PREMIER TRANSFORMING HEALTHCARE TOGETHER®

March 18, 2021

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington DC, 20201

Dear Secretary Becerra:

On behalf of the Premier healthcare alliance serving approximately 4,100 hospitals and health systems, hundreds of thousands of clinicians and 200,000 other provider organizations, I write to express our support of several of the Administration's key policy priorities and to offer our views, expertise and recommendations for achieving and sustaining better care at lower costs. **We share your commitment to continuing the Affordable Care Act's drive to value-based care, reducing barriers to interoperability and modernizing our healthcare supply chain.**

Premier is passionate about transforming American healthcare. With integrated data and analytics, collaboratives, and supply chain solutions we collaborate with our healthcare provider members to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide. Premier has collected its extensive experience, surveyed its healthcare provider partners, and reviewed lessons learned to develop our proposals. Below we detail three areas where we believe we can provide extensive experience, specific proposals, and lessons learned: healthcare supply chain reform, value-based payment reform, and improving data collection and access to enhance real-time outcomes.

Continuing ACA's Drive to Value-Based Care

A critical component to improving quality and reducing healthcare costs for all Americans is to allow providers to develop innovative approaches for delivering care in value-based arrangements. Value-based payment arrangements were a major focus of the Obama-Biden Administration with the Affordable Care Act (ACA) establishing the Center for Medicare & Medicaid Innovation (CMMI) to test alternative payment models (APMs). Further, the bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established incentives for clinicians to adopt APMs. Through large-scale data-driven collaboratives, the Premier healthcare alliance has for years worked with hundreds of hospitals, health systems and physician groups across the country to actively test and scale new models of care and build coordinated, population health capabilities through education, best practice sharing, measurement and benchmarking.

The coronavirus pandemic has showcased that a fee-for-service system (FFS) is unable to adjust to meet healthcare demands, with provider viability tied to volume rather than value and severe limitations on the ability to innovate care. According to a Premier survey, leading health systems and providers operating in value-based models had a head start over other providers in adapting care. Moreover, providers in the most advanced value-based arrangements (i.e., global budgets and capitation) were able to avoid financial challenges that many other providers faced.

Over the past decade, since the passage of ACA, we have gained critical experience in testing alternative payment approaches. We are now at a critical juncture in which **we must rapidly scale alternative**

13034 Ballantyne Corporate Place
Charlotte, NC 28277
T 704.357.0022
F 704.357.6611

444 North Capitol Street, N.W.
Suite 625, Washington, DC 20001
T 202.393.0860
F 202.393.6499

PREMIERINC.COM

payment approaches that allow providers to be in the driver's seat of care transformation. Providers with their local roots and direct role in care delivery are best situated to design population health solutions that are targeted to the needs in their communities, including addressing health equity. Moreover, moving from fee-for-service to value shifts the fundamental incentives from reactive, sickness-based care to proactive, wellness-based care. Without this change, the incentive to achieve health equity is significantly undermined.

This will require new partnerships between payers and providers that incent providers to be responsible for the quality and cost of care. We request that the Administration articulate a vision for the movement to value. When providers have a clear plan for moving to new models, they work aggressively to succeed in the model and more rapidly advance to the risk-bearing model. We provide the following recommendations that are central to a vision for accelerating the movement to value:

- **Ensure a level playing field.** We must recognize that the market forces in each region will define which types of entities are best suited for various functions such as financial risk management, benefit design and care management. A truly competitive environment is one in which providers can form unique arrangements and partnerships to best serve their populations. We must avoid approaches that advantage one provider type or risk-assuming entity over another. Moreover, we must unleash potential for providers to truly innovate care by providing flexibilities and incentives that are equivalent to those that plans in Medicare Advantage (MA) receive. Innovating care requires flexibility beyond what is currently allowable in FFS, yet current models have provided minimal flexibility. Providers are well suited to design unique care approaches for their population. When managing total cost of care, the FFS program integrity concerns are mitigated.

- **Provide adequate reimbursement in APMs.** Current approaches in APMs create a race to the bottom where providers must achieve year-over-year savings. A new paradigm is needed where benchmarking approaches are sustainable long-term (e.g. designing benchmarks that reduce spending trend rather than year-over-year savings), address unique population challenges (e.g. approaches specific to rural health providers) and incorporate non-medical costs that can address social determinants of health. Moreover, there must be comparability between MA and risk adjustment in Medicare alternative payment models.

- **Continue incenting providers to adopt risk-based arrangements.** MACRA effectively incented the movement to advanced APMs. Five years later, however, we have not achieved the movement to value we once hoped due to a slow rollout of new models and slow uptake by private payers. The bonuses should be extended, and other incentives should be put in place to encourage APM adoption. For example, the ACA and MACRA established programs that precipitated tremendous gains in quality and patient safety by holding providers accountable. As we renew focus on quality and patient safety with progress towards more interoperable data, we must shift incentives in those programs to encourage APM adoption. Additionally, we should consider other FFS incentives such as exempting providers participating in models from new FFS-centric payment cuts and incenting other providers to adopt APMs**.**

- **Encourage payers to offer risk-based arrangements.** Medicare has been a leader in advancing new payment approaches, with some payers following suit. To truly innovate care, we must rethink the roles and responsibilities of payers and providers. Payers have critical functions (e.g. claims processing, marketing) but are unable to innovate the care delivery process. We must give providers tools to change care delivery through new payment arrangements. The federal government should work with states and the private sector to spread the movement to APMs. For example, HHS could support states in incentivizing state Medicaid managed care

programs to enter into more APM arrangements with providers, rather than remaining on a FFS chassis. Moreover, CMMI must scale some models to create direction and permanence for providers and for private insurers to also scale, creating uniformity across the healthcare landscape.

Reducing Barriers to Interoperability and Improving Data Collection to Enhance Real-Time Outcomes

Utilizing data from multiple sources is integral to every aspect of healthcare delivery. The COVID-19 pandemic has exposed one of healthcare's fundamental weaknesses: the fragmented and siloed nature of care delivery and the lack of centralized coordination when it comes to managing and preventing disease spread. Foundational to all our recommendations above is the need for real-time access to data. We believe we must:

- **Enhance access to claims and EHR data.** Integrating claims and clinical data is integral to population health management. Provider real-time access to robust claims and electronic health record (EHR) data is limited. Federal efforts are needed to accelerate adoption and consistent implementation of data and interoperability standards, enhance certification of EHRs, require seamless and unfettered provider data access at the point of care and within the workflow and make claims-data more readily available. Ensuring providers' ability to efficiently implement third-party applications via open, public application programming interfaces (APIs) of their choosing is critical to providing high-quality, safe, and effective care. Enhanced EHR functionality via certification is essential to help ensure more efficient, effective and coordinated care across the care continuum.

- **Interoperability of healthcare and public health data**. Current approaches to tracking COVID-19 cases rely on home-grown, siloed and antiquated data collection systems that are grossly inadequate—data sets are incomplete, lagged and collected in the wrong settings, rendering them virtually useless for identification and/or prediction of disease spread trends. Public health surveillance was previously expected to improve due to increased use of EHRs and electronic exchange of health information; however, we have learned of much needed improvements. The nation needs real-time data for syndromic surveillance, providing an upstream alternative to identifying cases before tests can detect them or patients are hospitalized.

- **Integration and convergence of administrative and clinical data.** There is an increasing need to leverage administrative, financial, and clinical data. Foundational to data access and use is the need for data standards (content, transport, messaging) to ensure the ability to share, exchange and use data from disparate data sources and across health IT systems.

- **Ensure that post-acute care providers have interoperable data and access to clinical analytics technologies.** The clinical analytics technologies currently widely leveraged in hospitals and acute settings to detect patient care issues through surveillance, interventions and reporting capabilities that are needed to support antimicrobial stewardship programs are currently not widely used in skilled nursing facilities (SNFs). This is largely due to a lack of funding as SNFs and other post-acute providers were excluded from HITECH funds to purchase and implement EHR technology. SNFs should have the same access to tools that will help them combat infection spread during any future outbreaks of COVID-19 and during their day-to-day operations. SNFs are already challenged with meeting their more visible needs, such as testing and securing adequate PPE levels at their sites. A comprehensive approach is needed to ensure data collection is efficient, non-duplicative and being analyzed in ways that are helpful for facilities.

Modernizing our Nation's Healthcare Supply Chain

Since the onset of the pandemic, the industry and nation have recognized the need to unfurl our fragmented approach to supply. Moving forward, our charge is to fortify the U.S. healthcare supply chain with collaboration, coordination, and resiliency across federal, state, and private entities. At Premier, we've taken lessons we've learned from disasters and past outbreaks such as Ebola and H1N1 to encourage manufacturers to think more expansively about how they source and supply.

- **Coordination between the public and private sector.** Like President Biden, Premier continues to advocate for strong public-private coordination. During the pandemic, we've aligned supply chain stakeholders – including the federal government, group purchasing organizations, distributors, and manufacturers – to work together on strategies that increase access to supplies, diversify sourcing, and promote harmonization and interoperability.

  However, more can be done via public-private partnerships to help the nation move forward such as leveraging data to determine the exact amount of critical medical supplies and drugs on US soil at any given time. For example, ***Premier has created an automated, near real-time system to gain visibility into hospital inventory, including hospital stockpiles, that enables supply chain visibility to the SKU level.*** By overlaying supply chain data, it helps entities in both the public and private sector see where product, such as N95 masks, surgical gowns, gloves, etc., is stocked and gaps in resources. This enables the delivery of existing supplies to areas in greatest need and a data-driven approach to ramping up supply via tools such as the Defense Production Act.

- **Building broad-based resiliency into the supply chain through diversification and transparency.** Hardwiring resiliency into the supply chain means greater upstream visibility into the sources of raw materials and manufacturing facilities to assess vulnerabilities and create redundancy, thereby ensuring readiness during a crisis. Global sourcing needs to be just that – truly global. Rather than moving all manufacturing to the U.S., Premier strives for ensuring there is at least one domestic supplier of the final form, ancillary products and raw materials for critical medical supplies and drugs, and at least three global suppliers of these products from geographically diverse regions. Also needed is improved visibility into amount and types of critical products in the supply chain, from manufacturer to distributor to the hospital inventory.

- **Leveraging tax incentives to further incentivize onshoring of manufacturing.** As an additional avenue to incentivize domestic manufacturing capacity, Premier recommends offering tax incentives to domestic manufacturers of critical medical supplies and drugs. Specifically, Premier recommends 30% tax incentive for five years to support the domestic manufacturing of critical medical supplies and drugs, including their raw materials. Examples of how the tax incentive could be applied include, but are not limited to:
  - Investments in advanced manufacturing equipment or machinery
  - Investments to repurpose existing abandoned facilities
  - Investments to build new facilities
  - Investments to expand existing facilities
  - Investments to relocate foreign facilities back to the US
  - Investments to upgrade facilities to meet EPA requirements

  We would recommend Congress revisit this provision in five years to understand how the tax incentives have helped offset the cost of domestically manufactured goods and if the tax incentive rate should be adjusted accordingly.

- **Expanding strategic stockpiles.** Premier's recommendations for the Strategic National Stockpile is a dual public-private approach that would transition the SNS away from a central repository toward a coordinated hub-and-spoke model made up of federal resources linked to state and local resources, with an emphasis on collaboration and harmonization between all those maintaining inventories. Our approach would again leverage public-private partnerships to stock the stockpiles, rotate product to healthcare providers before it expires, allow health systems and regional buying groups to operate the stockpiles, maintain minimum supplies of critical products within the SNS, and rely on a public-private advisory council to provide input on the medical supplies and drugs housed in the SNS.

- **340B's impact on providers costs and access to drugs**: An antiquated and illogical component of the healthcare supply chain is the group purchasing organization (GPO) prohibition in the 340B Drug Pricing Program. Because of the prohibition and the way it has been implemented, hospitals that are eligible for 340B may not use a GPO to initially fill a prescription and may not use a GPO's private label products. These two restrictions increase healthcare costs for these hospitals by forcing them to fill a patient's initial prescription at wholesale acquisition cost (WAC) and deny access to private label drugs that are on the drug shortage list. This is because GPOs work to eliminate drug shortages by contracting with suppliers using a private label program. We call on the you and the Biden administration to repeal the Health Resources and Services Administration's policy release 2013-1. This will restore competition to the 340B supply chain and help GPOs eliminate drug shortages.

In closing, the Premier healthcare alliance appreciates the opportunity to share our recommendations for accomplishing the Administration's priorities. If you have any questions regarding our comments or need more information, please contact me at blair_childs@premierinc.com or 202.879.8009.

Sincerely,

Blair Childs
Senior Vice President, Public Affairs
Premier healthcare alliance