Recent healthcare reforms move away from a healthcare system that is reactive to illnesses and accidents, and pays providers for the volume of services to one that rewards improving patients’ health through higher quality, more efficient and coordinated care. While a great deal has been done to advance new quality improvement and payment models, the programs are overlapping, confusing and sometimes unfair. Moreover, some segments of the delivery system are left out.

The ultimate goal of healthcare reform should be a consumer-centered and healthcare provider-driven system that holds providers accountable for the total cost, quality and experience of care for a population. Medicare and Medicaid payment systems should be designed that incent providers to form jointly governed organizations to share risk and provide comprehensive, coordinated care together rather than competing across provider types.

This is a time of enormous investment by healthcare providers in health data technology, new care delivery models and programs to assure the health and well-being of the communities they serve should a disease or crisis occur. With these ongoing challenges, it is important that policymakers avoid one-off policy approaches without considering the holistic impact during this time of change. Particularly as we move to more accountability for providers, those who are taking the risk should be adequately rewarded to support efforts toward the development of coordinated care models that seek to improve population health. This roadmap is designed to present a more holistic framework that balances all these dynamics and those discussed within it.

We present below the following guiding principles, followed by a series of policy proposals, that will bring us closer to achieving this vision.

Our policy recommendations seek to:

1. Center care delivery on the whole person and integrate care into the community;
2. Incent and engage consumers as partners in their healthcare;
3. Share transparently performance results that are meaningful to consumers and providers and used across payers;
4. Incent participation in and allow choice of alternative payment models;
5. Ensure major policy changes are transitioned over time to reduce unintended consequences for all stakeholders;
6. Protect the medical education mission as well as access to services by disadvantaged and remote populations;
7. Empower patients and providers with interoperable, secure information systems;
8. Enable access to high-value, innovative technologies and services;
9. Remove burdensome and antiquated regulation that impedes cost containment, quality improvement and innovation; and
10. Ensure an adequate workforce that is trained in improving population health.

The Premier healthcare alliance has for years worked with hundreds of hospitals, health systems and physician groups across the country that are actively testing, measuring and scaling new models of care to consistent with these principles. A number of large scale collaboratives, including Premier’s accountable care, bundled payment and QUEST® collaboratives, have allowed Premier to evaluate and help build coordinated, population health capabilities through education, best practice sharing, measurement and benchmarking. Through these efforts, Premier has gained valuable insight on what works and does not work for different patient populations. It is based on these learnings that the Premier alliance has developed and presents the following possible policy options that could be implemented in combination or stand alone.
POLICY OPTIONS:

- **Accountable Care Organizations**: Refinements to the Medicare Shared Savings program must be made to ensure the continued success of Accountable Care Organizations (ACOs). (see ACO options paper)
- **Legal And Regulatory Barriers To Integrated Care**: The legal and regulatory barriers that thwart providers’ efforts to achieve better care for individuals, better population health and lower healthcare costs (the Triple Aim™) must be removed by re-envisioning the fraud and abuse laws and policies such as the site of service regulations. (see Legal and Payment Waivers options paper)
- **Data Access**: Data access is paramount to success and should move to closer to real time access of not only Medicare, but timely Medicaid, Veteran’s Administration and Department of Defense data to use for healthcare operations, research and commercial purposes that improve care while protecting beneficiaries’ privacy. (see Data Access options paper)
- **Layered Payment Model Demonstration**: Underlying fee-for-service (FFS) payments for most services should be replaced using a combination of bundled payments and capitation (see Layered Payment Model demonstration options paper), but FFS and even cost-based payment will need to remain for certain services such as low-volume, innovative new services or technologies and extremely costly care to ensure the right care is available.
- **Interoperable Health Information Technology**: Through use of standards and application programming interfaces, electronic health record (EHR) systems must move from being closed, inaccessible information silos to open, interoperable medical records on which applications may be written, easing the reliable exchange of information among care providers and patients (see Interoperable Health Information Technology options paper)
- **Consolidation Of Hospital Pay For Performance Programs**: Pay for value programs should hold providers accountable for areas within their control without creating duplicative penalties. (see Consolidation of Hospital Pay for Performance Programs options paper)
- **Critical Access Hospital Value-Based Purchasing Program**: Rural areas must not be left behind, but brought into the delivery system reform revolution through tailored programs that work in low-population density areas. (see Critical Access Hospital VBP/APM options paper)
- **Beneficiary Engagement**: Beneficiary engagement techniques should be embedded in all aspects of all programs such as measurement, transparency efforts, benefit design and payment. (see Beneficiary Engagement options paper)
- **Provider-Based Outpatient Clinics**: Site-neutral payments policies need to broadly consider how the use of provider-based clinics may help support an overall reduction in healthcare spending and improve the coordination and quality of care to patients.(see Provider-Based Outpatient Clinics options paper)
Accountable Care Organizations

PROBLEM

Accountable care organizations (ACOs) began as an idea to create a provider-led, people-centered, coordinated delivery model and have engendered sustained bipartisan support through several Congresses and Administrations. ACOs are widely viewed as a way to speed the movement toward paying for the value over the volume of care provided. To this end, ACOs are designed to closely connect groups of providers who are willing and able to take responsibility for improving the overall health status, care efficiency and experience for a defined population of healthcare consumers.

The Centers for Medicare & Medicaid Services (CMS) established a number of Medicare ACO programs including the Medicare Shared Savings Program (MSSP), Pioneer ACO model, Advanced Payment model and Next Generation ACO Model. Within these Medicare models, ACOs that meet quality of care targets and reduce the costs of their patients relative to a spending benchmark will be rewarded with a share of the savings they achieve for the Medicare program.

While these programs have attracted a large amount of interest from all provider types, current aspects of the programs create impediments that could hamper delivery system reform efforts and a greater level of participation in the programs going forward. For example, substantial legal and regulatory barriers still exist to ACOs’ efforts to integrate their clinical operations and services in ways likely to achieve significant efficiencies and higher quality care. Furthermore, fundamental changes are needed to stabilize beneficiary assignment, improve data access and better risk adjust for the acuity of ACOs’ patient population.

In addition, the application of the Budget Control Act’s 2 percent reduction in Medicare payments to ACOs’ shared savings amount creates a disincentive to engage in ACO models. MSSP ACOs that have generated savings are on the front lines of reforming our healthcare system to make it more sustainable. Many have had to make significant investments in the ACO infrastructure and resources to be successful, and sequestration cuts reduce the financial incentive for participating in the program. Medicare is already benefiting from the savings these providers are generating from their efforts to transform care and should not be expected to return yet another 2 percent on top of that. This perverse situation undermines the potential success of the program.

SOLUTION

The key to successfully implementing an ACO is clinical integration, which is a partnership among healthcare providers – including physicians, hospitals, ancillary providers or any combination thereof. To achieve this, changes should be made to Medicare ACO programs, including:

- Allowing providers to determine the most clinically appropriate setting of care without being penalized (such as removing the requirement that a beneficiary must have been an inpatient of a hospital for at least three consecutive calendar days to be eligible for skilled nursing facility coverage);
- Allowing ACOs to not only distribute shared savings from the program among themselves, but also distribute savings associated with internal cost reductions;
- Making permanent existing payment waivers and adopting new waivers, such as allowing ACOs to waive copayments for important services;
- Using a sliding scale to increase up to 10 percentage points the amount of savings that can be shared by ACOs that achieve the median of quality performance standards or achieves quality improvement scores above the median;
- Providing a choice of prospective or retrospective assignment of beneficiaries;
- Allowing certification of ACOs who qualify with fewer than or fall below the 5,000 beneficiary threshold by a de minimums number;
- Allowing providers engaging in ACOs access to their patients’ medical records on substance use—information that is needed for providers to understand the totality of a patient’s care needs and provide...
safe, effective and coordinated treatment. Due to complex regulatory requirements (42.C.F.R. Part 2), Medicare currently does not make records on substance abuse disorders available to Medicare ACOs, precluding providers from being able to make informed decisions, even though they are held accountable for them;

- Using a beneficiary attestation process for assignment to an ACO based on who they consider to be the provider responsible for coordinating their overall care, rather than CMS using claim-based assignment that assesses the provider from whom the beneficiary received the most services;
- Allow an ACO to assume greater risk by moving to a higher risk track annually; and
- Removing sequestration cuts from shared savings payments.

**ACTION**

Congress should enact legislation to make the above improvements to the MSSP, which will provide additional incentives focused on health outcomes, increase collaboration between patients and doctors, and provide ACOs with the policy environment needed to improve the health of the populations they serve.
Legal And Regulatory Barriers To Integrated Care

PROBLEM

Congress, CMS and commercial insurers seek to promote greater integration and coordination of care and payment among providers in order to improve both the quality of patient care and the efficiency with which services are delivered through quality-driven, value-based care delivery and payment models. Yet, the federal fraud and abuse legal framework and certain Medicare payment policies currently in place pose a major barrier to achieving this result for patients.

New models of care and payment, such as accountable care organizations (ACO) and bundled payments require provider arrangements that implicate federal fraud and abuse laws or regulatory requirements. Several laws enacted decades prior to the first ACOs pose a problem; among them are the antitrust, anti-kickback laws, the Stark physician self-referral law and the civil monetary penalties (CMPs) law. The physician self-referral laws are overly complex, impose strict liability and trigger draconian penalties unrelated to any actual harm. The anti-kickback statute is so broadly worded that coupled with the one purpose test, it calls into question any monetary arrangement between healthcare providers. The CMPs related to both beneficiary inducement (e.g., providing anything of value to a patient in order to encourage the patient to return to a particular provider) and gainsharing provisions work counter to the new incentives baked into alternative payment mechanisms. Healthcare providers that participate in innovative payment arrangements to incentivize coordinated and efficient care face criminal penalties, false claims allegations, civil fines, exclusion from Medicare, Medicaid and other federal health care programs, or loss of their medical license from their state medical board. In light of the potential crippling monetary damages, few health systems will proceed without clear legal protection.

Many of the problematic Medicare policies were established to protect the Trust Fund from excess spending under the old fee-for service (FFS) system. With the advent of new value-based purchasing and alternative payment models, many of these policies are no longer necessary. Not only do the overarching incentives to control costs mitigate underlying incentives for greater volume or the use of higher level settings of care, the incentives are tied to measurable quality and performance achievement or improvement. Thus, retaining such policies only serves to constrain providers’ ability to furnish care in the most appropriate setting for the beneficiary, undermine innovation and increase provider burden.

Finally, the Stark physician self-referral law imposes stringent constraints on any financial arrangements between physicians and other healthcare entities, even if the arrangements only apply to commercial and other non-federal healthcare patient care. The broad application of the Stark law needlessly chills and stifles the innovation needed to foster efficiency and improve quality in the healthcare system.

SOLUTION

The existing waivers under the Medicare Shared Savings Program (MSSP) and the Center for Medicare & Medicaid Innovation (CMMI) initiative do not extend to downstream providers or suppliers. As a result, an ACO cannot enter into an arrangement with a pharmaceutical company where the ACO receives a rebate on the cost of the drug or device if the long-term outcome does not meet certain expectations, often referred to as value-based contracting. Nor can an ACO pay a skilled nursing facility beyond what Medicare pays them so that they will accept medically complex patients to ensure their costs are covered and the patient is treated in the right setting. Thus, the anti-kickback waivers should be modified to encompass downstream providers and suppliers. Of specific concern is the one purpose test that effectively blocks arrangements among parties to establish relationships to coordinate and improve care and determine the safest and best setting for patients. The benefits of such innovative strategies should be weighed against the potential risk of fraud and abuse even if one purpose of the arrangement is potentially problematic. The Department of Health and Human Services (HHS) Office of Inspector General (OIG) should eliminate or redefine the “one purpose” test for anti-kickback statute liability and replace it with a balancing test that would require the OIG to prove either increased cost or actual harm to a patient.
Beneficiary Inducement CMP. The waivers do not go far enough. In order for the ACO model to be successful, it is critical that beneficiaries are adequately informed about the value, both in terms of quality and costs, of the provider options available to them. To this end, providers participating in ACOs should have an ability to provide detailed information, such as star ratings or provider quality tracking websites (such as Physician Compare) to beneficiaries on the various local providers available, as well as whether or not the particular provider is in the ACO network, in order to inform the selection. This approach will preserve the beneficiary’s choice of providers, while guaranteeing the patient-centered approach to care by ensuring the beneficiary is able to make an educated, informed decision. Despite not finalizing such a waiver in the final MSSP final rule for 2016, CMS requires in the proposed discharge planning rule that providers furnish quality information to beneficiaries. This leaves providers confused as to what is permitted under the law. CMS and OIG should permit ACO participants to provide detailed information on provider quality, such as star ratings, to aligned, or potentially aligned, beneficiaries without running afoul of anti-kickback and CMP laws.

Similarly, providers should be able to use tools to better engage beneficiaries in their care.

For example, routinely waiving patient co-payments or providing free transportation potentially implicates both the beneficiary inducement provisions in the CMP law as well as the anti-kickback statute because the co-payment waiver constitutes something of value provided to a patient. Yet, this severely restricts physicians and hospitals from taking cost-effective, compassionate steps to make sure that patients receive the care they need. While OIG has experimented within CMMI initiatives and MSSP, OIG should expand and make more broadly available waivers to the beneficiary inducement provisions in the CMP law and the anti-kickback statute.

Site of Service Payment Regulations. As an example, the care setting requirements such as the three-day inpatient stay required before skilled nursing facility services are covered by Medicare provides a perverse incentive to admit patients in the hospital and keep them there at a time when we are trying to avoid more costly inpatient stays. Another example is the inpatient rehabilitation 60 percent rule that limits the number of patients for which rehabilitation centers can provide care and still receive Medicare payment. As a last example, providers are not able to perform an in-home check before discharging a patient to ensure a safe environment given the particular condition (e.g. fall risks). Providers should have the flexibility to determine the best level and setting of care and patients should be empowered with choices.

ACTION

Specifically, the Department of Justice (DOJ), the HHS OIG and CMS should work with Congress to permanently accomplish the following changes:

- Create a broad exception in the anti-kickback, CMP and Stark laws to protect ACOs that meet certain conditions, regardless of whether those ACOs are participating in the MSSP;
- Extend the protection to such ACOs’ downstream providers and suppliers;
- Make permanent the existing anti-kickback statute and Stark law exceptions for donation and financial support of EHR software, related technologies, and training beyond 2021;
- Allow the use of beneficiary engagement tools such as the waiver of copays, transportation fees and the provision of information about the value of post-acute care settings within alternative payment models;
- Update the Stark Law:
  - Clarify how to establish, document, and apply the “volume or value of referrals” standard within the changing healthcare payment environment;
  - Expand and revise definition of fair market value to account for new payment models that incentivize performance (e.g., payment for consulting services or other professional services such as medical directorships);
- Eliminate or redefine the “one purpose” test for anti-kickback statute liability and replace it with a balancing test that would require either actual increased cost or harm to a patient;
- Modify reimbursement rules that direct the site of care within alternative payment mechanisms; and
- Create an FAQ process that allows providers to obtain additional guidance short of requesting an Advisory Opinion.
To remove obstacles and create more opportunities for providers to make lasting change and for patients to be more engaged in their care path, Congress should:

- Require the HHS Secretary to review and assess the anti-kickback statute and the Stark law in the context of the transformation of the healthcare system, specifically addressing: (1) how these laws should be modified to be more relevant to protecting against fraud and abuse in the context of new care and payment models aimed at providing better care at lower costs; and (2) a plan of action to address any changes to the legal frameworks that arise from the assessment, as well as a description of the actions that would need to be addressed by Congress to achieve those changes. The review process should include subject matter experts from CMS and the OIG and the Secretary also should consult with the DOJ, Internal Revenue Service (IRS) and the Federal Trade Commission (FTC).
Data Access

PROBLEM

Data analytics are key to success under value-based payments and alternative payment models. Successful quality improvement by healthcare providers requires effective use of clinical, pricing and other data. Access to data can empower risk modeling, and help providers identify patients who may benefit from targeted interventions, engage in effective patient engagement initiatives, design and evaluate quality improvement initiatives, identify and close clinical care gaps and cost control costs. However, the current regulatory framework for data sharing, the nation’s underdeveloped information technology architecture, and the barriers to electronic health record interoperability frustrate providers’ ability to access and harness data.

Data sharing is governed by a series of crisscrossing state and federal regulations that are often inconsistent with one another and incompatible with a digital health world. The same data sharing effort might be permitted by some federal laws and prohibited by others, undermining the conduct of important research and public health efforts. The lack of harmonization also results in an incomplete picture of dual-eligible patients who participate in both state and federal programs.

Moreover, the Medicare program expects providers to take on increasing accountability for beneficiaries, but the data provided to support these efforts are neither timely nor complete. For example, CMS currently does not provide claims data containing substance use diagnoses (whether it is the primary purpose of a visit or just listed as a comorbidity) to any providers in alternative payment models. Protecting the confidentiality of sensitive health information is laudable, but disparate treatment for alcohol and substance disorder information compared with other types of health information (for example, mental health), frustrates comprehensive data sharing and the development of a complete patient-centered care approach to care and the ability of healthcare providers to engage in managing their entire population’s health. In addition, while the ACOs and Bundled Payment for Care Improvement initiative participants receive monthly data files, the Comprehensive Care for Joint Replacement participants only get quarterly files. Missing and lagged data prevent providers from developing a truly patient-centered approach to managing the entire population’s care.

Electronic health record interoperability is the cornerstone for state of the art medical care, enhancing patient satisfaction and enabling data sharing in the event of national security events. Despite recognition of the importance of interoperability, it has been widely documented that our electronic health systems remain fractured and siloed, and that more work is also needed to create adequate exchange of health information.

SOLUTION

While CMS has made great strides in promoting access to government data, continued investments in its infrastructure and statutory permissions are needed. All alternative payment model participants should receive at least monthly data reports and files. In order to provide alcohol and substance disorder diagnoses (whether diagnosis or identified comorbidity) in the monthly files provided to ACOs or bundlers, Congress must modernize the underlying statute for 42 CFR Part 2.

Healthcare providers currently have limited access to Medicaid, the Children’s Health Insurance Program (CHIP), Veteran’s Affairs (VA) and TriCare data. Streamlined access to this information would assist healthcare providers with effectively managing care transitions between state and federal health programs.

The web of different state and federal laws should be harmonized to increase clarity and reduce burden on providers. Moreover, the conflicting federal laws should also be harmonized and updated to reflect the digital age.

Interoperable electronic health record (EHR) systems are needed to ensure patient information can be seamlessly shared across providers to improve care outcomes and efficiency.
ACTION

- Congress should require that CMS furnish providers engaged in population health (e.g. ACOs), that are under a data use agreement, with substance use diagnoses and services.
- CMS and the HHS Office of the National Coordinator for Health IT (ONC) should make data obtained under the EHR Incentive Program available in downloadable Excel files similarly to the quality information disseminated through the Hospital Compare and Physician Compare websites.
- CMS should allow providers to use the Virtual Research Data Center (VRDC) for research and non-research purposes, rather than downloading large claims files if they choose.
- CMS should include data from the quality reporting programs in the VRDC to enhance the research and operational analyses conducted on claims.
- CMS should add VA and Tricare data to the VRDC and ensure that the Medicaid and CHIP data in the VRDC is up to date.
- The Common Rule and HIPAA should be updated to clarify the definition of research and apply appropriate oversight criteria.
- Federal approaches to “identifiability” should be harmonized.
- Standards for de-identification should be balanced with other public policy goals surrounding data sharing and alternative options should be considered.
- Given the importance of leveraging federally-sourced data, the Privacy Act of 1974 should be updated to clarify when the Act applies and to modernize permitted uses and disclosures to reflect prevailing data sharing norms.
Layered Payment Model Demonstration

PROBLEM

The Centers for Medicare & Medicaid Services (CMS) established the Medicare Shared Savings Program (MSSP) to facilitate coordination and cooperation among healthcare providers to achieve the Triple Aim™ of reducing the overall cost of care while improving both the overall health and experience of the Medicare beneficiaries served. The model is designed to achieve this end by enhancing primary care, avoiding unnecessary services and focusing on patient wellness.

However, primary care physicians often find it difficult to make the necessary changes in their practice infrastructure and practice patterns without upfront capital. For instance, it is resource intensive to purchase new scheduling software or hire additional staff. Moreover, it is risky to expend such capital without knowing if savings will be returned to the practice at the end of the year.

In addition, the ACO attribution model that focuses accountability on primary care physicians leaves little room for the engagement of specialists. While gainsharing agreements between the ACO and specialists are possible, these incentives are often minimal and so far removed from the acute care services provided that it has little effect on practice patterns. The bundled payments model, on the other hand, creates a more concrete target and proximal payback for specialists leading to greater change.

While these two models are not mutually exclusive, and arguably synergistic, there have been no overt tests of the two being intentionally combined. Similarly, the models have not been tested in combination with private-payer or state Medicaid models. Misalignment between payer models can create issues in the implementation of Medicare models; for example, launching a mandatory Medicaid managed care program can dramatically shift benchmarks for the Medicare program.

Furthermore, the current models continue to be built on a foundation of fee-for-service payments with providers seeking to beat their prior performance year over year. At some point, providers will not be able to continue reducing their costs relative to themselves and will need payment models built off the best value in their community. And, as volume declines, providers per case payments must be adjusted up to a fair rate recognizing that the per case costs increase for those services that remain paid on fee-for-service. Future models need to explore using regional adjustments, prospective global budgets and underlying payments based on bundling and partial capitation.

SOLUTION

CMS should develop a voluntary demonstration that replaces reimbursement for primary care physician (PCPs) for their evaluation & management (E&M) services with a single monthly capitated payment that would be included in total spending for the purposes of comparing an ACO’s actual expenditures to its historical MSSP benchmark. This limited capitation would allow PCPs to focus their attention away from generating as many services as possible to better managing a panel of patients through new methods of care. PCP capitation would enable primary care practices to optimize their use of care teams that include physician extenders such as nurse practitioners and health coaches, to institute electronic visits, and to expand use of patient portals – all of which would facilitate having open access and enhance the patient experience. The care teams and e-care would be able to handle much of the routine, less complex care thereby allowing the PCPs more time for the care of the complex patient within the practice and encouraging them to have more complex patients on their panels.

The program would avoid pitfalls of the PCP capitation of the late 1980s and early 1990s, whereby PCPs unnecessarily triaged their patients to specialists. Combining the shared savings element of the MSSP with a PCP capitation would discourage the PCPs from referring patients unnecessarily to costly specialists. Simultaneously, the rigorous quality measures within the MSSP would ensure that the PCPs focus on appropriate referrals and transitions of care. With the PCPs freed from the Relative Value Unit (RVU) treadmill, they would be better able to 1) care for their patient within the confines of their office, thus utilizing less
unnecessary specialist (professional and ancillary) and hospital (emergency department and readmissions) services thereby lowering the overall cost of care; and 2) deliver high quality patient care and experience.

If, however, specialty acute care becomes necessary, the underlying payment for such services would fall under bundled payments rather than traditional fee-for-service. By setting unified targets across episodes of acute care, the ACOs can more directly associate savings with the work of specialists and provide more timely compensation for improved care at a lower cost. At the same time, the capitated primary care payments will ensure the continued engagement of the PCP and the overarching ACO incentives will temper the incentive to generate more episodes. All of the spending, whether through capitation, bundling or the remaining fee-for-service would be tallied and reconciled against the ACO’s historical benchmark to see if overall spending is lowered. As providers begin to achieve savings through better coordinated and higher quality care, an adjustment would be made to the per-service payment if the changes in practice resulted in a reduced volume of services. This will allow providers to remain financially healthy and ensure that the model continues to provide incentives for even greater improvements in the delivery of care. Our expectation is that by replacing much of the underlying fee-for-service foundation, ACOs will be even more successful at achieving the Triple Aim.

**ACTION**

- CMS should establish a voluntary pilot program to test primary care capitation and bundled payments as the underlying payment systems within the Medicare ACOs.
- All models should consider how the dual-eligible population is accounted for in the model, and make adjustments where state policies or models will impact the ACO.
- CMS should test all-payer ACO models, or at a minimum Medicare-Medicaid ACOs, that include capitation and bundled payments as the underlying payment system.
- In implementing the pilot program, the government and other payers should adjust hospital and other payments to match costs as rates of avoidable hospitalizations and outpatient services are reduced and there is an increase patient acuity.
Interoperable Health Information Technology

PROBLEM

Current health information technology (HIT) systems have fallen short on their promise to reduce costs and improve the quality of care mainly due to the lack of usable, interoperable electronic health records (EHRs) that allow for the exchange of protected data and the submission of clinical quality measures (CQM) and other e-measures. This is largely due to misaligned incentives and a lack of EHR vendor accountability for achieving interoperability. The end goal is to be able to seamlessly pull discrete data anytime, anywhere to ensure the right information about the right patient is available at the right time.

One of the main challenges for health systems is closed EHR systems that “lock” in healthcare data, hindering interoperability of EHR systems, medical devices, monitors and other information technology mechanisms that contribute to high quality, safe and cost-effective patient care. This also applies to achieving a more efficient supply chain. The current locked systems create serious consequences for patient care and safety as they hinder innovation, collaboration and free exchange of secure information critical in delivering informed, coordinated care. For example, the current systems require providers to double check data pulled from disparate devices to make sure the information matches. Not only is this inefficient, but it is another manual process that has the potential to create errors and patient-safety issues.

The movement towards value-based care and the advent of alternative payment models has created an even greater imperative for health information interoperability. Arrangements such as ACOs and bundled payments involve participation by multiple providers, suppliers and sometimes payers who are at risk for coordinating the care of patients, requiring the ability to aggregate information from different EHRs.

SOLUTION

The HHS Office of the National Coordinator for Health Information Technology (ONC) should increase its oversight of certified technologies. First, certified technologies should be required to use standardized formats so that information can be easily documented and extracted for multiple purposes including quality improvement. Second, certified technologies should be required to develop and implement application programming interfaces (APIs) that support health data architecture. Requiring open APIs as a foundational standard for healthcare data would reverse the current legacy of locked systems and enable the real-time exchange of information in EHR systems to reduce costs and improve patient safety.

The Centers for Medicare & Medicaid Services (CMS) and ONC should not hold hospitals and eligible professionals responsible for interoperability within the EHR Incentive Program until the path to such communications is cleared by vendors. Moreover, CMS and ONC should incentivize use of Certified EHR Technology (CEHRT) in all healthcare settings.

ACTION

- ONC should implement regulations that requires certified technologies to use standardized formats and APIs.
- Congress should enact legislation that:
  - Requires interoperability standards and implementation specifications be made through the regulatory process; and
  - Establishes certification requirements and enforcement authority for noncompliant vendors, including decertification and penalties. This should also provide protections for providers impacted by decertification.
- Congress should enact legislation to encourage post-acute care providers to adopt CEHRT.
Consolidation Of Hospital Pay For Performance Programs

PROBLEM

Hospitals are required to participate in five quality programs—the Hospital Acquired Conditions Reduction Program (HACRP), the Hospital Readmissions Reduction Program (HRRP), the Hospital Value Based Purchasing Program (HVBP), the Electronic Health Records (her) Incentive Program (Meaningful Use) and the Hospital Inpatient Quality Reporting Program (HIQR). Five separate programs creates an administrative burden as each program has distinct measurement timeframes, reporting periods and reporting requirements. While the measures for some programs are calculated by CMS, hospitals still must work to internally monitor these measures to improve care and avoid penalties. Monitoring five separate programs creates an administrative challenge and diverts resources away from care.

In addition to creating administrative burden the current programs duplicative penalties; for example, Medicare’s "triple threat" penalizes hospitals three times for the same infection under HVBP, HACRP and the HAC penalty. Two programs (HACRP and HRRP) are penalty-only programs that do not provide an opportunity for all to succeed and benchmarks are not set in advance so providers are unsure if working towards a certain target reduction will allow them to avoid a penalty.

SOLUTION

Consolidating the existing programs into one simplified program can address the flaws in the current programs while continuing to hold hospitals accountable for quality, safety and cost. Similarly, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) rolled the existing physician quality programs (Value-Modifier, Meaningful Use, Physician Quality Reporting System) into a new consolidated program (Merit-Based Incentive Payment System or MIPS); this sets the stage for consolidation of the hospital quality programs.

The Hospital Value-Based Purchasing Program (HVBP) has proved to be an effective vehicle because it is a well understood, tested method that addresses many of the flaws in the other programs—it incorporates achievement and improvement, allowing low-performers to rise rather than stagnate at the bottom, benchmarks in advance of performance, fostering collaboration among providers rather than pitting them against each other, and allows hospitals to estimate bonuses and penalties.

A draft bill creates a consolidated hospital pay for performance program by sunsetting HACRP, HRRP, the Meaningful Use payment adjustment and the HIQR payment adjustment. HVBP is then modified to include components of the other programs (i.e., all cause readmissions, demonstration of meaningful use) and the payment at risk is modified to 5 percent. The payment at risk is increased 0.5 percent for hospitals failing to demonstrate meaningful use or submit measures for IQR; accordingly, the maximum payment at risk is 6 percent. The total modified percentage at risk is equal to the percentage risk in the current programs:

- VBP: 2 percent of wage-adjusted operating payment in 2017
- HAC: 1 percent of adjusted payment
- Readmissions: 3 percent of wage-adjusted operating payment

The total modified percentage at risk does not include the percent at risk under the MU and IQR penalties because few hospitals receive these penalties.

- EHR: Reduction of ¼ of market-basket (0.6 percent in 2016)
- IQR: reduction of ½ of market-basket (1.2 percent in 2016)

ACTION

Congress should enact legislation to create a consolidated hospital pay for performance program.
Critical Access Hospital (CAH) Value-Based Purchasing (VBP) Program

PROBLEM

Reforming healthcare delivery models is the new imperative in healthcare, with new innovations focusing on evidence-based care, outcomes and transparency to deliver high quality and cost effective care. Yet, as our nation’s urban areas continue to modernize their delivery models, critical access hospitals (CAHs) that serve patients in our rural communities are increasingly being left behind. Rural Americans face unique challenges that create disparities in healthcare not found in urban areas. Rural residents, on average, are older, have lower incomes, report fair to poor health status, and suffer from higher rates of chronic illness and obesity. Additionally, small rural facilities face challenges in implementing quality improvement efforts including limited resources, small staffs, and inadequate information technology resources. Independent rural practices often do not have the devoted resources and technology to engage in care management, which is necessary to coordinate care and manage population health.

Under the current system, and with razor thin margins, there is no advantage for these small remote facilities to join in the journey to population health. This is evident by the very few ACOs that operate exclusively in non-metropolitan counties. To improve care and increase coordination for these vulnerable populations, CAHs need to have mechanisms that are different from existing models that will bring them into the fold. In the absence of such mechanisms, we risk creating a two-tiered system: one based on quality and accountability in urban and suburban settings, and another based on volume leading toward poor health outcomes in rural, less advantaged areas.

SOLUTION

To address this situation, we need a new model that focuses on rural priority areas and seeks to transform financial and clinical models at CAHs. The ideal solution is to create a unique value-based purchasing (VBP) program with CAHs across the U.S. and garner evidence of the program’s viability on a broad scale before nationwide implementation. The goal is to demonstrably improve quality and the patient’s experience of care while simultaneously reducing inpatient and outpatient costs in rural communities.

To accomplish this objective, the model would implement payment incentives tied to performance on: evidence-based care, mortality, safety, patient experience, care coordination and spending. Through this program, CAHs would earn up to 2 percent bonus on inpatient and outpatient services if they meet quality, patient experience and efficiency targets during the first and second years of the program. If, after three years, it can be demonstrated that the group of CAHs as a whole reduced total Medicare spending for the population they service, then a share of those savings would generate a pool for incentive payments to be distributed back based on related performance. If no statistically valid savings are shown, then no incentive payments would be paid out. This sets up a group shared savings pool that overcomes the statistical reliability challenges associated with calculating savings at the individual CAH level because of the low volume of cases.

As remote providers, CAHs serve patients with myriad conditions, including many of CMS’s priority conditions. These will be key improvement areas for the program. A preliminary measure set would bring focus to these conditions including: heart failure, acute myocardial infarction, diabetes, stroke, behavioral health, obesity, and COPD. Using this standardized set of metrics, the new VBP program will help CAHs demonstrate value by lowering inpatient admissions, readmissions and emergency department use as well as post-acute care. This in turn will reduce CMS spending while improving the quality of care delivered in rural communities.

The additional funding from the incentive pool would provide these small facilities with the incentive to begin the journey to population health despite their cost-based payment system without asserting undue risk that could close their doors. The program would create a sustainable model that could bring ACO-like incentives to improve health and healthcare at a lower cost to roughly 19 percent of the country’s population.
ACTION

Congress and the administration should take action to bring better coordinated and integrated value-based care to patients living in rural or underserved communities by enacting legislation to create a program that tests and allows for national scaling of VBP for CAHs.
Beneficiary Engagement

PROBLEM

One of the goals of healthcare reform is to improve the quality and affordability of care Medicare beneficiaries receive; however, this goal is not always achieved in the implementation of programs. First, while most programs link quality to payment and publicly report quality information, the quality information available is not easily understood or meaningful to beneficiaries. For example, measures of resource use and cost focus on global payments to providers rather than actual or potential cost to beneficiaries. Second, providers and beneficiaries have limited access to tools that can facilitate beneficiary self-management, such as patient tracking tools that are used to monitor weight in patients with congestive health failure and can automatically feed information to the provider. Similarly, current technologies have limited ability for beneficiaries to review or share their medical information with the providers of their choice. Current certified technologies keep information locked in proprietary systems and prohibit information from being easily shared between providers or between beneficiaries and providers. In addition, providers and beneficiaries cannot readily use telemedicine instead of in-person interactions. Finally, providers are limited in their ability to engage beneficiaries or tailor benefits and services to a particular patient need because they are prohibited from waiving copays or providing other services such as transportation or ongoing care management. Providing services that assist the beneficiary in obtaining healthcare are associated with improved patient satisfaction.

SOLUTION

Beneficiary engagement techniques should be embedded in all aspects of all components of programs such as measurement, transparency efforts, benefit design and payment. Measure development efforts should focus on measures that matter most to patients, including cost to beneficiaries, improvement in health and functional outcomes, and patient satisfaction. Once developed and implemented these measures should be posted to public sites in a timely manner so that beneficiaries can select providers based on recent information. In order to have beneficiary access to medical information and tools that promote self-management, certified technologies should enable the use of application program interfaces (API) that allow information to be shared across providers and beneficiaries. Finally, providers and systems should have the ability to form new payment models that will give beneficiaries benefits and services that are not covered in Medicare fee-for-service; this would require revisions to the Stark and Anti-kickback statutes.

ACTION

- CMS should implement measures that address the patients’ perspective on cost and outcomes in quality reporting programs.
- The HHS Office of the National Coordinator for Health IT (ONC) should implement regulations that require certified technologies to use standardized formats and application programming interfaces (APIs).
- The Centers for Medicare & Medicaid Services (CMS), the Department of Justice (DOJ) and HHS Office of Inspector General (OIG) should allow the use of beneficiary engagement tools such as the waiver of copays, transportation fees, in home technologies and the provision of information about the value of post-acute care settings.
- Congress should provide payment for services that keep beneficiaries in their homes and outside of care settings such as e-mail and phone consults as well as in home monitoring technologies.
- Congress should allow providers within alternative payment methodologies to provide telehealth services to Medicare beneficiaries even if the services are not billable.
Provider-Based Outpatient Clinics

PROBLEM

The December 2015 U.S. Government Accountability Office (GAO) report on hospital-physician consolidation concluded that Medicare could save money if payments were “site neutral,” that is, per service payment is the same regardless of setting. Accordingly, several laws and regulations have moved to establish site-neutral payments, including the recently enacted Bipartisan Budget Agreement of 2015 that establishes site-neutral payments for any new provider-based off-campus hospital outpatient departments. While these policies are aimed at preventing the conversion of physician practices to provider-based clinics, there are key differences between physician practices and provider-based outpatient clinics that result in higher overhead expenses for provider-based outpatient clinics. For example, hospital outpatient departments have costs associated with standby services incurred in 24-hour emergency department settings, which include around-the-clock availability of emergency services, cross-subsidization of uncompensated care, EMTALA and Medicaid, emergency back-up for other settings of care and disaster preparedness. Similarly hospital-outpatient departments have a wide range of staff and equipment, including clinics pharmacy, radiology and other diagnostic testing, care management, and access to a wide range of post-acute care services, which are not available in physician offices. Finally, hospitals have more comprehensive licensing, accreditation, and regulatory requirements than physician offices. For example, the provider-based facility payment to hospital outpatient departments supports the significant cost of providing ambulatory care services to hospital standards for quality and safety and meeting Centers for Medicare & Medicaid Services (CMS) conditions of participation.

The conversion of physician practices to provider-based clinics is characterized negatively with the rationale that similar services are now billed at a higher rate. Conversely, much of the hospital consolidation of physician practices is in response to CMS policies that require hospitals to be accountable for care provided outside of the inpatient setting, such as the readmissions reductions program and the episode spending measures. Accordingly, hospitals have partnered with physicians to establish provider-based outpatient departments in order to coordinate care across the continuum and manage the population’s health. GAO’s report demonstrates that areas with a large percentage of hospital-based clinics had a reduction or slower growth in evaluation & management services, which could lead to a reduction in overall costs. Hospital consolidation of physician practices has also maintained access, particularly in rural areas, when physician practices close. Provider-based outpatient clinics often operate as safety net providers, providing access for the uninsured and underinsured.

SOLUTION

All policies to establish site-neutral payments need to broadly consider how the use of provider-based clinics may help support an overall reduction in healthcare spending and improve the coordination and quality of care to patients. At a minimum, any site neutral payment policies must exempt provider-based clinics that bill under the tax identification number (TIN) of the ACO. ACOs that choose to shift care from the inpatient setting to outpatient facilities are making that decision based on what is best for the patient, and doing so in order to coordinate care across providers and manage their population’s health and overall costs.

ACTION

- Congress should reject enacting any new or expanding any existing site-neutral payment legislation.
- The Medicare Payment Advisory Committee (MedPAC) should study the impact of increased use of provider-based clinics to determine the impact on beneficiary outcomes and total costs.
- Congress and CMS should exempt provider-based clinics that are part of ACOs from existing or new site-neutral payment policies.
- CMS should delay implementing Section 603 of the Bipartisan Budget Act of 2015 until operationally feasible and narrowly follow the statute rather than using its authority to expand the provision.