MAYO CLINIC

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Value Indexing

We believe that the health care delivery system must be realigned to provide better value, i.e., better clinical outcomes, safety and patient satisfaction at lower cost. This should be a common goal for all health care professionals, hospitals, and other groups. Today's reimbursement system pays the most to those who perform the most services, and thus provides disincentives to efficient, high-quality providers.

In the medium- and long-term, new payment models should be developed to move away from paying for quantity and instead paying for improving health and truly rewarding effective, efficient care. As a short-term first step, we propose the use of value indexing within the current reimbursement system. Value is defined by an equation V=Q/C where Quality (Q) represents clinical outcomes, safety and patient-reported satisfaction and Cost (C) represents the cost of care over time.

A value index can be constructed for many types of payment models, including hospital DRG payments, physician fees, payment updates, and other payment formulas. Ideally, all providers should have a value index built into their payment formulas so that their financial incentives are all aligned to produce better quality care at a lower cost.

The use of value indexing can be applied using current payment formulas and payment areas (as under the physician fee schedule), or using other existing measurement areas such as hospital referral areas as under the analyses from the Dartmouth Atlas. Applying a value index to areas creates the incentive and catalyst for physicians, hospitals and other care providers to better coordinate patient care and integrate the delivery system.

This approach also eliminates the need to focus on line items or micromanagement of services such as imaging or lab utilization. This approach is simple, the data are already available and it is flexible enough to use over many years.

We acknowledge that this is a short-term transition tool for use within the current fee-for-service payment model. We fully support the need to move to a more comprehensive long-term reform of the Medicare payment model, but this is a first step in the right direction.

Attached are legislative specifications for applying a value index to the physician work component of the Medicare physician fee schedule. We are happy to provide similar specifications for other payment formulas as well.

Legislative Specifications

Purpose

To create a value index within the formula used to determine Medicare physician fees.

The proposal eliminates the current geographic indexing of the physician work component of the fee schedule, and applies instead a value index to the work component. It does not change the indexing of practice expense or malpractice expense.

The current fee schedule formula applies the geographic index to 25% of the work component, and there is currently a temporary floor at 1.0. This proposal applies the value index to the entire work component and there is no floor or ceiling.

Value Index

The value index for each part B physician payment area will be determined by the Secretary as a ratio of the quality component to the cost component for that payment area.

Quality Component

The quality component will be based on a composite quality score that reflects quality measures available on a state or payment area basis. The measures should reflect outcomes and health status for the Medicare population, patient safety, and patient satisfaction. The Secretary shall use the best available data, after consulting with AHRQ and private entities that compile quality data. The Secretary may modify the calculation of the quality component periodically as better data becomes available.

The quality component for a payment area will be the ratio of the quality score for that area to the national average quality score.

In the case of payment areas that are less than the entire state, if quality data is not sufficient to measure quality at the sub-state level, the quality component for a sub-state payment area will be the quality component for the entire state

Cost Component

The cost component will be based on total Medicare expenditures per beneficiary for the payment area, including both parts A and B expenditures. The Secretary may use total per beneficiary expenditures in the last 2 years of life (both parts A and B) as an alternative if the Secretary determines that such measure better takes into account severity differences among payment areas.

The cost component for a payment area will be the ratio of the cost per beneficiary for that area to the national average cost per beneficiary.

Budget Neutrality

The Secretary will adjust the conversion factor to ensure that total payments under the fee schedule as adjusted by the provisions of this amendment are equal in aggregate to fee schedule payments that would have been without the amendment.

Updates

The Secretary shall update the value index annually.

Effective Date

The value indexing shall apply to the Medicare physician fee schedule for years beginning after date of enactment.

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