Testimony of

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Examining Barriers to Expanding Innovative, Value-Based Care in Medicare

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Good afternoon. Chairman Burgess, Ranking Member Green, members of the subcommittee, thank you for the opportunity to testify today on what I believe to be one of the most important topics in American healthcare.

As our healthcare system evolves from a long-standing fee-for-service orientation to a patient-centered, value-based approach to care, I'm proud that the members of my organization, the Healthcare Leadership Council (HLC), are not only supportive of this transformation, but have led it. Our members are innovative hospitals, health plans, drug and device manufacturers, distributors, academic health centers, health information technology firms, and in fact are driving change within and across virtually every healthcare sector.

We appreciate your effort today to shine a light on some of the barriers that are preventing an optimal transition to value-based care that will result in better outcomes for patients and improved sustainability for the Medicare program. There are areas that warrant significant attention from the committee.

Legal barriers that exist are keeping healthcare innovators from accelerating toward value-based care. We believe it is essential to keep consumer protections in place while, at the same time, working in both the legislative and regulatory spheres to create an open, unobstructed pathway for value-focused activities that benefit both patients and the system as a whole.

The Stark Physician Self-Referral Law and the Anti-Kickback Statute were created to prevent overutilization and inappropriate influence in a fee-for-service environment in which healthcare sectors and entities operated in their own individual silos. Today,

however – in order to make the transformation to value-based care – we need greater integration of services, improved coordination of care with cross-sector collaborations, and payment that is linked to outcomes rather than volume. Adopting these new delivery and payment models becomes difficult when faced with outdated fraud and abuse laws and potential penalties of considerable severity.

For example, it is desirable for healthcare providers to achieve optimal health outcomes through coordinated care, meeting high quality and performance metrics, and saving money through the avoidance of unnecessary hospital admissions and office visits. And yet, there are obstacles to incentivizing this level of performance. If a hospital wishes to provide performance-based compensation, it can run afoul of the current fraud and abuse framework. In fact, in terms of maintaining good patient health, the legal status quo does not even allow physicians to provide patients with a blood pressure cuff or a scale to monitor healthy weight at home.

To achieve meaningful progress toward a value-based healthcare system, it is also necessary to address how to foster further success in alternative payment models, such as Accountable Care Organizations (ACO). We know that better care coordination results in better outcomes for patients, which is the goal of Accountable Care Organizations, but we must address flaws in the ACO structure. Currently, Medicare beneficiaries do not choose to enroll in a particular ACO. Rather they are assigned to one based on the physician they choose to see. Thus, the ACO is charged with the responsibility of managing this patient's care even though the patient is likely unaware they are under that umbrella.

Also, many Medicare beneficiaries may not be aware of the benefits of this approach. Proactively informing patients about the benefits of coordinating care among their providers and creating tangible incentives to encourage patients to remain in ACOs and other care delivery models that focus on coordination, information flow, and value will allow these models to better achieve quality outcomes while controlling costs.

Also, to optimize the effectiveness of ACOs, more progress needs to be made in data sharing and data interoperability, so that entities have real-time knowledge of workflows, care coordination, and progress toward quality measures.

Mr. Chairman, I need to also mention the importance of technology in the movement toward value-based care. Specifically, the expanded use of telemedicine is essential in more efficient utilization of healthcare resources and expanding the reach of health providers. We urge Congress and the administration to further address Medicare's

restrictions on reimbursement for telemedicine services. There is also considerable value to be found in making digital health applications more accessible for beneficiaries.

And, finally, as we talk about coordinated care, we must focus as well on how to gain the greatest patient and population health benefits from our healthcare workforce. All healthcare professionals must be empowered and rewarded to perform to the top of their professional license and to be valued members of care teams.

With this testimony, I am providing a copy of the HLC Red Tape Reforms, developed with input from our members earlier this year to identify areas that pose barriers to value-based care, as well as: an HLC white paper of potential regulatory and legislative modifications to the Anti-Kickback Statute and Physician Self-Referral Law to better support innovative and integrated care delivery and payment models; a selection of value-based examples; and examples of patient and program protection provisions that should remain in place, in relation to modernizing the Anti-Kickback Statute and Physician Self-Referral Law.

I thank you again for this opportunity to testify and look forward to responding to your questions.