

AHA Questions Public Performance Reports

American Hospital Association maintains that the limited data paint an incomplete picture.

BY FRANCES CORREA

FROM A FORUM SPONSORED BY THE ALLIANCE FOR HEALTH REFORM AND THE COMMONWEALTH FUND

WASHINGTON – At a recent hearing on public reporting of hospital performance data, panelists agreed on the importance of measuring for quality, but not on which measurement standards to use.

Current data used to evaluate performance are limited to too small a number of determining factors, asserted Nancy Foster, vice president for quality and patient safety at the American Hospital Association. Ms. Foster served on the five-person panel at a forum titled “Public Reporting of Quality Outcomes: What’s the Best Path Forward?”

In March, the Centers for Medicare and Medicaid Services published data on hospitals’ incidents of eight conditions: foreign object remaining after surgery, air embolisms, blood incompatibility, late-stage pressure ulcers, falls and

trauma, vascular catheter-associated infections, catheter-associated urinary tract infections, and manifestations of poor glycemic control.

The data present each condition per 1,000 discharges and include national rates of hospital-association conditions. The data were based on claims information submitted by Medicare patients from October 2008 through June 2010.

Ms. Foster maintains that the CMS data are not clinically sound. One example she gave was of hospitals with high reimbursement rates, so-called safety net hospitals that provide care to all individuals regardless of their ability to pay. These facilities, she emphasized, are generally located in communities that lack sufficient health care resources for the populations they serve.

“It shouldn’t be a surprise to us that if they can’t get their medications following discharge from the hospital, that if they can’t get into the right physician office or rehab treatment or whatever else

they need, those patients are going to come back to us in larger numbers than in communities where they have adequate access to all those kinds of resources,” Ms. Foster said.

Physicians will sometimes avoid treating patients who are sicker or on Medicaid because they are high risk and could make the hospital’s public reports look bad, said Dr. David Share, vice president of Value Partnerships at Blue Cross Blue Shield of Michigan.

“Sometimes the way we measure [quality] actually forces providers to focus on cohorts of patients who aren’t going to get the most benefit, but they’ll focus there because they’re concerned that they won’t look good if they don’t,” Dr. Share said. He added that lower-quality outcomes could also be based on a poor hospital system, not necessarily individual physician performance, which he said should be measured separately.

Gerald Shea, assistant to the president of governmental affairs for the AFL-CIO, Washington, argued that improvement is also a question of cost, which he said amounts to nearly \$250,000 to test and institute a quality measure.

“We’ve been severely hampered in this enterprise by basically only being able to develop those measures when somebody came forward and said ‘we’ll pay to develop them.’”

There may be flaws in the current data from public reporting, but Mr. Shea said reports have increased awareness for quality care and encouraged significant changes within hospitals. Since 2000, hospitals have increased their attention on factors including readmission rates, the importance of collegial cooperation, and hospital-association conditions, he said.

The Affordable Care Act will require health exchange plans to publicly report on quality of care based on 65 measures.

“There’s a lot of pressure now and a lot of opportunity to use public reporting and transparency as a true level to foster high performance in the country,” said Dr. Anne-Marie Audet, vice president for health systems quality and efficiency at the Commonwealth Fund. Systems continue to focus on ways to create better care and better health at a lower cost.

Thomas Scully, senior counsel at the law office of Alston & Bird in Washington, also served on the panel. ■

CMS Finalizes Plan to Pay Hospitals Based on Quality

BY MARY ELLEN SCHNEIDER

Starting in October 2012, about 1% of the payments that hospitals receive from Medicare will be calculated based on performance on clinical quality measures and patient satisfaction scores.

Details of the new initiative, known as the Hospital Inpatient Value-Based Purchasing program, were unveiled in a final rule released by the Centers for Medicare and Medicaid Services (CMS) on April 29. The initiative was mandated by Congress under the Affordable Care Act.

Under the program, CMS will take 1% of the payments that would otherwise go to hospitals under Medicare’s Inpatient Prospective Payment System and put them in a fund to pay for care based on quality. In the first year, CMS estimates that about \$850 million will be available through the fund. Medicare officials will score hospitals based on their performance on each of the measures compared to other hospitals and to how their performance has improved over time.

The program is the first step in shifting payments toward quality and away from volume, Dr. Donald Berwick, CMS administrator, said in a press conference.

“This is one of those areas where improvement of quality and reduction in cost go hand-in-hand,” Dr. Berwick said. “My feeling continues to be that the best way for us to arrive at sustainable costs for the health care system is precisely through the improvement of quality of care.”

Under the program, payments will be based on performance on 12 clinical

process-of-care measures and a survey of patient satisfaction. Process-of-care indicators include measures such as the percentage of patients with myocardial infarction who are given fibrinolytic medication within 30 minutes of arrival at the hospital.

For evaluation of patient satisfaction, a random sample of discharged patients will be surveyed about their perceptions, including physician and nurse communication, hospital staff responsiveness, pain management, discharge instructions, and hospital cleanliness.

The measures have been endorsed by such national panels as the National Quality Forum, and hospitals have already been reporting their performance on them through Medicare’s Hospital Compare website. The measures are weighted so that 70% of the payment is based on the quality measures and 30% is based on patient evaluations.

Over time, CMS plans to add measures focused on patient outcomes, including prevention of hospital-acquired conditions. And measures will be phased out over time if hospitals achieve consistently high compliance scores, Dr. Berwick said.

The new value-based purchasing initiative is only one way that hospital payments will be tied to quality. Starting in 2013, Medicare will reduce payments if hospitals have excess 30-day readmissions for patients who suffer heart attacks, heart failure, and pneumonia. In 2015, hospitals could see payments cut if they have high rates of certain hospital-acquired conditions.

The final rule on hospital value-based purchasing becomes final on July 1. ■

Incentives Boost Quality Reporting, e-Prescribing

BY ALICIA AULT

FROM THE CENTERS FOR MEDICARE AND MEDICAID SERVICES

About \$234 million in bonuses under the Physician Quality Reporting System and \$148 million in incentives for ePrescribing were paid out in 2009, according to the Centers for Medicare and Medicaid Services.

Participation in the now-voluntary PQRS has grown 50% per year since the program started in 2007 and currently includes one in five eligible health care professionals. In 2009, some 210,000 physicians and other eligible health care professionals participated, but just 119,804 clinicians reported data in a manner consistent with the necessary criteria for incentive payouts, the CMS said.

Emergency physicians had the highest rate of satisfactory reporting, the CMS said. In 2009, 31,000 reported on at least one quality measure and 79% received an incentive payment.

“Although participation in our pay-for-reporting programs is optional now, it should be regarded as imperative in terms of medical professionals’ shared goal of improving quality of care and patient safety,” CMS Administrator Donald Berwick said in a statement.

The average payment per professional was \$1,956 and the average payment per practice was \$18,525, according to the CMS. Payments, which were sent in the fall of 2010,

were equal to 2% of total estimated charges under Medicare Part B.

Physicians and health professionals could report on 194 measures. The three most frequently reported quality measures were performing electrocardiograms in the emergency department to diagnose chest pain; using electronic health records to organize and manage care; and, working with diabetics to control blood glucose levels.

Some notable improvements since the program’s inception included a near doubling of the number of physicians reporting that they had talked with diabetic patients about eye-related complications – from 52% in 2007 to 93% in 2009. Also, beta-blockers were recommended to patients with left ventricular systolic dysfunction by 95% of reporting physicians in 2009, as compared to 64% in 2007.

The PQRS program will remain voluntary until 2015, when the Medicare program will start withholding payments for lack of participation.

The first year of the e-Prescribing program was 2009. That year, 48,354 physicians received an e-Prescribing incentive payment, with an average payment of \$3,000 per individual and \$14,501 per practice.

The deadline for participation in the e-Prescribing program is much sooner than that for the PQRS program. Physicians will see pay reductions beginning in 2012 if they don’t participate in ePrescribing. ■