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.

Cardiology 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.

CN: 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. Furthermore, 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 do not have 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.

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

DR. BANKOWITZ

CN: 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.

CN: 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.

CN: 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

Feds Pushing Insurance Plan for Preexisting Conditions

BY FRANCES CORREA

FROM A HEALTH AND HUMAN SERVICES DEPARTMENT PRESS BRIEFING

A 40% premium cut and simpler enrollment procedures are two changes the federal government is employing to increase enrollment in the Pre-Existing Condition Insurance Plan, Health and Human Services Secretary Kathleen Sebelius announced during a press briefing.

Launched in July 2010 under the Affordable Care Act (ACA), the Pre-Existing Condition Insurance Plan (PCIP) provides an insurance option for people with preexisting conditions who have been denied coverage and have been without insurance for 6 months or more.

To increase awareness for the program, HHS will offer payment for insurance brokers and agents for successfully connecting eligible enrollees with the PCIP program, said Richard Popper, deputy director of insurance programs in the Office of Consumer Information and Insurance Oversight.

Those seeking coverage under the PCIP will no longer have to wait to receive a denial letter from their insurance company to enroll. Instead, they can provide attestation of their condition from their physician, nurse practitioner, or physician assistant. Patients with preexisting conditions still will be required to be without insurance for 6 months before they are eligible for coverage under the plan, said Mr. Popper. He added that HHS does not have the authority to waive the 6-month waiting period under the current health law.

Ms. Sebelius emphasized HHS's priority to increase enrollment in the program.

"It's encouraging to see more people who need health insurance the most getting it, but we know that's not enough," Ms. Sebelius said.

The measures comply with the ACA provision requiring the PCIP to align premiums and benefits with the private insurance market, Mr. Popper said. However, he said there's still plenty of room for new enrollees.

"We've been enrolling people at an increasing rate, but we know we have the capacity to cover even more people," Mr. Popper said.

He added that funding for the measures will fall under the original $5 billion set aside for the program through the health reform law, as well as existing member premiums.

Despite original HHS estimates that several hundred thousand people would benefit from the PCIP, 18,313 people were enrolled as of early May.

The PCIP is run by the federal government in 23 states and the District of Columbia; remaining states operate their own programs using funding from the ACA. HHS sent letters to those 27 state programs, encouraging them to consider similar reforms to their programs. ■