

Statement of
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on
Medicare Access and CHIP Reauthorization Act of 2015: Examining Physician Efforts to
Prepare for Medicare Payment Reforms
before the
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of the
Committee on Energy and Commerce of the U.S. House of Representatives
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Chairman Pitts, Ranking Member Green and distinguished members of the Energy and Commerce Subcommittee on Health, Thank you for the opportunity to testify on behalf of Aurora Health Care (Aurora), the largest private employer and integrated health care delivery system in the state of Wisconsin with 31,000 employees. I am Dr. Jeffrey Baillet, Co-President of Aurora Health Care Medical Group, one of the largest multi-specialty medical groups in the nation. As an Otolaryngologist - Head & Neck surgeon and medical group co-president, I am responsible for co-leading 2,600 primary and specialty physicians and advanced practice clinicians, who provide care to nearly 1.3 million patients a year at 180 clinic sites and 15 hospitals across eastern Wisconsin and northern Illinois. Our physicians, advanced practice clinicians and other caregivers provide a wide variety of care across 90 communities, including large cities with hundreds of thousands of people to rural towns with populations of less than a thousand. Aurora's diverse delivery system includes several community hospitals located in rural areas, urban hospitals, a psychiatric hospital, as well as Aurora St. Luke's Medical Center, the state of Wisconsin's largest hospital with over 700 beds, which is home to world class cardiovascular and neuroscience programs providing complex neuro, heart and vascular surgical and minimally invasive care.

Thank you for extending this opportunity to me to speak on the important topic of reforms included in the Medicaid Access and CHIP Reauthorization Act of 2015 (MACRA). I appreciate the opportunity to speak to this noteworthy congressional policy achievement and I am pleased to be a leader in this transition toward a value-based Medicare payment system not only as a medical group physician leader but also as Chair of the Physician-Focused Payment Model Technical Advisory Committee (PTAC). The PTAC was created by MACRA as an advisory panel appointed by the Comptroller General to consider physicians' and other stakeholders' proposals for new models that foster high quality, high value health care. The PTAC will then advise the Secretary of

Health and Human Services (HHS) regarding what payment models are likely to meet HHS' goals of better health and smarter spending. I am also fortunate to be serving as chair-elect of the American Medical Group Association (AMGA), which represents medical groups, health systems, and other organized systems of care, including some of the nation's largest, most prestigious integrated delivery systems. Today, one in three Americans receives their care from an AMGA member organization. My comments today are on behalf of Aurora and reflect our understanding of how to foster a culture that embraces quality and engages patients on their terms. We believe our experience in providing comprehensive care to a diverse population over an extensive geography and expertise as a high quality provider have afforded us with the insight to offer testimony today on how best multi-specialty and integrated delivery systems can prepare for the reforms included in MACRA.

With the enactment of MACRA, physicians and the larger healthcare community recognize and are preparing for a Medicare payment system that is transitioning away from an unsustainable fee-for-service model based on the volume and intensity of services provided to one that is value based, patient centered and accountable. Aurora and likeminded medical groups, physician practices and health systems appreciate that this transformation of care delivery is pressing both to enhance the quality of patient care and to address the financial challenges inherent in our current volume based system. It is equally important, however, 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. When implementing the regulations for MACRA's payment systems, whether it is for the Merit-Based Incentive Payment System (MIPS) or an Alternative Payment Model (APM), CMS should recognize that the healthcare system 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.

Aurora experienced the importance of this learning curve with our decision to participate in the Medicare Shared Savings Program (MSSP). Although we no longer participate in the program, we did not do so to avoid assuming risk. Rather, we elected to no longer participate in order to reassess our own infrastructure and care processes so that we eventually could reapply and be in a better position to succeed. Time is needed to review what does and does not work, and how to position our system for success in such a program. In our case, we needed to further integrate a newly acquired physician practice, with its own unique Tax Identification Numbers (TINs), into the Aurora structures and processes, including transitioning from paper to an electronic health record, before proceeding with the MSSP. Based on these lessons, we are preparing to submit an application to participate as a Track 3 Accountable Care Organization, which

allows for two-sided risk. This would not be possible without taking the time to assess our situation and adequately prepare for the new risk-based environment.

Physicians whether they are in small group practices, larger multispecialty medical groups or high performing integrated care delivery systems, must make significant investments to succeed in a risk-based environment. This includes implementing information technology and electronic health record systems, migrating to team-based care delivery, redesigning care processes as well as the physical care environment, and, perhaps most importantly, developing highly engaged physicians and caregivers to embrace and thrive in a culture that emphasizes continuous quality improvement and is focused on exploiting practice and process efficiency enhancements at every step of the care continuum.

In addition, 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's meaningful and actionable allowing care teams to deliver the highest quality of appropriate care that delivers the most value to patients. This also ensures best practices, once identified, can be disseminated across the entire healthcare system through shared learning and collaboration.

For example, Aurora provided well over 7 million patient visits in 2015. While data is constantly collected, extracted and analyzed, Aurora recognizes that this data is simply not a statistic on a particular disease or condition, but that each data point represents a life of someone in our community. Our culture, which is based on quality, appreciates the need to not only protect this data, but analyze it so it can help inform clinical practice decisions that result in the best possible outcomes for our patients. Based on this approach, for example, Aurora launched two predictive analytic pilots focused on preventing hospital admissions and readmissions for two patient cohorts, one with congestive heart failure (HF) and the second with chronic obstructive pulmonary disease (COPD). Using a predictive analytic tool, Optum One, Aurora was able to identify and stratify a population of HF patients who had an 80% or higher likelihood of needing to be hospitalized as a result of their disease within the upcoming six month period. We then redesigned our care approach to this cohort of patients using health coaches, frequent proactive outreach and engaging patients to take active ownership of their treatment and health status. A similar approach was utilized for the COPD patient cohort. This effort helped Aurora reduce our congestive heart failure related admissions by 60% in a 2 year period comparing the same HF cohort 1 year before and 1 year after intervention, a 20% reduction in COPD related admissions for the COPD cohort and a 20% reduction in all cause admission rates for both HF & COPD patient cohorts. Equally important, our interventions improved their health risk status making it less likely that they would need higher levels of care going forward. Aurora received national recognition for this work receiving the 2015 Optum & AMGA Award for Innovation in Population Health and has formed a partnership with the AMGA to share these learnings with other physician groups across the country.

Effective, coordinated care management using a team-based approach along with mining and converting large amounts of electronic health record data into actionable care delivery interventions to populations of patients with similar diagnoses is essential to providing care under MIPS or an APM. While MACRA recognizes the need for effective EHR use, such investments in health information technology are only the starting point. Aurora, for example, recently invested \$300 million in its care management infrastructure including a complete change out of our EHR system. While significant, this is more akin to a down payment or starting point than a turn-key solution. Another example of the critical importance of team-based care is the transitional care program Aurora Health Care has developed aimed at preventing readmissions. Each Aurora hospital has transitional care nurses that follow patients that are at a high risk for readmission. These nurses contact the primary care physician prior to discharge alerting them to fact that the nurse will be assisting with the patient's transition to home. They also monitor the patient for 30 days after discharge. This follow up includes in-person in home visits and phone calls. The nurse also works with the primary care office after discharge to help make any other care connections during those 30 days. The nurse documents in the EHR so that the care provided is visible to all who are caring for the patient. Over 70 % of patients discharged in this program have a follow-up appointment with their primary care physician with-in 7 days and this percentage continues to increase. The role of the transitional care nurse further emphasizes the importance of the need for physicians to partner with their care teams to most effectively manage populations of patients.

While Aurora has invested significant resources into care management and health information technology infrastructure, these investments will be challenging for solo and small physician practices. In rural communities, physicians in small practices with limited resources will need continued support to succeed in the transition to alternative payment and value-based delivery models. Congress should be commended for making special educational opportunities available for rural practices. MACRA provides for technical assistance to MIPS eligible professionals in small practices and practices in health professional shortage areas (HPSAs) and allocates \$20 million annually from FY 2016-2020 for CMS to execute this program. While CMS has not made any funding opportunity announcement or given any indication as to when it intends to do so, Congress was forward thinking in creating this program; and, as CMS implements MACRA, this funding program will be an important mechanism to make sure rural areas and small practices are not left behind.

In the meantime, to help solo and small group practices participate, Aurora is developing clinically integrated networks (CINs) across our geographic area. In 2014, for example, we 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

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.

To truly succeed in a risk-based environment and fully benefit from clinical integration, federal payers such as Medicare and commercial insurers need further alignment. MACRA creates an opportunity to facilitate improvements in this area. For example, quality measurement reporting and data requirements should be standardized across payer type. This avoids needless duplication and would streamline quality measurement reporting efforts.

One of the ways Aurora is preparing to succeed in MACRA implementation is by making substantial investments in improving and enhancing our hospital outpatient departments (HOPDs). Aurora's HOPDs stand on the front lines in delivering integrated and coordinated high-quality care in settings that are most appropriate and convenient for our patients. These unique capabilities have positioned HOPDs to play a leading and effective role in helping to transform America's health care system to a value-based system where delivery models will need to be heavily predicated on coordinated, patient-focused and team-based approaches. We encourage Congress to move swiftly to reduce the uncertainty over Medicare reimbursement policies for HOPDs currently under development created by the Bipartisan Budget Act of 2015, which only creates disincentive for these facilities to participate in any risk-based alternative payment models where they face further financial downside.

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.

As the regulations for MIPS and APMS are developed, it is vital that CMS continues to engage the stakeholder community, including provider groups, patient advocates, specialty societies, medical associations, payers and others. The healthcare provider community is eager to share its insights with CMS and to date, CMS is making a sincere effort to engage with the healthcare community stakeholders. I encourage CMS to build upon these efforts and activities taking into account stakeholder concerns, experiences and expertise as value-based parameters are being more clearly defined and implemented for patients. Ultimately, the outcomes resulting from the regulations that CMS implements will only be enhanced by the input from stakeholders within the healthcare community as the regulations are under development. I look forward to continuing to engage with CMS in the future as their work continues.

While a predominant focus of MACRA has been on primary care, it also is important to engage the specialist community where considerable healthcare resources are consumed. These physicians and their specialty societies are actively developing and deploying successful alternative care initiatives that are enhancing care quality at more affordable costs. Specialists are eager to play a larger role in facilitating the transition from volume to value-based care delivery and will serve a vital role in the continuum of care that patients will need going forward as the population ages. New alternative payment models that account for the care specialists provide should be included among the APMs ultimately developed and proposed to CMS for consideration.

While MACRA provides incentives to participate as an APM, there are several actions that CMS can take to ensure full and meaningful participation in the program. As it is developing the regulations for APMs, CMS should take steps to ensure providers have full access to claims data, data exchange formats are standardized, the risk-adjustment and physician attribution methodologies are improved, and patient engagement activities are supported. Claims data provides the most accurate and actionable information on the care we provide and how we can improve our processes to the benefit of our patients. Standardizing data exchanges creates continuity across the healthcare system and avoids unnecessary delays with data transfers and analysis. Appropriately accounting for the risk of a patient population is essential for providers to successfully take on risk and financial responsibility. Regarding patient engagement, CMS must recognize and account for the variety of patient engagement activities that a system such as Aurora may use to connect a provider to a particular patient. This can include virtual care, which may be new for patients. Telehealth also is an important tool in reaching patients and helping to manage their care. These systems need to be recognized and incorporated into APMs. With these changes, doctors will interact with the patients in ways that may be new and unfamiliar to them. It will be important that patients assume more ownership of their care; however, as providers and payers we must ensure they have the means and ability to do so. CMS also may wish to review AMGA's recent survey of its members on their ability to transition to risk. The report, which I have attached to this testimony, explored how multispecialty groups and integrated delivery systems are preparing for the transition to the risk-based environment.

MACRA represents a realistic opportunity for healthcare providers to improve the quality of care while reducing healthcare spending. High quality patient outcomes is paramount and the continuous improvement initiatives and redesigned infrastructure we have implemented at Aurora can serve as a guide to other providers as they transition to value based care delivery. In turn, Aurora appreciates the importance of providing value and quality care to our patients and we continually seek out better more effective ways to deliver care to our patients from our colleagues around the country. MACRA provides a viable framework to achieve these goals. We believe our experience in care coordination and care process re-design demonstrates our willingness to participate in a risk-based payment system. Moving forward, Aurora is prepared to fully participate in the development of new risk-based payment models that have the potential to improve patient care and bend the healthcare cost curve.