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EXAMINING BARRIERS TO EXPANDING INNOVATIVE,

VALUE-BASED CARE IN MEDICARE

THURSDAY, SEPTEMBER 13, 2018

House of Representatives

Subcommittee on Health

Committee on Energy and Commerce

Washington, D.C.

The subcommittee met, pursuant to call, at 1:15 p.m., in Room 2322 Rayburn House Office Building, Hon. Michael Burgess [chairman of the subcommittee] presiding.

Members present: Representatives Burgess, Guthrie, Shimkus, Latta, Lance, Griffith, Bilirakis, Long, Bucshon, Brooks, Mullin, Hudson, Collins, Carter, Green, Matsui, Castor, Lujan, Schrader, and Kennedy.

Staff present: Daniel Butler, Staff Assistant; Karen Christian, General Counsel; Jay Gulshen, Legislative Associate, Health; Brighton Haslett, Counsel, Oversight & Investigations;

James Paluskiewicz, Professional Staff, Health; Brannon Rains, Staff Assistant; Jennifer Sherman, Press Secretary; 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. We will go ahead and call the subcommittee to order, and thank you for your indulgence. We were waiting a few minutes because there was another hearing starting downstairs and some of our members may be joining us in progress.

But, for now, the hearing will come to order. I'll recognize myself five minutes for an opening statement.

And today, we are convening to discuss a topic that is of significant importance to the health care industry at large, and this is the ever-evolving transition to value-based care as well as new ways of assuming risk and the role technology can play in these efforts.

Over the course of the last few years, our health care system has begun a shift toward rewarding physicians for the quality of care rather than the quantity, and building off these efforts, providers, doctors, health systems, and payers are willing to explore new value-based arrangements and open the door to providing new benefits for their beneficiaries.

I am certain that many members of this subcommittee have taken meetings in their districts on this topic, especially in the past couple of years as the shift to value-based care has accelerated.

Notably, Congress passed the Medicare Access and CHIP Reauthorization Act of 2015 in the 114th Congress. For situational awareness, this is the 115th Congress, so that was two years ago.

This was a critical step in the right direction as we helped begin to shift Medicare towards being a more value-based payment system.

We have had other hearings about the Medicare Access and CHIP Reauthorization Act including the Merit-Based Incentive Payments Systems, conducting general oversight on the implementation of this crucial law.

A lot of the work that this subcommittee conducts is to oversee the influence in the health care industry as moving into coordination with the 21st century.

The Medicare Access and CHIP Reauthorization Act provided a platform for this effort to do so, and this afternoon we are going to hear from a number of people on the front lines who are working to deliver better outcomes at lower costs.

This hearing will provide us with a significant amount of information as we move forward in assessing value-based payments, where it holds the most promise, where there may be barriers that Congress might consider examining in the future to ensure its success.

I think it goes without saying everything we can do to lower the burden on physicians, freeze them up to deliver more in-patient care and that is the general direction that I think it's good for us to go.

Value-based care models have been effective and have gained support throughout the country as they have proven to improve

the quality of care and lower costs. This allows for positive outcomes for patients, physicians and insurers, as well as the overall health care system.

As we have heard from witnesses at other hearings on this topic, taking these models on as a physician or health care system can be a difficult but still a rewarding task.

Promoting innovation and quality are essential to modernizing American health care and enabling our world-class physicians to focus on providing coordinated quality care to their patients.

Value-based models have evolved over time since their inception in the early 1990s, beginning with the efforts among private payers and state Medicaid programs to reward improvements in care with financial incentives.

Models have grown broader and incentives more innovative as we have seen accountable care organizations and bundled payment programs, which address both quality and cost, take off across the country.

These newer and more advanced models have allowed for physicians and other professionals to voluntarily come together to provide more coordinated care for patients and rewarding physicians with bonuses for hitting certain quality measures and based payments on expected costs for specific episodes of care.

These models are the future of health care and it is important that Congress hear from the industry about how the implementation

of such models works on the ground, or to the extent it's not working it's important that we hear that as well.

Today, we have the chance to hear from witnesses about the models and ways that they are working to improve the quality of care or reducing cost.

I suspect we will hear about the critical role that the laws we have worked on, including the Medicare Access and CHIP Reauthorization Act -- the role that they have played in expanding innovation, but that barriers to implementing potentially beneficial models still exist.

So I certainly look forward to hearing the thoughts of our expert panel of witnesses about the challenges and achievements in the world of value-based care. So I want to anticipate by thanking our witnesses for their willingness to testify today.

We appreciate being able to have this important conversation and learn from your expertise.

Seeing that the ranking member of the subcommittee is not here, the chairman of the full committee is not here, and the ranking member of the full committee is not here, perhaps it would be prudent to proceed with witness statements and then we will allow those individuals -- as they arrive from their other hearing we will interrupt and allow them to deliver their opening statements.

And I do want to remind members that all members' opening statements will be made a part of the record.

So thanks to your witnesses for being here today and taking time to testify before the subcommittee. Each witness will have the opportunity to give an opening statement followed then by questions from members.

Today, we are going to hear from Dr. Nishant Anand, the chief medical officer for Adventist Health System; Ms. Mary Grealy, the president, Healthcare Leadership Council; Dr. Timothy Peck, CEO of Call9; Dr. Michael Weinstein, president, Digestive Health Physicians Association; Mr. Morgan Reed, president of the App Association; and Michael Robertson, chief medical officer for Covenant Health Partners.

Again, we appreciate all of you being here today. Dr. Anand, you are now recognized for five minutes for the purpose of an opening statement, please.

STATEMENTS OF DR. NISHANT ANAND, CHIEF MEDICAL OFFICER, ADVENTIST HEALTH SYSTEM; MARY GREALY, PRESIDENT, HEALTHCARE LEADERSHIP COUNCIL; DR. TIMOTHY PECK, CEO, CALL9; DR. MICHAEL WEINSTEIN, PRESIDENT, DIGESTIVE HEALTH PHYSICIANS ASSOCIATION; MORGAN REED, PRESIDENT, THE APP ASSOCIATION; DR. MICHAEL ROBERTSON, CHIEF MEDICAL OFFICER, COVENANT HEALTH PARTNERS

STATEMENT OF DR. NISHANT ANAND

Dr. Anand. Good afternoon, Chairman Burgess and members of the subcommittee. I am Dr. Nishant Anand and I serve at Adventist Health System as a chief medical officer for Population Health Services and the chief transformation officer.

We have 46 hospitals located in nine states serving 4 million people each year. This includes Florida Hospital Orlando, which is the largest single site Medicare provider and the second largest Medicaid provider in the nation.

We have accountable care organization arrangements in Kansas, North Carolina, and Florida. We serve more than 400,000 patients in our ACOs and we partner with several thousand physicians, two-thirds of which are independent physicians.

Additionally, we will participate in the BPCI advanced model and are successfully participating in the CJR program. Today, I speak to you as a board-certified emergency medicine physician and a health care professional who has led value transformations at Memorial Hermann Health System in Texas and at Banner Health

Network, which was a pioneer ACO, in Arizona.

In value-based care delivery, I know firsthand the benefits this brings to patients and the barriers that block providers from realizing its full potential.

We can improve the health and wellbeing of our patients but we need policy changes. As health care providers, there are many innovations that we would like to undertake that will improve the health and wellbeing of Medicare and Medicaid beneficiaries.

First, we desire to build high value networks that enable health care providers to ensure high quality care and reduce variation in care.

Second, we can expand shared technology services across that network. Third, we can develop common operational work flows to navigate patients across that complex network. Fourth, we can implement clinical pathways across the continuum of care -- pathways that reward the triple aim rather than fragmented care.

These four focus areas will help us achieve higher quality and more cost effective health care. However, barriers impede progress.

These barriers are Stark Law, misaligned value-based model initiatives, and operational challenges.

Number one, Stark Law modernization -- I am not an attorney and cannot speak to the complexity of the law. But as a physician, I experience the challenges of the Stark Law each and every day.

I believe that it causes barriers to doing the right thing

for our patients. The Stark Law was developed in a reimbursement world that paid providers based on the volume of services.

In today's world, where ACO providers coordinate care in a highly effective manner, these regulations serve more as a barrier than a protection for our patients.

While HHS issues waivers for APMs, the problem is these waivers are not permanent. Number two, encourage providers to move to value. We are concerned that policies contained in CMS' proposed ACO rule would discourage providers from participating in value-based care.

The existing financial benchmark to specialty and lower cost markets make it financially prohibitive to transition to a two-sided risk model and will deter providers from participating in the program.

If the benchmarks do not provide room for improvement, allowing providers to transition towards value-based care delivery over time, providers will not participate.

Benchmarks must also be accurately risk adjusted. Lastly, the proposal to limit shared savings payments from 50 percent to 25 percent of the savings will create an unsustainable business model.

Number three, real-life operational challenges -- to truly partner with private practice physicians, we want to share technology services such as clinical decisions support tools, telemedicine platforms, and referral solutions.

I know these tools will help us make better decisions for patient care that will ultimately lead to better outcomes and lower costs.

However, we need clarity that we can share these tools with our physicians to use with all patients. We need quick implementation of the 21st Century Cures Act.

As providers are investing in high value networks, we painstakingly work to ensure that our partnerships are with the best providers.

As a result, we need to refer our patients more intentionally, making sure that they see the best clinicians, which is sometimes at odds with the current Medicare conditions of participation.

In summary, I ask you consider a deeper dive into value-based reforms that will accelerate our journey. We are ready to go faster but need additional help with payment reform, focusing on holistic care as well as regulatory reform.

We need to help ACOs achieve critical mass in order to hit the tipping point where value-based care is what we deliver. This will allow us to achieve the coordination abilities as a community that will better serve our Medicare and Medicaid beneficiaries.

I thank you for your time and interest and look forward to your questions.

[The prepared statement of Dr. Anand follows:]

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Mr. Burgess. Thank you, Dr. Anand.

Ms. Grealy, you're recognized for five minutes, please.

STATEMENT OF MARY GREALY

Ms. Grealy. Good afternoon, Chairman Burgess and members of the subcommittee, and thank you for the opportunity to testify today on what I believe to be one of the most important topics in American health care.

As our health care system evolves from a long-standing fee-for-serve orientation to a patient-centered value-based approach to care, I am proud that the members of my organization, the Healthcare Leadership Council, are not only supportive of this transformation but have led it.

Our members are innovative systems such as Adventist health plans, drug and device manufacturers, distributors, academic health centers, health information technology firms, and all are driving change within and across virtually every health care sector.

We appreciate your effort today to shine a light on some of the barriers that are preventing an optimal transformation and transition to value-based care that will result in better outcomes for patients and improve sustainability for the Medicare program.

Today, I would like to focus on several areas that warrant significant attention of this committee. I will begin by saying a word about the legal barriers that are keeping health care innovators from accelerating toward value-based care.

Let me be clear. We believe it is essential to keep consumer and program protections in place while, at the same time, working in both the legislative and regulatory spheres to create an open unobstructed pathway for these value-focused activities that benefit both patients and the system as a whole.

The Stark Physician Self-Referral Law and the Anti-Kickback Statute were created to prevent overutilization and inappropriate influence in a fee-for-service environment in which health care sectors and entities operated in their own individual silos.

Today, however, in order to make the transformation to value-based care we need greater integration of services, improved coordination of care with cross-sector collaborations, and payment that is linked to outcomes rather than volume.

Adopting these new delivery and payment models becomes difficult when faced with outdated fraud and abuse laws and potential penalties of considerable severity.

For example, it is desired for health care providers to achieve optimal health outcomes through coordinated care, meeting high quality and performance metrics, and saving money through the avoidance of unnecessary hospital admissions and office visits.

And yet, there are obstacles to incentivizing this level of performance. If a hospital wishes to provide performance-based compensation, it can run afoul of the current fraud and abuse framework.

In fact, in terms of maintaining good patient health, the legal status quo does not even allow physicians to provide patients with a blood pressure cuff or a scale to monitor their healthy weight at home.

To achieve meaningful progress toward a value-based health care system, it is also necessary to address how to foster further success in alternative payment models such as accountable care organizations.

We know that better care coordination results in better outcomes for patients, which is the goal of accountable care organizations. But we must address the flaws in the current ACO structure.

Medicare beneficiaries today do not choose to enroll in a particular ACO. Rather, they are assigned to one based on the physician they choose to see.

So the accountable care organization is charged with the responsibility of managing the patient's care even though the patient is likely unaware they are even under that umbrella.

Medicare beneficiaries may also not be aware of the benefits of this approach. Patients should be proactively informed of the benefits of coordinating care among providers.

They should also be encouraged to remain in ACOs and other care delivery models that focus on coordination, information flow, and value.

Doing so will enable these models to better achieve quality

outcomes while controlling costs, and also to optimize the effectiveness of ACOs more progress needs to be made in data sharing and data interoperability so that entities have real-time knowledge of work flows, care coordination, and progress towards quality measures.

Mr. Chairman, I also need to mention the importance of technology and the movement towards value-based care. Specifically, the expanded use of telemedicine is essential to more efficient utilization of health care resources, expanding the reach of health care providers.

So we urge Congress and the administration to address Medicare's restrictions on reimbursement for telemedicine services and there's also considerable value to be found in making digital health applications more accessible for beneficiaries.

And, finally, as we talk about coordinated care, we must focus on how we can gain the greatest patient and population health benefits from our health care workforce.

All health care professionals must be empowered and rewarded to perform to the full extent of their professional license and to be valued members of health care teams.

Thank you again for the opportunity to testify and I look forward to your questions.

[The prepared statement of Ms. Grealy follows:]

**********INSERT 2**********

Mr. Burgess. Thank you, Ms. Grealy. Thank you for participating with us today.

Next, we'll hear from Dr. Timothy Peck. You're recognized for five minutes, please.

STATEMENT OF DR. TIMOTHY PECK

Dr. Peck. Thank you, Chairman Burgess, and please extend my gratitude to Ranking Member Green and members of the subcommittee for the honor to speak to you today.

I am here to share how I've seen firsthand how the lack of value-based care in Medicare fee-for-service system has led to wasted dollars on patient care.

My name is Timothy Peck. I am an emergency physicians and I am also an entrepreneur. I went to residency and did my chief here at Harvard Medical School and Beth Israel Deaconess and stayed on as faculty there.

I left my career in early 2015 to be an entrepreneur and solve a problem -- a problem that, in the emergency department, I lived every day.

Nineteen percent of the patients who arrive in an ambulance to the emergency department come from SNFs -- from skilled nursing facilities. One out of five patients I saw every day from an ambulance came from a SNF.

Nursing home patients and patients over 65 in general don't receive great care in the emergency department. Hospitals are not a great place to get well for those over 65.

Our own data on patients in nursing homes shows that 43 percent of patients in SNFs have dementia and almost all become delirious from moving them from a familiar place to the bright

lights of the emergency department.

In emergency departments we order every test under the rainbow. We put them in the hallway. They get renal failure and bed sores. We then admit them to the hospital that exposes them to infections and they often experience post-hospital syndrome condition in which most patients leave the hospital worse off than when they came in.

Although I knew this about emergency departments and hospitals because I worked there, I didn't know anything about nursing homes. I went to medical school. I went to residency, and I had never once stepped foot into a nursing home.

I needed to understand these patients better and why they were coming to me, and so I went and lived in a nursing home for three months myself.

CMS says two-thirds of the transfers are avoidable and 45 percent of the hospitalizations to the hospitals are avoidable for an estimated cost of about $20 billion per year.

I needed to understand why this was happening. Right now, as of this moment, the only way to get paid for this care is to go by what the fee-for-service system says, and that is to put those patients in an endless loop of expensive care in which they're treated in the nursing home at a cost, they're put in an ambulance at a cost, and admitted to the hospital at a cost, to go right back into the SNF again.

I needed to break this loop and, based on my research from

living in the nursing home, I created a model in which we embed a first responder in the nursing home 24/7 who connects to an emergency physician by telehealth, who is home, remote, 24/7 whenever there's any type of acute change in condition of that patient.

The emergency physician who's home directs the care of that patient and decreases hospitalizations by upwards of 50 percent, saving $8 million per 200-bed nursing home.

In our first nursing home we've served, Central Island Healthcare in New York, according to CMS' own nursing home compare website, the percentage of Medicare residents who are rehospitalized after admission to Central Island is 11.1 percent. The national average is 22.4 percent.

Because of their success on this measure, Central Island received the highest possible quality score under the new SNF value-based payment program.

One of our most recent SNFs, Terence Cardinal Cooke in Manhattan, has been able to lower its rehospitalization to single digits after full activation of the Call9 model.

There are 15,600 nursing homes in the U.S. and there are billions of dollars and millions of lives to improve. I, myself, had no way of getting paid for the fee-for-service -- from the fee-for-service system for this type of program, and so we treated 3,500 Medicare patients, losing money on every single one, to be able to give you the data on -- that I just quoted.

It's not just us. I know a lot of health systems, providers, and entrepreneurs who have amazing ideas. But they are in no way incentivized to execute them.

The only existing option for testing models is CMMI. When CMMI is able to succeed, it brings innovation to our patients, which they need.

However, in the startups world we had a saying that in order to learn you need to be flexible and fail fast, fail smartly, fail safely, but also fail inexpensively.

When CMMI doesn't work, it's far from inexpensive.

The other way we can bring innovations to the Medicare program is by lifting 1834(m) of the Social Security Act. The issue is that the fee-for-service schedule does not create value and lifting 1834(m) would not protect us from those fees. Changing fee-for-service is the way that we need to move forward.

Representatives Griffith, Lujan, Smith, Black, and Crowley have already championed a new approach, the RUSH Act of 2018. What this does is allows Medicare to avoid the $20 billion being spent on unnecessary hospitalizations and a novel approach in which providers can have value-based contracting instead of following the fee-for-service schedule. RUSH Act is the tip of the spear creating value-based contracting by supporting a program that has shown to increase quality and decrease costs.

The bill is set up in a way that when savings happen,

providers, nursing homes, and Medicare share in the potential savings. It's also set up in a way that providers get kicked out of the program if they don't save money or increase quality, which is how value-based care should be set up.

You can be the change agent. You can be the reason why we saved Medicare program, not only for the $20 billion being spent on nursing home patients, the billions being spent on unnecessary services every year.

The faster this happens, the less lives are lost and the more money that is saved.

Thank you to the committee and Congressmen Griffith and Lujan for introducing the RUSH Act. It's the first step to bringing value to Medicare.

[The prepared statement of Dr. Peck follows:]

**********INSERT 3**********

Mr. Burgess. Thank you, Dr. Peck.

Dr. Weinstein, you're recognized for five minutes, please.

STATEMENT OF DR. MICHAEL WEINSTEIN

Dr. Weinstein. Chairman Burgess and members of the subcommittee, thank you for inviting me to testify regarding the importance of removing barriers to value-based care in Medicare.

I am Dr. Michael Weinstein, a practicing gastroenterologist and president of Capital Digestive Care, an independent physician practice.

I am also president of the Digestive Health Physicians Association, which represents 78 GI practices across the country.

Independent physician practices provide high quality, accessible care in the community at much lower cost than identical services in the hospital setting, yet value-based arrangements are generally not available to us.

Physician practices are facing increasing challenges competing with mega-hospital systems that are favored by antiquated Medicare law and regulations.

Hospitals recently embarked on a buying spree of physician practices. The number of physicians employed by hospitals increased 50 percent from 2012 to 2015.

This has impacted costs, as hospitals seek to recoup their investments by capturing highly profitable ancillary services.

These are the same designated health services that are regulated by Stark self-referral law. Despite some reforms, significant disparities for high-volume services persist.

For example, Medicare pays nearly twice as much for colonoscopies in the hospital outpatient department as in an ASC. There is no clinical reason that nearly half of the 2.7 million colonoscopies continue to be performed in the more expensive setting.

Policy makers should be doing more to encourage robust competitive market that allows independent practices to compete and deliver value-based care.

Targeted policy changes will improve patient care and lower costs. Congress and CMS must improve the system the develop, evaluate, and approve alternative payment models.

A couple of years ago, CMS projected that 10 to 20 percent of physicians would be enrolled in an APM. Today, that number is just 5 percent.

PTAC was created to facilitate and recommend physician-developed APMs. It has examined 26 APM submissions with five recommended for implementation and six for limited scale testing.

But CMS has yet to implement a single APM recommended by PTAC. Moreover, many stakeholders have refrained from submitting proposals because they cannot test them first.

The Medicare statute permits HHS to waive the Stark and other fraud and abuse laws on a case by case basis only for approved APMs. It does not allow testing.

For example, PTAC recommended for pilot testing Project

Sonar, an APM designed to promote coordinated care for patients with chronic inflammatory bowel disease. But that testing could not occur under the statute without explicit approval of CMS. This means that both clinicians and policy makers lack data to determine if the APM worked or if modifications should be considered.

Also, access to affordable utilization data is needed to model and develop innovative payment arrangements. CMS charges $4,500 for one year of data from the HOPD and ASC setting, making multiple years of trend data cost prohibitive for many.

Deidentified utilization information should be available to the public, researchers, and stakeholders for free on a public website.

The ACA created waivers from the Stark and fraud and abuse laws for ACOs. This creates an uneven playing field for independent practices that would like to participate in value-based arrangements but cannot.

We do not advocate amending the Stark self-referral laws in the context of fee for service. But we do think the law needs to be modernized to encourage participation in APMs.

Explicit prohibitions on remuneration for value or volume make no sense under at-risk arrangements that limit Medicare cost exposure. Practices must be able to incentivize appropriate physician behavior for adherence to recognize treatment pathways. How can Medicare promote value-based care if physicians are

explicitly prohibited for paying for value?

Finally, patients need better and more accessible information about their treatment options. For example, under the law, screen colonoscopy is covered regardless of where it is provided and the patient has no co-pay and patients have no idea that there is a substantial hospital versus ASC cost differential.

Similarly, patients should be able to access uniform quality and patient outcome metrics across sites of service for identical procedures.

Solutions are available and achievable. DHPA has joined 24 other physicians organizations in endorsing the Medicare Care Coordination Improvement Act. That bill would provide the secretary the identical authority to waive statutory impediments for physician-focused APMs as provided to ACOs.

It would also repeal the volume and value prohibitions for physicians participating in APMs and permits testing of formerly submitted models while they are under review by CMS. Enacting such improvements would dramatically increase physician participation in value-based care.

We look forward to working with the committee on these ideas to strengthen the Medicare program, improve patient care, and conserve resources.

Thank you.

[The prepared statement of Dr. Weinstein follows:]

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Mr. Burgess. Thank you, Dr. Weinstein.

Mr. Green, we went ahead with opening statements from the witnesses, and if it's all right with you, we'll conclude our last two and then I will recognize you for an opening statement, if that's agreeable to you.

Mr. Green. Mr. Chairman, I will just submit my opening statement for you and I apologize for being late.

Mr. Burgess. That's not a problem. I know that there's a lot going on today.

Mr. Reed, you're recognized for five minutes for an opening statement, please.

STATEMENT OF MORGAN REED

Mr. Reed. Thank you, Mr. Chairman.

My name is Morgan Reed and I am the president of the App Association and executive director of the Connected Health Initiative -- a coalition of doctors, research universities, patient advocacy groups, and leading mobile health tech companies.

Our organization focuses on clarifying outdated health regulations and encouraging the move to value-based care through the use of digital health tools to improve the lives of patients and their doctors.

Demographics are set to overwhelm the Medicare system with, roughly, 70 million Americans enrolled by 2030. Yet, physicians and their teams are already reporting being overworked and burned out.

Moreover, patients report a high level of frustration with the health care system. It simply takes too long and costs too much. And yet, this is the same world where every person can pay their mortgage, monitor their package delivery, review their child's homework, all while sitting in the waiting room of that very doctor.

What's going on that we can't better engage with patients using the tools every single one of you has in the palm of your hand right now or strapped to your wrist?

Why is it that CMS reimburses nearly a trillion dollars a year, yet can't use those technologies to cover telemedicine in a meaningful way?

Why doesn't the system help doctors use tools that lower administrative burden, allow doctors to treat a patient and not the keyboard?

Well, since I don't want to leave this committee in a state of depression -- a condition, by the way, that has been proven to be treatable using digital patient engagement tools -- I want to lay out what we see as the key questions to be asked and the pathway forward for our sector.

First -- the first question we should always ask in this case is does the policy decision drive value for patients. Medicare beneficiaries -- wait a minute, let's call them what they really are -- people, who live in their districts, or better yet, how about -- let's we call them constituents -- have a simple goal.

They want to be healthy and they want to be independent, and for those with chronic conditions like type 2 diabetes they want treatment to help them stay as healthy as possible for as long as possible. For them, remote monitoring technologies are lifesaving tools.

One of our member companies, Podimetrics, is one such remote monitoring company. They make a foot mat that detects diabetic foot ulcers up to five weeks before they become clinically

present. This tech is not only more efficient than other methods but it also cuts down on hospital bills and ultimately saves limbs. Doctors like it because they stay engaged with the patient. But reimbursement under Medicare remains a question mark.

Second question -- does the policy decision drive value for care givers? We are all familiar with the horror stories from physicians on EHR adoption and the epic burnout we see as a result.

Patients rightfully complain that physicians seem disengaged when they're typing away at a keyboard. Meanwhile, doctors find they must subvert the system by typing asterisks or other characters in a field they don't use.

This not only creates extra work for them but ultimately will prevent entered data from being used predictably as part of machine learning or augmented intelligence systems.

And finally, does it drive value for taxpayers? Taxpayer value comes from a system that incentivizes the right things at the right time.

When it comes to preventative health, this begins with expansion of the CBO scoring window. I want to thank all of you who supported the Preventative Health Savings Act -- H.R. 2953 -- which would expand this window to 10 years. That's a good start. But preventative medicine can do much more.

For example, my friend, Congressman Harper, knows full well that the University of Mississippi Medical Centers' telehealth

program would save the state $189 million in Medicaid if just 20 percent of Mississippi's diabetic population were enrolled.

Just think of the taxpayer savings for the country if CMS supported what UMMC is doing today.

And here are a few actions that Congress and the administration can take to hit the mark. First, Congress should pass the Connect for Health Act -- H.R. 2556 -- to clarify that Medicare covers tech-driven tools that enhance efficiency and clinical efficacy including the removal of the outdated restrictions under 1834(m).

Second, for practices that still use fee-for-service model, CMS should adopt billing codes that cover activities that use patient-generated health data and remote patient monitoring.

CMS has done good work in unbundling CPT Code 9091 and the proposed new code CBCI(1) and CMS should continue to look at the ways that the Digital Medicine Payment Advisory Group can develop future codes that support new technology.

Third, Congress should file down regulations like the Anti-Kickback Statute in the Stark Law to allow providers to get technology into the hands of patients.

And finally, Congress should support the use of unlicensed spectrum, sometimes known as TV White Spaces technology to help cover rural populations so they can have high-speed internet in places traditional carriers don't cover cost effectively.

I want to remind everyone here that we all are or will be

part of the system, either as patient or caregiver. The least we can ask is for the system that treats us and the care teams that see us as real people, not just boxes on the spreadsheet.

Thank you very much.

[The prepared statement of Mr. Reed follows:]

**********INSERT 5**********

Mr. Burgess. Thank you, Mr. Reed.

And Dr. Robertson, you're recognized for five minutes, please.

STATEMENT OF DR. MICHAEL ROBERTSON

Dr. Robertson. Chairman Burgess, Ranking Member Green, and members of the subcommittee, thank you for the opportunity to testify on behalf of the National Association of ACOs.

NAACOS is the largest association of accountable care organizations representing more than 6 million beneficiaries through more than 360 ACOs. I share my perspective as a practising internal medicine physician since 1986 and currently as chief medical officer of Covenant Health Partners and Covenant ACO in Lubbock, Texas.

Covenant Health Partners formed in 2007 and we have had a clinically-integrated network for 11 years now. Through our network we have instituted robust health information technology, contracts for hospital services, and quality metrics for measures like hospital-acquired infections.

We then branched out to commercial contracts and in 2014 made the quantum leap to a three-year Track 1 Medicare Shared Savings Program agreement.

If we had not already had a clinically integrated network in place where we had already done much of the work to get ready for MSSP participation, it is unlikely we'd have made the decision to participate in the MSSP.

It is also important for us that we didn't have to be concerned about taking downside risk since we were in a share

savings only model. We learned that moving to value-based care is a massive undertaking that requires changing the behaviour of multiple providers.

We've had to change physician behavior, hospital behavior, skilled nursing facility behavior, home health agency behavior, and the list goes on.

In looking at our MSSP financial data we came to understand that much of our cost was coming from post-acute care, namely, skilled nursing facilities whose costs are 180 percent higher and home health agencies whose costs were 250 percent higher than national normative data.

We had to work closely with those providers to see costs go down and that took time and effort. By developing and working with providers in our preferred post-acute care network, we eventually got to a place where we have seen quarter by quarter decreases in costs in these areas.

Participation in the MSSP has allowed us to reinvest in technology and infrastructure to manage our patient population. In our first year of participation in the MSSP, we saved Medicare $5 million and our share of that was $2.5 million through the gains sharing arrangement.

We used the bulk of those funds to reinvest in our IT infrastructure and developed a physician dashboard for quality data such as adhering to evidence-based practices for chronic disease management and preventative care like pneumococcal

vaccines and colonoscopy for our patients are displayed.

We also invested in an analyst to review and manage our financial and quality data. One challenge we've had there is that financial data for Medicare is only available on a quarterly basis and then we receive that data some four to six weeks after that.

So any change in our process can be delayed. We also hired care coordinators and invested in software to manage care. We now receive real-time alerts through our care coordination system when our patients arrive at the emergency department that allow us to push a care plan for the patient to the emergency room physician so that he or she isn't working blind and can assist us in providing high-quality cost efficient care.

All of these things take time and money. Pushing too quickly to achieve results and take on risk without giving ample time for providers to develop the necessary infrastructure will mean providers will not participate.

In year one of our Track 3 agreement, we ended up with a small profit. But based on early actuarial work, at one point we thought we would have to repay CMS $1 million to $4 million because that financial reconciliation for the MSSP was is delayed by about eight months after the contract ends.

Had my physician board of directors been told they would even have to pay back $1 million, there's no way that we would have continued participation in the MSSP.

From a provider perspective, it doesn't make sense to assume financial risk to take care of Medicare patients as this entails accepting responsibility for costs the physicians cannot control such as the increasing costs of pharmaceuticals like chemotherapy.

I think CMS has had some very positive changes in the new proposed rule. The expansion of the three-day SNF waiver and the increased stability in the rule are both great improvements.

I do have significant concerns about the speed at which the agency is taking -- is asking people to move to risk though as well as the proposal to cut shared savings from 50 percent to 25 percent.

Two years is not enough time to take on risk. It took us 11 years and we are still hard at it, and the reduced shared savings amount is going to keep providers out of this program because it doesn't allow them to retain enough savings to reinvest in the IT infrastructure and care coordination that is needed to make these programs work.

Furthermore, the limitation of the risk score adjustment between positive 3 percent and minus 3 percent over an entire five-year contractual period will also be harmful as it will penalize physicians financially for taking care of patients who are sicker.

I commend this committee on its work to examine ways to

increase the use of value-based models and arrangements in the Medicare program.

Thank you for the opportunity to testify.

[The prepared statement of Dr. Robertson follows:]

**********INSERT 6**********

Mr. Burgess. And thank you, Dr. Robertson, and thanks to all of our witnesses for spending time with us this afternoon.

Mr. Green, I will once again offer to recognize you for an opening statement. If not, we'll go directly to questions.

Mr. Green. I think we'll go directly, and I ask unanimous consent to place my statement into the record.

Mr. Burgess. And without objection, so ordered, and --

[The information follows:]

**********COMMITTEE INSERT 7**********

Mr. Green. I will share it with all of you all. You can read it on the way home.

[Laughter.]

Mr. Burgess. The chair would remind all members that all members' opening statements will be made part of the record, filed following Mr. Green's missive.

So I will recognize myself five minutes for questions and, Dr. Weinstein, thank you for being here. You represent I guess what we would describe as independent physicians. Is that a fair assessment?

Dr. Weinstein. Yes, independent gastroenterologists -- about 1,900 across the country.

Mr. Burgess. So you raised the issue of independent physicians -- the difficulty they might have in accessing the alternative payment model and being able to participate in that.

Could you just kind of go over what are the major obstacles for the independent physician to be -- to be able to participate in an APM -- an alternative payment model?

Dr. Weinstein. Yes, certainly. Thank you.

Independent physicians, particularly specialty -- sub-specialty physicians take care of chronic disease. We don't do primary care. We are used when a patient needs a particular service or has a particular disease.

So in APMs -- in a standard ACO type APM, we are technicians,

in general. But an independent practice like ours takes care of a lot of patients with chronic inflammatory bowel disease, chronic liver disease. These are very high cost, high beta, high variable cost patients that generally are managed -- even their primary care is managed by gastroenterologists.

In developing an alternative payment model for inflammatory bowel disease, we grouped. Our association got together and used actuaries, did some data -- did the data analytics using our own data to determine what a model to take care of patients over a long period of time would be.

Project Sonar is a -- was that APM. It was actually the first APM presented to PTAC when PTAC started. It received a tentative approval for testing and then got stuck. It does use technology to engage patients in their own care to -- so that we could do outreach and try and identify patients before they show up in the emergency room, before they show up in the hospital.

So the difficulties in developing that APM, obviously, there was a cost burden in getting the actuarial data. There was an inability to test to model because of the Stark prohibitions and then not knowing how to modify it, obviously, it makes it difficult.

So we are sort of shut out of APMs as gastroenterologists because we don't have any alternative payment models that we can participate as independent physicians.

But we are very willing to invest in the technology to do

that.

Mr. Burgess. Sure. If we can overcome some of those obstacles and those obstacles would be what you just delineated. I may get back to you in a written question form about PTAC because I've got a particular sensitivity to that. PTAC was a creation of, basically, this subcommittee a couple Congresses ago and, conceptually, PTAC was there so that physicians would be back in charge of quality metrics as opposed to leaving that all up to the agency.

So it is very important to me the PTAC work and I am discouraged to hear that you're having trouble. So I may follow up with you on that because I do feel that it's such an important concept.

But Dr. Anand, let me just ask you, in moving to downside risk models to allow a system like Adventist to integrate independent physicians into your networks, is that a possibility?

Dr. Anand. Great question, Mr. Chairman.

From a philosophical perspective, two-thirds of our clinically integrated networks are independent physicians, and so we have always approached the -- with the philosophy that we want to have the best clinicians to be part of our networks.

Sometimes it's the best employed physician. Sometimes it's the best independent. But we hold ourselves to high standards. We want physicians who are going to be focused on quality at the best experience at an efficient cost.

So with that, as we transition into the post-MACRA world and the -- being part of an advanced APM becomes more important to our independent physicians, we've seen that as a great way for us who are in a Medicare shared savings model to align with our physicians who are going to be either subject to a penalty or a possibility of a bonus in the MIPS program or, alternatively, who are interested in taking more holistic care in moving towards an advanced APM model.

So MACRA is one of the big opportunities that's going to allow us to partner with their physicians. Too, taking downside risk allows us to coordinate care more across the continuum with the waivers that are present, with the ability to bring in more components of the delivery system.

We talked a lot about post-acute. We talked about our specialists. Bringing all those providers together in the -- and some are going to be independent, some will be academic, some will be employed -- that's going to allow us to coordinate care more holistically.

It's also going to allow us to share tools and technologies to achieve that coordination -- sometimes apps, sometimes EMR-integrated tools that are going to be part of it. There's an upside potential that could also be -- if the ACO is successful that's also going to be an attractive component for the physicians as well. So there's several components. In my mind, I think the MACRA component, especially as we transition into the later

years of the MACRA model into the advanced APM model I think there's going to be a lot of synergies with that -- with independent physicians.

Mr. Burgess. And I just want to address for you, since you brought up the interoperability title of 21st Century Cures, the oversight of the implementation of 21st Century Cures has been front and center in front of this subcommittee because the scientific aspects, the FDA NIH aspects. There was actually a mental health title.

So we've had separate hearings on both of those and the third, of course, was the interoperability title, which I thought deserved its own oversight or its own subcommittee implementation hearing. Because of the delay from the rule coming from the office of the national coordinator I was actually talked into postponing that last June.

In retrospect, perhaps we should have pushed again with the hearing. But and, obviously, we are up against some other things in the calendar which you may have heard about in the papers.

But at some point this year, I intend to have that interoperability title implementation hearing that you said would be critical for you.

Mr. Green, I recognize you five minutes for your questions, please.

Mr. Green. Thank you, Mr. Chairman, and I thank you for

your effort to make the system work.

Dr. Weinstein, about two weeks ago I was invited to speak to the gastroenterologists in Houston, Texas, and I was surprised after I got up and talked about MACRA and how we are trying to stay attuned to it as members of Congress, watching what the agency does.

At the end of it, which is not usual, I didn't have any questions at all. So I wasn't sure that the physicians were aware of what's going on.

Have you seen that? And that's not just one specialty. That was just one I happened to speak to a while back.

Dr. Weinstein. You know, I think the largest physician groups around the country have their ears to the ground as to what's happening with MACRA and MIPS. In a gastroenterology practice it's unfortunate that there really isn't a way for us to participate in APMs and we are looking at having to implement MIPS, which is a very expensive way to gather data and a very inefficient way to gather data and yet it has never been proven to help patient care.

So I think groups know -- smaller groups, I think, are unaware of what's happening. I am not sure --

Mr. Green. Although in the Houston area we should have a whole lot of gastroenterologists.

Dr. Weinstein. There's some very large groups in Houston. I am familiar with a couple of them.

Mr. Green. Okay.

Dr. Robertson, welcome to our committee. The chair is from north Texas. I am from Houston, and, obviously, we speak the same language, coming from Lubbock.

Can you speak for a little more on your organization's initial decision to transition in the ACO model and why this model was the best fit for your organization?

I think you answered some of that. You were already on that road that you thought the ACO would work.

Dr. Robertson. We were on the road because we had already gone into Track 1 in 2014. We were making a decision as to whether we wanted to participate another three years in Track 1 or move to a different model when a law called MACRA became on our horizon, and like many things in life, timing is everything.

This was fortuitous timing. We looked and the more we began to discover about MACRA, the more we knew we wanted to be qualifying providers under an advanced APM as opposed to being thrown in the briar patch of MIPS. The positive and negative variations in reimbursement under the MIPS systems is going to be very disruptive for physician practices, especially small physician practices.

Our ACO has a large employee medical group in it that's owned by Covenant Health. But 50 percent of our organization is composed of independent physicians, which are just one- or two-person groups.

The amount of money that has to be put into that to make those folks work under a MIPS system is horribly expensive and together, collectively, we thought that we could do better if we were in a risk-bearing program. We'd already had some experience under Track 1.

We saw what we could do from a quality perspective and we had been decreasing the amount of spend. The difference is, though, is the way they calculate your financial benchmarks under Track 3. Totally different than Track 1, and we really didn't have a good understanding of that when we entered into Track 3. So that's made that a little bit problematic for us.

Mr. Green. Going from what you were, what type of infrastructure changes and provider education and training did your organization undertake to implement the ACO model? Was it -- from where you went to what you're doing now?

Dr. Robertson. You know, we started in 2007 and initially just took commercial contracts. But we started then developing a way of showing physicians their individual performance. Every physician believes that they are the world's greatest physician and they provide absolutely good quality care.

The problem is our system is so broken that it encourages just transactional care. You're there for 15 minutes and then good luck to you, or you get to the hospital dismissal driveway -- good luck to you.

Doing this requires you to think differently. You own that

patient 365 days a year, 24 hours a day, and you have to have access to some data to help you understand where the spend is occurring and then you have to invest not only in IT systems to show physicians how they're performing but you have to hire a lot of people to help patients do things that you need for them to do.

You can't imagine that a patient is going to be able to take everything you tell them in a 15-minute visit. Our care coordinators can move out into the community with them, help them stay on track, help them set goals for self-care, and provide them some other opportunities to find medications that we sometimes prescribe that we have no idea are so expensive and get them access to the medications they need at a better price.

Mr. Green. Well, you know, our committee -- I've been on the committee since 1997 and it's, like, I got so tired of hearing about how bad the SGR was and that's why this committee wants to stay on top of it because the last thing we want to do is recreate the problems physicians had under the SGR, and that's why I appreciate the whole panel to be here.

By the way, my son-in-law is a gastroenterologist and my daughter is in infectious disease so and they do think they can cure everything.

[Laughter.]

Mr. Burgess. They probably can.

Mr. Green. And I am glad they can.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman.

The chair recognizes the gentleman from Kentucky, Mr. Guthrie, the vice chairman of the subcommittee, five minutes for your questions, please.

Mr. Guthrie. Thank you very much, and the first one -- question is for Mr. Reed, and I think I wrote it down. I was trying to write as you were saying it but I am not that quick.

But you talked about making changes and you said in your testimony make changes in the Stark and anti-kickback laws in order to get the technology in the hands of patients. I think that's pretty accurate what you said.

How does the anti-kickback statute prevent providers from giving patients the tools that may help them, and if we update the statutes how do we effectively protect against fraud and abuse?

Mr. Reed. Well, I think that's -- I think that's at the core of the question and I was very pleased to hear several other folks of this panel talk about the fact that the way that, especially in the ACO space, that it works is, as I understand it, if a physician group wants to provide technology to the hand of -- into the hands of a patient for remote patient monitoring or other patient engagement that might have -- part of it would be a referral that it kicks into a consideration under the anti-kickback.

The problem with that is that the very tool that I might put into the hands of a patient, a tablet like this one or anything like that, that I am going to use to gather data on the patient, I am going to want to necessitate a referral if one of the things that shows up from the evidence that I am collecting on that patient says, hey, they need to see a gastroenterologist.

And so the moment that I do that I am in trouble with the law. As far as where the fraud lies, the reality is the fact of remote patient monitoring and digital services it's a whole lot easier to monitor exactly what the use of that -- what the use of that device is doing, what it's entailing, how long it's used for.

In fact, the very data that we need to show effectiveness is also going to be very useful to demonstrating that it's not being used fraudulently.

So we think that removing that barrier for good recommendations to good gastroenterologists or infectious disease specialists like Mr. Green's daughter are the kind of tools that we need to make available, and the idea that a patient is now limited because I can't give them the tech that they need, that's just crazy.

Mr. Guthrie. I don't disagree with you.

So, Dr. Peck, so how are health care apps and telehealth services changing the nation's health care access? Sort of mentioned here, and how do we encourage telehealth, from our

perspective?

Dr. Peck. Thank you.

In terms of the apps question and technology, I do agree that there is the component that whenever I suggest to have an app in the hands of a patient, when they start to use it if it does generate the idea that they now need to see another physician that can cause a lot of problems in terms of self-referral.

So but moving into telemedicine, there's a lot of talk of 1834 and of Social Security Act, and lifting that. I would like to make the point that lifting that in 1834(m) seems to be a plug into the hole that fee-for-service Medicare beneficiary program has created for itself.

Because smaller companies, startups, innovations even of larger companies and of health care systems don't have a way necessarily to value-based contract with Medicare directly, they have no way to get paid for innovative programs that are outside the fee-for-service schedule.

If you have something that's innovative, new, better, cheaper, faster, and brings higher quality, well, that's perfect for value-based care.

So why can't we have a provider contract with Medicare? CMMI is one of the ways to do that. But, again, this is a long, arduous, expensive, and not very flexible process.

The RUSH Act, which I talked about, was introduced and the RUSH Act works for nursing homes but I want to broaden that out.

I think what's important about the RUSH Act, when you take a look at it, is that has this value-based arrangement idea with Medicare.

It allows the providers, the doctors, the nursing homes who are housing the patients, and Medicare to all share in any savings that are generated.

And then there's down side risk as well.

Mr. Guthrie. I've only got about 30 seconds. To anybody on the panel, so we are talking about Medicare -- with Medicare here and how difficult it is to innovate and change things.

Are you seeing in private -- when you're dealing with private health insurance and others?

Dr. Peck. I am talking about Medicare.

Mr. Guthrie. I know you are, but are you -- do you see it in your private world it's quicker to adapt and you're seeing these changes?

Dr. Peck. Yes.

Mr. Guthrie. So that we would lose these changes if we just went to pure Medicare for everybody?

Mr. Reed. Absolutely. There are problems on the innovation side, and here's one of the problems.

As we noted earlier, it's a trillion dollars. So anyone, any venture capitalist, when our members are looking at raising money, the VC is going to ask, well, what's the total addressable market, and when you have to describe that one-third of your total

addressable market is Medicare and Medicaid, the next question is so how do we get paid out of that system.

So when you look at 1834(m) as a plug that prevents -- and I am going to do something unheard of -- I am going to say something nice about a government agency -- CMS has actually done some good things lately to try to break free of where 1834(m) has been preventing forward progress.

But to your direct question, even though in the private sector there are ways around Medicare and Medicaid reimbursement, there's a trillion dollars of addressable market there that any wise venture capitalist is going to say how do we get to it, and with barrier like 1834(m) it's staving off our ability to move into that space.

So yes, it harms our ability on the Medicare and Medicaid side, and yes, it harms our ability to grow our businesses to cover more people.

Mr. Guthrie. Thanks. I am out of time. I yield back.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back.

The chair recognizes the gentleman from New Mexico, Mr. Lujan, five minutes for your questions, please.

Mr. Lujan. Mr. Chairman, thank you so very much for this important hearing and I want to thank our ranking member, Mr. Green, as well.

I would also like to acknowledge Chairman Walden and Ranking

Member Pallone for looking at how telehealth services can be used to improve access to quality care, to save patients and Medicare time, energy, and money.

Dr. Peck, you point out in your testimony that if skilled nursing facilities across the country are to implement telehealth services to scale then something needs to change within the billing system.

The skilled nursing facility value-based purchasing program authorized by the Protecting Access to Medicare Act is shifting Medicare's reimbursement for skilled nursing facilities to a value-based system.

SNFs are now evaluated on a hospital readmission measure that provides incentive payments to encourage SNFs to keep patients healthy.

Dr. Peck, how does Call9 and models like Call9 affect nursing homes' performance under this new reimbursement system?

Dr. Peck. Thank you for that question.

The new reimbursement system and models like Call9 that decrease hospitalizations -- unnecessary and avoidable hospitalizations -- increases the payments to nursing homes and rewarding them for that good behavior.

And I would mention in my testimony that one of our first nursing homes just finally got their value-based score and they were in the -- they are receiving a large bonus from that.

What that program doesn't do is incentivize the providers

-- the physician groups who are delivering that care. That program does give the bonus to the nursing home itself but not to the -- the providers, the doctors.

So it's a good program and I think it will help a lot and incentivize a lot of nursing homes to reduce hospitalizations but leaving out the physician groups.

Mr. Lujan. I appreciate that very much, especially in light of your testimony and the testimony of others that found that 19 percent of transfers to the emergency department are from skilled nursing facilities -- one in five.

You mentioned in your testimony that Call9 model uses additional clinical staff to complement the nursing home staff. Can you elaborate on how the Call9 staff work with nursing homes to treat patients?

Dr. Peck. Certainly. So our particular model we place first responders. These, by training, are EMTs, paramedics. They can be nurses with emergency experience -- CD techs.

What unites them all is that they understand emergencies and acute care. I think this is a key point. A broader point is that bringing -- what we do is we bring the emergency department to the nursing home in this way with the physician who is remote in this onsite.

Nurses in nursing homes are great at chronic care. That's what they do, and if they -- if the nursing homes had faculties and staff that could take care of emergencies, we wouldn't have

19 percent of the patients going to emergency department coming from nursing homes.

So what we do is put the emergency care in there to supplement but not -- and complement, excuse me, but not supplement what they do -- not replace what they do.

Mr. Lujan. Many members of the subcommittee worked on recent provisions to expand telehealth reimbursement for telestroke, end-stage renal disease, accountable care organizations, and Medicare Advantage plans.

Dr. Peck, how does the RUSH Act build on this successful legislation?

Dr. Peck. Right. So all of those legislations help address the CBO issue of the CBO scoring telehealth as -- usually as an additive program. The reason for this is they count it as a duplicative measure.

Telestroke -- I will key in on that one -- end-stage renal disease, we can key on that as well. It's very hard to make more strokes. It's very hard to make more sessions of dialysis every week for a patient.

So it controls itself in terms of the volume that's there and that lends itself perfectly to value-based arrangements and value-based contracting.

Our model is working with emergencies. It's very hard to rack up new emergencies and make more emergencies out of thin air. So when you have that kind of cap on a certain condition

I think that's a nice place to start to focus on to start to chip away at bringing value into Medicare.

Mr. Lujan. And the requirements under the RUSH Act speak to additional workforce. What qualifications will these people have and is there a way to train existing staff to accomplish the same goal or is there value to bringing in a new person?

Dr. Peck. Yes, I think there is ways to have existing staff become more trained in emergencies, have more skills for emergency medicine, be more comfortable in CPR type settings.

However, I do believe it's important to have additional staff if you're going to retain patients in a nursing home and more patients who are sick. Having the existing staff there and not augmenting with another person I think will take away from the care of the rest of the patients who don't have emergencies.

Mr. Lujan. I appreciate that. Thank you, Mr. Chairman.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back.

The chair recognizes the gentleman from Ohio, Mr. Latta, five minutes for your questions, please.

Mr. Latta. Thanks, Mr. Chair, and to our panel today, thanks very much for being here on this very important topic.

If I could start, Dr. Anand, with you. Do medical professionals or health practice of health practices face barriers, regulatory or otherwise, to adopt new technologies?

Dr. Anand. Yes, great question. So I think we've alluded

to several comments on the barriers that we face. One is related to being able to financially support the costs that go into implementing new technologies and tools.

With our independent physicians, when I was in Texas the average practice size was about one and a half for the independent physicians. Some places are a little bit larger.

But independent physicians don't have the capital in order to be able to make those purchases. When you're in an ACO construct and you apply the Stark waiver and the Stark exemptions, you can now, as a system, come together and allow them to access those tools and technologies and apply it across their patients.

The challenge we find is those tools and technologies, and it's a question that we've struggled with, is can you apply those tools and technologies only for Medicare beneficiaries or apply them broader, more widely, across all of the patients or the provider panel that the patients -- that they see.

And that's been a big struggle for us. We'd love to see the Stark waiver expanded and, in an ACO structure, provided at the provider level because as clinicians we can't sort out who's in which program and, you know, when a member is in another program.

We can use this tool and technology that's going to change care for this patient but we can't use it in that other patient situation.

So those are some of the challenges that we face. I think

if we could, in the ACO construct, we are coordinating care basically -- provide these tools and technologies and allow them to use those tools and technologies for all of their patients I think we'd be in a much better situation.

Mr. Latta. Let me ask you this -- just follow up on that. You're talking about your -- the independent practitioners out there. Would that also -- these barriers be disproportionately affecting small and rural providers because -- who could benefit quite a bit from telemedicine?

Dr. Anand. We do. In our health system we have several markets that are in rural markets. We have one in Asheville, North Carolina -- a campus that's there. We also have one in Manchester, Kentucky, and in those setting what we are finding is it's becoming harder and harder to have specialists and particular services provided in those markets.

Now, in our system, we have a great skill set and great number of specialists in our Orlando market and we would love to be able to provide that cognitive expertise to those folks in Manchester, Kentucky, as an example.

The reimbursement models we struggle with we'd love to be able to support the providers that are providing primary care services with the specialists that we have.

And so we struggle again with the Stark rules that go with it. But rural services, at least in my opinion, are going to continue to be harder to come by, especially with specialty

services, and when we have these large centers that can provide those services if we could figure out a way through the Stark exemption and payment models to transpose that cognitive skill to those markets our beneficiaries will be able to get much better care.

Mr. Latta. Well, if you look at the -- what we could do in Congress, what would you like to see us do specifically?

Dr. Anand. You know, I think if we could do two things -- one is allow us in certain -- especially rural markets and critical access and hospitals that don't have access to larger partnerships -- allow us to provide those tools and technologies through a Stark exemption.

Number two is if we could figure out a payment model where we could reward those services and cover some of the infrastructure costs that go with it I think that would allow us to be able to provide that service on a larger scale and, again, it would allow better access for beneficiaries and the patients that live in those smaller rural areas.

Mr. Latta. Mr. Reed, with my last minute I have, I am a firm believer that data has the power to spur change and data allows us to recognize important trends and patterns that, in turn, influences decision making and ultimately finds solutions.

How could Congress reduce these barriers to sharing health and patient data without compromising that patient privacy?

Mr. Reed. Well, it's a great question and, of course, it's

always good to remember that the P in HIPAA stands for portability, and I think that's at the core of where we stand.

We would urge Congress to do everything in your power to address what Dr. Burgess said earlier and that is let's see ONC's report on info blocking, because ultimately, as we are moving into this space where data has to be available and interoperable, we know that the only way to get a patient the solution that they need is to find out what's wrong with them, and the more data that all of these gentlemen here at this table, and Mary, can have, the better chance we have of correctly identifying the disease and, more importantly, getting you the right treatment at the right time.

So, first of all, we need to do better on interoperability. Second, we need to continue to push forward on finding the right terms and glossaries so that the notes fields, which are a key aspect of how a doctor communicates your story, not just your test results, becomes part of a record that can be used by every single person at this table. And so it starts with ONC. Let's see what they have to say.

Mr. Latta. Thank you very much.

Mr. Chairman, my time is expired and I yield back.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back.

The chair now is pleased to recognize the gentleman from Virginia, Mr. Griffith, five minutes for your questions, please.

Mr. Griffith. Thank you very much, Mr. Chairman.

First, before I do that, I have a letter that has been sent in support of the RUSH Act, which Dr. Peck was so kind to make nice comments about earlier that Mr. Lujan and I of this committee have signed onto along with a number of others, including Adrian Smith. But I have a letter, without objection, if we could submit that for the record.

Mr. Burgess. Without objection, so ordered.

[The information follows:]

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Mr. Griffith. We'll get that down to you. All right, I appreciate that.

And, Dr. Peck, again, thank you for your kind comments on the bill and I know we've got a lot more to do, and this just gets us started and you made some comments in that regard as well.

You also mentioned in your testimony that Call9 treats 80 percent of the patients you see in the nursing home versus transferring them to the emergency department.

How do you interact with the other 20 percent of patients that are still transferred to the emergency department?

Dr. Peck. It's a great question. That's where we get to save a lot of lives that otherwise wouldn't be saved. That's why I left my job as a traditional emergency physician. Someone took my job as an emergency physician after I left, right.

But these patients who we can't get to in their moment of emergency in these nursing homes they otherwise would be pulseless. They otherwise would be having very severe problems.

But with our program and other programs in nursing homes we can get to them at that point, and the average -- when you put all the numbers together after you call 911 it takes about 64 minutes including the wait to see an emergency physician. If you're pulseless, across the country that can be 36 minutes. So yeah, being with people at the moment of emergency saves lives.

Mr. Griffith. And that's very good. But I guess I am trying

to figure out, okay, what happens once they go off to the emergency room? You have decided that you all can't take care of it and you're getting 80 percent of them right there in the nursing home -- they never have to make that trip and, as you describe in your opening statement, with the bright lights that are confusing and the long wait and the ride in the -- in the back of a van. I mean, it's an ambulance. But when you're sick and not feeling well, it's just the back of a van.

Dr. Peck. Yes. Yes.

Mr. Griffith. So what -- how are you able to continue to interact with that 20 percent that's at the hospital?

Dr. Peck. Right, and we talk a lot about interoperability and pushing data over, and writing -- even being able to write notes in the same language that an emergency department needs to see and streamlining the data transfer is where there's a lot of opportunity to help those patients. Yes.

Mr. Griffith. All right.

And in your testimony, you stated that Call9 currently operates in 10 nursing homes in New York -- and this was in your written testimony -- but has not spread to more rural areas.

Yet, how would Medicare's reimbursement of technology-enabled care deliver models -- excuse me, delivery models allow for these models to reach more rural areas?

Dr. Peck. Yes. So right now, we are dependent on the Medicare Advantage and commercial payers to be able to make this

happen. So we have to go to areas where those MA penetrations is as high as possible, which is usually urban areas as well as larger nursing homes where there's more MA patients.

So we can't possibly go to smaller nursing homes or Medicare-heavy nursing homes right now. We would lose the company.

Mr. Griffith. Now, you said Medicare heavy. What about Medicaid-heavy nursing homes?

Dr. Peck. So -- right, so Medicaid patients -- long-term care Medicaid patients are usually dual eligible for the most part because they're over 65 for the most part, or disabled for the most part. So Part B is where these payments are coming from, not from the Medicaid program.

Mr. Griffith. Okay. I appreciate that.

You know, representing a fairly rural not affluent district, this is one of the reasons that I am pushing for these ideas because my constituents deserve to get just as good a care as those folks in the urban areas or in the wealthier areas.

Let's see if I have time to get one more in.

Dr. Peck, one issue policy makers have faced in advancing telehealth legislation is the lack of data, and I know everybody's talked about data, but the lack of that data on the effects of telehealth on actual Medicare beneficiaries, this is a hard barrier to overcome because without reimbursement for providing these services to Medicare beneficiaries there are few who are

going to be able to take the financial loss to build enough meaningful data.

How can Congress continue to support entrepreneurs in generating these meaningful data points?

Dr. Peck. Yes, it's vehicles to be able to get these models through after they're proven, the PTAC being one of those. We have held back our PTAC application at this point until we understand more about what the program intends to do.

We also see this opportunity -- the RUSH Act as the tip of the spear to be able to have Congress directly allow Medicare to contract with startups and entrepreneurs and innovative programs.

We need those on the -- on that side to be able for me, as an entrepreneur, to go to the venture community and raise money. They're not going to give it to me unless there's a way to make return on that investment.

Mr. Griffith. Right. Well, I appreciate it and appreciate all of you all being here. This is an important subject and I look forward to working with all of you as we move forward.

I yield back.

Dr. Peck. Thank you.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back.

The chair recognizes the gentlelady from California, Ms. Matsui, five minutes for questions, please.

Ms. Matsui. Thank you, Mr. Chairman. I want to thank the witnesses for joining us today. I am pleased that we are hosting this hearing to discuss how we transition towards rewarding value over volume in our health care system.

Thanks to the Affordable Care Act, the MACRA providers today have more opportunities than ever before to redesign how they deliver care to their patients.

Moving to value-based care is important. But we can't lose sight of the importance of the Stark Law in protecting the Medicare program from waste, fraud, and abuse.

Although a shift to value-based care may require re-examination of certain policies, the self-referral laws continue to serve an important purpose.

It is important to differentiate between changes to Start Law that would lead to more value-based payment models and coordinated care and changes that would gut the intention of Stark and allow the pay for play at the expense of patients.

Several of you note that the secretary has authority to waive the Stark Law for innovative value-based arrangements.

Mr. Reed, your testimony notes that you believe that HHS has clear authority to provide exceptions to the Stark Law. Can you expand on what steps you believe the secretary can take to modernize Stark to encourage high quality value-based care?

Mr. Reed. Well, I think you have heard from the multiplicity of the witness perspectives here that essentially the secretary

needs to look at the Stark and a kickback -- Stark and any kickback from the perspective of what is your ultimate goal.

You said the ultimate goal is to make sure that we don't have waste, fraud, and abuse. I would posit the primary goal of Medicare is to make sure that people over the age of 65 have the kind of care that helps them stay healthy and be independent.

And so when I look at it from the perspective of what is the capability of the -- of the secretary to waive, you used some key words, which was innovative technologies that can help improve the outcome.

And so I think that with each request for an exception I think it falls under the -- under that waiver authority. But I also would note that we have to be very careful with waiver authorities to something that Mr. -- Dr. Peck said earlier, which is when it only happens every year enough to renew, it makes it quite difficult when you sit down with a venture capitalist and your new board to say our entire business model is dependent on our hope that a kickback -- a waiver will continue to the next year.

Ms. Matsui. Yes.

Mr. Reed. And while we are not only bidden to the VC community, it does -- we have limited resources. It changes where you focus your time and energy if you have that possibility hanging over your head.

So I would like the waiver to be exercised on those innovative

technologies but in a manner in which allows us to really build and grow them and not just worrying about --

Ms. Matsui. Okay.

Mr. Reed. -- where there might be an over use.

Ms. Matsui. Okay. Now, I want to get into telehealth, because over the years a group of us on Energy and Commerce have worked together to advance the adoption and use of Telemedicine.

As CMS implements MACRA, we want to make sure that the new health technologies are integrated into new models of care from the start.

And, Mr. Reed, in MACRA Congress intended for telehealth and remote monitoring to be rewarded within the MIPS clinical practice improvement activities.

Can you comment on CMS' recent efforts to support and expand the use of these services?

Mr. Reed. Absolutely. We are very pleased that the MIPS program included IA activities. Especially, we think it's very important that they allowed for small practices to see their number -- to get an appropriate reward for engaging with their patients when it comes to using telemedicine and remote patient monitoring products.

I think what's really important though is for the parts that you're mentioning, which are critical, and are worthy of note, we don't think we should forget the fact that the APMs -- that there was no mention of remote patient monitoring as part of the

APMs --

Ms. Matsui. Right.

Mr. Reed. -- and I think it's important to note that, from our perspective, we appreciate what you have been doing both as a cosponsor of Connect for Health and as a cosponsor for the evidence-based Telemedicine -- Telehealth Expansion Act.

So we appreciate the work you have done in this space and we think that that all needs to be continued.

Ms. Matsui. Okay. Now, as CMS continues implementing MACRA, in what ways should Congress be thinking of program oversight with regards to promoting the use of telehealth and remote monitoring services?

Mr. Reed. Evidence. I mean, that's the real -- that's the real crux of this issue. We always take the perspective that every physician -- and the whole system has three real questions: does it work, will I be in trouble for using it, and then, finally, does it make economic sense.

And so that first question of evidence becomes critical. You have heard multiple people here talk about CMMI. I think it's ironic that CMMI -- we met with CMMI the other day. Love them, great people over there. But they told us, hey, we are going to move really fast and get this study out in 10 years.

[Laughter.]

Ms. Matsui. Okay.

Mr. Reed. Just recently all of you know that 10 years ago

there were no smart phones.

Ms. Matsui. That's right.

Mr. Reed. That's when that started. So and we are looking at the evidence that we need to bring to the fore. We cannot wait for CMMI and a 10-year study that hopefully shows how it all works.

We are going to have to use other sectors.

Ms. Matsui. Okay.

Well, thank you, and I've ran out of time so I yield back.

Mr. Guthrie. [Presiding.] Thank you, and I appreciate the gentlelady for yielding back and the chair now recognizes Mr. Bilirakis from Florida for five minutes for questions.

Mr. Bilirakis. Thank you, Mr. Chairman. I appreciate it very much and I thank the panel for their testimony today.

Dr. Anand, thank you for being here and I have a couple questions for you.

Adventist Health System has a sizeable -- as you know, a sizeable presence in Florida. You stated that earlier, and throughout the Tampa Bay area -- and I represent parts of the Tampa Bay area -- I want to commend you also for making such improvements -- tremendous improvements to Florida Hospital North Pinellas, which is my hometown hospital, and the community has really rallied around the hospital. So thank you so very much. A wonderful place.

Dr. Anand, how many of your doctors are involved in and how

many independent physicians are part of your accountable care organization?

Dr. Anand. Great question. When you look at the state of Florida, we've set up one accountable care organization that serves approximately 55,000 Medicare beneficiaries.

When you add our ACOs and our clinically integrated networks in the state of Florida, we have approximately 3,900 physicians of which two-thirds are independent physicians.

We partner with them in the Tampa market, for example. You know, the numbers may vary a little bit but that statistic -- about two-thirds holds pretty true.

Mr. Bilirakis. Okay. You have set up again and operate a number of ACOs. Is that correct? And where exactly in Florida? Is that at the Orlando area or is that in several hospitals in the Tampa Bay area?

Dr. Anand. Good question.

So what we've done, in order to help improve the care in Florida we've actually set up one statewide Medicare shared savings program -- one ACO -- that encompasses the whole area.

It starts -- it's in the Tampa market, goes into the Orlando market, brings together providers from the Daytona, Volusia, Flagler, Highlands, Hardee County. In the future, we'll actually be part of it as well.

And so what we are hoping to do is starting to bring together an improvement model where we can actually improve the care and

wellbeing of all the patients in Florida.

Mr. Bilirakis. Very good. Very good.

What makes your ACO unique when compared to other ACOs and how has your ACO been successful? How has it been successful in reducing costs and increasing outcomes?

Dr. Anand. Great question.

Mr. Bilirakis. Increasing outcomes -- that's the bottom line -- the quality of care. But go ahead, please, sir.

Dr. Anand. Great question.

So let me tackle the first question -- what makes our ACO different.

Mr. Bilirakis. Yes.

Dr. Anand. So from a organizational perspective, we fundamentally believe in holistic care. We believe that medical care is a small portion of the overall health and wellbeing of our patients and beneficiaries.

And so we focus on things that affect their social determinants of health -- their mental wellbeing, their spiritual wellbeing, some of their financial issues that we have.

And so we really take a holistic picture and approach to improving the health and wellbeing of those patients. The literature has confirmed over and over that when you apply that holistic approach you're going to get better health outcomes.

If you come and treat the emergency medicine physician as well -- if you treat the patient in the emergency department and

then they go off and they don't have the services that they need, they will be back in the emergency department over and over again.

And so that's been one of the fundamental approaches from the beginning is that we want to make sure we incorporate all of those elements into --

Mr. Bilirakis. Cost reduction is a factor as well.

Dr. Anand. Correct. From a -- from a cost reduction perspective, we focused on where the variation lies in care and there is tremendous variation as you go from region to region as well as provider to provider.

And what we do is we help provide the tools, the technology, the data, the analytics that empowers physicians to have the information that they need to provide the best level of care.

We are looking at pathways related to issues such as back pain where we can actually provide interventions and treatments that are going to make a lasting improvement such as physical therapy, rather than just going straight to surgical therapy, which may not improve outcomes initially.

Mr. Bilirakis. I like that.

Can you talk about some of the challenges you face in structuring your particular ACO when dealing with the Stark Law?

Dr. Anand. Yes. We -- that's a great question.

So we've had -- we had several challenges with the Stark Law. I think we've covered a lot. But just to summarize, if it was permanent I think that would be a big help.

Two, there's a lot of questions about the applicability of the Stark waivers for all patients. Some of our providers have 10 Medicare beneficiaries. Some of them have Medicaid beneficiaries.

Some of them have a hundred or 1,500 Medicare beneficiaries and what we would like to do is actually see the Stark waivers apply down at the provider level so that the provider doesn't have to realize that this patient is a Medicare beneficiary that's in an ACO program. This Medicare beneficiary is not -- this other one may be, but we are not quite sure right now.

It's too hard to operationalize from a physician perspective and so we'd like the Stark Law to apply to provider level. If we can do that, we can coordinate care effectively because we have the pathways. We know what the clinical pathways are and we can share it with the physicians and allow them to provide the best care.

The tools and technologies that we've talked about we have those available and we'd love to be able to share them with the physicians. But we still have confusion on if they can share it with just -- and use them just on their Medicare beneficiaries or if they can use it on all patients.

And so we love the direction that the committee is headed. We'd like to see an expansion in those particular instances.

Mr. Bilirakis. Very good.

Thank you very much, Mr. Chairman. I yield back.

Mr. Guthrie. The gentleman yields back.

The Chair now recognizes Mr. Long from Missouri for five minutes for questions.

Mr. Long. Thank you, Mr. Chairman.

And Mr. Reed, in your testimony you talk about the value telehealth can have for taxpayers. You state that evidence from practitioners contradicts the often overstated fears that telehealth could lead to a bonanza of over utilization.

Instead, telehealth could substitute for otherwise more expensive health care services. Could you talk about what the evidence has shown so far on the cost savings that telehealth could produce?

Mr. Reed. Absolutely, and I know it's a rival state but the also great state of Mississippi has done some amazing work with telemedicine and remote patient monitoring, particularly in the area of type 2 diabetes care.

What you see out of the University of Mississippi Medical center is an effort to directly engage with patients, particularly in the Delta, who have no care or no facility or an originating site within two hours.

It was crushing the state economically. But by putting a Tablet in the hands of folks at home with the necessary high-speed connection that exists in those areas what changed was the nurse practitioner could notice, hmm, your blood glucose is kind of high -- let's get on the phone. Oh, it was a family reunion?

Okay, stay off the pecan pie for the next week -- let's get that down.

And so what you saw is you didn't see an over utilization. What you saw was a stoppage of the kind of danger symptoms that went on. So instead of that person ending up on the pathway to blindness, on the pathway to losing a leg, you saw them engaging with a nurse, maybe with a little nagging, to say hey, back off that -- don't have that second piece -- let's get you in for a test.

So when you think of it in very simple terms, you're right -- maybe telemedicine means that they go have a face to face visit.

But if that face to face visit is a conversation about how they stay healthy, that's a whole lot cheaper than a face to face visit that results in an amputation or a -- or blindness or a treatment that they'll never recover from.

So I am okay with telemedicine leading to a lot of physician engagement because it's the kind of engagement that keeps people on the front side of the wave and not the back.

Mr. Long. So that's where the savings comes in then?

Mr. Reed. Absolutely.

Mr. Long. So how long would it take these cost savings to materialize?

Mr. Reed. Well, here's what's amazing. In states like Mississippi and in other places, they've seen 100 percent

reduction in readmissions in certain types of type 2 diabetic problems and they've had those -- they've had those results in a matter of two to three years.

So a lot of it is what kind of nurses you have -- we've had a lot of discussion about skilled nursing -- what kind of nurses you have and what elements you have to engage.

But we are not talking about a decade to see an improvement. We are talking about a short matter of years, depending on the condition and where that -- and where those people are in terms of their education.

Mr. Long. Okay. When you're talking about that they're using telehealth and monitoring their type 2 diabetes -- their glucose monitor, I guess, or whatever -- so these people are pricking their finger at home and then relaying to the nurse or practitioner, doctor --

Mr. Reed. Yes.

Mr. Long. -- over the iPad? Is that correct?

Mr. Reed. That's correct, and here's the part that's really good. It isn't just that that result goes. It's not passive. They put that result in. They get information and feedback on how they're doing.

The most dangerous thing, and I know every physician here knows, is a passive patient. A patient who's engaged in their care, they're on top of it. When they see that number on that iPad, they say to themselves, well, how does that look. Oh, it

doesn't look good -- what did I do. And then the nurse calls up and says hey, I didn't -- I didn't like what you're seeing, and here's the really good part. What if they're doing a great job? What if that is a great number?

Mr. Long. More pecan pie.

Mr. Reed. That's right. But more importantly, then that pecan pie -- what's even better, though -- what's even better is the next step -- the next step is the nurse calls up and says, you're doing a great job, and that creates an active engaged patient. That's where your savings come from. That's what eliminates people. You know, we are talking about numbers here but we are also talking about lives and quality of life. So it's important that we deal with the numbers but let's never forget about the people that are involved here.

Thank you.

Mr. Long. How do we ensure the long-term savings from telehealth are factored in beyond a 10-year window?

Mr. Reed. Well, I think that's something we've all been talking about here on the move that you and I believe your cosponsor on the Preventative Health Savings Act to try to move that ONC window.

I think that realistically, given the speed of technology -- like I said, there were no smartphones 10 years ago and then now none of you would ever be without three -- away from three feet from your smart phone.

So think what you have to look at is let's get -- let's extend the 10-year window but then let's also be cognizant of the fact that we are probably going to see some major shifts in the way that people are engaged in their daily lives with technology.

There's this concept that tech is just about kids. That's not true. Any of you have grandkids? I bet you you FaceTime with your grandkids on your -- on your mobile device.

If you think about where adults over the age of 65 are with technology it's a myth that people over 65 can't tech because they can tech just fine.

Mr. Long. And these new watches that Apple rolled out yesterday with the telehealth applications on there.

Mr. Reed. Correct.

Mr. Long. Pretty amazing stuff of what they -- I can't remember the CEO's name. Is it Cook now? Or whatever, but rolled out yesterday.

Mr. Reed. I will be happy to come by and show you one on September 22nd, I think.

Mr. Long. Okay. Very good. Thank you, Mr. Chairman. I yield back.

Mr. Burgess. [Presiding.] Chair thanks the gentleman. The gentleman yields back.

The chair recognizes the gentleman from Georgia, Mr. Carter, five minutes for your questions, please.

Mr. Carter. Thank you, Mr. Chairman, and thank all of you

for being here. This is certainly a very important hearing.

I want to start with you, Dr. Weinstein.

Full disclosure -- before I became a member of Congress I was an independent retail pharmacist so I appreciate independent health care practices.

You know, when I talk to my colleagues about the problems that we are having hanging on to independent retail pharmacies they think I am only talking about independent retail pharmacies. But I am not. I am talking about independent health care practices.

That's -- that, to me, is a real big problem here and one of the things I wanted to ask you to begin with is I am really troubled to hear that you're having trouble with -- that your practice is having trouble with participating in some of these cost-saving arrangements with Medicare because of the outdated CMS policies.

And I just wanted to ask you what do you think are some of the -- some of the advantages that perhaps the big hospital systems have over you, being an independent practice? Can you think right off of some?

Dr. Weinstein. Well, you know, hospital systems are really just people. So, you know, the big hospital systems -- I guess you might say that for the really complex tertiary care -- complicated surgical infectious -- somebody with a multi-system disease needing multi specialists, obviously -- hospital systems

are important.

But many of the diseases that we take care of are really isolated to gastroenterology or maybe gastroenterology and surgery. So one or two specialties, and that is -- the idea is to be able to get to those people, engage those patients before they need major hospitalization.

Mr. Carter. Right. Right.

Dr. Weinstein. That's where the savings is, and engaging those patients. I mean, the Project Sonar that I mentioned before, which was, you know, tentatively approved by PTAC but then didn't move forward, is a technology engagement with patients to determine how they're doing on a -- on a basis where they might ignore symptoms from time to time and engage them before they get to a hospital.

So there is certainly need for hospital systems for the very acutely sick. But the majority of patients, hopefully, can avoid hospitals.

Mr. Carter. Absolutely. Well, thank you and good luck. I am pulling for you. Trust me.

Dr. Weinstein. Thank you.

Mr. Carter. Mr. Reed, I want to go to you because I've very interested in this. I've had a company in my office that -- and help me to articulate this because I suspect you know about it better than I do.

But they are -- they're coming to Georgia now and they are

involved -- they have an app that they've created because in Georgia right now it takes three weeks on average to get an appointment with a primary care physician and in some areas, particularly in the area that I represent -- south Georgia, a very rural area -- it may take even longer to get that.

Well, they've come out with an app that can take advantage of cancelled -- cancellations or changes in a schedule and you can use that app but they're telling me that the only way they can bill for it outside of the private pay -- the only way they can bill for it for the Medicare patients is if they do it by flat fee and they want to do it on a per usage basis. Again, I am sure you understand that much better than me. But the rules are so antiquated that they can't do it.

Mr. Reed. That's correct. You know, I had my staff, prior to this hearing, poll through my written testimony and come up with a glossary of 44 different acronyms that I used -- just from my testimony -- and I am pretty sure that everybody here has the same number -- but that really represents the status that your company in the great state of Georgia is dealing with.

The problem that they face is they also get completely differing answers. For example, on the one you're talking about, when you look to share that information on an application like that on how you bill, you have got to deal with a couple of different systems, not only from an interoperability perspective but also how do you do the data sharing.

Right now, they can do a flat fee that somebody pays but if you try to do a per physician basis pay, there's no mechanism by which it processes through the Medicare or Medicaid system.

So they're really stuck out there in the fee-for-service or private payer model and it makes no sense because, as you say, when somebody drops off of an appointment that they can't get to, especially in areas like yours with a health care professional shortage area, this is the exact time that you want somebody to say hey, I need that patient, and as I said at the beginning, this demographic problem is only going to get worse, not better.

So when it come to the model, we really don't see MACRA and -- and I am sorry, we don't see CMS really providing pathways for those kind of innovative products at all.

Mr. Carter. Okay. Okay. Well, I see I am out of time. Thank you, and I yield back.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back.

The chair recognizes the gentleman from Indiana, Dr. Bucshon, five minutes for questions, please.

Mr. Bucshon. Thank you, Mr. Chairman.

Dr. Weinstein, can you talk about the challenges in developing and testing an APM like Project Sonar and also do you think that the current volume and value prohibitions in the Stark Law make it difficult to test APMs?

Dr. Weinstein. I do. Thank you for the question.

The problem with APMs in developing care pathways and determining how you're going to share the care of a patient, potentially, with other physicians outside of the convener, whether -- if the convener is an independent physician, if the convener is even a hospital system -- if you're going to interrelate with other physicians then you can't test that to see whether the technology communication is correct, whether the in-patient engagement is correct. You can't share the data because you will buck up against certain Stark regulations.

So if you -- it would be great to be able to test an APM all the outcomes, the technology that's needed, in a way that you are -- before you get to PTAC to know whether or not the -- before you get to a PTAC decision once the application is submitted and the current regulations don't allow you to test.

So, hopefully, I answered --

Mr. Bucshon. You did. I mean, it's pretty clear there are Stark and anti-kickback problems that are making it difficult. The Medicare Coordination Improvement Act, which I've introduced with my Democrat colleague, Dr. Ruiz, would allow practices legitimately developing and implementing an APM to essentially be exempt through waivers from these provisions.

Do you think this would encourage more practices to develop APMs?

Dr. Weinstein. I do. I think when we've polled, at least

in the Digestive Health Physicians Association, I think these very large groups are very interested in modelling opportunities to take care of patients under lower cost/better outcome care.

They've built the infrastructure to be able to do that. They're willing to take risk to do that. So I think more people would be willing to look into other diseases, not just inflammatory bowel disease but chronic liver disease and such, and thank you for submitting that bill.

Mr. Bucshon. You're welcome.

I yield back, Mr. Chairman.

Mr. Burgess. The chair thanks the gentleman.

The chair recognizes the gentleman from Illinois, Mr. Shimkus, five minutes for questions, please.

Mr. Shimkus. Thank you, Mr. Chairman.

I apologize for not being here. I've learned everything about forestry services, wildfires, prescribed burns, and the health effects of wildfires in the air. So that's where I've been the last two hours.

We wanted to get up here to make sure we, you know, set the records for some public policy. So some of the questions that I had have already been answered through the question and answer period. But I want to state that promoting greater value within our health care system is a worthy goal and I strongly support efforts to promote value-based models within our Medicare program and throughout our health care system. But current progress has

been slow.

As elected officials, we need to find ways to increase the value opportunities in the Medicare program to address issues of program solvency and improve the patient experience, both for beneficiaries and, just as important, their loved ones.

Reforms that empower all health care entities to engage in value-based reforms can lead to meaningful value for all, unleashing private sector innovations within the program at a time when our benefits to care and programmatic spending are sorely needed.

As this committee considers opportunities to promote value-based models, I recommend we consider two things. One is to explore opportunities to support all stakeholders -- patient, payers, manufacturers, vendors, and providers -- to enter in a and benefit from participating in value arguments -- arrangements; ensure that any reforms that are in this area are implemented in ways that ensure patient care and program spending are protected.

Medicare beneficiaries and taxpayers should benefit from our efforts, not be hurt by them. Hence, your discussion and debate, which I missed a lot of, on the anti-kickback statutes, the Stark Laws, and the like.

Also -- you also talked about, obviously, the patient care and the protection of the taxpayers -- spending.

So, Mr. Chairman and Ranking Member Green, although he's

not here -- we see the Honorable Congresswoman Matsui in his place -- I firmly believe that legislative approaches in this area should empower all Medicare entities to drive value throughout the program, ensure that beneficiary care and program spending are protected, and promote opportunities for beneficiaries to directly benefit from these reforms.

That's why I've asked my staff to begin developing legislation that creates avenues for all stakeholders -- patients, providers, payers, manufacturers, and others to enter into and succeed in value-based health care models throughout the Medicare program, not just within the constraints of CMMI.

I hope to work with you, Mr. Chairman and Ranking Member Green, and my colleagues on both sides of the aisle in developing an advocacy of such an approach.

Mr. Chairman, I would like to enter into the record a letter in support of the legislative efforts by the Breaking Down Barriers to Payment and Delivery System Reform Alliance and a letter from Advocate Aurora Health containing comments filed with CMS in response to its request for information regarding physician self-referral.

Mr. Burgess. Without objection, so ordered.

[The information follows:]

**********COMMITTEE INSERT 9**********

Mr. Shimkus. And with that --

Mr. Griffith. Would the gentleman yield?

Mr. Shimkus. I will yield.

Mr. Griffith. You know, Mr. Reed has talked about how we didn't have smart phones 10 years ago and the beauty of this is is that while our nursing homes might not be able to use telemedicine, you can go back and watch all the testimony later via your smart phone.

Mr. Shimkus. And you don't think I've done that?

Mr. Griffith. I don't you have done it yet. I think you will do it on the way home.

Mr. Shimkus. You bet. Thank you, and I yield back my time.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back.

I believe that all the members of the subcommittee have been recognized for questions and we'll now recognize Mr. Ruiz of California, who's not on the subcommittee but has presented himself here, and you're recognized five minutes for questions, please.

Mr. Ruiz. Great. Thanks for letting me sit in here and listen to this wonderful presentation and also this very -- participate in this very important conversation.

I was pleased to partner with my colleague and fellow physician, Congressman Bucshon, to introduce H.R. 4206, the Medicare Care Coordination Improvement Act, which would modernize

Stark Laws to make it easier for physician practices to successfully develop alternative payment models, or APMs, incentivized in MACRA, and it will also incentivize us to fully reach a value-based payment model that the ACA encourages.

I believe that Stark Law is important but it needs to be tweaked because currently physician practices are hampered from fully and successfully participating in APMs.

So the Stark Law was created to help curb some of the quantity-based payment models that we have developed in the past and oftentimes this Stark Law prevents physicians from referring to other physicians that they know in a medical home model-based in order to achieve a value-based payment model, which we want to move towards.

So we need to update and we need to tweak it so that we can encourage a value-based payment model and alternative payment model.

So this bill will give CMS the authority to give a narrow exception to Stark just for the time that the APM is being developed, which is the same waiver authority that was given to ACOs in the ACA.

So, Dr. Weinstein, thank you for being here today and for your testimony in support of this legislation. In your testimony, you referenced the slow pace at which independent physicians have been developing alternative payment models.

I am also concerned that in order for MACRA to succeed, we

need to break down barriers encourage more innovation and care delivery models to be put forward.

Can you give us a specific example of how, if we are able to pass this narrow exemption, an independent gastroenterology group like yours could improve patient care for your patients?

Dr. Weinstein. Again, thank you for the question and thank you for sponsoring -- submitting the bill.

As a specific example, we want to be able to reward physician behavior for following better care pathways and as opposed to just performing individual services.

So if I am going to work with a surgeon and I want to work with a particular surgeon in our -- in an APM for dealing with inflammatory bowel disease, then I want to reward that surgeon for following the care pathways to lower the cost of care.

If I am doing that then -- if I am rewarding him for value, for better outcomes, well, that actually flies in the face of some of the language of the original Stark Laws.

And I said it in my testimony -- we are not in favor of removing Stark prohibitions on fee-for-service standard, you know, self-referral, and things like that. That has nothing to do with modernizing the Stark rule for an alternative payment model, a model where groups of physicians -- independent physicians -- are sharing risk in managing a better outcome for a patient and in doing that in a way that does not violate the Stark Laws.

Mr. Ruiz. Thank you. I yield back.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back.

Seeing that there are no further members to ask questions, Mr. Reed, I do want to just point out you have graciously mentioned several times today the Public Health Savings Act -- the bill that I introduced with Diane DeGette some time ago -- actually, several Congresses ago -- and I had actually hoped to have a hearing on that before we concluded this year, just like it's -- it's on the list just like the data blocking bill from the Office of National Coordinator.

But it is an extremely important concept to be able to look for preventative health care at a wider window than the 10-year typical budgetary window that the Congressional Budget Office allows.

So I thank you for bringing that up and I am going to use that as additional gas in the tank to see if we can't get that hearing structured.

Mr. Reed. No, we'd love to help you gain more cosponsors. Thank you.

Mr. Burgess. Thank you.

Well, seeing that there are no other members wishing to ask questions, I do again want to thank our witnesses.

I do want to submit the following documents for the record from Advo Med, from the College of information -- I am sorry,

from the College of Healthcare Information Management Executives, Cancer Treatment Centers of America, National Association of Chain Drugs Stores, Medtronic, the American Society for Gastrointestinal Endoscopy, and Jeff Lemieux and Joel White article in "Health Affairs."

[The information follows:]

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

Mr. Burgess. Pursuant to committee rules, I remind members they have 10 business days to submit additional questions for the record and I ask the witnesses to submit their responses within 10 business days upon receipt of those questions.

And without objection, the subcommittee is adjourned.

[Whereupon, at 3:16 p.m., the committee was adjourned.]