The Honorable Joseph R. Pitts

1. **Do you believe the threat of the SGR slowed efforts of physician organizations to develop alternative care models? Can you explain?**

   Yes, the unpredictability caused by the SGR and the need to craft a "doc fix" every year stymied physician efforts to fully embrace value-based alternative payment and delivery models. Every year the pending expiration of SGR created a cloud of uncertainty hanging over practitioners across the nation who were forced to try to deal with the constant threat of drastic reductions in Medicare physician payment. Thanks to the Committee on Energy and Commerce's leadership for taking action to address this seemingly never-ending problem by passing MACRA, physicians can now turn their focus and attention away from the annual threat of Medicare cuts and direct their full efforts to improving the quality of patient care through care redesign, more effectively managing chronic illness and making the necessary infrastructure changes needed to be successful with the implementation of MIPS and alternative payment models. The new payment system provides stability as well as necessary incentives to move toward payment and delivery models that improve care for patients. MACRA was a milestone in Medicare physician payment policy by driving value-based care through existing programs and new payment models. However, physicians and other stakeholders must continue a robust dialogue with Congress and CMS to ensure this monumental undertaking succeeds.

2. **Which communication methods have been most effective for making physicians aware of, and prepared for, the changes?**

   Aurora Health Care, like many high-performing health systems, are actively working to develop tools to help physicians and caregivers prepare for MACRA and its implementation, including making substantial investments in areas that can help drive two-way communication between front-line physicians and physician and administrative leadership that informs, educates and enhances the awareness of what is necessary to improve the quality of care while keeping costs in check or reducing costs without degrading quality. Specialty societies and medical associations too are creating educational platforms by way of roundtables, webinars, detailed educational materials, and other leadership forums to assist healthcare leaders particularly, but also front-line physicians learn about the changes needed to be successful as MACRA comes on line.

   Equally, if not more important is the need for health care and policy leadership to create communication methodologies that engage physicians in ways where the needed transformational changes are being done with them, not to them. Maximizing the success of MACRA will only be possible with an engaged physician and caregiver workforce that's forward looking and invested in making the needed practice changes along with adoption of a culture of continuous quality improvement. The willingness of CMS and Congress to enlist physician and other stakeholder feedback is greatly appreciated and needs to intensify once the HHS Secretary finalizes the rules for MIPS and alternative payment models.

   Notwithstanding the above, it will take time to educate and provide the tools for front-line physicians to be successful in providing high quality, value-based care. Communication

methodologies need to be flexible and customized recognizing front-line physicians are in various stages of readiness to be successful in a value-based reimbursement system.

3. **MACRA provided great flexibility in its effort to streamline the three major physician quality reporting systems. It did this by sun setting and reconstituting them into a single reporting system, The Merit Based Incentive Program (MIPS). This provides CMS an opportunity to reevaluate these programs and make changes to them that furthers the legislation's goals of coordination and ease of reporting. Administrator Slavitt have made comments regarding Meaningful Use for example that appear to recognize this flexibility. What are your thoughts on this flexibility to eliminate duplicity reduce redundancy and increase effectiveness and simplicity in physician reporting?**

   Flexibility and simplicity are, and will continue to be, paramount in unburdening physician practices, a global challenge if not addressed, leads to physician burnout and disengagement. In large measure, active listening to physicians and stakeholders as the transformation to value-based care delivery advances will drive meaningful flexibility and simplicity. In addition, the measurement parameters that physicians and clinicians will be held accountable to achieve need to be critically thought through to ensure they maximize patient benefit and respect the associated financial ramifications while limiting unintended negative consequences. Performance measures and reporting requirements need to be structured in ways that maximize the principle that the practice focus and resources are deployed to benefit the patients not spent supporting inflexible, duplicative or redundant requirements degrading clinical efficiency and effectiveness.

   As the regulations are developed, I encourage CMS to continue to engage the stakeholder community, including provider groups, patient advocates, specialty societies, medical associations, payers, and others. The health care provider community is eager to share its insights with CMS and, to date, CMS has made a sincere effort to listen.

4. **MACRA, and MIPS specifically, is dependent on timely (ideally as close to real-time as possible) communication related to performance and improvement. However, many feel that current timeframes for the release of feedback reports are too long. This delay means that physicians are already well into the next reporting cycle and have no opportunity to change their behavior. Yet, MACRA rewards physicians who make notable jumps in quality to encourage that behavior. What do you believe CMS should do to provide more rapid and accurate feedback to physicians so physicians can have the ability to act on the information?**

   MIPS combines existing, separate programs into a single payment adjustment mechanism. Aurora Health Care shares the goals of the law in driving towards a robust value-based payment system. In transitioning from the current reporting and value-based payment programs, we urge CMS to carefully assess the integration of existing programs. It is imperative that a seamless, coherent transition occurs into the MIPS. As such, we ask CMS to integrate the programs through improvements that will eliminate obstacles, streamline reporting, enable interoperability and minimize administrative burden to providers.

5. **As you may know, telehealth is an issue of great interest to many of our members, including the bipartisan Energy & Commerce telehealth working group. Can the witnesses speak to their thoughts on the role telehealth can and should play in care delivery, particularly in the development of APMs?**

   MACRA will help unleash innovation by providing the needed incentives for physicians to adopt more efficient ways of providing care, including the utilization of innovative technologies such as telehealth. Telehealth offers a green field of opportunity to rethink care delivery in a way that is patient-centered and promotes care coordination and communication. With telemedicine, we will be able to increase patient touches and the frequency of those touches, and other new emerging technologies such as remote patient monitoring will allow us to be more informed about the patient's actual state of health. Regarding patient engagement, CMS must recognize and account for the variety of patient engagement activities that integrated delivery systems such as Aurora may use to connect a provider to a particular patient. This can include virtual care, which may be new for patients. These new systems and technologies need to be recognized and fully incorporated into APMs. With these changes, doctors will interact with the patients in ways that may be new and unfamiliar to them so new APMs must foster a rich culture of learning that promotes the adoption of these new technologies.

6. **Clinical data registries and certified EHRs are envisioned by MACRA as serving as critical reporting mechanisms for providers to interact with the Medicare program. Can you provide your thoughts on implementing these clinical data registries and how ideally both they and EHRs will be able to meet reporting requirements? Would this represent a decrease in administrative burden?**

   The successful use of information technology to harness new data in actionable and meaningful ways to impact health outcomes will be vital for ensuring MACRA reaches its full potential. Electronic health records are a small piece—the seeds, but there needs to be improved infrastructure to make meaningful strides in improving patient care and bending the cost curve.

   It is simply not enough to purchase an electronic health record (EHR) system. The data collected by these systems must be analyzed and interpreted in ways that, when reflected back to physicians and their care teams, it is meaningful and actionable and helps care teams deliver the highest quality of appropriate care and value to patients. This also ensures best practices, once identified, can be disseminated across the entire healthcare system through shared learning and collaboration.

   The infrastructure requirements to support clinical data registries and certified EHRs in terms of personnel, hardware, software licenses, registry maintenance, data analysis and user education are immense and place huge financial and administrative burdens on physicians especially those in single and small group practices who have limited access to financial and infrastructure assets.

In our current state, without robust interoperability, and additional financial recognition for developing these needed infrastructure system and processes, there is clearly an increased financial and administrative burden placed on physicians and healthcare systems. In the future, as this infrastructure becomes fully integrated into the fabric of the practice and additional financial recognition is provided for the value enhancements clinical registries and certified EHRs deliver, the financial and administrative practice burdens will begin to materially fade.

7. **As you know, failure to appropriately apply risk adjustment can inappropriately penalize providers who care for high risk or complicated populations which is why MACRA allowed for a professional to see their MIPS score adjusted – what are your thoughts on the successful implementation of risk adjustment and its importance to MIPs?**

CMS must be especially attentive to the impact of sociodemographic factors on performance measures used in MIPS and APMs. CMS should incorporate sociodemographic adjustment when necessary and appropriate. The evidence continues to mount that sociodemographic factors beyond providers' control – such as the availability of primary care, behavioral health services, physical therapy, easy access to medications and appropriate food, and other supportive services – influence performance on outcome measures.

- **What have been your personal experiences with other risk adjustment methodologies?**

Aurora's integrated delivery system includes several community hospitals located in rural areas, urban hospitals, a psychiatric hospital, and Aurora St. Luke's Medical Center, Wisconsin's largest hospital with more than 700 beds and home to world class cardiovascular and neuroscience programs, which provide complex neuro, heart and vascular surgical, and minimally invasive care. Our diverse and unique patient populations have provided us with an appreciation of the complexities of attempting to utilize a "one-size-fits-all" approach when it comes to risk adjustment approaches.

For instance, it is unfathomable yet conceivable under the new Medicare reimbursement system that some providers may be forced to contemplate avoiding treating patients who have complicated medical problems and decreased probability of recovery because they are more likely to lower the providers' performance scores. Additionally, providers may avoid treating disadvantaged populations for fear that they are less likely to comply with treatment plans, which could also drag down the provider's performance scores. Exacerbating this issue is the fact that safety-net hospitals and physician groups often have low or zero profit margins, so financial penalties for poor performance could jeopardize their business, thereby further reducing access to care for these populations.

The Honorable Gus Bilirakis

1. **One area that is addressed by MACRA, but that will require significant guidance by CMS, is physician participation in multiple alternative payment models or APMs. We wanted physicians to be able to experiment with different approaches to improving their practices while also recognizing that many APMs being developed by stakeholders are somewhat narrow in focus – centered on a specific disease or condition.**

   - **Can each of you speak to why it is important to allow physicians to experiment with different quality based payments?**

   As the direction of various payment models evolve, it will be important for providers to have the opportunity to try out and then expand new payment approaches that are successful in rewarding improved patient outcomes and smarter spending. Sophisticated multispecialty medical groups manage a diverse array of medical and surgical illnesses. Anticipating that some alternative payment models in development could be narrowly focused, allowing physicians to participate in multiple alternative payment models enables the full breath of the practice to actively participate in value-based care delivery. The purpose of payment reform is not to go from one bucket of payment to another but to encourage innovative approaches to unlocking the power of health care data, and finding new ways to coordinate and integrate care to improve quality and bend the cost curve. Expanding the number of primary and specialty physicians who become actively engaged in driving this transformation accelerates this innovation. Congress and CMS must ensure that an environment exists that promotes and fosters this type of behavior and removes any structural regulatory impediments that may discourage physicians and delivery systems from fully embracing value-based care delivery including alternative payment models.

   - **Can you speak to past experiences you may have had in managing different payment arrangements? How would you suggest CMS lay a positive foundation for physicians to be laboratories of care delivery?**

   Having been a leader of a moderately sized multispecialty medical group associated with a large university in a major city that experienced near financial collapse within 18 months of assuming full risk due to limited population management infrastructure, an incomplete specialty network leading to significant 'out of network' exposure and limited alignment with a hospital system for inpatient services, it is imperative that regulators appreciate the need to proceed cautiously during this transition. Medicare largely has been based on fee-for service payments since its inception and many physicians are in various stages of readiness for a value-based payment system. While systems such as Aurora and our physicians have early experience with value-based payment structures, there is and will continue to be a significant learning curve as providers begin to take on financial risk. Also regulators need to recognize that while the trend of hospitals and health systems employing physicians continues to accelerate, many employed physician groups remain a federation of practices, rather than high-performing fully integrated and unified medical groups. This need for integration is another reason why CMS should recognize that health care systems will need time to adapt and learn how to function in this new payment environment. Providing an incremental

approach that includes flexibility and rational exposure to financial risk will be vital in ensuring a successful transition to value-based payment. Congressional oversight of this process would be needed and welcomed.

2. **When we talk about payment models, there is a lot of focus on physicians, other providers, and delivery systems reforms improving quality and lowering cost. However, there is another component to the equation and that is patients. Patients will need to be involved and play an important role in helping to ensure these efforts are successful. What are your thoughts on the role patients can play to improve quality and lower costs while helping providers reform their delivery of care?**

   It is absolutely essential to empower patients to be partners in the transformation to value-based care delivery. Patient engagement is one of the most important guiding principles for ensuring MACRA is successful. Under new value-based care models, patients will move from passive receivers of care to active, informed participants making individual care and purchasing decisions. The underpinnings of the APM models are designed to improve and enhance patient care by advancing the quality spectrum forward improving patient outcomes. Included in the design of APM's is the ability to more effectively capture meaningful and actionable data and measurements providing new ways to analyze different patient populations and gauge impactful care redesign opportunities for specific cohorts of patients. Essential to these care redesign efforts are patients needing to take more ownership of their care. Doctors and other providers will be connecting with patients in significantly different ways including virtual care and team based care approaches and active patient engagement is vital to making these new care models successful.

   In summary, active patient engagement will be key to a successful transformation of our health care system that more effectively utilizes resources and rewards outcomes. Patients can have the most impact by making sure they are keeping themselves healthy through preventative care, and making sure they have regular access to care. Physicians must realize this and encourage their patients to be more proactive and assertive in keeping themselves healthy; including preventing emergency health events through preventative care approaches such as wellness visits and regular screenings.

3. **Dr. Bailet, you have been able to oversee many diverse payment models, and have experiences with models that were successful and others that were not. Allowing this experimentation with payment models is a goal of MACRA.**

   - **Can you speak to efforts that you believe are critical to ensuring progress is being made in sharing best practices and promoting a culture of learning so that others can learn what works or where difficulties were encountered?**

   A strong culture of learning and collaboration among practices of all sizes and specialties will be needed to make MACRA a success in improving patient care and bending the cost cruve. Aurora has been very active in collaborative activities with partners of all sizes. In 2014, for example, Aurora helped found AboutHealth, a clinically integrated network that

enhances clinical quality, increases efficiency, and improves customer experiences through shared practices. This network provides access to care for about 94 percent of Wisconsin's population and serves patients in Illinois, Iowa, Michigan and Minnesota. By creating a strategic partnership with other high performing healthcare systems in our region, we are able to build upon and advance clinical quality, efficiency and patient experience. For example, in 2015 and 2016, AboutHealth is focusing on the following 5 quality initiatives: Diabetes Mellitus type 2; Central Line Infections; Post-Operative Mortality; Patient & Family Centered Care; End of Life Care/Advance Care Planning; Total Knee Arthroplasty; Back Surgery; and, Ischemic Vascular Disease. All work done on these initiatives is not only implemented by the physicians in the member organizations, but also the physician networks of these member organizations. As a result, smaller practices have an opportunity to collaborate with larger systems to improve patient outcomes. AboutHealth is an example of how partnerships in Wisconsin between integrated delivery systems and small group practices can create a culture of learning and fostering of best practices to improve quality of care and reduce costs. This effort also helps small groups and solo practices that wish to maintain their independence from a larger system, such as Aurora, the ability to do so. By clinically integrating with other providers, we have the ability to collaborate on key aspects of patient care and avoid consolidations that are made out of financial necessity. Even with this support, however, practices in small and rural communities will need additional support and flexibility to successfully transition away from the fee-for-service to new payment and delivery models.

In addition, Aurora Health Care is currently participating in the Comprehensive Care for Joint Replacement Payment Model, Medicare's first mandatory bundled payment program. We hope to stay in close contact with CMS and other stakeholders to share our experiences on this initiative to ensure that a culture of continuous improvement informs our way forward on this important initiative.

- **How can CMS be the most helpful in making MACRA implementation successful and ensuring adequate stakeholder engagement occurs?**

MACRA envisions a system of care that spans facilities and provider types and is focused on the aggregate quality of care that the patient receives. In short, it facilitates breaking down many of the silos that have dominated healthcare for too long. While CMS has introduced a number of risk-based initiatives, the agency is still internally structured for and regulates by silos of care based on setting. Furthering the effort to reduce compartmentalization in the healthcare delivery system must be accomplished to accelerate MACRA's success but may be hindered until the regulatory environment and CMS' organizational structure evolves further.