

**HOUSE ENERGY AND COMMERCE COMMITTEE  
SUBCOMMITTEE ON HEALTH**

**“MACRA AND ALTERNATIVE PAYMENT MODELS: DEVELOPING  
OPTIONS FOR VALUE-BASED CARE”  
NOVEMBER 8, 2017**

Good morning, Chairman Burgess, Vice Chair Guthrie, Ranking Member Green and members of the Committee. My name is Dr. Daniel Varga. I am the Chief Clinical Officer and Senior Executive Vice President for Texas Health Resources, one of the nation’s largest faith-based, nonprofit healthcare systems with more than 350 points of access throughout North Texas. I am board certified in internal medicine and have more than 27 years of combined experience in patient practice, medical education and health care administration. I am speaking today as the clinical leader of the Texas Health Resources accountable care organization (ACO) as well as a participant in Premier Inc., an organization of which we are both an owner and member. We participate in many Premier performance improvement collaboratives, including its Population Health Management Collaborative. I will be sharing the results of both our organization and the Premier collaborative.

I have three points I would like to make to the Committee.

First, our decision to move to a two-sided risk, Next Generation ACO model was a direct result of the incentives included in the Medicare Access and CHIP Reauthorization Act (MACRA) and the fact that these alternative payment models are working. Each of the lawmakers on this Committee should be proud of your work and leadership in passing this important legislation.

I cannot stress enough how pivotal MACRA has been and the long-term, positive impact it will have for our nation. Health care providers have been trapped in a micro-managing, fragmented Medicare fee-for-service system. This system has stifled innovation, left providers to manage the challenges of perverse incentives, caused a focus on sickness rather than wellness, incited a duplication of services, undermined coordinated care, driven providers to focus on throughput and speed rather than patient-centered care, and ultimately led to increased health care spending. What's more, because Medicare is the dominant and most stable health care payer, it has become the template on which our health care system is built and private insurers follow.

In North Texas, we have an additional dilemma. While the Medicare fee-for-service program represents the dominant payer in many markets, because of North Texas's strong economic and population growth, more than 40% of practicing physicians do not participate in the Medicare fee-for-service program or severely limit their availability to fee-for-service beneficiaries. Thus, by creating for 2017 the only qualifying Advanced Alternative Payment Model within the area through our participation in the Next Generation ACO model, Texas Health Resources has been able to keep almost 3,000 physicians in the fee-for-service model. Therefore, the incentives that were created by MACRA are essential in order for us to maintain access to high quality physicians and the care they provide in our community.

Moreover, because of our participation in a Next Generation ACO, we have waivers from some of the constraining Medicare requirements. This enables us to work with our clinicians to innovate the care delivery process. We are also able to reduce the Centers for Medicare & Medicaid Service (CMS) reporting burden for our clinicians by reporting those measures for them as a group. Finally, the ability to earn bonuses by participating in the ACO has created an

additional incentive to move to this new care model. These are important reasons why MACRA is an essential building block in building a better health care system.

We have unquestionably seen this innovation and improvement in our Next Generation ACO.

Our experience has allowed Texas Health Resources to:

- Be among the top ten Medicare ACOs in achieving shared savings. Specifically, we achieved savings of \$29,958,600 in 2015 and \$37,268,130 in 2016;
- Care for 67,000 beneficiaries through a value-based delivery model;
- Garner and retain top talent, including 600 primary care physicians (40% employed, 60% independent), and 2,300 participating physicians - with our employed physicians covering two-thirds of our beneficiaries;
- Facilitate a model of care where independent physicians and employed physicians both perform well and are held to the same standards of performance;
- Provide an integrated information technology platform for both independent and employed physicians;
- Make big investments in advancing compliance, clinical integration, patient experience, quality, and coordination of care standards with an ACO budget of more than \$70 million for 2018;
- Build the necessary infrastructure to allow both independent and employed physicians to assume financial risk for the patients they manage and to succeed in that environment knowing that most independent physicians could not afford the investment or the risk on their own;

- Tighten our network of providers to create better outcomes for patients, including preferred relationships with Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, and Home Health Agencies based on objective clinical and efficiency metrics;
- Create an effective primary care management model with ongoing success in post-acute care and specialist utilization efficiency, which is essential to managing costs overall; and
- Increase our cost reduction efforts in Medicare Part A by focusing on appropriate hospitalizations.

While we are pleased with the progress we are making, we know we are not unique. Because we participate in Premier's Population Health Management Collaborative, we both learn from and see the remarkable successes of many other organizations. As part of Premier's Population Health Management Collaborative, we are able to 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 collaborative, as well as other Premier collaboratives, have an impressive record of consistently outperforming other health care providers in delivering improved outcomes in both public and private payment models.

The Medicare ACOs in Premier's collaborative have comprised approximately 6% of the total number of Medicare ACOs since the inception of the Pioneer ACO Model and Medicare Share Savings Program (MSSP) in 2012, and now the Next Generation ACOs. Yet, year over year, these ACOs have consistently performed better than other ACOs in the Medicare program,

despite the fact that the average benchmark for these ACOs is lower than the national average.

Specifically:

- Since 2012, each year about 50% of the Premier ACOs have achieved shared savings, better than the approximately 31% experienced by the rest. They have also outperformed on quality metrics compared to non-Premier ACO participants.
- Since 2012, Premier Medicare ACOs have delivered at least twice the amount of shared savings than the other ACOs, and thus increased savings to Medicare. In other words, had all ACOs performed at the same level as those in Premier's collaborative, Medicare could have potentially saved twice what it has so far with these programs.
- Since 2012, the 6% of Medicare ACOs in Premier's collaborative have generated 20% of the nation's savings.
- In 2016, the Pioneer and Next Generation ACOs comprised 19% of the total number of ACOs, yet delivered 33% of the nation's savings to Medicare. Moreover, 100% of these two-sided model participants in the Premier collaborative achieved shared savings compared to a little over 50% for the rest of the participants.
- Further, Premier collaborative members outperform in other alternative payment arrangements, such as bundled payment. In the Comprehensive Care for Joint Replacement (CJR) model, participants in Premier's Bundled Payment Collaborative performed 35% better than the national average in the first two quarters of performance year 1.

I share these results to demonstrate that, while there has been concern that alternative payment models are not delivering real savings for the nation, it is clear that with a planned approach and effective execution, these models can and are working.

My second point is that these value-based care and payment changes are a significant departure from the past, changing 50 years of culture and habit. This has a number of implications.

For one, you may hear anxiety and complaints from some providers. As we all know, change is hard, but the fee-for-service system has also been generous to many providers and suppliers. However, these changes are long overdue. They began in the early 2000s and should continue, as they are leading an important revolution in health care that will benefit our population and our economy.

It is essential that lawmakers and policymakers understand the consequences of this change and view the developments in our health care system from the vantage point of where we are headed and not from where we have been. There is a lot of talk in Washington about health care consolidation with the concern that it will drive up health care spending.

What is occurring, however, is that we are moving from a fragmented, fee-for-service system where providers are engaged in “coopertition” to deliver more services (both competing with and referring more business to other providers) to one where competition will be driven by high value networks that deliver differentiated outcomes.

As illustrated earlier, Texas Health Resources both works with independent clinicians and employed physicians, and we believe that this pluralistic model is vital to the success of our ACO. We do not want to simply employ physicians. We do, however, want to create a high-value network in which providers are aligned and have a shared objective to deliver high-quality,

cost-effective healthcare across ambulatory, behavioral, acute and post-acute providers, as well as with community partners. To achieve this Texas Health Resources has created a clinically integrated network of both employed and independent physicians, and other providers working to engage and satisfy patients, deliver better outcomes and manage spending. Our goal is to deliver care in the right setting, avoid duplicating services and achieve high-quality outcomes.

Our Dallas market is gradually being defined by providers organizing themselves into competing high value networks. Insurers have attempted to build these networks in the past, but we believe they will never truly succeed because they are simply not at the front line of care, engaging regularly with the patients they serve and embedded in the community. In fact, in many areas of care delivery, insurers simply create a conflicting and duplicative layer of excess in the healthcare system. Moreover, they are not in a position to identify breakthrough innovations that can delight consumers with service and convenience, as well as deliver better health outcomes.

Therefore, much of this work to better organize the health care market into high value networks is both necessary and desirable. Policymakers need to differentiate between consolidations to create excessive market power from organization of the market into a high value network. Moreover, policymakers must be careful not to tilt the playing field to the advantage of one provider group over another. If, for instance, payment models create an unequal advantage for physician- verses hospital-led models, it will only lead to hospitals acting to protect themselves by hiring more physicians.

My final point is that while significant progress has been made to move the micro-managing Medicare fee-for-service system to a value-based payment and delivery system, this Congress and administration must continue to build on the positive steps that have been made. There

remain significant problems with the structure of and rules that govern these programs. With needed changes, we believe more organizations will move to and succeed in these alternative payment models, benefitting both Americans and our nation. Some of the areas of greatest need include:

- Removing regulatory barriers that impede integration of health care providers and undermine efforts to reduce costs and improve quality;
- Modernizing the legal framework that was created in the Medicare fee-for-service program to allow ACOs to tailor care practices which ensure they are providing the right care to the right patient at the right time;
- Increasing flexibilities for ACOs to design their own programs, such as establishing networks and altering benefit designs;
- Exempting Medicare ACOs' shared savings from the sequestration cuts to avoid the double hit that ACOs now incur;
- Specifically for the Medicare Shared Savings Program, we recommend:
  - Allowing providers to choose prospective assignment in all ACO models;
  - Better risk adjustment for the acuity of ACOs' patient population;
  - Creating a quality bonus system that rewards rather than penalizes high performers;
  - Allow an ACO to assume greater risk by moving to a higher risk track annually;
- Creating new voluntary alternative payment models, including bundled payment models where the health system can be conveners; and



- Modernizing a 40-year old confidentiality law that blocks providers' access to substance use information on their patients, impeding their ability to provide proper care coordination and presenting a serious threat to patient safety.

Many of these needed changes are laid out in “Premier’s Delivery System Transformation Roadmap,” which offers a number of thoughtful recommendations to move our nation’s health care system to one that rewards value over volume. I strongly suggest the Committee review this Roadmap, of which the recommendations were derived both from organizations like Texas Health Resources and the collective experience of Premier’s collaboratives.

Thank you for the opportunity to testify before this important Committee. You have made a vital and lasting positive impact on our nation’s health care system with the design and enactment of MACRA. This has been pivotal progress that is working to benefit our patients, communities and our nation. I commend you for this accomplishment and urge you to build on this successful work.