

November 26, 2019

The Honorable Richard E. Neal
Chairman
Committee on Ways & Means
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Kevin Brady
Ranking Member
Committee on Ways & Means
1139 Longworth House Office Building
Washington, DC 20515

Submitted electronically to Rural_Urban@mail.house.gov.

Dear Chairman Neal and Ranking Member Brady:

The Premier healthcare alliance works alongside health systems and providers nationwide to improve the health of communities. As an alliance of more than 4,000 hospitals and approximately 175,000 other providers and organizations, Premier applauds your leadership in convening the Rural and Underserved Communities Health Task Force (Task Force) to identify legislative solutions to address the challenges that contribute to health inequities, particularly in rural and underserved communities. We appreciate the opportunity to respond to the request for information to help inform the development of bipartisan legislation to improve healthcare outcomes within rural and other underserved communities.

With a large, geographically-diverse provider network, nationwide data representing 45 percent of U.S. discharges and significant research and clinical expertise, Premier is uniquely positioned to address important questions on strategies aimed at improving care in rural and urban communities across the United States.

Our comments focus on the following issues:

- Removing obstacles to value-based healthcare for rural communities
- Addressing the opioids epidemic in rural and underserved communities
- Ensuring access to home infusion for vulnerable populations
- Prior authorization

Removing Obstacles to Value-based Healthcare for Rural Communities

The healthcare system works better for consumers when hospitals, physicians and other providers have aligned incentives to work together to improve the cost and quality of care. This is what accountable care organizations (ACOs) are designed to achieve. Consider the Medicare Shared Savings Program (MSSP) ACOs that generated [\\$740 million in savings](#) in 2018 alone while delivering high-quality care. A significant impediment to expansion of ACOs is how the spending benchmark is set in rural and other areas. Members of the Premier healthcare alliance support the ***Rural ACO Improvement Act (S. 2648)***, which would fix this flaw and help ensure all ACOs,

regardless of what communities they serve, can continue to deliver coordinated, high quality and less costly care.

In the MSSP, ACOs that meet quality-of-care targets and reduce the costs of their patients relative to a spending benchmark are rewarded with a share of the savings they achieve for the Medicare program. The benchmark is set based on the historical costs of the ACO's patients and the cost of the beneficiaries in the region. The intent of incorporating regional spending into the calculation is to prevent a "race to the bottom" in which ACOs are only competing against their own historical performance. CMS, however, includes the costs of ACO-assigned beneficiaries in determining the regional spending. So, when ACOs lower costs for their assigned population they are also reducing the regional costs, and the spending benchmark becomes more challenging to meet.

ACOs in certain areas of the country, namely those in rural communities, are particularly disadvantaged by this design flaw. ACOs must care for a minimum of 5,000 beneficiaries to participate in the MSSP, which often means that the ACO is the dominant provider in its region. When the cost of caring for those 5,000 beneficiaries is incorporated into the regional benchmark, the ACO population disproportionately impacts the benchmark, diluting the intended impact of capturing regional spending.

The Rural ACO Improvement Act (S. 2648) removes this unfair disadvantage that ACOs in certain parts of the country face by excluding ACO-assigned beneficiaries from the regional beneficiary population. ACO leaders in [Premier's Population Health Management Collaborative](#) and other [health system leaders](#) have identified this as a critical change to the program that will allow them to continue to invest time, technology, and resources into these care innovation efforts. Premier urges the committee members to support the Rural ACO Improvement Act.

Finally, we encourage Congress to explore ways in which the Center for Medicare & Medicaid Innovation can test new models of care in rural communities. With their local roots, ACOs and other population health management models are ideally suited to address important socio-economic issues and to link with community resources. CMS should consider programs that would better enable alternative payment models to serve complex populations in rural and underserved communities.

Addressing the Opioids Epidemic in Rural and Underserved Communities

As caregivers on the frontlines in your districts, our member health systems see the toll that the opioid epidemic takes on patients, families and communities daily. Among the problems exacerbating the opioids epidemic and getting in the way of these and other healthcare providers' efforts is a decades-old law, 42 CFR Part 2 (Part 2). This 1970s rule governing the confidentiality of drug and alcohol treatment and prevention records, which predates HIPAA and its robust patient confidentiality protections, prevents CMS from disclosing to providers their patients records on substance use without complex and multiple patient consents. Thus, CMS removes claims records where substance use disorder is a primary *or secondary* diagnosis before sending data to providers. Failure to update Part 2 means that CMS must remove data relating to substance use, which translates to providers prohibited from reviewing ***roughly 4.5 percent of inpatient Medicare claims***

and 8 percent of Medicaid claims, despite being accountable for the outcome of their patients' health and cost of care ([NEJM](#)).

This poses a serious safety threat to patients with substance use disorders due to risks from drug contraindications and co-existing medical problems. For example, buprenorphine and other drugs for medication assisted treatment coming to the market contraindicate with many other drugs, especially those for patients suffering from schizophrenia and bipolar disorder. ***Part 2 perpetuates the very stigma that causes discrimination by creating a two-tiered system*** in which those struggling with addiction receive uncoordinated, incomplete care that can exacerbate their condition, lead to unnecessary emergency department visits and even result in overdose.

These outdated regulations also run counter to new, innovative Medicare delivery care models, such as ACOs and bundled payments, which require intense care coordination and in which healthcare providers are at financial risk when caring for these patients. Disparate treatment for alcohol and substance disorder information compared with other types of health information (for example, mental health), impedes comprehensive data sharing, 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.

The financial cost of not addressing this problem is also steep. A [Premier analysis](#) found that U.S. hospitals spent \$11.3 billion annually, or 1 percent of all hospital expenditures, treating patients who experienced an opioid overdose. The portion shouldered by the government is significant.ⁱ Sixty-six percent of the patients were insured by Medicare and Medicaid, equally split between the two public programs.

In October, the Substance Abuse and Mental Health Services Administration (SAMHSA) released a proposed rule which takes some critical steps to modernize Part 2. The proposed rule opens the door to driving greater access to treatment records that will allow clinicians to more effectively help their patients. However, legislative action is also necessary in order to modify Part 2 and bring the sharing of substance use records into the 21st century.

The solution is to pass the Overdose Prevention and Patient Safety Act (H.R. 2062), which would amend Part 2 to align with HIPAA's treatment, payment and operation protections and to allow sharing of medical records among providers for those with addictions, just like we have done for every other disease and condition since 1996.

The legislation in no way compromises the existing privacy protections in Part 2 that protect an individual from having their information disclosed to the courts in civil proceedings, or to life and disability insurance companies, employers and landlords/housing agencies. In fact, the legislation includes provisions that strengthen the existing prohibitions on the use or disclosure of substance use treatment information in criminal proceedings.

If enacted, H.R. 2062 would have an immediate impact in the fight against opioid misuse, at virtually no cost to the taxpayer.

Ensuring Access to Home Infusion for Vulnerable Populations

Home infusion is a vital patient-centric service that has proven to lower healthcare costs and improve patient outcomes. Premier has long advocated for comprehensive home infusion reform to provide high quality patient care in the most clinically appropriate and cost-effective care settings. However, in the final CY 2020 home health/home infusion rule, CMS inappropriately defines “infusion drug administration calendar day” as it did in the CY 2019 home health/home infusion rule to restrict payment to when a skilled professional is in the patient’s home, now for both the temporary home infusion services benefit as well as the permanent one. CMS’ policy runs counter to Congressional intent clearly articulated in the 21st Century Cures Act and Bipartisan Budget Act of 2018.

Unfortunately, CMS’ latest rule underscores the need for legislation to address CMS’ limited definition. Payment under these rules is so limited that it will result in unintended consequences, such as restricting the availability of services for Medicare beneficiaries. Beneficiaries requiring medications without adequate Medicare home infusion reimbursement rates may no longer have the option of receiving therapy in their homes. Particularly for Medicare beneficiaries in rural and underserved areas that often lack reasonable access to facilities that provide infusion services, being treated in the home is critical. As a result of the rules, these beneficiaries may incur serious clinical consequences from being moved from their home into more expensive alternate site of care, such as a physician’s office, skilled nursing facility or a hospital. Beneficiaries who receive home infusion therapy are often susceptible to infection and other adverse clinical outcomes, which makes the outpatient care setting less optimal.

We urge the Committee to prioritize home infusion legislation to ensure continued access to home infusion services, particularly for vulnerable patients in rural and underserved areas, who may not be able to access infusion services otherwise.

Prior authorization

Used by some health insurance companies and federal healthcare programs, prior authorization is designed to act as a patient safety and cost-saving measure by putting guardrails in place to avoid inappropriate care. While prior authorization can be a tool to help ensure evidenced-based care, it can also limit timely patient access to medically necessary services and is costly, time-consuming and burdensome for healthcare providers. These barriers are especially acute for patients who already struggle to access high-quality, timely care. A main culprit is a lack of standardization, transparency and automation of the prior authorization process. The bipartisan [Improving Seniors' Timely Access to Care Act of 2019 \(H.R. 3107\)](#) is straight-forward legislation to solve this problem. The bill is supported by Premier and more than 375 other organizations and currently has [more than 130 co-sponsors](#).

The bill would help overcome the challenges with prior authorization that can cause care delays and harm to patients while diverting clinician resources. These include:

- **Prior authorization can delay care and harm patients.** In a recent [survey](#) conducted by the American Medical Association (AMA), 65 percent of healthcare providers report waiting at least 1 business day for a prior authorization decision from a health plan and 26 percent report waiting at least 3 business days. Because of this time lag, 91 percent of providers reported treatment delays and 28 percent say these delays resulted in a serious adverse event such as a death, hospitalization, disability, or permanent bodily damage for a patient in their care.
- **The prior authorization process is disconnected from the clinical workflow.** It's a manually-intense process that requires healthcare professionals to take time away from caring for their patients to engage with payers.
- Particularly time-consuming and challenging for providers is having to identify at the time of the patient encounter whether an authorization is required for a given service and, if so, what documentation health plans require to approve the care. This is largely due to the **lack of standardization of and information about prior authorization criteria and requirements** among insurers and plans.
- **A lack of end-to-end real-time automation of prior authorization** between payers and providers also creates tremendous inefficiencies and can further delay care. Without electronic prior authorization processes based on national standards, most electronic health records (EHRs), which providers use to record clinical data, have no way of communicating with payment systems run by insurers.

The Improving Seniors' Timely Access to Cares Act (H.R. 3107) would improve the prior authorization process for patients and clinicians treating the [23 million Americans in Medicare Advantage](#) plans by:

- Establishing an electronic prior authorization (ePA) process based on nationally-adopted standards and prioritizing standards that encourage seamless, real-time integration of the ePA program into EHR systems;
- Minimizing the use of prior authorization for services that are routinely approved by Medicare Advantage plans;
- Prohibiting additional prior authorization for medically-necessary services performed during a surgical or invasive procedure that already received, or did not initially require, prior authorization;
- Ensuring prior authorization requests are reviewed by qualified medical personnel and that plans adhere to evidence-based medicine guidelines;
- Requiring Medicare Advantage plans to annually report on the use of prior authorization and rates of delays/denials; and
- Directing HHS to issue regulations that ensure Medicare Advantage plans adopt transparent prior authorization programs, conduct annual reviews of services for which prior authorization was imposed and ensure continuity of care for beneficiaries.

Conclusion

The Premier healthcare alliance is committed to helping healthcare providers with their ongoing efforts to improve care coordination, outcomes and experience for patients in rural and underserved communities. We would welcome the opportunity to share more information about our work in these areas.

Sincerely,



Blair Childs
Senior Vice President of Public Affairs
Premier healthcare alliance

ⁱ Extrapolated from Premier's analysis of the total care for patients who experienced an opioid overdose in annual hospital costs (\$1.94 billion) across 647 healthcare facilities nationwide.