The Medicare Hospital Value-Based Purchasing Program and Imaging's Role

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EXECUTIVE SUMMARY

- Medicare and other payors are simultaneously seeking both a reduction in overall healthcare expenditures and an improvement in the quality of care for covered individuals. This movement recognizes the widespread belief that poor quality of care is expensive.
- Medicare will initially make payments to hospitals for inpatient acute care services based upon the hospitals' achievement of certain performance standards, notably including patient experience of care.
- Imaging professionals should keep their eyes and ears open and play an active role in the changes that are occurring within their hospitals and their healthcare communities more generally.

The healthcare delivery and reimbursement environment in the United States is currently undergoing significant transformation. The Federal healthcare programs, like many other third party payors, are taking bold steps to improve efficiency within the system by taking quality of care into consideration more than ever before. Under the new payment regime, which is increasingly paying for value as opposed to volume alone, Medicare and other payors are simultaneously seeking both a reduction in overall healthcare expenditures and an improvement in the quality of care for covered individuals. This movement recognizes the widespread belief that poor quality of care is expensive. Healthcare.gov, a Federal government website managed by the US Department of Health & Human Services (DHHS) states that: "[e]very year, as many as 98,000 Americans die from errors in hospital care. In addition to adding to the suffering of patients and their caregivers, these errors lead to significant unnecessary health care spending. Medicare spent an estimated $4.4 billion in 2009 to care for patients who had been harmed in the hospital, and readmissions cost Medicare another $26 billion."[1]

Perhaps one of the best examples of a Medicare program driving such change is the Hospital Value-Based Purchasing Program (referred to in this article as the "Program"). The Program was created under Section 3001 of the Affordable Care Act. The "Affordable Care Act" is a term that refers to the Patient Protection and Affordable Care Act, as amended by the Healthcare and Education Reconciliation Act of 2010. Under the Program, Medicare will initially make payments to 3500 hospitals for inpatient acute care services based upon the hospitals' achievement of certain performance standards during the applicable performance periods. The Centers for Medicare & Medicaid Services (CMS) has finalized a performance period of July 1, 2011 through March 31, 2012 that will apply to the performance measures for the Program during fiscal year 2013. The Program will apply with respect to payment for discharges occurring on or after October 1, 2012. Performance measures will be selected based upon their demonstrated ability to improve patient satisfaction and clinical processes.

Federal law requires that all of the performance measures be published on the "Hospital Compare" section of Medicare's website (www.hospitalcompare.hhs.gov) at least one year prior to the applicable period. Furthermore,

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the DHHS must announce the performance standards with respect to each performance measure at least 60 days prior to the beginning of the performance period for the respective fiscal year.

CMS has selected 13 performance measures to be used in the Program for fiscal year 2013, including, for illustration, each of the following:

- Percent of heart attack patients given PCI procedures (ie, procedures effective for opening blocked blood vessels) within 90 minutes of arrival.
- Percent of heart failure patients given discharge instructions.
- Percent of pneumonia patients whose initial emergency room blood culture was performed prior to the administration of the first hospital dose of antibiotics.
- Patient experience of care.

The patient experience of care measure will be based upon the Hospital Consumer Assessment of Health Care Providers and Systems (HCAHPS) survey, which is a measure currently used under the Medicare Inpatient Quality Reporting (IQR) program and available on the Hospital Compare website. The patient experience domain score (ie, HCAHPS performance) will account for 30% of a hospital's total performance score under the Program for fiscal year 2013. Although none of the Program's measures for fiscal year 2013 focus on medical imaging specifically, the quality of medical imaging provided to patients in hospital inpatient imaging departments and otherwise will certainly impact the patients' overall experience of care. Furthermore, it is possible that future measures will target imaging more directly. Beginning in fiscal year 2014, the Program will begin to determine payments to participating hospitals based not only upon the quality measures but also efficiency standards such as Medicare spending per beneficiary, which will be risk adjusted to take into consideration age, sex, race, severity of illness, etc.

Because information regarding each hospital's performance under the Program will be published on the Hospital Compare website, which is designed to present data in a clear and concise manner that can be easily accessed and understood by the general public, a hospital's achievements (or lack of achievements) under the Program may have a significant impact upon its reputation and therefore its long term financial success. By visiting the CMS Hospital Compare website, those within the medical imaging community can achieve a useful understanding of the website's scope, function, and potential impact upon the industry.

Paying for the Program

Medicare will pay for the Hospital Value-Based Purchasing Program through a two-step redistribution process. First, Medicare will reduce the Medicare Inpatient Prospective Payment System payments (more specifically, the base operating DRG payment) that all hospitals would have otherwise received. The reduction just described will equal 1% during fiscal year 2013 and will gradually increase to 2% for fiscal year 2017 and after. Second, Medicare will increase such payments to certain hospitals based upon their success relative to the various performance measures.[2] Eight hundred fifty million dollars is expected to be allocated to hospitals under the Program during fiscal year 2013. Each participating hospital will be scored based upon their performance compared to that of other hospitals (ie, their achievement scores) and also based upon how their own performance has improved over time (ie, their improvement scores). The participants who receive the highest performance scores under the program will receive the highest level of incentive payments. That being said, many (perhaps close to one-half) of participating hospitals will experience an overall reduction in payments as a result of this program.

The Medicare Hospital Value-Based Purchasing Program is designed to gradually become more powerful and more stringent. The amount of the Medicare payment reduction and also the related Medicare financial incentives that will be payable under the Program, both of which are described further above, will increase over time and those performance measures that experience a high level of compliance among participants will be replaced with measures that are more difficult to achieve.

Conclusion

Like many initiatives adopted pursuant to the 2010 Federal healthcare reform legislation, the Medicare Hospital Value-Based Purchasing Program serves as a catalyst for the current wave of integration among healthcare providers. In order to achieve the quality and efficiency goals embraced by the Program, hospitals will need the support of their physicians and other clinical and non-clinical staff members. In light of this fact and other market and societal factors, hospitals and health systems across the country

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are allocating tremendous resources to strengthen the alignment between themselves and their physicians through physician employment, co-management companies, physician hospital organizations, and other models. But entering an integrated arrangement alone does not guarantee successful alignment. Meaningful clinical integration requires a significant commitment on the part of all parties, building of trust, communication, a unified purpose, and other key factors.

One may ask how an individual radiologist, radiology physician practice, or other medical imaging provider should respond, if at all, to the Medicare Hospital Value-Based Purchasing Program considering that it targets hospitals. The answer is simple: they need to respond with action. Knowing how to take action is more difficult. First, radiologists and other medical imaging providers should continue and bolster efforts to ensure that patients are receiving the highest quality of care practicable. Among other areas, imaging facilities should focus on accurateness, appropriateness of testing, patient safety, and turnaround times. Second, imaging professionals should keep their eyes and ears open and play an active role in the changes that are occurring within their hospitals and their healthcare communities more generally. They need to ensure their voices are heard and their value to the healthcare delivery system is acknowledged. Maintaining the status quo is simply not an option.

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