

January 28, 2016

The Honorable Orrin Hatch
Chairman, Finance Committee
U.S. Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member, Finance Committee
U.S. Senate
Washington, DC 20510

The Honorable Johnny Isakson
Co-chairman, Chronic Care Working Group
Finance Committee
U.S. Senate
Washington, DC 20510

The Honorable Mark Warner
Co-chairman, Chronic Care Working Group
Finance Committee
U.S. Senate
Washington, DC 20510

Submitted electronically at chronic_care@finance.senate.gov

Dear Chairman Hatch and Senators Wyden, Isakson and 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 3,600 U.S. hospitals and 120,000 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 has 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 several proposed models of care and recommends changes to existing Medicare shared savings programs that we urge the committee to consider. These models and policy modifications 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. Premier is concerned that rural areas are being left behind and thus suggest a value-based payment model tailored to those areas that begins the journey to population health. In addition, we suggest the piloting of a payment model that combines bundled payments and capitation within the construct of the ACO program. We also propose modifications to the rules around access to substance abuse data for ACOs and the application of sequestration cuts to shared savings payments. In addition to these recommendations to address unmet needs of patients with chronic care, we have joined the American Medical Association, the American College of Physicians, the National Association of ACOs and the American Medical Group Management Association in submitting a separate letter to the Committee that offers recommendations to improve the current Medicare Shared Savings Program. Together, we believe these changes will provide even greater incentives to providers to coordinate care for patients living with chronic conditions.

Finally, we propose that the Committee adopt legislation to consolidate the existing hospital pay-for-performance programs to provide a holistic approach that appropriately influences systematic flaws in care delivery while rewarding hospitals for meeting the healthcare needs of all their patients, including those with chronic conditions.

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. Rural Americans 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, fewer staff 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.

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. This is evident by the very few ACOs that operate exclusively in non-metropolitan counties. 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. In the absence of such mechanisms, we risk creating a two-tiered system: one based on quality and accountability in urban and suburban settings, and another based on volume leading toward poor health outcomes in rural, less advantaged areas.

To address this situation, we need a new model that focuses on rural priority areas and seeks to transform financial and clinical models at CAHs. The ideal solution is to create a unique value-based purchasing (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, the model would implement payment incentives tied to performance on: evidence-based care, mortality, safety, patient experience, care coordination and spending. Through this program, CAHs would earn up to a 2 percent bonus on inpatient and outpatient services if they meet quality, patient experience and efficiency targets during the first and second years of the program. If, after three years, it can be demonstrated that the group of CAHs as a whole reduced total Medicare spending for the population they service, then a share of those savings would generate a pool for incentive payments to be distributed back based on related performance. If no statistically valid savings are shown, then no incentive payments would be paid out. This sets up a group shared savings pool that overcomes the statistical reliability challenges associated with calculating savings at the individual CAH level because of the low volume of cases.

As remote providers, CAHs serve patients with myriad conditions, including many of CMS' priority conditions. These will be key improvement areas for the program. A preliminary measure set would bring focus to these conditions including: heart failure, acute myocardial infarction, diabetes, stroke, behavioral health, obesity, and chronic obstructive pulmonary disease (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.

The additional funding from the incentive pool 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.

We urge the Committee to take action to bring better coordinated and integrated value-based care to patients living in rural or underserved communities by enacting legislation to create a program that tests and allows for national scaling of VBP for CAHs.

Layered payment model demonstration

The Centers for Medicare & Medicaid Services (CMS) established the Medicare Shared Savings Program (MSSP) to facilitate coordination and cooperation among healthcare providers to achieve the Triple Aim™ of reducing the overall cost of care while improving both the overall health and experience of the Medicare beneficiaries served. The model is designed to achieve this end by enhancing primary care, avoiding unnecessary services and focusing on patient wellness. However, the current program continues to be built on a foundation of fee-for-service (FFS) payments.

In addition, primary care physicians often find it difficult to make the necessary changes in their practice infrastructure and practice patterns without upfront capital. For instance, it is resource intensive to purchase new scheduling software or hire additional staff. Also, it is risky to expend such capital without knowing if savings will be returned to the practice at the end of the year.

Moreover, the ACO attribution model that focuses accountability on primary care physicians leaves little room for the engagement of specialists. While gainsharing agreements between the ACO and specialists are possible, these incentives are often minimal and so far removed from the acute care services provided that it has little effect on practice patterns. The bundled payments model, on the other hand, creates a more concrete target and proximal payback for specialists leading to greater change. While

these two models are not mutually exclusive, and arguably synergistic, there have been no overt tests of the two being intentionally combined.

One promising solution is replacing paying primary care physician (PCPs) for their evaluation & management (E&M) services with a single monthly capitated payment that would be included in total spending for the purposes of comparing an ACO's actual expenditures to its historical MSSP benchmark. This limited capitation would allow PCPs to focus their attention away from generating as many services as possible to better managing a panel of patients through new methods of care. PCP capitation would enable primary care practices to optimize their use of care teams that include physician extenders such as nurse practitioners and health coaches, to institute electronic visits, and to expand use of patient portals – all of which would facilitate having open access and enhance the patient experience. The care teams and e-care would be able to handle much of the routine, less complex care thereby allowing the PCPs more time for the care of the complex patient within the practice and encouraging them to have more complex patients on their panels.

The program would avoid pitfalls of the PCP capitation of the late 1980s and early 1990s, whereby PCPs unnecessarily triaged their patients to specialists. Combining the shared savings element of the MSSP with a PCP capitation would discourage the PCPs from referring patients unnecessarily to costly specialists. Simultaneously, the rigorous quality measures within the MSSP would ensure that the PCPs focus on appropriate referrals and transitions of care. With the PCPs freed from the RVU treadmill, they would be better able to 1) care for their patient within the confines of their office, thus utilizing less unnecessary specialist (professional and ancillary) and hospital (ED and readmissions) services thereby lowering the overall cost of care; and 2) deliver high quality patient care and experience.

If, however, specialty acute care becomes necessary, the underlying payment for such services would fall under bundled payments rather than traditional FFS. By setting unified targets across episodes of acute care, the ACOs can more directly associate savings with the work of specialists and provide more timely compensation for improved care at a lower cost. At the same time, the capitated primary care payments will ensure the continued engagement of the PCP and the overarching ACO incentives will temper the incentive to generate more episodes. All of the spending, whether through capitation, bundling or the remaining FFS would be tallied and reconciled against the ACO's historical benchmark to see if overall spending is lowered. Our expectation is that by replacing much of the underlying FFS foundation, ACOs will be even more successful at achieving the Triple Aim.

We urge the committee to establish a pilot program that layers bundled payments and primary care capitation together under the umbrella of the ACO framework to further sever ties with FFS and move toward population based payments.

Consolidation of hospital pay for performance programs

Hospitals are required to participate in five quality programs—the Hospital Acquired Conditions Reduction Program (HACRP), the Hospital Readmissions Reduction Program (HRRP), the Hospital Value Based Purchasing Program (HVBP), the EHR Incentive Program (Meaningful Use) and the Hospital Inpatient Quality Reporting Program (HIQR). Five separate programs creates an administrative burden as each program has distinct measurement timeframes, reporting periods and reporting requirements. While the measures for some programs are calculated by CMS, hospitals still must work to internally monitor these measures to improve care and avoid penalties. Monitoring five separate programs creates an administrative challenge and diverts resources away from care.

In addition to creating an administrative burden the current programs duplicate penalties; for example, Medicare’s “triple threat” penalizes hospitals three times for the same infection under HVBP, HACRP and the HAC penalty. Two programs (HACRP and HRRP) are penalty-only programs that do not provide an opportunity for all to succeed, and benchmarks are not set in advance so providers are unsure if working towards a certain target reduction will allow them to avoid a penalty.

Most importantly, the separate current policies can have a disproportionate adverse impact on the hospitals that are serving our most vulnerable populations. These patients do not always have access to appropriate follow up care in their communities and have difficulties managing their healthcare needs (i.e., affording medications for chronic conditions such as diabetes and heart failure). Premier believes that hospital value-based payment policy should be based on risk-adjusted, rate-based measures that are integrated into value-based purchasing to incentivize quality improvement, the systematic reduction of preventable readmissions and HACs, and the use of health information technology to accomplish all these goals.

Consolidating the existing programs into one simplified program can address the flaws in the current programs while continuing to hold hospitals accountable for quality, safety and cost. Similarly, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) rolled the existing physician quality programs (Value-Modifier, Meaningful Use, Physician Quality Reporting System) into a new consolidated program (Merit-Based Incentive Payment System or MIPS); this sets the stage for consolidation of the hospital quality programs.

The Hospital Value-Based Purchasing Program (HVBP) has proved to be an effective vehicle because it is a well understood, tested method that addresses many of the flaws in the other programs—it incorporates achievement and improvement, allowing low-performers to rise rather than stagnate at the bottom, benchmarks in advance of performance, fostering collaboration among providers rather than pitting them against each other, and allows hospitals to estimate bonuses and penalties.

Premier proposes legislation to create a consolidated hospital pay for performance program by sunseting HACRP, HRRP, the Meaningful Use payment adjustment and the HIQR payment adjustment. HVBP is then modified to include components of the other programs (i.e., readmissions, safety, demonstration of meaningful use) and the payment at risk is modified to 6 percent. The total modified percentage at risk is equal to the percentage risk in the current programs:

- VBP: 2 percent of wage-adjusted operating payment in 2017
- HAC: 1 percent of adjusted payment
- Readmissions: 3 percent of wage-adjusted operating payment

The total modified percentage at risk does not include the current the percent at risk under the Meaningful Use and HIQR penalties, because very few hospitals receive these penalties. Instead, hospitals that fail to submit sufficient measure data to support the calculations under the new system will receive the full 6 percent penalty.

Statutory and regulatory barriers to healthcare provider access to substance abuse records of their patients

Current legal requirements (e.g., section 543 of the Public Health Service Act and regulations under 42 CFR Part 2) for sharing substance abuse treatment records require patients to sign off for each individual healthcare provider to access those records. These complex consent requirements make it very difficult for ACOs and health information exchanges to share patient data related to substance use disorders. Additionally, because of these regulations, researchers have limited access to alcohol and drug abuse data.

The Centers for Medicare & Medicaid Services (CMS) has interpreted the regulations as precluding them from making records on substance abuse treatment in their control available to Medicare ACOs and other organizations involved in delivery reform models. As a result, many organizations have excluded that information from their systems which impedes efforts of healthcare providers to improve care and efficiency and which means that substance abuse and mental health patients will not benefit in the same ways as other patients from care coordination models. Instead, they will remain at higher risk for adverse events. CMS has also interpreted the regulations as prohibiting the release to researchers of data from such records related to Medicare beneficiaries. This impedes research intended to improve the quality of care, the efficiency of care, care coordination, etc. for Medicare beneficiaries.

We propose the following narrowly tailored legislative solutions to address these issues:

1. Section 543 of the Public Health Service Act (relating to requirements for confidentiality of records on substance abuse education, prevention, training, treatment, rehabilitation, or research) would be amended to remove the barrier that CMS believes exists to permit the agency to share

those patients' records with healthcare providers and suppliers participating in Medicare or the Center for Medicare & Medicaid Innovation delivery reform payment models.

2. The section would also be amended to clarify that CMS may make data from such records available to researchers pursuant to data use agreements for research intended to advance improvements in the quality of care and/or the efficiency of care furnished to Medicare beneficiaries.

Deterrents to shared savings models that improve care for patients with chronic conditions

A large number of providers, both hospitals and physicians, are actively working to change how healthcare is delivered and paid for, in an effort to improve outcomes, enhance the patient experience and bend the cost curve. Providers participating in alternative delivery and payment models, such as ACOs and bundled payments, are working to provide higher value and better coordinated care at lower costs in order to make healthcare more sustainable. These improvements in patient care directly benefit patients with chronic conditions, but require major investment of time and resources on the part of healthcare providers. Providers engaged in these models of care are able to share in the savings that they generate for Medicare.

Unfortunately, due to the cuts required by sequestration, these providers are not only having their initial Medicare reimbursement cut by 2 percent, but also their portion of the savings they achieve. As you know, the Budget Control Act of 2011 (BCA), requires a 2 percent across the board cut for the Medicare program. Thus, a Medicare payment to a provider of services, supplier, or plan is reduced by 2 percent though beneficiary copayments are not affected. Unfortunately, CMS is interpreting the BCA as applying to the portion of shared savings owed to participants of innovative delivery models, such as ACOs. This cut—which is on top of their initial 2 percent Medicare payment cut or minimum savings rate—provides a disincentive for these organizations to make major investments of time and resources and will discourage more providers from participating in these types of innovative models.

Instead of cutting hospitals, Congress should adopt and strengthen policies that continue to move us toward integrated care and reward healthcare providers that are achieving savings and improving quality. So long as the sequester continues, which Premier opposes, Congress should exempt shared savings received by providers participating in delivery system reforms, such as the MSSP and Medicare bundled payment programs, from the sequestration cuts. These sought-after savings are shared with the federal government and therefore accomplish the goal set out by the sequester, which is to reduce federal spending. It is counter-productive to tag on the 2 percent sequestration cut to the share of savings that providers receive in recognition of their successful efforts to improve the quality and efficiency of patient care. Additionally, it could jeopardize the very models that seek to provide better care for patients with chronic conditions that require a high degree of coordination.

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 and proposed legislation 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 MSSP.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Blair Childs". The signature is fluid and cursive, with the first name being more prominent.

Blair Childs

Senior vice president, Public Affairs

Premier healthcare alliance