Statement
of
Nicholas Wolter, M.D., and MHA- An Association of Montana Health Care Providers
before the
Committee on Finance
of the
U.S. Senate

"Roundtable to Discuss the Centers for Medicare and Medicaid Services" Hospital Value-Based Purchasing Program Implementation Plan"
March 6, 2008

Good afternoon, Chairman Baucus, Ranking Member Grassley, and distinguished members of the committee.

I am Nicholas Wolter, M.D, CEO of Billings Clinic in Billings, Montana. I sit on the Boards of MHA– An Association of Montana Health Care Providers, of the American Hospital Association, and of the American Medical Group Association. I am also completing a second term as a Commissioner on the Medicare Payment Advisory Commission. I very much appreciate the opportunity to share some thoughts on issues related to Pay for Performance and Value-Based Purchasing.

Given the wide geographic variation seen in annual costs per beneficiary and in performance based on currently available quality measures, an extremely important goal of Value-Based Purchasing should be to focus on high volume, high cost clinical areas with the intent of narrowing this geographic variation where evidence-based quality measures and well understood information about optimal expenditures for a given clinical condition exist. Value-Based Purchasing may well present the opportunity to improve quality and reduce costs in certain areas – for example: management of complex chronic disease, admission and readmission rates, end of life care, post operative complications and infection rates, and many others. Furthermore, the use of clinical effectiveness studies will help us look at widely varying utilization patterns in hopes of creating more standardization.

We should remember, however, that optimal care will likely increase costs in areas where there is under use of known evidence-based diagnostic and therapeutic interventions.

As much as possible, we should design Value-Based Purchasing to be patient centered. This means moving to payment models which cross silos and extend over time. Examples of this would be bundling of DRGs, payment for episodes, including a period of time post-discharge, and mini-capitation with annual payment for patients with chronic disease. As these payment models are designed, it will be critical to create synergy between hospital and physician quality and safety measures.

Since patient centered care is so important, it is also worth noting that newly emerging models of patient shared decision making offer significant potential to add value as well.

As new payment models are developed, they may incent over time, the formation of integrated systems of care, accountable care organizations, virtual groups and PHOs which may allow for more capability and accountability on the part of provider systems to deliver improved quality at more optimal cost. Many believe that reorganization of the underlying fragmented delivery system will be a key factor in our ability to deliver much improved value to patients and their families. In fact, trying to impose a Value-Based Purchasing system on top of currently fragmented silos of care is almost certainly likely to undershoot, at best, our potential for significant improvement.

With this in mind, policy makers and regulators should have the long view in mind. Design of Pay for Performance and Value-Based Purchasing tactics are in a very early phase. These will require significant refinement over time. In addition, the cultural changes required of providers, particularly hospitals and physicians, to come together to develop value-based delivery systems will create difficulty and take time, even if relatively powerful financial incentives are gradually implemented. A plan for policy makers to stick with a Value-Based Purchasing framework, which incents the formation of more accountable provider systems of care over 10-15 years will take vision and persistence, something often difficult to achieve in a complex political environment.

As we look at design principles and tactics which incent delivery system accountability and improve value, we should remember that quality and performance are system properties, lessons taught us by quality experts from other industries, and more recently, from health care as well. The synergy we need between hospital and physician measures will certainly require that we look at group and system level measures. Although individual physician measures will have a place, they are not likely to move us to quantum improvement in the absence of system approaches to major care redesign. Examples of this abound: ventilator associated pneumonia, central line infections, post operative infections rates, preventive care measures, reduction in admission rates for chronic disease patients with congestive heart failure, asthma, diabetes, etc., and more.

As we move in this direction, regulatory as well as payment policy changes will be needed. For example, gain sharing, which could promote clinical integration and reward significant improvement in quality and value, should be promoted not inhibited.

Billings Clinic is participating in the CMS Physician Group Practice Demonstration Project. Based on our experience thus far, we would urge improvement in severity adjustment methodologies used to calculate cost comparisons and ultimate rewards. In addition, methodologies which use a comparator group of beneficiaries will need refinement. We would also comment that measurement methodologies which use a statistically valid sampling approach are significantly superior to arduous chart abstraction methodologies requiring 80-100% chart review.

A few other thoughts. As we look at the myriad of quality and cost measures being developed, it will be important to bring consistency and standardization to bear. The role of the National Quality Forum and of the Hospital Quality Alliance going forward to develop standardized, evidence-based and consistent measures, will greatly contribute to the credibility and long term success of Value-Based Purchasing. Hopefully, these measures can be coordinated with others, including Joint Commission and private payers.

Pay for Performance and Value-Based Purchasing have rightly focused thus far on larger institutions where quality and cost variations represent significant opportunity for improvement. In Montana, we are very interested in the role small PPS and critical access hospitals can play going forward. Lower volumes might place a premium on process over outcomes measures, though consortiums of critical access hospitals, such as the Montana Rural Healthcare Performance Improvement Network, can create larger denominators.

Many of the current CMS core measures do not apply well to critical access hospitals. Nevertheless, pneumonia care, medication reconciliation, emergency department stabilization and transfer, and preventive care are all areas where appropriate measures exist or are being developed for small rural hospitals. The Montana Rural Healthcare Performance Improvement Network consortium of critical access hospitals has done work looking at initial care of acute myocardial infarction, emergency department transfer protocols, perioperative care, and stroke care. In addition, significant educational support around process improvement techniques and skill set development has been developed.

Rural PPS and critical access hospitals passionately wish to participate in Value-Based Purchasing, and they believe they are well poised to perform well, and to provide leadership in this area. Rural and critical access hospitals bring a major positive attribute in terms of developing Value-Based Purchasing models. Quite frequently, they represent integrated models of care or at least relatively tight and positive relationships exist between medical staff and hospitals. In addition, critical access hospitals are very interested in participating in a CMS outpatient critical access hospital measure set, and have even been frustrated with that implementation schedule.

The budget neutrality issue is difficult in a cost plus one percent payment environment. Perhaps a quality payment pool could be created on top of the current critical access hospital payment system, with careful plans to measure downstream value improvements related to quality measures as well as things such as medication reconciliation, readmission rates, or other savings opportunities. The opportunity for Value-Based Purchasing success in the rural and critical access hospital environment is quite significant.

Mr. Chairman and distinguished committee members, I very much appreciate your interest and attention to what is a vitally important strategic initiative which will help create improved performance on the part of American health care providers.

Bibliography

Chassin, et al. **The Urgent Need to Improve Health Care Quality**, JAMA, 1998; 280: 1000-1005.

Institute of Medicine. **Crossing the Quality Chasm: A New Health System for the 21st Century**, March 1, 2001.

McGlynn, et al. **The Quality of Care Delivered to Adults in the United States**, NEJM, June 26, 2003.

Fisher, Wennberg, et al. **Regional Variation in Medicare**, Annals of Internal Medicine, 2003; 138: 272-287, 288-298.

Crossin, F.J. **The Delivery System Matters**, Health Affairs, November/December, 2005.

Commonwealth Fund Commission on a High Performance Health System, November, 2007.

Medicare Payment Advisory Commission. **Report to the Congress: Assessing Alternatives to the Sustainable Growth Rate System**, March, 2007.

Cortese and Smoldt. **Taking Steps Toward Integration**, Health Affairs, 2007; 26 w68-w71.

Working Through the Frustrations of Clinical Integration, Hospital and Health Networks, January, 2008.