PART 3 in THA's educational series on hospital finance

Value-Based Payment

THE TRANSITION FROM VOLUME TO VALUE

Pressure from public and private payers to lower costs and improve health care outcomes is changing the way hospitals are paid. Instead of being reimbursed based on the number of services they provide, Texas hospitals increasingly are being paid based on the value or outcome of the care they deliver.

So-called value-based payment models align reimbursement with measures of clinical quality and rapidly are becoming a more common practice.

This document describes the challenges and opportunities Texas hospitals experience on the journey to meet state and federal requirements under specific value-based payment models.

Volume-Based Payment — **Value-Based Payment**

Value-Based Payment: Opportunities and Challenges

For nearly a decade, Texas hospitals have been navigating the changes and challenges associated with the transition from fee-for-service reimbursement to value-based payment.

Today's value-based payment models rely on objective measurements of care quality, which means providers must prove that they are meeting quality standards and improving patient care while also achieving cost efficiencies. However, the wide variety of quality metrics used in different VBP models can be administratively burdensome for hospitals. Hospitals need sophisticated analytics to measure financial and quality performance for each patient population, particularly as the number of measures a hospital must track can be conflicting and overlapping.

For example, a hospital may track various quality measures related to readmissions using different time intervals (15-days, 30-days and 90-days post discharge) and conditions or procedures (e.g., pneumonia, heart attack, heart failure) and report different measures to different public and private payers.

While Texas hospitals are committed to improving patient outcomes and reducing costs and invest significant financial and human resources into doing so, required quality metrics sometimes fail to reflect the total value of care hospitals provide. In addition, because hospitals are measured against standards of clinical quality without regard to patient population variables or other extenuating circumstances, **hospitals more often are penalized for program performance than are rewarded.** In addition, although hospitals are often the subject of financial penalties under VBP programs, achieving the desired outcomes depends on the involvement and buy-in of physicians and other clinicians as well.

Finally, hospitals have had little opportunity to collaborate or inform the process by which they are measured. **Data collection would be more effective if hospitals are full partners in crafting program requirements** and work with public and private payers to establish a standard set of quality measures to track and report to determine clinical and financial value.

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Pay for Performance

Pay for performance programs are a hybrid of fee-for-service and value-based payment models. Under P4P, financial incentives and penalties are tied to a hospital's performance on certain quality measures. Participating hospitals receive performance-based adjustments to their FFS Medicaid and Medicare reimbursement—either an incentive payment or reduction—for meeting or failing to meet certain quality measures.

Medicaid

For most Texas hospitals, except safety-net hospitals*, P4P in Medicaid represents a reimbursement loss. The Texas Health and Human Services Commission collects data on hospitals' potentially preventable events, such as avoidable hospital readmissions or emergency department visits, and uses it to determine quality and efficiency goals.

State legislation in 2013 required THHSC to hold managed care organizations and hospitals financially accountable for potentially preventable readmissions** within 15 days of the original discharge and potentially preventable complications*** flagged by the agency. Through the **Hospital Quality-Based Potentially Preventable Readmissions and Potentially Preventable Complications Program,** THHSC makes positive or negative adjustments to FFS inpatient Medicaid reimbursement based on a hospital's performance in the PPR and PPC categories. Hospitals deemed to have too many PPRs stand to lose 1 to 2 percent of payments, and those deemed to have too many PPCs stand to lose 2 to 2.5 percent of payments. The program originally only penalized hospitals, but lawmakers in 2015 gave THHSC authority to also provide incentive payments to safety-net hospitals. Eligible safety-net hospitals that perform 10 percent better for either PPRs or PPCs than the state average may receive an incentive payment.

THHSC measures several PPEs for hospitals participating in the Delivery System Reform Incentive Program under Texas' 1115 Medicaid Waiver, including potentially preventable hospital admissions****, PPRs and PPCs. Under THHSC's **1115 Waiver Pay-for-Reporting Program**, hospitals must submit quality data on an annual basis. DSRIP payments may be withheld until the completed report is submitted.

> Hospitals can **lose up to 6 percent** of their Medicare inpatient reimbursement depending on their performance in the three P4P programs.

Medicare

In order to receive Medicare reimbursement for inpatient and outpatient services, Texas hospitals must report scores of quality measures through a complex process. CMS then adjusts payment—upwards or downwards—depending on whether hospitals reached or failed to reach certain benchmarks. One P4P program provides incentive payments to hospitals with positive performance and reduces reimbursement for those with poor performance. Others are strictly penalty-based, meaning poorly performing hospitals receive reduced payments.

Hospitals can lose up to 6 percent of their Medicare inpatient reimbursement depending on their performance in the three P4P

Quality Measures Should Reflect the Population Receiving the Care

A well-documented flaw in VPB programs is the broad nature of some quality metrics that fail to consider variable nuances in care delivery and, therefore, are ineffective measures of clinical quality. For example, most Medicaid and Medicare programs that focus on potentially preventable readmissions do not consider patients' social risk factors, such as socioeconomic or health status, when determining penalties. Low-income patients are more likely to:

- Have language and cultural barriers that impede compliance with discharge instructions.
- Lack the necessary resources to purchase medications.
- Have other chronic conditions.
- Have few options for post-discharge care.

As a result, **Texas hospitals that care for more low-income or uninsured populations are more likely to incur a readmissions penalty for reasons often outside of the hospitals' control.**

Definitions

****Safety-net hospitals**
Safety-net hospitals are providers of last resort in their communities. They predominately provide care to Medicaid, uninsured and other vulnerable patients and provide services that other hospitals in the community do not, such as trauma care, inpatient behavioral health care and neonatal intensive care.

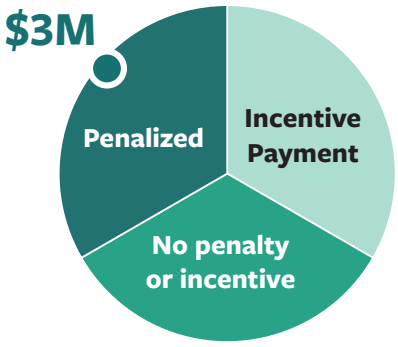
****Potentially preventable readmission**
A return hospitalization within a set time (usually 15-30 days post discharge) that is clinically related to the initial hospital admission and is due to lack of follow-up care.

*****Potentially preventable complication**
A harmful event or negative outcome, such as an infection or surgical complication that occurs after a hospital admission and may result from processes of care and treatment rather than the underlying illness.

******Potentially preventable hospital admission**
A hospital admission that may be reasonably prevented with adequate access to ambulatory care or health care coordination.

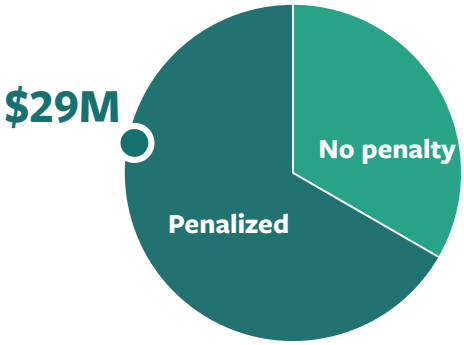
FFY 2018 Medicare Inpatient Reimbursement Cuts From Hospital Value-Based Purchsing Program

(Number of Hospitals and Penalty/Incentive Amount)



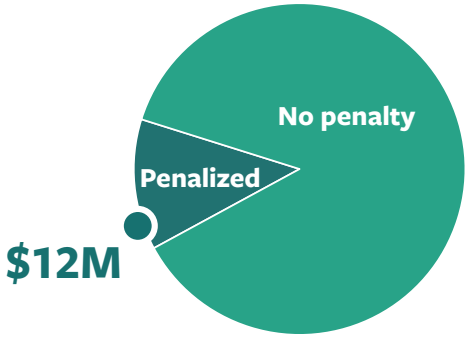
FFY 2018 Medicare Inpatient Reimbursement Cuts From Hospital Readmissions Reductions Program

(Number of Hospitals and Penalty Amount)



FFY 2018 Medicare Inpatient Reimbursement Cuts From Hospital-Acquired Condition Reduction Program

(Number of Hospitals and Penalty Amount)



programs.

The first is the **Hospital Value-Based Purchasing Program**. In place since 2013, this program rewards or penalizes acute care hospitals based on hospitals' performance. CMS withholds 2 percent of participating hospitals' Medicare inpatient payments and uses those reductions to fund value-based incentive payments. Hospitals can earn back those funds depending on their overall performance in four domains (clinical care, patient and caregiver-centered experience of care/care coordination, safety and efficiency and cost reduction) and how they compare relative to other participating hospitals. Hospitals can earn back a payment percentage that is less than, equal to or more than the original 2 percent reduction, but poorly performing hospitals are not further penalized. VBP is the only Medicare quality program in which hospitals can earn incentive payments. In FFY 2018, the more than 300 participating Texas hospitals saw a cumulative $3 million reduction across Medicare reimbursements:

- One-third were penalized.
- One-third did not receive a penalty or an incentive.
- One-third received an incentive payment.

The second P4P Medicare program is the **Hospital Readmissions Reduction Program**. Since FFY 2013, CMS has reduced Medicare reimbursement for hospitals deemed to have too many inpatient readmissions 30 days after a patient's initial discharge. Hospitals are measured on their readmissions rates for six specific conditions or procedures:

- Acute myocardial infarction.
- Heart failure.
- Pneumonia.
- Chronic obstructive pulmonary disease.
- Coronary artery bypass graft surgeries.
- Elective primary total hip and/or total knee arthroplasty.

Hospitals can lose up to 3 percent of inpatient reimbursement for all Medicare FFS hospitalizations, including those outside of the six conditions and procedures. In FFY 2018, more than two-thirds of the 300 plus participating Texas hospitals experienced a $29 million cumulative reduction to their Medicare inpatient reimbursement through this program.

The third Medicare P4P program is the **Hospital-Acquired Condition Reduction Program.** Since FFY 2015, CMS has reduced hospitals' Medicare inpatient reimbursement based on how often hospitalized patients contract a hospital-acquired condition—a condition one acquires while receiving treatment for another condition in an acute care setting. Hospitals are measured on their performance across certain hospital-acquired conditions, such as surgical site infections, pressure sores after surgery and others. Hospitals in the worst-performing quartile compared with the other participating hospitals nationwide automatically lose 1 percent of their inpatient reimbursement. Payments of higher performing hospitals are not affected. In FFY 2018, 16 percent of the more than 300 participating Texas hospitals experienced a cumulative $12 million reduction to their Medicare inpatient reimbursements.

Bundled Payments/Episodes of Care

The bundled payment/episode of care model provides a single negotiated payment shared by hospitals, post-acute care providers (e.g., rehabilitation hospitals, long-term care hospitals and skilled nursing facilities), physicians and other practitioners for all services performed for a single event, such as a total hip or knee replacement. Because payment is based on providers' comprehensive performance with respect to clinical standards of care, risk groups and complication allowances, the model requires a high degree of clinical coordination and integration.

The model incentivizes providers to improve efficiencies within an episode of care and prevent unnecessary episodes because they retain any savings they generate. Clinical integration is critical to achieve these cost savings. While hospitals can generate savings, incentivizing

hospitals to reduce patient utilization reduces procedure volume and overall revenue. Under the model, providers are paid less per episode or per patient than they would have received under traditional FFS reimbursement, and they typically have to cover the costs of services for procedures or conditions that exceed the agreed-upon reimbursement amount.

CMS planned to test this model through mandatory participation in the **Episode Payment Models** and **Cardiac Rehabilitation Incentive Payment Model**, but it canceled the programs several months before they were scheduled to begin.

Instead, CMS recently announced a new voluntary bundled payment program, **Bundled Payments for Care Improvement Advanced,** which will align financial incentives for hospitals and physicians during an episode of care for Medicare beneficiaries. Beginning Oct. 1, 2018 through Dec. 31, 2023, BPCI Advanced will test new bundled payments for 29 inpatient clinical episodes and three outpatient clinical episodes and measure provider performance across several quality measures, including hospital readmissions. Clinical episodes begin at the start of an inpatient admission or outpatient procedure and end 90 days after the end of the admission or procedure. Under the program, acute care hospitals and physician group practices can participate on two levels:

- Facilitating coordination of multiple downstream entities and bearing and assigning financial risk.
- Participating as one of the downstream entities that does not bear financial risk on behalf of other entities.

Regardless of participation level, all participants assume responsibility for downstream financial risk. Physician group practices and acute care hospitals that bear and assign financial risk submit claims that include the attending or operating physician's information. CMS will reconcile payments on a semi-annual basis, meaning it will compare total Medicare FFS expenditures for all services associated with a clinical episode against the target price to determine if a hospital owes money to CMS because it exceeded the negotiated cost of care or it is eligible to retain savings because expenses were lower than the negotiated cost of care.

Another bundled payment program, the **Comprehensive Care for Joint Replacement Model,** incentivizes hospitals, physicians and post-acute care providers to improve quality and efficiency of care for patients undergoing hip and knee replacements—the most common inpatient surgery for Medicare beneficiaries. Hospitals are financially responsible for quality and cost of episodes of care for hip and knee replacements from admission to 90 days after a patient is discharged. Initially mandatory in 2016 for all hospitals in counties with more than 50,000 people, the model is now voluntary for rural and low-volume hospitals and half of the hospitals in the previously mandated counties.

The Future of Value-Based Payment

While value-based payment is not new to Texas hospitals, the arrangements under which they operate are continually changing. Starting this year, for example, THHSC requires Medicaid managed care organizations to tie a certain portion of their payments to contracting providers, including hospitals, to value. THHSC recently built value-based care targets into its Uniformed Managed Care Contract, which includes terms and conditions applicable to all MCOs participating in Medicaid. The targets or quality measures vary based on the population the Medicaid managed care program serves (i.e., medically fragile children, children and youth in foster care, low-income children and pregnant women and adults with disabilities and people age 65 and over.) THHSC is working with the MCOs to help them meet new contractual requirements and provide information to affected parties, such as hospitals. Texas hospitals will work with stakeholders to develop arrangements that allow them to best meet their communities' needs.

THA's educational series on hospital finance includes:

Part I: Medicaid's Role in Hospital Financing
Part II: Local Provider Participation Funds in Texas
Part III: Value-Based Payment
Part IV: Rural Hospital Finance
Part V: Hospital Payment Sources
Part VI: The Role of Property Tax Revenue

Available at www.tha.org/hospitalfinance