National Business Group on Health

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Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

Congress Should Expand Pay-for-Value in Medicare Now

Issue: Congress is considering legislation that would implement broad-based value-based purchasing, or pay-for-value, on a program-wide basis in Medicare. Pay-for-value rewards health care providers for quality care and efficiency through higher reimbursement and payments.

Too often, health care payers and patients pay for health care without regard to whether the services were needed or performed well. While cost is tied to quality or performance in most other industries, in health care, including in Medicare, the opposite tends to happen—we end up paying more for poor service and the additional health care needed to "correct" poor quality. Furthermore, studies demonstrate that often no connection exists between current prices and quality in health care.

The ACA includes a number of measures that promote paying for value, including: implementing a value-based, budget neutral, payment adjustment (modifier) for all Medicare physician payments based on the quality of care relative to cost, beginning for specific physicians or groups in 2015 and all physicians in 2017, establishing a value-based purchasing (VBP) program that rewards acute-care hospitals with incentive payments for the quality of care they provide to people with Medicare. Hospitals face a potential payment cut of up to 3% in 2015 if they do not meet the quality measures, establishing the hospital readmissions reduction program and more.

The pay-for-value movement continues to rapidly expand in the marketplace. In recent years, employers and other health care purchasers have developed and adopted payment programs to reward quality and efficiency in the health care system. Today, most large insurers and health plans have provider incentive programs and leading employers are contracting with providers to base some or all payment on quality and performance.

Pay-for-value promises to advance evidence-based medicine, improve the quality of health care and the health of Medicare beneficiaries, which translates into better value for the Medicare program.

Position: The National Business Group on Health, a member organization of approximately 394 primarily large employers (including 67 of the Fortune 100) who provide coverage for over 55 million Americans, strongly urges Congress to pass legislation that would implement and align pay-for-value programs on a widespread basis in Medicare for hospitals, physicians, and other health care facilities and professionals. Paying for value in Medicare would harness the government's leverage as the largest purchaser of health care in the U.S. to improve the quality and efficiency of Medicare and the overall health care system.

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A Medicare pay-for-value program should include the following:

- Use performance measures adopted developed by nationally recognized quality measurement organizations, such as the National Committee for Quality Assurance (NCQA), researchers, and practitioner groups that have been vetted and recommended by consensus-building organizations that represent diverse stakeholders, such as the National Quality Forum (NQF);
- Reward efficiency in addition to quality;
- Focus on misuse and overuse on an equal level with underuse;
- To the extent possible, incorporate outcomes of care in addition to structure and process measures to measure performance;
- Make meaningful disclosure of performance results to the public, which will reinforce the value of paying for value;
- Expand the health information technology infrastructure so providers can report performance measures--some providers, particularly solo and small group physician practices and those serving low-income urban and rural areas, may need financial assistance to purchase needed systems, software, training and related services; and
- Consider expanding the proportion of Medicare payment and reimbursement based on performance over time.

Pay-for-Value in Medicare is Needed Now to Improve Quality and Safety:

A landmark 1999 Institute of Medicine (IOM) report estimated that preventable medical errors in hospitals might cause as many as 98,000 deaths annually. A more recent study in the *Journal of Patient Safety* states that medical errors leading to patient death are much higher than previously thought, and may be as high as 400,000 deaths a year. Many more people are injured in hospitals and countless more preventable deaths and injuries occur in outpatient setting

A 2003 RAND study found that patients received only 55% of recommended care for fairly common medical conditions for which a broad consensus exists on care standards.

The Dartmouth Atlas of Health Care's findings reveal wide variation in hospital care and outcomes for chronically ill Medicare patients and that up to 30% of Medicare spending may be for excessive and unnecessary care.