CMS Implementing New Medicare Quality Requirements
By Matt Klein and David Dirr

One key concept in Medicare reform is to base payments on the quality of care, rather than the quantity. In other words, Medicare payments in the future will in part be based on the results providers achieve for patients, rather than the number of procedures they provide. Over the next several years, the Centers for Medicare and Medicaid Services (CMS) will be implementing quality initiatives in an effort to improve care and reduce costs. To achieve the results mandated by these new quality initiatives, providers should be making plans to implement necessary changes and to incentivize physicians to assist providers in reaching quality benchmarks.

Readmissions Reduction Program
The Readmissions Reduction Program seeks to reduce unnecessary readmissions of patients to hospitals. A readmission occurs when a patient is discharged from a hospital and then readmitted to the same hospital or another hospital within a time period specified by the Secretary of Health and Human Services (HHS). Beginning in 2012, CMS will reduce Medicare payments to hospitals with excessive readmissions of patients who were originally admitted for heart attack, heart failure, or pneumonia. In 2013, the list will expand to include COPD, bypass surgery, and other heart and vascular procedures. The reduction in payments will be 1% in 2013, 2% in 2014, and 3% in 2015 and thereafter.

Hospital Acquired Conditions
Since 2008, CMS has refused to pay for Hospital Acquired Conditions (HACs). However, starting in 2015, CMS will reduce Medicare payments by 1% to providers with frequent occurrences of HACs. Thus, it will be even more important for medical staff to diagnose and record all pre-existing conditions upon admission as well as reduce the risk of HACs.

Hospital Value-Based Purchasing
In 2012, CMS will implement the Value-Based Purchasing (VBP) program, giving incentive payments to hospitals that meet established performance standards in certain Diagnostic Related Groups (DRGs). Hospitals that do not meet the performance standards will suffer a reduction in overall reimbursement because the incentive payments are funded by a 1% reduction in 2013 DRG payments and a 2% reduction in 2017 payments. A recent study found that 75% of all hospitals will suffer Medicare revenue losses if they do not make significant changes before the VBP program commences.

Incentivizing Physicians
If providers hope to meet the coming new quality standards, they must have the cooperation and assistance of physicians. Providers should consider programs to incentivize physicians to help providers meet their quality goals. However, such incentive programs can run afoul of the Stark law, the Anti-Kickback Statute, or the Civil Monetary Penalty law if not constructed properly. Providers must take care to ensure that physician incentive programs have articulable goals and clear quality criteria. The programs must not reward physicians solely for an increase in referrals, an increase in the utilization of procedures, beating profit projections, or a reduction in services to patients. Providers are advised to consult an attorney knowledgeable in the Stark law, the Anti-Kickback Statute, and the Civil Monetary Penalty law before implementing any physician incentive programs.