We Can See Our Future in Hospitals’ Present

You may refer to it as the Patient Protection and Affordable Care Act (PPACA), the Affordable Care Act (ACA, my choice) or even Obama-care. But whatever you choose to call it, health care reform, and whether you love it or hate it, America will never be the same.

The ACA introduced mandates, subsidies, and insurance reforms designed to reduce hospital readmissions, the law that are intended to reduce hospital readmissions compared with national averages for patients with diagnoses of acute myocardial infarction, congestive heart failure, or pneumonia. The penalty increases by 1% annually each calendar year until it reaches its maximum of 3% in 2015. By the end of this year, chronic obstructive pulmonary disease and elective hip and knee replacements will be added to the conditions that can trigger hospital-readmission penalties.

When the Centers for Medicare & Medicaid Services (CMS) launched the penalties in 2012, more than 2,200 hospitals were penalized some $280 million for exceeding readmission rates measured by Medicare from 2008 to 2011. One in 10 hospitals received the maximum 1% penalty, while about 3 in 10 received no penalty and the others fell in between. Perhaps unsurprisingly, institutions serving more impoverished patients were not only more likely to incur a penalty, but also to be hit with the maximum penalty.

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The second year of the HRRP began last October. CMS has estimated that 2,225 hospitals will be penalized $227 million due to excess readmissions in this fiscal year. For perspective, this amount represents 0.2% of total annual Medicare base payments to hospitals. About 34% of hospitals will not be penalized. Although the number of hospitals to be penalized is similar to that last fiscal year, there are considerable shifts among facilities getting hit. A Kaiser Health News analysis found that 1,371 hospitals will receive lower fines, while 1,074 will face greater penalties. As in the first year of the program, hospitals serving more low-income patients are about twice as likely to receive penalties (77% of such hospitals) as hospitals with the fewest poor patients (36%).

The HRRP has a structure that ensures two outcomes: 1) About half of the hospitals in the program are always going to face a penalty. 2) The overall amount of the penalties that Medicare imposes will remain the same even if hospital readmissions improve over time.

There is some early evidence that the HRRP has lowered readmissions. As reported online last year by the policy journal Health Affairs, CMS told Congress that the all-cause Medicare readmission rate in the last quarter of 2012 — the first 3 months of the program — had dropped to 17.8% from the historical norm of 19%. In gross numbers, that represents approximately 70,000 fewer Medicare hospital readmissions (Health Policy Brief: Medicare Hospital Readmissions Reduction Program, Health Affairs, Nov. 12, 2013).

Value Based Purchasing, HVBP

This ACA program is based on the data originally developed for Medicare’s Hospital Inpatient Quality Reporting Program, part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The essential concept of HVBP is that hospitals will be paid for inpatient services based on the quality of that care, not just its quantity.

The program will withhold funds from hospitals’ Diagnosis-Related Group (DRG) payments but then redistribute the money to hospitals according to the Total Performance Scores that Medicare calculates for each institution. Withholding began at 1% of total Medicare reimbursements in fiscal year 2013 and is progressively rising to a maximum of 2% by fiscal year 2017.

The HVBP is designed not only to promote better clinical outcomes for hospital patients, but also to improve their hospital experiences. Specifically, HVBP seeks to push hospitals to improve the quality and safety of care that they give to Medicare beneficiaries by:

▶ Eliminating or reducing the occurrence of adverse events (health care errors resulting in patient harm).
▶ Adopting evidence-based care standards and protocols that result in the best outcomes for the most patients.
▶ Re-engineering hospital processes to improve patients’ experience of care.
▶ The program will affect payments that account for the largest share of Medicare spending, inpatient-stay payments, at more than 3,500 hospitals across the country.

As of last October, Medicare had reduced DRG payment rates to all hospitals by 1.25%, collecting $1.1 billion for incentives payments. While every hospital will get something back, more than half are not recouping the 1.25% they have forfeited. The payment adjustments are applied to each Medicare patient stay over the year that started last October and runs through September 2014.

To assess quality, Medicare looked not only at how hospitals scored in comparison with other hospitals, but also how much each improved from 2 years ago, compared with other hospitals. A hospital is judged on whichever score is higher, so some hospitals with subpar quality rankings are still getting more money than others because they showed vast improvement. Fiscal year 2014 Total Performance Scores are made up as follows:

• 45% from how frequently hospital staff followed basic clinical standards of care, such as removing urinary catheters from surgery patients within 2 days to decrease the chance of infections.
• 30% from how patients rate the way they felt they were treated in the hospital, such as whether the doctors and nurses communicated well.
• 25% from mortality rates among patients with heart attacks, heart failure, or pneumonia, calculated from the number of Medicare patients who died in the hospital or within a month of discharge.

The 2015 and 2016 fiscal years’ scoring criteria are already established. They incorporate the above standards plus some involving health care—associated infections, an Agency for Healthcare Research and Quality measure, and Medicare spending per beneficiary.

PA/LTC has a rare opportunity before it. All of us – medical directors, attending physicians, and other clinicians – know that the future holds change for us and our patients. The hospital sector is currently facing the dramatic changes triggered by the ACA, and it is learning how to adapt.

The forces now driving the acute care health system will be at our front door in a few short years. The opportunity now exists to learn the practice models that will be successful and to determine those with whom we in PA/LTC wish to partner. A wise person learns from one’s own mistakes, but the truly wise person learns from the mistakes of others. Let us be truly wise.

By James Lett II, MD, CMD

Caring Transitions