PREMIER TRANSFORMING HEALTHCARE TOGETHER®

June 13, 2024

The Honorable Ron Wyden
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

Submitted electronically via email

Re: Bolstering Chronic Care through Physician Payment

Dear Chairman Wyden and Ranking Member Crapo:

Premier Inc. applauds the Senate Committee on Finance's interest in developing legislation to strengthen and advance the transition to value-based healthcare. Greater adoption of value-based care is improving the quality of care for American seniors by moving from a sickness-based healthcare system to one focused on wellness and outcomes. Under value-based care, healthcare providers are incentivized to deliver proactive, preventive care and provide higher quality care at a lower cost. Alternative payment models (APMs) have demonstrated that when physicians and other clinicians are held accountable for costs and quality and provided flexibility from fee-for-service (FFS) constraints, they can generate savings for taxpayers and improve beneficiary care. For example, in the last decade, accountable care organizations (ACOs) have generated savings to Medicare – including $1.8 billion in 2022 alone – while producing higher quality care for patients.

We are now at a critical juncture where we must rapidly scale alternative payment approaches that empower providers to guide care transformation**.** Providers, with their local roots and direct role in care delivery, are best situated to design population health solutions targeted to the needs of their local communities, including addressing health disparities. This will require new partnerships between payers and providers where providers are responsible for the quality and cost of care. In such an environment, appropriate incentives are needed to outweigh the risk, uncertainty and sizeable upfront and ongoing provider investments needed to participate in APMs. Additionally, value-based care – which improves both patient outcomes and Medicare's finances – will be a critical tool as our nation simultaneously grapples with the growing healthcare needs of the "Silver Tsunami" and impending Medicare insolvency. Congress can play a strong role in rebalancing those incentives and encouraging growth in Medicare programs that promote better patient outcomes at lower costs.

Below Premier offers several recommendations on how Congress can further advance high quality patient care through supporting value-based arrangements, including:

- Extend the Advanced APM incentive payments for at least two years while Congress continues to evaluate longer-term physician reforms. As part of this, Congress should design future incentives that are sustainable, predictable and timely;
- Strengthen the Medicare Shared Savings Program (MSSP) by eliminating the arbitrary high-low revenue distinction and delaying changes to quality reporting requirements;

- Expand access to APMs for diverse participants, including medical specialties, safety net, rural, small and other practices;
- Set a clear plan for moving beyond testing to nationally scale successful models;
- Expand opportunities for providers and stakeholders to provide input throughout the model lifecycle;
- Provide the Congressional Budget Office (CBO) with the tools necessary to forecast the longer-term budgetary impacts of legislation to ensure policymakers are equipped with the best data when crafting legislative solutions;
- Eliminate cost sharing for attributed beneficiaries who require chronic care management or receive health equity-related services, such as social determinants of health (SDOH) risk assessment or community health integration services;
- Extend telehealth flexibilities and Medicare hospital-at-home program.

I. BACKGROUND ON PREMIER INC.

Premier is a leading healthcare improvement company and national supply chain leader, uniting an alliance of 4,350 hospitals and approximately 300,000 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, 2.7 billion hospital outpatient and clinic encounters and 177 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. INCENTIVIZING PARTICIPATION IN ALTERNATIVE PAYMENT MODELS (APM)

Much of the progress in transitioning to value-based care has been due to the availability of a Medicare Advanced APM incentive payment for clinicians who have taken on increased financial risk for patient outcomes. These Advanced APM incentive payments allow clinicians to cover some of the investment costs of moving to new payment models, including expanding care teams, developing programs to improve beneficiary care and adopting population health infrastructure. Incentives also help to improve care for patients by giving clinicians financial resources to expand services beyond those covered by traditional Medicare.

However, eligibility for the Medicare Advanced APM incentive payments will expire at the end of calendar year 2024. Unless Congress acts, progress towards greater adoption of value-based care could suffer a significant setback. The incentive payments have given clinicians moving into Advanced APMs financial

flexibility to invest in care innovations, as well as financial stability as they undergo practice transformation. Further, in the absence of the bonus, many clinicians may find it more appealing to remain in or return to FFS since they may be eligible for a higher annual physician payment update.[1] As a result, failure to extend the incentive payments at a level that is higher than (or at least comparable to) the update available to clinicians under the Merit-based Incentive Payment System (MIPS) could both discourage new providers from entering Advanced APMs and may also result in current participants exiting, all to the detriment of improving patient outcomes while decreasing healthcare costs.

Premier urges Congress to support the ongoing transition to value-based healthcare by extending the Advanced APM incentive payments, ideally at the original 5 percent rate set under MACRA, for at least two years while it continues to evaluate longer-term physician reforms. At a minimum, Congress should set the Advanced APM incentive payments at a level that ensures those participating in Advanced APMs are eligible for higher rewards than those participating under MIPS. Additionally, to be eligible for the Advanced APM incentive payment, clinicians must participate in Advanced APMs that have either a certain percentage of payments or patients affiliated with the APM. The thresholds to qualify will rise steeply in calendar year (CY) 2025, requiring at least 75 percent of payments or 50 percent of patients to be affiliated with an Advanced APM. As a result, fewer clinicians will qualify. The increasingly high thresholds do not reflect the progress of the value-based care movement. Premier urges Congress to freeze the Qualifying APM Participant (QP) thresholds at their current levels.

As Congress considers reforms to physician payments and incentives around value-based care, there are several key steps it could take to strengthen existing incentives and models to improve the sustainability of long-term participation for all providers, including:

- **Establish sustainable long-term incentives for Advanced APM participants.** To maintain the momentum to value-based care, it is critical that Congress establishes incentives for those participating in Advanced APMs that are sustainable and strong enough to encourage the transition away from MIPS to more advanced value-based arrangements. Additionally, the existing framework for determining eligibility for MIPS or Advanced APM status is perceived as too complicated, with clinicians often not knowing their status in these programs until well after the performance year. Further, Advanced APM incentive payments are paid out two years after the performance year, which weakens the incentive. As Congress considers the design of future incentive payments, we encourage them to prioritize designing systems with simplified and predictable methodologies that allow for timely payment of incentives. Premier looks forward to working with Congress and other stakeholders on the design of these incentives.

- **Eliminate the arbitrary high-low revenue distinction to ensure all ACOs have the same opportunities to succeed under the program.** Several years ago, CMS began varying policies under the MSSP based on an ACO's revenue status as a means of differentiating ACOs by type of provider – hospital-led (high-revenue) vs. physician-led ACOs (low-revenue). This policy is built on a false premise that low-revenue ACOs outperform high-revenue ACOs and that low-revenue ACOs have less ability to control expenditures for beneficiaries. A Premier analysis found that differences between high- and low-revenue ACOs are driven by other factors beyond ACO composition, including geographic location and the types of beneficiaries attributed to ACOs.

[1] Under current statute, qualifying practitioners participating in Advanced APMs (known as QPs) will be eligible for a higher physician fee schedule (PFS) annual conversion factor (0.75 percent) compared to non-QPs (0.25 percent) starting in the CY 2026 payment year. However, non-QPs are also eligible for a maximum payment adjustment of up to 9 percent under the Merit-based Incentive Payment System (MIPS). As a result, CMS discussed in the CY 2023 PFS that the QP conversion factor is not expected to equate the anticipated maximum positive payment adjustment for non-QPs under MIPS until CY 2038 – meaning that remaining in FFS will be more advantageous for many clinicians.

Continuing to limit ACO policies and flexibilities to low-revenue ACOs only creates an unlevel playing field that disadvantages hospital-led ACOs relative to their physician-led counterparts. The best way to drive high-quality care for patients is to create incentives that drive all providers to collaborate and innovate to deliver high-quality, cost-effective healthcare. ***Premier urges Congress to eliminate the revenue-based distinction in MSSP and across all CMS value-based care programs to ensure that high performers are encouraged to participate regardless of provider type and allow providers to more effectively collaborate in ways that best meet the needs of their patients.***

- **Expand access to APM opportunities.** CMS should focus on filling the current gaps in APM opportunities for medical specialties, safety net, rural, small, and other practices that to date have struggled to join APMs due to high entry barriers or simply because there is no clinically relevant model available. These barriers include the high-low revenue distinctions as noted above, as well as risk glide paths that are prohibitive to rural participation in models, lack of flexibility in models, and insufficient data availability to determine if model participation is possible for ACOs.[2] ***Premier urges Congress to emphasize expanding access to APMs for diverse participants.***

- **Delay changes to MSSP quality reporting requirements.** Over the last few years, CMS has made several fundamental changes to the MSSP quality reporting requirements which have been difficult for even the most sophisticated of ACOs to implement and will ultimately hinder other providers who are considering entering the MSSP. For example, under the new requirements, ACOs will need to aggregate data across multiple providers and electronic health record (EHR) systems. Producing electronic clinical quality measures (eCQMs) from those disparate systems requires time, money and effort in changing workflows and acquiring new technology services. Additionally, several vendors have indicated that modifications to the EHR systems to support revised MSSP quality reporting requirements will not be available until after the requirements go into effect. Finally, one of the incentives for clinicians to move into Advanced APMs is that they are no longer required to report under the burdensome MIPS program. However, the recent MSSP reporting changes would have the effect of reverting reporting back to MIPS, which is antithetical to the goal of moving clinicians from volume to value. ***Premier urges Congress to advise CMS to implement a more gradual transition to these new requirements and continue to collect more data and stakeholder feedback.*** Given the numerous technical barriers to reporting, ***Premier also recommends that CMS recruit ACOs to pilot various approaches as an opportunity for CMS to evaluate and address many of these technical challenges and to adapt its requirements prior to requiring broad adoption.***

- **Set a clear plan for moving beyond testing to nationally scale successful models.** Over the past decade, CMMI has launched more than 50 payments models. However, to-date only three models have been certified for nationwide expansion. There are several reasons why more models have not been expanded, including narrow expansion criteria that do not consider the full impact of models and Administration discretion over whether models are even considered for expansion. Providers invest significant resources to participate in model tests and additional transparency is needed for why certain models are discontinued and not considered for expansion. ***Congress should require CMS to establish criteria for certifying and expanding models through a transparent rulemaking process***. As part of this, CMS should consider the broader impacts of model tests, including spillover effects of care redesign efforts on beneficiaries

[2] Rural providers face numerous challenges to participating in value-based care arrangements. Premier would welcome the opportunity to discuss and share detailed recommendations with the Committee in the near future.

not included in models. Models should qualify for expansion based not only on their cost savings capabilities but also their ability to enhance patient quality of care or access to care. Additionally, ***CMS should be required to publish an annual report on its determinations of whether to expand models***, ***including actuarial analyses and supporting information for the determination***. Evaluations of models should control for variables such as model overlap to ensure accurate and informed decisions regarding expansion. Finally, it is critical that CMS include provider voices in the design, implementation and evaluation of models.

- **Increase opportunities for stakeholder engagement in model development.** ***Premier encourages Congress to expand opportunities for providers and stakeholders to provide input throughout the model lifecycle.*** CMS should also engage stakeholders early on and throughout its own development of models. This will improve the clinical relevance of models and cut down on the near constant churn of model re-designs, which hinders participation.

- **Extend the scoring window to more accurately capture savings from preventive health initiatives.** ***Premier also encourages Congress to provide the Congressional Budget Office (CBO) with the tools necessary to forecast the longer-term budgetary impacts of legislation to ensure policymakers are equipped with the best data when crafting legislative solutions.*** The way in which CBO currently scores legislation severely constrains the ability of policymakers to accurately assess legislation that would prevent chronic disease or other poor outcomes, thereby avoiding greater costs down the road. Research has demonstrated that certain expenditures for preventive interventions generate savings when considered in the long term, but those cost savings may not be apparent when assessing only the first ten years—those in the "scoring" window. Long-term benefits from current preventive health expenditures may not be fully reflected, if at all, in cost estimates from CBO. For example, MSSP ACOs had statistically significant higher performance for quality measures related to diabetes and blood pressure control; breast cancer and colorectal cancer screening; tobacco screening and smoking cessation; and depression screening and follow-up. The higher quality performance by ACOs underscores how this type of coordinated, whole-person care can reduce federal healthcare expenditures in future years by preventing more intensive and expensive care that would be required to treat severe illness or disability resulting in the absence of these early, preventive interventions. Yet, when evaluating the cost of legislation to extend the current financial incentives to healthcare providers that participate in these models, using CBO's current estimation process grossly understates the long-term value of this population-based approach to healthcare. ***In order to capture potential long-term health savings in federal programs, Premier urges Congress to pass the bipartisan Dr. Michael C. Burgess Preventive Health Savings Act (H.R.766/S.114), which would allow Congress to more easily request CBO estimates of preventive health initiatives beyond the ten-year scoring window.***

III. IMPROVING PRIMARY CARE AND CHRONIC CARE

The Senate Finance Committee seeks comment on APM design flexibilities that would ease financial burden for patients who require chronic care management (CCM). Providers and care managers report many positive outcomes for beneficiaries who receive CCM services, including improved patient satisfaction and adherence to recommended therapies, improved clinician efficiency and decreased hospitalizations and emergency department visits. Unfortunately, under current policy, Medicare beneficiaries are subject to a 20 percent coinsurance requirement to receive CCM services due to CCM being billed as a separate code. ***Premier encourages the implementation of flexibilities that eliminate***

cost sharing for attributed beneficiaries who require chronic care management to ease the financial burden on beneficiaries and encourage them to seek out care management. Removing the coinsurance payment requirement would facilitate more comprehensive management of chronic care conditions and improve the health of Medicare patients. Additionally, removing patient coinsurance may facilitate greater care coordination for vulnerable patient populations.

Premier also encourages waiving coinsurance for new codes related to SDOH and addressing patients with complex medical needs that were recently adopted as part of the CY 2024 Physician Fee Schedule (PFS). We appreciate CMS' commitment to ensuring physicians have incentives to treat patients with complex needs. However, consistent with Part B statute, each of these services is now subject to beneficiary coinsurance. Premier is concerned that this will lead to low uptake given the intended population is unlikely to be able absorb these costs. Including these additional flexibilities in benefit design ensures that those who most need CCM can access it without prohibitive cost barriers.

IV. ENSURING BENEFICIARIES' CONTINUED ACCESS TO TELEHEALTH

Premier supports the Senate Finance Committee's efforts to extend telehealth flexibilities and "chart a responsible path forward that preserves access to crucial telehealth services under Medicare FFS." The flexibilities that CMS granted around Medicare telehealth during the COVID-19 public health emergency (PHE) highlighted that many services can be effectively and efficiently furnished remotely. Today, telehealth continues to serve as a means for providers to expand care to many patients who previously had access barriers, particularly in rural and underserved communities. Congressional action, however, is needed to preserve this important care tool, which is especially critical for those using telehealth to reach specialists at longer distances, for access to mental and behavioral health practitioners and those receiving ongoing remote care for chronic conditions. ***Premier urges Congress to extend the telehealth flexibilities for at least two years as policymakers continue to evaluate the impact of these policies on patient care and craft a longer-term policy.***

In addition to telehealth, Premier encourages Congress to extend flexibilities around Medicare hospital-at-home. In November 2020 in response to the COVID-19 pandemic, CMS promulgated the Acute Hospital Care at Home (AHCAH) waiver, which allowed Medicare patients to receive certain acute care services from the comfort and safety of their homes. With these flexibilities as the springboard, more than 300 hospitals across 37 states have embraced the "hospital-at-home" concept and have tailored their programs to meet specific patient and organizational objectives. The AHCAH program enables providers to effectively monitor and care for patients as they recover in the comfort of their own homes. This can include remote monitoring capabilities, in-home provider visits, telehealth, medication management and many other care strategies. Preliminary studies from both CMS and external researchers have found that Medicare patients treated under the CMS hospital-at-home initiative had low rates of mortality and few hospital readmissions. ***Premier urges Congress to further extend the Medicare hospital-at-home program beyond 2024 for at least two years as it continues to evaluate how these flexibilities can best support patient access to high quality care in their homes.*** As part of this, Congress should examine alternatives and refinements to the current hospital-at-home waiver to permit further adoption in rural and underserved areas.

VI. CONCLUSION

In closing, Premier appreciates the opportunity to submit our recommendations on ways Congress can further support and strengthen the movement to value-based care. If you have any questions regarding our comments or need more information, please contact John Knapp, Vice President of Advocacy, at john_knapp@premierinc.com or (202) 879-8008.

Sincerely,

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Premier Inc.