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Transforming
Healthcare
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October 24, 2011

The Honorable Patty Murray
U.S. Senate
448 Russell Senate Office Building
Washington, DC 20510

The Honorable Jeb Hensarling
U.S. House of Representatives
129 Cannon House Office Building
Washington, DC 20515

Dear Senator Murray and Congressman Hensarling:

On behalf of the more than 2,500 U.S. hospitals and 77,000-plus other healthcare sites that have united through the Premier healthcare alliance, I congratulate you on your appointment to lead the Joint Select Committee on Deficit Reduction (Joint Committee). Our alliance stands in support of your work to address the burgeoning budget deficit issues – both in mandatory and discretionary spending. Owned by hospitals and health systems, Premier is a performance improvement alliance that is using the power of collaboration to lead the transformation to coordinated, high quality, cost-effective care in order to improve the health of communities. *The Premier alliance works every day to improve the quality of care while safely reducing costs, and we are contributing annually billions of dollars in savings to federal healthcare programs.*

Because of this expertise and track record of success, we recommend the following reforms that we believe will spur on a faster transformation of our healthcare system to one that is more coordinated, higher quality and cost-effective. To that end, we urge Congress to include instructions with any sequestration or other enacted provider payment cuts that those cuts would be reduced proportionate with reductions in healthcare spending against projected increases.

Specifically, Premier recommends:

- **Building upon enacted, bipartisan payment and delivery system reforms so as to increase patient engagement and participation by healthcare providers.** It is critical to maintain the momentum of shared saving programs and other payment models that move toward more coordinated, cost-effective care. This can be accomplished by:



- Giving participants of shared savings and bundled payment programs credit for reductions in spending, thereby encouraging participation;
 - Exempting from the sustainable growth rate formula physicians who receive 25 percent of Medicare revenue through shared savings programs and providing them prospective guarantee for payment rates for services for ACO patients;
 - Allowing providers in shared savings programs to provide incentives that encourage beneficiary participation, loyalty and engagement;
 - Allowing providers to direct setting of care where appropriate without being penalized; and
 - Creating a national voluntary bundled payment program that has a shared savings component.
- **Speeding the implementation of reforms that will create a more competitive and vibrant market for hospital supplies, devices and pharmaceuticals.**
 - Implementing a unique device identification system (UDI) that will reduce costs across the entire supply chain, speed the Food and Drug Administration approval process and enable more effective comparative effectiveness research.
 - Prohibiting “gag clauses” in medical device contracts that impede hospitals’ ability to compare market prices and negotiate with manufacturers.
 - **Reforming the medical liability system by putting in place:**
 - A \$250,000 cap on noneconomic damages
 - A collateral source rule
 - A ban on subrogation by certain collateral sources
 - A fee schedule for attorney contingency fees
 - Periodic payments of future damages
 - A reasonable statute of limitations

Environmental context

Within the context of reducing the deficit, we first want to impress upon the Joint Committee the current environment that hospitals within the Premier alliance – and all hospitals nationwide – face as they seek to fulfill our core mission of improving the health of communities. According to the Medicare Payment Advisory Commission (MedPAC), total Medicare hospital margins remain negative (-5.2 percent in 2009) despite a recent slow-down in hospital cost growth. The lingering effects of the economic recession continue to impact the ability of many hospitals, particularly safety net hospitals, to stay fiscally viable. New financial pressures loom as Medicare and Medicaid **payment cuts in healthcare reform – which total \$155 billion** – are implemented and states, faced with distressed budgets, impose Medicaid and other healthcare spending reductions. This is all occurring during a period of monumental transformation in

healthcare that requires hospitals to make considerable investments. Some of the more significant factors impacting hospital care include:

- Across-the-board cuts to the market basket and productivity adjustments for Medicare inpatient and outpatient services.
- Reduced inpatient payments for hospitals to account for purported changes in documentation and coding due to the adoption of the new set of Medicare diagnosis-related groups (DRGs), which is based on a disputed analysis of the impact of the coding changes.
- Other payment changes that impose penalties for higher than expected readmissions, high ratios of hospital-acquired conditions and failure to adopt electronic health records (EHRs).
- The implementation of EHRs which requires an initial investment of between \$1 million to \$15 million for small hospitals and between \$75 million and \$250 million or more for larger health systems, according to Premier alliance members' projections.
- The growing problem of drug shortages, which has increased costs for hospitals by an estimated \$415 million a year due to the need to shift to high cost drugs and increased demands on hospitals to work around the shortages.¹ This does not include the substantial financial and patient care impact of shortage drugs where there are no alternatives.

Hospitals create jobs, stimulate the economy through spending and support other jobs and economic activity. Employing over 5.4 million people nation-wide, hospitals spend approximately \$342 billion on products and services from other businesses and are the second largest source of private sector jobs. Yet, we are already seeing hospitals lay off employees due to current economic pressures.

In light of these factors, we urge the committee to oppose reductions to Medicare provider payments for uncollectible patient debt, to direct and indirect graduate medical education funding and to disproportionate share hospital (DSH) payments. We are also extremely concerned about restricting states' ability to partially fund Medicaid programs through provider assessments and reductions to the federal share of Medicaid and Children's Health Insurance Program payments to states. These cuts, which would tend to hit the same institutions multiple times, would have negative long-term and destabilizing effects on hospital care, far outweighing any benefits of short-term savings that could be achieved.

Rather than piling on irrational, across-the-board cuts to providers, Congress should look to accelerate and account for the savings that can be achieved through delivery system reforms and to sustainable, market-driven strategies that are currently working in the healthcare industry.

¹ Coleen Cherici, Patrick McGinnis, Wayne Russell, Premier healthcare alliance. [Buyer beware: Drug shortages and the gray market](#). August 2011

The following recommendations are based on an analysis using the Premier Perspective[®] database, the nation's largest and most detailed clinical, financial and outcomes database, containing information for one out of every five – or 210 million – patient discharges in the United States. The recommendations for savings through delivery system reforms are based on analysis of real-world lessons learned from Premier alliance hospitals, including those participating in Premier's quality and cost improvement collaboratives such as the Hospital Quality Incentive Demonstration[™] (HQID), the QUEST[®]: High Performing Hospitals initiative and the Partnership for Care Transformation[™] collaboratives.

Recommendations for payment and delivery system reforms

The current fee-for-service payment system is misaligned with healthcare provider's attempts to achieve coordinated and cost-effective healthcare. We urge the Joint Committee to take advantage of efforts to reduce spending so as to spur the advancement of changes that will fix the perverse incentives in the payment system.

To that end, we recommend that any payment reductions be done in a way that encourages those healthcare systems and providers who are taking meaningful and measurable steps to reduce healthcare costs and manage care. It is also critical that new delivery system models and programs give providers levers to achieve these savings for the government. We recommend that:

- Organizations that are participating in programs that are designed to share savings with the government or offer a discount from current payment levels should be given credit for attained reductions in spending for the government. To that end, should the Joint Committee recommend cuts to providers – including those providers that are building shared savings programs or participating in bundled payment programs with discounted payments – or should the sequestration process be triggered, we recommend that savings achieved for the government by these providers be recognized as achieving these cuts. Specifically, we recommend that every dollar saved by the providers and accrued to CMS that are beyond the confidence interval or offered as specific payment reductions should offset on a dollar-for-dollar basis any proposed payment cuts. This reform will create a significant incentive for providers to work aggressively to both build coordinated care programs as well as reduce healthcare spending.
- We also recommend stronger incentives for physicians to participate in and lead the Medicare delivery reform effort. For example, physicians who are receiving at least 25 percent of their Medicare revenue through a Medicare shared savings program (including Pioneer accountable care organizations (ACOs)) should be exempted from annual uncertainties in payments under the sustainable growth rate payment system (if that

system remains in place) and receive a prospective guarantee for their payment rates for services for the ACO patients. This will provide a federal incentive to physicians to move toward more coordinated and accountable care, which will lower costs by transforming our fragmented and siloed healthcare system. This move would be consistent with and provide further incentive to developments in the private sector.

- The Center for Medicare and Medicaid Innovation has tested a number of bundled payment initiatives. The most recent initiatives require interested organizations to bid discounted prices at or below a minimum level of savings, with no opportunity for providers to share in the savings achieved beyond the minimum level of savings. The lack of shared savings increases the risk to providers with little business case to do so for the average hospital system. So as to improve the business case, encourage far more organizations to take part in these programs, increase the pace of adoption, and set more organizations onto the path of ACOs that will save even more in the future, the Joint Committee should recommend implementing a broad-scale national voluntary bundled payment program, rather than a pilot program, that allows providers to share in the savings with the Medicare program.
- To increase the success and, by extension, the savings potential of Medicare shared savings programs, these programs must allow for incentives that encourage beneficiary participation, loyalty and engagement. Providers participating in these programs should be allowed to offer items and/or services that promote better preventative care, encourage patients' compliance with their treatment plans and generate increased participation by the beneficiary. Such items or services could be free screenings or wellness items and services, co-pay and deductible waivers, as well as transportation vouchers. Without an Anti-Kickback Statute waiver to permit the furnishing of these types of services by participants of shared savings programs, participating providers are constrained in what they can provide to beneficiaries that will provide additional value and help them become more engaged as a healthcare consumer. Allowing providers to use such levers drawn from evidence-based care guidelines to influence beneficiaries will undoubtedly increase the effectiveness of the model and generate greater savings for the government.
- Medicare shared saving programs should also be structured in a way that allows participants to drive care where it is most appropriate and to the highest quality and most effective sites of service. Accountable care organizations, for example, will be mindful of care patterns that ultimately result in higher Medicare spending, as it will reduce the annual bonus, and the quality measurement process will ensure that the quality of care is maintained. Accordingly, payment policies should not be applied that penalize providers for directing the setting of care where appropriate. As long as the ultimate outcome is

measurably higher quality, cost-effective care, participants should be able to direct patients to the appropriate setting without reduced payment.

Recommendations for supply chain improvements

Total U.S. hospital and nursing home non-labor expenditures are estimated at approximately \$367 billion annually, with roughly \$263 billion impacted by market pressures imposed by group purchasing organizations (GPOs). Through a combination of improved alignment between physicians and hospitals, transparency around manufacturers' payments to physicians, comparative effectiveness research, removal of price confidentiality contracts and the implementation of unique device identification for all medical devices by 2012, we are confident that *GPOs will help hospitals avoid price inflation over the next 10 years to achieve cumulative savings of hundreds of billions of dollars.*

Improve transparency through the removal of price confidentiality contracts

An important part of the cost-saving equation is increasing the transparency of device costs, which would give hospitals the necessary information to engage with physicians in making informed, evidence-based decisions while tracking outcomes to ensure quality of care. Contractual provisions enforced by manufacturers often restrict hospitals from sharing with one another the prices they pay for devices. This impedes hospitals' ability to compare market prices and negotiate with manufacturers. Prohibiting these "gag clauses" would not only enable hospitals to collaborate with physicians to increase product standardization, it would also help reduce healthcare costs.

When hospitals and GPOs are allowed to share data on both quality and costs with physicians, they become partners in helping to reduce costs and improve quality. The power of such collaboration is evident in the savings achieved through hospitals and clinicians working with GPOs to aggregate supply purchasing and improve systems and processes that maximize efficiency, labor and expenses. The Schneller study referenced above estimates that GPOs save \$6.8 billion for hospital pharmaceuticals, \$8.5 billion for medical/surgical purchases, \$1.9 billion for cardiology implants and \$840 million for orthopedic implants.

We found in the analysis we conducted that 2-4 percent a year of the approximately \$57 billion that is spent annually on physician preference items, such as cardiovascular, orthopedics, spine, intraocular, ophthalmic, ear and other devices, could be saved through improved physician and hospital alignment, yielding 10-year cumulative savings of \$68-\$128 billion.² The ECRI Institute

² Analysis based on the Premier Inc., Perspective database, the nation's largest and most detailed clinical and financial database, holding information on more than 210 million patient discharges.

reached similar findings, concluding that hospitals could save approximately 3.1 percent on their total medical device purchasing by being able to negotiate with manufacturers to achieve savings for every device they buy.³

Unique device identification and evidence-based research

In a 1996 Efficient Consumer Response study titled “Improving the Efficiency of the Healthcare Supply Chain,” \$11 billion in annual savings was projected from the adoption of universal product numbers and the identification of standards for electronic data interchange and bar coding. This study was recently updated and now estimates that supply chain savings would total \$16 billion annually for a potential 10-year savings of up to \$150 billion. Numerous case studies and pilots around such standards – including one being conducted by the Department of Defense – have realized savings. These standards have also been used in other industries for many years and have proven to be effective.

In addition, UDI will greatly improve the FDA’s approval process for medical devices, saving the government significant resources. The lack of an industry-wide device identification system burdens FDA resources. The agency must weed through large databases of reported device problems from physicians and patients to identify trends that need follow-up.

The creation of a national unique device identification (UDI) system is a large, critical piece to fully recognizing savings and improving patient safety. In 2007, Congress included a UDI-related provision in the Food and Drug Administration Amendments Act of 2007 (Public Law 110-85). More specifically, section 226 of the legislation requires the Secretary of Health and Human Services to promulgate regulations establishing a UDI system for medical devices requiring the label of devices to bear a unique identifier. A proposed rule is currently under review by the Office of Management and Budget. The release of a proposed rule is long overdue, and we strongly urge the Joint Committee to include the implementation of UDI in the final package.

As part of a broader effort to make sound, science-based evidence the basis for medical practice, comparative effectiveness research offers a promising course to improving health outcomes while safely reducing costs. The current work underway by the Patient-Centered Outcomes Research Institute will lay the foundation to produce information that will help healthcare providers and patients evaluate medical innovations and determine which represent added value, which fail to offer enhancements to current choices and which treatments work for some patients and not for others. This will enable the provider community to take the findings and drive greater

³ Jeffrey C. Lerner, PhD, ECRI Institute. *The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary*. National Academy of Sciences

market competition around the evidence. The implementation of UDI will not only allow FDA and providers to quickly identify and pull ineffective medical devices off the market, preventing harm that adds tremendous cost to federal health programs, but it will facilitate more effective comparative effectiveness research.

Recommendations for medical liability reform

The current medical liability system is clearly broken, and there is widespread agreement among lawmakers, healthcare policy experts, opinion leaders and the public that reform is needed. In its March 2011 budget options document, the Congressional Budget Office scored a package of comprehensive medical liability reforms as providing \$62.4 billion in savings over 10 years – savings which will help the committee to achieve its deficit reduction goals. Premier urges the committee to recommend to Congress the package of changes to the medical liability system that CBO has projected will achieve these significant budget savings. Among other provisions, the package places a \$250,000 cap on subjective, noneconomic damages. These proposals also include:

- Collateral source rule reform allowing a party to introduce evidence of collateral source benefits received from a source independent of the defendant to prevent double recovery;
- Ban on subrogation by certain collateral sources;
- A fee schedule for attorney contingency fees to ensure victims of negligence receive the funds they need;
- Periodic payments of future damages; and
- A reasonable statute of limitations.

Premier believes enacting these reforms will not only help reduce the deficit, but also increase patient safety, ensure that injured patients are compensated quickly and fairly, improve provider-patient communications and foster an environment for affordable and accessible healthcare coverage.

We also encourage the Joint Committee to include in its proposal additional federal reforms that we believe would reduce the cost of healthcare and thus lower federal expenditures on healthcare programs. These include a certificate/affidavit of merit requirement (to ensure that only legitimate medical liability cases are filed in court), expert witness reforms (to prevent “hired guns” from providing inaccurate testimony in such cases) and “apology protections” (to improve patient-provider communications). Furthermore, we ask you to adopt the language of H.R. 816, the Provider Shield Act, clarifying that the Patient Protection and Affordable Care Act does not create new standards of care for medical liability lawsuits (in order to prevent a possible explosion of medical liability lawsuits that could be inadvertently triggered by the new law).

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Each of these reforms would save taxpayers money while simultaneously improving our healthcare and legal systems.

Conclusion

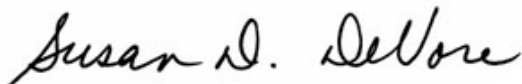
As the process set forth in the Budget Control Act moves forward, we urge the Joint Committee to put in place a mechanism to account for savings that are achieved by hospitals in the Medicare program. If any level of sequestration occurs and hospitals are successful in keeping the trend growth rate below what is projected, this work should be “credited” to them in future sequestration. In other words, if hospitals are able to achieve even deeper savings than the sequestered amount through use of group purchasing organizations and implementing delivery system reforms, that amount should be debited from the future years’ sequestration amount.

Finally, we would hope that any sector-specific Medicare or Medicaid-related savings identified by the Joint Committee will be credited to the impacted sector reducing the sequester impact. This way no individual sector will be asked to carry a disproportionate burden to both help reduce our debt while still being required to meet the needs of the nation’s poor and elderly.

We believe that the hospital community, working in conjunction with our members, has a real opportunity to significantly reduce healthcare costs. We believe that, with the aforementioned reforms, we can curb increases in the cost of medical devices, drugs and supplies in hospitals. This *conservatively* will amount to hundreds of billions of dollars in savings over the next decade. This does not account for the savings we believe will be achieved in the Medicare and Medicaid programs by new models of care that CBO is unable to score. Whereas additional scaling back of hospital payments will further undermine hospitals’ ability to provide seniors and the most vulnerable in our society the high quality care they deserve, the changes we have proposed will improve the health of both our economy and our communities.

Thank you for your commitment to achieving a resolution to the nation’s fiscal crisis. The Premier healthcare alliance welcomes the opportunity to provide any additional information you need on the budgetary benefits contained in our proposals.

Sincerely,



Susan DeVore
President and CEO

Attachment

Generating Healthcare Savings Projected Impact of Healthcare Reforms on Supply Chain Spending

Based on past experience and data extrapolation, the Premier healthcare alliance believes that significant healthcare expenditure reductions can be achieved within the hospital supply chain. The table below shows savings projections that could be realized by holding purchasing expense steady over the next 10 years.

<i>In Billions</i>	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019E	2010-2019
Price Inflation Forecast*		1.5	3.2	2.6	2.3	1.9	1.5	1.4	1.4	1.4	1.4	
Total GPO Spend	263	267	275	283	289	295	299	303	307	312	316	2,947
Revised	263	263	263	263	263	263	263	263	263	263	263	2,630
Savings	-	(4)	(12)	(20)	(26)	(32)	(36)	(40)	(44)	(49)	(53)	(317)

* Based on CMS Prospective Payment System (IPPS) Hospital 2002 Input Price Index using Global Insight Inc. Forecast Assumptions, by Expense Category: 1990-2018

Derivation of Baseline Data

According to an analysis by Locus Systems of CMS National Health Expenditures Accounts of non-labor expenditures by hospitals and nursing homes for calendar year (CY) 2007, the total potential group purchasing organization (GPO) marketplace in CY 2007 would have been \$367.3 billion. Of that, GPO purchasing volume accounted for \$263 billion; this reflects hospital GPO contract penetration at an average of 72%, which is based on analysis conducted by Eugene Schneller.⁴ The remaining 28% of supply expense includes off-GPO-contract purchasing and physician preference items that are typically advanced, high-price, lower-volume technology, such as cardiac devices and orthopedic implants. GPOs do not mandate on-contract purchasing, so hospitals are free to purchase directly from manufacturers without a GPO contract when desired.

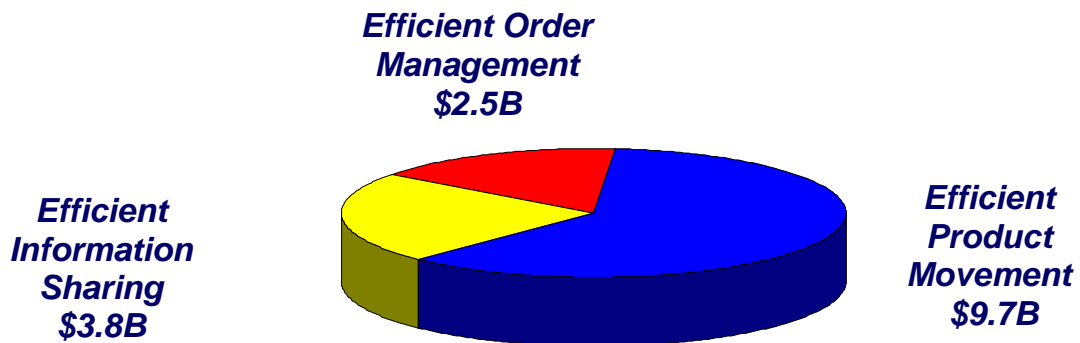
Savings Methodology

By aggregating purchasing and negotiating volume discounts from manufacturers, GPOs save the healthcare industry billions each year. In addition to these ongoing savings, the spreadsheet above indicates the opportunity to hold expenses of GPO purchasing volume steady, without incurring the annual inflationary increases projected by CMS. *This static expense projection yields a cumulative savings of \$317 billion over 10 years.*

We arrived at these conservative figures by adding savings we realistically believe can be achieved through a variety of reforms that will lead to a more transparent and streamlined healthcare supply chain. These savings include the following:

⁴ Schneller, Eugene, The Value of Group Purchasing – 2009: Meeting the Needs for Strategic Savings, Health Care Sector Advances, Inc., April 2009

1. \$68-128 billion savings through reduction of expense in physician preference items. This amount reflects a 2-4% savings on the estimated \$57 billion spent per year as a result of improved hospital-physician alignment, transparent disclosure of manufacturer payments of value to physicians and removal of confidentiality agreements. We arrived at the 2-4% savings by using the Premier Perspective[®] database, the nation's largest clinical and financial database with over 130 million patient records from more than 700 hospitals. Hospitals performing in the top quartile were identified based on cost metrics in physician preference areas such as cardiovascular, orthopedics, spine, intraocular, ophthalmic, ear and others. These hospitals are superior at aligning physicians with high quality and cost-effective use of physician preference devices. By moving all organizations to this top quartile performance, a range of 2-4% savings can be achieved each year. By aligning physicians and hospitals in this area, we have been able to achieve this level of cost reduction annually.
2. An additional \$16 billion per year in savings is projected from the adoption of unique device identification (UDI), according to the 2006 update of the 1996 Efficient Consumer Response study "Improving the Efficiency of the Healthcare Supply Chain." The majority of the savings are gained through more efficient information sharing, efficient order management, and efficient product movement (see chart below). However, there are additional opportunities for savings through physical distribution, transportation, order management, and inventory management. Additionally, all the players in the supply chain stand to share in the savings if the identification standards listed above are realized. Healthcare providers will realize 41% of the savings, while manufacturers will see 33% and distributors 26% of the savings.



*Efficient Healthcare Consumer Response (EHCR)

3. Evidence-based data derived from comparative effectiveness research can also be used to illustrate to physicians the clinical outcomes associated with product choices and practice patterns. With physicians making decisions on a foundation of evidence and best practices, there will be improved valuing of new drugs and devices, impacting the prices of these products.

4. Savings can be also driven by allowing competition in the area of biotech drugs. In the pharmaceutical industry, a brand will lose approximately 90% of its value if there are two or more competitors in the marketplace. By allowing biotech products to go generic through a biosimilar process, savings are estimated at a 20% reduction initially, with possible price reduction in the marketplace over time. GPOs speed the use of generics to generate savings for members and the same acceleration would be expected in follow-on biologics.