Under the health care reform law, starting in 3 years, hospitals will stand to be paid more for meeting quality and outcome measures. They will also be penalized for hospital-acquired conditions and readmissions.

Pilot projects will be launched to test new ways to deliver and pay for care to Medicare and Medicaid patients.

These are all part of the government’s plan to start shifting away from paying for the volume of services and toward paying for outcomes. Here are highlights.

**Paying for value**

**Value-based purchasing**

*When:* Starts 2012-2013

Starting in 2013, the government will start pay-for-performance, with 1% of hospitals’ DRG payments tied to their performance on quality and outcome measures. That will scale up to 2% in 2017.

- Measures will cover at least acute myocardial infarction, heart failure, pneumonia, the Surgical Care Improvement Project (SCIP), health care-associated infections, and patient experience (HCAHPS).
- Efficiency measures will be added in 2014.
- A value-based purchasing plan will be developed for ambulatory surgery centers.
- Demonstrations will be set up for inpatient critical access hospitals and certain other hospitals.

**Hospital-acquired conditions**

*When:* 2015

Hospitals in the top quartile for certain hospital-acquired conditions (HACs) will be paid 1% less for those. The conditions will be determined by HHS. These penalties will be on top of those already in place.

HAC information will be public.

The Department of Health & Human Services (HHS) will study applying the policy to other providers, including outpatient departments and ambulatory surgery centers.

**Reducing hospital readmissions**

*When:* 2012

DRG payments will be reduced for excess readmissions. Payments will be reduced by up to 1% in fiscal FY 2013, 2% in FY 2014, and not to exceed 3% in FY 2015 and beyond. Admission rates will be publicly reported. Some hospitals may be exempt.
A 2007 report found 9% of Medicare patients were readmitted within 15 days at a cost of about $8 billion. At 30 days, 13% had been readmitted; the price tag was $12 billion.

**National strategy to improve quality**

HHS will develop a national strategy and priorities for improving health care quality. This will include developing quality measures, collecting data, and making quality data public.

**Patient-centered Outcomes Research Institute**

This new nonprofit organization, not part of the government, will guide “comparative effectiveness” research efforts to help patients, clinicians, and policy makers make informed decisions. The evidence or findings cannot be used for coverage or reimbursement decisions.

**Testing new delivery models**

**CMS Innovation Center**

*When:* By 2011

A new center will be set up in the Centers for Medicare and Medicaid Services (CMS) to test new payment and delivery models to reduce Medicare expenses while preserving or enhancing quality.

Examples are “medical homes,” geriatric care coordination, and a collaborative of high-quality, low-cost organizations to share best practices.

**Accountable care organizations**

*When:* 2012

In this voluntary program, providers such as hospitals and physicians will work together to manage care for Medicare beneficiaries. Participants will be paid fee-for-service; if they stay under a target amount of spending per beneficiary, they would qualify for “shared savings.”

Accountable care organizations would promote evidence-based practice and patient engagement and be assessed under quality standards. They would have to operate for at least 3 years; cover at least 5,000 Medicare beneficiaries; and accept accountability for the total cost, quality, and care of these beneficiaries.

**Patient bundling pilot**

*When:* 2013

The voluntary pilot project will focus on giving integrated care during an episode for 1 to 8 conditions determined by HHS. The pilot will apply to a combination of acute care, physician services, outpatient, and postacute care, with a bundled payment for the care episode that would be split among the providers. The episode would cover from 3 days prior to admission to 30 days after discharge.