PREMIER TRANSFORMING HEALTHCARE TOGETHER®

June 26, 2023

The Honorable Bill Cassidy, MD
Ranking Member
Senate Committee on Health, Education, Labor and Pensions
Washington, DC 20510

Submitted electronically to: DUALS_Cassidy@cassidy.senate.gov

Re: Request for Feedback on Dual Eligible Discussion Draft

Dear Senator Cassidy:

Premier Inc. appreciates the opportunity to provide feedback on the discussion draft of legislation to advance integrated care for individuals who are dually eligible for Medicare and Medicaid, also known as dual eligible beneficiaries. Premier applauds your demonstrated commitment to achieving better healthcare and outcomes for the 12.5 million people who are jointly enrolled in Medicare and Medicaid. These patients account for a disproportionate share of healthcare spending and tend to be in poorer health than those enrolled in Medicare alone:

- While dual eligible beneficiaries make up 17 percent of traditional fee-for-service Medicare and 14 percent of Medicaid enrollees, they account for 33 percent of traditional Medicare spending and 32 percent of Medicaid spending.[1]
- More than four in 10 dual eligible beneficiaries (44 percent) were in fair or poor health compared to 17 percent of Medicare beneficiaries without Medicaid; 48 percent had at least one limitation in activities of daily living (ADLs) compared to 23 percent of Medicare-only beneficiaries. Further, dual eligible beneficiaries are more likely than those enrolled only in Medicare to have a mental health condition, Alzheimer's disease or other dementia, or an intellectual or developmental disability.[2]
- During the pandemic, dual eligible beneficiaries were more likely to contract or be hospitalized for COVID-19 than Medicare-only beneficiaries.[3]

As you have previously noted,[4] these patients often experience a fragmented system of care resulting from lack of coordination and communication between Medicare and Medicaid, which can lead to lowered health outcomes and increased healthcare expenditures. Improving care coordination will be key to addressing healthcare costs and achieving better health outcomes for this population.

Premier generally supports better integration of care for dual eligible beneficiaries. At the same time, Premier offers the following suggestions to ensure that the draft legislation appropriately recognizes the role of clinicians and other providers as critical components of providing coordinated care to these patients. Specifically, Premier recommends:

[1] https://www.kff.org/medicare/issue-brief/a-profile-of-medicare-medicaid-enrollees-dual-eligibles/
[2] Ibid.
[3] https://www.cms.gov/files/document/medicare-covid-19-data-snapshot-fact-sheet.pdf
[4] https://www.cassidy.senate.gov/newsroom/press-releases/cassidy-scott-carper-menendez-cornyn-and-warner-launch-bipartisan-effort-to-improve-care-for-patients-jointly-enrolled-in-medicare-and-medicaid

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- More explicitly articulating the role of the beneficiary's provider in development of the coordinated care plan by the integrated health plan's care coordinator;
- Expanding requirements around integrated care plans to explicitly include Medicare accountable care organizations (ACOs); and
- Requiring state Medicaid agencies to establish policies that foster better care coordination of benefits for dual eligible beneficiaries between the Medicaid program and ACOs, rather than placing the burden on the ACO to establish these contracts.

Premier also supports a review of the hospital star ratings program to ensure that the program accurately evaluates hospital performance and provides meaningful metrics for the patient community and hospital stakeholders.

I. BACKGROUND ON PREMIER INC.

Premier is a leading healthcare improvement company and national supply chain leader, uniting an alliance of 4,400 hospitals and approximately 250,000 continuum of care providers to transform healthcare. With integrated data and analytics, collaboratives, supply chain solutions, consulting and other services, Premier enables better care and outcomes at a lower cost. Premier's sophisticated technology systems contain robust data gleaned from nearly half of U.S. hospital discharges, 812 million hospital outpatient and clinic encounters, and 131 million physician office visits. Premier is a data-driven organization with a 360-degree view of the supply chain, working with more than 1,460 manufacturers to source the highest quality and most cost-effective products and services. Premier's work is closely aligned with healthcare providers, who drive the product and service contracting decisions using a data driven approach to remove biases in product sourcing and contracting and assure access to the highest quality products. In addition, Premier operates the nation's largest population health collaborative, having worked with more than 200 ACOs.

A Malcolm Baldrige National Quality Award recipient, Premier plays a critical role in the rapidly evolving healthcare industry, collaborating with healthcare providers, manufacturers, distributors, government and other entities to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide. Headquartered in Charlotte, North Carolina, Premier is passionate about transforming American healthcare.

II. STATE INTEGRATED CARE PROGRAMS FOR DUAL ELIGIBLE INDIVIDUALS

The discussion draft would require newly-created integrated care plans to provide coverage to dual eligible beneficiaries. Specially, Section 2203 of the draft legislation would require dual eligible beneficiaries to enroll in an integrated care plan to receive medical assistance. Plans would be required to assign a care coordinator to each enrolled beneficiary, who would be responsible for serving as a single point of contact between the beneficiary and the plan, helping the beneficiary make decisions about benefits and services, designing a comprehensive care plan and coordinating care across the continuum. The comprehensive care plan must be based on a health risk assessment administered by the plan that collects standard demographic data and information relating to health-related social needs (e.g., food insecurity, access to transportation, etc.). The plan must be designed to address the totality of the beneficiary's medical, functional, behavioral, social and caregiving needs and goals. The plan must also be implemented by an interdisciplinary care team that includes relevant specialists.

***Premier generally supports a focus on care coordination; however, Premier recommends that the role of the beneficiary's provider be more explicitly articulated in the legislation*.** Since the

beneficiary's provider is the one furnishing services and implementing the care plan, it is critical that they are actively involved in the care plan's development and not just a recipient of a fully-developed care plan provided by the beneficiary's health plan. Premier recommends that involvement of the provider be embedded into the language that requires development of the care plan: "**in consultation with the individual's primary care provider and any relevant specialists,** design a beneficiary-focused comprehensive care plan for the individual…" This dialogue between the care coordinator and the providers involved in care will be key to avoid duplication of efforts and maximize execution of the care plan.

Additionally, ***Premier recommends that the requirements around integrated care plans be expanded to explicitly to include Medicare ACOs*.** As currently drafted, all dual eligible beneficiaries would be required to enroll in an integrated care plan, such as a Medicare Advantage (MA) dual eligible special needs plan (D-SNP) or a Program of All-Inclusive Care for the Elderly (PACE). Medicare ACOs play a critical role in coordinating high-quality care for Medicare fee-for-service beneficiaries, including dual eligible beneficiaries. The Medicare Shared Savings Program (MSSP) ACOs continue to generate high-quality performance results and achieve overall savings to the Medicare program.[5] Today, MSSP ACOs serve more than 614,000 dual eligible beneficiaries.[6] Since beneficiaries who are enrolled in MA or PACE are excluded from the MSSP, limiting this provision to only integrated care plans could potentially prevent ACOs from continuing to coordinate care for dual eligible beneficiaries and eliminate a high-quality care option for these beneficiaries. As a result, ***Premier strongly recommends that the legislation explicitly include Medicare ACOs, such as MSSP, as an option for providing integrated coordinated care.***

Premier also appreciates that these beneficiaries would undergo periodic health risk assessments to identify social drivers that may influence health outcomes, and that those health drivers would be considered in development of the coordinated care plan. This is particularly important since by definition this population is low-income. Additionally, this requirement could be an important tool to advance health equity, given that more than half of dual eligible beneficiaries are people of color (compared with 20 percent of Medicare-only beneficiaries).[7] ***Premier recommends that the legislation explicitly address the provider's role in the risk assessment, and require that all patient-level data collected by the plan be communicated to the provider.***

Unfettered provider access to clinical data is necessary to understand where patients are in their community, how they interact with the healthcare system and what gaps are exacerbating health conditions – all core components of advancing health equity. However, data sharing remains a high-priority challenge for providers. In a recent Premier survey,[8] 80 percent of provider respondents said they do not have access to timely and/or comprehensive data on their patients, even in risk-based arrangements where such data is critical to providing high-quality patient care. Specifically, providers note that the data they receive from payers often reflects only a portion of the care received by beneficiaries. As payers and providers each seek to implement innovative models for addressing social determinants of health, equal access to data is necessary to level the playing field and enable multi-pronged approaches to advancing health equity. In particular, any patient data collected as part of the periodic health risk assessments should be shared with full transparency with the patients' providers, who are the frontline of patient care and patient experience. Premier also suggests that the health risk assessment include assessment of additional factors, including frailty, isolation/interaction with neighbors, or level of trust in the community/neighbors.

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[5] https://www.cms.gov/newsroom/press-releases/medicare-shared-savings-program-saves-medicare-more-16-billion-2021-and-continues-deliver-high
[6] https://www.cms.gov/files/document/2023-shared-savings-program-fast-facts.pdf
[7] https://www.kff.org/medicare/issue-brief/a-profile-of-medicare-medicaid-enrollees-dual-eligibles/
[8] https://premierinc.com/newsroom/blog/pinc-ai-survey-data-movement-to-risk-based-contracting-is-accelerating-but-gaps-remain

III. REQUIRING ACOS TO HAVE A STATE MEDICAID AGENCY CONTRACT

Section 302 of the discussion draft would require MSSP ACOs to have a contract in place with their state Medicaid agencies to either provide or arrange to provide benefits for dual eligible beneficiaries who are assigned to the ACO. As noted above, MSSP ACOs play a critical role in coordinating care for Medicare beneficiaries, including more than 614,000 dually eligible beneficiaries.

***While Premier is supportive of improving coordination of benefits between state Medicaid agencies and MSSP ACOs, Premier is concerned this provision would place significant burden on ACOs in operationalizing these contracts*.** There are several factors that could ultimately impact an ACO's ability to contract with its state Medicaid agency:

- As drafted, the provision will largely depend on the state's readiness and willingness to establish these types of contracts. Some of our member ACOs have noted challenges and delays by their states in implementing Medicaid existing policies. As a result, they have expressed significant concern about the ability and readiness of their states to work with them to establish these types of contracts in a timely manner.
- Many ACOs span multiple states, which further increases the burden and the complexity of having to negotiate contracts across multiple Medicaid agencies.
- As of March 2022, more than 280 individual Medicaid Managed Care Organizations (MCOs) plans were in place across 41 states.[9] Based on the draft language, it is unclear if the ACO would be required to contract with each individual Medicaid MCO, which would take significant time and resources for the ACO to operationalize.

The burden should not be placed on the ACO to effectuate these types of contracts. Rather, ***Premier recommends that the provision be revised to require that the State have policies in place that allow for better coordination of benefits between the State Medicaid agency or Medicaid MCO and the ACO.***

IV. REVIEW OF HOSPITAL QUALITY STAR RATING SYSTEM

Section 211 of the discussion draft would require CMS to review the hospital quality star rating program and identify changes that are needed to ensure "sufficient information is collected … to effectively measure hospital quality" within 180 days of enactment. ***Premier supports review of the hospital star ratings program to ensure that the program accurately evaluates hospital performance and provides meaningful metrics to inform shared decision making by patients and the hospital community.***

In particular, Premier recommends that CMS evaluate the following areas and principles as part of its review:

- *Ensure the methodology for setting star ratings is transparent, reliable and can be effectively replicated.* An effective quality measurement program enables hospitals to clearly understand where to focus and drive improvement. CMS should continue to prioritize a simplified methodology that uses an explicit approach to enable hospital and patient understanding.
- *Evaluate measure methodology to ensure hospitals can effectively evaluate their performance,* such as through root cause analyses within clinical subgroups and through trended analyses.

[9] https://www.kff.org/medicaid/state-indicator/medicaid-mco-enrollment-by-plan-and-parent-firm-march-2021/

Measure transparency is necessary for hospitals to identify opportunity and enact operational and procedural changes to improve quality of care.

- *Set star rating thresholds* through annual rulemaking to allow hospitals to better assess their performance and identify areas to focus improvement efforts.
- *Incorporate social risk factors.* CMS should work with stakeholders to consider a broader set of social risk factors beyond the current peer grouping methodologies based on dual eligible status.
- *Continue to utilize publicly available measures to ensure consistency across quality reporting programs and to reduce provider burden.* CMS should prioritize inclusion of measures that are endorsed, valid, reliable and aligned with other measures and quality programs.
- *Evaluate measure groupings and group weights to ensure they are balanced and reflect areas of importance to patients.*

V. CONCLUSION

In closing, Premier applauds your commitment to ensuring better integrated care for dual eligible beneficiaries and appreciates the opportunity to provide feedback on the discussion draft. If you have any questions regarding our comments or need more information, please feel free to contact Melissa Medeiros, Senior Director of Policy, at melissa_medeiros@premierinc.com.

Sincerely,

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