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Medicare Payment Must Reward Value

As Congress deliberates health reform, the notion of provider payment cuts is front and center. Some of the ideas under consideration include:

- Reduction or elimination of annual inflationary updates
- Non-payment for certain events, such as readmissions within 30 days
- Elimination of Medicare Disproportionate Share (DSH) and Medical Education payments

America's hospitals and the communities they serve are very concerned about any proposal that relies on payment cuts as the primary means by which to fund reform efforts. America's hospitals have found that they are not recession-proof, as so many policy experts proclaimed last year. Many hospitals and their communities are experiencing some of their toughest economic challenges in decades.

At the same time, there are hundreds of regions across the country that have long dealt with the added burden of having one of their primary purchasers of service – the Medicare program – disincentivize hospitals and physicians for their historic efficiency in providing care.

As a result, any payment changes being considered by Congress and the Administration that are made across-the-board will “bake in” these longstanding inequities and will do nothing to encourage changes in the delivery of health care services – changes that are needed to improve performance while limiting the growth of expenditures.

A New Approach: Value-Based Payments

We need to address a more basic question: ***Should the Medicare program reward and incent exemplary performance?***

We propose that Medicare move toward a system that rewards efficiency and high quality care. In other words, **the Medicare program should be a value purchaser.**

There are many paths and approaches to Medicare becoming a value purchaser, including episode-of-care models and more comprehensive care payments. These should be piloted and tested, with Medicare participating as part of purchaser coalitions in some regions. We support further development and implementation of these broader payment reforms.

However, we urge Congress to incorporate a critical interim refinement to Medicare's hospital and physician payment systems that will reward high-value regions – meaning health care markets that are both low cost and high quality. The value adjustment we are

proposing is incremental (i.e., not revenue neutral) to any inflation adjustment or general update to FFS hospital and physician payments.

Our proposal is fair and cost-effective. It would require the Secretary of Health and Human Services to develop a value-based incentive program that would apply to hospital FFS payment updates and encourage high level provider performance in defined local medical markets.

There are two main elements to our proposal:

1. Rewarding those providers that are in Hospital Referral Regions that have lower overall Medicare costs per beneficiary than the national average ,
2. Providing a further reward to the same providers in those HRRs if they have quality measures exceeding the national average.

Hospital Referral Regions (HRR) are aggregations of hospital service areas based upon where patients were referred for tertiary care. HRRs are used by the Dartmouth Atlas and in other studies of Medicare payment. HRRs are a more accurate way of grouping providers and Medicare recipients than geographic regions or states because they reflect the predominate patterns of treatment and provider relationships for patient populations.

The Dartmouth Atlas computes the average cost per Medicare recipient for each HRR, adjusting for age, sex, and race. The HRR average costs vary dramatically across the United States, ranging from \$5,311 for the Honolulu, HI HRR to \$16,351for the Miami, FL HRR.

Under this proposal, every acute and critical access hospital in a lower-than-average cost HRR would receive an add-on to both its inpatient DRG base rate and its outpatient APG base rate. In addition, Medicare-participating physician payments would receive an equivalent add-on. The amount of the add-on would be dependent upon how much lower the HRR cost is below the national average, as illustrated in the following table.

We propose a sliding scale payment add-on, from 0.5% to 2.5%.

Percent that the HRR is under the National average	Add-on to Medicare Payment
0.1% to 3%	0.5%
More than 3% and up to 7%	1.0%
More than 7% and up to 12%	1.5%
More than 12% and up to 20%	2.0%
More than 20%	2.5%

In addition, if those same providers have quality measures exceeding the national average, they will receive additional add-on payments, as outlined below.

For hospital-related service, the quality incentive payments will be based on the Clinical Process measures as displayed on the CMS web site “Hospital Compare”. These measures have been shown by scientific evidence to be effective in enhancing outcomes of care. For

the first year we recommend using the four hospital process of care measures currently being reported on the CMS Hospital Compare web site (www.hospitalcompare.hhs.gov): heart attack, heart failure, pneumonia and surgical care improvement. The average result for each category should be used.

We propose that the hospital-related quality incentive payments be based on individual hospital performance compared to national averages for each of the four measures. To qualify for a quality incentive payment, a hospital must exceed the national average for at least three of the four measures. If it does so, we suggest a 0.5% add-on to its inpatient and outpatient base rates. If it exceeds the average for all four of the measures, it would receive an add-on of 1.0%.

Because achieving higher quality performance requires teamwork and physician leadership we also recommend that these quality incentives apply to professional service payments related to care provided at qualifying hospitals.

Future refinements to this quality adjustment to hospital-related payments should incorporate additional quality measures as approved by AHRQ and the Secretary. Additional consideration also should be given in future years to weighting both absolute performance and improvement.

Finally, quality incentive payments for general outpatient services should be incorporated when CMS physician quality reporting initiative (PQRI) measures mature and are publicly reported.