

Economic Changes Affecting Your Bottom Line

It's time to lead the change or risk the payment changes leading you.

BY RYAN GRAVER

March 23, 2015, will mark the fifth anniversary of passage of the Affordable Care Act into law. As the health care marketplace continues its transition into a new normal of payment methods, key economic terms such as “risk” have now become paramount concepts for providers to not only understand, but embrace and incorporate into their business and clinical strategies. *Risk*, or the alignment of financial incentives organized to drive desired outcomes, is perhaps one of the more common terms found in current health care publications. As providers and hospitals find a growing percentage of their reimbursable dollars at risk by being tied to key performance measures, health care systems must be aware of how these measurements will directly affect the dollars they are paid. In health care, the process of bearing the risk you want and minimizing your exposure to the risk you do not want is not the same as in other markets. Simply not doing things that carry a particular risk may not be an option; providers cannot hedge in their treatment strategies nor can they diversify their portfolio of dollars enough to manage their risk.

This article examines the extent to which key payment risk programs are materializing and the dollars that are actually tied to these initiatives. Focusing on payment reform programs can help providers understand how changes in payments are having an impact on facilities and the economic challenge that is being created nationally. However, these challenges represent opportunities for providers to take a leadership position in affecting the change

necessary to achieve the thresholds of success that have been defined for all providers, especially those treating patients with cardiovascular-related diseases.

DECISION MAKING

A basic economic concept of information theorizes that market efficiency is likely to be at its maximum when information is comprehensive, accurate, and cheaply available. Medicare's payment risk programs are designed to measure and report information by assisting health care consumers in evaluating and making decisions as purchasers of health care services. Hospitals and providers must understand what information is being made public and begin to acknowledge that patients are now, more than ever, consumers of health care. Public websites, such as hospitalcompare.gov and physiciancompare.gov, were not designed to provide information to hospitals and providers in an effort to benchmark and improve performance; rather, they were designed to inform patients on the performance of the health

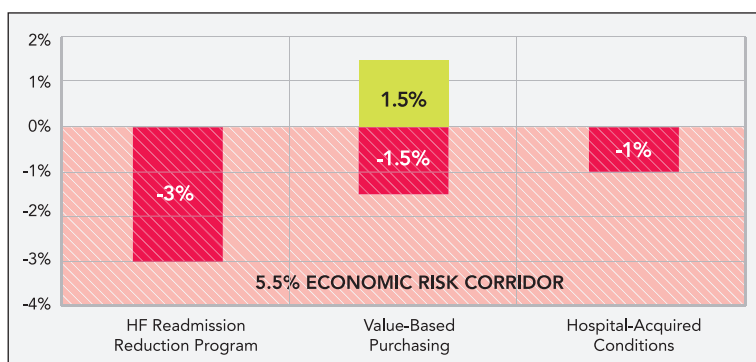


Figure 1. Percentage of Medicare dollars at risk.

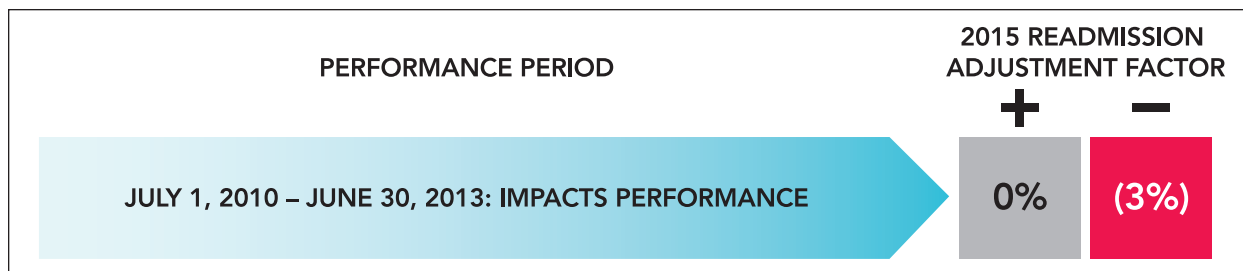


Figure 2. Understanding trailing performance periods.

care options available in their respective marketplace. Medicare is betting that patient relationships will not be enough to sustain purchasing decisions; patients will seek care based upon outcomes, quality, and cost as the era of information-driven consumerism in health care unfolds. Although individual market dynamics are still critical in determining the rate at which these changes are likely to affect specific organizations, the trends are clearly accelerating. Providers can no longer wait and see how these programs will materialize; hospital payments from Medicare are quickly approaching the billion-dollar threshold nationally. Again, clinician leaders who educate themselves on how payments are calculated, what performance measures are affecting these payment calculations, and what quality/cost measures are being publicly reported, will be armed with information that is essential for successfully navigating the new normal of health care.

MEDICARE PAYMENT CHANGES AND NEW PERFORMANCE MEASURES FOR 2015

The Centers for Medicare & Medicaid Services projects that total Medicare spending on inpatient hospital services will decrease by approximately \$756 million in fiscal year (FY) 2015.¹ Beginning on October 1, 2014, hospitals were, for the first time, faced with managing a 5.5% risk associated with performance (Figure 1). This performance was measured under three programs: the Readmission Reduction, Value-Based Purchasing, and Hospital-Acquired Condition programs.

The macroeconomic impact of these programs is aimed at reducing or slowing the rate of spending growth associated with Medicare inpatient payments. The Henry J. Kaiser Family Foundation reported that Medicare's benefit payments totaled \$583 billion in 2013 and roughly one-fourth (or approximately \$140 billion annually)² was for inpatient hospital services. Although a \$756 million reduction in an estimated \$140 billion market represents only a 0.5% reduction in revenue in an industry that operates on an average of single-digit margins, this reduction represents real financial headwinds. In December 2014, Moody's, the

largest rating agency for hospitals, cited factors such as weak growth in operating cash flow in saying that the outlook for the United States nonprofit hospital industry remains negative in 2015. This year, Moody's expects operating margins will weaken as hospitals struggle to simultaneously operate under the fee-for-service model and models that focus on improving health care quality and reducing health care costs, such as those that are part of the Patient Protection and Affordable Care Act.³

Readmission Rate Reduction

The first penalties having an impact on payment associated with the Readmission Reduction Program took effect on October 1, 2012. This is a true penalty program in that hospitals cannot receive additional monies for outstanding performance; rather, they face a reduction in payments as a result of their performance. The penalty for the Readmission Reduction Program affects the base Medicare diagnosis-related group payment for all discharges throughout the FY, which starts on October 1st and lasts until September 30th of the following year. The penalties have increased 1% per year from 2012 to reach the current maximum of 3% in FY 2015. The performance period for 2015 began on July 1, 2010, and ran through June 30, 2013 (Figure 2). Medicare utilizes a 3-year rolling average performance period and a risk-adjustment methodology to calculate the excess readmission ratios that include adjustment for factors that are clinically relevant (including patient demographic characteristics, comorbidities, and patient frailty).

For FY 2015, the readmission reduction program has placed up to 3% of a hospital's operating base payment at risk tied to readmission rates after initial treatment of heart attack, heart failure, pneumonia, chronic obstructive pulmonary disease, and total knee arthroplasty/total hip arthroplasty. Cardiology providers should be aware that although percutaneous coronary interventions were considered, they were not added to the list for 2015; coronary artery bypass grafting has been added to the measures list for FY 2017.

This year, Medicare announced that 2,610 hospitals did not meet performance standards and will receive a payment reduction. Under the penalties, three-quarters of hospitals that are subject to the Hospital Readmissions Reduction Program are being penalized. Over the course of the year, Medicare estimates that the fines will total approximately \$428 million.⁴

Value-Based Purchasing

The term *Value-Based Purchasing* refers to a set of activities, outcomes measures and costs thresholds, which Medicare has established as requirements for providers to achieve that will derive “value” to Medicare as the purchaser of health care services and for patients as the recipients of those same services. Under the Value-Based Purchasing program, a total of 1,375 hospitals will have their Medicare payments reduced in 2015. This is the only program that can adjust a hospital’s payments up or down, and for FY 2015, this can total as much as 1.5%. The Value-Based Purchasing program is scheduled to increase by 0.25% per year up to 2% by FY 2017. Medicare reports that for hospitals receiving a penalty, the reductions will range from 0.01% to 1.24%. The average penalty for 2015 is -0.3%. That’s higher than the -0.26% penalty in 2014 and the -0.21% adjustments in 2013.

Value-Based Purchasing is also the only payment penalty program that includes an incentive, which is paid for through the reduction of payments to hospitals that were penalized. The 1.5% reduction produced a pool of \$1.4 billion in 2015 and will be distributed to a total of 1,714 hospitals that will have their Medicare payments increased to reflect what Medicare has deemed the delivery of higher-valued services.

There are four dimensions of the Value-Based Purchasing program and the weighting of each dimension will change over time (Figure 3). The initial dimensions of the program were clinical process-of-care measures, also known as *core measures*, and patient experience of care, also known as *HCAHPS*. An example of these

measures that interventional cardiologists can improve upon is to perform percutaneous coronary intervention within 90 minutes of hospital arrival. For FY 2015, hospitals were measured on a baseline period from January 1 to December 31, 2011, and their actual performance period ran from January 1 to December 31, 2013. Patient experience is known as the Hospital Consumer Assessment of Healthcare Providers system, in which providers are measured on the effectiveness of their communication and the overall patient experience.

Over time, outcome and efficiency metrics increase in their respective weighting. The current outcome metric is 30-day, risk-adjusted mortality for acute myocardial infarction, heart failure, and pneumonia. Just as Medicare has added metrics to the Readmission Reduction Program, most observers believe that additional conditions will be added to this list.

Last, efficiency is the measure of spending per Medicare beneficiary, which measures Medicare’s costs beginning 2 days prior to admission through 30 days after discharge. If a patient goes to a skilled nursing facility, has a readmission, or presents at the emergency department, these are all services that are consumed, and hospitals are benchmarked against the median

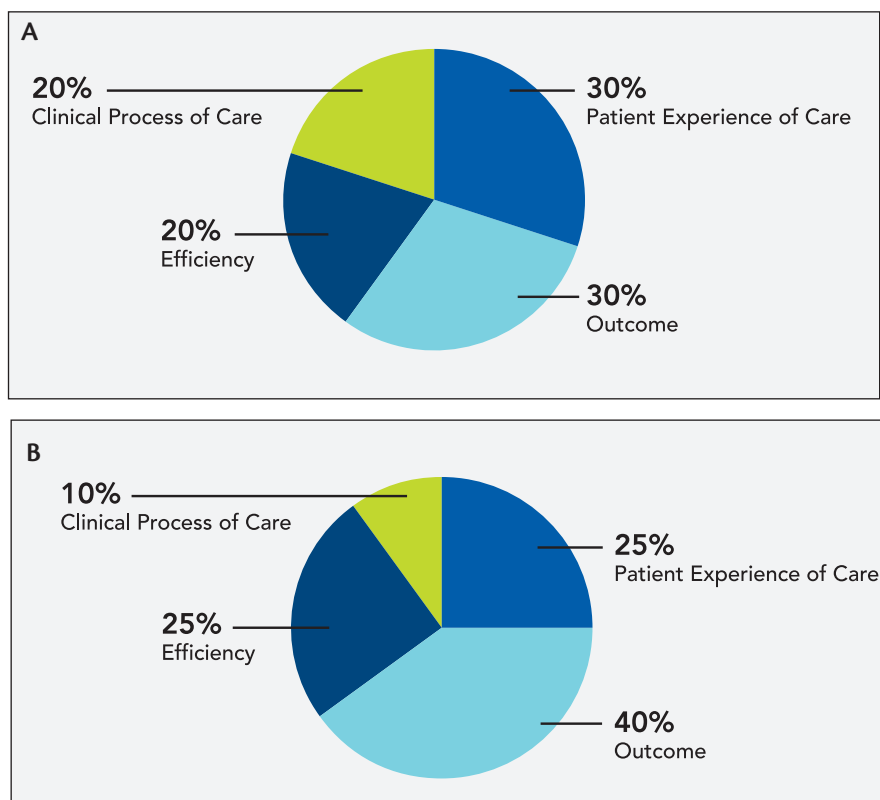


Figure 3. VBP domain weighting will grow toward cost and outcomes. 2015 VBP domain weighting, 1.5% risk (A). 2016 VBP domain weighting, 1.75% risk (B).

Medicare spending per beneficiary across all hospitals during the performance period.

Hospital-Acquired Conditions

FY 2015 marked the first year of the implementation of penalties associated with the Hospital-Acquired Conditions program. The cardiovascular-related Hospital-Acquired Conditions measures are (1) vascular catheter-associated infection; (2) surgical site infection, mediastinitis, after coronary artery bypass grafting; and (3) surgical site infection after cardiac implantable electronic device. Although Medicare has refused to pay hospitals for the cost of treating patients who suffer what it determined were avoidable complications since 2008, this year, 721 hospitals will be penalized up to a 1% reduction in their Medicare inpatient base payments. This penalty will result in an estimated \$373 million in payment penalties for FY 2015. Medicare calculated eligible hospital performance under the Hospital-Acquired Conditions program in a similar manner to the readmission adjustment factor and calculated a total score for each hospital.⁵

THE REAL IMPACT

The macroeconomic effect of these programs is significant and growing; however, it is difficult to examine the true implications in terms of billions or hundreds of millions of dollars when it is spread across thousands of facilities. Let us evaluate the microeconomic impact of how these penalties can potentially affect a single hospital. In 2013, Becker's Hospital published 13 statistics on hospital profit and revenue from 2011.⁶ The report noted that the average revenue per hospital was \$151.9 million, and that the average profit per hospital was \$10.7 million (ie, a 7% margin). In this scenario, if we assume that the hospital's Medicare base payment equaled \$80 million, the average hospital would have \$4.4 million of risk tied to its performance. If the hospital received the full penalty across all three payment reduction programs, its revenue would decrease to \$147.5 million, and its margin would decrease from 7% to 4%, or \$6.2 million. Having less revenue and fewer resources to invest, purchase capital, or expand services can have a significant impact on a hospital's ability to perform and compete. Hospitals facing penalties cumulating in the reduction of their revenue are faced with a necessity to reduce expenditures or increase other sources of revenue.

Through the first 5 years of the Affordable Care Act, hospitals and providers are managing risk and appear to be making significant improvements. The Department of Health and Human Services released a report, which found that a reduction in Hospital-Acquired Conditions

from 2010 through 2013 resulted in 1.3 million fewer patients harmed, 50,000 fewer patient deaths, and an estimated \$12 billion in health cost savings.⁷ The alignment of financial incentives to quality measures and outcomes appears to be the new normal of health care and, at least thus far, is making a difference. With additional payment reform programs, such as the Accountable Care Organization, and bundled payments further testing new methods of aligning incentives that are tied to the overall health care consumption of a population or the total costs of care associated with an episode, providers are faced with a new paradigm that they must understand, manage, and lead.

CONCLUSION

Although the bar associated with these programs is getting higher, both in terms of the percentage of risk that must be managed and the number and complexity of measures, it is important to step back and examine the primary clinical area of focus associated with Medicare's payment penalty programs. Driven by a report to Congress in June 2007, MedPac⁸ identified the seven conditions or procedures representing the highest costs to Medicare; five of the seven were related to cardiovascular health (ie, heart failure, acute myocardial infarction, coronary artery bypass graft, percutaneous transluminal coronary angioplasty, and other vascular disease). Of these conditions, we see many reflected in Medicare's payment penalty initiatives. This year represents the first year of Medicare's Physician Value-Based Purchasing program and Quality and Resource Use Report (with supplemental reports), which will be made public. The Quality and Resource Use Report is Medicare's measurement of quality and resource utilization, which benchmarks providers both on a cost-per-patient basis (patients are attributed to providers), as well as cost-per-patient episode, such as heart failure admission plus 30 days of postacute care. Providers, especially interventional cardiologists, have the greatest opportunity to enhance hospital performance under these new payment programs.

Today, health care providers are faced with staying current in the rapidly changing field of clinical medicine and in the evolving field of health care economics. Information that is made available to patients and purchasers of health care as a means to drive an informed health care consumer base also empowers health care leaders who, in addition to managing their exposure to risk, are leveraging new opportunities in the \$3 trillion dollar United States health care marketplace. In addition to Medicare's efforts to link payments to quality, private insurers are actively limiting their beneficiaries' access

to “low-quality/high-cost” providers as a means to narrow their network. Information, transparency, risk, and opportunity are all concepts that providers must use to empower themselves.

In 2014, MedAxiom published compensation results and integration statistics. The report showed that for the first time in 5 years, the average cardiologist compensation declined 7.9%, even though 64% of providers were either employed by or in the process of integrating with a hospital.⁹ Of course, there are number of factors affecting this decline, but given the significant and largely cardiovascular focus of hospital payment penalties, the challenge to providers is: How will you respond? Are you part of your hospital's quality committee? Are you being incentivized for improvements in these program measures? Are you part of a community where you can share best practices and learn from other groups about what works and what doesn't? Are you empowered with data? Do you know your hospital's performance, and do you yet know your physician group's performance?

This year represents the largest point of payment risk to hospitals yet reflected under the Affordable Care Act, and interventional cardiologists are faced with tremendous opportunity. It is time to lead the change or risk the payment changes leading you. ■

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