Purchaser Business Group on Health

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July 10, 2024

The Honorable Jason Smith
Chairman
Committee on Ways and Means
1100 Longworth House Office Building
Washington, DC 20515

The Honorable Richard Neal
Ranking Member
Committee on Ways and Means
1100 Longworth House Office Building
Washington, DC 20515

Dear Chairman Smith, Ranking Member Neal, and members of the Committee,

Thank you for your interest in improving value-based care for patients and providers. The Purchaser Business Group on Health ("PBGH") applauds your efforts to gather information on how Congress and the Center for Medicare and Medicaid Services ("CMS") can improve our value-based care models to ensure our investments improve outcomes and reduce costs for patients. While the Innovation Center has seen limited success, in the employer market we have seen how properly designed models can reduce costs for patients, employers, and the federal government while improving care quality for both Medicare and non-Medicare patients.

PBGH is a nonprofit organization that represents 40 public and private purchasers that collectively spend $350 billion annually on health care and cover over 21 million employees and their beneficiaries. PBGH's mission is to advance a health care system that delivers quality outcomes and a seamless patient experience that is equitable and affordable for consumers and purchasers. Our goal is to be a change agent by creating and enabling increased value in the health care system through purchaser collaboration, innovation, and action and through the adoption of best practices. PBGH's members represent diverse private sector industries as well as public sector purchasers.

The current health care system has incentivized *sick* care over *health* care, increasing costs for taxpayers, workers, and employers. We support efforts to transition to a system that emphasizes patient health and rewards providers for keeping patients healthy. At PBGH, we believe primary care is essential to a healthy workforce and employees' access to a high-value health care system. Research has proven that robust primary care systems can lower overall health care utilization, decrease rates of disease and mortality, and increase the use of preventive services, enabling a true *health* care system. However,

primary care in the US is chronically underfunded; while primary care accounts for 55% of visits in the US, it receives only 4-7% of health care dollars, on average.[1]

That is why we have invested in advanced primary care ("APC") models that redirect existing health care spending to high-quality, equitable and evidence-based care while holding total cost flat.[2] PBGH first launched its primary care improvement initiative in 2014. From 2014 – 2019, this CMS-funded multi-stakeholder driven quality program helped avoid nearly 50,000 hospital bed days, reduced emergency room utilization and generated about $186 million in total savings.[3]

California Advanced Primary Care initiative

Building on that progress, PBGH's California Quality Collaborative and the Integrated Healthcare Association launched the California Advanced Primary Care initiative, a multi-payer effort where Aetna, Aledade, Anthem Blue Cross, Blue Shield of California, Health Net, Oscar, and United agreed to strengthen primary care together from 2022-2025. Through this initiative, we have developed a common value-based primary care model that provides prospective and performance-based payments, with the goal of increasing total potential payment for primary care providers by 30%. On October, 1 Aetna, Blue Shield of California, and Health Net will launch a demonstration project to test the model in up to 30 independent primary care practices throughout the state. This demonstration project is unique because the plans are funding technical assistance and a common reporting platform to help the practices get the most out of the new payment model.

In January 2022, we also launched the Advanced Primary Care Measurement Pilot, which brought together four large purchasers in California, including California Public Employees' Retirement System ("CalPERS"), Covered California, eBay and San Francisco Health Services System agency, to test our advanced primary care measures for practice-level performance at the state level. The pilot, which concluded in 2023, is an example of ways to ease the administrative burden on providers who wish to participate in value-based care models, as it relies on existing data aggregated across purchasers and health plans to provide a more complete picture of individual practice performance. Through these efforts we created an Advanced Primary Care Measure Set of pediatric and adult quality measures categorized into five quality domains: health outcomes and prevention, patient reported outcomes, patient safety, patient experience, and high value care.[4]

[1] PBGH (Dec. 2023) "End-of-Year Report: California Advanced Primary Care Initiative" *CQC* [Link]

[2] PBGH defines APC as including integrated mental health care and access. See PBGH's APC attributes here.

[3] PBGH (Dec. 2020) "Lessons in Scaling Transformation: Impact of California Quality Collaborative's Practice Transformation Initiative" *CQC* [Link] at **pgs. 11, 22**.

[4] PBGH (Apr. 2021) "Advanced Primary Care Measure Set" *CQC and IHA* [Link] *(Revised Nov. 2023)*

We are excited about the future of advanced primary care and hope our learnings can inform others and shape future policy discussions as Congress looks to re-examine the Medicare Access and CHIP Reauthorization Act ("MACRA") and the Medicare Physician Fee Schedule ("MPFS") to better align around value-based care.

High value maternity care

While PBGH believes primary care is the lynchpin to successful uptake of value-based care, we have seen other examples of how coordinated, patient-centered care can lower costs, such as in maternity care. PBGH works with employers, providers and health plans to develop a maternity care system that embraces high-value services, reduces outcomes variation and incentivizes safety across the prenatal, perinatal and postpartum care continuum. PBGH's Comprehensive Maternity Care Workgroup is working to define comprehensive maternity care which ensures high-quality, equitable maternal and infant health outcomes. Some of these care attributes include:

- **Team-based**: Patients receive care from a primary maternity care provider, such as an OBGYN, midwife or family medicine doctor, who is supported by and supports members of an interdisciplinary care team, such as doulas, mental health specialists, maternal fetal medicine specialists, lactation consultants, pediatricians, family planning specialists, primary care providers or community health workers. Under the direction of the maternity care provider, care team members communicate and coordinate to address patients' needs and provide care appropriate to their training and expertise.

- **Integrated**: Patients' physical, mental and social needs are assessed, screened and communicated across their maternity, pediatric and primary care teams and with other care providers and settings. Care teams reach out proactively to identify and address patients' care needs and to offer additional support for patients at high or rising risk. Health information and care activities outside of the maternity care team are integrated into patients' care plans

- **Whole-person**: Maternity care should focus not just on the maternity episode but also consider other factors, including social determinants of health, to promote health and treat diseases. Maternity providers should coordinate with primary care, mental health specialists and social services to provide special consideration for high-risk patients with mental health needs and/or substance use disorders. Comprehensive maternity care includes restoring health, promoting resilience and preventing diseases in the lives of the birth participant, children and supporting spouse/family.

Collaborative, integrated team-based care improves health outcomes and the patient experience for mothers and babies. Not only does team-based care introduce a wider variety of perspectives and backgrounds, but it also increases the likelihood that the patient's wishes are at the center of care, enhancing the patient experience and improving health equity. A team-based care model that allows both physicians and midwives to work at the top of their license is likely to improve collaboration and satisfaction in practice for physicians, preventing burnout.

In May 2024, PBGH and our members released our Maternity Care Common Purchasing Agreement to improve outcomes for mothers and newborns. This Agreement embodies a consensus among employers and public purchasers on what constitutes high-value, affordable and equitable maternity services and establishes specific expectations for health plans and providers. A common purchasing agreement facilitates adoption by diverse public and private purchasers and offers an example that CMMI may wish to adopt to expand as it seeks to expand its impact.

PBGH also called attention to the vital importance of strengthening a focus on equity in maternal health in its recent comments to CMS's IPPS rule.[5] Our comments highlight the critical role equity data play in improving maternal health. In May 2023, PBGH released its Comprehensive Maternity Care Standards and Measure Set, articulating attributes that define comprehensive maternity care which ensures high-quality, equitable maternal and infant health outcomes. In addition to ensuring hospitals have a streamlined, meaningful measure set to focus on, it is critical to ensure outcomes and quality measures are stratified by race, ethnicity and language ("REaL") and sexual orientation and gender identity ("SOGI") data where available. This is an important step to ensure targeted interventions to improve inequities.

Policy Priorities to Advance Value-Based Care

PBGH envisions a future of health care that is patient-centered, team-based, and rewards providers based on the value of care, not the number of services provided. But if we are to promote meaningful change in how we pay for health care in the US, employers and health care purchasers must be part of the solution. Every day our members are innovating to create models that are patient-centered and focus on the value of care. They are finding success in improving the health of their members and lowering the cost of doing so. A functional market does not – and cannot – require the world's largest employers to absorb annual cost increases of 4 – 20% with no corresponding increase in quality or outcomes. We believe that removing barriers to high-value care and innovation will benefit the entire health care system. To do this, we must:

[5] PBGH (Jun. 10, 2024) Comments to CMS on Maternal Health in re: 2024 IPPS Rule [Link]

1. Enable purchasers to innovate by removing barriers for employers and other private purchasers to advance efforts in value-based care and contracting. PBGH supports policies and interventions that enable private purchasers to innovate, remove barriers to employers and other private purchasers to advance efforts in value-based care and contracting, increase competition, reduce costs and drive quality and patient satisfaction. PBGH's member organizations demonstrate an unwavering commitment to innovative benefit offerings and purchasing high-quality care. This includes:

- embracing alternative payment models that depart from fee-for-service and incentivize physicians to provide valuable, not unnecessary or low-value, care;

- prioritizing advanced primary care by building the infrastructure when health insurers will not, to lower their population's cost of care and improve health;

- creating new direct payment models for rural hospitals where employers band together to pay hospitals directly to keep critical departments open and viable;

- forming direct contracts with large, integrated health systems around the country, eliminating administrative waste, streamlining care delivery and sharing the financial gains with employees through no copays, no cost-sharing on generic drugs, HSA contributions, and other benefit design innovations.

We strongly encourage Congress to eliminate federal and state barriers that limit or discourage participation in alternative payment models across the employer market. Some employers are being hindered from adopting value-based care at the state level due to a complex patchwork of regulatory oversight for health insurance that has evolved over time in service of several goals, some of which can be at odds with each other. Easing federal and state restrictions to alternative payments models for employers and others in the commercial market will promote multi-payer collaboration. Specifically, purchasers need more clarity from the Department of Labor on capitated payment arrangements in self-funded plans in California, specifically, in order to move forward with the promise of value.

Likewise, we strongly encourage Congress to remove existing restriction on first dollar coverage for primary and preventive care. We have seen firsthand how increased access to primary care improves the health and wellness of patient populations and existing policies can present barriers to this necessary care.

We also believe there is an opportunity for CMS to better align with purchasers through organizations like PBGH and our partners to ensure we are all rowing in the same direction. This can be accomplished by creating pathways to engage private purchasers in CMMI models to promote multi-payer collaboration and encourage meaningful public-

private partnerships that improve quality, reduce costs, and move the whole system forward. Under the current landscape, where providers have significant market power, there is little incentive to transition toward value-based payment, especially with smaller employers. Collaboration between CMMI and large employers is therefore a significant opportunity.

Furthermore, we urge Congress to support employers' efforts to make use of existing price transparency data, which in their current form require a tremendous amount of technical expertise to be made useful and actionable. PBGH has spent considerable time and effort scouring the data vendor marketplace on behalf of our members to better understand if, and how, data vendors are using the new health care price transparency data. We have found that few data vendors are incorporating both into their work. PBGH is seeking to change that by gathering together over half a dozen jumbo employers and public purchasers to embark on a joint transparency data project. However, this effort has proven exceptionally difficult as the existing data sets are at an immature stage and require significant resources to access and analyze. This presents a barrier for smaller employers to make use of the full suite of transparency data and we urge Congress to make a public financial investment in helping employers reduce their health care costs by supporting data transparency work. This could be done through 501(c)(3) non-profit entities like PBGH who coordinate, support, and provide technical assistance to employers in this pioneering work.

In addition, we believe Medicare and Congress should work together to authorize payment models and increase payment rates for advanced primary care models that achieve high quality outcomes and reduce total cost of care. MedPAC and other experts have observed that certain procedures and specialty services are overpriced, based on the relative value units (RVUs) used to calculate payment rates to physicians. Congress and HHS should consider structural and process changes to correct this imbalance.

2. Improve and build on price transparency efforts to include actionable and streamlined quality metrics and data standards. To truly achieve value-based care, we need robust and aligned quality data – not just price data – across all payers. PBGH is a national leader in redesigning how quality is measured and reported as the basis of a transformed, patient-centered health care system. Whether helping patients and employers compare providers and health plans, assessing patient experience and outcomes, or quantifying performance for specific interventions and procedures, PBGH's efforts are designed to increase accountability and improved value across the health care continuum. As mentioned above, PBGH's Comprehensive Maternity Care Workgroup is defining comprehensive maternity care purchasing standards, which ensure high-quality, equitable maternal and infant health outcomes.

Full transparency on prices, quality and equity is needed across providers for purchasers to ensure value for their employees, as well as standardized measures of quality, patient experience, appropriateness, and total cost of care. These data sets are invaluable to assess the potential impact of proposed transactions. As such, we support many of the transparency policies contained within the "Lower Costs, More Transparency Act" (H.R. 5378) passed out of the House on December 11, 2023, and commend the committee for its leadership. This includes codifying and expanding federal price transparency rules; ensuring that health plan fiduciaries are not contractually restricted from receiving cost or quality of care information about their plan; [6] increasing transparency into hospital outpatient billing practices; and correcting Medicare payment discrepancies. Similarly, we strongly support policies that require transparent PBM reporting to plan sponsors, but urge the committee to extend spread pricing prohibitions into the commercial market and take up other efforts to lift the veil on PBMs and other service providers to ensure compensation practices are fully exposed, so employers can ensure full line of sight into contracts and spending to better drive value for employees and beneficiaries.

We also encourage Congress to consider more granular transparency, including data reporting by provider quality metrics at the brick-and-mortar level, which truly shine a light on the quality of care that a patient can expect to receive. Finally, we urge additional transparency into health care industry transactions and ownership. This is vital in understanding the impact of the corporate transformation of U.S. health care. Purchasers and patients deserve transparency into the ownership of the places where they are seeking and purchasing care and the impact on quality, costs and access. To do this, it is critical to expose the chain of corporate ownership and web of financial interests that are now almost totally opaque to patients, purchasers, policymakers, researchers, and regulators. The inclusion of only price and billing transparency (as seen in the House-passed Lower Costs More Transparency Act), misses a key opportunity amid an increasingly consolidated health care landscape. Ideally, ownership transparency would involve the development of a modern data system to collect data and the identity and attributes of entities with an ownership stake in health care facilities and track changes resulting from horizontal and vertical mergers, acquisitions, and joint ventures between health systems, health insurers, retailers, and PE firms.[7]

We believe that moving to value-based care will serve as another key lever to reduce the incentives for consolidation, as our fee-for-service system incentivizes profit-minded

[6] On this vital point, specifically, PBGH strongly supports language in the Health Care PRICE Transparency Act 2.0 (S. 3548). While the Senate bill is narrower in scope than the Lower Costs, More Transparency Act, its provisions for employer data access are stronger and contain more specific requirements that would greatly enhance the ability of employers to drive value in their health care purchasing practices. For these reasons, PBGH supports the Senate bill's language on data access and price transparency be adopted in (reconciled with) the House bill.

[7] Singh and Brown (Sep. 23, 2023) "The Missing Piece In Health Care Transparency: Ownership Transparency" *Health Affairs* [Link]

companies to drive utilization of high-cost, sometimes lower-value services, and undermines the utility of services such as primary care. PBGH is working with our members to embrace alternative payment models that depart from fee-for-service, align incentives among physicians and hospitals, and incentivize physicians to provide valuable, not unnecessary or low-value, care. PBGH has also launched a novel transparency data demonstration project, which will home in on key regional markets around the country (where our members have sufficient headcount) and combine the new transparent data sets with employers' respective claims price and quality data, to provide each employer with insights into how their networks and plan design stack up against the potential within their market.

3. Reduce anti-competitive negotiation and contracting practices. Finally, we urge Congress to take action to address anti-competitive negotiation and contracting practices that can limit purchasers and employers' options in their pursuit of value-based models that will achieve lower cost, high-quality care.[8]

We strongly support legislation at the federal and state levels that would remove gag clauses on the sharing of price and quality information by providers; ban anti-competitive contracting practices including "anti-tiering" or "anti-steering" clauses; ban "all-or-nothing" contracting which demands higher payment rates for the entire system; and other anti-competitive clauses such as most-favored nation ("MFN") clauses, leveraged by dominant insurers to ensure they receive the lowest prices, often to the detriment of smaller purchasers. PBGH President and CEO Elizabeth Mitchell has testified before the Senate Committee on Health, Education, Labor and Pensions on the importance of advancing these provisions.[9] In addition to such anti-competitive behavior being used to gain market power and raise prices, it also hinders purchasers' ability to create innovative, high-value programs such as high-performance networks, which incentivize patients to use specific providers and facilities with higher quality and lower prices.

States have also moved to restrict the anticompetitive contracting practices at the heart of California's complaint against Sutter. Although state attorneys general may be able to prosecute anticompetitive behavior – such as the use of anticompetitive contracting provisions by dominant systems – legislation prohibiting these contract clauses is necessary to improve state enforcement authority and disrupt the distorted bargaining dynamic. For example, Michigan and North Carolina ban specific anti-competitive practices, while Massachusetts has empowered an agency to publicly review contracts for

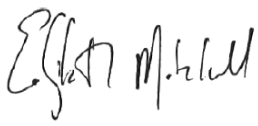
[8] PBGH also recently submitted comments to the Administration to this effect, in response to a Tri-Agency request for information issued by the DOJ, FTC, and HHS. See PBGH's detailed comment letter here.

[9] Mitchell (Jun. 18, 2019) "Testimony to the U.S. Senate Committee on Health, Education, Labor & Pensions on the Lower Health Care Costs Act" [Written] / [Live Recording]

monopolistic terms on an ongoing basis. Rhode Island and Colorado have capped rate increases exceeding specified growth targets to impede unequal bargaining power that can lead to market failures.[10] While Sutter removed many of these anti-competitive terms from its contracts, they are still being used as a tactic in private provider-insurer negotiations. Thus, any state or federal legislation must aim to address not just anti-competitive language in contracts but also underlying anti-competitive behavior throughout the negotiations process. More recent state legislation – such as that in Washington state (HB 2066) – has aimed to enable states to regulate what health plans do through contracts as well as other anti-competitive behavior.

Thank you again for the opportunity to comment, and we look forward to working with the committee on these important issues. If you have any questions or wish to collaborate further, please contact Elizabeth Mitchell, President and CEO, at emitchell@pbgh.org.

Sincerely,



Elizabeth Mitchell, President and CEO
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[10] King (Nov. 17, 2020) "Addressing Health Care Consolidation: Policy Solutions" *Assembly Health Committee* [Link]