Committee on Energy and Commerce

Opening Statement
of
Subcommittee on Health Ranking Member Gene Green
September 13, 2018

Examining Barriers to Expanding Innovative, Value-Based Care in Medicare

Good afternoon and thank you all for being here today.

Today's hearing is titled, "Examining Barriers to Expanding Innovative, Value-Based Care in Medicare."

I want to thank the Chairman for having this hearing and I thank all of our witnesses for joining us today.

Today's hearing focuses on the current transition in the Medicare Program away from fee-for-service and towards a value-based payment system that is centered on the patient.

One of the main ways the Affordable Care Act sought to reduce health care costs is by encouraging doctors, hospitals and other health care providers to form networks that coordinate patient care and become eligible for bonuses when they deliver that care more efficiently.

ACA took a carrot-and-stick approach by encouraging the formation of accountable care organizations, or ACOs, in Medicare.

Today, there are 472 ACOs operating in the United States, caring for 9 million beneficiaries.

In 2015, our committee passed the Medicare Access and CHIP Reauthorization Act (MACRA), which expanded on the ACA to further encourage the use of value-based compensation by encouraging providers to create incentives to participate in new care delivery models that increase quality and reduce costs.

Starting next year, Medicare providers must participate in either the Merit-Based Incentive Payment System (MIPS) or an Advanced Alternative Payment Model. Both options are value-based systems. This has led providers in recent years to adopt new care delivery systems.

Studies have shown that valued-based care systems lower costs to the overall health system while improving patient outcomes, a win-win that everyone should support.

ACOs saved Medicare an estimated $1.1 billion in 2017, with a net savings of $314 million after bonuses were paid out. This is a significant improvement over previous years and a clear sign that ACOs are succeeding as intended.

Additionally, the experience with the Shared Savings Program has shown that ACOs do better over time, both in terms of performance on quality measures and at generating savings, as they gain experience with care transformation.

Studies have shown that ACOs have reduced readmissions from skilled nursing facilities, generated fewer emergency department visits and hospitalizations, and had less Medicare spending overall relative to comparison groups.

I am concerned with the proposed rule the Centers for Medicare & Medicaid Services (CMS) issued on August 17 that would shorten the onramp for new ACOs to take on downside financial risk from 6 to only 2 years.

I am also concerned that the proposed rule cuts shared savings in half for certain ACOs from 50 percent to 25 percent.

I am looking forward to hearing from out witnesses who have managed or have experience with ACOs on their views on the proposed rule and whether this proposal may be harmful to current and new entrants.

I know some stakeholders are interested in making changes to the Stark Act and Anti-Kickback statute. I agree that Congress should be open to revisiting current laws if these regulations are bona fide barriers to value-based care.

However, the Stark Act and Anti-Kickback statute were put in place to protect patients and taxpayers from potential abuses, including subjecting patients to unnecessary testing and referring patients to lower quality services.

According to the Government Accountability Office last year, improper payments in Medicare accounted for $51.9 billion. The Stark Act and Anti-Kickback statute continue to serve important roles in protecting taxpayers from waste, fraud, and abuse.

Any effort to reexamine these laws must place the importance of protecting patients and taxpayers from excessive costs and abuse at the top of the priority list.

Thank you again, Mr. Chairman, for holding this hearing, and I yield the remainder of my time.