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# Medicare Plan for Payments Irks Hospitals

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WASHINGTON — For the first time in its history, Medicare will soon track spending on millions of individual beneficiaries, reward hospitals that hold down costs and penalize those whose patients prove most expensive.

The administration plans to establish "Medicare spending per beneficiary" as a new measure of hospital performance, just like the mortality rate for heart attack patients and the infection rate for surgery patients.

Hospitals could be held accountable not only for the cost of the care they provide, but also for the cost of services performed by doctors and other health care providers in the 90 days after a Medicare patient leaves the hospital.

This plan has drawn fire from hospitals, which say they have little control over services provided after a patient's discharge — and, in many cases, do not even know about them. More generally, they are apprehensive about Medicare's plans to reward and penalize hospitals based on untested measures of efficiency that include spending per beneficiary.

A major goal of the new health care law, often overlooked, is to improve "the quality and efficiency of health care" by linking payments to the performance of health care providers. The new Medicare initiative, known as value-based purchasing, will redistribute money among more than 3,100 hospitals.

Medicare will begin computing performance scores in July, for monetary rewards and penalties that start in October 2012.

The desire to reward hospitals for high-quality care is not new or controversial. The idea can be traced back to a bipartisan bill introduced in Congress in 2005, when Democrats and Republicans were still working together on health care. However, adding in "efficiency" is entirely new and controversial, as no consensus exists on how to define or measure the efficiency of health care providers.

The new health care law directs the secretary of health and human services to develop "efficiency measures, including measures of Medicare spending per beneficiary." Obama administration officials will decide how to calculate spending per beneficiary and how to use it in paying hospitals.

Administration officials hope such efforts will slow the growth of Medicare without risking the political firestorm that burned Republicans who tried to remake the program this year.

In calculating Medicare spending per beneficiary, the administration said, it wants to count costs generated during a hospital stay, the three days before it and the 90 days afterward. This, it said, will encourage hospitals to coordinate care "in an efficient manner over an extended time period."

If, for example, an 83-year-old woman is admitted to a hospital with a broken hip, she might have hip replacement surgery and then be released to a nursing home or a rehabilitation hospital. When she recovers, she might return to her own home, but still visit doctors and physical therapists or receive care from a home health agency. If she develops a serious infection, she might go back to the hospital within 90 days.

The new measure of Medicare spending per beneficiary would include all these costs, which — federal officials say — could be reduced by better coordination of care and communication among providers.

Here, in simplified form, is an example offered by federal officials to show how the rewards might work. If Medicare spends an average of $9,125 per beneficiary at a particular hospital and if the comparable figure for all hospitals nationwide is $12,467, the hospital would receive high marks — 9 points out of a possible 10 awarded for efficiency. This measure, combined with measures of quality, would be used to compute an overall performance score for the hospital. Based on this score, Medicare would pay a higher or lower percentage of each claim filed by the hospital.

Federal officials are still working out details, including how to distribute the money.

Charles N. Kahn III, president of the Federation of American Hospitals, which represents investor-owned companies, said he supported efforts to pay hospitals according to their performance. But he said the administration was "off track" in trying to hold hospitals accountable for what Medicare spends on patients two or three months after they leave the hospital.

"That's unrealistic, beyond the pale," Mr. Kahn said.

Since 2004, Medicare has provided financial incentives to hospitals to report on the quality of care, using widely accepted clinical measures.

Much of the information is posted on a government Web site (hospitalcompare.hhs.gov), but it has not been used as a basis for paying hospitals.

For years, federal health officials have emphasized the importance of higher-quality care, mentioning efficiency as an afterthought. Now, alarmed at the trajectory of Medicare costs, they emphasize efficiency as an equally important goal.

Under the new health law, Medicare will reduce payments to hospitals if too many patients are readmitted after treatment for heart attacks, heart failure or pneumonia. In addition, Medicare will cut payments to hospitals if they do not replace paper files with electronic health records, and it will further reduce payments to hospitals with high rates of preventable errors, injuries and infections.

Hospital payments account for the largest share of Medicare spending, and Medicare is the single largest payer for hospital services.

Senators Max Baucus, Democrat of Montana and chairman of the Finance Committee, and Charles E. Grassley, Republican of Iowa, have led efforts to pay health care providers for their performance — for the quality of services, rather than the quantity. House members from Iowa, Minnesota, Washington and Wisconsin have pushed for measures of efficiency, saying Medicare should reward low-cost, high-quality care of the type they say is provided in their states.

Without opposing the change, lawmakers from higher-cost states like Massachusetts and New York say the payment formula needs more work.

Teaching hospitals worry that the new policy will penalize them because they treat sicker, more expensive patients. Medicare officials tried to allay this concern, saying they would adjust the data to take account of patients' age and the severity of their illnesses, as well as geographic differences in hospital wages.

Still, Kenneth E. Raske, president of the Greater New York Hospital Association, said the formula "tends to discriminate against inner-city hospitals with large numbers of immigrant, poor and uninsured patients."

By contrast, J. Kirk Norris, president of the Iowa Hospital Association, welcomed the new plan. "Medicare ought to pay for value," he said.

Administration officials said they were aware of concerns that some hospitals might try to increase their performance scores by avoiding high-risk patients. The officials said they would watch closely for signs of such a problem.

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