IHA Federal Legislative Position 2009
Medicare Value-Based Purchasing

⋆ Overview

Policymakers and those in the health care industry have been taking steps toward making the Medicare program a purchaser of value, beginning in 2003 when Congress linked Medicare payments to the reporting of quality measures. As required by the Deficit Reduction Act of 2005 (DRA), the Centers for Medicare & Medicaid Services (CMS) submitted a plan to Congress on implementing a Medicare value-based purchasing (VBP) program for hospitals. Since the submission of this plan in 2007, legislation has been passed expanding the number of quality reporting measures and increasing the payment penalty for those hospitals choosing not to participate in the quality reporting program. Measures and payment update factors have been expanded to include hospital outpatient services, with payment penalties beginning in 2009 for hospitals electing not to report the outpatient indicators. Most recently, VBP legislation has been introduced in the United States House of Representatives, and Senators Grassley and Baucus on the Senate Finance Committee have released a bipartisan discussion draft of VBP legislation.

⋆ Iowa Hospital Association Position

Iowa hospitals are leading the way in providing high-quality, low-cost health care. The 2008 Dartmouth Atlas Project ranked Iowa first in the nation for health care system efficiency, concluding that the state should serve as a model for the country. Dartmouth found that Medicare spent an average of $39,243 per chronically ill patient for end-of-life care in Iowa, the lowest in the nation and more than 30 percent below the national average of $52,838. The 2007 Commonwealth Fund report, "Aiming Higher; Results from a State Scorecard on Health System Performance," underscores Iowa hospitals' commitment to ensuring Iowans continue to receive high-quality, low-cost health care. The report ranks Iowa second in the nation across key dimensions of health system performance. Iowa was the only state to rank in the top quartile across all five assessments: access, quality, avoidable hospital use and costs, equity and healthy lives.

IHA continues to support the Medicare program becoming a purchaser of value. Any attempt, however, to move toward a value-based payment system must include measures for enhancing the efficiency of health care delivery. In addition, the Medicare Payment Advisory Commission (MedPAC) has commented that "efficiency measures should be included in the hospital VBP program as soon as possible," and that it "believes that a P4P program will be incomplete until it includes measures of both quality and provider resource use." Private industry, through the Leapfrog Group, states that "efficiency is an attribute of performance that examines the relationship between a specific output of the healthcare system (e.g., a quality outcome for a patient) and the resources needed to create that output (e.g., costs)." A Medicare VBP program must include both quality and efficiency benchmarks when evaluating and rewarding hospital

performance. The failure to include an efficiency factor in moving Medicare to a VBP methodology will continue to promote outcome disparities for recipients. A Medicare VBP program should create a more rational payment methodology and move away from some of the well-recognized inadequacies of the current payment system.

A VBP program should also:

- **Align incentives among hospitals, physicians and other providers.** Aligning incentives across hospitals, physicians, and other providers will help create the efficient delivery of care as well as encourage the coordination of care. As exemplified across the country, hospitals and physicians are willing to engage in partnerships that improve outcomes for care. Examples of this include Iowa's development of the Iowa Healthcare Collaborative (IHC), a provider-led nonprofit organization that works toward the goal of higher quality of care by aligning hospitals and physicians, promoting responsible public reporting, engaging the community for clinical improvement, and raising the standard of care in Iowa.
- **Provide incentives to encourage care coordination.** The fragmentation of the delivery of health care in the Medicare system creates overutilization and a VBP program should provide incentives to encourage care coordination. In the State of Iowa, progress is being made through legislation and changes in physician practices involving the concept of a medical home. A medical home is a model for delivering effective, efficient and patient-centered care. The National Committee for Quality Assurance (NCQA) has also set standards for the recognition of medical home status.
- **Use consistent and objective performance measures.** The inclusion of evidence-based measures that have been endorsed by the National Quality Forum (NQF) and adopted by the Hospital Quality Alliance (HQA) helps ensure the consistency and objectivity of the measures adopted.
- **Minimize the data collection burden for providers and insure that all hospitals have an opportunity to participate and succeed.** A VBP program involving smaller facilities, such as Critical Access Hospitals (CAHs), should focus on the hospital outpatient setting as opposed to the inpatient setting as the majority of business for CAHs occurs on the outpatient side. In 2007, total inpatient admissions for Iowa CAHs were 63,000. In contrast, during that same year, the total outpatient visits for Iowa CAHs were just over 3 million. It is also important that policymakers be mindful of the many current demands on providers to report information related to quality.
- **Phased-in approach.** The implementation of a VBP plan should be phased-in over a number of years to allow providers to become comfortable with the measures being used to evaluate the efficiency and quality of care provided.