November 12, 2013

Senate Finance Committee
Finance Committee Office
219 Dirksen Senate Office Building
Washington D.C. 20510

Re: Discussion draft document, Sustainable Growth Rate (SGR) Repeal and Medicare Physician Payment Reform, prepared by the House Ways & Means and Senate Finance Staff Committees

Dear Committee Members:

CHE Trinity Health is pleased to submit these comments on the discussion draft regarding SGR repeal and Medicare physician payment reform which was released October 30, 2013.

CHE Trinity Health is the second-largest Catholic health care delivery system in the nation, serving people and communities in 20 states from coast to coast with 82 hospitals, 88 continuing care facilities and home health and hospice programs that provide more than 2.3 million visits annually. It was formed in May 2013, when Trinity Health and Catholic Health East completed their consolidation to strengthen their shared mission, increase excellence in care and advance transformative efforts with their unified voice. With annual operating revenues of about $13.3 billion and assets over $19 billion, the new organization returns more than $800 million to its communities annually in the form of charity care and other community benefit programs. CHE Trinity Health employs nearly 86,000 people, including nearly 4,000 employed physicians.

We appreciate the committees’ ongoing efforts to improve the Medicare payment system for physicians and other providers, especially considering the current unsustainability of Medicare spending. CHE Trinity Health has provided detailed comments that follow this cover letter to support the committees’ work on a permanent solution to the SGR. We appreciate the ability to respond to this discussion draft document. If you have any questions, please feel free to contact Tonya Wells at wellstk@trinity-health.org or 734-343-0824.

Sincerely,

Tonya K. Wells
Vice President, Public Policy & Federal Advocacy
**General Comments**

Overall, CHE Trinity Health supports repealing the SGR and shifting Medicare payment to a more value-based reimbursement system that rewards high-quality, efficient providers. We believe that streamlining the structure of Medicare payment and consolidating the goals of various Centers for Medicare & Medicaid Services (CMS) value-based payment initiatives will help to reduce duplicative reporting programs and also improve efficiency throughout the system.

CHE Trinity Health believes that there is a real opportunity to permanently address the SGR given that the Congressional Budget Office’s latest cost to repeal the SGR is now at $140 billion over 10 years – significantly lower than previous estimates. However, we are concerned that the discussion draft does not address pay-for(s) for the cost to repeal SGR and implement the new performance-based incentive payment program. We ask the committees to provide information, or solicit feedback on, pay-for(s) being considered so that stakeholders can engage constructively. In particular, we urge that pay-for(s) not simply reduce payments to other Medicare providers, including acute care providers. These types of payment reductions would represent a cost-shift within the program – and acute care providers in particular are already implementing risk-based payment models across payers and facing tremendous payment pressures as a result.

Secondly, we are concerned that, under this proposal, physicians would see no inflationary or other payment adjustments for a decade. Though we understand the need to reduce spending, preventing provider payment to keep pace with inflation will make it extremely difficult for practices to make necessary investments to succeed under value-based payment models.

Lastly, CHE Trinity Health supports efforts to develop alternative payment models (APMs) and support providers in the movement to value-based payments. In the same spirit, the committees’ proposal pushes providers towards greater risk-based contracting, but a more comprehensive definition (beyond requiring two-sided risk and a qualify component) of what qualifies as an APM is necessary.

**Clinical Practice Improvement Activities**

CHE Trinity Health recognizes the need for Medicare to encourage providers to better manage clinical financial risk. Under the proposal, participants in Medicare advanced APMs would automatically receive half of the highest possible clinical practice improvement activities score—regardless of their actual performance under that model. However, providers who receive a significant portion of their revenue from advanced APMs (public or private) would be completely exempt from the VBP program and would instead receive a 5% bonus payment to be applied each year between 2016-2021 (if the outlined revenue threshold for that year was met).

To better align these two components of the proposal, we recommend that providers participating in any advanced APM—regardless of whether it is Medicare, Medicaid, or commercially-led—automatically receive half of the possible clinical practice improvement activities score. This would better support providers as they take on risk under various payer arrangements and would also help specialists and providers in rural areas as they further transition into flexible arrangements with public and private payers.

More broadly, the current proposal would be difficult to apply to specialists. Given the limited Medicare (and commercial) APMs available for specialists and the fact that many of the measures that would not be applicable to them as they fall under the clinical practice improvement activities and the quality components, this proposal may disproportionately negatively impact specialists. We recommend the committees consider the relevance and applicability of this and subsequent iterations of the proposal to specialists.

In addition, we support the proposal that providers in a certified medical home would receive the full clinical practice improvement score. CHE Trinity Health is committed to medical homes as a model for coordinating care and reducing costs. We are a leading participant in the state-wide Michigan Primary Care Transformation Project (MiPCT) - the largest patient-centered medical home (PCMH) project in the nation. Over 400 primary care practices affiliated with 35 physician/physician hospital organizations comprising 1,900 primary care physicians and mid-level providers are participating across public and private payers. As the committees continue deliberations, we recommend that more information be provided on how certification would be gained or which organizations would be qualified to make this assessment. Further, we strongly support developing
new payment codes for care management services for individuals with complex care needs. In our practices we have seen how improved care management can serve to improve quality of care, reduce costs, and enhance patient experience.

**Resource Use**

CHE Trinity Health supports that the proposal would set a target for identifying and revaluing misvalued services, smooth downward payment adjustments, and would direct the Government Accountability Office to study the RUC processes for making recommendations on valuation of physician services. We appreciate that the new systems proposed would utilize physician-developed standard of care guidelines – allowing for appropriate flexibility – to avoid unnecessary care.

However, we are concerned that the 10 percent penalty for providers who fail to submit information to HHS to assist in accurate valuation under MPFS is too severe. We propose that providers who fail to share this information see a smaller reduction in payment. Similarly, we recommend that the committee extend the timeline of the phase-in of RVU adjustments of 20% or more to a five-year period. Lastly, CHE Trinity Health would like to engage with the committees further on finding ways – short of non-payment – to ensure appropriate utilization of imaging and electrocardiogram services.

**Data Sharing and Technical Assistance**

We are fully supportive of the committee’s proposal that HHS work with Quality Improvement Organizations to provide assistance to small practices in rural areas or health professional shortage areas. In addition, we recommend that the committee consider providing these practices with additional support by creating a second, more gradual track to value-based payment for them with upfront capital for investment in data capture and analytical capabilities. The payment component could be structured similarly to the Advanced Payment Accountable Care Organization (ACO) model which has successfully supported the formation of 35 ACOs in rural areas.

CHE Trinity Health also supports data transparency efforts that aim to improve care and reduce costs. However, we are concerned that the proposal would give certain qualified entities (QEs) the authority to sell data analyses to insurers or employers at the same time as they are shared with providers. Given that the proposal would allow QEs to also gain access to data from Medicaid/CHIP and Medicare Advantage, data should be shared with providers first to give them sufficient time to analyze the data and adjust their clinical processes as necessary, prior to the data being offered externally. In addition, any data that would qualify as data available for sale should be blind as to the source and in the aggregate, not broken down by individual practice.

**Roll-out of Program to Professionals**

CHE Trinity Health appreciates that the committees have started to lay out an implementation timeline. We believe that a key consideration in designing a rollout should be to ease the shift from the SGR to APMs within practice groups. One way of accomplishing this would be to adopt the rollout methodology used under the Value-Based Payment Model (VBPM) which is based on size of the practice. Using that format, this proposal would be first applied to groups of 100 or more eligible professionals (EPs) in 2017. Then, in 2018, it would apply to groups of 10 or more EPs, and in 2019, applied to all EPs. We propose the definition of EP follow the definition used under the Value-Based Payment Modifier as well.