FEATURE STORY

REPRINT April 2018

hfm
healthcare financial management association hfma.org

Warren E. Beck
Cherie Kelly-Aduli
Brian B. Sanderson

protecting revenue at risk

Healthcare organization leaders should be familiar with and create strategies for effective performance under Medicare's new "pay-for-value" quality programs.

Since the Affordable Care Act (ACA) was signed into law in 2010, several quality programs that focus on value-based payment have been initiated by the Centers for Medicare & Medicaid Services (CMS), with the goal of holding providers accountable for the value and quality of care they provide. These quality programs require healthcare providers to be knowledgeable about and operationally responsible for publicly published metrics that represent good quality. The programs also have established an environment in which providers must exhibit high-quality performance or risk takebacks of their Medicare revenue and the possibility of costly penalties and fines.

AT A GLANCE

The Centers for Medicare & Medicaid Services has created several programs that reward and penalize based on value in three categories:
> Hospital quality-based programs
> Hospital clinical management programs
> Physician quality-based programs

For organizations to succeed within this challenging financial landscape, in which an increasing amount of their Medicare revenue is put at risk, their leadership must have a thorough understanding of these often-complicated regulations and a set of strategies for successfully navigating them. To make the best decisions for their organizations and ensure they thrive in this new environment, healthcare administrators must familiarize themselves with existing revenue-at-risk programs and learn about their requirements. These programs fall within three major groups: hospital quality-based programs, hospital clinical management programs, and physician quality-based programs. The financial impact as a percentage of total revenue for each of these programs depends on the percentage of Medicare revenue in the business and the types of specialty surgical services offered to patients.

Hospital Quality-Based Programs

There are four quality-based programs that affect hospital providers. Hospitals that fail to comply with program requirements face not only revenue loss but also steep penalties. It is estimated that these programs assessed nearly $1.4 billion in penalties in 2017, a 20.4 percent increase from 2016.[a] For 2018, the following hospital quality-based programs are

a. "Paying for Hospital Quality," *Kaiser Health News*, 2018.

each seeing fewer hospitals penalized compared with 2017 as reported by CMS:[b]

> Hospital Value-Based Purchasing (VBP) program—1,211 penalized in 2018, compared with 1,343 in 2017
> Hospital-Acquired Condition (HAC) Reduction program—751 penalized in 2018 compared with 769 in 2017
> Hospital Readmission Reduction program (HRRP)—2,573 penalized in 2018 compared with 2,597 in 2017

Although fewer hospitals are affected, it is likely that total penalties for 2018 will approximate the level of 2017.

Hospital VBP program. The Hospital VBP program was authorized as part of the ACA and became effective in FY13. The program gives incentive payments to acute care hospitals for the quality of care provided to their Medicare beneficiaries. CMS rewards hospitals based on 25 percent of each of the following categories:

> Patient safety: Number of infections such as catheter-associated urinary tract infection (CAUTI), central line-associated bloodstream infection (CLABSI), and surgical site infection (SSI)
> Mortality rates: Number of observed deaths versus expected deaths from acute myocardial infarction (AMI), heart failure, and pneumonia
> Cost of care: Medicare spending per beneficiary
> Patient experience: Results of the HCAHPS survey (based on factors such as cleanliness, communication, and noise)

As of FY17, hospitals participating in the program can have as much as 2 percent of Medicare revenue annually withheld from hospital-based DRG operating payments, and they have the opportunity to earn back the withheld amount and up to a 2 percent incentive based on performance scores.

HAC Reduction program. The HAC Reduction program was authorized as part of the ACA in 2010, and the program became effective in FY15. CMS-reported HAC scores are based on the weighted average performance of two domains. The first domain involves the Patient Safety and Adverse Events Composite, known as PSI 90, a composite measure based on patient safety indicators (PSIs) established by the Agency for Healthcare Research and Quality (with indicators including pressure ulcers, postoperative hip fracture, and postoperative sepsis).[c] The second domain involves infection rates (such as CLABSI, CAUTI, SSI, methicillin-resistant *Staphylococcus aureus*, and *Clostridium difficile* infection).

As of FY17, in each year of participation, hospitals that rank in the worst-performing quartile of all acute care medical and surgical hospitals face a 1 percent reduction of base DRG operating payments.

HRRP. The HRRP was authorized as part of the ACA in 2010 and became effective in FY13. Under the program, CMS measures excess readmissions by using a ratio that divides a hospital's number of "predicted" 30-day readmissions for heart attack, heart failure, pneumonia, chronic obstructive pulmonary disease, hip and knee replacement, and coronary artery bypass graft surgery by the number that would be "expected" based on an average hospital with similar patients. The ratio is compared with actual observed readmissions; a ratio greater than 1.0000 indicates excess readmissions.

As of FY17, hospitals annually face up to a 3 percent reduction of base DRG operating payments for each condition.

b. Advisory Board, "Your Hospital's VBP Penalty or Bonus for 2018, Mapped," Nov. 8, 2017; Castellucci, M., "New Data From CMS' Hospital-Acquired Condition Program Have Analysts Questioning Value," *Modern Healthcare*, Dec. 21, 2017; Haefner, M., "769 Hospitals See Medicare Payments Cut Over High HAC Rates: 7 Things to Know," Becker's Clinical Leadership & Infection Control, Dec. 22, 2016; Advisory Board, "2,573 Hospitals Will Face Readmission Penalties This Year. Is Yours One of Them?" Aug. 7, 2017.

c. For additional detail about the PSI 90 Composite, see CMS, Hospital-Acquired Condition Reduction Program Fiscal Year 2018 Fact Sheet, www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2018-HAC-Reduction-Program-Fact-Sheet.pdf.

Hospital Outpatient Quality Reporting (OQR) program. The OQR program, mandated by the Tax Relief and Health Care Act of 2006, became effective for payments beginning in calendar year 2009. Under OQR, CMS requires that hospitals report data using standardized measures of care to receive the full update to their outpatient prospective payment system (OPPS) payment rate. The program was modeled after the Hospital Inpatient Quality Reporting program.

As of FY17, hospitals must meet data reporting rules to receive the full OPPS payment update. Those hospitals that do not participate or do not meet requirements may have their payment update reduced by 2 percent.

Hospital Clinical Management Programs

Three CMS programs require hospital providers to take full risk for certain medical diagnoses.

Comprehensive Care for Joint Replacement (CJR) model. The CJR model became effective April 1, 2016, and to date, participation has climbed to 791 hospitals in 67 metropolitan statistical areas (MSAs). The model's aim is to support higher-quality, more efficient care for Medicare beneficiaries undergoing the most common inpatient surgeries—i.e., hip and knee replacements. The Dec. 1, 2017, CMS final rule established that participation in the CJR model automatically terminated for participant hospitals located in the 33 voluntary participation MSAs, low-volume hospitals, and rural hospitals as of Feb. 1, 2018, unless the hospitals notified CMS of their election to continue participating in the CJR model. The model applies to all patients undergoing hip and knee procedures:

- MS-DRG 469—Major joint replacement or reattachment of lower extremity with major complications or comorbidities
- MS-DRG 470—Major joint replacement or reattachment of lower extremity without major complications or comorbidities

Hospitals receive a "target" cost of care and are financially responsible for the initial hospitalization and the continuing 90 days following discharge. The target cost of care is discounted between 1.5 and 3 percent.

Additional program elements include:

- Reconciliation payments (where providers are paid by CMS or refund to CMS the difference between the actual cost of the episode and the target rate)
- Beginning in year two, transition to "downside risk" (where payments are made back to CMS for exceeding target cost of care)
- Four-year stop-loss and stop-gain (limits on the amount of financial gain or loss incurred by a provider managing to the target cost) transitions from 5 percent in year one to 20 percent in year four

Bundled Payments for Care Improvement (BPCI) initiative. The BPCI initiative comprises four broadly defined care models in which providers take financial and performance risk for an entire episode of care.

Model 1 began April 2013. Under this model, hospitals receive discounted fee-for-service (FFS) payments for all DRGs, and physicians are paid 100 percent of fee schedule. The revenue at risk for hospitals is in the discounted FFS payments.

Models 2 and 3 both began October 2013, and both apply to selected DRGs. Under model 2, the hospital assumes risk for the hospital and post-acute care period, whereas under model 3, the hospital assumes risk for the post-acute care period only. In both models, revenue at risk is reflected in hospitals receiving a target cost of care while assuming financial responsibility for the initial hospitalization and the continuing 30, 60, and 90 days post discharge.

Model 4 also began October 2013. Hospitals receive bundled payment for an inpatient episode and are responsible for payment to all physicians and other practitioners. Hospitals assume revenue risk by managing bundled payment for all costs.

For models 1 and 4, there is retrospective review but no payment reconciliation. For models 2 and 3, providers are paid by CMS or refund to CMS the difference between the actual cost of the episode and the target rate.

BPCI Advanced. CMS announced this new voluntary bundled payment model on Jan. 9, 2018.[d] BPCI Advanced includes 32 clinical episodes, with 29 in the inpatient setting and three in the outpatient setting. CMS may elect to revise the episodes on an annual basis beginning Jan. 1, 2020.

Under the program, provider payments are based on the quality of performance during a 90-day episode of care. A clinical episode begins at the start of an inpatient admission to an acute care hospital (anchor stay) or at the beginning of an outpatient procedure (anchor procedure). The clinical episode ends 90 days after the end of the anchor stay or the anchor procedure.

CMS selected seven quality measures for BPCI Advanced. The all-cause hospital readmission measure and the advanced care plan measure are required for all clinical episodes. The other five measures apply only to select clinical episodes.

BPCI Advanced qualifies as an advanced alternative payment model (APM) under the Quality Payment Program established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), and participants are eligible for bonuses under MACRA, which is discussed further under the next heading in this article.

The first group of providers begin participation in the model Oct. 1, 2018, and the performance period runs through Dec. 31, 2023. Providers selected on Oct. 1, 2018, to participate first in BPCI Advanced are held accountable for at least one clinical episode and may not add or drop clinical episodes until Jan. 1, 2020. Providers had until March 12, 2018, to apply for the first round of participation. A second opportunity to apply for BPCI Advanced is scheduled for January 2020.

A fourth program, episode payment models, was eliminated by CMS.[e]

Physician Quality-Based Programs

CMS has initiated several quality-based programs for physician practices to encourage delivery of higher-quality and more cost-efficient care.

MACRA. MACRA ended the CMS sustainable growth rate formula, replacing it with performance-based payments that reward physician practices for quality and value of care delivered. Hospitals can choose from two tracks: the Merit-based Incentive Payment System (MIPS) and advanced APMs.

Under MIPS, physician practices earn an incentive based on evidence-based and practice-specific quality data. The program is for physicians, physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists (CNSs), and certified registered nurse anesthetists (CRNAs).

There are four components to the MIPS program:
> Quality (replaces the Physician Quality Reporting System [PQRS])
> Improvement activities (a new category)
> Advancing care information (replaces meaningful use)
> Cost (replaces the value-based modifier)

The APM program provides incentive payments for high-quality, cost-efficient care beginning in 2019 if 25 percent of payments are received through an APM or 20 percent of patients are seen through an APM. Examples of APMs include Comprehensive Primary Care Plus (CPC+), Shared Savings Program tracks two and three, CJR track one, and Comprehensive End-Stage

d. U.S. Department of Health & Human Services and Centers for Medicare & Medicaid Services, "CMS Announces New Payment Model to Improve Quality, Coordination, and Cost-Effectiveness for Both Inpatient and Outpatient Care," press release, Jan. 9, 2009.

e. Dickson, V., "CMS Makes it Official: Two Mandatory Bundled Payment Programs Cancelled," *Modern Healthcare*, Nov. 30, 2017.

Renal Disease (ESRD) Care. The revenue risk includes the following elements:

> MIPS data must be submitted for 2017 by March 31, 2018, to earn up to a 4 percent incentive.
> Participation in an APM in 2017 with data submission by March 31, 2018, can earn a practice up to a 5 percent incentive.
> Failure to send any 2017 data results in a 4 percent penalty in 2019 (MIPS only).
> A four-year transition period exists for penalties and incentives: 4 percent for 2019, 5 percent for 2020, 7 percent for 2021, and 9 percent for 2022.
> MIPS participation begins with a transition year in 2017. Partial data submissions will prevent any penalties in 2019 and may qualify for incentives if certain scoring thresholds are achieved.
> The 2018 submission requires a full year of performance data to determine 2020 penalties and incentives.
> MIPS participation begins with a transition year in 2017. Partial data submissions will prevent any penalties in 2019 and may qualify for incentives when reaching certain scoring thresholds.
> The 2018 submission requires a full year of performance data to determine 2020 penalties and incentives.

Value-Based Payment Modifier (VBPM) program. The VBPM program began in 2015 based on 2013 performance (with a two-year lag). It features automatic downward payment adjustments for failure to participate in CMS's PQRS. The VBPM program's final year is 2018, based on 2016 performance. MIPS then begins in 2019. VBPM program elements include the following:

> The program provides for a FFS differential payment based on the quality of care furnished compared to the cost of care.
> Measurement is aligned with the PQRS.
> The program affects physicians, PAs, NPs, CNSs, and CRNAs with special application of penalties and incentives depending on group size.
> Payments and incentives must be budget neutral.
> Scoring is based on three quality measures and six cost measures.

Effective for FY18, nonparticipation in PQRS results in a 2 percent penalty. Poor quality and cost measurement performance could result in a as much as a 4 percent penalty. The incentive percentage is not yet known, as penalties and incentives must be budget neutral. Additional incentives exist for participants for achieving top 25 percent performance on risk scores.

CPC+. As noted earlier, the CPC+ program is an example of an APM under MACRA. Round one of CPC+ began on Jan. 1, 2017, and round two began Jan. 1, 2018. Each phase includes five performance years. Currently, 18 states and regions are participating.[f]

CMS is testing the CPC+ program to determine whether a healthier patient population will result from increased capabilities and better care processes. Two payment tracks allow for comparison of cost and quality. Participants in one of those tracks will receive a higher care management fee (CMF) due to a higher population risk and a higher comprehensive primary care fee for more intense patient services. Revenue risk goes into effect for FY18 and includes the following elements:

> Track one and track two CMFs, paid per beneficiary per month, are $15 and $28, respectively. Annual reporting of spending is required, and no technology purchases are allowed.
> The track one and track two performance-based incentive payments are $2.50 and $4 per beneficiary per month, respectively. Payments are made in advance and are subject to quality and cost performance.

Strategies for Success

Leaders can take several steps to maintain high scores in CMS quality programs and optimize

f. Comprehensive Primary Care Plus, Centers for Medicare & Medicaid Services.

financial opportunities, including reduction of lost revenue. Considerations should be given to creating a quality leadership committee with committed clinicians, establishing quality improvement teams that are skilled at process improvement, investing in IT support for data mining and developing quality dashboards for continual monitoring of performance, and developing physician leaders to drive quality improvement through the organization.

Management also plays an important role in maintaining organizational financial health while participating in revenue-at-risk programs. The following action steps are critical for success.

Build a culture of continuous improvement. Organizations that have great reputations for delivering high-quality care have effective, committed leaders who drive continuous quality improvement efforts and set the tone from the top. They also have plans in place so that a patient experiences harm, the incident is evaluated immediately, systemic issues that contributed are addressed, and a plan is put in place to prevent future errors. Active quality teams also help evaluate processes and design interventions for preventing harm and maintaining high-quality care.

Commit the appropriate resources. Healthcare leaders should allocate necessary resources in several important areas to improve quality performance in their organizations. These efforts should focus on three areas.

First, leaders should focus on acquiring technology and data analytics. Up-to-date electronic health records and quality data analytics are essential. Organizations also can benefit from assembling analytics teams made up of clinical quality nurses who can dedicate time to evaluating data, identifying negative trends, overseeing improvement committees, and correcting process flaws when harm occurs.

Second, attention should be given to surveying patient satisfaction. HCAHPS survey scores are an important component of value-based programs. Providers should commit resources to selecting a high-quality vendor to manage surveys and capture these critical data.

Third, effort should focus on improving employee satisfaction. High employee morale is a proven contributor to delivery of high-quality care and should be an organizational priority.

Encourage clinician involvement. Physician input and buy-in to any quality initiative are essential. Physicians and other clinicians should be included on quality teams and involved in critical decisions about addressing quality of care delivery and improving patient experience.

Recommit to rounding. Senior-leader rounding is far from a new concept, but such one-on-one interactions remain an important way for leaders to communicate with physicians and other staff members and to listen to issues and concerns.

Revenue-at-risk programs are here to stay. However, with a thorough understanding of program rules and regulations and strategies for compliance, organizations can remain financially strong within this new environment. ■

About the authors

Warren E. Beck
is a leader for healthcare financial operations with Crowe Horwath LLP, Nashville, Tenn. (warren.beck@crowehorwath.com).

Cherie Kelly-Aduli
is CEO of QPP Consulting Group in Mandeville, La. (cheriekellyaduli@gmail.com).

Brian B. Sanderson
is the managing principal of the Crowe healthcare services group, Oak Brook, Ill. (brian.sanderson@crowehorwath.com).