OVERVIEW OF THE QUALITY FIRST ACT

To provide for a program of quality measurement and reporting and for the use of value-based payment in Medicare for inpatient hospital services.

Quality Measures

- Quality measures must be evidence-based, consensus-based and statistically valid (endorsed by NQF and recommended by HQA).
- Initially, this program will include the process measures for four specified conditions/performance areas: acute myocardial infarction (AMI), heart failure, pneumonia, and Surgical Care Improvement/ Surgical Infection Prevention (SCIP/SIP). Excludes mortality measures and HCAPHS.
- Authority is provided for HHS to continue its work on the development of new measures to include in reporting, such as efficiency, patient outcomes, emergency care, care coordination, patient safety, and structural measures such as the use of health IT.

Public Reporting

- Public reporting will continue as an important tool for quality improvement and as a process through which hospitals can gain experience with new measures.
- The current Hospital Compare web site will be upgraded to enhance its user-friendliness and its flexibility to meet different users' needs.

Data Submission, Validation, and Review

- Maintains current timeline for data submission and validation. Provides for a resubmission period of 30 days to allow for the correction of errors. Hospitals are provided with the opportunity to review their data prior to public posting or use in the value-based payment program.

Performance Standards and Value-Based Payment

- Performance benchmarks will be established on each of the quality measures that takes into consideration the current level of performance and the amount of improvement.
- All hospitals will have a financial incentive to improve.
- The value-based payment program shall be established in a budget-neutral manner.

Financing Value-Based Payments

- Up to 2 percent of hospital payments will be at stake for value-based payment. Each hospital will be eligible to earn all or a portion of that two percent depending on its performance on the quality measures.
- Bonus payments are made to high-performing hospitals from the pool of funds made available by payment reductions arising from any hospitals not achieving the full-incentive benchmark level.

Implementation of Value-Based Payment and Transition from Pay for Reporting

- *Initial Year (FY 2011).* The value-based payment program will begin in FY 2011 with the benchmark levels announced in FY 2009 using hospital performance data from FY 2008. Hospitals' payments will be adjusted in FY 2011 based on performance on quality measures in FY 2010.
- *Transition.* A four-year phased-in transition would be implemented as follows: 0.50 percent for fiscal year 2011, 1.0 percent for fiscal year 2012, 1.5 percent for fiscal year 2013; and 2.0 percent for fiscal year 2014.

Additional Provisions

- *Small Hospitals.* To provide for successful incentives, a value-based program relies on measurement of a sufficient number of cases to be meaningful. The Secretary is directed to determine the best way for the small hospitals to participate in quality improvement efforts.
- *Additional Incentive Pool.* Savings identified from improvement in quality and efficiency could be used to establish a bonus pool to fund additional value-based incentive payments, including shared improvement programs between hospitals and physicians.
- *Report to Congress.* HHS is required to submit a report after initial year on program. GAO is also directed to evaluate its impact.