PREMIER TRANSFORMING HEALTHCARE TOGETHER®

June 17, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD, 21244

Dear Administrator Brooks-LaSure

On behalf of the Premier healthcare alliance serving more than 4,100 U.S. hospitals and health systems, hundreds of thousands of clinicians and approximately 200,000 other providers and organizations, I write to express our support of several of the Administration's key policy priorities and to offer our views, expertise and recommendations for achieving and sustaining better care at lower costs. **We share your commitment to continuing the Affordable Care Act's drive to value-based care and reducing barriers to interoperability.**

Premier is passionate about transforming American healthcare. With integrated data and analytics, collaboratives, and supply chain solutions we collaborate with our healthcare provider members to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide. Premier has leveraged its extensive experience, surveyed its healthcare provider partners, and reviewed lessons learned to develop specific proposals to promote value-based payment reform and improve data collection and access to enhance real-time outcomes.

CONTINUING ACA'S DRIVE TO VALUE-BASED CARE

A critical component to improving quality and reducing healthcare costs for all Americans is to allow providers to develop innovative approaches for delivering care in value-based arrangements. Value-based payment arrangements were a major focus of the Obama-Biden Administration with the Affordable Care Act (ACA) establishing the Center for Medicare & Medicaid Innovation (CMMI) to test alternative payment models (APMs). Further, the bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established incentives for clinicians to adopt APMs. Through large-scale data-driven collaboratives, the Premier healthcare alliance has for years worked with hundreds of hospitals, health systems and physician groups across the country to actively test and scale new models of care and build coordinated, population health capabilities through education, best practice sharing, measurement and benchmarking.

The coronavirus pandemic has showcased how the fee-for-service system (FFS) failed to adapt to meet healthcare demands of the pandemic. Provider's dependence on volume and the restrictions of fee-for-service rules undermined innovation, provider's financial well-being, and managing the health of populations. According to a Premier survey, leading health systems and providers operating in value-based models had a head start over other providers in adapting care. Moreover, providers in the most advanced value-based arrangements (i.e., global budgets and capitation) were able to avoid financial challenges that many other providers faced.

Over the past decade, since the passage of ACA, we have gained critical experience in testing alternative payment approaches. We are now at a critical juncture in which **we must rapidly scale alternative payment approaches that allow providers to be in the driver's seat of care transformation.**

13034 Ballantyne Corporate Place
Charlotte, NC 28277
T 704.357.0022
F 704.357.6611

444 North Capitol Street, N.W.
Suite 625, Washington, DC 20001
T 202.393.0860
F 202.393.6499

PREMIERINC.COM

Providers with their local roots and direct role in care delivery are best situated to design population health solutions that are targeted to the needs in their communities, including addressing health equity. Moreover, moving from fee-for-service to value shifts the fundamental incentives from reactive, sickness-based care to proactive, wellness-based care. Without this change, the incentive to achieve health equity is significantly undermined.

This will require new partnerships between payers and providers that incent providers to be responsible for the quality and cost of care. We request that the Administration articulate a vision for the movement to value. When providers have a clear plan for moving to new models, they work aggressively to succeed in the model and more rapidly advance to the risk-bearing model. We provide the following recommendations that are central to a vision for accelerating the movement to value.

Ensure a level playing field. We must recognize that the market forces in each region will define which types of entities are best suited for various functions such as financial risk management, benefit design and care management. A truly competitive environment is one in which providers can form unique arrangements and partnerships to best serve their populations. We must avoid approaches that advantage one provider type or risk-assuming entity over another. Moreover, we must unleash potential for providers to truly innovate care by providing flexibilities and incentives that are equivalent to those that plans in Medicare Advantage (MA) receive. Innovating care requires flexibility beyond what is currently allowable in FFS, yet current models have provided minimal flexibility. Providers are well suited to design unique care approaches for their population. When managing total cost of care, the FFS program integrity concerns are mitigated.

Provide adequate reimbursement in APMs. Current approaches in APMs create a race to the bottom where providers must achieve year-over-year savings. A new paradigm is needed where benchmarking approaches are sustainable long-term (e.g. designing benchmarks that reduce spending trend rather than year-over-year savings), address unique population challenges (e.g. approaches specific to rural health providers) and incorporate non-medical costs that can address social determinants of health. Moreover, there must be comparability between MA and risk adjustment in Medicare APMs.

Continue incenting providers to adopt risk-based arrangements. MACRA effectively incented the movement to advanced APMs. Five years later, however, we have not achieved the movement to value we once hoped due to a slow rollout of new models and slow uptake by private payers. The bonuses should be extended, and other incentives should be put in place to encourage APM adoption. For example, the ACA and MACRA established programs that precipitated tremendous gains in quality and patient safety by holding providers accountable. As we renew focus on quality and patient safety with progress towards more interoperable data, we must shift incentives in those programs to encourage APM adoption. Additionally, we should consider other FFS incentives such as exempting providers participating in models from new FFS-centric payment cuts and incenting other providers to adopt APMs**.**

Encourage payers to offer risk-based arrangements. Medicare has been a leader in advancing new payment approaches, with some payers following suit. To truly innovate care, we must rethink the roles and responsibilities of payers and providers. Payers have critical functions (e.g. claims processing, marketing) but are unable to innovate the care delivery process. We must give providers tools to change care delivery through new payment arrangements. The federal government should work with states and the private sector to spread the movement to APMs. For example, HHS could support states in incentivizing state Medicaid managed care programs to enter into more APM arrangements with providers, rather than remaining on a FFS chassis. Moreover, CMMI must scale some models to create direction and permanence for providers and for private insurers to also scale, creating uniformity across the healthcare landscape.

RECCOMENDATIONS FOR PROMOTING VALUE

Medicare Shared Savings Program

The Medicare Shared Savings Program (MSSP) has been one of the most successful value-based arrangements to-date. In 2019, the program generated $1.19 billion in total net Medicare savings. MSSP ACOs have also continued to furnish high-quality care, with more than 90 percent of ACOs earning quality improvement points in 2019. There are several opportunities to further strengthen the MSSP and ensure providers continue to build on these successes. These include:

- **Removing ACO beneficiaries from the regional benchmark to ensure ACOs are not penalized** as they achieve savings for their assigned populations.

- **Eliminating the arbitrary high-low-revenue distinction** to ensure that high performers are encouraged to participate in models regardless of provider type. This will allow providers to more effectively collaborate in ways that best meet the needs of their population.

- **Providing a step-wise approach to the change in MSSP quality reporting.** As part of CY2021 rulemaking, CMS finalized several changes to how ACOs report quality data. We believe the adoption of these changes will place significant burden on providers, especially in light of the ongoing pandemic. We recommend CMS create a transition to reporting by electronic clinical quality measures (eCQM) and registry by limiting the reporting population to ACO aligned beneficiaries.

- **Test innovations within MSSP.** In order to take advantage of new and proven enhancements and flexibilities, MSSP ACOs must consider leaving a permanent program to participate in a model test. To recognize the longstanding commitment of MSSP ACOs and the success of the program, CMS should incorporate the COVID-19 flexibilities into the model and test new flexibilities within the model. CMS has previously tested additional approaches within MSSP in the Track 1+, AIM and CHART-ACO models.

Innovation Center Models

The Innovation Center has tested numerous payment models that have allowed providers the opportunity to innovate care delivery while achieving savings to Medicare and the healthcare system overall. However, few models have been expanded to date. Value-based care is working, yet the arbitrary and excessively high certification bar for a model to scale is preventing wider spread adoption of meaningful changes. The spillover effect of the movement to value has been significant, shifting the way providers deliver care and compete. The impact has affected providers both in and out of APMs. This makes evaluating a model against a control group extremely difficult. Premier calls on CMS to recognize the current limitations of the evaluation approach and rethink the criteria for model expansion. We urge CMS to expand models that have lowered the growth in spending, sustained or improved quality, improved beneficiaries experience and reduced provider burden.

We recommend CMS adopt Premier's detailed recommendations on the Innovation Center portfolio. These include recommendations on:

- **Direct Contracting- Global and Professional Models.** The Direct Contracting Model Global and Professional Tracks include many design features that Premier has long promoted, including the opportunity to incorporate primary care capitation into an ACO-like structure. However, there are

several key design features that may make providers with prior experience in APMs less likely to participate in the Direct Contracting model. Premier recommends that CMS open a second application opportunity after making changes to the model that would allow more providers to participate.

- **Direct Contracting Geographic Model.** Premier supports testing a geographic approach to reduce costs and improve quality of care for Medicare beneficiaries. However, we are concerned that the Geo model – as it is currently designed – does not provide a practical opportunity for most providers to participate as the accountable entity. Several key aspects of the model design would require providers to develop new capabilities, such as paying downstream entities. As CMMI reevaluates this model, we ask that you consider Premier's recommendations to ensure providers are not disadvantaged in the model and to test this alignment approach within other models.

- **CHART Model.** We appreciate the Biden Administration's interest and commitment to improving the quality and sustainability of rural healthcare. The Community Health Access and Rural Transformation (CHART) Model – Community Transformation Track model offers providers a unique opportunity to transform healthcare in their communities by restructuring hospital care and repurposing rural facilities. Additionally, the ACO Transformation Track provides valuable upfront investments and assistance to rural participants to help overcome the operational and financial barriers to participating in MSSP. Premier recommends that CMS further strengthen the CHART model by reducing the discount, making Medicaid participation optional and incorporating services across the care continuum.

- **Bundled Payments.** With several bundled payment programs approaching the conclusion of their test we encourage CMS to engage stakeholders in **developing approaches for more cohesively incorporating bundled payments into total cost of care models.** CMS should establish approaches that allow total cost of care entities to align with CMS-established bundled payment program. Additionally, CMS could establish approaches for allowing total cost of care entities to establish downstream bundled payment arrangements, such as through nested bundled payments. We also understand that CMS in considering a mandatory model to follow the Bundled Payments for Care Improvement Advanced (BPCI-A) model. **It is imperative that a mandatory bundled payment model does not hinder the growth of total cost of care models**. Additionally, CMS should engage stakeholders early and consider the following principles for mandatory models.

- **Maternal Health Models.** Our nation's healthcare system has lacked comprehensive and reliable data on maternal health outcomes, resulting in gaps in maternal care. Premier has engaged with the Department of Health and Human Services Office of Women's Health to leverage Premier's data to understand precisely what is driving America's poor performance on both maternal and infant mortality and morbidity. Specifically, we are collecting standardized national data and applying those insights to performance improvement work with a collaborative of hospitals across the nation. The next critical step is to **develop and test a standardized alternative payment approach that could be readily adopted by states and other payers**. We recommend CMS test a prospective bundle that begins with pregnancy and extends one-year post-partum. The model should work towards comprehensive total cost of care for mothers and newborns by including infant outcomes in the model prior to inclusion of infant cost of care.

Ensure Access to Home Infusion Services

For decades, home infusion has been recognized as a safe and effective method of delivering critical drugs to some of the country's most vulnerable patients, many who suffer from advanced chronic diseases, such as congestive heart failure, cancer, and primary immune deficiency. Unfortunately, CMS adopted a narrow and inappropriate definition of "infusion drug administration calendar day" prior to the COVID-19 pandemic that provides restricted payment to providers under Medicare Part B only when a skilled professional is present in the patient's home. CMS' definition does not adequately reimburse for all the important pharmacy services that are needed to treat a beneficiary. The decision runs counter to Congressional intent and overlooks those pharmacy services that are critical each day a patient receives medication therapy.

Premier continues to be concerned with CMS' narrow and inappropriate definition on behalf of the 4,800 home infusion locations serviced by Premier's Alternate Site division. Home infusion requires a range of professional services, starting with pharmacy and care intake, drug delivery and care coordination, and remote and direct patient monitoring. **We urge CMS, again, to revise the existing definition of infusion drug administration calendar day to allow for reimbursement of home infusion professional services each day that an infusion drug physically enters the patient's body, irrespective of whether a skilled professional is in the individual's home.** Premier hopes that we, along with home infusion stakeholders, can work with CMS to fix the limited definition to one that is workable for providers and beneficiaries.

REDUCING BARRIERS TO INTEROPERABILITY AND IMPROVING DATA COLLECTION TO ENHANCE REAL-TIME OUTCOMES

The COVID-19 pandemic has exposed one of healthcare's fundamental weaknesses: the fragmented and siloed nature of care delivery and the lack of centralized coordination when it comes to managing and preventing disease spread. It is essential to address ongoing interoperability challenges so that providers can improve care delivery, patient safety and performance, and to drive operational efficiencies. Premier continues to advocate for, develop and implement innovative solutions to achieve open data access across health IT systems and technologies to support the industry's value-based care transition across the care continuum. Interoperability will enable systems to move beyond simply recording data in electronic health records (EHRs) toward integrating and combining data to streamline analytics on supply chain, financial, public and population health and clinical care for evidence-based decision-making. Without connectivity across the care continuum, data collection is fragmented and does not provide the total picture necessary for healthcare providers to deliver informed, coordinated care.

Recent HHS regulations have helped move us toward a more competitive health IT ecosystem comprised of EHRs enhanced with additional functionality from third-party applications. In this vision, data moves seamlessly to and from patients and providers, across the care continuum, and the marketplace no longer favors data constrained within EHRs. By adopting additional critical policies and recommended changes, CMS and its federal partners can help drive and accelerate this new reality.

Premier recommends HHS take the following actions:

- **Enhance access to claims and EHR data.** Integrating claims and clinical data is integral to population health management. Provider real-time access to robust claims and EHR data is limited. Federal efforts are needed to accelerate adoption and consistent implementation of data and interoperability standards, enhance certification of EHRs, require seamless and unfettered provider data access at the point of care and within the workflow and make claims-data more

readily available. Ensuring providers' ability to efficiently implement third-party applications via open, public application programming interfaces (APIs) of their choosing is critical to providing high-quality, safe, and effective care. Enhanced EHR functionality via certification is essential to help ensure more efficient, effective and coordinated care across the care continuum.

- **Facilitate Interoperability across the care continuum and with public health**. Current approaches to prevent, manage, mitigate, and track cases during the COVID-19 public health emergency relied on home-grown, siloed, and antiquated data collection systems that are grossly inadequate—data sets are incomplete, lagged and collected in the wrong settings, rendering them virtually useless for identification and/or prediction of disease spread trends. Public health surveillance was previously expected to improve due to increased use of EHRs and electronic exchange of health information; however, the pandemic revealed much-needed improvements. The nation needs real-time data for syndromic surveillance, providing an upstream alternative to identifying cases before tests can detect them or patients are hospitalized.

- **Establish cross-continuum data standards**. Measuring interoperability across settings will provide valuable insight into providers' ability to share information that supports care coordination. CMS should focus on developing cross-continuum standards, rather than extending the collection of standards developed for siloed settings of care to additional providers. A holistic approach is needed for data standards whereby standards are developed for use across care settings, though provider types vary in the level of acuity and types of conditions they are clinically appropriate to serve. There are at present a limited number of common data elements across inpatient, outpatient, and post-acute care; however, these elements could serve as a starting point for cross-continuum patient assessment.

- **Integrate administrative and clinical data.** There is an increasing need to leverage administrative, financial, and clinical data for multiple use cases, including payment, performance and quality improvement, research and predictive analytics. Foundational to data access and use is the need for the development and consistent and timely implementation and adoption of data and interoperability standards (content, transport, messaging) to ensure the ability to share, exchange and use data from disparate data sources and across health IT systems. We encourage CMS to continue to work with the Office of the National Coordinator for Health IT (ONC) and its Health Information Technology Advisory Committee (HITAC) and the National Committee for Vital and Health Statistics (NCVHS) to further address the convergence of administrative and clinical data and data standards. Additional efforts are needed to harmonize the disparate approaches to and types of standards, including those required under HIPAA and ONC's rules for CEHRT and information blocking.

- **Reduce provider burdens by automating prior authorization.** Premier supports improving the electronic exchange of healthcare data, streamlining and automating processes related to prior authorization, and reducing provider administrative and reporting burdens. Premier supports efforts to encourage value-based healthcare delivery that emphasizes integrated and coordinated care for patients, as well as to make the administrative aspect of healthcare delivery, such as information exchange for treatment, payment, or healthcare operations purposes, more efficient. Premier advocates for meaningful privacy and security rights for the protected health information (PHI) of our patients. The primary goal is to ensure provider access to accurate health information at the point of care to inform healthcare decisions and achieve best patient outcomes. This must be accomplished in a manner that minimizes regulatory and administrative data collection, documentation, and reporting burdens, as well as related costs for providers administrative burdens on providers.

- **Implement the Appropriate Use Criteria program.** Hospitals and health systems endeavor with their clinicians to implement evidence-based care. Premier works with our members to organize evidence-based performance improvement collaboratives with the express purpose to scale reliable practices that follow the evidence. Included in Protecting Access to Medicare Act (PAMA) of 2014 is a program designed to ensure that clinicians follow evidence-based care practices when they order advanced imaging exams. This program uses automated technology to alert physicians if they are not fully following the evidence in ordering an advanced imaging test. This technology is a step forward in healthcare delivery and is consistent with our proposal to automate prior authorization. Implementation of the appropriate use criteria program has been delayed multiple times. With the public health emergency now abating, we need to move forward with implementation of this technology in 2022 to help achieve a more evidence-based healthcare system.

- **Ensure that post-acute care providers have interoperable data and access to electronic clinical surveillance technologies.** Premier recognizes the critical need for preventing and reducing healthcare-associated infections (HAIs) across the healthcare system and supports CMS' ongoing efforts to advance such measures in skilled nursing facilities (SNFs). One step further, we believe CMS should pursue mechanisms that will reduce HAIs in the first place and lead to better quality outcomes. In the acute care setting, Premier is an established leader in implementing clinical surveillance systems to help translate data into action to improve patient outcomes. Unfortunately, clinical analytics technologies are currently not widely used in SNFs. SNFs should have the same access to tools that will help them combat infection spread during any future outbreaks of COVID-19 and during their day-to-day operations, but unfortunately funding remains a significant barrier. **Therefore, in addition to measure development, Premier urges CMS to explore policy options to incentivize SNFs to adopt clinical surveillance technology to reduce and prevent HAIs.**

- **Ensure providers Access to Data at the Point of Care.** Providers need robust, scalable, and interoperable health IT systems and applications to improve clinical decision making and outcomes. CMS should focus additional attention on the ongoing need for providers to be able to have real-time access to data at the point of care and within workflow. The movement towards value-based care and APMs has created an even greater imperative for health information exchange and interoperability, across sites of care. Advanced payment models such as ACOs and bundled payments involve participation by multiple providers, suppliers and sometimes payers who are at risk for coordinating the care of patients, requiring the ability to access and aggregate information from different EHRs, health information technology applications and across multiple facilities and care settings. Data are essential to achieve the vision of a consumer-centered and healthcare provider-driven healthcare system.

  The inability to access and integrate timely and complete data across the care continuum from multiple sites of service, diverse providers and various data sources threatens quality of care, patient safety and efficiency. The lack of access to complete and timely data adds inefficiencies and costs to the healthcare system and hampers population health efforts, public health surveillance and reporting.

- **Promoting Interoperability.** Premier urges CMS to consider identifying a set of priority health IT activities as alternatives to the traditional program measures. Allowing hospitals to meet CMS' goals of coordinating care and achieving interoperability through providers' existing health information technology activities would allow hospitals greater flexibility in their approaches to

improving care delivery and ensuring patients' access to their data. Additionally, we recommend that CMS' Promoting Interoperability program recognize hospitals', health systems' and other providers' use of health IT beyond legacy EHRs, such as third party applications to report public health data (including clinical and syndromic surveillance, innovative use(s) of machine learning, artificial intelligence and natural language processing to help facilitate data capture from unstructured text.

- **Advancing Interoperability in Innovative Models**. Premier applauds CMS' efforts to promote interoperability across the healthcare spectrum through model testing that focuses on using emerging standards, models leveraging non-traditional data and technology-enabled patient engagement platforms. Premier strongly recommends ongoing efforts to design and test new and innovative, health IT enabled payment and service delivery models. Premier supports advancing interoperability across the care continuum to help ensure interoperability across EHR systems and settings of care to unlock barriers to data sharing and care coordination between health systems, physician group practices, independent physicians, and post-acute care settings. Ongoing measurement to understand the status of health information technology adoption by providers and the ability of providers to share information across the continuum will be important in understanding the effectiveness of interoperability initiatives.

CONCLUSION

In closing, the Premier healthcare alliance appreciates the opportunity to share our recommendations for accomplishing the Administration's healthcare priorities. If you have any questions regarding our comments or need more information, please contact me at blair_childs@premierinc.com or 202.879.8009.

Sincerely,

Blair Childs
Senior Vice President, Public Affairs
Premier healthcare alliance