

July 9, 2013

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Joe Pitts
Chairman, Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairmen Upton and Pitts:

On behalf of the Premier healthcare alliance, we appreciate the opportunity to comment on the latest draft of the sustainable growth rate (SGR) repeal and reform proposal and a set of accompanying questions posed by you and your staff. As you know, Premier is a provider-owned performance improvement alliance of more than 2,800 leading hospitals and health systems and 95,000-plus other healthcare sites using the power of collaboration and technology to lead the transformation to coordinated, high-quality, cost-effective care.

Tying measurement to payment

Question #1 asks about how best to tie quality performance to payment. In addition, Attachment A describes two proposed payment scenarios for the Update Incentive Program, the “Threshold” or “Benchmark” Model and the Percentile Update Incentive Payment Model. The Premier alliance recommends the first approach since it provides appropriate incentives for all physicians to improve their performance. In contrast, the second approach guarantees that some portion of the physician community, such as physicians scoring at or below the 25th percentile on some benchmark, must always incur a payment penalty of some kind, no matter how well they care for their patients or how little difference there is between their performance and that of physicians at the 50th, 75th or even 90th percentiles. This adversarial approach to performance improvement undermines collaboration and can lead to arbitrary payment distinctions without significant performance differences.

Alignment with the Physician Quality Performance System (PQRS)

Question #7 asks whether the new quality system should align and coordinate with PQRS. The Premier alliance believes this would be extremely important. In fact, we think that PQRS should be viewed as the source of potential measures for application under the new quality system. Moreover, we believe that measures should not be used under the new quality system

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for payment update purposes until physicians have had an opportunity to become familiar with them through reporting, much as the Hospital Inpatient Value-Based Purchasing Program does not adopt a measure until measure data have been reported on the Hospital Compare website for a full year.

Efficiency measures

Question #8 asks whether the committee should explore efficiency measures. The Premier alliance would encourage you to do so. The National Quality Strategy developed by the Department of Health and Human Services refers to six measure domains, one of which is efficient use of healthcare resources. The value modifier developed by the Centers for Medicare & Medicaid Services (CMS) includes a cost component in its value calculations. Further, hospitals will be held accountable for both quality and efficiency under the Hospital Inpatient Value-Based Purchasing Program. Alignment on measures across the care silos is an important principle. Thus, we see no reason why a Medicare physician payment reform effort should not concern itself with both quality and efficiency issues.

Alternative payment models

The latest draft proposal includes a lengthy section on the process under which physicians would be allowed to opt out of the physician fee schedule if they are paid under a recognized alternative payment model (APM). The Premier alliance has several concerns regarding the current draft provisions. First, we are not convinced that the process for identifying alternative payment models requires the involvement of a non-governmental body, what the draft labels the APM contracting entity. Second, we are concerned that the process to be followed would not necessarily permit certain ongoing care transformation efforts, such as the Medicare Shared Savings Program (MSSP), the Pioneer ACO model, and the Bundled Payments for Care Improvement (BPCI) Initiative, to be considered alternative payment models. This is because the current draft appears to divide alternative payment models into only two categories: 1) Concepts that need to be tested through some new demonstration project and 2) those that have already been shown to be successful through some past demonstration project. However, as you know, the MSSP is not a demonstration or pilot project, but a new facet of the Medicare program, which is not time-limited. The Pioneer and BPCI programs are ongoing and could convert to national programs in the near future. And while both the ACO and bundled payment models are certainly very promising, their ultimate impact on healthcare quality and costs remains to be established.

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In any event, we do not believe it would be wise for an SGR reform plan to disrupt these ongoing efforts. We recognize, of course, that allowing physicians participating in these initiatives to “opt out” would present certain challenges, since payment under both approaches is still largely based on current fee-for-service policies. In sum, the Premier alliance urges you to ensure that nothing in the SGR reform legislation interferes with ongoing efforts to improve healthcare delivery, such as the MSSP and bundled payment initiatives. One way to do this would be to deem the MSSP, the Pioneer ACO model, and the BPCI Initiative to be alternative payment models for purposes of the proposed opt-out process.

Per-episode payments

Question #13 asks whether the replacement payment model to SGR should move further toward episodic care. The Premier alliance believes that bundled payment arrangements beyond those contemplated under the BPCI Initiative should be developed and made available to providers nationwide on a permanent basis. Such a national “Advanced Bundled Payment” program would signal that Congress and CMS are dedicated to improving quality and safely reducing costs through such a mechanism. Bundled payment arrangements also would offer providers a stepping stone along the path to population health management. Attachment A provides additional details regarding the kind of “Advanced Bundled Payment” program that the Premier alliance strongly recommends for your consideration.

Finally, it is critical that the APMs reward high-quality, integrated care. The Premier healthcare alliance believes that integration and coordination of care will achieve higher quality and more cost-effective care, but only if the physician incentives align with these goals. To the extent that payments under these APMs partially rely on fee-for-service, they should not be subject to cuts if other volume and quality control mechanisms exist within the model.

Conclusion

In closing, the Premier healthcare alliance appreciates this latest opportunity to provide input regarding Medicare physician fee schedule reform. The preceding comments should be viewed as supplementing the comments we previously provided to you in letters dated February 25, April 15, and June 10, 2013.

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Please do not hesitate to contact James Miller, director of federal affairs, at 202.879.8008 or james_miller@premierinc.com if you would like to discuss our comments further.

Sincerely,

A handwritten signature in black ink, appearing to read "Blair Childs". The signature is fluid and cursive, with a large initial "B" and "C".

Blair Childs
Senior vice president, Public Affairs
Premier healthcare alliance

Attachment: Appendix A

Attachment A

Specifications for advanced bundling legislation

- **Directs the Secretary, similarly to Section 3023 of the ACA, to implement bundled payments** for integrated care furnished by a group of providers, during an episode of care for beneficiaries with specific conditions that require inpatient care, but on a national voluntary basis instead of a pilot program.
- **Requires a legal entity** that has the authority to contract and administer quality and efficiency arrangements.
- **Includes:** Acute care inpatient services; physician services; outpatient hospital services – including emergency department services; post-acute care services – including home health services; skilled nursing services; inpatient rehabilitation services; inpatient hospital services furnished by a long-term care hospital; and other services as the Secretary determines appropriate.
- **Spans an episode of care from three days** prior to an inpatient admission to **90 days following discharge**. The Secretary has flexibility to establish additional periods based on data analysis. Current law provides for 30 days following discharge.
- Requires an **application** that is approved by the Secretary to receive bundled payment for a **five-year period**. Further specifies that providers can **select one or more** of at least the following conditions:
 - (A) Hip/knee joint replacement,
 - (B) Lumbar spine fusion,
 - (C) Coronary artery bypass graft,
 - (D) Heart valve replacement,
 - (E) Percutaneous coronary intervention with stent, and
 - (F) Colon resection.
- **Provides full transparency that requires sufficiently advance notice of the providers' participation in bundled payments** that the beneficiary may seek care elsewhere if they so choose.
- Refines current law by allowing **shared savings and quality and efficiency arrangements**. It also clarifies the conditions of approval for such quality and efficiency arrangements, such as including the methodology in the application and including a quality measurement component.

- Requires the **Secretary, similarly to current law, to furnish claims data** under parts A and B **and quality data** to a group of providers of services and suppliers interested in submitting applications and quarterly after approval.
- **Provides an alternative prospectively paid bundled payment methodology.**
- **Refines current law with quality measures and reporting requirements:** Requires the Secretary to select quality measures (including quality measures of process, outcome, and structure, as appropriate) on participating providers, which to the extent practicable are endorsed and validated by the National Quality Forum. Quality measures must include measures of the following:
 - (A) Mortality,
 - (B) Patient outcomes,
 - (C) Patient safety,
 - (D) Avoidable hospital readmissions,
 - (E) Patient experience of care, and
 - (F) Other measures determined appropriate by the Secretary.
- **Develops quality performance requirements for payment of shared savings: No payment of shared savings** may be made to a qualified **entity that fails** to meet the quality performance thresholds for the year involved.
- **Provides further clarification from current law on the necessary waivers to carry out the program:** Requires the **Secretary to waive such provisions** and related advisory opinions, which include but are not limited to:
 - Sections relating to Physician Self-referral;
 - Sections relating to the Quality and Efficiency Arrangements Civil Monetary Penalties (CMP);
 - Sections relating to the Anti-kickback Statute;
 - Sections relating to the Inducement CMP;
 - Sections relating to the three-day acute hospitalization prerequisite before eligibility for post-hospital extended care services;
 - Sections with respect to home health services;
 - Sections relating to the requirement that an individual be confined to his or her home to be eligible for benefits for home health services;
 - Sections relating to limitations on the amount, frequency and duration of home health services; and
 - OIG advisory requirement relating to the prohibition of free preoperative home safety assessments by home health agencies for patients scheduled to undergo surgery.

- **Requires independent evaluation and reports on the program, similarly to current law:** The Secretary is required to conduct an independent evaluation of bundled payments to qualified entities (interim report at year 3 and final on year 5), including the extent to which such payments have resulted in:
 - (A) Improved quality measures established,
 - (B) improved health outcomes,
 - (C) Improved applicable beneficiary access to care, and
 - (D) reduced spending.