PREMIER TRANSFORMING HEALTHCARE TOGETHER®

December 16, 2020

The Honorable Joseph R. Biden
President-Elect of the United States of America
Office of the President Elect

The Honorable Kamala Harris
Vice President-Elect of the United States of America
Office of the President Elect

Dear President-Elect Biden and Vice-President Elect Harris:

On behalf of the Premier healthcare alliance serving approximately 4,100 hospitals and health systems, hundreds of thousands of clinicians and 200,000 other provider organizations, I write to express our **shared commitment to continuing the Affordable Care Act's drive to value-based care.**

Since the passage of the Affordable Care Act, we have gained meaningful experience testing various approaches to shift our payment system to focus on value rather than volume. **We must now rapidly transition from fee-for-service (FFS) and testing alternative payment models (APMs) to a system in which value is the dominant payment system and providers have options to innovate care for their populations.** Our recommendations reflect a decade of collaborating with members to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide. The Premier Population Health Management Collaborative has worked with well over 200 ACOs and includes approximately 450 hospitals and tens of thousands of clinicians across 80 markets working together to align, measure and improve population health. Their results have outpaced the nation, generated net savings of $716 million over the course of five years.

The coronavirus pandemic has showcased that a fee-for-service system (FFS) is unable to adjust to meet evolving healthcare demands, with provider viability tied to volume rather than value and severe limitations on the ability to innovate care. 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.

To speed the transition to value we must **focus on total cost of care and quality, allowing the accountable entities the ability to define population-specific payment systems and care delivery approaches**. Below we offer approaches for accelerating the movement to value:

- Set a clear timeline for the transition from FFS to APMs
- Incent providers to adopt risk-based arrangements
- Engage stakeholders to establish an overarching framework for APM adoption and progression to risk
- Encourage provider-led transformation in Medicaid
- Renew focus on quality, patient-safety and health equity
- Reduce barriers to interoperability and real-time data

Set a clear timeline for the transition from FFS to APMs.

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. Currently, providers have significant uncertainty in the movement to risk. Delays in the availability of models, limited availability to enter models and a message from current CMS leadership that the models do not work have stymied the

movement to value. **A vision for the transition from FFS to APMs is needed so that providers can determine the approaches (i.e. models) they must take to prepare for a payment environment that is almost entirely value based.**

After more than ten years of testing models, we remain in a continual testing phase rather than entering a period of greater process certainty and scaled adoption. We know that value-based payments have contributed to a reduction of healthcare spending. In 2010, CMS Office of the Actuary's 10-year projection for healthcare spending predicted that 19.8 percent of gross domestic product (GDP) would be spent on healthcare in 2020. In fact, 18 percent of GDP is currently being spent. In total, more than $600 billion of that projected spending has been avoided.

Model expansion is inherently hampered by the evaluation approach. Evaluations tend to focus on savings compared to a benchmark rather than long-term changes in healthcare spending and growth. While it will be important for your Administration to review the framework for evaluation and expansion and assess current models and models in development, stakeholders need a signal that the shift to value endures. It is imperative that your Administration **signal a renewed commitment to the movement to value.** We request that in the first 100 days, CMS engage in a national dialogue to establish a timeline and framework for moving to value.

Create incentives for providers to adopt risk-based arrangements.

The bipartisan Medicare Access and CHIP Reauthorization Act (MACRA) aimed to incent providers to adopt advanced APMs by providing a bonus to clinicians who meet certain participation thresholds in advanced APMs and easing clinician reporting burdens for those in non-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. Recognizing that participants do not achieve savings or significantly reduce costs until the third or fourth year of the model, approaches and incentives are needed to keep providers whole during the transition to value.

We have been working with Congress to extend the bonuses and to adjust the thresholds that allow clinicians to qualify for the advanced APM bonus. However, there are opportunities to improve the clinician incentives by CMS. For example, the clinician reporting program, the Merit-based Incentive Payment System (MIPS), has set a low bar for performance, providing most clinicians with a moderate positive payment adjustment. This translates to FFS remaining a more financially successful option than APMs.

Accordingly, the underlying FFS incentives must be considered as levers for encouraging the adoption of APMs. This concept extends beyond clinician incentives and should be explored across the entire healthcare continuum. For example, providers who enter advanced APMs could be held harmless in their respective quality incentive programs or be exempt from certain FFS payment policies, such as site-neutral payment. Overall, when providers are held accountable for total cost-of-care and quality, the incentives shift so that the constraints of FFS are rendered unnecessary. Every payment tool available should be considered to reward those who are in risk-based APMs.

Establish a framework for the future of value.

Along with signaling a continued commitment to value, **we encourage CMS to engage stakeholders in establishing an overall framework for the future of value-based payment models**. To date we have tested a variety of models that address total cost of care, care for high-risk populations, clinical episodes, and primary care. An unintended consequence is an incredibly complex framework of advanced APMs, making it difficult for participants to define pathways for success and creating misaligned incentives

across providers. The invaluable learnings from the past and current models must be translated into a broader framework for abandoning FFS. We believe the following principles should be the foundation for an overarching framework for value-based care:

Provide maximum flexibility in new and existing advanced APMs. Innovating care requires flexibility beyond what is currently allowable in FFS, yet current models have provided minimal flexibilities. Many of the regulatory flexibilities introduced during the COVID-19 pandemic that providers would like to see made permanent have not historically been allowed in FFS due to concerns of cost, fraud or abuse. Some of these flexibilities (e.g., telehealth) have been tested in APM models but with more restrictions than allowed during the public health emergency. In order to significantly shift care and address high-priority issues, such as social determinants of health, providers need far more flexibility than currently allowed.

Current payment models are built upon a FFS chassis and maintain most FFS requirements, yet expect providers to innovate care. Conversely, Medicare Advantage plans are provided ample flexibility, yet many maintain a FFS structure. Providers are best suited to design unique care approaches for their population. When providers are managing total cost of care, the FFS program integrity concerns are mitigated. For example, providers in risk-based APMs should maintain the telehealth benefits provided under the public health emergency.

Ensure adequate reimbursement in APMs. Current approaches in APMs create a race to the bottom where providers must achieve year-over-year savings. Reimbursement inadequacy surfaced as the most significant barrier to APM adoption in a Premier 2019 survey. A new paradigm is needed where benchmarking approaches are sustainable long-term and address unique population challenges. Specifically, benchmark approaches should consider:

- Reducing the spending trend rather than year-over-year savings;
- Avoid penalizing those in historically low-cost regions, those who have achieved significant savings to-date and rural providers by reducing the discounts or ceasing the savings required (e.g. after a certain level of cost reduction, eliminating savings on the benchmark for rural providers);
- Account for the clinical risk of the population by incorporating risk adjustment approaches that reflect that Medicare populations will become more complex over time; and
- Incorporate non-medical costs that can address social determinants of health.

Ensure a level playing field for all providers. The best way to drive high-quality care for patients is to create incentives that drive all the providers in a system to collaborate to innovate and deliver high-quality, cost-effective healthcare. Accordingly, all providers should have equal opportunity to succeed in new payment arrangements. Current CMS models, however, disadvantage certain provider types. For example, the Medicare Shared Savings Program (MSSP) was recently modified to force high-revenue ACOs, a proxy for hospital-led ACOs, to take on risk faster than others. Similarly, Direct Contracting provides more favorable benchmarks to new entrants than entities who have made previous investments in bearing risk.

Advantaging one group over another can also create perverse incentives to undermine a competitor overall. Whenever there is an uneven playing field, one competitor will use it to their advantage over another. Alternatively, competitors can take steps to game the system. High performers should be encouraged to participate in models regardless of provider type. An explicit goal of APMs must be to incent providers to work collaboratively to benefit patients.

Establish a hierarchy for models that ensures sustainability and reduces complexity. The current models create a complex framework and present challenges for providers who wish to

operate in multiple models or when several models are operating within the same region. If we are to rapidly advance APMs an overarching framework is needed for model overlap and interaction. **Precedence should be given to entities managing total cost of care as they represent the most risk and address the full continuum of care.** This would provide total cost of care entities opportunity to design novel care interventions and payment approaches. For models that do not account for total cost of care, CMS should give consideration to the number of beneficiaries served, length of episode, percentage of cost of care included in the model, level of risk, addressing specialized complex conditions and the entities' prior commitments and investments in value-based care.

Premier has long advocated for a layered-payment demonstration where a total cost of care entity can implement other value models, such as bundled payments and primary care capitation, within the total cost of care arrangement. The Direct Contracting Global and Geographic models represent a starting point for this approach; however, the models require significant revision to enable providers success.

Address health inequities and disparities within payment models. Greater emphasis should be placed on addressing health equity and the social determinants of health. Successful population health interventions have established partnerships with communities to improve equity and reduce disparities; however, these approaches have not been incorporated into payment. We must build on these lessons learned and adopt approaches that drive entities engaged at every level of care delivery to pursue high-quality value-based care that is equitable, person-centered, and holistic. This will involve measuring and reporting information related to health disparities in order to identify solutions. Premier's robust data collection methodologies have been used by HHS to understand disparities in maternal outcomes. We are eager to work with the Biden-Harris Administration to enhance measurement of disparities and define value-based approaches for reducing disparities.

Encourage provider-led transformation in Medicaid.

The federal government should work with states to incentivize state Medicaid managed care programs to enter into more APM arrangements with providers, rather than remaining on a FFS chassis. CMS should support states in defining approaches to shift managed care behavior, such as:

- Reducing Medicaid payment rate cuts for MCOs that meet a certain percentage of provider VBP contracts. These higher payments would be reflected in provider reimbursement, thus incenting participation by providers.
- Providing points to MCOs in procurement contracts for those that have more providers in VBP contracts, with higher points awarded to the most advanced (e.g. capitation) VPB contracts.
- Incorporating up front funding to providers as part of MCO agreements, where providers would receive anticipated savings up front with a risk of repayment if savings are not achieved.
- Incentivizing MCOs to share claims data with providers to help them manage their Medicaid populations.

While some states have worked to move toward increased value additional technical and financial support is needed from CMS.

Renew focus on quality and patient safety.

The ACA and MACRA established programs that precipitated tremendous gains in quality and patient safety by holding providers accountable. A decade later these programs are no longer achieving their stated goals. For example, there is not a statistically significant difference in performance between

hospitals that are given a penalty for readmissions and those that avoid the penalty. Additionally, the measures used to assess the quality of APMs were built for FFS payment programs. With progress towards more interoperable data, quality and patient safety must shift to measures that rely on clinical information, rather than claims, and incorporate patient reported information. **We urge your Administration to set a long-term vision for quality.**

Reducing Barriers to Interoperability and Real-Time Data

Care innovation relies on access to actionable data at the point of care. 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. Integrating claims and clinical data is integral to population health management. Providers' real-time access to robust claims and electronic health record (EHR) data is limited. **Federal efforts are needed to accelerate adoption and consistent implementation of 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.**

In closing, the Premier healthcare alliance appreciates the opportunity to share our recommendations for accomplishing your 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