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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
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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, JSheehan@familiesusa.org, for further information and to let us know how we can best be of service to you.

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