POLICY & PRACTICE

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Checking Musculoskeletal Injuries

The consumer group Public Citizen is urging the federal government to require businesses to report employees' musculoskeletal injuries more specifically. The Occupational Safety and Health Administration last year proposed an extra box on an OSHA form where employers would indicate any such injuries. This year, OSHA pulled back the proposal while asking for more comments. In a letter, Public Citizen urged the requirement for the checkbox, saying it would not overly burden even small businesses and would provide much-needed data on repetitive-stress injuries.

A Vote for Arthritis Data

Sen. Robert Menendez (D-N.J.) and Rep. Jim Gerlach (R-Pa.) introduced the Psoriasis and Psoriatic Arthritis Research, Cure, and Care Act of 2011. Their bill (H.R. 2033 in the House and S. 1107 in the Senate) would build on the $1.5 million already given to the Centers for Disease Control and Prevention in 2009 for collecting psoriasis-related data. An additional $1.5 million each year would continue the project from 2012 to 2017. The bills would also urge the National Institutes of Health to create a virtual "center of excellence" to share information on psoriasis and psoriatic arthritis.

Group Suggests Payment Fixes

An official of the American College of Rheumatology told lawmakers they could fix the ailing Medicare physician payment system by first dumping the Sustainable Growth Rate (SGR) formula and setting a series of incremental pay increases for the next 5 years. In written comments to the House Ways and Means Committee, Dr. Tim Laing, chairman of the college's government affairs committee, said that repealing the SGR and setting the increases would allow enough time to test, adjust, and implement new payment models. Dr. Laing asked Congress to extend 10% payment bonuses for primary care physicians to rheumatologists and to correct the pay disparity between physicians who perform procedures and those who do cognitive work. "With the additional training rheumatologists and other cognitive specialists receive, they have been lumped together with surgical and procedural specialties even though their patient care aligns more with primary care," Dr. Laing wrote. "Recognizing the differences in these specialties is important when reforming the physician payment system."

1 Billion Deal With Disabilities

More than 1 billion people have some form of disability, according to the first-ever World Report on Disability by the World Health Organization and the World Bank. People with mental and physical disabilities are twice as likely as are others to say they lack health care because available providers' skills are inadequate, and three times as likely to report being denied needed health care, according to the report. In a forward, theoretical physicist Stephen Hawking, who lives with motor neuron disease, said, "We have a moral duty to remove the barriers to participation for people with disabilities, and to invest sufficient funding and expertise to unlock their vast potential." The report encouraged governments to step up their efforts to make services accessible to people with disabilities.

No, It's Never Healthy

The Food and Drug Administration has warned online retailers to stop marketing tobacco products with unsubstantiated claims that the products can reduce the risk of tobacco-related diseases. In 11 warning letters, the agency cited the online retailers for various illegal claims, including use of terms such as "light," "mild," "low," "less toxic," and "safer." Companies cannot make these claims without FDA approval, and the FDA has not okayed any such claim for tobacco products. The agency also cited some Internet retailers for selling flavored cigarettes. "There is no known safe tobacco product," Dr. Lawrence Deyton, director of the FDA's Center for Tobacco Products, said in a statement. "It is illegal for tobacco companies or retailers, including Internet sellers, to make unsubstantiated claims or statements that imply tobacco products reduce health risks."

Bill Seeks to Repeal Tan Tax

A Republican congressman and 24 cosponsors have introduced a bill to repeal the 10% "regressive tax" on tanning services that was part of the Affordable Care Act. "The health care law unfairly imposes onerous taxes, like the tan tax, on our nation's business owners and consumers, slowing economic growth and costing jobs," the bill's sponsor, Rep. Michael Grimm (R-N.Y.), said in a statement. The Indoor Tanning Association supports the bill, as does the National Federation of Independent Businesses and the National Taxpayers Union, Rep. Grimm said. The tanning group's president, Dan Humiston, said in a statement, "In reality, this tax takes money out of the pockets of some of those least able to afford it: working women, who are not only customers but also make up a majority of our business owners; and college students, who are both customers and employees."

–Mary Ellen Schneider

IMPLEMENTING HEALTH REFORM

The Hospital Value-Based Purchasing Program

Beginning late next year, hospitals will be paid in part based on their performance on 12 clinical quality measures and patient satisfaction scores.

Under the new Hospital Value-Based Purchasing program, mandated by the Affordable Care Act, officials at the Centers for Medicare and Medicaid Services will set aside 1% of hospital payments under the Medicare IPPS (Inpatient Prospective Payment System) to pay for care based on quality.

In the first year, the fund will have about $850 million to make quality-incentive payments.

Dr. Richard Bankowitz, chief medical officer for the Premier Healthcare Alliance (a network of more than 2,500 U.S. hospitals and 73,000 other health care sites) shared his views on the new program and the potential impact it will have on cost and quality.

RHEUMATOLOGY NEWS: The measures are weighted so that 70% of the incentive payment is based on the 12 quality measures, and 30% is based on patient evaluations. Is this the best way to measure the success of hospitals in improving quality?

Dr. Bankowitz: Based on our experience with the Hospital Quality Incentive Demonstration VBP (value-based purchasing) project, which helped to pioneer the concept of VBP/pay for performance, the Premier Healthcare Alliance strongly supports policies that link payment to quality outcomes. However, we are disappointed that the CMS essentially ignored comments from the field on the proposed Medicare VBP rule. We believe that the CMS inappropriately weighted the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey. Although inclusion of HCAHPS is an important advancement of patient-centered care, a 30% weighting is excessive, because research shows that high-acuity or depressed patients score their experience at a lower level. Because of this, we believe that the CMS's policy will disadvantage hospitals that take on complex patients.

'Performance thresholds should be established at a level that all hospitals ... could be expected to achieve.'

DR. BANKOWITZ

RN: Are Medicare officials using the right quality measures? What factors need to be considered in choosing measures?

Dr. Bankowitz: Premier supports the inclusion of harm and health care–acquired condition measures in VBP. However, the measures are duplicative of the CMS's current nonpayment policy. The CMS needs to reconsider its overall approach to health care–acquired conditions to ensure that each policy is mutually exclusive and that hospitals are not inappropriately hit with double penalties for the same event. Such quality measures (based on billing data) are unreliable and should not be used; instead, the CMS should wait for the inclusion of more robust clinical outcomes measures. We were disappointed with the selection of the Agency for Healthcare Quality and Research patient-safety and inpatient-quality indicators in the VBP program. These measures lack substantial evidence to support their ability to identify true differences in hospital performance, and some have very high false-positive rates. Using "buggy" measures to determine payment is highly inappropriate, and will unfairly penalize hospitals with reduced reimbursement, even in cases where no quality or safety events have occurred.

RN: Are hospitals ready to take this step?

Dr. Bankowitz: We believe that the majority of hospitals are ready to move toward a pay-for-performance environment, but the CMS's rule does not make this transition optimal. Premier has long argued that performance thresholds should be established at a level that all hospitals reasonably could be expected to achieve. Setting the threshold at the median in the baseline period is overly ambitious in the first year of the program, and fails to take into account the time needed to establish robust quality-improvement infrastructures.

RN: Is this program likely to meet the goals of lowering cost while improving quality?

Dr. Bankowitz: Directionally, there are myriad proposals both through health reform and in the private market that are moving the system forward and aligning incentives to reward quality outcomes, as opposed to volume-based fees for service. For example, in addition to the VBP program, reform calls for payment penalties for hospitals with high readmission rates and the recently released Medicare shared-savings program rules are predicated on the desire to pay for improved quality that is delivered at a lower cost. Moreover, private payers are pushing for value-based reimbursement overall, and hospitals will increasingly have to achieve the goals of better quality and lower costs in order to survive in the future. Broadly, all these programs are pushing us to a new way of reimbursing and delivering care, a change that is long overdue, considering the quality gaps in the current system as well as the unaffordable trajectory of health care spending.

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RN: How could this program help pave the way for pay for performance at the physician level?

Dr. Bankowitz: Many pay-for-performance programs exist today in private markets. Traditionally, however, hospitals have had a challenging time implementing pay for performance with physicians, as there are legal issues that prevent this type of cooperation and coordination, including the Stark Law, civil monetary penalties law, and antitrust laws. What's encouraging is that these traditional barriers are starting to go away. In the recent Medicare shared-savings proposed rule, for instance, a number of waivers were proposed that would allow hospitals and other providers to share in savings generated and to provide compensation for physicians who are able to achieve better quality outcomes at a lower cost. Provided that these remain in the final rule, we would anticipate that a greater portion of physician pay will ultimately be tied to their ability to deliver better health and greater value. ■

DR. BANKOWITZ, *a board-certified internist and medical informaticist, is the chief medical officer at the Premier Healthcare Alliance. He is also a senior scholar with the center for health care policy at Thomas Jefferson University in Philadelphia.*

COMMENTARY

AMA's Factions in Opposite Corners

The recently concluded American Medical Association annual meeting displayed deeply held conflicting opinions among the voting members of its House of Delegates.

The prevailing majority endorsed individual responsibility to either purchase health insurance or pay a penalty for not participating as a fundamental aspect of health reform. This group, predominantly composed of representatives of national specialty societies, New England, Midwestern, and Western states, believes that without universal commitment to the risk pool, the ability to sustain a healthy insurance market would be uncertain. The elimination of preexisting conditions makes "free riders" who buy insurance only at the onset of illness a potential threat by causing escalation of premiums on the remaining chronically ill, a subsequent collapse of the private market ,and the inevitable creation of a governmental payer system based on tax revenues.

BY WILLIAM E. GOLDEN, M.D.

A passionate minority of nearly 40% hold strong libertarian views and hail predominantly from Southern and mid-Southern states and small, private practice clinical sites. To them, the government should never violate individual liberty by mandating participation in an insurance pool. They generally believe that fee schedules are a violation of their autonomy, and that doctors and patients should be able to freely contract with each other to establish total fees for health services. Government regulation regarding public health issues, access to health care, and the provision of medical services should be minimal. Testimony from this group is often impassioned and persistent.

The nature of the debate at the meeting left little middle ground for a mutually satisfying compromise. Moreover, it is not easy to ascertain the views of the nearly 1 million practicing physicians who are increasingly engaged in salaried practice and who have not been joining the AMA. Testimony at the House of Delegates meeting now features debates between traditional representatives (state society, private practice physicians) and a somewhat more diverse population of delegates from national specialty societies. While the AMA's policy on health reform was essentially reaffirmed last week, the inherent tensions between these two large factions within the organization will persist for quite some time.

DR. GOLDEN *is professor of medicine and public health at the University of Arkansas, Little Rock.*

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 on April 29. The initiative was mandated by Congress under the Affordable Care Act.

Under the program, the 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, the 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 during 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.

To evaluate patient satisfaction, a survey of a random sample of discharged patients will be taken 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 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. ■

As Health Reform Law Takes Effect, Hospitalists Have a Chance to Shine

BY MARY ELLEN SCHNEIDER

FROM THE ANNUAL MEETING OF THE SOCIETY OF HOSPITAL MEDICINE

GRAPEVINE, TEX. – Hospitalists will have new opportunities to show just how indispensable they are as the provisions of the Affordable Care Act go into effect, according to Dr. Robert Kocher, who helped formulate the health reform law that was enacted last year.

Dr. Kocher, an internist who previously served as a member of President Obama's National Economic Council, said that hospital administrators will be looking to hospitalists to help them cope with elements of the health reform law such as requirements to reduce readmissions and possible participation in accountable care organizations.

The new law also makes "productivity adjustments" that cut Medicare payments to hospitals, he said.

Thus, hospitals will be under pressure to be as efficient as possible and hospitalists will be in a position to help reduce costs in various ways, from reducing redundancies on care teams to improving handoffs, said Dr. Kocher, a principal at the Center for U.S. Health System Reform at McKinsey & Company.

Hospitalists have an opportunity to show their worth as hospitals try to better use technology to drive down costs. "Technology lowers prices in every other part of the economy, but it doesn't in health care," Dr. Kocher said. "There's no reason why that shouldn't be possible in health care."

And physicians shouldn't drag their feet in preparing for the implementation of the new law, because despite efforts to repeal it, it's here to stay, Dr. Kocher predicted. "I doubt this Congress is going to meaningfully change the law," he said.

The one place where the law could be threatened is in the courts, he said. Several challenges are winding their way through the federal court system, and legal experts expect that the issue of the law's constitutionality will end up before the Supreme Court.

A ruling from the high court is likely to be very close, but it's unclear what direction it will go in, Dr. Kocher said. Even if the court were to strike down the law's mandate that individuals purchase health insurance, there are other ways in which the government could incentivize people to buy coverage, he added. ■