

**PREMIER**



# **Federal Affairs Network Meeting**

## **June 16, 2009**

Danielle A. Lloyd, MPH  
Senior Director, Reimbursement Policy

# Senate Finance Committee Proposals

## Value Based Purchasing (P:\$12B) [CBO:\$3B]

- **Measures** selected from Medicare pay-for-reporting program
- **FY 2012**, data collection year
- **Funding**: reduce all Medicare MS-DRGs (not DSH, IME, outliers) by 2% in FY2013, 3% in FY2014, 4% in FY2015, and 5% in FY2016 and beyond.
- Hospitals **scored** with a single, composite performance score.
- **Reward** for higher of quality improvement or quality attainment.
- Top 25% **earn back** withheld money; 26th to 75th percentile receive payment based on a sliding scale, and bottom 25th percentile receive no VBP payment.
- **Unused incentive funds** returned to the Medicare Trust Fund.
- **Test** VBP models for non-qualifying CAHs and small hospitals

## Premier Position on VBP

- Regardless of how the **payment bundles** change, measures to ensure we are paying for value are needed
- Program should be **budget-neutral**, not budget saver
- Threshold for earning full incentive payment should be set at a level that **all hospitals** can reasonably achieve—a percentage of hospitals should not be forced to “fail”
- **Savings to Medicare** should be kept in the program to create a reward pool to drive continued improvement.
- VBP reductions and incentives payments should apply only to **relevant Medicare Severity-Diagnosis** Related Groups.

## Premier Position on VBP

- **Technical assistance** should be available to hospitals with lower performance or serve vulnerable populations
- Measures should be **NQF** endorsed and HQA adopted
- **Physician quality** measures should be aligned
- **Field-testing** among a broad group of hospitals should be conducted before they are used in P4P
- **Proprietary** measures should be used only if made fully transparent and hospitals are not required to pay a fee
- Mandate that all **EHR** products provide a utility that can be certified to abstract the data necessary for quality reporting

## Readmissions (P:\$8B) [CBO:\$8B]

- **2010**, CMS calculates national and hospital-specific readmission rates of PPS hospitals for 8 high volume conditions selected by the Secretary
- **2011**, CMS provides data to hospitals on their risk-adjusted readmission rates, excluding not “potentially preventable” readmissions, related to national average
- All hospital readmissions counted, even to a different hospital
- **FY 2013**, hospitals with readmission rates > 75<sup>th</sup> percentile for selected conditions subject to 20% payment withhold for the selected MS-DRGs based on prior year’s performance.
  - Hospital receives full payment if patient not readmitted within 30 days for “preventable” readmission
  - Withheld money returned to Medicare Trust Fund If patient readmitted

## Premier Position on Readmissions

- Readmissions policies should be based on **risk-adjusted, rate-based** measures integrated into VBP
- Support HELP approach that compels hospitals with high rates to work with **patient safety organizations**.
- “**Stick-only**” approaches will not raise all boats
- Designating **highest quartile** as outliers is inappropriate
- Hospitals should not be **solely accountable**
- Hospitals that serve a high volume of **low-income** patients will disproportionately experience the adverse effects.

## Premier Position on Readmissions

- Risk-adjusted, rate-based measures integrated into value-based purchasing is the preferred mechanism
- If a case-level adjustment is implemented, CMS should:
  - Identify those patients admitted for likely treatment failures (i.e. post-operative infection or venous thromboembolism);
  - Query the system to determine if the patient has been previously admitted for a non-emergent surgery (excluding trauma, injuries, clinical trials etc.) to any hospital within 7 days;
  - Reduce initial admission payment based on a percentage of the readmission payment.
- This does not require payment withholds
- This applies equally to all hospitals and could be implemented in FY 2010

## Bundling payment (P:\$17B) [CBO:\$19B]

- **FY 2015:** bundled payment of acute inpatient hospital services *and* post-acute care services (including HHA, SNF, IRF and LTCH services) occurring or initiated within 30 days of the acute hospital discharge
- **Physician services** excluded from bundle
- Three-stage process:
  - **FY 2015**, bundling applied to conditions in top 20 percent of post-acute care spending identified by Secretary
  - **FY 2017**, bundling applied to conditions in the next 30 percent of post-acute care spending
  - **FY 2019**, bundling applied to conditions in the remaining 50 percent of post-acute care spending
- **Bundled payment amount** = inpatient MS-DRG + post-acute care costs in that MS-DRG + expected 30-day readmissions + adjustments for efficiencies
- Bundled **payment to** one entity so long as hospital involved

## Premier Position on Bundling

- Bundled payment holds **promise** for improving coordination of care and improved patient outcomes.
- Common incentives must be implemented for **physicians**.
- Start with **voluntary pilot** as substantial policy analysis and testing must occur before national implementation.
- Begin with **discrete procedures** not chronic illness.
- The Bundle should only include services **provided** within 30-days rather than **initiated**.
- Rates should cover costs of hiring “patient navigators” and other innovations in reducing readmissions etc.

# Accountable care organizations (ACOs) [CBO:\$480M]

- 2012, qualifying providers (such as individual physician practices, physician group practices, hospital-physician joint ventures and hospitals employing physicians) could voluntarily form ACOs
- Qualification requirements include:
  - minimum two-year participation;
  - Provide primary care to at least 5,000 Medicare beneficiaries
  - Have contracts with core group of specialists
  - Able to undertake joint decision-making; and
  - Can institute and report quality and cost measures and coordinate care
- Must meet quality measures to receive incentive payment: (1) clinical processes and outcomes; (2) patient perspectives on care; and (3) utilization and costs
- Paid past FFS per-beneficiary spending + national growth rate
- Savings > 2% shared 50/50 with Government with possible cap
- Beneficiaries assigned to ACO physicians from whom they received most primary care in previous year – beneficiaries still free to seek care elsewhere

## Premier Position on ACOs

- Support **aligning physician and hospital** incentives through ACOs.
- **Voluntary testing** of policy will provide valuable experience and lessons from which the entire field will benefit.
- Include a broad array of **organizational types**, including hospitals that contract with physicians, to encourage the spread of ACOs in the most markets possible.
- CMS should share timely and **comprehensive data** with participants to inform their efforts .
- Shared savings should not be capped so long as quality standards are being met.

# President's Proposals

# President's Radio Address—June 13

Source	Health Care Reserve Fund (\$ in billions) 10 years
<b>FY 2010 Budget</b>	<b>\$635</b>
– Medicare and Medicaid Savings	\$309
– Revenues	\$326
<b>Additional Medicare and Medicaid Savings</b>	<b>\$313</b>
– Incorporate productivity adjustments into Medicare payment updates	\$110
– Reduce hospital subsidies for treating the uninsured as coverage increases	\$106
– Pay better prices for Medicare Part D drugs	\$75
– Other	\$22
<b>Total</b>	<b>\$948</b>

## Contact information

Danielle A. Lloyd, MPH  
Senior Director, Reimbursement Policy  
Premier Inc.

444 N. Capitol St, NW, Suite 625  
Washington, DC 20001-1511

Phone: 202.879.8002

Fax: 202.393.0864

E-mail: [danielle\\_lloyd@premierinc.com](mailto:danielle_lloyd@premierinc.com)

Web site: <http://www.premierinc.com/>