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Moving From A Medicare Fee-For-Service System To A Pay-For-Performance System

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As part of the Patient Protection and Affordable Care Act's (PPACA's) sweeping health reform measures, Medicare will continue its transformation in 2013 from a passive payor of claims to an active purchaser of healthcare services. In previous initiatives from the Centers for Medicare and Medicaid Services (CMS) and as strengthened by PPACA, providers will soon not only be rewarded for attainment of quality measures and improvement from baseline, but also penalized for poor performance on quality measures related to common and high-cost conditions, such as cardiac, surgical complications, and pneumonia care.

The Department of Health and Human Services (HHS) is to submit a more comprehensive value-based purchasing (VBP) program to Congress by January 1, 2011. Therefore, details are still in flux. However, this systemic change to the Medicare Prospective Payment System has been evolving since at least 2000. HHS has acquired a substantial cache of information through a number of reporting programs and VBP demonstrations including: the Reporting Hospital Quality Data for Annual Payment Update program (RHQDAPU); the Premier Hospital Quality Incentive Demonstration (HQID); the Physician Group Practice (PGP) Demonstration; and the Medicare Care Management Performance (MCMP) Demonstration. In each of these programs and demonstrations, participant providers have been eligible for financial incentives based upon their reporting of and performance on standardized quality of care measures as specified by CMS. The groundwork for payment reform and VBP has been laid through these reporting programs and quality demonstrations. We anticipate that much of what CMS has learned through these programs will be incorporated into the forthcoming regulations and guidelines pertaining to VBP.

CMS is developing similar quality measures for application to all hospitals that treat Medicare beneficiaries, relying on input from other stakeholders, including physicians, other providers, and suppliers. As with current performance rate and survey data, these additional measures will be posted on a "Hospital Compare" website in 2012, at least one year before the beginning of the initial performance period. Performance standards based upon specified measures selected by the Secretary will be established and posted at least 60 days before the beginning of each performance period.

Each participating hospital will receive a total performance score based upon progress towards these performance standards as reported during a specified performance period. Each hospital's performance score will be determined by the greater of its achievement score or its improvement score for each measure. Hospitals achieving high total performance scores will be eligible to receive a value-based incentive payment for that fiscal year.

The incentive payment will be calculated as a percentage of the hospital's base diagnosis-related group (DRG) payment per discharge. Beginning in 2013, the base DRG payment for each hospital will be reduced by an amount equal to the percentage of the value-based incentive for that year. In other words, each hospital's base DRG amount will be reduced by the following percentages:

- 2013 base DRG will be reduced by 1%;
- 2014 base DRG will be reduced by 1.25%;
- 2015 base DRG will be reduced by 1.5%;
- 2016 base DRG will be reduced by 1.75%; and
- 2017 and beyond base DRG will be reduced by 2.0%.

PPACA calls for the total cost to Medicare under the VBP system to be budget neutral. Therefore, for each fiscal year, the total amount available for payment of value-based incentives to eligible hospitals will equate to the total dollars saved as a result of the decrease in the base operating DRG payments for that fiscal year. Furthermore, beginning in 2015, hospitals in the top 25th percentile of certain hospital acquired conditions will be subject to an additional 1% Medicare payment penalty.

In short, beginning in 2013, acute care hospital revenue will be significantly reduced unless the hospital is regularly employing, reporting, and meeting the clinical quality measures performance standards identified by CMS.

Next Steps

In anticipation of this dramatic shift in Medicare payment methodology, we recommend that all hospitals assess their current quality measurement and tracking systems to ensure they are ready to take full advantage of this trend in the coming years. It is likely

that a significant investment in IT along with changes in medical records management will be necessary to achieve a fully operational and certified electronic health record (EHR). Moreover, hospitals must engage in a thoughtful analysis of their relationships with physicians and other ancillary providers in order to determine how to effectively align their collective various interests and incentives. Clinical integration will be necessary to achieve the consistent levels of quality and economic efficiencies necessary to receive appropriate payment for all Medicare providers within the delivery system.

Additionally, the Hospital Quality Alliance (HQA), a public-private collaboration which includes CMS, the American Hospital Association (AHA), the Federation of American Hospitals, and the Association of American Medical Colleges, have begun the establishing of a set of "easily understandable" hospital quality standards. These measures will likely be largely integrated into the clinical quality measures selected by CMS for purposes of determining each hospital's eligibility for a performance-based incentive payment. Therefore, directors of hospital quality and compliance should stay abreast of these evidence-based guidelines and quality measures as they are approved and to incorporate them into hospital policies, procedures, clinical guidelines, and tools, such as standard forms for diagnosis related physician order sets.

On another note, hospitals should be aware that Congress has mandated through PPACA that expanded hospital quality performance information will be made publicly available to consumers on the "Hospital Compare" website. Beginning in 2014, Medicare will post information regarding each hospital's performance with respect to: (a) each specified measure assessed during the performance period; (b) each specified condition or procedure tracked during the performance period; and (c) its total performance score for the period. Medicare will also periodically post on the website, aggregate quality information concerning: (a) the number of hospitals who received value-based incentive payments; (b) the range and total amount of incentive payments; and (c) the number of hospitals who received less than the maximum available incentive payment for each fiscal year of the program.

Ms. Smith is a shareholder whose current practice focuses primarily on assisting healthcare providers in the development and implementation of the quality and clinical integration measures necessary to adapt to the reformation of existing reimbursement and payment structures. Since 1998, Ms. Smith has regularly represented health systems, hospitals, and physicians in a broad array of litigation, risk management, and civil appellate matters. Ms. Smith received her law degree from Indiana University School of Law in 1994 and is a member of the Indianapolis Bar Association, Indiana State Bar Association, American Bar Association, American Health Lawyers Association, Healthcare Financial Management Association, American Health Information Management Association, and Defense Research Institute.

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