NEAL R. GROSS & CO., INC.

RPTS METCALF

HIF312140

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, D.C.

The subcommittee met, pursuant to call, at 10:00 a.m., in Room 2123 Rayburn House Office Building, Hon. Michael Burgess [chairman of the subcommittee] presiding.

Members present: Representatives Burgess, Guthrie, Barton, Shimkus, Murphy, Blackburn, Lance, Griffith, 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 Eddatel, 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, Health; Jennifer Sherman, Press Secretary; Hamlin Wade, Special Advisor, 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.

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 remained 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 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 Baliet, 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. Patients are counting on us. Not congressmen, but doctors. They are counting on us to get this right. It has been 2-1/2 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:]

**********INSERT 1**********

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.

[The prepared statement of Mrs. Blackburn follows:]

**********COMMITTEE INSERT 2**********

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.

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 five 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.

[The prepared statement of Mr. Green follows:]

213 **********COMMITTEE INSERT 3**********

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

Mr. Burgess. Without objection, so ordered.

[The information follows:]

**********INSERT 4**********

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.

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:]

**********COMMITTEE INSERT 5**********

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

STATEMENTS OF JEFFREY BALIET, M.D., CHAIRPERSON, PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE; AND, ELIZABETH MITCHELL, VICE CHAIRPERSON, PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE

STATEMENT OF JEFFREY BALIET

Dr. Baliet. 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 Baliet, 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.

[The prepared statement of Dr. Baliet follows:]

416

417 **********INSERT 6**********

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. Baliet 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 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 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 community-wide

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 prepared statement of Ms. Mitchell follows:]

**********INSERT 7**********

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. Baliet, 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. Baliet. 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. Baliet. 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. Okay, 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. Baliet?

Dr. Baliet. 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. Baliet. 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 ten, all ten 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. Baliet 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. Baliet. 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 to 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 sharpens 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 ten 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. Baliet. 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. Baliet, 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. Baliet. 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. Baliet. Yes. We don't -- well, because of our public schedule because we can't deliberate in private --

Mrs. Blackburn. Okay.

Dr. Baliet. -- 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. Okay. 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. Baliet. 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. Baliet 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 tenth 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. Baliet. 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. Okay.

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

Ms. Matsui. Sure.

Dr. Baliet. -- 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. Baliet. 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. Baliet. 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 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. Baliet. Yes, five. We have deliberated on six, voted on five, with recommendations to the secretary.

Mr. Barton. Okay. 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. Baliet. 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. Baliet. Yes.

Mr. Barton. -- which we don't have right now.

Dr. Baliet. 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. Baliet. 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. Baliet. 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. Baliet. 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. Baliet. 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. Baliet. 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. Baliet. 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. Baliet. The secretary and HHS.

Mr. Barton. Okay, 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. Baliet. I get it. Okay.

Mr. Barton. -- says okay, we are going to switch from this old system to this new system A.

Dr. Baliet. 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. Baliet. 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. Baliet. 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. Baliet. 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. Baliet. 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. Baliet. Yes.

Mr. Barton. Okay, 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. Baliet. 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. Yeah. 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. Baliet 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. Baliet. 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 ten criterion 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 ten 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. Baliet, 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. Baliet. 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. Baliet. 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. Baliet. 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 community-wide. 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. Baliet. Thank you.

Mr. Burgess. 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. Baliet, 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 impuning 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. Baliet. 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. Baliet. No, we don't. And that -- no, we don't.

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

Dr. Baliet. 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. Baliet. 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. Okay, Dr. Baliet?

Dr. Baliet. So to follow on with Elizabeth's comments, there are unintended consequences. These models have elements that are new. They have not been, 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. Okay. 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. Baliet. 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. Baliet. 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. Okay, 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. Baliet. 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. Baliet. 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. Okay, 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 follows:]

**********INSERT 8**********

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, five 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. Baliet has insights.

Dr. Baliet. No.

Mr. Bucshon. Maybe I will ask that for --

Dr. Baliet. Played one on TV, right?

Mr. Bucshon. -- 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. Baliet?

Dr. Baliet. 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. Baliet. I haven't seen that.

Ms. Mitchell. I haven't seen that either.

Mr. Bucshon. Not really?

Dr. Baliet. No.

Mr. Bucshon. Okay, 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. Baliet. I agree.

Mr. Bucshon. Do you have any comments?

Dr. Baliet. 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. Baliet. 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. -- because you are exactly right. We have to address that.

Mr. Kennedy. Doctor, anything else?

Dr. Baliet. 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, yeah, 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. Baliet. 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 examples 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. Baliet, 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. Baliet. 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. Baliet. 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. Okay, 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. Baliet. Yes.

Mr. Guthrie. Specialty interests not special interests.

Dr. Baliet. 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. Okay, 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. Baliet and then I will go to Ms. Mitchell.

Dr. Baliet. 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. Okay.

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

Dr. Baliet. 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 secretary set -- so 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 ten criterion including the extent to which proposals provide value over volume, increase care coordination, improve quality, et cetera, can you describe the ten criteria established by the secretary, particularly the criteria designed by the PTAC as, quote, high priority criteria?

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

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

Dr. Baliet. There is three.

Mr. Ruiz. Give me the top two.

Dr. Baliet. 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 ten criteria easily?

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

Dr. Baliet. 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. Baliet. I don't have the number available. It is more

than one.

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

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

Mr. Butterfield. But you do collect the data?

Dr. Baliet. 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. Baliet. Well, the applications are highly variable from application to application. And I think --

Mr. Butterfield. In terms of quality?

Dr. Baliet. Right.

Mr. Butterfield. Quality?

Dr. Baliet. 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. Baliet. Absolutely, yes.

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

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

numbers specifically 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. Baliet. 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 five 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. Baliet. Thank you for your support. Thank you.

Ms. Mitchell. Thank you.

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

Dr. Baliet, 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 FRIEDMAN, D.O., AMERICAN COLLEGE OF PHYSICIANS; DANIEL VARGA, M.D., CHIEF CLINICAL OFFICER, TEXAS HEALTH RESOURCES, PREMIER, INC.; BILL WULF, M.D., CEO, CENTRAL OHIO PRIMARY CARE PHYSICIANS, CAPG; COLIN EDGERTON, M.D., AMERICAN COLLEGE OF RHEUMATOLOGY; BRIAN KAVANAGH, M.D., CHAIR, AMERICAN SOCIETY FOR RADIATION ONCOLOGY; AND, FRANK OPELKA, M.D., MEDICAL DIRECTOR, QUALITY AND HEALTH POLICY, AMERICAN COLLEGE OF SURGEONS

STATEMENT OF LOUIS 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 ten 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 systems. 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:]

**********INSERT 9**********

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's 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 ten 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:]

**********INSERT 10**********

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 BILL 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, D.C., 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 reformed 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 seven 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:]

**********INSERT 11**********

Mr. Burgess. The chair thanks the gentleman.

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

STATEMENT OF COLIN 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 1-1/2 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 the 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:]

**********INSERT 12**********

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 5-1/2 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's 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 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:]

**********INSERT 13**********

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 century-long 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:]

**********INSERT 14**********

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. Okay, 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, Representative 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 website 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 website 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 okay 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 -- okay.

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.]