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November 26, 2008

Mr. Donald S. Clark
Federal Trade Commission
Office of the Secretary
Room H-135 (Annex F)
600 Pennsylvania Avenue, NW
Washington, DC 20580

RE: Emerging Health Care Competition and Consumer Issues — Comment Project No. P083901

Dear Mr. Clark:

On behalf of the Premier healthcare alliance serving more than 2,000 not for profit hospitals and health systems and more than 53,000 other healthcare sites, we appreciate the opportunity to respond to the Federal Trade Commission's (FTC's) solicitation of comments on competition among healthcare providers based on quality information. Premier, a 2006 Malcolm Baldrige National Quality Award recipient, operates one of the leading healthcare purchasing networks and the nation's most comprehensive repository of hospital clinical and financial information.

Premier is dedicated to the principles of value-based purchasing; our goal is for our hospitals to be in the top quartile for highest quality and lowest cost. Premier supports our members in achieving this goal by collecting, analyzing and sharing knowledge nationwide, aggregating purchasing, managing the nation's largest clinical database of quality improvement information, and promoting insurance risk management. Our members are demonstrating their commitment to this goal by, among other things, participating in the Premier Hospital Quality Incentive Demonstration (HQID) project with the federal agency the Centers for Medicare & Medicaid Services (CMS), and our new collaborative project QUEST: High Performing Hospitals Collaborative initiative (Quality, Efficiency, Safety and Transparency). These two programs rely on transparent measurement to foster quality improvement and safely reduce costs among our member hospitals.

Premier is also a measure developer. While our foremost objective is to develop measures that assist our hospitals in internal quality improvement and cost reduction efforts, rather than to create measures for public reporting programs, one of our measures has been endorsed by the National Quality Forum (NQF) and others are in the pipeline. Thus, both Premier's members and Premier itself have a vested interest in appropriate market competition based on quality and are uniquely suited to comment in this area.

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Premier applauds the FTC for bringing together nation-wide experts to discuss the use of quality information in healthcare competition at its October 30 workshop. We agree with many of the issues and concerns raised by the panelists. Given that there was no opportunity for public comment during the session, however, we would like to share some thoughts and recommendations in this area.

Quality measurement has long been used by hospitals for performance improvement, but only recently has the intent shifted to encompass empowering consumer choice and decision-making through nation-wide transparent data. While we know that only a small minority of patients currently use the Hospital Compare data for this purpose, we must also remember that this type of publicly available quality and pricing data is a relatively new concept to healthcare. As more and more meaningful measures become available, younger more computer savvy generations become engaged, more hospitals adopt interoperable health information technology systems, and payers begin to differentiate provider payment and benefit design based on quality, the information will become more meaningful, valuable and widely used.

Along this road, however, we must be careful to ensure that hospitals are not over burdened by the collection of these measures; the measures remain useful for internal quality improvement activities; and that the structure of such reporting programs allow providers to work with and learn from each other. Ultimately, the primary goal is to improve the quality of healthcare services. Our QUEST program, for instance, is built on the fundamental principle of collaboration. While competition based on quality may be an ultimate goal for consumer choice, and hospitals welcome that, we have to ensure that data and best-practice sharing are not hindered as this is how hospitals make the most progress in improving quality and reducing costs.

In addition, the current payment policies that reward providers for volume rather than quality and reimburse based on site of care versus an episode of care, create perverse incentives that make it exceedingly difficult for providers to improve outcomes. Incentives must be aligned between hospitals, physicians and post-acute care providers to reward collaboration, improved quality and greater efficiency. Strategies to increase value must also incentivize providers (carrots) to make changes on their own rather than instituting government mandates on providers (sticks). Such policies should not be instituted on a case-by-case basis where the care of any given individual may be unduly influenced, but rather should be applied on a population basis, where possible, to change the system as a whole.

At the workshop, the FTC staff asked what it could do to enhance healthcare competition. Below are some of Premier's recommendations.

1. **Medicare Value-Based Purchasing**— Support a nation-wide value-based purchasing program based on the extension to the Premier CMS Hospital Quality Incentive Demonstration (HQID) model of basing a portion of provider payments on performance on quality measures. The FTC should also encourage CMS to:

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a. Follow a **transparent and systematic process** in introducing new measures into the system.
b. Incorporate new process, outcomes, efficiency and structural **measures** into any Medicare VBP system.
c. Add broad **domains** of quality improvement such as readmissions and hospital-acquired conditions that may be scored differently then the rest of the measures to any Medicare VBP model.
d. Support the implementation of **ICD-10** that will allow a more granular level of information to be collected and used to track progress in quality improvement and set payment rates.
e. Incent **public and private initiatives** focused on collaborative improvement and knowledge-sharing among hospitals.
f. Allow providers to supplement the efforts of Quality Improvement Organizations through a **voucher system** to participate in private collaboratives to improve quality.
g. Track public and private evidenced-based payment incentive programs and encourage **coordination.**
h. Use Medicare administrative and quality data to investigate the relationship between **race, gender, and poverty** and health outcomes and share this information with providers.

2. **Proprietary Quality Measures**—Urge CMS not to adopt proprietary measures in public quality reporting programs, unless fully transparent, as we believe this will lead to monopolistic suppliers of quality measures and stifle marketplace competition. We believe that proprietary measure developers should be required to provide hospitals with the means to regularly calculate their performance on a required measure without necessarily purchasing the entire proprietary system. By doing so, not only will hospitals benefit from a choice of vendors, but consumers will gain from useful, comparable data that will assist them in the important choice of where to seek healthcare. We provided more detailed comments on this issue prior to the workshop.

3. **Quality Measure Standards**—Support the National Quality Forum's efforts to standardize common measure elements to reduce the burden on providers and improve comparability of data.

4. **Gain-sharing**—Encourage the Congress and Department of Health and Human Services (both CMS and the Office of the Inspector General) to establish safe harbors under the Anti-Kickback, Civil Monetary Penalties and Stark laws that allow hospitals and physicians to collaborate on quality improvement initiatives and share the resulting savings. CMS is actively considering such an exception with comments due February 17.

5. **Health Information Technology (HIT)**—Support the adoption of HIT by hospitals through financial incentives as part of value-based purchasing

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initiatives or through grants, loans etc. Also, support standards and certification of HIT products to ensure interoperability, which is the key to harnessing the information from decision support systems into public reporting and other programs.

6. **Evidenced-Based Guidelines**—Expand evidenced-based guidelines through clinical research including the relationship between specific process indicators as well as a "bundle" of care on patient outcomes. Encourage the Agency for Healthcare Research and Quality to continue posting such information on their Web site for public access.

7. **Comparative Effectiveness**—Support a new federally sanctioned, private organization that includes appropriate representatives of stakeholders that is funded by both the government and private stakeholders to prioritize and sponsor research, including meta-analysis, cohort studies, literature reviews and controlled clinical trials to ascertain comparative effectiveness.

In closing, Premier appreciates the opportunity to submit these comments on competition among healthcare providers based on quality information. Contact Danielle Lloyd, senior director for reimbursement policy, at 202.879.8002 if you would like to discuss further.

Sincerely,

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