to exempt Round 1 participants in the CPC+ Model from the 50-eligible clinician gap, given the timing of the final rule and CPC+ Round 1 participation agreements. However, we would also like to reiterate our previous recommendation that CMS use patient panel size attributed to the medical home rather than clinician count for the application of these standards. While we support flexibility for smaller entities, such an approach will help promote consistency between the definitions under MACRA and those used by CMS in determining specific program requirements.

Additionally, we support CMS's proposal that the financial risk standards for Other Payer Medical Homes would be identical to and aligned with the Medicaid Medical Home Standard. For example, utilizing the suggested alignment, CPC+ organizations would not be limited by their ability to qualify for Advanced APMs based on the size threshold and could be assessed using the Medical Home Model Financial Risk Criteria.

Nominal Financial Risk Amount Standard for Other Payers/All Payer Combination Option

In the CY 2017 MACRA final rule, CMS finalized a nominal financial risk amount standard for Other Payers under the All Payer Combination Option as follows:

- Marginal risk of at least 30%;
- Minimum loss rate of no more than 4%; and
- Total risk of at least 3% of the expected expenditures for which the APM Entity is responsible

CMS is proposing to add the 8% revenue-based standard, which applies to Medicare Advanced APMs under the 2017 final rule, as an alternative to the 3% expenditure-based standard. This change would align with the nominal amount standard for Medicare Advanced APMs.

Comments:

We have previously expressed concern that, contrary to the stated goals of alignment across Advanced APMs and Other Payer Advanced APMs, the marginal risk rate and minimum loss rate standards were eliminated for Advanced APMs yet retained for Other Payer Advanced APMs in the MACRA final rule for CY 2017. We understand that currently designated Advanced APMs under the Medicare Option already meet the marginal risk and minimum loss standards – and that CMS intends that all future Advanced APMs under the Medicare Option meet them as well. We believe it is important for

Advanced APMs under the Medicare Option to have the same nominal financial risk amount standard as Advanced APMs under the Other Payer Option to promote consistency, alignment, and a level playing field. While we support adding the 8% revenue-based standard as an option for meeting the total risk criteria as it is consistent with the standard for Medicare Advanced APMs, there is still a discrepancy between the standards, as articulated under MACRA regulation, with the elimination of the marginal risk and minimum loss rates for Medicare Advanced APMs. We believe that lack of alignment between Medicare and other payer requirements in nominal financial risk standards creates an unlevel playing field and we strongly encourage CMS to align the nominal financial risk standards for Advanced APMs and Other Payer Advanced APMs.

Additionally, we continue to believe that there should be a separate pathway to determine whether Medicaid APMs are Other Payer Advanced APMs given states' varying degrees of progress in adopting APMs. CMS should provide maximum flexibility in the design of Medicaid APMs, especially for determining financial risk. Medicaid providers typically receive lower reimbursement rates but are more likely to treat a higher proportion of high-risk and complex patients, and may not be able or prepared to accept the same levels of financial risk for their Medicaid business as other providers.

QP Determinations for All Payer Combination Option

Under the CY 2017 MACRA final rule, Qualifying APM participant (QP) determinations under the All-Payer Combination Option are made at either the APM Entity or individual eligible clinician level, depending on the circumstances. In this proposed rule, CMS is proposing that QP determinations under the All-Payer Combination Option would be calculated at the individual eligible clinician level only. CMS' rationale is that they are trying to account for the fact that participation in APMs will vary across payer and that eligible clinicians in the same APM Entity group would not necessarily have agreed to share risk and rewards as an APM Entity group.

Comments:

We believe CMS should offer a flexible approach that allows for QP determinations to be made at the group level when the structure of the group aligns for an Advanced APM and an Other Payer APM. We recognize that this approach may not account for the variety of organizational structures that exist outside of a group-level structure, hence the need for a flexible approach that can accommodate QP determinations at the individual eligible clinician level as well.

Determination of Other Payer Advanced APMs

In the CY 2017 final rule, CMS laid out a process under which, to be assessed under the All-Payer Combination Option, APM Entities or eligible clinicians would have to provide CMS with information regarding their payment arrangements with Other Payers, including the amount of revenues for services furnished through the arrangement, the total revenues from the Other Payer, the number of patients furnished any service through the arrangement, and the total number of patients furnished any service through the Other Payer. In addition, the APM Entity or eligible clinician would have to submit to CMS an attestation from the Other Payer that the submitted information is correct.

CMS is proposing that the requirement for attestation from the Other Payer be eliminated. Instead, APM Entities or eligible clinicians would need to certify information they submit. In addition, CMS is proposing to add a voluntary “payer-initiated” process starting in 2018. Under this option, payers could submit payment arrangement information for Medicaid (including both Medicaid fee-for-service and health plan arrangements), Medicare health plans (including MA plans, Medicare-Medicaid plans [MMPs], cost plans, and Programs of All-Inclusive Care for the Elderly [PACE] plans) and Center for Medicare & Medicaid Innovation (CMMI) multi-payer models for CMS to decide on regarding whether the arrangements qualify as Other Payer Advanced APMs. For Medicare health plans, CMS is proposing that information be submitted during the annual bidding process. Regarding Medicaid, CMS is proposing that any state and territory may request that the agency determine whether payment arrangements qualify and that the submission window would be between January 1 and April 1 of each year. This payer-initiated option would be offered to other payer types, including commercial and other private payers, starting in 2019 prior to the 2020 All Payer QP Performance Period.

Comments:

We support the proposal to add a voluntary “payer-initiated” process, beginning with the 2019 performance period, and urge CMS to maintain the voluntary nature of this pathway. Additionally, we recommend CMS open the payer-initiated process to other payer types, including commercial and other private payers, starting in 2018 for the 2019 performance period rather than waiting until 2019 for the 2020 performance period. Since the 5% bonus payment is time-limited to 6 years, delaying the ability to count commercial arrangements removes a significant portion of the bonus benefit. A delay could also further impede the transition to value-based care for Medicare, unnecessary constraining participation and working against CMS’ goal to encourage providers to join advance APMs.

Given that this option will allow certain other payers, including payment arrangements authorized under Medicaid, MA, and CMMI multi-payer models, to request that CMS determine whether their other payer arrangements are Other Payer Advanced APMs starting prior to the 2019 All-Payer QP Performance Period, it is critical that CMS develop the submission form and the additional guidance CMS intends to offer regarding the payer initiated process and make both available to payers as soon as possible with an opportunity and sufficient time for public comment. Moreover, we are concerned with CMS' proposal to wait until the annual bid process and recommend that CMS should provide for a rolling certification process for all payers, so that payers may submit Advanced APM determination requests throughout the year prior the performance period and that CMS certify APMs for three years if the payer attests that the contract will not change, given that many APM contracts are multi-year so as to foster a sustained partnership.

We would also like to reiterate our concern, originally stated in our 2016 comment letter, regarding the potential scope of the required information, particularly since the proposal contemplates some payer competitively-sensitive information being provided by APM entities or eligible clinicians (through the eligible clinician initiated process). While we appreciate CMS' intent to avoid dissemination of potentially sensitive contractual information and to keep information confidential to the extent permitted by federal law, even with such protections, there are still risks of disclosure. As such, we recommend that the information required be limited to the minimum data necessary to achieve the purpose of assessment. In addition, we strongly recommend that the information be pre-designated as falling under Exemption 4 of the Freedom of Information Act and not be shared with other agencies or used for any purposes other than the determination of whether a putative QP meets the threshold. We also urge CMS to provide assurance that the limited information to be posted on the CMS website will not be expanded without further rulemaking.

Additionally, we strongly recommend that CMS permit Medicaid plans to submit arrangements for Advanced APM determinations instead of only allowing submission by states. States do not have the capacity to be solely responsible for Advanced APM submissions to CMS on behalf of Medicaid plans. We believe Medicaid managed care plans that are working and contracting with providers are best positioned to submit timely and accurate Advanced APM requests.

Finally, we urge CMS to allow for flexibility for Medicaid provider Advanced APMs. Medicaid providers are often already paid in a way that resembles the assumption of risk; as such, requiring additional risk or burdensome requirements could reduce the ability to include Medicaid Advanced APMs in MACRA. As mentioned previously, CMS should provide maximum flexibility in the design of

Medicaid APMs, especially for determining financial risk. We urge CMS to ensure that implementation of the Other-Payer Advanced APMs does not adversely impact provider participation in Medicaid, and instead promotes participation by creating new incentives and reducing administrative burdens for Medicaid-participating providers.

MA Plans as Advanced APMs under the Medicare Option

Under the current MACRA rule, MA plans are treated as Other Payers, and payments and patients attributable to MA plans cannot be counted toward QP determinations under the Medicare Option. Clinicians taking risk in a contract with an MA plan are only eligible to receive credit for their participation through the All-Payer Combination Option beginning in payment year 2021.

In the proposed rule, CMS indicates that the agency is considering and welcomes comments on using its waiver and demonstration authorities to allow eligible clinicians to receive credit toward QP determinations for their risk-based arrangements with MA plans under the Medicare Option.

Comments:

AHIP commends CMS for considering and soliciting ideas on creating a way for individual clinicians and clinician groups to receive credit for their financial risk based arrangements with MA plans. Value-based contracts between MA plans and providers groups have been found to improve utilization, such as increasing office and preventive visits and decreasing emergency department and inpatient hospital admissions, while increasing survival rates.¹ Surveys suggest that while the vast majority of MA plans have some form of value-based contracts with network providers — ranging from patient-centered medical homes and bundled payments to shared savings/risk and global capitation — there is substantial opportunity to expand.² A voluntary demonstration under Section 1115A authority testing APMs in MA would further encourage providers to move away from volume-based payments towards risk-based contracts and help meet CMS' stated goals of moving more providers towards value based payment arrangements. We stand ready to work with CMS to develop the details of the demonstration model.

¹ Mandal, Alope K., Tagomori, Gene K., Felix, Randell V., Howell, Scott C. Value-based contracting innovated Medicare Advantage healthcare delivery and improved survival. *American Journal of Managed Care* 23(2): e41-e49. February 2017.

² Deloitte. Unlocking the potential of value-based care in Medicare Advantage. 2016. Available online at: <https://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/value-based-care-in-medicare-advantage.html>

We recommend that CMS consider the following guiding principles in designing a voluntary MA Advanced APM incentive demonstration program:

- + **Basic structure.** *One approach CMS could take under the demonstration would be to simply treat providers that (i) contract with MA plans, and (ii) meet requirements regarding EHR usage, quality and financial risk, as participating in Medicare Advanced APMs for QP determination purposes. Thus, for example, payments received from the MA plan, or patients served that were enrolled in the MA plan, would be taken into account in determining whether a provider meets the 25 percent minimum Medicare payment amount threshold or 20 percent minimum Medicare patient threshold, respectively. As with the existing Advance APM track, an APM incentive payment for these QPs would then be calculated based on the total amount of FFS Medicare payments they received. Providers participating in the demonstration would be exempt from MIPS, including both reporting requirements and any payment adjustments. This approach would therefore align with existing rules under MACRA that exempt QPs participating in Medicare Advanced APMs from MIPS. Under this approach, CMS should deem provider contracts with MA plans that include reporting under the Star Ratings System to meet the requirement of reporting on quality measures comparable to those used under MIPS, given the strong role that the Star Ratings program plays in MA. We also recommend that CMS permit flexibility in meeting EHR and financial risk requirements, such that alternative criteria may be applied to meet an equivalent standard, to continue to promote the type of private sector innovation observed to date.*
- + **Infrastructure Support.** *Another design element that CMS could consider would allow for advance payment to providers that do not currently qualify as QPs. This type of funding mechanism would create ready access to the capital providers require to invest in the infrastructure (e.g., IT, data analytic, patient engagement) necessary for transitioning to risk based payment arrangements. CMS could use the Advanced Payment ACO Model as a guide, which makes several types of upfront payments to participating providers as an advance on shared savings the organizations are expected to earn under the model.*
- + **Budget-neutrality.** *We understand the importance of developing a demonstration program that is designed to either reduce federal spending or remain budget neutral while enhancing quality. We recommend that CMS work with AHIP and the industry to consider ways to design the program and appropriately consider savings so this goal is achieved. For example:*

- *We believe potential savings need to be considered over the duration of the demonstration, rather than on a year-by-year basis, to recognize the time it can take to recognize the positive impacts that come from changes in practice patterns, and better care coordination and disease management. Under the MA-VBID model, for example, participating plans show budget neutrality over the five-year demonstration period of performance.*
- *CMS could consider reducing the potential costs of the program by making providers eligible for a range of bonus payments attributable to participation in an MA Advanced APM rather than a flat 5% bonus, with the largest payments reserved for providers in certain arrangements (e.g., capitation) that may be expected to achieve the greatest savings. Even if a provider receives a reduced amount, when it is combined with savings from avoiding MIPS reporting requirements, it could help providers adopt alternative payment arrangements.*
- *In considering potential sources of savings, CMS should consider the impact on the MA program, not just the FFS program. By encouraging MA providers to adopt alternative payment arrangements, the demonstration can reduce MA plan bids, thereby reducing costs to the government. As described above, value-based contracting in MA has been found to improve utilization – by increasing low-cost, high-value services like preventive visits and reducing high cost services like hospital readmissions – and increase survival rates, which over time will lower MA plans' cost of care. As such, increases in value based contracting arrangements should lead to lower MA costs – and therefore lower MA bids – than in the absence of the demonstration. Like the evaluation approach that CMS is using for the MA-VBID model, CMS could evaluate this demonstration for its impact on (a) outcomes, satisfaction, and out-of-pocket costs, (b) expenditures for participating health plans, and (c) plan bids over time to determine if the model results in savings.*
- *We also strongly encourage CMS to consider potential savings for the FFS program. Research demonstrates that where penetration is strongest, the MA program has had a "spillover effect" of decreases in Medicare FFS spending. Researchers have found that in counties with high baseline MA penetration rates, each 10-percentage point increase in MA penetration was associated with a decrease in FFS spending of \$154 per patient*

annually.³ Therefore, the adoption of alternative payment arrangements in MA by providers who might otherwise remain in MIPS could lead to changes in practices of care that will result in cost savings in the FFS program. These savings should also be factored into the demonstration program.

- + **Development of an Attestation Process.** CMS should develop a clinician-initiated attestation process that would be limited to collecting minimum, necessary data. Through this attestation process, clinicians would indicate the percent of payments, or patients, associated with qualifying MA payment arrangements. Inclusion of an attestation process would not only minimize administrative burdens for the agency, plans and providers, but would also help to ensure that proprietary or commercially sensitive information is adequately protected. Any payer-initiated attestation process would be voluntary.
- + **Preservation of the Non-interference Clause.** §1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in the terms and conditions of an MA organization's contracts with providers. CMS cannot, under the statute, dictate pricing or contract terms between MA plans and their network providers. Moreover, specific information on risk sharing, capitation amounts, or shared savings arrangements between MA plans and their network providers is likely to be proprietary and commercially sensitive and disclosure of such contract-specific details would be anti-competitive. Therefore, while we support the goals of the demonstration to encourage providers to adopt APMs, it is critical that the demonstration remain voluntary, that it not involve the disclosure of competitively sensitive information, and that it otherwise be designed in a way to best preserve private sector negotiation and the principles of the non-interference clause.

AHIP welcomes the opportunity to work with CMS to develop an MA Advanced APM incentive demonstration program guided by the principles described above. These principles are critical for ensuring that CMS' demonstration program effectively levels the playing field between FFS and MA, such that providers have equal incentives to take risk. Such a demonstration would recognize and reward the successful, innovative practices that MA plans and providers have already developed to better serve their patients, as well as ensure that the MA program continues its progress in delivering better care, improved health, and lower costs for Medicare beneficiaries.

³ Johnson, Garret, Figuero, Jose F., Zhou, Xiner, Orav, E. John, Jha, Ashish K. Recent growth in Medicare Advantage enrollment associated with decreased fee-for-service spending in certain US counties. *Health Affairs* 35(9):1707-1715. September 2016.

Physician-Focused Payment Models (PFPs)

MACRA established the Physician-Focused Payment Technical Advisory Committee (PTAC) to assess additional APM proposals submitted by stakeholders and the CY 2017 final rule requires that PFPs include Medicare as a payer.

In the proposed rule, CMS is seeking comments on broadening the definition of PFP to include payment arrangements that involve Medicaid or the Children's Health Insurance Program (CHIP) as a payer even if Medicare is not included as a payer. CMS' rationale is that a broader definition might be more inclusive of potential PFPs that could focus on areas not generally applicable to the Medicare population and could engage more stakeholders in designing PFPs.

Comment:

We support CMS' proposal to broaden the definition of PFPs and recommend that CMS consider including payment models submitted by commercial payers in the PFP definition. Additionally, PTAC may wish to consider payment models for ancillary providers, such as long-term care, durable medical equipment, and laboratories. If CMS chooses to expand the definition of PFPs and/or the types of other provider payment models that can be vetted by PTAC, CMS should ensure that committee members have the expertise necessary to properly evaluate and grade such models.

Thank you for the opportunity to provide these comments. We look forward to continuing to work with CMS in the national effort to transition to value-based health care.

Sincerely,

A solid black rectangular box used to redact the signature of Richard A. Bankowitz.

Richard A. Bankowitz, MD, MS, MBA, FACP
Executive Vice President, Clinical Affairs

STATEMENT FOR THE RECORD
SUBMITTED TO THE
HOUSE ENERGY AND COMMERCE COMMITTEE
SUBCOMMITTEE ON HEALTH
“MACRA AND ALTERNATIVE PAYMENT MODELS: DEVELOPING
OPTIONS FOR VALUE-BASED CARE”
NOVEMBER 8, 2017
Submitted By the Health Systems for Stark Reform (HSSR) Coalition

The HSSR Coalition (the “Coalition”) respectfully submits the following statement for consideration by the Committee on Energy & Commerce, Subcommittee on Health. Our members are health systems on the forefront of new payment models, providing the full continuum of care in collaboration with multiple care settings and technology companies. As such, they are uniquely positioned to contribute a nuanced perspective on Medicare Access and CHIP Reauthorization Act of 2015 (“MACRA”) and Alternative Payment Models (“APMs”). The current members of this coalition are: Adventist Health System, Aurora Health Care, Intermountain Healthcare, NewYork Presbyterian, and UnityPoint Health. We appreciate the opportunity to provide these comments to the Committee.

The transition to value-based care requires new types of partnerships and payment arrangements among health industry stakeholders. The Coalition members are more than just hospital systems, but instead provide comprehensive care through a network of healthcare providers including physicians, hospitals, urgent care centers, home health and hospice agencies, and skilled nursing facilities. They deliver services to meet the health needs of entire communities and regions. The Coalition members can provide insight into operational issues and challenges that result from the current fraud and abuse regulatory landscape, specifically the Physician Self-Referral Law (“Stark Law”), to the adoption of value-based care models. From this unique position, the Coalition members advocate for common sense modernization that will advance patient health.

The Coalition members strongly support the Committee’s exploration of opportunities to promote value-based care under MACRA and APMs. Since 2015, the Coalition and policy experts, including Kevin McAnaney and Troy Barsky have worked together to develop policies and draft legislation to modernize the Stark Law. In their current form, this law forms a barrier to the nationwide transition to value-based care.

To ensure that outdated laws do not stand in the way of innovation, the Coalition encourages the Committee to consider the following proposals, to strengthen the potential of MACRA and APMs to encourage coordinated care and meaningful collaboration among all healthcare entities:

- Create a Coordinated Network Arrangements exception to the Stark Law. This exception would protect all arrangements within a clinically integrated network or value based arrangement, such as Bundled Payment Arrangements and Accountable Care Organizations, regardless of whether entities are participating in a Medicare value based model.
- Allow HHS to employ waivers of the Stark Law for any arrangement that is “reasonably related” to an APM under MACRA.
- Introduce definitions that would provide clarity to providers on permissible value-based care arrangements.

Reform of the Medicare program and the Stark Law must allow for participation of all healthcare entities to coordinate care for patients. MACRA and APMs will only be successful if all healthcare entities are able to innovate together to coordinate care for patients. While one intent of MACRA was to encourage physicians to move to value based care models, the shift to APMs demonstrates that all healthcare entities must work together to provide high quality care to patients. And in turn, any waivers or new fraud and abuse exceptions must equally protect all entities who are participating in these new value based arrangements.

The Coalition strongly supports the efforts of the Committee as it explores this very important issue and stands ready to provide assistance in any way we can to achieve these necessary reforms.



800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100 Phone
www.aha.org

**Statement
of the
American Hospital Association
before the
Subcommittee on Health
of the
Committee on Energy and Commerce
of the
U.S. House of Representatives**

November 8, 2017

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to submit comments on the implementation of alternative payment models (APMs) in the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.

Nearly one year into implementation, the MACRA's Quality Payment Program (QPP) continues to have a significant impact, not only on physicians and others clinicians, but also on the hospitals and health systems with whom they partner to deliver care. There remains strong interest from the field in participating in advanced APMs to support new models of care, and to qualify for the bonus payment and exemption from the QPP's Merit-based Incentive Payment System (MIPS). However, opportunities to access the advanced APM track remain significantly constrained. In the calendar year (CY) 2018 QPP final rule, the Centers for Medicare & Medicaid Services (CMS) estimates that as few as 10 percent of eligible clinicians will qualify for the advanced APM track in 2018.

The AHA urges Congress to continue working with CMS to provide greater opportunity to participate in advanced APMs. In addition, we urge Congress to consider changes to the fraud and abuse laws to allow hospitals and physicians to work together to achieve the important goals of new payment models – improving quality, outcomes and efficiency in the



delivery of patient care. Finally, opportunities remain to improve fairness and reduce burden under the MIPS.

BROADENING OPPORTUNITIES FOR ADVANCED APM PARTICIPATION

The AHA supports accelerating the development and use of alternative payment and delivery models to reward better, more efficient, coordinated and seamless care for patients. Many hospitals, health systems and payers are adopting such initiatives with the goal of better aligning provider incentives to achieve the Triple Aim of improving the patient experience of care (including quality and satisfaction), improving the health of populations and reducing the per capita cost of health care. These initiatives include forming accountable care organizations (ACOs), bundling services and payments for episodes of care, developing new incentives to engage physicians in improving quality and efficiency, and testing payment alternatives for vulnerable populations.

Despite the progress made to date, the field as a whole is still learning how to effectively transform care delivery. There have been a limited number of Medicare APMs introduced so far, and existing models have not provided participation opportunities evenly across physician specialties. Therefore, many physicians likely are exploring APMs for the first time. **As a general principle, the AHA believes the APM provisions of the MACRA should be implemented in a broad manner that provides the greatest opportunity for physicians who so choose to become qualifying APM participants.** Particularly in the early years of MACRA implementation, the agency should take an expansive approach that encourages and rewards physicians who demonstrate movement toward APMs.

The AHA continues to be concerned that CMS's regulations only allow participation in APMs with downside financial risk to "count" toward the advanced APM track. This approach excludes current Medicare APMs with the largest number of participants, including Track 1 of the Medicare Shared Savings Program (MSSP). We urge Congress to work with CMS to expand its definition of financial risk in the QPP's advanced APM track to include the investment risk borne by providers who participate in APMs.

CMS's narrow definition fails to recognize the significant up-front investment that must be made by providers who develop and implement APMs. Providers who participate in APMs invest significant time, energy and resources to develop the clinical and operational infrastructures necessary to better manage patient care. For example, an AHA analysis estimated start-up costs of \$11.6 million for a small ACO and \$26.1 million for a medium ACO.

We appreciate that CMS has offered the Track 1+ MSSP model in an attempt to create a glide path to assuming downside risk. Nevertheless, clinicians participating in shared savings-only models are working hard to transform care delivery; under CMS's policy, their significant investments and efforts will not be sufficiently recognized. Regardless of whether an APM entails downside risk, providers must acquire and deploy infrastructure and enhance their knowledge base in areas, such as data analytics, care management and care redesign. Further, one metric for APM success – meeting financial targets – may require providers to reduce utilization of certain services, such as emergency department visits and

hospitalizations through earlier interventions and supportive services to meet patient needs. However, this reduced utilization may result in lower revenues. Providers participating in APMs accept the risk that they will invest resources to build infrastructure and potentially see reduced revenues from decreased utilization, in exchange for the potential reward of providing care that better meets the needs of their patients and communities and generates shared savings. This risk is the same even in those models that do not require the provider to repay Medicare if actual spending exceeds projected spending.

In addition, restricting the advanced APM track to models with downside risk may inhibit the movement toward APMs, especially among early APM adopters. If clinicians cannot engage with existing model participants – which have a head start on building infrastructure and engaging in care redesign – they instead must start from scratch. While we acknowledge CMS’s interest in encouraging providers to move toward accepting increased risk, such an interest must be balanced with the reality that providers are starting at different points and will have different learning curves. CMS should define financial risk in a way that provides a path for physicians who are interested in participating in risk-bearing models – particularly those who are exploring such models for the first time – rather than serving as a barrier to entry.

LEGAL IMPEDIMENTS TO IMPLEMENTATION OF NEW PAYMENT MODELS

By tying a portion of most physicians’ Medicare payments to performance on specified metrics and encouraging physician participation in APMs, MACRA marks another step in the health care field’s movement to a value-based paradigm from a volume-based approach. To achieve the efficiencies and care improvement goals of the new payment models, hospitals, physicians and other health care providers must break out of the silos of the past and work as teams. Of increasing importance is the ability to align performance objectives and financial incentives among providers across the care continuum.

Outdated fraud and abuse laws, however, are standing in the way of achieving the goals of the new payment systems, specifically, the physician self-referral (Stark) law and anti-kickback statute. These statutes and their complex regulatory framework are designed to keep hospitals and physicians apart – the antithesis of the new value-based delivery system models. A 2016 AHA [report](#), *Legal (Fraud and Abuse) Barriers to Care Transformation and How to Address Them (Wayne’s World)*, examines the types of collaborative arrangements between hospital and physicians that are being impeded by these laws and recommends specific legislative changes.

Congress should create a clear and comprehensive safe harbor under the anti-kickback law for arrangements designed to foster collaboration in the delivery of health care and incentivize and reward efficiencies and improvement in care. Arrangements protected under the safe harbor would be protected from financial penalties under the anti-kickback civil monetary penalty law. In addition, the Stark Law should be reformed to focus exclusively on ownership arrangements. Compensation arrangements should be subject to oversight solely under the anti-kickback Law.

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

As the MIPS is the QPP track in which the vast majority of clinicians will participate, the AHA believes it is vitally important that CMS implement the MIPS in a way that measures providers accurately and fairly; minimizes unnecessary data collection and reporting burden; focuses on high-priority quality issues; and fosters collaboration across the silos of the health care delivery system. To achieve this desired state, we have recommended that CMS prioritize the following MIPS policy approaches:

- Adopt gradual, flexible increases in reporting requirements in the initial years of the program to allow the field sufficient time to adapt;
- Streamline and focus the MIPS quality and cost measures to reflect the measures that matter the most to improving outcomes;
- Allow facility-based clinicians the option to use their facility's CMS quality reporting and pay-for-performance results in the MIPS;
- Employ risk adjustment rigorously – including sociodemographic adjustment, where appropriate – to ensure providers do not perform poorly in the MIPS simply because of the patient mix and communities they serve; and
- Align the requirements for eligible clinicians in the advancing care information (ACI) performance category with the requirements for eligible hospitals and critical access hospitals (CAHs) in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs.

CMS has made progress in addressing several of the above priorities. For example, in the first two MIPS performance years (CYs 2017 and 2018), CMS has used an incremental approach to increasing MIPS data reporting requirements, and reduced the number of required quality measures from the previous Physician Quality Reporting System. **In addition, the AHA applauds CMS for responding to our long-standing request to develop a facility-based measurement option for the MIPS that will be available in 2019. While we believe it could be adopted sooner, the option ultimately will help clinicians and hospitals alike spent less time collecting data, and more time improving care.** Congress can help make the reporting option even more effective by encouraging CMS to consider future expansion of the option to a broader array of facility types, such as post-acute care providers.

Furthermore, Congress should encourage CMS to continue refining its approach to accounting for both clinical and sociodemographic factors in measuring performance outcomes. CMS took an important step toward recognizing the impact of sociodemographic and other risk factors on outcomes by adopting a “complex patient bonus” in the MIPS in 2018. Clinicians receive up to five bonus points on their MIPS Final Scores based on a Medicare claims-derived proxy for patient complexity (Hierarchical Condition Categories, or HCCs), and well as the number of patients dually eligible for Medicare and Medicaid that a clinician or group treats. Dual-eligible status is a proxy for sociodemographic factors.

However, experience from the use of HCC scores in the value-based payment modifier (VM) raises significant questions about its adequacy in accounting for patient risk. CMS used HCC scores to provide modest increases to performance scores to groups treating significant numbers of high-risk patients. Unfortunately, the results of the 2016 VM program show that group practices caring for patients with more clinical risk factors were still significantly more likely to receive negative VM adjustments. Furthermore, while dual-eligibility is an established proxy for sociodemographic status, there are others – such as income and education – that may be more accurate adjusters for particular measures. We urge that the patient complexity bonus be viewed as an interim step while more sophisticated adjustment approaches are developed.

CONCLUSION

Thank you for the opportunity to share our views on the implementation of advanced APMs in MACRA's QPP. The AHA looks forward to working with Congress, CMS and all other stakeholders to ensure MACRA enhances the ability of hospitals and physicians to deliver quality care to patients and communities.



The Voice of the Nurse Practitioner™

November 7, 2017

The Honorable Michael Burgess
Chairman
Committee on Energy and Commerce
Subcommittee on Health
2336 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Gene Green
Ranking Member
Committee on Energy and Commerce
Subcommittee on Health
2470 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman and Ranking Member:

The American Association of Nurse Practitioners (AANP), representing more than 234,000 nurse practitioners (NPs) in the United States, would like to offer the following information for the record regarding the *MACRA and Alternative Payment Models: Developing Options for Value-Based Care* hearing the Subcommittee is holding on Wednesday, November 8, 2017.

NPs are advanced practice registered nurses who are prepared at the masters or doctoral level to provide primary, acute, chronic and specialty care to patients of all ages and walks of life. Daily practice includes: assessment; ordering, performing, supervising and interpreting diagnostic and laboratory tests; making diagnoses; initiating and managing treatment including prescribing medication and non-pharmacologic treatments; coordinating care; counseling; and educating patients and their families and communities. NPs practice in nearly every health care setting including clinics, hospitals, Veterans Affairs and Indian Health Care facilities, emergency rooms, urgent care sites, private physician or NP practices (both managed and owned by NPs), nursing homes, schools, colleges, retail clinics, public health departments, nurse managed clinics, homeless clinics, and home health. NPs hold prescriptive authority in all 50 states and the District of Columbia. It is important to note that 89.2% of NPs are certified in primary care, the majority of whom see Medicare and Medicaid patients. NPs complete more than one billion patient visits annually.

As the Committee continues to explore the implementation of MACRA and alternative payment models (APMs), we urge you to include the perspective of nurse practitioners in these discussions. As you know NPs have long been Medicare Part B providers, are recognized ACO providers, and were included as providers in the MACRA legislation previously passed by this committee. They are recognized in the final rule as eligible clinicians under the Merit-based Incentive Payment System and as participants in APMs, with one exception, as discussed below. We understand that this transition is an ongoing process, however, as this significant change from volume to value-based care continues, it is essential that all providers be included in the development of patient payment models so that all patients receive high quality healthcare from the Medicare provider of their choice.

Administration: PO Box 12846 • Austin, TX 78711 • Email: admin@aanp.org • Website: aanp.org
Government Affairs: 225 Reinekers Lane, Suite 525 • Alexandria, VA 22314 • Email: governmentaffairs@aanp.org

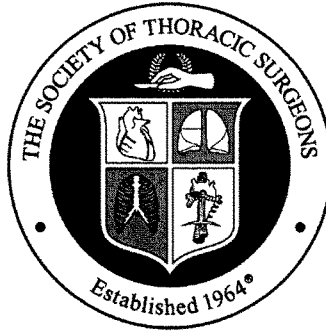
Of particular interest to NPs is full participation in the Medicare Shared Savings ACO Program. Under current law, NPs can join the Shared Savings ACO, but their patients only count toward the shared savings if they see a physician for one visit a year. While this restriction does not prevent individual nurse practitioners from joining the ACO, it does prevent their patients from being assigned to the Medicare Shared Savings ACO and attainment of any benefits that result from such participation. We urge the Committee to examine H.R. 1160, the *ACO Assignment Improvement Act of 2017*, to allow the assignment of NP patients under the Medicare Shared Savings Program. As the transition to value-based care moves forward and more nurse practitioners provide primary care services to Medicare patients, this burden will continue to act as a barrier to patient and NP participation in Shared Savings ACOs.

As we have previously stated, AANP would like to serve as a resource and participate in these discussions, including those with the Physician Technical Advisory Committee (PTAC), as the Committee continues its examination of these important issues. We are actively engaging with our membership to solicit feedback on new payment models, which will be helpful as this process moves forward. Please contact the MaryAnne Sapio, V.P. Federal Government Affairs, governmentaffairs@aanp.org, 703-740-2529 should you or your staff require any additional information.

Sincerely,



David Hebert
Chief Executive Officer



The Society of Thoracic Surgeons

Statement to the House Energy and Commerce Committee
Health Subcommittee Hearing
November 8, 2017

MACRA and Alternative Payment Models: Developing Options for Value-Based Care

The Society of Thoracic Surgeons (STS) appreciates the opportunity to submit a statement for the record for the House Energy and Commerce Health Subcommittee hearing on “MACRA and Alternative Payment Models: Developing Options for Value-Based Care.” Founded in 1964, The Society of Thoracic Surgeons is a not-for-profit organization representing more than 7,500 surgeons, researchers, and allied health care professionals worldwide who are dedicated to ensuring the best possible outcomes for surgeries of the heart, lung, and esophagus, as well as other surgical procedures within the chest. The mission of the Society is to enhance the ability of cardiothoracic surgeons to provide the highest quality patient care through education, research, and advocacy.

In passing the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Congress sent a clear signal to the medical community that the health care system should transition from a fee-for-service, volume-based payment model to one that incentivizes care quality. STS was pleased with this development because we have been pioneers in quality measurement and improvement over the past quarter-century. As Congress is aware, many of the alternative payment models (APMs) introduced to date have focused on primary care. We hoped that MACRA would finally provide the pathway to help us to develop a specialty-specific APM that took advantage of the wealth of quality information being collected in the STS National Database. We remain excited at the opportunity to bring value-based payment into cardiothoracic surgery. Below we discuss the many ways in which The Society of Thoracic Surgeons is attempting to bring this to fruition.

The STS National Database was established in 1989 as an initiative for quality assessment, improvement, and patient safety among cardiothoracic surgeons. The Database has three components—Adult Cardiac Surgery, General Thoracic Surgery, and Congenital Heart Surgery. The fundamental principle underlying the STS National Database initiative has been that surgeon engagement in the process of collecting information on every case, combined with robust risk adjustment based on pooled national data, and feedback of the risk-adjusted data provided to the individual practice and the institution, will provide the most powerful mechanism to change and improve the practice of cardiothoracic surgery for the benefit of patients. The Adult Cardiac Surgery Database has 90 to 95 percent penetration across all the cardiothoracic surgery practices in the country.

On December 10, 2013, STS held a policy planning meeting with members of STS leadership to discuss and identify key features to include in any cardiothoracic surgery APM model. Over the course of the past few years, STS has designed a quality-based payment program specifically related to cardiothoracic diseases (including coronary artery bypass grafting (CABG), valve repair and replacement procedures, and treatments for lung cancer) that relies on the robust data in the STS National Database as the foundation for quality measurement and improvement. The STS APM Whitepaper, included as an addendum to this statement, provides a high-level summary and framework for the heart team and lung cancer care team APM.

The STS APM Whitepaper presents CMS with an opportunity to identify and reward for value in healthcare. What the Whitepaper lacks is the infrastructure for that value-based payment. While we have had the opportunity to interact with 2 bundled/episode payment programs in the last year that offered acceptable infrastructure: the CABG Episode Payment Model (EPM) bundle and the ACS/Brandeis bundle, realistically for cardiothoracic episodes, both of these models failed to adequately incorporate the advanced quality measurement and improvement mechanisms developed by STS via the robust data available in our National Database. Basically, we have two puzzle pieces that fit together perfectly to make exactly the picture that CMS and Congress are looking for – a win on a specialty-specific APM in one of the largest cost centers in the Medicare program.

STS firmly believes that APMs should be developed in partnership with the clinical community and provide added incentives to clinicians to provide quality and cost-efficient care. However, in December 2016, the Center for Medicare and Medicaid Innovation (CMMI) and the Centers for Medicare and Medicaid Services (CMS) finalized plans to implement a Coronary Artery Bypass Graft (CABG) Model in the Advancing Care Coordination through Episode Payment Models (EPMs). Unfortunately, the CABG EPM was significantly flawed because it required that only two quality measures be used: all-cause mortality and a patient satisfaction survey. STS argued that CMS should use the STS CABG Composite Score, a five-part composite quality measure that has been endorsed by the National Quality Forum and includes all-cause mortality as a quality measure, specifically because the mortality rate for CABG is approximately 2%. This means that under the proposed CABG EPM, CMS would not have been able to differentiate among 98% of providers in the model. Using the STS CABG Composite, CMS would be using the same quality metrics that STS has used, alone and in partnership with Consumer Reports, to publicly report on hospitals' complete CABG performance. [See STS Public Reporting: <http://publicreporting.sts.org/>].

In late 2016, the American College of Surgeons and Brandeis University submitted a proposed physician-focused payment model (PFPM) to the PFPM Technical Advisory Committee (PTAC) for review. The model focused on procedure episodes and called for each qualified participant within an APM to assume risk in the episode(s) for which he/she provides care. Although PTAC approved the ACS/Brandeis model for limited testing by CMMI, the panel noted concerns with how the proposal fulfilled the "value over volume" criterion. It should be noted that where PTAC identified concerns with the ACS/Brandeis proposal, the STS APM Whitepaper offers solutions. The STS APM Whitepaper is a quality-based payment methodology that lacks a payment infrastructure. The ACS/Brandeis model is a payment infrastructure that can be enhanced by the quality-based measurement components provided by STS.

Policy-makers and thought leaders have largely indicated that bundled payments for episodes of care are a central tenet of alternative payment. At this stage, we feel the best opportunity for success is to identify a way to incorporate the STS quality data into the episode of care that CMS has already identified for the CABG EPM or the episodes of care being developed for limited testing through the ACS/Brandeis APM proposal. Rather than starting from scratch, we can build on gains made by CMMI with the EPM and by ACS/Brandeis with their PFPM proposal. Further, our quality-based payment methodology addresses critical gaps in all the models that have been proposed thus far – we have a validated and meaningful way to measure quality and we know how to tie it to payment.

Additionally, we believe that there is a role for other stakeholders in the APM-development process. For example, as we incentivize physicians to improve efficiency in the health care system, we run the risk of squeezing out innovations that, while costly at their inception, provide dividends over time. We are beginning to think about the concept of "risk" in a payment model to include the concept of medical innovation and the role that industry may play in support of evidence-based quality improvement.

We are actively pursuing all possible partnerships and look forward to working with Congress, CMS, and CMMI to bring to fruition a payment model that could provide quality incentives and efficiencies to one of the largest cost centers in the Medicare program. We hope to serve as an example for all of medicine. We are eager to be an active partner in the effort to drive medicine to value-based payment and we are more than willing to go first.

**Statement for the Record****House Energy and Commerce Hearing****MACRA and Alternative Payment Models: Developing Options for Value-based Care****Wednesday, November 8, 2017**

On behalf of over 18,000 board-certified orthopaedic surgeons, the American Association of Orthopaedic Surgeons (AAOS) would like to commend Chairman Michael Burgess and Ranking Member Gene Greene for holding the Energy and Commerce Subcommittee on Health hearing, "MACRA and Alternative Payment Models: Developing Options for Value-based Care." The AAOS appreciates your willingness to look critically at alternative payment models (APMs).

As you know, AAOS and the entire physician community worked closely with Congress on drafting and implementing the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. In addition to repealing the flawed Sustainable Growth Rate (SGR) formula, this legislation offered a number of ways to improve the previous reimbursement and reporting frameworks, such as streamlining requirements and lowering penalties, reducing administrative burdens, and increasing flexibility and support for small and solo practices. We have continued to work with members of Congress and the Centers for Medicare & Medicaid Services (CMS) as the rules for years one and two of this new framework are finalized, and we remain committed to ensuring the legislation is improved over time. Certainly, opportunities to examine and refine the MACRA framework – such as that provided by today's hearing – will ensure the legislation improves delivery of care for Medicare patients across the country.

In addition to the Merit-Based Incentive Payment System (MIPS) program, the second track or MACRA provides bonus payments for physicians who participate in alternative payment models (APMs) that hold providers financially accountable for health care costs. Eligible APM participants must tie payments to specified quality measures, use certified electronic health record (EHR) technology, and assume more than nominal financial risk. Further, certain APMs enable physicians to qualify for a five percent bonus payment as "Advanced APMs" while other APMs may improve physicians' MIPS scores as "MIPS APMs."

The AAOS strongly supports efforts by CMS to make appropriately structured APMs available to physicians and other providers, including bundled and episode-of-care payment models. We have supported previous efforts by CMS through the Center for Medicare and Medicaid Innovation (CMMI) to develop bundled payment models in the area of musculoskeletal care. One such initiative, the Bundled Payments for Care Improvement (BPCI) program, addresses episode-based payment approaches to delivering care to beneficiaries with multiple types of clinical episodes, including musculoskeletal conditions. AAOS believes that properly

317 Massachusetts Avenue NE
Suite 100
Washington, D.C. 20002-5701
PHONE 202.546.4430
www.aaos.org/dc

constructed APMs have the potential to generate savings for Medicare while having positive effects on patient care. In fact, many AAOS members have been leaders in developing, implementing, and evaluating episode-of-care payments under the ACE Demonstration Project and the BPCI.

However, the revenue and patient thresholds for eligible clinicians to become qualifying providers (QPs) under MACRA is quite onerous for specialty physicians. Finalized rules require that in 2019, 25 percent of Medicare payments and 20 percent of patients are qualifying thresholds to receive the increased APM bonus. These patient count and payment thresholds are very high for specialty physicians and most of them are likely to not qualify on these levels. Moreover, attempts to meet these thresholds may magnify sub-specialization and incentivize procedure-focused practice. While there are some exceptions on threshold requirements for specialists who participate in multiple APMs, AAOS would like to note that these requirements are restrictive.

It is heartening to note that MIPS APMs will have their resource use component weight reduced to zero with the 10 percent reassigned to increase weights for CPIA and ACI thereby creating a pathway of qualification from MIPS APMs to Advanced APMs. Nevertheless, in the spirit of the MACRA legislation, the AAOS has consistently requested reductions in unnecessary and burdensome requirements to qualify for Advanced APMs that cause resources to be spent on administrative costs rather than patient care. At present, there are no Advanced APMs available for orthopaedic surgeons to embrace, and to date there is no clear guidance whether or not CJR will be considered an Advanced APM. We have also requested for a clear pathway for rapid approval and implementation of physician-directed APMs.

Additionally, the AAOS has noted that APMs (including BPCI and the Comprehensive Care for Joint Replacement model) that require coordinated care across settings reveal limitations in the current Stark Law. The Stark Law is structured to control the volume of referred services, and it is a strict liability statute that leads to heavy penalties to unintentional and technical errors by physicians and their staff. Liability statutes, like the Stark Law, do not encourage physicians to participate in coordinated care models as the costs of compliance and disclosures required can be prohibitive for small and medium-sized physician practices.

Physician referrals in Accountable Care Organizations (ACOs) are theoretically exempt from the Stark Law requirements through fraud and abuse waivers. The AAOS believes there should be similar exceptions and protections for physicians and physician groups participating in APMs, and strongly encourages Congress to protect in-office ancillary services exception.

Finally, the AAOS encourages the Committee to consider the ways in which qualified clinical data registries (QCDRs) can play a critical role in improving quality and patient care within APMs. Under Section 105(b) of MACRA, Congress directed CMS to provide QCDRs access to

real-time Medicare claims data for purposes of linking such data with “with clinical outcomes data and [perform] risk-adjusted, scientifically valid analyses and research to support quality improvement or patient safety.” Increased participation in APMs can be encouraged by providing QCDRs timely access to this data to perform validation and analysis. The data QCDRs collect provides a wealth of clinical information for measure developers and, absent full implementation of this provision of MACRA, represents an underutilized resource. All participants should also be allowed to submit advanced APMs’ quality data through a QCDR, as is the case for MIPS and some current APMs. Having an incentive bonus for participation in a QCDR for those qualifying APM participants would also encourage these QPs to contribute to this valuable reservoir of clinical data.

Thank you again for holding this important hearing on Medicare’s payment systems and programs. The AAOS is committed to continue working with Congress and the Administration to ensure that patients have access to the highest quality musculoskeletal care. Please contact Catherine Boudreaux, Senior Manager of Government Relation (boudreaux@aaos.org) if you have any questions or if the AAOS can serve as a resource to you.

