Impact Of Value-Based Programs On Acute Care Hospitals

This article continues our series on the topic of how the shift to value is changing health care delivery, and how clinical redesign and reducing clinical variation are central to increasing value. You can find links to the other articles in the series at the bottom of this article.

Novia's clients are experiencing a barrage of changes in how they are measured and reimbursed. Specifically, Medicare, other public and private payers, and even some large employers are shifting from paying hospitals and clinicians based on fee-for-service volume to paying based on value. Some of the programs with the largest impact are the various shared savings ACOs, Bundled Payments for Care Improvement (BPCI), Comprehensive Care for Joint Replacement (CJR) program, MACRA's Quality Payment Program (QPP) for physicians, and most recently, Episode Payment Models (EPMs) which will extend bundled payments to include cardiac services (among other changes). This post will discuss the impact of these value-based payment programs on acute care hospitals.

Before going further, it is worth noting that most observers in early 2017 expect the Trump administration to continue the shift to value. One possible difference is that the mandatory nature of some of these programs may be changed by the new HHS Secretary Tom Price.

What Do All Of The Major Value-Based Programs Have In Common?

There are a number of overlapping characteristics shared by most of these programs. Here are eight examples of high-impact changes that hospitals and clinicians must address.

1. Shifting to value means improving quality and/or reducing costs; most of these programs require both to happen simultaneously to maximize reimbursement.
2. New quality measures and cost targets are required to be reported and continuously improved.
3. Performance against quality and cost benchmarks will determine if hospitals and clinicians receive penalties or bonuses.
4. Bundled payments for the identified episodes will cover the majority of Part A and Part B fee-for-service (FFS) services delivered for the acute care stay and 90 days post-acute.
5. For bundled payments, reimbursement amounts begin as a blend of the hospital specific and regional average reimbursements and shift over the 5-year pilot to be based fully on the regional average.
6. For bundled payments, penalties and incentives are increased over the 5-year program, beginning at 5% and moving to 20% in performance years 4 and 5. Penalties are not phased in until the second quarter of the second performance year.

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7. In most programs, in order to earn incentives, specific quality targets must also be met.
8. MACRA's QPP introduces new quality and cost measures across 4 categories and includes results for the full 90-day episode as well.

What Are The Major Management And Operational Implications?

Hospitals and physicians will be required to work together like never before as a result of the integration of these value-based programs (not to mention the same shift to value being made by private insurers, employers, and some state Medicaid programs). Sharing common goals and aligned incentives for the first time in a long time creates enormous challenges and opportunities. The following is a brief summary of some of the key implications for hospitals and physicians.

- The need to manage the end-to-end continuum of care over the acute and post-acute 90-day episode.
- Medical staff education and engagement: Clarity will be required regarding who is bearing risk and potentially receiving penalties or rewards across the spectrum of programs shifting to value.
- Anticipate physicians asking hospitals to participate in Alternative Payment Models (APMs) to help them qualify for the 5% bonus available through MACRA's QPP.
- Develop new partnerships with post-acute service providers, including management and measurement systems, with an emphasis on clinical outcomes to ensure value.
- Enhance measurement processes to support new quality and performance measurement to ensure the data is available to demonstrate value and earn incentives.
- Develop new strategies to engage physicians and manage performance including new compensation programs and professional service agreements.
- Evolve your care management programs to include clinical variation to reduce costs, increase quality and demonstrate value.
- Integrate your physician engagement activities in response to the many value-based programs being implemented simultaneously.

The last two items above relate to the opportunity to share reconciliation bonuses and penalties as well as internally derived cost savings with other providers across the care continuum. This offers an excellent opportunity to align incentives for all clinicians providing care in a bundle.

The shift from fee-for-service to value based-payments requires providers to demonstrate improved quality, reduced costs, or both in order to avoid penalties and potentially earn incentive payments. The impact of this shift on clinical practice patterns, care coordination, physician / hospital integration and quality and cost reporting are significant. Physicians and hospitals that begin now to plan and implement necessary changes will be best positioned to take advantage of the opportunity to earn more reimbursement from Medicare and other payers driving the shift to value.

Our next article in this series will demonstrate how clinical redesign to reduce clinical variation is the best approach to succeeding in the new a value-based environment.

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About the Author

John Malone is a Vice President with our sister company, Novia Strategies. Novia Strategies is one of the longest-established clinician-owned healthcare consultancies in the country. The firm provides a variety of services designed to reduce costs and improve quality, including clinical redesign, care management, non labor, staffing and productivity, compensation and benefits, surgery, pharmacy, technology and revenue cycle.

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