HOUSE COMMITTEE ON WAYS & MEANS
Health Subcommittee Hearing

"Improving Value-Based Care for Patients and Providers"

June 26, 2024 – 3:00 PM

OVERVIEW

On June 26, the House Ways and Means Health Subcommittee held a hearing titled, "Improving Value-Based Care for Patients and Providers." During the hearing, Members and witnesses discussed Accountable Care Organizations (ACOs), Congressional oversight, the Hospital Readmission Reduction Program (HRRP), Medicare Advantage (MA), the quality bonus program (QBP), preventive medicine, telehealth, hybrid payments, mobile clinics, cancer screening, patient outreach, private equity (PE), consolidation, minimum staffing ratios, Federally Qualified Health Clinics (FQHCs), "food is medicine" approaches, total-cost-of-care arrangements, rural provider participation in CMMI models, and transparency at CMMI.

OPENING STATEMENTS

- Chairman Vern Buchanan (R-FL)*
  **Opening statement not yet available*
- Ranking Member Lloyd Doggett (D-TX)

WITNESS PANEL

- Dr. Sarah Chouinard – Chief Medical Officer, Main Street Health
- Mr. Stephen Nuckolls – CEO, Coastal Carolina Health Care; PA, Coastal Carolina Quality Care
- Dr. Matthew Philip – Chief Medical Officer, Duly Health & Care
- Dr. Robert Berenson – Institute Fellow, Urban Institute

QUESTION AND ANSWER SUMMARY

Rep. Adrian Smith (R-NE) – Congress does not discuss value-based care enough. There have been some successes, one of the most noteworthy being Accountable Care Organizations (ACOs), which demonstrate "higher performance metrics on a wide slate of quality measures, including diabetes and blood pressure control, cancer screenings, tobacco cessation, and even depression screening and follow up." Workforce shortages are a challenge for ACOs in rural areas, especially the shortage of non-physician providers of primary care. There are not enough rural physicians to meet the needs of rural health systems. My constituents rely on primary care provided exclusively by nurse practitioners (NPs) or physician assistants (PAs), but current law requires these clinicians to refer patients to an outside doctor to be assigned to an ACO. My legislation, the ACO Assignment Improvement Act (H.R. 7665), would allow NPs and PAs to assign their patients to ACOs directly without the additional visit, allowing

patients to benefit from the more coordinated care of ACOs more easily and more efficiently. I also would like to highlight the Strengthening Innovation in Medicare and Medicaid Act (H.R. 6732), which provides for more oversight and accountability for the Center for Medicare and Medicaid Innovation (CMMI or CMS Innovation Center), which has failed to achieve fiscal savings and improve patient care. This bill will ensure CMMI model testing aligns with its original mission. CMMI must focus on its original intent, wind down failed initiatives as quickly as possible, and expand and certify successes. There has been bipartisan concern since CMMI's creation that its models appear to exceed intended payment incentives for cost savings and quality improvement. How can Congress protect CMMI from political abuse and ensure models are aligned with the goals of controlling costs and improving care?

Dr. Berenson – CMMI's record has been mixed, but I'm not sure if its problems have been politically directed. I was on the Physician-Focused Payment Model Technical Advisory Committee (PTAC) for three years and we received great proposals from physicians who identified problems in how they were delivering care and had ideas to improve it; these physicians did not need a full-scale model from CMMI, just coding improvements and payment improvements in the basic fee schedule. The majority of recommendations were coding initiatives in the fee schedule. CMMI should focus on a few basic models, and ACOs seem to be the major ones that have "some legs." CMMI should not try to solve every problem with a full-scale model. Improvements to payment methods can happen through the fee schedule. For clarification, fee-for-service (FFS) and the fee schedule are not synonymous – we already do bundled payments through the fee schedule. These improvements can be made through normal notice and comment rulemaking.

Ranking Member Lloyd Doggett (D-TX) – I am concerned about the reclassification of inpatient hospital information concerning observation stays. This could have consequences for the patient and Medicare coverage. I support Rep. Joe Courtney (D-CT)'s legislation to ensure observation counts toward eligibility for skilled nursing home care. Dr. Berenson, could you elaborate on gaming hospitalization data and the flaws in relying on it as a quality measure?

Dr. Berenson – It turns out the Hospital Readmission Reduction Program (HRRP) was only a success because observation stays were not included in the calculations. Similarly, Medicare Advantage (MA) plans claimed they had reduced hospital stays compared to traditional Medicare; research concluded MA plans were more aggressive in reclassifying patients under observation stays for which payment is done under Part B rather than as a Part A inpatient stay. MA plans actually had higher readmission when true inpatient stays, observation stays, and follow-up emergency room (ER) visits were totaled. The readmission penalty is one of the major failures of pay-for-performance – the disincentive to reduce readmissions revealed a major equity problem that adversely affected hospitals in low-income areas lacking ambulatory care and community and family resources. Studies are beginning to show that reduced readmissions also compromised quality for patients with congestive heart failure. This may not be a valid quality measure and may be driving bad science.

Ranking Member Doggett – How would you reform the quality bonus program (QBP) to ensure there are genuine improvements?

Dr. Berenson – One of the basic flaws of QBP for MA plans is that it is the only program that is upside-only. A virtue of the Merit-based Incentive Payment System (MIPS) is that it was designed such that penalties pay for rewards. Three- and four-star plans are getting paid very generously under QBP. "The critique is fairly major – we would do a basic reevaluation of whether it is achieving anything other than providing windfall profits for MA plans." Research shows MA plans provide about the same quality as traditional Medicare – no better, no worse – yet they are receiving huge bonuses. There are some excellent MA plans – I do not want to imply that MA should be "done away with" – but it is one of the problems with moving to full capitation: the plans receive "a big slug of money from the federal government" and then have a direct incentive to try to deny care. I believe in blended payment models: part FFS, part capitation.

Rep. Mike Kelly (R-PA) – This business model is complex. I am going to cede my time to Dr. Wenstrup.

Rep. Brad Wenstrup (R-OH) – When I came to Congress I expected to crack down on bad doctors, but the threat of malpractice is enough to keep doctors in check. Congress has gotten too involved – nothing Congress did drove successes in my practice. Medicine today does not put enough value on the healthy human life, and that is where savings come. I co-lead the Value in Health Care Act (H.R. 5013), and I think

it makes some changes to the program parameters, but it will need review even if it passes. As a doctor, my pay kept going gown in FFS. I did not give up on my time with the patient, but paperwork increased and so did costs within my office. Prevention is key in healthcare. I am a podiatrist; one year, Arizona decided to drop podiatric services under Medicaid and their costs went up because podiatrists do a lot of prevention for ulcers, vascular disease, neuropathy, and congestive heart failure, and we direct patients to the right care. Arizona's costs soared and amputations increased. I tell insurance companies they should eliminate three copays a year for insulin-dependent diabetics to visit their doctor because it would prevent hospitalizations.

Rep. Mike Thompson (D-CA) – There is bipartisan agreement that healthcare is too expensive and healthcare spending is out of control. The pay-for-service model is flawed and has consequences for patients and the Treasury. We all agree with maximizing the value to patients with each dollar spent. My district is rural and my wife is a healthcare provider in my rural district, but it is also important to recognize that underserved patients are underserved regardless of whether they live somewhere rural, urban, or suburban. I see a bright spot in the advancement of technology, especially telemedicine, artificial intelligence (AI), and other areas of rapid advancement. How can that benefit some of the challenges we face today?

Dr. Berenson – I assume this is in the context of communication technology, which underlies telemedicine with patient portals.

Rep. Thompson – I mean information technology (IT) as it pertains to the delivery of healthcare and the accessibility of healthcare.

Dr. Berenson – It is a major development that underscores the desire to improve value-based care, which would include robust use of telecommunications – phone calls, emails, texts, and patient portals – between doctors and patients, doctors and other doctors, and doctors and pharmacists, for example. "All of that should be going on much more than now, and it points to the flaws in value-based payment or current payment, let's put it that way." CMS correctly, in my opinion, has a limited definition of telemedicine, allowing it for services that are a substitute for a face-to-face visit, yet a lot of activities that occur are short communications rather than substitutes. A primary care doctor calling a patient after a visit to see how they are doing is not paid for under FFS; the National Academy of Medicine proposed to move primary care to a hybrid payment model in which a major piece of compensation comes from a per-beneficiary, per-month payment that provides support for robust communication outside of FFS. CMMI and CMS are mounting a program resulting from the National Association of Accountable Care Organizations (NAACOS) to move to a hybrid payment model for Medicare Shared Savings Program (MSSP) ACOs wishing to participate, creating a much more logical payment model for primary care. Research shows that up to 30 percent of what primary care doctors do clinically on a daily basis is not paid.

Rep. Wenstrup – In the context of cost savings through prevention, what are some things that are keeping people healthy?

Dr. Chouinard – One thing that is important to think about is the use of mobile technologies for things like diabetic eye exams. In rural West Virginia, some patients do not get screenings due to transportation barriers – instead of solving the transportation barrier, we can support new tools that allow people to receive services in their communities. There is a project called Bonnie's Bus that brings mobile mammograms to women who would not otherwise be able to make it to a screening center. The biggest barrier to prevention in rural America is getting to the physical locations. Main Street Health does conduct some services in office, but we don't have a mammography suite, for example. This is not innovation in the sense that this is not new technology, but it is innovative in that I do not think it is leveraged enough in rural primary care.

Mr. Nuckolls – We are also in a rural area and set up a cancer screening program for smokers in our area. We set up this quality measure even though it is not one that is included in the program, but we have successfully identified a lot of cancers early. We are spending more money upfront as an ACO, but we know it is investment in the long-term health of our patients. One issue came up: the U.S. Preventive Services Task Force (USPSTF) recommends screening everyone up to age 80 but Medicare only covers screening up to age 77; we are in the enhanced track, meaning we keep 75 percent of our savings. We decided to do it anyway for these patients because we view this money as ours and we are a protector of the Medicare Trust Fund because we are at-risk.

Unfortunately, our ACO will have to “do something else next year” because there are not enough savings once the benchmark is lowered and the “meager savings that we’re allowed to carry forward is not enough to cover the cost of these programs, so we’ll have to do something different.” That is something that will have to be addressed.

Dr. Philip – Duly Health & Care created breakthrough care centers that focus on the sickest five percent of patients who account for up to 50 percent of healthcare costs. These centers have a multidisciplinary approach that resulted in a 20 percent decrease in hospitalizations and a 25 percent decrease in readmission rates. Duly Health & Care also used AI and machine learning (ML) to create a predictive analytics model to assess things physicians would not know, like how many times a patient is calling in, how frequently a patient is scheduling visits, and similar metrics that represent “a cry for help from our patients.” The model is 70 percent accurate in predicting a hospitalization or an ER visit, meaning we can come to the patient before they need to come to us.

Rep. Judy Chu (D-CA) – I would like to talk about private equity (PE) because consolidation across healthcare is affecting patient care and provider compensation. PE ownership is damaging the entire health system, aggressively buying out healthcare systems across the country only to sell off assets three to five years later after slashing staffing, cutting quality, and jeopardizing access to healthcare for entire communities. The fundamental principle behind PE is antithetical to the goals of protecting patients and taxpayer dollars. What impact does it have on patient care, healthcare costs, and the healthcare workforce when a PE-owned healthcare facility closes due to bankruptcy? How can Congress increase oversight of PE in healthcare and understand the impact on providers and patients? How would transparency measures ensure better patient care at PE-owned facilities?

Dr. Berenson – Even before the big rise in PE, even not-for-profit hospital systems had billions of dollars sitting in the stock market. This is the context around consolidation. There are unique aspects about PE that make it more challenging for the public good than “just providers acting in their own interest.” It creates a major gap in care when a community loses a central organization. I read a story about a PE company that bought an ER in a small Tennessee hospital and decided not to have any doctors in the ER; quality problems naturally arose at that ER. “The financial pressures are such that they will make some very bad decisions: clearly, staff layoffs are a major problem.” There is a long menu that policymakers have suggested to address it, and antitrust plays a role. There should be lower thresholds for mergers. One problem with PE is sequential purchases that become a mega-system. There could also be more attention to mandated staffing ratios, though I know this is controversial. Limiting the share of the acquisition price that is financed with debt is another option. This issue needs more attention at both the state and federal levels.

Rep. Danny Davis (D-IL) – I worked at two Federally Qualified Health Centers (FQHCs) when there were only 10 in the country, three of which were in Chicago. How impactful is the FQHC approach in providing services to rural and urban disadvantaged communities?

Dr. Chouinard – FQHCs are a critical part of the solution. The FQHC where I worked was the only provider in many of the nine central West Virginia counties we were in. Quality is ingrained in the FQHC approach; we ensure patients with the most need get the most health, and FQHCs should remain in place.

Rep. Davis – Some areas still do not have FQHCs, meaning there is opportunity to expand them. Dr. Berenson, where is the trend going in healthcare, whether it be PE ownership or non-for-profit entities?

Dr. Berenson – There is pervasive greed across the healthcare system, from the pharmaceutical industry to insurance to hospitals, and increasingly doctors with PE who are looking for loopholes in payment systems. The culture of healthcare is being threatened and deserves attention. It needs to be more difficult for greed to succeed. On FQHCs, I wanted to add that the workforce shortage is increasing because nobody wants to enter primary care at the residency level and those who do enter general internal medicine often become hospitalists rather than working on the frontlines of delivering care. The fee schedule is partly the cause of this trend because it pays more lucratively for procedural specialties. FQHCs should thrive, but the workforce – including NPs and PAs – needs to be available to support them.

Rep. Davis – FQHCs have been effective acquisitions to healthcare delivery.

Chairman Vern Buchanan (R-FL) – Human nature is self-interest, so there should be incentives for consumers of health to take more responsibility. People should be more educated. Some things cannot be prevented, but a lot of it can be. The two things that "are better than drugs and everything else" are exercise and diet. I have read that there is "40 percent obesity, type 2 diabetics." People should be more educated on their health so that they need to see doctors less. Doctors and hospitals are complaining that they are not being reimbursed enough. I am concerned that operators are buying everything up to make a profit. I support preventive care and we need to set up the right incentives. My mother died of colon cancer. The system is broken. Health starts with diet and exercise; the food we eat is part of the problem because it is highly processed and has no nutritional value. Medicare spent $1.1 trillion in payments this year.

Dr. Chouinard – When I worked with the FQHC, we had a program called the Farmacy program and we worked with local farmers to bring boxes of food to patients. There were a lot of vegetables that people did not know how to cook, so we also had to add cooking instructions. It was a small study, but we had diabetic patients who were poorly controlled, and their blood sugar came down during the program with no changes to their medicines. We need to consider expanding our care teams to include non-credentialed members. Main Street has health navigators who help with things like motivational interviewing techniques; for example, helping a patient understand the risks if they turn down a colonoscopy.

Chairman Buchanan – In Florida, a doctor I know gets a lot of patients from the Midwest and the Northeast who are on six or seven medications and could stop taking half of them if they started walking two miles a day.

Mr. Nuckolls – Our ACO has reduced our hospitalizations by 38 percent and reduced ER visits by 29 percent through a combination of factors because the program was set up to incent keeping patients healthy. The real question is the "invisible hand:" calling patients between visits, talking to their wives about their diets, calling to ask if they have been exercising, and checking in to let them know you care. The benchmark is why more doctors are not doing this. The incentives need to be there so providers groups are empowered to do the right thing and treat patients like you would treat your parents.

Chairman Buchanan – My concern is that with the way the system is set up right now, what is the incentive? The incentive right now is set up such that "if I do more, I make more." The idea should be that if you do less and they are healthier, that is the incentive.

Mr. Nuckolls – The whole problem is the benchmark. It should be more profitable to do total-cost-of-care arrangements, but the benchmarks are not currently set that away.

Dr. Philip – Duly Health & Care started a culinary medicine program after realizing that many people did not know how to cook; it's not that they didn't want to eat healthy, they just did not know how. We trained them how to cook healthy meals as a pilot program and saw significant improvements in their health. It also created a cycle that decreased reliance on medication, reduced medication side effects, and encouraged patients to exercise. We are now scaling culinary medicine programs across the network.

Dr. Berenson – I have high blood pressure, and I have managed it with diet, exercise, and home monitoring. Some ACOs and MA plans have set up successful programs to get 80 percent of patients under control, but nationally the performance is dismal. It is an example of an area where patients could be educated and trained to take responsibility for managing the condition.

Rep. Carol Miller (R-WV) – In West Virginia, it can take five hours to get to the hospital where your physician is located. Medicare's value-based care models have left rural providers behind multiple times. A 2021 Government Accountability Office (GAO) report showed rural providers participate in these programs at lower rates. What factors prevent rural providers from participating in value-based payment systems?

Dr. Chouinard – Administrative burden comes to mind. In small practices, it is hard to dedicate a team to understand the opportunity, track what needs to be tracked, and report what needs to be reported. Main Street is trying to alleviate some of that burden for rural physicians so they can participate. Primary Care Associations

(PCAs) are another source of information. Demand for care is also so high that making the change, adopting new technology tools, and everything else that comes with it is just too difficult. I took my job at Main Street because I wanted to help reduce administrative burdens on clinicians so that we do not lose more of them.

Rep. Miller – CMMI's Emergency Triage, Treat, and Transport (ET3) Model failed to consider rural providers. Many eager West Virginia providers were ineligible because CMMI did not factor in that not all rural communities have an alternate site of care within their model regions. I sent a letter to CMS last year highlighting this issue and requesting a statewide treat-in-place demonstration in West Virginia; CMS denied the request and ended the ET3 model two years early. How can CMMI integrate small, rural, and independent providers into its models? What factors of rural care delivery does CMS need to consider?

Dr. Chouinard – Volume thresholds are problematic. In rural emergency rooms, many patients come in who do not need to be in the emergency room. Another factor is social isolation and loneliness – lots of patients who are anxious and lonely call emergency services, think they're having a heart attack, and get transferred. Programs that would engage rural seniors and provide extra support – such as phone calls between visits – might identify symptoms of an actual heart attack in a congestive heart failure patient and bring them into the office. I agree with your suggestion to think about the unique scenarios such as geographic distance and volume of people in rural communities when designing future models.

Rep. Claudia Tenney (R-NY) – My district is also rural and sprawling. CMMI needs to rethink how it engages with participants and relevant stakeholders to encourage participation and retention. It would also be better served if it operated more transparently. How can CMMI improve its communication and transparency regarding ACO changes and benchmarking calculations, and how would this help in rural areas?

Mr. Nuckolls – Rural areas are critical with the way the benchmarking process works because critical access hospitals (CAHs) are paid differently than other hospitals. CMMI has an opportunity to be transparent and develop unique benchmarks to serve rural communities. When we started our ACO, we were in a rural area, and rural means underserved. When you add more services, you end up spending more money, so we ended up spending more money and breaking even during our first contract period; after we got control of our patients and started participating in a lot of these programs, and we reduced hospitalizations and ER visits. We were part of several CMMI programs, such as Track 1+, the Advance Payment ACO Model, and we are considering the ACO Realizing Equity, Access, and Community Health (REACH) Model. CMMI does a reasonable job communicating with ACOs, but it could do better. We need data sooner so we can respond to it.

Rep. Tenney – A county in my district cannot get a single provider to run a federally-funded health center. Costs, recruitment, and retention are a problem. How can we make this program work so we can get the innovation we need along with a new payment view and then use that to attract and retain skilled physicians?

Mr. Nuckolls – We need stable physician payments; there must be inflation updates. Physicians have been losing money each year, and we would not be able to recruit into our area without our ACO savings. Unfortunately, due to the way the benchmarks are set, we will have to leave the program at the end of this year. The Advanced Alternative Payment Model (A-APM) payments have helped offset the lack of inflation updates.

Rep. Tenney – What challenges are inhibiting rural providers from participating in value-based payment systems? How can CMS and Congress help keep excellent healthcare in these communities? These communities are aging and need healthcare.

Dr. Chouinard – Recruiting providers to rural communities will require offering a more attractive way to practice medicine. Building outpatient primary care models that allow providers to spend the most time with the sickest patients would help, as would expanding care teams to have diabetic educators and other supporters who can do extra work with patients.

Rep. Tenney – Physicians, NPs, and other providers are all overwhelmed because patient needs are not prioritized based on health levels. We could do so much more with CMMI on this.

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