October 15, 2023

The Honorable Michael Burgess, M.D.
U.S. House of Representatives
2161 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Drew Ferguson, IV, D.M.D
U.S. House of Representatives
2239 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Lloyd Smucker
U.S. House of Representatives
302 Cannon House Office Building
Washington, D.C. 20515

The Honorable Earl L. "Buddy" Carter
U.S. House of Representatives
432 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Blake D. Moore
U.S. House of Representatives
1131 Longworth House Office Building
Washington, D.C. 20515

The Honorable Rudy Yakym III
U.S. House of Representatives
349 Cannon House Office Building
Washington, D.C. 20515

Submitted electronically via hbcr.health@mail.house.gov

Dear Representatives Burgess, Ferguson, Smucker, Carter, Moore and Yakym:

The Health Care Transformation Task Force (HCTTF) applauds the House of Representatives' Budget Committee for establishing a Health Care Task Force to examine key drivers of our nation's health care spending and solutions to improve health outcomes while bending the cost curve. The Budget Committee's Task Force is currently soliciting feedback from stakeholders and experts on solution to improve outcomes, reduce federal health spending in the budget, as well as opportunities to build upon the Congressional Budget Office's (CBO) ability to project the impact of health care policies.

HCTTF is a consortium that supports accelerating the pace of transforming the delivery system into one that better pays for value. Representing a diverse set of organizations from various segments of the industry – including providers, payers, purchasers, and patient advocacy organizations – we share a common commitment to transform our respective businesses and clinical models to deliver better health and better care at reduced costs. We strive to provide a critical mass of policy, operational, and technical support from the private sector that, when combined with the work being done by CMS and other public and private stakeholders, can increase the momentum of delivery system transformation. HCTTF appreciates the opportunity to provide input to the Budget Committee's current solicitation.

We are encouraged by CBO's recent report reflecting a significant bending of the cost curve over the past decade. There are many factors for this trend, and value-based care efforts like care coordination and better outcomes for hypertension and diabetes patients through

medication management have been recognized for their positive contributions. Clearly, there is more to do and the realization of a full transition to value-based care delivery system would provide an even greater contribution to this positive trend.

I. Regulatory, statutory or implementation barriers that could be addressed to reduce health care spending

A. Refine the CMS Innovation Center's Model Expansion Authority

The Center for Medicare and Medicaid Innovation (CMMI), also referred to as the CMS Innovation Center, is a key platform for testing innovative payment and care delivery models with goals of improving quality of care for Medicare beneficiaries and reducing costs to the program's Trust Funds. By statute, CMMI is directed to test innovative payment models for the Medicare, Medicaid, or Children's Health Insurance Programs. These Phase 1 models are designed to either reduce federal spending, improve quality of patient care, or both. CMMI's Phase 1 models are subject to formal evaluations to determine whether these statutory mandates are satisfied and, if they are, qualifying models can be certified by the CMS Office of Actuary (OACT) for expansion into larger Phase 2 models with a broader reach and greater impact.

To date, CMMI has tested over 60 models designed to meet these statutory objectives. However, only a handful of models have qualified for expansion into a Phase 2 model. This is in part because of the high bar that current statute apparently imposes through its undefined term "certification." The CMS OACT has interpreted the statutory term "certification" to mean that there must be at least a 95 percent certainty that a Phase 2 model will result in cost savings. Experts believe that this standard is overly onerous and has resulted in some promising models being discarded. With the limited number of expanded models, health care providers are also less interested in investing the time and resources in a model that will most likely be of limited duration.

Congress should revisit this statutory term certification and provide a definition that presents a more reasonable standard. CMMI should be positioned to expand more promising models and to achieve greater and more lasting delivery system reform that not only saves the Trust Fund dollars, but also provides higher quality person-centered care for Medicare beneficiaries.

B. Reform the Physician Self-Referral and Antikickback Laws to Better Support Uptake of Alternate Payment Arrangements

The Physician Self-Referral and Anti-Kickback Laws continue to pose barriers to innovative arrangements among health care providers, suppliers and clinicians and undue burden on the health care industry stakeholders working to improve quality and lower costs. Alternate Payment Models (APMs) by design seek to make sure that patients receive the right care in the right setting at the right time. They do not present the concerns for self-dealing and overutilization of services that these laws were designed to combat in a traditional fee-for-service world.

CMS and the Office of Inspector General recently issued updated rules about the applicability of these laws to APMs. While helpful, the new rules do not go far enough. HCTTF urges Congress to pass legislation that in the context of these laws:

- Expressly provides that care coordination is not remuneration.
- Expressly provides that housing, food, and transportation provided to existing or prospective patients is not an inducement for care.
- Permit compensation to a health care provider or clinician for reducing the cost of a patient's episode of care, including distributing actual or projected savings amounts.
- Permit limited spending by healthcare providers to address social risk factors or other social drivers of health that impact overall health.

II. Efforts to promote and incorporate innovation into programs like Medicare to reduce health care spending and improve patient outcomes

A. Advance Alternate Payment Arrangement in Both Original Medicare and Medicare Advantage

HCTTF is a strong proponent of alternate payment models (APMs) to effectuate delivery system reform that improves quality of care while reducing cost. We are dedicated to advancing the adoption of value-based care models in Medicare and across federal health care programs as a lever to accelerate the transition to a sustainable, cost efficient, consumer focused health care delivery system. The current outdated Medicare fee-for-service system creates the wrong incentives for clinicians and providers by paying them individually for every test ordered or procedure furnished, resulting in payments based on the volume of services provided and not necessarily on the value and outcomes of those services.

Value-based care and related payment models focus on providing patients with the right care at the right time in the right setting. Through robust care coordination, these models eliminate duplication of services and reduce or eliminate low or no value care, which by many estimates equates to approximately 30 percent of all Medicare expenditures.

We believe Congress should create greater incentives for providers and commercial payers to enter into risk based, sustainable APMs both in Original Medicare and Medicare Advantage. We recommend Congress pass legislation that would:

- Enable population-based payment models that support care coordination and hold providers accountable for total cost of care and outcomes. These models should have different levels of accountability or risk to allow providers with varying experience with APMs – such as small, rural, and safety net providers including critical access hospitals – to participate.
- Enable advanced primary care models that provide adequate funding for robust care coordination across primary care physicians and specialists and to support the infrastructure necessary for interoperable data sharing among clinicians and health care institutions.
- Advance models that hold providers accountable for outcomes with a set of parsimonious, uniform quality measures that include patient-reported quality measures (*i.e.*, patient-reported outcome measures and patient-reported experience measures)

- Create an incentive for Medicare Advantage plans that rewards them for engaging in two-sided risk models with their network providers.
- Extends the financial incentive for providers to engage with Advanced Alternate Payment Models (AAPMs).

B. Enact the Value in Health Care Act of 2023

An important first step to help control health care spending would be for Congress to pass the Value in Health Care Act of 2023 (H.R. 5013). This legislation would:

- Extend value-based care payment incentives and ensure that qualifying thresholds remain attainable for clinicians.
- Remove barriers to participation in APMs, such as eliminating regulatory barriers for clinicians and improving financial methodologies.
- Evaluate opportunities to create greater parity between Original Medicare APMs and Medicare Advantage plans.
- Support continued innovation in the Medicare Shared Savings Program by encouraging CMS to establish a voluntary full risk track.

This legislation addresses several concerns with current CMS policies. It also ensures that providers remain incentivized to participate in APMs and seek to advance their willingness to take on greater risk in exchange for greater rewards for lowering spending and improving quality.

C. Enact Legislation to Require Value-Based Care and Related Payment Models in Other Federal Health Care Programs

The House Budget Committee should also focus on passing legislation that requires other federal health insurance programs to adopt value-based care initiatives that better manage population health for federal health care beneficiaries beyond Medicare and Medicaid. Military health insurance programs – both for veterans and active military – have a great opportunity to better serve their constituencies with value-based care and payment models. The same is true for the Federal Employee Health Benefit Program participants.

Both the federal government's military and civilian health insurance program participants present populations that often participate in these programs for long periods of time, making them better suited for population health models that over time produce better population health at lower cost through high quality care that focuses on wellness and preventive care over sick care involving tests and procedures. When health care is needed, these models focus on providing the right care in the right setting at the right time, and reducing the amount of low or no value care that is provided. These benchmark principles for desired patient care would positively impact health insurance recipients across a wide range of federal programs.

III. Examples of evidence-based cost-effective preventive health care measures or interventions that can reduce long-term health care costs

Addressing patients' social needs is increasingly being seen as necessary to achieving better health for individuals and communities. Helping individuals be healthy and therefore

requiring less use of the health care system is important to driving better population health. However, the health care ecosystem – including payment models for care delivery – have not yet evolved to the point where patients' social needs are meaningfully integrated into care delivery. We urge Congress to consider legislation in the following areas to help develop a macro environment that promotes population health over sick care.

A. Investing in Community Health Workers

Medicare allows for payment to clinicians for health care services, but in most cases does not provide reimbursement for individuals who are better trained to help identify and address patients' social needs. Congress should provide authority for payment to be made to professionals – including but not limited to community health workers – who are skilled in helping patients address their social needs. This investment will likely result in healthier populations that will utilize fewer services due to the reduction or mitigation of chronic disease.

B. Integrating Food Is Medicine into Primary Care

Food is Medicine refers to a spectrum of programs, services, and other interventions that recognize the critical link between food and nutrition. These services include the provision of appropriate foods to people with chronic or complex medical conditions and are often low-cost high return interventions for these populations. Congress should create new programs that incentivize reimbursement for evidence-based community nutrition, produce prescriptions, or medically tailored meal programs in Medicaid programs.

C. Providing Access to Affordable, Stable Housing

There is growing evidence that housing stability and location can significantly impact access to health care services, reduce long-term health care costs, and drive better patient outcomes. Congress should strengthen and expand tax incentives, like the Low-Income Housing Tax Credit, that support investment in developing and maintaining affordable housing and take other steps to support initiatives that provide housing so that individuals and communities can realize and maintain better population health.

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HCTTF appreciates the opportunity to provide these perspectives to the House Budget Committee and stands ready to support the Committee in any way. Please contact HCTTF Executive Director Jeff Micklos (jeff.micklos@hcttf.org) with any questions about this letter or for further support of the Committee's efforts.

Sincerely,

The Health Care Transformation Task Force