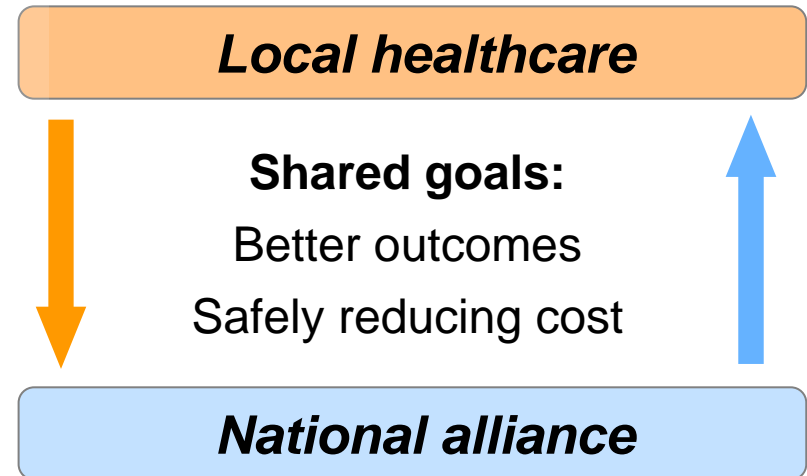
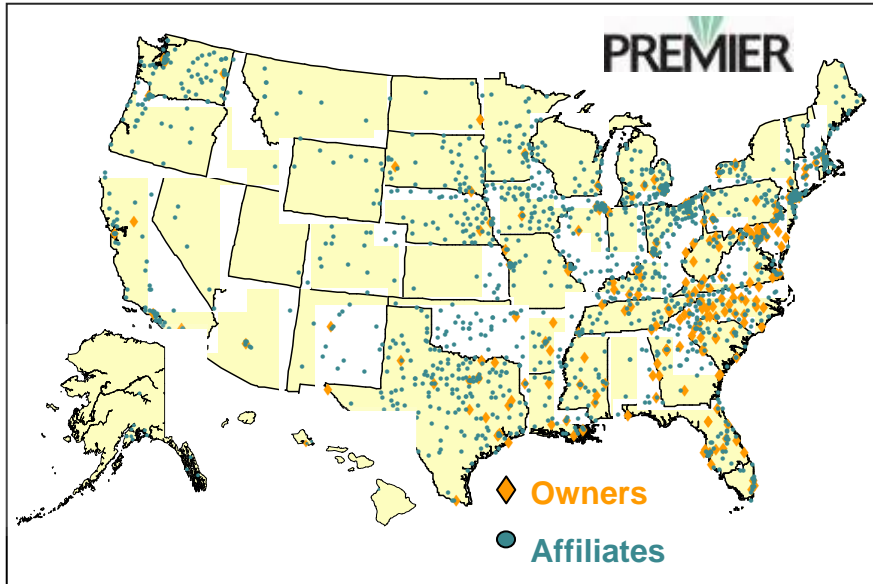


History and Future Outlooks for Hospital P4P

Richard A. Norling
President and CEO
Premier Inc.



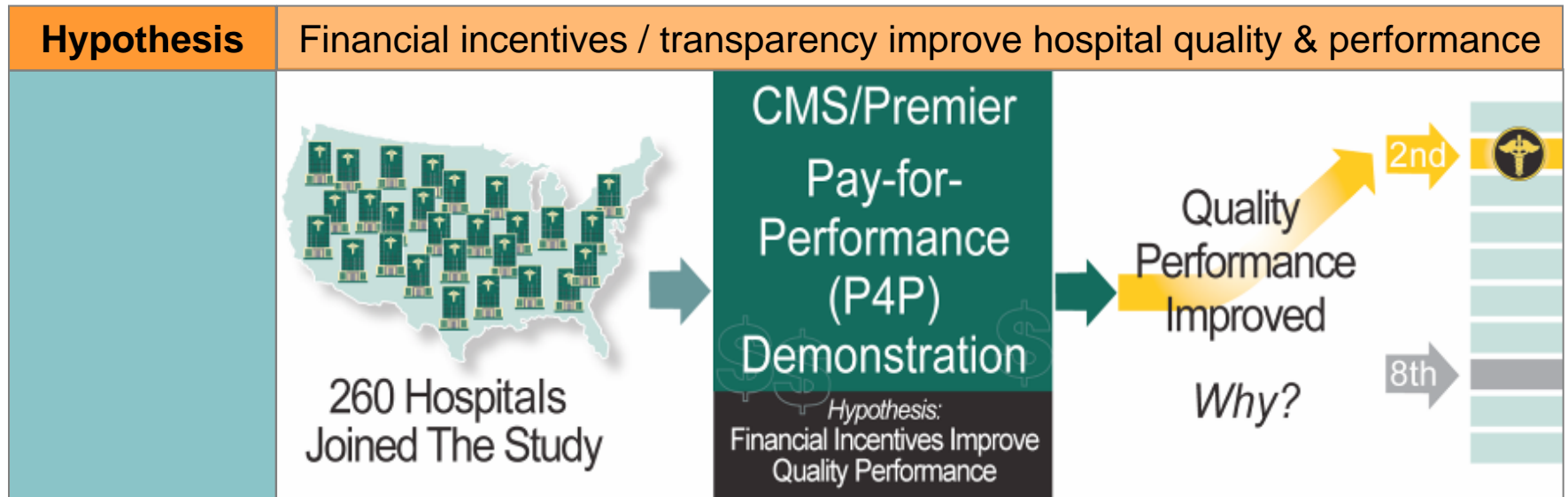
Bringing Nationwide Knowledge to Improve Local Healthcare



- Owned by 200 not-for-profit hospitals and health systems
- Serving more than 2,100 hospitals and 54,000 other providers
- Sharing of clinical, labor and supply chain data for benchmarking
- \$33 billion in group purchasing volume – largest in U.S.
- Highest ethical standards - leading Code of Conduct
- Diversity, safety and environmental programs
- Recipient of 2006 Malcolm Baldrige National Quality Award

Overview of Premier/CMS P4P project

Premier is leading the first national CMS pay-for-performance demonstration for hospitals. More than 260 Premier hospitals participate voluntarily.



Findings

- Financial incentives did focus hospital executive attention on measuring and improving quality.
- Hospitals performance has improved continuously over time.

Hospital Quality Incentive Demonstration (HQID)

Key Facts

- Three year demo (2003-2006); extended for three additional years through Oct. 2009
- 250 hospitals in 37 states
- **Quality measures**
 - First 3 years: 33 nationally recognized measures in five clinical conditions:
 - Heart attack (Acute myocardial infarction (AMI))
 - Heart bypass surgery (Coronary artery bypass graft (CABG))
 - Heart failure (HF)
 - Community acquired pneumonia (PN)
 - Hip and knee replacement surgery (Hip/Knee)
 - Second three years: 41 nationally recognized measures in multiple clinical conditions
- **Financial incentives**
 - First three years: Top 2 deciles in each condition rewarded; Penalties for hospitals still in the bottom 2 deciles in each condition (set in year 2)
 - Second three years: Awards paid for threshold attainment, most improvement, and top performer; similar penalty methodology

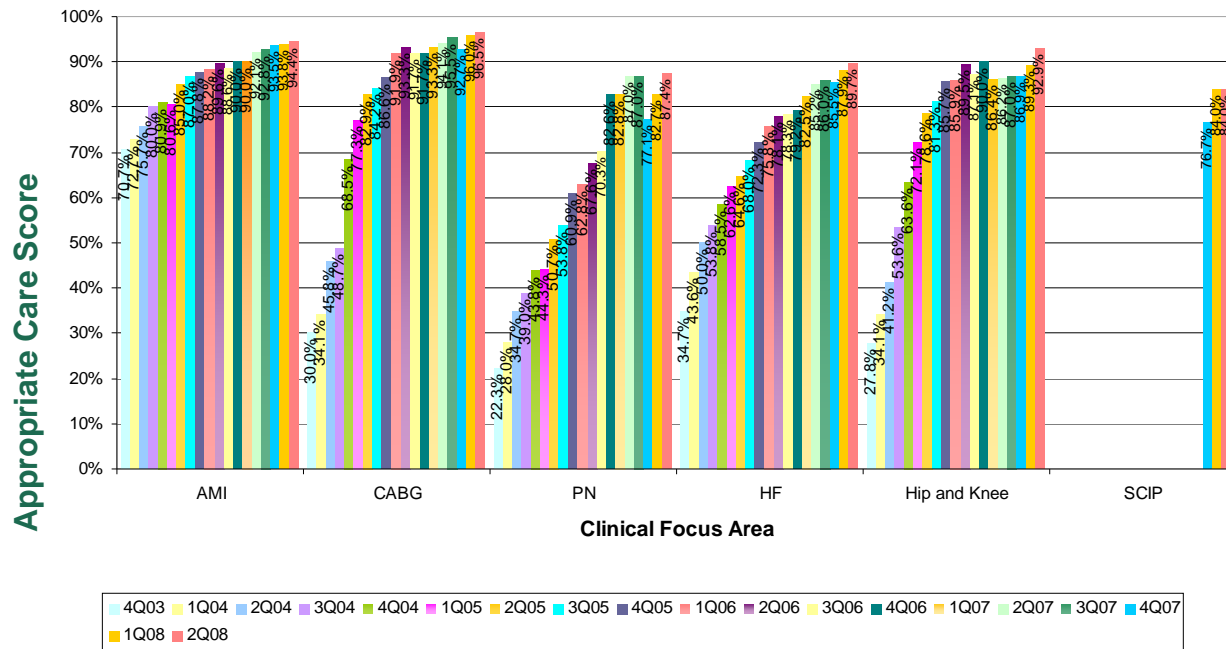
More Patients Are Reliably Receiving Evidenced-based Care

**Avg. improvement
from 4Q03 to 2Q08 in
all clinical areas
(19 quarters)
55.05%**

| Clinical Area | Improvement (percentage points) |
|---------------|---------------------------------|
| AMI | 23.7% |
| CABG | 66.5% |
| Pneumonia | 65.1% |
| Heart Failure | 54.9% |
| Hip & Knee | 65.1% |

Evidence-based Care Improvements

CMS/Premier HQID Project Participants Appropriate Care Score:
Trend of Quarterly Median (5th Decile) by Clinical Focus Area
October 1, 2003 - June 30, 2008 (Year 1, 2, and 3 Final Data; Year 4 and 5 Preliminary)



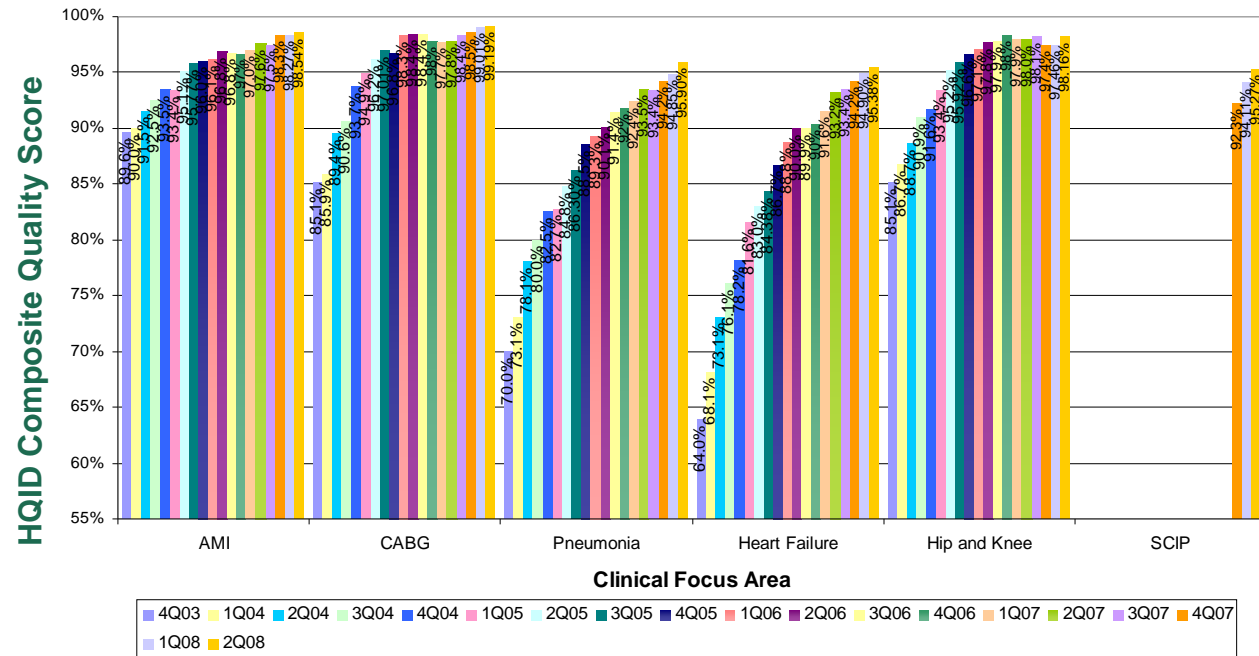
Dramatic and Sustained Improvement

Avg. improvement
across all 5 clinical
areas for median CQS
(19 quarters)
18.66%

| Clinical Area | Improvement (percentage points) |
|---------------|---------------------------------|
| AMI | 8.9% |
| CABG | 14.1% |
| Pneumonia | 25.9% |
| Heart Failure | 31.4% |
| Hip & Knee | 13.0% |

CMS HQID Composite Quality Score

CMS/Premier HQID Project Participants Composite Quality Score:
Trend of Quarterly Median (5th Decile) by Clinical Focus Area
October 1, 2003 - June 30, 2008 (Years 1, 2, & 3 Final Data; Years 4 and 5 Preliminary Data)



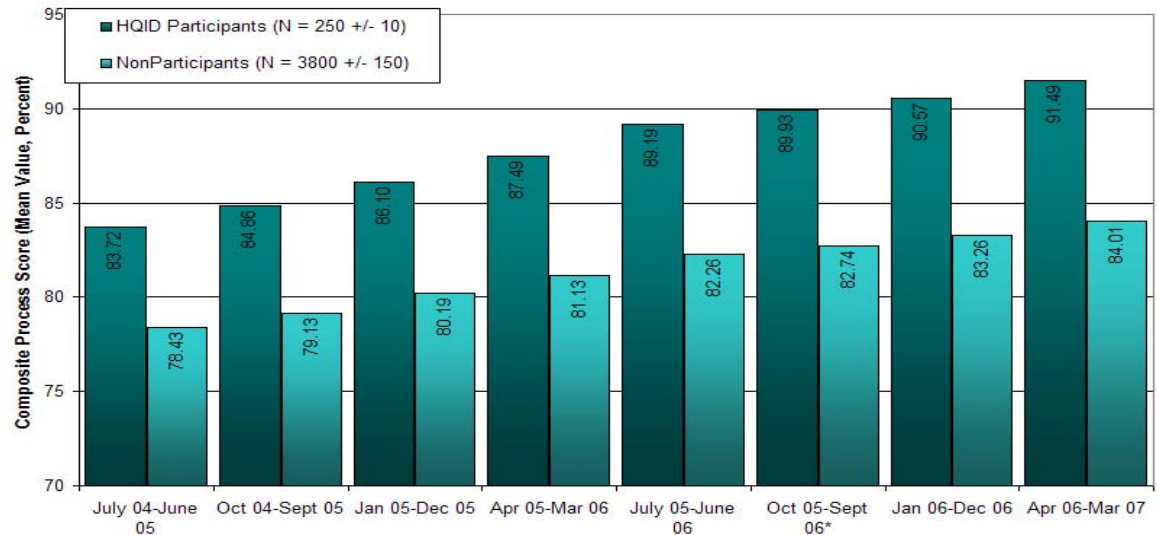
In Broader Comparison, HQID Hospitals Excel

National Leaders in Quality Performance

- HQID participants avg. 6.5% higher than Non-Participants
- Avg. improvement for HQID participants = 7.8%
- Avg. improvement for Non-participants = 5.6%
- New England Journal of Medicine publication by Lindenauer et al. (February 2007) found that hospitals engaged in P4P achieved quality scores 2.6 to 4.1 percentage points above other hospitals due solely to the impact of P4P incentives.

HQID hospitals have higher quality ratings* than national hospitals overall
 *CMS process score

Premier Engagements Compared to National Group Trend
 Hospital Compare Data
 19 Process Measures Aggregated to Overall Composite Process Score



Comparison of HQID Participation, Premier Member, and Non-Premier Status

*Beginning with Oct 05-Sept 06 the influenza vaccination measure became unsuppressed and the number of process measures increased from 18 to 19

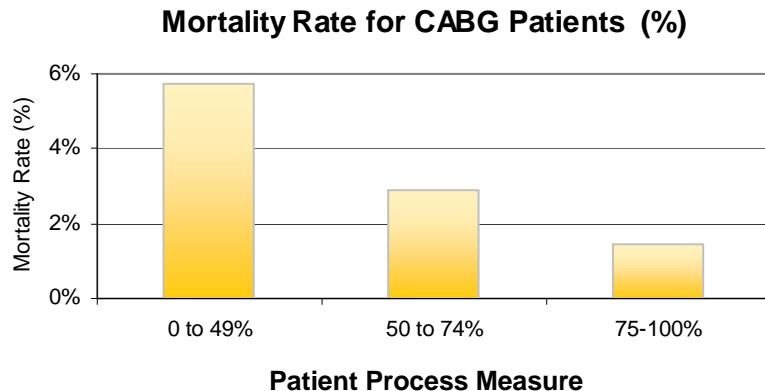
A composite of 19 measures shared in common between HQID and Hospital Compare shows P4P hospitals performing above the nation as a whole

Premier Performance Pays Research

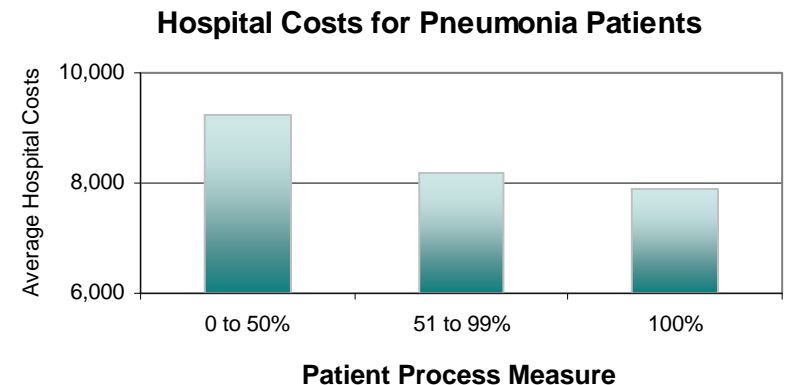
Premier's Performance Pays study demonstrated that when evidence-based care is reliably delivered, quality is higher and costs are lower.

The recently updated study using all payors and three years of data (over 1.1 million patients), confirms this result.

Study finds higher reliable care yields lower mortality rates for heart bypass surgery patients



Study finds higher reliable care yields lower hospital costs for patients with pneumonia



Improvement and Savings Over Three Years

Avg. cost improvement per patient across all clinical areas

\$1,063

| Clinical Area | Improvement |
|----------------------|-------------|
| Heart Attack | \$1,599 |
| Heart Bypass Surgery | \$1,579 |
| Pneumonia | \$811 |
| Heart Failure | \$1,181 |
| Hip Replacement | \$744 |
| Knee Replacement | \$463 |

Avg. improvement in mortality across four clinical areas

1.87%

| Clinical Area | Starting Score | Ending Score | Improvement |
|----------------------|----------------|--------------|-------------|
| Heart Attack | 8.86% | 6.59% | 2.27% |
| Heart Bypass Surgery | 2.51% | 1.55% | 0.95% |
| Pneumonia | 9.28% | 6.89% | 2.39% |
| Heart Failure | 4.84% | 2.99% | 1.86% |

If all hospitals in the nation were to achieve this improvement, the estimated cost savings would be greater than **\$4.5 billion annually** with estimated **70,000 lives saved per year**

International Portability of P4P

UK North West “Advancing Quality” Program

England’s largest health authority using Premier/Medicare P4P project as a model for improving patient care

- 40 hospitals across the NW region
- Measured in five clinical areas
- Program initiated on Oct 1
- Expected savings = £17M each year in reduced LOS, re-admissions



Overview of Advancing Quality

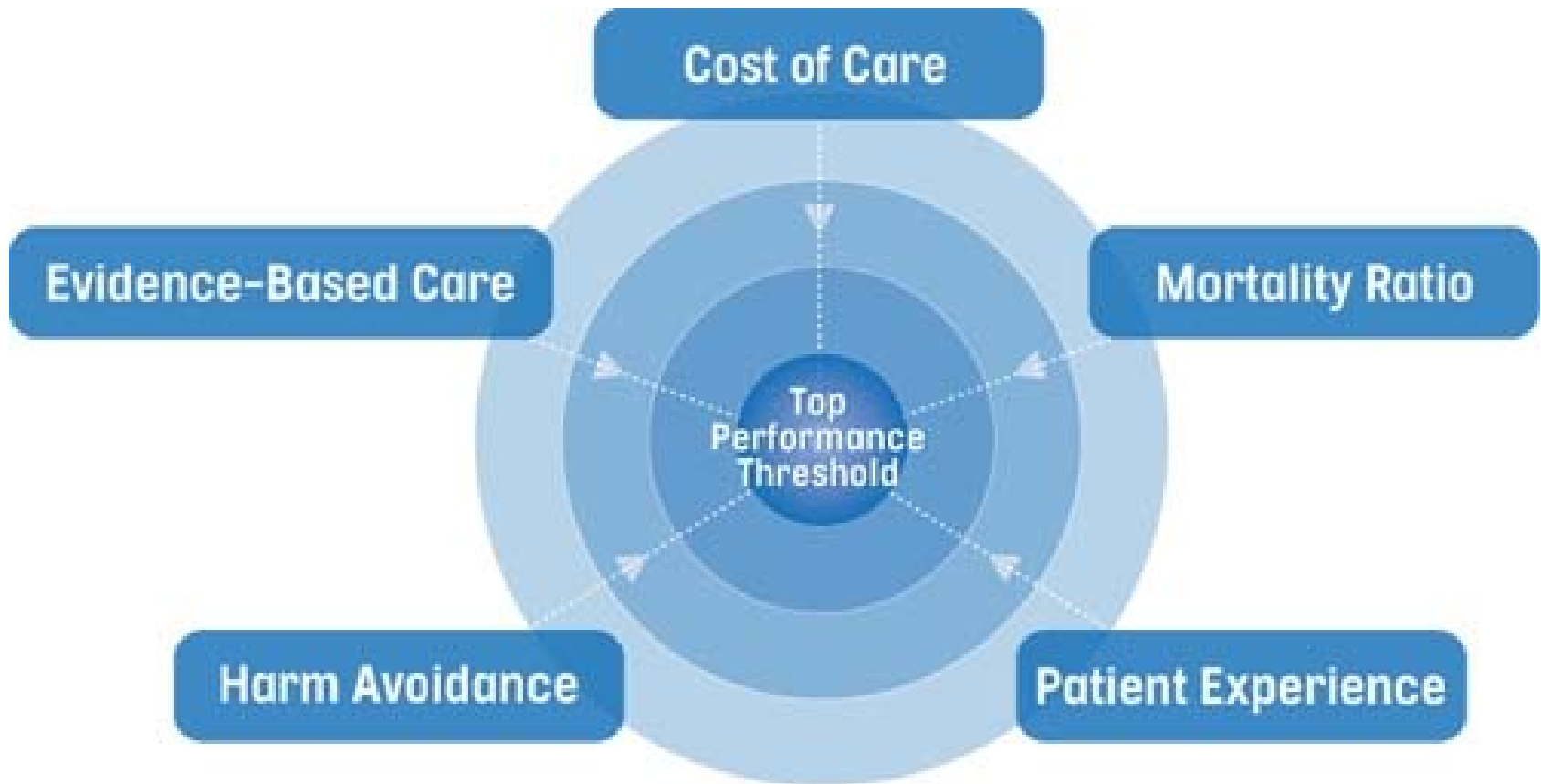
- Value creation is the objective
- Measurement is systematic
- Measurement supports the objective
- Sound logic underlies each performance measure
- Selection of measures unambiguous
- A measurement culture exists
- Clear rationale for incentive compensation
- Management encourages open communication of results
- Measurement system is simple to use
- Measures processes (inputs) and outcomes

Next-Generation of P4P is QUEST: A Focus on Quality, Efficiency, Safety, with Transparency



- A collaborative of more than 160 hospitals treating approximately 2.3 million patients annually, QUEST is designed to help springboard hospitals to a new level of performance.
- QUEST is not theory and rhetoric. It's about benchmarking, implementing, measuring and scaling innovative solutions to the complex task of caring for patients.
- QUEST's multidimensional approach is unlike any other attempted.
- QUEST represents a promise for measurable improvements in quality, safety and cost of care for patients and shared results to benefit all in healthcare.

Optimizing Quality, Efficiency and Safety: Moving to High Performance Healthcare Delivery



QUEST Advisory Panel



- **Agency for Healthcare Research and Quality (AHRQ)**
- **Alliance for Nursing Informatics, University of Minnesota**
- **American Board of Internal Medicine**
- **American College of Surgeons**
- **American Health Information Management Association**
- **American Heart Association**
- **American Hospital Association**
- **American Society for Healthcare Risk Management (ASHRM)**
- **Blue Cross Blue Shield Association (BCBSA)**
- **Centers for Disease Control and Prevention (CDC)**
- **Centers for Medicare & Medicaid Services (CMS)**
- **Institute for Healthcare Improvement (IHI)**
- **International Center for Nursing Leadership University of Minnesota**
- **John D. Stoeckle Center for Primary Care Innovation, Massachusetts General Hospital**
- **National Business Coalition on Health**
- **National Patient Safety Foundation (NPSF)**
- **National Quality Forum**
- **Office of the National Coordinator for Health Information Technology**
- **The Commonwealth Fund**
- **The Joint Commission**
- **The Rand Corporation**

Aggressive, Three-Year Improvement Goals

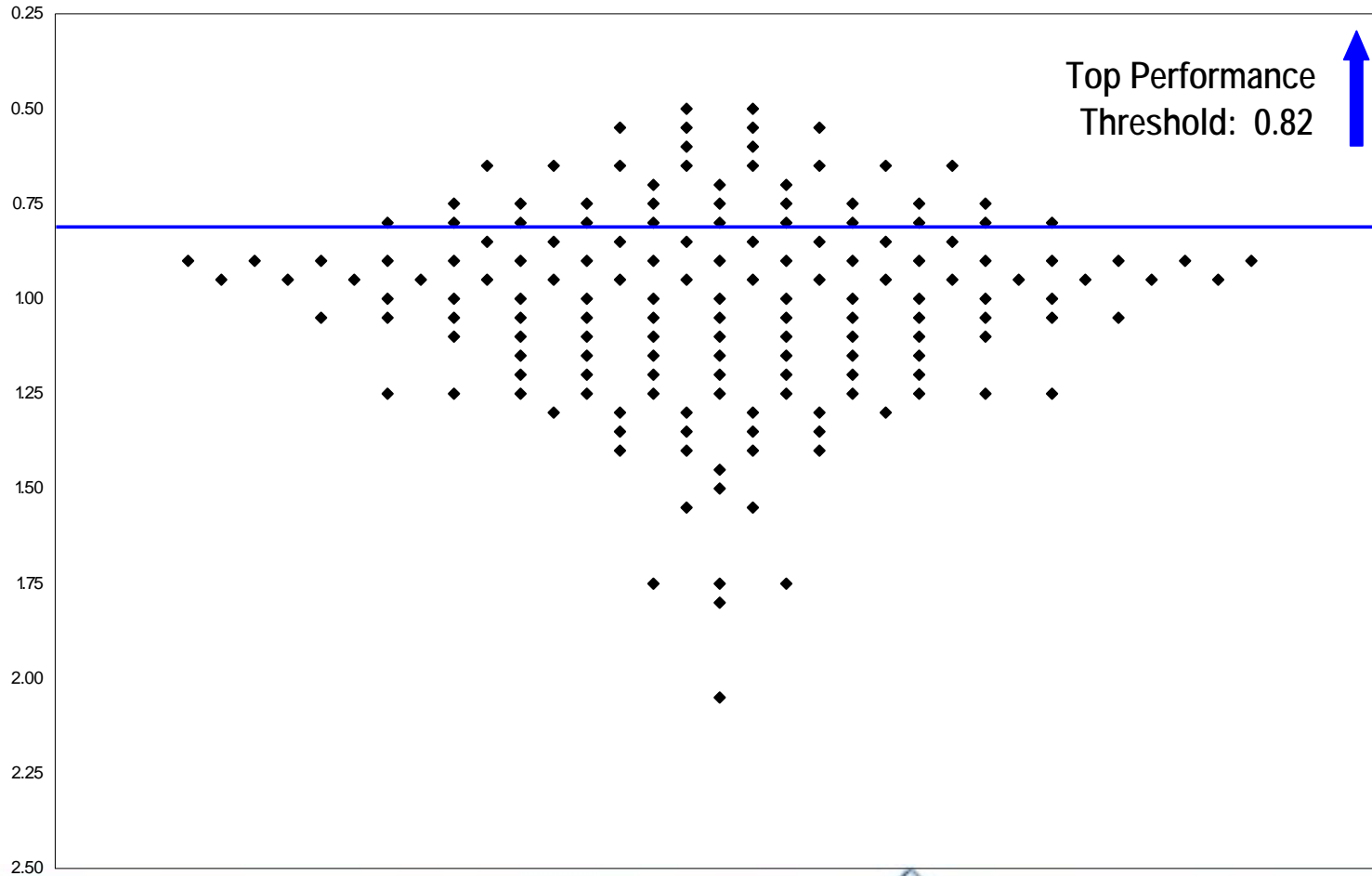
- **Save Lives** – Achieve a mortality rate that is 17 percent less than expected.
- **Improve efficiency** – Reduce inpatient costs below the mid point among participating hospitals.
- **Deliver the most reliable and effective care** – Deliver every recommended evidence-based care measure for each patient.
- **Improve patient safety (year 2 measure)** – Prevent incidents of harm in more than 20 categories, including healthcare-acquired infections and birth injuries.
- **Increase Satisfaction (year 2 measure)** – Dramatically improve the patient care experience.

QUEST Analysis

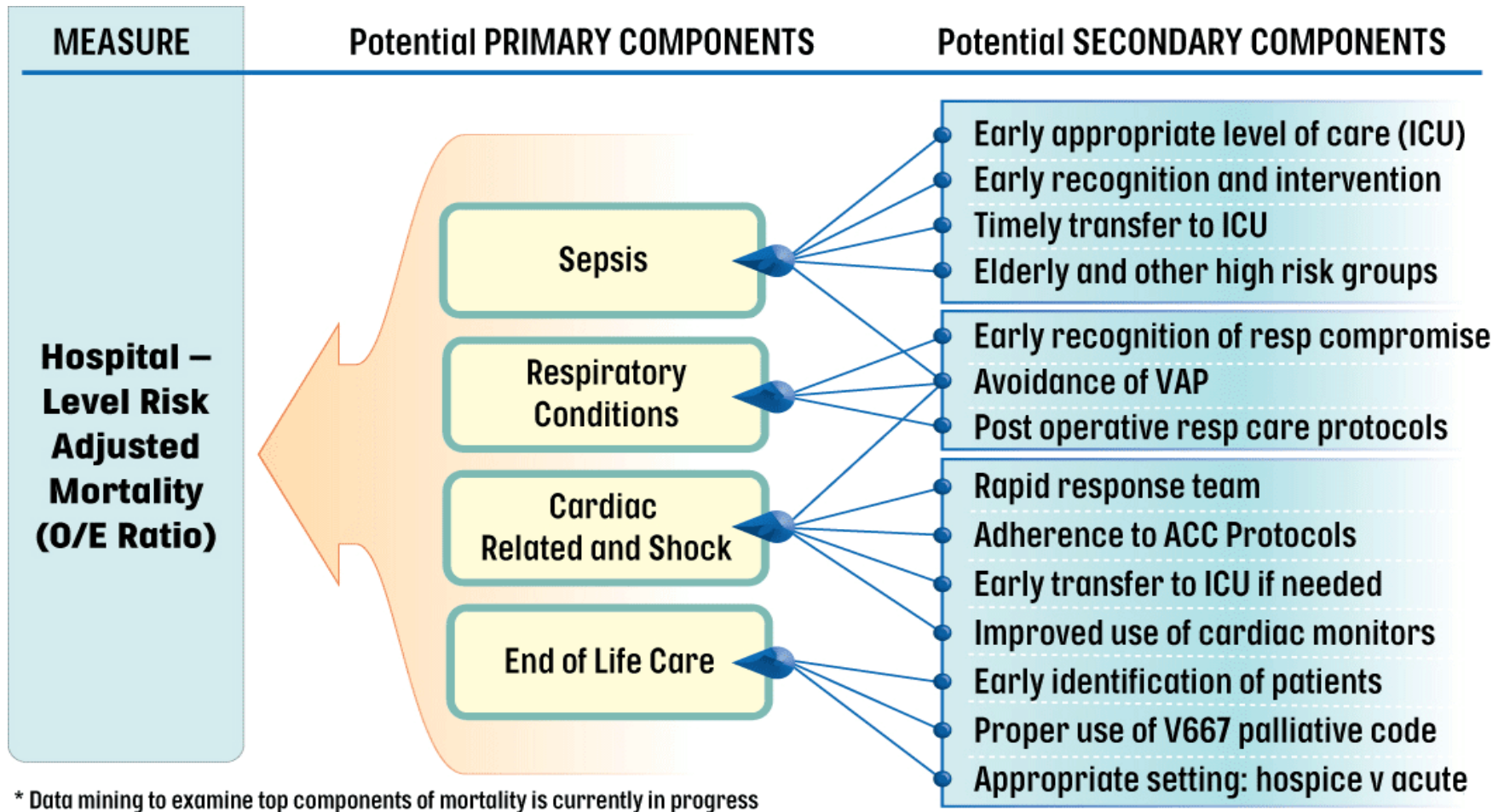
- If all QUEST hospitals attained the project's quality goals over the three-year period:
 - Patient mortality could be reduced by 17 percent, or 8,628 lives saved a year;
 - Reliability of care could improve by nearly 13 percent, or 22,364 more patients receiving all evidence-based appropriate care a year.

QUEST Mortality Goal: Move Hospitals over the Top Performance Threshold (O/E = 0.82)

Distribution of QUEST Hospitals on Observed vs. Expected Mortality Ratio
Baseline Period: July 1, 2006 through June 30, 2007



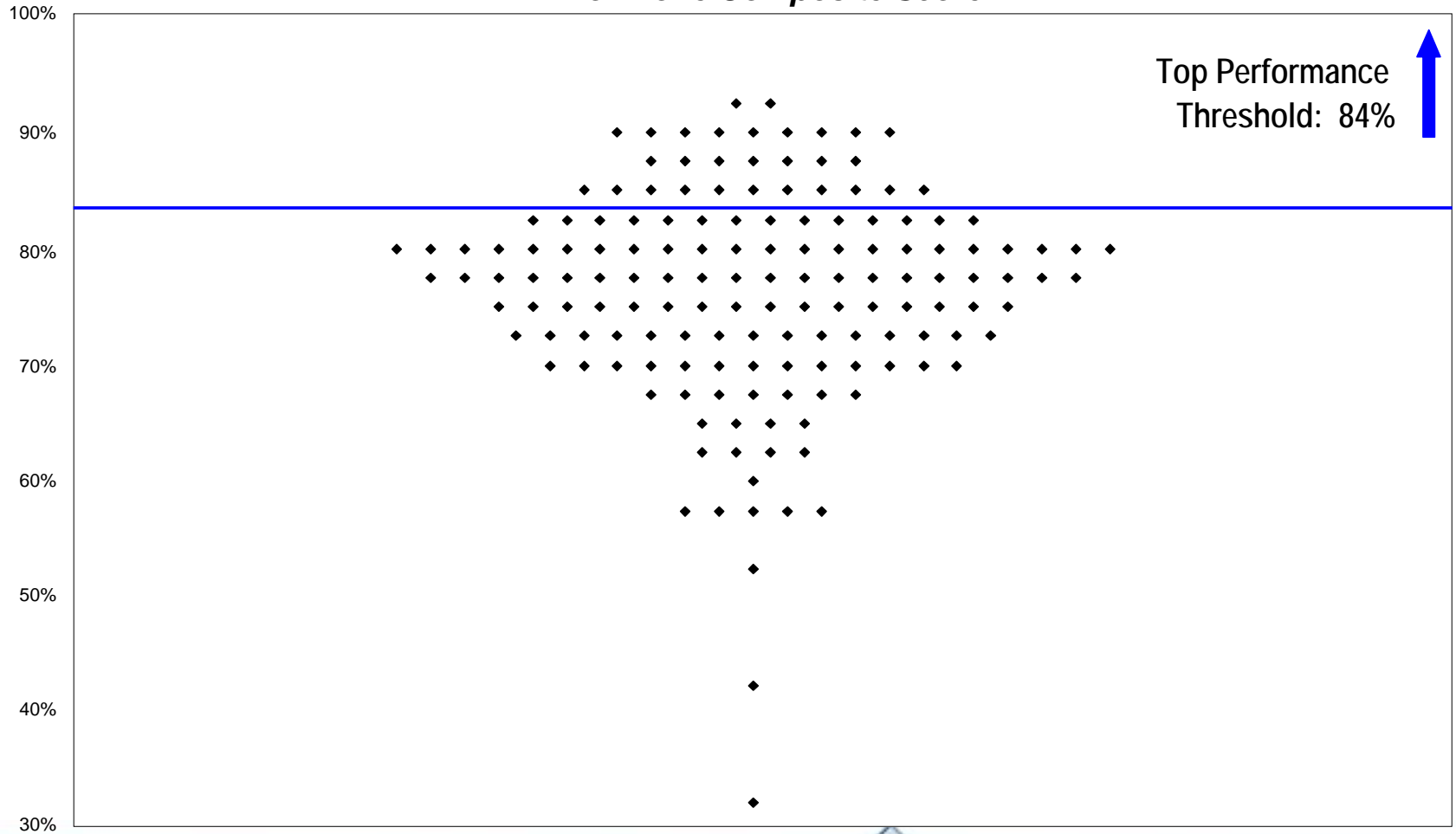
Our Mortality Measure and Potential Components



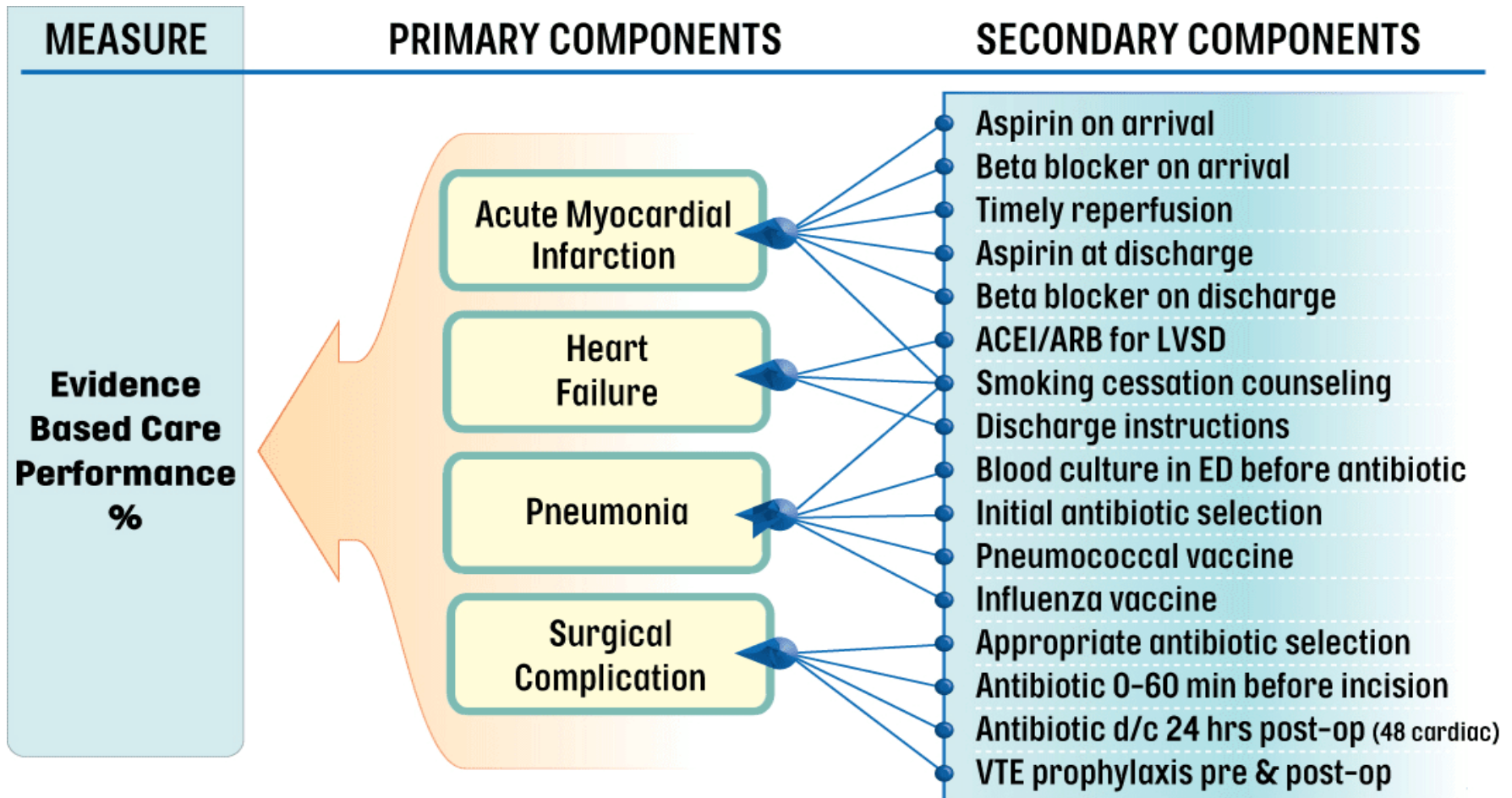
* Data mining to examine top components of mortality is currently in progress

QUEST Baseline Performance Result Evidence-Based Care (TPT 84%)

Distribution of QUEST Hospitals on Evidence-Based Care Rates
All-or-None Composite Score



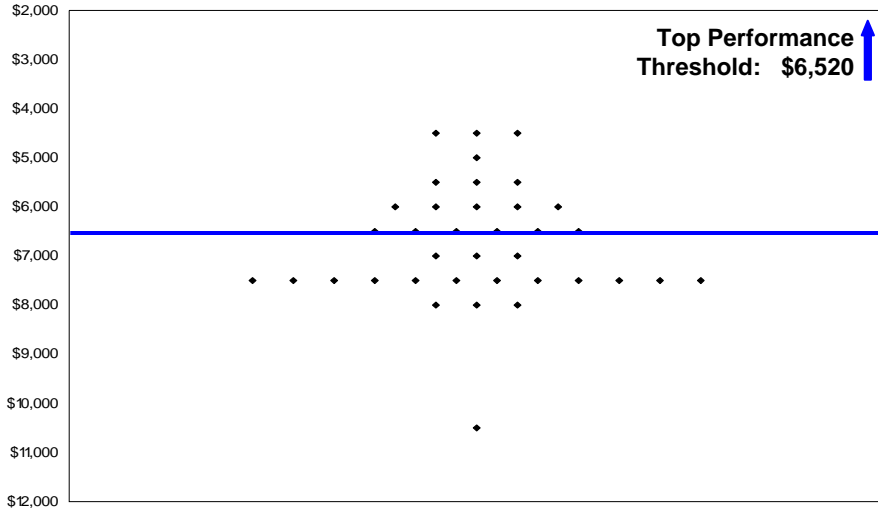
Our Evidence Based Care Performance Measure: “All or Nothing Score”



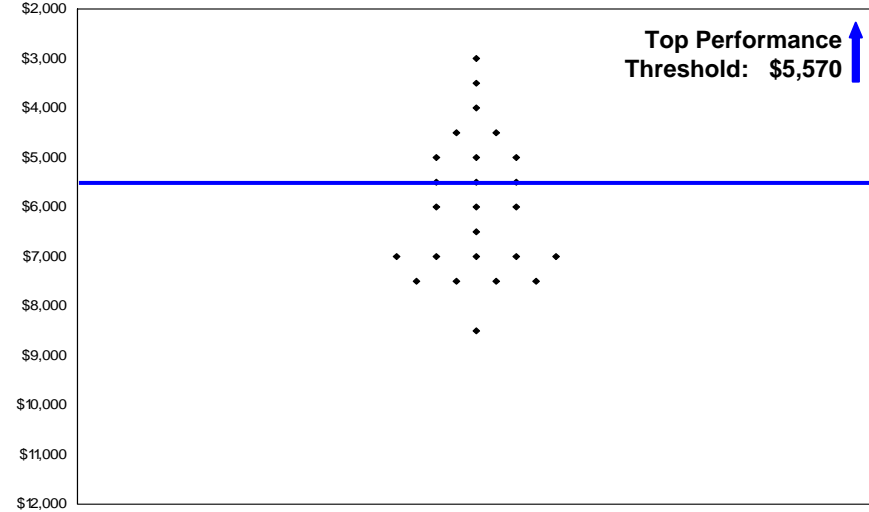
QUEST Baseline: Distribution of Hospitals on Total Inpatient Cost per Case Mix Adjusted Discharge

TEACHING

> 375 Beds +

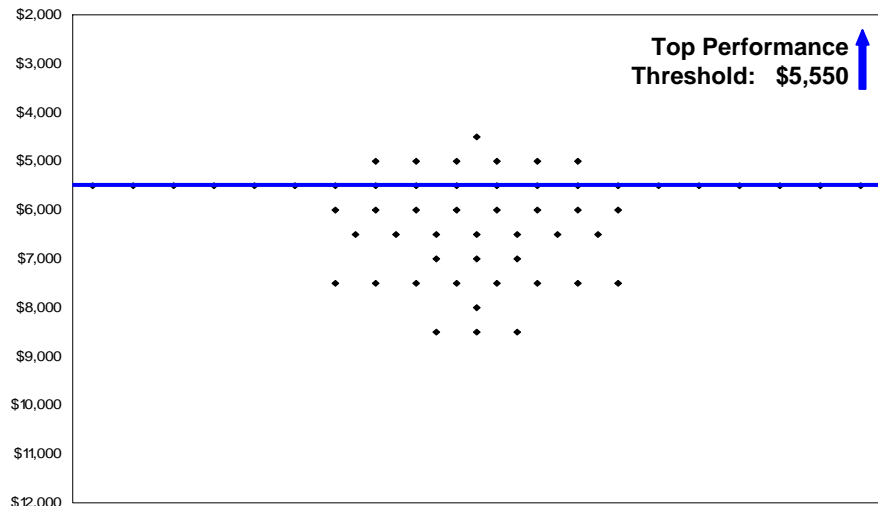


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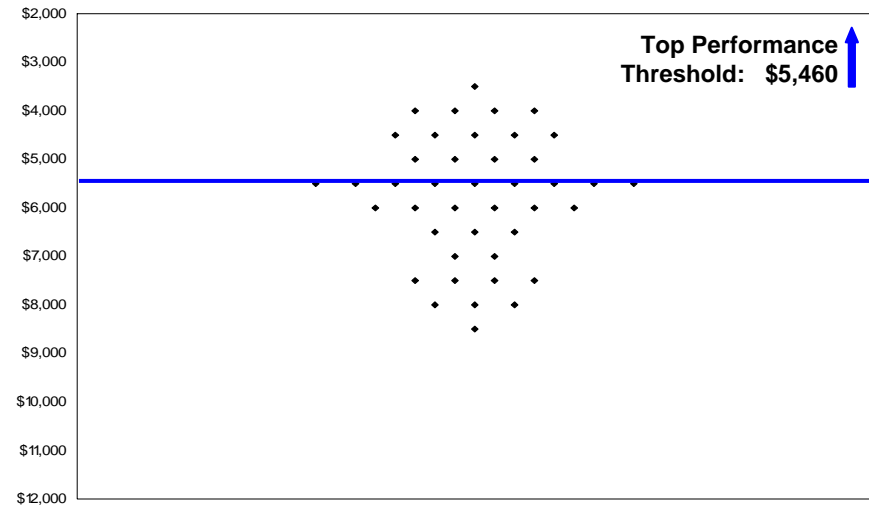


NONTEACHING

> 175 Beds +

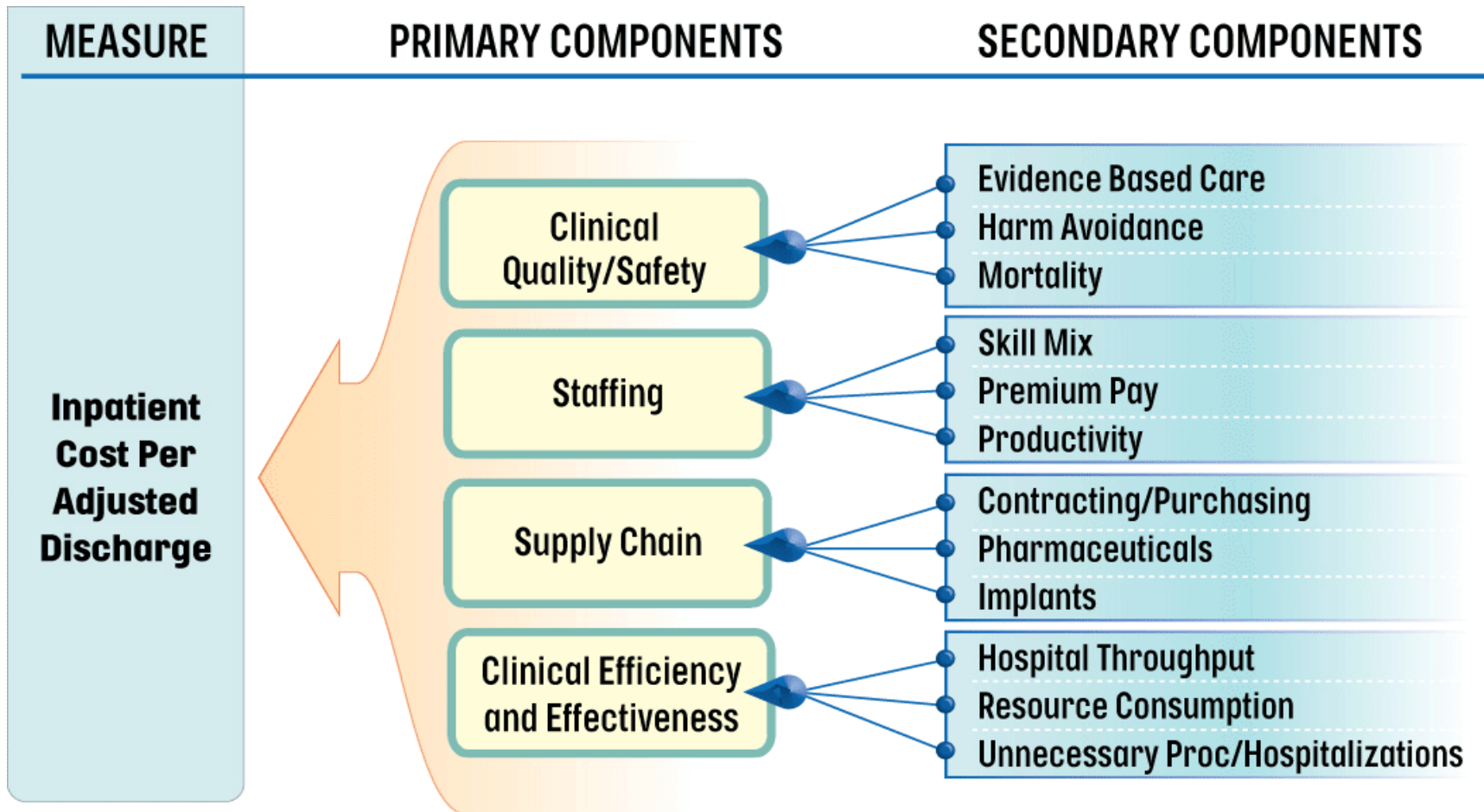


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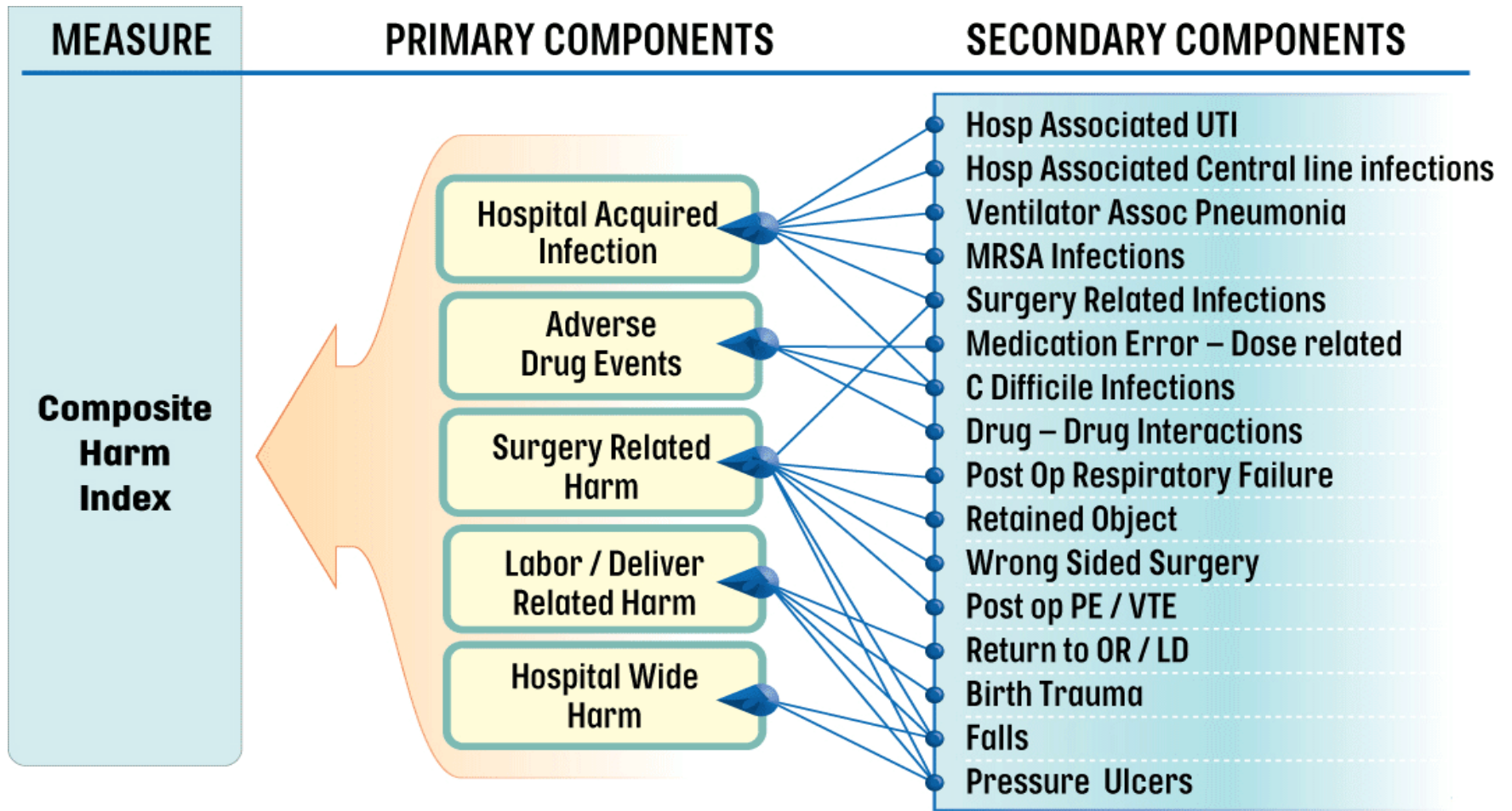


Baseline Period: July 1, 2006 through June 30, 2007

Our Efficiency Measure (Cost of Care) and Components

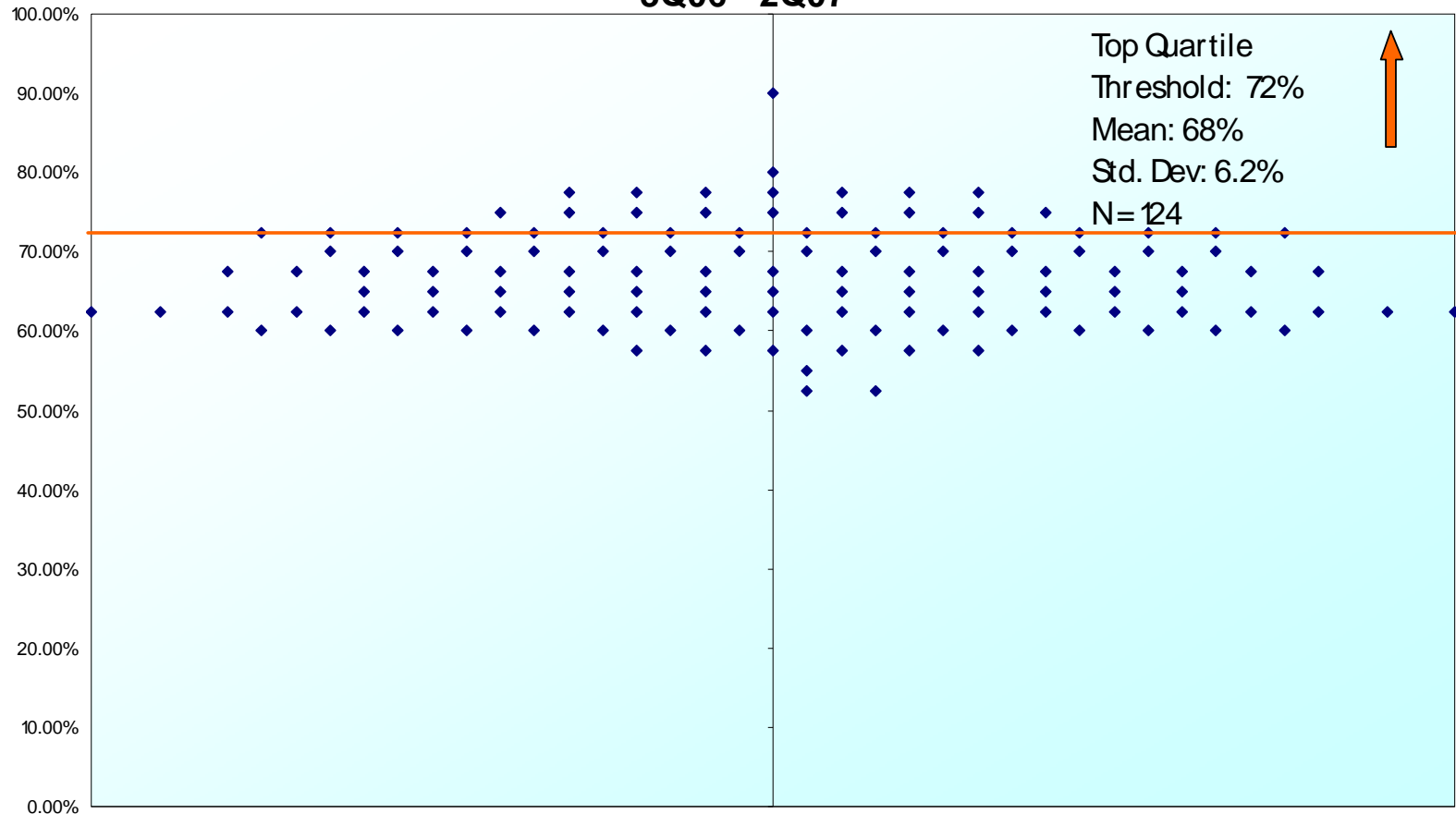


Our Harm Measure and Potential Components

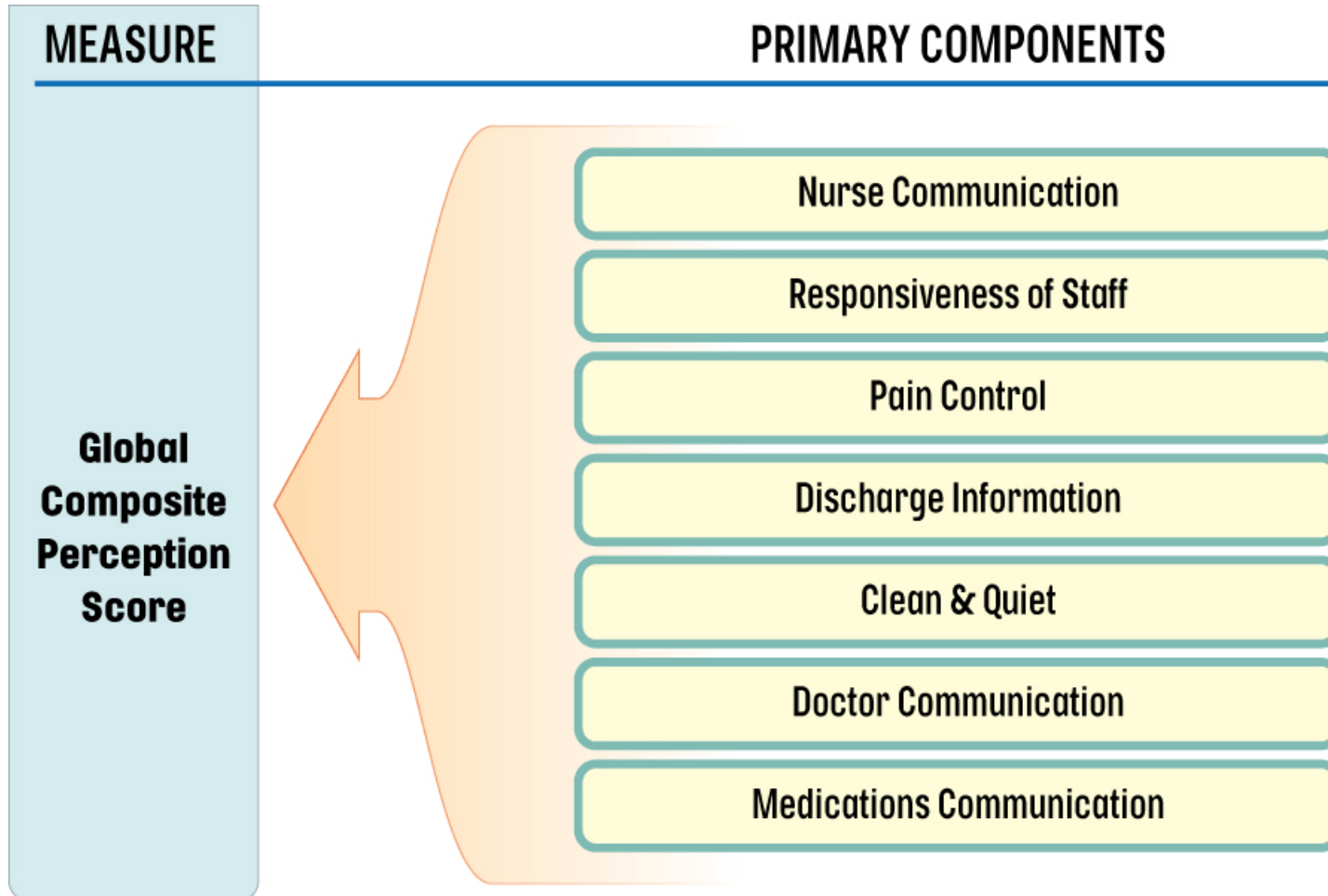


Patient Experience: Global Measure Composite Score

Distribution of HCAHPS Top Box Global Measures Composite Score
QUEST Hospital Compare Facilities
3Q06 - 2Q07

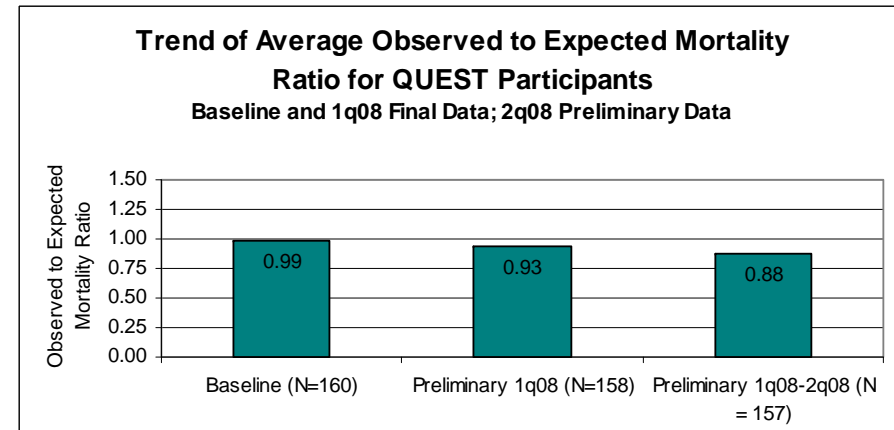
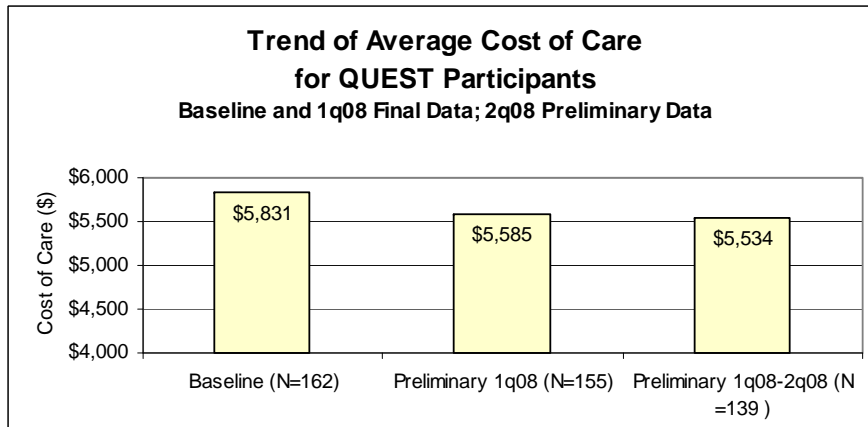
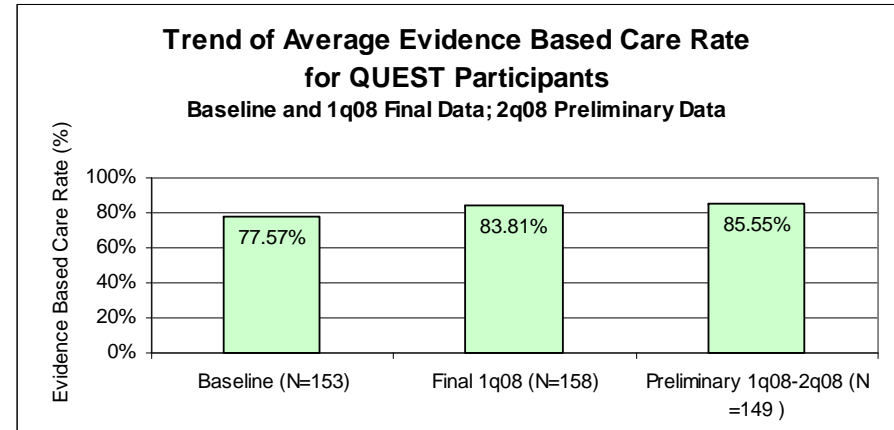


Our Patient Experience Measure and Potential Components



QUEST Participants Show Improvement Through Second Quarter 2008 (Preliminary Results)

- 7.98% increase in avg EBC Rate of participants from baseline to preliminary 1q08-2q08 data
- 0.11 reduction in the avg Observed to Expected Mortality Ratio among participants from baseline to preliminary 1q08-2q08 data
- \$297 decrease in the avg Cost of Care for participants from baseline to preliminary 1q08-2q08 data



Observations on Collaborative Execution

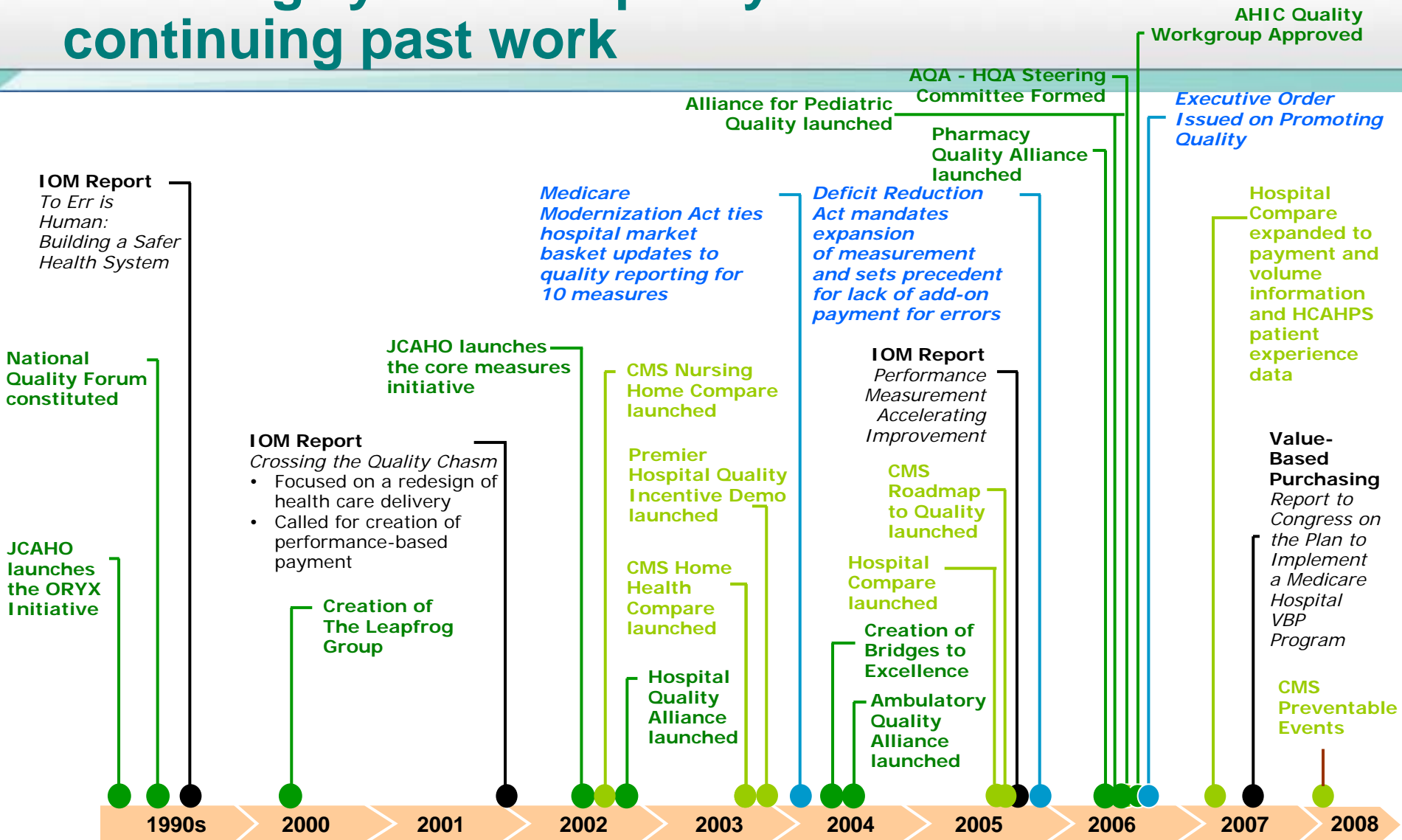
- Transparency and Healthy Competition is Key
 - Everyone likes being held up as a best performer; no one wants to see their institution at the bottom of the list
- Trust in each other and in a partner are critical
 - Data must be credible – not perfect
 - Since the group is entirely open with results, both good and bad, there needs to be a trust that information won't be misused
- Focusing on a “higher purpose” can excite and motivate and makes competitive concerns less important
 - By constantly focusing on the improved health of the patient and the community, the group engages in true collaboration
- All change is local but some problems are universal
 - We have found a small number of “usual suspects” account for many of the avoidable deaths in the population
 - Finding best performers in these problem areas can uncover success strategies that can be shared among all participants

What to Expect From Washington in 2009 and Beyond

Blair Childs
Senior Vice President,
Public Affairs
Premier Inc.



2007 and 2008 are additional “building” years for quality: continuing past work



Value-Based Purchasing

- Twin tools:
 - *Transparency* to facilitate patient awareness and choice, as well as performance improvement by providers; and
 - *Differential payment* to further incentivize providers to change practices, and reduce healthcare spending.

More Quality Measurement

- To get full market basket update for FY 2010:
 - (1) Surgical Care Improvement Project (SCIP)
 - (1) Hospital readmissions
 - (5) Patient Safety Indicators (AHRQ)
 - (4) Inpatient Quality Indicators (AHRQ)
 - (1) Cardiac surgery measure (STS)
- Retires pneumonia oxygenation assessment
- Total of 43 quality measures
 - AMI 30-Day Risk Standardized Readmission Measure (Medicare patients)
 - Pneumonia 30-Day Risk Standardized Readmission Measure (Medicare patients)
- AMI 30-Day Risk Standardized Readmission & Pneumonia 30-Day Risk Standardized Readmission Measure (Medicare patients) in Final Outpatient Rule

Pride or Prejudice, Payers Driving Transparency

- May 21 ad to promote the *Hospital Compare* Web site
- CMS ads in 58 major dailies
- Featured hospitals in each market and their performance on two measures (clinical process measure and HCAHPS measure)

Compare the Quality of Your Local Hospitals

Visit www.hospitalcompare.hhs.gov

Here is a sample of what you'll see

| Hospital Name | Percentage of people who received antibiotics 1 hour before surgery | Percentage of people who always received help when they wanted it |
|---------------------------------------|---|---|
| Anne Arundel Medical Center | 84% | 60% |
| Baltimore Washington Medical Center | 66% | 57% |
| Bon Secours Hospital | 64% | 50% |
| Carroll Hospital Center | 76% | 63% |
| Franklin Square Hospital Center | 84% | 59% |
| Good Samaritan Hospital | 84% | 47% |
| Greater Baltimore Medical Center | 69% | 47% |
| Harbor Hospital Center | 90% | 59% |
| Harford Memorial Hospital | 66% | 54% |
| Howard County General Hospital | 84% | 47% |
| Johns Hopkins Bayview Medical Center | 66% | 51% |
| Maryland General Hospital | 66% | 60% |
| Mercy Medical Center Inc | 95% | 52% |
| Northwest Hospital Center | 88% | 57% |
| Saint Agnes Hospital | 90% | 65% |
| Sinai Hospital of Baltimore | 92% | 53% |
| The Johns Hopkins Hospital | 95% | 56% |
| Union Memorial Hospital | 95% | 62% |
| University of Maryland Medical Center | 93% | 51% |
| Upper Chesapeake Medical Center | 93% | 59% |
| Maryland State Average | 89% | 65% |

These and other hospitals are demonstrating their commitment to quality improvement by submitting information to Hospital Compare. Information in this ad was collected between July 2006 and June 2007. Check the website regularly for all the most current data available.



"The more information I have to make a choice, the better."
Daisy, 72

This chart shows two ways hospital quality is measured. Getting an antibiotic at the right time before surgery reduces your risk of infection. And, knowing you will get help quickly from hospital staff may make you stay more comfortable. Hospitals that give recommended care and good service may help you avoid other health problems. When choosing a hospital, discuss quality and patient experience information with your doctor.

More hospitals. More information. This is just a sample of hospitals in your area and only two of the quality measures you'll see on Hospital Compare. Visit www.hospitalcompare.hhs.gov to see more. Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

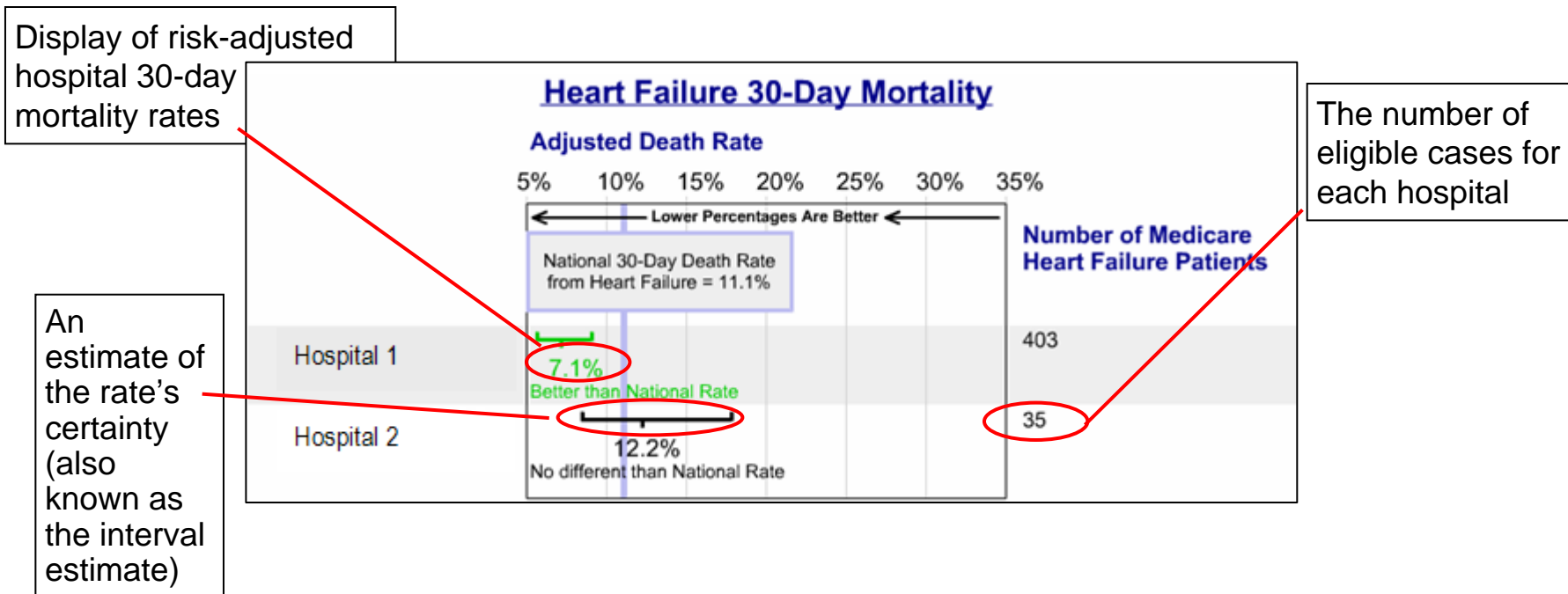


*My Health.
My Medicare.*

The Hospital Compare website was created by the Federal Government's Centers for Medicare & Medicaid Services with the collaboration of the Hospital Quality Alliance (HQA). The HQA represents associations for consumers, hospitals, doctors and nurses, employers, accrediting organizations, and Federal agencies to promote reporting on hospital quality of care.

CMS Publicly Reporting Risk-standardized, 30-day Mortality Measures for AMI, HF and PN

- The August 20, 2008 posting of mortality measures to *Hospital Compare* is the second annual posting for AMI and HF mortality and the first public reporting for PN mortality.
- All three measures will be refreshed annually, and hospital-specific reports will be distributed to all participating hospitals for each annual preview period.



- CMS is contemplating additional changes for displaying 30-day mortality measures.

Source: CMS Presentation Barry Straube 6/4/2008; Quality Net <http://www.qualitynet.org/dcs/ContentServer?cid=1163010398556&pagename=QnetPublic%2FPage%2FQnetTier2&c=Page; Hospital Compare; Booz Allen Analysis>

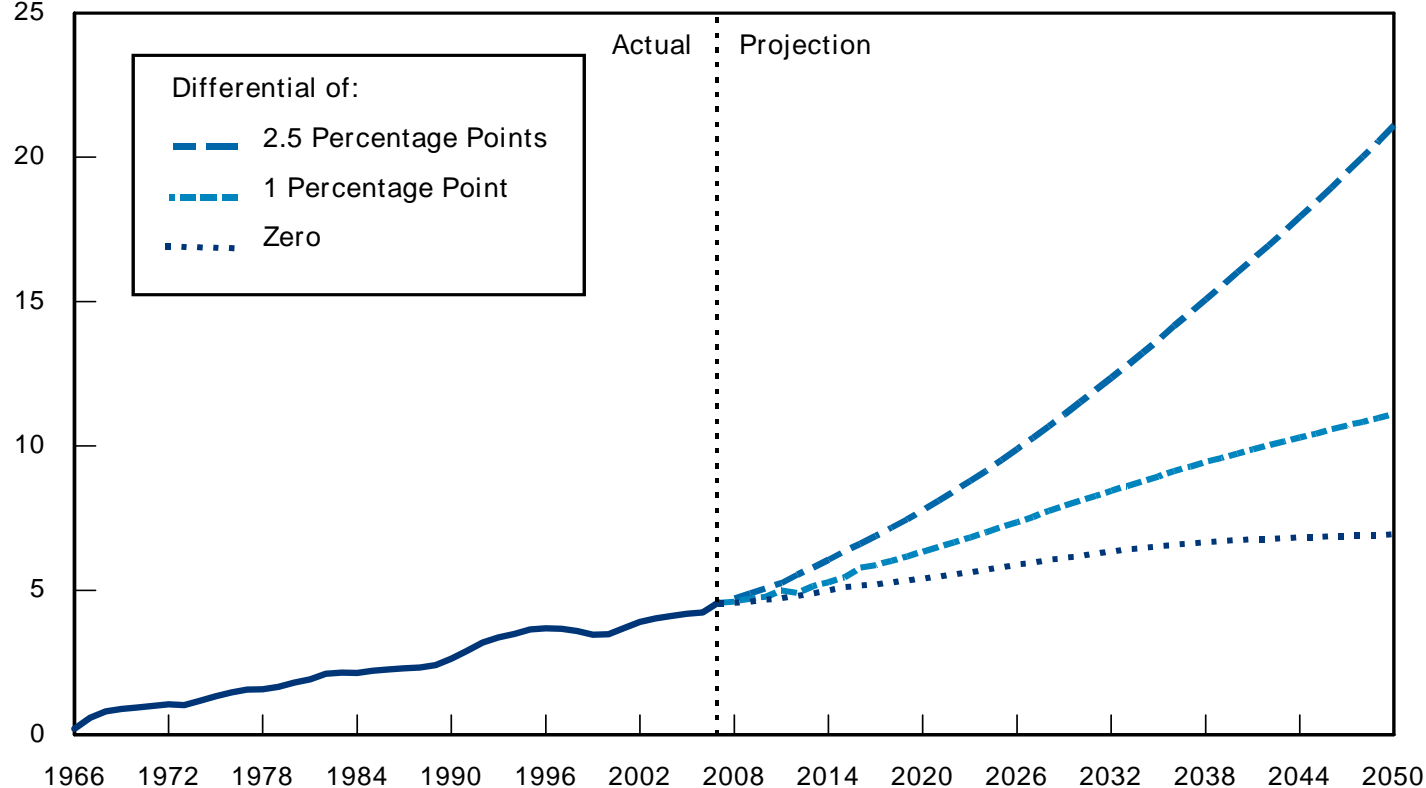
Hammer: Hospital-acquired Conditions

- As of October 1, hospitals will not receive higher payment for:
 1. Object left in during surgery (acute reaction to foreign substance);
 2. Air embolism;
 3. Blood incompatibility;
 4. Catheter-associated urinary tract infections;
 5. Pressure ulcers (Stages III/IV);
 6. Surgical site infections, e.g., Vascular catheter-associated infections;
 7. Mediastinitis after coronary artery bypass graft;
 8. Hospital-acquired falls leading to injuries (including fractures, dislocations, intracranial injury, crushing injury and burns).
 9. Venous Thromboembolism after hip and knee replacement*;
 10. Poor Glycemic control (Ketoacidosis & Coma- *hypoglycemic* & *hyponormal*); and

Hidden Agenda: Government spending on healthcare is unsustainable – Impact???

Total Federal Spending for Medicare and Medicaid Under Assumptions About the Health Cost Growth Differential

Percent of GDP



Tax rates 2050:

10% → 26%

25% → 66%

35% → 92%

Healthcare spending as a portion of GDP is projected to take the largest one year climb ever from 16.6% in 2008 to 17.6% in 2009.

CMS Actuaries, 2/27/09

Obama FY 2010 Budget proposal

More details in the Spring

- **10-year \$1.7 trillion healthcare budget blueprint with few details**
 - \$630 B “reserve fund” to jump-start health reform efforts
 - **Difference** of \$1 trillion to fund (more \$?; more savings?: deficit?; more taxes?)
- **Savings include hospital payment reform (10-yr savings):**
 - Hospital **P4P** programs (\$12 billion)
 - **Bundled payments** for inpatient stay and 30-day post-acute care (\$17.6B)
 - Reduce payments to hospitals with high **readmission** rates (\$8.4B)
- **Other proposals contained in the budget:**
 - Reform of Medicare **physician payment formula**, including performance-based payments for coordinated care
 - Address financial conflicts of interest in **physician-owned specialty hospitals**
 - Increase CMS budget to **attack fraud, waste and abuse**
 - Increase Medicaid **drug rebate** for brand-name drugs from 15.1% to 22.1% of AMP
 - Prohibit anticompetitive agreements between **brand and generic manufacturers**
 - \$330MM for healthcare **providers in medically underserved areas**

Rep. Altmire VBP bill – Quality FIRST Act

- Rep. Altmire (D-PA) introduced Quality FIRST Act 9/25/08 (expected to reintroduce in 111th Congress)
- Incentive payments based on hospitals' performance on evidence-driven, consensus-based quality measures
 - AMI, HF, PN, SCIP (clinical areas to be expanded in subsequent years)
- Hospitals rewarded for attainment of threshold announced 2 years in advance, as well as for improvement
- Establishes reasonable thresholds based on what all hospitals can achieve in a realistic timeframe
- Hospitals receive separate scores—and are rewarded—for each clinical area, rather than one single score for all measures
- Budget neutral, with up to 2% of hospital payments at stake

Baucus-Grassley VBP Bill Discussion Draft

- Senate Finance Committee Chairman Baucus & Ranking Member Grassley released discussion draft of VBP legislation 11/19/08
- Phased in over 5 yrs, beginning in FY 2012
- Incentive payments based on hospitals' performance on evidence-driven, consensus-based quality measures
 - AMI, HF, PN, SCIP, overall patient satisfaction (clinical areas to be expanded in subsequent years)
- Hospitals rewarded for attainment of threshold, as well as for improvement
- HHS to develop methodology of determining performance score that results in appropriate distribution to all hospitals
- Incentive payment applied to all DRGs after 3-yr transition period
- Budget neutral, with 2% of hospital payments at stake, once fully phased-in

Thank you

Questions? Comments?

www.premierinc.com