

June 10, 2013

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Joe Pitts
Chairman, Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairmen Upton and Pitts:

On behalf of the Premier healthcare alliance, we appreciate the opportunity to comment on the latest draft of the sustainable growth rate (SGR) repeal and reform proposal and a set of accompanying questions posed by you and your staff. As you know, Premier is a performance improvement alliance of more than 2,800 leading hospitals and health systems and 95,000-plus other healthcare sites using the power of collaboration and technology to lead the transformation to coordinated, high-quality, cost-effective care.

Questions for Comment on Phase 1:

The Period of Payment Stability

Question #1 asks for input about the appropriate length of the planned period of payment stability. The Premier alliance believes that a value-based payment system should be implemented as soon as possible, hopefully requiring no more than a three-year period of stability. The Physician Quality Reporting System (PQRS) already provides a huge menu of performance measures from which to choose and a modest period of stability should provide sufficient time to address measure gaps and related issues. Providing a longer period would unnecessarily delay movement to an improved payment update methodology, one based on physician performance.

We would note, however, that it would be preferable to use performance measures for payment purposes only after providers have had sufficient experience with the measures and measure data have been publicly available for review for a sufficient period of time. Under the hospital value-based purchasing (VBP) program, measures are not used until hospital performance on these measures has been posted on the *Hospital Compare* website for at least one year. Ideally, a similar policy would apply under a system of quality-based physician

payment updates. The reason this phased in approach was adopted in the VBP program was so that providers could gain familiarity with the measures, review their accuracy, and ensure the validity of the measure prior to their being tied to financial consequences. Insuring validity is critical in avoiding unintended consequences of the incentives.

Further, the Premier alliance believes that performance targets should be set in advance (not calculated after the performance period has ended), thereby providing an opportunity for all providers to meet or exceed these targets. Incentive targets can be powerful motivators of behavior change, but in order to be effective, providers must be able to work towards a well-defined target. Also, since additional performance measures, especially those involving electronic health record (EHR)-related specifications, will undoubtedly be required even given the large number of currently available measures, it would be extremely important for Congress to provide the necessary resources to facilitate the timely development of such measures.

Timely Feedback

Question #3 focuses on the performance feedback process. Feedback intervals should be sufficient to allow providers to improve their performance during a given performance period. Feedback provided only after the performance period has ended would not permit providers to monitor their performance and motivate change over time. Ideally, providers would receive feedback reports on a monthly basis. At the very least, quarterly reports should be made available and these reports should include actionable information, not simply undigested data that providers would find difficult to comprehend or use effectively.

Peer Provider Cohorts

Questions #4 and #5 address possible ways to define Peer Provider Cohorts. The Premier alliance believes that consideration should be given to defining cohorts based on the provider of a given service or service category to which the specific performance measures apply. For example, if performance measures relating to a given service or service category are adopted, the Peer Provider Cohort for such performance measures should include all provider specialties furnishing the service or service category, rather than creating separate Peer Provider Cohorts based on provider specialty. Such a framework encourages all providers to adopt a best practice for the service, rather than regress to the mean of their own specialty.

Non-Physician Providers

Question #6 asks about measurement sets for non-physician providers. The Premier alliance believes it would be a mistake to assume that non-physician providers will always need unique

measurement sets or scoring methodologies. For example, where both physicians and non-physician providers, such as nurse practitioners and physician assistants, furnish the same or similar services, we believe it would make sense to apply the same performance measures to such services (no matter which provider specialty furnishes them) and to scoring performance on such measures across all involved providers. This would be consistent with the advice provided above relating to Peer Provider Cohorts and would encourage adoption of best practice no matter the source.

Questions for Comment on Phase II:

Existing Programs

Question #1 seeks input regarding the future of existing programs, such as the Physician Quality Reporting System (PQRS), quality reporting under the electronic health record (EHR) meaningful use requirements, and the value-based payment modifier (VBM) under the Medicare physician fee schedule. The Premier alliance believes it would be critically important to align performance measures across all Medicare programs as quickly as possible, while recognizing that not all performance measures will necessarily be appropriate for public reporting and/or payment update purposes. We also believe that these aligned measures should have electronic specifications as soon as possible, in recognition of the growing adoption of EHRs. Creating a situation in which measures are not aligned and differ only slightly in definition across programs creates a disproportionate burden on providers and diverts away from improvement toward measures reconciliation. Moreover, such a situation has potential to confuse consumers and payors and to negate the usefulness of any of the measures. Finally, while continuing the existing PQRS and EHR meaningful use programs would make sense, especially under the aligned, e-specified measures approach we recommend, we presume that any new system of quality-based payment updates would substitute for the currently mandated VBM. Maintaining both the VBM and a new quality-based update methodology strikes us as duplicative and inadvisable as it is likely to mean rewarding or penalizing providers twice for the same performance and unnecessarily complicating program administration.

Stakeholder Involvement

Questions #4, #7 and #8 focus on critically important issues relating to stakeholder input at various points in the performance measurement development and selection process. First, the federal agencies should be directed to create Technical Expert Panels (TEPs) to seek input on any measures they develop and accept public comment on the measure construction. Second, the existing National Quality Forum (NQF) and Measure Applications Partnership (MAP)

processes should be relied upon for stakeholder input at several critical points in the measure evaluation and selection process. The MAP process has been specifically designed to incorporate a wide cross section of stakeholders from across the industry. Third, we believe it would be important to provide stakeholders with a formal opportunity to comment during the rulemaking process. As we have emphasized before, when measures are accepted by providers as meaningful and important, such provider buy-in can result in enormous quality and efficiency improvements. On the other hand, when measures are seen as inappropriate or problematic, the opposite becomes true: providers dismiss the process as political at best, harmful to patients at worst, and become disengaged. Thus, a meaningful opportunity to provide comment on the performance measures being considered for use in a payment update methodology and related matters would be critically important.

Measure Weighting

Question #5 seeks input regarding measure weighting in a quality scoring system and notes that quality measures are divided into structure, process, and outcomes categories. An alternative measure classification scheme could use the measure domains recently developed under the Department of Health and Human Services (HHS) National Quality Strategy: (1) Patient and family engagement; (2) patient safety; (3) care coordination; (4) population and public health; (5) efficient use of healthcare resources; and (6) clinical processes/effectiveness. Regardless of how measures are grouped or categorized, great care is needed in determining appropriate measure or domain weights. For example, if there is only a single outcomes measure applicable to a given Peer Provider Cohort, we do not believe it would be appropriate to give this measure an unduly high weight, especially during the early years under a quality-based payment update methodology, given recognized limitations in available risk-adjustment methodologies. Similarly, when performance is scored by measure domain, all relevant domains should be sufficiently balanced (that is, they should each have a reasonable number of measures). The Premier alliance also recognizes that process measures are likely to be the primary measures available for use initially, and thus can be weighted heavily at first, with a greater shift to other domains as measures become available. Furthermore, the Premier alliance does not believe that structural measures should be used for payment determination purposes as there is rarely evidence of a relationship to outcomes and such measures also create scoring challenges.

New Providers

Question #6 focuses on newly practicing providers. For such newly practicing providers, the Premier alliance believes the initial year's focus should be on performance measure reporting. Further, in that initial year, such providers should not incur any payment penalties or otherwise

be disadvantaged. We believe it would be reasonable for the reformed Medicare physician payment system to treat them neutrally in their first year in practice.

Assessing Performance

Finally, question #9 seeks input on appropriate ways to assess provider performance when determining payment incentives. The Premier alliance urges you *not* to adopt a scoring methodology that ends up guaranteeing that some proportion of providers must always incur payment penalties, no matter how well they perform (such as a methodology that applies penalties to the “bottom” 25th percentile, even where performance on a measure actually varies little). The idea of having a permanent bottom quartile is counterproductive because even though a provider’s performance may be good, they are still at risk of incurring a penalty. An example of this is the Affordable Care Act’s hospital-acquired conditions (HAC) policy in which hospitals performing at the bottom quartile are penalized. If such a policy does what is intended and creates a rising tide that lifts all boats, there will always be a quartile of hospitals that incur a penalty, regardless of how well they are performing and whether their HAC rate is statistically different from other hospitals not receiving a penalty. Instead, performance should be assessed against targets set in advance (as noted above), not those determined after a performance period has ended. Creating a framework in which all providers could win, rather than a tournament framework, encourages collaboration and sharing of best practice. In addition, performance assessment should consider both the level attained on a measure by a provider as well as the amount of improvement on the measure by that provider over time. We learned, as part of the CMS Premier Hospital Quality Incentive Demonstration, that improvement points are integral to ensuring lower performers do not stagnate at the bottom, but rather have line of sight to bonuses. We also believe it would be important to ensure consistent measurement across provider specialties in terms of depth, breadth and specific measures for like services.

Conclusion:

In closing, the Premier healthcare alliance appreciates this latest opportunity to provide input regarding Medicare physician fee schedule reform. The preceding comments should be viewed as supplementing the comments we previously provided to you in letters dated February 25 and April 15, 2013. While we have not repeated our earlier comments here, we wish to emphasize two key points addressed in considerable detail in the earlier letters. First, we believe it is critical that any Medicare physician fee schedule reform effort not disrupt ongoing physician and other provider efforts to make care transformations through such mechanisms as the Medicare Shared Savings Program, the Pioneer Accountable Care Model

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and bundled payment arrangements. The latest draft of the SGR repeal and reform bill would provide an opt-out for providers from normal fee schedule rules for providers paid under alternative payment models, which the draft defines as mechanisms by which Medicare payment is made for “most or all of the items and services furnished by such provider.” The draft then goes on to indicate that such mechanisms include accountable care organizations, medical homes, and bundled payments. However, the underlying routine payment within these programs remains fee-for-service at this time. Thus Congress will need to consider how to alter the fee-for-service system for these physicians to encourage their participation, rather than truly allowing them to “opt out” of fee-for-service. Further, it may make more sense under the ACO model to consider a portion of patients attributed to the alternative payment model as opposed to the level of services. In addition, we wonder about the potential for the “most or all” standard to preclude provider “opt-out” when, for example, bundled payment arrangements do not appear to meet the “most or all” standard. We presume that the committee intends to allow providers participating in bundled payment arrangements for a certain portion of their services (but not necessarily “most or all” of them) to be allowed to continue to participate in these bundled payment arrangements without interference, and we would encourage you to make this explicit.

Second, to the extent that a reformed Medicare physician payment system will rely upon registry reporting, policy makers should ensure that all aspects of registry data specifications, collection and measurement calculation algorithms will be fully transparent, and that registry reporting will not impose administrative or cost burdens on physicians or hospitals, or lead to the other potential problems described in our previous communications.

Please do not hesitate to contact James Miller, director of federal affairs, at 202.879.8008 or James_Miller@PremierInc.com if you would like to discuss our comments further.

Sincerely,

A handwritten signature in black ink, appearing to read "Blair Childs". The signature is fluid and cursive, with a large initial "B" and "C".

Blair Childs
Senior vice president, Public Affairs
Premier healthcare alliance