PREMIER TRANSFORMING HEALTHCARE TOGETHER®

January 9, 2024

The Honorable Charles Schumer
Senate Majority Leader
U.S. Senate
Washington, DC 20510

The Honorable Mike Johnson
Speaker of the House
U.S. House of Representatives
Washington, DC 20515

The Honorable Mitch McConnell
Senate Republican Leader
U.S. Senate
Washington, DC 20510

The Honorable Hakeem Jeffries
House Minority Leader
U.S. House of Representatives
Washington, DC 20515

Re: Critical Healthcare Priorities for Immediate Congressional Action

Dear Leader Schumer, Leader McConnell, Speaker Johnson and Leader Jeffries:

On behalf of Premier Inc. and the providers we serve, thank you for your leadership and bipartisan support of our nation's healthcare system. 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. 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.

As the new year begins, and as Congress embarks on the second session of the 118th Congress, Premier urges lawmakers to take action to protect Americans' access to high-quality and cost-effective care by addressing pressing legislative healthcare priorities. These include:

- Preventing impending cuts to Medicaid disproportionate share hospital (DSH) payments that would exacerbate the intense financial pressures facing hospitals and threaten access for our most vulnerable populations;
- Providing continued funding for community health centers as well as other expiring public health and workforce training programs;
- Reinstating incentives under Medicare to support movement to alternative payment models that deliver high-value care for beneficiaries;
- Continuing policies to prevent providers from being disenrolled in the 340B drug discount program;
- Mitigating Medicare payment reductions to physicians and other key providers; and
- Reauthorizing the Pandemic and All-Hazards Preparedness Act (PAHPA).

A number of these policies have been addressed on a temporary basis through January 19, 2024 under the terms of the current continuing resolution (CR). Others, however, lapsed at either the end of fiscal year (FY) 2023 or at the end of the calendar year. As Congress reconvenes, it is critical that lawmakers act in a bipartisan and bicameral manner to protect patients and support providers. Furthermore, beyond these pressing near-term actions, Premier urges lawmakers to work in a bipartisan manner throughout the 118th Congress to advance additional meaningful legislation to serve patients and improve healthcare.

As Congress considers these asks, Premier urges Congress to avoid cuts to hospitals and providers that would have a destabilizing effect on their ability to serve their communities. Fundamentally, Premier disagrees with the notion that healthcare innovation must be paid for

through healthcare cuts. America's aging population necessitates the need to innovate and invest in our healthcare infrastructure to support a healthy future for our nation. Premier urges Congress to work with healthcare stakeholders to identify novel funding mechanisms to create a sustainable, reliable, and world-class healthcare system of the future.

I. PREVENTING LOOMING MEDICAID DISPROPORTIONATE SHARE HOSPITAL (DSH) CUTS

The Medicaid DSH program was created to help offset uncompensated care costs for hospitals that provide care to large numbers of Medicaid and uninsured patients. These hospitals provide critical services and are economic and healthcare anchors in their communities. More than 2,500 hospitals in the U.S. receive DSH payments which help keep many hospitals financially viable and able to provide care to vulnerable individuals.

The Affordable Care Act (ACA) implemented cuts to DSH hospitals under the hypothesis that the need for DSH payments would decrease as coverage expanded. Unfortunately, coverage expansion has not occurred at the anticipated rate resulting in continued need for DSH payments to ensure coverage for vulnerable patients. While the onset of these cuts has been delayed until Jan. 19 under the CR, further legislative action is needed to prevent these reductions beyond that date. Left unaddressed, these cuts will result in an $8 billion cut for hospitals in FY 2024 and $8 billion in each of the following three years.

Any cut to DSH hospitals at this time would be detrimental as providers continue to experience significant fiscal challenges. In addition, the Medicaid program and its beneficiaries face a particularly difficult transition this year as states reinstitute eligibility redeterminations related to the expiration of the public health emergency (PHE) that is estimated to increase the need for hospitals to provide care to those that lose coverage.

Premier urges Congress to protect access to care for our nation's most vulnerable patients by preventing the pending Medicaid DSH cuts for at least two years.

II. EXTENDING FUNDING FOR IMPORTANT PUBLIC HEALTH PROGRAMS

Premier urges Congress to extend funding for important public health programs that have been temporarily extended through the CR. These include:

- **Community Health Centers (CHCs):** The federally supported CHC system supports more than 1,400 organizations and has created an affordable healthcare option for more than 30 million people nationwide, many in rural and underserved communities as well as veterans and children. CHCs increase access to crucial primary care, improve the well-being of countless Americans and reduce government spending on healthcare. The CHC Fund (CHCF) accounts for nearly 70 percent of health center funding and allows CHCs to serve on the front lines in our battle against addiction and mental health. CHCs have historically received bipartisan support in Congress and ***Premier urges lawmakers to ensure there is no interruption to CHC funding for at least two years to support critical care in America's communities.***

- **Workforce Training Programs:** Persistent workforce shortages continue to challenge healthcare providers and Premier believes[1] addressing these challenges will require a multi-pronged approach, and a mix of both near-term and longer-term solutions. Regarding near-term solutions, ***Premier urges Congress to reauthorize critical workforce training programs for at least two years to ensure no further degradation of the healthcare workforce***. These programs include the Teaching Health Centers Graduate Medical Education (THCGME) program, the Children's

[1] https://premierinc.com/downloads/Premier-Comments_HELP-Committee-Workforce-RFI.pdf

Hospital Graduate Medical Education Program (CHGME) and the National Health Service Corps (NHSC) that provide essential and comprehensive services for rural and tribal communities as well as children across the U.S. These programs expand our ability to deliver primary care across the country and are fundamental to tackling the healthcare labor shortage.

Additionally, under the Conrad 30 program, each state is allocated 30 waivers that exempt J-1 physicians from the requirement to return to their country of origin in exchange for three years of service in an underserved community. While a temporary extension of the program's authorization until Feb. 2, 2024 was included in the CR, Premier urges Congress to move quickly to extend this program which has helped Americans in rural and underserved areas receive medical care.

III. REAUTHORIZING THE SUBSTANCE USE DISORDER PREVENTION THAT PROMOTES OPIOID RECOVERY AND TREATMENT FOR PATIENTS AND COMMUNITIES (SUPPORT) ACT

The SUPPORT Act, which passed in 2018 with robust bipartisan support, has been instrumental in helping our nation address the opioid epidemic through programs and policies that impact treatment, prevention and recovery. Unfortunately, the SUPPORT Act authorization was allowed to lapse as of Sept. 30. The ongoing opioid epidemic continues to overwhelm hospitals[2] with an estimated 66 million emergency department visits and 760,000 inpatient admissions each year.

In recent weeks, legislation to reauthorize SUPPORT has advanced with strong bipartisan support through committee in both the House and Senate. ***Premier urges Congress to reauthorize the SUPPORT Act for at least two years to*** reduce barriers to receiving and delivering care for substance use disorders by improving payment policies, expanding care delivery options to include telehealth,, reducing unnecessary regulatory and administrative burden for providers and strengthening the behavioral healthcare workforce.

IV. EXTENDING INCENTIVES FOR ADVANCED ALTERNATIVE PAYMENT MODELS (APMS)

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. 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. In the last decade, accountable care organizations (ACOs) have generated savings to Medicare – including $1.8 billion in 2022 – while producing higher quality care for patients.[3]

Much of this progress 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 expired Dec. 31. 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. As a result, failure to extend the incentive payments

[2] https://premierinc.com/newsroom/premier-in-the-news/how-opioid-misuse-is-costing-health-systems
[3] https://www.cms.gov/newsroom/press-releases/medicare-shared-savings-program-saves-medicare-more-18-billion-2022-and-continues-deliver-high

could both discourage new providers from entering advanced APMs and may also result in current participants exiting.

Premier recently joined more than 600 other national, state and local organizations in sending a letter to Congressional leadership calling for Congress to extend eligibility for the Advanced APM incentive payments for two years to ensure physicians and other clinicians continue to participate in Advanced APMs. These provisions are also included in the bipartisan "Value in Health Care Act" (H.R. 5013 / S. 3503).

Premier urges Congress to support the ongoing transition to value-based healthcare by extending the Advanced APM incentive payments for at least two years.

V. EXTENDING TEMPORARY RELIEF FOR 340B HOSPITALS

Section 121 of the Consolidated Appropriations Act of 2023 (CAA) provided temporary relief to 340B hospitals at risk of losing access to the program due to impacts associated with the COVID-19 PHE on the DSH percentage threshold. Unless relief is extended, protections will expire when at-risk hospitals file their next Medicare cost reports, a process that will begin as early as November for some hospitals. That means these hospitals are in jeopardy of completely losing access to the program or experiencing a major loss of 340B savings used to provide critically needed care in their communities. According to some estimates, more than 400 hospitals – including many small, rural hospitals – are at-risk of losing eligibility in the coming months because of pandemic-era effects, including the Medicaid redetermination process, continuing to lower their DSH percentages.[4] In addition, many states are further disadvantaged as their social security offices are severely backlogged in processing claims for supplemental security income (SSI) which is impacting their DSH thresholds. As such, hospitals should not be penalized for the failure of government agencies to efficiently process claims in a timely manner. Even a temporary loss of 340B savings can seriously jeopardize safety-net hospitals, particularly smaller, rural institutions that are already facing serious financial challenges.

Recently, members of Congress have advocated for the extension of this critical provision. [5]

Premier urges Congress to pass a two-year extension of the 340B eligibility protections that were authorized in Section 121 of the CAA to protect access to care.

VI. MITIGATING REDUCTIONS TO MEDICARE REIMBURSEMENT FOR PHYSICIANS AND OTHER PROVIDERS

Effective Jan. 1, 2024, providers paid under CMS' Physician Fee Schedule (PFS) are subject to a 3.4 percent Medicare Part B payment cut stemming from the provisions in the calendar year 2024 Medicare PFS final rule. Given the unprecedented financial challenges and record inflation that providers are facing, ***Premier urges Congress to take action to mitigate the impact of physician cuts for at least two years.***

Additionally, Congress extended until Jan. 19 a temporary floor of 1.0 to raise the physician work Geographic Practice Cost Indices (GPCI) value to the national average for localities with values below it. Without further action to extend the work GPCI floor beyond that date, rural physician practices will face even greater payment cuts, undermining access to care in these communities. ***Premier urges lawmakers to extend the physician work GPCI floor of 1.0 to any locality that would otherwise have an index value below that level for at least two years.***

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[4] https://www.ruralhealth.us/NRHA/media/Emerge_NRHA/Advocacy/Government%20affairs/2023/NRHA-340B-Extender-Letter-final.pdf

[5] https://www.warnock.senate.gov/newsroom/press-releases/senators-reverend-warnock-ossoff-push-senate-leadership-to-prevent-potential-closures-of-hospitals-serving-low-income-georgians/

Finally, in November, CMS finalized plans to implement cuts totaling 9.48 percent to home healthcare providers starting in 2024. Additionally, CMS plans to implement at least $3.5 billion in temporary "claw back" cuts to home health payments. Home healthcare allows approximately 3.5 million Medicare beneficiaries to be treated in the cost-effective setting they prefer most – their homes. These cuts, which could total up to $20 billion over the next 10 years, would make it harder for patients to leave the hospital and go home with care that helps them recover and rehabilitate. ***Therefore, Premier urges Congress to take action to mitigate the impact of these cuts to home healthcare.***

VII. REAUTHORIZING THE PANDEMIC AND ALL HAZARDS PREPAREDNESS ACT (PAHPA)

Premier urges the House and Senate to act in a bipartisan manner to reauthorize PAHPA. Authorization for most of PAHPA expired Sept. 30, and a temporary extension of authorization was not included as part of the CR. The existence of PAHPA during the COVID-19 pandemic was instrumental in supporting the nation's rapid response and as a nation we are less prepared to face public health crises while it remains unauthorized.

Premier has shared detailed recommendations on priorities and potential improvements in connection with PAHPA with both the Senate Health, Education, Labor and Pensions (HELP) Committee and House Energy and Commerce Committee[6]. Premier supports themes within the bills passed by each committee related to public-private collaboration, bidirectional data sharing, the need to standardize and modernize data collection and focus on individuals with disabilities. However, Premier is concerned that the current proposals do not sufficiently heed the lessons learned from the COVID-19 pandemic and apply them in a manner that will fundamentally alter our nation's response to future pandemics or emergency responses. As noted in prior comments, ***Premier urges Congress to reconsider bolder, bigger, and more impactful policies for inclusion in any final package, such as provisions to strengthen the Strategic National Stockpile, address drug shortages, modernize the supply chain data infrastructure and incentivize domestic manufacturing.*** Timely reauthorization of PAHPA is a vital health priority if we are to avoid undermining our nation's preparedness infrastructure.

To this end, Premier supports the bipartisan Medical and Health Stockpile Accountability Act (H.R. 3577) which would enable – for the first time – real-time data on the entire supply chain for critical medical supplies needed to treat patients during emergencies. This information will allow healthcare providers, manufacturers, distributors and the government to pinpoint the intersection of supply and demand, more effectively secure needed products, and better identify areas of vulnerability to prevent supply shortfalls. This legislation also aligns with recommendations from the Government Accountability Office (GAO) and Business Executives for National Security.

A growing body of analysis points to why we need a national automated data collection infrastructure that can track critical product availability – from the manufacturer, to distribution, to stockpiles, to hospital inventory – like the one proposed in H.R 3577.

- In May of 2022, an Assistant Secretary for Preparedness and Response (ASPR) Essential Medicines Supply Chain and Manufacturing Resilience Assessment[7] found that the COVID-19 pandemic illustrated the vulnerabilities of the U.S. pharmaceutical supply chain and how dramatically a crisis can impact its integrity. Spikes in demand for critical medicines coupled with

[6] https://premierinc.com/downloads/Premier-Comments_EC-PAHPA-RFI_FINAL.pdf
https://premierinc.com/downloads/Premier-Comments_HELP-PAHPA-RFI_FINAL.pdf
https://premierinc.com/downloads/Premier-Statement_EC-Committee-Hearing_PAHPA.pdf
https://premierinc.com/downloads/Premier-Statement_HELP-Committee-Hearing_PAHPA.pdf
https://premierinc.com/downloads/Premier-Comments_Senate-HELP-PAHPA-Discussion-Draft_July-2023_FINAL.pdf

[7] https://www.armiusa.org/wp-content/uploads/2022/07/ARMI_Essential-Medicines_Supply-Chain-Report_508.pdf

global supply chain disruptions left the United States struggling with shortages and distribution challenges that had direct implications on patient care.

- In October 2023, the Department of Health and Human Services Office of Inspector General stated in a report[8] that the Strategic National Stockpile was not positioned to respond effectively to the COVID-19 pandemic. The report further noted challenges associated with the stockpile relying on multiple information technology systems.

- In December of 2023, the US Department of Veteran's Affairs Office of Inspector General (VA OIG) issued a report[9] concerning significant deficiencies found in Denver's Logistics Center, including the fact that inventory records did not align with on-hand supplies or include all goods. In the case of a national emergency, this lack of inventory control could result in serious delays of essential products to those in need.

Finally, in a letter submitted to Congress, more than 50 health systems, national hospital organizations and suppliers voiced for including H.R. 3577 as part of PAHPA reauthorization.

VIII. CONTINUE TO WORK TOWARDS ADVANCING CRITICAL BIPARTISAN POLICIES TO IMPROVE ACCESS TO CARE

In addition to addressing critical healthcare issues demanding immediate attention in advance of expiration of the CR, Premier urges lawmakers to continue to work throughout the 118th Congress to advance other critical bipartisan and bicameral policies that would close gaps in healthcare access and improve the delivery of care. Specifically, Premier urges Congress to address the following before the conclusion of the 118th Congress:

- **Ensuring Patient Access to Long-Term Care Pharmacy Services:** Long-term care (LTC) pharmacies provide specialized and distinct services for elder, vulnerable beneficiaries residing in LTC facilities across the country, yet no statutory definition of LTC pharmacies exists under current federal law or regulations. The lack of a statutory LTC pharmacy definition has led to conflicting and inappropriately applied policy directives across federal agencies and congressional proposals, presenting hurdles for vulnerable seniors. Premier encourages lawmakers to enact legislation that would establish a uniform LTC pharmacy definition that explicitly identifies important LTC pharmacy service offerings.

- **Addressing Flaws in CMS' Ability to Measure True Costs of Providing Care** - Hospitals continue to experience significant fiscal challenges stemming from a combination of increased labor costs, record inflation and lagging reimbursement rates that do not account for these unprecedented financial challenges. Premier has expressed significant concerns to CMS[10] that the methodology used to determine annual hospital payment updates does not adequately capture the true costs hospitals have faced over the last few years, especially as it relates to labor. A PINC AI™ analysis found that labor costs have increased by more than 15 percent since the start of FY 2020 through the first half of FY 2023 and do not show signs of returning to a lower level. We believe that CMS must adopt new or supplemental data sources, such as PINC AI™ data, to ensure labor costs are adequately reflected in the future Medicare hospital payment updates.

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[8] https://oig.hhs.gov/oas/reports/region4/42002028.pdf

[9] https://www.vaoig.gov/reports/audit/significant-deficiencies-found-vas-denver-logistics-center-inventory-management

[10] https://premierinc.com/downloads/Premier-Comments_-IPPS-FY-2024-Proposed-Rule_FINAL.pdf

- **Preserving Medicare Patient Access to Home Infusion:** CMS' narrow interpretation of the Medicare Part B home infusion services benefit has resulted in unintended consequences for providers across the continuum and threatened vulnerable patients' access to home infusion therapy. Premier supports the bipartisan and bicameral Preserving Patient Access to Home Infusion Act (S. 1976 / H.R. 4104) which would clarify Congressional intent by making key policy changes to the home infusion services benefit. These changes are supported by a broad coalition of stakeholders and would improve patient access to care.

- **Protecting the Healthcare Workforce:** The healthcare workforce is currently experiencing severe shortages because of unprecedented pressures exacerbated by the pandemic, pushing our healthcare system to its limits. Recently, Premier published the results of a survey providing key insights on the incidence of workplace violence in healthcare settings. Premier supports the bipartisan Safety from Violence for Healthcare Employees (SAVE) Act (S. 2768 / H.R. 2584) which would provide federal protections for healthcare workers who experience violence and intimidation in their workplace settings.

- **Building Supply Chain Resiliency:** The pandemic exposed significant shortcomings in our medical supply chains and resulted in shortages of critical goods, services, and medications. Premier urges Congress to advance bipartisan solutions that will ensure that critical medical products are delivered safely, swiftly, and efficiently to providers and patients. Premier supports the Medical Supply Chain Resiliency Act (S. 2115 / H.R. 4307), introduced by Senators Tom Carper (D-DE) and Thom Tillis (R-NC) and Representatives Michelle Steel (R-CA) and Brad Schneider (D-IL) which would strengthen the resilience and dependability of the United States' medical supply chain in the face of future threats to public health and national security by establishing stronger ties with trusted trade partners. The bill authorizes the President to enter into trade agreements with trusted trade partner countries and establishes a trusted trade partner network. The bill would help diversify sourcing for medical devices and pharmaceuticals and enable timely access to the vital supplies providers need to care for patients during a public health crisis or national security threat.

  Premier further urges Congress to consider additional policies to reduce overreliance on foreign manufacturers, such as leveraging the tax code to incentivize domestic manufacturing of critical supplies, broadening and applying to private payors the current Medicare payment incentives for hospitals to purchase domestically manufactured critical medical supplies and pharmaceuticals, and redefining requirements for government purchasers to buy domestically.

- **Pursuing a Thoughtful, Consensus-driven Approach to Artificial Intelligence (AI) Policy:** Premier supports the responsible development and implementation of AI tools across the healthcare industry, where AI is already demonstrating its ability to help improve patient outcomes and provider efficiency. AI holds great potential for empowering the healthcare workforce, mitigating supply chain shortages, advancing health equity and driving higher-quality care. While Premier believes that AI can and should play a critical role in advancing healthcare and spurring innovation, Premier also believes that AI cannot and should not replace the practice of medicine.

  Premier has thought critically about the potential legislative and regulatory framework for AI in healthcare and recently published an Advocacy Roadmap for AI in Healthcare.[11] As interest on Capitol Hill in AI continues to grow, Premier urges lawmakers to continue to work closely with stakeholders to ensure that any legislative initiatives balance the ability of providers and payers to deploy AI technology to its full potential, while still protecting individual rights and safety. While Premier embraces AI's potential, we also acknowledge that trust – among patients, providers, payers, policymakers and suppliers – is critical for the responsible adoption of AI tools in healthcare settings. To earn trust, AI tools must be subject to clear statutory, regulatory and subregulatory guidelines that ensure transparency and protect individual rights and safety.

[11] https://premierinc.com/downloads/AdvocacyRoadmap-AI-OnePager_FINALv2_Aug-2023.pdf

Premier strongly supports AI policy guardrails that include standards around transparency and trust, bias and discrimination, risk and safety, and data use and privacy. Furthermore, Premier recommends that AI technology in healthcare should be held to a standardized, outcomes-focused set of metrics, such as accuracy, bias, false positives, inference risks, recommended use and other similarly well-defined values. It is essential to focus transparency efforts on the accuracy, reliability and overall appropriateness of AI technology outputs in healthcare to ensure that the evolving tool does not produce harm.

- **Alleviating the Harm, Burdens and Costs of Prior Authorization in Healthcare:** While prior authorization can support evidence-based care, it can also limit timely patient access to medically necessary services and be costly, time-consuming and burdensome for healthcare providers and insurers. The current system of prior authorization is plagued with an overreliance on faxes, phone calls and a literal paper trail, which too often results in care delays and increased costs. Transitioning to electronic prior authorization transactions could save the healthcare system millions annually, improve patient safety, end harmful care delays and remove provider burden. Premier urges lawmakers to continue work begun in previous Congresses to enact legislation, such as the bipartisan and bicameral Improving Seniors' Timely Access to Care Act, which would streamline prior authorization requirements under Medicare Advantage plans. The House unanimously passed the legislation in the 117th Congress and, on July 26, 2023, the House Committee on Ways and Means approved legislation that incorporates the Improving Seniors' Timely Access to Care Act, with minor technical corrections.

- **Providing Further Extensions of Telehealth and Hospital at Home Policies:** Greater utilization of telehealth made possible by waivers provided under the COVID-19 PHE has had a transformative effect on healthcare by reducing barriers to access. Likewise, additional COVID-19 PHE waivers allowed patients to receive certain acute care services from the comfort and safety of their homes. More than 200 hospitals have embraced the "hospital at home" concept and have tailored their programs to meet specific patient and organizational objectives. Temporary extensions of both programs are currently in place until the end of 2024. Premier supports further examination of how these policies have been most effective and how further extending them can continue to support patient care.

- **Incentivizing Adoption of Interoperable Information Technology in Long-Term and Post-Acute Care Settings:** Premier urges Congress to look towards expanding the use of technology in long-term and post-acute care (LTPAC) settings (skilled nursing, home health, hospice, long-term acute care facilities, inpatient rehabilitation facilities) to reduce healthcare expenditures while improving patient safety and quality of care. Unfortunately, the reality today is that inequitable access to and use of interoperable health information technology (HIT) persists across the continuum as programs authorized and funded under the Health Information Technology for Economic Clinical Health (HITECH) Act excluded LTPAC providers.

  As it stands today, the rate of adoption and use of interoperable HIT among LTPAC providers lags far behind acute and ambulatory care providers. While current technology gaps and inconsistencies in adoption for these settings make it difficult to obtain a complete analysis, the full extent with which technology, such as electronic health records and electronic clinical surveillance technology, could be used to rein in costs has clearly not yet been realized. Ongoing Department of Health and Human Services (HHS) and GAO reports[12] have sited challenges for LTPAC providers with regards to interoperability and data exchange and areas of opportunity. A comprehensive technology approach is needed to reduce medication errors, manage and control the spread of infectious

[12] See: Electronic Health Records: HHS Needs to Improve Planning and Evaluation of Its Efforts to Increase Information Exchange in Post-Acute Care Settings | U.S. GAO and Interoperability Among Office-Based Physicians in 2019 (healthit.gov)

diseases, prevent duplicative testing, reduce administrative burden and ensure care coordination as well as regulatory compliance.

The time is ripe to address these longstanding and ongoing challenges that will promote safety and efficiency while generating savings in LTPAC settings. Federal support is necessary to ensure interoperability of HIT and data exchange and sharing across the care continuum, including technological functionality to improve quality of care, patient safety and infection control in rural America.

- **Improving CBO Modeling Capabilities on Healthcare Policies:** 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. Not accounting for these factors can also produce insufficient evidence of any "offsetting" effect of policies on federal spending. In order to capture potential long-term health savings in federal programs, Premier urges Congress to pass the bipartisan, bicameral Preventive Health Savings Act (S.114 / H.R.766), which would allow Congress to more easily request CBO estimates of preventive health initiatives beyond the ten-year scoring window.

IX. CONCLUSION

In summary, Premier looks forward to working with Congress to advance bipartisan policies with broad stakeholder support to strengthen our nation's healthcare infrastructure, improve patient access and lower the cost of care.

If you have any questions regarding our comments or need more information, please contact me at soumi_saha@premierinc.com or 732-266-5472.

Sincerely,

Soumi Saha, PharmD, JD
Senior Vice President of Government Affairs
Premier Inc.

cc: Senate Finance Chairman Wyden
Senate Finance Ranking Member Crapo
Senate HELP Chairman Sanders
Senate HELP Ranking Member Cassidy
Ways & Means Chairman Smith
Ways & Means Ranking Member Neal
Energy & Commerce Chair McMorris Rodgers
Energy & Commerce Ranking Member Pallone