

The Financial Effect of Value-Based Purchasing and the Hospital Readmissions Reduction Program on Safety-Net Hospitals in 2014 (A Cohort Study)

Take Away Points

- Compared to other hospitals, safety-net hospitals incur greater financial penalty under the Value-Based Purchasing (VBP) and the Hospital Readmissions Reduction (HRRP) programs.
- Formulas determining penalties lack adjustment for patients' socioeconomic status (SES), despite SES representing such a substantial component of predicting post-hospital utilization. Safety-net hospitals serve a high percentage of low socioeconomic patients—a population that is at a higher risk for readmissions.
- The magnitude of payment reductions and penalty received depends on the definition of “safety-net hospitals” employed.

The Issue

The Affordable Care Act (ACA) created the Value-Based Purchasing (VBP) and the Hospital Readmissions Reduction (HRRP) programs to improve hospital care. The VBP penalizes or rewards hospitals based on quality scores (i.e., average process, patient experience, and survival scores) while the HRRP penalizes hospitals with high readmission ratios for acute myocardial infarction, heart failure and pneumonia. However, there are concerns that these programs disproportionately penalize safety-net hospitals. Safety net hospitals serve higher percentage of patients with low socioeconomic status—a population that is at a higher risk for readmission and more likely to rate their care quality poorly.

Source

Gilman M, Hockenberry JM, Adams EK, Milstein AS, Wilson IB, & Becker ER (2015). The Financial Effect of Value-Based Purchasing and the Hospital Readmissions Reduction Program on Safety-Net Hospitals in 2014. *Annals of Internal Medicine*, 163 (6), 473-436.

Study Methods and Design

The purpose of the study was to estimate the magnitude of the overall, combined financial effect of the VBP and HRRP programs on safety-net hospitals in 2014; and compared the probability of being penalized and the magnitude of penalty between safety-net and non-safety-net hospitals. The researchers also examined differences using two definitions of safety net: hospitals in the top quartiles of the Medicare disproportionate share hospital (DSH) patient percentage and the Medicare uncompensated care (UCC) payment per bed. The Medicare UCC payment was introduced under the ACA and is based on the number of the uninsured patients across the nation. Prior to the Affordable Care Act, Medicare used the DSH measure—a score that is based on the amount of supplementary Social Security income (SSI) patients and non-SSI Medicaid patients treated—to reimburse hospitals serving larger proportions of low SES patients.

Study sample consisted of 3,022 hospitals that participated in at least one of the VBP and HRRP programs and could be linked to complete information across six data sources: Centers for Medicare and Medicaid Services (CMS) 2014 value-based purchasing scores on payment adjustment and the process-of-care, patient experience, and mortality scores (a weighted average of these scores is used to adjust the total diagnosis-related group-based payment that each hospital receives); CMS 2014 HRRP

payment adjustment and weighted average of the excess 30-day readmissions ratios for AMI, HF, and pneumonia; Medicare Impact File for 2014; CMS financial dataset on the total base Medicare operating inpatient payment in 2011; CMS projected Medicare uncompensated care (UCC) payment for 2014; and the American Hospital Association survey data for 2011.

The study employed descriptive statistics to compare VBP and HRRP scores between safety-net and non-safety net hospitals; and tests of means, graphical and regression-based methods to compare average VBP payment adjustment, HRRP penalty and the overall change in payment rate (total and per bed payment) between safety-and non-safety-net hospitals using the UCC and DSH definitions.

Key Findings and Limitations

- **Hospital characteristics:** Under the UCC and DSH definitions, safety-net hospitals, compared to others, were more likely to be for-profit, teaching hospitals, urban, with 300 or more beds. However, more safety-net hospitals had public ownership status in the DSH definition.
- **Differences in VBP:** Under both the UCC and DSH definitions, safety net hospitals were more likely to receive a reduced payment rate (63% vs. 51%); and less likely to receive bonus payments (37% vs. 49% for DSH and 40% vs. 49% for UCC). Safety net hospitals had worse scores on average process score (56 vs 60) and patient experience scores (35 vs 42)—the two measures that account for 75% of the VBP payment adjustment in 2014. However, safety-net hospitals did not differ from others in average survival score.
- **Differences in HRRP:** Compared to others, safety net hospitals had higher readmission rates for AMI, HF, and pneumonia; were at a higher risk for receiving a reduced payment rate under the HRRP; and had higher payment penalty magnitude (\$99, 800 vs. \$71,600 for DSH and \$139,300 vs. \$58, 400 for UCC).
- **Combined effect of VBP and the HRRP:** Safety-net hospitals received a larger total penalty with the penalty being significantly higher under the UCC definition (\$115,900 vs. \$66,600 for DSH and \$150,100 vs. \$54,900 for UCC). When analyzed per bed, the difference between safety-net hospitals and others was \$104 under the DSH and \$107 under the UCC definitions.
- **Limitations:** These results could be different if alternative definitions of safety-net hospitals are employed. Also, the study did not examine whether the VBP and HRRP programs led to better care.

“Discussion of the HRRP, which currently leads to larger penalties than VBP, centers on whether the CMS should adjust readmission rates according to socioeconomic status (SES).”

Final Thoughts

- Although the penalties are relatively small, their longitudinal effect could compromise safety-net hospitals ability to deliver care with detrimental consequences for the populations served by these hospitals. Importantly, the study also found that safety-net hospitals currently did not differ from others in average survival score.
- The authors’ supplemental analysis suggests that approximately 1 in every 10 safety-net hospitals in the top quartile of DSH definition are receiving payment rate reductions of at least 1.0%. Receiving this reduction annually will translate into significant financial loss for these hospitals already experiencing slim margins. Also, the CMS’ transition from DSH to UCC as mandated by the Affordable Care Act may result in less revenue for hospitals as the number of uninsured patients declines, and insured patients seek care elsewhere.
- In addition to adjustments for the severity of illness, CMS should consider adjusting readmission rates according to socio-economic status with the goal of preventing disproportionate penalties and payment reduction among safety net hospitals.