Premier healthcare alliance

ALIGNMENT

More than 4,100 US hospitals and health systems and over 200,000 other providers and organizations

Strategic board alignment

Premier field force embedded in member health systems

LONG-TERM EXPERIENCE

Member owner tenure averages **~20 years**

CO-INNOVATION

Co-develop solutions with members

Committees composed of **~400** individuals, representing **~130** member hospitals

More than 1,500 hospitals in performance improvement collaboratives

MORE THAN **200K** alternate sites/other provider organizations

4,100 U.S. hospitals and health systems **ARE PREMIER MEMBERS**

Data on more than **45%** U.S. hospital discharges

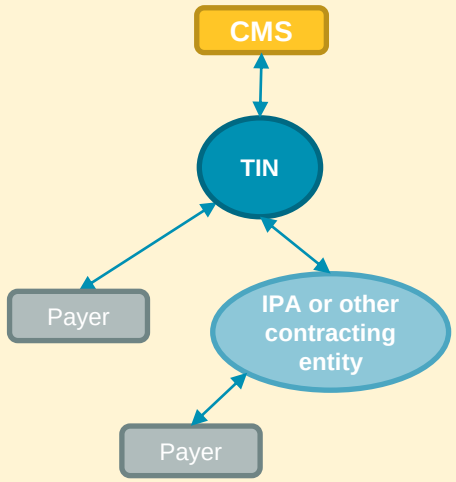
$67B group purchasing volume

Changes to MSSP Quality Performance Standard

- As part of last year's Physician Fee Schedule (PFS), **CMS overhauled its Quality Performance Standard for the Medicare Shared Savings Program (MSSP):**
  - ACOs to report by electronic clinical quality measures (eCQMs) or registries
    - Requires reporting of all-payer data, not just data for ACO-aligned beneficiaries
    - Optional in CY2021, but required in 2022
  - Benchmark MSSP performance against all Merit-based Incentive Payment System (MIPS) participants, not just other MSSP ACOs
- **Changes will require substantial time and resources and will place significant burden on providers**
- **Premier recommends that the Administration establish a smoother transition to the new reporting requirements by:**
  - Limiting reporting to only aligned beneficiaries
  - Starting with lower data completeness threshold
  - Setting benchmarks specific to MSSP rather than MIPS

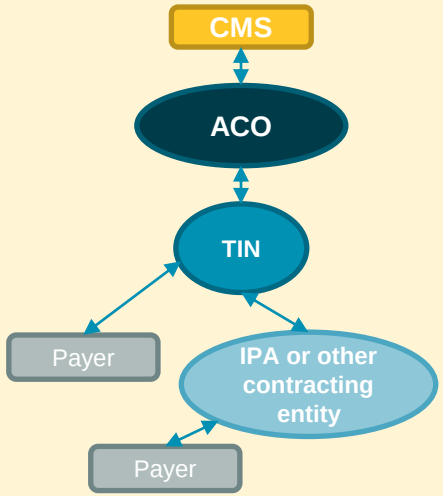
ACO Quality Reporting Differs from MIPS Reporting

MIPS Group Reporting



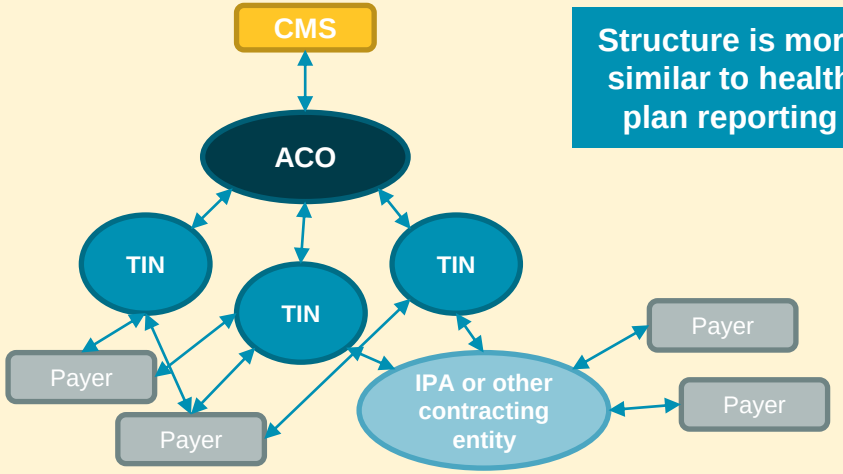
- ✓ **Reported at the TIN Level**
- ✓ **Likely to be on one EMR**
- ✓ **Universe of patients is knowable to reporting entity (e.g., Group).** Reporting to CMS includes all payer data but reporting entity has a direct relationship with all patients
- × TIN may have **some duplicate reporting** if other payers or IPA requires quality reporting

Single TIN ACO Reporting



- ✓ **Likely to be on one EMR**
- × **Universe of patients may or may not be known to reporting entity** (i.e., ACO)
- × TIN may have **some duplicate reporting** if other payers or IPA requires quality reporting
- × Existing TIN-payer **contracts may not allow for sharing of non-aligned beneficiary data**

Multi TIN ACO Reporting



Structure is more similar to health plan reporting

- × **Likely on multiple EMRs**
- × **Universe of patients unlikely to be known to reporting entity (i.e., ACO)**
- × TIN may have **some duplicate reporting** if other payers or IPA requires quality reporting
- × Existing TIN-payer **contracts may not allow for sharing of non-aligned beneficiary data**
- × **Data integrity issues magnified by complexity of aggregation across multiple EMRs** (e.g., duplicate patients, inconsistent specs interpretation by EMR vendor)

EMR = Electronic Medical Record | IPA = Independent Physician Association | TIN = Taxpayer Identification Number
Source: America's Physician Groups

Challenges to adopting reporting changes

- **Many ACOs have multiple EHRs across their organization** – requiring them to produce eCQMs across disparate systems
  - Requires time and money to change workflows and acquire new technology services
  - CEHRT standards do not require EHR vendors to provide support in combining data from multiple EHRs to produce a single result
- **Requiring ACOs to report on all patients creates several challenges for ACO participants:**
  - Results in a significantly larger amount of data to be reported
  - May not have necessary contracts in place to collect data beyond their ACO population
  - Have limited opportunity to impact care outside of ACO – quality measurement no longer true metric of an ACO's performance
- As a result of the burden and costs associated with this policy, **many ACOs are considering narrowing their participant lists or leaving the MSSP all together**

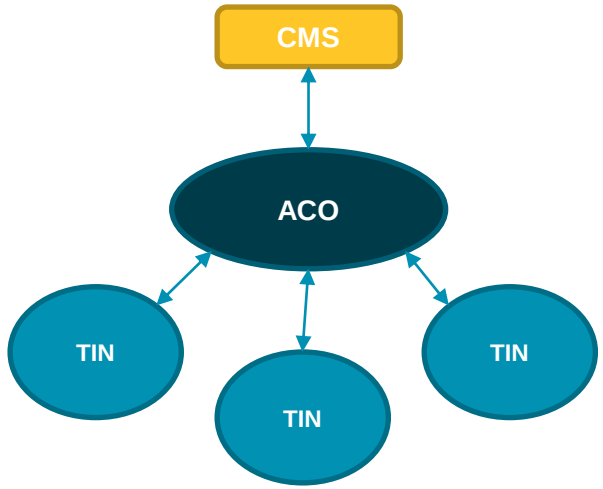
Establish transition to new reporting requirements by:

- Limiting ACO Reporting to aligned population
- Setting lower data completeness
- Allow individual TINs or each unique EHR instance to submit data to CMS on interim basis and CMS combine data

New requirements come with significantly higher reporting burden

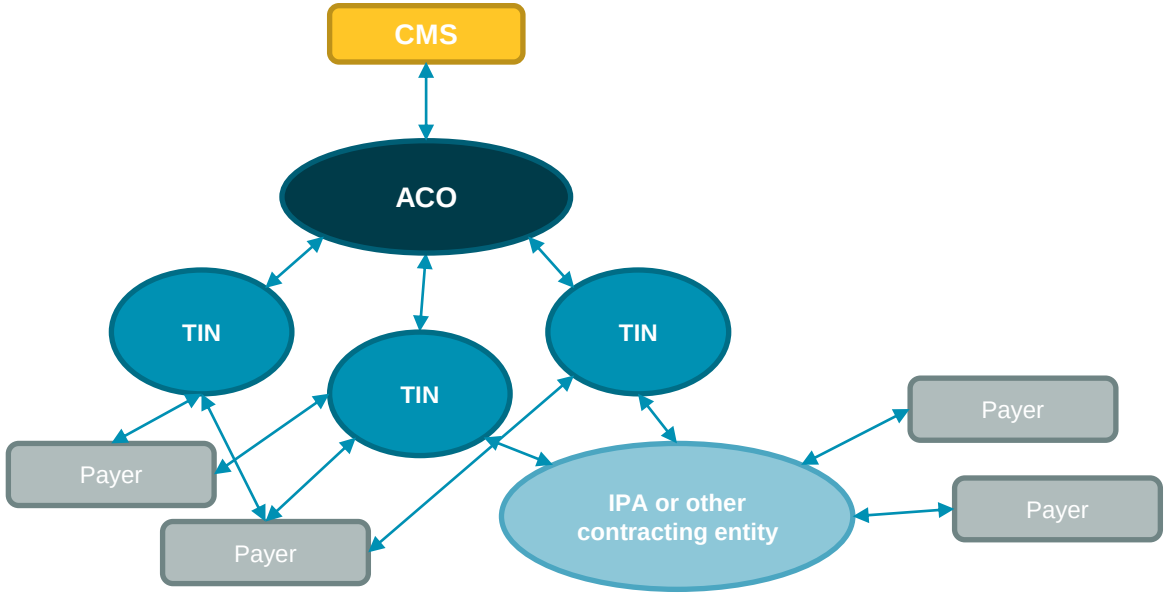
Example: Member has ~76,000 Medicare beneficiaries aligned to its ACO

Current Web Interface Reporting



Reports on sample of 600 ACO-aligned beneficiaries per measure

New eCQM or Registry Reporting Requirements



Must combine data from multiple EHRs used across TINs

Required to submit data on more than 200 times the number of aligned beneficiaries, depending on measure – E.g.,:

- Depression screening and follow up: ~269,000 patients across all payers
- A1C control: ~43,450 patients
- BP control: ~107,000 patients

Clarify and establish quality performance benchmarks in advance

- To be eligible for shared savings, ACOs must achieve a certain level of quality performance
- Moving forward CMS will set this performance benchmark based on overall quality score for MIPS
  - 30th percentile for 2021; 40th percent for 2022
- **Several issues with this approach:**
  - **MSSP and MIPs are fundamentally different programs**
  - Aligning APM quality measure set with MIPs **runs counter to goal of moving clinicians from volume to value**
  - **Holding ACOs to MIPs benchmark will also significantly disadvantage ACOs**
    - Unlike ACOs, MIPS participants can select which measures they report – incentivized to select measures perform well on
    - As a result, MIPS overall quality score tends to skew high, even if individual measures do not
    - Premier's analysis found that ACOs will need to achieve at least the 60th percentile on each individual measure to achieve a 30th percentile overall quality score

Modify requirements by:

- Setting benchmark specific to MSSP, rather than MIPS
- Establishing benchmarks in advance to inform ACO quality improvement activities

Additional Policy Recommendations

- **CMS should retain its pay-for-reporting option for new entities and when measures are first introduced or undergo significant changes**
  - Allowing a year of pay-for-reporting provides ACOs with valuable time to evaluate current workflows, data capture, and other operational strategies necessary to monitor and report measures
- **Seek additional stakeholder input on MSSP Quality Measure Set**
  - Use the Measure Applications Partnership (MAP) to provide input on the ideal measure set for MSSP
  - Include measures that are designed specifically for ACOs, rather than pulling measures from other programs (e.g., MIPS)

Premier Recommendations

- **Limit ACO reporting to aligned populations and start with lower data completeness**
- **Clarify and establish quality performance benchmarks in advance**
  - Set benchmarks specific to MSSP rather than MIPS, which is a fundamentally different program
  - Publish in advance quality measure benchmarks
- **Seek additional input on MSSP quality measure set**
- **Retain pay-for-reporting option for new entities or when measures are newly introduced or modified**

