CMS Finalizes Plan to Pay Hospitals for 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 with other hospitals and with 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 per-

centage of patients with myocardial infarction who are given fibrinolytic medication within 30 minutes of arrival at the hospital.

To evaluate 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. A complete list of the measures is available at http://www.healthcare.gov/news/factsheets/valuebasedpurchasing04292011b.html.

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 officials plan 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 of care. Starting in 2013, Medicare will reduce payments to hospitals if they have excess 30-day readmissions for patients who suffer heart attacks, heart failure, and pneumonia. And in 2015, hospitals could see their payments cut if they have high rates of certain hospital-acquired conditions.

The final rule on hospital value-based purchasing will be published in the Federal Register in May and becomes final on July 1. ■

E-Prescribing Rules May Be Eased by CMS

BY ALICIA AULT

The Centers for Medicare and Medicaid Services has proposed modifying the rules for e-prescribing so more physicians could claim exemptions from the criteria and therefore avoid being penalized in 2012.

In a conference call, agency officials said the change was in response to indications from providers and professional societies that many prescribers might not be able to meet the requirements of the current incentive program.

"Today's rule demonstrates that CMS is willing to work cooperatively with the medical professional community to encourage participation in electronic prescribing," Dr. Patrick Conway, chief medical officer at CMS and director of the agency's Office of Clinical Standards and Quality, said in a statement.

Under the current incentive program, eligible prescribers were due to get a 1% bonus payment for 2011 and 2012 and a 0.5% bonus in 2013. For prescribers who did not meet the criteria, there would be a penalty imposed in 2012. The penalty would escalate in 2013 and 2014.

The final Medicare Physician Fee Schedule for 2011 contains exceptions, along with two hardship exemptions. Practices are exempt if they are in a rural area without high-speed internet access or an area without enough available pharmacies for electronic prescribing.

Under the proposed rule, prescribers who use certified EHRs can now claim this as a "qualified" e-prescribing system. This move was designed to more closely align the e-prescribing program with the program that offers incentives for meaningful use of electronic health records. The proposed rule would also create four additional hardship exemption categories.

Prescribers also would be granted an extension, until Oct. 1, 2011, to apply for the hardship exemption. ■

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