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The Blue Cross and Blue Shield Association

Before the United States Senate Finance Committee

Roundtable on Hospital Value-Based Purchasing (VBP)

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Introduction

I am Dr. Allan Korn, Senior VP and Chief Medical Officer of the Blue Cross and Blue Shield Association. I greatly appreciate the opportunity to offer the perspective of the Association and its 39 independent, community-based and locally-operated Blue Cross and Blue Shield (BCBS) companies that collectively provide coverage to 100 million Americans. Medicare is of special importance to us because of our history of involvement since the program's inception in 1965: BCBS Plans have been the major administrators as fiscal intermediaries and carriers of the fee-for-service Medicare program, and BCBS Plans enroll 3.5 million Medicare beneficiaries in Medicare Advantage and Prescription Drug Plans.

We applaud the Committee for focusing on the need to reform our healthcare system to improve quality, value, and access. We are concerned that a healthcare system that is unaffordable for many today will not work for even more people tomorrow. We must make addressing both rising healthcare costs and extending coverage to everyone a national priority.

To that end, the Association has proposed a comprehensive five-point plan – *The Pathway to Covering America* – that builds on the employer-based system to improve quality, rein in costs, and expand coverage to all Americans.

One of the most important components of our plan is changing incentives to promote better care. Today, providers are generally paid based on the number of services they provide – even if these services are ineffective, redundant, or harmful. We believe the incentives in our system must be changed to advance the best possible care, not just more services. As I will discuss later in my remarks, this is the direction that Blue Cross and Blue Shield Plans are moving. And this is the direction that we recommend the government take: our plan includes a recommendation that the government incorporate pay-for-quality incentives into Medicare. Implementing value-based purchasing in Medicare would help change our reimbursement system from paying for more care to a system that rewards providers for delivering quality outcomes.

Quality Measures

We strongly support using nationally recognized performance measures as a foundation for value-based purchasing.

To the extent possible, we recommend using measures endorsed by the National Quality Forum (NQF), a public-private partnership that brings together a wide array of stakeholders. The NQF-endorsed measures represent the "best in class," enabling "apples to apples" comparisons, and reducing provider burden to respond to requests for performance information.

Because of the NQF's importance, we would urge that the federal government support the NQF by designating it as a National Coordinating and Standard-Setting Center for Performance Measures, and by providing stable and adequate funding.

When NQF-endorsed measures are not available, we recommend that CMS rely on measures based on other nationally recognized guidelines or measures identified or endorsed by the

respective national or statewide medical specialty society or association. In addition, because of the heavy resources needed to mine medical charts for pertinent information – largely a manual process because of the still-low rate of electronic health records' adoption – a concerted effort should be made to select measures that can be abstracted through administrative claims data.

BCBSA has relied on NQF-endorsed measures and measures developed in collaboration with leading medical societies and professional organizations to drive our innovative Blue Distinction Centers, which are designed to raise the bar on healthcare quality across the country. Blue Distinction recognizes facilities that meet objective, evidence-based thresholds for clinical quality; the Blue Distinction Centers provide Blue members with a credible and transparent means of identifying hospitals that meet their individual healthcare needs for select procedures and conditions.

Through Blue Distinction Centers, Blue members have access to hospitals nationally with Blue Distinction designations for transplants (more than 75 facilities), bariatric surgery (more than 200 facilities), cardiac care (more than 400 facilities) and, starting next month, complex and rare cancers (more than 80 facilities).

To become a Blue Distinction Center, hospitals successfully complete an RFI that requires them to satisfy objective, evidence-based selection criteria build around structure, process, and outcome measures. For example, to be designated a Blue Distinction Center for Cardiac Care, a hospital, among other things, must (1) have American Association of Cardiovascular and Pulmonary Rehabilitation Cardiac Program Certification (a structure measure); (2) provide aspirin to patients on arrival (an NQF-endorsed process measure); and (3) have 30 day Risk-Adjusted AMI Mortality (an NQF-endorsed outcome measure that is used by CMS) that is less than 16.4%.

I am pleased to report that aggregate data studied to date confirm that Blue Distinction Centers are associated with improved outcomes. For example, analysis of a geographically dispersed sample of more than 10,000 cases for one Blue Plan found that Blue Distinction Centers for Cardiac Care had significantly lower readmission rates for Acute Myocardial Infarctions (even though they had slightly higher risk scores), than facilities that submitted RFIs but did not meet Blue Distinction's selection criteria. Moreover, although cost does not enter into Blue Distinction Center selection criteria, the same Blue Plan data showed that hospitals that were awarded Blue Distinction status because they met all RFI-required criteria demonstrated lower cost per event ($25,160) than hospitals that failed to meet RFI-required criteria ($39,018).

Separate from and in addition to Blue Distinction, individual BCBS Plans are increasingly using Quality-Based Incentive Programs to change incentives to promote better care. Plans modify reimbursements to hospitals and physicians based on consensus quality standards endorsed by the NQF or designed by other third-party experts such as the Hospital Quality Alliance. For example, Blue Cross and Blue Shield of Hawaii has a Quality Service Recognition (QSR) program that is a voluntary program for its PPO participating physicians and hospitals. It provides financial incentives for meeting national clinical quality benchmarks in the delivery of care. In 2006, the program paid $16.9 million to 17 hospitals and 2,575 physicians. QSR has been in place for more than eight years. The Hawaii Plan was the first health plan in the nation to develop and implement such a pay-for-performance incentive program.

A number of Blue Cross and Blue Shield Plans are expanding their quality-based incentive programs by launching pilots with local hospitals using Premier's Quality-Safety-Efficiency-Transparency (QUEST) program. Premier, Inc. is a hospital performance improvement alliance with 1,700 participating not-for-profit hospitals and health systems serving communities nationwide. QUEST is a three-year program through which participating hospitals will report data to Premier on a set of clearly defined performance measures encompassing aspects of quality, efficiency, safety, and patient satisfaction. BCBSA serves on QUEST's advisory panel, and is working with Premier to determine the best ways to support and provide incentives to hospitals participating in the QUEST program.

Performance Standards

We believe the goal of value based purchasing should be to raise all providers' performance. Setting minimum thresholds, or scoring providers on a "curve" that allows only a certain percent to be considered high-performers, are not optimal strategies. Paying only for performance at the highest levels discourages providers at lower levels that cannot hope or expect to be eligible for incentive payments. Instead, as we do in Blue Distinction, we would urge CMS to set high standards for performance, see how many providers reach that standard, and then help other providers who fall short meet that standard in future years. Indeed, helping denied facilities is an important part of Blue Distinction. We give "report cards" to such facilities to help them pinpoint areas for improvement, and BCBS Plans work with those facilities to improve and reapply.

Two other features of Blue Distinction that we would urge CMS to include in its VBP programs:

- Reevaluate facilities every 18 to 24 months; and
- Raise quality standards in each RFI cycle.

Continually raising the bar for Blue Distinction Centers is feasible because Plans work with facilities, a point that is relevant to the question of implementation.

Implementation

Hospitals, especially smaller or rural hospitals, or hospitals serving vulnerable populations, will need a good deal of education and support to change their workflows and adopt process improvements to make the most of value-based purchasing. One reason that we believe it is feasible to raise quality standards in each RFI cycle of Blue Distinction is that BCBS Plans work with the facilities on an ongoing basis. In the context of Medicare, it will be up to the Medicare Administrative Contractors to play this role. Therefore, it is critical that a Medicare VBP program be accompanied by additional administrative funding for Medicare contractors to educate hospitals about the new program, and to provide them ample technical support.

Monitoring the success of value based purchasing and quality recognition programs is a challenge. In some ways this is only the first step in transforming payment to support better, not more, care. However, this important step must be evaluated according to the overall goals of the program.

Structure of Incentives

Finally, let me offer our perspective on the critical question of how to structure incentives. BCBSA and BCBS Plans' extensive experience indicates that incentive programs work best when the goal is raising performance of all providers, rather than creating marked winners and losers. This is true of both recognition and financial reward programs.

Taking money away from the low-performers (as in a budget-neutral program) should be avoided – it will only make it more difficult for the low-performers to improve in succeeding years. To raise the quality bar, incentives must be available to all to achieve high standards.

Conclusion

In conclusion, BCBSA and BCBS Plans commend this Committee for its commitment to value-based purchasing, because the incentives in our healthcare delivery system must be changed to promote the best care for patients. Changing incentives to reward providers for delivering high quality care is a central plank of our comprehensive proposal for improving the quality and value of our healthcare system.

As the government continues to incorporate pay-for-quality incentives into Medicare, we would urge CMS to consider our perspectives on the major questions raised today:

- To the greatest extent possible, depend on – and give support to – the National Quality Forum. When NQF-endorsed measures are not available, rely on measures based on other nationally recognized guidelines or measures identified or endorsed by the respective national or statewide medical specialty society or association.

- Set the performance bar high with the goal of raising all providers' performance. CMS should not set minimum thresholds, or score providers on a "curve" that allows only a certain percent to be considered high-performers.

- Provide hospitals sufficient education and support, which will require additional administrative funding for Medicare contractors.

- Reward providers who raise performance, but do not take money away from low-performers.

Again, thank you for the opportunity to participate in the Roundtable, and I look forward to your questions.