



**Comments on Value Based Care Programs  
June 23, 2026, Benchmark Hearing  
Submitted Electronically to [OPM.HCBI@ct.gov](mailto:OPM.HCBI@ct.gov)  
Kathleen Holt, State Healthcare Advocate**

Thank you for the opportunity to provide comments on Value Based Care Programs. The Office of the Healthcare Advocate (“OHA”) is an independent state agency with a consumer-focused mission: assuring that consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under their health plans; assisting consumers to resolve disputes with their health insurance carriers and providers; informing legislators and regulators regarding problems that consumers face accessing care; and proposing solutions to those problems. OHA staff have daily front-line insight to the growing struggles, despair, and helplessness most CT healthcare consumers are experiencing – impacting their health and quality of life.

Over the past decade, I have been appointed to, and served on, multiple Centers for Medicare and Medicaid Services (CMS) Technical Expert Panels (TEPs) for payment reform, including Universal and Value Based Care (VBC) payment programs.

I will direct my remarks specifically on behalf of consumers who are left out of care because their providers are disincentivized to serve them by VBC. As many TEP members have noted, the fatal flaw inherent in every VBC program and something that must be solved for, is the administrator’s continuous attempts to build a one-size-fits-all VBC model system. Quality measures and payment incentives that drive a VBC model may be successful for 80% of the covered population, but what works

80% of the time inadvertently removes the remaining 20% of people from care (or highly discriminates against serving them). CMS aggregates data for VBC, which, in theory, shows VBC success for the 80% majority. For other people needing services, who are outliers to the standard criteria, the unintended consequences of disincentives created by VBC is devastating. Time and again, TEP feedback suggested CMS and the Centers for Medicare and Medicaid Innovation (CMMI) apply VBC models only to the population that could be best served by the VBC, along with an alternate, but equally strong, criteria incentive to best serve those who would be disadvantaged by a particular VBC program. However, in final rules CMS time and again has determined that the only exception to VBC models will be for people who live in a persistive vegetative state.

The best way to illustrate this VBC flaw, which likely has contributed to tens of thousands of premature deaths, is to follow the impact of an example CMS VBC program. Medicare's Home Health Value Based Program (HHVBP) is predicated on a payment system that heavily incentivizes payments for the first 30 days of care and for people who are admitted to home health care directly from the hospital. This criteria typically describes someone who requires intense physical/occupational/speech therapy after surgery and applies to the majority of consumers, for which a VBC program with the built-in measurements would be appropriate. However, the criteria serve to heavily penalize payment to home health agencies for patients with chronic, long-term conditions who have a home health care order through a community admission process (examples include people living with ALS, MS, Alzheimers, post-stroke, paralysis). To compound the problem, the majority of 11 quality measures for CMS HHVBC require improvement in the patient's condition (examples of the measures include improvement in independent bathing, improvement in mobility, improvement in the ability to eat and take medications independently). Any home health agency that admits patients who meet criteria for service coverage but does not achieve early discharge of the

patient or fails to improve in their condition, penalizes the total provider scoring, which is compared to its peers, and forces penalties upon it. Under HHVBP most home health agencies therefore screen out longer-term patients who need services but who will not be able to improve, even though the services are covered by Medicare for management and preventing function decline.

These concerns about VBC are a cautionary tale to Connecticut. VBC programs have promise but they must be developed and applied appropriately so they do not create incentives to leave individuals out of service. If someone cannot be fairly measured through the criteria created for a VBC program, there should be another mechanism outside the VBC program to encourage practitioners to provide services.

Thank you, again, for the opportunity to submit these remarks.