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**STATEMENT
of the
Federation of American Hospitals
to the
U.S. House of Representatives Committee on Ways & Means Subcommittee on Health
“Improving Value-Based Care for Patients and Providers ”
June 25, 2024**

The Federation of American Hospitals (FAH) submits the following statement for the record in advance of the House Ways & Means Committee Subcommittee on Health hearing titled “Improving Value-Based Care for Patients and Providers”. We believe that improving quality, retaining and improving access to care, and addressing costs for patients should be at the core of any health care innovation strategy Congress intends to implement or evaluate.

The FAH is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, childrens’, and cancer services.

The FAH is committed to supporting and promoting quality care for patients and providers through value-based care. Our primary concern with value-based payment for physicians is two-fold: insufficient payment and increased burden, exacerbated by rising input costs and looming physician and staffing shortages. Congress needs to consider the overall state of physician payment adequacy to ensure physician payment updates are more in line with the current high rate of inflation. We also support the extension of the five percent Alternative Payment Model (APM) incentive payments to support transitions to value-based care. Even still, many physicians in rural hospitals and hospitals in underserved areas do not qualify for these payments.

Rather than creating new requirements and models, Congress should urge CMS to build upon existing efforts by groups and organizations that incentivize improvement rather than just reporting, thereby reducing burden. Implementing value-based payment models remains costly in terms of time and financial resources for health care providers, necessitating significant ongoing investments in Electronic Health Records (EHRs) and other systems to meet new government requirements. These changes demand clinician time and commitment, including ongoing

education and adaptation to workflow changes. Streamlining reporting requirements would allow providers to focus more on patient care.

In addition, any new value-based care models should be tested appropriately and on a voluntary basis through the Center for Medicare and Medicaid Innovation (CMMI). Congress should reject any mandatory value models that require participation by physicians, hospitals or other providers. Forcing providers to participate in models that they may not be prepared to undertake will ultimately threaten access to patient care for Medicare beneficiaries by requiring steep discounts on payment rates that are already well below the cost of care, imposing excessive administrative burdens, and increasing providers' financial volatility – especially when participants are required to assume the costs of unrelated providers. For example, with the proposed Transforming Episode Accountability Model (TEAM) demonstration's focus on communities with less experience participating in bundled payment models and higher safety net needs, the reduction in access to elective surgical care is likely to fall on some of the most underserved in the community.

We appreciate the Subcommittee's commitment to improving the quality of our health system for the benefit of patients and providers. As Congress considers the role of value-based payments going forward, it remains critical that any innovation must consider the widespread effects on physician payment, increased burden, and maintaining patient access to care.