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U.S. House Committee on Ways and Means Health Subcommittee
Hearing on "Modernizing Care Coordination to Prevent and Treat Chronic Disease"
November 19, 2025

Chair Buchanan Ranking Member Doggett, and distinguished Members of the Committee — thank you for the opportunity to appear before you today to discuss how coordinated, value-based care is improving outcomes and lowering costs for Americans living with chronic conditions.

My name is Dr. Ashish Parikh, and I serve as Chief Population Health Officer at Summit Health–VillageMD, a physician-led provider group comprised of primary care, multi-specialty care, and urgent care centers across 8 states. We participate in outcomes-based alternative payment models with Medicare, Medicaid, and Commercial payers including the Medicare Shared Savings Program and the ACO Reach Model. We treat millions of unique individuals annually and are the primary care medical home for over 750,000 patients.

As Chief Population Health Officer, my role is to help support our strategy to deliver high-quality, evidence-based, outcomes-driven care to achieve the quadruple aim of better care at a lower cost with better experience for patients and care teams. I am also a practicing primary care internist in New Jersey, and I see firsthand how proactive, coordinated care can change a patient's health trajectory and quality of life.

**The Challenge**

Chronic diseases are a leading driver of illness and spending in our nation. Six in ten adults have at least one chronic condition[1], and four in ten have two or more. [2] These account for 90 percent of the $4.5 trillion spent annually on health care with Medicare bearing a major share of that burden.[3]

Despite this investment, too many patients face a fragmented system - disconnected providers, duplicative tests, and preventable hospitalizations. In its current state, the fee-for-service (FFS) payment model incentivizes volume over value and can lead to unnecessary or avoidable services. For example, Medicare FFS pays more for short-stay inpatient admissions than for observation or outpatient management, which could result in unnecessary hospital admissions, when those patients could instead be appropriately treated in lower-acuity settings. On the other hand, in alternative payment models, providers are rewarded for clinical appropriateness rather than volume, leading to more use of ED observation, home-based care, and rapid follow-up instead of unnecessary admissions. Aligning incentives across care teams through alternative payment models supports coordinated care focused on what is best for the patient.

Additionally, unstable or decreasing reimbursement prevents provider groups from investing in resources such as data analytics, care managers, social workers, and pharmacists needed to optimally manage patients with chronic conditions, since much of the work they do is not reimbursable. Over the past decade, the nominal increases in reimbursement rates have lagged

far behind the rising costs of delivering care in ambulatory practices. In addition, there continues to be tremendous pressure placed on providers by recent health insurance down-coding policies, through which payments are subject to unilateral reduction – even without prior notification.

**The Promise of Coordinated, Value-Based Care**

At Summit Health–VillageMD, we believe that both stabilizing payments for care delivered, and alternative payment models that reward population-based outcomes are key to solving the chronic condition crisis that we are facing.

Through alternative-payment models offered by CMS through the Innovation Center, Summit Health-VillageMD is demonstrating that coordinated, value-based care delivers better health outcomes at lower cost. As an accountable care organization, or ACO, we take responsibility for the overall outcomes of our attributed population. Through quality metric measurement and reporting, we have proven that we deliver high quality care, reflected in higher rates of screening for conditions like depression, better management of chronic conditions such as diabetes and hypertension, and better outcomes such as lower hospitalization and rehospitalization rates for our patients with chronic conditions. And this leads to less suffering within our communities as well as lower cost of care.

We do this by investing in our population health management ecosystem. We have an advanced data analytics platform that allows us to identify patients with high needs and offer individualized supportive care while also finding those individuals who do not come in for needed care so we can proactively reach out to them. Our care management nurses educate and support our patients with chronic conditions in between visits. Our social workers can help patients overcome barriers to good health by connecting them with community-based organizations. And our pharmacists work with patients to improve adherence to medications, reduce drug-related adverse events such as falls, and help patients with medication affordability. Summit Health also has a large behavioral health team since we know that emotional wellbeing is essential for overall health and disease management.

And all of these teams work in coordination with the patients' primary care and specialty providers so that the providers can best use their limited time in the office visits with patients to focus on the highest impact care such as screenings, preventive services, chronic condition management, and reduction of risk of complications including hospitalizations.

**Results**

Our results in MSSP and ACO REACH speak to the effectiveness of our care model:

- Overall quality of care:
    - Our ACO REACH entities are measured on hospital admission rates, readmission rates, timely follow-up after discharge, and patient experience. All 5 of our entities achieved high quality scores with two receiving payments from the high performing pool for scores of 100%+. We expect all 5 of our ACOs to receive high performing pool payments for 2024 performance year (data is embargoed).
- Prevention: Our group has higher rates of Annual Wellness Visits than the overall Medicare population

- VillageMD: 74% and Summit: 78% (all ACO median: 64%; national Medicare rate: 60%)

- Chronic condition management: In MSSP for PY2024, we are in the 9th decile for diabetes control and in the 10th decile for blood pressure control.
  - Summit Health (NY and NJ) has exceeded the MSSP quality standard and outperformed the national mean for every year of participation. We have developed the capability to submit eCQMs for quality reporting reflecting superior care for all our patients beyond Medicare.
- Better Patient Outcomes: Our coordinated care leads to lower emergency department (ED) visits and hospitalizations
  - In ACO REACH for PY2024, we expect to be in the 90th percentile or above in the Unplanned Admissions for the Patients with Multiple Chronic Conditions measure in 5 out of 6 ACO REACH entities.
  - In 2024 our admissions per thousand in our MSSP ACO was at 191 compared to MSSP Median of 229 and National Medicare FFS average of 272. Our ED visits per 1000 was 435 compared to MSSP Median of 617 and National Medicare FFS average of 698.
- Overall Cost of Care: Our care model leads to less suffering and better well-being for our patients as well as overall reduced cost of care.
  - In 2023, Village Medical had two of the top four performing Standard ACO REACH participants, as measured by gross savings percentage. This generated $36M for the CMS trust fund and $104M for our group to reinvest in our patient care.[4] (we expect even greater savings in 2024—data is embargoed)
  - Our MSSPs have generated gross savings every year since 2016. In 2024 alone we generated $35M of gross savings resulting in $9M for CMS and $26M for our group to reinvest.

**Why It Works**

Our care model works because alternative payment models align incentives around what truly matters: outcomes and patient experience.

We empower our primary care teams with actionable data, integrated technology, and the clinical support of care managers, pharmacists, and behavioral health specialists. That allows us to address both medical and social needs, proactively managing chronic conditions and preventing avoidable complications and hospitalizations.

Through aligned incentives, our model also improves clinician satisfaction and fosters accountability for results rather than volume. It rewards providers who are focused on longitudinal whole-person care beyond the transactional visit, procedure, or interaction. This financial stability allows groups like ours to continue to offer support services and ensure viability of our group.

**Policy Opportunities**

We are grateful for the Committee's leadership in supporting the delivery of great care to all Americans. We urge continued action to:

1. Strengthen Medicare reimbursement rates and annual adjustments to keep up with the increasing costs of outpatient medical practice
2. Further enhance payments that promote preventive services and primary care, the foundation for better overall health.
3. Continue to advance alternative payment models that allow providers to take accountability for their patients' outcomes and appropriately sharing in the savings generated through better care and outcomes.
4. Make pandemic telehealth flexibilities permanent for better patient access and continuity.
5. Reduce the administrative and reporting burdens on ACOs as these divert resources from patient care.
6. Advance interoperability and data sharing, to ensure care coordination across settings. Hold technology partners such as EHR vendors accountable for supporting interoperability.
7. Continue to partner with ACOs to identify and stop fraud, waste, and abuse, and hold ACOs harmless for identified fraud, waste, and abuse.
8. Expand site-neutral payments and modernize the ambulatory surgical center covered procedure list to support lower cost, safer sites of service for procedures that do not need to be performed in the hospital.
9. Prohibit commercial insurers from unilaterally downcoding billed claims without appropriate notification and transparency regarding their methodologies.
10. Reform prior authorization processes to reduce administrative waste, prevent dangerous delays in care, and allow clinicians to focus on delivering timely, high-value treatment.

**Patient stories:**
I would like to close with two specific stories that can put the impact of coordinated, outcomes-based care into context.

First, is how we managed our patients during the pandemic. The metro NYC area had some of the highest rates of infection and hospitalization during the early stages of the pandemic. When the entire world shut down, we were able to continue to give care to our most vulnerable patients. Because we had a network of urgent care centers, we could ask all patients with covid symptoms to go there for testing and treatment, allowing us to keep our offices open for our high-risk and potentially immunocompromised patients who needed care from their cardiologists, oncologists, and other providers. Secondly, we were able to identify our highest-risk chronic condition patients through analytics and proactively reach out to them with remote provider visits and care management support. And through these efforts, not only did we keep our patients safe and their conditions well managed but prevented avoidable ER visits at a time when our hospitals were over capacity.

And on a more personal level, recently during my scheduled office time, my first patient of the morning told me she was having suicidal thoughts. After I spoke to her for a while, I was able to connect her directly with one of our integrated behavioral health specialists via a secure tablet that we have in all our Summit primary care offices. The specialists spoke to the patient for 45 minutes while I went on to see my other scheduled patients. When I went back into the exam room, together with the patient and the psychologist, I was able to determine that she was safe to return home with intensive support from our team over the next few days. This saved the patient

an unnecessary ED visit and I was also able to stay on schedule with all my other patients that morning, reducing disruption to others who needed to be seen.

Both stories had positive outcomes because we have population health management infrastructure that is supported by investments made from appropriate reimbursement for the care we give through both fee-for service and alternative payment models.

**Closing**

I thank the committee for offering us the chance to share our care model, our passion for better care, and our willingness to partner for a healthier America. We have shown that coordinated, patient-centric, outcomes-based, value-based care works for patients, clinicians, and taxpayers. The evidence from Summit Health–VillageMD shows that when we reward prevention, partnership, and accountability, we achieve better outcomes and lower costs.

On behalf of our clinicians and patients, I thank the Committee for your continued leadership in strengthening the Medicare program and advancing coordinated care that delivers value for all Americans. I look forward to your questions.

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