PREMIER

September 30, 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 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 nationwide knowledge, aggregating group 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 initiative (Quality, Efficiency, Safety and Transparency). Attached, you will find additional information on these two

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programs that 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 (NQF works to promote a common approach to measuring healthcare quality). Thus, both Premier's membership and Premier itself have a vested interest in appropriate market competition based on quality and are uniquely suited to comment in this area.

PUBLIC QUALITY MEASURE REPORTING

We believe that there is an area of concern that the FTC did not include in its questions for public comment that we would like to raise for consideration during the workgroup meetings. **Specifically, we urge the FTC to address the use of proprietary measures in public quality reporting programs, as we believe this has the potential to lead to monopolistic suppliers of quality measures and further stifle marketplace competition by denying consumers access to transparent information on the quality of healthcare.**

CMS proposed in its fiscal year (FY) 2009 Medicare inpatient prospective payment system rulemaking to add 15 cardiac surgery measures as part of its reporting hospital quality data for annual payment update (RHQDAPU) program. The measures would be reported in FY 2009 and affect Medicare payment in FY 2010 based on data from the Society of Thoracic Surgeons (STS) Cardiac Surgery Clinical Data Registry:

- Participation in a Systematic Database for Cardiac Surgery
- Pre-operative Beta Blockade
- Prolonged Intubation
- Deep Sternal Wound Infection Rate
- Stroke/CVA
- Postoperative Renal Insufficiency
- Surgical Reexploration

- Anti-platelet Medication at Discharge
- Beta Blockade Therapy at Discharge
- Anti-lipid Treatment at Discharge
- Risk-Adjusted Operative Mortality for CABG
- Risk-Adjusted Operative Mortality for Aortic Valve Replacement
- Risk-Adjusted Operative Mortality for Mitral Valve Replacement/Repair
- Risk-Adjusted Mortality for Mitral Valve Replacement and CABG Surgery
- Risk-Adjusted Mortality for Aortic Valve Replacement and CABG Surgery

These measures would have been added to the existing 30 measures for which hospitals must report publicly or face a two percentage point reduction in their annual inflationary adjustment to their inpatient Medicare payments. CMS did not finalize these measures, in response to public comment, and instead adopted other measures bringing the total number of measures to 42. However, in the final rule CMS made it clear that these measures would be proposed again next year.

Premier adamantly opposes the integration of quality measures based on proprietary methodologies and algorithms into the hospital public reporting program unless they are made fully transparent. CMS should seek other mechanisms to collect and report such cardiac measures. Our concerns are twofold.

Firstly, one of the cornerstones of RHQDAPU program is transparency. Public reporting of quality measures is only meaningful to consumers if the measures used are reliably comparable across all reporting institutions. This requires that institutions follow identical data collection protocols and can only occur if the measure reporting and calculation mechanism is transparent and understood by all participants including the public at large. Without this transparency, the reporting will not appropriately engender marketplace competition as consumers will not be able to truly and accurately compare hospitals.

We are concerned that the proprietary nature of private registries could diminish the transparency of the program. While CMS does suggest that hospitals could submit data on their own to CMS, rather than through the registry, it does not currently have a mechanism to do so and does not mention any requirements that the entire registry data collection and measurement

process be made public. **We believe that all aspects of the registry data specifications, collection and measurement calculation algorithms would need to be placed in the public domain before such data are integrated into the program.** This action would permit all parties to reliably replicate the measure(s) used for public reporting. If the information is not transparent, the data collected will not be comparable for public reporting as it will not be in the same format, using the same nomenclature, based on the same calculation with appropriate risk adjustment, and from the same time frame submitted on the same interval.

The measures from the STS registry initially proposed for payment in FY 2010 do not meet these transparency criteria. The recently released NQF task force report on intellectual property even gives the STS registry as an example of measures they have endorsed, but the information provided "is inadequate for complete system evaluation by NQF and provides inadequate information for replication of the system by vendors and others." STS has made the registry data elements available, however the actual measure algorithms detailing how the data elements are used, derived values and other information are not in the public domain. The STS specific risk factor elements are available; however, the detailed risk model specifications are not. Therefore, institutions are not able to calculate the measures in a consistent or comparable fashion. **The information necessary for public reporting and appropriate marketplace competition are not transparent.**

Secondly, because the risk models are not transparent or in the public domain, individual institutions would not have the ability to apply these models unless they joined the STS registry. This would force the market to move to an individual company potentially driving up participation fees as well as associated proprietary software products, "certified" data vendors or data auditors' fees. In addition, requiring participation in registries to comply with public reporting may unintentionally encourage the proliferation of registries around other measures (i.e. orthopedic), create costly requirements on hospitals and allow monopolistic pricing power for private vendors. We estimate that it would cost a mid-sized hospital $1.5 million per year to implement the proprietary measures currently endorsed by NQF or those under consideration. This will also doubly burden hospitals in those states, like New York, that already require their hospitals to participate in state-based registries that are different from the private registries the federal government may endorse.

Premier supports and encourages private sector innovation, which can contribute valuable methodologies that enhance quality measures. However, we believe that for a measure to be NQF endorsed and CMS adopted within the public reporting programs, the measure developer should be obligated to:

1) Disclose the methodology openly to the scientific and peer community so that the specifics of the measure may be completely understood (no black boxes), and
2) Provide a mechanism for those entities being measured to quickly, easily and with minimal cost access the methodology for application to their own data (no monopolies).

There are many ways by which a private company can recoup its costs and make a profit while also making public its methodologies, algorithms and data sources. Many business models are viable under these two constraints. Most of these would be based upon some additional value that the measure developer could uniquely provide. Here are a few examples.

- Value-added data processing: Although the methods might be available for free or for limited cost to individual institutions, clearly the measure developer could provide enhanced, more costly services for such value-adds as quicker, more convenient or more extensive data processing.
- Value-added analytics and reporting: Most institutions will require more than a simple method of applying the methodologies or risk adjustment. Many will want extensive reporting and analysis of their data. There is virtually no limit to the amount of value-added reporting that can be provided to a customer.
- Value-added comparative data: The developer of a measure may have access to a large amount of comparative data that might have been used in the measure construction. Access to comparative data could be offered as a value-add for an additional fee
- Value-added services: There is virtually no limit to the type and number of services that could be offered to institutions in order to help them improve and achieve top performances. Nothing under the constraints above would preclude a measure developer from offering such service, and though they may not be able to offer such services uniquely, as the measure developer they could enjoy considerable competitive advantage in this area.
- Third Party Commercial Licensing: Of course, measure developers would be able to enter into licensing agreements with commercial vendors who wish to incorporate the methods into their own commercial value-added products.

Premier is setting an example by making public the information necessary to replicate our NQF-endorsed measure as well as one other measure publicly available for free on our Web site or at minimal cost for software. The information will, however, remain subject to the same appropriate copyright constraints as measures developed by federal agencies such as the Agency for Healthcare Research and Quality (AHRQ). The information is available in the following ways:

- For institutions engaged directly in research or scholarly work, Premier is making available to qualified researchers and analysts, software with which they can obtain risk-adjusted values for their own data directly.
- For any organization wishing access to this data, Premier is making available through a publicly accessible tool on its Web site the ability to process multiple units of data and receive calculated risk-adjusted values.
- All documentation required for construction of the risk model will be publicly available on the Premier Web site.

By putting the methodologies and algorithms in the public domain, 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.

In closing, Premier appreciates the opportunity to submit these comments on competition among healthcare providers based on quality information. We look forward to participating in the broader discussion on these issues this fall. Please do not hesitate to contact Danielle Lloyd, senior director for reimbursement policy, at 202-879-8002 if you would like to discuss further.

Sincerely,

Blair Childs
Senior vice president, Public Affairs

Attachments:
1. Hospital Quality Incentive Demonstration Overview
2. Quest Overview

CMS/Premier Hospital Quality Incentive Demonstration: Year 3 Results

March 2008

About the CMS/Premier Hospital Quality Incentive Demonstration (HQID)

Launched in October 2003 by the Premier healthcare alliance and the Centers for Medicare & Medicaid Services (CMS), the Hospital Quality Incentive Demonstration (HQID) pay-for-performance project involves more than 250 hospitals in 35 states. These hospitals submit data to Premier for analysis, which then submits the data to CMS for validation.

The first national project of its kind, HQID is designed to determine if economic incentives to hospitals are effective at improving the quality of inpatient care. Participating hospitals report process and outcome measures in five clinical areas – acute myocardial infarction (AMI), congestive heart failure (CHF), coronary artery bypass graft (CABG), pneumonia, and hip and knee replacement.

The model used in the project includes financial incentives for the top 20 percent of hospitals in each of the five clinical areas. The top 10 percent of hospitals receive a 2 percent incentive payment for patients in that clinical area. Hospitals in the second decile receive a 1 percent incentive payment. Hospitals in the top 50 percent of each clinical area receive public recognition on the CMS Web site.

Findings through the third year of the HQID

Improvements in quality of care saved an estimated 2,500 AMI (heart-attack) patients in that related focus area alone over the project's first three years, according to an analysis of mortality rates at hospitals participating in the HQID project.

In addition, third-year results from the project demonstrate a significant improvement in quality of care across five clinical focus areas as measured by more than 30 nationally standardized quality indicators. The average improvement of the composite quality scores (CQS), an aggregate of all quality measures within each clinical area, between the project's second and third year was 4.4 percent for total gains of 15.8 percent over the project's first three years.

The average CQS improved significantly between the inception of the program and the end of Year 3 in all five clinical focus areas:

- From 87.5 percent to 96.1 percent for patients with AMI;
- From 84.8 percent to 97.4 percent for patients with coronary artery bypass graft;
- From 64.5 percent to 88.7 percent for patients with heart failure;
- From 69.3 percent to 90.5 percent for patients with pneumonia;
- From 84.6 percent to 96.9 percent for patients with hip and knee replacement.

In addition, the range of variance among participating hospitals also is closing, as those hospitals in the lower deciles continue to improve their quality scores and close the gap between themselves and the demonstration's top performers.

Rural hospitals overall demonstrated even greater improvement than non-rural hospitals in the first three years of the HQID. While rural hospitals started out with a lower composite quality score than non-rural hospitals, they experienced an average overall improvement of 11.71 percent across all clinical areas, compared to 10.89 percent for urban hospitals.

When compared to the rest of the nation's hospitals tracked in Hospital Compare, the quality score of hospitals in the HQID project (on 19 publicly reported quality indicators) was 7.48 percentage points higher by March 2007, confirming that performance incentives are effective at improving quality of care.

QUEST: High Performing Hospitals

PREMIER

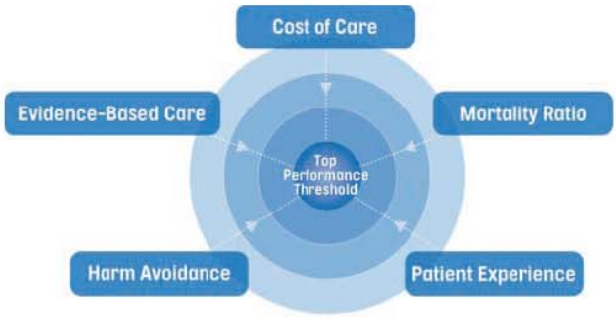
Achieving Unprecedented Results in Quality, Cost of Care, and Safety, with Transparency

WHAT IS QUEST?

QUEST: High Performing Hospitals is a dynamic program designed to assist hospitals and healthcare systems in driving healthcare to unprecedented levels of performance. Developed by Premier, the Institute for Healthcare Improvement (IHI) and a group of hospital leaders, QUEST builds on the success of the Premier/CMS Hospital Quality Incentive Demonstration (HQID) and helps to prepare for an increasingly challenging healthcare future. QUEST seeks to develop the next generation of quality, cost of care, and safety metrics with a consistency and standardization that does not exist today.

In QUEST, industry leaders, IHI, and forward-thinking hospitals are working with the Premier healthcare alliance to develop and share the best practices for improving performance in quality, cost of care, safety, and transparency across five dimensions.

- Care
- Cost of Care
- Mortality Ratio
- Patient Experience
- Harm Avoidance



With a unified commitment to the high standards of QUEST, participating hospitals will move into the top quartile of performance within three years and further secure a position as an industry leader, differentiating the quality of services in local markets and across the nation.

WHAT DOES SUCCESS LOOK LIKE?

The success of QUEST will measure movement from baseline performance into top-quartile performance. Working with other dedicated QUEST participants and industry thought leaders, a number of specific benefits will be realized:

- Achieve rapid improvements in quality, cost of care, and safety
- Broaden top performers' recognition to payers, employers, and consumers
- Influence industry development of consistent quality metrics
- Share in a reward pool for demonstrated performance improvement

DRIVING HEALTHCARE TO NEW LEVELS OF PERFORMANCE

Through this program, hospitals and healthcare systems will learn better practices, become the best in all dimensions of care, and learn adoption strategies to achieve reliable results – and thus, will become industry leaders who succeed to differentiate the quality of their services in local markets and across the nation.

FOR MORE INFORMATION

Please visit www.premierinc.com/quest or contact the Premier Solution Center, 800.805.4608.

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ABOUT PREMIER INC., 2006 MALCOLM BALDRIGE NATIONAL QUALITY AWARD RECIPIENT

Serving more than 2,000 U.S. hospitals and 53,000-plus other healthcare sites, the Premier healthcare alliance and its members are transforming healthcare together. Owned by not-for-profit hospitals, Premier operates one of the leading healthcare purchasing networks and the nation's most comprehensive repository of hospital clinical and financial information. A subsidiary operates one of the nation's largest policy-holder owned, hospital professional liability risk-retention groups. A world leader in helping healthcare providers deliver dramatic improvements in care, Premier is working with the United Kingdom's National Health Service North West and the Centers for Medicare & Medicaid Services to improve hospital performance. Headquartered in San Diego, Premier has offices in Charlotte, N.C., Philadelphia and Washington. For more information, visit www.premierinc.com.

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