Statement by Ranking Member Frank Pallone, Jr.
House Energy and Commerce Committee
Subcommittee on Health
Hearing on "Examining Barriers to Expanding Innovative, Value-Based Care in Medicare"

September 13, 2018

Today's discussion is important to help Congress understand the different ways we might expand innovative, value-based care in our Medicare program.

The Affordable Care Act (ACA) took major steps towards improving the quality of our healthcare system by creating new models of delivery within the Medicare program. These new models were intended to transform clinical care and shift from a volume- to a *value*-based care model, such as Accountable Care Organizations (ACOs) and Patient Centered Medical Homes (PCMHs).

With the passage and implementation of the Medicare Access and CHIP Reauthorization Act (MACRA), we entered the next phase of healthcare delivery system reform. MACRA built on the ACA's efforts by offering opportunities and financial incentives for providers to transition to new payment models known as Advanced Alternative Payment Models, or A-A-P-Ms. AAPMs require providers to accept some financial risk for the quality and cost outcomes of their patients.

MACRA also created the Merit-Based Incentive Payment System, or MIPS, an alternative path for clinicians to make the shift away from a volume-based system to a value-based system that focuses on quality, value, and accountability. Together these new programs were designed to influence doctors to make change and the law gives them great flexibility in choosing the right model for the right provider.

Unfortunately, I have been disappointed thus far with the Trump Administration's progress on building on these successes and their lack of actions to move the Medicare program to a value-based system.

Most notably they have rejected the goals made under the previous administration, to make 50 percent of all Medicare payments to hospitals and doctors through value-based models by the end of 2018.

They have not taken meaningful action to expand the number of Alternative Payment Models available to Medicare providers. They have failed to test or implement any physician-focused payment models and have cancelled or scaled back a number of bundled payment models.

Meanwhile, CMS has taken steps to undermine MACRA's MIPS program, by exempting 60 percent of Medicare physicians from its requirements. While I understand that there are challenges with MIPS, I don't think the answer is to just exempt providers from its requirements. Nor do I think that is what Congress envisioned. By exempting these doctors entirely, the Administration is choosing not to engage small providers—a lost opportunity to say the least.

I am also concerned that the Administration's proposed regulation on ACOs will dampen enthusiasm for engaging in these models. The evidence is unequivocal that ACOs have both improved the quality of care for Medicare beneficiaries, and saved the Medicare program money.

As our two witnesses with experience with the ACO program will testify today, the kind of cultural change required to implement

an integrated, patient-centered, system like an ACO takes time and investment in people and in systems. While I support efforts to get more ACOs to embrace financial risk, the proposed rule could potentially cut the program off at its knees by requiring ACOs to take on risk within two years, and by lowering the shared savings rate.

Let me conclude by addressing the issues of Stark and the Anti-Kickback Statute. I know some stakeholders view these laws as a barrier to value-based payment reform. I would be interested in hearing about specific instances in which Stark and the Anti-Kickback Statute have posed barriers to value-based payment arrangements. But I also want to stress the continuing importance of these laws, which are intended to ensure that doctors do what is best for patients, not what is best for their bottom line. There is empirical evidence that these laws operate to prevent overutilization in

Medicare. This is bad for both patients and taxpayers. So, we must proceed with great caution in making changes to these laws.

I also want to underscore—eliminating or reducing the effectiveness of the Stark and Anti-kickback laws is not a delivery system reform agenda. On its own, deregulation does not move us to value. That will require transformative leadership at HHS, and an industry-wide commitment to align financial incentives with healthcare quality and performance, with the patient always at the center.

I look forward to discussing these and other issues with the panel today. I yield back.