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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. ■