IMPROVING VALUE-BASED CARE FOR PATIENTS AND PROVIDERS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTEENTH CONGRESS

SECOND SESSION

JUNE 26, 2024

Serial No. 118–HL05

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PUBLISHING OFFICE

57–159 WASHINGTON : 2024

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PUBLIC SUBMISSIONS FOR THE RECORD

United States House Committee on
Ways & Means
CHAIRMAN JASON SMITH

FOR IMMEDIATE RELEASE
June 18, 2024
No. HL-05

CONTACT: 202-225-3625

Chairman Smith and Health Subcommittee Chairman Buchanan Announce Subcommittee Hearing on Improving Value-Based Care for Patients and Providers

House Committee on Ways and Means Chairman Jason Smith (MO-08) and Health Subcommittee Chairman Vern Buchanan (FL-16) announced today that the Subcommittee on Health will hold a hearing to examine the challenges and opportunities associated with delivering better health outcomes and Medicare savings through value-based care. The hearing will take place on **Wednesday, June 26, 2024, at 3:00 PM in 1100 Longworth House Office Building**.

Members of the public may view the hearing via live webcast available at https://waysandmeans.house.gov. The webcast will not be available until the hearing starts.

In view of the limited time available to hear the witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record can do so here: WMSubmission@mail.house.gov.

Please ATTACH your submission as a Microsoft Word document in compliance with the formatting requirements listed below, **by the close of business on Wednesday, July 10, 2024**. For questions, or if you encounter technical problems, please call (202) 225-3625.

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All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Please indicate the title of the hearing as the subject line in your submission. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.
All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

ACCOMMODATIONS:

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Note: All Committee advisories and news releases are available on the Committee website at http://www.waysandmeans.house.gov/.

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IMPROVING VALUE-BASED CARE FOR PATIENTS AND PROVIDERS

WEDNESDAY, JUNE 26, 2024

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The Subcommittee met, pursuant to call, at 3:00 p.m. in Room 1100 Longworth House Office Building, Hon. Vern Buchanan [Chairman of the Subcommittee] presiding.

Chairman BUCHANAN. The subcommittee will come to order.

Good afternoon. Thank you to the witnesses for being here today to discuss the crucial issue before us: improving value-based care for patients and providers.

Simply put, the current system, fee-for-service, that model in health care is not working. Paying for each medical service without regards to the patient's outcome leads to inefficient care delivery, providers' burnout, and no improvement on patient's care. This is not the way health care should be delivered in our country.

In contrast, value-based care emphasizes providing actual quality care to the patient while improving their health outcomes, healthy outcomes, and generating savings instead of incentivizing and paying providers based on how many patients they see through a given day.

In 2023, only 17 percent of Medicare providers participated in the value-based care payment system under traditional Medicare, while some studies show that Medicare Advantage is up to 40 percent participation in the value-based care delivery.

If implemented correctly, value-based care will lead to lower health care spending costs and a healthier life. In fact, studies show that value-based care can result in annual health savings systems of nearly $700 per patient, and improve the healthy outcomes.

While this transition towards health value-based care has been a commendable and bipartisan initiative in the past for the Centers for Medicare and Medicaid, innovation has in many ways dropped the ball in moving on to something at least cost effective.

Value-based care has a lot of promise. But to fully transition Medicare to this model, we need CMMI to pursue models that save money and instill transparency and accountability so that we can truly incentivize patients to live a healthier life.

Chairman BUCHANAN. I am pleased at this point to recognize the gentleman from Texas, Mr. Doggett, for his opening statement.

Mr. DOGGETT. Well, thank you, Mr. Chairman. Thank you for the hearing, and our witnesses for appearing today.

Improving quality of care while reducing cost to the taxpayer and patients is certainly a worthy goal we all share. While I support paying for value over volume, efforts to achieve that so far have achieved very mixed results. Over the last decade, the Center for Medicare and Medicaid Innovation has launched more than 50 models, but only six have delivered actual savings and two demonstrated some improvement in quality.

I like the concept of value-based care. It is just the implementation that I find problematic. With this modest track record, I think our goal today, with your help, is to dig deeper into why these models have struggled, identify the success stories, and use lessons learned to improve Medicare payments.

One of the primary challenges, I think, is that in achieving value-based care we still struggle over what value really means. Marginal improvements are often treated as of high value, and some supposed improvements have not been validated as indicators of true clinical improvement. While providers are asked to provide literally reams of data, it is unclear whether we are collecting the right data or using appropriate methodologies in analyzing it.

Some of us sat in this very room and heard years back the grand promise of Medicare Advantage. It was going to provide great value by expanding beneficiary choices, reduce health inequities, and save taxpayer dollars. More for less, it certainly has actually resulted in our having to pay billions of dollars more in Medicare Advantage payments than for traditional Medicare, and for some people actually lower quality.

Costing an average of 22 percent more than if the same beneficiaries had remained in traditional Medicare, Medicare Advantage is being dramatically overpaid. Some estimates range as high as $83 billion in wasted taxpayer dollars this year. That is enough money to provide hearing and vision coverage to the nearly half of beneficiaries with hearing loss, and one-third who struggle with vision.

MA plans aren't just getting paid more to deliver the same care that could be received under traditional Medicare; they are sometimes covering less care. MA plans continue to interfere with the doctor-patient relationship through burdensome prior authorization requirements, step therapy, and other management tools. One study found that 82 percent of prior authorization denials that were appealed were ultimately overturned and found to be necessary and appropriate, but that is still a problem particularly for smaller health care practices to engage in those appeals.

For the care that is delivered, many physicians face inadequate payment. We learned at an earlier hearing that a number of Medicare Advantage plans are actually paying less, 20 percent less, than traditional Medicare. So we have higher spending, skimping on care, and underpaid doctors all as—under—all done under the brand of value.

While some alternative payment models appear to show greater promise and achieve the outcomes that we are seeking, they must be carefully designed to avoid repeating the failures of Medicare Advantage. These models also should serve as the back door—or

should not serve as the back door for further privatization of Medicare.

I share the concern that I have heard directly from Austinites in my hometown about ACO REACH, which has allowed some entities convicted of fraud to participate. One review of the model found at least 10 companies convicted of fraud, including 4 Medicare Advantage insurers convicted of hundreds of millions of dollars of fraud for submitting unsupported diagnosis codes to receive inflated payments. Similarly, private equity-owned practices and management companies continue to expand in Medicare through alternative payment models.

As part of today's discussion we do need greater attention on improving the Medicare physician fee schedule. Providers are rightfully wanting to see payments that keep pace with inflation, as recommended by the independent Medicare Payment Advisory Commission. We also continue to underpay primary care providers who offer some of the most important and high-value preventive care. And, of course, Medicare Advantage plans, which now cover more than half of beneficiaries, may reimburse less than the fee schedule. To achieve greater value, payment reform must include MA reform.

I look forward to the insights you have to offer. Thank you.

Mr. DOGGETT. And I yield back, Mr. Chairman.

Chairman BUCHANAN. Thank you. And I will now introduce quickly the witnesses.

Dr. Chouinard is the Chief Medical Officer of Main Street Health.

Mr. Nuckolls is CEO of Coastal Carolina Health Care, and a PA for Coastal Carolina Quality Care.

Dr. Philip is Chief Medical Officer of Duly Health and Care.

Dr. Berenson is the Institute Fellow at the Urban Institute.

Thank you for joining us today. Your written statements will be made part of the record, and each have five minutes for your oral remarks.

Mrs. Chouinard, you may begin.

STATEMENT OF SARAH CHOUINARD, CHIEF MEDICAL OFFICER, MAIN STREET HEALTH

Dr. CHOUINARD. Chairman Buchanan, Ranking Member Doggett, and members of the subcommittee, thank you for the invitation to participate in this hearing. My name is Sarah Chouinard, I am a family physician. I was born in Huntington, West Virginia, where I went to medical school and trained in a rural family medicine program. For almost 20 years I worked in rural West Virginia as a frontline doctor. During that time I was leading a Federally Qualified Health Center, where we saw 48,000 patients annually. Today I have the pleasure of being chief medical officer at Main Street Health, the nation's largest rural, value-based care business.

In rural America patients are sicker, often more economically disadvantaged, and geographically isolated. There are 20 percent less primary care physicians and 85 percent less specialists in rural areas compared to urban. The uneven distribution impacts the health outcomes in rural populations. The people? Salt of the Earth. But the problems are real. If I could summarize the key les-

son learned from my almost 20 years as a rural doctor, it would be this: Rural health care is the biggest health inequity in the United States.

In the fee-for-service model, there is little time or room for projects when things are even really going well. Previous demonstration projects created to address problems like social determinants of health have not typically had the potency to transform practices because they are executed off the side of the desk, and they are fraught with challenges. Add to that a lot of projects are grant funded, and when the grant expires, so does the care that goes with it.

For example, when I was at Community Care of West Virginia, I co-chaired CMMI's Transforming Clinical Practice Initiative. It was designed to support over 140,000 clinicians in sharing quality improvement lessons learned to try to lead to better outcomes and reduced costs. It had solid objectives, and I was excited to lead the charge. Unfortunately, during that project, West Virginia became ground zero for the opioid epidemic. As you can imagine, transformation took the back seat.

The problem with health care in rural America is not the physician community. Rural doctors are bright, and focused, and committed. They love their patients. They are pillars of their communities and very invested. The problem is that it is too hard for patients in rural communities to execute on their care plans. We have an opportunity before us with value-based care to build a model that addresses this key challenge.

Let me give you an example. Let's take a patient. We will call him Roger. Roger has chronic obstructive pulmonary disease, and in order to stay well he has to have a nebulizer machine that he plugs into the wall to deliver medicine to his lungs. And as long as Roger had both his medicine and the machine, things went pretty well. Well, Roger falls on hard times and is unable to keep up with his bills. As such, Roger can't use his nebulizer. In the month that that happened, this patient ended up in the emergency room three times and was admitted to the hospital. All of that was totally avoidable, very expensive, and completely inefficient.

But there is a path forward. In my role at Main Street Health we are solving problems just like Roger's with our value-based care model that leverages the unique relationships that PCPs have with their patients. What Roger really needed was an extra set of hands to support him navigating his utility bill. Main Street's model has three key pillars.

First, we expand the care team by adding someone we call a health navigator. It is someone we train, who we hire from the community, and they become experts in resource navigation, resources that impact patient outcomes. In Roger's case, his health navigator helped him get his power restored. He got control of his chronic condition and stopped going to the emergency room. Focusing on these types of non-medical needs is essential to improving the health outcomes in rural areas.

Second, we also give patients a flat payment that is per patient that we pay by taking on all the risk in our value-based care arrangements. This is up-front, reliable revenue that providers can count on.

And then, finally, we don't require practices to adopt any new technology. Instead, we integrate with their existing Electronic Health Records so that there is no need for them to learn a new system, and it creates a better experience for the doctors and for the patients.

So while there are many challenges in rural health care, I remain an optimist on the possibility of improving care in rural America. I see that possibility every day at Main Street, where we partner with over 3,800 rural providers across 26 states.

Thanks for the invitation to testify, and I really appreciate being able to share my experiences.

[The statement of Dr. Chouinard follows:]

MAIN STREET HEALTH

Written Testimony by Sarah Chouinard, MD

Chief Medical Officer

Main Street Health

Testimony to the House Committee on Ways and Means, Subcommittee on Health

June 26, 2024

900 Main Street, Nashville, Tennessee, 37206

Chairman Buchanan,Ranking Member Doggett, and distinguished members of the Subcommittee, thank you for the invitation to participate in this hearing. My name is Sarah Chouinard, MD. I am a family physician and currently serve as the Chief Medical Officer for Main Street Health. I am a past co-chair for the Centers of Medicaid & Medicare Services' (CMS) Transforming Clinical Practice Initiative and past president of the West Virginia state chapter of the American Academy of Family Physicians. I grew up in Huntington, WV, where I attended medical school and completed my rural health track residency. For the 18 years after graduating medical school, I was Chief Medical Officer and a frontline physician at Community Care of West Virginia (CCWV), a Federally Qualified Health Center serving 48,000 rural patients annually. Today, I am Chief Medical Officer for Main Street Health, a rural value-based care company partnering with more than 3,800 rural primary care providers in 26 states and caring for over 650,000 rural seniors across America. I took this position to help address some of the toughest problems in healthcare, focusing on rural health equity. My intent in this testimony is to offer insights from my career by describing four lessons I have learned and offering three thoughts for future care delivery models serving rural patients.

I have seen firsthand how the current fee-for-service payment model leaves patients feeling overwhelmed by its complexity and doctors feeling overextended and unsupported.[1] Even in a sophisticated, outcomes-driven community health center like CCWV, a typical day in the life demands charting, filling out health plan forms, population health management phone calls, conferring with specialists, office management, data gathering, and community involvement. Burnout in fee-for-service medicine is real.[2] Compounding these problems, expenditure on primary care in the U.S. has diminished over the past decade, from 6.2% in 2013 to 4.6% in 2020 across all insurance types.[3] Medicare, which insures 1 in 3 rural adults, spends only an estimated 4.2% of its total spending on primary care.[4,5] Primary care providers need assistance, and the problems are exacerbated in rural settings.

Rural patients are older, sicker, and have higher rates of chronic diseases than urban and suburban Americans.[6] With over 60 million people living in rural areas, we can significantly impact the health of our country by focusing on rural health.[7] These circumstances warrant federal attention aimed at new models of care delivery. This opportunity for positive change is the reason I left my job of 18 years to join Main Street Health three years ago.

Main Street Health's mission is to bring value-based care to rural communities across the United States. Even though we launched only three years ago, we are already the nation's largest provider of value-based care focused exclusively on serving rural America. We believe in the old ways of medicine when healthcare was simpler. By partnering with local rural providers, we reinforce the importance of trust and relationship-driven care in rural communities. We have found that rural providers need more resources to ensure patients have access to the right care at the right time. That's why we provide our partner clinics with a community health worker (which we call a Health Navigator), data, and tools to succeed in a value-based care delivery model.

From my experience as a frontline primary care provider and as Chief Medical Officer at multiple rural healthcare organizations, here are four lessons I have learned that may be informative as you build future rural healthcare policies:

1. **Rural healthcare must be seen as one of the most – if not the most – important dimensions of improving healthcare inequities.**
   A health disparity, as defined by the U.S. Department of Health and Human Services, is a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage.[2] They adversely affect groups of people who have systematically experienced greater obstacles to health, like rural Americans. People living in rural areas often face significant barriers to healthcare access, including geographic isolation, limited

transportation options, and a shortage of healthcare providers. While 20% of the U.S. population resides in rural areas, only 10% of physicians practice there.[8] This discrepancy results in less access to primary care, creating inefficiencies that increase reliance on emergency care and leading to higher costs for the healthcare system.[9] The five leading causes of death (heart disease, cancer, unintentional injuries, chronic lung disease, and stroke) are significantly higher in rural areas compared to urban areas.[10] Simply applying models and workflows that have been successful in urban settings to rural communities is insufficient. Rurality is its own unique health disparity and new models must be built in consideration of these differences.

2. **Rural healthcare solutions need to build on the unique relationships that exist between patients and providers in rural communities.**
   Rural communities are built on trust, and new ideas are best received when they deeply involve the community itself.[11] At CCWV, we had 17 outpatient clinics scattered across small West Virginia towns. Each geography had its uniquely challenging characteristics, but what was consistent was that providers wore multiple hats as community leaders. Our patients were our neighbors. Doctors served as Little League coaches, attended church with their patients, and cared for generations in each family. The old ways of medicine where doctors visit patients in their homes, stay after hours to see sick kids, and meet worried patients in the office on the weekends to assuage concerns is still alive and well across rural America. We should make sure not to forget this, as there is incredible power in these relationships that can be used to significantly improve care in rural America.

3. **Rural clinicians need more resources to succeed in transforming care, but these resources must be focused on driving outcomes that matter to patients vs. just supporting the current delivery system.**
   At CCWV, we served as a hub in the community and as a safety net for patients. Being remote, access to comprehensive services was a challenge. For example, dental care was often not available in our communities, even though regular dental care is associated with 23% lower rates of ischemic stroke.[12] We routinely received federal grants to enhance our scope of services, like providing dental care, that would extend our ability to care for patients. However, once the grant lapsed, the care ended. The problem with grant funding is that grant dollars are not a sustainable source of funding. Grants are also often complicated in their requirements and the money is restrictive. Resources need to be focused on long-term programs that are connected to improving outcomes for patients. While no model is perfect, models like Medicare Advantage and the Medicare Shared Savings Program (MSSP) that have clear and transparent quality metrics, the potential to offer additional resources and payment to providers, and proven sustainability are the types of models that have the potential to transform rural healthcare over time.

4. **Addressing non-medical needs is important if you want to improve healthcare in rural America**.
   More than genetic factors or access to healthcare services, non-medical needs, often referred to as social determinants of health, have a greater influence on health.[13] In the fee-for-service model, addressing these non-medical needs – such as coordinating transportation, educating patients on their insurance, and solving for food or housing insecurity – is not incentivized. When I was in practice, understaffed care teams in a fee-for-service model did not have the time to focus on resource coordination. However, through the type of value-based care programs we participate in at Main Street Health, we have been able to embed Health Navigators in each of our partner clinics, and these individuals have been able to focus on caring for patients' non-medical needs. For example, we had a patient, who we will call Roger, who went to the emergency room three times in one month for respiratory complaints. Roger's Health Navigator leaned in and discovered that Roger was unable to pay his electric bill due to a short-term personal problem.

Without electricity, he could not use his electric nebulizer machine at home and sought emergency care for shortness of breath. Roger's Health Navigator helped him apply for a long-standing program offered by the local electric company that covers a specific dollar amount of monthly bill payment. With power restored, Roger ceased going to the emergency room and regained control of his chronic condition. Focusing on these type of non-medical needs is essential to improving health outcomes in rural areas.

In light of these lessons learned, there are three thoughts I would consider if I was designing policies focused on improving healthcare in rural America.

1. **New value-based care models in rural communities must be simple and easy to both understand and implement; these models should not require rural providers to change their technology tools and should not require significant upfront investments from rural providers.**
   Rural health providers are often solo practitioners or small practices who lack administrative support.[14] It is unrealistic that overstretched primary care providers in small town America can stay abreast of policy updates, nuanced quality measure changes, and program opportunities while practicing in geographically and economically isolated communities.[15] On average, the primary care practices Main Street partners with have fewer than three providers in each clinic. These practices do not have quality improvement teams or in-house IT departments to track quality or payment metrics. If rural practices are to participate in value-based care models, the models must be simple and easy to understand and implement.

   In our experience, it is important that new models do not require rural practices to change the technology they use. Over the past three years, Main Street has partnered with primary care practices that use 87 different Electronic Medical Records (EMRs), ranging from very simple software applications that are hosted on-site to more robust, cloud-based platforms. Had we asked these practices to change their EMR system or use new technology, they would not have partnered with us. Instead, we have learned how to build integrations with practices' existing EMR systems to provide clinicians the data and information they need in the EMR that they are used to working in every day.

   CMS has made some progress on simplifying a subset of its value-based care programs. For example, the Medicare Shared Savings Program (MSSP) has gone from 10 quality measures in prior years to three quality metrics this year. However, it is unclear exactly how the implementation of these three measures will work in many rural practices, as the current CMS requirement is that these three measures be submitted through new electronic integrations that many rural practices and their EMRs may or may not be capable of. While Main Street has been able to help rural practices meet this new requirement through our integrations with practices' existing EMRs, many rural practices may not be able to meet this requirement on their own.[16]

   Making upfront financial investment in new payment models is also unrealistic for most small rural primary care clinicians. Part of our success at Main Street is due to providing upfront, reliable revenue to providers rather than making them wait on shared savings payments. CMS has made some strides in this area, including launching the Advance Investment Payments (AIP) model, which offers eligible ACOs in rural and underserved areas an upfront payment of $250,000 and two years of quarterly payments if they enter the MSSP program.[17] CMS should continue to invest in similar easy-to-understand payment models.

   To the extent that CMS models remain complex and hard to understand, it is likely that there will need to be groups like Main Street Health, regional rural hospital associations, statewide

Federally Qualified Health Clinic associations, and others who step in to partner with small rural primary care practices to help them participate in CMS's value-based care models. While this may be an okay outcome from a policy perspective, having CMS models be simple enough for practices to participate on their own would likely be ideal and lead to more rapid adoption of value-based care models across rural America.

2. **Rural care delivery needs to leverage every clinician (and non-clinician) at the top of his or her license.**
To be able to deliver care in rural environments successfully, every member of a rural care team needs to work at the top of his or her license, and we need to learn how to leverage non-clinical staff like community health workers. At the core of Main Street's model is the Health Navigator, a non-clinical community health worker that we place in each clinic.[18] Health Navigators work directly with patients and offer assistance to seniors and clinicians to do all the things the clinic's current staff typically doesn't have time for: calling a patient after a hospitalization to ensure they come back to the primary care office for a visit, helping close quality gaps, and ensuring a patient's non-medical needs are met. We have seen first-hand that our Health Navigators make a tremendous difference in the lives of our patients and providers; they have helped close well over 100,000 HEDIS quality gaps for our clinic partners.

Clinicians must also be able to work at the top of their license, and rural value-based care models need to be able to support this. For example, today there are 28 states where nurse practitioners have full-practice authority and can open their own practice.[19] Inconsistent with this policy, however, nurse practitioners cannot serve as qualifying providers for attribution to an accountable care organization (ACO) in the Medicare Share Savings Program (MSSP). Currently, the program requires beneficiaries to have 1 or more visits with a qualifying physician to be attributed to an ACO. Allowing primary care nurse practitioners to serve as qualifying providers for the sake of attribution (at least in rural practices where they are the most senior clinician) could be an effective way to expand access to this value-based program while simultaneously recognizing the importance of every provider working at the top of his or her license in rural communities.[35]

3. **Virtual care creates an emerging opportunity to increase access to specialty care in rural America.**
Limited access to specialty care in rural communities has been shown over and over again to negatively impact the health and survival of rural patients.[20, 21] However, virtual care is creating significant new opportunities for specialty care delivery in rural America. For example, in many rural communities, patients with stroke symptoms can often experience a delay in care or stroke diagnosis due to the distance they need to travel to access specialized neurological services. However, this can, and in many cases is, now being addressed by the availability of virtual telestroke consultations that allow rapid consultation with a specialized neurological teams for diagnosis and treatment of patients who present in a rural hospital with stroke symptoms. These models have been shown to improve timely diagnosis and treatment for patients exhibiting stroke symptoms across rural America.[22] Telecardiology models are also showing promise for bridging the gap in rural specialty care. For example, in rural areas with a limited access to cardiologists and their associated procedures (e.g., ECG, echocardiography), patients too often are transferred immediately to the large metro hospital for a workup. Research has shown routine availability of electrocardiograms (ECGs) at the primary care level that are then read by a virtual cardiologist can facilitate early referrals to secondary care, reduce unnecessary referrals where appropriate, and improve both short-term and long-term mortality.[23, 24]

Policy needs to support these types of virtual specialty care delivery models in rural areas. For example, today, some of these virtual specialty models involve a specialist conducting a virtual

visit with a patient and then prescribing a drug that can be infused for treatment on site at a patient's local hospital. However, these infusions are only sustainable in many case if the local hospital is eligible for 340B. Approximately 75% of hospitals in rural America are Critical Access Hospitals.[25] While the 340B program is arguably too large and being taken advantage of by many organizations, the fact that Critical Access Hospitals in rural America cannot access the 340B program for some of the most important specialty drugs seems inequitable and is a significant hindrance to expanding these virtual models into many rural communities (as background, excluding Critical Access Hospitals from access to certain 340B-eligible specialty drugs was a policy compromise made by Congress during the negotiations around the Affordable Care Act).[26, 27]

As demonstrated by the above, I am an optimist on the possibility of improving care in rural America. I am seeing the progress that can be made every day at Main Street Health, as we partner with over 1,200 clinics and 3,800 rural providers across the country. If we continue to leverage the unique relationships that rural primary care providers have with their patients, create more simple value-based care models like Medicare Advantage and MSSP, leverage clinicians and non-clinicians at the top of their ability, and implement new virtual specialty delivery models, there is a true opportunity to improve the delivery of care in rural America and to decrease the rural health disparity that exists today across our country. Thank you for inviting me to testify and share my experiences.

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Chairman BUCHANAN. Thank you.
Mr. Nuckolls, you are now recognized.

STATEMENT OF STEPHEN NUCKOLLS, CEO, COASTAL CAROLINA HEALTH CARE AND PA, COASTAL CAROLINA QUALITY CARE

Mr. NUCKOLLS. Chairman Buchanan, Chairman Smith, Ranking Member Doggett, Ranking Member Neal, and distinguished members of the subcommittee, thank you for holding today's hearing. My name is Stephen Nuckolls, and I serve as the chief executive officer of a physician-owned, multi-specialty medical practice that serves several rural counties in eastern North Carolina.

Our practice was established in 1997, with the goal of maintaining physician independence, wanting to manage our patients under a program that incentivized health. That opportunity arrived with the Medicare Shared Savings Program. We were among the first 27 to join in April of 2012, and one of only five to receive upfront funding from Medicare's Innovation Center.

Throughout our tenure in the program, our savings rate has steadily increased, and for last year we are projecting a savings rate of 15 percent. Cumulatively, we have saved $84 million, netting $28 million in savings to Medicare. This is a 900 percent return on the $3 million upfront investment from the Innovation Center.

In addition to this financial return, our assigned patients have received significantly better care. We have reduced hospitalizations by 39 percent and reduced ED visits by 28 percent. During this time our colorectal and breast cancer screening rates, along with blood sugar control for patients with diabetes, have ranked in the top one percent of the program.

We achieved this success by implementing common-sense programs and strategies, including improving access to care, enhancing our quality programs, providing home visits, revising provider and staff compensation systems, and creating appropriate incentives to ensure engagement from our specialty providers.

I offer four opportunities for Congress to ensure that value-based care is sustainable and can grow.

First, continue Advanced APM incentives. Most of the top performers in the MSSP are independent medical practices who have transitioned to downside risk. Our organization was initially hesitant to take on this risk, but the five percent AAPM bonus was a crucial incentive. It encouraged us to make this important move, and remains essential for retaining and attracting staff and providers, especially now as inflation has vastly outpaced the reimbursements we receive from Medicare and other payers.

Second, address incentives across the continuum of care. Many people refer to ACOs as primary care models. While performance of primary care physicians is critical, our group's success demonstrates that the higher levels of quality and savings that can be achieved when physicians across specialties work together. For instance, our cardiologists help with key quality metrics, train our PCPs on appropriate referrals, help ensure appropriate use of high-cost medications and other treatments.

Unfortunately, many important specialties have joined larger systems that can offer higher compensation due to higher reimbursements under fee-for-service. The financial incentives provided by our ACO and MACRA's five percent bonus payment have allowed us to narrow the compensation gap with these systems, and help achieve our goal of remaining independent.

Third, removing regulatory burden. I believe more organizations would join and performance could improve if the program included more non-financial incentives—allowed organizations to provide beneficiary incentives. For example, providers in ACOs are still subject to the same coding reviews as those who do not participate. Since these organizations are taking on downside risk, isn't it reasonable to exempt them from programs designed to control the fee-for-service model?

Similarly, wouldn't it make sense for providers in these programs to offer incentives comparable to what Medicare Advantage plans provide, such as waiving beneficiary cost shares to encourage preventive care?

Finally, ensure that programs who are successful can remain in the programs.

In closing, we have enjoyed exceptional performance in the MSSP. But unfortunately, our ACO is unlikely to renew our contract when it ends at the end of this year. The program's benchmarks are established based on organization's most recent costs. So when you perform well, like we have, the benchmarks are lowered. CMS has yet to adequately address the benchmark ratchet, and doing so is essential to the long-term viability of the program.

Early on we were advised by a prominent health system consultant to avoid actions that could harm our profitable fee-for-service operations. We chose not to follow his advice, and I am proud that our organization has taken these steps for both our patients and the Medicare Trust Fund. However, it is not yet clear from our actions if our actions will be in the organization's best long-term financial interests. Thank you.

[The statement of Mr. Nuckolls follows:]

Written Statement for the Record

Of
Stephen Nuckolls

Chief Executive Officer, Coastal Carolina Quality Care
Board Member, National Association of ACOs

For the
House Ways and Means Health Subcommittee

Hearing on
"Improving Value-Based Care for Patients and Providers"

June 26, 2024

Chairman Buchanan, Chairman Smith, Ranking Member Doggett, Ranking Member Neal, and members of the subcommittee, thank you for the opportunity to testify. My name is Stephen Nuckolls, I am the chief executive officer of the independent multispecialty medical practice, Coastal Carolina Health Care and its accountable care organization (ACO), Coastal Carolina Quality Care (CCQC). I'm also a founding member of the National Association of ACOs (NAACOS) and serve on the Executive Committee of its Board of Directors.

My testimony reflects the experience of Coastal Carolina and the broader NAACOS membership. NAACOS represents more than 470 ACOs who provide care for over 9.1 million beneficiary lives through Medicare's population health-focused payment and delivery models, including the Medicare Shared Savings Program (MSSP) and the ACO Realizing Equity, Access, and Community Health (REACH) Model. In addition to the Medicare models, NAACOS' members are engaged in value-based arrangements across Medicare, Medicaid, and commercial insurance. We applaud the subcommittee for holding this hearing to discuss ways to deliver better health outcomes and savings through value-based care (VBC).

Coastal Carolina is a testament to the opportunity for value-based care to reduce costs, improve patient outcomes, and allow providers to remain independent. Coastal Carolina is a physician owned multispecialty medical practice serving Craven, Pamlico, and Jones counties in eastern North Carolina. Our practice was formed in 1997 with the hope that we would be able to manage our patients under a program that provided incentives to keep our patients healthy. That opportunity arrived with the launch of the MSSP in 2012. We were among the 27 to join in the first round of applications in April 2012 and were 1 of 5 to receive advanced investment funding from the Center for Medicare and Medicaid Innovation.

Since that time, our cost of care has been below the established budget or benchmark by $84 million, netting the Medicare program $28 million in savings. For 2023 we project our cost per beneficiary will be 15% below our budget. We have delivered a 900% return to Medicare on the initial $3 million advanced investment payment. In addition to the financial return, our more than 10,000 patients aligned to the ACO have received better care. Since the start of the program, we have reduced hospitalizations 39 percent, from 318 per thousand beneficiaries to 193 per thousand beneficiaries, and reduced emergency department visits by 28 percent, from 620 per thousand beneficiaries to 447 per thousand beneficiaries. Moreover, our colorectal and breast cancer screening rates and blood sugar control for patients with diabetes ranks in the top 1% of the program.

The financial savings have not only accrued to the benefit of the Medicare program but have also benefited patients who have lower out of pocket costs and their supplemental insurance carriers whose claims have declined proportionately. Also, when we work on quality performance, we do it for all populations, not just those assigned to us under the various programs.

Beyond Coastal Carolina's experience, there are proven successes nation-wide. Over the last decade, the MSSP has grown to be the largest and most successful value-based care program in Medicare. As of 2024, there are 602 ACOs coordinating care for 13.4 million Medicare beneficiaries across Medicare's

ACO programs.[1] ACOs have been a good financial investment for the government. In the last decade, ACOs have generated more than $22.4 billion in savings with $8.8 billion being returned to the Medicare Trust Fund while maintaining high quality scores for their patients.[2] Providers in alternative payment models (APMs) also help make the Medicare program stronger by reducing improper payments. Using enhanced data and analytics, ACOs regularly identify and report instances of fraud, waste, and abuse.

Moreover, the growth of APMs has also produced a "spill-over" effect on care delivery across the nation, slowing the overall rate of growth of health care spending. A recent study from the Institute for Accountable Care found that 75% of organizations participating in Medicare ACOs in 2022 also had VBC payment arrangements with Medicare Advantage (MA) or commercial plans and more than 30% had such arrangements in Medicaid.[3] For Coastal Carolina, since entering MSSP we have been able to move other contracts from fee for service (FFS) payments to ones where we have incentives to control the total cost of care. Currently, over 75% of our primary care physician's patients are covered under a total cost of care arrangement.

While VBC is working and more than 400,000 clinicians have made the transition to advanced APMs, misaligned incentives are hampering the movement to VBC. I offer four opportunities to improve Medicare's transition to APMs.

1. **Revise APM benchmarks (or budget) so that providers are not penalized for their prior success.**
2. **Continue financial incentives to join APMs.**
3. **Address incentives across the continuum of care.**
4. **Remove regulatory burden and increase flexibility, providing stronger nonfinancial incentives to adopt value.**

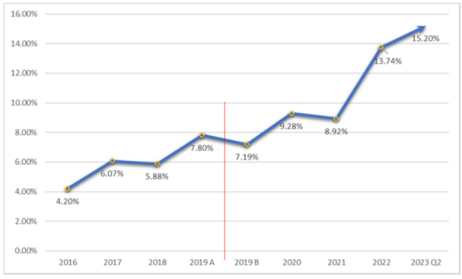
SUSTAINABLE BENCHMARKS

ACO benchmarks are a race to the bottom approach that makes it difficult for clinicians to remain in the program and be successful. Benchmarks in ACOs are set using a combination of historical spending for the aligned beneficiaries and regional and national spending trends. Over the next two years, the majority of MSSP participants will enter new contract agreements and have their benchmarks rebased and lowered due to achieving savings during the current contract cycle. While CMS has adopted policies to reduce the impact of the ratchet (i.e., prior savings adjustment, accountable care prospective trend) these policies do not go far enough and many ACOs may face deep reductions to their benchmarks.

For Coastal Carolina, the impact of the benchmark ratchet is significant. As outlined in the graph below, our ACO, like others, has been successful in lowering costs compared to its benchmarks. Prior to entering the MSSP our assigned patient cost per beneficiary was slightly above the expected cost.[4] Ten

[1] https://www.cms.gov/newsroom/press-releases/participation-continues-grow-cms-accountable-care-organization-initiatives-2024
[2] https://www.naacos.com/wp-content/uploads/2024/01/NAACOS2022ACOSavingsResource.pdf
[3] https://www.ajmc.com/view/allpayer-value-based-contracting-in-organizations-with-medicare-acos.
[4] CCHC Report for 2012 generated by CMS' Physician Quality Reporting System.

years later our cost per patient is 25 percent below the region.[5] Assuming that we maintain our current savings rate of approximately 15 percent and apply the 5 percent cap on the prior savings adjustment or regional efficiency adjustment, our benchmark will be reduced by 10 percentage points or 66% of last year's savings. If you calculate the savings to Medicare using the regional efficiency calculation, excluding our assigned beneficiaries from the calculation, CMS will retain 80% of the cumulative savings.



Ultimately, this policy means that our ACO is unlikely to renew our contract when it ends this year. The CMS policies to partially mitigate the benchmark ratchet (5 percent savings or regional efficiency adjustment) is insufficient to cover the costs of running the programs we operate. While our independent ACO is unlikely to continue, our medical practice is reviewing its options with other organizations.

It is critical that we ensure that ACOs have fair and accurate benchmarks so that providers do not have to face the tough decision to leave a program in which they were previously successful. The savings achieved in these models directly impact patient care by expanding care teams, providing additional beneficiary services that are not billed to Medicare, ensuring provider retention with enhanced provider payment, and investing in technology or other services that enable care coordination and population health management. Lowering benchmarks because of the ratchet effect reduces providers' ability to improve care and reduces the ACO's opportunity to achieve success and reinvest shared savings into beneficiary care. **We need benchmark approaches that do not penalize clinicians for prior success in the model.**

Conversely, in our risk arrangements within Medicare Advantage we do not face ratcheting benchmarks. While our risk arrangements in MA are impacted by MA policy changes, it is far more predictable and stable.

[5] This figure was calculated from data provided to us by CMS in our 4th Quarter and Final Settlement reports for 2022. The regional figure excludes assigned patients from regional per capita costs.

FINANCIAL INCENTIVES TO JOIN APMS

Congress passed MACRA in 2015 to eliminate Medicare's sustainable growth rate (SGR) formula, establish unified quality reporting systems, and provide financial incentives for clinicians to join APMs. MACRA's incentive payments have been effective in facilitating clinicians' transition to advanced APMs. To illustrate the progress that's been made since MACRA became law, as of January 2024, more than 70 percent of the 602 ACOs participating in the MSSP and REACH programs have moved into two-sided risk tracks.[6] MACRA's incentive payments have enabled health care practices to allocate resources towards enhancing care coordination, improving patient outcomes, and reducing unnecessary health care costs. Additionally, they have supported practices in covering services that traditional Medicare does not reimburse.

The advanced APM incentives have been critical for Coastal Carolina. Across our practice we have received $600-700,000 annually in advanced APM incentives. Comparatively, this is 5-10 percent of our shared savings and less than 1% percent of our benchmark. The incentives have been critical in two areas. **First, the incentives provided assurance for the movement towards downside risk**. For a smaller ACO like ours, it was difficult to convince our clinicians to go at risk. The incentives provided financial certainty while becoming comfortable with operating in risk-based arrangements. **In recent years, the advanced APM incentives and shared savings are covering the shortfalls that we lose each year to inflation.** This has allowed Coastal Carolina to maintain clinicians and hire new clinicians, remaining competitive with larger organizations, and help pay for our value-based programs. The absence of permanent solutions for clinician payment updates combined with ratcheting benchmarks in APMs ultimately jeopardizes the adoption of value-based care.

While we have been encouraged that Congress has passed two short-term extensions of MACRA's advanced APM incentive payments, and provided temporary relief from physician payment cuts, more is needed to drive and sustain positive movement to value-based care. With MACRA's incentive payments set to expire at the end of 2024, there will be a stronger financial incentive to remain in FFS. **We support the Value in Health Care Act (H.R. 5013), which extends MACRA's original advanced APM incentive payments along with a freeze of the qualifying thresholds for Performance Years 2025 and 2026.** This approach would ensure that financial incentives to adopt, or remain in advanced APMs, are stronger than the projected incentives in the Merit-based Incentive Payment System (MIPS). At a minimum, the current incentives should be extended to allow additional time for consideration of more extensive payment reforms. While an incentive higher than MIPS is ideal, an extension of current incentives would provide an equivalent incentive to the maximum MIPS performance, based on CMS' current projections.

Beyond a short-term extension of advanced APM incentives, we believe the following principles should be met when designing long-term incentives:

- Provide timely incentives. The current incentive approach is not directly tied to care delivery as there is a two-year lag between the performance year to qualify and the payment year.
- Ensure providers are not penalized for receiving incentives. The higher conversion factor for clinicians in advanced APMs are included in APM expenditures and may make it difficult to meet

[6] https://www.cms.gov/files/document/2024-shared-savings-program-fast-facts.pdf

benchmarks. The advanced APM incentive are excluded from APM expenditures. Similarly, the incentive of a higher conversion factor update should not impact a clinician's ability to meet the financial target in their APM.

- Ensure that incentives are strongest to join an APM. The misaligned incentives are also directly tied to the opportunity to achieve higher financial gain in MIPS. This program needs revision in order to redesign APM incentives that are permanent, stable, and predictable.

ADDRESSING INCENTIVES ACROSS THE CONTINUUM

MACRA established incentives to adopt APMs for clinicians providing services under Medicare Part B. To further the movement to value-based care, we must ensure that there are incentives across the continuum of care. The backbone of the ACO model is primary care, driving beneficiary alignment to the model. However, many ACOs employ a team-based approach that creates incentives for clinicians to work collaboratively to follow evidence-based guidelines to achieve the program's goals. We regularly monitor performance of the providers rendering care to our assigned patients and work to ensure they are receiving the highest quality evidence-based care possible. Similarly, ACOs are incented to encourage beneficiaries to receive clinically appropriate care in the most appropriate setting that is not always the most expensive.

Unfortunately, other parts of the care continuum have minimal incentive to work with the ACO to innovate care when they are continued to be paid by volume. As I note above, the ACO has allowed us to help retain clinicians in our practice, particularly specialists. Cardiologists and many other specialists receive substantial subsidies when working for hospital systems. We use shared savings payments to subsidize their revenue to make it comparable to what they would receive in other settings.

ACOs and other APMs can drive success by only focusing on primary care focused strategies and programs; however, they will not reach their full potential without bringing in specialists and other providers who continue to be paid FFS. **We must reexamine the overall financial incentives that have caused many providers across the continuum to remain outside of value-based care.** This includes examining opportunities to improve benchmarks within APMs. The ratcheting benchmarks described above serve as deterrent for providers with profitable service lines, there is no incentive to invest and implement programs that reduce these profits and penalize success.

REMOVING BURDEN AND INCREASING FLEXIBILITY

MACRA provided both regulatory relief and financial incentives to encourage adoption of APMs. Specifically, MACRA created pathways for reducing provider burden by excluding all clinicians in advanced APMs from MIPS. While this is conceptually the right approach, we have not gone far enough in reducing regulatory burden for providers who are bearing financial risk. Moreover, we're concerned that CMS has restored some of the regulatory burden that was previously removed.

Increased program flexibility and reduced oversight for clinicians in APMs is needed. For example, we remain subject to audits by the Medicare Administrative Contractor for certain spending patterns. At Coastal Carolina, we recently received an audit related to increased ordering of urine drug screens; however, our staff were merely following appropriate guidelines established by our board to help ensure controlled substances were not being diverted. When we're ultimately held to total cost of care and outcomes, we should not be subject to these audits.

Similarly, CMS could increase its use of waivers, allowing providers to operate with fewer restrictions leading to a reduction in provider burden and increased care innovation. To date, the waivers have been limited and can also be burdensome. For example, MSSP only has waivers for telehealth and the 3-day rule for skilled nursing facility stays. Yet the ACO REACH model has access to many additional waivers. We believe all APMs should have access to all available waivers and that those waivers shouldn't be limited to certain models.

One specific opportunity to enhance waivers would be to improve the MSSP Beneficiary Incentive Program (BIP). This program was established in 2018 to help eliminate financial barriers to accessing care. Unfortunately, the current program structure prevents the use of the incentive because an ACO must furnish incentive payments in the same amount to each eligible beneficiary for all qualifying services. As a result, the program is too costly and complex for ACOs to implement.

In fact, HHS reported to Congress that as of October of 2023 no MSSP ACOs have established or operated a BIP.[7] The statute should be modified so that ACOs can (1) select a subset of services or patients to provide cost-sharing incentives and (2) provide a beneficiary incentive for the full amount of coinsurance for the service.

We must ensure APMs and MA are both viable options for innovating care. Providers are engaged in risk-based arrangements across payers; as such they are accountable for cost and outcomes of Medicare beneficiaries in MA and traditional Medicare. Unfortunately, the variation in program rules often means that providers must manage to the model rather than the patient.

We need greater alignment between APMs and the MA program to ensure that both models provide attractive, sustainable options for innovating care delivery and to ensure that APMs do not face a competitive disadvantage. This includes establishing parity between program flexibilities to reduce clinician burdens and improve patient access to care and driving the adoption of value-based arrangements between APMs and MA. Similarly, there is opportunity to reduce burden for providers who are in risk-based arrangements in MA. For example, exemption from prior authorization requirements creates a strong incentive to adopt risk-based arrangements in MA. The Government Accountability Office (GAO) should explore opportunities to improve APM alignment with MA and encourage adoption of risk-based arrangements in MA.

[7] https://www.govinfo.gov/content/pkg/CMR-HE22-00184510/pdf/CMR-HE22-00184510.pdf#:~:text=The%20purpose%20of%20the%20BIP%20is%20to%20allow,be%20no%20more%20than%2023%20dollars%20in%202023

We must reinstate burden reductions established in MACRA. While exemption from MIPS has been a strong non-financial incentive for providers to join APMs, we are concerned that CMS has removed some of this burden reduction. Specifically, CMS has aligned APM reporting requirements with MIPS by requiring clinicians in APMs to report Promoting Interoperability (PI) and requiring ACOs to report electronic clinical quality measures (eCQMs) ahead of industry readiness.

Fundamentally, we believe aligning APM measurement with FFS measurement is a flawed approach, rather FFS measurement should prepare clinicians for adopting APMs. CMS should:

- Develop measures that assess population health, rather than applying FFS measures to APMs.
- Exclude all APMs from MIPS and eliminate MIPS APMs.
- Rescind the recently finalized rule requiring advanced APMs to report PI.
- Delay the planned retirement of the web interface reporting system for at least three years and require CMS to test digital quality changes for a subset of APMs and ACOs to identify key challenges and unintended consequences that need to be resolved before moving forward on a program-wide basis.

CONCLUSION

Thank you for this opportunity to appear before the subcommittee to discuss ways to improve Medicare's transition to value-based care. Coastal Carolina and NAACOS' members are committed to providing the highest quality care for patients while advancing population health goals for the communities we serve. We look forward to your continued engagement to improve the Medicare payment system.

Chairman BUCHANAN. Thank you.
Dr. Philip, you are now recognized.

STATEMENT OF DR. MATTHEW PHILIP, CHIEF MEDICAL OFFICER, DULY HEALTH AND CARE

Dr. PHILIP. Thank you, Chairman Buchanan, Chairman Smith, Ranking Member Doggett, and respective members of the subcommittee. I appreciate the privilege of being able to share our experience. My name is Matthew Philip. I am an internal medicine physician and interim value-based care chief medical officer at Duly Health and Care.

Duly is one of the largest independent medical groups, multi-specialty medical groups in the country, and serves over a million patients in both urban and rural contexts in Illinois, Indiana, Missouri, and Iowa. We have grown to about 90,000 value-based care lives in Medicare Advantage and ACO REACH, and we are very proud of that.

Over the years, as I would share my experience with senior executives at different health systems both locally and across our great nation, I would hear a similar refrain from each of those executives: Value-based care sounds great, but we make money when patients are sick, not when they are healthy.

In fact, one president of a large, local hospital actually asked me, "How can I increase emergency room visits and hospitalizations?" When he saw the look on my face, he said, "Oh no, just from a business standpoint how would I do that."

While that is shocking to hear, the horror of that kind of hit home when my father was diagnosed with an aggressive kind of leukemia about eight years ago. I saw a system that was geared towards sending patients to emergency rooms and hospitals, and every path seemed to lead us back there. Thankfully, by calling in a lot of favors and years learning how to navigate the health care system, we were able to prevent every emergency room visit and hospitalization, and my father is doing well today. In fact, he is babysitting the grandkids so I can testify here.

Now, not every patient has a happy ending to that story. In fact, for far too many patients, health care happens to them instead of happening for them. And my goal is that if we can reduce three key barriers, value-based care can fulfill the promise it was initially created for. If we address greater alignment, reducing regulatory burden, which has already been mentioned, and better data sharing, we should see much larger participation and better patient outcomes.

In terms of alignment, improving hospital-based alignments can decrease a lot of friction in the system. In fact, my father's story exemplifies this. Many times we are building systems around hospitals with coordinators in hospitals and physicians in and around hospitals to provide patients with choice and alternatives. Better aligning reimbursement with investments in value-based care can also make a big difference. For instance, right now, if we invest in value-based care, the return on that investment may take 12 to 18 months to realize. That causes decreased investment to maintain solvency while we are waiting for that reimbursement to hit home.

Decreasing regulatory and administrative burdens also would improve the care for individual providers, patients, patients, as well as medical groups. Ranking Member Doggett already mentioned this in his remarks, but value-based care is—aligns directly with how physicians were trained. They want patients to do well, they want to prevent problems from happening, and they want the whole person to receive the care that they desire and they deserve. But often times the refrain I hear from my partners is there is so many boxes to check. All those boxes, all those prior auths that have been mentioned decrease that provider-patient relationship because they are so busy checking boxes on a computer screen. That really undermines the care, that trusted bond between a provider and a patient, which is the bedrock of achieving great outcomes in health care.

Reducing burdens to launch new and innovative programs is also another key. Duly created a mobile integrated health care program with a paramedic group in the State of Illinois. We were approved by the Illinois Department of Public Health for paramedics to go into the home to meet patients where they are, instead of always expecting them to meet us where we are. We have seen improved outcomes with that, preventing [sic] care, treating crisis early, instead of waiting for them to get worse.

And in rural health this can make a dramatic difference because of the disparities that have already been mentioned in health care that—especially in rural communities, leading to increased mortality in rural communities, as well. Can you imagine the difference if paramedics could go to the home, provide intravenous care for patients while they are making their one or even two-hour trips to their local hospital? This could also help rural health care systems, as well.

Finally, data lags. Improving data lags could make a dramatic difference in health care by improving outcome and preventing fraud and identifying it early. An example of this is in the Quality Withhold program in ACO REACH. Duly has still not received our quality outcomes for quarter one, and it is almost the end of June. If we don't know how we are performing, how are we supposed to improve those outcomes? So we are creating internal solutions to try to help that.

CMS alerting value-based care groups of irregular spending above trend could have prevented issues like the DME spending, similar to our local bank describes to us when our spending meets irregular practices.

In conclusion, value-based care has come a long way, but there is still a lot of opportunity. It would be helpful if PTAC proactively sought feedback from groups like ours, and CMMI included that feedback in their reports.

Thank you to the Ways and Means Subcommittee for this incredible opportunity.

[The statement of Dr. Philip follows:]

June 26, 2024

The Honorable Jason Smith

Chair

House Ways and Means Committee

The Honorable Vern Buchanan

Chair

House Subcommittee on Healthcare

Dear Chairman Smith, Chairman Buchanan, ranking member Doggett, ranking and respected members of the committee:

I am an Internal Medicine physician who is privileged to serve as the interim Value-Based Care Chief Medical Officer of Duly Health and Care. I appreciate the opportunity to share my experience-based perspective on how Congress can promote value-based payment models to improve patient outcomes and control costs. Duly Health and Care is the largest independent multi-specialty group in the nation. We serve over 1 million individuals in urban and rural communities in Illinois, Indiana, Missouri, and Iowa. We have progressively incorporated value-based payment systems within our group over the past 15+ years. I hope that sharing our experience can make value-based care more accessible for both patients and providers.

Value-Based Alignment:

Over the years, I have conversed with many senior health systems executives. A consistent response I get is "VBC sounds great, but we make money when people are sick, not when they are healthy." One president of a large hospital even asked me "how can I increase emergency room visits and hospitalizations," which of course is not best for patients or our health system.

The horror of this misalignment hit home when my father was diagnosed with an aggressive form of leukemia and sought care at a large nearby health system. Despite our multiple calls and efforts, the soonest hematology appointment was in 8 weeks. As I implored the staff to see him sooner, I was repeatedly told "I guess he'll have to go to the emergency room." We were only able to navigate the healthcare system by using tips and tricks I had learned practicing medicine, and by calling in numerous favors. Thankfully, we secured prompt treatment and avoided the hospital, but far too often, our fathers and mothers, sisters and brothers and loved ones experience similar challenges. This needs to change.

I'm excited that value-based care can change this. These payment models encourage preventative care and early, coordinated interventions that lower spending, while traditional hospital-based models profit from emergency visits and hospital admissions. These misaligned incentives cost our country in dollars, health, and wellness. Rural communities experience it most, where there is less access to preventative care and less competition among health systems, leading to higher mortality rates.

Duly's Transition to Value Based Care:

Over the last 15 years at Duly, I have helped many talented partners adopt value-based care in their practices. Today, Duly has almost 90,000 patients in Medicare Advantage and ACO REACH, and 250,000 patients in commercial value-based programs. We started first with shared savings programs, and then began full risk in 2011. Ongoing investments in our care model, health infrastructure, and data reporting have positioned us for success.

It has become increasingly hard for even a large organization like Duly to succeed as programs have increased in regulatory barriers, fraud, mismatched benchmarks, and decreased revenue. These factors put pressure on provider groups' ability to make the continued investments required to succeed in these models. This is particularly true for small and medium-sized provider groups trying to enter these programs for the first time.

There are several steps CMS can take to ease these barriers to promote greater participation:

1. **Simplify payment models and increase predictability:**
   Value-based care models require significant upfront capital while the payments lag. Provider groups are also often asked to take on risk for care over which they have no control, such as Medicare Advantage benefit design set by payers and Part D. These challenges, coupled with competing hospital incentives, discourage provider participation for large and especially small groups. A more nuanced approach could:

   - **Better align hospitals' goals to value-based care.** Hospitals play a critical role in but are often at-odds with value-based care goals. My father's example highlights a system that often does not focus on health and at times displays little care. Another common example is when hospital often send my complex patients home too early because they are incentivized to turn beds over quickly. This leads to more readmissions and higher skilled nursing utilization – the opposite of VBC goals.
   - **Accelerate payments to providers**. The impact of value-based care investments and interventions are often not seen for 6+ months. Accelerating payments could reduce the investment burden. Tying risk adjustment work to in-year payments, similar to Medicare advanced disease programs, would allow providers to be appropriately compensated for member conditions sooner than 12+ months. This would reduce provider financial burden, particularly for patients new to Medicare.
   - **Reduce impact of uncontrollable financial performance metrics.** Factors like CMMI's retrospective trend adjustment (RTA) or Coding Intensity Factor (CIF) can dramatically change profitable performance into unsustainable losses. Program management becomes impossible as the goals change constantly, leading many organizations to exit risk models.

2. **Reduce administrative burden that takes time away from patients:**
   A consistent refrain I hear from providers is that there are too many "check the box" activities required by these programs, which inhibits the provider and patient relationship.
   - **Simplify "check the box" quality tasks.** At Duly, we focus on simplified targets to leave room for the patient and provider relationships.
     - **Focusing on the patient's needs**: I work in one of our complex care clinics that provide high-touch support for our highest risk patients, who can account for 50% of healthcare expenses. With a model that emphasizes the patient and provider relationship, we have seen almost 20% fewer hospitalizations and 25% fewer hospital readmissions.
     - **Patient example**: One patient mentioned her prior provider relationship seemed more like he/she was checking boxes, understandable given the complexity of HEDIS/Star measures. At the end of her visit, I wrote her a prescription for "a bell she can ring when she wants her husband to do the dishes." She read the note intently then burst into laughter. She told me months later that she would have done anything for me after that encounter and truthfully the feeling was mutual. Practically, that moment led to amazing compliance on her part with completing her gaps of care. It also decreased my feeling of provider burnout. Later, our goals of care conversation occurred on an equal playing field where she made it clear that when it was her time, she wanted to pass away surrounding by her loved ones at home. The wisdom of ages rings true that caring is good medicine.
   - **Reduce the burden to launch innovative care models.** Duly started a mobile integrated healthcare program (MIH) with a paramedic vendor certified by the Illinois Department of Public Health (IDPH). With this program, we go to our highest risk patients in their home, preventing health crises before they happen. We deployed a pilot of this program to one of our 90-year-old patients who was wheelchair bound and could not come to see his primary care provider of many years, and did not feel comfortable with telehealth. When we came to his home, checked his vitals, and facilitated a telehealth visit with his primary care provider his eyes lit up and he was amazed we would come to him. He said, "this is like when providers would do house calls when I was growing up." This program could be especially powerful for rural patients who may travel over an hour to seek care. Imagine being able to meet rural patients where they are and provide potentially lifesaving intravenous medications while they travel to a rural health hospital. While exciting, this program required months of working with the state for approvals. This could be deployed much faster with lower regulatory burdens.
   - **Simplify Voluntary Alignment in ACO REACH:** We know that value-based care interventions benefit patients, but administrative barriers currently inhibit enrolling more patients. For example, multiple steps, forms, and prolonged timeline has slowed our ability to enroll patients in ACO REACH, including those who are eager to participate and have been seeing our primary care providers for years.

3. **Improve patient and financial data sharing:**
   Data lags make it difficult for providers to influence clinical outcomes, monitor financial performance, and alert CMS of potential fraud / abnormalities. Better data sharing would improve patient outcomes and performance for high quality providers. Specifically:

   - **Improve timely, actionable data sharing.** Two examples to highlight**:**
     - Duly still has not received our Q1 quality withhold performance for our ACO REACH patients, nearly 3 months after the quarter close. This delay dramatically shortens the time providers have to address identified care gaps. Duly has built internal reports to share feedback in days, not months.
     - **Mandate hospital Admission/Discharge/Transfer (ADT) alerts**. We have to beg and pay hospitals for ADT alerts, which allow us to know when one of our value-based care patients is admitted or discharged from the hospital. Despite our efforts, we still miss this vital information for over 10% of our population. This means we cannot apply our transitions of care processes, which are proven to lower readmission rates. Requiring all hospitals to make these alerts available for providers at risk would help patient's outcomes.
   - **Expanding Qualified Health Information Networks (QHIN).** Further expanding TEFCA governed data exchange across EHRs would benefit patients, providers and risk bearing entities with better coordination of care. For example, we have patients in community hospitals where we can not see their health records and it can take days to weeks to obtain their records. This leads to duplication of testing and waste, but more seriously unnecessary hospital readmissions.
   - **Eliminate financial responsibility for patients who opt-out of data sharing.** It is very challenging to appropriately manage a patient without comprehensive data. This gap fails the patient and places the financial consequences on our providers.
   - **Increase early response rates to fraud and make provider groups whole for the fraud they could not control (e.g., recent DME issue):** These claims were processed and paid by Medicare before provider groups even saw the data. We identified these claims and alerted CMS in early 2024. However, we have been required to absorb the full cost, totaling a significant portion of our company's annual earnings. Early communication to provider groups when DME spending is going above trend can help with early detection and better avoid fraud.

Conclusion:

Value-based care has come a long way over the years, but there is still so much opportunity. Improved mechanisms to receive and implement feedback from providers actively participating in MA and ACO REACH is critical to building and accelerating momentum in VBC. There is no great way to test these programs before implementation, which is why PTAC proactively seeking feedback from provider groups and CMMI including that feedback is critical to implementing innovation, decreasing regulatory burden, and reducing total cost of care. Otherwise, great ideas can be missed, and we may have to learn through the longer and often more painful path of personal experience.

Thank you for the opportunity to provide feedback and share suggestions to improve value-based care for patients and providers. I very much appreciate the work of the Ways and Means Subcommittee on Health in moving us forward in our goal of better patient outcomes and decreased fiscal burden. Duly and I are committed to continuing our support for Value-Based Care and the great work of the Ways and Means Subcommittee on Health.

Sincerely,

Mathew Philip MD

Interim VBC CMO

Duly Health and Care

Chairman BUCHANAN. Thank you.
Dr. Berenson, you are now recognized.

STATEMENT OF DR. ROBERT BERENSON, INSTITUTE FELLOW, URBAN INSTITUTE

Dr. BERENSON. Thank you. My name is Robert Berenson. I am an institute fellow at the Urban Institute. The views I am going to express today are my own, and should not be attributed to the Urban Institute as trustees or its funders, and I am going to be declaring some contrarian views so it was important to say that.

I very much appreciate the opportunity to provide testimony to the committee as it attempts to determine why the value-based payment approach is adopted in the Affordable Care Act, and the Medicare Access and Chip Reauthorization Act, better known as MACRA, have not succeeded in improving quality or lowering the rate of spending growth, and what changes might be warranted.

It is a subject that I have been deeply involved with throughout most of my career as a practicing general internist in a small practice just eight blocks from here on Capitol Hill, where the people live, as medical director of a PPO in two physician independent practice associations, as a senior official at CMS in the Clinton Administration in charge of provider payment policy, as vice chair of MedPAC, and as an initial member of the Provider-Focused Payment Model Technical Advisory Committee, or PTAC. So I have had broad experience, both as a clinician and as a policy wonk.

I am a proponent of the need to move to value-based care, improving quality while decreasing wasteful spending and ensuring access. However, I believe that value-based payment as the mechanism to promote better care delivery has gotten off track and needs a thorough reevaluation and reformulation. Many of the concepts that I comment on here are embedded in MACRA.

First, using quality measures and performance-linked payment incentives, known as pay-for-performance, has not worked to improve quality, and has failed at a very high cost in actual administrative resources and, perhaps more importantly, in opportunity costs. The preoccupation with ratings has suppressed professional interests in other, more effective initiatives to improve quality, in my opinion. In fact, CMS deserves credit for reducing the adverse effects of the MIPS by exempting nearly 500,000 clinicians from the program, and by providing only minimal bonuses and penalties. The program did not blow up because CMS understood that there were some flaws in the concepts, in my opinion.

Beyond MIPS, in a recent review of the Quality Bonus Program for Medicare Advantage plans, my Urban Institute co-author and I concluded that pay-for-performance programs across all Medicare providers in MA plans has not worked as envisioned, and deserves a critical congressional review about whether to continue this approach. Pay-for-performance has proved both conceptually flawed and operationally dysfunctional.

Next, although the physician-oriented MSSP ACOs have had modest success, as you have heard, programs on alternative payment models has lagged because Congress and CMS have failed to address the serious flaws of the Medicare physician fee schedule, leaving it as an unstable foundation on which to place alternative

payment models. While fees diverge—when fees diverge substantially from production costs as endemic in the fee schedule, physicians' behavior is affected to a large extent, making the marginal incentives in APMs insufficient to counter the direct incentives from the distorted fee levels.

Further, how clinicians spend their time and what services they provide, order, or refer for have as much or more to do with value received as do APMs. Currently, the fee schedule produces too many technically-oriented services and not enough time spent by clinicians in all specialties with patients in diagnosing, explaining, and counseling, and in managing care, especially for patients with multiple serious chronic conditions.

In short, the fee schedule should not be in a separate silo from APMs as now, both in Congress and in CMS.

In my written testimony I also addressed the need for a technical advisory panel in CMS for improving the process for setting fees, the opportunities to enhance fee schedule with bundled payment, including prospective per capita payments, and why the PTAC, of which I was an initial member, hasn't worked out as envisioned.

I also comment on the AMA's request for an annual update based on the Medicare Economic Index. Although a partial MEI update for practice expense portion of fees has merit, this time, in contrast to the trade with repealing the SGR in MACRA, Congress should ask for a different and more viable quid pro quo: concrete measures to improve the accuracy of the fee schedule.

Thank you for the opportunity to testify today. I look forward to answering your questions.

[The statement of Dr. Berenson follows:]

Statement of
Robert A. Berenson, MD
Institute Fellow, Urban Institute

before the
Committee on Ways and Means
Subcommittee on Health
United States House of Representatives

IMPROVING VALUE-BASED CARE FOR PATIENTS AND PROVIDERS

June 26, 2024

* The views expressed are my own and should not be attributed to the Urban Institute, its trustees, or its funders.

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Chairman Buchanan, Ranking Member Doggett, and members of the subcommittee:

I sincerely appreciate the opportunity to provide testimony to the committee as it attempts to determine why the value-based payment approaches adopted in the Affordable Care Act (ACA) and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) have not succeeded in improving quality or lowering the rate of spending growth and what changes might be warranted. It is a subject I have been deeply involved with throughout most of my career: I have served as a general internist in a practice just a few blocks from here; medical director of a preferred provider organization and two independent practice associations; senior official at the Centers for Medicare and Medicaid Services (CMS) in the Clinton administration in charge of provider payment policy in traditional Medicare and contracting with private risk plans, now known as Medicare Advantage plans; vice-chair of the Medicare Payment Advisory Commission (MedPAC); and an initial member of the Provider-Focused Payment Model Technical Advisory Committee (PTAC).

As an Institute fellow at the Urban Institute for the past 20 years, the majority of my work has focused on issues related to payment to physicians and other clinicians, in Medicare and more generally. I write frequently on why and how physician payment reform has gotten off track and have advocated for more value-based *care*, higher quality, and reduced spending increases while still ensuring access. Where I strongly disagree with the direction of health policy is on current concepts embedded in the value-based *payment* provisions of the ACA and MACRA.

In 2013, I testified before the Energy and Commerce Committee on the topic of building a future Medicare physician payment system. In that testimony, I expressed the view that central elements of how value-based payments were being considered were simplistic and would not improve care. I offered an alternative view of what would move payment to support enhanced care value. Congress proceeded to adopt MACRA provisions that I had testified would fail, while at the same time ignoring the long-standing need to fix the broken Medicare Physician Fee Schedule. As MedPAC vice-chair, I did support repealing the dysfunctional Sustainable Growth Rate (SGR), whose pervasive shadow had chilled interest in considering needed fee schedule reforms.

In short, Congress chose the wrong quid pro quo—the term then commonly applied to the trade-off for SGR repeal. Instead of making long-needed improvements to the Medicare fee schedule that would have substantially improved the value of care for beneficiaries and taxpayers, MACRA doubled down on "pay for performance" in the form of a merit-based incentive payment system (MIPS) and provided modest incentives for clinicians to participate in alternative payment models (APMs).

The evidence has shown that MIPS has failed and become a high-cost burden for clinicians without actually improving the quality of care. Demonstrations of APMs are needed but will continue to have limited impact without substantial fee schedule fixes. Now, 11 years after my testimony, as important MACRA provisions expire, I am experiencing a Yogi Berra moment of "*déjà vu* all over again." I reviewed my previous testimony and found major parts to be as relevant now as they were then. I cannot say it is better today, so I will quote some text from that testimony[1]:

[1] Robert A. Berenson, "SGR: Data, Measures and Models: Building a Future Medicare Physician Payment System," Statement before the Energy and Commerce Committee, February 14, 2013.

"Value can be improved not only by improving how well particular services are provided but also by improving the kind and mix of services that beneficiaries are receiving. The Medicare fee schedule for physicians and other health professionals produces too many technically oriented services, including imaging, tests, and procedures, and not enough patient-clinician interaction to diagnose and develop treatment approaches consistent with a patient's values and preferences, and continuing engagement to assure implementation of mutually agreed upon treatment plans. Similarly, the fee schedule does not encourage care coordination and other patient-centered activities that would actually improve patient outcomes, including their own sense of well-being. In urging more attention to modifying payments and payment methods to obtain a better mix of clinician services, I want to emphasize that while I agree with the conventional policy wisdom that fee-for-service as a payment method has substantial, inherent flaws and over time needs to be replaced—mostly—fee-for-service gets an undeservedly bad reputation because of its flawed implementation in Medicare and by private payers, which largely rely on the Medicare Fee Schedule in setting their own fee schedules.

...In fact, I believe it is necessary, if seemingly paradoxical, to take firm steps to improve the fee schedule in order to implement new and improved payment reform models for a number of reasons. First, the migration to new payment models that better reward prudent care will not be easy or quick. Despite hopes for a fast track to new payment approaches, it will take years for the Medicare payment pilots to be tested, refined, and then scaled up to be implemented on a widespread basis. Second, fee schedule prices are building blocks for virtually all of the payment reform approaches being tested, most notably bundled episodes, but also shared savings and global payments for accountable care organizations. Errors in individual fees in the Medicare fee schedule would therefore be carried over into the bundled episodes and shared savings calculations.

Third, entities like ACOs will work best when formed around multispecialty group practices and independent practice associations, which would be well positioned to accept care responsibility for a population and to organize needed services across the spectrum of providers. But specialties that continue to be generously rewarded from distorted prices under current public and private fee schedules, such as cardiology and radiology, prefer to continue in large single specialty practices or to cash out and accept hospital employment rather than join with primary care physicians to form and maintain the medical group. Perpetuating the current, nearly 3:1 compensation differences between important specialists and primary care will frustrate the transition to ACO–like delivery systems, even if they are supported by new payment approaches."

'Pay for Performance' (P4P) Is Fatally Flawed

Quality-of-care experts and other policy analysts are increasingly joining earlier skeptics, including myself, to question whether using direct financial rewards and penalties to perform better on a small number of quality and cost measures—known as pay for performance (P4P)—can achieve their goals. Elizabeth McGlynn, widely acknowledged as a leading quality-of-care expert, noted in 2020, "Despite nearly two decades of experimentation with standardized measurement, public reporting, and reward-and-penalty programs, average quality performance in US health care remains about the same."[2] Michael McWilliams, a Harvard policy researcher and a leading evaluator of accountable care

[2] Elizabeth A. McGlynn, "Improving the Quality of US Health Care—What Will It Take?" *New England Journal of Medicine* 383, no. 9 (2020): 801–4.

organizations (ACOs), recently wrote, "After two decades of efforts relying on quality measurement and performance-linked payment incentives, we need new ideas and new conversations."[3]

My Urban Institute colleague Laura Skopec and I recently published an issue brief concluding that P4P approaches, which Congress has mandated across 20 different provider payment systems in Medicare[4] have failed for many reasons, which we grouped into two basic categories: (1) serious flaws with the measures used and their lack of reliability, and (2) serious adverse effects from the obsessive focus on measuring performance.[5] One of the most serious effects has been the preoccupation of providers and Medicare Advantage (MA) plans with their ratings, to the exclusion of other, often more useful approaches to actually improving care value. Lara Gotein, a physician trying to improve the quality of care in her small New Mexico hospital, observed in *Health Affairs*, "Ironically, metrics-based programs can undermine quality improvement by shifting resources and attention to measurement and reporting and away from actually improving quality."[6] Many trying to improve quality echo the same complaint about the role of the so-called measurement industrial complex. Measuring seemingly has become an end in itself rather than a facilitator of improved value.

P4P in Medicare takes several forms: bonus only, balanced bonuses and penalties, and penalty only. The Quality Bonus Program in Medicare Advantage provides windfall profits to most MA plans, yet the research evidence is clear that, overall, the quality of care in Medicare Advantage is about the same as in traditional Medicare,[7] acknowledging that certain MA plans—especially some special needs plans and group practice–based HMO–model MA plans, based on anecdotal reports—provide exemplary care.

MACRA's MIPS theoretically assesses both bonuses and penalties for clinician performance on a small number of quality measures, with funds collected from penalties used to finance bonuses. CMS deserves great credit for minimizing the potentially harmful impact of flawed measurement in MIPS by exempting nearly 500,000 clinicians, largely due to what CMS considered insufficient Medicare patient volume, and by minimizing the size of the penalties and bonuses received.[8]

A major P4P program created by the ACA is the Hospital Readmission Reduction Program (HRRP), the primary penalty-only P4P program in Medicare, which I supported at the time of ACA passage. Unfortunately, HRRP has exhibited various measurement problems and produced unanticipated

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[3] J. Michael McWilliams, "Professionalism Revealed: Rethinking Quality Improvement in the Wake of a Pandemic," *NEJM Catalyst* 1, no. 5 (2020).

[4] Douglas B. Jacobs, Michelle Schreiber, Meena Seshamani, Daniel Tsai, Elizabeth Fowler, and Lee A. Fleisher. "Aligning Quality Measures across CMS–The Universal Foundation," *New England Journal of Medicine* 388, no. 9 (2023): 776–79.

[5] Robert A. Berenson and Skopec Laura, "The Medicare Advantage Quality Bonus Program: New Ideas and New Conversation" (Washington, DC: Urban Institute, 2024), https://www.urban.org/research/publication/medicare-advantage-quality-bonus-program-new-ideas-and-new-conversations.

[6] Lara Goitein, "Clinician-Directed Performance Improvement: Moving Beyond Externally Mandated Metrics," *Health Affairs* 39, no. 2 (2020): 264–72.

[7] Robert A. Berenson, Bowen Garrett, and Adele Shartzer "Understanding Medicare Advantage Payment: How the Program Allows and Obscures Overspending" (Washington, DC: Urban Institute, 2022), https://www.urban.org/research/publication/understanding-medicare-advantage-payment.

[8] US Senate Committee on Finance, "Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B" (Washington, DC: US Senate Committee on Finance, 2024), https://www.finance.senate.gov/imo/media/doc/051723_phys_payment_cc_white_paper.pdf.

negative effects. Indeed, my colleague Skopec and I recently published an article documenting that the rates of preventive hospitalizations and emergency room visits have never been validated as legitimate quality measures, even as they have been adopted widely in research and policy.[9] When adjusted for hospitals redesignating inpatient admissions as observation stays—the designation for short-stay hospitalizations, which are not measured in HRRP—the data do not show that readmissions for the selected conditions have declined.[10] Even worse, initial research suggests that reduced hospitalizations for congestive heart failure, the leading cause of hospitalization in Medicare, can reduce quality for those patients.[11] An extensive literature also demonstrates that the program exacerbates inequity across hospitals, because hospitals serving a poorer population with fewer community and family resources will naturally have greater difficulty providing necessary care on an ambulatory basis.

In short, HRRP has not worked as envisioned. Congress urgently needs to reconsider its two-decade commitment to P4P approaches across Medicare payment systems. It can start by repealing MIPS and instead work on addressing the poor value produced by the Medicare fee schedule.

Alternative Payment Models

In contrast to P4P, quality and efficiency can be advanced with the implementation of alternative payment models. APMs for physicians, which constitute the bulk of APMs being tested by the Center for Medicare and Medicaid Innovation (CMMI), need to be built on a solid, well-functioning fee schedule foundation. CMS initially, and later CMMI's affiliated Health Care Payment Learning and Action Network (LAN), have long held that fee-for-service provides "no link to quality and safety."[12] I strongly disagree. How physicians and other health professionals spend their clinical time and what additional services they provide, order, or refer have as much or more to do with the value of care furnished as do the marginal incentives that APMs contain. Other countries produce as good or better quality at much lower costs relying on fee-for-service-based fee schedules rather than APMs.[13] A more accurate fee schedule should be a strong foundation for APMs.

The LAN typology that dismisses fee-for-service as having no link to quality exalts so-called population-based payment, previously called capitation (payment per capita rather than for services furnished), as having the greatest potential link to care value. That designation ignores the central reality that every payment method has strengths and weaknesses, such that the objective of value-

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[9] Robert A. Berenson and Laura Skopec, "How Preventable Hospitalizations Became A Widely Used But Flawed Quality Measure," *Health Affairs*, June 3, 2024, https://www.healthaffairs.org/content/forefront/preventable-hospitalizations-became-widely-used-but-flawed-quality-measure.

[10] Amber K Sabbatini, Karen E. Joynt-Maddox, Joshua M. Liao, et al., "Accounting for the Growth of Observation Stays in the Assessment of Medicare's Hospital Readmissions Reduction Program," *JAMA Network Open* 5, no. 11 (2022).

[11] Ankur Gupta and Gregg C. Fonarow, "The Hospital Readmissions Reduction Program—Learning from Failure of a Healthcare Policy." *European Journal of Heart Failure* 20, no. 8 (2018): 1169–74.

[12] Health Care Payment Learning and Action Network (HCP LAN), *Alternative Payment Model APM Framework* (Baltimore, MD: HCP LAN and The MITRE Corporation, 2017), https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf.

[13] Naoki Ikegami, "Fee-for-Service Payment—An Evil Practice that Must Be Stamped Out?" *International Journal of Health Policy Management* 4, no. 2 (2015): 57–9.

based payment reform should be to mix and match different payment methods to accentuate the positives and mitigate the negatives.

There is growing recognition among beneficiaries and policymakers that pure payment methods—such as fee-for-service and per capita payment—can produce major adverse effects that should be mitigated. Many MA plans funded by pure capitation are able to siphon off a substantial portion for their own profits while inappropriately denying service to their enrollees and obligated payments to providers.

Although I had been a proponent of pure population-based payments to organizations like ACOs to give them more control over how to allocate resources to better serve their enrolled or attributed populations, I now see the merits of blending fee-for-service and population-based payment to clinicians and shared savings to the ACOs. One challenge that needs to be addressed is the mismatch between the ACO's desire to achieve shared savings and the way its constituent physicians are paid via the Medicare fee schedule, which incentivizes more care, needed or not. ACOs can assist care delivery choices and reduce spending for certain activities, such as reducing the often unneeded referrals to skilled nursing facilities (SNFs) or inpatient rehabilitation after a common joint replacement surgery. However, for the bread-and-butter care provided by physicians, the distorted fees in the fee schedule undermines ACOs' ability to achieve savings.

To its credit, responding to recommendations from the primary care panel at the National Academy of Medicine, CMS recently announced an ACO Primary Care Flex option under the Medicare Shared Savings Program waiver authority, under which primary care clinicians would be paid through a "hybrid" payment—part fee-for-service and part per capita payments. In contrast to current value-based payment notions, the hybrid payment approach in essence attempts to minimize payment incentives to do too much or too little but rather seeks incentive neutrality so that the practice can serve the patient's best interests rather than their own. The National Association of Accountable Care Organizations and the Primary Care Collaborative worked with CMS to design the hybrid model, which is scheduled for initial implementation in 2025.

Anticipated lessons from ACO Flex and from the already completed CMMI primary care demonstrations should provide the needed experience to allow adoption of a hybrid payment model for all primary care clinicians in Medicare,[14] the point being that "fee-for-service" and "fee schedules" are not synonymous. The Medicare fee schedule already includes examples of bundled payments (10- and 90-day global periods) for most surgical and other procedures, rather than separate payments for post-procedure hospital and office visits, such as a monthly per capita payment for managing dialysis and a monthly chronic care management payment. Given explicit authority to include prospective payment in the fee schedule, CMS could proceed to adopt a hybrid payment approach for primary care clinicians in the Medicare fee schedule through regular rule making.

When I served as an initial member of PTAC, my colleagues and I found that many submitted proposals had thoughtful concepts and could produce desirable care improvements that did not require

[14] Robert A. Berenson, Adele Shartzer, and Hoangmai H. Pham, "Beyond Demonstrations: Implementing a Primary Care Hybrid Payment Model in Medicare," *Health Affairs Scholar* 1, no. 2 (2023).

CMMI to test an entirely new payment model, which would then need to pass muster with the CMS Office of the Actuary for broad adoption in Medicare. Instead, the proposals from specialty societies and others constituted suggestions that seemed more appropriate for adoption within the Medicare Physician Fee Schedule, with the challenge often coming down to issues of operational feasibility. The relevance for this subcommittee's consideration is that APM development and adoption and Medicare fee schedule maintenance and improvement are currently in separate substantive and organizational silos at CMS, consistent with Congress's erroneous view that the fee schedule and APMs are wholly separate endeavors.

PTAC could be reconfigured, first, to report to the CMS administrator, the logical place to have its views expertly considered, rather than to the secretary of the US Department of Health and Human Services. Second, PTAC should expand its advice beyond just APMs to include considerations of process improvements to coding and payment in the fee schedule.[15] Additionally, CMS will require a technical advisory committee to support CMS staff as they determine what fixes are needed to the process of setting fees in the fee schedule, as proposed in draft Whitehouse-Cassidy legislation.

The AMA Proposal

Last year, the American Medical Association (AMA) initiated a major campaign "to explore long-term payment solutions for the broken Medicare physician payment system."[16] However, instead of proposing fixes to what we agree is a broken system, the AMA merely proposed updating annual fee increases for inflation in practice costs and changing the budget-neutrality provision that dilutes the value of relative value units for established codes in the fee schedule. The AMA's supporting analysis claims that Medicare fee schedule payments have substantially lagged inflation in practice expenses for two decades. However, as MedPAC has shown, actual payments—as reflected in spending per beneficiary, rather than prices—were much higher because of substantial growth in service volume.[17] Although cumulative fee update growth over the time frame was 12 percent, compared with Medicare Economic Index (MEI) growth of 45 percent, growth in per beneficiary spending was a cumulative 94 percent, meaning that volume growth more than offset the gap between the MEI and annual fee updates.

Although a partial MEI update for the 50 percent of fees that represent practice expenses has merit, the far greater problem (as the AMA writes but then ignores), is that the Medicare physician payment system is broken, and as such prevents the successful adoption of value-based payments in Medicare. Congress could adopt a far better quid pro quo than it did in MACRA, this time in exchange for a partial annual MEI update factor. The trade-off should be specific actions to improve the Medicare fee

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[15] Robert A. Berenson and Paul B. Ginsburg, "Improving the Medicare Physician Fee Schedule: Make It Part of Value-Based Payment," *Health Affairs* 38, no. 2 (2019): 246–52.

[16] "Medicare Basics Series: The Medicare Economic Index," American Medical Association, June 3, 2024, https://www.ama-assn.org/practice-management/medicare-medicaid/medicare-basics-series-medicare-economic-index.

[17] Medicare Payment Advisory Commission, *Medicare Payment Policy* (Washington, DC: MedPAC, 2023), https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_v2_SEC.pdf.

schedule, as outlined in a recent comment letter with contributions from former CMS and MedPAC career staff responsible for the fee schedule.[18]

Enacted in the Omnibus Reconciliation Act of 1989, the current Medicare Physician Fee Schedule has been in place, largely unchanged, for 32 years. Although many payment codes have come and gone, the basic legislative requirements for what fees should reflect—relative resource costs—need to be reconsidered if Congress is truly interested in adopting value-based payment for services provided by physicians and other clinicians. More immediately, Congress should understand that APMs by themselves cannot achieve what Congress seeks without urgent attention toward fixing the major fee distortions that directly influence clinician behavior.

[18] Medicare Payment Advisory Commission, *Medicare Payment Policy*.

Chairman BUCHANAN. Thanks for your testimony. We now move to the Q-and-A session.

Mr. Smith from Nebraska.

Mr. SMITH of Nebraska. Thank you, Mr. Chairman, and thank you to all of our witnesses, certainly, for sharing your perspective, very valuable insight. I think that value-based care doesn't get enough discussion here. So I am glad that we can have this hearing today.

There have been, you know, successes. I think one of the most noteworthy successes of the various value-based care initiatives the Medicare program has attempted over the last couple of years with ACOs, and so they show higher performance metrics on a wide slate of quality measures, including diabetes and blood pressure control, cancer screenings, tobacco cessation, and even depression screening and follow-up. We all know that is important. With their current success in mind, I want to draw attention to one of the main challenges for ACOs in rural areas. And as you know, workforce shortages exist in a very acute manner. And also we want to focus on the importance of non-physician providers of primary care.

While we do value our rural physicians, there simply are not enough to meet the needs of our rural health systems, not just in Nebraska but across America. Many of my constituents rely on primary care provided exclusively by nurse practitioners or physician assistants, but under current law these clinicians have to refer their patients to an outside doctor in order for their patients to be assigned to an ACO.

My bill, the ACO Assignment Improvement Act, which I recently reintroduced with Representative Kilmer, would allow nurse practitioners and PAs to directly assign their patients in ACOs without the additional visit, allowing them to more easily benefit and more efficiently benefit from the coordinated care ACOs offer.

On a different note, I would also like to highlight legislation I have worked on for some time which would provide for more oversight and accountability of CMS's Centers for Medicare and Medicaid Innovation, or CMMI. While the potential for fiscal savings and improved patient care is obvious, CMMI has roundly failed in achieving these goals, as was noted in CBO's assessments from last fall.

The Strengthening Innovation in Medicare and Medicaid Act, which has previously had bipartisan support, includes a variety of common-sense proposals to make sure CMMI model testing actually lines up with its original mission. An agency tasked with designing innovative payment policies to save taxpayer dollars and improve patient experiences must be protected from politicization and abuse.

Rather than existing as a tool for presidents to end-run around Congress and implement sweeping changes to Federal law, CMMI should focus on its original intent, testing limited models, evaluating results, and expanding and certifying successes while winding down failed initiatives as quickly as possible.

My legislation would implement simple, common-sense protections that would minimize whiplash to patients and providers pushed into or pulled out of mandatory models they knew were destined for failure. Standards for the initial size and scope of mod-

els, requirements to consider impacted stakeholder feedback, and even targeted judicial review will ensure future CMMI models are designed to scientifically test, then either expand or wind down policy proposals, rather than make sweeping, unilateral changes.

So Dr. Berenson, since CMMI's creation, there has been strong bipartisan concern about CMMI models appearing to exceed intended payment incentives for cost savings and quality improvement. What, in your opinion, would be the most practical measures that Congress could take to protect CMMI from political abuse, and also ensure models are aligned with the goals of controlling costs and improving care?

If you could, turn on your microphone there.

Dr. BERENSON. I am sorry about that. Clearly, CMMI's record has been mixed. I am not sure that it has been politically-directed problems, but I guess the point I would make here is that often—well, I will go back to the PTAC experience that I had. I was on PTAC for three years. We got some very good proposals from a range of physicians who identified problems in how they were delivering care, and had ideas about what they needed for improvement.

What they did not need was a full-scale model that a—that CMMI had to test. What they needed were coding improvements and payment improvements, and the basic fee schedule. The large majority of their recommendations—my response, and I think I convinced other members of PTAC—were we could solve this problem with some coding initiatives in the fee schedule.

So I think that CMMI should be focused on a few basic models, and ACO seems to be the major one that has some legs, and should not be sort of trying to solve every problem through a full-scale model. Here is where I distinguish between a payment method and a full-scale model. We need to improve the methods, and that can happen in the fee schedule. People think that fee-for-service and the fee schedule are synonymous concepts, but we already pay for bundled payments in the fee schedule in a number of ways. We could enhance that, and go through and make those improvements through normal notice and comment rulemaking, and not have to do it all through the through the CMMI approach.

Mr. SMITH of Nebraska. Okay, thank you. Thanks again to all of our witnesses.

I yield back.

Chairman BUCHANAN. Mr. Doggett, you are recognized.

Mr. DOGGETT. Dr. Berenson, one of the concerns that I have had is the reclassification of inpatient hospital information concerning observation stays. That, as you know, can have big consequences for the patient when they get the bill, and relates to what Medicare covers.

Years ago in this committee I secured approval of modest legislation to at least provide notice to the patient, which became law, so that they would know about the two-midnight rule. I am also a long-time supporter of our colleague Joe Courtney's legislation that is designed to ensure that observation counts toward eligibility for skilled nursing home care.

Can you elaborate a little on your testimony concerning the gaming of hospitalization data and the flaws in relying on that as a quality metric?

Dr. BERENSON. Yes. The initial—well, in reference to the hospital readmission program, or readmission reduction program, the initial sort of reviews of the program were that it was a modest success, but it turned out that research demonstrated that it was only a success because observation stays were not included in the calculations.

Similarly, Medicare Advantage plans claim that they had reduced hospital stays compared to traditional Medicare, or research studying that issue had concluded that Medicare Advantage plans had reduced spending—I am sorry, had reduced hospital stays when compared to traditional Medicare.

But it turned out that they were more aggressive at getting patients reclassified as observation stays in which the patient—the payment is done through the outpatient part B approach, rather than as a part A inpatient stay. And when you add it up, all of the true inpatient stays, their observation stays, and their ER visits as follow-up, they actually had higher readmissions of events with—higher readmission events. So that issue exists.

The readmission penalty is one of the major flaws or failures of pay-for-performance. It turns out that by—with this incentive to reduce readmissions, it revealed a major equity problem that hospitals in low-income areas, which lacked the ambulatory care, the community resources or family resources to treat a patient safely on an outpatient basis were adversely affected compared to hospitals in more affluent areas.

And then, ultimately, what happened was that studies are beginning to show that readmissions—reduced readmissions compromise quality, in particular for patients with congestive heart failure. So that is when my colleague and I reviewed the history of ambulatory care sensitive conditions as a quality measure, and have raised questions about whether it is even a valid quality measure, even though it is being used widely across research and policy.

So we are—the pressure to have measures and to rank hospitals or physicians or MA plans is driving bad science, rather than creating good science. So that is my concern.

Mr. DOGGETT. How would you reform the Quality Bonus Program to ensure genuine improvements?

Dr. BERENSON. Well, the Quality Bonus Program for MA plans, one of the basic flaws with it is it is the only program that is upside only. The MIPS program, one of its virtues is that, as it was designed, the penalties were going to pay for the rewards. And as I said earlier, CMS has successfully minimized the impact of that. In MA it is upside only. And in fact, three and four-star plans are getting paid very generously.

The critique is fairly major. We would do a basic reevaluation of whether it is achieving anything other than providing windfall profits for MA plans outside of what they are doing. The research shows that MA plans provide about the same quality as traditional Medicare, no better, no worse, and yet they are receiving huge bonuses for achieving these scores.

There are some excellent MA plans. I don't want to imply that MA is—should be done away with or anything. There are incentives, but the—it is one of the problems with moving to full capitation. The plans receive a big slug of money from the Federal Government, and then have a direct incentive to try to deny care. That is how they have used it.

I am a big believer in having blended payment models, part fee-for-service, part capitation. It is complex, but I think that is the kind of conversation we should be having.

Mr. DOGGETT. Thank you very much, and thanks to all our witnesses.

Chairman BUCHANAN. Mr. Kelly of Pennsylvania.

Mr. KELLY. Thank you, Chairman.

And Dr. Berenson, thank you for describing it as complex. I don't know that anybody on this panel, other than Dr. Wenstrup, who is a doctor, understands this business model. I have no idea why people would go into medicine today, including my roommate at Notre Dame who had three daughters, and I said, "So, Jed, are the girls going to join your practice?"

He says, "What are you talking about? I don't want them to go anywhere near this, and I can't wait to get out of it myself."

So having said that, I would rather talk to somebody that actually relies on the revenue to drive the business model. I am going to cede my time to Dr. Wenstrup, because I am fascinated how we expect non-productive policies to have any influence on the quality of what we do deliver.

So Dr. Wenstrup.

Dr. WENSTRUP. Thank you, I appreciate that, and I want to thank you all for being here today.

When I first got to Congress, and I am diving into these issues on health, I thought, man, we must have a lot of really bad doctors in our country that are doing bad things all the time. We better crack down on them. We better make sure they are doing the right thing. And so all these programs—okay, I guess maybe we should incentivize good outcomes, you know, I guess we need to do that because maybe people aren't doing the right thing.

I didn't find that in my community in Cincinnati. If there was a bad doctor, they generally rose to the surface, and you knew who it was, and it took care of itself, you know, they lost privileges, or their society came down on them. That is all it took. The threat of malpractice is enough for you to adhere to community standards and do the best for your patients because you are an entrepreneur, and the only way your business grows is by taking care of people and doing it well.

We have gotten way too involved, way too involved. And I understand the value of positive outcomes. That is how your practice grows. I never cared what Washington thought. I thought what my referring doctors thought. I thought about what my patients thought and what the community thought, what my reputation was. That is what drove good outcomes. Nothing Washington did had anything to do with those successes. And we in medicine today do not put enough value on the healthy human life. That is where the savings come, is the healthy human.

I so appreciate you, Doctor. I am going to mispronounce your name, Dr. Chouinard. And, you know, I have covered Appalachia. I know what you are talking about, and I so appreciate what you had to say.

You know, I am a co-lead on the Value in Health Care Act, and it is a bipartisan bill, and I think it makes some changes to the program parameters. But even if passed, it is going to need review. Because if we are doing something that just—you know, what I have seen over my time, my pay kept going down, down, down in fees for service, and I didn't give up on my time with the patient because that, to me, was sacrosanct. But it did increase paperwork, and it did increase costs within my office.

And yes, thank you for that, because it is very scary. [Laughter.]

Anyway, but the value of the healthy human life is unbelievable. I know when I first took my kids to the pediatrician I was like, "I came here to this practice."

They said, "We might have your chart in the basement." They pulled out the chart. There was a three-by-five card stapled in it, and it had the date, and it just said, "Okay." Okay. And guess what? The doctor kept me healthy. And when there was something to be done—there was more to it, but we have gone so far to documenting, documenting, documenting. The real document is how that patient feels at the end of the day. That is all that matters, and that is what we should be concerned about.

So prevention is key. You know, you talk about how do I increase my admissions and fill more beds and do all this? That is not the answer for the future. It is not. I am a podiatrist. Arizona, one year, thought it would be great under Medicaid to drop podiatric services. Guess what? Their costs went way up, because we do a lot of prevention, prevention of ulcers, and we are the first to detect vascular disease, neuropathy, things like that, right, congestive heart failure. We get patients into the right care. That went away. Their costs went way up, amputations soared. They begged them to come back.

But this is where the savings is, is in the value of the healthy human life. I say to insurance companies, why don't you incentivize—if you have a group, a business maybe that has 100 insulin-dependent diabetics, maybe you put into the plan that they have no co-pay three times a year to go to their doctor. You will probably prevent hospitalizations and increased costs because they are being checked up on.

My time is up, but I am not done. I guess I will get to go back when it is my time and ask some questions, but I hope—I want you to chime in on what I had to say. [Laughter.]

Thank you.

Chairman BUCHANAN. Mr. Thompson of California.

Mr. THOMPSON. Thank you, Mr. Chairman. Thanks to the witnesses for being here today.

You know, you will find on this committee that we most certainly have our disagreements, but I think there is a lot of bipartisan agreement on a couple of main points in regard to health care. I think we would probably all agree that health care is too expensive, and health care spending is out of control. Pay-for-service model has some major flaws, with consequences for both patients

and the U.S. Treasury. And I think we all agree that we should try and maximize the value to patients with each dollar that we spend.

And before I ask a question that I have, I just want to circle back on the whole idea of rural health care. And I represent a very rural district, and I know the issue fairly well. My wife is a health care provider in that rural district. But I think it is important that we recognize that underserved is underserved in a rural area, in an inner city, or in a suburb. And so we do have our challenges in the rural areas, but that—we are not alone.

Dr. Berenson, one area where I think there is a bright spot, if you will, is in the advancement of technology. I have long been a proponent of telemedicine, and I have worked a lot in that space, but we also have artificial intelligences quickly moving forward. And there is other areas of rapid advancement in technology. Can you speak to how you see that benefitting some of the challenges that you have heard—that you know about and that you have heard from my colleagues and myself today?

Dr. BERENSON. Well, I assume you are referring mostly to communication technology, which underlies telemedicine with patient portals and much more——

Mr. THOMPSON. Well, information technology as it pertains to the delivery of health——

Dr. BERENSON. Yes.

Mr. THOMPSON [continuing]. Care and the accessibility of health care.

Dr. BERENSON. Yes, no, it is a major development. And it makes the point where the desire to improve value-based care, which would have robust use of telecommunications, meaning phone calls, email, texts, patient portal communications with doctors and patients, doctors and other doctors, doctors and pharmacists, all of that should be going on much more than now. And it points to the flaws in value-based payment—or current payment, let's put it that way.

CMS correctly, I believe, has a limited definition of telemedicine. They basically say telemedicine is for services that are a substitute for a face-to-face visit. And yet a lot of the activities that go on and should go on are short communications, they are not substitutes for visits.

I remember after I had practiced for 15 years and ran into one of my patients when I was doing policy, she thanked me for being a very good primary care doctor, and she said, "You are the only doctor who ever called me after a visit to see how I was doing," and she very much appreciated that. Well, that is not paid for, and it can't be paid for fee-for-service, because the billing costs are more than the value of that phone call.

And that is what leads me and the Academy of Medicine, which made a formal proposal to move, at least for primary care, to a hybrid payment model, where a major piece of their—of compensation would come from a per-member or per-beneficiary, per-month payment. It would provide the support for robust communication like that outside of fee-for-service. You can't do that fee-for-service.

And in fact, I know Steve over here, Dr. Nuckolls, is very much part of it. There is going to be a new program that CMMI and CMS are mounting, which resulted from NACOs, the Association of

ACOs, and the Primary Care Collaborative to move to a hybrid payment model for MSSP ACOs that wish to participate in it. So we have a much more logical payment model for primary care, which isn't all just fee-for-service.

And I think we need to get—well, one final thing—I know I am talking too much—there has been research showing that primary care docs, about 25 to 30 percent of what they do during the day, clinically, is not paid for. These are the small ticket items. We don't have much from other specialties about that. But if you—if we had a database showing that specialties also are doing that, they could be getting payments, as well, lump sum payments to cover that so that they don't have to do unnecessary procedures to cover their overhead.

Mr. THOMPSON. Thank you very much. I yield back.

Chairman BUCHANAN. Yes, the committee stands in recess and will reconvene immediately following the last vote in this series.

[Recess.]

Chairman BUCHANAN. Let's go back to the doctor from Ohio, Wenstrup.

Doc, you are up.

Dr. WENSTRUP. Thank you. Good to be back with you. Thanks for sticking around and waiting.

I think, you know, the question I have pertains to new ideas, new innovations. You all gave great testimonies. As a matter of fact, you answered most of our questions in your testimonies, which was awesome, so I don't mind hearing some things being repeated. But when you talk about cost savings through prevention, let me hear some of your ideas of the things that you are doing that are keeping people healthy.

Dr. CHOUINARD. Thanks for asking.

So, you know, one of the things that I think is really important to think about is the use of mobile technologies for things like diabetic eye exams for diabetic patients. So, you know, in rural West Virginia I would have patients who would not get their diabetic eye screening because it would be a transportation barrier. And so making sure that we are supportive of being able to do things that, instead of solving the transportation barrier, instead we work with new tools that allow people to get services that they need right in their communities.

So there is another project. It was called Bonnie's Bus. It was a mobile mammography unit that would come and set up shop, you know, once a month, and allow women who otherwise couldn't make it to a tertiary center to get screening done in place.

So I think, when I think about prevention, the biggest barrier in rural America is getting to the places that can do that. We do some things in the office, but, you know, we don't have a mammography suite, for example. So I think that that is an important—it is not innovation meaning that technology has been around a long time, but I don't think enough people are leveraging things like that in rural primary care.

Mr. NUCKOLLS. We are also in a rural area. One of the programs that we set up earlier this year is a low-dose cancer screening for smokers. We have a lot of smokers in our area, and so we really started tracking pack years and making sure we were meet-

ing the criteria of the U.S. Preventive Task Force. We set up this quality measure, even though it is not one of the ones that is in the program. But we have been very successful at identifying early a lot of cancers. We are spending a little more money as an ACO up front, but we know it is an investment in the long-term health of our patients.

One issue came up where the U.S. Preventive Task Force recommends that we screen everybody up to age 80, but Medicare only covers it to age 77. And so this was a predicament in our committee. And we basically talked about it. And with the—you know, we are in the enhanced track, which means we keep 70 percent of the—or 75 percent of the savings.

So in this scenario what I told the doctors was, I said, if we got paid by Medicare for this, you would get $100. If you don't bill Medicare for it because it is not covered, you would still get, you know, through shared savings, you are only getting an extra $25. Does it make sense to not order it for $25? Of course not. So we said just do it for these patients. We had that freedom because we look at this money as ours, and that we are here to be a protector of the Medicare trust funds because we are at risk.

Unfortunately, the way the budgets are working, our ACO will have to do something else next year. There is not enough savings once the ratchet comes in and they lower that benchmark. We are now 25 percent below our region when we started the program 10 years ago. We can't cut costs as much anymore. So the meager savings that we are allowed to carry forward is not enough to cover the cost of these programs, so we will have to do something different next year. But to me, that is something that really needs to be addressed.

Dr. WENSTRUP. Well, let us know what you come up with next year.

Mr. NUCKOLLS. Okay, thank you.

Dr. WENSTRUP. Thanks.

Dr. PHILIP. Two quick programs. We created these breakthrough care centers that focus on the sickest 5 percent of patients that can account for up to 50 percent of health care costs. And we have a multi-disciplinary approach, and we found a 20 percent decrease in hospitalizations and a 25 percent decrease in readmission rates, as well as multiple different areas focusing on that patient-physician relationship and utilizing our whole team of resources to prevent problems from happening instead of reacting to them.

The second thing is we created, with AI and machine learning, a predictive analytics model that looks at things that physicians wouldn't know about, how many times patients are calling in, how frequently they are scheduling visits. So essentially, every call is a cry for help from our patients, and we found it is 70 percent accurate in predicting a hospitalization or an ER visit. So we can come to them before they even think to come to us.

Dr. WENSTRUP. Yes, that is——

Dr. PHILIP. And then they feel the care that we talk about.

Dr. WENSTRUP. Thank you.

Dr. BERENSON. I don't manage any direct care at this point——

Dr. WENSTRUP. Right.

Dr. BERENSON [continuing]. So I will defer to my colleagues on that question.

Dr. WENSTRUP. Okay, fair enough. And it is all, listen, really helpful. Keep up the good work, and thanks for the feedback.

I yield back.

Chairman BUCHANAN. Ms. Chu, California.

Ms. CHU. Yes. We are here to talk about value and patient care, and I would like to talk about private equity because it—this consolidation across health care, I think, is affecting patient care and also provider compensation.

I am particularly concerned about the damaging impacts of private equity ownership on our entire health system. And Dr. Berenson, I understand you have quite a bit of knowledge about this. Over the last decade, private equity fund assets have more than doubled, totaling $8.2 trillion in 2023. Private equity companies are aggressively buying out health facilities across the country, only to sell off their assets three to five years later, after slashing staffing, cutting quality, and jeopardizing access to health care for entire communities. The fundamental principle of private equity, acquiring and selling assets for maximum profits, is entirely antithetical to the goals of protecting patients and safeguarding taxpayer dollars in the Medicare program.

As of January, 460 hospitals and one-third of emergency rooms in the U.S. were owned by private equity firms, and in 2023 alone, private equity owned one-fifth of health care companies that filed for bankruptcy. So Dr. Berenson, when a private equity-owned healthcare facility closes down due to bankruptcy, what impact does this have on patient care, health care costs, and the health care workforce?

And what actions would you recommend Congress take to increase oversight and better understand the impact of private equity in healthcare on providers and patients?

And how can transparency measures help us ensure better patient care at private equity-owned facilities?

Dr. BERENSON. The problems you have identified pretty clearly. I have been actually doing a lot of work on the issue of hospital consolidation before this big rise in private equity, and did a study with colleagues looking at health system audited financial statements to find that even not-for-profit hospital systems had billions of dollars sitting in the stock market. In fact, on any given financial statement, often a health system's performance, operating margins were based more on what happened with the stock market than it did with their patient care activities. And so that is sort of the context around consolidation.

I have recently then—because private equity has taken off so much—have done some reading, I hadn't actually worked very much in private equity. And I am finding that there are some unique aspects to private equity that make it even more challenging for the public good than just providers acting in their own interest. And you ticked off some of it.

So there are—when a community loses a central organization like Hahnemann in Philadelphia, it is a major gap in care.

I was—about six, eight months ago I was reading one of the trade press and saw a news story that a private equity company

that had bought an emergency room, essentially, that—was now the—in charge of the emergency room at a small Tennessee hospital, made the brilliant decision to not have any doctors in the emergency room. And lo and behold, there were some quality problems in that emergency room. This was not rocket science, that you need to have some doctors in the emergency room, but the financial pressures are such that they will make some very bad decisions. Clearly, staff layoffs are a major problem, declining staff ratios, et cetera.

So there is just a long menu that policy people have suggested about what to do about it. There are—anti-trust plays a role. There needs to be lower thresholds for looking at a potential merger than currently exists. One of the problems with private equity is that they are sequential purchases, so any given purchase doesn't hit the threshold, but when combined it becomes a mega-system that controls a certain service area.

There could be more attention to mandated staffing ratios, which I know is controversial. CMS is trying to do that for nursing homes and getting pushback. But I think mandating minimum staffing ratios.

Limit the share of the acquisition price that is financed with debt because what happens now is that the purchased organization is the collateral for the debt. And so there is more likely to be bankruptcies and denial of care to the population.

This is just a little snapshot of—what you are raising is a real important question that needs more attention, probably at the state level as much as at the Federal level.

Ms. CHU. Thank you for that thorough answer.

And I yield back.

Chairman BUCHANAN. Mr. Davis of Illinois.

Mr. DAVIS. Well, thank you. Thank you, Mr. Chairman. And let me thank our witnesses for their patience and forbearance, and they have stayed with us to the end of the day.

I couldn't resist coming back because I spent time working at two Federally Qualified Health Centers, Dr. Chouinard, when there were only 10 in the country, and three of those 10 were in Chicago at that time. And so I have watched them grow, develop, become a part of rural service. Let me ask you. How impactful would you say that the Federally Qualified Health Centers have been in helping provide the services that are needed in rural America, which is indeed a disadvantaged area, as well as urban disadvantaged areas as well?

Dr. CHOUINARD. I think that they are a critical part of the solution. And in my experience in central West Virginia, we were in nine counties, and in many of those counties we were the only provider.

And Federally Qualified Health Centers, it is in their DNA to think about quality. They—we have focused on quality measure sets, population health management, making sure that people don't slip through the cracks. The care that Federally Qualified Health Centers give is excellent. We have really paid attention to making sure that the patients who have the most need get the most help.

So I would be in strong favor of encouraging that Federally Qualified Health Centers remain in place.

Mr. DAVIS. And so remain as well as—I know that there are some areas that still don't have them, which means that there is still opportunity to create more——

Dr. CHOUINARD. Yes, sir.

Mr. DAVIS [continuing]. Than what we actually have. Thank you.

Dr. Berenson, let me ask you, what is trending as we see the continuous development of health care, whether it is the private equity-owned centers or hospitals, or the not-for-profit entities that most of these operations are?

Dr. BERENSON. Well, it happens that I was going to bring this up if I had a chance. Don Berwick, who was a former acting administrator of CMS and a major expert on quality and quality improvement, wrote an essay last year in the Journal of the American Medical Association which was basically about the pervasive greed across the health care system, regrettably. Virtually every party, whether it is pharma, insurance, hospitals, and increasingly, doctors with private equity are looking at the loopholes and the payment systems or otherwise, and figuring out how to do well.

So I think the culture of health care is really being threatened right now, and deserves real attention to figure out. We have got to make it more difficult for greed to succeed, I guess, is what I would say.

I wanted to briefly make a comment on the last question about FQHCs. I just finished being on the board of the D.C. PCA, which is the association of D.C. FQHCs, and I agreed with everything that you said, with—one more thing to add is that we are going to have—we do have and will have an increasing workforce shortage.

Nobody wants to go into primary care at the residency level. If they do go into, let's say, general internal medicine, they often become hospitalists and not on the front lines of delivering care. And I think the Medicare—to beat a dead horse, the Medicare fee schedule is partly the cause of that. It pays so much more lucratively for many of the procedural specialties than it does for primary care.

So FQHCs should thrive. They should be—they should continue to be created. But we need a workforce, and that includes nurse practitioners and physician assistants. We need a workforce. And left to current trends, that is going to be lacking.

Mr. DAVIS. Well, thank you very much. I think they have certainly been real effective acquisitions to health care delivery.

Thank you, Mr. Chairman, and I yield back.

Chairman BUCHANAN. We might have a few more coming, but let me just say I maybe am not a doctor, but, you know, you live a certain amount of your life, and you go through a lot of different things, a lot of things you see. We started a bunch of businesses and ended up with, you know, thousands of employees. But one of the things—one thing I am pretty good at is, you know, building my companies, one of the most powerful things, because human nature is—self-interest is building the proper incentives for, you know, consumers of health.

But I am big on "be the CEO of your own health." People have to take more responsibility. Some might not. Maybe it is not a priority to them. That is fine. But we need to be educators. We need

to bring people more into how they—you know, someone said many years ago—maybe it is not true, or maybe it is—that 50 percent of people that have their first heart attack don't see the next day. When I heard that 20 years ago—maybe that number someone said is somewhat comparable today, or maybe not as much—but I heard that. I thought to myself I don't like the percentage. How do I not, you know, get in that category? I don't want to have, you know, the cancer or the heart disease to begin with. And a lot of it—some of you can't prevent, but there is some of it, a lot of it, that you can prevent.

We are spending $4.4 trillion in health care. That is what we are spending. And you can compare that anywhere on the planet. Someone was telling me today, Vern, you spend so much more, four times more than we spend, and you got—our people live seven years older. So whether that is true or not, I don't know.

But what I have kind of figured out, there is, you know, two things that are better than drugs and everything else—especially is the whole thing on exercise is medicine. We are built to move. And if you don't, you know, if you don't want to do that, that is fine. I am a cyclist myself. If you don't want to do that, that is fine. But the point is that it does have a huge impact. Someone said it gives you three to four more years, longevity and all that.

Same thing with diet. You know, someone wrote a big column in the Wall Street Journal, one of the past Senators. I had dinner with him, and you know, his whole thing, he never gave a prescription out for food. He gives it out for, you know, drugs, or whatever is, but he has changed his mind. He is a doctor, a very successful doctor, you know. And he said, but that makes a big difference.

Now, I read something like 15, 20 years ago because I am always reading this little book or this book, and it made sense to me—was that it had an equation. And I was trying to figure out because, you know, a lot of us, when you—like a yo-yo when you get in your 40s or 50s, you gain weight, and lose a little weight, and gain weight, but you got to be conscious of it all the time. If you are not, you are going up. But this book changed my thinking and changed my life from that standpoint.

What was the equation? It was on the top line they measured the most nutritional food. On the bottom line they measured the calories. So what is the biggest, most nutritional food and the fewest calories? And they listed every food that you can consume. I tell people I have an 80/20 rule. You know, I am going to go out and have an ice cream or go out and do this and that, but 80 percent I want to be a little bit more scientific in what I am eating.

So you put together that formula along with, you know, walking two miles a day, five days a week, it makes—it goes a long way. We have—I don't know if it is the right number, but I have read 40 percent obesity, Type 2 diabetics, and now it is playing with children.

So, I mean, we are in the health care business, but my sense is that—I told you human nature, people work their pay plans. And the bottom line, when you do fee-for-service, the incentive is there to do that. I would rather see us find out how to—find a way to how we can have people be more healthy and educate them so that they need to see the doctors less than everything else.

A lot of doctors, just myself, is they either give you a pill or cut you in a sense. That is the way they make money, you know, in terms of that. There is a lot of great doctors and trying to do the right things, but I have met, you know, some doctors that are more interested in your nutritional—just how you are doing, your blood counts and all the other stuff.

So that is kind of my thinking on it. And I read a book that said CEO—you need to be the CEO of your own health care. So I think—I don't know how we get there, but I am concerned when you take a lot of these operators that come in town and, you know, basically buy up everything with a hedge fund or whatever, and, you know, a lot of the doctors are complaining, others, hospitals, they are not getting reimbursed enough. Well, how is it that all these operators can come in where they are looking for 25 percent—I was in business for 30 years before I got here—they are looking for 25, 30 percent returns, so they put a million bucks up, they are looking for $2.5 million in five years? What are they doing? Why are they getting involved in it? Because, obviously, they feel like there is a lot of waste and everything else.

But my point is how do we set up the right incentives? How do—I am very big on preventative care the best we can. You know, my mother died of colon cancer and, you know, she didn't have the test along the way. And when you finally—she thought she had the flu. But there is things like, for example, with lungs, I mean, they do something, they say that is the biggest killer of cancer. Why aren't we doing something with that preventatively?

So that is just how I look at this whole thing, and take a little bit different perspective. I think our system is kind of broken. It is not—we have got a lot of exceptional doctors, a lot of people do their best, but I just hate to see we are, you know, we are spending more money than anybody else and we are sicker than anybody else. There is something wrong with that.

Now, you make the argument what—we have the best technology and, you know, great machines, you know, they take all kinds of X-rays and everything else. But I am interested in all of us being healthier. And I think that health starts with diet and exercise. It seems very basic, but it is getting back to that.

A lot of the food I think we eat is part of the problem. It is not anybody's fault in a sense, but there is no nutritional value in it. It is highly packaged food. They have taken everything out of there. They are eating it, but there is a lot of calories and no nutrition. And I—not everything, but a lot of things. Fruits and vegetables—set that aside for a minute, but a lot of the things you go in a grocery store and you buy, cereal or whatever you are buying, a lot of it is not, you know, very good food. And I would question whether it is food at all.

So—but anyway, I wanted to throw that out. That is just my general thinking, what I have seen in my own life and others. And I just think we have got to find a way to educate people and get them more excited about taking a look at this, because we—frankly, and do you know what we spent this year in Medicare, any idea how much we sent out in payments? $1.1 trillion this year, $1.1 trillion. When I got here was like $600 billion. Now it is $500 billion above that. And so it is pretty crazy.

So let's roll down and, you know, you can be critical or whatever, but that is just kind of where I am at, what my thinking is, and we will start with the young lady first.

Dr. CHOUINARD. Yes, I couldn't agree with you more. Hear, hear. Two things come to mind.

Much like you mentioned, we had a project when I was at the FQHC that we called the Farmacy Program, with an F, as in farm food, and you could write prescriptions for patients. And we worked with local farmers to bring boxes of food to patients. And interestingly, there were a lot of vegetables in there that people didn't know how to cook, and not something that you would eat raw. And so we sort of tacked on to that, you know, a couple of cooking instructions, cooking cards, et cetera. It was a small study, but we had diabetic patients who were poorly controlled. And as a result, we think—of the project—their hemoglobin A1C came down, their blood sugar came down with no changes in their medicine. So just echoing that I think you are right on point.

The other thing I think that you mentioned is, you know, this idea of expanding the care team. You mentioned something about—you know, someone on the panel mentioned something about decreased ratios of—staffing ratios. I think we have to think about expanding our care teams to include, in some cases, I think noncredentialed care team members. Main Street has this concept of a health navigator as someone who we—you know, we help patients navigate resources, but they also do things like when patients have said no to a colonoscopy, they call the patient back and, you know, try to turn a no into a yes. Just simply motivational interviewing techniques, you know, making sure that the patient understands the, you know, the risk-reward.

So I agree, I think those two things we can do is really focus on food and also make sure that, you know, clinicians can practice at the top of their degrees and also have these, you know, maybe nonclinical people doing that lifting.

Chairman BUCHANAN. Yes. I am in Sarasota, Florida, but I have a doctor that, you know, I work with, but a lot of—he gets a lot of new patients from the Midwest and the northeast now, and New York more. And he says a lot of them come in, they are 75, they are on 6 pills. And he says to them, "You want to get off half of that?"

And they say, "Doc, what do you mean?"

He says, "Do you want to get off half of that?"

He says, "What are you talking about? I have been on it for 10 years, 6 years."

He said, "I want you to start walking two miles a day for five days, and I will take you off half of the medicine."

Now, that might be a little exaggerated, I don't know, but that is kind of what I was told. But my point is there is a lot to be said——

Dr. CHOUINARD. Yes.

Chairman BUCHANAN [continuing]. For moving and I think more of a—I am more of a plant-based guy. Now, it doesn't mean I won't eat all the other stuff, but—occasionally, but I try to move it from what I used to be to where I am at now, and I never have to think about my weight or anything else where I did before.

Go ahead.

Mr. NUCKOLLS. Chairman Buchanan, I think you are 100 percent on target with what you are doing. Our ACO, as I mentioned earlier, has reduced our hospitalizations 38 percent, and reduced emergency room visits by 29 percent. We have done that through a combination of factors. Part of it is this program was set up to incent keeping patients healthy, so we are doing all of those things that you just talked about with our patients.

The real question is the innovations that we have done, the incentives that we are responding to—this is the invisible hand that Adam Smith wrote about, okay—we are following that to help keep patients healthy, calling them in between visits, talking to their wives about their diet, calling them. Have you been exercising during this week? Quick phone calls, quick check-ins to let them know you care. And when you do let them know you care, you are going to get more of it.

Chairman BUCHANAN. Yes.

Mr. NUCKOLLS. What we need is more—it is the benchmark, and that is why we don't have more doctors and more health systems doing this. Right now fee-for-service is profitable. You mentioned earlier about cutting on you. It is more profitable to cut on you now than to do the types of things we are. That is why the system has not moved more quickly to this model.

We have got to get the incentives right so that free hand can continue to empower enterprise, empower provider groups, you know, regardless of who owns them, to do the right thing. We have—our true north is we want you to treat patients like you would your parents. And so if that takes extra time to work with them, we spend that extra time with them. And that is why I think we have had such great results on this. And if we can just take what we do in North Carolina and spread that to other places, I think we can solve a lot of problems.

Chairman BUCHANAN. Yes, I just—again, I just think, if you own a business and you got a vision for your company, and you just line up a lot of how you pay people with those incentives, and recognize people that way, you will get that result.

And my concern is just with the way the system is set up now. What is the incentive?

Mr. NUCKOLLS. Right.

Chairman BUCHANAN. It is just—and someone said it, maybe you said it earlier—the incentive is set up. If I do more, I make more. I got to pay the bills and everything else. That is not where we want to be. The idea is if you do less and they are healthier, then there is an incentive.

Mr. NUCKOLLS. Yes, and so the whole problem is with the benchmark. If we can get the benchmark straight, so it is more profitable to do total cost of care arrangements, value-based care, you will get more of that. Right now the benchmarks are not set that way.

Chairman BUCHANAN. Yes, go ahead. I got the ladies over here, so I got to get going. [Laughter.]

Dr. PHILIP. Yes, thank you, Chairman Buchanan. That is a great question. I agree with everything you said.

We have seen very similar evidence. We call it food is medicine. Exercise is medicine, as you referenced. So we actually started a culinary medicine program because what we realized is many individuals didn't know how to cook. And so it is not that they didn't want to eat healthy, they just didn't know how to do that. And so we started training them how to actually cook the meals.

Chairman BUCHANAN. Beautiful.

Dr. PHILIP. We did that as a pilot. We saw significant improvements in their health, and it created this virtuous cycle where they saw that, wait a minute, if I just eat this, then I have half the number of pills, just as you said. And then it created a feedback loop. And we are like, hey, if you start exercising, then we can get you off the other pills. Then they had less side effects from the pills. There is a study showing that if you are on six or more pills, the side effects of the new pill are more than the benefit of that new pill, as well.

And so now we are recording those culinary medicine programs, scaling it across our network. And we have care allies in the clinic that are working with our providers to educate patients on these programs because the providers didn't have that extra 20 or 30 minutes to go above and beyond. So these care allies can actually then connect the dots and be that hub-and-spoke model, where they are taking these resources and bringing it to the patients.

And so it is—one of the things I see is that patients come in and they feel almost defeated. They feel helpless. They feel like they can't make a difference. So once you start creating some positive momentum, then it then it builds from there.

Chairman BUCHANAN. Thank you.

Doc.

Dr. BERENSON. I am going to give you a personal reflection in my own situation, as I have high blood pressure. As a physician I have known that for 40 years. And so I have managed my blood pressure, diet, exercise, et cetera, but the national control of blood pressure has actually declined in the last decade. It is now—with the new science coming out of NIH, only 25 percent of the population's blood pressure is in acceptable levels, and as a result we have unnecessary heart attacks, strokes, kidney failure. It increases more in minority populations. And yet the standard of care still is go in once in a while to have a blood pressure by a doctor.

And there is this thing called white coat hypertension, where the blood pressure is probably not even reliable because people get anxious when they go to the doctor. In my case, I have a home blood pressure machine. I monitor my blood pressure, I take control of my blood pressure, and I think every patient could be doing that.

Now, some of the ACOs and Medicare Advantage plans have successfully set up programs to get 70, 80 percent of their patients under control. But nationally, the performance is dismal, and it is an example of where we could have—educate and train patients to really take responsibility for managing it.

And so I agree with your remarks completely, and we have a long way to go to actually put it into effect.

Chairman BUCHANAN. That is pretty good, four for four.

Mrs. Miller from West Virginia.

Mrs. MILLER. Thank you, Mr. Chairman——

Chairman BUCHANAN. Thank you.

Mrs. MILLER [continuing]. And thank all of you for your patience today. I hope they gave you some nice water and a few things to keep you from starving to death while you have seen our lifestyle, there is no control. I mean, the last 3 days I have had—started—one started at 3:45 in the morning, finished at 10:00 at night, you know. But anyway, thank you.

I am really thrilled. I think you all know that I have somebody from a home on the panel, and a very special woman who grew up in Huntington, West Virginia, which is where I am from and she is from. She was schooled there, went to the university, to the medical school, and practiced in West Virginia for such a long time. And she has been a tireless advocate for the people in West Virginia.

But it isn't just—I mean, those same people are in Missouri, they are in upstate New York, they are in Tennessee. We are rural. And so her life has been so interesting doing that, as well as PEIA, which is West Virginia's Public Employees Insurance Agency. She stepped into that as director for quite a while. So she served as the Chief Medical Officer at the state's second-largest Federally Qualified Health Center. And in that role she oversaw clinics across the central part of our state.

Our state is so mountainous, it is so rural. And I have worked endlessly on rural health care because it could take you five hours to get to the hospital if that is where your physician is. And our roads are like this and like this. And if you were a crow, you could fly over it, but you can't. So it is quite a practice—I mean, quite a problem sometimes for people to get where they need to be.

So as I said, I have dedicated my time here and on the health committee to help rural West Virginians and rural patients all over the country. And people who live in urban areas don't really comprehend the difference.

Unfortunately, with Medicare's value-based care models, we have now seen multiple instances of the rural providers being left behind and unable to participate. According to a 2021 report from the Government Accountability Office, rural providers participate in value-based care programs at lower rates than non-rural providers. And I don't know if you have covered any of this because I haven't been with you for the last three hours, but Dr. Chouinard, in your opinion, what are some of the primary factors preventing our rural physicians from participating in value-based payment systems?

Dr. CHOUINARD. Administrative burden comes to the top of the pile. When you are in small practices, it becomes very difficult to dedicate a team to be able to, first of all, understand what the opportunity is, and then the tracking that goes along with it, the reporting that has to go along with it.

So I think one of the reasons—you know, at Main Street what we are trying to do is take some of that burden off, so that rural clinicians have a better glide path to participate. There are other aggregators. Primary care associations are another, you know, great stopping place for people to find information and to really be able to figure out how to participate.

I think, on top of that, we are just so busy, the demand for care is so high, that in order to make that change there are a lot of, you

know, technology tools that we need to use, other things that just feel like there is sort of this sentiment of throwing up your hands, that it becomes too difficult.

So the reason that I took my job at Main Street—it was a tough decision to leave patient care and do something like this—it is because I think that if—I can create this impact by making sure that not only by giving this health navigator to practices who help take some of the, you know, daily administrative burden off of clinicians, but then also be able to support them in ways that they can stay in place. One of my fears is that we lose rural clinicians because it is just too darn hard. So if we can support them in those ways, I think that is really the most important thing we can be thinking about right now.

Mrs. MILLER. And you know once you have met those people in the area, as a physician, you become so engaged with them. It is a different thing.

One particular example of a value-based care model that failed to adequately consider rural providers was the CMMI's Emergency Triage, Treat, and Transport, or ET3 model. The ET3 model was launched as a voluntary, 5-year payment model to provide greater flexibility for EMS providers following a 911 call, and those providers, including those in the State of West Virginia, were thrilled to have a chance to treat certain conditions at the scene of a 911 call, or to transport patients to alternative sites of care outside of the typical emergency room transport.

And many rural providers were discouraged, however, when they learned that CMMI did not adequately consider that not all rural communities have an alternate site of care within their model regions, which made them unable to participate in the model. So I, with a lot of other West Virginians, sent a letter to the CMS administrator last year highlighting this issue, and asking for the agency to consider allowing West Virginia to advance a statewide demonstration of a treat-in-place model since the state wasn't able to participate in the ET3 model. Not only did CMS deny the state's request, but unfortunately, they then decided to end the ET3 model 2 years early, rather than remedy the issues that prevented EMS providers from participating in the first place.

Dr. Chouinard, I am sure you are familiar with these issues, particularly from your time with PEIA, but in your opinion, how can CMMI do a better job of integrating small, rural, and independent providers into models?

And what factors of rural care delivery does CMS not seem to adequately consider when creating these models?

Dr. CHOUINARD. One of the things I think is problematic are volume thresholds. In the example that you gave, I think there were—I can't remember the exact numbers, but you had to have X number of transports in order to participate. Well, the only county in West Virginia who met that threshold was Kanawha County.

Mrs. MILLER. A big one.

Dr. CHOUINARD. Right. And so, having served in a rural emergency room, lots of patients came in who did not need to be in the emergency room.

Mrs. MILLER. Yes.

Dr. CHOUINARD. But again, by law, there was really no choice.

I think the other thing that contributes to a model like that is social isolation and loneliness. Lots of patients who are anxious and lonely end up calling EMS. As a result, think they have a heart attack and get transferred. By thinking about programs that would engage rural seniors to be able to have rural seniors have extra support, we—you know, we mentioned these, you know, phone calls in between visits, checking on patients, making sure that we are getting ahead of things in the vein of prevention, ensuring that if a congestive heart failure patient is—you know, their ankles are swollen or they are short of breath, that we are getting ahead of that and bringing them into the office.

So I do think that your suggestion that we think about the unique scenarios, problems, the geographic distance and just the volume of people in rural communities should be a thrust of design principles in future models.

Mrs. MILLER. Thank you so much.

I yield back.

Chairman BUCHANAN. Thank you.

Ms. Tenney, New York.

Ms. TENNEY. Thank you, Mr. Chairman.

And thank you all to the witnesses. And we also appreciate your patience. It is a little bit of a crazy day here.

I kind of have the similar situation that my colleague from West Virginia has. I have upstate New York, which is very rural. My district is very sprawling. We have long access to get to medical centers, and that is why we are just so concerned about how this model is working. And I just appreciate your firsthand experience on how we are going to move from these fee-for-service to value-based systems in Medicare, and especially when it relates to the Center for Medicare and Medicaid Innovation.

So I guess I want to talk a little bit about what the chairman had to say on some of the savings and things that we can do in this area. And I believe my estimation is I think that CMMI needs to rethink the way it engages with participants and relevant stakeholders to encourage greater participation. And you have cited that, Doctor, your own benefit and retention. And also CMMI would be better served if it operated more transparently, provided more opportunities for the public to actually give the output as to what they think their medical outcomes are.

So I wanted to ask first, Mr. Nuckolls, despite efforts to share more information, there are still areas of the CMMI process that remain opaque. How can CMMI improve its communication and transparency regarding the accountable care organization changes and benchmarking calculations?

I think you alluded to this earlier, but if you could—how can that help, and how would it be better to be transparent in, say, a rural area where we have real trouble accessing even medical professionals?

Mr. NUCKOLLS. Yes, so rural areas are critical as—with the way the benchmarking process works. You have critical access hospitals that are paid in a different way than other hospitals are. And so CMMI, I think, has a wonderful opportunity to be transparent and to help develop unique benchmarks that can serve rural communities.

When we first started our ACO, we were in a rural area, and rural means underserved. And so when you add more services to people, you end up spending a little bit more money on that. And so what happened during our first contract period, we ended up spending a little more money, and we didn't—we ended up breaking even for our first contract. But after that, once we got control of those patients and we started doing a lot of the programs that we are talking about, we have been able to reduce our hospitalizations by 39 percent, our emergency room visits by 28 percent since that time. So we have really been able to get out.

We were part of several CMMI programs—Track 1+, the Advanced Payment Model, and we are looking at Project REACH, the REACH ACOs for next year, perhaps.

Ms. TENNEY. Okay.

Mr. NUCKOLLS. And so they do a reasonable job of communicating with ACOs from a number of the ACOs. I am a founding member of the National Association of ACOs. We do a lot of advocacy on behalf of REACH ACOs, as well as traditional ones. But CMMI could do better. We need data sooner so that we can respond to it.

Ms. TENNEY. Okay. Well, you know, so you just touched on something. It is the cost in rural hospitals. There is some—I have a county, actually, in my sprawling, 14-county district where we can't get a provider at all, no physician, no medical doctor into that community to run a federally funded health center. I mean, that is how destitute we are.

But when you talk about cost—how do we get to the recruitment and retention? Because that is a big problem now. And how do we make this program work so we can get the innovation we need from the program and a new kind of payment view, and then be able to get and attract and keep, you know, our skilled medical physicians in these areas? I guess that is, you know, kind of based off of what you just said.

Mr. NUCKOLLS. So I think there are a couple of things. We need stable physician payments, as Dr. Berenson said earlier.

We have to get inflation updates. We have been losing money each year.

Ms. TENNEY. Exactly.

Mr. NUCKOLLS. We would not be able to recruit into our area without the ACO savings.

Unfortunately, the way the benchmarks are set, we will have to leave the program at the end of this year. They continue to ratchet down the benchmarks each year, so that will make it very difficult in the future for us to recruit into rural areas if we do not have those shared savings coming in.

And the Advanced Alternative Payment Model payments really help—have helped defray those inflation—the inflation costs that we have had where we have not gotten inflation updates for many, many years.

Ms. TENNEY. Yes, there is—I could do this—I know why Vern took so long. There is a lot to talk about, especially in rural hospitals. I am going to—I have one more question for you, but I——

Chairman BUCHANAN. Was I that long?

Ms. TENNEY [continuing]. Wanted to jump to Dr. Chouinard.

Could you describe—I mean, we know that this—could you describe the challenges that are inhibiting these rural providers from participating in value-based payment systems, and how we could get CMS and Congress to help make sure that our, you know, Advanced Alternative Payment Methods are met?

How do we do that and keep, you know, excellent health care in our communities? Because we still—we have a very—I think the average constituent in my region is a 65-year-old woman. So we have an aging community, but they are really in need of health care. And I have, I think, one of the highest percentages of Medicare recipients in my district of any of the districts in Congress.

Dr. CHOUINARD. So sort of——

Ms. TENNEY. That was a lot.

Dr. CHOUINARD. Two parts to that question.

As far as recruiting people to rural communities, I mean, one of the things to think about is how do we offer a more attractive way to practice medicine.

Ms. TENNEY. Right.

Dr. CHOUINARD. No one wants to go in and see 25 patients, and deliver 15-minute health care, and also not have an idea of what—you know, how sick these patients are or are not.

And so if we could build models, outpatient primary care models where we could, you know, look at a pyramid of our patients and understand that the top 10 percent, who are the very sickest and the very highest need, what if I could spend an hour with that patient? What if we could really go through everything that they needed to understand about their chronic condition?

In addition, as I have mentioned before, expand these care teams so that there are diabetic educators so that we can do extra work with patients. I think that what physicians are afraid of is the—it is like looking down the barrel of a gun when you think about walking into the—to the morning clinic, and figuring out how to get to 5:00 with the demand of inbound requests.

And in addition, just the fee-for-service sort of churn of seeing patients.

Ms. TENNEY. Yes, I love that idea. I mean, I work hard to take care of myself. I am 63 years old. I haven't been to the doctor in four years, mostly because my job is so demanding and I just haven't had time to get my—but I know I follow Chairman Buchanan's rules for being healthy. You know, I eat better, I exercise, I go to his seminars and the books he brings from all these doctor experts about how to live a long and healthy life. But that is true, though.

I mean, when I—my physicians are all overwhelmed. You go in, and they are on the computer for the whole time talking to you.

Dr. CHOUINARD. Right.

Ms. TENNEY. The nurse practitioners are overwhelmed. Everybody in the system is overwhelmed because we aren't prioritizing the needs of patients based on their health levels. And I think that is a great—it was just very insightful, and I know you all know that, but I think it is great to hear that. And we really want to focus on health care and making sure we get better outcomes.

I really think that we could do so much more with CMMI on this and—I am sorry, but my time is way over. But I wanted to say thank you to all of you. And this is a really important discussion.

I thank the chairman again for holding this important meeting, and all of you for being patient and giving us your insights. Thank you.

Chairman BUCHANAN. Well, thank you. Let me just say I have got two documents, one doc for seniors to submit, as well as Congressman LaHood has got a letter we need to submit.

So, so submitted.

[The information follows:]

March 15, 2024

VIA EMAIL

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7500 Security Boulevard
Baltimore, MD 21244

RE: SUPPLEMENT TO PUBLIC COMMENT LETTER on *"CMS-2024-0006; Advance Notice of Methodological Changes for CY 2025 for MA Capitation Rates and Part C and Part D Payment Policies"*

The following information is submitted as a supplement to provide new data that expands upon points made in the March 1, 2024 comment letter from the trade group, Physicians for MA Beneficiaries. We have new data on how the continued implementation of the new risk adjustment model is negatively impacting beneficiaries under our care. Our timely submitted comment letter, attached, noted that this supplemental information would be forthcoming.[1]

Recall, *Physicians for MA Beneficiaries*, is a coalition of value-based physician organizations delivering "advanced primary care" to more than 200,000 Medicare beneficiaries at more than 800 locations. Our member physician practice models are consistent with CMS' definition of "advanced primary care" which CMS says consists of "improving primary care financing through increased, stable revenue that moves practices away from fee-for-service payments that pay for the volume of services delivered and toward support for team-based care, coordination with specialty providers, and community-based supports."

I. Profile of Impacted Patients

MA up to now has offered our physicians the ability to be at the front line of realizing CMS' vision of a "health system that achieves equitable outcomes through high quality, affordable, person-centered care." We specialize in treating low- to middle-income beneficiaries with high rates of chronic conditions. These are the very patients whose care is being

[1] See pages 7 and 8 of our March 1, 2024 comment letter, attached.

disproportionately and increasingly impacted by the ongoing implementation of the new V28 risk adjustment model.

- 25% to 40% of our patient panels are dual eligible for Medicaid and Medicare.
- The prevalence of diabetes among our patient panels ranges from 30% to 60%.
- Our physicians manage congestive heart failure in at least 20% of our patients.
- Our physicians manage angina, which is a symptom of significant heart disease, in at least 10% of our patients.

II. Observed Impact of V28 on Premiums and Benefits

CMS stated that it "anticipated stable premiums and benefits for individuals in 2025" under its proposals.[2] Instead, CMS should anticipate adverse changes in premiums and benefits for many beneficiaries in 2025 given the adverse changes observed by our provider members so far in 2024:

- Approximately one-third of our responding members report that their MA patients are already faced with increased cost-sharing in 2024.

- In addition to our member data, analysis by other stakeholders show that:

    - Deductibles have increased by 12% on average[3]
    - Some states are seeing average premium increases of up to 50%[4]
    - Supplemental benefits reductions. Among the 20 most popular categories of supplemental benefits, 9 categories are being offered in fewer plans and 13 will be available to fewer beneficiaries[5]
    - The most negative impact on risk scores in 2024 is for dual eligible beneficiaries and the 2025 impact is expected to be worse[6]

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[2] CMS, 2025 Medicare Advantage and Part D Advance Notice Fact Sheet (Jan. 31, 2024); https://www.cms.gov/newsroom/fact-sheets/2025-medicare-advantage-and-part-d-advance-notice-fact-sheet.
[3] Analysis of CMS Landscape Files for CY 2024, Elevance Health Comment Letter on CY 2025 Advance Notice, pg. 24 (Mar. 1, 2024).
[4] Id.
[5] Id.
[6] Milliman, Impact of Medicare Advantage Part C Risk Score Model Change on 2024 Risk Scores (Feb. 2024); https://snpalliance.org/wp-content/uploads/2024/02/SNP-Alliance-2024-CMS-HCC-Model-Change-Survey-20240227.pdf

III. Observed Impact of V28 on Access to Preventive and Other Necessary Care

CMS stated that the continued implementation of V28 "is not expected to reduce access to preventive and other necessary care."[7] On the contrary, even with the phased-in implementation of the V28 model, a significant has already been observed ad should be publicly acknowledged and considered by CMS as reason to halt the continued phase-in of the V28 model.

- Approximately one-third of our responding members report that they've already dropped patient support services of non-emergency medical, which significantly curtails access for some of the most at-risk beneficiaries unable to find a way to get to crucial appointments.

- Half of our responding members report that average patient panel sizes have increased in 2024. This increased panel size is occurring partly due to insufficient funding to attract new physicians to fill vacancies, partly due to physicians exiting the value-based care space because of inadequate compensation, and partly due to increased burnout amongst the remaining providers being asked to care for larger panels with less support. This means that there are fewer physicians to see beneficiaries. The remaining physicians are burdened by higher workload with fewer support services, and the beneficiaries face longer wait times and shorter appointment times. All our responding members report that average patient panel sizes will increase further in 2025.

- All our responding members report that they have been forced to cancel plans to open or expand clinics in 2024 to meet the demand of a growing beneficiary population. One third of responding members report that they have been forced to commence some clinic closures in 2024 and anticipate ongoing further consolidation of clinic practices in 2025. This most significantly impacts at-risk populations in smaller communities, sometimes doubling or tripling the miles needed to travel to find providers or clinics able to care for their medical needs Patients seeking to transition to "advanced primary care" practices from traditional primary care are consistently finding long wait times and reduced capacity for care.

- All our responding members report that they will have to terminate clinical staff positions in 2025 if the new risk adjustment model continues. One member anticipates the need to eliminate 50% of clinical staff positions in 2026 under current trends. Dropping clinical staff necessarily has an impact on our members' ability to offer patient support services and person-centered care and increases the administrative and non-clinical workload on physicians, further exacerbating physician burnout and turnover.

- All our members report that the payment reductions continuing under current trends will necessitate eliminating physician positions in either 2025 or 2026.

[7] CMS, 2025 Medicare Advantage and Part D Advance Notice Fact Sheet (Jan. 31, 2024).

This summary and data provide growing evidence to CMS of the reality that reductions in MA plan rates have been and continue to be largely passed through to at-risk value-based providers treating MA beneficiaries through advanced primary care models. These cuts thus directly impact beneficiaries and the physicians most invested in caring for them. Such reductions should not and cannot be simply perceived as cuts to MA plans but rather as cuts to services for MA beneficiaries and the provider groups who treat them. Ongoing and further implementation of V28 is set to have devastating consequences on our nation's vulnerable seniors and shrink or eliminate many of the very groups of physicians who have so passionately invested in advanced primary care models.

Further implementation of V28 should be put on hold and CMS should report to Congress on the MA populations most impacted by V28 and the extent of benefit and access reductions in 2024. Beneficiary impact will otherwise be much worse in 2025.

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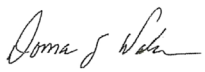
Thank you for your attention to these comments on the Advance Notice.

We request a meeting with you to further discuss the data we are producing on beneficiary impact and to answer any technical questions you may have on how advanced primary care practices are impacted by reductions in MA rates. Feel free to reach us at Donna.Walker@inhealthmd.com or Phall@ebglaw.com.

Respectfully,



Donna Walker
President

cc: Chiquita Brooks-LaSure, Administrator
Jonathan Blum, Principal Deputy Administrator & Chief Operating Officer
Cheri Rice, Deputy Director, Center for Medicare

March 1, 2024

VIA REGULATIONS.GOV

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RE: CMS-2024-0006; Advance Notice of Methodological Changes for CY 2025 for MA Capitation Rates and Part C and Part D Payment Policies

Physicians for MA Beneficiaries, a coalition of 22 value-based care provider organizations collectively treating over 200,000 Medicare beneficiaries at more than 800 locations,[1] submits the following comments on the *Advance Notice of Methodological Changes for Calendar Year (CY) 2025 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies*. Our coalition was formed so that CMS could hear the perspective of physicians on the front line of day-to-day care for MA beneficiaries. We want CMS and all stakeholders to understand how the Advance Notice, and in particular the new risk adjustment model, impact Medicare beneficiaries and our ability to deliver coordinated and preventive care.

I. SUMMARY OF COMMENTS

- Policymakers must acknowledge the reality that reductions in MA plan rates are largely passed through to at-risk value-based providers treating MA beneficiaries.
- Cuts therefore directly impact provider compensation and the level of patient centered preventive services available to treat and manage chronic conditions in vulnerable populations. Cuts should be understood as, not cuts to MA plans, but rather cuts to services for MA beneficiaries.
- Further implementation of V28 should be put on hold and CMS should report to Congress on the MA populations most impacted by V28 and the extent of benefit and access reductions in 2024. Beneficiary impact will otherwise be much worse in 2025.

[1] The majority of our present coalition members' locations are in Florida but our members treat beneficiaries in multiple states. Shortly, we will report new members joining with more locations in other states.

- Rate cuts in 2025 combined with double-digit increases in medical expense trends does not leave providers enough premium to maintain quality care for their patients.
- Our risk-bearing coalition members project a 15%-25% reduction in premium revenue to care for patients under the proposed policies for 2025. This will manifest as access restriction and reduced services.

II. Background on the Role of Value-Based Care Physicians in Treating MA Beneficiaries

a. *Value-Based Providers are Already Delivering to MA Beneficiaries the Advanced Primary Care that CMS Wishes to Expand into Medicare Fee-for-Service (FFS)*

In 2021, CMS set a goal of having "100% of Traditional Medicare beneficiaries in accountable care relationships by 2030."[2] CMS states that a mechanism to achieve this goal is through "advanced primary care", which CMS says consists of "improving primary care financing through increased, stable revenue that moves practices away from fee-for-service payments that pay for the volume of services delivered and toward support for team-based care, coordination with specialty providers, and community-based supports."[3] The CMS Innovation Center's Vision is a "health system that achieves equitable outcomes through high quality, affordable, person-centered care."[4]

MA evolves and adapts to manage specific health needs of beneficiaries. The providers who comprise our coalition are already making this value-based care vision a reality for our Medicare patients today in a way that FFS does not:

- Frequent check-in visits for patients identified as high acuity
- Advanced care clinic with additional clinical services to specifically serve patients who would otherwise go to the ED
- Post discharge timely follow-up and transition of care coordination with hospitalist teams
- Kidney care program serving patients in their home
- Case conferences for complex patients
- Protocol orders and/or acute rescue kits for patients with history of exacerbations/acute events
- Transportation to provider visits
- Home visit nurse practitioners and home health services
- Virtual Care clinic

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[2] CMS, *The CMS Innovation Center's Strategy to Support Person-centered, Value-based Specialty Care*, (Nov. 7, 2022); https://www.cms.gov/blog/cms-innovation-centers-strategy-support-person-centered-value-based-specialty-care

[3] Id.

[4] CMS, *Person-Centered Innovation – An Update on the Implementation of the CMS Innovation Center's Strategy*, pg. 3 (Nov. 2022); https://www.cms.gov/priorities/innovation/data-and-reports/2022/cmmi-strategy-refresh-imp-report.

- 24-hour access to providers through same-day access at walk-in clinics and 24/7 nurse line
- Dedicated in house and partnered pharmacists to support medication adherence, medication reconciliation, and appropriate therapeutic treatments
- Onsite spirometry to assess pulmonary function
- On site specialty care and other care, such as labs, imaging, x-ray, vascular ultrasounds, fundoscopy for diabetic retinal exams, echoes for early detection of heart failure
- ER Follow-up coordinators
- Preferred provider network of specialists who have proven patient health outcomes and cost efficiency
- Physician-led patient education sessions weekly or monthly
- Onsite wellness centers for social, mental and physical well-being, which may include exercise equipment, hair salons, educational seminars, exercise classes
- Ambulatory Care management
- Transitional care management
- Employed hospitalist model

We have built the capacity to give our patients longer appointments of face-to-face time with their physicians, as well as giving our physicians fewer patients to focus on daily, providing time to develop treatment plans for all chronic conditions, rather than just treating the acute condition. "Medicare Advantage enrollees were more likely than beneficiaries in traditional Medicare to receive preventive care services, such as annual wellness visits and routine checkups, screenings, and flu or pneumococcal vaccines, based on several studies, with similar findings for people of color and beneficiaries under age 65."[5] This is because the efficiency of coordinating care through primary care visits reduces the demand for specialty care services.

MA has substantially lower utilization and expenditures than FFS, even after rigorously adjusting for member enrollment differences across the two programs, including baseline demographic, clinical, and social risk factors. MA enrollees have more than 50% fewer inpatient stays and 22% fewer emergency doctor (ED) visits.[6]

These improvements in outcomes are driven by purposeful investment in programs to allow 24-hour access through nurse triage, same day walk in access, home based care delivered by clinicians, nurses, paramedics, etc. There are protocols designed for rapid treatments for acute problems which help reduce the risk of admission for ambulatory care sensitive conditions. Care

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[5] Kaiser Family Foundation, *Beneficiary Experience, Affordability, Utilization, and Quality in Medicare Advantage and Traditional Medicare: A Review of the Literature* (Sept. 16, 2022); https://www.kff.org/medicare/report/beneficiary-experience-affordability-utilization-and-quality-in-medicare-advantage-and-traditional-medicare-a-review-of-the-literature/#:~:text=Preventive%20services%3A%20Medicare%20Advantage%20enrollees,for%20people%20of%20color%20and.

[6] Harvard-Inovalon Medicare Study: *Utilization and Efficiency Under Medicare Advantage vs. Medicare Fee-for-Service*, pg. 8; https://www.inovalon.com/wp-content/uploads/2023/11/PAY-23-1601-Insights-Harvard-Campaign-Whitepaper_FINAL.pdf.

coordination from inpatient to outpatient is a crucial component of readmission control. Clinical pharmacists and wellness visits help assure medication adherence in the ambulatory setting. There are programmatic investments for disease management, case management and accentuated focus on patients who utilize a lot of services. All these investments seem to pay off with reduced need for hospitalization despite patients having multiple chronic illnesses.

Through these numerous personalized touchpoints, we establish true relationships with our patients to better help them lead healthier, happier lives. We observe this resulting in lower rates of ER visits and hospital admissions which translates to lower costs to the healthcare system. MA also frequently outperforms FFS on achieving satisfactory quality measure scores.[7]

These results are possible because we have been willing to take on the burden of patient engagement, team-based care path planning and coordination to get better outcomes and reduce inappropriate or unnecessary utilization. MA drives more lasting investment in team-based, patient-centered care platforms than those in CMMI demonstrations. MA value-based providers have opened and are opening up offices and clinics dedicated to seniors, often in underserved areas. Whereas many CMMI models are an accounting exercise as opposed to a change in care paths available.

Wealthier seniors can afford access to these services by paying concierge fees or purchasing a Medigap policy to assure predictable expenses. That is why MA remains the best option to meet the health care needs of low- and middle-income beneficiaries. The 20% coinsurance of FFS is unaffordable for many seniors. MA's maximum out-of-pocket limit reduces the fear for beneficiaries of unlimited potential out-of-pocket costs which might otherwise affect those in FFS. Extra assistance with paying prescription drug cost-sharing and Part B premiums are additional reasons why MA has become a more attractive choice for lower income beneficiaries.[8]

Part B premiums have been increasing rapidly and have an outsized increased cost for wealthier seniors. Those lower- and middle-income seniors who choose MA are able to recoup the Part B premium increase through lower out-of-pocket expenses for coinsurance, co-pays and supplemental benefits like dental, hearing and optical. On balance, MA beneficiaries' out-of-

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[7] Timbie, Bogart, Dahlberg, et. al., *Medicare Advantage and Fee-for-Service Performance on Clinical Quality and Patient Experience Measures: Comparisons from Three Large States*, Health Serv. Res., 52(6):2038-2060 (Dec. 2017); https://pubmed.ncbi.nlm.nih.gov/29130269/#:~:text=Principal%20findings%3A%20Overall%2C%20MA%20outperformed,reported%20better%20access%20to%20care.

[8] *See* The Commonwealth Fund, *As It Grows, Medicare Advantage Is Enrolling More Low-Income and Medically Complex Beneficiaries: Recent Trends in Beneficiary Clinical Characteristics, Health Care Utilization, and Spending*, Issue Brief (May 13, 2020). ("Between 2012 and 2015, the MA population grew younger and included greater proportions of racial and ethnic minorities. There were also more low-income beneficiaries, more living in poor neighborhoods, and more living in neighborhoods where few residents have college degrees. While chronic conditions had not become more prevalent by 2015, a greater proportion of beneficiaries had complex medical needs.") https://www.commonwealthfund.org/publications/issue-briefs/2020/may/medicare-advantage-enrolling-low-income-medically-complex.

pocket costs, which is often what they prioritize, is lower despite the slightly higher Part I premiums that are drawn from Social Security payments.

MA also provides a means for physicians to be fairly compensated for aligning their worl with the outcomes of their patients. It allows physicians to continue to treat seniors while escaping plummeting FFS payment rates, instead of dropping Medicare patients altogether.

b. Federal Reductions in MA Plan Payment Rates are Generally 100% Passed Through to Beneficiaries and Providers

Federal policy makers need to understand that reductions in federal payments to MA plans are generally passed through to beneficiaries and providers. Value-based care arrangements for delivering advanced primary care typically consist of providers like our coalition members taking on sole responsibility for entire health services spend on a precentage of risk adjusted premium. Therefore, our coalition members feel as if reductions in MA payments through the new HCC risk adjustment model are penalizing providers who have done the most to deliver the reality of value-based care to Medicare beneficiaries.

Additional reductions to MA will undermine the value-based care goals CMS has already achieved through MA. Stable, predictable federal funding is a prerequisite to the private investments needed to make value-based care available to beneficiaries. The alternative to risk-assuming, entrepreneurial providers supported by private investment is standards FFS practices of 1 or 2 physicians that lack funding for NP/PA staff support and tech infrastructure to enable patient engagement and patient follow-up, as well as the additional services listed above to improve outcomes and prevent ED Visits and Hospital Admissions.

III. Halt Further Implementation of the V28 Risk Adjustment Model Pending Analysis of Impact on Most Vulnerable Beneficiaries (Sec. G)

CMS introduced a new Part C risk adjustment model in 2024. The new model updated the data years used to calculate Part C risk factors, transitioned to the use of ICD-10 diagnosis codes for identifying hierarchical condition categories (HCCs), and made numerous changes to the diagnoses and HCCs included in the payment model. In the final Rate Notice, CMS decided to phase in the model over a period of 3 years rather than implement it entirely in 2024 as originally proposed. In 2024 CMS blended Part C risk scores using 33% of the risk score based on the new model and 67% of the risk score as calculated under the old model. For 2025, CMS proposes to continue phasing in the new model with a blend risk score based on 67% of the new model and 33% of the old model.

Continued phase-in of the risk adjustment model will further degrade our ability to deliver advanced primary care to Medicare beneficiaries in 2025. Beneficiaries will have less access to a lower level of advanced primary care.

a. Beneficiary Cost-Sharing Increased and Benefits Offered Decreased in 2024 Due to the V28 Risk Adjustment Model

CMS states that it "anticipated stable premiums and benefits for individuals in 2025" under its proposals.[9] In fact, CMS should anticipate the opposite given what has been measured and recorded for 2024.

Equally troubling evidence exists at the national level to contradict the claim. Analysis by Milliman shows that the average value-add for general enrollment MA plans stopped growing in 2024 due to "MAOs . . . reducing benefit levels or are keeping them level versus investing in additional offerings or increasing the richness of offerings."[10] This effectively means the end of innovation in benefit design to address beneficiary needs. Milliman analysis also shows that, far from being stable, the national average cost-sharing (MOOP) for general enrollment MA plans *increased* in 2024. BRG estimates "the value of supplemental benefits or reductions to premiums and cost sharing could fall by $33 pmpm or more per beneficiary per month, on average."[11] The reduction of value is projected at $24 for MA beneficiaries in Florida, and a reduction of value of $43 for dual-eligible beneficiaries in Florida.[12] This would result in our beneficiary patients facing an additional increase in the health care costs and/or reduction in benefits in 2025.

More generally, analysis of the 2024 MA landscape files shows the number of MA plans available in the market declined by 10%, with some states seeing declines of more than 20%. The number of zero premium plans declined by 13% overall. In addition, average plan deductibles increased by 12%. If such premium and benefit instability was observed in the first year of the phase-in of the HCC risk adjustment model, we are not aware of any argument as to why the impact in 2025 would not be the same or worse.

We will shortly supplement this comment letter with additional data on our coalition members' observed impact of the new risk adjustment model on beneficiary cost-sharing and benefits in 2024.

[9] CMS, 2025 Medicare Advantage and Part D Advance Notice Fact Sheet (Jan. 31, 2024); https://www.cms.gov/newsroom/fact-sheets/2025-medicare-advantage-and-part-d-advance-notice-fact-sheet.
[10] Milliman, *State of the 2024 Medicare Advantage Industry: General enrollment plan valuation and benefit offerings* (Jan. 16, 2024); https://www.milliman.com/en/insight/state-of-the-2024-medicare-advantage-industry-general-enrollment.
[11] BRG, *MA Advance Notice Does Not Offset Rising Medical Costs and Could Lead to Reduced Healthcare Value for Beneficiaries* (Feb. 2024); https://media.thinkbrg.com/wp-content/uploads/2024/02/23124301/BRG-MA-Modeling-White-Paper-2024_Final.pdf.
[12] Id.

b. Access to Preventive and Other Necessary Care Was Reduced in 2024 for Enrollees with Complex Needs Due to the V28 Risk Adjustment Model and Will be Reduced Further in 2025 and Beyond

CMS states that the contoured implementation of V28 "is not expected to reduce access to preventive and other necessary care."[13] In fact, this impact is being observed now and should be publicly acknowledged and considered by CMS as reason to halt the continued phase-in of the V28 model in 2025.

We will shortly supplement this comment letter with additional data on our coalition members' observed impact of the new risk adjustment model on preventive care, patient panel sizes, care coordination, beneficiary cost-sharing and access, and supplemental benefits in 2024.

c. Clinical Analysis of V28 and Its Relation to Our Patients' Observed Health Status

Risk adjustment is intended to reduce or eliminate "the incentives to enroll only the healthiest, and thus least expensive, beneficiaries while steering clear of the sickest and costliest—thereby rewarding Medicare Advantage insurers to the extent that they achieve genuine efficiencies over traditional Medicare in addressing the same health conditions."[14]

The changes implemented in the V28 model work against this intent by disincentivizing MA plans from enrolling patients with certain conditions. One prevalent example of this is in diabetic patients with complications. There is significant variability in the cost of care for diabetic patients with and without complications. CMS rationalized their decision to constrain the weight of the multiple diabetes HCC groups with an example of a laboratory identified complications with minimal clinical significance. We do not believe this supports the need for constraint. Rather, it signals the potential need to remap individual ICD-10-CM codes across the HCC groups.

We agree with the decision to reclassify diabetes with hyperglycemia to a less severe HCC group, aligning with the HHS risk adjustment model. Recategorizing this complication of diabetes and simultaneously weighting all the diabetic HCC group coefficients the same, nullifies anything gained in the HCC group reclassification.

Major depression diagnosis codes for mild, unspecified, and in remission included in the V24 model HCC 59 were remapped to nonpayment HCC in the V28 model. We disagree with CMS's expectation that patients with "sufficiently serious" depression will be coded as moderate

[13] CMS, 2025 Medicare Advantage and Part D Advance Notice Fact Sheet (Jan. 31, 2024).
[14] *UnitedHealthcare Ins. Co. v. Becerra*, 16 F.4th 867, 873-74 (D.C. Cir. August 13, 2021, reissued Nov.1, 2021), cert. denied, 142 S. Ct. 2851 (U.S. June 21, 2022) (No. 21-1140).

or severe.[15] Most risk-bearing provider groups serve as Primary Care providers. It is unrealistic for Primary Care providers to know the highest level of ICD-10-CM specificity for all conditions encompassed within the ~74,000 ICD-10-CM codes. While coding specificity is the goal of Risk Model Principle 5, it is a tradeoff in fulfilling Principle 2 (predictive power of medical expenditures). If the goal of the V28 model is truly to "better direct resources to plans with beneficiaries with higher health care needs"[16] preserving the predictive power of Principle 2 should supersede Principle 5.

CMS's rationale for excluding angina pectoris (apart from unstable) from V28 model was due to diagnosis and coding variability.[17] Discrepancies between diagnostic criteria and coding criteria should be addressed in the annual revision of the ICD-10-CM codes not addressed through the application of a blanket solution to the risk adjustment model impacting all beneficiaries.

The complete removal of vascular disease, including PVD and PAD, presents insurmountable challenges as these conditions are prevalent among Medicare beneficiaries. Studies show that "PAD has significant impact on mortality; individuals with PAD have a two- to six-fold higher relative risk of death over a 10-year period versus the general population"[18] and "ten[%] of individuals over 60 years of age have PAD and the prevalence continues to increase with age."[19]

Additional conditions such as protein calorie malnutrition and atherosclerosis with intermittent claudication were removed from the V28 model due to CMS's belief that the differential coding patterns between MA and FFS for these conditions indicates discretionary coding variation (2024 Final Announcement, p.90). Comparing MA and FFS coding patterns inherently results in differentiation due to FFS provider groups narrow focus on Evaluation and Management (E/M) leveling and lack of provider training, education, and compliance oversight of ICD-10-CM specificity selection. Principle 2 states that "A primary purpose is to develop a system for risk-adjusting capitation payments to Medicare + Choice plans." We do not believe remapping these conditions to non-payment HCCs fulfills this primary purpose of appropriately predicting medical expenditures for these diagnostic categories.

d. CMS Should Halt Further Phase-in of V28 in 2025

In light of the evidence of negative impact to-date on beneficiaries' benefits, cost-sharing, and access to advanced primary care, CMS should cease any further implementation of the V28 HCC risk adjustment model pending public and transparent analysis of the extent of impact on

[15] CMS, 2024 Rate Announcement, p. 85.
[16] 2024 Announcement, p. 76.
[17] 2024 Announcement, p. 96.
[18] Chapter 96: Diagnosis and Management of Diseases of The Peripheral Arteries. (n.d.). Access Medicine.
[19] Criqui MH, Aboyans V, *Epidemiology of peripheral artery disease*, Circulation Research (April 2015).:

beneficiaries, particularly the impact on low-income special needs beneficiaries with access to advanced primary care. Implementation of V28 was finalized without independent or transparent validation of CMS' assertions about lack of impact on beneficiaries. In truth, as we are showing, all MA reductions are passed through to beneficiaries.

Value-based providers are willing to help improve the MA program and are doing so by accepting the current revenue reduction embedded in the blended V24-V28 model but it needs to be held fixed at 2/3-1/3 until more assessment on impact is completed and longer-term planning to survive the changes can be done.

Regardless of CMS's decision on continued implementation of the V28 model, CMS should return major depressive disorder, recurrent, mild (F33.0) and major depressive disorder, single episode, mild (F32.0) back into the risk model. To say that these codes do not require costs by removing them is clinically inaccurate and is harming beneficiaries by compromising the integrity of the risk model. Further, the diabetic HCC group coefficients should be returned to their original weights.

e. Adverse Impact on Beneficiaries if V28 Phase-in Continues in 2025

i. Frequent, Wild Swings in Revenue Discourage Investments in Infrastructure Needed to Make Value-Based Care Available to Beneficiaries

The reality is that the vast majority of value-based care and advanced primary care enjoyed by Medicare beneficiaries today is due to private investments. Medicare FFS continues to struggle with demonstration programs to identify a sustainable platform to offer advanced primary care with a focus on quality of care, provider performance and the patient experience. Such models are already being delivered to MA beneficiaries through advanced primary care platforms supported by private investment. However, that progress is put at risk when federal MA rates are reduced or do not keep up with utilization and cost trends.

For example, reports document that private investments in MA have dropped precipitously to a 6-year low.[20] Those investments will diminish further or cease in 2025 under continued V28 implementation. Appropriate incentives (i.e., stable, predictable federal funding) are a prerequisite to the private investments needed to make value-based care available to beneficiaries. The alternative to risk-assuming, entrepreneurial providers supported by private investment is standards FFS practices of limited physicians who lack resources for NP/PA staff support and tech infrastructure to enable patient engagement and patient follow-up. In fact, we are already observing some value-based care providers in our area shift to focus on FFS beneficiaries, decreasing access to providers for MA beneficiaries in a high penetration area and providing instead to FFS beneficiaries services that amount to less than advanced primary care.

[20] See Private Equity Stakeholder Project, pg. 11 (Jan. 2024). https://pestakeholder.org/wp-content/uploads/2024/02/PESP_Report_Medicare_Advantage_Feb2024.pdf.

Our coalition members have been working to increase the primary care physician base and inspire a new generation of medical students to select primary care as a career. It is projected that 28.56 million Americans will turn 65 between 2024 and 2030. As they age, their care needs will predictably increase. The revenue reductions from V28 undermine the ability and willingness to invest in the commitment to building the future workforce. The changes that will come from the planned next phase V28 roll out will reduce the size of the primary care workforce while demand for services will be increasing. The negative impact on access will be particularly hard felt in underserved areas of communities where support for transportation will be cut as is staffing, with no groups sitting in reserve seeking to move into those markets.

ii. More Physicians to Drop Medicare Patients

Numerous stakeholders express concern over an emerging shortage of Medicare primary care providers in the midst of the baby boom generation's senior years. The shortage of primary care physicians is projected to reach up to 48,000 by 2034.[21] Keep in mind that under the current reimbursement landscape, Medicare FFS payments, adjusted for inflation, declined 30% from 2001 to 2024.[22] This trend leads more physicians to abandon Medicare FFS. 65% of doctors won't accept new Medicare patients.[23] From 2016 to 2021, the number of primary care physicians billing Medicare declined each year, from 142,000 physicians in 2016 to 135,000 physicians in 2021.[24]

Cutting funding for providers who treat MA beneficiaries will accelerate the rate of physicians abandoning Medicare altogether. This is because physicians increasingly rely upon more favorable rates and arrangements under MA as a means to financially justify treating Medicare beneficiaries. If MA reductions are continued in 2025 and passed through from plans to providers, more of those value-based care providers will be unable to avoid losses in treating MA enrollees and will stop accepting Medicare. Eliminating MA as the last refuge from payment cuts for physicians treating Medicare beneficiaries will accelerate departure of physicians from the program and will make primary care provider shortages harder to ignore for policy makers.

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[21] See AAMC, *The Complexities of Physician Supply and Demand: Projections From 2019 to 2034*, pg. 3 (June 2021); https://www.aamc.org/media/54681/download?attachment. Note: the current supply of new primary care physicians is not keeping up with need. Family Physicians have been more likely to become outpatient primary care physicians than Internal Medicine Physicians. There are 1,500 family physicians graduating from residency programs each year. Yet, there are more than 1,500 family physicians retiring from patient care each year.

[22] AMA, Medicare updates compared to inflation in practice costs (2001–2024) (Jan. 2024); https://www.ama-assn.org/system/files/2024-medicare-updates-inflation-chart.pdf.

[23] Medscape, *Why Doctors Are Disenchanted With Medicare* (June 1, 2023); https://www.medscape.com/viewarticle/992642?form=fpf.

[24] Medical Economics, *Primary care physician numbers down as other clinicians increase from 2016 to 2021* (Aug. 1, 2023); https://www.medicaleconomics.com/view/primary-care-physician-numbers-down-as-other-clinicians-increase-from-2016-to-2021. ("Based on primary care physicians per 1,000 beneficiaries, the number dropped from 2.7 in 2016 to 2.3 in 2021.")

For physicians remaining with Medicare, their patients will see longer wait times due to increased patient panels which will strain providers' ability to effectively focus on patient experience and increase provider burnout.

IV. EFFECTIVE GROWTH RATE (SEC. A)

We strongly urge CMS to update the effective growth rate to appropriately reflect the documented increase in Medicare utilization and costs, including inflation. We are concerned that the proposed growth rates for 2025 do not fully account for the range of costs and increased utilization that should be included in the growth percentages, particularly considering the impact of inflation.

When compared to available metrics that measure Medicare costs and medical inflation, the 2.44% is not in line with available data. Specifically, the proposed effective growth rate is well below the Medicare Trustees' projected 5.80% growth in per beneficiary Medicare costs in 2025.[25] The CMS Office of the Actuary figures are also inconsistent with the effective growth rate, stating that Medicare spending per beneficiary growth is anticipated to be 5.60% in 2025.[26]

We see numerous public reports indicating that MA plans have recently experienced significantly higher utilization and cost trends and expect these trends to continue throughout 2024 and beyond.[27] Such trends reported by plans reflect what our coalition members observe at the provider level. Other reports suggest sustained higher cost trends in additional markets.[28]

We note that CMS' own data, as shown in the Advance Notice, also reflects higher cost growth in 2023 – 7.2% growth in the non-ESRD FFS USPCC and 6.9% growth in the non-ESRD Total USPCC. Similarly, the Medicare Trustees, in their 2023 report, projected per beneficiary cost growth of 6.1% for 2023. Importantly, the Trustees project per beneficiary cost growth of 4.8% and 5.8% for 2024 and 2025, respectively.[29]

We also are concerned about the lack of transparency into CMS' analysis and assumptions used to calculate the growth percentages. We continue to request transparency on how the growth percentages were developed, and that CMS provide any analysis, explanation, and methodologies the agency utilized.

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[25] Centers for Medicare & Medicaid Services: *2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (2022): https://www.cms.gov/files/document/2022-medicare-trustees-report.pdf.

[26] https://www.cms.gov/files/document/release-presentation-slides-national-health-expenditure-projections-2022-31-growth-stabilize-once.pdf.

[27] See, for example: https://finance.yahoo.com/news/cvs-health-corporation-nyse-cvs-150040535.html; https://finance.yahoo.com/news/humana-inc-nyse-hum-q4-165223864.html.

[28] See: https://www.pwc.com/us/en/industries/health-industries/library/behind-the-numbers.html.

[29] Medicare Trustees, 2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (Mar. 2023); https://www.cms.gov/oact/tr/2023.

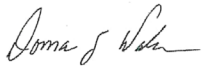
V. 2025 Proposed and Alternative RxHCC Models

We are supportive of the Alternative RxHCC Model published in the Advance Notice - 2025 RxHCC Model Relative Factors (2018/2019 calibration). We believe a model calibrated on the two most recent years not impacted by the COVID-19 pandemic, 2018 diagnoses and 2019 expenditures, is the better predictor of gross drug spending between the two models proposed in the 2025 Advance Notice. CMS included Special Needs Plans (SNPs) when determining the Part D normalization factor proposed in the 2025 Advance Notice, however, it excludes these plans when determining the National Average Bid Amount. This variance should be explicitly addressed by CMS with opportunity for stakeholder comment.

***

Thank you for your attention to these comments on the Advance Notice. We remain available to answer any technical questions that may arise out of these comments. Please feel free to reach us at Donna.Walker@inhealthmd.com or Phall@ebglaw.com.

Respectfully,



Donna Walker
President

cc: Chiquita Brooks-LaSure, Administrator
Jonathan Blum, Principal Deputy Administrator & Chief Operating Officer
Meena Seshamani, Director, Center for Medicare
Jennifer Wuggazer Lavio, Office of the Actuary
Cheri Rice, Deputy Director, Center for Medicare
Jennifer Shapiro, Director, Medicare Plan Payment Group

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COMMITTEE ON
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Congress of the United States
House of Representatives
June 26, 2024

The Honorable Vern Buchanan
Chairman
Ways and Means Health Subcommittee
1100 Longworth House Office Building

The Honorable Lloyd Doggett
Ranking Member
Ways and Means Health Subcommittee
1100 Longworth House Office Building

Chairman Buchanan and Ranking Member Doggett,

I would like to thank the Ways and Means Health Subcommittee for having this important and timely hearing today on improving value-based care for patients and providers. As Congress continues to discuss how to best navigate the complexities of modern healthcare, we must work together to educate members on the importance of value-based care. The fact is that value-based care is a model that not only treats illnesses but also prioritizes prevention, collaboration, greater financial stability, and patient satisfaction.

During my time in Congress, I have been a proud leader in seeking solutions to improve and expand value-based care. I am the lead sponsor of the Value in Health Care Act, bipartisan legislation that makes several important reforms to ensure that alternative payment models (APMs) continue to produce high-quality care for the Medicare program and its beneficiaries.

Specifically, the Value in Health Care Act of 2024 would provide a two-year extension of the Medicare Access and CHIP Reauthorization Act (MACRA) incentive payments for advanced APMs, authorize the Centers for Medicare and Medicaid Services (CMS) to adjust the thresholds to allow more opportunities for rural, underserved, primary care or specialty practices into APMs, eliminate the revenue-based distinction that can penalize rural and safety net providers, and create a fairer and more transparent process to set financial spending targets.

As we look at the future of value-based care, I urge this subcommittee to take a strong look at extending financial incentives for APMs and ensuring that benchmarks for accountable care organizations (ACOs) are sustainable over the long-term. It is critical that we ensure that ACOs have accurate benchmarks to incentivize greater participation and promote fairness in value-based care.

Thank you for your attention to these important matters. I share your commitment to improving healthcare delivery and advancing value-based care and look forward to continued work with members of this subcommittee.

Sincerely,

Darin LaHood
Member of Congress

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Chairman BUCHANAN. I would like to thank our witnesses. And I really do, because you have it's been a long day for appearing before us today.

Please be advised that members have two weeks to submit written questions to the answers later in writing. Those questions and your answers will be made part of the formal hearing record.

And with that, the subcommittee stands adjourned.

[Whereupon, at 5:39 p.m., the subcommittee was adjourned.]

MEMBER QUESTIONS FOR THE RECORD

VERN BUCHANAN
DISTRICT 16, FLORIDA
FLORIDA DELEGATION
CO-CHAIR

COMMITTEE ON WAYS AND MEANS
TAX-WRITING COMMITTEE
SUBCOMMITTEES:
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CHAIRMAN
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Congress of the United States
House of Representatives
Washington, DC 20515-0916

07/08/24

Dr. Chouinard: Can you speak to the importance of CMMI balancing the goal of reduced costs with protections for patient access? Do you believe that appropriate demo size and scope are an important factor in CMMI's ability to monitor patient impact and access to care, especially when it comes to health care settings with unique challenges, like rural areas?

Dr. Chouinard: In the context of value-based care models, what strategies and practices are stakeholders implementing or can adopt in the future to effectively help patients navigate the complexities of accessing cell and gene therapies and ensure that patients can access these treatments sustainably?

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COMMITTEE ON WAYS AND MEANS

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COMMITTEE ON STRATEGIC COMPETITION BETWEEN THE UNITED STATES AND THE CHINESE COMMUNIST PARTY

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June 28, 2024

Questions for the Record from Representative Michelle Steel (R-CA)
House Committee on Ways & Means
Hearing on Improving Value-Based Care for Patients and Providers

As we look to promote value-based care, the integration of behavioral health with primary care holds great potential.

Evidence-based approaches such as the Collaborative Care Model have shown the ability to improve patient outcomes, save money, and reduce stigma related to behavioral health – by improving access to timely and effective treatment in the primary care setting where patients often first demonstrate a need for behavioral health services.

My legislation, the COMPLETE Care Act, along with Rep. Kildee, seeks to help incentivize and support primary care providers to adopt these evidence-based models.

Question 1: Dr. Chouinard, Dr. Philip, and Mr. Berenson: What else can Congress do to help support and promote the use of integrated care models?

Wait times for accessing specialty care appears to be a growing problem, especially for underserved and rural communities.

For Medicare patients, I have seen data showing wait times of over 80 days to see a specialist.

These long wait times are a big deterrent in seeking medical care and lead to a surge in emergency room visits – both increasing Medicare costs and worsening patient outcomes.

At the same time, workforce shortages continue to be a problem and the current economy is making it extremely difficult for small and independent providers to remain in business or avoid consolidation.

Current demonstrations and existing federal agency initiatives have not focused on delivery models among providers in rural and underserved communities that serve a mix of patients, especially at Community Health Centers and Rural Health Clinics.

To address this matter, I introduced the EASE Act, which will connect specialty care providers with many patients via telehealth in desperate need of quality care.

This proposal can help manage complex conditions like diabetes and can offer a sustainable value-based model that improves care and drives down costs.

Sincerely,

Michelle Steel
Member of Congress

MAIN STREET HEALTH

July 22, 2024

The Honorable Vern Buchanan
Chair, Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
1139 Longworth House Office Building
Washington, DC 20515

Attn: Abigail Chance, Professional Staff Member

Dear Chairman Buchanan,

Enclosed are the responses to written questions for the record submitted to me following the Subcommittee's June 26, 2024, hearing entitled, *Improving Value-Based Care for Patients and Providers*.

Thank you for the opportunity to provide this material to the Committee.

Sincerely,

Sarah Chouinard, MD
Chief Medical Officer
Main Street Health

Enclosure
cc: The Honorable Lloyd Doggett
Ranking Member

U.S. House of Representatives Committee on Ways and Means – Subcommittee on Health
Follow-Up Questions to Hearing on "Improving Value-Based Care for Patients and Providers"
(June 26,2024)

Chairman Buchanan:

1. **Can you speak to the importance of CMMI balancing the goal of reduced costs with protections for patient access? Do you believe that appropriate demo size and scope are an important factor in CMMI's ability to monitor patient impact and access to care, especially when it comes to health care settings with unique challenges, like rural areas?**

   Answer:
   Balancing the goals of reducing costs while protecting patient access should be a central design principle as CMMI builds future rural healthcare models. While as a country we need to ensure healthcare costs are better controlled, we also need to ensure that this does not come at the expense of patients, especially those in rural areas, losing access to care. As part of this effort, it is important to ensure there is appropriate sizing for demonstration projects so that patient access to care can be monitored. This is especially important in rural areas, where decreases in access to care are more likely to occur given the unique challenges of rural areas such as provider shortages, lack of specialty care access, and geographic isolation.

2. **In the context of value-based care models, what strategies and practices are stakeholders implementing or can adopt in the future to effectively help patients navigate the complexities of accessing cell and gene therapies and ensure that patients can access these treatments sustainably?**

   Answer:
   Patients need access to specialists who can prescribe cell and gene therapy treatments that are hard to access in rural communities. Virtual specialty care facilitated by local care navigators is one viable solution. Local care navigators can assist with connecting patients to virtual specialists, provide patient education about complex cell and gene therapy treatment options, and help patients gain access to medication Patient Assistance Programs that patients may be eligible for based on their specific circumstances and therapy.

MAIN STREET HEALTH

July 22, 2024

The Honorable Michelle Park Steel
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
1139 Longworth House Office Building
Washington, DC 20515

Attn: Abigail Chance, Professional Staff Member

Dear Congresswoman Steel,

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Thank you for the opportunity to provide this material to the Committee.

Sincerely,

Sarah Chouinard, MD
Chief Medical Officer
Main Street Health

Enclosure
cc: The Honorable Vern Buchanan
Chairman

The Honorable Lloyd Doggett
Ranking Member

U.S. House of Representatives Committee on Ways and Means – Subcommittee on Health
Follow-Up Questions to Hearing on "Improving Value-Based Care for Patients and Providers" (June 26,2024)

Congresswoman Michelle Steel:

1. **As we look to promote value-based care, the integration of behavioral health with primary care holds great potential. Evidence-based approaches such as the Collaborative Care Model have shown the ability to improve patient outcomes, save money, and reduce stigma related to behavioral health – by improving access to timely and effective treatment in the primary care setting where patients often first demonstrate a need for behavioral health services. My legislation, the COMPLETE Care Act, along with Rep. Kildee, seeks to help incentivize and support primary care providers to adopt these evidence-based models. Question 1: Dr. Chouinard, Dr. Philip, and Mr. Berenson: What else can Congress do to help support and promote the use of integrated care models? Wait times for accessing specialty care appears to be a growing problem, especially for underserved and rural communities. For Medicare patients, I have seen data showing wait times of over 80 days to see a specialist. These long wait times are a big deterrent in seeking medical care and lead to a surge in emergency room visits – both increasing Medicare costs and worsening patient outcomes. At the same time, workforce shortages continue to be a problem and the current economy is making it extremely difficult for small and independent providers to remain in business or avoid consolidation. Current demonstrations and existing federal agency initiatives have not focused on delivery models among providers in rural and underserved communities that serve a mix of patients, especially at Community Health Centers and Rural Health Clinics. To address this matter, I introduced the EASE Act, which will connect specialty care providers with many patients via telehealth in desperate need of quality care. This proposal can help manage complex conditions like diabetes and can offer a sustainable value-based model that improves care and drives down costs.**

   Answer:
   Congress could take several actions to encourage rural participation in integrated care models,. Because there is often a shortage of behavior health specialists in rural America, ensuring already available education and training funds are used to train more behavioral health specialists, where there is a real need and a lot of good paying jobs, is key. Because there are often not enough local behavioral health specialists to serve all the patients with behavioral health needs in rural communities, ensuring that virtual behavior health care is available in primary care clinics throughout rural America is also important. This could be encouraged by ensuring that behavioral telehealth services are reimbursable at sustainable levels in all rural primary care settings as well as by streamlining cross-state licensures for behavioral health specialists

2. **As we look to promote value-based care, the integration of behavioral health with primary care holds great potential. Evidence-based approaches such as the Collaborative Care Model have shown the ability to improve patient outcomes, save**

money, and reduce stigma related to behavioral health – by improving access to timely and effective treatment in the primary care setting where patients often first demonstrate a need for behavioral health services. My legislation, the COMPLETE Care Act, along with Rep. Kildee, seeks to help incentivize and support primary care providers to adopt these evidence-based models. Question: For all of the witnesses: As we look at improvements to value-based care models, how can virtual integrated delivery models improve access to care and reduce wait times?

Answer:
Congress could take several actions to encourage rural participation in integrated care models. Because there is often a shortage of behavior health specialists in rural America, ensuring already available education and training funds are used to train more behavioral health specialists, where there is a real need and a lot of good paying jobs, is key. Because there are often not enough local behavioral health specialists to serve all the patients with behavioral health needs in rural communities, ensuring that virtual behavior health care is available in primary care clinics throughout rural America is also important. This could be encouraged by ensuring that behavioral telehealth services are reimbursable at sustainable levels in all rural primary care settings as well as by streamlining cross-state licensures for behavioral health specialists

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07/08/24

Mr. Nuckolls: Medicare Advantage has served as an example for value-based care in the Medicare program. However, in the 2025 Medicare Advantage and Part D rate notice, the Biden Administration announced they are cutting program.

- *What negative impact could these cuts have on MA efforts to expand value-based care?*

Mr. Nuckolls: Your organization has been a participant in the Medicare Shared Savings Program since its early days.

- *Can you expand on ways to strengthen and expand the program to make it more attractive to more providers?*

Mr. Nuckolls: Can you speak to the importance of CMMI having clear, predictable, and consistent model parameters for both patients and providers? I have heard from constituents about retroactive or mid-model changes resulting in provider attrition which also ultimately harms patients.

Mr. Nuckolls: In the context of value-based care models, what strategies and practices are stakeholders implementing or can adopt in the future to effectively help patients navigate the complexities of accessing cell and gene therapies and ensure that patients can access these treatments sustainably?

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June 28, 2024

Questions for the Record from Representative Michelle Steel (R-CA)
House Committee on Ways & Means
Hearing on Improving Value-Based Care for Patients and Providers

As we look to promote value-based care, the integration of behavioral health with primary care holds great potential.

Evidence-based approaches such as the Collaborative Care Model have shown the ability to improve patient outcomes, save money, and reduce stigma related to behavioral health – by improving access to timely and effective treatment in the primary care setting where patients often first demonstrate a need for behavioral health services.

My legislation, the COMPLETE Care Act, along with Rep. Kildee, seeks to help incentivize and support primary care providers to adopt these evidence-based models.

Question: For all of the witnesses: As we look at improvements to value-based care models, how can virtual integrated delivery models improve access to care and reduce wait times?

Sincerely,

Michelle Steel
Member of Congress

July 29, 2024

The Honorable Vern Buchanan
Chair
House Ways and Means Subcommittee on Health
1139 Longworth House Office Building
Washington, DC 20515

Re: QFR Responses

Dear Chairman Buchanan:

Thank you again for the opportunity to testify at the Ways and Means Health Subcommittee hearing on "Improving Value-Based Care for Patients and Providers." Please see my written responses to your questions for the record.

1. **Medicare Advantage has served as an example for value-based care in the Medicare program. However, in the 2025 Medicare Advantage and Part D rate notice, the Biden Administration announced they are cutting program. What negative impact could these cuts have on MA efforts to expand value-based care?**

   As discussed in my written testimony, in order to lower the growth in health care spending we must ensure that APMs and Medicare Advantage (MA) provide incentives for providers to improve care and lower wasteful spending. Continued cuts to physician payment under the Medicare physician fee schedule or MA, jeopardize beneficiary access to care and reduce provider's investment in value-based care programs. Stabilizing and ensuring payment adequacy for all Medicare programs (MPFS, MSSP, MA, etc.) is necessary to support the infrastructure and staffing necessary for many providers to transition to value-based payment. Going forward we need greater alignment between APMs and the MA program to ensure that both models provide attractive, sustainable options for innovating care delivery and to ensure that APMs do not face a competitive disadvantage. Policymakers should explore opportunities to improve APM alignment with MA and encourage adoption of risk-based arrangements in MA.

2. **Your organization has been a participant in the Medicare Shared Savings Program since its early days. Can you expand on ways to strengthen and expand the program to make it more attractive to more providers?**

In my written testimony I've outlined four opportunities to improve Medicare's transition to APMs, which includes:

1) **Revising APM benchmarks (or budget) so that providers are not penalized for their prior success.**

   While CMS has adopted policies to reduce the impact of the "ACO benchmark ratchet," these policies do not go far enough and many ACOs may face deep reductions to their benchmarks. Lowering benchmarks because of the ratchet effect reduces providers' willingness to make meaningful investments to improve care. We need benchmark approaches that do not penalize providers for prior success in the model.

   Now that we are nearly 13 years into APMs, benchmarks that are based predominately on historical spending are beginning to fail us. We have several members, including our ACO, who are leaving the MSSP because their benchmark will be significantly ratcheted. So far, all of them are remaining in APMs and joining an existing REACH ACO. However, with REACH coming to an end and the unfavorable evaluation, they will face the same challenge in a few years. While CMS has had RFIs on administrative benchmarks, there was no mention of it in the proposed 2025 MPFS. The MSSP needs a dedicated focus on building sustainable benchmarks, if they wish to achieve their full potential. We have been thinking the best approach would be for ASPE to do a report on benchmark approaches that are sustainable. The report should be informed by actuarial analysis and multistakeholder input, perhaps a TEP as well.

2) **Continue financial incentives to join APMs.**

   MACRA's APM incentives have helped nearly 400,000 clinicians (over 70 percent of ACOs) transition into advanced APMs that take on downside risk. These payments also help these providers expand services beyond what's covered by traditional Medicare and cover shortfalls that physician practices encounter due to cuts to fee schedule reimbursements. We support approaches like the Value in Health Care Act (H.R. 5013) that will extend APM incentives and ensure that qualifying thresholds remain attainable. Ensuring that there are stronger financial incentives for APMs vs MIPS will help maintain and encourage new participation in value models.

3) **Address incentives across the continuum of care.**

   ACOs and APMs can achieve success by prioritizing primary care strategies and programs. However, their full potential cannot be realized without integrating specialists and other providers who still operate under fee-for-service (FFS) models. It is crucial to reassess the financial incentives that have kept many providers outside of value-based care.

4) **Remove regulatory burden and increase flexibility, providing stronger nonfinancial incentives to adopt value.**

Increased program flexibility and reduced oversight for clinicians in APMs is needed. We must ensure APMs, and MA are both viable options for innovating care. We must reinstate burden reductions established under MACRA. Specifically, MACRA included exempted clinicians in APMs from certain MIPS reporting requirements. CMS has reinstated certain MIPS reporting while also significantly changing the ACO quality reporting program to be more burdensome by requiring ACOs to adopt technologies ahead of CEHRT and 21st Century Cures implementation timelines and require ACOs to report quality on care provided to patients covered by other payers. We should reverse these burdensome requirements by extending the CMS web interface reporting approach at least 3 years and exempting clinicians in APMs from reporting the MIPS promoting interoperability category.

3. **Can you speak to the importance of CMMI having clear, predictable, and consistent model parameters for both patients and providers? I have heard from constituents about retroactive or mid-model changes resulting in provider attrition which also ultimately harms patients.**

   Over the past decade, CMMI has advanced multiple successful models focused on improving care for patients, while addressing Medicare costs. While population health models have seen encouraging growth and positive results, only a few of the models tested have subsequently been expanded or extended, a reality that can create significant uncertainty for participants and make them hesitant to invest in new payment models. Policymakers should ensure that promising models have a more predictable pathway – both for initial implementation and for permanent adoption into Medicare – rather than being cut short due to overly stringent criteria.

   To accomplish these goals, Congress should do the following:
   - Direct CMS and CMMI to focus on filling the current gaps in APM opportunities for all types of providers, engage stakeholder perspectives during APM development, and improve its evaluation strategies by providing more data on the effectiveness of specific innovations and waivers.
   - Broaden the criteria by which CMMI models qualify for expansion based on enhancing the quality of patient care or access to care, rather than making expansion contingent on achieving the short-term cost savings.

4. **In the context of value-based care models, what strategies and practices are stakeholders implementing or can adopt in the future to effectively help patients navigate the complexities of accessing cell and gene therapies and ensure that patients can access these treatments sustainably?**

   While Medicare ultimately decides coverage for new therapies and treatments, the CMS Innovation Center plays a key role in testing new payment models for expanding access to new treatments and therapies. ACOs and other APMs also help patients navigate the complexities of the health care

system. For example, ACOs are designed to help patients by focusing on proactive, whole-person care. Many patients struggle to find the right doctor and get good quality care at the right time and setting. ACOs do things differently by rewarding providers for coordinating patients' care and improving health outcomes. The team-based approach employed by ACOs helps patients by:

- Listening to patients' personal health goals and supporting patients with multiple conditions by coordinating with different providers and creating care plans that support those goals.
- Proactively reaching out to patients to help find workable alternatives when treatment plans don't fit their lives or medications are too expensive.
- Developing trusted relationships with their patients, which is key to getting the right care at the right time.

Sincerely,

Stephen Nuckolls
Chief Executive Officer, Coastal Carolina Quality Care
Board Member, National Association of ACOs

July 29, 2024

The Honorable Michelle Steel
1127 Longworth House Office Building
Washington, DC 20515

Re: QFR Responses

Dear Representative Steel:

Please see my written responses to your questions for the record from the House Ways and Means Health Subcommittee hearing on "Improving Value-Based Care for Patients and Providers."

1. **As we look to promote value-based care, the integration of behavioral health with primary care holds great potential. Evidence-based approaches such as the Collaborative Care Model have shown the ability to improve patient outcomes, save money, and reduce stigma related to behavioral health – by improving access to timely and effective treatment in the primary care setting where patients often first demonstrate a need for behavioral health services. My legislation, the COMPLETE Care Act, along with Rep. Kildee, seeks to help incentivize and support primary care providers to adopt these evidence-based models. As we look at improvements to value-based care models, how can virtual integrated delivery models improve access to care and reduce wait times?**

First, I'd like to thank you and Rep. Kildee for your work and dedication to improving access to behavioral health care.

Accountable care models create financial incentives for providers to establish evidence-based programs such as the Collaborative Care Model (CoCM) to better meet the needs of patients and, over a longer-term period, help reduce the growth in costs. Our organization, along with many others, have started CoCM and have increased access and reduced wait times for behavioral health services. Once a patient is identified in our organization, they receive a call and have their first appointment typically within 48 hours. In addition to this virtual access our organization has used its value-based payments to launch a new onsite behavioral health clinic. We would not have offered these programs without the incentives provided by value-based care. Unfortunately, we may have to wind these programs down as fee-for-service payments do not cover the costs and our value-based care benchmarks are ratcheted lower to the point where it is no longer profitable for us to operate.

Despite these challenges NAACOS is engaged in continued discussions with our members and other stakeholders to understand the challenges and develop solutions for providers to continue to expand virtual and in-person behavioral health programs.

Sincerely,

Stephen Nuckolls
Chief Executive Officer, Coastal Carolina Quality Care
Board Member, National Association of ACOs

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07/08/24

Dr. Philip: Can you speak to the importance of CMMI having clear, predictable, and consistent model parameters for both patients and providers? I have heard from constituents about retroactive or mid-model changes resulting in provider attrition which also ultimately harms patients.

Dr. Philip: In the context of value-based care models, what strategies and practices are stakeholders implementing or can adopt in the future to effectively help patients navigate the complexities of accessing cell and gene therapies and ensure that patients can access these treatments sustainably?

Dr. Philip: What should Congress do to ensure CMMI models fully protect patients, account for patient impacts, and maintain continuity of care for seniors across the country? Is more robust congressional oversight needed to protect patients from sweeping models that fall short of meeting patient needs and maintaining access to providers and treatments? What actions are needed to keep any Administration from using CMMI as a political tool rather than a proving ground – on a small scale – to test policy changes tailored to patient needs?

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COMMITTEE ON WAYS AND MEANS

COMMITTEE ON EDUCATION AND THE WORKFORCE

COMMITTEE ON STRATEGIC COMPETITION BETWEEN THE UNITED STATES AND THE CHINESE COMMUNIST PARTY

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June 28, 2024

Questions for the Record from Representative Michelle Steel (R-CA)
House Committee on Ways & Means
Hearing on Improving Value-Based Care for Patients and Providers

As we look to promote value-based care, the integration of behavioral health with primary care holds great potential.

Evidence-based approaches such as the Collaborative Care Model have shown the ability to improve patient outcomes, save money, and reduce stigma related to behavioral health – by improving access to timely and effective treatment in the primary care setting where patients often first demonstrate a need for behavioral health services.

My legislation, the COMPLETE Care Act, along with Rep. Kildee, seeks to help incentivize and support primary care providers to adopt these evidence-based models.

Question 1: Dr. Chouinard, Dr. Philip, and Mr. Berenson: What else can Congress do to help support and promote the use of integrated care models?

Wait times for accessing specialty care appears to be a growing problem, especially for underserved and rural communities.

For Medicare patients, I have seen data showing wait times of over 80 days to see a specialist.

These long wait times are a big deterrent in seeking medical care and lead to a surge in emergency room visits – both increasing Medicare costs and worsening patient outcomes.

At the same time, workforce shortages continue to be a problem and the current economy is making it extremely difficult for small and independent providers to remain in business or avoid consolidation.

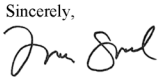
Current demonstrations and existing federal agency initiatives have not focused on delivery models among providers in rural and underserved communities that serve a mix of patients, especially at Community Health Centers and Rural Health Clinics.

To address this matter, I introduced the EASE Act, which will connect specialty care providers with many patients via telehealth in desperate need of quality care.

This proposal can help manage complex conditions like diabetes and can offer a sustainable value-based model that improves care and drives down costs.

Question 2: For all of the witnesses: As we look at improvements to value-based care models, how can virtual integrated delivery models improve access to care and reduce wait times?

Sincerely,



Michelle Steel
Member of Congress

VERN BUCHANAN
DISTRICT 16, FLORIDA

FLORIDA DELEGATION
CO-CHAIR

COMMITTEE ON WAYS AND MEANS
TAX-WRITING COMMITTEE
SUBCOMMITTEES:
HEALTH
CHAIRMAN
TRADE

Congress of the United States
House of Representatives
Washington, DC 20515-0916

07/08/24

Dr. Berenson: Can you speak to the importance of CMMI balancing the goal of reduced costs with protections for patient access? Do you believe that appropriate demo size and scope are an important factor in CMMI's ability to monitor patient impact and access to care, especially when it comes to health care settings with unique challenges?

Dr. Berenson: Can you speak to the importance of CMMI having clear, predictable, and consistent model parameters for both patients and providers? I have heard from constituents about retroactive or mid-model changes resulting in provider attrition which also ultimately harms patients.

Dr. Berenson: In the context of value-based care models, what strategies and practices are stakeholders implementing or can adopt in the future to effectively help patients navigate the complexities of accessing cell and gene therapies and ensure that patients can access these treatments sustainably?

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July 29, 2024

House Committee on Ways & Means, Subcommittee on Health
Hearing on Improving Value-Based Care for Patients and Providers
Questions for the Record submitted to Dr. Mathew Philip

Questions from Representative Vern Buchanan

Question 1: Can you speak to the importance of CMMI having clear, predictable, and consistent model parameters for both patients and providers? I have heard from constituents about retroactive or mid-model changes resulting in provider attrition which also ultimately harms patients.

Answer 1: Clear, predictable, and consistent model parameters are required to make CMMI models sustainable for both providers and patients. CMMI's current models include metrics and parameters that impact financial performance, sometimes drastically, without clear methodology. ACOs lack insight into their true results until the performance year has ended. For example –

- **Quality measures**: In ACO REACH, 2% of revenue is withheld from participants for quality measures. For an organization like Duly, this is a significant amount of payment at risk. The reporting on our quarterly performance is often delayed multiple months. For example, Q1 2024's performance was reported at the end of June. An ACO's quality score is evaluated relative to other ACOs, so there is no clear and objective target for us to reach. As groups leave ACO REACH, due to these challenges, the metrics become harder to reach leading to further attrition.
- **Retrospective trend adjustment (RTA)**: Similarly, the retrospective trend adjustment to CMS benchmarks can swing wildly each month. ACOs have no control or insight into where the RTA will land. For instance, in May 2024, the RTA was estimated at 0.963. In July 2024, the current RTA estimate is 1.005. This swing can equal between a quarter and half of the company's earnings annually.
- **Fraudulent billing**: The widespread DME fraud in 2023 adversely impacted ACO performance. While CMS has recently announced plans to address this, ACOs have been left to cover these financial losses in the meantime. More proactive, timely responses to these types of issues can make models more palatable to providers.

Without consistent, predictable metrics and timely performance data, provider groups are unable to understand their performance in these models. The unpredictability of these measures can blindside ACOs with significant financial losses, which ultimately contributes to provider attrition and harms patients.

Question 2: In the context of value-based care models, what strategies and practices are stakeholders implementing or can adopt in the future to effectively help patients navigate the complexities of accessing cell and gene therapies and ensure that patients can access these treatments sustainably?

Answer 2: Cell and gene therapies are starting to show a clear proof of concept and represent a powerful tool for longer-term patient outcomes and costs. However, the upfront cost of these therapies and the current insurance system create barriers for patient access. In an environment where patients may only stay with the same payer for 2-3 years, payers are disincentivized from approving these costly therapies. Some potential practices we could consider include -

- **Adjusting payment based on patient longevity with the payer**: Matching the benefits of these therapies, which in many cases last for many years, with the costs could help provider greater access to these treatments. Costs could be spread over multiple years so that if a patient switches insurance plans, the new payer will assume some of the cost within a defined time frame.
- **Creating a centralized fund**: Payers could contribute to a centralized fund that is responsible for payment of these therapies so that no payer unfairly assumes a disproportionate share of costs.

Question 3: What should Congress do to ensure CMMI models fully protect patients, account for patient impacts, and maintain continuity of care for seniors across the country? Is more robust congressional oversight needed to protect patients from sweeping models that fall short of meeting patient needs and maintaining access to providers and treatments? What actions are needed to keep any Administration from using CMMI as a political tool rather than a proving ground – on a small scale – to test policy changes tailored to patient needs?

Answer 3: More robust congressional oversight is needed to protect patients and providers in these models. CMMI historically has rolled out wide-sweeping changes, which do not serve the best interests of patients and providers, without adequate testing. However, this only becomes clear after the fact. For example, we are just now reviewing results and learnings from 2022 programs.

Providers and patients could benefit from a more careful rollout approach. Smaller, pilot programs could demonstrate the value and benefit of the program prior to scaling. The current approach leads to widespread, frequent changes that blindside providers, contribute to provider attrition, and create care gaps for patients.

Additionally, providers need more forums through which we can provide feedback to inform iteration and positive change. PTAC (Physician-Focused Payment Model Technical Advisory Committee) is one forum to do this, but it is not clear PTAC is fulfilling its initial congressional intent. Requiring PTAC members to have active direct experience with CMMI programs, such as Medicare Advantage and ACO REACH, can provide active real time feedback based on real world experience. While it would be unfair to expect CMMI to design a perfect model each time, it is discouraging for providers when our voices are not heard to help refine these models together. We provide care for seniors in these models each day, and we have valuable insight that can drive better outcomes for all.

Questions from Representative Michelle Steel

Question 1: What else can Congress do to help support and promote the use of integrated care models?

Answer 1: Integrated, total person care is an increasingly unmet need, particularly in rural areas. An estimated 150 million Americans live in areas that lack mental health professionals. Additionally, more than 60 percent of psychiatrists are 55 or older, which will present access challenges in the future. We need to reimagine care delivery to focus on scalable, lower cost models that can address growing access challenges.

- **Expanding telehealth**: Telehealth can make care more accessible to all communities. Telehealth is consistently used by Duly to maximize the reach of our behavioral health and specialty providers. Additionally, our care teams can go to patients' homes to help facilitate a telehealth visit with their primary care physician. We have seen telehealth consistently lift barriers, such as transportation and access, to help our patients flourish.

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HEALTH AND CARE

- **Integrating behavioral health in primary care**: Training primary care practitioners to engage in behavioral health can help alleviate shortages across the country and ensure behavioral health is incorporated into total person care. Aligning reimbursement to encourage primary care and behavioral health integration will be an important enabler of this shift.
- **Reimagining how local communities deliver care**: There are pilot programs that train community members to extend the supply of behavioral health. One such model trained grandmothers in evidence-based talk therapy known as "problem-solving therapy." These programs have been shown to decrease depression, anxiety and suicide rate in communities. These types of programs could address workforce shortages, create more social connectedness, and empower older Americans with renewed purpose. While some pilots have been done to date, there is an opportunity to further explore these alternative models.

Question 2: As we look at improvements to value-based care models, how can virtual integrated delivery models improve access to care and reduce wait times?

Answer 2: Virtual models expand access to care for patients, removing barriers such as transportation challenges, travel time, or patient condition. Patients love the ability to communicate with their physicians without the inconvenience of making and traveling to another appointment. In some circumstances, virtual care delivery can also reduce the staff needed to conduct visits, alleviating staffing shortages. At Duly, we use virtual care in a variety of contexts -

- **Increasing coordination between primary care and specialty care**: While a patient is in clinic visiting their PCP, a specialist can join virtually to ensure coordination of care and address open questions. This takes away the burden of separate follow-up visits, increases connectivity between primary and specialty care plans, and provides same-day access for the patient.
- **Reaching patients who can't make it into the office**: Whether they don't have transportation or just don't feel up for travel to a physical office, patients have a variety of reasons why they may refuse an in-person appointment. Historically, this would create a gap in the patients' care. With telehealth, we're able to follow-up with patients in the convenience of their home to prevent complications before they happen and triage patients to the appropriate care when needed.

Robert Berenson MD responses for the record to questions as follow up to the Committee on Ways and Means Subcommittee on Health hearing of June 26 on value-based care.

Representative Buchanan questions about CMMI"s role on testing new care models

Response: Consistent with my hearing testimony, I think the CMMI emphasis on wholly new payment models is inappropriate, as he mediocre results of demonstrations of new models over more than a decade have demonstrated. I was an original member of PTAC; in my three years, we reviewed almost 30 proposed payment models. Only a handful, at most, were truly original and complete payment models. Rather, many of the proposals were thoughtful attempts designed to address a particular barrier in care and could have been accomplished through coding and/or fee level changes within the Medicare Physician Fee Schedule (MPFS). The needed changes did not need a full-fledged payment model, yet that is what specialty societies and other clinical organizations provided, enticed also by the 5 percentage point payment boost that advanced APMs produce. Unfortunately, and inappropriately, PTAC had nothing to do with legacy payment models in Medicare so had no place to file recommendations for fee schedule enhancements.

In short, in standing up CMMI, Congress misunderstood the purpose for needed research and development. Alpha and beta testing of new coding approaches is needed, but not necessarily comprehensive payment models, to improve the value of care received by Medicare beneficiaries. That means that the CMS Center for Medicare needs additional resources, perhaps reallocated from the CMMI budget and relying on the expertise of CMMI staff, to test incremental improvements to the MPFS. CMS staff can learn a lot about operational challenges in new payment approaches revealed through demonstrations – lessons that then can result in incremental improvement in the see schedule through the standard notice-and-comment rule making process. Finally, this year, in the recently promulgated 2025 MPFS notice of proposed rulemaking, CMS has explicitly indicated that lessons learned from ten years of primary care payment model demonstrations are being introduced in the MPFS. The new coding will finally move in a value-based direction,

It is not surprising that the most successful new payment model taking place post-ACA has been the MSSP program that was adopted to apply immediately nationally across Medicare – not subject to a demonstration through CMMI. Yet, MSSP has been improved over the years through usual rulemaking, without the unrealistic need to obtain certification of effectiveness by the Office of the Actuary. Most improvements in payment approaches for providers other than clinicians and hospitals continue to be made through legislative and regulatory changes administered by the Center for Medicare, not CMMI.

Based on my views about how innovation should take place for clinicians and other providers, I have no opinion about the details of demo designs and parameters. The whole strategy for CMMI needs to be reconsidered. I have not studied cell and gene therapies so cannot offer an opinion about assuring access to these important services.

Representative Steel question about promoting integrated care.

Response: I will refer to some of the points Representative Steel made to support her question to make a few responses.

Rep. Steel emphasizes the need to integrate behavioral health and primary care, a wothy objective. First, I would point out that the Medicare Physician Fee Schedule (MPFS) in 2022 approved $1.3 billion more in spending for dermatologists than for all behavioral health clinicians, including psychiatrists, psychologists, and clinical social workers. Spending for the latter group comprised only 2.5 per cent of allowed charges in the MPFS. It is clear indication that the fee schedule produces suboptimal value for the Medicare beneficiary population, largely because of extreme payment distortions (payments that deviate substantially from production costs) in the MPFS and why I emphasized in my testimony the priority of getting MPFS prices right to allow alternative payment models to work as intended.

I provide this data to make the point that although integration of behavioral health care with primary care holds real potential, there are practical barriers to success of this strategy. For example, we already have a shortage of the primary care clinician workforce, and many of the current cadre of primary care physicians are opting out into concierge and direct primary care practices – or retiring -- leading to an even greater workforce shortage. Primary care clinicians are already working "like hamsters on a treadmill" so not necessarily eager to take on the challenge of integrated behavioral health in a major way.

A key to promoting integration is to move away from near total reliance on fee-for-service (FFS) as the dominant payment method used in the MPFS. FFS inherently allows – even promotes – care silos, rather than integration. The good news, however, is that in the recently announced MPFS notice of proposed rulemaking, CMS importantly has included new codes that would pay extra for patients with chronic conditions on a prospective per capita, monthly basis, regardless of the actual services furnished. Over time, this prospective payment approach can surely be expanded to promote integrated care for beneficiaries with behavioral health conditions, if not already included, in addition to paying for the collaborative care model that has been included in the MPFS for some years.

I would reiterate that true integration won't happen on a broad basis as long as the MPFS underpays both for primary care and for behavioral health care, while overpaying, sometimes, egregiously, for minor procedures, imaging, tests, and treatments. Changing this fee schedule orientation likely will require creation of a technical expert panel in CMS, as proposed in the draft legislation proposed by Senators Cassidy and Whitehouse. The TEP can address flawed processes CMS uses to set fees, processes that directly contribute to fee distortions. The TEP would work with CMS staff to figure out how best to include new coding that supports integration while preserving access and quality.

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Statement

of the

American Hospital Association

for the

Committee on Ways and Means

Subcommittee on Health

of the

U.S. House of Representatives

"Improving Value-Based Care for Patients and Providers"

June 26, 2024

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to provide feedback on the transition to value-based care.

THE ROLE OF ALTERNATIVE PAYMENT MODELS IN VALUE-BASED CARE

Our members support the U.S. health care system moving toward the provision of more outcomes-based, coordinated care and are continuing to redesign delivery systems to increase value and better serve patients. Over the last 14 years, many of our hospital and health system members have participated in a variety of alternative payment models (APMs).

While the movement to value holds tremendous promise, the transition has been slower than anticipated and more needs to be done to drive long-term system transformations.

There are principles that we believe should guide the development of APM design to make participation more attractive for potential participants. These include:

- **Appropriate On-ramp and Glidepath to Risk.** Model participants should have an adequate on-ramp and glidepath to transition to risk. They must have adequate time to implement care delivery changes (integrating new staff, changing clinical workflows, implementing new analytics tools, etc.) and review data prior to initiating the program.
- **Adequate Risk Adjustment.** Models should include adequate risk adjustment methodologies to account for social needs and clinical complexity. This will ensure models do not inappropriately penalize participants treating the sickest, most complicated and underserved patients.
- **Voluntary Participation and Flexible Design.** Model designs should be flexible, incorporating features such as voluntary participation, the ability to choose individual clinical episodes, the ability to add components/waivers and options for participants to leave the model(s).
- **Balanced Risk Versus Reward.** Models should also balance the risk versus reward in a way that encourages providers to take on additional risk but does not penalize those that need additional time and experience before they are able to do so. A glidepath approach should be implemented, gradually migrating from upside only to downside risk.
- **Guardrails to Ensure Hospitals Do Not Compete Against Their Own Best Performance.** Models should provide guardrails to ensure that participants are not penalized over time when they achieve optimal cost savings and outcomes performance. Participants must have incentives to remain in models for the long-term.
- **Resources to Support Initial Investment.** Upfront investment incentives should be provided to support organizations in their transition to value-based payment. For example, to be successful in such models, hospitals, health systems and provider groups must invest in additional staffing and infrastructure to support care delivery redesign and outcomes tracking.
- **Transparency.** Models' methodology, data and design elements should be transparently shared with all potential participants. Proposed changes should be vetted with stakeholders.
- **Adequate Model Duration.** Models should be long enough in duration to truly support care delivery transformation and assess the impact on outcomes. Historically, models have been too short and/or have had multiple, significant design changes even within the designated duration, making it difficult for participants to self-evaluate and change course when necessary.
- **Timely Availability of Data.** Model participants should have readily available, timely access to data about their patient populations. We would encourage the dedication of resources from the Centers for Medicare & Medicaid Services (CMS)

(staff and technology) to provide program participants with more complete data as close to real-time as possible.

- **Waivers to Address Barriers to Clinical Integration and Care Coordination.** This entails waiving Medicare program regulations that frequently inhibit care coordination and work against participants' efforts to ensure that care is provided in the right place at the right time.

POLICIES TO SUPPORT HOSPITAL TRANSITIONS TO VALUE-BASED CARE

Extension of Advanced APM Incentive Payments. The bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was also intended to support the transition to value-based care. MACRA provided advanced incentive payments (5%) for providers participating in advanced APMs through 2024. These payments were designed to assist with the provision of non-fee-for-service programs like meal delivery programs, transportation services, digital tools and care coordinators which promote population health, among other services.

However, MACRA statute only provided the advanced APM bonuses through the calendar year (CY) 2024 payment period. We appreciate Congress acting through a provision in the Consolidated Appropriations Act (CAA) of 2023 to extend the advanced APM incentive payments at 3.5% for the CY 2025 payment period and again in the CAA of 2024 to extend through 2026 at 1.88%.

While lower than the current 5% incentive payment rate, the incentive provides crucial resources. Because participation in the advanced APM program has fallen short of initial projections, spending on advanced APM bonuses has fallen well short of the amount the Congressional Budget Office projected when MACRA was originally scored. Repurposing the spending shortfall for APM bonuses in future years will serve to accelerate our shared goal of increasing APM adoption. **We urge the extension of these incentive payments.**

Eliminate Low-Revenue/High-Revenue Qualifying Criteria. Congress also should urge CMS to eliminate its designation of ACOs as either low- or high-revenue. The agency has used this label as a proxy measure to, for example, determine if an organization is supporting underserved populations and/or if the organization is physician-led to qualify for advance investment payments. Yet, there is no valid reason to conclude that this delineation, which measures an accountable care organization's (ACO) amount of "captured" revenue, is an accurate or appropriate predictor of whether it treats an underserved region. In fact, analysis suggests that critical access hospitals, federally qualified health centers and rural health centers are predominantly classified as high-revenue. Further, both low- and high-revenue ACOs are working to address health equity as part of their care transformation work; assistance investing in these efforts would help across the board. **We urge the removal of problematic high/low revenue thresholds that preclude rural and critical access hospitals from obtaining necessary resources for infrastructure investment.**

Support Investment in Resources for Rural Hospitals. Congress should encourage CMS to continue its resources and infrastructure investment to support rural hospitals' transition to APMs. According to a Government Accountability Office report, only 12% of eligible rural providers in 2019 participated in the advanced APM program; of those that participated, just 6% of rural providers participated in two or more advanced APMs, compared to 11% of those not in rural areas. These models are often not designed in ways that allow broad rural participation, and the AHA supports continued efforts to better support rural hospitals' migration to advanced APM models. **In particular, the AHA since 2021 has supported the establishment of a Rural Design Center within the Center for Medicare and Medicaid Innovation (CMMI), which would focus on smaller-scale initiatives to meet rural communities' needs and encourage participation of rural hospitals and facility types. A Rural Design Center would help develop and increase the number of new rural-focused CMMI demonstrations, expand existing rural demonstrations and create separate rural tracks within new or existing CMMI models.**

We support the Value in Health Care Act (H.R. 5013/S. 3503), which would extend incentive payments, remove revenue distinctions and improve financial benchmarks to ensure participants are not penalized for success.

RECENT CENTER FOR MEDICARE AND MEDICAID INNOVATION (CMMI) MODELS

Proposed Transforming Episode Accountability Model. On April 10, as part of the inpatient prospective payment system (PPS) proposed rule, the CMMI proposed a new mandatory payment model — Transforming Episode Accountability Model (TEAM) — that would bundle payment to acute care hospitals for five types of surgical episode categories: coronary artery bypass graft, lower extremity joint replacement, major bowel procedure, surgical hip/femur fracture treatment and spinal fusion. It would make acute care hospitals responsible for the quality and cost of all services provided during select surgical episodes, from the date of inpatient admission or outpatient procedure through 30 days post-discharge.

The AHA has significant concerns with the TEAM payment model. We are supportive of the Department of Health and Human Services Secretary's goal of moving toward more accountable, coordinated care through new APMs. However, CMS is proposing to mandate a model that has significant design flaws, and as proposed places too much risk on providers with too little opportunity for reward in the form of shared savings, especially considering the significant upfront investments required. If CMS cannot make extensive changes to the model, it should not implement it at this time. To do so would make TEAM no more than a thinly disguised payment cut, as it fails to provide hospitals a fair opportunity to achieve enough savings to garner a reconciliation payment.

The proposal does not align with the principles we outlined above. For example, we have previously commented on the necessity for waivers to support care coordination, more gradual glidepaths to two-sided risk and reasonable discount factors to ensure

financial viability. If anything, TEAM is a step backward with fewer waivers, shorter timelines to assume downside risk and more aggressive discount factors that make cost savings more challenging.

Moreover, the tremendous scope of this rule and its aggressive 60-day comment period made it challenging to fully evaluate and analyze the proposal and its significant impact on hospitals and health systems. The five types of surgical procedures proposed for inclusion in TEAM comprise over 11% of inpatient PPS payments in 2023 — a staggering amount that does not even include the outpatient payments that would be at risk as part of the model. While the AHA worked closely with our hospital and health system members to assess the potential impact of TEAM on the important work they do in caring for their patients and communities, the incredibly short comment period severely hampered our ability to provide comprehensive comments.

We strongly recommend that CMS make TEAM voluntary, lower the 3% discount factor and make several changes to problematic design elements.

Proposed Increasing Organ Transplant Access Model. Just four weeks after TEAM was proposed, CMS proposed another mandatory payment model for kidney transplants. The Increasing Organ Transplant Access (IOTA) model would test whether performance-based incentives or penalties for participating transplant hospitals would increase access to kidney transplants for patients with end-stage renal disease while preserving or enhancing quality of care, improving equitable access to kidney transplant care and reducing Medicare expenditures. The model would run for six years, beginning Jan. 1, 2025. Hospitals eligible for participation would include non-pediatric transplant facilities conducting at least 11 kidney transplants during a three-year baseline period. It is anticipated that 90 hospitals would be required to participate.

While we appreciate CMMI's goals of increasing access to kidney transplants, we are again left questioning the model design elements and are concerned that the model as written may have unintended consequences by focusing so heavily on volume (namely sub-par matches). Also, as mentioned above, implementation of complex payment models requires significant time, resources and staffing on the part of hospital participants. But CMMI has proposed a start date of Jan. 1, 2025. Given the transformation that is already occurring nationally under provisions of the Organ Procurement and Transplantation Network Act, this aggressive timeline is untenable. Additionally, we are concerned that CMMI is again proposing mandatory participation. As mentioned in our principles, it is critical that organizations can assess whether models are appropriate to best serve the needs of their patients and communities. Therefore, participation should be voluntary.

CONCLUSION

The APM model design principles we outlined above would support more organizations' abilities to provide accountable and coordinated care. The AHA urges Congress to

extend APM incentive payments, for CMS to remove problematic high- and low-revenue thresholds that preclude rural and critical access hospitals from obtaining necessary resources for infrastructure investment, and for CMMI to make models such as TEAM and IOTA voluntary.

The AHA appreciates your efforts to examine these issues, and we look forward to working with you.

AAOE American Association of Orthopaedic Executives
American Alliance of Orthopaedic Executives

To Whom It May Concern,

The American Alliance of Orthopaedic Executives (AAOE) submits these comments and recommendations on behalf of our over 1,300 members and 660 medical practices across the country. Our mission is to promote quality health care practice management in the orthopedic and musculoskeletal industry. We appreciate the opportunity to provide comments on improving value-based care for patients and providers.

Support for Value-Based Care Model

Focus on Patient-Reported Outcome Measures (PROMs)

AAOE supports a value-based care model centered on quality of care measured through Patient-Reported Outcome Measures (PROMs), complication monitoring, cost comparison, and patient-focused metrics. Instead of rewarding volume, new value-based payment models must incentivize improved results in cost, quality, and outcome measures. Currently, there is a focus on merely "checking the boxes" to meet measures that may not even be relevant to patient care and outcomes, which often leads to a decline in the quality of care, as providers are more concerned with meeting metrics than with the care provided. By increasing or decreasing payments based on outcomes, providers will be incentivized to enhance the quality of care or face reduced payments.

Incentives for Better Outcomes

For organizations with poorer outcomes, payment reductions should be redistributed to organizations with better outcomes. Organizations with scores in the lowest 10% may cease performing certain procedures, thereby driving patients to organizations with higher outcome scores. This approach will result in better patient outcomes across the board and increase the competency of those performing the procedures as they see more patients. Ultimately, this steers patients to the most qualified providers and improves quality and outcomes for patients.

Support for Orthopedic-Specific PROMs

AAOE strongly supports the use of reliable and valid orthopedic-specific PROMs like HOOS, KOOS, and PROMIS-10. These surveys are free for providers to utilize and, if replacing MIPS/MACRA requirements, will result in more meaningful outcomes for patients and providers. The use of outcome measures that are specific to the medical care being provided is important to measure the quality of the specialist care being provided.

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Conclusion

AAOE is ready to provide thoughts and engage in conversations about the current situation and future direction of the health care industry. We thank you for the opportunity to comment and look forward to working with the Committee on the transition to value-based care.

Joseph Mathews, PT, DPT
2024-2025 AAOE President

Dr. Paul Bruning, DHA
2024-2025 AAOE Advocacy Council Chair

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July 10, 2024

House Ways and Means' Health Subcommittee

Hon. Jason Smith
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Hon. Richard Neal
Ranking Member, House Ways and Means Committee
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Hon. Vern Buchanan
Chair, House Ways and Means Committee Health Subcommittee
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Dear Chairman Smith, Ranking Member Neal, Chairman Buchanan and Ranking Member Doggett;

The American College of Allergy, Asthma and Immunology's (ACAAI's) Advocacy Council is pleased to provide this letter for the record for the Health Committee's June 26th hearing on value-based care.

ACAAI represents more than 6,000 board certified allergists and healthcare professionals. Allergists specialize in treating both adult and pediatric patients with chronic conditions such as asthma, food allergies, hives or urticaria, stinging insect hypersensitivity, sinus problems, allergic rhinitis, anaphylaxis, immune deficiencies, and atopic dermatitis or eczema, among other things.

The Advocacy Council supports the Subcommittee's work to reduce financial and administrative burdens and improve the value-based care system. Additionally, we are happy to see that the Subcommittee is concerned about how issues such as low Medicare reimbursements and burdensome Medicare Advantage prior authorization systems compound the challenges practices face with value-based payment models.
This letter includes our recommendations for how Congress can improve value-based care.

- **Center for Medicare and Medicaid Innovation**

One of the ways Congress can help the healthcare workforce is by improving how models are developed by the Center for Medicare and Medicaid Innovation (CMMI). In particular, we believe Congress must do more to require CMMI to support physician-focused payment models (PFPMs), which were an important part of the MACRA legislation that created value-based payment programs such as the Merit-based Incentive Payment System (MIPS).

Congress' original intent to advance PFPMs has been neglected by CMMI. MACRA recognizes that CMMI is not the only entity that should develop Medicare value-based payment models. Physicians should be allowed to develop ideas in parallel to CMMI.

In 2019, ACAAI proposed a Patient-Centered Asthma Care Payment (PCACP) model to the Physician-Focused Payment Model Technical Advisory Committee (PTAC). Despite approval from PTAC, the model received no engagement from CMMI. This is part of a greater trend by CMMI to largely ignore PTAC recommended models.

Congress wanted these models to be an important part of the value-based payment landscape, yet CMMI has not approved any of the several dozen PFMPs recommended by the PTAC.

We hope that CMMI will grow its provider stakeholder outreach to implement more physician-focused models.

- **Merit-based Incentive Payment System**

Value-based payment programs such as MIPS and Alternative Payment Models (APM) are a major source of administrative burdens. The cost and quality goals of these programs are laudable but require a substantial resource investment to succeed, with limited opportunities for significant payment increases. Congress must simplify these programs and recalibrate the payment incentives to ensure that they provide meaningful financial rewards.

MIPS has been strongly criticized by MedPAC, which suggested that it should be eliminated and replaced. MedPAC hopes that the burdensome MIPS program can be replaced by Congress with a new voluntary program.

The administrative and financial burdens put upon providers to adhere to these value-based care models is currently untenable while providers are already operating on a net payment reduction. ACAAI hopes that Congress will act to reform MIPS to make it easier for providers to achieve value-based care while easing financial and administrative burdens.

- **Medicare Reimbursement Burdens**

Physicians continue to endure low Medicare reimbursement rates. According to MedPAC, medical inflation as measured by MEI has outpaced updates to the Medicare Physician Fee Schedule (PFS) Conversion Factor (CF) by over 20% since 2010. This is before other cuts such as the looming 4% PAYGO cut in 2025 and the 2% sequestration cuts are factored in.

Value-based payment programs such as MIPS are the only way for physicians to earn meaningful positive payment adjustments in Medicare. However, the cost practices must incur to participate in these programs offsets the potential positive adjustments.

Low Medicare payments further incentivize practices to avoid other APMs that require practices to bear financial risk.

Congress should reform Medicare payments to physicians as part of a broader effort to improve value-based care.

We recommend that Congress:

1. **Pass H.R. 2474**, the Strengthening Medicare for Patients and Providers Act, which permanently ties annual Medicare reimbursement updates to MEI.
2. **Pass H.R. 6371**, the Provider Reimbursement Stability Act of 2023, which reforms how CMS budget neutrality adjustments are calculated.
3. **Permanently waive the 4% PAYGO** reduction from ARPA.
4. **Stop extending Medicare Sequestration** payment reductions. Sequestration was supposed to expire in 2021. It has since become clear that Congress does not intend to let sequestration ever expire.
5. **Restore funding for the MIPS Exceptional Performance bonus** and the full Advanced APM Incentive Payment.

- **Conclusion**

Thank you for reviewing our recommendations for how to address problems related to value-based care. Clinicians are facing a wide array of clinical, administrative and financial burdens that are exacerbated by complex value-based care requirements. There is much that Congress can and should do to help relieve these pressures. Additionally, there is a clear need to improve CMMI along with MIPS and other models.

Thank you for considering our recommendations. Please do not hesitate to contact Matt Reiter (reiterm@capitolassociates.com) if you wish to discuss our recommendations further.

Sincerely,

Gailen Marshall, Jr., MD, PhD, FACAAI
President, ACAAI

Travis A. Miller, MD, FACAAI
Chair, Advocacy Council

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Statement for Hearing on
"Improving Value-Based Care for Patients and Providers"

House Ways and Means Health Subcommittee

June 26, 2024

AHIP is the national association that represents health insurance plans that provide coverage, services, and solutions for over 205 million Americans through employer-sponsored insurance, the individual insurance market, and public programs such as Medicare and Medicaid.

Health plans are committed to moving the health care system from volume to value. Through financial incentives and other methods, value-based care programs aim to hold providers more accountable for improving patient outcomes while also giving them greater flexibility to deliver the right care at the right time. Patients deserve a health care system centered around their needs and focused first and foremost on delivering affordable, evidence-based care that works. Health insurance plans are working in partnership with physician organizations, hospitals, and other important stakeholders to move toward a health care system that puts patients at the center.

We appreciate the Subcommittee's interest in advancing health care models that incentivize providers to focus on the quality of services delivered. Medicare Advantage (MA) serves an important role in advancing value-based care, and we believe the recommendations outlined below will accelerate the move to value-based care and that learnings from MA can inform the development of value-based care initiatives in other programs and markets.

MA Provides Better Quality Services than Fee-For-Service Medicare, Improving Preventive Care and Patient Outcomes

Health insurance providers in Medicare Advantage are driving value-based care adoption across the country. The MA program serves as a promising model for value-based care initiatives, as its design shifts the focus from volume to value and aligning financial incentives with patient outcomes and quality care. MA encourages providers and plans to deliver coordinated, effective, and patient-centered care.

A large body of evidence demonstrates the higher quality of care in MA, driven by care coordination. MA has been shown to provide better quality of care on various clinical quality measures,[1] reduce hospital admissions and readmissions, reduce patient days spent in rehabilitation facilities and

[1]Agarwal, R., Connolly, J., Gupta, S., et al; "Comparing Medicare Advantage and Traditional Medicare: A Systematic Review;" Health Affairs 40(6): 937-944 (June 2021); https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.02149.

nursing homes, and lower hospital use in the last days of life.[2,3,4,5] Research has found that MA plans outperform FFS Medicare across a range of metrics, and that MA outperforms FFS on 10 of 11 clinical quality measures, suggesting that MA plans keep their enrollees healthier than their FFS counterparts.[6]

Studies also suggest that MA does a better job addressing complex care needs than FFS Medicare. In one cross-sectional study of 1.8 million Medicare beneficiaries, those enrolled in MA had lower rates of hospital stays, ED visits, and 30-day readmissions. Overall, the study found that among Medicare beneficiaries with complex care needs, those enrolled in MA had lower rates of acute care utilization, suggesting that managed care activities in MA positively influence the nature and quality of care provided to these beneficiaries.[7]

Studies have also found better outcomes for patients with specific chronic diseases when they are covered by MA. When compared to patients with FFS Medicare, MA members with end stage renal disease have lower mortality and reduced rates of inpatient and skilled nursing facility (SNF) admissions and lower inpatient and SNF days when an admission did occur.[8] Further, all MA plans deliver affordable coverage to members by capping annual out-of-pocket costs.

Finally, it is worth noting that recent survey data representing 87% of covered lives nationally collected by the Health Care Payment Learning & Action Network (LAN), in collaboration with AHIP, shows that 57.2% of health care payments from MA plans were tied to value-based care arrangements, compared to 41.4% in FFS Medicare.[9] In fact, since the LAN began measuring alternative payment model (APM) adoption by line of business six years ago, MA plans have outpaced FFS Medicare and all other lines of business in moving toward APMs for both shared savings only and two-sided risk models.

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[2] Kumar, A., Rahman, M., Trivedi, Amal, N. et al.; "Comparing post-acute rehabilitation use, length of stay, and outcomes experienced by Medicare fee-for-service and Medicare Advantage beneficiaries with hip fracture in the United States: A secondary analysis of administrative data;" PLoSMed 15(6): e1002592.
[3] Jung D., DuGoff E., Smith M., et al.; "Likelihood of hospital readmission in Medicare Advantage and Fee-For-Service within same hospital;" Health Serv Res. 2020;55:587–595.
[4] Schwartz, A., Slaoui, K., Foreman, R., et al.; "Health Care Utilization and Spending in Medicare Advantage vs. Traditional Medicare: A difference-in-difference analysis;" JAMA Health Forum (2021).
[5] Sungchul, P., Teno, J., White, L., Coe, N.; "Effects of Medicare advantage on patterns of end-of-life care among Medicare decedents;" Health Serv Res (February 13, 2022).
[6] AHIP; "Medicare Advantage Provides Higher Quality of Care and Better Rates of Preventive Service Use When Compared to Original Medicare;" https://www.ahip.org/news/press-releases/new-study-demonstrates-higher-quality-of-care-in-medicare-advantage-when-compared-to-original-medicare.
[7] Antol, D., Schwartz, R., Caplan, A., et al.; "Comparison of Health Care Utilization by Medicare Advantage and Traditional Medicare Beneficiaries with Complex Care Needs;" JAMA Health Forum (2022).
[8] Powers, B., Yan, J., Jingsan, et al; "The Beneficial Effects of Medicare Advantage Special Needs Plans for Patients with End-Stage Renal Disease;" Health Affairs 39(9): 1486–1494 (September 2020).
[9] https://hcp-lan.org/apm-measurement-effort/2023-apm/.

We appreciate the Subcommittee's interest in improving a health care framework that incentivizes providers to focus on the quality of services delivered and have detailed recommendations to continue to drive the health care system from volume to value.

Recommendations to Accelerate Adoption of Medicare Value-based Care Models

Efforts to move towards a value-based health care system have shown promising results with respect to achieving better patient outcomes and driving affordability. Value-based arrangements drive progress toward improving population health, enhancing patient experience, bolstering health equity, and reducing health care costs. Results show that accountable care organizations (ACOs) in the Medicare Shared Savings Program (MSSP), the largest and longest running Medicare value-based program to date, saved Medicare $4.3 billion in 2022, resulting in a net savings of $1.8 billion after accounting for shared savings owed to successful participants.[10] Of the 482 ACOs in the program, 84% achieved savings for Medicare with 63% earning shared savings; shared savings payments allow ACO participants to earn higher reimbursements than if they were in FFS and provides funding that can be re-invested in additional practice transformation and care improvement activities.

Maintain an advanced APM bonus
AHIP supports appropriate financial incentives under Medicare Part B to encourage provider participation in Medicare advanced APMs. APMs emphasize preventative, coordinated, and patient-centered care and drive affordability with a focus on outcomes, bringing greater value to health care for patients. To the extent that Medicare is structured to entice providers into advanced APMs, those organizations will be more likely to enter private sector value-based contracts, thereby magnifying the positive impact for more Americans.

We support a solution that retains the availability of an advanced APM financial incentive that adjusts the FFS conversion factor upwards and/or offers a lump sum bonus based on prior year FFS billings for providers that participate in value-based arrangements built on FFS. However, this methodology does not reflect the advancements made in value-based care since the passage of the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015, which first codified the incentive payments and concept of advanced APMs. Incentives such as financial bonuses can be a powerful motivator for providers to join advanced APMs.

AHIP supports modifying the qualifying participant (QP) methodologies to provide more flexibility in how clinicians reach requisite thresholds to receive advanced APM incentives. AHIP encourages the Subcommittee to consider ways to account for the growing MA enrollee population and recognize the progress made toward robust advanced APM adoption in the MA market when making any changes to the thresholds required to earn advanced APM incentives. We also suggest the Subcommittee consider lowering the Medicare threshold such that more providers can qualify for advanced APM incentives through their participation in Other Payer arrangements, including MA.

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[10] https://www.cms.gov/newsroom/press-releases/medicare-shared-savings-program-saves-medicare-more-18-billion-2022-and-continues-deliver-high.

Congress could also consider whether patients served and payments received by providers through MA advanced APMs should count toward QP determinations under the Medicare Option. This would not generate bonuses on MA payments, but rather would demonstrate the committed nature of the provider's participation in alternative payments to drive the bonus on traditional Medicare payments. While health plans offer their own incentives to encourage providers to participate in value-based contracts, Medicare incentives remain a powerful tool to motivate behaviors that positively impact Medicare beneficiaries overall.

AHIP also supports modifications that permit more specialists to meet QP thresholds. Congress should consider establishing separate thresholds for specialist participation and/or evaluate other opportunities to update the QP methodology to account for specialist contributions to value-based payment transformation.

Offer more risk-based options
To date, full risk has only been available in CMS Innovation Center models, such as the Next Generation ACO Model and the Direct Contracting Model, which have been retired. AHIP strongly supports the creation of a voluntary, permanent option under the MSSP that features full risk. Key components of a full-risk MSSP track could include 100% shared savings and loss rates and options for capitated payments. The Next Gen ACO Model tested several polices that could be incorporated into a new MSSP track. We stress that participation in any new higher risk option under the MSSP should be voluntary and that CMS should not require or mandate progression by providers into higher risk tracks. Providers should be permitted flexibility to advance to higher risk and more advanced payment approaches at their own paces. To achieve robust participation in such a track, we recommend the subcommittee support CMS in development of a financial model that incentivizes providers to participate by supporting specialty integration and sufficiently investing in providers.

Address health equity
The MA program serves a population that is more diverse than FFS Medicare, and recent demographic data underscore the importance of MA in addressing care gaps through care management for underserved populations. Recent data show that 59% of Hispanic Medicare enrollees, 57% of Black Medicare enrollees, and 43% of Asian-American Medicare enrollees have chosen MA.[11]

Similarly, APMs, including ACOs and other programs, have the potential to improve health equity more effectively than FFS, as the flexible funding streams in value-based models and emphasis on realigning incentives better enable strategies to tackle social determinants of health (SDOH) and encourage equitable care.

Incorporating resources and incentives to address SDOH and improve health equity into APMs can attract more diverse clinicians and facilities to participate in them. Addressing the non-clinical

[11] https://www.ahip.org/resources/medicare-advantage-demographics

SDOH factors that impact access to health care and health behaviors allows individuals to more easily adhere to the care and treatment plans recommended for them and to live healthier lives, which in turn can improve outcomes, reduce costs, and advance health equity.

Leverage private sector innovation to grow APM participation
AHIP believes Medicare APMs can be strengthened by leveraging the work of health plans. Health plans have worked with provider partners to develop and implement value-based arrangements that span various clinical specialties, including condition- and specialty-specific payment arrangements, oncology medical homes, and advanced primary care models, and have designed arrangements to accommodate a diverse continuum of providers, such as physician groups, hospitals, ACOs, community-based organizations, and safety net providers.

These efforts have shown promising results with respect to achieving better patient outcomes, driving cost efficient care, promoting a focus on equitable care, and providing sustainable funding to practices.[12] Given that MA offers more opportunities for more providers to participate in value-based models that drive better care for their enrollees, we encourage FFS Medicare to look to this work for ideas on how to reach those previously left out of Medicare APMs.

Encourage multi-payer APM demonstrations
AHIP encourages the Subcommittee to support multi-payer alignment goals, as alignment across payers in APM design creates a stronger business case for providers to join them by increasing the total share of revenue flowing through value-based arrangements and reducing burden. Moreover, provider organizations with aligned incentives across multiple payers can also experience reduced operational burden and greater success in achieving program goals of generating cost savings and better outcomes.[13] The CMS Innovation Center has a goal that all new models make multi-payer alignment available by 2030.[14] We believe encouraging the Innovation Center to involve health plans from the inception and development of its models, rather than waiting to invite participation after implementation is underway, will better drive alignment.

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[12] *See, e.g.,* Amanda Sutherland, PhD; Emily Boudreau, PhD; Andy Bowe, MPH; et al; "Association Between a Bundled Payment Program for Lower Extremity Joint Replacement and Patient Outcomes Among Medicare Advantage Beneficiaries;" JAMA (June 2023); https://jamanetwork.com/journals/jama-health-forum/fullarticle/2806412 (study evaluating a bundled program for lower extremity joint replacement (LEJR) surgeries between an MA plan and physician group practices found the arrangement was associated with a decrease in episode spending of 2.7%, equivalent to savings of $598 per episode, without evidence of differences in episode quality).

[13] *See, e.g.*, Michael Zhu, Robert S. Saunders, David Muhlestein, William K. Bleser, Mark B. McClellan; "The Medicare Shared Savings Program In 2020: Positive Movement (And Uncertainty) During A Pandemic;" Health Affairs (October 14, 2021); https://www.healthaffairs.org/do/10.1377/forefront.20211008.785640. "When organizations participated in ACO programs beyond Medicare, the ACOs were more likely to receive bonuses and generate savings. … This effect of payer participation was further increased if the organizations participated in Medicare, Medicaid, and commercial ACO programs; 92 percent of these ACOs were able to receive a bonus payment, while 100 percent generated savings."

[14] https://www.cms.gov/priorities/innovation/strategic-direction-whitepaper.

Clarify inclusion of all value-based payment in the medical loss ratio (MLR)
We also request that the Subcommittee urge CMS to clarify that one-time lump sum payments to providers for joining value-based arrangements or taking downside risk are considered quality improvement activities within the MA medical loss ratio. CMS has used up-front incentive payments to advance value-based care, including the Advance Incentive Payments within the MSSP. Allowing MA plans to count similar payments as quality improvement activities would expand opportunities for plans to incentivize provider participation in APMs and allow providers to invest in infrastructure, staffing, technology, or other resources needed to advance value-based care. These funds would be especially valuable for rural providers who have limited resources for such investments and may have greater difficulty joining and succeeding in APMs.

Improving quality care while reducing provider burden
As the Subcommittee looks for opportunities to enhance patient-centered care and outcomes, we encourage you to consider ways to align quality improvement activities with private sector efforts. As value-based purchasing efforts have scaled in both the private and public sectors, so have the number of performance measures providers are required to report. Aligning measures is one important strategy to reducing clinician burden.

To address this issue, AHIP launched the Core Quality Measures Collaborative (CQMC). The CQMC is a public-private partnership between AHIP and CMS, with membership comprised of more than 70 member organizations, including health plans, primary care and specialty societies, consumer and employer groups, and other quality collaboratives. The CQMC works to identify Core Measure Sets, scientifically sound measures that efficiently promote a patient-centered assessment of quality and should be prioritized for adoption in value-based purchasing and APMs across payers. Aligning measures across public and private payers reduces the time clinicians must spend on processes to support quality measurement.

Conclusion
We appreciate the opportunity to comment on this critical topic and welcome the opportunity to work with the committee to continue driving health care from volume to value.

Alzheimer's Association and Alzheimer's Impact Movement Statement for the Record

United States House Committee on Ways and Means, Health Subcommittee Legislative Hearing on Improving Value-Based Care for Patients and Providers

June 26, 2024

The Alzheimer's Association and Alzheimer's Impact Movement (AIM) appreciate the opportunity to submit this statement for the record for the House Ways and Means Health Subcommittee hearing on "Improving Value-Based Care for Patients and Providers." We are grateful to the Subcommittee for leading and implementing policies that improve the lives of people living with dementia and their families.

Founded in 1980, the Alzheimer's Association is the world's leading voluntary health organization in Alzheimer's care, support, and research. Our mission is to eliminate Alzheimer's and other dementia through the advancement of research, to provide and enhance care and support for all affected, and to reduce the risk of dementia through the promotion of brain health. AIM is the Association's advocacy affiliate, working in a strategic partnership to make Alzheimer's a national priority. Together, the Alzheimer's Association and AIM advocate for policies to fight Alzheimer's disease, including increased investment in research, improved care and support, and the development of approaches to reduce the risk of developing dementia.

Millions of Americans living with dementia often face the challenge of navigating complex care landscapes without adequate support, leading to poorer health outcomes, high rates of hospitalization, and significant caregiver stress. According to the Alzheimer's Association's *2024 Facts and Figures and Special Report*, nearly 7 million Americans are living with Alzheimer's. By 2050, that number will approach 13 million. Sixty percent of health care workers believe that the U.S. health care system is not effectively helping patients and their families navigate dementia care. A majority of caregivers (70 percent) report that coordinating care is stressful, and two in three (66 percent) have difficulty finding resources and support for their needs. Unfortunately, our work is only growing more urgent.

Importance of Value-Based Care

Caring for an individual living with dementia involves many unique and often challenging elements. Dementia care management is a model of care that enables individuals living with Alzheimer's and their caregivers to more seamlessly navigate the health care and social support systems and obtain more timely access to care. Last year, the Centers for Medicare & Medicaid Services (CMS) announced a new alternative payment model, the Guiding an Improved Dementia Experience (GUIDE) Model. This announcement was made after Alzheimer's advocates and bipartisan congressional champions had been growing support in Congress for the bipartisan Comprehensive Care for Alzheimer's Act (H.R. 1637 / S. 626). The GUIDE model

will begin on July 1, 2024, through the Center for Medicare and Medicaid Innovation (CMMI), and will focus on providing key supportive services to people with dementia, including comprehensive, person-centered assessments and care plans, care coordination, and 24/7 access to a support line. People living with dementia and their caregivers will also have access to a care navigator who will help them access services and support.

In addition, the model will help people with dementia and their caregivers access education and support by providing a link between the clinical health care system and community-based providers. Model participants will help caregivers access respite services, which enable them to take temporary breaks from their caregiving responsibilities.

The initiative will continue to work to improve the health outcomes and caregiving experience of underrepresented individuals and their families through increased access to specialty dementia care. The GUIDE Model will provide financial and technical assistance for developing new dementia care programs targeted to underserved areas.

Addressing the Gap in Dementia Care for Individuals and Caregivers

The Dementia Care Navigation Service (DCNS), powered by Rippl and the Alzheimer's Association, leverages Rippl's proven model of on-demand dementia care and the extensive resources of the Alzheimer's Association, including its 24/7 Helpline and community education programs. Later this year, the service will roll out across the nation through both public and private payers, delivering the gold standard of dementia care to thousands of individuals and their caregivers who otherwise do not have access to the comprehensive care they desperately need. The DCNS has been approved by CMS to participate in the eight-year GUIDE Model pilot program.

Preparing the Dementia Workforce

People with Alzheimer's and other dementias receive care and support from a wide variety of health and long-term care professionals. But, the medical, psychological, and social care needs of those living with dementia often make care delivery challenging and more demanding than for those with other health conditions. As our nation ages and the demand for such care increases, more must be done to ensure an adequately trained workforce.

Today, only half of those living with Alzheimer's disease are diagnosed, and of those, only half are told of their diagnoses. In 85 percent of cases, the initial diagnosis of Alzheimer's is made by a non-dementia specialist — usually a primary care provider. Overburdened primary care providers are too often unable to access the latest patient-centered dementia training.

Project ECHO programs, which are virtual continuing education programs for health care providers, have shown they can help address the knowledge gaps felt by many primary care providers and reach rural and medically underserved areas where primary care physicians are especially strained.

Through the use of Project ECHO, the Accelerating Access to Dementia & Alzheimer's Provider Training (AADAPT) Act (H.R. 7688 / S. 4276) would provide virtual Alzheimer's and dementia education and training to more primary care providers to help them better detect, diagnose, care, and treat Alzheimer's and other forms of dementia. The bipartisan bill would expand the current ECHO program to provide grants specifically for Alzheimer's and dementia to address the knowledge gaps and workforce capacity issues primary care providers face.

Conclusion

The Alzheimer's Association and AIM appreciate the Subcommittee's steadfast support and continued commitment to issues important to the millions of families affected by Alzheimer's and related dementias. We would be glad to serve as a resource to the Subcommittee as they monitor these important issues and how they relate to individuals living with Alzheimer's and related dementias.

July 9, 2024

The Honorable Jason Smith, Chair
House Committee on Ways & Means
U.S House of Representatives
Washington, DC 20510

The Honorable Richard Neal, Ranking Member
House Committee on Ways & Means
U.S House of Representatives
Washington, DC 20510

The Honorable Vern Buchanon, Chair
Ways & Means Subcommittee on Health
U.S House of Representatives
Washington, DC 20510

The Honorable Lloyd Doggett, Ranking Member
Ways & Means Subcommittee on Health
U.S House of Representatives
Washington, DC 20510

Dear Chairman Smith, Ranking Member Neal, Chairman Buchanon, and Ranking Member Doggett,

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association appreciates the opportunity to submit comments for the hearing "Improving Value-Based Care for Patients and Providers."

APTA is dedicated to building a community that advances the physical therapy profession to improve the health of society. As experts in rehabilitation, prehabilitation, and habilitation, physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability for individuals across the age span, helping individuals improve overall health and prevent the need for avoidable health care services. Physical therapists' roles include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession's vision of transforming society by optimizing movement to improve the human experience.

"The Economic Value of Physical Therapy in the United States" a recently released APTA report, showcases the cost-effectiveness and economic value of physical therapist services for a broad range of common conditions. The report compares physical therapy with alternative care across a suite of health conditions commonly seen within the U.S. health care system. The report underscores and reinforces the importance of including physical therapists and physical therapist assistants as part of multidisciplinary teams focused on improving patient outcomes and decreasing downstream costs.

While the report highlights the economic value that physical therapy brings to the U.S. health care system, such value is not maximized due to the unique challenges faced by physical therapists under the Medicare Physician Fee Schedule (MPFS). Physical therapist and physical therapist assistants play a critical in the delivery of services to beneficiaries who have chronic care conditions; however, therapists and other non-physician providers who are paid under the MPFS

are often overlooked when it comes to enacting meaningful reforms to payment and administrative burden challenges. To improve chronic care services, broader reforms to the current fee schedule to addresses these challenges must be made.

APTA's comments below offer a series of policy recommendations for the committee's consideration to decrease health care costs and reduce administrative burden that are supported by APTA's recent economic report. Our comments also mirror the recommendations laid out in the "Policy Principles of Outpatient Therapy Reform Under the Medicare Physician Fee Schedule" that provides a roadmap offering recommendations specific to outpatient therapy that need to be made for the continued sustainability of physical therapy under Medicare. The "Policy Principles of Outpatient Therapy Reform Under the Medicare Physician Fee Schedule" are endorsed by APTA, APTA Private Practice, the American Speech-Language-Hearing Association, and the American Occupational Therapy Association.

Background

The 2015 Medicare Access and CHIP Reauthorization Act, known as MACRA, replaced the flawed Sustainable Growth Rate formula with the Quality Payment Program, or QPP. The QPP comprises two tracks: the Merit-based Incentive Payment System, or MIPS, and Advanced Alternative Payment Models, also known as AAPMs. The Centers for Medicare & Medicaid Services (CMS) began implementing the QPP in 2017, with the eventual goal of moving providers out of MIPS and into AAPMs. There are a number of foundational issues with MACRA and the QPP that disproportionately impact nonphysician qualified health care providers such as physical therapists. In addition, there are logistical and operational barriers for therapists to participate in MIPS and AAPMs. Some of the current challenges facing therapy providers include:

- **MACRA Has Not Stabilized Payment Under the Medicare Physician Fee Schedule**. MACRA sought to stabilize payments by repealing the Sustainable Growth Rate formula and providing payment adjustments under the QPP. Despite that goal, these changes replaced relief from the growth rate cuts with payment cuts to the conversion factor – as a result, budget neutrality requirements limit the effectiveness of payment incentives provided under MIPS and have required annual legislative intervention to stave off untenable cuts to payment. Further, nonphysician providers, including therapists, have few options to receive payment adjustments under the QPP that would otherwise serve to offset payment cuts. In 2021, the average payment per therapy claim *was the same as it was in 2010*. Since 2021, therapy services have been cut further because of reductions to the conversion factor. An additional 15% cut to services provided by physical therapist assistants was implemented in 2023. This decrease in payment is simply not sustainable if we are to have a robust workforce that supports access to rehabilitation therapy services nationwide. Providers are suffering under a workforce shortage and MACRA policies are reducing resources needed for adequate therapists to meet patient access needs.

- **Inability of facility-based outpatient therapy providers to participate in bonus Payment structures.** While outpatient private practice therapy services are paid under the Medicare Physician Fee Schedule, or MPFS, services provided in facility-based

settings, such as hospital outpatient departments, rehabilitation agencies, and skilled nursing facilities are not considered to be a part of the MPFS. Rather, the 1997 Balanced Budget Act required that payments for facility-based outpatient therapy services be "based-on" the value of those services as set forward in the MPFS. While therapy services provided under the fee schedule are billed through an individual's National Provider Identifier, all facility-based outpatient therapy services are billed through the facility, and not the individual therapist. This distinction is not insignificant. According to MedPAC, 63% of all Medicare outpatient therapy services are provided in facility-based settings, yet facility-based outpatient therapy providers have had no way to receive payment updates or bonus payments. However, these services are subject to budget neutrality cuts and any other policy affecting therapy payments through the physician fee schedule – such as the multiple procedure payment reduction, also known as MPPR, and cuts to services provided by physical therapist assistants.

- **QPP Does Not Promote Value-Based Care or Effectively Measure Quality of Care**. The QPP does not allow for adequate participation for therapists in either MIPS or AAPMs. The lack of appropriate quality metrics and a failure to include all outpatient providers of therapy services in MIPS and AAPMs have prevented the shift to value-based care. These problems are compounded by slow and ineffective mechanisms used to innovate within the QPP. This means physical therapists who were not fully considered in the QPP's design still cannot meaningfully participate.

- **Barriers to Therapist Participation in MIPS.** Most physical therapists are not required to participate in MIPS but are encouraged to opt in to the program. However, extremely limited payment incentives serve to dissuade optional participation given that the cost of compliance outweighs even the highest historical incentives earned under the programs. Without specialty measurement sets, therapy cost measures, or otherwise comparable options available to most physicians, therapists have few reasons to participate under the program and suffer compounding pay cuts under the MPFS without any opportunity for mitigation through the QPP.

- **CEHRT is a Threshold Barrier for Therapists in MIPS and AAPMs.** Promoting interoperability through Certified Electronic Health Record Technology, or CEHRT, was part of MACRA's original vision. AAPMs promote this by requiring CEHRT as a prerequisite for AAPM opportunities, and under MIPS providers are scored on the "promoting interoperability" measure category. CEHRT options are simply not available for physical therapists, as their requirements are costly, burdensome, and contain many requirements that are specific only to physicians. As a result, physical therapists cannot participate in AAPMs, and will receive scores of zero under MIPS in the interoperability category. Without vendors working to develop CEHRT for therapists (in part because there aren't enough potential users to justify vendors' expense of CEHRT development), these providers will never be able to participate meaningfully. Requirements must be relaxed or modified, otherwise physical therapists will continue to be assessed on an uneven playing field.

- **Barriers to Participation in AAPMs**. In addition to CEHRT as a threshold barrier to participation, the Qualifying Participant, or QP, threshold to earn incentives under the program also is not realistically achievable for physical therapists. Further, while there is a Partial QP designation, it does not offer any incentives to participate, and serves more to prepare clinicians who believe they would meet the QP threshold in the future. AAPMs could have therapist-specific thresholds or offer incentives for partial QPs to incentivize participation by therapists.

The challenges that MACRA has created for therapy providers are compounded by the current budget neutrality policies under the MPFS that have resulted in year-over-year cuts. Despite Congress's annual intervention since 2020 to provide additional funding to the fee schedule to mitigate the impact of the cuts, therapy providers still had to absorb multiple payment reductions. The challenges associated with budget neutrality threaten to re-create the decades-long problems created by the Sustainable Growth Rate; an urgently needed solution is necessary to prevent increased spending associated with temporary, year-end fixes.

Recommendations

To provide greater stability under the MPFS for nonphysician providers such as physical therapists, and to help account for a decade of cuts to payments to therapy services, we recommend the following policies be included in any legislative package aimed at reforming the Medicare Physician Fee Schedule to ensure patient access to care and stability of providers.

Eliminate the Multiple Procedure Payment Reduction Policy

The MPPR Policy, first implemented in 2011, applies to physical therapy, occupational therapy, and speech-language pathology services provided under Medicare Part B. Because of MPPR, when therapists bill more than one "always therapy" service (identified by CPT code) on the same day for the same patient, all therapy services beyond the first are subject to a reduction in the practice expense portion of that code.

Under this policy, the therapy service with the highest practice expense value is reimbursed at 100%, and the practice expense values for all subsequent therapy services, provided by all therapy clinicians, are reduced by 50%. The work and malpractice components of the therapy service payment are not reduced. In the 2011 Medicare Physician Fee Schedule, CMS first proposed the implementation of a 25% MPPR across therapy services. Congress reduced this reduction amount to 20% in the Physician Payment and Therapy Relief Act of 2010 (H.R. 5712). This 20% MPPR was in place from Jan. 1, 2011, to March 31, 2013. Without any further analysis demonstrating a need to increase the MPPR, Congress implemented a permanent 50% MPPR in the American Taxpayer Relief Act of 2012, which was implemented by CMS on April 1, 2013. The average payment per therapy claim in 2013 (after MPPR) was 8.5% less than the average therapy claim in 2010 (before MPPR).

Our organizations have opposed the MPPR policy since its inception. It is inherently flawed, because the American Medical Association Relative Value Scale Update Committee, which assigns values to CPT codes, already ensures that any potential duplication in work or practice expense is addressed as part of the code valuation process. Certain efficiencies that occur when multiple therapy services are provided in a single session were explicitly taken into account when relative values were established for these codes. The application of MPPR to the "always therapy" codes results in a duplicative and excessive reduction of these codes and is having a significant impact on the financial viability of therapy practices — ultimately impacting access to vital therapy services.

The percentage of payment reduction was arbitrarily decided by the 112th Congress and does not reflect actual utilization data regarding how many units of a therapy service are typically delivered in a treatment session, and it does not recognize that OT, PT, and SLP interventions are separate and distinct from each other. When CMS first proposed the MPPR, they purposefully did not consider how therapy services are provided in facility-based settings, even stating that it does "not believe it would have been appropriate for us to consider institutional patterns of care." (See page 70).

With the potential exception of greeting the patient, clinical staff activities that are elements of the practice expense are not duplicative in nature and should not be reduced in value, especially when delivering different services during the therapy session. For instance, if therapeutic exercises using hand weights are provided for one unit, followed by self-care retraining in the kitchen for one unit, then the equipment, supplies, and clinical staff activities are entirely separate for each of these procedures. Each requires its own disinfection, patient positioning, and other set-up and clean-up processes before and after the procedure. Under the current policy, despite those services being separate and distinct, and having a separate and distinct practice expense, payment for the second unit is reduced even though the values of the two codes do not include any duplicative cost.

MPPR also applies across therapy disciplines delivered on the same date regardless of the distinct services and supplies provided to the patient. While the first therapy discipline (e.g., physical therapy) would receive payment under MPPR at 100% for the first unit and 50% of the practice expense for all other units, a second or third discipline (e.g., occupational therapy or speech-language pathology) delivering services on that date would have all provided service units reduced. This occurs even though the expertise, equipment, clinical staff, and supplies utilized for one therapy service have no overlap with the other services provided. This policy penalizes providers when scheduling multiple therapies on the same date, which disproportionately affects beneficiaries in rural and underserved communities where transportation issues may require therapy services to be delivered on the same day to reduce the need for repeat visits to the clinic.
**Note – APTA has draft legislative language available for this recommendation.*

Provide Flexibility in the Supervision of Physical Therapy Assistants to Alleviate the Challenges Facing the Physical Therapist Workforce in Rural and Underserved Areas

Medicare allows for general supervision of occupational therapy assistants (OTAs) by occupational therapists, and physical therapist assistants (PTAs) by physical therapists in all settings, except for outpatient private practice under Part B, which requires direct supervision. While therapy providers must comply with their state practice act if state or local practice requirements are more stringent than Medicare's, the standard in 49 states is general supervision of PTAs, making this an outdated Medicare regulation — which arbitrarily applies only to private practice — more burdensome than almost all state requirements. Standardizing a general supervision requirement for private practices will help ensure continued patient access to needed therapy services and give small therapy businesses more workforce flexibility to meet the needs of beneficiaries.

The inconsistency of supervision policies between settings jeopardizes employment opportunities for OTAs and PTAs as well as the needs of Medicare beneficiaries in medically underserved and rural communities that rely so heavily on their services. Standardizing the supervision requirement from direct to general for private practices will help ensure continued patient access to needed therapy services and give private practices more flexibility in meeting the needs of beneficiaries. This small modification would better promote timely access to therapy services.

Congress should enact the Enabling More of the Physical and Occupational Workforce to Engage in Rehabilitation Act, or EMPOWER Act, (H.R. 4878/ S. 2459), bipartisan legislation that would assist the therapy workforce by permitting general supervision of physical therapist and occupational therapy assistants under Medicare Part B outpatient practices. According to an independent report published by Dobson DaVanzo & Associates in September 2022, this change in supervision is estimated to save up to $271 million over 10 years.

Reform MACRA to Allow Broader Participation by Therapy Providers

Within MACRA, the QPP has posed significant challenges to nonphysician providers, including PTs, OTs, and SLPs. Therapists in particular have struggled to meaningfully participate in MIPS or engage in AAPMs, in part because CMS has failed to pilot or implement several alternative payment and delivery models applicable to therapy providers. Congress must enact meaningful reforms to the QPP that recognize the value of therapy providers and allow them to provide effective oversight of the QPP to determine its effectiveness at measuring therapy performance and outcomes.

The value of any quality program depends on the ability of all providers to participate. To address the current shortcomings of the QPP including limited opportunities for therapists' participation in the program, Congress should authorize a stakeholder workgroup to identify barriers and develop recommendations for the Secretary of the Department of Health and Human Services on rulemaking to ensure that the QPP comprehensively measures the impact of all care received by Medicare beneficiaries. **Note – APTA has draft legislative language available for this recommendation.*

Reduce the Impact of Inflation on Providers and the Patients They Serve

Providers paid under the Medicare Physician Fee Schedule do not receive the annual inflationary update upon which virtually all other Medicare providers can rely on to better weather periods of fiscal uncertainty. Providing an annual inflationary payment update to the Medicare Physician Fee Schedule's conversion factor based on the Medicare Economic Index, or MEI, will provide much-needed stability to the Medicare payment system. The MEI is a measure of inflation faced by health care providers with respect to their practice costs and general wage levels.

Health care providers, including rehabilitation therapists, continue to face increasing challenges as they seek to provide Medicare beneficiaries with access to timely and quality care. Congress has taken action to mitigate some of the recent MPFS cuts on a temporary basis, nevertheless, reimbursement continues to decline. According to an American Medical Association analysis of Medicare Trustees data, when adjusted for inflation, Medicare payments to clinicians have declined by 26% from 2001 to 2023. The failure of the MPFS to keep pace with the true cost of providing care, combined with year-over-year cuts resulting from the application of budget neutrality, sequestration, and alternative payment and value-based care models that are unavailable to therapists, clearly demonstrates that the fee schedule is broken. Increasingly thin operating margins disproportionately affect small, independent, and rural practices, as well as those treating low-income or other historically under-resourced or marginalized patient communities – undermining efforts to improve equity in health care and social determinants of health.

An inflationary update will provide budgetary stability to clinicians – many of whom are small business owners – as they contend with a wide range of shifting economic factors such as increasing administrative burdens, staff salaries, office rent, and purchasing of essential technology. Providing an annual inflation update equal to the MEI for fee schedule payments is essential to enabling practices to better absorb payment distributions triggered by budget neutrality rules, performance adjustments, and periods of high inflation. A more stable payment system will also help providers to invest in their practices and implement new strategies to provide high-value care.

APTA strongly support the Strengthening Medicare for Patients and Providers Act (H.R. 2474), legislation that would provide such an annual inflationary update to the physician fee schedule's conversion factor based on the Medicare Economic Index to help ensure patient access to the critical services our members provide. H.R. 2474 was introduced by Reps. Raul Ruiz, D-Calif., Larry Bucshon R-Ind., Ami Bera, D-Calif., and Mariannette Miller-Meeks, R-Iowa.

Provide Improved Transparency in the CPT Code Valuation Process

The work of the American Medical Association Relative Value Scale Update Committee, or AMA RUC, is in essence the work of a federal advisory committee but is not subject to the requirements of the Federal Advisory Committee Act. Congress could make the RUC valuation process subject to this act or could create a specific set of transparency requirements specifically for the RUC. AMA confidentiality agreements and related restrictions should only be limited to voting details and should not apply to valuation surveys, policies, procedures, any other data collection, or debate. The lack of transparency in the AMA RUC processes used for CPT code valuation, and during the

debate before a vote, creates a system that is easily politicized, potentially pits different health care specialties against one another in a fight over funds limited by budget neutrality, and makes it difficult to report concerns outside the process. Further, confidentiality requirements can lead to a lack of accountability for following rules and procedures and exacerbate the power imbalance experienced by the nonphysician members of the RUC Health Care Professionals Advisory Committee, or HCPAC,[1] whose payments are established through this process but who are not represented by the AMA. The HCPAC is regularly required to meet and present data separately from the larger RUC, with a physician required to chair HCPAC meetings as the primary arbiter of nonphysician valuation issues.

Direct CMS to Exercises Greater Oversight of the CPT Code Valuation Process

The process for valuing CPT codes is labor intensive, complicated, and nuanced. The AMA RUC has developed the expertise to administer this process over more than 30 years. Despite this expertise, CMS sometimes rejects the RUC and RUC HCPAC recommendations, choosing to undervalue or not value codes that have gone through this extensive, complex AMA valuation process. This process requires dozens of hours of specialty society staff time as well as expert advisor time to prepare and present at numerous meetings for various stakeholders, including the Practice Expense Workgroup, the Research Subcommittee Workgroup, and the Relativity Assessment Workgroup, among others. CMS must be a stronger leader in the process and must exercise its oversight authority to ensure that, if it continues to place such extensive time and resource burdens on specialty societies, the code values put forward by the RUC are accepted by CMS. To this end Congress should direct CMS to do the following:

1. CMS should play a stronger role in the development of the rules and procedures used during the valuation and data collection process. This will help to ensure that CMS has the expertise on staff to confirm that policies and procedures are followed, provide appropriate oversight, and guarantee that the process is reflective of and equitable for **all** specialties that bill CPT codes for health care services.

2. CMS should establish an external appeals process that can be triggered before values are published in the Medicare Physician Fee Schedule proposed rule. For this reason, we support the reinstatement of a refinement panel. Currently if CMS chooses to simply not value a code, or if CMS undervalues a code compared to the RUC recommendation, there is no process of appeal, except to submit a comment during the public comment period of the fee schedule proposed rule. This is an inadequate way to challenge a decision given the complexity and time-intensive nature of the valuation process.

3. CMS should clarify how the list of reference codes (used for the purpose of establishing future relative values) should be developed. The reference list plays a crucial, but opaque, role in setting relative values.

[1] The HCPAC is made up of 12 organizations that do not represent physicians, but instead represent nonphysician specialties that are paid for services based on the resource-based relative value scale and that utilize CPT codes. The AMA does not represent nonphysician providers.

4. CMS should develop an independent advisory panel to examine existing issues in the valuation process, analyze trends that might inappropriately skew relative values, and suggest ways the process may need to evolve to account for continued changes in the health care landscape, including innovations. For example, the current valuation process disincentivizes building in efficiencies to medical services, as those services are then devalued under the current process. Congress should give CMS the flexibility to implement the recommendations of such a panel.

Congress Should Separate High-Value Procedures from the RUC Process and Remove These Procedures from Calculations of Budget Neutrality Under the Medicare Fee Schedule

Since the establishment of the current relative value unit and rate setting process, there has been a major shift in the services provided in outpatient settings. Services that used to be provided in the hospital under Medicare Part A are now being provided in outpatient settings under Medicare Part B. This increase in high-tech, high-cost services that used to be reimbursed under Part A is skewing relativity and squeezing lower-cost specialties because of budget neutrality.

Reduce Administrative Burden for Therapy Services Provided Under Medicare Part B

Medicare Part B guidelines permit Medicare beneficiaries to receive therapy evaluation and treatment services with or without a physician order. The PT, OT, or SLP may evaluate that patient, formulate a plan of care, and commence treatment in either instance. However, under current certification requirements, the therapy provider must submit the plan of care to the patient's physician *and have it signed* within 30 days in order to receive payment. If the deadline is approaching and the referring physician still hasn't returned the signed plan of care, the rules say it's up to the therapist to obtain that signature; without it, the PT is faced with halting treatment or face the prospect of not getting paid by Medicare.

Given the current pressures on therapy providers, including recent year-over-year fee schedule cuts, we are united in seeking opportunities to reduce administrative burden without compromising patient safety or quality of care as a way to mitigate the impact of these payment cuts for therapy providers and our physician colleagues, as well as to best serve our patients expeditiously and without financial risk to their therapy providers. The time and resources spent by both therapists and physicians in procuring a timely signature when a physician order is already present adds unnecessary cost, potentially delays essential services, and fails to contribute to improved quality of care.

Congress should enact legislation that would clarify a new care coordination model such that when outpatient therapy services are provided under a physician's order, the plan of care certification requirements shall be deemed satisfied if the qualified therapist submits the plan of care to the patient's referring physician within 30 days of the initial evaluation. The order would confirm the physician's awareness of the therapy episode and proof of submission of the plan of care would demonstrate the coordination and collaboration between the physician and the therapist called for by CMS.

APTA strongly supports the Remove Duplicative Unnecessary Clerical Exchanges Act, or the REDUCE Act (H.R. 7279). This bipartisan bill would streamline the current plan of care certification requirement under Medicare Part B to reduce administrative burden and paperwork for physical therapists and physicians. The REDUCE Act was introduced in the U.S. House of Representatives by Reps. Don Davis, D-N.C., and Lloyd Smucker, R-Pa.

Conclusion

APTA appreciates the opportunity to share our perspective and recommendations to the committee that will provide long-term stability and reform to the Medicare Physician Fee Schedule and bolster value-based care. Should you have any questions, please contact Justin Elliott, APTA Vice President of Government Affairs, at justinelliott@apta.org. Thank you for your time and consideration.

Sincerely,

Roger Herr, PT, MPA
President

ASHA
American
Speech-Language-Hearing
Association

July 10, 2024

The Honorable Vern Buchanan
Chair
Committee on Ways and Means
Subcommittee on Health
1139 Longworth House Office Building
Washington, DC 20515

The Honorable Lloyd Doggett
Ranking Member
Committee on Ways and Means
Subcommittee on Health
1129 Longworth House Office Building
Washington, DC 20515

Dear Chairman Buchanan and Ranking Member Doggett:

On behalf of the American Speech-Language-Hearing Association (ASHA), I write to provide feedback related to the Subcommittee's hearing on June 26, 2024, "Improving Value-Based Care for Patients and Providers."

ASHA is the national professional, scientific, and credentialing association for 234,000 members, certificate holders, and affiliates who are audiologists; speech-language pathologists (SLPs); speech, language, and hearing scientists; audiology and speech-language pathology assistants; and students. Audiologists specialize in preventing and assessing hearing and balance disorders as well as providing audiologic treatment, including hearing aids. SLPs identify, assess, and treat speech, language, swallowing, and cognitive communication disorders.

ASHA supports the quadruple aim of enhancing patient experience, improving population health, reducing costs, and improving the clinician experience. Audiologists and SLPs are uniquely positioned to provide upstream interventions in the areas of hearing, balance, speech, language, cognition, and swallowing that will increase functional independence and decrease downstream costs.

Audiologists are integral members of clinical teams involved in episodes relating to dementia, craniofacial surgery, cytomegalovirus, acquired brain injury, hearing loss, and vertigo, among others. SLPs are members of interprofessional collaborative teams addressing a variety of illnesses and injuries including, but not limited to, acquired brain injury, aerodigestive disorders, head and neck cancer, dementia, craniofacial disorders, and developmental disabilities. All of these conditions require the knowledge and skills from a range of health providers for effective management.

Audiologists and SLPs participate, on a limited basis, in quality reporting programs such as the Medicare Merit-based Incentive Payment System (MIPS) and some private value-based care initiatives. However, nonphysician qualified health care providers have had a limited opportunity to meaningfully participate in alternative payment models (APMs) and other value-based care initiatives. ASHA is eager to explore, refine, and develop models to create opportunities for nonphysicians to fully participate in the transition from fee-for-service to value-based care, especially since including audiologists and SLPs in these models has been extremely limited to date.

MIPS and APMs currently use broad outcome measures (e.g., smoking cessation, BMI) for nonphysician providers. ASHA is committed to moving beyond the use of broad quality measures that do not reflect critical health care services provided by audiologists and SLPs. As

models grow to include all health care settings, ASHA encourages Congress, the Centers for Medicare & Medicaid Services (CMS), and the Center for Medicare & Medicaid Innovation (CMMI) to adopt outcome measures that take into account functional domains pertinent to the services provided by audiologists and SLPs—including hearing, communication, balance, swallowing, and cognition. We are committed to assisting CMS and CMMI in assessing all domains of function to accurately capture patient outcomes, quality of life, and independence.

Outcome measures should include functional measures that are influenced by nonphysician providers to avoid a disincentive for physicians referring patients for essential services, including those provided by audiologists and SLPs. If value-based payment models are only designed to measure and reward for services provided by physicians—while failing to reflect the essential role of nonphysician providers on the care team—such models run the risk of underutilizing critical nonphysician services to the detriment of patient health outcomes, quality of life, and overall cost of care to the health system.

As currently structured, the MIPS Value Pathways (MVPs) and many of the approved APMs are physician-driven and focused on the entire episode of care. The quality measures often do not capture the services of nonphysicians, including audiologists and SLPs; therefore, there are no incentives for physicians to incorporate these specialty providers into the model. Audiologists and SLPs are not responsible for managing the full range of medical services a patient may need but could be held accountable for the cost of care associated with the types of interventions they provide as a member of a multidisciplinary team participating in an APM. **ASHA urges Congress to direct regulators to develop models that capture the quality and cost associated with nonphysician services to ensure APMs are achieving their goal of improving the quality of care patients receive while protecting the fiscal health of Medicare.**

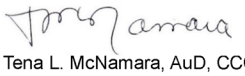
As Congress continues exploring possible avenues for updating value-based care programs created by the Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10), **ASHA urges the Subcommittee to address the continued erosion of Medicare payment rates to providers from multiple sources, including budget sequestration and reductions to the Medicare Physician Fee Schedule (MPFS) Conversion Factor (CF).** The latter are the result of budget neutrality requirements within the MPFS that create a zero-sum dynamic between Medicare providers, which is counterproductive toward our shared goal of ensuring beneficiaries have access to all clinically necessary health care services. **ASHA urges the Subcommittee to stop MPFS CF cuts to providers in 2025 and reverse budget sequestration cuts that are currently impacting Medicare providers.**

Our country is already facing a shortage of health care providers, reducing Medicare Part B payments further threatens patient access to care. In addition to payment cuts, the gap between provider payment rates and rising practice costs has continued to widen considerably due to inflationary pressures. In the absence of an annual inflationary payment update—as the MPFS is the only Medicare payment system without an annual adjustment for inflation—high inflation represents a de facto payment cut to providers, on top of the sequestration and MPFS CF cuts providers have faced in recent years. **ASHA urges the Subcommittee to advance H.R. 2474, the Strengthening Medicare for Patients and Providers Act, which adds an annual inflationary update to the MPFS.**

Thank you for the opportunity to provide a statement for the record. ASHA is committed to working with the Subcommittee to identify opportunities for improving value-based care programs and ensuring all members of the multidisciplinary care team receive appropriate

compensation for their services. If you have additional questions, please contact Josh Krantz, director of federal affairs for health care, at jkrantz@asha.org.

Sincerely,



Tena L. McNamara, AuD, CCC-A/SLP
2024 ASHA President

The Honorable Jason Smith
Chairman
Committee on Ways and Means
1100 Longworth House Office Building
Washington, DC 20515

The Honorable Richard Neal
Ranking Member
Committee on Ways and Means
1100 Longworth House Office Building
Washington, DC 20515

July 9, 2024

Dear Chairman Smith, Ranking Member Neal, and members of the Committee,

We thank the Committee on Ways & Means for its interest in improving value-based care for patients and providers. California Schools VEBA ("VEBA") wholeheartedly supports the goal of advancing better health outcomes and savings through value-based care and applauds the Committee for investigating how we can learn from past challenges and explore opportunities to advance adoption and success in the future.

A VEBA – or a voluntary employees' beneficiary association – is a tax-exempt trust established by employers or employee groups to provide benefits – including health care – to their members. The California Schools VEBA was founded in 1993 through the combined efforts of school superintendents and representatives of both the California Teachers Association and the California School Employees Association to combat rising health care costs in Southern California. Since then, VEBA has grown to more than 73 participating employers – including school districts, municipalities, and public sector employers – with more than 150,000 members and is the fourth largest purchaser of health care in the state of California.

VEBA strives to leverage its collective purchasing power to keep health care premiums low and ensure access to comprehensive benefits designed to keep employees physically and mentally healthy. Governed by a joint labor-management Board of Directors and organized as a 501c(9) non-profit health care trust, all funds are spent on member benefits and health improvement, and the board has a legal obligation to do what's right for the members that they serve. VEBA has developed a stellar reputation for doing just that – delivering high-value care, providing health resources that are effective, affordable, and of the highest quality and value.

VEBA renewals have consistently outperformed the national market while eschewing traditional cost containment strategies like shifting costs to employees, limiting optionality and adopting high-deductible health plans (HDHPs). We firmly believe in offering a variety of plan designs and expansive provider networks, ensuring low out-of-pocket costs and shielding members from price increases, while providing a comprehensive suite of well-being and wraparound programs. Instead of shifting costs to employees to reduce care consumption and increasing barriers to access, VEBA has reigned in costs through innovative, patient-focused care and quality programs. For example, our first-of-its-kind direct contracting program leads to stable premiums while delivering on our high-quality commitments to our members. While California

school districts that are not members of VEBA typically see annual premium increases of 12-14%, VEBA members average around just 4-5%.[1]

VEBA not only has a reputation for delivering high-value care, but there is strong buy-in from members – as well as a 94%-member satisfaction rating – that collectively agree we can make a difference in the health care delivery system. The trust and satisfaction we built over the past decades has enabled us to think about the long-term cost drivers of health care in a more creative and personalized manner. The value-based tools VEBA leverages have not only saved member employers millions of dollars but our philosophy of personalized population health results in better care and improved well-being of the individual employees who have become their own health advocates. We hope our learnings can inform others and push the system to adopt value-based, higher-quality, lower-cost and more patient-centric health care.

VEBA's Value-Based Care Innovation

Performance Network

VEBA is focused not only on offering high-quality care but on actively helping members to navigate their health benefits and own their health care decisions. For example, in 2010, VEBA developed a "performance network" aimed at incentivizing members to select higher-quality, lower-cost providers. By analyzing cost and quality data from both public sources and our proprietary database of millions of physician encounters, VEBA created a stratified health care provider network categorized into three tiers: 1) providers who deliver high-quality care for a reasonable cost; 2) providers who did not meet either the cost or the quality threshold; and 3) providers who delivered average to good care but at prices 180% or more of the county average.

A fourth, hidden tier included providers excluded from the network because their quality was deemed unacceptable at any price. To nudge members to the top tier of providers, VEBA used financial incentives – choosing a provider in the top tier resulted in lower out-of-pocket costs, both at the time of service and in premiums. This design allowed VEBA to preserve choice for members who may, for example, want to remain with a provider not in the top tier, while successfully migrating 96% of the population to tier one, high-value providers. The results were outstanding: the first year of savings amounted to around $50 million (approximately 10% of premiums) and was achieved with a member satisfaction rate of 94%.

The structure of the program also allowed VEBA to offer over 90% of its membership improved benefits, which has allowed VEBA to save members and employers hundreds of millions of dollars. The significance of the savings was recognized by the Regional Taxpayers Association of San Diego. Due to the significant success of the model, VEBA was able to enter discussions with higher-cost and/or lower-quality facilities, most of whom agreed to reduce costs and/or improve their quality to achieve better tier placement in the future.

[1] Comparison completed by Tall Pine Consulting LLC, 2020.

Direct Contracting

VEBA's Performance Network served as the proof of concept for our recent direct contracting initiative, as it showed significant savings, improved outcomes, and satisfaction. However, we were still significantly constrained in what we could do by the contracts carriers were negotiating on our behalf. Direct contracting is now serving as a tool for VEBA to remove the middleman and directly partner with providers on innovative primary care and prevention in ways not currently contemplated by existing health plans, often due to their shortsighted outlook in managing health. We did not come to this easily, however. Currently, self-funded employer plans and union trusts in California are unable to directly enter into risk-based contracts with provider groups. Instead, today any direct contracts are required by state law to operate on a fee-for-service basis, which leads to misalignment of incentives, overutilization, and ultimately higher costs. In an effort to realign incentives and deliver better outcomes for our members, VEBA began exploring a legislative fix in 2017-2018 to enable the use of risk-bearing contracts, and we were ultimately successful in advancing a solution in 2020. The state bill (AB1124) created a four-year pilot program to allow an approved applicant to contract directly with a provider group(s) in such a risk-bearing contract, with an independent review agency monitoring the pilot to gauge the cost savings, patient impact, and care delivery over time.[2] VEBA was selected to build the first pilot program in California.

Establishing the direct contracting program required an extensive application with the California Department of Managed Health Care (DMHC) and took more than eight months from submission to conditional approval. While we encountered several challenges along the way, such as finding an administrator for the program, given that most Third Party Administrators (TPAs) operate on leased networks from the carriers on a fee-for-service basis, we are excited to have gone live with membership effective January 1, 2024, and hope to secure an extension in the upcoming legislative session.

The network consists of several large, integrated systems, including Sharp Rees-Stealy, Sharp Community Medical Group, University of California San Diego, and Rady Children's Hospital, with 15 participating employers representing 2,368 subscribers and 4,442 total members. Our annual budget is $34 million, which represents a 2% savings (roughly $700,000) for the pilot population. This is based on conservative pricing estimates and is expected to compound over the ensuing years.

The contracts in the network delegated risk to the medical groups for portions of the care to effectively align the incentives of VEBA to lower costs through healthier membership with the interests of the medical groups. The carve-outs for the plans were negotiated to mitigate risk as reasonable reimbursement rates.

VEBA is hopeful that this pilot proves the cost savings and quality-driving power of risk-based arrangements such as this. We look forward to a more permanent solution and support removing barriers to allow for greater participation in risk-based contracts.

[2] California Senate Floor Analysis of AB 1124.

Policy Priorities to Advance Value-Based Care

If we are to meaningfully address the $4.5 trillion elephant in the room – otherwise known as US annual health care spending, along with issues surrounding access, quality, chronic disease and culturally appropriate care –innovators like VEBA must be supported in their efforts continue to keep pushing the system towards patient-centered, value-based care and prove that when done right, members will find better outcomes, higher levels of satisfaction, and through it all – lower costs. We must remove barriers to high-value care innovation and empower other employers – including small and mid-size employers – to join in. We truly believe that a rising tide lifts all boats; we want to move the whole system forward together. To do this we must:

1. **Remove barriers to employer participation in value-based programs, such as high-performance networks and direct contracting, and incentivize adoption across the health care ecosystem.** Direct contracting is a cost containment tool that small and midsize employers can leverage to improve care delivery, quality and cost for employees. Independent, impartial research conducted by the U.C. Berkeley School of Public Health and the Integrated Healthcare Association consistently shows that the solution to rising health care costs is to increase the percentage of health care that is delivered through clinically integrated providers that share the financial risk with health plans, government and employer payers. To date, this kind of health care financing and delivery model has been used in the fully-insured, employer-sponsored HMO, Medicare Advantage and Medi-Cal Managed Care market segments.[3]

   We strongly encourage Congress to eliminate federal and state barriers that limit or discourage direct contracting across the employer market. As discussed above, VEBA worked for years to advance legislation in California just to get a pilot to allow us to enter into a direct contract arrangement with well-known hospital systems with the goal of reducing cost and giving our members access to high-quality in-network care. Smaller employers cannot move forward with such innovation if Congress does not act to remove barriers. We encourage the committee to support legislation that would encourage employers to enter into risk-based arrangements, including direct contracting arrangements, through the creation of a grant program and educational efforts to support this vital shift in the way we pay for and deliver health care.

   VEBA also supports passing legislation that bans anticompetitive terms in facility and insurance contracts that restrict access to higher-quality, lower-cost care (e.g. the provision contained within Section 302 of the Lower Health Care Costs Act in the 116th Congress). Currently, “anti-tiering” and "anti-steering" clauses in contracts between providers and health plans restrict plans from creating innovative, high-value programs such as VEBA’s high performance network. This change would allow more employers to do what VEBA has been so successful in doing – offering tiered provider networks and incentives for enrollees

[3] California Senate Floor Analysis of AB 1124.

to use lower-cost and higher-quality providers. In our experience – and confirmed by the CBO's estimates – this reduces costs for the plan and for the system overall.

Similarly, VEBA supports other efforts aimed at increasing adoption of value-based care arrangements, including in Medicare, as a large-scale purchaser of health care, ideally with both up- and downside-risk. As the largest payer of health care, Medicare's adoption of value-based care arrangements can positively impact the entire health care ecosystem.

2. **Increase transparency into health care claims and encounter data, along with information on costs and quality for health care providers.** In order for programs such as our performance network to work, health care purchasers need data that includes meaningful cost and quality metrics for providers, health systems, pharmacy benefit managers (PBMs) and other service providers. VEBA was fortunate to have access to quality and cost data from California's Office of the Patient Advocate, which was critical to the development of our tiers. However, access to such data is unique and should be universally accessible. We believe that having even greater transparency could triple our savings in years to come, decreasing costs and increasing efficiencies while also driving beneficial outcomes for our members and beyond. VEBA strongly encourages provider-level quality data and creating flexibility to exclude providers from in-network status, where there is evidence of a pattern of consistently poor care outcomes.

   Additionally, our analysis indicates that at least 25% of health care claims may be fraudulent, excessive, miscoded, or indicate an abuse of the system, with hundreds of millions of dollars in fraudulent claims going unchallenged every year. We are actively working with California stakeholders to create access to meaningful data, including representation on the All Payer Claims Database project, which is encouraging ERISA plans to self-report data. Access to cost and utilization data, along with actual claim payments and contract allowance amounts for hospitals and ambulatory surgical centers, will empower public agency employers and public employee-related trusts, such as VEBA, to access the data necessary to improve health care for employees and reduce costs. A change such as this will help ensure we are using taxpayer funds cost-effectively and efficiently through more informed negotiation and better plan design.

   VEBA spends over $1 billion a year in health care; we want to know every word and every dollar in our contracts, which are getting increasingly complex through carve-outs and various financing mechanisms. To be good stewards and fiduciaries of our members' care, we must have this transparency.

   We also support many of the transparency policies contained within the "Lower Costs, More Transparency Act" (H.R. 5378) passed out of the House on December 11, 2023, and commend the committee for its leadership. This includes codifying federal price transparency rules and adding new price transparency measures (Sections 101- 105), as well as provisions to ensure that health plan fiduciaries are not contractually restricted from

receiving cost or quality of care information about their plan (Section 401) and language aimed at increasing transparency into hospital outpatient billing practices and correcting Medicare payment discrepancies (Sections 203-204). Similarly, we strongly support policies that require PBM reporting to plan sponsors (Section 106), but urge the committee to extend spread pricing prohibitions into the commercial market (Section 202). Additional insight into contracts and elimination of opaque practices and terms is critical to fully understand our health care spending and drive additional value.

3. **Ease federal and state restrictions on pooling, with appropriate protections, for small employer groups to bring the VEBA value to other employers.** VEBA is now the fourth-largest purchaser of health care in the state of California, aggregating more than 73 participating public employers and over 150,000 members – including four of the top ten largest school districts in California. We use our market power to directly negotiate with medical groups and hospital centers, exerting greater influence as a group with the collective power to impact change and deliver higher-value care. Enabling employer pooling through VEBAs, Association Health Plans (AHPs), and other mechanisms – ensuring appropriate guardrails – saves taxpayers money and can significantly reduce costs for employers so they can focus on their core business. In VEBA's case, this means improving retention of teachers and custodians while directing critical and limited resources to furthering student education.

   Over the years, numerous employers have asked if they can have access to the California Schools VEBA. Unfortunately, California law imposes limits on AHPs and the current VEBA rules prohibit us from either starting a new pool or expanding access to many employers. We support easing federal and state restrictions with appropriate protections for small employer groups so they can join a large risk pool such as VEBA's, protecting them from rate rebound and enabling them to deliver higher-quality, lower-cost care to their members. VEBA is also concerned about state laws that prohibit the development of high-quality association or employment-based health plans. VEBA believes that with updated safeguards, these could provide meaningful market options for small and mid-size employers to bring the benefits of pooling to a smaller market, like VEBA does for educators and civil servants.

We appreciate your work and effort on behalf of the American people and stand ready to work with you. For more information, please visit www.vebaonline.com or contact Heather Meade at heather.meade@ey.com.

Signed,

Laura Josh
California Schools VEBA

OCHIN

A driving force for health equity

Transmitted via electronic mail to wmsubmission@mail.house.gov

June 25, 2024

The Honorable Jason Smith
Chairman
Ways & Means Committee
U.S. House of Representatives
1011 Longworth House Office Building
Washington, DC 20515

The Honorable Vern Buchanan
Health Subcommittee Chairman
Ways & Means Committee
U.S. House of Representatives
1011 Longworth House Office Building
Washington, DC 20515

Re: *Statement for the Record – Hearing on Improving Value-Based Care for Patients and Providers*

Dear Chairman Smith and Subcommittee Chairman Buchanan,

On behalf of OCHIN, we appreciate the opportunity to submit comments for the record in response to the U.S. House of Representatives' Ways & Means Committee's Subcommittee on Health *Hearing on Improving Value-Based Care for Patients and Providers*. OCHIN is a national nonprofit health information technology and research network that serves over 2,000 community health care sites with 25,000 providers including Critical Access Hospitals (CAHs), rural and frontier health clinics as well as federally qualified health centers and local public health agencies in 43 states, reaching more than 6.1 million patients. The Centers for Medicare and Medicaid Innovation (CMMI) authority to test new models that can drive improved health outcomes and improve efficiencies is essential for rural providers that are facing a sustainability crisis. To date, few CMMI models have included rural providers (rural health clinics and CAHs, for example) and there remains an urgent need to test models to address the challenges Rural America faces including lack of access to specialty care. We support maintaining CMMI authority while urging increased focused on rural models and models to support underserved communities as there are significant opportunities to drive savings, improve operational efficiency, and improve outcomes in these areas. CMMI also has an opportunity to increase engagement with communities to learn more about their needs and improve transparency in the process utilized to develop new models.

OCHIN: DRIVING INNOVATION, ACCESS, AND SELF-SUFFICIENCY

For over two decades, OCHIN has advanced health care solutions by leveraging the strength of our network's unique data set and the practical experience of our members to drive technology innovation for patients and providers in rural and other underserved communities. OCHIN offers technology solutions, informatics, evidence-based research, and workforce development and training in addition to policy insights. We provide the clinical insights and tailored technologies needed to expand patient access, connect care teams, and improve the health of rural and medically underserved communities. With over 137 million clinical records exchanged last year, OCHIN puts "one patient, one record" at the heart of everything we do to connect and transform care delivery. In addition, OCHIN maintains a broadband consortium network to support rural health care providers access Federal Communications Commission (FCC) subsidies.

THE CHALLENGE: RURAL INNOVATION MODELS

We urge Congress and CMMI to focus on opportunities and challenges to the successful transition to value-based pay within rural and underserved communities including the need to break down barriers to care and provide and expanded access to integrated specialty care. In rural communities across the nation, the infrastructure, workforce, and sustainable funding needed to keep the doors open among CAHs and community clinics simply do not exist. In a recent analysis, half of rural hospitals could not cover their costs, up from 43% the previous year and 418 rural hospitals across the U.S. are "vulnerable to closure."[1] Innovative and fundamental investments, such as testing virtual specialty models as proposed in H.R. 7149/ S. 4078 Equal Access to Specialty Care Everywhere Act of 2024 (EASE Act of 2024), are needed to support rural America—communities that serve as the bedrock of America's independence and self-sufficiency.

Rural communities face unique and formidable challenges that threaten their resiliency and sustainability. Across the nation among rural providers, the current payment and delivery models are not meeting patient needs and are de-stabilizing the viability of rural providers. CMMI is the only vehicle for testing new models in rural and underserved communities. Rural providers must manage:

- Higher Per Patient Costs and Risk. Rural providers shoulder higher per patient costs due to the lower volume of patients served yet payment policies do not reflect this basic financial reality. Rural hospitals need volume to lower their marginal cost to improve sustainability. Covering existing costs without a margin and at a loss prevents them from modernizing infrastructure (including health IT), investing in workforce development, cybersecurity, and digital health innovations including AI. Further, with the focus on value-based payment (VBP), identifying high-risk patients and implementing population health management strategies are essential for success in such models. Yet, rural providers have smaller patient populations, making it challenging to achieve meaningful risk stratification and develop targeted interventions for improving outcomes and reducing costs. There is an urgent need for CMMI to test new models and undertake additional demonstrations that identify sustainable delivery models in rural and underserved communities—this work is at a nascent stage.

- Restrictive and Uncertain Telehealth/Virtual Services Regulatory and Payment Policies. The change in Medicare reimbursement, potential reduction in reimbursement due to AMA's CPT Editorial Panel telehealth coding changes, and varied state Medicaid, managed care and commercial health insurer payment policies creates confusion, complexity, administrative burden, and financial barriers for rural healthcare providers and those in other underserved communities. It also creates significant risk where continuous changes heighten compliance challenges. There is an unprecedented level of evidence demonstrating the value of virtual services to patients and providers in rural and other underserved areas. Yet, Medicare and other payers continue to add new restrictions and documentation requirements. And the regulatory environment also continues to change (licensure and controlled substance prescribing). This comes at a time of shortages and record rates of clinician and operational staff burn-out. This drives complexity and cost which ultimately closes the door for rural patients and providers. CMMI can extend these flexibilities to test, for example, the delivery of specialty care through telehealth and other virtual modalities which is critical to evaluate the impact on outcomes and efficiencies created by providing care in lower cost sites of care earlier in the progression of disease.

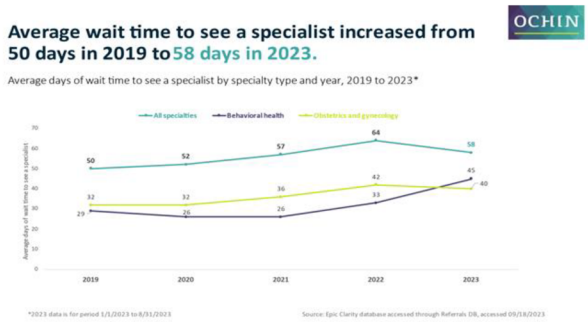
CMMI AUTHORITY AND THE EASE ACT DEMONSTRATION

An area where CMMI authority to test new models is best exemplified by HR 7149/ S 4078 EASE Act of 2024. This legislation enjoys bipartisan support and would require CMMI to undertake a virtual specialty network demonstration, which would offer integrated services in rural and other underserved communities to test the effectiveness of increasing access to specialty care through a range of virtual modalities. Furthermore, the EASE Act would test a dedicated network of specialists that is integrated into the primary care practices of federally qualified health centers, rural health clinics, other community health clinics and in partnership with other rural providers. Using technology to bridge the gap could help us deliver fully integrated care and bring us one step closer to high quality and high value care. This demonstration is an important assessment of a range of virtual care options including telehealth and eConsults (consultation between a primary care clinician and specialist concerning a specific patient) when delivered in coordination and collaboration with a patient's primary care clinician. In order to transition to new value-based models, timely access to specialty care services is an essential building block.

Representatives Michelle Steel and Susie Lee, and Senators Markwayne Mullin, Kyrsten Sinema and Thom Tillis introduced the EASE Act to encourage CMMI to create a new payment model for rural and underserved communities to reduce long wait times many seniors and residents face in these communities when seeking care from a specialist. The bill was developed based on years of data OCHIN collected and reviewed to help community health centers and rural hospitals improve care integration and work with independent, large group physician practices across the country, as well as collecting data to create a new value-based payment model.

The case for CMMI's authority to test new models is crucial for rural communities—particularly in the area of specialty care access. Lack of access to integrated specialty care for patients who live in rural and other underserved communities is a persistent challenge that will only deepen due to endemic clinician shortages and demographic trends driving increased clinical need. Patients and primary care providers in underserved communities need ready access to specialists to address chronic conditions like diabetes, heart disease, and mental health conditions. Left untreated chronic conditions drive higher disease burden and cost to the health system while worsening health disparities.

OCHIN network data reflects local, regional, and national trends of limited access and lengthy wait times for specialty care, which drives health disparities in rural and other underserved communities. This reality was documented in the OCHIN network before the COVID-19 PHE and similar trends have continued despite the availability of extensive telehealth flexibilities during the COVID-19 PHE. The overall average wait time to see a specialist has increased to 58 days in 2023 from 50 days in 2019.



The average wait time to see certain specialists is even more pronounced: neurologists (84 days), gastroenterologists (71 days), and ophthalmologists (66 days). OCHIN conducted a specialty demonstration to pair a rural provider with a dermatologist utilizing eConsults. This modality saved 59% of what would have otherwise been referrals to a dermatologist. The average time to obtain care was reduced from 55 days to 10 days. Further, for patients who needed an in-person appointment with a dermatologist, they were prioritized based on need, and were typically seen more quickly than standard referrals.

The wait time for patients and providers in the OCHIN network are not anomalies. Several recent publications underscore this is a challenge prevalent throughout the country. For example, in Pittsburgh, it is reported that wait times have continued to grow. Two major health systems in Pittsburgh, University of Pittsburgh Medical Center (UPMC) and Allegheny Health Network, were asked to provide their specialist wait times by a news outlet. Reportedly, both refused, but UPMC issued a statement that "[n]ationwide, there has been an influx of people seeking to catch up on specialty care they may have delayed during the pandemic and most U.S. health systems are facing challenges accommodating demand." Across the country in California there are reports that Medicare Advantage patients with chronic illnesses face geographical isolation as there is a lack of in-network providers for several hundred miles and require patients to travel far for care.[1] However, many patients may not be able to travel to far locations for care due to their chronic health conditions or lack of transportation.

Specialist shortages, geographic mismatches, lack of transportation and other structural impediments including in some cases lack of competitive rates to commercial health insurers contribute to these delays. However, two powerful factors include the lack of: (1) specialist networks with requisite licensure and ready willingness to accept referrals from providers in rural and underserved communities; and (2) streamlined technological connections and technical assistance to support operational needs and coordination for specialists and primary care providers in rural and underserved communities.

[1] Tara Bannow, "Physicians Take Medicare Advantage to Task for Rural Patients' Care Gaps," STAT, June 2, 2024, https://www.statnews.com/2024/06/03/medicare-advantage-cms-comment-care-gap-provider-network/.

This is why CMMI authorities are critical to conduct demonstrations among providers with the most challenging mix of patients to ensure provider sustainability in rural and underserved communities. While the recent CMMI's Making Care Primary Model (MCP) demonstration contains many essential provisions to support sustainable transitions to value based payment, a key component that will undermine participant success remains the lack of dedicated specialty care clinician networks. The MCP model (which is limited to eight states) provides a nod to specialty care access by providing a payment mechanism for services but does not address the lack of access that primary care providers and their patients have to clinician specialty networks that will accept the patient mix they serve. Such virtual specialty clinician networks do not exist. It also does not include rural health clinics.

While Congress looks for ways to improve outcomes and reduce cost; and medical schools continue to look for ways to grow our physician workforce, one pathway that can fill the needs of communities (especially rural areas) and prevent costly hospital admission is the EASE Act which looks to utilize telehealth or e-consults to help our most vulnerable populations receive timely care.

CONCLUSION

The focus of both Congress and CMMI to address the payment needs of rural and underserved communities is crucial to ensuring the success of the transition to a value-based pay system. We also applaud efforts to increase transparency into the process for model selection and prioritization.

Thank you for your leadership. Please contact me at stollj@ochin.org if you would like additional data and information.

Sincerely,

Jennifer Stoll
Chief External Affairs Officer

HEALTHCARE LEADERSHIP COUNCIL

June 26, 2024

The Honorable Vern Buchanan
Chair
House Ways and Means Committee
Subcommittee on Health
Washington, D.C. 20515

The Honorable Lloyd Doggett
Ranking Member
House Ways and Means Committee
Subcommittee on Health
Washington, D.C. 20515

RE: Ways and Means Health Subcommittee Hearing on Improving Value-Based Care for Patients and Providers

Dear Chair Buchanan and Ranking Member Doggett:

The Healthcare Leadership Council (HLC) thanks the Health Subcommittee for holding this hearing on improving value-based care for patients and providers.[1] HLC and its member companies have long championed patient-centered value-based care as a solution to both improve patient outcomes and reduce spending. More recently, HLC reiterated a commitment to this longstanding goal by releasing a consensus report, *Achieving the Promise of Patient-Centered Value-Based Care*, outlining current policy recommendations to advance value-based care.

HLC is an association of CEOs and C-suite executives from all sectors of healthcare working to shape the future of the U.S. healthcare system. HLC is the exclusive forum for the nation's healthcare industry leaders to lead on major, sector-wide issues, generate innovative solutions to unleash private sector ingenuity, and advocate for policies to improve our nation's healthcare delivery system. Members of HLC – hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, laboratories, biotech firms, health product distributors/wholesalers, post-acute care providers, homecare providers, group purchasing organizations, and information technology companies – advocate for measures to increase the quality and efficiency of healthcare through a patient-centered approach.

Overview

The more fulsome shift to value-based care will require continued changes in the way our healthcare system is structured and operates. We urge Congress to do more to catalyze reimbursement reform from paying for volume to paying for value, including through the following actions: (1) leverage learnings from the Center for Medicare and Medicaid Innovation's (CMMI's) value-based models; (2) extend telehealth and Acute Hospital at Home waivers; (3) improve alternative payment models (APMs); (4) update the Congressional Budget Office's (CBO's) modeling approach; (5) expand electronic prescribing of controlled substances; (6) maintain enhanced federal flexibilities for streamlining Medicaid renewals; (7) realign incentives

[1] U.S. House Committee on Ways & Means, Health Subcommittee Hearing on Improving Value-Based Care for Patients and Providers (June 2024), https://waysandmeans.house.gov/event/health-subcommittee-hearing-on-improving-value-based-care-for-patients-and-providers/.

to reduce fraud, waste, and abuse; and (8) Modernize the Physician Self-Referral (Stark) Law and Anti-Kickback Statute (AKS). HLC offers the following solutions to modernize the nation's healthcare system to both improve patient outcomes and reduce spending:

1. **Leverage Learnings from the Center for Medicare and Medicaid Innovation's (CMMI's) Value-based Models: Achieve Savings and Increase Participation**

After over a decade of projecting that the models initiated by CMMI would reduce Medicare spending, the Congressional Budget Office (CBO) issued a report estimating that in its first decade of operation, CMMI's efforts had actually elevated federal spending by $5.4 billion between 2011 and 2020.[2] In considering the efficacy of this estimation, overall federal spending may not necessarily reflect cost mitigation. Savings alone should not be the only factor to consider when evaluating the effectiveness and potential of CMMI. Two important takeaways from this report can enhance CMMI's work and lead to more successes moving forward.

First, we have already witnessed the impact that CMMI can have in helping to transition the healthcare system from its traditional fee-for-service orientation to a value-based framework. Continuing this progress will lead to greater cost-efficiency within the system, while attaining positive patient outcomes and enhancing equity, without undermining healthcare quality. In the years to come, CMMI should hone its focus on developing and incenting sustainable bipartisan payment models to further meaningful overall savings through patient-centered coordinated care.

Second, it is critical that health providers participate in and realize value through CMMI's innovative payment and delivery models. CBO also notes that CMMI "might achieve larger net budgetary savings in its second decade by drawing on the lessons from past models when designing new ones." We must ensure that providers' incentives to participate in the models are not outweighed by burdens of operating under the models. When new models create onerous burdens on those organizations that might otherwise want to engage, the result is lack of participation. As CBO stated in its report, there have been instances in which CMMI models have created inconsistent and even contradictory mandates for providers to follow, creating unnecessary paperwork and expense.

Listening to health providers, responding to their concerns and ideas, and incentivizing participation in new demonstration projects is critical in CMMI's second decade. Mandatory participation models may seem the best approach for success (although MedPAC has noted some of the limitations and lack of evidence); however, creating cost-effective voluntary models that are appealing to providers and their patients will yield more lasting results. Legislation that helps focus CMMI's mission on driving toward value-based care should be considered to improve CMMI's success as opposed to tying its hands.

2. **Extend Telehealth and Acute Hospital Care at Home Waivers: Improve Access**

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[2] Federal Budgetary Effects of the Activities of the Center for Medicare & Medicaid Innovation, Congressional Budget Office (September 2023), https://www.cbo.gov/publication/59274.

Over the past several years, our country has seen the dramatic impact that telehealth has had in helping individuals access healthcare. The flexibilities in permitting telehealth as a means of delivering and receiving healthcare during COVID-19 were and continue to be broadly supported by providers, payers and patients. It is in the best interests of all stakeholders to ensure these flexibilities are preserved so that access to care is maintained.

HLC has prioritized, advocated, and commended the extension of Medicare telehealth waivers established during the COVID-19 pandemic through December 31, 2024. We thank the full Committee for advancing H.R. 8261, the "Preserving Telehealth, Hospital, and Ambulance Access Act."[3] We applaud the proposed legislation for removing existing prohibitions under Section 1834(m) of the Social Security Act that prevent patients from receiving telehealth services where they are located as well as supporting translation capabilities. However, we believe a two-year extension is short of what industry needs. Telehealth can change the way industry operates as we implement new technologies, but the necessary investments will not occur if the tenure of these investments remains uncertain. We encourage the Committee to evaluate legislative proposals that encourage confident investment by industry for providing care in new modalities.

HLC also recommends exploring further innovative options for patients to receive care at their place of residence, such as the Acute Hospital Care at Home (AHCAH) waiver program. The five-year extension of the Acute Hospital Care at Home (AHCAH) demonstrates support for a waiver program that has been tremendously successful. Hospitals cite the AHCAH waiver's utility in ensuring rural patients receive necessary care without having to leave their residence, improving patients' comfort, and limiting exposure to infection in the hospital setting.[4] Given these successes, we urge Congress to consider expanding the care covered by these types of waivers beyond acute needs.

HLC looks forward to working with you to ensure we do not move backwards in providing critical access to services for patients generally, as well as for seniors and other vulnerable populations through innovative healthcare delivery.

3. **Improve Alternative Payment Models (APMs): Spur Transition to Patient-Centered, Value-Based Care**

HLC and our members recognize the importance of value-based care models to improve patient outcomes while reducing costs by using dollars more efficiently. However, the transition to a system focused on the whole health of a patient rather than a system that reimburses for each service has been cumbersome and protracted. Incentives must be realigned throughout the healthcare system to spur expeditious change.

Released in April, HLC's value-based care report offers concrete recommendations to accelerate the transition from traditional fee-for-service payment healthcare models to models

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[3] Preserving Telehealth, Hospital, and Ambulance Access Act of 2024 (house.gov)
[4] 5 Lessons Learned About Hospital at Home Programs [White Paper], Health Recovery Solutions, https://www.healthrecoverysolutions.com/resources/white-paper/hospital-at-home.

prioritizing value, prevention, and wellness.[5] Culminating from a roundtable discussion with more than 70 leaders from health systems, payers, purchasers, patient advocacy, retail health, public policy and academia, this report encapsulates proposals to achieve the full potential of patient-centered value-based care. This consensus document was developed to advance value-based care by:

- Strengthening incentives to encourage participation in full-risk models;
- Improving data integration and interoperability to assess success and make progress towards health equity goals; and
- Shaping value-based care programs to reach and impact patients beyond the traditional clinical parameters and address the real-world needs that affect wellbeing.

The report also includes specific recommendations for the private sector, Congress, and the Centers for Medicare and Medicaid Services (CMS). HLC's report endorses H.R. 5013, the "Value in Health Care Act," bipartisan legislation that builds on the successes of APMs and improves health equity and access to care. Specifically, this bill extends the five percent advanced APM incentives and gives CMS authority to adjust APM qualifying thresholds so that the current one-size-fits-all approach does not disincent the inclusion of rural, underserved, primary care or specialty practices in APMs. To allow more clinicians to continue the transition to value, the bill establishes a voluntary track for accountable care organizations in the Medicare Shared Savings Program to take on higher levels of risk and provides technical assistance for clinicians new to APMs. The bill also removes revenue-based distinctions that disadvantage rural and safety net providers and improves financial benchmarks so that APM participants are not penalized for their own success. HLC strongly urges Congress to pass H.R. 5013.

4. **Update CBO's Modeling Approach: Recognize and Incorporate Long-Term Savings from Preventive Health**

Improving access to preventive health services and appropriately reflecting the savings investments generate into budget scoring are critical elements to reducing healthcare spending and improving patient health outcomes. Chronic diseases are responsible for 7 of 10 deaths among Americans each year; and these conditions account for 90 percent of the $4.1 trillion our nation spends annually on medical care.[6]

We applaud the U.S. House of Representatives for unanimously passing H.R. 766, the "Dr. Michael C. Burgess Preventive Health Savings Act." This bipartisan legislation will allow Congress to more easily request CBO estimates of preventive and innovative health initiatives beyond the ten-year scoring window in order to capture potential long-term health savings in federal programs. Research has demonstrated that certain expenditures for preventive health interventions generate savings when considered in the long term, but those

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[5] Achieving the Promise of Value-Based Care for All, Healthcare Leadership Council (April 2024), https://www.hlc.org/download.php?file=/wp-content/uploads/2024/04/HLC-Wellvana-AdventHealth-Roundtable-Report-Final.

[6] Health and Economic Costs of Chronic Diseases, Centers for Disease Control and Prevention (October 2023), https://www.cdc.gov/chronicdisease/about/costs/index.htm.

cost savings may not be apparent when assessing only the first ten years—those in the current "scoring" window. This legislation will allow Congress to see the full savings of enacting prevention-focused policy measures, an important step to assess the financial impact and advance legislative solutions to curtail the impact of chronic diseases.

5. **Expand Electronic Prescribing of Controlled Substances: Reduce Costs and Curtail Errors**

E-prescriptions, particularly for controlled substances, are an important tool for cost savings and fraud reductions. Paper prescriptions of controlled substances are inefficient and susceptible to fraud and human error. HLC urges the Committee to support H.R. 7312, the "Electronic Prescribing for Controlled Substances Act", bipartisan legislation that will close the gap in the electronic prescription of controlled substances (EPCS) in the commercial market. The EPCS 2.0 Act will both reduce healthcare costs—through fewer unnecessary trips to the doctor and fewer costly mistakes in the prescription distribution chain—and improve patient health outcomes by preventing errors as well as the misuse and unlawful diversion of medications. The original "Every Prescription Conveyed Securely Act" (EPCS Act), which passed in 2018 as part of the SUPPORT Act, required providers to employ e-prescribing for controlled substance prescriptions covered under the Medicare Part D program. Between 2019 and 2021, the percentage of EPCS transactions nearly doubled from 28 percent to 73 percent.[7] With such significant progress, we believe that now is the time for federal action to ensure all controlled substance prescriptions are issued electronically, not just those for Medicare Part D beneficiaries and for individuals in states with mandatory e-prescribing laws.

HLC urges the House to pass H.R. 7312 to enact the EPCS 2.0 Act to reduce opioid "doctor shopping" and eliminate administrative burden and costly errors associated with paper prescribing.

6. **Maintain Enhanced Federal Flexibilities for Streamlining Medicaid Renewals: Reduce Unnecessary and Burdensome Paperwork**

As states look beyond the "unwinding" of continuous coverage requirements related to the COVID-19 Public Health Emergency and evaluate their Medicaid redetermination and renewal processes, Congress and CMS have the opportunity to implement long-term improvements. Enhanced flexibilities afforded by the government combined with and private sector assistance have helped preserve appropriate enrollment and assuage unnecessary churn. However, more needs to be done. HLC encourages Congress to collaborate with CMS to make permanent and promote the flexibilities available to states that advance continuity of coverage beyond the unwinding period. These include flexibilities that alleviate the administrative burden on individuals, such as enhancements to auto-renewal (ex parte) processes and enabling Medicaid managed care organizations (MCOs) to assist with outreach and paperwork.
During the unwinding period, CMS highlighted existing policies and provided states with new waiver authorities under section 1902(e)(14)(A) of the Social Security Ac to streamline ex parte renewals. These flexibilities contributed substantially to increasing ex parte renewal rates in

[7] Surescripts, 2021 "National Progress Report."

states during the unwinding period, nearly doubling rates. In January 2024 states achieved an average ex parte renewal rate of 46 percent, compared to the average ex parte renewal rate of 24.7 percent at the beginning of the unwinding period in May 2023.[8] To build on this progress, HLC urges Congress to work with CMS to make temporary ex parte flexibilities permanent and to continue exploring policies to help states increase and streamline ex parte renewals.

With individuals for whom state agencies lack sufficient data for ex parte renewal or who may be ineligible for Medicaid, MCOs play a critical role in promoting continuity of coverage. MCOs reduce procedural terminations and facilitate alternative coverage through education about the redetermination process and individualized assistance with paperwork in those states that have adopted these flexibilities. MCO's are well-suited to partner with Medicaid agencies to reduce administrative burdens on both beneficiaries and states. HLC encourages Congress to work with CMS to make permanent the flexibility allowing MCOs to help Medicaid members fill out and submit renewal forms. Congress should also collaborate with CMS to continue strategies to enhance MCOs' ability to conduct non-marketing outreach to individuals to provide information on renewal or alternative coverage options.

7. **Realign Incentives for Efforts to Address Fraud, Waste, and Abuse: Maximize Resources for Patient Care**

Fraud, waste, and abuse (FWA) are estimated to account for up to 10 percent of costs for health plans; efforts to combat fraud and wasteful spending play a crucial role in ensuring that healthcare resources are directed towards actual patient care.[9] We believe Congress can make significant strides in reducing medical spending and improving patient care by recharacterizing FWA mitigation efforts costs as part of quality improvement rather than administrative functions. This reclassification would incent organizations to engage more actively in fraud prevention and waste reduction, ultimately leading to a more efficient, cost-effective, and patient-centered healthcare system.

8. **Modernize Physician Self-Referral (Stark) Law and Anti-Kickback Statute (AKS): Realize Opportunities of Evolving Innovation**

HLC appreciates steps taken in recent years by the Office of the Inspector General (OIG) for the Department of Health and Human Services (HHS) to modernize the Stark and Anti-Kickback Statute safe harbors, allowing them to align more with value-based arrangements that encourage coordinated care and a patient-focused model of treatment. However, to realize the evolving innovation of the health sector, we encourage Congress to grant the Secretary of Health and Human Services greater authority to create new safe harbors and exceptions to existing AKS and Stark policies. The landscape of the healthcare sector is rapidly changing, and the impact of certain regulations is rarely predicted with complete accuracy. Additional flexibility

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[8] Unwinding Watch: Tracking Medicaid Coverage as Pandemic Protections End, Center on Budget and Policy Priorities (March 2024), https://www.cbpp.org/research/health/unwinding-watch-tracking-medicaid-coverage-as-pandemic-protections-end.

[9] US Department of Justice, Health Care Fraud (January 21, 2020), https://www.justice.gov/archives/jm/criminal-resource-manual-976-health-care-fraud-generally.

would recognize the significant challenges required to make effective revisions to the Stark Law or the AKS.

While it is important to ensure that financial relationships are only for the purpose of improving care, providers have struggled to comply with the Stark Law, given its imposition of a strict liability framework for all violations. Violations of the AKS are an intent-driven analysis, and we support Congress taking steps to harmonize the standard for violations to ensure providers who unintentionally violate the Stark Law are not unduly punished.

HLC applauds the broad approach to AKS safe harbors that was ultimately adopted in the Office of the Inspector General (OIG) 2021 Final Rule, particularly the focus on connecting and ensuring all patients receive high quality care. However, too much guidance has made the safe harbors difficult to leverage and largely ineffective. Specifically, the precise measures used to ensure the laudable goal of equal access to services are detrimental in operation; while these measures are intended to prohibit discriminatory practices, restricting value-based entities from making different offerings based upon patient insurance type prohibits offering more specific services to areas of greater need.

We also recommend lifting barriers currently in place and allowing all relevant stakeholders to fully participate in value-based arrangements without threat of legal repercussions. The AKS expressly excludes pharmaceutical and medical device manufacturers as well as laboratories from substantially all the newly created safe harbors in the 2021 Final Rule.[10] Excluding these stakeholders fails to recognize the extensive information sharing and individual care assistance they provide within the value-based ecosystem. Measurable improvements to care coordination require significant interactions among patients, providers, and all other stakeholders. OIG's approach in determining which and how entities may participate in safe harbors fails to consider innovative ways that stakeholders can contribute to the care delivery process by applying new payment methods that encourage value-based arrangements.

Conclusion

HLC appreciates the Committee's efforts to address the critical issue of value-based care. HLC and its member companies are eager to collaborate on initiatives to streamline healthcare processes to enhance both efficiency and patient care. If you have any questions, please do not hesitate to contact me at kmahoney@hlc.org or (202) 449-3442.

Sincerely,

Katie Mahoney

Katie Mahoney
Executive Vice President and Chief Policy Officer

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[10] Eligibility for the Value-Based Safe Harbors, the Patient Engagement and Support Safe Harbor, and the Personal Services and Management Contracts Safe Harbor for Outcomes-Based Payment, Office of the Inspector General, U.S. Department of Health and Human Services (November 20, 2020), https://oig.hhs.gov/reports-and-publications/federal-register-notices/Ineligible-Entities-Chart.pdf.

AAOS
American Association of Orthopaedic Surgeons

Statement for the Record

Ways and Means Health Subcommittee Hearing on Improving Value-Based Care for Patients and Providers

June 26, 2024

On behalf of its 39,000 orthopaedic surgeon members, the American Association of Orthopaedic Surgeons (AAOS) is pleased to submit this statement for the record of the June 26, 2024, hearing, "Improving Value-Based Care for Patients and Providers" before the U.S. House of Representatives Committee on Ways & Means' Health Subcommittee. AAOS appreciates the opportunity to share our recommendations for improving health outcomes and savings to the Medicare program through the implementation of value-based care initiatives.

AAOS members have been at the forefront of alternative payment adoption since the Medicare and CHIP Reauthorization Act (MACRA) was passed in 2015. In the ensuing years, our members have been subjected to numerous iterations of quality and cost measures, mandatory and voluntary alternative payment models (APMs) such as the Comprehensive Care for Joint Replacement (CJR) and Bundled Payments for Care Improvement Advanced (BPCI-A), and most recently learned they may be subject to a new, mandatory surgical episode model, the Transforming Episode Accountability Model (TEAM) should it be finalized as proposed in the Fiscal Year 2025 Medicare Hospital Inpatient Prospective Payment System rule. Through all of this, we have remained a steadfast partner in innovation and savings. Yet, the reward for successful innovation and efficiency has largely been decreased reimbursement along with substantial administrative burden.

Impact of Current Value-Based Care Programs

As it pertains to orthopaedic surgery, a shift to value-based models has proven to be complicated and costly with limited return on the investment to CMS. Physicians are overloaded with administrative burden to comply with the numerous value-based payment models and patients are often unaware that they are participating in such arrangements, thus limiting the effectiveness of such programs. While each of these models and programs have attempted to improve quality and contain costs to the Medicare program, evidence suggests that their success has been limited at best. A 2023 report from the Congressional Budget Office (CBO) analyzing the CMS' Center for Medicare and Medicaid Innovation (CMMI) activities in the first ten years of its operation determined that they increased direct spending by $5.4 billion. Furthermore, CMMI spent $7.9 billion on model operation, yet those models (including CJR and BPCI-A) only reduced spending on health care benefits by $2.6 billion.[1]

Instead of continuing to promote burdensome, complicated models which are subject to changes in methodology year-over-year, Congress should direct CMS and CMMI to explore options for providing care in a way that is of high value while remaining accessible in implementation. This may look like a

[1] https://www.cbo.gov/system/files/2023-09/59274-CMMI.pdf

single system for designing and operating all value-based payment models, with one platform for measure testing, approval, and use, as well as the same single platform for reporting. Such a platform would ideally be compatible with both government-operated and privately-operated value-based care programs.

AAOS also supports the creation of voluntary, physician-led alternative payment models that expand access to quality specialty care through wraparound approaches to musculoskeletal disorders.[2] This includes care teams that assess the clinical and social factors that make surgical and nonsurgical interventions safe, effective, and long-lasting. Orthopaedic surgeons should remain the foremost leaders of these care teams which may include mid-level practitioners, nurse navigators, physical therapists, social workers, and dietitians. Essential to improved access is reduced administrative burden which detracts from time spent with the patient and slows the treatment process.

The incentives for shifting to value-based care models should be strong enough to encourage participation without imposing mandatory changes on practices, which are often resource intensive to adopt. As the BPCI-A and CJR models come to an end and CMMI considers the design and requirements for the next generation of APMs, it is essential that they remain voluntary. The earlier mentioned TEAM proposed model may be considered a first iteration of this next generation, however, given that it is mandatory and hospital-controlled, it leaves patients and physicians with limited autonomy over their care plan. Instead, AAOS believes that creating specialty care pathways for the treatment of musculoskeletal conditions within Accountable Care Organizations (ACO) will be one way to accomplish this.

Simplifying existing quality reporting programs to reduce physician burden is also critical. This may include, but is not limited to, eliminating, or updating the MIPS program reporting requirements or removing model overlap with other APMs. We also strongly support the use of Patient-Reported Outcome Measures (PROMs) to assess quality, as well as the use of Qualified Clinical Data Registries (QCDRs) to report quality measures. At the same time, it takes substantial time and resources for QCDRs to update their data capture capacity and IT resources to capture quality data. Implementation timelines for any new provisions must be considered vis-a-vis these factors impacting physician quality reporting.

Currently, physicians are disincentivized to report through a QCDR or devote resources to measure development or QCDR development when there is no stability in quality reporting policies. The policies of the current Merit-based Incentive Payment System (MIPS) fail to acknowledge the time needed to put new guidelines and standards of care into practice. In addition, it takes time for sufficient data to be collected for benchmarking and tracking progress over time and physicians incur additional implementation costs.

[2] https://www.aaos.org/globalassets/advocacy/issues/aaos-response-to-rfi-on-episode-based-models-november-2023.pdf

These challenges, as well as CMS' MIPS scoring policies, contribute to physician hesitation to adopt new quality measures. AAOS believes that the field of performance measurement and the shared goal to improve the quality of care for patients are negatively impacted by these policy decisions. While AAOS understands the cost measure benchmarks are based on performance year Medicare claims data and thus are not published in advance of the performance period, AAOS believes CMS must take steps to inform physicians about their target spending and patient population throughout the measurement period.

Need for Congressional Intervention

Congress has the authority to reshape and refine the way that value-based care models are structured to ensure that physician experts lead the shift to quality and patient-centered models. Specifically, the AAOS has encouraged CMS to develop incentives for interested participants to engage in a model that would reward innovation and high-value patient care.[3] This voluntary, nationwide model should be available for any set of surgeons, facilities, and providers who seek to collaborate in innovative ways to generate high quality, improved care coordination, and lower costs for musculoskeletal care. It is essential that these interested parties also have the infrastructure necessary to carry out an episode of care approach to payment and delivery. A key component of this is ensuring that any payment structure used is one that accounts for inflation and other changes that have a direct impact on the financial viability of physician practices.

Given Congress' oversight of CMS and CMMI, we ask that Congress consider their authority to urge CMS to establish an APM that recognizes the critical role of specialty physicians in treating and managing chronic conditions. Particularly considering the growing proportion of Medicare dollars spent on specialty care and the prevalence of conditions that are treated by specialists, such as osteoarthritis and osteoporosis, there must be a financially viable option for these physicians to lead care within the increasingly popular ACO system. The financial risk and potential rewards of providing high value specialty care must be shared downstream with physician-led specialist teams to incentivize high value behavior. In the absence of this, if the entire bundle of risk and potential reward is siloed with the ACOs and primary care providers as it currently stands, then their only "lever" to reducing the cost of musculoskeletal health care will be to avoid referring patients to specialists, leading to inappropriate rationing, lost patient function/independence, high levels of dissatisfaction, and in some cases, overutilization of inappropriate care. Therefore, to ensure high quality care, certain conditions require a clearly defined pathway for care to be subcontracted and led by the appropriate specialists.

To achieve the Medicare savings that CMS aims for, it mandates that the experts who work directly with patients on key decision making are incentivized toward value. Toward that end, **AAOS asks Congress to encourage CMMI to explore and immediately pilot a program for the management of chronic, prevalent conditions such as osteoarthritis of the knee, as delineated, with plans to**

[3] https://www.aaos.org/globalassets/advocacy/issues/aaos-specialty-care-reimbursement-model.pdf

AAOS
American Association of Orthopaedic Surgeons

expand into other conditions as the reconciliation, monitoring, and payment mechanisms are refined from this initial model.

We also recommend that new models should begin with no risk and allow progression to risk-bearing as experience is accumulated. Special emphasis must be given to rural locales where large geographic areas must be covered to gain efficiency. This will require more effective use of telemedicine from physician-to-physician, and not just from physician to patient. Risk-bearing is challenging in a sparsely populated area as there is no option to distribute care elsewhere.

AAOS has also voiced support for the American Medical Association's (AMA) legislation aimed at transforming the MIPS program into the Data-Driven Performance Payment System (DPPS). We believe that this legislation takes important steps to address the challenges and shortcomings of the current MIPS program, and we are particularly pleased with several provisions that will enhance the role of clinical data registries, promote the use of innovative health information technology, and support the transition to value-based care. The proposed legislative text successfully tackles the key issues with the current MIPS program by appropriately balancing the incentive structure with the need for financial stability, mitigating the disproportionate distribution of steep penalties, ensuring CMS provides timely and actionable data, and incorporating clinically relevant and less burdensome metrics.

Conclusion

Reforming the Medicare payment system to properly account for the ever-increasing costs of practicing medicine continues to be a top priority for our member surgeons. Recognizing and acting on the untapped value of true payment reform that takes a holistic approach to meeting the needs of patients and physicians is possible if Congress acts on the policies discussed above. At the same time, AAOS supports immediate efforts to provide an annual, inflation-based update to the Medicare Physician Fee Schedule equal to the full amount of the Medicare Economic Index, and we believe such an update is necessary to maximize the potential benefits of these proposed policies.

Thank you for the opportunity to submit comments for the record. The Committees' work to improve the value-based care landscape for patients and physicians is essential for ensuring long-term access to quality care and a stable safety net for America's most vulnerable beneficiaries. We look forward to working with you to refine and strengthen these provisions further as the legislative process moves forward. Please feel free to contact Lori Shoaf (shoaf@aaos.org) if you have any questions or if the AAOS can further serve as a resource to you.

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June 20, 2024

The Honorable Jason Smith (R-MO)
1011 Longworth House Office Building
Washington, DC 20515
Subject: Physician Focused Payment Model Technical Advisory Committee

Dear Congressman Smith,

It has been announced that a subcommittee hearing titled **"Improving Value-Based Care for Patients and Providers" will be held on June 26th.** I would like to submit the following comments for this meeting.

I have served on the Physician-Focused Payment Model Technical Advisory Committee (PTAC) for the last three years and have just agreed to participate for another three-year term. My participation on the PTAC originally resulted from a nomination by the American Gastroenterological Association (AGA), who nominated me based on the fact that my project proposal to the PTAC in 2017 (Project Sonar) became the first PTAC recommended physician focused payment model.

Unfortunately, despite the fact that PTAC recommended Project Sonar for further testing to the secretary of HHS, no further testing ever materialized. Despite the lack of progress by HHS, Project Sonar has become a solution in the commercial space as a value-based care company, SonarMD, Inc., which works with commercial health plans to bring the original PTAC proposed solution to patients with chronic GI illnesses. We have had successful commercial deployments in New Jersey, Illinois, Minnesota and California with Blue Cross Plans.

Project Sonar is one of 34 PTAC recommended solutions, none of which have ever been implemented by CMS or CMMI. (It should be noted that these proposals were recommended during the last presidential administration.) As a result, no projects have been submitted to PTAC in almost three years.

This lack of implementation was recently noted on page 17 of the May 17, 2024 Senate Whitepaper titled "Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B". See paragraph below:

> "Moreover, with respect to A-APM options, under MACRA, Congress codified the Physician Focused Payment Model Technical Advisory Committee (PTAC), designed in an effort to advance a range of A-APMs tailored to achieve broad participation among clinicians from all specialties and subspecialties. In practice, despite dozens of proposals recommended by PTAC after submission and consideration, none have

> seen implementation due to not meeting required criteria, although CMS has acknowledged concepts and ideas included in certain proposals. As a result, many clinicians convey they see a lack of clinically relevant A-APM options within Medicare's value-based care initiatives."

Although no proposals have been submitted to the PTAC over my term, we have been fulfilling the mission of the PTAC by holding theme-based discussions at our meetings and regularly gather numerous subject matter experts to present in public forums on specific topics such as rural health, chronic disease management, innovations in care management, addressing health related social needs, successful structures for total cost of care models and other pressing issues. These groups convene to discuss opportunities within these areas and propose solutions, facilitating the exchange of ideas and the creation of comprehensive documentation that combines existing literature with real-world insights from national experts. These documents have become invaluable resources for reference and education as you can see on the comprehensive PTAC website.

CMMI and CMS have been following our work. We have witnessed exceptional engagement from Liz Fowler, PhD, JD, as the Deputy Administrator and Director of the Center for Medicare and Medicaid Innovation. During her tenure, she and her team have shown outstanding support and involvement with the PTAC. They consistently attend our meetings, listen to the discussions, and review our final reports to incorporate our findings into their alternative payment models. We meet regularly to discuss questions CMMI has regarding the next phase of model design and plan upcoming meetings of PTAC to delve into issues of interest to inform that development.

The statutory mission of PTAC is to make comments and recommendations to the Secretary of Health and Human Services (the Secretary, HHS) on proposals for PFPMs submitted to PTAC by individuals and stakeholder entities.

The committee members feel strongly that we are fulfilling this mission through our theme-based meetings. During these meetings our committee works very hard to find and bring cutting edge value-based care solutions to the decision makers in CMS and CMMI. We would love to continue to do so but also need to know that our work is making a difference.

We are grateful for your foresight in establishing this committee and hope it will continue its important work well into the future. Our future meetings will focus on addressing serious illness in total cost of care models and the glidepath to the 2030 goal for total cost of care. We welcome your insights into topics of interest, and we would be happy to meet in person to discuss your ideas about the next evolution of PTAC.

Sincerely,

Lawrence R Kosinski, MD, MBA, AGAF
Member Physician Focused Payment Model Technical Advisory Committee
Member – Governing Board American Gastroenterological Association
Founder – SonarMD, Inc.

mapRx
Medicare Access for Patients Rx℠
Convened by Lupus Foundation of America

Clinical Evidence Driving Patient Access in Medicare Part D

Case study for improving Obesity coverage

Medicare Part D is a critical benefit that has provided millions with access to prescription medications since 2006. However, despite the program's successes, there have been significant patient access challenges—specifically, Part D's exclusion of certain medically necessary drugs and services. As the medical community's understanding of disease states evolves, the Part D program must evolve. A key example is Part D's exclusion of Food and Drug Administration (FDA)-approved anti-obesity medications (AOMs) that address the treatable metabolic chronic disease of obesity.

The prevalence of obesity in the United States (US) population has increased steadily since the 1960s. Now more than 100 million Americans live with obesity,[1] and it has major health and economic implications for the country. As the nation continues to grapple with the COVID-19 pandemic, we have learned that obesity and obesity-related diseases are the second greatest risk factors, after older age, for hospitalization among COVID-19 patients.

Coverage policies constantly evolve as clinical evidence advances and, with that, the Medicare program advances its coverage of medications and services. The program has evolved over time, covering previously non-covered items based on new indications and clinical evidence. For example, Medicare has changed the way it covers mental health services and bariatric surgery. Yet it has not kept pace with advances in the medical community's understanding of obesity or its treatment, despite the prevalence of obesity, its significant negative impact on the health of Medicare beneficiaries, and the cost to society.

Approximately 35% (over 13 million) of adults in the US aged 65 and over between 2007 and 2010 were living with obesity.[2] Congress has an opportunity to amend the Social Security Act to clarify that FDA-approved AOMs that treat a chronic disease—obesity—are medically necessary treatments for "chronic weight management" and should be covered under Part D.

The Centers for Medicare & Medicaid Services (CMS) must recognize its authority to interpret the statutory exclusion of certain uses of drugs and categories of drugs to permit coverage of medically accepted indications of drugs, even when other uses of those drugs might be excluded under the statute. This authority should be applied to FDA-approved AOMs as it has done in other instances.

UNDERSTANDING OBESITY

There has been a significant paradigm shift in the clinical understanding of obesity. At the onset of the disease, scientists believed that obesity was simply an energy imbalance—more calories consumed than expended.

In 1994, leptin was discovered, changing the way the medical community thought about obesity.[3] The hormone, which is secreted by fat cells, acts in the brain to suppress appetite following a meal.[4]

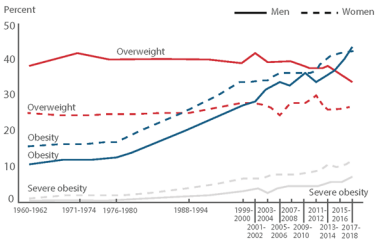
In 2013, the American Medical Association recognized obesity as a disease state with multiple pathophysiological aspects that require a range of interventions to advance obesity treatment and prevention.

The stunning rise of obesity in the US

According to the Centers for Disease Control and Prevention (CDC), obesity is epidemic in the US and a major risk factor for a broad range of chronic diseases including diabetes, hypertension, cardiovascular disease, Alzheimer's disease and related dementias, osteoarthritis, and several cancers.[5] As depicted in **Figure 1**, the obesity rate in the US has tripled in the last 50 years.[6] In the early 1960s, fewer than 14% of US individuals had a body mass index (BMI) over 30 vs 42% in the 2017 to 2018 period. It is important to note that 44.8% of adults aged 40 to 59 years live with obesity and as obesity prevalence continues to rise, Medicare must consider future costs and greater resource needs.

About **2 in 5** adults and **1 in 5** children and adolescents in the US live with obesity.[7]

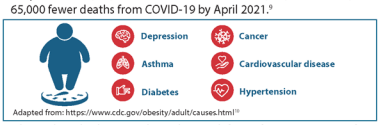
Figure 1. Age-adjusted trends in overweight, obesity, and severe obesity among men and women aged 20-74: US, 1960-2018



Notes: Data are age-adjusted by the direct method to the US Census 2000 estimates using age groups 20-39, 40-59, and 60-74. Pregnant women are excluded from the analysis.
BMI definitions: Overweight, 25.0-29.9 kg/m²; obesity, 30.0-39.9 kg/m²; severe obesity, ≥40.0 kg/m².
Key: BMI – body mass index; US – United States.

Obesity affects a wide range of other therapeutic areas

Obesity and obesity-related diseases are the second greatest risk factors, after older age, for hospitalization among COVID-19 patients. In fact, the CDC reported that 78% of patients who have been hospitalized, needed a ventilator, or died from COVID-19 lived with overweight or obesity and had at least 1 underlying health condition, many of which were obesity-related diseases.[8] One study showed that a 25% reduction in the rate of obesity could have led to 120,000 fewer hospitalizations, 45,000 fewer intensive care unit (ICU) admissions, and 65,000 fewer deaths from COVID-19 by April 2021.[9]



Adapted from: https://www.cdc.gov/obesity/adult/causes.html[10]

Obesity has also been implicated as a risk factor for certain types of cancer, cardiovascular disease, and diabetes, among other conditions that affect health and healthcare costs.[11] Additionally, adults living with obesity have a 55% higher risk of developing depression over their lifetime compared to people not living with obesity.[12]

The increase in these conditions' prevalence across the nation has major implications for the health and well-being of the population.

OBESITY IS A CRIPPLING PUBLIC HEALTH AND FINANCIAL THREAT IN THE US

The rising prevalence of obesity in the US imposes a substantial public health and economic burden due to both direct medical care costs and indirect productivity-related costs.

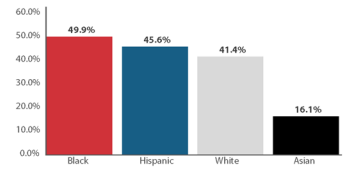
In 2016, the total cost of chronic diseases due to obesity and overweight was **$1.72 trillion**—equivalent to 9.3% of the US gross domestic product.

In 2016, chronic diseases driven by the risk factors of obesity and overweight accounted for $480.7 billion in direct healthcare costs in the US, with an additional $1.24 trillion in indirect costs due to lost economic productivity.[13] The total cost of chronic diseases due to obesity and overweight was $1.72 trillion—equivalent to 9.3% of the US gross domestic product. Obesity as a risk factor is by far the greatest contributor to the burden of chronic diseases in the US, accounting for 47.1% of the total cost of chronic diseases nationwide. Additionally, failure to treat those living with obesity with the full continuum of care leads to increased job absenteeism, presenteeism, disability, and payments from workers' compensation insurance. One study found that obesity raises the number of workdays lost to illness or injury by 3 days per worker per year (from 2.34 to 5.34), or by 128.2%.[14] These lost workdays translate to a per-worker annual productivity loss caused by obesity ranging from $270.79 to $541.58 and at the US national level, $13.42 billion to $26.84 billion.[14]

Racial and ethnic minorities live with obesity at higher rates

The burden and cost of obesity are particularly pronounced among communities of color. Non-Hispanic Black populations have the highest prevalence of obesity at 49.6%, followed by Hispanic populations at 44.8% and non-Hispanic White populations at 42.2% (**Figure 2**).[15] African American women live with obesity at the highest rate among any demographic group; approximately 4 out of 5 African American women live with overweight or obesity. Native Hawaiians/Pacific Islanders are 80% percent more likely to live with obesity than non-Hispanic White populations.[16] US-born Asians and Pacific Islanders are at higher risk of living with obesity, and the risk for immigrants increases with the duration of residency.[17] Living with obesity places racial and ethnic groups at higher risk for the development of obesity-related diseases such as diabetes, hypertension, high cholesterol levels, heart disease, stroke, and some cancers.[18]

Figure 2. Adults living with obesity by race/ethnicity



As CMS continues to emphasize the need to examine health equity, the agency must assess whether its programs and policies perpetuate systemic barriers that limit full and equal participation by people of color and underserved groups and aim to identify the best methods to assist agencies in assessing equity with respect to obesity.

CLINICAL EVIDENCE EVOLVES; SO SHOULD COVERAGE POLICIES

Science and innovation drive the need for access

Clinical guidelines recommend evidence-based obesity care including intensive behavioral therapy (IBT), AOMs, and bariatric surgery, stating "the addition of pharmacotherapy produces greater weight loss and weight loss maintenance compared with lifestyle therapy alone."[19] The American Association of Clinical Endocrinologists (AACE) and American College of Endocrinology (ACE) clinical practice guidelines identify 5 FDA-approved AOMs: CONTRAVE (naltrexone HCl and bupropion HCl), SAXENDA (liraglutide), BELVIQ (lorcaserin hydrochloride) (discontinued), XENICAL (orlistat), and QSYMIA (phentermine/topiramate ER).[20] The guidelines recommend that "clinicians and their patients with obesity should have access to all approved medications to allow for the safe and effective individualization of appropriate pharmacotherapy" and identify drug preferences and contraindications for patients with certain comorbidities and clinical characteristics. However, seniors currently only have limited coverage for IBT and surgery.

AOMs are a critical part of the obesity care continuum, particularly for people for whom lifestyle intervention alone does not work or who have multiple comorbidities. Most patients living with obesity are not able to achieve and maintain a healthy weight with healthy eating and increased physical activity alone.[19] FDA-approved AOMs are proven to help patients living with obesity. One study found that when combined with lifestyle intervention, all drugs currently approved by the FDA for chronic weight management produced greater obesity reduction (5%-12%) and sustained the obesity reduction for a greater length of time than did lifestyle intervention alone.[21] As a result, a growing number of commercial and Medicaid plans recognize the importance of AOMs in the obesity care continuum and offer coverage for AOMs; however, patients covered under these plans lose access to the medicines they need when they turn 65 and enroll in Medicare.

CMS currently excludes AOMs from coverage on the basis that they are "agents for weight loss."[22] However, modern AOMs are not "agents for weight loss." In fact, modern AOMs are very different from weight loss products that were commercialized in decades past. For example, in the 1990s, use of fen-phen drove the perception that weight loss drugs are unsafe and can have severe side effects. ("Fen-phen" refers to the use in combination of the drugs fenfluramine/phentermine and phentermine/dexfenfluramine.) In the 1990s, some physicians began prescribing fenfluramine or dexfenfluramine in combination with phentermine, often for extended periods of time, for use in weight loss programs, often by people who did not have the disease of obesity.[23]

While the prescription medications fenfluramine, phentermine, and dexfenfluramine received individual approval by the FDA, use of the drugs in combination never received FDA approval. In September 1997, the FDA asked the manufacturers to voluntarily withdraw dexfenfluramine and fenfluramine from the market.[24] The FDA's withdrawal request came after echocardiogram testing of patients taking fen-phen suggested that fenfluramine and dexfenfluramine were the likely cause of heart valve problems. In the 1990s, several other weight loss medications were withdrawn from the market due to severe cardiovascular side effects, including aminorex (pulmonary hypertension), phenylpropanolamine (stroke), and sibutramine (myocardial infarction and stroke).[25,26]

Modern AOMs approved by the FDA are significantly different from products withdrawn from the market in previous years because they are included within more comprehensive treatments than just weight loss. In 2007, the FDA issued draft guidance to manufacturers outlining expectations for AOMs.[27] The FDA has encouraged manufacturers developing AOMs to look not only at the effectiveness of these medications with respect to weight but also importantly at the impact of these medications on "secondary efficacy endpoints" such as blood pressure and pulse, lipoprotein lipids, fasting glucose and insulin, and HbA1c (in type 2 diabetics). The FDA has further stated that changes in common obesity comorbidities "should be factored into the efficacy assessment of investigational and weight-management products." The FDA also stated that its draft guidance on weight management drugs applies to products "for medical weight loss, which can be defined as a long-term reduction in fat mass *with a goal of reduced morbidity and mortality through quantifiable improvements in biomarkers such as blood pressure, lipids, and HbA1c.*"

Since this guidance was issued, several products have since been approved by the FDA to meet this standard, with an indication of "chronic weight management." Unlike the products of the past, studies have shown that many of the currently approved products generally have favorable effects on cardiometabolic parameters.[28] Many of these products are approved for long-term use, and they are recommended in specialty society guidelines and guidelines for the Department of Defense. When combined with lifestyle changes, beneficiaries taking AOMs lose 3% to 12% more weight than those who do not include prescription medications in their obesity treatment. Those taking medication also sustained obesity reduction.

Pharmacotherapy agents can be grouped by treatment period as short-term weight loss agents and chronic weight management agents.[29] ACE and ACE clinical practice guidelines emphasize that obesity is a chronic condition and identified 5 AOMs for use as an adjunct to behavioral interventions: naltrexone/bupropion, liraglutide 3 mg, orlistat, phentermine/topiramate, and lorcaserin HCl (discontinued).[19] (The FDA subsequently approved a sixth AOM, IMCIVREE [setmelanotide].) The guidelines recommend that "clinicians and their patients with obesity should have available access to all approved medications to allow for the safe and effective individualization of appropriate pharmacotherapy" and identify drug preferences and contraindications for patients with certain comorbidities and clinical characteristics.[19,30]

CASE STUDIES FOR TREATMENTS THAT ARE NOW ROUTINE AFTER EVIDENCE EVOLVES

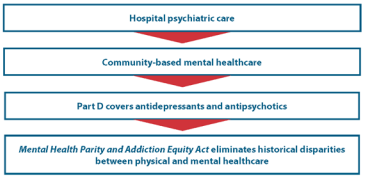
Health insurance coverage of treatments and procedures typically follows the clinical evidence. As the medical community's understanding of the clinical efficacy of a therapeutic evolves, treatments that may not have been covered in the past can become routine. Additionally, payers can become nuanced about how they cover treatments, such as providing access to products for FDA-approved uses while prohibiting coverage for treatments that are not.

As the following case studies demonstrate, coverage for services and products is not static; changes occur as clinical evidence emerges to support use.

Mental health

Treatment for mental illness has changed dramatically over the past century, but particularly in the past quarter-century. The evolution of insurance coverage for mental health treatment has also shifted. Insurers did not begin including mental health services until the 1950s, when insurance policies included hospital psychiatric care. Before the period of deinstitutionalization, which started in the late 1950s when most long-term care in psychiatric hospitals was replaced with community-based mental healthcare, there was little reason for private insurers to cover services that were paid for by the government (**Figure** 3).[31]

Figure 3. The advancing progress of mental healthcare



The modern view of mental illness has evolved tremendously, with a shift in the cultural conversation and availability of more effective treatments. For example, the American Psychological Association conducted a poll in 2018 of over 1,000 US adults; 87% agreed that having a mental health disorder is nothing to be ashamed of.[32]

Before the expansion of Medicare Part D, depression was often undertreated in adults over 65. In 2003, Congress established Medicare Part D, which allowed Medicare coverage of outpatient prescription drugs. This change provided much-needed prescription drug coverage for seniors and people living with disabilities, including many people living with mental illness. The current policy requires all Part D prescription drug plans and Medicare Advantage plans to include "all or substantially all" of the medications in 6 protected classes on their drug formularies.[33] Two of the 6 protected classes are antidepressants and antipsychotics. Congress included this policy to ensure that Medicare beneficiaries living with some of the most complex conditions, like mental illness, are not discriminated against. It also ensures that they have access to a range of treatment options that meet their individual needs.

In 2008, Congress passed the *Mental Health Parity and Addiction Equity Act* to eliminate historical disparities between insurance coverage of behavioral health treatment and medical treatment.[34] As a result of the legislation, large group health plans that offer mental health coverage must place this coverage equal to physical illness coverage. A few years later, the *Affordable Care Act* required small group and individual health plans sold in the insurance marketplaces to cover mental health services at a level comparable to that of medical services.[35] Moreover, parity rules were also applied in 2016 to Medicaid managed care plans, thus covering the bulk of low-income residents covered by the program.[36] Due to those laws, insurers cannot write policies that charge higher copays or deductibles for mental healthcare, nor may they impose lifetime or annual upper limits on the amount of mental health coverage.

Most recently, mental health has been affected in the wake of the coronavirus pandemic and subsequent changes in the daily lives of Americans. Stress and worries associated with contracting COVID-19, along with job loss, child-care arrangements, and loss of loved ones, are some of the many ways the pandemic might affect mental health.

As the Commonwealth Fund noted, numerous recent policy changes have facilitated Medicare beneficiaries' ability to access mental health services during the pandemic, including the implementation of coinsurance parity for outpatient mental healthcare, the closing of the "doughnut hole" for prescription drugs, and new financial mechanisms to support depression screening and mental health management.[37]

Bariatric surgery

As previously stated, the medical community's understanding of obesity has evolved over the past 20 years. Through 2005, Medicare reimbursed for bariatric procedures on a regional basis. A study performed that year of the complete, nationwide fee-for-service Medicare population undergoing bariatric surgery from 1997 through 2002 found that the early risk of post-surgical death in this population was higher than suggested by prior studies.[38] Additionally, the study found bariatric surgery performed at higher-volume facilities and by higher-volume surgeons led to improved outcomes in the older Medicare population. CMS responded by restricting coverage of bariatric surgery to hospitals designated as centers of excellence (COEs) by 2 major professional organizations.[39]

Because of its proven effectiveness, bariatric surgery is now widely covered by health insurance, including Medicare and Medicaid.

Since 2002, government researchers have noted that bariatric surgery has become safer due to a combination of factors that include, but are not limited to, increased use of the laparoscopic approach, achievement of the learning curve as bariatric surgeons have gained more experience, and more regimented fellowship training programs.[40] CMS subsequently lifted the COE requirement, broadening access to beneficiaries.

The rising prevalence of the obesity epidemic and its harmful effects on overall health have increased public support for obesity treatments. It is now widely accepted that diet and exercise do not always lead to long-term, significant obesity reduction.[41] Bariatric surgery can greatly improve a patient's chance of achieving long-term obesity reduction and reduce obesity-related comorbidities. Because of its proven effectiveness, bariatric surgery is now widely covered by health insurance, including Medicare and Medicaid.[42] As the obesity epidemic continues to worsen in the US, increasing coverage of these effective and life-saving surgeries is a valuable option for patients and providers.

SEROSTIM (somatropin [rDNA origin] for injection)

In the past, CMS has recognized its authority to interpret the statutory exclusion of certain uses of drugs and categories of drugs to permit coverage of medically accepted indications of drugs, even when other uses of those drugs might be excluded under the statute. For example, CMS interpreted the prohibition on agents for weight gain to permit Part D coverage of drugs used to treat AIDS wasting and cachexia. SEROSTIM is indicated for the treatment of HIV patients with wasting or cachexia "*to increase lean body mass and body weight* and improve physical endurance."[43] Despite this indication, CMS covers the drug under Part D, noting that "prescription drug products being used to treat AIDS wasting and cachexia *are not considered agents used for weight gain*"[22] but treat a medically accepted chronic disease. In this instance, CMS has clearly exercised its interpretative authority to cover an FDA-approved drug whose primary indication is "to increase lean body mass and body weight" and will not be considered an agent used for weight gain.

PART D IS AN OUTLIER; OTHER PAYERS COVER AOMs

Part D's coverage exclusion of AOMs makes it an outlier among payers across the healthcare system. While coverage varies, other payers recognize obesity as a chronic disease and the important role AOMs play in improving health, reducing disease, and increasing health equity. The following payers and payer groups do cover AOMs:

Federal Employees Health Benefits Program (FEHBP)

The FEHBP's annual call for benefit and rate proposals (call letter) to carriers sets forth the policy goals and initiatives for the program for the coming plan year. In its 2023 call letter, FEHBP reminded carriers of the Office of Personnel Management's (OPM) letter in 2014 clarifying "that it is not permissible to exclude weight loss drugs from FEHB coverage on the basis that obesity is a 'lifestyle' condition and not a medical one or that obesity treatment is 'cosmetic.'"[44,45]

OPM stated in the 2023 call that carriers "…are not allowed to exclude AOMs from coverage based on a benefit exclusion or a carve-out. FEHB carriers must have adequate coverage of FDA-approved AOMs on the formulary to meet patient needs and must include their exception process within their proposal." It is important to note that OPM's emphasis on coverage of AOMs was a key part of its response to President Biden's Executive Order on advancing racial equity and supporting underserved communities.

Department of Veterans Affairs (VA)

The VA's Clinician's Guide to Weight Management states that "Obesity is a chronic, complex disease requiring lifelong commitment to treatment and long-term maintenance."[46] It acknowledges that although lifestyle changes alone can result in weight loss for some, many patients who are overweight and obese need additional interventions for weight reduction.

The agency supports long-term use of weight loss medications in individuals who are obese or overweight, as it "can improve blood pressure, dyslipidemia, glycemia, markers of inflammation, and insulin resistance."

TRICARE

Since 2017, TRICARE has covered AOMs, changing a longstanding policy that excluded coverage for obesity. In 2018, the Defense Health Agency (DHA), which delivers the TRICARE health plan, added 4 generic weight loss medications to the Department of Defense's pharmacy formulary—phentermine, benzphetamine, diethylpropion, and phendimetrazine—and would cover several other medications, including SAXENDA, BELVIQ (since discontinued), and XENICAL, under certain circumstances.[47] In 2022, TRICARE included the first branded AOM on formulary

In supporting coverage for AOMs, the then-director for disease prevention, disease management, and population health policy and oversight in the office of the Assistant Secretary of Defense for Health Affairs supported coverage of the drugs, stating, "It's clear from the scientific literature, if you can reduce excess body fat in the individual, then you lower their risk of comorbid diseases related to excess body fat… this is the general literature, not specific to DHA or Health Affairs, but a 5% to 10% reduction in body weight can lower blood pressure [and] decrease insulin requirements for diabetics. It's in the best interest for preventing major chronic diseases."

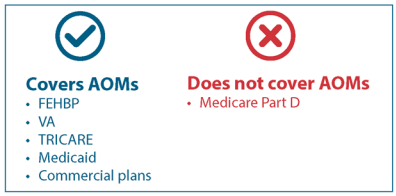
Medicaid and commercial payers

Medicaid and commercial payer coverage for obesity treatments is varied across states and plans. However, as with other payers, Medicaid and commercial coverage of AOMs is more robust than Part D, providing beneficiaries with treatment options not available under Part D and making Part D's coverage exclusion even more of an outlier among payers.

It is clear that, with the exception of Part D, payers across the health system have evolved coverage policies of AOMs to reflect changes in our understanding of obesity as a disease and the role AOMs can play in improving health. Moreover, AOM coverage policies of the payers above help to improve health equity among their covered populations.

PART D MUST EVOLVE TO COVER AOMs

As demonstrated in this paper, coverage for valuable treatments can evolve when clinical evidence emerges to support medical necessity. And yet, while clinical evidence can shift the access paradigm for beneficiaries, it does not always adapt quickly enough. The Medicare Part D program can continue to ensure beneficiaries have access to the care they need that could ultimately benefit the health of the entire program.



Like any medical or scientific discipline, the evidence for obesity treatment continues to evolve. However, the Medicare Part D coverage policy for AOMs has stagnated; the coverage exclusion for weight loss drugs is obsolete in the face of new FDA-approved AOMs.

FDA-approved AOMs are used to treat obesity, a chronic and treatable disease state with multiple pathophysiological aspects. AOMs do not treat "weight loss" or "weight gain" but provide chronic weight management, with the goal of improving the medical condition of obesity, which itself has clinical markers that go beyond the issue of weight. As discussed above, our understanding of obesity and our ability to treat it has evolved significantly in the past 20 years.

Given the linkage of obesity with chronic, life-threatening diseases; the higher risk of adverse COVID-19 outcomes for those living with obesity; and the availability of multiple, safe, long-term anti-obesity treatments, it is long overdue that Medicare Part D recognize AOMs as important therapies that treat a severe, chronic disease—obesity. Further, AOMs help manage associated conditions, beyond weight loss alone, to reduce overall morbidity and mortality.

Legislative solution

Congress has an opportunity to amend the Social Security Act to clarify that FDA-approved AOMs are not "agents for weight loss" but rather clinically recommended treatments for "chronic weight management" that treat a chronic disease—obesity—and may therefore be covered under Part D.

Congress could also encourage CMS to use its interpretative authority to update its coverage policy on FDA-approved AOMs.

Regulatory solution

CMS does not require congressional action, but instead can use its interpretative authority to establish AOM coverage through revised Part D plan guidance and/or regulation. The agency must evolve its thinking and stop minimizing the obesity space by saying it is about weight loss.

Policy solutions for Part D to enable access to AOMs

Congress can act to make a technical change clarifying that AOMs are Part D-covered drugs

CMS can establish AOM coverage through revised Part D plan guidance and/or regulation

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For:

United States House Committee on Ways & Means:
Subcommittee on Health

Hearing on:

"Improving Value-Based Care for Patients and Providers"

June 26, 2024

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Introduction

The National Association of Chain Drug Stores (NACDS) appreciates the opportunity to submit a statement for the record for the United States House Committee on Ways & Means Subcommittee on Health's hearing on "Improving Value-Based Care for Patients and Providers." NACDS applauds your continued work to improve healthcare for the American people and we encourage the Subcommittee to leverage the nation's pharmacies in your work to improve healthcare quality, access, equity, and to reduce healthcare spending.

The U.S. healthcare system incurs the highest spending and conversely yields the worst health outcomes, compared to other high-income countries.[1] This data indicate that the U.S. spends about twice as much as our peers on healthcare, with the lowest life expectancy and the highest rate of people with multiple chronic health conditions.[2] To achieve superior results, the nation desperately needs new solutions, especially those that leverage the entire healthcare continuum, including the unique accessibility and clinical expertise of the nation's most accessible healthcare providers – pharmacies and pharmacists.

About **90% of Americans live within 5 miles of a community pharmacy**[3] and **85%** of adults report that **pharmacies are easy to access**.[4] Pharmacies are open extended hours – including nights and weekends – when other healthcare providers are unavailable. Across populations, people visit pharmacies more often than other healthcare settings. Moreover, **more than 70%** of Americans support pharmacists performing more healthcare services, like testing and treatment for routine conditions, and helping patients prevent chronic diseases, a top driver of healthcare costs.[5]

When the expertise of pharmacies was more fully leveraged during the recent public health emergency, pharmacy interventions averted more than 1 million deaths, prevented more than 8 million hospitalizations, and **saved $450 billion in healthcare costs**.[6] Additionally, a recent study found that a 50% uptake of a pharmacist-prescribing intervention to improve blood pressure control would be associated with **$1.137 trillion in cost savings** and could save an estimated 30.2 million life years over 30 years.[7] More detail on the tremendous value of pharmacies in improving healthcare quality and costs can be found in a 2021 report available here, "Accelerating the Center for Medicare and Medicaid Innovation's Mission: Integrating Community Pharmacy Care into Value-Based Programs Amid COVID-19 Pandemic Recovery & Beyond."

However, despite a multitude of research examples and published literature on the value of pharmacies and pharmacists to improve health outcomes through clinical services and save downstream healthcare dollars, pharmacists are omitted as healthcare providers in Medicare and therefore, have yet to be directly engaged as

[1] The Commonwealth Fund. U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes. January 2023, available at: https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022
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care providers in existing CMS Innovation Center value-based care models.

In fact, a new report published by the Milken Institute's Feeding Change on key policy changes necessary to leverage the value of pharmacies to advance Food is Medicine recommends specifically that policymakers should "Recognize pharmacists as eligible providers under Medicare Part B to establish reimbursement for clinical services," among other recommendations. As a critical starting point to better utilizing pharmacists to improve healthcare quality and value, **NACDS urges the Subcommittee to support passage of H.R. 1770**, and consider future opportunities to better leverage their expertise in innovative healthcare models, including value-based care. For more information, please see the Milken Institute's Report, published in June 2024, titled, "Catalyzing Action for Pharmacist-Provided Food Is Medicine Care," available here.

The accessibility and clinical expertise of pharmacists and pharmacies can drive healthcare solutions that improve access and quality, while also mitigating preventable spending that results from suboptimal health outcomes. The unique footprint and infrastructure of community pharmacies should be leveraged in advancing new healthcare models and solutions for the American people that prioritize better health outcomes, disease prevention, and cost-savings. **To better leverage pharmacies in transforming healthcare to help meet the needs of communities across America, NACDS strongly recommends the Subcommittee members consider:**

1. **Supporting access to pharmacist services through the successful passage of the *Equitable Community Access to Pharmacist Services Act* (H.R. 1770/S. 2477)** in Medicare Part B – and consider similar opportunities to foster the public's access to pharmacist services more broadly. Once enacted, H.R. 1770 would promote Medicare beneficiary choice to access pharmacist services for common health threats like influenza and COVID-19, building on the effectiveness and broad reach of pharmacy-based care during the recent public health emergency, including in rural and underserved areas. Following the passage of this critical legislation, NACDS urges the Subcommittee to encourage the inclusion of community pharmacies in existing and future value-based care models, especially in the design and implementation of innovative models that seek to expand healthcare access, advance healthcare outcomes and equity, and promote healthcare savings.

2. **Support "Real PBM reform"** in Medicare and Medicaid like those included in H.R. 5378 and measures advanced through the Senate Finance Committee.

Discussion

Support access to pharmacist services to promote better health and control healthcare costs

Despite their proven ability to improve health outcomes and save downstream healthcare dollars, pharmacists are currently among the only healthcare professionals omitted from Medicare statute as Part B providers and have consequently been underutilized in value-based care models to date. As a result, pharmacists' accessibility and clinical expertise have been largely untapped in promoting better care quality, value, and access, including in rural and underserved communities. Bipartisan legislation (H.R. 1770/S. 2477) would help address this omission in Medicare by providing payment for essential pharmacist services under Medicare Part B and ensuring pharmacists can continue to protect vulnerable senior communities from common threats like flu and

COVID-19. As mentioned above, pharmacy interventions during the COVID-19 pandemic averted more than 1 million deaths, prevented more than 8 million hospitalizations, and saved $450 billion in healthcare costs.[8] This critical legislation builds on that proven success and would help support Medicare beneficiaries with the option to seek routine care for common illnesses from their local pharmacies, helping to enhance access and quality in a manner that meaningfully supplements existing care capacity in a tangible and cost-effective way. Consider, for example, individuals who may benefit from having additional access options and the choice to seek routine care services at their local pharmacies, instead of foregoing care until their condition worsens and ultimately leads to a costly hospital visit that could have been avoided. Congress can help the nation achieve a healthier and more sustainable healthcare system, prioritizing access, outcomes, and value by supporting the successful passage of H.R. 1770.

Throughout the recent public health emergency, pharmacies were a trusted, equitable provider of vaccinations, tests, and antivirals, providing nearly 340 million COVID-19 vaccines to date, in addition to more than 42 million tests, and dispensing more than 8 million antiviral courses.[9] During 2022-2023, more than two-thirds of adult COVID-19 vaccinations were administered at pharmacies[10] and compared to medical offices during the 2023-2024 season, pharmacies provided more than 90% of COVID-19 vaccines.[11] With respect to testing, pharmacies provided 87% of the free tests administered through the Improving Community Access to Testing (ICATT) program.[12] Similarly, in considering pharmacies' impact on antiviral access, HHS reported that 87.5% (35,000 of the 40,000) antiviral dispensing sites were pharmacies.[13]

Pharmacies unequivocally demonstrated their ability to meaningfully expand critical access to care across vulnerable communities during the recent pandemic, and the American people have taken notice. According to a poll conducted by Morning Consult and commissioned by NACDS in October of 2023, 81% of adults in the U.S. believe it's important to update policies to ensure that patients permanently have the same access to pharmacy vaccination, testing, and treatment services that were available during the COVID-19 pandemic.[14] H.R. 1770 would help to achieve this and fill gaps in healthcare access for seniors.

Not only did pharmacies provide unparalleled access to COVID-19 vaccines, tests, and antivirals, but they also surpassed expectations when it came to serving vulnerable and underserved communities. For example, 43% of people vaccinated through the Federal Retail Pharmacy Program were from racial and ethnic minority groups, exceeding CDC's goal of 40% — the approximate percent of the U.S. population comprised of racial and ethnic groups other than non-Hispanic White.[15] Additionally, with respect to bivalent COVID-19 vaccinations, pharmacies administered 81.6% and 60.0% of bivalent vaccine doses in urban and rural areas, respectively.[16] Pharmacies also supported concerted efforts to foster testing and antiviral access in vulnerable and rural

[8] https://pubmed.ncbi.nlm.nih.gov/36202712/
[9] https://www.liebertpub.com/doi/10.1089/hs.2023.0085
[10] https://www.liebertpub.com/doi/10.1089/hs.2023.0085
[11] https://www.cdc.gov/vaccines/imz-managers/coverage/covidvaxview/interactive/adult-vaccinations-administered.html
[12] Miller MF, Shi M, Motsinger-Reif A, Weinberg CR, Miller JD, Nichols E. Community-based testing sites for SARSCoV-2 — United States, March 2020–November 2021.MMWR Morb Mortal Wkly. 2021;70(49):1706-1711.
[13] US Department of Health and Human Services. https://www.hhs.gov/about/news/2023/04/14/factsheet-hhs-announces-amend-declaration-prep-act-medical-countermeasuresagainst-covid19.html
[14] https://accessagenda.nacds.org/dashboard/
[15] https://www.gao.gov/assets/720/718907.pdf
[16] https://www.cdc.gov/mmwr/volumes/73/wr/mm7313a2.htm?s_cid=mm7313a2_e&ACSTrackingID=USCDC_921-DM125690&ACSTrackingLabel=%20This%20Week%20in%20MMWR%3A%20Vol.%2073%2C%20April%204%2C%202024&deliveryName=USCDC_921-DM125690

communities, helping to ensure access points across diverse populations, especially in those communities without other healthcare providers within reach.

The Subcommittee can help make better healthcare access, improved outcomes, and lower downstream costs a reality by supporting the successful passage of the *Equitable Community Access to Pharmacist Services Act* (H.R. 1770/S. 2477). More information on this important legislation is available from the Future of Pharmacy Care Coalition here.

Following the passage of this critical legislation, NACDS urges the Subcommittee to consider additional opportunities for pharmacies to serve the American people in the future to address healthcare needs and to participate in value-based care models, including to help combat rising rates of chronic diseases as top drivers of poor health and rising healthcare spending in the United States. Research strongly supports the ability for pharmacists to improve health outcomes and control healthcare costs through better prevention and management of chronic diseases and a wide variety of other health conditions. Also, it is important to consider the connection between diet-related diseases and poor outcomes from common conditions like flu and COVID-19. For example, data reported to CDC from January to May 2020 indicated that COVID-19 hospitalizations were 6 times higher and deaths 12 times higher for people with COVID-19 and an underlying medical condition such as diabetes or heart disease.[17] Also, there is a strong connection between influenza and cardiovascular disease.[18]

Healthcare payment model reform to reward value-based care, better quality, and improved clinical outcomes can help align incentives toward what really matters - better health, while lowering unnecessary and preventable costs for our healthcare system. For example, a CMS Innovation Center-funded, pharmacy-led chronic care management initiative was designed to serve an underserved population. This initiative aimed to optimize patient health and reduce avoidable hospitalizations and emergency visits for high-risk patients by integrating pharmacists into safety net clinics. This collaborative program resulted in reduced rates of uncontrolled blood sugar by nearly a quarter (23%), improvements in LDL with 14% more patients controlled, and improvements in blood pressure with 9% more patients controlled at 6 months in the intervention group (collaborative care model with pharmacists as leads) versus the control group (primary care physicians only). Through this project, pharmacists identified 67,169 medication-related problems in 5,775 patients, which resulted in a 33% reduction in readmissions per patient per year.[19]

Additionally, NACDS' Nourish My Health campaign highlights the important opportunity to leverage pharmacies to help address major public health needs, such as diet-related chronic diseases and social determinants of health, which are often key aspects of value-based care programs and models. Nourish My Health is a nationwide public education campaign aimed at highlighting the connection between eating nutritious foods and reducing the risk of diet-related heart disease, diabetes, and cancer. Campaign messaging highlights the following calls to action: (1) Get a baseline health screening (blood pressure, cholesterol, blood sugar/blood glucose, and body mass index) and learn about your risk for nutrition-related diseases; (2) Improve your baseline numbers by adding healthy foods to your diet to live longer and healthier; and (3) Access important information

[17] https://archive.cdc.gov/www_cdc_gov/diabetes/library/reports/reportcard/diabetes-and-covid19_1702491562.html
[18] https://www.nfid.org/influenza-vaccination-is-critical-for-patients-with-heart-disease/
[19] Chen SW. Comprehensive Medication Management (CMM) for Hypertension Patients: Driving Value and Sustainability. University of Southern California. http://betheresandiego.org/storage/files/cmm-for-htn-usc-steven-chen-condensed-slide-deck.pdf ; Chen SW. Integration of Pharmacy Teams into Primary Care. The Center for Excellence in Primary Care and the Center for Care Innovations. May 2015. https://www.careinnovations.org/wp-content/uploads/2017/10/USC.CEPC_.pharm_webinar_FinalV.pdf

about healthy foods, lifestyle modifications, and health screenings through the campaign website and related resources. In addition to leading health organizations engaging in the campaign, numerous pharmacy organizations have also activated in the campaign, sharing key messages and resources with their audiences across communities, and providing important interventions, like baseline health screenings. To date, Nourish My Health has achieved nearly 180 million impressions, reaching Americans across the country, including rural and underserved populations. The campaign has also garnered more than 9,000 responses to a nutrition security survey developed by the Food is Medicine Institute at the Friedman School of Nutrition Science and Policy at Tufts University. Please visit nourishmyhealth.org for more information.

Furthermore, pharmacists as medication experts are positioned to help reverse increased spending attributable to suboptimal medication use and promote better health outcomes. For example, it was estimated that up to $21.9 billion could be saved within the U.S. healthcare system by optimizing medication use.[20] Also, it has been estimated that lack of medication adherence causes 125,000 deaths, at least 10% of hospitalizations, and hundreds of billions of preventable healthcare spending.[21] Healthcare spending on non-optimal medication therapy is estimated at $528.4 billion per year[22] and medication nonadherence is estimated to cost the system $290 billion per year.[23] Importantly for Medicare beneficiaries, it was recently estimated that medication nonadherence for diabetes, heart failure, hyperlipidemia, and hypertension resulted in billions of Medicare fee-for-service expenditures, millions in hospital days, and thousands of emergency department visits that could have been avoided. If the 25% of beneficiaries with hypertension who were nonadherent became adherent, Medicare could save $13.7 billion annually, with over 100,000 emergency department visits prevented and 7 million inpatient hospital days that could be averted.[24] Pharmacists can help curb these wasteful spending trends and improve health more broadly.

Also, looking across quality measures used in existing CMS programs, pharmacists are well-positioned to help address a wide variety of quality measures by optimizing medication use, improving uptake of preventive care like screenings and vaccinations, and supporting improvements in chronic disease control. Research continues to support pharmacists' ability to meaningfully impact these priority clinical areas, yet this opportunity has remained untapped.

Despite a multitude of research examples and published literature on the value of pharmacies and pharmacists to improve health outcomes and save downstream healthcare dollars, pharmacists and pharmacies have yet to be directly engaged as care providers in Medicare Part B and have been omitted from existing CMS Innovation Center value-based care models. The Subcommittee should swiftly act on these key opportunities to improve outcomes, advance access, and reduce preventable healthcare spending by supporting the passage of H.R. 1770

[20] Shrank WH, Rogstad TL, Parekh N. Waste in the US Health Care System: Estimated Costs and Potential for Savings. JAMA. Published online October 07, 2019322(15):1501–1509. doi:10.1001/jama.2019.13978
[21] Viswanathan M, Golin CE, et al. Interventions to Improve Adherence to Self-Administered Medications for Chronic Diseases in the United States: A Systematic Review. Ann Intern Med. 2012. https://annals.org/aim/fullarticle/1357338/interventions-improve-adherence-self-administered-medications-chronic-diseases-united-states
[22] Watanabe JH, McInnis T, Hirsch JD; "Cost of Prescription- Drug Related Morbidity and Mortality;" Annals of Pharmacotherapy; March 26, 2018. http://journals.sagepub.com/doi/10.1177/1060028018765159
[23] Rosenbaum L, Shrank WH; "Taking Our Medicine - Improving Adherence in the Accountability Era;" New England Journal of Medicine; August 22, 2013. Shrank WH, Polinski JM; "The Present and the Future of Cost-Related Non-Adherence in Medicare Part D;" J Gen Intern Med 30(8):1045–6.
[24] Lloyd, Jennifer T., Maresh, Sha, Powers, Christopher, Shrank, WH, Alley, Dawn E; "How Much Does Medication Nonadherence Cost the Medicare Fee-for-Service Program?"; Medical Care; January 2019.

and considering subsequent opportunities to integrate community pharmacies in innovative healthcare models.

Supporting "Real PBM Reform"

PBMs' opaque and self-serving business practices, including their abuse of pharmacy performance measures in the Medicare Part D program, lead to inflationary effects on drug prices, restrictions on patient access, and unfair and below-cost pharmacy reimbursement. The ability of pharmacies to provide prescription medications and related care to patients is often controlled and manipulated by the three largest vertically integrated PBM insurers, which threatens pharmacies' viability and the patients who rely on them for care and access. A recent article in the New York Times exposes the secretive and harmful practices of PBMs that inflate prescription drug prices, limit patient choice, and force pharmacies to accept below-cost payments. The article, titled *"The Opaque Industry Secretly Inflating Prices for Prescription Drugs"*, gives an example of how a PBM required a patient in rural Middleport, N.Y. to pay for a more expensive brand-name inhaler instead of the generic one they usually get at their pharmacy. The patient could not afford the extra $60 and decided to leave without their asthma medication. This is just one of the many ways that PBMs jeopardize the health and well-being of Americans who depend on pharmacies for their prescriptions and care.[25]

America's pharmacies have also been struggling with reimbursement challenges for decades, due to or exacerbated by the absence of oversight and understanding of the competition-eroding practices of PBMs that impact timely patient access, pharmacy sustainability, and pharmacy's innovative vision to empower patients' total health and wellness. As illustrated by MedPAC, **Medicare Part D's direct and indirect remuneration (DIR) fees, or fees that PBMs claw back from pharmacies weeks or months after they pay pharmacy claims, skyrocketed from $8.7 billion (11%) in 2010 to $62.7 billion (29%) in 2021**, which is in part due to the expanded market leverage of PBM-insurers and a non-transparent pharmaceutical supply chain. As we've seen historically, these challenges could lead to beneficiary non-adherence, financial harm to beneficiaries, downstream hospitalizations resulting in increased healthcare costs, and more pharmacy closures.

NACDS applauds Chairman Wyden and Ranking Member Crapo for prioritizing this bipartisan issue of PBM reform this Congress and for your continued commitment to fight for better healthcare and lower costs for Americans. Comprehensive PBM reform is needed to help our healthcare system innovate and instill increased transparency and accountability for PBMs, to help ensure the economic viability of pharmacies, and to help foster heightened access to healthcare and improved health outcomes for the people and communities they serve.

The Pharmacy Benefit Manager Marketplace and Impact on Pharmacies

Prescriptions filled by patients who are paying cash without any form of insurance or discount card account for only about 3% of the total volume of prescriptions.[26] While approximately 91% of prescriptions filled have a payment component coming from Medicare Part D, Medicaid, or a commercial insurance plan, these plans are ordinarily administered by PBMs. The top three PBMs manage about 80% of prescription drug volume.[27] Five of the top six PBMs are owned by large national health insurers. This business environment makes it very difficult for pharmacies to negotiate fair business practices and transparency because the PBMs and health insurers have more commercial market power and leverage in the relationship due to their size and scale. This creates a one-way street with negative consequences for patients, pharmacies, employers, taxpayers, and communities – seemingly for all but the PBMs and payers.

[25] How PBMs Are Driving Up Prescription Drug Costs - The New York Times (nacds.org)

[26]Source: IQVIA, National Prescription Audit & RxInsight, June 2022; Approximately 5.4% of patients use a discount card to assist with payment.

[27]https://www.xcenda.com/insights/skyrocketing-growth-pbm-formulary-exclusions-concerns-patient-access

Retail pharmacies are in crisis, facing unsustainable financial pressures as they are increasingly reimbursed by payers below the cost of buying and dispensing prescription drugs. Dire financial pressures have forced an alarming number of pharmacies to take drastic steps, such as possibly paring back hours of operation and delaying innovative care services that otherwise could improve health outcomes. PBMs' retroactive fees and claw backs often occur weeks or months after a transaction closes, when the PBM arbitrarily decides to recoup a portion of the pharmacy's reimbursement. These fees and claw backs have made the economic viability of community pharmacies increasingly difficult, due to the unpredictability of reimbursement and the increased damage to bottom lines.

PBM tactics may be contributing to pharmacy closures, which leads to a reduction in access to vital healthcare services, especially in rural areas where options are already limited. Communities across the nation depend on neighborhood pharmacies among all healthcare destinations. **A recent study published in the Journal of the American Medical Association found that pharmacy closures led to a significant drop in medication adherence for older adults taking cardiovascular medications, which has obvious, negative implications for patient health and healthcare costs.** Preserving patient access to robust pharmacy provider services and networks like health screenings, disease state management, vaccinations (e.g., flu, COVID-19), patient counseling, medication adherence, and testing— all in addition to essential medication access — can help improve health outcomes and generate overall healthcare savings for Americans.

We look forward to continuing to work with the Subcommittee and other Members of Congress to stop the manipulation by PBMs both domestically and internationally once and for all because the clock is ticking. Without PBM reform, we can expect there to be continued increases in patients' medication costs, limits on patients' choice of pharmacies, restrictions on access to medicines that are right for patients, and jeopardy of the sustainability of the pharmacies and pharmacy teams on whom patients rely.

To that end, please see below **NACDS' Principles of PBM Reform** to increase transparency and ensure comprehensive reform of harmful PBM tactics and practices:

I. Help to Preserve Patient Access to Pharmacies by Addressing PBM's Retroactive Pharmacy Fees

Retroactive DIR Fees/Claw Backs – Pharmacy access can be undermined when health plans and their middlemen, PBMs, arbitrarily "claw back" fees retroactively from pharmacies weeks or months after a claim has been adjudicated/processed. This manipulation of pharmacy reimbursements may diminish access to care *(e.g., pharmacies being forced to close their doors or pare back hours and healthcare services)* when PBMs are unpredictable, not transparent, and payment falls below a pharmacy's costs to acquire and dispense prescription drugs. Policymakers should consider enacting laws that prohibit payers or PBMs from retroactively reducing and/or denying a processed pharmacy drug claim payment and obligating them to offer predictable and transparent pharmacy reimbursement to better protect pharmacies as viable and reliable access points of care for patient services.

II. Provide Fair and Adequate Payment for Pharmacy Patient Care Services

Reasonable Reimbursement & Rate Floor – Pharmacy access remains at risk when PBMs reimburse pharmacies below the cost to acquire and dispense prescription drugs. Pharmacy reimbursement that falls below the costs to acquire and dispense prescription drugs threatens future sustainability for pharmacies to continue providing valuable medication and pharmacy care services to communities. Policymakers should enact laws to adopt a reimbursement rate floor that requires PBMs to use comprehensive reimbursement models that are no less than the true cost to purchase and dispense prescription drugs to help maintain robust public access to pharmacies.

Standardized Performance Measures – A crucial part of comprehensive DIR fee reform is advancing pharmacy quality that improves outcomes for beneficiaries and drives value in care which are essential to controlling costs in the healthcare system. Arbitrary performance measures developed by PBMs assess the performance of the pharmacy without pharmacies' input and create a moving target for pharmacies to show value and improve health outcomes. Measures vary across the various plans and dictate DIR fees (or claw backs at the State level) imposed on pharmacies, as well as help create substantial system dysfunction and unnecessary spending in the Part D program. Policymakers should enact laws to standardize PBMs' performance measures for pharmacies to help set achievable goals for pharmacies before signing a contract to promote harmonization in the healthcare system and improvements in health outcomes.

III. Protect Patient Choice of Pharmacies

Specialty – Some PBMs require patients with rare and/or complex diseases to obtain medications deemed "specialty drugs" from designated pharmacies or mail-order pharmacies which limits patient choice to their convenient local neighborhood pharmacies where specialty drugs can also be filled. Prescription drugs should not be classified as "specialty drugs" based solely on the cost of the drug or other criteria used to limit patient access and choice—instead, should focus on clinical aspects such as requiring intensive clinical monitoring. Policymakers should enact laws to establish appropriate standards for defining and categorizing specialty drugs to ensure comprehensive and pragmatic patient care and access and prohibit PBMs from steering patients to designated pharmacies, including those owned by the PBMs, for their prescription needs.

Mail Order – Medication access and care can be weakened when PBMs manipulate the system by requiring patients to use mail-order pharmacies only. Some plans impose penalties such as higher copays or other financial disincentives for choosing a retail pharmacy instead of a mail-order pharmacy which is often owned by the PBM. Policymakers should support patient choice and access by enacting laws to prohibit PBMs from requiring or steering patients to use mail-order pharmacies.

Any Willing Pharmacy - Due to PBMs' network and contract barriers, pharmacies willing and ready to serve patients may be ineligible to provide important pharmacy services and patients may experience unnecessary delays and interruptions in patient care. Patients should have the choice and flexibility to utilize the pharmacy that best meets their healthcare needs. Policymakers should enact laws that require PBMs and plans to include any pharmacies in their networks if the pharmacy is willing to accept the terms and conditions established by the PBM to help maximize patient outcomes, and cost savings and ensure patient access to any willing pharmacy of their choice.

IV. Enforce Laws to Stop PBM Manipulation and Protect Pharmacies and Patients

Audits – PBMs routinely conduct audits to monitor a pharmacy's performance and reverse or claw back pharmacy payments when there are alleged issues with a particular pharmacy claim. PBM audits interrupt the pharmacy workflow, can extend wait times, and detract attention from the quality of care patients receive. Policymakers should enact laws that support fair pharmacy audit practices to ensure timely patient care delivery at community pharmacies and bring efficiency, transparency, and standardization to the PBM audit process.

Oversight Authority – There are growing concerns that pro-pharmacy and pro-patient legislative successes might be undercut if PBMs fail to comply with such laws and/or states fail to fully enforce these laws. Such failure could significantly impact pharmacy reimbursement and overall patient access. Policymakers should establish and enforce laws already on the books to regulate harmful PBM

reimbursement practices that may harm patients and the healthcare system as we know it, especially at the pharmacy counter, and empower state regulators to do the same to enforce PBM transparency and fair and adequate pharmacy reimbursements.

Conclusion

NACDS appreciates the opportunity to submit our feedback to help inform the Subcommittee's work to improve healthcare quality and value for the American people. Importantly, NACDS urges the Subcommittee to support the passage of H.R. 1770, in addition to comprehensive PBM reform. We encourage Congress to better leverage the expertise of pharmacists and pharmacies in your efforts to improve healthcare outcomes, access, and value, and to reduce preventable, downstream healthcare spending. For questions or further discussion, please contact NACDS' Sara Roszak, Senior Vice President, Health and Wellness Strategy and Policy at sroszak@nacds.org or 703-837-4251.

NARA
The National Association of Rehabilitation Providers and Agencies

July 10, 2024

United States House of Representatives
Ways and Means Committee
Subcommittee on Health
Hearing on Improving Value-Based Care for Patients and Providers

Electronically submitted: wmsubmission@mai.house.gov

Dear Chairman Jason Smith and Health Subcommittee Chairman Vern Buchanan,

We thank you for the opportunity to provide our perspective based on the June 26, 2024, Ways & Means Health Subcommittee hearing entitled, "Hearing on Improving Value-Based Care for Patients and Providers".

The National Association of Rehabilitation Providers and Agencies (NARA) represents over 90,000 physical therapy, occupational therapy and speech-language pathology providers through our member organizations who provide therapy across the United States to Medicare beneficiaries. They provide therapy in all settings across the continuum such as outpatient clinics, skilled nursing facilities, assisted living facilities, hospital outpatient, hospital inpatient, in the beneficiary's home, and in retirement communities. As a member-driven organization, NARA promotes the growth and business success of physical therapy, occupational therapy, and speech-language pathology providers through education, support, and advocacy. NARA's membership demographics give us a unique insight into payment and quality programs across the full healthcare landscape.

Introduction

NARA members are very supportive of value-based care for patients and providers, and in fact have provided education and opportunities for our members to learn how to effectively transition out of a fee-for-service model of care. Since many of our members work in collaboration with other health care providers it is essential that we understand how to contribute, but also that we have an opportunity to demonstrate the value we can bring to the health care system. This context frames our comments below. First, we discuss opportunities to increase our participation in quality programs and the influence that the stability of the reimbursement system has on our ability to participate. Next, we provide examples of how NARA members could provide solutions to the health care deserts in rural and underserved areas of the country. Finally, we provide evidence that supports the fact

that early referral to rehabilitation services can have real downstream effects through reducing costs and improving healthcare outcomes.

Quality Programs and Reimbursement Stability

We agree with Chairman Buchanan's statement that the fee-for-service (FFS) system is not working, and value-based care is better for the patients and generates savings for public and private payers. Rehabilitation providers are generally considered an ancillary provider, but we work collaboratively with other health care providers such as: primary care physicians, orthopedic surgeons, dentists, physician assistants, nurse practitioners, and podiatrists. The intent of the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015 was to provide a path to transition from a fee-for-service to a fee-for-value payment system in healthcare. The Merit-Based Incentive Payment System (MIPS) established by MACRA became effective January 1, 2017. MIPS rolled three existing quality and value reporting programs into one program. Eligible Medicare Part B clinicians are scored annually on their participation in 4 categories: Quality, Promoting Interoperability, Improvement Activities and Cost. Clinicians receive a score on a 100-point performance scale which results in a Composite Performance Score (CPS). The CPS is then used to determine a clinician's eligibility for a bonus in a subsequent payment year. Unfortunately, most physical therapists (PT), occupational therapists (OT) and speech-language pathologists (SLP) are excluded from the program. Currently, those therapists who provide outpatient therapy services under Medicare Part B and bill through **rehabilitation agencies, skilled nursing facilities (SNFs), and hospital outpatient departments are unable to participate in MIPS** because they bill on the UB-04 Institutional Claim form (CMS 1450). Per the MedPAC report on outpatient therapy services payment system in November 2021,[1] 61% of therapy spending for Part B services was submitted by providers on the UB-04 (CMS 1450) form. As a result, MIPS applies to less than 39% of Part B therapy providers. **NARA recommends modifying the program to allow the vast majority (61%) of therapy providers to participate in MIPS. This would give access to more providers to participate in value-based care through a mechanism already established by the Centers for Medicare and Medicare Services (CMS).**

Conversely, rehabilitation providers and other providers who bill for services under their own NPI on the CMS 1500 form are eligible to participate in MIPS. Depending on the volume of Medicare FFS services a therapist bills in a 12-month period, they may be deemed a provider who is required to participate or one who can volunteer to participate. Many of these providers find the overall level of effort and cost to participate are not worth the 1-2% potential bonus in their payments. The cost to participate in and comply with MIPS can be significant. According to study from 2019, on average it cost practices nearly $13,000 per physician to participate in MIPS in 2019, with even greater costs incurred by smaller

[1] https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_opt_final_sec.pdf

practices (Khullar et al. 2021). However, another study found that surgeons participating in the 2021 MIPS performance year found that most surgeons received bonus payments, but they only averaged $1,341 (Maganty et al. 2024) per surgeon. Based on the cost and the payments sited in these two studies, the time and financial costs to participation are not close to being offset by the bonus. The costs to participate include staff time to understand the requirements of the program which change annually, substantial payments to registries to report the quality measures, use of certified electronic health record technology (CEHRT), and provider training to ensure successful reporting. For those therapists deemed to be required to participate but choose not to participate after weighing the return on investment, they become subject to a penalty of up to 9% on their subsequent FFS payments.

Another obstacle many providers, such as rehabilitation providers, experience is the inability to obtain points in the Promoting Interoperability performance category which makes up 25% of the score, as they do not utilize a CEHRT, putting them at greater risk of being penalized. The cost to change EHRs, train providers and back-office staff, and do a major overhaul on current documentation processes is substantial and simply out of reach for most providers. We want to be clear, however, that **NARA supports interoperability and recognizes the value it has in reducing administrative burden** for providers while improving the overall experience for providers and patients. During the hearing, Matthew Philip (Duly Health & Care) testified that value-based care requires a large amount of paperwork undermining the relationship between the provider and the patient and by mitigating data lags, fraud could be prevented, and outcomes improved. We agree with Mr. Philip's statement, but also want to note that there remain significant disparities across provider types as to their ability to utilize interoperable solutions.

An additional barrier to MIPS participation for rehabilitation providers is the lack of applicable quality measures applicable to the rehabilitation specialty. Many of the available quality measures are focused on primary care. However, to successfully report in MIPS, a clinician must choose at least 6 quality measures to report over a 12-month performance period. This has caused rehabilitation providers to "force" quality measures to fit within their practice population or risk a negative adjustment. We believe that while this was likely not the intent of the MIPS system, it has effectively resulted in a significant number of clinicians reporting measures just for the sake of reporting, without meaningfully capturing the value of rehabilitation services. Additionally, the limited number of available quality measures makes it difficult to appropriately compare quality measures across similar clinicians **NARA asks that CMS work with interested parties to identify measurement gaps within the rehabilitation specialty so that more appropriate and meaningful quality measures that are more applicable to rehabilitation providers are adopted into the MIPS program.**

NARA believes any value-based program should include the following core components: (1) a cost savings component; (2) standardized measures across providers and settings; (3) does not require substantial costs to participate; and (4)

provides incentives that justify providers' costs and administrative burden to participate.

Finally**, we recommend Congress direct CMS to analyze MIPS data that has already been collected and share a report with the healthcare industry.** MIPS has been in existence for over 7 years, and yet there has been minimal analysis of the data collected and shared with providers to determine the success of the program. De-identified data should also be made available to providers to perform their own analysis. **NARA supports Ranking Member Lloyd Doggett's comments that we need to define what value means and then ensure providers are collecting the "right" data and analyzing it effectively.** Without analyzing the 7 years of MIPS data, we have no insight into whether it is working as intended to improve the quality and value of care.

In summary, the MIPS system is based on winners and losers in the points system. If rehabilitation providers are unable to achieve 100% of the points, which they are not able to in calendar year 2024 since they earn zero points in the CEHRT category, they have a greater chance of losing and being penalized with a negative payment adjustment. Since rehabilitation providers have seen reimbursement cuts of nearly 30% over the past 10 years and have no relief in sight, another cut makes Medicare beneficiaries' access to these vital services unsustainable.

Some immediate actions Congress can take to support Medicare payment reform in the short term to ensure providers are reimbursed appropriately for the services they provide which will go a long way in maintaining access to care for patients. These are:

- Pass the Strengthening Medicare for Patients and Providers Act (HR 2474) which would modify certain adjustments to payment amounts under the physician fee schedule based on a service's relative value, a conversion factor and a geographic adjustment factor.
- Pass the Physician Fee Schedule Update and Improvements Act (HR 6545) which would enact reforms by extending Medicare payment floor for work geographic index to January 1, 2025; update the budget neutrality threshold from $20 million to $53 million for 2025 and provide an inflationary adjustment for 2030 and every five years thereafter; and update direct costs used to calculation the practice expense relative value at least every five years.
- Pass the Provider Reimbursement Stability Act (HR 6371) which would reform the Medicare Physician Fee Schedule budget neutrality requirements by raising the budget neutrality threshold from $20 million to $53 million and increasing it every five years by the cumulative increase in the Medicare Economic Index; updating practice expense inputs, such as clinical labor costs, at least every five years; and limiting the year-to-year conversion factor variance to no more than 2.5% each year.

- Pass the REDUCE Act (HR 7279) which would clarify a new streamlined model that when outpatient therapy services are provided under a physician's order, the plan of care certification requirement will be deemed satisfied if the qualified therapist simply submits the plan of care to the patient's referring physician within 30 days of the initial evaluation; therapists would no longer need to obtain a signed plan of care within 30 days from the referring physician.

Rural and Unserved Areas

During this hearing, Sarah Chouinard (Main Street Health) noted that there are approximately 85% fewer specialists in rural areas, yet this population is at the biggest risk due to being economically disadvantaged and geographically isolated. This combination frequently leads to these individuals receiving fewer preventative services and delaying care when they do need medical care, which results in a sicker, more chronically ill population. **Rehabilitation providers, NARA members, could help to address these disparities but are often unable to break into these areas due to administrative or regulatory reasons.**

Some immediate actions Congress can take to help reduce this situation is by passing the following bills that have been introduced in the 118th Congress:

- Expanded Telehealth Access Act (HR 3875) which would instruct CMS to permanently adopt the current temporary waiver of restrictions on Medicare payment for services delivered via telehealth by physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, and speech-language pathologists.
- The EMPOWER Act (HR 4878) which would remove the current direct supervision requirement for physical therapist assistants (PTA) and occupational therapy assistants (OTA) providing Medicare Part B services in a private practice setting.
- The SAFE Act (HR 7618) which would ensure that beneficiaries who were identified by their physicians as having experienced a fall in the year prior to their Initial Preventive Physical Examination (Annual Wellness Visit) would be referred to a physical therapist for falls screening and preventive services.
- The Physical Therapist Workforce and Patient Access Act of 2023 (HR 4829) which would allow physical therapists to participate in the National Health Service Corps Loan Repayment Program, helping to ensure that individuals in rural and underserved areas have access to need therapy care.

Early Referral to Rehabilitation Providers Can Save Money

There is evidence to support that early referral to physical therapy results in a lower risk of subsequent medical service utilization among patients after an episode of acute low back

pain relative to those who received physical therapy (PT) at later times[2]. In 2022, a study[3] found early PT groups had lower incidence of advanced imaging, injections, chiropractor visits, orthopedic surgeon & pain specialist visits, and emergency room visits compared with patients who did not receive early PT. This early intervention with PT found that patients spent on average $2,700 less on low back pain-related care than those who received delayed PT during the 18 months after injury[4].

In September 2023, the American Physical Therapy Association (APTA) published the "The Economic Value of Physical Therapy in the United States" which analyzed 8 separate conditions typically treated by physical therapists and physical therapist assistants from knee osteoarthritis to cancer rehabilitation. The result was net savings ranging from $2,144 for falls prevention to $39,533 for carpal tunnel syndrome treatment with the conclusion that these results demonstrate that when medically appropriate, the widespread use of the selected physical therapy services would deliver both health and economic benefits to patients and the United States health care system. These results are not surprising considering physical therapists do not prescribe opioids, order imaging, or treat patients with injections or surgery[5]. This aligns with statements from Chair Vern Buchanan that the U.S. is spending more money, yet we are still sicker than anybody else, and that everyone should be the "CEO of their own health." Physical therapy for musculoskeletal conditions is lower risk and utilizes exercise, manual therapy, and functional activity training as its primary interventions. Additionally, physical therapy and occupational therapy provide education and recommendations for an ongoing healthy lifestyle resulting in significant cost savings for the system and patients.

Some immediate actions Congress can take to ensure early intervention for physical therapy, occupational therapy, and speech-language pathology that will prevent the need for patients to need higher cost services are:

- Pass the SAFE Act (HR 7618) which would ensure that beneficiaries who were identified by their physicians as having experienced a fall in the year prior to their

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[2] Gellhorn AC, Chan L, Martin B, Friedly J. Management patterns in acute low back pain: the role of physical therapy. Spine (Phila Pa 1976). 2012 Apr 20;37(9):775-82. doi: 10.1097/BRS.0b013e3181d79a09. PMID: 21099735; PMCID: PMC3062937.

[3] Marrache, M., Prasad, N., Margalit, A. *et al.* Initial presentation for acute low back pain: is early physical therapy associated with healthcare utilization and spending? A retrospective review of a National Database. *BMC Health Serv Res* **22**, 851 (2022). https://doi.org/10.1186/s12913-022-08255-

[4] Fritz JM, Childs JD, Wainner RS, Flynn TW. Primary care referral of patients with low back pain to physical therapy: impact on future health care utilization and costs. Spine (Phila Pa 1976). 2012;(37):2114–21.

[5] The Economic Value of Physical Therapy in the United States. Available at: https://www.valueofpt.com/

Initial Preventive Physical Examination (Annual Wellness Visit) would be referred to a physical therapist for falls screening and preventive services.

- Pass the Personal Health Investment Today, or PHIT, Act (HR 1582) which would allow a medical care tax deduction for up to $1,000 (or $2,000 for joint return or head of household) of qualified sports and fit expenses per year. This would incentivize patients to be healthier physically.

Conclusion

NARA supports value-based care payment models. However, we strongly believe the model should be inclusive, streamline data collection, and avoid being so cost prohibitive that it limits provider participation. The program must include methods to measure downstream cost and quality measure analysis that promote peer comparison across patient populations and diagnostic groups. Permanent Medicare payment reform should be passed rather than temporary one- or two-year patches. It is challenging for providers to plan and build for the future in operations and patient care when temporary fixes promote uncertainty. Telehealth is a great example of the adverse effect of these patches. It requires an investment in infrastructure that providers hesitate to commit to when access is temporary. Congress and CMS can act now to pass legislation that has been introduced (and listed above) to decrease administrative burden, reform payment and make permanent the ability for rehabilitation providers to deliver telehealth and other innovative programs.

We thank you for the opportunity to provide comments related to this hearing. Should you have any questions concerning these comments, please contact Christie Sheets, NARA Executive Director at christie.sheets@naranet.org.

Respectfully submitted,

Kelly Cooney, M.A., CCC-SLP, CHC
President
National Association of Rehabilitation Providers and Agencies

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Purchaser Business Group on Health

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July 10, 2024

The Honorable Jason Smith
Chairman
Committee on Ways and Means
1100 Longworth House Office Building
Washington, DC 20515

The Honorable Richard Neal
Ranking Member
Committee on Ways and Means
1100 Longworth House Office Building
Washington, DC 20515

Dear Chairman Smith, Ranking Member Neal, and members of the Committee,

Thank you for your interest in improving value-based care for patients and providers. The Purchaser Business Group on Health ("PBGH") applauds your efforts to gather information on how Congress and the Center for Medicare and Medicaid Services ("CMS") can improve our value-based care models to ensure our investments improve outcomes and reduce costs for patients. While the Innovation Center has seen limited success, in the employer market we have seen how properly designed models can reduce costs for patients, employers, and the federal government while improving care quality for both Medicare and non-Medicare patients.

PBGH is a nonprofit organization that represents 40 public and private purchasers that collectively spend $350 billion annually on health care and cover over 21 million employees and their beneficiaries. PBGH's mission is to advance a health care system that delivers quality outcomes and a seamless patient experience that is equitable and affordable for consumers and purchasers. Our goal is to be a change agent by creating and enabling increased value in the health care system through purchaser collaboration, innovation, and action and through the adoption of best practices. PBGH's members represent diverse private sector industries as well as public sector purchasers.

The current health care system has incentivized *sick* care over *health* care, increasing costs for taxpayers, workers, and employers. We support efforts to transition to a system that emphasizes patient health and rewards providers for keeping patients healthy. At PBGH, we believe primary care is essential to a healthy workforce and employees' access to a high-value health care system. Research has proven that robust primary care systems can lower overall health care utilization, decrease rates of disease and mortality, and increase the use of preventive services, enabling a true *health* care system. However,

primary care in the US is chronically underfunded; while primary care accounts for 55% of visits in the US, it receives only 4-7% of health care dollars, on average.[1]

That is why we have invested in advanced primary care ("APC") models that redirect existing health care spending to high-quality, equitable and evidence-based care while holding total cost flat.[2] PBGH first launched its primary care improvement initiative in 2014. From 2014 – 2019, this CMS-funded multi-stakeholder driven quality program helped avoid nearly 50,000 hospital bed days, reduced emergency room utilization and generated about $186 million in total savings.[3]

California Advanced Primary Care initiative

Building on that progress, PBGH's California Quality Collaborative and the Integrated Healthcare Association launched the California Advanced Primary Care initiative, a multi-payer effort where Aetna, Aledade, Anthem Blue Cross, Blue Shield of California, Health Net, Oscar, and United agreed to strengthen primary care together from 2022-2025. Through this initiative, we have developed a common value-based primary care model that provides prospective and performance-based payments, with the goal of increasing total potential payment for primary care providers by 30%. On October, 1 Aetna, Blue Shield of California, and Health Net will launch a demonstration project to test the model in up to 30 independent primary care practices throughout the state. This demonstration project is unique because the plans are funding technical assistance and a common reporting platform to help the practices get the most out of the new payment model.

In January 2022, we also launched the Advanced Primary Care Measurement Pilot, which brought together four large purchasers in California, including California Public Employees' Retirement System ("CalPERS"), Covered California, eBay and San Francisco Health Services System agency, to test our advanced primary care measures for practice-level performance at the state level. The pilot, which concluded in 2023, is an example of ways to ease the administrative burden on providers who wish to participate in value-based care models, as it relies on existing data aggregated across purchasers and health plans to provide a more complete picture of individual practice performance. Through these efforts we created an Advanced Primary Care Measure Set of pediatric and adult quality measures categorized into five quality domains: health outcomes and prevention, patient reported outcomes, patient safety, patient experience, and high value care.[4]

[1] PBGH (Dec. 2023) "End-of-Year Report: California Advanced Primary Care Initiative" *CQC* [Link]

[2] PBGH defines APC as including integrated mental health care and access. See PBGH's APC attributes here.

[3] PBGH (Dec. 2020) "Lessons in Scaling Transformation: Impact of California Quality Collaborative's Practice Transformation Initiative" *CQC* [Link] at **pgs. 11, 22**.

[4] PBGH (Apr. 2021) "Advanced Primary Care Measure Set" *CQC and IHA* [Link] *(Revised Nov. 2023)*

We are excited about the future of advanced primary care and hope our learnings can inform others and shape future policy discussions as Congress looks to re-examine the Medicare Access and CHIP Reauthorization Act ("MACRA") and the Medicare Physician Fee Schedule ("MPFS") to better align around value-based care.

High value maternity care

While PBGH believes primary care is the lynchpin to successful uptake of value-based care, we have seen other examples of how coordinated, patient-centered care can lower costs, such as in maternity care. PBGH works with employers, providers and health plans to develop a maternity care system that embraces high-value services, reduces outcomes variation and incentivizes safety across the prenatal, perinatal and postpartum care continuum. PBGH's Comprehensive Maternity Care Workgroup is working to define comprehensive maternity care which ensures high-quality, equitable maternal and infant health outcomes. Some of these care attributes include:

- **Team-based**: Patients receive care from a primary maternity care provider, such as an OBGYN, midwife or family medicine doctor, who is supported by and supports members of an interdisciplinary care team, such as doulas, mental health specialists, maternal fetal medicine specialists, lactation consultants, pediatricians, family planning specialists, primary care providers or community health workers. Under the direction of the maternity care provider, care team members communicate and coordinate to address patients' needs and provide care appropriate to their training and expertise.

- **Integrated**: Patients' physical, mental and social needs are assessed, screened and communicated across their maternity, pediatric and primary care teams and with other care providers and settings. Care teams reach out proactively to identify and address patients' care needs and to offer additional support for patients at high or rising risk. Health information and care activities outside of the maternity care team are integrated into patients' care plans

- **Whole-person**: Maternity care should focus not just on the maternity episode but also consider other factors, including social determinants of health, to promote health and treat diseases. Maternity providers should coordinate with primary care, mental health specialists and social services to provide special consideration for high-risk patients with mental health needs and/or substance use disorders. Comprehensive maternity care includes restoring health, promoting resilience and preventing diseases in the lives of the birth participant, children and supporting spouse/family.

Collaborative, integrated team-based care improves health outcomes and the patient experience for mothers and babies. Not only does team-based care introduce a wider variety of perspectives and backgrounds, but it also increases the likelihood that the patient's wishes are at the center of care, enhancing the patient experience and improving health equity. A team-based care model that allows both physicians and midwives to work at the top of their license is likely to improve collaboration and satisfaction in practice for physicians, preventing burnout.

In May 2024, PBGH and our members released our Maternity Care Common Purchasing Agreement to improve outcomes for mothers and newborns. This Agreement embodies a consensus among employers and public purchasers on what constitutes high-value, affordable and equitable maternity services and establishes specific expectations for health plans and providers. A common purchasing agreement facilitates adoption by diverse public and private purchasers and offers an example that CMMI may wish to adopt to expand as it seeks to expand its impact.

PBGH also called attention to the vital importance of strengthening a focus on equity in maternal health in its recent comments to CMS's IPPS rule.[5] Our comments highlight the critical role equity data play in improving maternal health. In May 2023, PBGH released its Comprehensive Maternity Care Standards and Measure Set, articulating attributes that define comprehensive maternity care which ensures high-quality, equitable maternal and infant health outcomes. In addition to ensuring hospitals have a streamlined, meaningful measure set to focus on, it is critical to ensure outcomes and quality measures are stratified by race, ethnicity and language ("REaL") and sexual orientation and gender identity ("SOGI") data where available. This is an important step to ensure targeted interventions to improve inequities.

Policy Priorities to Advance Value-Based Care

PBGH envisions a future of health care that is patient-centered, team-based, and rewards providers based on the value of care, not the number of services provided. But if we are to promote meaningful change in how we pay for health care in the US, employers and health care purchasers must be part of the solution. Every day our members are innovating to create models that are patient-centered and focus on the value of care. They are finding success in improving the health of their members and lowering the cost of doing so. A functional market does not – and cannot – require the world's largest employers to absorb annual cost increases of 4 – 20% with no corresponding increase in quality or outcomes. We believe that removing barriers to high-value care and innovation will benefit the entire health care system. To do this, we must:

[5] PBGH (Jun. 10, 2024) Comments to CMS on Maternal Health in re: 2024 IPPS Rule [Link]

1. Enable purchasers to innovate by removing barriers for employers and other private purchasers to advance efforts in value-based care and contracting. PBGH supports policies and interventions that enable private purchasers to innovate, remove barriers to employers and other private purchasers to advance efforts in value-based care and contracting, increase competition, reduce costs and drive quality and patient satisfaction. PBGH's member organizations demonstrate an unwavering commitment to innovative benefit offerings and purchasing high-quality care. This includes:

- embracing alternative payment models that depart from fee-for-service and incentivize physicians to provide valuable, not unnecessary or low-value, care;
- prioritizing advanced primary care by building the infrastructure when health insurers will not, to lower their population's cost of care and improve health;
- creating new direct payment models for rural hospitals where employers band together to pay hospitals directly to keep critical departments open and viable;
- forming direct contracts with large, integrated health systems around the country, eliminating administrative waste, streamlining care delivery and sharing the financial gains with employees through no copays, no cost-sharing on generic drugs, HSA contributions, and other benefit design innovations.

We strongly encourage Congress to eliminate federal and state barriers that limit or discourage participation in alternative payment models across the employer market. Some employers are being hindered from adopting value-based care at the state level due to a complex patchwork of regulatory oversight for health insurance that has evolved over time in service of several goals, some of which can be at odds with each other. Easing federal and state restrictions to alternative payments models for employers and others in the commercial market will promote multi-payer collaboration. Specifically, purchasers need more clarity from the Department of Labor on capitated payment arrangements in self-funded plans in California, specifically, in order to move forward with the promise of value.

Likewise, we strongly encourage Congress to remove existing restriction on first dollar coverage for primary and preventive care. We have seen firsthand how increased access to primary care improves the health and wellness of patient populations and existing policies can present barriers to this necessary care.

We also believe there is an opportunity for CMS to better align with purchasers through organizations like PBGH and our partners to ensure we are all rowing in the same direction. This can be accomplished by creating pathways to engage private purchasers in CMMI models to promote multi-payer collaboration and encourage meaningful public-

private partnerships that improve quality, reduce costs, and move the whole system forward. Under the current landscape, where providers have significant market power, there is little incentive to transition toward value-based payment, especially with smaller employers. Collaboration between CMMI and large employers is therefore a significant opportunity.

Furthermore, we urge Congress to support employers' efforts to make use of existing price transparency data, which in their current form require a tremendous amount of technical expertise to be made useful and actionable. PBGH has spent considerable time and effort scouring the data vendor marketplace on behalf of our members to better understand if, and how, data vendors are using the new health care price transparency data. We have found that few data vendors are incorporating both into their work. PBGH is seeking to change that by gathering together over half a dozen jumbo employers and public purchasers to embark on a joint transparency data project. However, this effort has proven exceptionally difficult as the existing data sets are at an immature stage and require significant resources to access and analyze. This presents a barrier for smaller employers to make use of the full suite of transparency data and we urge Congress to make a public financial investment in helping employers reduce their health care costs by supporting data transparency work. This could be done through 501(c)(3) non-profit entities like PBGH who coordinate, support, and provide technical assistance to employers in this pioneering work.

In addition, we believe Medicare and Congress should work together to authorize payment models and increase payment rates for advanced primary care models that achieve high quality outcomes and reduce total cost of care. MedPAC and other experts have observed that certain procedures and specialty services are overpriced, based on the relative value units (RVUs) used to calculate payment rates to physicians. Congress and HHS should consider structural and process changes to correct this imbalance.

2. Improve and build on price transparency efforts to include actionable and streamlined quality metrics and data standards. To truly achieve value-based care, we need robust and aligned quality data – not just price data – across all payers. PBGH is a national leader in redesigning how quality is measured and reported as the basis of a transformed, patient-centered health care system. Whether helping patients and employers compare providers and health plans, assessing patient experience and outcomes, or quantifying performance for specific interventions and procedures, PBGH's efforts are designed to increase accountability and improved value across the health care continuum. As mentioned above, PBGH's Comprehensive Maternity Care Workgroup is defining comprehensive maternity care purchasing standards, which ensure high-quality, equitable maternal and infant health outcomes.

Full transparency on prices, quality and equity is needed across providers for purchasers to ensure value for their employees, as well as standardized measures of quality, patient experience, appropriateness, and total cost of care. These data sets are invaluable to assess the potential impact of proposed transactions. As such, we support many of the transparency policies contained within the "Lower Costs, More Transparency Act" (H.R. 5378) passed out of the House on December 11, 2023, and commend the committee for its leadership. This includes codifying and expanding federal price transparency rules; ensuring that health plan fiduciaries are not contractually restricted from receiving cost or quality of care information about their plan; [6] increasing transparency into hospital outpatient billing practices; and correcting Medicare payment discrepancies. Similarly, we strongly support policies that require transparent PBM reporting to plan sponsors, but urge the committee to extend spread pricing prohibitions into the commercial market and take up other efforts to lift the veil on PBMs and other service providers to ensure compensation practices are fully exposed, so employers can ensure full line of sight into contracts and spending to better drive value for employees and beneficiaries.

We also encourage Congress to consider more granular transparency, including data reporting by provider quality metrics at the brick-and-mortar level, which truly shine a light on the quality of care that a patient can expect to receive. Finally, we urge additional transparency into health care industry transactions and ownership. This is vital in understanding the impact of the corporate transformation of U.S. health care. Purchasers and patients deserve transparency into the ownership of the places where they are seeking and purchasing care and the impact on quality, costs and access. To do this, it is critical to expose the chain of corporate ownership and web of financial interests that are now almost totally opaque to patients, purchasers, policymakers, researchers, and regulators. The inclusion of only price and billing transparency (as seen in the House-passed Lower Costs More Transparency Act), misses a key opportunity amid an increasingly consolidated health care landscape. Ideally, ownership transparency would involve the development of a modern data system to collect data and the identity and attributes of entities with an ownership stake in health care facilities and track changes resulting from horizontal and vertical mergers, acquisitions, and joint ventures between health systems, health insurers, retailers, and PE firms. [7]

We believe that moving to value-based care will serve as another key lever to reduce the incentives for consolidation, as our fee-for-service system incentivizes profit-minded

[6] On this vital point, specifically, PBGH strongly supports language in the Health Care PRICE Transparency Act 2.0 (S. 3548). While the Senate bill is narrower in scope than the Lower Costs, More Transparency Act, its provisions for employer data access are stronger and contain more specific requirements that would greatly enhance the ability of employers to drive value in their health care purchasing practices. For these reasons, PBGH supports the Senate bill's language on data access and price transparency be adopted in (reconciled with) the House bill.

[7] Singh and Brown (Sep. 23, 2023) "The Missing Piece In Health Care Transparency: Ownership Transparency" *Health Affairs* [Link]

companies to drive utilization of high-cost, sometimes lower-value services, and undermines the utility of services such as primary care. PBGH is working with our members to embrace alternative payment models that depart from fee-for-service, align incentives among physicians and hospitals, and incentivize physicians to provide valuable, not unnecessary or low-value, care. PBGH has also launched a novel transparency data demonstration project, which will home in on key regional markets around the country (where our members have sufficient headcount) and combine the new transparent data sets with employers' respective claims price and quality data, to provide each employer with insights into how their networks and plan design stack up against the potential within their market.

3. Reduce anti-competitive negotiation and contracting practices. Finally, we urge Congress to take action to address anti-competitive negotiation and contracting practices that can limit purchasers and employers' options in their pursuit of value-based models that will achieve lower cost, high-quality care.[8]

We strongly support legislation at the federal and state levels that would remove gag clauses on the sharing of price and quality information by providers; ban anti-competitive contracting practices including "anti-tiering" or "anti-steering" clauses; ban "all-or-nothing" contracting which demands higher payment rates for the entire system; and other anti-competitive clauses such as most-favored nation ("MFN") clauses, leveraged by dominant insurers to ensure they receive the lowest prices, often to the detriment of smaller purchasers. PBGH President and CEO Elizabeth Mitchell has testified before the Senate Committee on Health, Education, Labor and Pensions on the importance of advancing these provisions.[9] In addition to such anti-competitive behavior being used to gain market power and raise prices, it also hinders purchasers' ability to create innovative, high-value programs such as high-performance networks, which incentivize patients to use specific providers and facilities with higher quality and lower prices.

States have also moved to restrict the anticompetitive contracting practices at the heart of California's complaint against Sutter. Although state attorneys general may be able to prosecute anticompetitive behavior – such as the use of anticompetitive contracting provisions by dominant systems – legislation prohibiting these contract clauses is necessary to improve state enforcement authority and disrupt the distorted bargaining dynamic. For example, Michigan and North Carolina ban specific anti-competitive practices, while Massachusetts has empowered an agency to publicly review contracts for

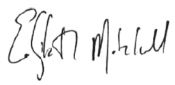
[8] PBGH also recently submitted comments to the Administration to this effect, in response to a Tri-Agency request for information issued by the DOJ, FTC, and HHS. See PBGH's detailed comment letter here.

[9] Mitchell (Jun. 18, 2019) "Testimony to the U.S. Senate Committee on Health, Education, Labor & Pensions on the Lower Health Care Costs Act" [Written] / [Live Recording]

monopolistic terms on an ongoing basis. Rhode Island and Colorado have capped rate increases exceeding specified growth targets to impede unequal bargaining power that can lead to market failures.[10] While Sutter removed many of these anti-competitive terms from its contracts, they are still being used as a tactic in private provider-insurer negotiations. Thus, any state or federal legislation must aim to address not just anti-competitive language in contracts but also underlying anti-competitive behavior throughout the negotiations process. More recent state legislation – such as that in Washington state (HB 2066) – has aimed to enable states to regulate what health plans do through contracts as well as other anti-competitive behavior.

Thank you again for the opportunity to comment, and we look forward to working with the committee on these important issues. If you have any questions or wish to collaborate further, please contact Elizabeth Mitchell, President and CEO, at emitchell@pbgh.org.

Sincerely,



Elizabeth Mitchell, President and CEO
Purchaser Business Group on Health

[10] King (Nov. 17, 2020) "Addressing Health Care Consolidation: Policy Solutions" *Assembly Health Committee* [Link]

To: US House Committee on Ways and Means, Subcommittee on Health
From: National Lactation Consultant Alliance
Re: Subcommittee Hearing on Investing in a Healthier America: Chronic Disease Prevention and Treatment, September 11, 2024
Date: September 30, 2024

Thank you for the opportunity to testify on investing in a healthier America. Chronic illness and diseases claim too many American lives each year. Cancer, obesity, diabetes, hypertension, and cardiovascular disease stalk children and adults throughout the country. Prioritizing preventive care can save lives and dollars, with "food as medicine" being a known preventive strategy. Feeding decisions at the outset of life have the potential to shape and positively contribute to optimal health outcomes.

Breastfeeding is protective of the infant and the state of lactation functions to protect the mother. Initiatives, programs, preventive healthcare measures, outreach, and educational offerings to both the public and to healthcare providers regarding breastfeeding and its challenges should be a part of any efforts to reduce chronic disease in the maternal and infant populations. Breastfeeding and the state of lactation have known effects on lowering maternal hypertension.[1] Breastfeeding results in risk reduction for cardiovascular disease by 14%, stroke events by 12%, and death from cardiovascular disease by 17%.[2] Systolic blood pressure falls by 15mmHg and diastolic falls by 10mmHg during an individual breastfeeding session.[3] Eighteen years after pregnancy, any breastfeeding is associated with improved cardiometabolic outcomes and greater blood pressure and cholesterol benefits in women with and without a history of hypertensive disorders of pregnancy.[4] Preterm infants' heart function is significantly lower than that of healthy full-term babies and are more likely to develop heart problems later in life -- including heart disease, heart failure, systemic and pulmonary high blood pressure, with a higher risk of death from heart disease. In a study of 80 preterm infants, those initially fed only their mother's breastmilk had improved heart function at 1 year of age approaching the level found in healthy full-term babies. Specifically, preemies who received high amounts of mother's milk during the first weeks of life had healthier heart structures and functions and a better heart response to stress at age 1 than did preemies who were given higher amounts of formula.[5]

It is also important to assure that breastfeeding can flourish in the face of challenges and that families have equitable access to clinical lactation care provided by the International Board Certified Lactation Consultant (IBCLC®). An IBCLC® is a clinical lactation care provider as

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[1] Countouris, M.E., et al. (2016). Effects of lactation on postpartum blood pressure among women with gestational hypertension and preeclampsia. *American Journal of Obstetrics and Gynecology, 215*(2), 241.e1-8.
[2] Tschiderer, L., et al. (2022). Breastfeeding is associated with a reduced maternal cardiovascular risk: Systematic review and meta-analysis involving data from 8 studies and 1 192 700 parous women. *Journal of the American Heart Association, 11*(2), e022746.
[3] Jonas, W., et al. (2008). Short- and long-term decrease of blood pressure in women during breastfeeding. *Breastfeeding Medicine, 3*(2), 103-109.
[4] Magnus, M.C., et al. (2023). Breastfeeding and later-life cardiometabolic health in women with and without hypertensive disorders of pregnancy. *Journal of the American Heart Association, 12*(5), e026696.
[5] El-Khuffash A, Lewandowski AJ, Jain A, Hamvas A, Singh GK, Levy PT. Cardiac Performance in the First Year of Age Among Preterm Infants Fed Maternal Breast Milk. *JAMA Netw Open.* 2021;4(8):e2121206.

defined by the US Women's Preventive Services Initiative[6] and a preferred provider in acute and high risk situations.[7] Any efforts to reduce the burden of chronic disease in the maternal and infant populations should include IBCLCs®.

Should you have any questions or require more information and consultation, feel free to get in touch with the National Lactation Consultant Alliance at the contact information below.

Kindest regards,

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[6] US Women's Preventive Services Initiative. (2022). Breastfeeding services and supplies. https://www.womenspreventivehealth.org/recommendations/breastfeeding-services-and-supplies/
[7] Stark, A.R. et al., (2023). Standards for levels of neonatal care: II, III, and IV. *Pediatrics, 151*(6), e2023061957.

Statement for the Record

of the

National Association of Rural Health Clinics
1009 Duke Street
Alexandria, VA 22314

to the

United States House of Representatives
Committee on Ways and Means
Health Subcommittee

Improving Value-Based Care for Patients and Providers

June 26, 2024

On behalf of the over 5,500 Rural Health Clinics (RHC) across the nation, the National Association of Rural Health Clinics (NARHC) sincerely appreciates the opportunity to provide a statement for the record following the recent Subcommittee on Health's hearing on value-based care.

The RHC program, first created in 1977, provides outpatient care for over 60% of rural America and 11% of the entire country (approximately 38.7 million patients). Overall, the Rural Health Clinic program has been tremendously successful at bolstering access to healthcare across rural America. Despite this significant profile, there was unfortunately no mention of Rural Health Clinics during last week's hearing. If the Subcommittee is serious about addressing rural health inequities, we urge the Subcommittee to better understand the design and needs of the predominant model of outpatient care in rural areas.

NARHC supports the efforts of Congress and CMS to increase health care quality, while reducing cost. Primary, outpatient care is an essential component of this effort. However, the unique mechanisms of RHC reimbursement have made it difficult and/or impossible for RHCs to participate in Medicare quality programs. The majority of current quality initiatives available to providers are designed for traditional fee-for-service (FFS) settings and do not translate well into the RHC space. CMMI has recognized this fact themselves and has subsequently chosen to exclude RHCs from models such as "Primary Care First" and "Making Care Primary." In explaining why RHCs were excluded from the Making Care Primary model, CMMI wrote to us that "RHCs are paid on a different basis, using a different system than FQHCs and other facility-based and freestanding primary care practices, and we are not able to operationally accommodate another payment system in this model at this time."

We concur with CMMI that it is difficult to accommodate RHCs into these value-based models and believe that this is why either CMMI or Congress should create a **quality payment program designed specifically for RHCs.** Over the last several years, we have consistently made this request to CMMI, to no avail, and would welcome Congressional action to develop an RHC-specific value-based model based on the following tenets.

We believe that for an RHC-specific quality program to be successful, it must be:
1-Simple to participate in; and 2-Designed to work with the current RHC payment mechanisms.

1-Simplicity of Participation

Any RHC quality program should be simple to explain and simple to participate in. Ideally, RHCs would focus their efforts on a small subset of easily reported outcomes-based measures. The focus should be on improving patient outcomes, not mastering (and keeping up to date with) reporting rules and strategies.

Further, these measures should be easily reported through Medicare Part A claims on a UB-04 form. While it may be infeasible to report certain outcomes measures through the UB-04 form, NARHC continues to hear from our community that claims-based reporting is superior to registry-based reporting.

2-Cohesion with the RHC payment model

RHCs are paid by Medicare through a single All-Inclusive Rate (AIR) for every RHC encounter throughout the year. This AIR payment is based on the RHC's costs per visit and is subject to certain upper-payment limits (or caps) depending on whether the RHC is grandfathered or not. In the RHC payment model, Medicare reimbursement for face-to-face encounters does not vary from code to code. As we alluded to above, RHCs bill Medicare on a UB-04 form, not a CMS 1500.

We believe that any successful RHC quality program would incentivize improved patient outcomes by augmenting this core payment mechanism, not replacing it. A simple one to two percent adjustment to an RHC's AIR based on their quality performance would provide significant motivation to the RHC community to participate in the value-based program. Populations served by RHCs experience a myriad of additional factors that present challenges to their access to care and health outcomes. A specific model that accounts for these factors and provides further opportunities to improve upon them would be especially valuable.

We look forward to continuing to engage both Congress and CMS in efforts to design an RHC specific value-based care program. We believe that such a quality reporting program could be implemented in a cost neutral way that would improve efficiency and encourage improved value-based care across the entire RHC program.

The National Association of Rural Health Clinics thanks the House Committee on Ways and Means Health Subcommittee for organizing this hearing to discuss improving value-based care. We hope that the above statement helps illuminate the impacts and potential impacts of CMMI and other value-based care programs on the 5,500 Rural Health Clinics across the country. Should the Subcommittee have any questions, the NARHC is happy to serve as a resource. Please contact us by phone at (202) 543-0348, and email us at Sarah.Hohman@narhc.org, or Nathan.Baugh@narhc.org.

Charles N. Kahn III
President and CEO

STATEMENT
of the
Federation of American Hospitals
to the
U.S. House of Representatives Committee on Ways & Means Subcommittee on Health
"Improving Value-Based Care for Patients and Providers "
June 25, 2024

The Federation of American Hospitals (FAH) submits the following statement for the record in advance of the House Ways & Means Committee Subcommittee on Health hearing titled "Improving Value-Based Care for Patients and Providers". We believe that improving quality, retaining and improving access to care, and addressing costs for patients should be at the core of any health care innovation strategy Congress intends to implement or evaluate.

The FAH is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, childrens', and cancer services.

The FAH is committed to supporting and promoting quality care for patients and providers through value-based care. Our primary concern with value-based payment for physicians is two-fold: insufficient payment and increased burden, exacerbated by rising input costs and looming physician and staffing shortages. Congress needs to consider the overall state of physician payment adequacy to ensure physician payment updates are more in line with the current high rate of inflation. We also support the extension of the five percent Alternative Payment Model (APM) incentive payments to support transitions to value-based care. Even still, many physicians in rural hospitals and hospitals in underserved areas do not qualify for these payments.

Rather than creating new requirements and models, Congress should urge CMS to build upon existing efforts by groups and organizations that incentivize improvement rather than just reporting, thereby reducing burden. Implementing value-based payment models remains costly in terms of time and financial resources for health care providers, necessitating significant ongoing investments in Electronic Health Records (EHRs) and other systems to meet new government

requirements. These changes demand clinician time and commitment, including ongoing education and adaptation to workflow changes. Streamlining reporting requirements would allow providers to focus more on patient care.

In addition, any new value-based care models should be tested appropriately and on a voluntary basis through the Center for Medicare and Medicaid Innovation (CMMI). Congress should reject any mandatory value models that require participation by physicians, hospitals or other providers. Forcing providers to participate in models that they may not be prepared to undertake will ultimately threaten access to patient care for Medicare beneficiaries by requiring steep discounts on payment rates that are already well below the cost of care, imposing excessive administrative burdens, and increasing providers' financial volatility – especially when participants are required to assume the costs of unrelated providers. For example, with the proposed Transforming Episode Accountability Model (TEAM) demonstration's focus on communities with less experience participating in bundled payment models and higher safety net needs, the reduction in access to elective surgical care is likely to fall on some of the most underserved in the community.

We appreciate the Subcommittee's commitment to improving the quality of our health system for the benefit of patients and providers. As Congress considers the role of value-based payments going forward, it remains critical that any innovation must consider the widespread effects on physician payment, increased burden, and maintaining patient access to care.

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