Documents for the Record

Subcommittee on Health Hearing
"Checking-In on CMMI: Assessing the Transition to Value-Based Care"
June 13, 2024

Majority:

- June 12, 2024 – Statement submitted by the Healthcare Leadership Council
- June 12, 2024 – Statement submitted by OCHIN
- June 12, 2024 – Statement submitted by Value-Based Care Stakeholders
- June 13, 2024 – Statement submitted by the Medical Group Management Association
- June 13, 2024 – Statement submitted by Families USA
- June 13, 2024 – Statement submitted by the Federation of American Hospitals
- June 13, 2024 – Statement submitted by the Hematology/Oncology Pharmacy Association, the American Association of Psychiatric Pharmacists, and the American College of Clinical Pharmacy
- June 13, 2024 – Statement submitted by the American College of Physicians
- June 13, 2024 – Statement submitted by the American Academy of Dermatology Association
- June 13, 2024 – Statement submitted by the Alzheimer's Association and Alzheimer's Impact Movement
- June 13, 2024 – Statement submitted by the American Academy of Family Physicians

Minority:

- June 13, 2024 – Statement submitted by the American Hospital Association
- June 13, 2024 – Statement submitted by the Community Catalyst

HEALTHCARE
LEADERSHIP COUNCIL

June 12, 2024

The Honorable Brett Guthrie
Chairman
Energy and Commerce Committee
Subcommittee on Health
Washington, D.C. 20515

The Honorable Anna Eshoo
Ranking Member
Energy and Commerce Committee
Subcommittee on Health
Washington, D.C. 20515

RE: Hearing of the Energy and Commerce Committee Subcommittee on Health titled, "Checking-In on CMMI: Assessing the Transition to Value-Based Care."

Dear Chairman Guthrie and Ranking Member Eshoo:

The Healthcare Leadership Council (HLC) thanks you for holding this hearing to assess the transition to value-based care.[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. 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. In the Center for Medicare and Medicaid Innovation's (CMMI's) second decade, it should focus on developing and incenting sustainable bipartisan payment models, while ensuring that providers' incentives to participate in the models are not outweighed by burdens of operating under the models.

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. It 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.

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

[1] Hearings, House Energy and Commerce Committee, Subcommittee on Health (June 2024), https://energycommerce.house.gov/posts/chairs-rodgers-and-guthrie-announce-health-subcommittee-hearing-on-cms-innovation

[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.

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.

HLC appreciates the Subcommittee's attention to the critical issue of accelerating the shift to value-based care. HLC and its member companies are eager to collaborate on initiatives to enhance both efficiency and patient care throughout our healthcare system. If you have any questions, please do not hesitate to contact me at [redacted] or [redacted].

Sincerely,

Katie Mahoney

Katie Mahoney
Executive Vice President and Chief Policy Officer

OCHIN

A driving force for health equity

[redacted]

June 12, 2024

The Honorable Cathy McMorris Rodgers
Chair
Energy and Commerce Committee
U.S. House of Representatives
2125 Rayburn HOB
Washington, D.C. 20515

The Honorable Brett Guthrie
Chair
E&C Committee Health Subcommittee
U.S. House of Representatives
2434 Rayburn HOB
Washington, D.C. 20515

Re: *Statement for the Record – Hearing on "Checking-In on CMMI: Assessing the Transition to Value-Based Care"*

Dear Chairs McMorris Rodgers and Guthrie,

On behalf of OCHIN, we appreciate the opportunity to submit comments for the record in response to the U.S. House of Representatives' Energy and Commerce Committee's Subcommittee on Health *Hearing on Checking-In on CMMI: Assessing the Transition to Value-Based Care*. 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 revive 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.

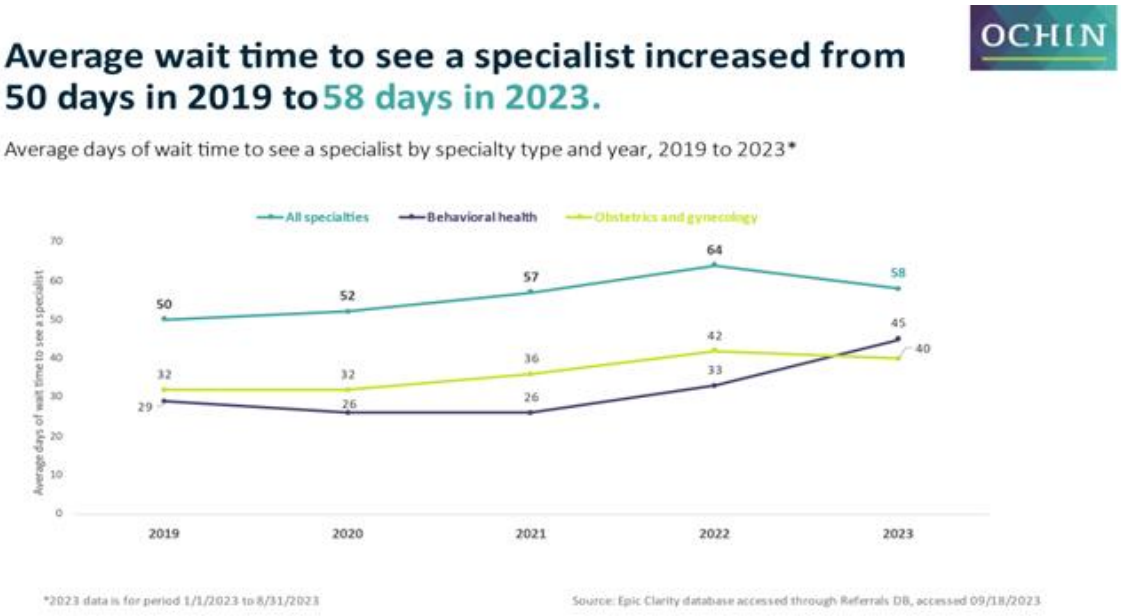
CMMI AUTHORITY AND THE EASE ACT DEMONSTRATION

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 (HR 7149 / S.4078) 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. In Kansas, hundreds of rural hospitals are on the brink of closure and the threat of closure has only increased as they must contend with Medicare Advantage. Through Medicare Advantage, many patients do not have access to other benefits needed for their care, and as these small rural hospitals do not turn away patients, they bear the burden of sacrificing increased staffing and money to care for patients.[2]

[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/.
[2] Michael Mcaullif, "Rural Hospitals Facing Low Medicare Advantage Pay Risk Closing," Modern Healthcare, May 14, 2024, https://www.modernhealthcare.com/politics-policy/rural-hospitals-medicare-advantage-pay-closing.

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.

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 [redacted] if you would like additional data and information.

Sincerely,

Jennifer Stoll
Chief External Affairs Officer

June 12, 2024

The Honorable Brett Guthrie
Chair
House Committee on Energy and Commerce
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Washington, DC 20515

The Honorable Anna Eshoo
Ranking Member
House Committee on Energy and Commerce
Subcommittee on Health
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Re: Value-Based Care Stakeholder Recommendations to Improve CMMI

Dear Chairman Guthrie and Ranking Member Eshoo:

The undersigned organizations appreciate the opportunity to submit comments to the House Energy and Commerce Subcommittee on Health in response to the hearing, "Checking-In on CMMI: Assessing the Transition to Value-Based Care."

Over the past decade, the Centers for Medicare and Medicaid Innovation (CMMI) has advanced multiple successful models focused on improving care for patients, while addressing Medicare costs. For example, the Next Generation Accountable Care Organization (ACO) Model produced nearly $1.7 billion in gross Medicare savings over six years, while also reducing hospitalizations and increasing annual wellness visits. CMS is continuing to evaluate the ACO REACH Model (formerly Direct Contracting Model), which includes 173,000 physicians and other health care providers collectively furnishing care to 2.6 million beneficiaries. Preliminary results from the Direct Contracting Model found reductions in high-cost care and reduced emergency department (ED) visits.

The Comprehensive Primary Care Plus (CPC+) Model tested moving physician practices from fee-for-service to population-based payments. The model resulted in greater investment in behavioral health integration and reduced outpatient ED visits, acute hospitalizations, and ambulatory specialist visits through increased focus on population health. Additionally, CMMI tested two approaches for specialty focused models, including the Bundled Payments for Care Improvements (BPCI) Model, which produced savings and improved outcomes for care following procedures or hospitalizations.

Despite the successful elements of these models, none have been permanently expanded. The models also present uncertainty for participants as they conclude without a pathway for a new model (i.e. Next Generation ACO Model) or there are significant model changes that make model participation untenable (i.e. BPCI-Advanced Model). We believe there are opportunities to provide a broader, more predictable pathway for more types of clinicians to engage in APMs. To date, there has been insufficient model development for all types of physicians and other clinicians. 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.

Congress should work with CMMI to 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 medical specialties, safety net, rural, small, and other practices that, to date, have struggled to join APMs due to high entry barriers or simply because there is no clinically relevant model available.
- 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. For example, CMMI should be instructed to consider whether a model effectively expands participation to more physician and other health care provider types or offers enhanced benefits and services to beneficiaries.
- Direct CMMI to engage stakeholder perspectives during APM development. For example, CMMI could ask the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to review models under development by the Center and set priorities for model development. Additionally, CMMI should make more data available so that stakeholders can develop models that have a higher likelihood of producing actuarial savings. CMS should also engage stakeholders early on and throughout its own development of models. This will improve the clinical relevance of models and cut down on the near constant churn of model re-designs, which hinders participation.
- Direct CMS to improve its evaluation strategies by providing more data on the effectiveness of specific innovations and waivers and better controlling for other variables such as complications due to model overlap.

We thank the subcommittee for holding this important hearing. Our organizations look forward to working with you to improve CMMI to continue improving and advancing value-based care model development.

Sincerely,

American Medical Association
America's Physician Groups
Health Care Transformation Task Force
National Association of ACOs
Premier Inc.

Cc:
Chairwoman Cathy McMorris Rodgers
Ranking Member Frank Pallone

June 13, 2024

The Honorable Brett Guthrie
Chairman
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The Honorable Anna Eshoo
Ranking Member
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Washington, DC 20510

Re: MGMA Testimony for House Committee on Energy and Commerce Subcommittee on Health's Hearing, "Checking-In on CMMI: Assessing the Transition to Value-Based Care"

Dear Chairman Guthrie and Ranking Member Eshoo:

On behalf of our member medical group practices, the Medical Group Management Association (MGMA) would like to thank the Subcommittee for holding this important hearing examining the state of the Center for Medicare and Medicaid Innovation Center (CMMI) and the transition to value-based care. Innovative value-based care models allow medical groups to provide cost-effective, quality-driven care. It is imperative that physician practices have feasible pathways to joining Alternative Payment Models (APMs) and are able to successfully sustain participation.

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical group practices ranging from small private medical practices to large national health systems, representing more than 350,000 physicians. MGMA's diverse membership uniquely situates us to offer the following policy recommendations.

The *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA) was enacted to repeal the flawed Sustainable Growth Rate (SGR) formula, stabilize payment rates to physicians in Medicare fee-for-service, and incentivize physicians' transition to value-based care models. While there has been progress in the development of APMs under CMMI, more work needs to be done to effectively design and deploy these models so that more medical groups are able to participate.

MGMA's policy priorities to promote the success of physician practices in APMs are as follows:

- Support the development of new, voluntary physician-led APMs that meet the needs of practices of varying types, sizes, and specialties to inherently drive more widespread participation.
- Reinstate the 5% payment bonus for APM participation beyond the 2025 payment year, for a period of at least six years.
- Lower the qualifying participation (QP) thresholds and allow CMS the flexibility to adjust them to ensure the criteria to achieve QP status is not set arbitrarily high.
- Provide support for participants through upfront investments, resources, and tools.

- Design and implement APMs that provide sufficient supports for physician practice participants, as well as appropriate financial incentives and regulatory flexibilities.[1]

APM Development

APMs must be designed to address the challenges facing medical groups if the Centers for Medicare and Medicaid Services (CMS) wants to meet its goal of having every Medicare beneficiary in an accountable care arrangement by 2030. There are numerous barriers preventing medical groups from both joining and successfully participating in APMs due to application requirements and parameters around many of the CMMI models. Seventy-eight percent of medical groups reported that Medicare does not offer an APM that is clinically relevant to their practice, with 56% of respondents being interested in participating in a clinically relevant model if one were to exist.[2] The Congressional Budget Office found that accountable care organizations (ACOs) led by independent physician groups were associated with greater savings, thereby demonstrating the value of expanding access to these arrangements.[3]

CMMI and private sector entities under the Physician-Focused Payment Model Technical Advisory Committee (PTAC) can develop APMs. Unfortunately, CMMI, who possess the sole responsibility to test and implement an APM, has yet to test any of the models PTAC has recommended.

In conjunction with a shortage of APMs, 94% of medical groups reported that moving to value-based care initiatives has not lessened the regulatory burden on their practices.[4] This is exemplified by recently finalized changes in the 2024 Medicare Physician Fee Schedule that added burdensome Promoting Interoperability reporting requirements in the Medicare Shared Savings Program, as well as certified health information technology utilization requirements that are set to take effect in 2025. One of the main benefits of joining an APM is the reduced Merit-based Incentive Payment System (MIPS) reporting burden — these policies undermine the success of groups joining value-based care arrangements.

APM Incentive Payment and Qualifying Participant Threshold

Shifting program requirements and financial incentives instituted under MACRA do not align with enabling physician practices to successfully participate in APMs. Congress recently extended the APM incentive payment at 1.88% for 2024 — a decrease from 3.5% in 2023, and 5% in 2022. MGMA strongly urges Congress to reinstate the full 5% as this payment is necessary to cover costs, support investments, and safeguard the financial viability of medical groups in the program.

Further, the qualifying participation (QP) threshold to participate in an APM is unreasonably high. Participants need to meet this threshold to qualify for the APM incentive bonus and to avoid reporting under MIPS; it was set to increase this year, but Congress intervened by freezing the threshold in the *Consolidated Appropriations Act of 2023.* Medical groups should not be subject to an excessively high threshold that fosters uncertainty and hinders their ability to participate — MGMA supports giving CMS the flexibility to adjust the QP threshold so that it is not set arbitrarily high. The *Value in Health Care Act*

[1] MGMA, Alternative Payment Models Issue Brief, 2024.
[2] MGMA, 2023 Annual Regulatory Burden Report, Nov. 2023.
[3] Congressional Budget Office, Medicare Accountable Care Organizations: Past Performance and Future Directions, April 16, 2024.
[4] *Supra* note 2.

of 2023 would work to address the APM incentive payment and QP threshold problems facing practices, along with making other important changes to APMs.

Conclusion

MGMA thanks the Subcommittee for examining the state of value-based care and CMMI. We look forward to collaborating with the Subcommittee to enact legislation to support and bolster medical groups' ability to succeed in value-based care arrangements. If you have any questions, please contact James Haynes, Associate Director of Government Affairs, at [redacted] or [redacted].

Sincerely,

/s/

Anders Gilberg
Senior Vice President, Government Affairs

FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

Statement for the Record
House Energy and Commerce Subcommittee on Health
Hearing on "Checking-In on CMMI: Assessing the Transition to Value-Based Care"
Prepared by Families USA
June 13, 2024

Chairs Rodgers and Guthrie and Ranking Members Pallone and Eshoo, on behalf of Families USA, we want to thank you for holding this hearing on the crucial payment and delivery reforms needed in the U.S. health care system and the critical role of the Center for Medicare and Medicaid Innovation (CMMI) in beginning to shift health care payment and delivery away from broken fee-for-service (FFS) economic incentives that do not deliver on health. We'd also like to thank Liz Fowler, Deputy Administrator and Director of CMMI, for her leadership of CMMI and her testimony today.

There has long been broad, bipartisan recognition that we need to reform health care payment in the U.S.[1] Importantly, CMMI has been a beacon of innovation and leadership in the health system transformation movement, and has played a critical role in beginning to shift the way the U.S. pays for and delivers health care away from broken fee-for-service economics, and towards a system that holds the health care sector accountable for affordable care that reduces disparities and improves health outcomes. But more work is needed to challenge the entrenched business interests of the health care sector, and their efforts to preserve status quo fee-for-service economics.

Central to improving the health and health care of our nation's families is realigning the economic incentives of health care payment and delivery so that the health care sector will only economically thrive when it is providing affordable, high quality health care to our nation's families. Ultimately, policy solutions should reorient health care payment and delivery to be aligned with consumers and families and to achieve our common goal of improved health for ourselves and our families that is affordable and economically sustainable. We applaud today's discussion of these important issues.

Health Care Affordability and Quality Crisis

Our country is in the midst of a health care affordability and quality crisis where our nation's families are struggling in a health care system whose payment and delivery structure incentivizes high cost, low quality care. Almost half of all Americans have reported forgoing medical care due to the cost, almost a third have indicated that the high cost of medical care interferes with their ability to secure basic needs like food and housing, and a quarter of a million Americans face medical debt.[2]

Some of the most talented people in our nation work in the health care sector, and some of the most important health care innovations across the globe are made here in the United States. Despite this, our families have worse health outcomes than families in other peer countries, and health care is becoming less and less affordable for many Americans.[3,4,5] For example, the U.S. has the lowest life expectancy, the highest rates of infant mortality and among the highest rates of maternal mortality compared with other industrialized nations.[6] Furthermore, health care acquired infections are one of the top 10 causes of death in the U.S., causing more than 72,000 patients to die each year.[7] These health outcomes are even worse for people of color, who experience higher rates of illness and death across a range of health conditions compared with their white counterparts.[8]

Health care spending now accounts for more than 18% of the U.S. gross domestic product, and total U.S. health care spending nearly doubled in just a decade, rising from $2.6 trillion in 2010 to $4.5 trillion in 2022.[9] During that same period of time, average family health insurance premiums increased by almost 50%. As a result, premiums have grown 50% faster than our paychecks and 2.5 times faster than overall inflation.[10] This rising cost of health care also translates into higher copays and deductibles. Together, these costs put a significant strain on our economic security.

At its core, our nation's affordability and quality crisis is driven by a fundamental misalignment between the business interests of the health care sector and the health and financial security of our nation's families. The current business model allows big health care corporations to generate high volumes of tests and procedures through fee-for-service payment, the predominant model in the US health care system, and to generate the highest possible fees (price) for each service.[11] The unchecked power of large health care corporations, and broken fee-for-services economics have established high medical bills, difficulty navigating the system, and poor health outcomes as the status quo of the American health care system.

Broken Fee-for-Service Economics Incentivize High Cost, Low Quality Care

Fee-for-service payment incentivizes health care providers to make money without any real links to the quality of care by performing more high-profit or high-margin procedures – typically surgeries, hospital admissions and medical tests, rather than by allowing providers to generate a profit or margin based on keeping people healthy and reducing disparities.[12] Fees for hospital admissions, procedures, office visits and tests are priced too high, and fees for making care accessible and effective often are priced too low or at zero.[13] Moreover, patients can be billed for each additional service, driving up the cost of their care.[14] A 2017 survey of physicians found that 25% of tests and 11% of procedures were considered unnecessary medical care, and over 70% of physicians believed that doctors are more likely to perform unnecessary procedures when they profit from them.[15]

Even more problematic is the fact that FFS economics fail to adequately address the factors that determine health. It is well established that 80% to 90% of what drives variations in peoples' health is determined by the socioeconomic and environmental factors in their lives, yet the predominant model for how health care is paid for in the U.S., including the majority of value-based payment models, offers no payment for addressing the social determinants of health.[16] By definition, FFS provider payments provide a very narrow view of health and health care by signaling to providers that they can only be reimbursed for delivering the clinical care that drives 10% to 20% of health.[17] By offering no payment for services that address the social determinants of health and paying so much for hospital admissions and procedures, the economic incentives of FFS actually work against the professional responsibilities and desires of providers to improve health or reduce disparities. Importantly, FFS provider payments predominate in all forms of insurance, including private employer-sponsored coverage, managed care, Medicare and Medicaid, and all forms of insurance have the potential to reorient incentives to move away from FFS provider payments.[18]

The Broken Promise of Payment Reform

One of the biggest barriers to shifting away from FFS economics has been the double-dealing of the health care industry when it comes to payment reform. While big health care corporations have been price gouging and paying their CEOs tens of millions of dollars, many of these same medical monopolies and other actors in the health care sector have been aggressively marketing to the public and policymakers about their movement away from FFS and toward new value-based payment models.[19,20] Meanwhile, payment reform efforts by the health care sector have largely failed to move away from the

broken economic incentives of FFS.[21] Across the nation, the vast majority of payment arrangements continue to be anchored in broken FFS economics, with less than 10% of all health care services flowing through truly redesigned, non-FFS incentives that drive toward better care, lower costs, and improved health outcomes.[22,23] Most of the health care sector's claims about engaging in value-based payments are exaggerated and misleading.

While health care executives publicly support payment reform and the shift to value-based health care, they privately express concerns about the potential loss of revenue they may experience from shifting out of the FFS payment model toward a new payment model that holds health care providers accountable for health outcomes and costs.[24] The result is that many health care executives are slow to engage in payment reform or do not engage at all, thereby preserving status quo FFS economics in U.S. health care.[25]

To the extent that there has been major activity from the health care sector *in the name of payment and delivery reform* over the last decade, it has been focused on vertical and horizontal consolidation, which destroys competition, weakens quality of care and drives higher prices under FFS economics.[26] For example, Aetna and Humana promoted payment reform goals as a key focus of their 2015 merger, claiming that the merger would provide Aetna with enhanced ability to work with providers and create value-based payment agreements resulting in better care to consumers.[27] They then abandoned the merger after the federal government successfully challenged it as an illegal monopoly.[28]

The University of Pittsburgh Medical Center, operating a dominant system in one of the country's most concentrated health care markets, also touted its achievements in payment reform.[29,30] However, UPMC financial records from 2022 suggest that the system has yet to make a meaningful transition away from FFS payment.[31] While these FFS prices continue to increase, bolstering UPMC's operating margins to record levels, there continues to be no accountability that these higher prices will result in improved health outcomes.[32,33]

In 2019, Mass General Brigham health system announced its updated branding would focus on "a value-based model that delivers affordable primary care, secondary care and behavioral health in the community," ostensibly making patient-centered programs and services central to delivering better outcomes for its patients.[34] Three years later, the system was placed on a performance improvement plan by the Massachusetts Health Policy Commission due to its outsized contributions to unsustainable cost growth in the state.[35]

The ability of the health sector to continue generating margins or profits based on FFS economics and monopolistic pricing under the guise of payment reform has resulted in only modest changes in moving the health care sector toward true value, changes that have mostly been insufficient in delivering on the promise of affordable, quality care.[36] Meanwhile, increases in health care industry consolidation have enabled many providers to leverage high commercial FFS rates and gain "must-have" status for insurance networks in a particular health care market.[37] These market dynamics not only increase the differential between Medicare and commercial insurance prices, but also reduce providers' enthusiasm to move toward value-based payment approaches and away from the easy profits of medical monopolies, price gouging and churning on FFS.[38]

The Real Promise of Payment Reform

To solve our nation's affordability and quality crisis, we have to have an honest discussion about the underlying financial incentives that are driving the health care sector. We have to change these incentives to ensure that the health care sector only makes money when it is focused on keeping people healthy or efficiently providing the most effective treatments in a well-coordinated way when patients are sick. Such payment reform must ensure that health care is affordable and that families are economically stable in seeking and receiving health care services.

The ability of payment reform to fulfill its promise hinges on moving away from FFS economics and creating new financial incentives that reward health care providers for keeping patients healthy and for addressing illness effectively and without waste and price gouging.[39] To make this transformation, the economics of the health sector's business model must be inverted to enable the sector to generate revenue by keeping people healthy and ensuring health care is affordable, rather than by billing for unnecessary visits and procedures and engaging in anti-competitive behavior and price gouging.[40] The key ingredient to successful payment reform is making it economically advantageous for health care providers to address whole-person health needs. In other words, there must be a viable business model for providers to make the switch to non-FFS payment models, such as population-based payments, which hold providers accountable for health outcomes and the total cost of patient care.

Population-based payment models are based on paying one health care provider — typically a primary care organization or a health system — a single monthly payment, out of which the organization then pays for some or most health care costs for a whole population. Such payment arrangements are coupled with strong quality and outcome metrics to ensure that as providers' economics change, patients' health thrives. In this way providers are "at risk" for care that is wasteful and does not improve or protect patients' health. Providers make money when they are efficient and improve or protect patients' health, and they lose money if they are being wasteful or provide poor-quality care. This model, therefore, is structured to incentivize providers to deliver well-coordinated, high-quality, person-centered care. And the payments can be used to cover a wide range of services, including preventive health, care coordination, wellness services and services that address the social determinants of health, as well as standard medical procedures and services.[41]

These types of payment systems have a much greater impact if most insurers that contract with an organization, including public and private payers, are aligned. Such alignment unifies the organization's economics around population health and allows for real transformation of the way health care is organized and delivered.[42] Without this financial alignment, FFS economics will continue to dominate and incentivize high-margin and high-profit procedures, instead of what's best for patients' health.

CMMI Has a Critical Role in Shifting Towards a Population-Based Payment System

CMMI has been a major leader in this space by making strategic investments into the health care system that have triggered key transformational changes to the way the U.S. pays for and delivers health care. For example, CMMI has been on the leading edge of improving data collection and quality measurement, making investments in primary care to establish a more sustainable reimbursement model for primary care and safety-net providers, centering health equity in model design and implementation, and improving quality performance and financial benchmarks in key payment models.[43,44] There have been key lessons learned from CMMI's first 10 years operating, and those

lessons are essential to implement in the next 10 years in order to create non-FFS economics that hold the health care system accountable for meeting the population health and affordability needs of the American people. Importantly, CMMI has reflected many of those learnings in their new 2021 Strategy Refresh and has released a series of new promising models that have begun to reflect their updated strategy including driving towards population-based payments, increasing access to care, and opportunities for generating savings to the Medicare program. Examples of those models include:

- Accountable Care Organization (ACO) Primary Care Flex. This is an ACO primary care delivery model tested in the Medicare Shared Savings Program (MSSP) to increase the number of low revenue ACOs (such as small physician groups that may include small hospitals serving rural communities) in MSSP. Low revenue ACOs have historically demonstrated more savings and stronger potential to improve the quality and efficiency of care delivery. The core function of this model is to shift primary care payment away from fee-for-service and establish a regional, upfront, monthly payment for low revenue providers.[45]
- States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model. This is a total cost of care model that aims to drive state and regional health care transformation and multi-payer alignment to lower health care costs and improve the health of a state population. States will be held accountable for state-specific Medicare all payer cost growth and primary care investment targets, and population and health equity outcomes.[46]
- Transforming Episode Accountability Model (TEAM). This is a new proposed mandatory bundled payment model that would test if episode-based payment for five select surgical procedures lowers costs and improves outcomes.[47]

CMMI is an essential laboratory for testing non-FFS payment models such as population-based payment models, and scaling those models nationally through the Medicare program to establish a sustainable reimbursement system that financially incentivizes whole-person care and population health improvements.

We encourage this committee to continue working with colleagues in the House and Senate to support the important work of CMMI in driving meaningful improvements to US health care payment and delivery. This includes CMMI's work to implement key models that shift away from fee-for-service economics and towards population-based payment models that better align the business interests of the health care system with the health and financial security of our nation's families. We also encourage Congress to work to ensure that there is an increase in the number of mandatory payment models in which providers are required to participate. Voluntary payment models allow providers to self-select into models which can lead to "selection bias" where providers only participate in the models that are more lucrative to them, rather than the model that is best for patients and generating savings to Medicare.[48] Mandatory payment models are more likely to achieve results that could be scalable across the health care system, including the potential for increasing Medicare savings.[49]

Additionally, Congress should work to increase the number of global hospital budget and multi-payer models operated by CMMI to address both high hospital prices and fee-for-service economics through accountability for the total cost of care. Finally, we encourage Congress to advance the development of a primary care hybrid payment in the Medicare Physician Fee Schedule. The traditional fee-for-service payment model has continued to underinvest in primary care and leave primary care providers vulnerable to economic hardship while failing to incentivize the care that makes people healthy. A

hybrid model would provide primary care practices with both the flexibility and consistency of population-based payments, and the benefits of low-risk, per-visit payments to bolster the primary care workforce in meeting the needs of our nation's families.[50]

Conclusion

Thank you again for holding this hearing on CMMI's role in better aligning the economic incentives of the health care sector with the needs of consumers and families. Ultimately, policy solutions should reorient health care payment and delivery to the goal that we all have — improved health for ourselves and our families that is affordable and economically sustainable. The journey to fully transforming our health care system is long, but Congress holds the power to take the next critical steps. Families USA stands ready to support you in this essential and urgently needed work. Please contact Jane Sheehan, Deputy Senior Director of Federal Relations at Families USA, [redacted], for further information and to let us know how we can best be of service to you.

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Federation of American Hospitals™
Charles N. Kahn III
President and CEO

STATEMENT
of the
Federation of American Hospitals
to the
U.S. House of Representatives Committee on Energy and Commerce
"Checking-In On CMMI: Assessing the Transition to Value-Based Care"
June 10, 2024

The Federation of American Hospitals (FAH) submits the following statement for the record in advance of the House Committee on Energy and Commerce hearing entitled "Checking-In On CMMI: Assessing the Transition to Value-Based Care." As the Committee considers the past performance and future promise of the Center for Medicare and Medicaid Innovation's (CMMI) next direction, the FAH believes that the patient must be at the center of that evaluation.

The FAH is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members are diverse, including teaching and non-teaching, short-stay, rehabilitation, long-term acute care, behavioral health hospitals in urban and rural America, and they provide a wide range of inpatient, ambulatory, post-acute, emergency, childrens', and cancer services.

The purpose of CMMI is to test innovative payment and service delivery models that maintain or reduce program expenditures while preserving or enhancing quality of care, with an emphasis on models that improve coordination, quality, and efficiency of health care furnished to Medicare and Medicaid beneficiaries. We agree with the intent behind this mission and believe that improving quality, retaining and improving access, and addressing cost for patients should be at the core of any innovation strategy CMS seeks to implement. CMMI has an important role in driving innovation in healthcare and the potential to inform the policy debate on critical health care payment policies through real world evidence reported to Congress, as required under the statute.

We appreciate that CMS has historically emphasized and focused on testing voluntary models, generally on a small-scale. CMS has successfully demonstrated that it is fully capable of testing models under section 1115A solely through providers of services and suppliers that volunteer to participate in those models. Experience with the Bundled Payments for Care Improvement (BPCI) Initiatives shows a substantial number and range of providers and suppliers willing to participate in carefully crafted models.

However, the FAH has long held that CMS has the authority to test models only on a voluntary basis. The use of Innovation Center authority to effectively impose new Medicare payment policy throughout large swaths of the country without Congressional consideration would be a significant overreach of CMMI authority. Mandatory provider and supplier participation in CMMI models

runs counter to both the letter and spirit of the law that established CMMI. There is no language in the statute or any legislative history that supports the interpretation that Congress delegated its authority to make permanent changes to the program to the Secretary through the CMMI.

Recently, CMMI has taken steps to advance models that mandate – or allow states to mandate – the participation of health care providers. These models include hospital-centered proposals such as the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model, Transforming Episode Accountability Model (TEAM) and the Increasing Organ Transplant Access (IOTA) Model. Advancing Medicare payment policy on such a wide-scale, without the benefit of understanding patient and provider impact through testing on a smaller-scale, puts Medicare beneficiaries and providers at risk. Given that CMMI is tasked with testing payment models that are considerably different than Medicare's current payment structure, it is imperative that CMS understand the impacts of those changes prior to seeking to advance them more broadly.

The FAH appreciates CMMI's commitment to the patient's role in the health care delivery system. As Congress and the Administration consider CMMI's role going forward, it remains critical that any innovation advanced by the agency must be faithful to all Medicare and Medicaid beneficiaries, ensuring that their access to and choice of provider is preserved.

Statement from the Hematology/Oncology Pharmacy Association, the American Association of Psychiatric Pharmacists, and the American College of Clinical Pharmacy
in response to the
Energy and Commerce Health Subcommittee Hearing: "Checking-In on CMMI: Assessing the Transition to Value-Based Care"
June 13, 2024

On behalf of the Hematology/Oncology Pharmacy Association, the American Association of Psychiatric Pharmacists, and the American College of Clinical Pharmacy, we commend Chair Guthrie, Ranking Member Eshoo, and members of the Energy and Commerce Subcommittee on Health for holding a hearing examining how the CMS Center for Medicare and Medicaid Innovation (CMMI) serves beneficiaries. We are pleased to submit this statement on an Integrated Payment Model leveraging Clinical Pharmacists to enhance patient outcomes, reduce waste, and drive value.

It is estimated that $528 billion dollars a year, equivalent to 16 percent of total health care spending, is consumed due to inappropriate or otherwise ineffective medication use. [1] Given the central role that medications play in care and treatment of chronic conditions, combined with the continuing growth in the range, complexity and cost of medications − and greater understanding of the genetic and physiologic differences in how people respond to their medications − the nation's health care system consistently fails to deliver on the full promise medications can offer.

Clinical pharmacists are licensed pharmacists with specialized, advanced education and training who possess the clinical competencies necessary to deliver comprehensive medication management in team-based, direct patient care environments and achieve medication optimization.

We appreciate Director Fowler's commitment to comprehensive medication management. As the committee considers the role and authority of CMMI, we propose an Integrated Payment Model using Clinical Pharmacists in coordinated healthcare teams to improve patient outcomes, save payers money, and decrease the strain on the healthcare system. We envision an integration model derived from a recent state-wide program in Michigan called the Michigan Pharmacists Transforming Care and Quality (MPTCQ) program. The MPTCQ, which grew from a partnership between Blue Cross Blue Sheild of Michigan and Michigan Medicine, is a statewide provider-payer program which integrates pharmacists within physician practices throughout the state of Michigan. According to a Michigan-based study on the outcomes of clinical pharmacist integration in a community oncology practice, embedded clinical pharmacist care improved patient outcomes, including improved rates of patient education, medication adherence, and improved dose intensity.[2]

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[2] JCO Oncol Pract 19, 2023 (suppl 11; abstr 61); https://meetings.asco.org/abstracts-presentations/227601

This legislative initiative proposal would require CMMI to establish a demonstration project to codify the value of paying for comprehensive clinical pharmacy services provided by clinical pharmacists integrated into the patient care team. Due to unmet needs of the population, the location of the first phase of these demonstration projects and the providers participating in this evaluation program would be required to be in a medically underserved area as defined by the Health Resources and Services Administration.

Additionally, this legislative proposal would require CMS to promulgate a standard collaborative practice agreement which would define the scope of practice, rights, and responsibilities for clinical pharmacists in the larger care delivery setting. These would include but are not limited to:

- Perform patient assessment for medication-related factors;
- Order laboratory tests necessary for monitoring outcomes of medication therapy;
- Interpret data related to medication safety and effectiveness;
- Initiate or modify medication therapy care plans on the basis of patient responses;
- Provide information, education, and counseling to patients about medication related care;
- Document the care provided in patients' records;
- Identify any barriers to patient compliance;
- Participate in multidisciplinary reviews of patients' progress;
- Communicate with payers to resolve issues that may impede access to medication therapies; and
- Communicate relevant issues to physicians and other team members

Thank you again for the opportunity to provide these comments and for your commitment to overseeing the CMMI program. We look forward to working with the Health Subcommittee as you continue to work on this important issue. Should you have any questions or require further information, please contact Brooke Boring, HOPA's Senior Manager of Health Policy & Advocacy at [redacted].

Statement for the Record
American College of Physicians
Hearing before the House Energy and Commerce Subcommittee on Health
"Checking-In on CMMI: Assessing the Transition to Value-Based Care"
May 13, 2024

The American College of Physicians (ACP) is grateful for the opportunity to submit this statement for the House Energy & Commerce Subcommittee of Health's hearing, "*Checking-In on CMMI: Assessing the Transition to Value-Based Care*." We appreciate Chairman Guthrie and Ranking Member Eshoo for your interest in finding cost-effective bipartisan solutions to further transition our health care system to one that prioritizes value and high-quality care. The College strongly supports the transition to value-based payment and the role that the Center for Medicare and Medicaid Innovation (CMMI) plays in designing, testing, and implementing new payment models that move health care towards this goal. ACP has been appreciative of the Innovation Center's investment in primary care through several demonstration pilots that ACP supports. We look forward to a productive discussion on thoughtful policy solutions to stabilize and improve the primary care physician payment system and create a more affordable, sustainable, and equitable health system that improves patient access to primary care and health outcomes.

ACP is the largest medical specialty organization and the second largest physician membership society in the United States. ACP members include 161,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge, clinical expertise, and compassion to the preventive, diagnostic, and therapeutic care of adults across the spectrum from health to complex illness.

ACP's Policy Aligns with the Innovation Center's Strategic Goals

In 2022, ACP provided comments in response to *CMMI's White Paper: Driving Health System Transformation - A Strategy for the CMS Innovation Center's Second Decade*. We were very pleased to find many parallels between CMMI's strategy and ACP's own objectives and recommendations for improving health care. CMMI's strategy and priorities, as laid out in the White Paper, are consistent with ACP's recommendations issued in our 2020 Vision for the U.S. Health Care System and 2021 Comprehensive Framework to Address Disparities and Discrimination in Health Care. ACP shared our strong support and appreciation of CMMI's overarching goals to reduce model complexity and administrative burden, streamline participation requirements, address inequities, and increase primary care engagement. Along with our support for these priorities, ACP emphasized that any new models should increase quality and access without imposing undue burdens on physicians and other health care clinicians. Further, we underscored the strong need for participating practices to receive the necessary upfront resources and ongoing support to be able to succeed in advanced alternative payment models (APMs).

CMMI Plays a Critical Role in the Transition to Value-based Health Care

Since its inception in 2010, CMMI has tested over 50 advanced APMs aimed at rewarding physicians and other health care clinicians for delivering high-quality and cost-effective care. CMMI, together with Medicare's Quality Payment Program (QPP), as established by the bipartisan Medicare Access and CHIP Reauthorization Act (MACRA), are making meaningful improvements to value-based care. ACP has written several letters to Congress in support of CMMI where we highlighted that any

decrease in funding for CMMI would severely impact the ability for CMS to test new models of care and would undermine MACRA's goal to improve care for Medicare beneficiaries. Further, under current law, Congress did intend for CMMI's funding to be available until expended so that it could be deliberate in how to allocate resources without the pressure of expiring funding. **While we appreciate that the health subcommittee wants to evaluate the effectiveness of CMMI, we urge against any legislative action that could limit or restrict the range and length of possible CMMI models and/or add required congressional approval to expand actuarially proven innovation models. These restrictions would greatly hinder—if not defeat—CMMI's ability to quickly and effectively implement successfully developed innovation models into the Medicare and Medicaid programs to advance value-based care.**

CMMI Invests in Primary Care

In 2021, the United States spent approximately $4 trillion on health care expenditures, which made up 17.4% of our country's gross domestic product. Despite the U.S. spending nearly twice as much per capita on health care compared to other high-income countries, we rank lower in population health metrics. According to the Centers for Disease Control and Prevention (CDC), 90% of health care expenditures were spent on treating and managing chronic diseases, both physical and mental. Further, chronic diseases are the leading causes of illness, disability, and death in the United States.

Research shows that investment in primary care, including preventive health programs, can lead to long-term health and economic benefits. While the initial costs to establish and implement these programs may be high, the long-term advantages – both in cost-savings and improved health outcomes – will likely outweigh the initial costs. However, not all benefits for preventive health efforts, including investments in value-based primary care, can be captured within a 10-year period, which is the current window that the Congressional Budget Office (CBO) used to conclude that the Innovation Center's demonstration pilots increased federal spending between 2011 and 2020. There is recognition in Congress that there are limitations to CBO's scoring of preventive health care, with the House of Representatives passing the *Dr. Michael C. Burgess Preventive Health Savings Act, H.R. 766*. This legislation would enable the CBO to capture the cost-savings associated with preventive health care legislation more accurately, beyond the existing 10-year window, for two additional 10-year periods. ACP supports H.R. 766 as it would allow Congress and the public to have a better understanding of the long-term benefits of proposed health care investments.

A report by the National Academy of Sciences, Engineering, and Medicine calls on policymakers to increase the investment in primary care as evidence shows that it is critical for "achieving health care's quadruple aim: enhancing patient experience, improving population health, reducing costs, and improving the health care team experience." The report urges reforms to ensure that the Medicare physician payment system no longer undervalues primary and cognitive care, and more adequately incentivizes the type of quality, value-based care that patients need. Thus, we appreciate that CMMI's demonstration pilots have allowed more primary care practices to move into APMs by providing them with the necessary resources they need to invest in innovative care delivery strategies to improve patient health outcomes. Data shows that investing in value-based primary care is effective. Primary care practices participating in new and innovative payment models are generating cost savings by reducing emergency department visits and hospitalizations while improving the quality of care being delivered.

The College has long advocated for increased investment in primary care to ensure that patients have access to preventative and continuous comprehensive care. As internal medicine physicians who make up 24% of the physician workforce in this country, we play a role in preventive health by helping to reduce the prevalence of chronic diseases, which improves health outcomes. Not only are we uniquely qualified and positioned to manage chronic illnesses, but we are also trained to identify risk-factors that can lead to such illnesses. We can effectively encourage patients towards preventive measures, such as increasing their physical activity and eating healthier. Our role can be supported by innovative payment models that would provide primary care clinicians with the financial support, tools, and resources to meet our patients' health goals and social needs – helping to improve population health outcomes.

ACP appreciates CMMI's focus on advancing primary care through the testing and implementation of several primary care focused APMs, including the following models:

- **Making Care Primary (MCP)**
  - The MCP Model will launch in July 2024 in eight states and will include many features intended to facilitate an accessible on-ramp for primary care physicians who do not have prior experience in a value-based payment model. The MCP model includes elements designed to promote health equity, which ACP has long championed, including through our policy paper, *Reforming Physician Payments to Achieve Greater Equity and Value in Health Care*. ACP is eager to see physicians begin participating in the MCP model later this year, and how it impacts patient care.
- **Primary Care First (PCF)**
  - The PCF Model was launched in 2021 and is a voluntary, multi-payer, five-year model that is operating in 26 regions across the country. The model offers enhanced payments to support advanced primary care services. PCF is designed to help primary care practices support their patients by prioritizing the clinician-patient relationship. ACP appreciates that the model provides a variety of payment approaches to support internal medicine and primary care practices, from smaller and independent practices to larger integrated ones; it includes a range of risk options available to practices, and it could potentially reduce administrative burdens that would allow physicians to spend more time with their patients.
- **Comprehensive Primary Care Plus (CPC+)**
  - The CPC+ program was launched in 2017 and supported the advancement of the primary care medical home model of health care delivery. CPC+ strengthened the ability of internists and other primary care clinicians, in thousands of practices nationwide, allowing them to deliver high value, high performing, effective, and accessible primary care to millions of patients. The success of the model has allowed for several iterations of it to be used across many states, providing quality primary care to beneficiaries in Medicaid, Medicare Advantage, and private insurance.

Recommendations to Advance CMMI's Mission

While we appreciate the innovative work that CMMI is doing to transform health care delivery, we offer the following recommendations to further strengthen its mission. The Physician-focused Payment Model Technical Advisory Committee (PTAC) was established as part of MACRA to achieve its goal of moving physicians into APMs. PTAC provides recommendations to CMMI on physician-developed APMs models that could be successfully implemented. We remain concerned that CMMI has not implemented many of the testing of models recommended by PTAC. ACP strongly supports

PTAC's role in advising the Innovation Center on APMs and believes that priority should be given to APMs that are designed by practicing physicians who will be participating in them. **We urge CMMI to develop a clear pathway for testing models recommended by PTAC to be implemented as APMs under MACRA. Strong physician engagement and buy-in would allow CMMI to further accelerate value-based payment and care delivery for patients within Medicare and Medicaid.**

In our joint letter to CMMI with other medical specialty societies, we highlighted that "the physician community has devoted significant effort to develop well-designed APM proposals that can help transform Medicare's payment system consistent with the goals of MACRA. Many frontline physicians who have experienced the barriers to value-based care in their practices have put in years of work to develop patient-centered APMs that could offer meaningful benefits to patients and savings for the Medicare program if implemented by CMMI. These APMs would improve care for patients with asthma, cancer, kidney disease, inflammatory bowel disease, and other conditions, and enable physicians to deliver primary care, emergency care, surgery, palliative care, and outpatient specialty care to patients in higher-quality, lower-cost ways." The letter includes several examples of physician-developed APMs that CMMI should consider for implementation.

Additionally, the College would like to see a more transparent and inclusive approach to how CMMI designs and implements its demonstration models and urges CMMI to prioritize stakeholder engagement. The College supports the need for transparency in model design and for CMMI to collaborate with a broad range of stakeholders. We strongly recommend that those stakeholders include specialty societies, frontline clinicians, and patients and families. Stakeholder collaboration should be incorporated into the development, testing, and implementation of APMs with a focus on ensuring that those models are truly leading toward improved quality and value that is meaningful not only to payers and clinicians, but also to patients and their families. Collaboration with stakeholders is a critical component of decreasing unnecessary administrative tasks that lead to clinician and patient burden. **While CMMI has conducted stakeholder outreach early in the development process for some models, we strongly urge the Innovation Center to actively engage with physicians who will be participating in these models throughout both the model development and implementation processes.**

Once again, we thank you for the opportunity to underscore our strong support for CMMI's mission and to provide key recommendations that would further strengthen value-based care. ACP stands ready to serve as a resource to promote these policies. Should you have any questions, please contact Vy Oxman, Senior Associate of Legislative Affairs, at 2[redacted] or via email at [redacted].

U.S. House Committee on Energy and Commerce
Subcommittee on Health

Hearing:
Checking-In on CMMI: Assessing the Transition to Value-Based Care

June 13, 2024

Statement for the Record
American Academy of Dermatology Association

Chairman Guthrie and Ranking Member Eshoo, on behalf of the more than 17,500 U.S. members of the American Academy of Dermatology Association (AADA), we thank you for the opportunity to submit a statement for the record regarding your hearing, "Checking-In on CMMI: Assessing the Transition to Value-Based Care."

Stabilizing the Medicare physician payment system is critical to fortify independent medical practices, combat consolidation, and maintain access for patients. With the passage of the Medicare Access and CHIP Reauthorization Act (MACRA), Congress intended physicians to have opportunities to participate in Medicare Alternative Payment Models (APMs). However, nearly ten years later, the Center for Medicare and Medicaid Innovation (CMMI) has failed to approve models to meet the needs of specialty physicians. The lack of approval and insufficient payment does little to incentivize the creation of additional APMs. Patients, especially those outside the hospital setting, are missing out on the benefits of APMs, such as more timely and accurate diagnoses, improved patient-physician shared decision-making about treatment plans, as well as savings from enhanced care coordination and smarter choices about when to use biologics and other therapies.

The AADA recommends that Congress reauthorize crucial incentive payments to increase physician participation in Advanced APMs, make participation thresholds for earning the incentive payments more flexible and realistic, and update the criteria for adopting and expanding Medicare APMs. Meaningful pathways are needed for APM proposals developed by stakeholders to be implemented in Medicare. Specialty societies have a critical role to play in the development and vetting of APMs to ensure that case severity is accounted for with proper risk adjustment.

The AADA supports CMMI in establishing opportunities for specialties to engage in value-based initiatives through episode-based payment models, as it would allow for comprehensive care for patients. However,

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to ensure success there must be a shift in how episode-based payment models coexist with population-based Medicare Accountable Care Organizations (ACOs). The AADA maintains that to improve quality of care, reduce health disparities, and increase cost savings, CMMI must broaden the inclusion of specialties in ACOs by incentivizing specialty participation in appropriately risk-adjusted episode-based payment models. Moreover, it is imperative that CMMI continues to uphold the voluntary nature of specialty participation and preserves the availability of a fee-for-service option to ensure flexibility and choice for both patients and specialty physicians. Without a plurality of choice in APM models, physicians again will be financially pressured to sell practices which will exacerbate consolidation.

The AADA emphasizes the urgent need for CMMI to adopt a new approach that ensures specialties have opportunities to participate in value-based care initiatives. ***Specifically, the AADA recommends that CMMI take a more inclusive, flexible, and collaborative approach when evaluating physician developed APMs. Specialty societies are best positioned to develop episode-based APMs that not only enhance patient care and are relevant to physicians but also have the greatest potential for cost savings.*** Furthermore, participation in APMs developed, vetted, and promoted by physicians will boost confidence and familiarity with alternative payment systems among participating specialists.

The lack of specialties integrated with ACOs poses a significant challenge for existing efforts to provide high-quality, coordinated care, while reducing costs. While CMMI has a goal of expanding the number of beneficiaries involved in care networks and aims to include all Medicare fee-for-service beneficiaries in ACOs by 2030, the AADA warns against attributing all traditional Medicare beneficiaries to ACOs and supports the flexibility for patients to receive care outside of an ACO as there is insufficient involvement of specialist physicians***.***

To increase specialty and primary care integration and improve patient experience and clinical outcomes, the AADA recommends the structure of episode-based payment models be properly risk-adjusted (with specialty specific case severity definitions) with appropriate attribution methodology, incentivize specialty participation, and remain voluntary, with the continued availability of fee-for-service. When constructing episode-based care models, it is crucial to integrate appropriate risk adjustments into the framework that accounts for disease severity, comorbidities, and other complex conditions that can impact the cost of care.

CMS must incorporate appropriate risk-adjustment methodologies for underserved communities and patients with higher risk due to social determinations of health. CMMI must prioritize risk adjusting for underserved and higher risk patients from the start of model design to ensure that health disparities are addressed, and that physicians' payments are adequate to cover the costs of the services provide. By doing this, resources are allocated where they are most needed, effectively bridging the gap of healthcare disparities and enhancing patient outcomes.

The attribution methodology used in an episode-based payment model should be based solely on the services provided, and no outside factors. Physicians must be held accountable for the costs directly associated with the services they administer. When developing an episode-based payment model, the Innovation Center must incorporate attribution methodologies that ensure specialty doctors are only

held accountable for the care they provide within the ACO framework, rather than being held accountable for the entirety of a patient's healthcare expenses.

There must be incentives for participation to improve specialties engagement in ACOs. Physicians should be eligible for financial bonuses when they deliver care effectively, demonstrating quality outcomes that directly correspond to the episode of care they provide. CMMI could also consider including financial incentives that are structured to encourage ACOs to better promote access to specialty care for patients within their population. However, there should be careful consideration that ACO participation does not require burdensome administrative tasks that pressures the physician practice to purchase or use a larger system's electronic health record or practice management software. Such requirements would make participation in the ACO cost prohibitive. CMMI could increase non-financial incentives that encourage specialist participation, such as reducing the burden of federal reporting requirements that are currently imposed on specialists.

The AADA strongly emphasizes the importance of maintaining voluntary participation in episode-based payment models. By allowing CMS to test various payment approaches and assess their effectiveness, voluntary models avoid placing burdensome mandates on physicians and other providers. Furthermore, ***in conjunction with supporting value-based payment initiatives that incorporate specialty input, the AADA advocates for the continued viability of fee-for-service and the flexibility to provide care outside of an ACO***.

On behalf of the AADA and its member dermatologists, thank you for holding this hearing to review CMMI's failure to develop and approve value-based care models that meet the needs of specialty physicians. The AADA welcomes the opportunity to work with Congress to identify a permanent solution to stabilize the Medicare physician payment program and continuing to improve quality, patient outcomes, and efficiencies. We appreciate your commitment to protect public health while not creating excessive burdens on physicians, especially for small practices that may lead to limited access to and delays in care.

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

United States House Committee on Energy and Commerce, Health Subcommittee Legislative Hearing on Checking-In on CMMI: Assessing the Transition to Value-Based Care

June 13, 2024

The Alzheimer's Association and Alzheimer's Impact Movement (AIM) appreciate the opportunity to submit this statement for the record for the House Energy and Commerce, Health Subcommittee hearing on "Checking-In on CMMI: Assessing the Transition to Value-Based Care." We are grateful to the Subcommittee and CMMI 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.

AMERICAN ACADEMY OF FAMILY PHYSICIANS

June 13, 2024

The Honorable Brett Guthrie
Chairman
Health Subcommittee
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Anna Eshoo
Ranking Member
Health Subcommittee
Committee on Energy and Commerce
U.S. House of Representatives
2322 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Guthrie and Ranking Member Eshoo:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 130,000 family physicians and medical students across the country, I write to share the family physician perspective in response to today's hearing titled "Checking-In on CMMI: Assessing the Transition to Value-Based Care."

The Center for Medicare and Medicaid Innovation (CMMI) was created by the Affordable Care Act (ACA) in 2010 to test new payment and service delivery models that could improve care quality and efficiency for Medicare, Medicaid and Children's Health Insurance Program (CHIP) beneficiaries. In contrast to traditional fee-for-service (FFS) payment, value-based payment (VBP) arrangements, such as population-based payments or accountable care organizations (ACOs), better support and encourage physicians to deliver a more comprehensive set of services, such as care coordination and addressing health-related social needs (HRSN), through prospective payment and flexibility. These types of arrangements invest in the longitudinal, continuous relationships primary care physicians have with their patients in ways that FFS has not historically and enable practices to tailor care to better support patients.

For these reasons, the AAFP has long advocated to accelerate the transition to value-based care using alternative payment models (APMs) that provide prospective, population-based payments to support the provision of comprehensive, longitudinal primary care. We strongly believe well-designed APMs provide primary care a path out of the under-valued and overly burdensome fee-for-service payment system that exists today and, in turn, will better enable the Medicare program to meet the needs of its growing and aging beneficiary population in new and innovative ways.

Elevating primary care is central to CMMI's strategy and, while progress is slower than many of us would like, it has had a meaningful impact on accelerating the transition to value-based payment and increasing the adoption of APMs. The AAFP believes CMMI is integral to this transition and that there are opportunities for Congress to better enable and encourage to the Innovation Center to use other markers of success for primary care APMs.

Value of CMMI Demonstrations

Early CMMI demonstrations have better informed our understanding of what does and doesn't work in primary care APMs, providing lessons learned and driving model improvements in

later demonstrations. For example, the Accountable Care Organization Investment Model (AIM), a former primary care and population management model administered by CMMI, offered advance payments to accountable care organizations (ACOs) to fund practice transformation. The model demonstrated savings and reduced inpatient admissions, readmissions, post-acute care utilization and emergency department visits while maintaining quality. The success of AIM led to permanent changes to the Medicare Shared Savings Program (MSSP), incorporating advanced investment payments (AIP) to support physician participation in new ACOs. In 2022, MSSP saved Medicare $1.8 billion, making it the sixth year in a row that the program generated savings while producing high-quality performance results.[i]

Some learnings from early CMMI primary care models are APMs that provide upfront or advanced payments, multi-payer alignment, robust data sharing infrastructure, and technical assistance are enablers of success. Primary care physicians still face significant barriers to entering and sustaining participation in VBP arrangements. Practices must comply with an ever-increasing number of federal and state regulations, negotiate contracts with multiple payers, acquire and effectively aggregate and analyze data to track patient utilization, treatment adherence, and identify outstanding needs – all while doing their primary job of taking care of patients. This creates an immediate and high barrier to entry, particularly for independent practices that don't have the upfront capital or resources.

This is why models that provide upfront, reliable payments – especially across payers and in conjunction with other supports such as access to data – have proven to be more effective at supporting primary care practices' participation and success in improving outcomes and achieving savings longer-term. For example, practices participating in Comprehensive Primary Care + (CPC+) not only received population-based, per-member-per-month (PMPM) payments, but CMMI provided them with a robust data dashboard and other technical assistance that enabled new practices to join the model and successfully reduce emergency visits and hospitalizations. CMMI also partnered with state Medicaid agencies and commercial payers to drive alignment across payers in CPC+ regions, which in turn provided practices with greater financial support across their contracts, improved data and information sharing in many regions, and accelerated care delivery innovations.

In December 2023, the final CPC+ evaluation report was published, which showed participating practices reduced outpatient ED visits, acute inpatient hospitalizations, and acute inpatient expenditures.[ii] Independent, physician-owned practices in CPC+ successfully reduced acute hospitalizations and inpatient expenditures while hospital- and system-owned practices increased acute inpatient expenditures across both CPC+ tracks and either reduced acute hospitalizations at a lower rate than independent owned practices (Track 1) or increased acute hospitalizations (Track 2).

By the end of CPC+, practices had used the prospective payments they received as part of the model to invest in care delivery transformation that would not have been possible if FFS was their only source of revenue. These practices reported that they:

- Provided patients with after-hours access to a physician or other clinical staff member who has real-time access to the practice's EHR;
- Used designated care managers, typically on-site staff who are nurses or medical assistants, to deliver longitudinal care management services;
- Increased the use of behavioral staff to offer behavioral health counseling at a higher rate than comparison practices;
- Co-located a pharmacist at the practice site to support comprehensive medication management; and

- Convened and collected feedback from patients during Patient and Family Advisory Council (PFAC) meetings.

The Academy is also encouraged by CMS' recent announcement of a new model, ACO Primary Care Flex, which will heed some of our existing recommendations and provide low revenue ACOs participating in MSSP with a one-time upfront shared savings payment and a prospective PMPM payment. CMMI's forthcoming Making Care Primary (MCP) model, which is set to launch in July, also builds upon lessons learned from CPC+ and Primary Care First (PCF) and provides participants who are new to value-based care with upfront payments to develop infrastructure and build advanced care delivery capabilities. CMMI is also working with state Medicaid agencies and other payers in the selected states to align MCP and state programs, helping facilitate the multi-payer alignment that has contributed to successful aspects of earlier models.

Additionally, early CMMI models have shown the importance of meeting practices where they are, rather than electing a "one-size-fits-all" approach to practices entering VBP. For example, MCP will integrate this philosophy by providing three tracks to practices that each focus on goals aimed at creating pathways to enter value-based payment.

Goals for CMMI Model Design and Evaluations

A September 2023 report from the Congressional Budget Office (CBO) projected CMMI would increase net federal spending based on the Center's activities during the first decade of operation. However, the benefits of the aforementioned and other models, including ACOs, are widespread and are not accounted for in the CBO report. The model evaluations CBO relied on for this report were for brief model tests and focused on aggregate, national results. **The AAFP has long noted CMMI model evaluations are likely unable to capture the full benefits of primary care, including the long-term impacts of improving access to and quality of primary care services.**

For example, improving access to and utilization of preventive services is likely to increase total cost of care in the short term, while reducing spending and use of costly services in the long-term as illness is avoided or treated earlier. This is particularly true as the Innovation Center expands its focus on health equity and caring for patients with both complex clinical and social needs. Evaluations capture short-term costs but not long-term gains.

Demonstrating savings in primary care often takes several years as physicians build relationships with their patients, use data to better manage their care, and increase utilization of preventive and other high-value services, like care management. For example, one family physician who ran a physician-led MSSP-participating ACO in Nebraska shared that although their cost overall was lower than expected for the first three years of participation in the program they did not meet the Medicare shared savings threshold and therefore did not receive any money from Medicare for their ACO efforts. In fact, they did not receive their first shared savings payment for a full five years after their ACO started. His perspective is if they had not received PMPM payments for their Medicare population through the CPC+ program and their largest commercial contract, they likely could not have sustained their efforts and achieved this success.

Because of how long it can take for savings to manifest in primary care, the Academy has advocated for longer CMMI model test periods. We believe that the success of early models – according to the current CMMI evaluation criteria – was hindered due to relatively short model test periods. Further, all CMMI primary care model evaluations have been done at the national level, which may be masking regional successes. Currently, federal statute only allows CMMI to expand

models that reduce health care spending and maintain quality, or improve performance on quality metrics without increasing spending.

That statutory framework has prevented CMMI from making important model improvements or continuing to test models that do not show significant savings within a short model test period, ultimately causing more complexity and financial instability for participating physician practices. As the CMS evaluation of 21 models noted, the tested primary care models served large panels of relatively healthy, mostly low-cost Medicare beneficiaries and focused on preventing disease and improving care coordination.

It can be more costly on the front-end of models to get practices to participate, particularly those that require more significant resources and supports to get a foothold in VBP. Things like one-time advanced payments may often be balanced out by savings on the backend, but it requires enough test time for those to actually be realized and sustained. Longer time windows for investments in care coordination, staffing, clinical workflow redesign, health information technology, and data analytics, as well as greater engagement of primary and specialty care providers, may be needed to reduce spending in primary care models.

The challenge of short model test periods has been one of the lessons learned by CMMI, and they have been incorporating that recognition into newer model announcements. For example, CPC and CPC+ were four- and five-year models, respectively. Similarly, Next Gen ACO was five years and AIM was four years. However, new and forthcoming models like States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model will be eleven years and MCP will be ten and a half years.

The CBO report also fails to account for improvements in quality, which is one of the statutory requirement models can meet for expansion. Excluding quality from this report, particularly as CMMI has renewed efforts to evaluate quality within and across their models, narrows the lens and does not provide a full picture of the Innovation Center's impact over time. As part of its strategic refresh upon reflection of its first decade, CMMI has explicitly stated it's strengthening it's focus on quality through a new Quality Pathway, which will use quality priorities to better inform future model evaluations and the potential for expansion based upon quality.

CMMI models have had impacts across and within markets that are not captured in CMMI's evaluations. To date, little is known about the impacts of multi-payer participation in CMMI's primary care portfolio although some regions have done their own independent analyses. Understanding differences in regional performance, including contributing factors to challenges and successes, is critical to fully interpreting the success of past and future models. CPC+ spurred the creation of similar primary care alternative payment models in Medicaid and commercial plans across the country – many of which continue to operate today even though CPC+ has sunset. However, CBO notes in the report that it is unable to capture these downstream impacts.

Further, the CBO report does not take into account Medicare savings (or those accrued in other lines of business) that we know have been achieved in MSSP – the only nationwide value-based payment model. As of January 2024, SSP ACOs include over 634,000 participating clinicians who provide care to almost 11 million people with Medicare.[iii] Recent MSSP results emphasize that primary care-led alternative payment models most effectively achieve cost savings. One New York Times report noted that Medicare spending is about $3.9 trillion dollars lower than previous projections expected, with changing clinician behavior and cost consciousness being one explanation.[iv] This report indicates the potential impacts of the MSSP program and the value movement overall may have had significant effects on Medicare spending that aren't captured by CBO.

As the Subcommittee examines the Innovation Center's progress, we believe there are opportunities to build upon and improve the original statute to better support CMMI's role in accelerating the transition to value-based payment. Specifically, **Congress should consider enabling and encouraging CMMI to evaluate several other markers of success for primary care APMs**, such as whether they successfully bring new physicians into value-based payment, improve patient experience measures, markedly improve care delivery transformation, enable more beneficiaries to access the behavioral health services they need, and when applicable, evaluate models both nationally and regionally. These additional criteria would allow CMMI to continue testing models that show early markers of success and iterate upon them to meet current patient, clinician, and market needs.

Thank you for continuing to focus on the importance of transitioning our health care system away from prioritizing volume over value. We look forward to working with Congress to better support CMMI's integral role in this meaningful shift, particularly within primary care. Should you have any questions, please contact Natalie Williams, Senior Manager of Legislative Affairs at [redacted].

Sincerely,

Tochi Iroku-Malize, MD, MPH, MBA, FAAFP
American Academy of Family Physicians, Board Chair

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Statement

of the

American Hospital Association

for the

Committee on Energy and Commerce

Subcommittee on Health

of the

U.S. House of Representatives

"Checking-In on CMMI: Assessing the Transition to Value-Based Care"

June 13, 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. The AHA appreciates the Centers for Medicare & Medicaid Services' (CMS) continued efforts to develop innovative payment models to reward providers based on outcomes rather than patient volume.

Over the last 14 years, many of our hospital and health system members have participated in a variety of alternative payment models (APMs) developed by the Center for Medicare and Medicaid Innovation (CMMI). Some APMs have generated net savings for taxpayers while maintaining quality of care for patients.

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. CMMI plays a critical role in ensuring that hospitals and providers are set up for success in the various models they deploy. But some of the CMMI models were designed with requirements that made implementation exceedingly difficult and success even more so.

There are principles that we believe should guide the development of APM design. 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.

To ensure that these and other practical considerations are appropriately included in CMMI models, we believe the agency would benefit enormously from consulting an

advisory group of hospital and health system leaders who are managing or have managed the kind of organizations that would be part of the models CMS is trying to build.

TEAM PROPOSED PAYMENT 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.

INCREASING ORGAN TRANSPLANT ACCESS PROPOSED 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

Again, the AHA supports the health care system moving toward the provision of more accountable, coordinated care. We recognize the critical role CMMI plays in advancing innovative payment models. We have recommended principles that should guide the development of APM model design and are concerned that recent model proposals such as TEAM and IOTA are steps backwards. The AHA appreciates your efforts to examine these issues, and we look forward to working with you.

Community Catalyst

Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515

June 13, 2024

Dear Members of the Energy and Commerce Committee,

Community Catalyst – a health justice and advocacy organization, with established relationships with over 300 partner organizations across 40+ states, would like to provide in-depth endorsement for the CMS Center for Medicare and Medicaid Innovation (CMMI), in its critical mission to enhance healthcare quality, promote health equity, and drive cost-effectiveness within the Medicare system. With a strong focus on race equity and health justice, Community Catalyst recognizes the multifaceted landscape in which CMMI functions. Considering recent insights from the Congressional Budget Office (CBO) concerning CMMI's spending, our aim is to offer a comprehensive analysis of its initiatives and their profound impact on beneficiary and population health outcomes. It is essential to recognize that CMMI's mission extends beyond cost containment only. It serves as a laboratory for innovation, which can foster creativity and learning, increasing quality experiences and outcomes of beneficiaries. By testing novel approaches, CMMI contributes to a dynamic health care landscape—one that adapts to evolving patient needs, technological advancements, and societal shifts.

Unaccounted Cost Savings and Quality Improvements:

CMMI's emphasis on health equity principles and addressing social determinants of health can lead to considerable cost savings and quality enhancements. A Deloitte research article underscores the urgency of addressing health disparities. These inequities—linked to race, socioeconomic status, and other social determinants—have far-reaching consequences. They not only compromise the health and wellness of beneficiaries, but also strain our health care system and perpetuate inefficiencies. Failure to address health disparities could cost the U.S. health care system approximately $320 billion annually. Deloitte projects this to exceed $1 trillion by 2040 if unaddressed, and this demands immediate attention. CMMI's commitment to incorporating equity principles into its models is commendable, welcomed, and a necessary ingredient for all models moving forward. By screening for health-related social needs (SDOH) and considering the broader context of beneficiaries' lives, CMMI models aim to bridge gaps and promote health equity. These efforts align with the broader movement toward value-based care and population health management. One of the limitations of the CBO estimates, is that the analysis of final model evaluations often fails to capture specific "ingredients" in models – such as screening for SDOH and equity principles, potentially undervaluing the impact of individual components on the overall outcomes of the healthcare system.

Long Term Savings Through Prevention and Population Health Management:

While immediate cost savings may not always be apparent, focusing on prevention and population health models can yield significant long-term benefits. By detecting health risks early, preventive measures can avert costly treatments down the line. Early intervention or chronic condition management reduces the need for expensive medical interventions in the future. For example, CMMI could work more directly with Community Based Organizations (CBO's), who provide critical public health and healthcare infrastructure, and play a critical role. Proven multi-dimensional community-based programs with multi-dimensional interventions around physical activity, tobacco cessation, and nutrition improvements lead to overall health and cost savings.

Additionally, an updated analysis estimated that at least 234,000 deaths from COVID-19 between June 2021 and March 2022 could have been prevented with a primary series of vaccinations. These vaccine-preventable deaths represent 60% of all adult COVID-19 deaths since vaccines became widely available.
In 2017, almost 3 million premature deaths across OECD countries could have been avoided through better prevention and health care interventions, accounting for over one-quarter of all deaths. Between 20% and 40% of premature deaths in the United States from leading causes (such as heart disease, cancer, respiratory diseases, stroke, and unintentional injury) could be prevented.

Incorporating User-Centered Desing and Co-Design in Health Innovation:

We firmly believe that health care should begin with the end user—the patient. User-centered design places patients at the center of decision-making processes. By actively involving patients, caregivers, and health care providers, we ensure that models, interventions, and services align with their needs, preferences, and lived experiences. Co-design methodologies empower beneficiaries to shape the future of health care. Their input informs everything from care pathways to technology adoption.

Community Catalyst actively collaborates with CMMI, and it underscores our commitment to patient-centric approaches. We also participate in the Person Perspectives Council and the Accountable Care Action Collaborative within the LAN HCPLAN (Health Care Payment Learning and Action Network), which reinforces our dedication to involving beneficiaries in decision-making. Together, we strive to co-create models that resonate with the diverse needs of diverse, systemically excluded, and underserved communities.
We also applaud CMMI for its dedication to exploring how it may incorporate patient reported outcome measures and experiences into model design. PROMs and PREMs allow us to assess health system performance from the patient's perspective. PROMs capture patients' views of their health status, while

PREMs measure their perceptions of care experiences. These measures drive quality improvement, enhance patient engagement, and contribute to better outcomes.
Beyond practical benefits, involving patients in co-design is ethically sound—it's the right thing to do. However, it also leads to more cost-effective care. Engaged patients are more likely to adhere to treatment plans, reducing unnecessary utilization and preventing complications. For instance, health coaching programs, navigation support and remote monitoring tools have demonstrated both improved outcomes and financial savings.

Opportunity Costs and Social Return on Investment (ROI) in Health Innovation:

Traditionally, health care evaluations have focused on financial returns, often measured through ROI. However, this approach overlooks broader societal benefits and the impact on patients' health and well-being. As we explore alternative payment models, we should also consider alternative cost savings models. Social ROI emerges as a more appropriate methodology. As an advocate for the advancement of cost-effective and patient-centered healthcare models, we believe that understanding the true impact of investment in healthcare requires a comprehensive evaluation of returns on investment (ROI) alongside social return on investment (SROI).

It is imperative to highlight that the current cost and savings estimates of CMMI models, focusing on ROI, fail to capture the full scope of benefits that could be generated by incorporating SROI considerations. By emphasizing the opportunity costs associated with prioritizing quality and cost-effectiveness, the CBO and CMMI have the potential to unlock avenues for achieving greater cost savings and enhanced healthcare outcomes. The exclusive reliance on ROI metrics may overlook the broader societal and individual impacts that resonate beyond financial returns only.

Moreover, we would like to draw attention to the inherent limitation in existing cost-effectiveness models concerning the exclusion of "patient affordability" as a significant dimension. The oversight of patient affordability as a vital input not only hinders a comprehensive assessment of cost effectiveness but also neglects the lived experiences and financial constraints faced by beneficiaries of healthcare services.
As CMMI embraces initiatives focused on screening for social determinants of health (SDOH) and providing navigation support, there is a distinct opportunity to enhance the affordability of health and wellness of beneficiaries. By recognizing the interplay between addressing SDOH factors and improving patient affordability, CMMI is poised to foster a more sustainable and inclusive healthcare environment that prioritizes the well-being of all beneficiaries, and to actualize additional cost savings.

Learning from Failures and Driving Improvement:

Leveraging insights from successful and unsuccessful models and initiatives within CMMI's initial decade is pivotal for refining strategies and enhancing healthcare quality and experiences for beneficiaries. Beyond focusing solely on savings, it is important to understand the broader impact of these models on the quality of care and beneficiary outcomes. However, the current evaluation framework utilized by the Congressional Budget Office (CBO) often overlooks the valuable lessons that can be gleaned from failures and setbacks in healthcare innovation.

We must also acknowledge that failures are not merely setbacks but essential components of a continuous quality improvement (CQI) methodology. Understanding the root causes of failures, identifying areas for improvement, and implementing corrective measures based on these learnings can result in unrecognized cost savings in the long term. By fostering a culture that embraces failure as an opportunity for growth and innovation, CMMI can drive sustainable improvement and innovation in healthcare delivery.

The omission of these crucial insights from the CBO score evaluation may lead to an incomplete understanding of the effectiveness and value of CMMI's models. By incorporating an analysis of both successes and failures, policymakers can gain a more comprehensive understanding of the long-term impact of healthcare innovation programs. These insights are essential for driving continuous improvement, fostering innovation, and ultimately, enhancing the quality and efficiency of healthcare services for beneficiaries.

In conclusion, CMMI's commitment to innovation, quality enhancement, and health equity aligns closely with our organization's mission of advocating for equitable healthcare outcomes. We urge the Energy and Commerce Committee to meticulously assess the multifaceted impact of CMMI's initiatives and prioritize policies that enhance health equity, quality care, and beneficiary empowerment.

Thank you for considering this detailed endorsement. We look forward to engaging in fruitful discussions and collaborative efforts aimed at advancing health equity, quality care, and cost-effectiveness for all Medicare beneficiaries.

Best Regards,

Dr. Brandon G. Wilson
Senior Director of Health Innovation, Public Health & Equity
Community Catalyst

1. Federal Budgetary Effects of the Activities of the Center for Medicare & Medicaid Innovation
2. US Healthcare Can't Afford Health Inequities
3. Advancing Health Equity, Eliminating Health Disparities, and Improving Population Health
4. Policy Recommendations for Reducing Healthcare Costs
5. How Can We Pay for a Healthy Population
6. A Review and Analysis of Economic Models of Prevention Benefits
7. Engaging patients to improve quality of care: a systematic review
8. Four Ways Patient Engagement Reduces Costs
9. New Research Details Specific Recommendations for CMS, Others, on Making Dual Eligible Enrollment Person-centered
10. Elevating the Beneficiary Perspective: Recommendations on How the CMS Innovation Center Can Enhance Beneficiary Engagement
11. The social value of investing in public health across the life course: a systematic scoping review