PREMIER TRANSFORMING HEALTHCARE TOGETHER®

May 31, 2013

The Honorable Max Baucus
Chairman
Finance Committee
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Orrin Hatch
Ranking Member
Finance Committee
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Baucus and Ranking Member Hatch:

On behalf of the Premier healthcare alliance serving more than 2,800 leading hospitals and health systems and 93,000-plus other healthcare sites, we appreciate the opportunity to comment on issues relating to Medicare physician payment reform and sustainable growth rate (SGR) repeal, including specific questions posed in your May 10, 2013, letter to the healthcare provider community.

Premier is a performance improvement alliance using the power of collaboration and technology to lead the transformation to coordinated, high quality, cost-effective care. Premier hospitals and health systems employ physicians and also partner with physicians across the country in seeking better ways to reduce the fragmentation of healthcare and increase coordination of care. Premier operates a number of large-scale collaboratives, including those focused on accountable care organizations (ACOs) and bundled payment, in which Premier hospital members align with physicians to push for improved quality at a reduced cost. At the end of the day, fair compensation is essential to ensure that physician services provided in hospitals and health systems continue to be available in the community and that physicians are given the opportunity to continue their care transformation efforts.

On behalf of the Premier alliance, I would like to begin by thanking you for the time and effort that you and your staff are devoting to Medicare payment reform and SGR repeal issues. We strongly agree with your conclusion that the “broken” SGR formula must be repealed. Premier also strongly endorses the development and use of alternative payment models and shares your belief that “a robust quality component” must be an integral part of both the current and future payment systems.

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Valuing physician services

Your May 10 letter requested input on ways to ensure that physician services are valued appropriately. There are several dimensions to this issue. The Premier alliance's comments focus on one of these—value-based purchasing—under which physician payment amounts (including updates and additional bonus payments) would be based on physician performance on quality measures. In many ways, this would resemble the hospital Value-Based Purchasing (VBP) Program, which is now underway. Premier believes that recent experience under this hospital program can help inform the more detailed development of a comparable physician payment program. We, therefore, offer our thoughts regarding issues that need to be taken into account in designing such a physician payment program. In doing so, we also bring to bear our experience as participants in the Premier/CMS Hospital Quality Incentive Demonstration (HQID), under which a portion of provider payments was based on performance on quality measures.

First, we would urge policy makers not to underestimate the challenges involved in identifying clinically meaningful quality measures, especially at the physician specialty, subspecialty and individual physician levels. This will be particularly challenging because of the need to ensure a statistically valid number of cases for each measure at the individual physician or physician practice level.

Second, there will also be the further problem of picking a workable performance period of suitable length, and for which physicians receive sufficient advance warning. In this regard, it is important to highlight the fact that under a number of current Medicare programs, such as the Physician Quality Reporting Program and the Electronic Health Record (EHR) Incentive Program, the reporting periods are as much as two years in advance of the year in which a payment adjustment is applied. For example, while EHR payment adjustments will not begin until 2015, it is physician performance in 2013 that will typically determine the 2015 payment adjustment. This long lag time is both undesirable and unfortunate, but any SGR reform effort must take into account the possibility that a similar lag time might be required under certain circumstances. In short, if a physician's update factor under the Medicare physician fee schedule or applicable payment adjustments (penalties) must be known prior to January 1 of some year, then CMS must complete the requisite data analyses and other calculations well in advance of that date, which is likely to necessitate reliance on physician performance data from a relatively distant prior year.

Third, the Premier alliance recommends a 17-element framework (see Attachment A) for processing, prioritizing and implementing measures based on the evolving landscape. We believe this framework is equally valid for the Medicare Hospital VBP Program and for any similar endeavor affecting Medicare physician payment. Its goal is to ensure that any measures adopted by CMS will be sufficiently mature prior to their application for Medicare payment purposes and have the support of the provider community.

With this framework in mind, the Premier alliance would further highlight the following points:

- The number of quality measures applying to an individual physician or physician practice should be reasonable in number and involve as little reporting burden as possible. In fact, maximal alignment with the EHR meaningful use quality reporting requirements should be the goal rather than adoption of some competing or duplicative reporting requirement for SGR reform purposes.

- Quality measures need to be mature enough for use in payment determinations. For example, under the Hospital VBP Program, measures are not used until hospital performance on the measures has been posted on the *Hospital Compare* website for one year prior to the start of a performance year. Also, policy makers need to recognize that not all measures appropriate for quality measurement are also appropriate for integration into payment policy. While some measures may have value for quality improvement purposes, they may lack the sensitivity and specificity required for use as comparative, publicly reported measures or for use in determining Medicare payments.

- The measures selected should have substantial evidence to support their ability to identify true differences in provider performance, focus on issues within the provider's control, and be sufficiently risk-adjusted.

- No matter what type(s) of quality measures are considered, they should be subjected to thorough field testing prior to adoption. Such field testing will be important to validate the measures for accuracy, precision, sensitivity, specificity, efficacy, collection burden and unintended consequences to quality of care.

- When performance is scored by measure domain, all relevant domains should be sufficiently balanced (that is, they should each have a reasonable number of measures).

- Baseline and performance periods should be of reasonable length (at least one year) and every effort should be made to avoid overlapping time frames for sequential performance periods, where the same data are used more than once.

- Providers should be given the opportunity to review and request correction of measure rates and scores, as well as an opportunity to appeal.

Lastly, we cannot overemphasize the importance of adopting measures through the rulemaking process, where providers have an opportunity to provide input regarding proposed measures. When measures are accepted by providers as meaningful and important, such provider buy-in can result in enormous quality and efficiency improvements. On the other hand, when measures are seen as inappropriate or problematic, the opposite becomes true: providers dismiss the process as political at best, harmful to patients at worst, and become disengaged.

Reducing unnecessary service utilization

You also asked for input on policies that could help reduce unnecessary utilization of healthcare services, thereby improving health and reducing Medicare expenditures. In this regard, the Premier alliance believes that it would be extremely important to ensure that any SGR repeal and reform plan does not disrupt ongoing physician and other provider efforts to make care transformations that will ultimately lead to better patient outcomes and lower overall costs. Such efforts are now underway under both the Medicare Shared Savings Program (MSSP) and the Pioneer ACO Model, and they will soon commence under the Bundled Payments for Care Improvement (BPCI) Initiative being conducted by the Center for Medicare and Medicaid Innovation. Appropriate physician compensation under these models is key to incenting the necessary changes in care and additional efforts required to reduce overall spending.

We, therefore, urge you to ensure that your plan gives physicians participating in alternative reimbursement models, under Medicare, the opportunity to continue their care transformation efforts. In our view, it would be a serious mistake to adopt physician payment policies that would interfere with these important initiatives or fail to provide payment stability for participating physicians. Thus, providers participating in alternative payment models should be rewarded by insulating them from major payment reductions that may be applied to the fee-for-service payment system.

Second, in order to help address the problem of unnecessary utilization, Premier believes that it would be important to maximize the number of alternative payment models from which providers can choose and avoid taking an unduly narrow or fixed view of what alternative payment models could qualify for the provider opt out mentioned above. For example, we believe that bundled payment arrangements beyond those contemplated under the Center for Medicare and Medicaid Innovation's BPCI Initiative should be developed and made available to providers nationwide on a permanent basis. Such a national "Advanced Bundled Payment" program would place a stake in the ground, signaling that Congress and CMS are dedicated to improving quality and safely reducing costs. Such bundled payment arrangements also would offer providers a stepping stone along the path to population health management. Attachment B provides additional details regarding the kind of "Advanced Bundled Payment" program that the Premier alliance believes would make an important contribution to the problem of unnecessary service utilization.

Incentivizing physician practice transformation

Finally, you asked for input about ways that Medicare could effectively incentivize physician practices to undertake the structural, behavioral and other changes needed to participate in alternative payment models.

First, Premier believes that every effort should be made to remove unnecessary barriers to provider participation in alternative payment models. For example, under the MSSP, the decision to define an ACO as a collection of provider billing tax identification numbers (TINs), rather than either individual national provider identifiers (NPIs) or TINs, has imposed a barrier to MSSP participation for larger integrated delivery networks and medical group practices interested in forming ACOs that include only a subset of the physicians in their networks, or in having subsets of their organization participate in different shared savings programs. In brief, we believe that CMS should be directed to work with the provider community to identify and remove barriers such as this one so that as many providers as possible can participate in alternative payment models.

Second, it would be important to remove legal barriers to physician practice transformation. At the Federal level, these barriers include: inadequate antitrust guidance relating to clinical integration arrangements; provisions of the Ethics in Patient Referral Act ("Stark Law"), the anti-kickback statute, and the Civil Monetary Penalty law; uncertainty about IRS views regarding payments by tax-exempt organizations to physicians in a clinical integration program; and professional liability policies that lead to defensive medical practices. Many of

these laws were intended to combat inappropriate incentives resulting from the fee-for-service system that are dramatically reduced if not removed under the alternative payment models.

Registry reporting of clinical quality measures

Your letter referred to a provision in the American Taxpayer Relief Act of 2012 (ATRA) providing a new option for physicians to participate in certain clinical data registries. The Premier alliance would, therefore, like to take this opportunity to provide a few comments regarding registry reporting.

First, the Premier alliance believes that the use of registries should be fully transparent. Unfortunately, registries' measure methodologies and algorithms are often not publicly available and transparent today. Nonetheless, public reporting of quality and efficiency measures is only meaningful if the measures used are reliably comparable across all reporting providers. Consistent data collection processes can only occur if the measure reporting and calculation mechanism is transparent and understood by all participants and by the public at large. The Premier alliance believes that all aspects of registry data specifications, collection and measurement calculation algorithms should be placed in the public domain before such data are integrated into Medicare payment policies. Failure to ensure full transparency would prevent CMS and other stakeholders from validating the measures or results, and conducting additional analyses on the data to further program goals. If providers will be held responsible for their performance on these metrics, full transparency is necessary to ensure trust in the outcomes. Use of proprietary, black box measures would be even more concerning when it comes to beneficiaries making critical healthcare decisions based on the metrics.

Second, to the extent that different physician specialties would report through different registries, there would likely be additional issues. For example, policy makers would need to guard against the possibility that one registry would adopt "easy" measures while another would adopt more challenging ones of greater value to patient care. Similarly, different registries might adopt different numbers of measures, or measures involving different reporting burdens and costs. All of this could easily create an unlevel playing field across physician specialties. And increased reliance on the registry option could lead to the proliferation of registries, each potentially becoming a silo unto itself. Reporting through registries would also raise questions about the degree to which reported information would be passed along to CMS, publicly disclosed, and/or made accessible to various stakeholders, including hospitals

and health systems. We believe that CMS should act as a default registry for reporting purposes, serving as a central repository for reported quality data, and provide feedback and other useful assistance to the reporting physicians.

Third, we are concerned that increased reliance on physician reporting through proprietary registries could end up having negative consequences for hospitals. Today, a number of registry reporting programs actually impose burdens on hospitals, which must pay the registry fee and devote hospital staff resources to data reporting tasks, even though much of the data reported relates to care furnished by individual physicians. Thus, while we understand the desire to reduce physician reporting burdens, this goal must not be achieved by simply increasing hospitals' reporting burdens.

Fourth, there is the danger that registry reporting could be a step backward if such reporting relies unduly on manual, data-abstraction efforts. Rather than continue to perpetuate a reporting environment that relies on manual abstraction of data, the Premier alliance believes that the emphasis moving forward should be on developing automated measures collected from EHRs.

Fifth, it is also worth noting that the most expensive and resource intensive patients, namely patients with multiple chronic conditions and complex social needs, do not fall neatly into any registry. Patient registries tend to be organ or procedure specific when population health is intended to take a more holistic approach to caring for high-risk, high-cost patients with multiple chronic conditions. Thus Premier fears a reliance on registries runs counter to the principle of patient-centered, coordinated care.

Finally, the Premier alliance believes that there must always be an alternative method for submission of clinical quality measures that does not require registry participation and the payment of a fee. Providers must not be required to purchase a particular registry's product establishing a de facto monopoly with no protections to prevent the registry from raising prices and taking advantage of providers. Requiring participation in registries to comply with Medicare requirements may also unintentionally encourage the proliferation of registries, which will decrease rather than increase efficiency through further fragmenting quality measurement.

Conclusion

In closing, the Premier healthcare alliance appreciates the opportunity to submit these comments and we urge you to continue to keep open the channels of communication with stakeholders. We look forward to being of continuing assistance as the committee considers further reform of the Medicare payment system. 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 and related matters further.

Sincerely,

Blair Childs
Senior vice president, Public Affairs
Premier healthcare alliance

Attachments

A. Premier alliance-recommended framework for processing, prioritizing, and implementing quality measures
B. Specifications for advanced bundling legislation

Attachment A

Premier alliance-recommended framework for processing, prioritizing, and implementing quality measures

1. CMS should undertake analyses and share them with the public, identifying areas in which it believes measures should be developed and indicate whether these measures will be reported under other existing programs, such as EHR meaningful use or separately.

2. To the extent possible, new measures should only be added to the EHR meaningful use program so that providers are not overwhelmed by competing, potentially duplicative programs.

3. The measures may be developed by various organizations across the country from academic institutions to health plans, but need to be developed with automation in mind, ideally using data elements that exist in EHRs today.

4. The measures must be considered as part of the National Quality Forum's (NQF's) consensus building process and be formally endorsed, specifying whether the measure status is field tested, and ready for provider data collection or public reporting.

5. Field testing should be conducted to validate the measures for accuracy, precision, sensitivity, specificity, efficacy, collection burden, and unintended consequences to quality of care. The unintended consequences of the measure should be evaluated with regards to patient effectiveness, patient safety, timeliness and automation.

6. If field testing identifies flaws in the measures that suggest material changes should be made, the measures should be reconsidered by NQF.

7. CMS should consult with other federal agencies such as the Centers for Disease Control and Prevention and the Agency for Healthcare Research and Quality, given their experience with developing definitions, testing, data collection, healthcare-associated infection reporting and research.

8. Through the relevant rulemaking process, CMS should include the measures that it is specifically recommending for the fiscal or calendar year following the one to which the rule applies. While CMS may discuss issues for subsequent fiscal years, it should not formally propose measures at that time.

9. In the rule, CMS should provide the public with information on:
    - The measures
    - The risk adjustment methodology
    - Who developed each measure
    - Which organization suggested the measure for CMS adoption
    - Whether the NQF is actively considering the measure or has endorsed it
    - Whether other consensus bodies are actively considering or have endorsed the measure
    - Which organizations have field tested the measure
    - The results of the field tests
    - Where related evidence-based practice guidelines can be found
    - Detailed measure specifications
    - Why CMS is adding measures outside of the EHR meaningful use program (if relevant)
    - The plan for automation of the measures
    - Where the data elements can be found in an EHR

10. CMS should consider staggering the adoption of measures to ease the burden on providers.

11. Measures should be finalized in the relevant final rule (for physicians, the Medicare physician fee schedule final rule) and not in other unrelated final rules, such as the Hospital Outpatient Prospective Payment final rule.

12. Timelines should not be presented for disease conditions or concepts of measures that are not yet in existence or sufficiently through the consensus process. Such concepts should be addressed as discussion-only items.

13. Data specifications for proposed measures should be posted at the time the relevant proposed rule is published. CMS should endorse only measures where the exact

specifications and methodologies for calculation are completely public, replicable and can be automated.

14. Subsequent changes to data specifications should be posted and communicated to providers through an e-mail list notification.

15. CMS should seek comments on the retirement of measures through the rulemaking process. Retirement should occur when the standard of care has changed or performance of the preponderance of providers is at or very near perfect. Or, when an outcome measure is integrated that can take the place of a process measures (i.e., urinary tract infection rates versus catheter removal timing). Data collection should not continue, due to burden – based on meaningful use quality measures being automated – and value-based purchasing policies, unless there is a compelling argument that the standard of care may deteriorate if collection and monitoring does not continue.

16. Once the measures have been endorsed, field tested and publicly reported for at least a year, CMS may consider integrating the measures into its public reporting and value-based purchasing policies.

17. Only metrics where the ideal performance level is known should be used in payment penalty programs. Any metric which has an unknown ideal performance level should be included in models similar to hospital value-based purchasing to avoid unintended consequences. An example of an unknown target level would be C-section rates for which there is no established ideal rate (e.g. target rate is not clearly zero nor clearly 100 percent).

Attachment B

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
    (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 home in order to be eligible for benefits for home health services;
    - Sections relating to limitations on the amount, frequency and duration on 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.