1077 Gorge Blvd
Akron, Ohio 44310
234.312.5259
summahealth.org

Mr. Donald J. Trump
President-elect of the United States
Transition Team
1717 Pennsylvania Ave., NW
Washington, DC 20006

The Honorable Michael R. Pence
Vice President-elect of the United States
Transition Team
1717 Pennsylvania Ave., NW
Washington, DC 20006

Dear President-elect Trump and Vice President-elect Pence:

Summa Health writes today to introduce you to our integrated healthcare delivery system and to offer targeted administrative improvement recommendations as you develop your regulatory agenda for the 2018 payment years and beyond.

Based in Akron, Ohio, Summa Health is one of Ohio's largest integrated healthcare delivery systems. Summa serves more than one million patients each year in comprehensive emergency, acute, critical, outpatient and long-term/home-care settings and excels in providing cardiac care, emergency department, women's health, stroke, orthopedics, cancer and geriatric services.

The largest employer in the Akron area, Summa integrates the resources of five-owned and joint venture hospitals, a regional network of ambulatory centers, a network of more than 1,000 physicians that includes more than 350 employed physicians in multi-specialty groups, a 120,000+ member provider-owned health plan, a system-level foundation and 9,500 employees, nurse and healthcare professionals. SummaCare, our health plan, is a high-performing health plan, having achieved 4-Stars in the Medicare Advantage program for the 2017 plan year. Additionally, we helped create and are leaders in NewHealth Collaborative (NHC), the only Medicare Shared Savings Program (MSSP) Accountable Care Organization in Ohio that has achieved shared savings for three straight measuring periods ($28 million in shared savings), while also scoring in the 95th percentile nationally for quality. We are participating in several Center for Medicare and Medicaid Innovation (CMMI) models: we are mandatory participants in the Cardiac Care, Comprehensive Care for Joint Replacement/Surgical Hip and Femur Fracture Treatment bundled payment models; we have SummaCare as a payer partner and Summa Health Medical Group physicians participating in the Oncology Care Model (OCM – Track 1); and we have SummaCare as a payer partner and 14 primary care practices about to start work in the Comprehensive Primary Care Plus (CPC+) program, Track 2.

It is from our integrated delivery system vantage point that we offer the following suggestions for administrative simplification and improvement to make the nation's healthcare system work better for health care providers, health plans and patients alike.

Place a moratorium on the application of any automatic downward adjustments to Medicare Advantage Organization (MA) Star Ratings (individual measures and overall Star Ratings) based upon programmatic audit findings and compliance actions, and provide an immediate opportunity for affected plans to seek a revised Star Rating computation for purposes of accessing a 2017 or 2018 quality bonus payment.

Rationale:
Congress carefully crafted Section 1857(g)(3) of the Social Security Act to authorize the types of intermediate sanctions CMS may impose, and reducing an MA plan's Star Rating is not an authorized remedy. Yet, CMS has increasingly done so by tying audit findings and compliance actions to the Star Ratings program since Congress authorized that the Star Ratings be used to compute and convey Medicare Advantage quality bonus payments (QBPs). ***In doing so, CMS has inappropriately double-penalized plans that have been subject to programmatic audit and compliance action***. These double penalties are particularly onerous on small, provider-sponsored plans like SummaCare, plans that operate on slim margins and do not have the scale and size of larger plans to absorb such penalties. In addition, the impacts are also felt by beneficiaries and our providers as plans that receive QBPs are able to provide extra benefits or reduced cost-sharing to beneficiaries. Moreover, plans are increasingly executing value-based contracts with providers based upon MA Star Rating performance. In SummaCare's case, our plan was audited and sanctioned in 2014, remedied all issues associated with the audit and sanction in 2015, only to then have our MA Star Rating reduced in 2016 for the same set of underlying issues that resulted in the sanction in 2014. As a result of the 2016 Star Ratings reduction, SummaCare is set to experience a $13 million loss in revenue for 2017.

This critically important administrative simplification recommendation – to de-link programmatic audit findings from the MA Star Rating program – is supported by AHIP, the nation's largest health insurance trade association. Like AHIP, SummaCare believes that both program audits and the Star Ratings program are important facets of the MA program. However, they are separate and distinct assessments of plan performance – both are valuable to ensure plans are serving as good stewards to the government and to Medicare beneficiaries, but they should be distinct.

Regulatory Vehicles to Institute Change: The 2018 Advance Notice and Call Letter, typically released in mid-February each year, with a 10-day to two-week comment period, or via sub-regulatory guidance using the HPMS format.

Align quality measures and specifications across public quality reporting and performance initiatives.

Rationale:
As CMS moves away from fee-for-service to paying for value, the agency is increasingly tying Medicare payer and provider reimbursement to quality metric reporting and performance. While Summa Health actively supports the move away from purely volume based care, we face a quality measurement and reporting environment that is more and more disjointed and burdensome. Clinicians must report multiple quality measures on highly similar patient populations to different entities. Measure specifications (i.e. numerators and denominators) are often not aligned among payers or within CMS, which has resulted in confusion and complexity for reporting purposes, as well as increased spending on administrative tracking systems. For example, within different CMS divisions, CMS is producing a myriad of quality measure programs for the Medicare population in an uncoordinated fashion. As an example, at least 5 different divisions within CMS publish quality measure reporting and performance requirements for clinicians to report on – the CMS MA Star Ratings quality measures program is authored within the Center for Medicare's Drug Benefit and C and D Data Group, while the Medicare Shared Savings Program (MSSP) quality measure set is developed within the Performance Based Payment Policy Group. Meanwhile, in the Center for Medicare and Medicaid Innovation, the Seamless Care Models group developed the CPC+ quality measure set. While the work that was announced early in 2016 of the Core Quality Measure Collaborative is a good start, more alignment work must continue and on an expedited basis to avoid the needless administrative burden associated with redundant, disconnected quality measurement requirements. There must be a unifying and rationalizing force within the new CMS leadership team that focuses on ensuring quality reporting and performance requirements generated by CMS are as harmonized and aligned as possible.

Possible Regulatory Vehicles to Institute Change:
Annual Medicare regulations, including regulations associated with the Medicare Advantage program and the Quality Payment Program. Additionally, we highly encourage the new Administration to continue the work started by the Core Quality Measures Collaborative, accelerating its implementation and embrace across all divisions within CMS.

Provide more regulatory flexibility in payment reform models by eliminating antiquated rules grounded in fee-for-service and coordinate new models to avoid unintended duplication or competition of market forces.

Rationale:
CMS's continued application of fee-for-service (FFS) regulatory barriers within payment reform models often hinders providers' ability to identify and place beneficiaries in the most clinically appropriate setting. It also inhibits their ability to test new, more patient-centered and streamlined clinical pathways. Testing new approaches in an environment free from

artificial barriers to care coordination, such as waiving the 3-Day Skilled Nursing Facility (SNF) rule for all ACO- aligned beneficiaries, will more effectively advance solutions that improve clinical outcomes and reduce overall costs and care variation. In addition, modernizing the beneficiary attribution requirements in the ACO rules by embracing prospective attribution will more fully allow the care coordination promise of the ACO construct to work. When clinicians know who their patients are, they are empowered to care for those patients better. As such, we encourage the Administration, to the greatest extent of its authority, to waive the regulations that CMS or Congress established for use in a FFS reimbursement, but that stymy value-based care redesign across provider settings. In addition, there are currently multiple payment models that have been introduced or are proposed with the intention of providing mechanisms to test better systems of care, including: the Medicare Shared Savings Program (CMS), the Next Generation Program (CMMI), and multiple mandatory bundled payment initiatives (CJR, OCM, etc). While all of these programs are well intentioned and directionally correct, they impose competing business models on the same physicians and health systems, with competing patient attribution, metrics for success, and financial models. We encourage the Administration to work with CMS and CMMI to develop more logical and complementary programmatic development and implementation to mitigate the unintended consequences of the competing forces within these and other value based programs.

Possible Regulatory Vehicles to Institute Change: Annual Medicare regulations.

Revise the yet-to-be finalized 340B HRSA guidance that, in its proposed form, would reduce the volume of expensive drugs eligible for 340B discount pricing.

Rationale:

As providers, patients and payers alike increasingly bear the burden of skyrocketing pharmaceutical prices, the 340B program must be preserved and protected so that hospitals can continue to provide comprehensive treatment services to low-income patients. In its proposed form, the HRSA 340B guidance would add significant new administrative burdens to participating hospitals. In addition, the guidance significantly narrows the patient eligibility definition, thereby reducing the number of drugs that qualify for 340B pricing.

Therefore, we respectfully ask that the Administration not finalize the proposed 340B HRSA guidance. If the Administration chooses to move forward with 340B HRSA guidance, we suggest that revised 340B HRSA guidance be reissued in proposed form that contains a less limiting definition of "patient of a covered entity."

Possible Regulatory Vehicles to Institute Change: the 340B guidance, HRSA RIN 0906-AB08.

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At Summa Health, we are committed to the Triple Aim, working to improve the total health of the communities we serve by coordinating each patient's care. We thank you for your review of our administrative simplification suggestions, and we look forward to working with your Administration over the coming months as you seek to implement your administrative simplification priorities. If we can provide further detail or specification on our above mentioned priorities, please contact Mairin Mancino, Advocacy Director, at mancinom@summhealth.org or 234-312-5258.

Sincerely,

Michael Dalton
System Director, Advocacy & Health Policy
Summa Health