Health Policy Today:
The Gradual Shift to Outcome-Based Reimbursement

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THE U.S. healthcare system is in the midst of a transformation to improve patient care and reduce costs and is slowly transitioning from a fee-for-service model to outcomes-based reimbursement. As a first step, different care settings are being rewarded (or not penalized) for reporting quality-based metrics, to increase transparency of outcomes and performance to payers and patients. On November 14, 2014, The Centers for Medicare & Medicaid Services (CMS) announced the formation of the Office of Enterprise Data and Analytics (OEDA), tasked with overseeing improvements in data collection and dissemination. "As CMS works to shift the focus from volume of services to better health outcomes for patients, coordinating care, and spending dollars more wisely, the need for CMS to analyze data across its multiple programs and provide greater access to this data, whether in granular or aggregate form, will only intensify."[2]

CMS is now routinely analyzing claims data in real time and applying predictive analytics to proactively identify fraud and abuse and track key metrics such as hospital readmissions. Patients and professionals can now easily see how a provider is performing across key quality metrics, such as patient satisfaction and infection rates, simply by going to www.cms.gov.

With the continued growth in ACOs (to over 625 in 2014)[3], along with expansion by hospitals into post-acute and the payer space, there is greater focus on improved care coordination and total cost of care. Hospitals cannot be focused merely on historic profit measures such as patient length of stay – getting them to a lower cost care setting quickly – but also need to be focused on ensuring those discharged patients do not have an unplanned re-admission. This means ensuring discharged patients requiring ongoing wound care are transitioned to a post-acute setting with advanced therapies, when beneficial, as well as coordinating care with post-acute counterparts to ensure wound care therapy is used appropriately (and stopped at the right time) for the most cost-effective outcomes.

Coordination of care across settings will help all care settings financially if re-admissions can be avoided. Avoidable readmissions cost Medicare $17 Bn per year; today, approximately 1 in 5 elderly patients is readmitted within 30 days of discharge, doubling the cost of that episode.[4,5]

Re-admissions may soon have an impact on everyone's bottom line: The Medicare SNF Value Based Payment Program begins FY 2019 with an effective date of 10/1/2018. SNFs will begin receiving quarterly feedback on their readmission performance in 2016; that gives the SNFs next year to focus on improvements. Once in effect, SNF Medicare payments will be reduced 2%, and a portion will be redistributed as incentive payments for SNFs that perform well on a hospital readmission measure. SNFs performing in the top 60% on the measure will receive 50–70% of the 2% reduction back; those in the bottom 40% lose the full 2%.[6] With thin margins to begin with, SNFs *must* focus on quality outcomes and referral generation to ensure ongoing viability.

Home health and wound care clinics also suffer when a patient is re-admitted, through lost revenue on the post-acute episode as well as the potentially negative impact on referrals to their point of care. Hospitals will be laser focused on those outpatient clinics that can support the patient in the outpatient setting to prevent avoidable re-admissions. In the first years of the hospital re-admission penalty, 71% of all hospitals in the program received a penalty, which is applied to all claims submitted for their entire fiscal year. In the most recent report, 2610 were estimated to incur penalties, which average at about $125,000 per hospital.[3,4]

In addition to penalties for unplanned re-admissions, hospitals can receive value-based incentive payments through the CMS hospital Value Based Purchasing Program. These incentive payments amount to 1.5% in FY 2015, up to 2% by 2017. As it relates to quality wound care, a hospital's score can be improved by minimizing Pressure Ulcer incidence, Post Operative Wound Dehiscence Rate, and Surgical Site Infections (SSIs) related to abdominal hysterectomy and colon surgery. Perhaps equally importantly, Patient Experience scores also affect 30% of a hospital's score and potential payment. And Home Health Agencies will soon also experience incentive payments:

In November, 2014 CMS announced plans to initiate a pay-for-reporting requirement for episodes of care beginning on or after July 1, 2015, which

could affect payments by 2 percentage points. By CY2016, CMS hopes to implement a Home Health Value Based Payment model in a selection of states, with performance incentives (or penalties) in the range of 5 to 8% of payments.[7]

With the growing attention on quality, it is becoming increasingly important to develop clinical wound care protocols to ensure therapy and product decision-making are not made on unit cost alone. Equally important is total cost of care and key quality metrics which can affect overall profitability, such as infection rate, re-admission rate, dehiscence, length of stay, and patient satisfaction. Additionally, close collaboration and coordination of care across care settings to ensure optimal wound management will help contribute to the overall goals of healthcare: improving patient care and lowering total cost.

References:

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