Federation of American Hospitals™
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STATEMENT
of the
Federation of American Hospitals
to the
U.S. House of Representatives Committee on Energy and Commerce
"Checking-In On CMMI: Assessing the Transition to Value-Based Care"
June 10, 2024

The Federation of American Hospitals (FAH) submits the following statement for the record in advance of the House Committee on Energy and Commerce hearing entitled "Checking-In On CMMI: Assessing the Transition to Value-Based Care." As the Committee considers the past performance and future promise of the Center for Medicare and Medicaid Innovation's (CMMI) next direction, the FAH believes that the patient must be at the center of that evaluation.

The FAH is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members are diverse, including teaching and non-teaching, short-stay, rehabilitation, long-term acute care, behavioral health hospitals in urban and rural America, and they provide a wide range of inpatient, ambulatory, post-acute, emergency, childrens', and cancer services.

The purpose of CMMI is to test innovative payment and service delivery models that maintain or reduce program expenditures while preserving or enhancing quality of care, with an emphasis on models that improve coordination, quality, and efficiency of health care furnished to Medicare and Medicaid beneficiaries. We agree with the intent behind this mission and believe that improving quality, retaining and improving access, and addressing cost for patients should be at the core of any innovation strategy CMS seeks to implement. CMMI has an important role in driving innovation in healthcare and the potential to inform the policy debate on critical health care payment policies through real world evidence reported to Congress, as required under the statute.

We appreciate that CMS has historically emphasized and focused on testing voluntary models, generally on a small-scale. CMS has successfully demonstrated that it is fully capable of testing models under section 1115A solely through providers of services and suppliers that volunteer to participate in those models. Experience with the Bundled Payments for Care Improvement (BPCI) Initiatives shows a substantial number and range of providers and suppliers willing to participate in carefully crafted models.

However, the FAH has long held that CMS has the authority to test models only on a voluntary basis. The use of Innovation Center authority to effectively impose new Medicare payment policy throughout large swaths of the country without Congressional consideration would be a significant overreach of CMMI authority. Mandatory provider and supplier participation in CMMI models

runs counter to both the letter and spirit of the law that established CMMI. There is no language in the statute or any legislative history that supports the interpretation that Congress delegated its authority to make permanent changes to the program to the Secretary through the CMMI.

Recently, CMMI has taken steps to advance models that mandate – or allow states to mandate – the participation of health care providers. These models include hospital-centered proposals such as the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model, Transforming Episode Accountability Model (TEAM) and the Increasing Organ Transplant Access (IOTA) Model. Advancing Medicare payment policy on such a wide-scale, without the benefit of understanding patient and provider impact through testing on a smaller-scale, puts Medicare beneficiaries and providers at risk. Given that CMMI is tasked with testing payment models that are considerably different than Medicare's current payment structure, it is imperative that CMS understand the impacts of those changes prior to seeking to advance them more broadly.

The FAH appreciates CMMI's commitment to the patient's role in the health care delivery system. As Congress and the Administration consider CMMI's role going forward, it remains critical that any innovation advanced by the agency must be faithful to all Medicare and Medicaid beneficiaries, ensuring that their access to and choice of provider is preserved.