NATIONAL BUSINESS GROUP ON HEALTH
50 F Street, NW • Suite 600 • Washington, D.C. 20001
202.628.9320 • Fax 202.628.9244
www.businessgrouphealth.org

Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

Senate Committee on Finance

Statement of Helen Darling, President, National Business Group on Health

Good afternoon, Chairman Baucus, Senator Grassley and members of the Committee. I am Helen Darling, President of the National Business Group on Health (Business Group), a member organization representing 300 large employers that provide coverage to more than 55 million U.S. workers, retirees and their families. The Business Group is the nation's only non-profit organization devoted exclusively to finding innovative and forward-thinking solutions to large employers' most important health care and related benefits issues. Business Group members are primarily Fortune 500 and large public sector employers, with 63 members in the Fortune 100.

The Business Group applauds the leadership of the Senate Committee on Finance for holding today's Roundtable and the progress that the Centers for Medicare and Medicaid Services (CMS) have made in advancing value-based purchasing in Medicare. We appreciate this opportunity to share our thoughts with you about the CMS' plan to implement a Hospital Value-Based Purchasing Plan (VBP) and we strongly urge the Congress to pass legislation that would implement pay-for-performance on a widespread basis in the Medicare program.

As you all know, it is estimated that Medicare will be bankrupt by 2019, seven years earlier than previously expected and 23 years earlier than Social Security. We believe it is necessary for the financial future of Medicare as well as for the quality and safety of care received by beneficiaries that pay-for-performance be used to harness the government's leverage as the largest purchaser of health care in the U.S. to move Medicare and all other payers towards paying for effective health care and quality outcomes rather than units or volume of services, as is currently done.

Too often, payment under Medicare and throughout the health care system in the U.S. is made without regard to whether services are needed or are performed well. Fisher and colleagues (Annals of Internal Medicine, 2003) estimate that under the current system up to 30% of Medicare spending may be for excessive and unnecessary care. In addition, the Dartmouth Atlas of Health Care's most recent findings reveal wide variation in hospital care and outcomes for chronically ill Medicare patients. While cost is tied to quality or performance in most other industries, in health care, including in Medicare, the opposite tends to happen—we end up paying more for poor service and the additional health care needed to "correct" poor quality. Fortunately, Medicare is beginning to reverse this tendency by not paying for so-called "never events."

CMS' effort to stop payments for "never events," is a significant first-step to improving the quality of care in the Medicare program. As you know, a landmark 1999 Institute of Medicine (IOM) report estimated that preventable medical errors in hospitals might cause as many as 98,000 deaths annually. Many more people are injured in hospitals and countless

more preventable deaths and injuries occur in outpatient settings. Beginning on October 1, 2008, Medicare no longer will pay for eight preventable hospital errors, including catheter-caused urinary tract infections, injuries from falls, and leaving objects in the body after surgery. Nor can hospitals bill the injured patient for those extra costs. In the future, Medicare will continue to add additional errors to the no-pay list; including: ventilator-caused pneumonia, drug-resistant staph infections and other known errors. We hope the Congress will reinforce the importance of these steps that not only protect beneficiaries from egregious harm but will also save the Medicare program, its beneficiaries and the hospitals billions of dollars.

With the clinical comparative effectiveness research conducted by the Agency for Healthcare Research and Quality (AHRQ), the federal government and its research partners are producing important information that will help eliminate inappropriate treatments and ensure that the government only pays for effective, high quality health care that works. It is important that the public and private sectors act together to develop the research evidence base for treatment and coverage policies so that clinicians, policy-makers, and consumers are able to make decisions that improve the quality of care and quality of life.

Pay-for-performance promises to advance evidence-based medicine, improve the quality of health care for beneficiaries and improve the efficiency of the Medicare program. With VBP, CMS is taking the next step towards moving from being primarily a **passive payer** for health care to an **active purchaser** for health care, using its enormous power to buy the best possible care for millions of beneficiaries, just as Congress has asked it to do. By using its huge purchasing power to drive excellence in care delivery, Medicare is not only protecting and helping its beneficiaries but it will also make the health care delivery system in the U.S. better and safer for all Americans, all of whom will be beneficiaries once they turn 65 or disabled.

It is vital for the federal government to fully transition Medicare to a pay-for-performance system based on quality and efficiency. We already know that Medicare pay-for-performance for hospitals works. Under the Premier Hospital Quality Improvement Demonstration, more than 250 participating hospitals received bonuses over three-years for boosting the quality of care provided to Medicare beneficiaries. Preliminary results show that for the 30 quality measures on which the project was based, participating hospitals saw an average improvement of nearly 12 percentage points over the first two years. ***Estimates based on the results from the demonstration project to all of the country's hospitals could mean 5,700 fewer deaths and savings (conservatively) of as much as $1.35 billion annually.***

A recent study by CMS in Health Affairs reported that U.S. spending on health care is expected to double (over the next 9 years). It is urgent that the federal government work with employers and other purchasers to change the current system. The pay-for-performance movement continues to rapidly expand in the private marketplace. In recent years, employers and other health care purchasers have developed and adopted payment programs to reward quality in the health care system. As sponsors of health plans, employers currently use their flexibility, under ERISA, to innovate and close the gap between the quality of care that we have and the quality of care that we should have and need.

Many employers are already developing and implementing strategies aimed at improving the quality and value of the health care they purchase. Many National Business Group on Health members have taken the lead in promoting pay-for-performance, health care quality and transparency by participating in initiatives such as the Leapfrog Group Hospital Rewards Program, Bridges to Excellence and the pay-for-performance programs of the Integrated Healthcare Association to make true health care transparency and quality a reality. Today, most large insurers and health plans already have a provider incentive program based on performance.

Pay-for-Performance Successes in the Private Sector:

1. **Leapfrog Hospital Rewards Program (LHRP):** The Leapfrog Group, a coalition of major companies and other large private and public health care purchasers that provide benefits to more than 37 million Americans in all 50 states, rates 1,300 hospitals based on quality and value. The LHRP rewards hospitals for their performance in both the quality and efficiency of inpatient care based on nationally accepted measures to reduce medical errors and standardize hospital care. LHRP payout focuses on five clinical areas that collectively account for 20 percent of commercial spending on inpatient services and 33 percent of commercial admissions to hospitals, including: coronary artery bypass graft (CABG) or bypass surgery; percutaneous coronary intervention (PCI) or angioplasty; acute myocardial infarction (AMI) or heart attack; community acquired pneumonia (CAP); and deliveries/newborn care. Actuarial studies estimate that only 5 to 8 percent of hospitals nationwide achieve excellent performance in both quality and efficiency for these areas. ***If all hospitals met the clinical score of the top 25 percent participating in the LHRP, 66,000 lives and $18.5 billion could be saved annually while avoiding 145,000 readmissions and 187,000 medication errors.***

2. **Bridges to Excellence (BTE) Programs:** BTE, a not-for-profit company, led by a multi-stakeholder board of directors comprised of physicians, employers and health plans, has published lessons learned and best practices of four pilot region pay-for-performance programs that included: rewarding physicians for practicing re-engineering and adopting health information technology; improving outcomes for patients with diabetes through preventive care (including more cost-efficient care); improving intermediate outcomes for patients with diabetes, hypertension, hyperlipidemia, coronary artery disease and cardiovascular disease; and implementing measures of effective ambulatory care treatment protocols for patients with recent cardiac events. BTE's Diabetes Care Link (DCL) pay-for-performance program shows proven savings among recognized physicians between 10 and 15 percent per patient per year. Similarly, BTE's Cardiac Care Link (CCL) pay-for-performance program estimates performance measure savings of up to $350 per patient per year. In addition, BTE's Spine Care Link (SCL) pay-for-performance program estimates savings of up to $205 per patient per year. The BTE programs have identified a number of key lessons learned and best practices to implement a successful pay-for-performance program, including:
   - Using standard performance measures of clinical quality, focusing mostly on intermediate outcomes derived from medical chart reviews, not just claims;

- Giving providers clearly defined costs and benefits of the program, which helps them determine the value of participating;
- Using independent third-party organizations to measure the performance of providers, reviewing the data reported by these providers from medical records in their practice;
- Bringing together many payers and/or purchasers to make rewards meaningful to providers;
- Encouraging providers to adopt better systems of care, including health information technology, to systematically improve the delivery of care;
- Assisting small practices which need significant help in re-engineering, as there are not many resources available to help them;
- Understanding that a focus on a single disease may limit program uptake among primary care physicians;
- Realizing that providers that become recognized in BTE's programs are happy to get more patients – even those with chronic illness; and that
- Employers and plans should combine a pull (bonus) with a push (steerage) to maximize the impact of a pay-for-performance program among their plan members.

3. **Integrated Healthcare Association (IHA):** IHA, a multi-stakeholder association based in California consisting of major health plans, physician groups, and hospital systems, academics, consumers, purchasers (including employers), pharmaceutical and technology representatives has established uniform quality performance measures, incentive payments to physician groups and a public report card. Stakeholders have made progress towards improving clinical quality reporting, patient experience, use of information technology (IT) and patient care. Eighty-seven percent of physician groups reporting all clinical measures improved their overall clinical score by 5.3 percentage points from Year 1 to Year 2. One-hundred and thirty physician groups participating since the beginning of the program improved from 3 to 5 percentage points on patient experience measures and from Year 1 to Year 2 there was a 54 percent increase of physician groups qualifying for at least a partial credit for IT adoption.

The National Business Group on Health Believes Medicare's VBP and Pay-For-Performance Program Should Include the Following:

- Medicare should continue to adopt performance measures developed by nationally recognized quality measurement organizations, such as the National Committee for Quality Assurance (NCQA), researchers, and practitioner groups that have been vetted and recommended by consensus-building organizations that represent diverse stakeholders, such as the National Quality Forum (NQF) and measures established by the AQA Alliance and the Hospital Quality Alliance (HQA) Steering Committee.
- Incorporate the lessons learned from the Leapfrog Hospital Rewards Program (LHRP), Bridges to Excellence and the pay-for-performance programs of the Integrated Healthcare Association.
- Learn from the success achieved from the Premier Hospital Quality Improvement Demonstration to expand pay-for-performance throughout the Medicare program.

Under this program, improvements in quality of care saved 1,284 acute myocardial infarctions (heart attacks). Patients also received approximately 150,000 additional recommended evidence-based clinical quality measures, such as smoking cessation, discharge instructions and pneumococcal vaccination. Participating hospitals report process and outcome measures in five clinical areas – acute myocardial infarction (AMI/heart attack), congestive heart failure (CHF), coronary artery bypass graft (CABG), pneumonia, and hip and knee replacement. The top 10 percent of hospitals receive a 2 percent incentive payment for patients in that clinical area. Hospitals in the second tier receive a 1 percent incentive payment. Hospitals in the top 50 percent of each clinical area receive public recognition on the CMS Web site.

- The transition of Medicare from pay-for-reporting to pay-for-performance should coordinate the VBP with the Physician Quality Reporting Initiative. Including physicians is a vital component to improving quality across the health care system as recent reports have found that only one fifth of eligible doctors participated in the physician reporting program.
- Rewarding quality is paramount but rewarding quality care that is provided efficiently is also important and should be an essential part of any pay-for-performance initiative in Medicare.
- When measuring quality, focusing on misuse and overuse is equally important as underuse. There is plenty of evidence that more care is not always better for patients or even good for them. We also want to help people understand that choosing healthy lifestyles and evidence-based disease prevention and screenings can do as much or more for their health and quality of life as health care. Medicare has taken some excellent first steps with its "Welcome to Medicare" program and preventive services but more can and should be done.
- To the extent possible, performance measures should incorporate outcomes of care and patient satisfaction in addition to structure and process measures.
- CMS should improve the meaningful disclosure of easy-to-understand performance results to the public, including Medicare data, which will reinforce the value of the VBP and pay-for-performance.
- The health care system will need sufficient health information technology infrastructure for on-going surveillance to report performance measures. Some providers, particularly solo and small group physician practices and those serving low-income urban and rural areas, may need financial assistance to purchase needed systems, software, training and related services.

Again, thank you for inviting me to speak on this important topic. We look forward to continuing to work with the Committee and CMS to transition our health care system to one based on transparency, value, quality and efficiency that we can all be proud of and that serve its beneficiaries well for exactly the kind of health care and quality of life they deserve.