STATEMENT
Of
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To the United States Senate Committee on Finance

Re: Bolstering Chronic Care through Medicare Physician Payment

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Thank you, Chairman Wyden, Ranking Member Crapo, and members of the Committee, for the opportunity to testify today about how to improve care for people with chronic conditions. My name is Melanie Matthews and I serve as the Chief Executive Officer of PSW and President of MultiCare Care Connected. I have over 20 years of health care experience with a focus on the delivery of value-based care.

Founded by independent physicians, PSW has led healthcare innovation with the guiding principle of supporting the physician-patient relationship to improve the quality of care since its inception in 1995. Committed to the value of innovation, PSW's approach is to meet our partners 'where they are'. We seek to find the complimentary balance of organizational experience and operational strength to support our partner's success. PSW's diversified business portfolio includes payer network operations, accountable care models, and advisory and management solutions; this collective work accounts for more than 400k member lives with a clientele of hospital systems, payers, vendors, and provider practices.

In 2017, PSW Created its first accountable care organization (ACO): NW Momentum Health Partners (NWMHP). NWMHP was created to give our partner providers the ability to join a single network and engage in new Innovative Federal Payment Models. Since then, NWMHP has participated in several CMS Innovation Center models: the Next Generation ACO Model, the Bundled Payments for Care Improvement Advanced (BPCI) Model, Global and Professional Direct Contracting (GPDC) Model, and the ACO Realizing Equity, Access, and Community Health (REACH) Model.

In 2018, PSW began its partnership with MultiCare Health System and MultiCare Connected Care (MCC). MCC was developed to be the Clinically Integrated Network (CIN) for MultiCare Health System and participate as an ACO in the Medicare Shared Savings Program (MSSP). MCC's ACO includes all MultiCare Health System hospitals and several other provider organizations throughout Washington State.

Accountable Care is Improving Care Delivery and Lowering Costs

Through our vast experience, we have seen how accountable care (also called alternative payment models) delivers coordinated care that best meet the needs of people, particularly those with chronic conditions. Accountable care delivery holds providers responsible for the cost of care and health outcomes. As opposed to a fee-for-service system where the incentives are aligned toward greater volume, accountable care focuses on healthier populations and people.

Accountable care efforts have shown that holding clinicians responsible for total cost of care and patient outcomes improves care, expands access, and saves money for federal programs:

- Accountable care improves care experiences by holding providers responsible for patient outcomes and creating cash flow through up-front or population-based payments that providers can use to invest in tailored care management programs, including for the chronically ill. Accountable care strategies including care coordination, care transitions programs (smoothing the transition from hospital to home for example) and care management for medically complex patients improve people's care experiences.[1]
- Accountable care expands access to care, for example, increasing weekend and evening hours appointments, using data to identify gaps in care, and developing relationships with community providers and social needs organizations to improve health outcomes and address social determinants of health.[2]
- By incentivizing preventative care and reducing wasteful spending, accountable care saves money. Advanced APM accountable care organization (ACO) portfolio (ACOs that take on two-sided risk, including two-sided risk Medicare Shared Savings Program and CMS Innovation Center ACOs) saved $4.2 billion in traditional Medicare in 2022,[3] and a total of $8.4 billion in gross savings after taking into account spillover effects in Medicare Advantage.

Chronic Care Management Successes in Accountable Care Delivery

PSW's Chronic Care Management (CCM) program, overseen by the Chief Medical Officer (CMO) and Chief Nursing Officer (CNO), is specifically designed to enhance the quality of life for patients dealing with chronic health conditions. Its primary objectives are to reduce health disparities, minimize unnecessary healthcare costs, and align with value-based reimbursement

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7347295/
[2] https://accountableforhealth.org/wp-content/uploads/2024/02/BRG_ImprovingAccessThroughValueBasedCare2024.pdf
[3] https://www.naacos.com/assets/docs/pdf/2023/NAACOS2022ACOSavingsResource.pdf

systems. This initiative places a strong emphasis on empowering patients to take charge of their health through active engagement with primary care services.

The CCM program is particularly geared towards individuals with chronic diseases who require support for self-management to improve health outcomes. It operates within home settings, where patients or their designated representatives assume responsibility for self-care under professional guidance. Notably, the program takes a proactive approach by identifying patients with poorly controlled chronic conditions or significant negative impact of social determinants of health, with the overarching goal of enhancing patient well-being and health outcomes.

One of the program's core strategies is to foster long-term positive outcomes by ensuring patients and their caregivers possess the necessary knowledge and skills to identify and address health concerns promptly. A Registered Nurse plays a pivotal role in this process by developing and executing personalized care plans. This nurse collaborates closely with a multidisciplinary team comprising physicians, licensed practitioners, social workers, discharge planners, pharmacists, and other healthcare professionals as needed.

Services provided through the CCM program are highly individualized, tailored to support patients with chronic conditions in improving their overall health and well-being. The program places a strong emphasis on patient education and empowerment for effective chronic disease management and self-care. Through a collaborative team approach involving the patient, Nurse Care Manager (NCM), and Primary Care Provider (PCP), the program strives to achieve the patient's specific health goals.

Additionally, comprehensive documentation of services follows stringent National Committee for Quality Assurance (NCQA) requirements. Participation in the Complex Care Management Program is voluntary, with patients having the option to opt out at any time, provided they meet the established enrollment criteria. This comprehensive approach ensures that patients with complex health issues receive holistic care tailored to their individual needs, ultimately aiming for improved health outcomes and quality of life.

Patient Example

A patient with multiple health issues, including congestive heart failure, experienced setbacks due to hospitalizations for sepsis and pneumonia. Despite adhering to prescribed medications, their symptoms worsened at home. After enrolling into a PSW ACO Care Management program, a PSW Nurse Care Manager began engaging with the patient and recognized critical signs. The Nurse Care Manager immediately took action by contacting the primary care physician and recommending daily monitoring of weight and blood pressure. With the remote monitoring and PCP's adjusted medication regimen, the patient rapidly improved within two days, avoiding further complications. This success highlights the vital role of ACO Care Management programs in providing timely support and interventions for patients dealing with complex health issues, enabling them to recover at home.

ACO successes

NWMHP and MCC have played a pivotal role in transforming healthcare delivery and improving patient outcomes in Washington State, resulting in significant cost savings for Medicare. Through their innovative and patient-centered approaches, these ACOs have collectively saved $120 million for Medicare while maintaining an impressive average quality score of 96% and an average savings rate of 4.5% from 2017 to 2022.

NWMHP's emphasis on accountable care has led to notable advancements in patient outcomes across the state. By prioritizing coordinated care initiatives, they have streamlined care transitions, reduced hospital readmissions, and bolstered preventive care services. NWMHP has partnered with independent providers and Critical Access Hospitals (CAHs) alike to expand access to care and benefits to Medicare beneficiaries. Moreover, NWMHP's proactive approach to preventive care has resulted in increased utilization of wellness visits and recommended screenings, fostering early detection and management of health conditions.

Similarly, MCC's commitment to accountable care has yielded positive outcomes for patients throughout Washington State. Through targeted programs focusing on chronic disease management, MCC has empowered patients to better manage their conditions, leading to improved health outcomes and reduced healthcare expenditures. The emphasis on preventive screenings, including mammograms and flu vaccines, has promoted proactive health management and wellness among beneficiaries. Additionally, MCC's efforts in care coordination have facilitated smooth transitions for patients navigating different care settings, ensuring continuity of care and optimal patient experiences.

The combined achievements of NWMHP and MCC underscore their dedication to delivering high-quality care while driving cost savings for Medicare. Their success stories exemplify the transformative impact of accountable care models in enhancing care coordination, promoting preventive services, optimizing chronic disease management, and ultimately, improving patient outcomes and healthcare affordability in Washington State.

Federal Policy can Drive Better Care for Chronically Ill People

The Medicare Access and CHIP Reauthorization Act (MACRA) has been instrumental in driving participation in accountable care that improves care for people. MACRA included incentives for participation in two-sided risk models, where providers can share in savings if they beat spending targets while improving quality or repay losses if they exceed those targets. Participants also received an incentive payment for participating in a two-sided risk arrangement, known as the advanced APM bonus. Those incentives served as a powerful motivator to grow accountable care and allowed participants to reinvest into the health care delivery system to expand access, improve care, and support our clinical network. As a result, substantially more clinicians today, including specialists, are participating in accountable care as compared to before MACRA was enacted. ACO participation in the Medicare Shared Savings Program has more than doubled, from 220 ACOs providing care to fewer than five million

Medicare beneficiaries in 2012,[4] to 480 ACOs providing care to nearly 11 million aligned beneficiaries in 2024.[5]

While accountable care has shown progress toward the goals of better outcomes and lower costs, additional work is necessary to drive change to the way care is delivered in Medicare and for other payers. Now, nearly 10 years after MACRA's passage and over a decade into our ACO and APM experience, we know more about what incentives work to drive participation in APMs. Specifically, we would recommend:

- Extend the advanced APM bonus in the short term to demonstrate Congress's bipartisan continued commitment to ensuring better care for patients in traditional Medicare.
- Restructure the bonus in the longer term to strengthen that commitment, delinking advanced APM bonuses from volume of services provided and shortening the time between payment and performance (which is currently a two-year delay).
- Focus on advanced APM policies that simplify and support provider participation and create clear advantages for participating in an advanced APM.
- Strengthen the data infrastructure to support accountable care and population health.

Incentives for beneficiaries to engage.

Creating incentives for beneficiaries to engage with ACOs is crucial to ensuring that the intended programs developed by ACOs have a true impact on the population. Cost Sharing incentives, for example, can increase access services that otherwise might be avoided or forgone. In Washington State, Columbia County Health System saw this as they embarked on a journey to provide greater support to their patients at risk of or diagnosed with Chronic Obstructive Pulmonary Disease (COPD). Recognizing the challenges faced by these individuals, Columbia County Health System developed a comprehensive program in collaboration with their Chronic Care Management efforts.

This program was designed to offer additional support and resources, including regular nurse consultations, enhanced care coordination, increased primary care visits, and facilitated access to community-based and state-funded services to address social determinants of health. However, despite the immense potential of this program to improve patient outcomes and quality of life, Columbia County Health System encountered a significant obstacle: low enrollment among Medicare beneficiaries.

The primary deterrent to enrollment was the financial burden imposed by coinsurance payments, rendering many beneficiaries unable to afford these healthcare services. It was

[4] https://www.federalregister.gov/documents/2014/12/08/2014-28388/medicare-program-medicare-shared-savings-program-accountable-care-organizations
[5] https://www.cms.gov/newsroom/press-releases/participation-continues-grow-cms-accountable-care-organization-initiatives-2024.

evident that without addressing this barrier, the program's impact would be severely limited, denying vulnerable populations access to the care they desperately needed.

In response to this challenge, Columbia County Health System, with the support of our ACO, implemented the ACO REACH Cost Sharing Waiver. This strategic decision to waive coinsurance payments proved to be a game-changer. By alleviating the financial burden on beneficiaries, we witnessed a remarkable surge in program enrollment.

The waiver not only facilitated greater participation but also translated into tangible improvements in patient outcomes. Patients with COPD who previously struggled to access care now had the means to engage proactively in managing their health. This translated into increased use of primary care, improved disease management, and ultimately, enhanced quality of life for these individuals.

The success story of Columbia County Health System's COPD program underscores a fundamental principle: when we remove financial barriers and create incentives for engagement, we unlock the full potential of ACO initiatives to deliver transformative healthcare solutions. It is imperative that we continue to explore and implement innovative strategies, such as cost-sharing waivers, to ensure equitable access to quality care for all beneficiaries.

Support Provider Participation in Sustainable, Effective Accountable Care

ACOs have supported and improved care for chronically ill individuals for over a decade. Through two main avenues, the Medicare Shared Savings Program and the ACO portfolio at the CMS Innovation Center, participants in these total cost of care models, where providers are accountable for population health and cost, have consistently demonstrated savings and care improvements.

More can be done to support these models as well. In the Medicare Shared Savings Program, CMS can continue to develop options with greater levels of financial risk and reward, such as a full risk ACO that was included in the Value in Health Care Act, introduced earlier this year. In addition, Congress and CMS should work to ensure that there are clear advantages under MACRA to participating in MSSP, disentangling MSSP participants from burdensome MIPS requirements.

The ACO portfolio at the CMS Innovation Center has been a mainstay of that portfolio since the Innovation Center’s creation and continuing across Administrations with bipartisan support. Congress should support continued operation of ACO models at the CMS Innovation Center that support the transition to population-based payments, experiment with new waiver flexibilities, and allow greater pursuit of coordinated care strategies that support patient care.

Conclusion

I thank the Committee for the opportunity to testify today. On behalf of PSW and MultiCare Care Connected, we look forward to continuing to work with you to advance the United States health care delivery system to get better outcomes for patients.

Melanie's Affiliations

Accountable for Health (A4H) – Board Member

National Association of ACOs (NAACOS) – Board Member and Chair-Elect

America's Physician Groups (APG) – Board Member

Health Care Transformation Task Force (HCTTF) – Board Member

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