

Statement of
Jeffrey Bailet, MD
Chair - Physician-Focused Payment Technical Advisory Committee
And
Elizabeth Mitchell
Vice Chair – Physician-Focused Payment Technical Advisory Committee
on
Medicare Access and CHIP Reauthorization Act of 2015: Examining Physician Efforts to
Prepare for Medicare Payment Reforms
before the
Subcommittee on Health
of the
Committee on Energy and Commerce of the U.S. House of Representatives
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Chairman Burgess, Ranking Member Green and distinguished members of the Energy and Commerce Subcommittee on Health, thank you for the opportunity to testify on behalf of the Chair and Vice Chair of the Physician Focused Payment Technical Advisory Committee (PTAC). We are Jeffrey Bailet, Executive Vice President of Health Care Quality and Affordability at Blue Shield of California (BSC), the third largest nonprofit health plan in California, insuring 4.1 million members and Elizabeth Mitchell, CEO of the Network for Regional Health Improvement (NRHI), a national network of multi-stakeholder Regional Health Improvement Collaboratives with over 30 members across the US. As an Otolaryngologist - Head & Neck surgeon and as a BSC Executive Vice President, I am responsible for leading all medically related activities for the health plan including quality, medical and network management, provider contracting and relations and our Accountable Care Organization (ACO) strategy. As the CEO of NRHI, I am responsible for leading our members and state-affiliated partners working at the state and regional level to transform care and payment toward the goals

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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