The Relationship Between National Health Care Policies and Quality Improvement in Neurosurgery

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KEYWORDS

• Quality • Value • Mandate • Measure • Federal • Legislation

KEY POINTS

- Physicians face an unprecedented level of accountability for factors often outside their control and of questionable significance.
- Neurosurgeons and other largely hospital-based specialties face pressure to comply with often overlapping and conflicting federal mandates on multiple fronts.
- Rapid implementation of these programs has resulted in misguided strategies and, in many cases, may be causing more harm than good.
- It is critical that policy makers first establish the data infrastructure needed to most accurately identify and most appropriately target gaps in care.

INTRODUCTION

As US policymakers continue to grapple with unacceptable rates of medical errors, unsubstantiated variations in practice patterns, and potentially avoidable spending, physicians are finding themselves in the center of a perfect storm. Today's physician faces not only multiple, often conflicting, regulatory requirements that interfere with the daily practice of medicine but also an unprecedented level of accountability for factors often outside their control and of questionable significance. These misguided mandates, aimed at improving US health care system performance, have produced little evidence to date of actually raising the bar on anything but confusion and frustration.

Despite significant financial investments, the United States remains one of the least efficient health care delivery systems in the developed world.[1,2] US physicians also have one of the lowest rates of job satisfaction.[3] Frustrations are likely to increase as patient-centered care is further eroded, and physicians are forced to divert an increasing portion of their attention to administrative compliance with one-size-fits-all care mandates.

Although many reforms are being implemented in the private sector and at the local and state level, most are driven by policies enacted at the federal level. Recent federal regulatory actions have shepherded in a new era of health care delivery and payment reforms that has fundamentally restructured incentives and revolutionized information sources that drive clinical decision making. These reforms were heavily influenced by the findings of the Institute of Medicine,[4,5] which not only identified dramatic deficiencies in the quality of US health care, but demanded that the nation aggressively address these problems.

As early as 2006, President Bush issued an executive order "to ensure that health care programs

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administered or sponsored by the Federal Government promote quality and efficient delivery of health care through the use of health information technology, transparency regarding health care quality and price, and better incentives for program beneficiaries, enrollees, and providers."[6] The Tax Relief and Health Care Act of 2006 was enacted soon after, establishing the Physician Quality Reporting Initiative (now known as the Physician Quality Reporting System or PQRS). The Medicare Improvements for Patients and Providers Act of 2008 made the PQRS a permanent feature of the Medicare program and authorized financial incentives and penalties for electronic prescribing. The groundbreaking American Reinvestment and Recovery Act of 2009, which included the Health Information Technology for Economic and Clinical Health (HITECH) Act, subsequently authorized a more than $19 billion investment in the nation's health information technology (HIT) infrastructure and federal incentives to encourage physicians and hospitals to use HIT in a meaningful manner. The Patient Protection and Affordable Care Act (ACA) of 2010 went one step further by transforming these largely voluntary, incentive-only initiatives into mandates with increasing penalties. The ACA also heavily emphasized value over volume, holding health care providers accountable for not only the quality of their care, but their ability to control costs.

DISCUSSION

Whether in private practice or academics, part of a large integrated system, or largely independent, few neurosurgeons will remain untouched by these increasingly complex and punitive policies. Those policies and programs most likely to have impacted the daily practice of neurosurgeons recently or in the coming years are summarized below.

Hospital Inpatient Quality Reporting Program

Under the Hospital Inpatient Quality Reporting (IQR) Program, originally mandated under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, hospitals that do not successfully report to the Centers for Medicare and Medicaid Services (CMS) on a designated set of quality measures will see a reduction in their annual payment increase.

The Hospital IQR Program measure set has grown from a starter set of 10 quality measures to a set of more than 60 measures for the fiscal year (FY) 2017 payment determination. These measures include both chart-abstracted and claims-based clinical process of care measures, including 8 new stroke measures and 8 venous thromboembolism measures; outcomes measures focusing on mortality, surgical complications, health care–associated infections, and readmissions; survey-based patient experience measures; cost measures that evaluate all Medicare Part A and B spending on specific episodes (eg, pneumonia and heart failure) and broader episodes spanning 3 days before admission to 30 days before discharge; and structural measures that assess features of hospitals to assess their capacity to improve quality of care, such as participation in a clinical data registry.

Starting with the FY 2015 payment determination, the penalty for the Hospital IQR will increase to one-quarter of a hospital's annual payment update. As a result of growing penalties and separate efforts to further tie hospital payment to performance on a subset of these measures (described below), neurosurgeons and other largely hospital-based specialists have likely experienced a recent surge in institutional pressure to comply with these metrics.

Hospital Value-Based Purchasing Program

Expanding on the IQR, the Hospital Value-Based Purchasing Program (VBP), a separate ACA-authorized program, redistributes reductions made to hospitals' Medicare Diagnosis-Related Group payments based on a hospital's performance on a subset of the IQR measures. In FY 2015, hospitals stand to lose up to 1.5% of their Medicare diagnosis-related group payments under this program and up to 2.0% by FY 2017. To date, more hospitals have received penalties than bonuses, and the average penalty amount continues to increase.[7]

For FY 2015, 20% of a hospital's performance score will be based on clinical processes of care, such as removing urinary catheters from surgery patients within 2 days and administering prophylactic antibiotics within 1 hour before surgery to decrease the risk of infection. Thirty percent of a hospital's performance score will be based on patient satisfaction, such as whether the physicians and nurses communicated well. Another 30% will be based on outcomes, including mortality rates for heart attacks, heart failure, or pneumonia that occurred in the hospital or within a month after discharge, as well as select hospital-acquired infections, such as central line–associated blood stream infections. The remaining 20% will be based on how well a hospital manages costs for each admission from the 3 days before each admission to 30 days after discharge. Because post–acute care spending in the first 30 days after