

June 22, 2015

The Honorable Orrin Hatch
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
United States Senate
Washington, DC 20510

The Honorable Johnny Isakson
United States Senate
Washington, DC 20510

The Honorable Mark Warner
United States Senate
Washington, DC 20510

Submitted electronically at chronic_care@finance.senate.gov

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

On behalf of the Premier healthcare alliance, we appreciate the opportunity to offer recommendations on ways to improve care for vulnerable Medicare beneficiaries with chronic conditions. Premier is a leading healthcare improvement company, uniting an alliance of approximately 3,400 U.S. hospitals and 110,000 other providers to transform healthcare. With integrated data and analytics, collaboratives, supply chain solutions, and advisory and other services, Premier enables better care and outcomes at a lower cost.

Premier commends Senate Finance Committee leaders for recognizing the urgent need to find better ways to care for Medicare beneficiaries with chronic conditions. As identified by the working group, the increasing number of people living with multiple chronic conditions have significant consequences for the health of all Americans, but especially for the Medicare population. With spending for chronic conditions accounting for the preponderance of total healthcare expenses in this country, these trends also have enormous implications for Medicare spending.

Multiple chronic conditions also expose weaknesses in today's delivery system. Patients with chronic conditions report conflicting advice and diagnoses from physicians for the same symptoms. Drug interactions are common, sometimes resulting in unnecessary hospitalizations and even death. Moreover, people with multiple chronic conditions are admitted more frequently to hospitals with conditions that could be better managed in the primary care setting. However, the Medicare fee-for-service system provides few incentives for physicians and other caregivers

to coordinate with one another, nor does it reward prevention efforts designed to avert disease or slow its progression.

The Premier healthcare alliance has for years worked with hundreds of hospitals, health systems and physician groups across the country that are actively testing, measuring and scaling new models of care to address the shortcomings of the fee-for-service model. A number of large scale collaboratives, including Premier's accountable care, bundled payment and QUEST® collaboratives, have allowed Premier to evaluate and help build coordinated, population health capabilities through education, best practice sharing, measurement and benchmarking. Through these efforts, Premier has gained valuable insight on what works and does not work for different patient populations. Based on our learnings, Premier has devised two proposed models of care that we urge the committee to consider. These models are specifically designed to address the critical need for better coordinated, higher quality and more efficient care for people with multiple chronic conditions—particularly for those in areas of the country that are underserved and not adequately served by existing models.

Ambulatory Intensive Care Units

Our first proposed service delivery model is designed to change the dire state of chronic care in America. Specifically, the program seeks to identify and target this population with intensive primary care services that are based on predictive modeling, care management and a high level of individual engagement. This, in turn, will reduce morbidity, mortality and total cost of care for patients with three or more chronic conditions in a commercial, Medicare and/or Medicaid managed care plan.

Under this model, participants would implement Ambulatory Intensive Care Units (A-ICUs) to address many of the barriers that historically prevent or dissuade chronically ill patients from accessing primary healthcare services. Separate from a patient-centered medical home, participants will be charged with better managing chronic conditions exclusively within a clinically integrated, financially accountable, high-performing care practice, which can be implemented in a standardized, replicable way at voluntary sites across the country. As part of the approach, participants can use a common predictive modeling solution to assess patient risk and identify those with multiple chronic conditions and behavioral health issues that lead to morbidity, mortality and higher costs of care. Once identified, participants will develop technology-assisted, evidence-based care pathways for better managing chronic conditions and behavioral health needs, with an eye toward lowering hospital utilization, including inpatient bed days, length of stay, admissions, readmissions and ED visits.

As part of the test for change, participants would focus on creating innovative beneficiary engagement strategies, including financial incentives for patients such as waived co-pays for visits to the special care center; transportation vouchers; and other services such as weight

management support, heart failure scales or remote monitoring technologies. To assess the effectiveness of these interventions, participating organizations would develop a series of beneficiary engagement measures, and implement processes for routine review and revision of care plans.

The effectiveness of risk-based capitated primary care payments covering services provided to beneficiaries who enroll in special care centers could also be tested. Specifically, we propose that Medicare pay a capitated primary care payment of approximately \$77.40 each month, an 80 percent increase over the historical amount spent on primary care in Medicare fee-for-service. An add-on enhanced primary care management fee of \$20 in the first year and \$15 in the second year, with the third years paid out of grant funds. Up to 30 percent of the add on care management payments will be at risk, subject to meeting benchmark criteria for quality measures, including all cause hospital admission rate, 30-day readmission rate, ED utilization rate and HEDIS measures collected through the MSSP program. Organizations that do not meet the quality benchmarks in year one will be required to either pay back the 30 percent at the end of the performance year, or will have the 30 percent deducted from year two payments.

Although the model calls for new investments in primary care, analytics, clinical models and decision support, research from similar implementations across the nation indicates the potential for a net cost reduction of 18.03 percent to Medicare, 21.8 percent to Medicaid and 21.8 percent to commercial payers.

Critical Access Hospital (CAH) Value-Based Purchasing (VBP) Program

Reforming healthcare delivery models is the new imperative in healthcare, with new innovations focusing on evidence-based care, outcomes and transparency to deliver high quality and cost effective care. Yet, as our nation's urban areas continue to modernize their delivery models, Critical Access Hospitals (CAHs) that serve patients with multiple chronic conditions in our rural communities are increasingly being left behind. Very few ACOs operate exclusively in non-metropolitan counties. Rural Americans also face unique challenges that create disparities in healthcare not found in urban areas. Rural residents, on average, are older, have lower incomes, report fair to poor health status, and suffer from higher rates of chronic illness and obesity. Additionally, small rural, facilities face challenges in implementing quality improvement efforts including limited resources, small staffs, and inadequate information technology resources. Independent rural practices often do not have the devoted resources and technology to engage in care management, which is necessary to coordinate care and manage population health. To improve care and increase coordination for these vulnerable populations, CAHs need to have mechanisms that are different from existing models that will bring them into the fold.

To address this situation, we urge the Working Group to consider a new model that focuses on rural priority areas and seeks to transform financial and clinical models at CAHs. Specifically,

we propose testing a unique VBP program with CAHs across the U.S. and garner evidence of the program's viability on a broad scale before nationwide implementation. The goal is to demonstrably improve quality and the patient's experience of care while simultaneously reducing inpatient and outpatient costs in rural communities.

To accomplish this objective, this proposed model would implement payment incentives tied to performance on: evidence-based care, mortality, safety, patient experience, care coordination and spending. The selected measures are taken from those used in existing programs proven to foster quality improvement. As remote providers, CAHs serve patients with myriad conditions, including many of CMS' priority conditions. These will be key improvement areas for the program. Premier has developed a preliminary measure set that we believe will bring focus to these conditions including: heart failure, acute myocardial infarction, diabetes, stroke, behavioral health, obesity, and COPD. Using this standardized set of metrics, the new VBP program will help CAHs demonstrate value by lowering inpatient admissions, readmissions and emergency department use as well as post-acute care. This in turn will reduce CMS spending while improving the quality of care delivered in rural communities. Under the current system, and with razor thin margins, there is no advantage for these small remote facilities to join in the journey to population health. The additional funding would provide these small facilities, with the incentive to begin the journey to population health despite their cost-based payment system without asserting undue risk that could close their doors.

The program would create a sustainable model that could bring ACO-like incentives to improve health and healthcare at a lower cost to roughly 19 percent of the country's population, many with chronic conditions. Even with the costs associated with developing the model and implementing the program, Premier conservatively believes this model, if tested with 100 CAHs, would save Medicare \$106 million over the course of three years.

Medicare Shared Saving Program

In addition to proposing two new models of care, we also offer several recommendations to improve the current Medicare Shared Savings Program (MSSP). Earlier this month, CMS released a final rule that made vital changes to the MSSP that we believe will remove many of the impediments to Medicare ACO development, attract more participants and maximize the success of the program. However, we urge Congress to direct CMS to make additional changes that will provide even greater incentives to providers to coordinate care for patients living with chronic conditions, including:

- **Payment waivers to eliminate barriers to care coordination:** In the final rule, CMS only waives the skilled nursing facility (SNF) three-day stay requirement, and limits that waiver to just those that participate in Track 3, the highest risk option, starting in 2017. Premier believes that any and all payment waivers that can improve care delivery should be equally available to all MSSP participants, and all assigned beneficiaries. Specifically,

we urge Congress to ensure that CMS allows the following waivers for all Model 1, Model 2 and Model 3 MSSP participants:

- The SNF three-day stay rule, which requires Medicare beneficiaries to have a prior inpatient stay of no fewer than three consecutive days in order to be eligible for Medicare coverage of inpatient SNF care;
 - Hospital discharge planning requirements that prohibit hospitals from specifying or otherwise limiting the information provided on post-hospital services;
 - Medicare requirements for payment of telehealth services, such as limitations on the geographic area and provider setting in which these services may be received; and
 - The homebound requirement for home health, which requires that a Medicare beneficiary be confined to the home to receive coverage for home health services.
- **Prospective beneficiary assignment:** While Premier supports CMS decision to prospectively assign Medicare beneficiaries to Track 3 ACOs, we strongly encourage the Congress to direct the agency to allow ACOs the option to choose prospective beneficiary assignment for Track 1 and 2 ACOs. Prospective assignment would increase certainty for the ACO and provide a more narrowly defined, stable, target population and help minimize unexpected changes in its benchmark. These outcomes are valuable to ACOs in all tracks – not just those that take on increased risk.
 - **Voluntary assignment for all tracks:** CMS said in the final rule that it will use the 2017 physician fee schedule rulemaking process to allow beneficiaries to join an ACO by attesting that a practitioner participating in the ACO is responsible for their care coordination. We urge Congress to ensure CMS promptly allows the option of beneficiary attestation. Providing beneficiaries with chronic conditions with the opportunity to voluntarily align with an ACO would balance the important considerations of enabling beneficiaries to take a greater role in managing their health by choosing their providers with ACOs' interest in reducing beneficiary turnover, which would help provide a more defined and stable beneficiary population up front.
 - **Attribution at the Tax Identification Number (TIN) and National Provider Identifier (NPI) level:** Premier also urges Congress to instruct CMS to use a combination of TIN and NPI for assignment to prevent specialists from being restricted to active participation in only one ACO. In addition, because the definition of an ACO is a collection TINs, rather than either individual NPIs or TINs, larger delivery systems may have to bring in numerous hospitals across multiple states under current regulations. Thus, Premier has long argued that CMS should allow these TINs to split in order to allow a single market, for example, to enter the program on their own.
 - **Option of regional trending and benchmarks for all tracks:** CMS indicates in the final rule that it will initiate further rulemaking later this year to implement a methodology to reset ACO benchmarks in part based on trends in regional fee-for-service costs rather than solely ACOs' own recent spending. Premier believes that the financial

benchmarking methodology needs to be improved to ensure predictability, accuracy and stability over time. CMS should not require an ACO to continually beat its own best performance. We urge Congress to instruct CMS to provide the option of equally weighting the three benchmark years, as well as the option to account for shared savings payments when resetting the benchmark.

- **Two-way risk adjustment for all tracks:** Finally, we urge Congress to ask CMS to consider additional changes to increase the accuracy of the risk adjustment methodology. Specifically, CMS should use Hierarchical Condition Categories (HCC) coding comparison between the ACO assigned beneficiaries and the comparison group to create a risk adjustment factor. This factor should be adjusted in both directions when health status changes. Premier is concerned that by only counting HCC scores that work against the ACO for the continuously enrolled population, the current policy actually disadvantages ACOs that take on the management of the sickest populations with greater medical need. CMS should also explore the feasibility of concurrent risk adjustment which could be superior to the current prospective model.

Conclusion

Again, thank you for your efforts to develop bipartisan legislative solutions to improve care for those with chronic conditions. We hope you will consider the proposed solutions we have put forward. We have kept the description of these models at a high level, but we would welcome the opportunity to share our proposals, which we have fully developed, in more detail. We are also glad to provide more detailed comments on our recommended fixes to the Medicare Shared Savings Program.

For additional information, please do not hesitate to contact Margaret Reagan at Margaret_reagan@premierinc.com or 202.879.8003.

Sincerely,



Blair Childs
Senior Vice President, Public Affairs
Premier healthcare alliance