Statement for the Record

Hearing of the Energy and Commerce Committee,
Subcommittee on Health
on
Examining Barriers to Expanding Innovative, Value-Based Care in Medicare

September 13, 2018

The Breaking Down Barriers to Payment and Delivery System Reform Alliance ("the Barriers Alliance") applauds the Energy and Commerce Health Subcommittee for holding a hearing entitled "Examining Barriers to Expanding Innovative, Value-Based Care in Medicare."

The Barriers Alliance is comprised of providers, payers, patient groups, device and pharmaceutical manufacturers, health IT vendors and other organizations with a common interest – working to reform regulatory and legislative barriers that impede opportunities for all stakeholders to engage in value-based arrangements within federal health care programs.

Whether the arrangement is an Alternative Payment Model (APM), Accountable Care Organization (ACO), Value-based Contract (VBC), or other new payment model, the Alliance believes that all those who operate, deliver, or receive care and coverage under a federal health care program can participate in activities that better manage the cost, delivery or outcome of a health care encounter. Patients, providers, manufacturers, vendors and payers all have role to play, and having all parties working together to support the same value proposition offers the best chance for Medicare beneficiaries and the Medicare Trust Fund to realize the benefits of alternative value payment arrangements.

For example, a key determinant of success in several of the Medicare APMs that have been implemented by CMS is effective care coordination. By incenting providers within an episode of care to coordinate care plans and delivery of services, care fragmentation and variability can be reduced and utilization of services optimized to meet the patient's needs, resulting in improved outcomes and lower cost. We believe that these types of collaborative approaches, when encouraged under any form of value-based model, can achieve similar results.

Federal statute and regulations have shaped the operation of federal health care programs like Medicare for decades, many of which were created at a time when the needs of patients, availability of medical products and treatments, and social considerations with regards to quality of care and spending were much different than they are today. While these requirements play an important role regulating the programs to safeguard patient safety concerns and prevent fraudulent activity today, we recognize that these approaches may also create administrative barriers that hinder development of novel health care delivery and payment models. Regulations under the Medicare program that prohibit a health care beneficiary or entity from engaging in an activity, regardless of whether it is fraudulent or not, may limit improper behavior but also

activities that can improve care quality and manage costs more effectively. Consider the fact that the sharing of data and analytic capabilities between two stakeholders attempting to effectively target wasteful or inappropriate practice patterns can be impeded by federal law and regulation, and therefore might not be allowed under the program.

Therefore, we are grateful for the Committee's efforts to examine statutory and regulatory barriers (include the Anti-Kickback Statute and Stark Law) that prohibit activities designed to improve care coordination, allow stakeholders to manage costs more effectively, and encourage better outcomes for beneficiaries. We believe that efforts by lawmakers to identify and address such barriers can only improve efforts to create more value within federal health care programs.

When considering ways forward, the Alliance believes that lessons learned from the establishment and operation of the Centers for Medicare and Medicaid Innovation (CMMI) can be instructive. CMMI was established by Congress through passage of the Patient Protection and Affordable Care ACT (PPACA) to promote "innovative payment and service delivery models to reduce program expenditures …while preserving or enhancing the quality of care."[1] CMMI is able to facilitate new payment and service delivery models through the use of waivers from federal statutes and rules. This waiver authority, supported by rules governing how entities are to operate within these models, is designed and used by CMS to allow organizations the flexibility needed to succeed within a value-based model while ensuring for beneficiary care and the financial health of the program.

The Alliance recommends that Congress take a similar approach by identifying a process for multiple stakeholders – health plans, manufacturers, and others – to enter into and use alternatives to current statutory and regulatory requirements within alternative payment and service delivery models. Specifically, we recommend that Congress consider establishing a set of criteria that CMS could use to designate eligible organizations with waiver authorities outside of CMMI. Responsibility for satisfying these criteria would fall on organizations willing and able to take on the obligation of ensuring spending and beneficiary care on behalf of the program. By establishing a process where beneficiary and federal spending protections are established up front, we believe that a greater freedom to identify, adopt, and employ successful value based models in the Medicare program would be realized as a result. We anticipate that this approach could be developed in such a way that direct and tangible benefits could be realized by individual beneficiaries, and improve fraud protection for the program.

We again commend the Committee for its leadership and would like to offer our help moving forward.

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[1] CMS website: https://innovation.cms.gov/About/index.html