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