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"Examining Barriers to Expanding Innovative, Value-Based Care in Medicare"

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Good morning Chairman Burgess, Ranking member Green and members of the Subcommittee. My name is Dr. Nishant Anand. I serve at Adventist Health System as the Chief Medical Officer for Population Health Services and the Chief Transformation Officer. We have 46 hospital facilities located across nine states, serving four million people every year. Specific to Florida, where I am based, our largest hospital, Florida Hospital Orlando, is the largest single site Medicare provider and the second largest Medicaid provider in the nation. Our patients reflect the communities we serve in; diverse in age, race, ethnicity, income and payor. We treat everyone. Our Population Health Services Organization (PHSO) exists to guide and support our larger health system in its adoption of transformative, value-based integrative health care models. We have Accountable Care Organization (ACO) arrangements in Kansas, North Carolina, and most recently Florida, where we have 55,000 beneficiaries in our Medicare Shared Savings Program (MSSP) ACO. In all our ACOs and Clinical Integrated Networks (CINs) we serve more than 400,000 individuals. Additionally, we will participate in the Bundled Payment Care Improvement Advanced (BPCI-A) model later this fall and have been successfully participating in the Comprehensive Joint Replacement bundled payment model.

Today, I am speaking to you as a senior leader at Adventist Health System, an organization that is committed to our patients' health journey over their lifetime and the well-being of our communities at

large. We focus on the proactive, not just the reactive parts of health care with the goal of intervening before disease or illness occurs.

I also speak to you as a board-certified ER physician and as a health care professional who has led value transformations at other health systems. At Memorial Hermann Health System, in Houston, Texas, I ran their MSSP ACO, one of the highest performing ACOs in the country. At Banner Health Network, in Phoenix, Arizona, I helped transition the delivery system to a model supporting population health as a Pioneer ACO. Throughout my career, I have experienced not only the positive impact that a value-based system can have on patients' lives, but also the barriers that block providers from realizing the full potential of value-based care. I believe there are ways that we can change the delivery model that will enable us to reach more lives more effectively. We can improve the health and well-being of our seniors, but only together.

Across the nation, we are going through different stages of health care transformation. Starting with the Affordable Care Act, Medicare began the transition to a value-based payment system, through the development of ACOs and value-based quality payment programs. Now, as health care providers grapple with a post-MACRA world, and the evolving payment models, we are in a position and have begun focusing on redesigning the delivery of care to embrace value and focus where the opportunities lie. We know where to improve the health and well-being or our seniors. This can be done in four non-sequential steps.

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

Second, we can expand shared technology enablement services. To build a truly effective and high functioning network, providers must have a single, or multiple connected, Electronic Medical Records (EMRs). This will enable providers to know their patients and design pathways across physician

practices and hospitals. Moreover, providers need access to tools to help them do their job with greater ease and accuracy—telemedicine, clinical support tools, and referral solutions, for example.

Third, we can develop common operational workflows. As we continue our journey towards value, we have developed and honed new workflows that we believe are designed for effective care delivery. However, we can only implement these workflows with our beneficiaries within value-based models (e.g. ACOs). Knowing this is the best care we can deliver, we would like to extend these workflows to all Medicare and Medicaid beneficiaries, not just those connected to value-based models.

Fourth, we can implement clinical pathways across the continuum of care. With a focus on prevention, standard clinical pathways can lead to positive outcomes, and hopefully avoid unnecessary high-intensity, high-cost services.

I believe that these four opportunities will help us realize value-based health care. However, there are barriers that impede our ability to effectively redesign the delivery of care to embrace value. These barriers are as follows:

1. **The Stark Law needs modernization.** The Stark Law was developed in a reimbursement world that paid providers based on the volume of services. As CMS and Congress look to shift the financial risk of health care delivery into the provider community, as we collectively move toward value, the Stark Law is an impediment. I am not an attorney and cannot speak to the complexity of the law, but as a physician, I experience the shortcomings and challenges of Stark Law in real-life. ACOs come together, not with the intent to self-refer, but with the intent to coordinate care in a highly effective manner. Moreover, as I seek to transform our care delivery model, I work with our attorneys who continue to hit roadblocks as we work to develop high-performing networks.

2. **Payment incentives in value-based models, like ACOs, must be aligned with value.** The current structure of ACOs make it very difficult for providers to engage in value-based

arrangements. The model structure and financial incentives must enable and encourage provider participation, not stand in their way.

3. **Real-life operational challenges that make it difficult for providers to participate in value-based arrangements must be addressed.** There are real challenges that we face regarding interoperability, sharing enabling technology with our physicians and navigating the care of our patients.

Only when we address these challenges head on will we empower and enable providers to successfully embrace value-based health care delivery. This document will expand on the four opportunities that I believe are before us, explore the barriers that impede a faster transition to value, and provide ideas on potential solutions.

Opportunities to Embrace Value

Developing High-Performing Networks

Developing and effectively managing high-performing networks is key to value-based care. A high-performing network is a highly coordinated, comprehensive model of care. This includes acute, post-acute, ambulatory and wellness services. This requires highly aligned physicians and may include the creation of CINs that align goals and incentives. Scale and size are needed to successfully engage physicians in providing wholistic care. However, it is very difficult for physicians to achieve the necessary size and scale, while only focusing on certain value-based arrangement beneficiaries. Often, physicians engaging in a single value-based payment model will struggle to have more than a handful of beneficiaries connected to the alternative payment model within their overall patient base. Moreover, taking care of patients wholistically requires additional time and efforts that are not rewarded in today's payment world. In fact, it is penalized. This can be addressed through a payment reform model that exists in some commercial payer arrangements.

As we build networks we need to be able to refer our patients to the quality providers that make up our network—in particular, to specialists. If we can refer patients into these high functioning networks, then we will see better outcomes, more coordinated and less duplicative care, lower cost and a better patient experience.

Shared Technology Enablement Services

As networks of providers are created through ACOs, providers must engage with their patients and one another more effectively and efficiently. Providers must have the ability to easily share patient information across and between different providers. Moreover, we need to be able to equip caregivers with technology that will enable them to do their job with more accuracy, efficiency and ease. This is especially true in small physician practices that may not be able to obtain these technologies or support their use by themselves.

Interoperability, a world in which information is shared and transferred seamlessly, will enable more consumer-centered care and provide new possibilities in clinical care delivery. This requires diverse EMRs that are seamlessly connected. At Adventist Health System, approximately two thirds of the physicians that we work with across our CIN and ACO are independent. That means we are simultaneously navigating over thirty different EMR platforms. This makes it increasingly difficult to share patient information between the providers that make up our network. The result is a consumer experience that is difficult and cumbersome, tests and treatments that are duplicated, and vital lifesaving information that is not always available.

Common Operation Workflows

We are encouraged that both Congress and the Administration share our goals to transform health care and continue to drive a value-based care agenda. To help us on this journey, we participate in the Premier Healthcare Alliance's Population Health Management Collaborative. As part of this collaborative, we can analyze and benchmark clinical and claims data with peers; receive clinical and

strategic support from national experts; as well as learn from and share insights and best practices with many other organizations participating in alternative payment models to improve performance.

This experience guides the development of operational workflows that help us care for and navigate our patients through their health journey. We are on the journey towards value-based care because we believe it is best for our patients. However, we are unable to utilize these operational workflows on patients that are not in our value-based arrangements. Physicians struggle to operationalize two workflows. To embrace value, we must be able to develop and implement common operation workflows with the patient in mind. If physicians have tools and technology at their disposal to navigate patients on their care journey, we want to help all our patients, not just those in a value-based delivery model.

From a providers' perspective, we believe that increased accountability for quality and cost is a critical component of the transformation that we are seeking in health care. Payment reform is a fundamental and essential component of change. There is, however, a delicate balance between pushing providers to risk and pushing them away from making needed changes. The movement to value involves significant changes in health care delivery in the opposite direction of the fee-for-service system's incentives that rewards care that is reactive, duplicative, and uncoordinated.

Clinical Pathways Across the Continuum of Care.

Clinical Pathways are medical best practices designed to reduce variation, improve quality of care and maximize the outcomes for our patients. While we have made great strides in developing standard Clinical Pathways in the medical field, I believe there is a real opportunity to develop Clinical Pathways that are rooted in preventative medicine. By doing so, we can provide our patients with the best chance of a positive outcome, and hopefully avoid unnecessary high-intensity, high-cost services. We must focus on prevention and not reaction. Only when we focus on preventing the disease from even starting and design a health care and payment delivery system that incentivizes providers to prevent disease, will we ever

truly realize value in health care. Historically, preventative care was not specifically reimbursed. The nation will need to be more attentive about creating prevention incentives if this important pathway to bend the cost curve is to succeed.

Regulatory Barriers that Impede Value

To realize value—through the creation of high-functioning networks, shared enabling technology, developing common workflows and standard clinical pathways—we need your help. There are existing barriers that impede our ability to provide a truly value-based delivery system.

Stark Law Modernization

For example, the Stark Law was enacted with the intent to regulate financial arrangements among physicians (or their immediate family members) and certain health care providers. The Stark Law is highly complex and has created a minefield for the health care industry due to its huge financial penalty risks and its unclear provisions. These risks result in health care providers avoiding value-based arrangements.

Congress recognized the challenges that Stark Law creates by authorizing the Secretary of HHS with the authority to issue regulatory waivers for new models of care, such as MSSP. The very existence of these waivers demonstrates that providers need relief from the Stark Law to participate in value-based payment models. The problem is that these waivers are issued program-by-program and are not permanent. Additionally, confusion between federal and state statutes continue to persist and providers need clarity to understand the limits of what can be done.

Adventist Health System has been part of the Healthcare Coalition for Stark Reform, and recently submitted comments to The Centers for Medicare and Medicaid Services in response to the Request for Information Regarding the Physician Self-Referral Law. Our comments provide much greater depth on

our position and thoughts on how we can modernize the Stark Law to enable more providers to engage in value-based delivery models.

Align Payment Model Incentives

As Alternative Payment Models are developed, it is critical that we ensure that the incentives of each model are aligned with value-based care delivery. We are concerned that policies contained in CMS's recently released proposed redesign of the MSSP, if finalized, would discourage organizations from participating in value-based care. As we describe below, we are most concerned with the current benchmark standards, the lack of risk adjustment, and the 25% limit to shared savings payments.

First, the existing financial benchmarks make it financially prohibitive to transition to a two-sided risk model and will deter providers from participating in the program. If a provider is in an efficient market, the benchmarks are set much more aggressively. If the benchmarks do not provide room for improvement, allowing providers to transition towards value-based care delivery over time, providers will not participate. We must find a way to adjust for the regional variations across the country.

Second, benchmarks must take into consideration risk adjustment for social determinants of health to ensure that the financial expenditure benchmarks more accurately reflect the underlying health status of the ACO's population.

Third, CMS is also proposing to limit shared savings payments to 25% percent of the total, down from the current 50%. Shared savings payments are critical as part of the transformation toward value-based care and are necessary for our Adventist Health System ACO to continue to make the infrastructure investments needed to transform our processes and care delivery. A lower shared savings rate means we will have less to reinvest into population management and care coordination. Coupled with the aggressive progression to risk, this low savings rate provides little incentive for ACOs to join the MSSP and does not support a sound business plan for organizations to stay in the model. It would be unfortunate to slow the

movement to value by establishing an ACO model where the business model fails to offer a sufficient return to cover the investment costs.

Fourth, the proposed timeline to spur providers into two-sided risk does not take into consideration the reality of many providers. The journey towards accountable care is long, requiring organizations to fundamentally change their operations through new legal structures, alter staffing, adopt new technologies, engage in more robust data analytics, and alter structures with an emphasis on ambulatory care rather than inpatient care. Providers must also address the opportunity costs associated with seeking to reduce inpatient admissions and shift care to lower paying sites of service. These changes have not happened overnight, and organizations need time to make them before taking on significant financial risk.

Lastly, we are uncertain where these shared savings programs will end up. By design, the targets get more difficult to hit each year. If we can design a path to Medicare Advantage or an analogous program, that would give us a destination to work towards and make investments for.

Operational Challenges

As providers build high-functioning, high-performing networks, challenges remain in operationalizing care delivery models.

Interoperability

I believe that efforts to achieve interoperability should be centered on the patient. As patients navigate throughout the continuum of care—through physician offices, hospitals, same-day surgery centers, or community clinics—their records should be easily transferrable between all organizations. In an ideal state of interoperability, patients would not be placed under the burden of having to seek their medical records from different providers.

One of the greatest challenges to achieve this level of interoperability is the lack of a single patient identifier that can move from system to system and ensure records can be passed between disparate entities without fail. The lack of a national patient identifier makes it difficult for data to be exchanged seamlessly between organizations. Regardless of the electronic system, there will always be variability in the registration and data entry processes at each organization. This will prevent the health care industry from achieving full positive identity matching.

Moreover, EHR systems are expensive and there is a lack of competition with, what are essentially, monolithic EHR systems. We believe that the federal government has an important role to play in addressing these issues and advancing reforms that will improve the interoperability of EHR data by taking the following steps:

- The Office of the National Coordinator for Health IT (ONC) should designate an open Application Programming Interface (API) standard(s) for EHRs (i.e., FHIR; CDS hooks) to ensure that APIs are implemented consistently and to ensure fair market adoption and implementation across EHR platforms.

- Providers must be able to connect any third-party application (conformant to the recognized standard API and successor standards) of their choosing to their EHR.

- Providers must be able to use third party applications (conformant to the recognized standard API and successor standards) without obtaining "permission" from or pre-registering the application with their EHR vendor.

- APIs should support bulk data extract and real-time data update/exchange.

- EHR vendors should not put limits on the data extracted or the frequency of data requests.

- Certified EHR vendors should be required to disclose all known material limitations (such as fees or costs) associated with their API's functionality and app integration services and capabilities.

By taking these steps, ONC will facilitate the development of applications that can provide clinical decision support and other tools that providers can use to improve the quality and cost effectiveness of care. It will also enable the exchange of data between different EHR systems.

Enabling Provider Technology to Physicians in Independent Practice

To truly partner with our employed, as well as private practice, physicians, we want to share technology enabled services. As the volume of data and information becomes available, clinical support tools help physicians sort through enormous amounts of digital data to suggest evidence-based next steps for treatment. As technology advances, telemedicine can help skilled specialists connect with rural patients who otherwise have very limited access. Technology enabled services can bolster our physicians to embrace value-based delivery principles and models. For example, we are piloting a physician referral system at a sub-set of our hospitals. With a CIN or ACO, I believe I can implement this referral system to help our clinicians guide our patients to the right setting of care at the right price to meet their needs. I know this tool will help us make better decisions for patient care that will ultimately lead to better outcomes and lower cost. However, we are not confident that we can share this tool with physicians outside of our CIN and ACO, even though we believe it will help them deliver better care. Even if we are not taking risk, we want to do the right things for our patients and there is not clarity on whether or not we can.

Care Navigation

Value-based models have specific waivers (i.e. anti-referral) to enable physicians to engage differently with their patients. These waivers are very important to physicians. However, waivers only apply to Medicare beneficiaries attributed to us in our given ACO. The reality is that not all patients in a physician's panel are part of a single, or any, value-based payment model. If, for example, a physician has a panel of 1000 and only 10 patients are part of a value-based model, it is very difficult to regularly

identify and engage with the 10 patients differently than all the other patients. When it comes to the ACO waivers, it is difficult for a physician to know who is covered and who is not. It is critically important that waivers be extended to all Medicare and Medicaid beneficiaries treated by a physician so that when a patient comes into one of our facilities or office practices, we can coordinate and navigate their care across our network. Physicians find it difficult to operationalize treating patients differently. By attributing value-based delivery to the provider and not the patient, we can ensure that providers focus on what should be their primary focus—their patients.

In a value-based delivery model, all health providers are centered on the shared goal of positive patient outcomes. This requires access to high-quality providers. In our ACO and CINs we partner with 2684[1] independent physicians to collectively serve our patients. We diligently work to ensure that we partner with the best providers in our region, regardless of whether they are in independent private practice or in an employment arrangement. Knowing that our providers are the best chance for our patients' success, we want to refer patients within these high functioning networks. We believe we will see better outcomes and lower cost.

A patient's choice of provider may result in a patient choosing a low-quality provider, such as one that has higher rates of readmission or infection. In a value-based world, providers are at risk for patient outcomes and total cost of the care provided. This risk goes beyond the hospital walls and across the post-acute setting. Therefore, care management plays an increasingly important role; helping guide a patient across this continuum of providers, ensuring that our patients receive the best care in the best and least expensive setting. To do that in a meaningful way, we need to direct our patients more intentionally to the right providers. When health systems are investing in high-performing provider networks to be successful at value-based delivery models, we are painstakingly working to ensure that our partnerships are with the highest-preforming providers.

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[1] As of July 2018

Conclusion

In health care and payment delivery reform, we can focus on short-term, medium-term or long-term efforts. Today, we often focus on short-term improvement. That is, a concentration on complex patients with multiple chronic conditions. Yes, this will lead to better outcomes for this specific population group and lower cost in the immediate time, but what if we looked to medium-term efforts? Focusing on chronic conditions, such as diabetes, that may take 10 years to materialize. I believe we would see a longer return in both patient outcomes and lower costs. But if we were to focus on prevention, I believe that would be a game changer. This requires more work up front from clinicians and more testing to get to the root cause of the problem. But the downstream effects are dramatic.

In summary, I would ask your indulgence to consider a deeper dive into value-based reforms that will accelerate this journey that we are on. To build high performing networks, we must be able to assist physicians who are in solo or small practices make the investment in tools and technologies. To share technology enablement services with providers, we must overcome the barriers to interoperability. To develop common operation workflow, ACOs must be operationalized to enable physicians to focus on patient care, not on administration. And if we are to implement clinical pathways rooted in prevention, we must redesign our reimbursement system to reward providers for preventing disease, not just treating it. To achieve this, we must modernize the regulatory environment that currently slows providers down on their journey towards value-based health care delivery.

We in the health care delivery industry are ready to go faster but need additional help with payment reform focusing on wholistic case as well 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 beneficiaries. I thank you for your time and interest.