

THE AFFORDABLE CARE ACT AND THE MEDICARE PROGRAM: LINKING MEDICARE PAYMENT TO QUALITY PERFORMANCE

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INTRODUCTION

The Patient Protection and Affordable Care Act (“ACA”),¹ as amended by the Health Care and Education Reconciliation Act of 2010,² is signature legislation that will fundamentally change the health care sector of the United States. One of the ACA’s major reforms changes the way in which Medicare pays health care providers and rewards providers for providing high quality care.

Value-based purchasing is a major strategy for reducing the escalation of Medicare expenditures. The theory of value-based purchasing is to change the basis of payment for services from a formula based on events and resources used in an episode of care to a formula based on performance measured by specific quality measures.³

This Article reviews the development of value-based purchasing in the Medicare program since its inception. The Article then explains how the ACA expands and enhances value-based purchasing from only inpatient hospitals to physicians and other providers. Then the Article analyzes what the future implications of value-based purchasing will be for the U.S. health care industry.

I.
BACKGROUND

This Section describes the Medicare program and its journey toward value-based purchasing.⁴ One might think that value-based purchasing was a new creation with the ACA, but that is not the case. Since 2002, the Medicare program has been moving toward

1. Patient Protection and Affordable Care Act, Pub. L. No. 111-48, 124 Stat. 119–1024 (codified as amended in scattered sections of 20, 21, 25, 26, 28, 29, 30, 36, and 42 U.S.C.).

2. Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029–83 (2010).

3. See generally AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, THEORY AND REALITY OF VALUE-BASED PURCHASING: LESSONS FROM THE PIONEERS (Nov. 1997), available at <http://www.ahrq.gov/legacy/qual/meyerrpt.htm>.

4. Eleanor D. Kinney, *The Affordable Care Act and the Medicare Program: The Engines of True Health Reform*, 8(2) YALE J. HEALTH POL’Y L. & ETHICS.

value-based purchasing for all health care providers.⁵ As explained herein, Congress and the administrations of Presidents George W. Bush and Barack Obama have been designing and laying the groundwork for this program for many years on a non-partisan basis.

A. *The Concept of Value-Based Purchasing*

The value-based purchasing programs for all providers follow essentially the same model.⁶ Providers start with voluntary quality reporting with the development of quality and efficiency measures, which later become mandatory. The payment is based on reported quality measures. Centers for Medicare & Medicaid Services (“CMS”) has described a “template” for value-based purchasing systems for all providers and professionals:

- Identification and promotion of the use of quality measures through pay-for-reporting
- Payment for quality performance
- Measures of physician and provider resource use
- Payment for value—promote efficiency in resource use while providing high-quality care
- Alignment of financial incentives among providers
- Transparency and public reporting⁷

The idea of value-based purchasing had been percolating among private payers, policy makers, and scholars for many years.⁸ By 2007, many private payers were using pay-for-performance to compensate providers and health plans.⁹

5. CTMS. FOR MEDICARE & MEDICAID SERVS., ROADMAP FOR IMPLEMENTING VALUE DRIVEN HEALTHCARE IN THE TRADITIONAL MEDICARE FEE-FOR-SERVICE PROGRAM 5 (2012) [hereinafter ROADMAP FOR IMPLEMENTING], *available at* https://www.cms.gov/QualityInitiativesGenInfo/downloads/VBPRoadmap_OEA_1-16_508.pdf.

6. *Id.*

7. *Id.* at 4.

8. See Vittorio Maio et al., *Value-Based Purchasing: A Review of the Literature*, THE COMMONWEALTH FUND (May 2003), http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2003/May/Value%20Based%20Purchasing%20%20A%20Review%20of%20the%20Literature/maio_valuebased_636%20pdf.pdf.

9. See SHARON SILOW-CARROLL & TANYA ALTERAS, THE COMMONWEALTH FUND, VALUE-DRIVEN HEALTH CARE PURCHASING: FOUR STATES THAT ARE AHEAD OF THE CURVE (Aug. 15, 2007), *available at* http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2007/Aug/Value%20Driven%20Health%20Care%20Purchasing%20%20Four%20States%20that%20Are%20Ahead%20of%20the%20Curve/1052_Silow%20Carroll_value%20driven_purchasing%20pdf.pdf; Meredith B. Rosenthal et al., *Employers' Use of Value-Based Purchasing Strategies*, 298 J. AM. MED. ASS'N 2281 (2007); Meredith B. Rosenthal et al., *Pay for Per-*

The American Medical Association (“AMA”) and some medical specialty societies had developed policy positions on pay-for-performance (“PFP”) as well.¹⁰ Several prominent bipartisan organizations also prepared recommendations.¹¹ The AMA has announced five policy principles to guide PFP programs that reflect their recommendations about such programs.¹² These include:

1. *Ensure quality of care*—Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality of care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician’s sound clinical judgment and should not adversely affect PFP program rewards.
2. *Foster the patient/physician relationship*—Fair and ethical PFP programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients’ health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.
3. *Offer voluntary physician participation*—Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of non-participating physician practices. These programs support participation

formance in Commercial HMOs, 355 NEW ENG. J. MED. 1895 (2006); *see also* Andrew M. Ryan & Jan Blustein, *The Effect of the MassHealth Hospital Pay-for-Performance Program on Quality*, 46 HEALTH SERVICES RES. 712 (2011).

10. AM. MED. ASS’N, GUIDELINES FOR PAY-FOR-PERFORMANCE PROGRAMS (2005), *available at* <http://www.ama-assn.org/ama1/pub/upload/mm/368/guidelines4pay62705.pdf>; AMERICAN COLLEGE OF PHYSICIANS, ETHICS, PROFESSIONALISM AND HUMAN RIGHTS COMMITTEE, PAY-FOR-PERFORMANCE PRINCIPLES THAT ENSURE THE PROMOTION OF PATIENT CENTERED CARE – AN ETHICS MANIFESTO (2007), *available at* http://www.acponline.org/running_practice/ethics/issues/policy/p4p_ba.pdf; AMERICAN ACADEMY OF FAMILY PRACTICE, PAY-FOR-PERFORMANCE POLICIES (2010), <http://www.aafp.org/online/en/home/policy/policies/p/payforperformance.html> (last visited Apr. 9, 2013).

11. THE COMMONWEALTH FUND COMM’N ON A HIGH PERFORMANCE HEALTH SYS., THE PATH TO A HIGH PERFORMANCE U.S. HEALTH SYSTEM: A 2020 VISION AND THE POLICIES TO PAVE THE WAY (Feb. 2009), *available at* <http://www.commonwealthfund.org/Publications/Fund-Reports/2009/Feb/The-Path-to-a-High-Performance-US-Health-System.aspx?page=all>; JOSEPH ANTOS ET AL., THE ENGELBERG CENTER FOR HEALTH CARE REFORM AT THE BROOKINGS INSTITUTE, BENDING THE CURVE: EFFECTIVE STEPS TO ADDRESS LONG-TERM HEALTH CARE SPENDING GROWTH (Aug. 2009), *available at* http://www.brookings.edu/~media/Files/rc/reports/2009/0826_btc/0826_btc_fullreport.pdf.

12. AM. MED. ASS’N, *supra* note 10.

by physicians in all practice settings by minimizing potential financial and technological barriers, including costs of start-up.

4. *Use accurate data and fair reporting*—Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment on, and appeal results prior to the use of the results for programmatic or any other reporting.
5. *Provide fair and equitable program incentives*—Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement among all participating physicians.¹³

The Institute of Medicine (“IOM”) weighed in with a major initiative on value-based purchasing. Congress was dissatisfied with the pace of quality improvement and thus mandated in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (“MMA”) that the IOM conduct a study of the quality improvement infrastructure.¹⁴ In response, the IOM launched the Redesigning Health Insurance Performance Measures, Payment, and Performance Improvement Project.¹⁵ The IOM Committee charged with this project produced three reports detailing policy approaches to improving the quality of health care: (1) measurement and reporting of performance data; (2) payment incentives; and (3) quality improvement initiatives.¹⁶

There has been considerable scholarship addressing implementation issues.¹⁷ A 2008 review of pay-for-performance evalua-

13. *Id.*

14. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 107, 117 Stat. 2066 (codified at 42 U.S.C. § 1320, 36 U.S.C. § 150303).

15. BD. ON HEALTH CARE SERVS., INST. OF MED., PERFORMANCE MEASUREMENT: ACCELERATING IMPROVEMENT (2005), available at <http://www.iom.edu/Reports/2005/Performance-Measurement-Accelerating-Improvement.aspx>.

16. INST. OF MED., REWARDING PROVIDER PERFORMANCE: ALIGNING INCENTIVES IN MEDICARE (2007); INST. OF MED., MEDICARE’S QUALITY IMPROVEMENT ORGANIZATION PROGRAM: MAXIMIZING POTENTIAL I (2006); INST. OF MED., PERFORMANCE MEASUREMENT: ACCELERATING IMPROVEMENT (2005).

17. See Karen Davis & Stuart Guterman, *Rewarding Excellence and Efficiency in Medicare Payments*, 85 THE MILBANK QUARTERLY 449 (2007); Arnold M. Epstein, *Pay for Performance at the Tipping Point*, 356 NEW ENG. J. MED. 515 (2007); Meredith B.

tions reported that improvements in quality measures occurred in all the efforts analyzed, but the authors were unsure about the contribution of financial incentives to quality improvement.¹⁸ The CMS-funded Premier Hospital Quality Incentive Demonstration of value-based-purchasing reported improvements ranging from 2.6 to 4.1 percent over the two-year period.¹⁹ A later review of value-based purchasing by analysts at CMS reported that between 2006 and 2010, hospital performance improved on ninety-one percent of the measures included in CMS' inpatient pay-for-reporting program and that a new trend of slowing growth in health care costs had emerged.²⁰

B. Medicare's Journey to Value-Based Purchasing

Amending the Social Security Act ("SSA"),²¹ Congress established the Medicare program to provide health care coverage for the elderly. Medicare, a federal social insurance program, administered by CMS within the Department of Health and Human Services ("DHHS"), provides insurance for hospital and extended-care services as well as supplementary medical insurance for physician and associated services to the elderly, disabled, and certain individuals with end-stage renal disease.²²

The Medicare program is comprised of four parts. Parts A and B were contained in the original Medicare statute and are called "Fee-for-Service" Medicare. Part A, Hospital Insurance Benefits for Aged and Disabled, covers hospital and extended-care services.²³ Part B, Supplementary Medical Insurance Benefits for Aged and Disabled, provides physician and other outpatient services.²⁴ Part C, now called Medicare Advantage, was established in the Balanced

Rosenthal & R. Adams Dudley, Commentary, *Pay-for-Performance: Will the Latest Payment Trend Improve Care?* 297 J. AM. MED. ASS'N 740 (2007).

18. Jon B. Christianson et al., *Lessons from Evaluations of Purchaser Pay-for-Performance Programs: A Review of the Evidence*, 65 MED. CARE RES. & REV. 5S (2008).

19. Peter K. Lindenauer et al., *Public Reporting and Pay for Performance in Hospital Quality Improvement*, 356 NEW ENG. J. MED. 486, 486 (2007).

20. See Jordan M. VanLare & Patrick H. Conway, *Value-Based Purchasing—National Programs to Move from Volume to Value*, 367 NEW ENG. J. MED. 292, 292 (2012).

21. Social Security Amendments of 1965, Pub. L. No. 89-97, tit. I §§ 101–11, 121–22, 79 Stat. 290–353 (codified as amended at 42 U.S.C. § 1395 (2006)).

22. In 1972, Congress added the disabled and individuals with end stage renal disease to those eligible for Medicare. Social Security Amendments of 1972, Pub. L. No. 92-603, tit. II, § 299I, 86 Stat. 1329 (codified as amended at 42 U.S.C. § 1395c (1982 & Supp. 1985)).

23. 42 U.S.C. §§ 1395c–1395i (2012).

24. 42 U.S.C. §§ 1395j–1395w-5 (2012).

Budget Act of 1997.²⁵ Medicare Part C covers the same services as Parts A and B but is delivered through a private health plan which has the option of providing additional benefits over and above the Medicare Fee-for-Service benefit package under Parts A and B.²⁶ Established in the MMA,²⁷ Part D is a voluntary prescription drug benefit program.

1. A History of Medicare Payment Reform

The original Medicare statute granted hospitals and physicians almost complete autonomy in setting the level of payment for services provided to their beneficiaries, chiefly because of considerable political opposition to the programs from providers. Initially the Medicare program paid hospitals the costs, as calculated by hospitals, of providing services to beneficiaries with the only requirement that the costs be “reasonable.”²⁸ For physicians, “reasonable” was defined with reference to usual and customary charges in the market place charged by all physicians.²⁹ Other health care providers were paid on a similar basis. These reimbursement methodologies put control over the cost of care in the hands of the providers. Not surprisingly, these methods proved very costly and Medicare expenditures grew at alarming rates immediately upon implementation of the program.³⁰ The seriousness of the cost problem surfaced shortly after the inauguration of the Medicare and Medicaid programs³¹ and has dominated the healthcare debate ever since.

a. Hospital Payment

Congress adopted an inpatient prospective payment system (“IPPS”) for acute-care inpatient hospitals in the Social Security

25. See Pub. L. No. 105-33, § 4001 (codified as amended at SSA §§ 1851–59; 42 U.S.C. § 1395w-21 (2012))

26. 42 U.S.C. § 1395w-22(a)(3) (2012).

27. Pub. L. No. 108-173, § 911, 117 Stat. 2066, 2378–86 (to be codified at 42 U.S.C. § 1395kk-1).

28. Social Security Amendments of 1965, Pub. L. No. 89-97, § 102(a), 79 Stat. 286 (codified as amended at 42 U.S.C. §§ 1395(f)(b), 1395x(v)).

29. Social Security Amendments of 1965, Pub. L. No. 89-97, § 102(a), 79 Stat. 286 (codified as amended at 42 U.S.C. § 1395l(a)).

30. Marian Gornick et al., *Twenty Years of Medicare and Medicaid: Covered Populations, Use of Benefits, and Program Expenditures*, HEALTH CARE FIN. REV. 13, 35–45 (Supp. 1985).

31. See *Reimbursement Guidelines for Medicare: Hearing Before the S. Comm. on Fin.*, 89th Cong. (1966); STAFF OF THE S. COMM. ON FIN., 91ST CONG., MEDICARE AND MEDICAID: PROBLEMS, ISSUES, AND ALTERNATIVES 53, 140–43 (Comm. Print 1970).

Amendments of 1983.³² The chief objective of this payment system was to change incentives in hospital financial behavior. IPPS applies only to “subsection (d) hospitals,” as defined under section 1886(d)(1)(B) of the Social Security Act. Figure 1 presents eligible and excluded hospitals under subsection (d).

Figure 1 “Subsection d Hospitals”
<p>Included Hospitals under § 1886(d) Section 1886(d)(1)(B) of the SSA generally defines a “subsection (d) hospital” as a “hospital located in one of the fifty States or the District of Columbia.</p>
<p>Excluded Hospitals under § 1886 Psychiatric hospitals Rehabilitation hospitals Long term care hospitals Children’s hospitals Cancer hospitals</p>

The Medicare prospective-payment system pays a fixed price per case and allows hospitals to keep savings while putting them at risk for costs incurred over and above the price per case. Under the prospective payment system, the Medicare program pays hospitals a fixed price for each Medicare case based on the diagnosis related group (“DRG”) in which the patient’s particular condition falls.³³

DRGs are a classification system that groups similar clinical conditions and the procedures furnished by the hospital during the stay.³⁴ There are three levels of severity in the Medical Severity–Diagnosis Related Groups (“MS-DRGs”) based on secondary diagnosis codes: (1) Major Complication/Comorbidity (“MCC”); (2)

32. Social Security Amendments of 1983, Pub. L. No. 98-21, § 601(c)(1), 97 Stat. 65 (codified as amended at 42 U.S.C. § 1395ww).

33. 42 U.S.C. § 1395ww(d)(1) (2012); Interim Final Rule, Medicare Program; Prospective Payments for Medicare Inpatient Hospital Services, 48 Fed. Reg. 39,752 (Sept. 1, 1983) (interim final rule) (to be codified at 42 C.F.R. pts 405, 409, 489).

34. DEP’T OF HEALTH & HUMAN SERVS., CTRS. FOR MEDICARE & MEDICAID SERVS., ACUTE CARE HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEM 2 (Apr. 2013) [hereinafter ACUTE CARE HOSPITAL], available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AcutePaymtSysfctsh.pdf>; *Acute Inpatient PPS*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/AcuteInpatientPPS/> (last modified Aug. 1, 2012).

Complication/Comorbidity (“CC”); and (3) Non-Complication/Comorbidity (“Non-CC”). The three groups reflect differences in the severity of illness and resource use.³⁵ A weight, reflecting the average relative costliness of cases in that group compared with the costliness for the average Medicare case, is assigned to each MS-DRG.³⁶ The standard price per case for the operating costs and capital costs for all hospitals in the United States reflects the costs which “efficient facilities are expected to incur in furnishing covered inpatient services.”³⁷

Upon the discharge of a Medicare beneficiary, the hospital assigns a principle diagnosis code to the patient’s case, up to twenty-four secondary diagnoses that indicate comorbidities, and up to twenty-five procedures furnished during the hospital stay.³⁸ These data are submitted to the Medicare contractor for the relevant area.

The Medicare contractor, using a computer program called a “grouper,” assigns the patient’s case a DRG. In this process, patient charges are standardized to account for the effects of regional area wage differences, indirect medical education costs, and additional payments to hospitals that treat a large percentage of low-income patients (referred to as “disproportionate share payments”).³⁹ The labor-related share is adjusted by the wage index applicable to the area where the hospital is located, and if the hospital is located in Alaska or Hawaii, the non-labor share is adjusted by a cost of living adjustment factor.⁴⁰ A variety of other so-called policy adjustments, such as modifications to reflect the cost of indirect medical education and the disproportionate share for low-income beneficiaries, are made to Medicare’s final payment to the hospital for that case.⁴¹

b. Physician Payment

In the Social Security Amendments of 1983, Congress directed the Secretary of DHHS to study possible methods of paying physicians according to a methodology similar to the prospective payment system for hospitals.⁴² In 1989 Congress enacted a revised

35. ACUTE CARE HOSPITAL, *supra* note 34 at 2.

36. *Id.* at 3.

37. *Id.*

38. *Id.* at 2.

39. *Id.* at 3–8.

40. *Id.* at 3.

41. *Id.* at 4–8.

42. Social Security Amendments of 1983, Pub. L. No. 98-21 § 603(a)(2)(B), 97 Stat. 65, 166.

payment system for physician services that paid physicians based on the time and resources involved in treating specific conditions rather than on a charge basis.⁴³ Congress enhanced the system in the Omnibus Budget Reconciliation Act of 1990.⁴⁴ The Health Care Financing Administration (“HCFA”), the predecessor agency of CMS, promulgated the final rule implementing the system effective January 1, 1992.⁴⁵

In these two pieces of legislation, Congress replaced the disaggregated fee schedule based on historical charges with the Resource-Based Relative Value Scale (“RBRVS”), which is based on “relative value units” (“RVUs”) for three cost components of medical care: (1) physicians’ work effort; (2) physicians’ practice expenses; and (3) malpractice liability insurance expenses.⁴⁶ The Medicare Physician Fee Schedule lists more than 7,400 unique covered services and their payment rates for physicians and other therapists.⁴⁷

The formula for the payment a physician receives for a service is based on three components. The first component is the sum of the three RVUs for work effort, practice expense, and malpractice liability insurance expense. The second component is Geographic Practice Cost Indices (“GPCI”). GPCIs are adjustments that are applied to the three relative values to account for geographic variations in the costs of practicing medicine in different areas within the country.⁴⁸ The sum of the adjusted relative values is then multiplied by the “conversion factor,” a factor developed to adjust payments to conform to the “sustainable growth rate.” In the Balanced Budget Amendments of 1996, Congress established the “sustainable

43. Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, sec. 6104, § 1842(b) (codified as amended at 42 U.S.C. 1395u(b)(a)(14)) (current version at 42 U.S.C. § 1395u(a)(14)(A)(i)).

44. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, §§ 4102–12, 101 Stat. 1388.

45. Final Rule, Medicare Program; Fee Schedule for Physician Services, 56 Fed. Reg. 59502 (Nov. 25, 1991) (codified at 42 C.F.R. pt. 414).

46. DEP’T OF HEALTH & HUMAN SERVS., CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE PHYSICIAN FEE SCHEDULE: PAYMENT SYSTEM FACT SERIES 1, 2–3 (Apr. 2013) [hereinafter MEDICARE PHYSICIAN FEE SCHEDULE], available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLN-Products/downloads/MedcrePhysFeeSchedfctsh.pdf>; *Physician Fee Schedule*, CMS.GOV (last modified Sept. 10, 2013), http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html?redirect=/PhysicianFeeSched/01_overview.asp.

47. MEDICARE PHYSICIAN FEE SCHEDULE, *supra* note 46, at 2.

48. *Id.* at 3.

growth rate” factor that uses the real GDP to adjust for volume and intensity of services.⁴⁹

2. A History of Medicare Quality Reform⁵⁰

The Social Security Amendments of 1965 required hospitals to have utilization review committees as a condition of participation in Medicare.⁵¹ However utilization review alone was not sufficient to control excess utilization of services. In 1972, Congress enacted the very unpopular Professional Peer Review Program to establish independent utilization review by organizations dominated by physicians, but later repealed the program.⁵²

In 1982, in preparation for enactment of the new hospital prospective payment system, Congress established the Medical Utilization and Quality Control Program in preliminary legislation to support the move to prospective payment for hospitals.⁵³ This program established Peer Review Organizations (“PROs”) to review the utilization of services provided to Medicare beneficiaries to ensure that they were medically necessary and met professionally recognized standards of quality. In the early 1990s, HCFA fundamentally changed the mission of PROs from quality assurance to quality improvement,⁵⁴ and in 2002, CMS changed the name of PROs to Quality Improvement Organizations (“QIOs”) to reflect their new focus.⁵⁵

49. Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4503, 111 Stat. 251, 433–34 (codified as amended at 42 U.S.C. § 1395w-4(f)(2)(A)(iii) (2006)).

50. The material in this section is based on material in Eleanor D. Kinney, *The Affordable Care Act and the Medicare Program: The Engine for True Health Reforms*, 13 YALE J. OF HEALTH POL’Y, L. & ETHICS (forthcoming 2013), available at <http://srn.com/abstract-2170574>.

51. Social Security Amendments of 1965, Pub. L. No. 89-97, § 102(a), 79 Stat. 286 (codified as amended at 42 U.S.C. § 1395x(k)).

52. Social Security Amendments of 1972, Pub. L. No. 92-603, § 249F, 86 Stat. 1329 (codified as amended at 42 U.S.C. §§ 1320c-1 to c-19).

53. Peer Review Improvement Act of 1982, Pub. L. No. 97-248, § 1511, 96 Stat. 383 (codified as amended at 42 U.S.C. § 1320c (2000)). See Timothy Stoltzfus Jost, *Administrative Law Issues Involving the Medicare Utilization and Quality Control Peer Review Organization (PRO) Program: Analysis and Recommendations*, 50 OHIO ST. L.J. 1, 5 (1989).

54. See Anita J. Bhatia et al., *Evolution of Quality Review Programs for Medicare: Quality Assurance to Quality Improvement*, 22 HEALTH CARE FIN. REV. 69 (2000).

55. Office of Inspector General-Health Care; Medicare and Medicaid Programs; Peer Review Organizations: Name and Other Changes—Technical Amendments, 67 Fed. Reg. 36,495, 36,539 (May 24, 2002) (to be codified at 42 C.F.R. chs. I, IV, V).

In the 1980s, spurred on by health services research indicating that little was known about whether expensive medical procedures were more efficacious than less expensive treatment approaches, policy makers and third-party payers turned to health services research for answers.⁵⁶ In the mid 1980s, HCFA launched an aggressive program of health services research on outcomes of care that would serve as the basis of medical practice guidelines and coverage policy for federal health insurance programs.⁵⁷

Three developments in health services research shaped the future of quality assessment in health care organizations and paved the way for the value-based purchasing program. First, the work of Dr. John Wennberg and his colleagues demonstrated sharp variation in services provided to Medicare beneficiaries among different geographic areas for the same conditions.⁵⁸ This finding dramatically documented provider-induced demand for services and the resulting inefficiencies, including the provision of often unnecessary care.

The second important development was the application of the theories of Total Quality Management ("TQM") and Continuous Quality Improvement ("CQI"), developed by William E. Deming and Joseph Juran,⁵⁹ to health care institutions.⁶⁰ According to TQM/CQI theory, quality management should strive to reduce statistical variation in products and production to a level that is uniform and predictable while also meeting the expectations of

56. See generally HEALTH SERVICES RESEARCH: KEY TO HEALTH POLICY (Eli Ginzberg ed., 1991); IMPROVING HEALTH POLICY AND MANAGEMENT: NINE CRITICAL RESEARCH ISSUES FOR THE 1990s (Stephen M. Shortell & Uwe E. Reinhardt eds., 1992).

57. William L. Roper et al., *Effectiveness in Health Care: An Initiative to Evaluate and Improve Medical Practice*, 319 NEW ENG. J. MED. 1197, 1197-98 (1988); William L. Roper & Glenn M. Hackbarth, *HCFA's Agenda for Promoting High-Quality Care*, 7 HEALTH AFFAIRS 91, 95-96 (1988).

58. John E. Wennberg et al., *Professional Uncertainty and the Problem of Supplier-Induced Demand*, 16 SOCIAL SCIENCE AND MEDICINE 811, 812-15 (1982); John E. Wennberg & Alan Gittelsohn, *Variations in Medical Care Among Small Areas*, 246 SCI. AM. 120 (1982); John E. Wennberg & Alan Gittelsohn, *Small Area Variation in Health Care Delivery* 182 SCIENCE 1102 (1973).

59. W. EDWARDS DEMING, *THE NEW ECONOMICS FOR INDUSTRY, GOVERNMENT, EDUCATION* (1993); W. EDWARDS DEMING, *OUT OF THE CRISIS* (1986); J. M. JURAN, *JURAN ON LEADERSHIP FOR QUALITY: AN EXECUTIVE HANDBOOK* (1989); J. M. JURAN, *MANAGERIAL BREAKTHROUGH: A NEW CONCEPT OF THE MANAGER'S JOB* (1964).

60. See generally DONALD M. BERWICK ET AL., *CURING HEALTH CARE: NEW STRATEGIES FOR QUALITY IMPROVEMENT* (1990); Donald M. Berwick, *Continuous Improvement as an Ideal in Health Care*, 320 NEW ENG. J. MED. 53 (1989); Glenn Laffel & David Blumenthal, *The Case for Using Industrial Quality Management Science in Health Care Organizations*, 262 J. AM. MED. ASS'N 2869, 1869 (1989).

customers. Since the 1990s, data-driven TQM/CQI theory and practice has become an integral part of quality assurance and improvement concepts in the health care field.⁶¹

The third critical development was the patient safety movement inspired by the IOM 2000 report, “To Err Is Human.”⁶² This report made two important factual findings that have precipitated a revolution in U.S. health care. These observations were: (1) an estimated 44,000 to 98,000 people die each year in hospitals from medical injury; and (2) systems failures, rather than poor performance by individual practitioners, cause at least half of patient injuries.⁶³ The IOM report recommended that providers create a culture of safety in institutions by borrowing from quality science in the engineering industries.⁶⁴ Providers were largely persuaded by these findings and implemented data-driven strategies to reduce risks to patient safety.⁶⁵

In 2001, CMS (the successor of HCFA) began launching quality initiatives “to assure quality health care for all Americans through accountability and public disclosure.”⁶⁶ CMS established the Health Care Quality Improvement Initiative (“HCQII”) to move from addressing individual clinical errors to helping providers improve care generally.⁶⁷

In 2002, hospital associations, employers, payers, consumer organizations, the Joint Commission, and CMS established the Hospital Quality Alliance (“HQA”) to make “meaningful, relevant, and easily understood information about hospital performance accessi-

61. See generally CURTIS P. McLAUGHLIN & ARNOLD D. KALUZNY, CONTINUOUS QUALITY IMPROVEMENT IN HEALTH CARE: THEORY, IMPLEMENTATIONS, AND APPLICATIONS 28–32 (3d ed. 2005); ELLEN MARSZALEK-GAUCHER & RICHARD J. COFFEY, TRANSFORMING HEALTHCARE ORGANIZATIONS: HOW TO ACHIEVE AND SUSTAIN ORGANIZATIONAL EXCELLENCE 83–116 (1990).

62. INST. OF MED., COMM. ON QUALITY OF HEALTH CARE IN AM., TO ERR IS HUMAN: BUILDING A SAFER HEALTH CARE SYSTEM (Linda T. Kohn et al. eds., 2000), available at <http://www.nap.edu/openbook.php?isbn=0309068371>.

63. *Id.* at 26.

64. *Id.* at 79–80

65. See generally INST. OF MED., COMM. ON DATA STANDARDS FOR PATIENT SAFETY, BOARD ON HEALTH CARE SERVICES, PATIENT SAFETY: ACHIEVING A NEW STANDARD FOR CARE (Phillip Apsden et al. eds., 2004), available at http://books.nap.edu/openbook.php?record_id=10863.

66. *Quality Initiatives—General Information*, CTRS. FOR MEDICARE AND MEDICAID SERVS. (last modified Aug. 14, 2013), <https://www.cms.gov/qualityinitiatives/geninfo/>.

67. Stephen F. Jencks & Gail R. Wilensky, *The Health Care Quality Improvement Initiative: A New Approach to Quality Assurance in Medicare*, 268(7) J. AM. MED. ASS'N 900, 900 (1992).

ble to the public and to inform[] and encourag[e] efforts to improve quality.”⁶⁸

In July 2003, CMS launched the National Voluntary Hospital Reporting Initiative which morphed into the “Hospital Quality Alliance: Improving Care through Information,” a public-private collaboration to improve the quality of care provided by the nation’s hospitals “by measuring and publicly reporting on that care.”⁶⁹ In CMS’s Hospital Quality Initiative, CMS works with the HQA and other key stakeholders with the support of Agency for Healthcare Research and Quality (“AHRQ”), the National Quality Forum (“NQF”), and the Joint Commission, among other organizations.⁷⁰ Through this initiative, CMS developed a standardized set of hospital quality measures for use in voluntary public reporting. As part of this initiative, CMS has launched the website www.hospitalcompare.hhs.gov to provide information on the comparative performance of hospitals on health care quality.⁷¹

The MMA established the authority for the Hospital Inpatient Quality Reporting (“IQR”) program.⁷² Like IPPS, this new program applied only to so-called “subsection (d) hospitals” (See Figure 1). CMS promulgated a final rule implementing this section in 2005.⁷³

A very important step in the development of value-based purchasing was the Premier Hospital Quality Incentive Demonstration, initiated in 2003.⁷⁴ This demonstration, conducted in partnership with Premier Healthcare Alliance, a national health care

68. *HQA Program Overview*, QUALITYNET, <http://qualitynet.org> (follow “Hospitals – Inpatient” drop-down list; then follow “Hospital Quality Alliance (HQA)” hyperlink) (last visited Apr. 11, 2013).

69. ROADMAP FOR IMPLEMENTING, *supra* note 5, at 5.

70. CTRS. FOR MEDICARE & MEDICAID SERVS., *Hospital Quality Initiative Overview* (2008), <https://www.cms.gov/hospitalqualityinits/downloads/HospitalOverview.pdf>.

71. *Hosp. Compare*, CTRS. FOR MEDICARE & MEDICAID SERVS., www.hospitalcompare.hhs.gov (last visited Apr. 11, 2013).

72. Pub. L. No. 108-173, § 501(b) (codified as amended at 42 U.S.C. § 1886(b)(3)(B)(vii)); Hospital Inpatient Value-Based Purchasing Program, 76 Fed. Reg. 25,490, 26,492 (codified at 42 C.F.R. pts. 422 and 480).

73. Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates, 69 Fed. Reg. 48,915 & 49,078 (Aug. 11, 2004) (codified at 42 C.F.R. pts. 403, 412, 413, 418, 460, 480, 482, 483, 485, and 489). CMS adopted additional requirements in 2005. See Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates, 70 Fed. Reg. 47,278 & 47,420 (Aug. 12, 2005) (codified at 42 C.F.R. pts. 405, 412, 413, 415, et al.).

74. See *Premier Hospital Quality Incentive Demonstration*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalPremier.html> (last modified Jan. 9, 2013).

performance improvement organization, involves hospitals across the nation and tests whether paying hospitals for performance on various quality metrics would shift the performance upward across the whole group of hospitals.⁷⁵ In evaluation results, announced in 2010,⁷⁶ participating hospitals improved performance across the board.⁷⁷

The Deficit Reduction Act of 2005 (“DRA”) authorized the launch of the value-based purchasing program.⁷⁸ DRA required a reduction by two percent of the applicable percentage increase in payment for covered hospitals that do not submit quality data in a form, manner, and at a time specified by the Secretary of DHHS.⁷⁹ DRA called for the Secretary to develop a plan for the hospital value-based purchasing program that would begin in fiscal year 2009.⁸⁰ In 2007, CMS submitted this plan to Congress.⁸¹ In the 2007 final rule for the inpatient prospective payment system, CMS implemented this reduction requirement.⁸²

75. *Premier Hospital Quality Incentive Demonstration: Rewarding Superior Quality Care: Fact Sheet*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Dec. 2011), *available at* <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Downloads/HospitalPremierPressRelease-FactSheet.pdf>.

76. News Release, U.S. Dep’t of Health and Human Services’ Centers for Medicare & Medicaid, Medicare Demonstrations Illustrate Benefits in Paying for Quality Health Care (Dec. 9, 2010), *available at* http://www.pharmacychoice.com/news/article.cfm?Article_ID=660868.

77. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., DIV. OF RESEARCH ON TRADITIONAL MEDICARE, EVALUATION OF THE PREMIER HOSPITAL QUALITY INCENTIVE DEMONSTRATION (Mar. 3, 2009), *available at* https://www.cms.gov/reports/downloads/Premier_ExecSum_2010.pdf; STEPHEN KENNEDY ET AL., ABT ASSOCIATES INC., EVALUATION OF THE PREMIER HOSPITAL QUALITY INCENTIVE DEMONSTRATION: IMPACTS ON QUALITY, MEDICARE REIMBURSEMENTS, AND MEDICARE LENGTHS OF STAY: VOL. 1 & 2 (Dec. 2008).

78. Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 5001(b), 120 Stat. 28, 29–30 (2006) (codified as amended at 42 U.S.C. § 1395www(b)(3)(B)(vii)).

79. *Id.* § 5001(a), at 28 (codified as amended at 42 U.S.C. § 1395www(b)(3)(B)(vii)); Hospital Inpatient Value-Based Purchasing Program, 76 Fed. Reg. 25,490, 26,492 (codified at 42 C.F.R. pts. 422 and 480).

80. Pub. L. No. 109-171, § 5001(b) (codified as amended at 42 U.S.C. § 42 U.S.C. 1395ww(b)(3)(B)(vii)).

81. CMS, REPORT TO CONGRESS: PLAN TO IMPLEMENT A MEDICARE HOSPITAL VALUE-BASED PURCHASING PROGRAM (Nov. 21, 2007).

82. Hospital Inpatient Prospective Payment Systems Implementation of the Fiscal Year 2007 Occupational Mix Adjustment to the Wage Index, 42 C.F.R. § 412.64(d)(2) (2012); *see* Christopher P. Tompkins et al., *Measuring Outcomes and Efficiency In Medicare Value-Based Purchasing*, 28 HEALTH AFFAIRS 2 w251 (Mar./Apr. 2009).

In 2006, Congress turned to quality reporting for physicians. In the Tax Relief and Health Care Act of 2006, Congress established a quality reporting program, named the Physician Quality Reporting Initiative (“PQRI”), for physicians and other eligible professionals.⁸³ The Medicare Improvements for Patients and Providers Act of 2008 made the PQRI permanent.⁸⁴ This act also established the Physician Feedback Reporting Initiative, which provided feedback to physicians from the data they reported to CMS on how they compared with other physicians on the same measures.⁸⁵

A very important development in quality reporting and payment reform was the establishment of a formal role for the National Quality Forum (“NQF”). NQF is a non-profit organization with a mission to improve the quality of American health care. The membership of NQF is diverse and includes a wide variety of health care stakeholders, including consumer organizations, public and private purchasers, physicians, nurses, hospitals, accrediting and certifying bodies, supporting industries, and health care research and quality improvement organizations.⁸⁶ As NQF asserts, “NQF’s unique structure enables private- and public-sector stakeholders to work together to craft and implement cross-cutting solutions to drive continuous quality improvement in the American healthcare system.”⁸⁷

The Medicare Improvements for Patients and Providers Act of 2008 required the Secretary to “contract with a consensus-based entity such as the National Quality Forum” regarding performance measurement.⁸⁸ The central duty of this consensus-based entity is to “synthesize evidence and convene key stakeholders to make recommendations . . . on an integrated national strategy and priorities for health care performance measurement in all applicable settings.”⁸⁹ Among other requirements, the entity’s membership must include people with experience with urban health care issues, safety net

83. Medicare Improvements and Extension Act of 2006, Pub. L. No. 109-432, Div. B, § 101(b), 120 Stat. 2922, 2972 (codified as amended at 42 U.S.C. § 1395w-4 (2006)); see *Physician Quality Reporting System*, CTRS. FOR MEDICARE AND MEDICAID SERVS., <https://www.cms.gov/PQRS/> (last modified Sept. 27, 2013).

84. Medicare Improvements for Patients and Providers Act of 2008, Pub. L. No. 110-275, § 131(b)(1), 122 Stat. 2493, 2521 (codified as amended at 42 U.S.C. § 1395w-4(k)(2) (2006)).

85. 42 U.S.C. § 1395w-4(n)(1).

86. *About NQF*, NATIONAL QUALITY FORUM, http://www.qualityforum.org/About_NQF/About_NQF.aspx (last visited Apr. 15, 2013).

87. *Id.*

88. 42 U.S.C. § 1395aaa (a).

89. 42 U.S.C. § 1395aaa (b).

health care issues, rural and frontier health care issues, and health care quality and safety issues.⁹⁰ CMS awarded the contract to NQF to serve as the “consensus-based entity.”⁹¹

NQF has specific responsibility regarding the endorsement of measures, as the entity must consider whether a measure meets the following criteria:

- The measure is “evidence-based, reliable, valid, verifiable, relevant to enhanced health outcomes, actionable at the caregiver level, feasible to collect and report, and responsive to variations in patient characteristics, such as health status, language capabilities, race or ethnicity, and income level.”⁹²
- The measure is “consistent across types of health care providers, including hospitals and physicians.”⁹³

In addition, the entity is required to maintain and update measures,⁹⁴ promote the development of electronic health records,⁹⁵ and make reports to Congress.⁹⁶

By the time the ACA was enacted in 2010, the federal government was well on its way to implementing a value-based purchasing program for IPPS hospitals. The groundwork had been laid with the design of the program and the development of quality measures in the years since enactment of MMA in 2003. Congress would likely have continued the process of developing and implementing value-based purchasing institutional health care providers irrespective of whether comprehensive health reform legislation was enacted.

90. 42 U.S.C. § 1395aaa (c)(3).

91. HHS, Secretarial Review and Publication of the Annual Report to Congress Submitted by the Contracted Consensus-Based Entity Regarding Performance Measurement, Notice, 77 Fed. Reg. 56920 (Sept. 14, 2012).

92. 42 U.S.C. § 1395aaa (b)(1)(B)(2).

93. 42 U.S.C. § 1395aaa (b)(1)(B)(2).

94. 42 U.S.C. § 1395aaa (b)(1)(B)(3).

95. 42 U.S.C. § 1395aaa (b)(1)(B)(4).

96. 42 U.S.C. § 1395aaa (b)(1)(B)(5); *see* NATIONAL QUALITY FORUM, IMPROVING HEALTHCARE PERFORMANCE: SETTING PRIORITIES AND ENHANCING MEASUREMENT CAPACITY (Mar. 1, 2009), *available at* <http://goo.gl/ahc5zf>.

II.
LINKING PAYMENT TO QUALITY OUTCOMES
UNDER THE MEDICARE PROGRAM

Figure 2 Part 1—Linking Payment To Quality Outcomes Under The Medicare Program
Sec. 3001. Hospital value-based purchasing program
Sec. 3002. Improvements to the physician quality reporting system
Sec. 3003. Improvements to the physician feedback program
Sec. 3004. Quality reporting for long-term care hospitals, inpatient rehabilitation hospitals, and hospice programs
Sec. 3005. Quality reporting for PPS-exempt cancer hospitals
Sec. 3006. Plans for a value-based purchasing program for skilled nursing facilities and home health agencies
Sec. 3007. Value-based payment modifier under the physician fee schedule
Sec. 3008. Payment adjustment for conditions acquired in hospitals

The ACA's changes to the Medicare program are contained in Titles III and IV. Title III, Subtitle A, Part 1 advances the Medicare value-based purchasing program for hospitals, physicians, and other providers.⁹⁷ Figure 2 lists the relevant sections in Subtitle A, Part 1. As is evident in the section titles, value-based purchasing entitlements vary by the type of provider. The system for inpatient IPPS hospitals is by far the most developed.

A. Hospital Value-Based Purchasing Program (Section 3001)

Section 3001 of the ACA establishes the value-based purchasing program for IPPS hospitals.⁹⁸ This program covers 3,500 U.S. hospitals.⁹⁹ In Spring 2011, CMS issued the final rule establishing the Hospital Value-Based Purchasing Program under the Medicare

97. See PATRICIA A. DAVIS ET AL., CONG. RESEARCH SERV., R41196, MEDICARE PROVISIONS IN PPACA (P.L. 111-148) (2010), available at http://assets.opencrs.com/rpts/11-148_20100421.pdf.

98. Affordable Care Act § 3001(a) (codified as amended at § 1886(o) of the Social Security Act, 42 U.S.C. § 1395ww(o)).

99. Press Release, Ctrs. for Medicare and Medicaid Servs., CMS Issues Final Rule for First Year of Hospital Value-Based Purchasing Program: Final Rule Will Promote Better Clinical Outcomes and Patient Experiences of Care (Apr. 29, 2011), available at <http://www.cms.gov/apps/media/press/factsheet.asp?Counter=3947>.

IPPS.¹⁰⁰ The ACA Value-Based Purchasing Program marks a definite departure from how the Medicare program has paid hospitals in the past. As CMS asserts:

Starting in October 2012, Medicare will reward hospitals that provide high quality care for their patients through the new Hospital Value-Based Purchasing Program. This program marks the beginning of an historic change in how Medicare pays health care providers and facilities—for the first time, hospitals across the country will be paid for inpatient acute care services based on care quality, not just the quantity of the services they provide.¹⁰¹

1. Program Design

Figure 3
Hospital Quality Measures under the ACA
Required Conditions for Quality Measures
<ul style="list-style-type: none"> - Acute Myocardial Infarction (AMI) - Heart Failure - Pneumonia - Surgeries, as measured by the Surgical Care Improvement Project - Healthcare-Associated Infections, as measured by the prevention metrics and targets established in the HHS Action Plan to Prevent Healthcare-Associated Infections
Topics in the HCAHPS Survey
<ul style="list-style-type: none"> - Communication with Doctors - Communication with Nurses - Responsiveness of Hospital Staff - Pain Management - Communication about Medicines - Discharge Information - Cleanliness of the Hospital Environment - Quietness of the Hospital Environment

Establishment of the Program (42 U.S.C. § 1395ww(o)(1)). The Secretary must establish a hospital value-based purchasing program for hospitals that meet specified performance standards.¹⁰² The program applies to all Medicare inpatient hospital discharges occur-

100. Hospital Inpatient Value-Based Purchasing Program, 76 Fed. Reg. 26490 (May 6, 2011) (codified at 42 C.F.R. Parts 422 and 480); *see also* Hospital Inpatient Value-Based Purchasing Program, 76 Fed. Reg. 2454 (proposed Jan. 13, 2011).

101. Administration Implements New Health Reform Provision to Improve Care Quality, Lower Costs, HEALTH CARE.GOV (Apr. 29, 2011), <http://www.healthcare.gov/news/factsheets/2011/04/valuebasedpurchasing04292011a.html>.

102. 42 U.S.C. § 1395ww(o)(1)(A).

ring on or after October 1, 2012.¹⁰³ The program applies to all “subsection (d) hospitals” (See Figure 1). ACA excludes hospitals already subject to payment reductions, hospitals cited for deficiencies that pose immediate jeopardy to the health or safety of patients, and hospitals without the minimum number of cases, measures, or surveys.¹⁰⁴

Measures (42 U.S.C. § 1395ww(o)(2)). ACA establishes measures for ascertaining hospitals’ achievement of high quality healthcare for Medicare beneficiaries.¹⁰⁵ ACA charges the Secretary of DHHS with selecting measures but mandates that the measures pertain to the five conditions presented in Figure 3.¹⁰⁶

Quality measures must also be related to the Hospital Consumer Assessment of Healthcare Providers and Systems Survey (“HCAHPS”),¹⁰⁷ which collects data on patients’ perspectives on hospital care in a standardized fashion.¹⁰⁸ The HCAHPS survey addresses the eight key domains, which are listed in Figure 3.¹⁰⁹ The measures must also be made in consultation and with the endorsement of NQF.¹¹⁰

For payments regarding discharges occurring during fiscal year 2014 and beyond, the Secretary must include efficiency measures, including measures of “Medicare spending per beneficiary.”¹¹¹ Such measures must be adjusted for factors such as age, sex, race, severity of illness, and other factors that the Secretary determines appropriate.¹¹²

Performance Standards (42 U.S.C. § 1395ww(o)(3)). The Secretary must also establish “performance standards” for each quality measure, which include “levels of achievement and improvement.”¹¹³ The standards also reflect “practical experience” with the measures involved, such as “whether a significant proportion of hospitals

103. 42 U.S.C. § 1395ww(o)(1)(B).

104. 42 U.S.C. § 1395ww(o)(1)(C).

105. 42 U.S.C. § 1395ww(o)(2).

106. 42 U.S.C. § 1395ww(o)(2).

107. 42 U.S.C. § 1395ww(o)(2)(B)(i)(II); see generally *CAHPS Hospital Survey*, HCAHPS, <http://www.hcahpsonline.org/home.aspx> (containing detailed information about the survey).

108. *CAHPS Hospital Survey*, *supra* note 107.

109. *Id.*

110. 42 U.S.C. § 1395ww(o)(2).

111. 42 U.S.C. § 1395ww(o)(2)(B)(ii).

112. 42 U.S.C. § 1395ww(o)(2)(ii).

113. 42 U.S.C. §§ 1395ww(o)(3)(A)–(B).

failed to meet the performance standard during previous performance periods.”¹¹⁴

Performance Period (42 U.S.C. § 1395ww(o)(4)). The Secretary must establish and announce the performance standards within sixty days prior to the beginning of the performance period for the fiscal year involved.¹¹⁵ The performance period is a fiscal year.¹¹⁶

Hospital Performance Score (42 U.S.C. § 1395ww(o)(5)). The Secretary must also establish a methodology for assessing the total performance of each hospital based on performance standards for the selected measures.¹¹⁷ The product of this methodology is the so-called “hospital performance score” for an individual hospital during the performance period.¹¹⁸

The methodology must comport with several criteria. Specifically, the methodology must result in “an appropriate distribution of value-based incentive payments among hospitals achieving different levels of hospital performance scores, with hospitals achieving the highest hospital performance scores receiving the largest value-based incentive payments.”¹¹⁹ The methodology must also provide that the hospital performance score is determined using the higher of its achievement or improvement score for each measure¹²⁰ and for the assignment of weights for categories of measures as the Secretary determines appropriate.¹²¹ The Secretary shall not set a minimum performance standard in determining the hospital performance score for any hospital.¹²²

Calculation of Value-Based Incentive Payments (42 U.S.C. § 1395ww(o)(6)). The ACA then addresses the calculation of the value-based incentive payment.¹²³ In the case of hospitals that CMS determines meet (or exceed) the performance standards for the performance period, CMS must increase the hospital’s base operating DRG payment amount, with some adjustments,¹²⁴ for each discharge occurring in such fiscal year by the value-based incentive payment amount.¹²⁵ The value-based incentive payment amount for

114. 42 U.S.C. § 1395ww(o)(3)(D).

115. 42 U.S.C. § 1395ww(o)(3)(C).

116. 42 U.S.C. § 1395ww(o)(4).

117. 42 U.S.C. § 1395ww(o)(5)(A).

118. *Id.*

119. 42 U.S.C. § 1395ww(o)(5)(B)(i).

120. 42 U.S.C. § 1395ww(o)(5)(B)(ii).

121. 42 U.S.C. § 1395ww(o)(5)(B)(iii).

122. 42 U.S.C. § 1395ww(o)(5)(B)(iv).

123. 42 U.S.C. § 1395ww(o)(6).

124. 42 U.S.C. § 1395ww(o)(7)(B)(i).

125. 42 U.S.C. § 1395ww(o)(6)(A).

each discharge of a hospital in a fiscal year is equal to the product of: the value-based incentive payment percentage for the hospital for such fiscal year¹²⁶ and the base operating DRG payment amount for the discharge for the hospital for such fiscal year.¹²⁷

The Secretary must specify the value-based incentive payment percentage for a hospital for a particular fiscal year.¹²⁸ In specifying the value-based incentive payment percentage for each hospital, CMS must ensure that such percentage is based on the hospital's quality measures and that the total amount of value-based incentive payments to all hospitals in such fiscal year is equal to the total amount available for the estimated value-based incentive payments for such fiscal year.¹²⁹

Funding for Value-Based Incentive Payments (42 U.S.C. § 1395ww(o)(7)). Funding for value-based incentive payments will come from assigned payments to hospitals under the Medicare prospective payment system. Specifically, the total amount available for value-based incentive payments for all hospitals for a fiscal year will be equal to the total amount of reduced payments for all hospitals in their usual payment amounts.¹³⁰ The amount of reduction in fiscal year 2013 is one percent and moves to two percent by 2017.¹³¹

Announcement of Net Result of Adjustments (42 U.S.C. § 1395ww(o)(8)). There are also specific requirements in the ACA regarding the announcement of net results of adjustments. Specifically, the Secretary must inform each hospital of adjustments to payments for relevant fiscal years no later than sixty days prior to the fiscal year involved.¹³²

Lack of Effect in Subsequent Fiscal Years (42 U.S.C. § 1395ww(o)(9)). The Secretary must make such reductions for all hospitals in the fiscal year involved, regardless of whether the hospital has been determined by the Secretary to have earned a value-based incentive payment.¹³³ Nevertheless, there will be no effect on other Medicare payments.¹³⁴

126. 42 U.S.C. § 1395ww(o)(6)(B)(ii). For the definition of "value-based incentive payment percentage," see 42 U.S.C. § 1395ww(o)(6)(C).

127. 42 U.S.C. § 1395ww(o)(6)(B)(i). For the definition of the base operating DRG payment amount, see 42 U.S.C. § 1395ww(o)(7)(D).

128. 42 U.S.C. § 1395ww(o)(6)(C)(i).

129. 42 U.S.C. § 1395ww(o)(6)(C)(ii).

130. 42 U.S.C. § 1395ww(o)(7)(A).

131. 42 U.S.C. § 1395ww(o)(7)(C).

132. 42 U.S.C. § 1395ww(o)(8).

133. 42 U.S.C. § 1395ww(o)(9).

134. *Id.*

Public Reporting (42 U.S.C. § 1395ww(o)(10)). The Secretary must make information available to the public regarding the performance of individual hospitals under the Program.¹³⁵ The Secretary must also ensure that a hospital has the opportunity to review and submit corrections for the information to be made public about the hospital before its release.¹³⁶ Furthermore, such information must be posted on the Hospital Compare website in an easily understandable format.¹³⁷ The Secretary must also post on the Hospital Compare website aggregate information on the Program, including: (1) the number of hospitals receiving value-based incentive payments; (2) the range and total amount of such value-based incentive payments; and (3) the number of hospitals receiving less than the maximum value-based incentive payment available to the hospital for the fiscal year involved and the range and amount of such payments.¹³⁸

2. Implementation Issues

The ACA also imposes some obligations on the Secretary regarding implementation of the value-based purchasing program.¹³⁹

Appeals (42 U.S.C. § 1395ww(o)(11)). The Secretary must provide hospitals with an opportunity to appeal various adverse decisions. The Secretary must establish a process by which hospitals may appeal the calculation of their performance assessment with respect to the performance standards and their performance score in a timely manner.¹⁴⁰ However, a hospital cannot challenge the quality measures, performance standards, and methodologies used to calculate payments under value-based purchasing.¹⁴¹

Promulgation of Regulations (42 U.S.C. § 1395ww(o)(12)). The ACA requires that the Secretary promulgate regulations to carry out the program, including (1) the selection of measures; (2) the methodology used to calculate hospital performance scores; and (3) the methodology used to determine the amount of value-based incen-

135. 42 U.S.C. § 1395ww(o)(10)(A)(i).

136. 42 U.S.C. § 1395ww(o)(10)(A)(ii).

137. 42 U.S.C. § 1395ww(o)(10)(A)(iii).

138. 42 U.S.C. § 1395ww(o)(10)(B).

139. 42 U.S.C. § 1395ww(o)(11).

140. 42 U.S.C. § 1395ww(o)(11).

141. 42 U.S.C. § 1395ww(o)(11)(B).

tive payments.¹⁴² CMS promulgated the requisite final rule in May 2011.¹⁴³

The actual text of the rule is only two pages long and addresses the authority of CMS to obtain data from Quality Improvement Organizations.¹⁴⁴ The bulk of the Federal Register notice was devoted to describing the process for selecting the quality measures and performance standards, the methodology for calculating the hospital performance scores, and the methodology for determining the value-based incentives.

Website Improvements (ACA §3001(a)(3)). The Secretary is also required to make website improvements.¹⁴⁵ Specifically, the Secretary must develop standard Internet website reports tailored to meet the needs of various stakeholders such as hospitals, patients, researchers, and policymakers. The Secretary must also seek input from such stakeholders in determining the type of information that is useful and the formats that best facilitate the use of the information.¹⁴⁶

3. Required Studies and Reports (ACA §§3001(a)(4) & (5), 3001(b))

GAO Study and Report (ACA §3001(a)(4)). The Government Accountability Office (“GAO”) is required to conduct a study of the program with an interim report due to Congress by October 1, 2015 and a final report due by July 1, 2017.¹⁴⁷

HHS Study and Report (ACA §3001(a)(5)). The Secretary is also required to conduct a study of the value-based purchasing program with a report to Congress due by January 1, 2016, with recommendations for such legislation and administrative action.¹⁴⁸

Required Demonstrations (ACA §3001(b)). Section 3001(b) calls for the Secretary, within two years, to conduct value-based purchasing demonstration programs for critical access hospitals and for hospitals with insufficient numbers of cases for participation in the regular value-based purchasing program.¹⁴⁹

142. 42 U.S.C. § 1395ww(o)(12)).

143. Hospital Inpatient Value-Based Purchasing Program, 76 Fed. Reg. 26,490 (May 6, 2011) (codified at 42 C.F.R. pts. 422 & 480); *see also* Hospital Inpatient Value-Based Purchasing Program, 76 Fed. Reg. 2454 (proposed Jan. 13, 2011).

144. 76 Fed. Reg. at 26,546–47 (codified at 42 C.F.R. pts. 422.153 & 480.101–44).

145. 42 U.S.C. § 1395ww(b)(3)(B).

146. 42 U.S.C. § 1395ww(b)(3)(B)(x)(I).

147. ACA § 3001(a)(4); *see* DAVIS ET AL., *supra* note 97.

148. ACA § 3001(a)(5); *see* DAVIS ET AL., *supra* note 97.

149. ACA § 3001(b).

*B. Payment Adjustment for Hospital-Acquired Conditions
(Section 3008)*

An important step toward linking Medicare payment to quality performance was the Medicare program's identification of so-called "never events" and not paying for associated hospital care needed because of the "never event." In 2002, NQF published a report, *Serious Reportable Events (SRE's) in Healthcare*, identifying twenty-seven adverse events occurring in hospitals that are "serious, largely preventable[,] and of concern to both the public and healthcare providers."¹⁵⁰ Examples of these "never events" are: foreign objects left in the patients during surgeries, blood transfusion incompatibility issues, infections associated with catheters, serious pressure ulcers, in-hospital trauma such as burns, electrical shocks and falls, certain surgical site infections, and various types of air emboli.¹⁵¹ According to NQF, the report's objective was "to establish consensus among consumers, providers, purchasers, researchers, and other healthcare stakeholders about those preventable adverse events that should never occur and to define them in a way that, should they occur, it would be clear what had to be reported."¹⁵²

In the DRA of 2005, Congress required the Secretary to identify conditions that: "(a) are high cost or high volume or both; (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis; and (c) could reasonably have been prevented through the application of evidence-based guidelines."¹⁵³ In August 2007, CMS adopted a final rule identifying eight "never events" for which, beginning October 2008, Medicare would not provide additional payment to hospitals unless the events were present on admission.¹⁵⁴ The ACA also updated and built

150. *National Voluntary Consensus Standards for Serious Reportable Events in Healthcare*, NATIONAL QUALITY FORUM, http://www.qualityforum.org/projects/hacs_and_sres.aspx (last visited Sept. 28, 2013).

151. Payment Adjustment for Provider-Preventable Conditions Including Health Care-Acquired Conditions, 76 Fed. Reg. 32,816, 32,817 (June 6, 2011) (to be codified at 42 C.F.R. pts. 434, 438, & 447).

152. See NATIONAL QUALITY FORUM, PATIENT SAFETY: SERIOUS REPORTABLE EVENTS IN HEALTHCARE—2006 UPDATE 2 (2007).

153. Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 5001(c), 120 Stat. 28, 30 (2006) (codified as amended at 42 U.S.C. § 1395ww(d)(4)); see DEP'T OF HEALTH AND HUMAN SERVS., CTRS. FOR MEDICARE AND MEDICAID SERVS., HOSPITAL-ACQUIRED CONDITIONS (HAC) IN ACUTE INPATIENT PROSPECTIVE PAYMENT SYSTEM (IPPS) HOSPITALS (Oct. 2012), available at <https://www.cms.gov/HospitalAcqCond/downloads/HACFactsheet.pdf>.

154. Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2010 Rates, 74 Fed. Reg. 43,754 (Aug. 27, 2009) (to be codified at 42 C.F.R. pts. 412, 413, 415, 485, & 489); see also CTRS. FOR

upon this program.¹⁵⁵ Furthermore, the ACA also requires CMS to conduct a study with a report on recommendations on how to extend this strategy to other institutional providers.¹⁵⁶

Adverse payment adjustments mark a great change in Medicare's relationship with providers. Formerly the Medicare program paid providers regardless of whether they generated expenses associated with their errors without question. Now hospitals are punished when they provide highly sub-standard care. Presumably hospitals will have greater incentives to improve the safety for their patients.

C. QUALITY REPORTING AND PAY-FOR-PERFORMANCE FOR PHYSICIANS

Long before the ACA was adopted, the Medicare program moved toward the establishment of value-based purchasing programs for physicians and other health care providers.¹⁵⁷ Title III, Subtitle A, Part 1 of the ACA contains sections that modify and expand these value-based purchasing programs for physicians. Under the authority of the new ACA provisions, CMS has created the Physician Feedback/Value-Based Modifier Program, which provides comparative performance information to physicians as part of the Medicare program's efforts to improve the quality and efficiency of medical care.¹⁵⁸ These goals are achieved, in the words of CMS, "by providing meaningful and actionable information to physicians so they can improve the care they furnish, and by moving toward physician reimbursement that rewards value rather than volume."¹⁵⁹ The Program contains two primary components: the preparation of the Physician Quality and Resource Use Reports ("QRURs") and the development and implementation of a Value-Based Payment Modifier ("VBPM").¹⁶⁰

MEDICARE & MEDICAID SERVS., MEDICARE NATIONAL COVERAGE DETERMINATIONS MANUAL: CHAPTER 1, PART 2 COVERAGE DETERMINATIONS, §§ 140.6–140.8 (2012), http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part2.pdf (discussing specific examples of "never events" that are not covered by Medicare).

155. 42 U.S.C. §1395ww.

156. *Id.*

157. ROADMAP FOR IMPLEMENTING, *supra* note 5, at 5.

158. *Medicare FFS Physician Feedback Program/Value-Based Payment Modifier: Background*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Background.html> (last modified Apr. 17, 2013).

159. *Id.*

160. *Id.*

1. Improvements to the Physician Quality Reporting System
(Section 3002)

Section 3002 of the ACA enhances the quality reporting initiative for physicians,¹⁶¹ which Congress established in the Tax Relief and Health Care Act of 2006.¹⁶² The Physician Quality Reporting Initiative is now a voluntary program for eligible practitioners and provides an incentive payment to physicians and/or practices that satisfactorily report data on specified quality measures.¹⁶³

The ACA extends this voluntary program until 2014.¹⁶⁴ It also renamed the initiative to the Physician Quality Reporting System (“PQRS”) and established the Physician Compare website.¹⁶⁵ By 2015, eligible professionals must submit data on quality measures for covered professional services or incur a percent reduction in the fee schedule amount for service provided for that pay period.¹⁶⁶ The percentage reductions will be one and a half percent in 2015 and two percent thereafter.¹⁶⁷ CMS promulgated a proposed rule to implement these and other changes for physicians in July 2012.¹⁶⁸

The ACA requires the Secretary to provide timely feedback to eligible professionals on their performance on submitting data on selected quality measures.¹⁶⁹ It also requires the establishment of an informal appeals process by January 1, 2011 for an eligible professional to seek a review of the determination that he or she did not satisfactorily submit data on selected quality measures.¹⁷⁰

Under the Maintenance of Certification (“MOC”) Program incentive, physicians who are eligible for the PQRS can receive an additional 0.5 percent incentive payment if they meet the MOC requirements as well. To qualify, physicians must undergo a “qualified Maintenance of Certification program practice assessment,” as de-

161. 42 U.S.C. 1395w-4(a)(8).

162. Medicare Improvements and Extension Act of 2006, Pub. L. No. 109-432, Div. B, § 101(b), 120 stat. 2922, 2975 (codified as amended at 42 U.S.C. § 1395w-4 (2006)).

163. *Physician Quality Reporting System*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/PQRS/> (last modified Sept. 27, 2013).

164. 42 U.S.C. § 1395w-4(a).

165. *Id.*; 42 U.S.C. § 1395w-5(a).

166. 42 U.S.C. §. 1395w-4(a)(8)(A).

167. 42 U.S.C. § 1395w-4(a)(8)(A)(ii).

168. Medicare Physician Fee Schedule, 77 Fed. Reg. 44,721 (proposed Jul. 30, 2012) (to be codified at 42 C.F.R. pts. 410, 414, & 415).

169. 42 U.S.C. § 1395w-4(m)(5)(H).

170. 42 U.S.C. § 1395w-4(m)(5)(I).

fined in the ACA, which must include an initial assessment that demonstrates the physician's use of evidence-based medicine, a survey of patient experience with care, and implementation of a quality improvement intervention to address a practice weakness identified in the initial assessment. The assessment must also require the practice to reassess performance improvement after the intervention.

Section 3002(c) of the ACA, as augmented by § 10327(b), also authorizes "an MOC for physicians over and above the PQRS."¹⁷¹ Beginning in 2011, physicians may earn an additional incentive of half a percent of the fee schedule amount of services by participating in this program.¹⁷² The major program requirement is completion of a "qualified Maintenance of Certification program practice assessment" and participation in other activities developed by medical specialty societies under the American Board of Medical Specialties.¹⁷³

After 2014, the Secretary may incorporate participation in an MOC Program and successful completion of a qualified MOC Program practice assessment into the composite of measures of quality of care for the application of the value-based payment modifier. The ACA also seeks to integrate physician quality reporting with the electronic medical record.¹⁷⁴

2. Improvements to the Physician Feedback Program (Section 3003)

The ACA expands the current Physician Feedback Reporting Program.¹⁷⁵ Specifically, the initiative, using claims data, provides reports, called Physician Quality and Resource Use Reports ("QRURs"), to physicians and physician groups.¹⁷⁶ These QRURs contain information on the resource use, costs, and quality of care provided to Medicare patients, including quantification and com-

171. 42 U.S.C. §1395w-4(k)(4).

172. ACA § 10327(a)(7) (codified as amended at SSA § 1848(m)(7), 42 U.S.C. § 1395-w4(m)(7)).

173. 42 U.S.C. §1395w-4(k)(4).

174. 42 U.S.C. § 1395w-4(m)(7); see *EHR Incentive Programs*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/EHRIncentivePrograms/> (last modified June 26, 2013).

175. 42 U.S.C. § 1395w-4(n)(A)(1).

176. See *Medicare FFS Physician Feedback Program/Value-Based Payment Modifier*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/index.html?redirect=/Physicianfeedbackprogram/> (last modified Apr. 17 2013).

parisons of patterns of resource use and costs among physicians and medical practice groups.¹⁷⁷

For reports on utilization, the Secretary must develop an “episode grouper” by January 2012 that combines separate but clinically related items and services into an episode of care for an individual patient.¹⁷⁸ The grouper will enable production of individualized reports that compare the per capita utilization of physicians to other physicians who see similar patients. The details of the grouper must be made available to the public and endorsed by the NQF.¹⁷⁹ The methodologies used must meet statutory standards and be available to the public as well.¹⁸⁰ Furthermore, there is no administrative or judicial review of the grouper’s design, methods, or determinations.¹⁸¹ Finally, the feedback program must be coordinated with other value-based purchasing programs.¹⁸² CMS promulgated a proposed rule to implement these and other changes in physicians in July 2012.¹⁸³

3. Value-Based Payment Modifier under the Physician Fee Schedule (Section 3007)

Section 3007 of the ACA mandates that by 2015, the Secretary must establish the Value-Based Payment Modifier (“VBPM”) that provides for differential payment to physicians or physician groups based on quality performance.¹⁸⁴ To establish the VBPM, the Secretary must develop appropriate risk adjusted measures of quality of care that also reflect outcomes of care.¹⁸⁵ The ACA requires that implementation begin with rulemaking for fiscal year 2013.¹⁸⁶

CMS promulgated a proposed rule to implement these changes in physician payment in July 2012.¹⁸⁷ Beginning January 1, 2015, CMS must apply the VBPM to specific physicians and physician groups that CMS determines appropriate.¹⁸⁸ No later than Jan-

177. *See id.*

178. 42 U.S.C. §§ 1395w-4(n)(A)(9)(i) & (ii).

179. 42 U.S.C. §§ 1395w-4(n)(A)(9)(iii) & (iv).

180. 42 U.S.C. §§ 1395w-4(n)(A)(9)(C) & (F).

181. 42 U.S.C. § 1395w-4(n)(A)(9)(G).

182. 42 U.S.C. § 1395w-4(n)(A)(10).

183. Medicare Physician Fee Schedule, 77 Fed. Reg. 44,721 (proposed Jul. 30, 2012) (to be codified at 42 C.F.R. pts. 410, 414, & 415).

184. 42 U.S.C. § 1395w-4(p)(1).

185. 42 U.S.C. § 1395w-4(p)(2)(B)(i).

186. 42 U.S.C. § 1395w-4(p)(4)(B)(i).

187. Medicare Physician Fee Schedule, 77 Fed. Reg. 44,721 (proposed Jul. 30, 2012) (to be codified at 42 C.F.R. pts 410, 414, & 415).

188. 42 U.S.C. § 1395w-4(p)(4)(B)(iii).

uary 1, 2017, the VBPM must be applied to all physicians and physician groups.¹⁸⁹ In applying the payment modifier, the Secretary must take into account the special circumstances of physicians or groups of physicians in rural areas and other underserved communities.¹⁹⁰ The Secretary must also coordinate the VBPM with the Physician Feedback Program.¹⁹¹ Finally, the ACA prohibits administrative or judicial review of the issues in the design, implementation, and application of the payment modifier.¹⁹²

D. QUALITY REPORTING AND PAY-FOR-PERFORMANCE FOR OTHER INSTITUTIONAL PROVIDERS

Title III, Subtitle A, Part 1 of the ACA contains sections that move forward these value-based purchasing programs for all types of Medicare providers.

1. Quality Reporting for Long-Term Care Hospitals, Inpatient Rehabilitation Hospitals, and Hospice Programs
(Section 3004)

Effective 2014, section 3004 of the ACA extends the quality-reporting requirement to long-term care hospitals,¹⁹³ inpatient rehabilitation hospitals,¹⁹⁴ and hospice programs.¹⁹⁵ The Secretary must develop and publish the quality measures for these institutions by 2012 and make quality data from these institutions available to the public through a website.¹⁹⁶

2. Quality Reporting for PPS-exempt Cancer Hospitals (Section 3005)

Section 3005 of the ACA establishes a quality-reporting program for PPS-exempt cancer hospitals.¹⁹⁷ Historically the Medicare program has exempted major cancer hospitals that are designated as comprehensive or clinical cancer centers by the National Institutes of Health from the prospective payment system.¹⁹⁸ Beginning

189. *Id.*

190. 42 U.S.C. § 1395w-4(p)(6).

191. 42 U.S.C. § 1395w-4(p)(9).

192. 42 U.S.C. § 1395w-4(p)(10).

193. 42 U.S.C. § 1395ww(m).

194. 42 U.S.C. § 1395ww(j).

195. 42 U.S.C. § 1395f(i).

196. 42 U.S.C. §§ 1395f(i)(5), 1395ww(j)(7), & 1395f(i)(5).

197. 42 U.S.C. § 1395cc.

198. 42 U.S.C. § 1395ww(d)(1)(B)(v) (2011); see *Medicare PPS Excluded Cancer Hospitals*, CTRS. FOR MEDICARE AND MEDICAID SERVS. (Aug. 1, 2012), https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/PPS_Exc_Cancer_Hospasp.html.

in 2014, cancer hospitals will have to submit data on quality measures to the Secretary in a manner the Secretary specifies.¹⁹⁹ By October 1, 2012, the Secretary must publish quality measures for cancer hospitals that will be effective in fiscal year 2014.²⁰⁰ The quality measure must be endorsed by the NQF, but the Secretary of DHHS may specify measures not so endorsed as long as consideration has been given to the NQF's endorsed measures.²⁰¹ The data on which these measures are based must be made available to the public and the measures must be published on a CMS website.²⁰²

3. Plans for a Value-Based Purchasing Program for Skilled Nursing Facilities and Home Health Agencies (Section 3006)

Section 3006 of the ACA requires the Secretary develop a plan to implement a value-based purchasing program for skilled nursing facilities,²⁰³ home health agencies,²⁰⁴ and ambulatory surgery centers.²⁰⁵ For all three types of providers, the Secretary must develop a plan for reporting quality measures in a collaborative and transparent process and report to Congress on plans for skilled nursing facilities and home health agencies by October 2011 and plans for ambulatory surgery centers by January 2011.²⁰⁶

III.

PROSPECTS FOR SUCCESS AND CHALLENGES

The history of Medicare payment methodologies has been one of the federal government's struggles to get control of the cost levers in the Medicare program. By necessity, the original architects of the Medicare program placed the levers in the hands of providers. As Wilber Cohen, the Secretary of the Department of Health, Education, and Welfare when the Medicare programs was enacted, explained: "The ideological and political issues were so dominating that they precluded consideration of issues such as reimbursement alternatives and efficiency options."²⁰⁷

199. 42 U.S.C. § 1395cc(k).

200. 42 U.S.C. § 1395cc(k)(W)(3).

201. *Id.*

202. *Id.*

203. ACA § 3006(a).

204. ACA § 3006(b).

205. ACA § 3006(f).

206. ACA §§ 3006(a), (b), & (f).

207. Wilber J. Cohen, *Reflections on the Enactment of Medicare and Medicaid*, in 7 HEALTH CARE FIN. REV. 3, 5 (Supp. 1985).

As described in Section I above, in the 1980s and 1990s, the federal government was able to wrest control of the price of care with IPPS for hospitals and the Medicare Physician Fee Schedule. Both of these programs established a prospective price for a unit of service and transferred the risk of inefficient services from the Medicare program to providers for inefficient services. These reforms were great first steps for the Medicare program, especially in an environment in which physicians and hospitals had tight control over the content of medical care and the definition of its quality.²⁰⁸

However, these payment strategies did not get a handle on controlling the volume of services nor did they address the increasingly complex and costly content of services with new technology. Consequently, entrepreneurial physicians and providers had great incentives to provide more, and arguably unnecessary, services. Nor was their much incentive for physicians to limit diagnostic tests and medical procedures when they felt the threat of medical liability lawsuits. And CMS's efforts to control volume and expense of physician services proved difficult if not impossible, as shown by the experience with the Medicare sustainable growth rate for payments under the physician fee schedule.²⁰⁹

With rising costs, the Medicare program and other public and private payers struggled to find ways to get better value for their money. In the 1980s and 1990s, as discussed above,²¹⁰ the federal government turned to health services research to determine how to assess the quality of care empirically and determine if Medicare expenditures were being well spent in terms of outcomes and efficiency. The focus on quality outcomes, variations in practice, TQM/CQI, and patient safety were all fundamentally data-driven and created a new environment of accountability for physicians, hospitals, and the entire health care sector. The definition of quality had become empirically based and was no longer the sole province of physicians. The stage was set for the quality reporting and value-based purchasing programs of the next century.

The ACA has extended and further developed the value-based payment system first contemplated in the MMA in 2003.²¹¹ CMS

208. See generally PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE: THE RISE OF A SOVEREIGN PROFESSION AND THE MAKING OF A VAST INDUSTRY* (1982) (tracing physicians' and hospitals' largely successful defense of professional autonomy against corporate and governmental control).

209. See *MEDICARE PHYSICIAN FEE SCHEDULE* *supra* note 46 and accompanying text.

210. See *supra* notes 56–60 and accompanying text.

211. See generally *ROADMAP FOR IMPLEMENTING*, *supra* note 5, at 12.

describes this process in the proposed rule to implement Section 3000 of the ACA:

In recent years, we have undertaken a number of initiatives to lay the foundation for rewarding health care providers and suppliers for the quality of care they provide by tying a portion of their Medicare payments to their performance on quality measures. These initiatives, which include demonstration projects and quality reporting programs, have been applied to various health care settings, including physicians' offices, ambulatory care facilities, hospitals, nursing homes, home health agencies, and dialysis facilities. The overarching goal of these initiatives is to transform Medicare from a passive payer of claims to an active purchaser of quality health care for its beneficiaries.²¹²

Value-based purchasing represents a fundamental paradigm shift for physicians. Largely due to the developed body of health services research since the mid-20th Century, today quality of care is the shared province of providers and payers and is measured with empirical techniques and outcomes. Today's physicians operate in an environment of data-driven health care and are accustomed to the evaluation of data of their care by their superiors in provider organizations, payers, and policy makers. Entrepreneurial physicians and other providers who seek to provide unnecessary and unduly expensive services are more easily exposed than in the past when physicians and providers had sole authority to define the quality and content of medical care.

It is too soon to know if value-based purchasing will work. Concerns have been expressed regarding whether programs can actually identify and reward high quality of care, although the results of the Premier Hospital Quality Incentive Demonstration and other evaluations have been promising.²¹³ Clearly value-based purchasing, when combined with the other reforms of medical practice contemplated in the ACA, could collectively have a considerable impact on the escalation of costs in the health sector and in the Medicare program in particular. And with the decision of the Supreme Court of the United States upholding the ACA in June 2012,²¹⁴ value-based purchasing can now proceed as anticipated in the ACA without interruption.

212. Hospital Inpatient Value-Based Purchasing Program, 76 Fed. Reg. 2454, 2455 (proposed Jan. 13, 2011).

213. See *supra* notes 19, 74–77, and accompanying text.

214. See *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2608 (2012).

However, there is a ray of hope. Could it be that the various strategies that Congress has initiated in the Medicare program to link payment to quality and to promote efficiencies are finally paying off? Analysts at CMS published an article in the leading health policy journal *Health Affairs* describing very encouraging trends in the control of Medicare expenditures and attributing the trend to the economic conditions since 2008.²¹⁵ In the Commonwealth Fund blog, President Karen Davis, a preeminent health policy expert, suggested that the reforms in Medicare and in the private sector may be changing health care expenditures fundamentally. Dr. Davis states:

At a minimum, dire predictions that the Affordable Care Act would fail to control costs and, in fact, accelerate spending have not been borne out by the early experience. It now appears that both the costs of covering the uninsured and Medicare spending are substantially below pre-reform estimates.²¹⁶

CMS's value-based purchasing reforms are the fruits of an enormous investment in health-services research on quality that the federal government initiated in the 21st Century. The federal government, in collaboration with stakeholders (particularly, physicians and hospitals), has sponsored research, tested promising concepts in demonstrations, and supported the infrastructure for researchers to conduct and disseminate research on improving patient safety, improving quality measures, and the comparative effectiveness of competing medical treatments and procedures. This large federal investment will provide the scientific evidence on which to predicate payment reform. This investment represents enormous public involvement in delineating the content and quality of medical care, a role traditionally enjoyed exclusively by the medical profession.

However, the medical profession has been responsive to the incentives in payment systems and has even taken entrepreneurial advantage of money-making opportunities in these payment systems. Since 1965, the federal government has assumed an enormous role in financing the health care services for a third of the

215. Anne B. Martin et al., *Growth in US Health Spending Remained Slow in 2010; Health Share of Gross Domestic Product Was Unchanged from 2009*, 31 HEALTH AFF. 208 (2012), available at http://thinkprogress.org/wp-content/uploads/2012/01/2011-1135_p2.pdf.

216. Karen Davis, *Bending the Health Care Cost Curve: New Era in American Health Care?*, THE COMMONWEALTH FUND BLOG (Jan. 18, 2012), <http://www.commonwealthfund.org/Blog/2012/Jan/Bending-the-Health-Care-Cost-Curve.aspx>.

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U.S. population. It therefore has an appropriate role in assuring that the money it spends for these services is wisely spent. Clearly efforts to control price and volume have not worked. What other strategy is there except improving quality and paying only for high quality care?

CONCLUSION

In a sense, value-based purchasing is the best and last hope that the Medicare program has for its long-term sustainability. Value-based purchasing will encourage providers to reorganize in ways that promote efficiency and collaboration with other types of providers toward the same end. Value-based purchasing is intended to curb the entrepreneurial behavior among providers to provide expensive care to more people. It is not intended to curb entrepreneurialism in the pursuit of better and more efficient methods of providing necessary care.

