June 1, 2017

The Honorable Pat Tiberi
Chair, Committee on Ways & Means, Subcommittee on Health
U.S. House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Sander Levin
Ranking Member, Committee on Ways & Means, Subcommittee on Health
U.S. House of Representatives
1139E Longworth House Office Building
Washington, DC 20515

Re: Public Comment in response to the Committee on Ways and Means, Subcommittee on Health Hearing "*Current Status of the Medicare Program, Payment Systems, and Extenders*"

Dear Chairman Tiberi, Ranking Member Levin, and members of the Committee on Ways and Means, Subcommittee on Health:

On behalf of the Healthcare Quality Coalition (HQC), we write to provide comments on the Ways and Means Subcommittee on health hearing "*Current Status of the Medicare Program, Payment Systems, and Extenders*." We were very pleased to hear committee members acknowledge value-based care policy and payment systems, and we appreciate the inclusion of rural extenders as part of the hearing. The HQC supports the development of robust value-based payment initiatives. Our members believe properly structured incentives to provide high value care (e.g. high quality, low cost care) will result in better care for patients at a lower cost for payers.

The HQC is comprised of hospitals, physicians, health systems, and associations committed to value-based healthcare. Organized in 2009, the HQC supports efforts to create a sustainable healthcare delivery system through incentivizing high-value care. We believe value-based payment policies can drive better quality, lower the cost of care, and reduce overall healthcare costs.

We believe value-based payment policies can drive better quality, lower the cost of care, and reduce overall costs for the Medicare program. The HQC strongly supports continued implementation of

payment systems that reward value and we are pleased to provide written testimony on public policy that can help maintain a viable, sustainable Medicare program.

Continued Movement to Value-based Payment

Medicare's predominantly fee-for-service (FFS) payment system, which rewards quantity over quality, is now widely acknowledged to be fragmented, inefficient, and financially unsustainable. The FFS system pays physicians based on the services they provide, and offers no incentives to coordinate care resulting in a fragmented care system. . FFS payments also create a financial incentive to promote volume over value, encouraging overutilization and discouraging low-cost, high-value services. Given the rising cost of health care and the resultant threat to the nation's long-term economic security, a payment system that supports an inefficient delivery system is not only undesirable but also unsustainable.

The HQC believes that Medicare should pay for value in the health care system. As a starting point, the HQC has supported and focused on programs that make modifications to the FFS scheme, such as the Physician Value-based Payment Modifier and Hospital Value-based Purchasing. These payment adjustments however, are built on the FFS chassis, and the fundamental incorrect incentives of FFS remain the predominant payer source in the Medicare system. Many providers, hospitals and integrated healthcare systems are further invested in alternative payment models through the Centers for Medicare and Medicaid Innovation (CMMI). Further investing and advancing value-based payment policy and not relying on across-the-board payment reductions helps to achieve the goal toward improved community health. We appreciate the work the committee has done in advancing value-based care, such as past enactment of the bi-partisan Medicare Access and CHIP Reauthorization Act.

Payment Extenders: Targeted Policies aimed for Access and Equity

Targeted payment programs aim to provide assistance and relief for the continued access to services in improved equity in reimbursement. Many of these policies impact providers and hospitals in rural areas. We ask Congress to act on these policies before they expire this year. These policies include:

- **Geographic Practice Cost Index (GPCI) work component floor**. Physician services payments are adjusted based on a provider's physical location. This policy establishes a minimum 1.0 for those states and areas adjusted below the national average for provider wages. Better wages data can help alleviate the need for a floor policy, but until improved data is accepted and implemented by CMS, we support a permanent extension. This policy directly impacts physician services in rural areas.
- **Medicare low-volume hospital adjustment**. This policy helps offset the costs of operating a hospital that has a low number of Medicare discharges. This important payment helps maintain viability, and should continue to be assessed based on the number of Medicare patients admitted only, not total hospital admissions.
- **Add-on payment for ground ambulance services**. This payment provides equity to rural EMS providers who travel greater distances in rural and remote service areas. The loss of this payment is equivalent to over a 20 percent Medicare reimbursement reduction jeopardizing many rural EMS service providers.

- **Medicare-Dependent Hospital (MDH) Program extension**. Created in 1987, the MDH program was established to provide relief for small rural hospitals with no more than 100 beds serving a high percentage of Medicare beneficiaries. The MDH program helps keep hospitals operational and protects Medicare beneficiaries access to care.

Reform and Advance Value-based Policy in Medicare for Hospitals

To continue driving forward value-based policy, we ask the Ways and Means Committee to collaborate and develop bi-partisan legislation that would consolidate and reform performance and value-based payment for hospital services. We have long believed, to the extent feasible, that Medicare Part A and B should include comparative value-based reimbursement policy. To that end, we offer the following key points of emphasis for devising an improved Medicare value-based payment for hospitals. We were very pleased and supportive of the Ways and Means Health subcommittee's hearing last session (October 2016) entitled, *"The Evolution of Quality in Medicare Part A."* Specifically, we asked the committee to continue this work and we support developing further policy to:

- Consolidate and reform existing penalty-only programs into an improved Hospital Value-Based Purchasing Program, offering incentives and rewards for high performance.
- Improve efficiency as a unit of *value* by modifying the improved Hospital Value-Based Purchasing program to weigh measures of cost and quality equally.
- Advance value-based care by increasing the amount of payment tied to hospital performance.
- Eliminate overlap with quality measures between separate hospital programs and improve the consistency of risk-adjustment and benchmarking.
- Provide opportunities for developing and expanding hospital-driven Alternative Payment Models.

Conclusion

The HQC appreciates the opportunity to provide comments and ideas for ensuring a sustainable Medicare program. We believe the long-term viability of this program lies in crafting reimbursement for services provided to Medicare beneficiaries that reflect robust value-based policy with measures of cost and quality. We look forward to being an active partner with the committee in moving value forward.

Please feel free to contact us with any questions.

Sincerely,

The Healthcare Quality Coalition

The Healthcare Quality Coalition represents healthcare providers throughout the nation dedicated to the concept of value-based care. In short, we believe healthcare entities should be held accountable for the quality and value provided to the patients and communities we serve. The HQC is committed to developing value-based payment initiatives in a way that encourages fair payment to providers delivering high value care to the patients they serve. www.qualitycoalition.net