October 15, 2023

The Honorable Michael Burgess, M.D.
U.S. House of Representatives
2161 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Drew Ferguson, IV, D.M.D
U.S. House of Representatives
2239 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Lloyd Smucker
U.S. House of Representatives
302 Cannon House Office Building
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The Honorable Earl L. "Buddy" Carter
U.S. House of Representatives
432 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Blake D. Moore
U.S. House of Representatives
1131 Longworth House Office Building
Washington, D.C. 20515

The Honorable Rudy Yakym III
U.S. House of Representatives
349 Cannon House Office Building
Washington, D.C. 20515

Submitted electronically to: hbcr.health@mail.house.gov

Re: Request for Information on Solutions to Improve Patient Outcomes and Reduce Health Spending

Dear Representatives Burgess, Ferguson, Smucker, Carter, Moore and Yakym:

Premier Inc. appreciates the opportunity to submit comments to the request for information (RFI) issued on August 25, 2023 to inform policy solutions to improve patient outcomes and reduce federal healthcare spending. Premier applauds the House Budget Committee Health Care Task Force for its leadership and dedication to identifying the drivers of healthcare spending and legislative approaches to achieve a more cost-effective healthcare system. Premier further appreciates your thoughtful approach to seeking stakeholder input in the development of policies to enable healthcare providers to offer improved services and care in the communities they serve, while also reducing spending.

Premier's responses to the RFI reflect the concerns of our member hospitals, health systems and continuum of care providers which have a vested interest in improving health outcomes in their communities, reducing provider and patient burden and curbing rising healthcare costs.

In our comments, Premier has identified the following actions that Congress can take to modernize the healthcare system, promote innovation, increase patient access to quality and affordable care and improve returns on federal investments:

- Support a continued emphasis on movement to value by passing the bipartisan Value in Health Care Act (H.R. 5013) and reforming the Stark and anti-kickback statues.
- Permanently extend certain telehealth flexibilities with appropriate guardrails to allow providers to continue to furnish services effectively and efficiently to patients remotely.
- Hold the Food and Drug Administration (FDA) accountable for implementing provisions in the Coronavirus Aid, Relief, and Economic Security (CARES) Act aimed at preventing drug shortages.
- Streamline, standardize and implement automation of the prior authorization process for Medicare Advantage beneficiaries by passing policies contained in the Improving Seniors' Timely Access to Care Act.

- Consider policies that incentivize nursing homes and other long-term and post-acute care (LTPAC) providers to implement electronic health records (EHRs) and electronic clinical surveillance technology to provide meaningful assistance with infection control.
- Pass the bipartisan, bicameral Preserving Patient Access to Home Infusion Act (S. 1976 / H.R. 4104) to expand access to infusion services in the home, which is often the safest, most clinically appropriate, cost-effective and desirable setting for Medicare vulnerable beneficiaries.
- Pass the bipartisan, bicameral Preventive Health Savings Act (S.114 / H.R.766), which would allow Congress to more easily request Congressional Budget Office (CBO) estimates of preventive health initiatives beyond the ten-year scoring window to capture potential long-term health savings in federal programs.

Our detailed recommendations are included below.

I. BACKGROUND ON PREMIER INC.

Premier is a leading healthcare improvement company, uniting an alliance of more than 4,350 U.S. 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, 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 accountable care organizations (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. REGULATORY, STATUTORY OR IMPLEMENTATION BARRIERS THAT COULD BE ADDRESSED TO REDUCE HEALTHCARE SPENDING

Remove Legal and Regulatory Barriers that Impede Innovation: Premier aims to lead the transformation to high-quality, cost-effective healthcare by supporting the holistic movement from volume to value. As covered further below, this includes value-based arrangements and payment models such as accountable care organizations (ACOs), bundled payments and value-based contracts for drugs and devices. One area that Congress could address to better enable these innovations is reforms to Stark and anti-kickback laws to foster arrangements that promote care coordination and advance the delivery of value-based care, while also protecting against harms caused by fraud and abuse. The Stark and anti-kickback statutes pose barriers to innovative arrangements among healthcare providers and suppliers and undue burden on the healthcare industry generally as it strives to improve the quality and value of healthcare delivery for patients. These laws were enacted to address issues for a different healthcare delivery system where providers of services and other stakeholders could encourage overutilization of services. However, new models of healthcare delivery encourage value and emphasize care coordination and integration to

increase both the quality and efficiency in the delivery of services to patients. Existing safe harbors and exceptions are not designed to accommodate innovative arrangements used in new models of care delivery and those that do apply fail to address specific issues raised under these arrangements or do not afford adequate protection from liability.

Stark and anti-kickback reform is necessary so that providers, suppliers and the healthcare system can innovate care that otherwise may be seen as beneficiary inducement. Modernizing these statutes will also provide a valuable tool to constrain healthcare cost escalation. ***Premier urges Congress to advance legislation revising Stark and AKS policies using a new statutory framework focused on value-based care.***

Expand Telehealth Flexibilities: Telehealth was a critical tool during the COVID-19 public health emergency, allowing providers to continue to furnish much-needed services to patients from the safety of their homes. The flexibilities the Centers for Medicare & Medicaid services (CMS) granted around telehealth served to highlight that many services can be effectively and efficiently furnished remotely. Congress recognized the value in easing barriers to virtual care and extended key telehealth flexibilities in the Consolidated Appropriations Act (CAA) of 2023 through the end of 2024, as advocated by Premier. Moreover, according to a Premier survey, 93 percent of respondents supported making these waivers permanent.

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 remove regulatory barriers to telehealth by permanently extending certain telehealth flexibilities with appropriate guardrails to allow providers to continue to furnish services effectively and efficiently to patients remotely.*** Congress can do this by:

- Allowing for certain services to be continued to be furnished via audio-only telehealth. This includes allowing diagnoses obtained from audio-only telehealth services for risk adjustment purposes to be counted under the Medicare Advantage program to ensure that health costs are adequately covered while providing the information care teams need to manage patient care.
- Increasing telehealth flexibilities in the Medicare Shared Savings Program (MSSP) and CMS Innovation Center models. While these programs and models offer some existing telehealth flexibilities, these waivers are often limited and require burdensome reporting requirements.

Hold FDA Accountable for Implementing Drug Shortage Provisions: Drug shortages continue to plague the healthcare system and have grown in both number and intensity in the past several years.[1] Drug shortages invariably impact patient care, adding time and expense as providers manage supplies and search for therapeutic alternatives that can be less effective and more costly, potentially delaying treatment. Drug shortages are also a major driver of skyrocketing costs – contributing to over half a billion dollars in increased healthcare expenditures annually. A study found that prices for drugs in shortage increased more than twice as quickly as they would in the absence of a shortage – adding $230 million a year to U.S. drug

[1] FDA Annual Report to Congress for CY 2022. Available at: https://www.fda.gov/media/169302/download?utm_medium=email&utm_source=govdelivery

costs.[2] Another study found that the price of fluphenazine tablets in 2016 increased by over 2000 percent during a shortage.[3]

In addition to the increase in drug prices, drug shortages cause a multitude of downstream impacts to the healthcare system such as:

- Increased labor costs associated with managing drug shortages, estimated to be $216 million annually.[4]
- Increased potential for adverse events, and consequently increased costs to the healthcare system such as increased hospital days due to the unavailability of a critical medication. For example, a shortage of norepinephrine was significantly associated with increased mortality amongst patients with septic shock.[5] The FDA estimates that the norepinephrine shortage resulted in $13.7 billion of projected losses to the U.S. healthcare system.[6]
- Decreased procedures and diagnostic testing. For example, a recent shortage of contrast media resulted in approximately 10 percent of patients who needed advanced imaging, such as computerized tomography (CT) scans, unable to receive one.[7] Similarly, current shortages of oncology agents are resulting in healthcare providers having to make difficult decisions regarding rationing available supply and prioritizing which patients should receive treatment.

Premier served as the lead proponent of the Mitigating Emergency Drug Shortages (MEDS) Act which was incorporated and signed into law as part of the CARES Act in March 2020. These provisions provide additional authority to the FDA to proactively address drug shortages and develop market-based incentives for the manufacturing of these critical drugs, including on-shore manufacturing. Unfortunately, it has been more than three years since the passage of these provisions and FDA has yet to fully implement any of them.

For example, FDA published draft guidance on risk management plans in June 2022 and updated Food and Drug Administration Safety and Innovation Act (FDASIA) Title X reporting requirements in April 2023, but has yet to finalize them. Furthermore, in the FDA's recent report to Congress for FY 2022, the FDA notes the CARES provisions but does not speak to an implementation timeline or how the new authorities helped mitigate shortages.[8]

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[2] Hernandez I, Sampathkumar S, Good CB, Kesselheim AS, Shrank WH. Changes in Drug Pricing After Drug Shortages in the United States. Ann Intern Med; 170:74–76. doi: 10.7326/M18-1137

[3] Fox E. R., Tyler L. S. (2017). Potential association between drug shortages and high-cost medications. Pharmacotherapy 37, 36– 42. 10.1002/phar.1861

[4] "Impact of drug shortages on U.S. health systems" (American Journal of Health-System Pharmacy, October 2011). https://www.ncbi.nlm.nih.gov/pubmed/21930639

[5] Vail, Emily, Gershengorn, Hayley, Hua, May, Walkey, Allan, Rubenfeld, Gordon & Wunsch, Hannah. (2017). Association Between US Norepinephrine Shortage and Mortality Among Patients With Septic Shock. JAMA. 317.DOI: 10.1001/jama.2017.2841

[6] 6 FDA Public Hearing Identifying the Root Causes of Drug Shortages and Finding Enduring Solutions. Available at: https://healthpolicy.duke.edu/events/drug-shortage-task-force

[7] https://premierinc.com/newsroom/blog/anatomy-of-a-shortage-a-lack-of-contrast-media-supplies-compromised-care-for-up-to-10-percent-of-patients-in-key-clinical-categories

[8] FDA Annual Report to Congress for CY 2022. Available at: https://www.fda.gov/media/169302/download?utm_medium=email&utm_source=govdelivery

In addition, Premier has significant concerns that FDA is moving forward with implementing its new statutory authority in a manner that does not align with Congressional intent.[9] [10] For example, in passing the CARES Act, Congress intended to create upstream visibility into potential disruptions in the pharmaceutical supply chain and hold Active Pharmaceutical Ingredient (API) manufacturers accountable for reporting discontinuances and interruptions to help mitigate potential downstream shortages as early as possible. In draft guidance, the FDA proposes passing this burden to finished-dose manufacturers who may not have proper visibility into API production, supply, or market share to determine early warning signals of a potential shortage, which is counter to the intent of the legislative language to hold manufacturers of API accountable for supply chain sustainability. Therefore, Premier has urged FDA to reevaluate its interpretation of the CARES Act provisions and extend notification requirements regarding discontinuances and interruptions in the manufacturing of API to the manufacturer of the API itself.

Given continued delays with the FDA implementing statutory authorities from more than three years ago, Premier recognizes it is difficult to provide FDA with additional statutory authority absent understanding how prior laws are impacting drug shortages. Therefore, ***Premier urges Congress to hold oversight hearings with FDA, including representatives from the Office of Drug Shortages, to understand the reason for the delay in the FDA implementing its CARES Act statutory authorities. Further, the oversight hearings should examine whether FDA's interpretation of its statutory authority is consistent with Congressional intent.***

III. EFFORTS TO PROMOTE AND INCORPORATE INNOVATION INTO PROGRAMS LIKE MEDICARE TO REDUCE HEALTHCARE SPENDING AND IMPROVE PATIENT OUTCOMES

Ensuring Continued Support for Value-based Care: A critical component to improving quality and reducing healthcare costs is to support innovative approaches for delivering care in value-based arrangements. Innovative Medicare alternative payment models (APMs) – such as ACOs, bundled payment and other value-based care models that encourage clinical integration, innovation in care delivery and improved coordination across the continuum of care - have achieved savings for the Medicare program. In August, CMS announced that Medicare Shared Savings Program (MSSP) ACOs achieved more than $1.8 billion in savings to Medicare in Performance Year 2022. CMS also reported that participating ACOs had a higher average performance on applicable quality measures compared to other similarly sized non-participating clinician groups. This is the sixth consecutive year that the program has achieved net savings for Medicare while delivering high-quality care. More than 11 million Medicare fee-for-service beneficiaries benefit from care furnished by providers affiliated with an ACO[11] who have brought all their value-based, wellness-focused care delivery sophistication to bear on the populations they serve. Overall, healthcare providers participating in APMs generated more than $17 billion in savings, with $6.4 billion in savings returned to the Medicare program.[12]

One of the main policy levers to support these continued savings and improved outcomes, however, is scheduled to expire at the end of the calendar year. Absent Congressional action, the payment incentive for providers who participate in the MSSP and other advanced APMs will no longer be available after Dec. 31, 2023. ***Premier urges the Task Force to support a continued emphasis on movement to value by***

[9] https://premierinc.com/downloads/Premier-Comments_FDA-Guidance-on-Risk-Management-Plans-to-Mitigate-Drug-Shortages.pdf
[10] https://premierinc.com/downloads/Premier-Comments_FDA-Guidance-on-Notifications-for-Supply-Disruptions-to-Mitigate-Drug-Shortages.pdf
[11] CMS Press Release, "Medicare Shared Savings Program Saves Medicare More Than $1.8 Billion in 2022 and Continues to Deliver High-quality Care," August 24, 2023, https://www.cms.gov/newsroom/press-releases/medicare-shared-savings-program-saves-medicare-more-18-billion-2022-and-continues-deliver-high
[12] https://valuebasedcare.org/avbpc-value-101/ (slides 8, 9)

passing the bipartisan Value in Health Care Act (H.R. 5013). This bill provides incentives to encourage providers to participate in APMs and removes barriers to even greater cost savings, better care coordination and faster movement to value-based care models. This includes extending bonuses for providers who participate in an APM an additional two years and increasing the shared savings rate. An independent analysis found that a previous version of the Value in Health Care Act would save $280 million over 10 years.[13]

Streamlining the Prior Authorization Process: Used by some health insurance companies and federal healthcare programs, prior authorization is intended to protect patient safety and lower costs by putting guardrails in place to avoid inappropriate care. However, too often it can also limit timely patient access to medically necessary services and be costly, time-consuming and burdensome for healthcare providers. The HHS Office of the Inspector General (OIG) issued an alarming report finding that Medicare Advantage plans often denied or delayed patients' access to medically necessary services and burdened physicians, even though the requests met Medicare coverage rules.[14] These inappropriate denials were due in large part to human error during the manual claims processing reviews. A main culprit is a lack of automation of the prior authorization processes. In fact, 72 percent[15] of prior authorizations are conducted either partially or entirely manually, using faxes and phone calls.

In a recent survey of more than 1,000 physicians, 94 percent of providers reported treatment delays due to current prior authorization processes and 25 percent say these delays resulted in hospitalization. The prior authorization process is also burdensome to providers and patients and is disconnected from the clinical workflow. It is a manually intensive process that requires healthcare professionals to take time away from caring for their patients to engage with payers. According to the survey, two out of five physicians have staff who work exclusively on prior authorization. Practices complete an average of 45 prior authorizations per physician, per week. This equates to physicians and their staff spending almost two business days (14 hours) each week completing prior authorizations.

Congress can vastly improve the prior authorization process for Medicare Advantage beneficiaries by passing policies contained in the Improving Seniors' Timely Access to Care Act, which has broad bipartisan, bicameral support in Congress and is supported by more than 500 organizations. 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. The bill would streamline, standardize and implement automation of the prior authorization process for certain Medicare Advantage services and procedures. Transitioning to fully electronic prior authorization transactions could save the health system $449 million annually[16], improve patient safety, end harmful care delays and remove provider burden.

Premier is in the process of collecting information to quantify the effects of payment denials and delays, including the administrative costs and burden of pursuing denials and/or delays in claims payments. Premier looks forward to sharing our findings with the Task Force in the coming weeks.

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[13] The Moran Company, "Value in Health Care Act: Improvement to Medicare's ACOs and APMs: Fiscal Implications," August 2021 https://www.naacos.com/assets/docs/pdf/2021/ValueActScore082021.pdf
[14] HHS OIG, "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care." April 2022. https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf
[15] CAQH, "2022 CAQH INDEX® A Decade of Progress," 2023, https://www.caqh.org/sites/default/files/2023-05/2022-caqh-index-report%20FINAL%20SPREAD%20VERSION.pdf
[16] Ibid

Support the Responsible Development and Implementation of AI Tools Across the Healthcare Industry: AI enabled technology has the potential to transform healthcare by decreasing costs, reducing provider burden, and most importantly, improving patient outcomes while minimizing adverse events. Premier supports policies and regulations that enhance the creation of AI tools and the use of AI in healthcare to empower providers, patients and improve clinical and operational efficiency. At the same time, it is critical that a regulatory framework for AI remain nimble and flexible to adapt to an evolving technology landscape and not stifle innovation. 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. ***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.***

As Congress contemplates policies to govern the use of AI in healthcare – including a federal investment and incentive framework – Premier urges lawmakers to do so in the context of its long-term and widespread value for patients and the healthcare system. Specifically, ***Congress should take into consideration the great potential AI holds for lowering healthcare spending and improving outcomes by empowering the healthcare workforce, mitigating supply chain shortages, advancing health equity and driving higher-quality care. Premier encourages the Task Force to review Premier's guiding principles[17] that support the responsible development and implementation of AI tools across the healthcare industry.***

IV. EXAMPLES OF EVIDENCE-BASED, COST-EFFECTIVE PREVENTIVE HEALTH MEASURES THAT CAN REDUCE LONG-TERM HEALTH COSTS

Leveraging Technology to Prevent Infection Spread in Nursing Homes: COVID-19 brought to the forefront the specific challenges nursing homes face in containing the spread of infectious disease. The virus accelerated at nursing homes because residents are generally vulnerable to its complications and more susceptible in the contained space of the facilities. While data about infections in nursing homes is limited, the Centers for Disease and Prevention (CDC) notes that, even prior to the pandemic, a staggering 1 to 3 million serious infections occur every year in these facilities and as many as 380,000 people die of the infections in nursing homes every year.[18]

Infection prevention oversight and training at nursing homes is a challenge in and of itself with limited staffing and several layers or reporting requirements. This challenge is compounded by limited EHR functionality at the sites. Without a comprehensive infection prevention surveillance workflow, the surveillance, tracking, documenting and reporting of epidemiologically significant organisms and infection is difficult for everyday risks, such as multi-drug resistant organisms, but also when an outbreak like COVID-19 occurs.

Clinical analytics technologies are currently widely leveraged in hospitals and acute setting to detect patient care issues through surveillance, interventions and reporting capabilities that are needed to support antimicrobial stewardship programs. These systems use data from EHRs and have significantly helped clinicians and pharmacists in acute settings identify overuse of antibiotics and drug-bug mismatches, reduce time-to-appropriate therapy and enhance therapy for difficult-to-treat pathogens. Those health

[17] Premier Inc., "Premier's Advocacy Roadmap for the 118th Congress: Artificial Intelligence in Healthcare." August 21, 2023. https://premierinc.com/newsroom/policy/premiers-advocacy-roadmap-for-the-118th-congress-artificial-intelligence-in-healthcare
[18] CDC. June 2020. https://www.cdc.gov/longtermcare/index.html

systems already utilizing clinical surveillance technology were well positioned to respond to COVID-19 before the pandemic hit. Health systems that used these technologies for infection control and prevention also contributed to significant cost savings, including:

- $1,469,907 incremental cost savings in first year at Good Shepherd Medical Centers
- $29,144 C. diff intervention savings in one year at St. Elizabeth's Hospital
- $241,756 cost savings from interventions for South Texas Veterans Healthcare System

Unfortunately, clinical analytics technologies are currently not widely used in nursing homes and other long-term and post-acute (LTPAC) settings. These settings should have the same access to tools that will help them combat infection spread during any future disease outbreaks and during their day-to-day operations, but unfortunately funding remains a significant barrier as programs authorized and funded under the Health Information Technology for Economic Clinical Health (HITECH) Act excluded long-term and post-acute care (LTPAC) providers. These entities are already challenged with meeting their more visible needs, but a more comprehensive approach is needed to ensure data collection is efficient, non-duplicative and being analyzed in ways that are helpful for facilities. Furthermore, it is critical that lessons learned from meaningful use are applied forward as we develop cohesive solutions to address the lack of EHRs and clinical surveillance technology in nursing homes and create appropriate incentives for adoption.

Premier encourages Congress to consider policies that incentivize nursing homes and other LTPAC providers to implement EHRs and electronic clinical surveillance technology to provide meaningful assistance with infection control. Upfront federal investments in infection prevention will help avoid adverse outcomes that often require care in more intensive, expensive settings.

Ensuring Access to Home Infusion Services: Certain patients with serious infections, cancer, heart failure, immune system diseases and other conditions who need IV therapies can receive their medications in their own home, a more cost-effective and desirable setting for many patients and their families as compared to institutional settings such as a hospital or nursing home. Home infusion services are coordinated by specialized pharmacies responsible for case management, customizing medication plans, sterile drug preparation, clinical assessments and monitoring, coordination with the patient's other healthcare providers, delivering equipment and supplies, and providing 24/7 patient support. Nurses conduct periodic in-person visits to educate the patient, perform physical assessments, and maintain the vascular access device. However, three years after CMS implemented the home infusion services benefit and according to CMS its own data[2], beneficiaries utilizing the benefit has severely declined, and providers are not enrolling to participate in the inadequate benefit.

To increase Medicare beneficiary access to home infusion therapy services, Premier and providers across the continuum, including hospitals and health systems[1], urge Congress to pass the bipartisan Preserving Patient Access to Home Infusion Act (S. 1976 / H.R. 4104). The bipartisan bill includes policy fixes that would address this decline by creating alignment between Medicare payment policies and successful coverage by commercial plans. Specifically, the legislation would:

- Require CMS to pay home infusion providers for professional services each day the drug is administered, aligning Medicare policy with that of commercial plans;
- Enumerate the specific services to be included in the reimbursement, including those extensive pharmacy services that are performed remotely; and
- Allow physician assistants and nurse practitioners to order home infusion services for Medicare patients — consistent with authority provided to these practitioners for other home health services, which would promote greater access to home infusion, including in rural and underserved areas.

Receiving infusion services in the home is often the safest, most clinically appropriate, cost-effective and desirable setting for Medicare beneficiaries. This legislation is expected to achieve savings by allowing patients to receive care in their homes as opposed to more expensive care settings, such as hospitals or nursing homes. Commercial insurers have long recognized that home infusion improves patient's quality of life while reducing the burden on other, costlier sites of care, and creating efficiencies within the healthcare system. Typically, commercial insurers reimburse home infusion at rates that are far less than the cost of providing care for those same patients at hospitals.[19] Moreover, when Congress passed the Bipartisan Budget Act of 2018, which established a transitional payment for home infusion therapy services for calendar years 2019-2020, CBO estimated that the federal government would save $910 million over three years alone by keeping patients out of more expensive care settings.[20]

V. COMMENTS ON THE CONGRESSIONAL BUDGET OFFICE'S MODELING CAPABILITIES ON HEALTHCARE POLICIES, INCLUDING LIMITATIONS OR IMPROVEMENTS TO SUCH ANALYSES AND PROCESSES

Premier applauds the Task Force for examining the capabilities of the Congressional Budget Office (CBO) 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, ACOs participating in the MSSP 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.[21] 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.

Another example that faces similar challenges in capturing the long-term savings of federal investments is reimbursement for cancer screening. While Medicare pays for some of the screening tests used to help find cancer types, this is limited to only five cancer types in the U.S.: breast, colon, cervical, prostate and, in high-risk smokers, lung cancer. More than 600,000 people die from cancer each year in the U.S., according

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[19] The Medicare Payment Advisory Commission, "Medicare coverage of and payment for home infusion therapy." June 2012. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/chapter-6-medicare-coverage-of-and-payment-for-home-infusion-therapy-june-2012-report-.pdf

[20] CBO Estimated Direct Spending and Revenue Effects of Division E of Senate Amendment 1930, the Bipartisan Budget Act of 2018. February 8, 2018. https://www.cbo.gov/system/files?file=115th-congress-2017-2018/costestimate/divisione.pdf

[21] CMS Press Release, "Medicare Shared Savings Program Saves Medicare More Than $1.8 Billion in 2022 and Continues to Deliver High-quality Care," August 24, 2023, https://www.cms.gov/newsroom/press-releases/medicare-shared-savings-program-saves-medicare-more-18-billion-2022-and-continues-deliver-high

to the American Cancer Society.[22] This is in large part because the majority of cancers are found in later stages when treatment options are limited. More than 70 percent of cancer deaths are from cancers that lack recommended early detection screening. Studies[23] have demonstrated that stage at diagnosis has the greatest impact on costs, with decreased costs for patients diagnosed early in the disease compared to those diagnosed at later stages. With these outcomes in mind, Premier augmented its AI-enabled clinical decision support technology to alert clinicians to patients who present an elevated risk of cancer and may benefit from early detection with a multi-cancer early detection blood test that can detect more than 50 types of cancer. When a cancer signal is detected, this test predicts the cancer signal origin, or where the cancer is located in the body, with high accuracy to help guide the next steps to diagnosis.[24] While clearly this approach gives patients the best chances of a successful outcome and avoids the high costs of later stage treatments, the financial benefits of this new early cancer detection technology may appear outside the usual ten-year period that CBO employs in its estimates.

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. Specifically, the legislation:

- Allows the Chairman or Ranking member of either budget or health-related committees to request an analysis of the two 10-year periods beyond the existing 10-year window;
- Requires CBO to conduct an initial analysis to determine whether the provision would result in substantial savings outside the normal scoring window;
- Defines preventive health as an action designed to avoid future healthcare costs that is demonstrated by credible and publicly available epidemiological projection models, incorporating clinical trials or observational studies in humans; and
- Provides a narrow, responsible approach that discourages abuse while encouraging a sensible review of health policies and programs.

Lawmakers need sound information, and today's scoring methods and procedures may not work as well as needed in analyzing certain efforts to prevent costly complications of chronic diseases. With chronic illness and poor outcomes absorbing an increasingly larger share of healthcare spending, advancing policies to help avoid these costs have only grown in importance.

VI. CONCLUSION

In closing, Premier appreciates and shares the Task Force's goals of improving patient outcomes and reducing health spending. Premier looks forward to working with the House, under your leadership, to advance solutions that enable healthcare providers to offer improved services and care in the communities they serve, while also reducing overall healthcare costs.

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[22] American Cancer Society Press Release, "American Cancer Society Releases Latest Cancer Statistics, Launches Initiative to Address Prostate Cancer Resurgence and Disparities," January 12, 2023, https://pressroom.cancer.org/FactsandFigures23

[23] Mariotto, A. B., Enewold, L., Zhao, J., Zeruto, C. A., & Yabroff, K. R. (2020). Medical Care Costs Associated with Cancer Survivorship in the United States. https://aacrjournals.org/cebp/article/29/7/1304/72361/Medical-Care-Costs-Associated-with-Cancer

[24] Premier Inc., "GRAIL and Premier's PINC AI™ Partner to Support Patient Access to Galleri® Multi-Cancer Early Detection Blood Test." January 10, 2022. https://premierinc.com/newsroom/press-releases/grail-and-premiers-pinc-ai-partner-to-support-patient-access-to-galleri-multi-cancer-early-detection-blood-test

If you have any questions regarding our comments, or if Premier can serve as a resource on these issues, please feel free to contact me at soumi_saha@premierinc.com or 732-266-5472.

Sincerely,

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