The Impact of Value-Based Purchasing in the Healthcare Industry

Presented By:
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Today’s Objectives

• Discuss the current healthcare environment
• Review what the healthcare quality initiative is
• Discuss the impact of quality outcomes data on providers and the impact on financial reimbursement
• Discuss what we should be doing
CURRENT HEALTHCARE ENVIRONMENT
Factors Influencing Healthcare

- Financial pressures
- Reduction in payments due to MS-DRGs and RAC initiatives (medical necessity, coding, and clinical significance)
- Reduction in outpatient payments due to APC bundling and regulatory audit initiatives (medical necessity and coding)
- Increase in Pay for Performance (Quality) initiatives / Value-Based Purchasing (increase quality of care and patient experience while reducing healthcare costs)
Factors Influencing Healthcare

- Peer review organizations publishing quality scores
- Healthcare consumerism
- Managed care and third party payor contract implications
- Data Mining
- ICD-10 implementation on October 1st, 2015
- Healthcare reform
WHAT IS THE QUALITY HEALTHCARE INITIATIVE (VALUE-BASED PURCHASING)?
**Value-Based Purchasing**

• “Value-Based Purchasing” is a term for initiatives aimed at improving the quality, efficiency and overall value of healthcare.

• Value-Based Purchasing includes financial incentives that reward providers for:
  • Delivery of care efficiencies
  • Submission of data and measures
  • Improved quality of care
  • Patient safety
How is Quality Measured?

- Based on reported outcomes:
  - Diagnoses and procedures
  - Severity of Illness (SOI)
  - Risk of Mortality (ROM)
  - Morbidity
  - Length of Stay (LOS)
  - Resource Consumption
  - Cost per patient
  - Case Mix Index (CMI)
  - Readmission rates
  - Patient Satisfaction
How is Quality Measured?

• Many are reported by ICD-9 codes (soon to be ICD-10 codes)
• Patient care data generated by medical record documentation (EHRs)
• Cost / charge data
• Patient surveys
Who’s Looking at the Data?

• Payors
• Medicare Administrative Contractors (MACs)
• Office of Inspector General (OIG)
• State agencies
• Quality Improvement Organizations (QIOs)
• RACs and other Regulatory Audit Agencies
• Healthcare facilities
• Beneficiaries / patients
• Centers for Medicare and Medicaid (CMS)
• EVERYONE!
Value-Based Purchasing

• Quality measures used for Value-Based Purchasing fall into four categories:
  • Process measures
  • Outcome measures
  • Patient experience
  • Structure measures
# Value-Based Purchasing

<table>
<thead>
<tr>
<th></th>
<th>Medicare Goals of Value-Based Purchasing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Viability</td>
<td>Ensure the traditional Medicare fee-for-service program is protected</td>
</tr>
<tr>
<td>Payment Incentives</td>
<td>Link payment to the value (quality and efficiency) of care</td>
</tr>
<tr>
<td>Joint Accountability</td>
<td>Providers share clinical and financial accountability for healthcare</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>Care is evidence based and account driven to better manage diseases</td>
</tr>
<tr>
<td>Ensuring Access</td>
<td>Ensure access to high quality affordable care</td>
</tr>
<tr>
<td>Safety and Transparency</td>
<td>Beneficiaries receive information on the quality, cost, and safety of their care</td>
</tr>
<tr>
<td>Smooth Transitions</td>
<td>Payment systems support well-coordinated care across providers and settings</td>
</tr>
<tr>
<td>Improved Technology</td>
<td>EHRs help providers deliver high quality, efficient and coordinated care</td>
</tr>
</tbody>
</table>
CMS Quality Initiatives

- Hospital Value Based Purchasing (HVBP)
- Hospital Inpatient Reporting Program (IQR)
- Hospital Readmissions Reduction Program
- Hospital Acquired Conditions Reduction Program (HACs)
- Hospital Outpatient Reporting Program (OQR)
- Physician Quality Reporting System (PQRS)
- Ambulatory Surgery Center Quality Reporting (ASCQR)
CMS Quality Initiatives

- Inpatient Rehabilitation Facility Quality Reporting Program (IRFQRP)
- Long-term Care Hospital Quality Reporting Program (LTCHQR)
- PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR)
- Inpatient Psychiatric Facility Quality Reporting Program (IPFQR)
- Home Health Quality Reporting Program (HH QRP)
- Hospice Quality Reporting Program
- End-Stage Renal Disease Quality Initiative
Examples of Reporting Agencies

- Facilities and Physicians are profiled by various agencies, examples include:
  - Thomson Reuters: [www.100tophospitals.com](http://www.100tophospitals.com)
  - Health Grades: [www.healthgrades.com](http://www.healthgrades.com)
  - Joint Commission: [www.jcaho.com](http://www.jcaho.com)
  - Leap Frog Group: [www.leapfroggroup.org](http://www.leapfroggroup.org)
  - Hospital Quality Report: [www.hospital-quality.com](http://www.hospital-quality.com)
  - Physician Compare: [www.medicare.gov/PhysicianCompare](http://www.medicare.gov/PhysicianCompare)
## Health Grades: Sample Hospital
(Patient Safety Indicator Reporting)

<table>
<thead>
<tr>
<th>Health Grades</th>
<th>Worse than Average</th>
<th>Average</th>
<th>Better than Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death in procedures where mortality is usually very low</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Pressure sores or bed sores acquired in the hospital</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Death following a serious complication after surgery</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collapsed lung due to a procedure or surgery in or around the chest</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Catheter-related bloodstream infections acquired at the hospital</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
# Health Grades: Sample Hospital
(Patient Safety Indicator Reporting)

<table>
<thead>
<tr>
<th>Event</th>
<th>Worse than Average</th>
<th>Average</th>
<th>Better than Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deep blood clots in the lungs or legs following surgery</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Bloodstream infection following surgery</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Breakdown of abdominal incision site</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Accidental cut, puncture, perforation or hemorrhage during medical care</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Foreign objects left in body during a surgery or procedure</td>
<td>3 Events</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Health Grades: Sample Physician (Patient Safety Indicator Reporting)

• Dr. “Name” Specialties
  • Cardiology
  • View specialty

• Procedures Dr. “Name” Performs
  • Cardiac Catheterization (incl. Coronary Angiography)
  • Cardiac Imaging
  • See all 9 procedures

• Conditions Dr. “Name” Treats
  • Aneurysm and Dissection of Heart
  • Angina and Acute Coronary Syndrome
  • See all 27 conditions

• More About Dr. “Name” Background
  • Sanctions
  • Malpractice
  • Board Actions
  • Education & Training
  • Languages Spoken
Severity of Illness (SOI) and Risk of Mortality (ROM)

- All ICD-9-CM codes have established Severity of Illness and Risk of Mortality
  - 1 Minor
  - 2 Moderate
  - 3 Major
  - 4 Extreme
- Once all diagnoses and procedures are coded, a complicated algorithm is used to determine the APR-DRG SOI/ROM scores for the patient
SOI and ROM

- CMS uses these scores to determine the average SOI and ROM for the patients of a hospital or Physician
- CMS determines the Mortality Index, based on risk adjustment, to determine the ratio of actual deaths to expected deaths
- MS-DRGs have a geometric length of stay (LOS) which can be compared to the actual LOS
SOI and ROM

- Higher SOI/ROM scores support medical necessity for admission and longer length of stays
- Each MS-DRG has a relative weight which reflects average hospital resources used to treat the patient and establishes reimbursement
- CMS is able to compare actual costs to expected costs
SOI and ROM

- Relative weights are also used to determine the Case Mix Index which is another way to reflect how sick your patients are.
- This data is used to profile both the hospital and Physician.
- When the patient’s SOI and ROM is not accurately reflected by Physician documentation and a poor outcome occurs, it appears as though complications are occurring in healthy patients.
## SOI and ROM Example

<table>
<thead>
<tr>
<th>Clinical Documentation</th>
<th>Codes to........</th>
<th>SOI / ROM</th>
</tr>
</thead>
<tbody>
<tr>
<td>“acute renal insufficiency”</td>
<td>593.9 Disorder of kidney and ureter</td>
<td>1/1</td>
</tr>
<tr>
<td>“acute renal failure”</td>
<td>584.9 Acute kidney failure, unspecified</td>
<td>3/3</td>
</tr>
<tr>
<td>“acute kidney injury”</td>
<td>584.9 Acute kidney failure, unspecified</td>
<td>3/3</td>
</tr>
<tr>
<td>“chronic renal insufficiency”</td>
<td>585.9 Chronic kidney failure, unspecified</td>
<td>1/1</td>
</tr>
<tr>
<td>“CKD, stage III”</td>
<td>585.3 Chronic kidney disease, stage III</td>
<td>1/2</td>
</tr>
<tr>
<td>“end stage renal disease”</td>
<td>585.6 End stage renal disease</td>
<td>2/2</td>
</tr>
</tbody>
</table>
SOI / ROM Impact

- Case Mix
- Mortality rates
- Contract negotiations
  - Stop MS-DRG reductions
  - Improved E/M professional fee arrangements
  - Quality data metric reporting (medical necessity)
- Validate care delivered
- Prevention of random audits by regulatory agencies
- Value-Based Purchasing
IMPACT IN THE PROVIDER SETTING
Issues that Impact Quality Data and Financial Performance

- Incomplete, ambiguous, and/or clinically incongruent documentation
- Incorrect or incomplete coding
- Sequencing of coded data
- Understanding complexity (SOI and ROM)
- Conflicting documentation requirements to providers – coding vs. quality vs. clinical definitions
Documentation Impact on Quality Data Reporting

- Physician and Other Provider Documentation
- DRG Assignment, Severity-Level Profiles, and Risk-Adjusted Profiles
- HIM Retrospective Queries and Final Code Assignment
- Clinical Documentation Improvement (Concurrent Queries)
- Quality Measures Data Collection (prior to complete medical record)
Issues that Impact Quality Data and Financial Performance

- Lack of coordinated system for flagging, reviewing and correcting quality concerns
- Lack of knowledge by team members related to coding and quality definitions
- Identification of issues retrospectively resulting in compliance risk
P4P Financial Impact – IPPS 2015

• P4P moves into higher gear, significant updates finalized
  • FY 2015 marks the first year that three pay-for-performance (P4P) programs—value-based purchasing, readmissions, and hospital-acquired-conditions—will apply for inpatient payments. Collectively, these programs place 5.5% of inpatient reimbursement at risk for hospitals, with only VBP having any potential financial upside for good performance.
  (Advisory Board, Aug 5, 2014 article (“Early takeaways from the final FY 2015 inpatient rule”))
P4P Financial Impact – IPPS 2015

- Hospital-Acquired Conditions Reduction Program
  - Acute care hospitals that report the most hospital-acquired conditions will see Medicare reimbursement reductions of 1% in FY 2015.

- Readmission Reduction Program
  - Of the three P4P programs, the readmissions penalties are the most significant for inpatient payments in FY 2015. Hospitals may now lose up to 3% of reimbursement moving forward, depending on their readmissions performance.

(Advisory Board, Aug 5, 2014 article (“Early takeaways from the final FY 2015 inpatient rule”))
# 2015 HVBP CMS Reimbursement Impact

<table>
<thead>
<tr>
<th>VBP Program</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Value Based Purchasing</td>
<td>1%</td>
<td>1.25%</td>
<td>1.5%</td>
<td>1.75%</td>
<td>1.75%</td>
</tr>
<tr>
<td>Hospital Readmissions Reduction Program</td>
<td>1%</td>
<td>2%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Hospital Acquired Conditions</td>
<td></td>
<td></td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2%</td>
<td>3.25%</td>
<td>5.5%</td>
<td>5.75%</td>
<td>5.75%</td>
</tr>
</tbody>
</table>
Hospital IQR Program – IPPS 2015

• In FY 2015, general acute-care hospitals will see a 1.4 percent rate increase if they successfully participate in the Hospital IQR Program and are meaningful electronic health record (EHR) users. Hospitals that do not successfully participate in the Hospital IQR Program and do not submit the required quality data electronically will be subject to a one-fourth reduction of the market basket update (previously these hospitals received a 2 percentage point reduction).
Currently, the Hospital IQR Program includes the following:

- Chart-abstracted measures, such as heart attack and surgical care improvement measures
- Claims-based measures such as mortality and readmissions
- Healthcare-associated infections measures
- Survey-based measures, such as patient experience of care
- Structural measures that assess features of hospitals to assess their capacity to improve quality of care.
Future Value-Based Purchasing Impact

• The Department of Health and Human Services (HHS) announced in January a new set of goals and a timeline for tying Medicare payments to quality or value through alternative payment models.
  • Tie 30% (up from 20%) of traditional Medicare payments by the end of 2016 thru ACO’s (Accountable Care Organizations) and bundled payments
  • Tie 50% by the end of 2018
• HHS also set a goal of tying 85% of all traditional Medicare payments to quality or value by 2016 and 90% by 2018 through programs such as Hospital Value-Based Purchasing and Hospital Readmission Reduction Programs.
HHS Delivery System Reform Goals

![Diagram showing historical performance and goals for Alternative payment models, FFS linked to quality, and All Medicare FFS.](image)
Future Value-Based Purchasing Impact

- Passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which permanently repealed the sustainable growth rate (SGR) formula for physician reimbursement in the Medicare program.
- Two provisions of the legislation that have attracted attention include:
  - Merit-Based Incentive Payment System (MIPS); and
  - Support for transition to alternative payment methods (APMs).
Future Value-Based Purchasing Impact

• Beginning in 2019, bonuses will be available for eligible professionals who score well in MIPS, which will become the new pay-for-performance program under the Medicare system.

• The current penalty calculations under the Physician Quality Reporting System (PQRS), electronic health records/meaningful use (EHRs/MU) and the value-based payment modifier (VBM) would end at the close of 2018.

• MIPS will gauge program performance based on four categories: quality, resource use, meaningful use, and clinical practice improvement activities.
Future Value-Based Purchasing Impact

- MIPS is intended to build upon and improve current quality measures and concepts in effect now for PQRS, MU and VBM. The next step will be publication of regulations on the details of how MIPS will be implemented.

- MACRA also provides incentives for physicians to develop and participate in new models of healthcare delivery/payment. Professionals who receive a significant share of their revenues through an APM are slated to receive bonuses each year from 2019-2024.
Future Value-Based Purchasing Impact

• Many, many more VBP / Quality initiatives, we’ve discussed only a few today.......
WHAT SHOULD WE DO
Financial Strategies to Improve VBP Performance

- Know where your hospital stands on each selected measure for the baseline period and identify which measures have the best rate of return.
- Understand how discharge volume by measure factors into the VBP score
- Ensure pricing is competitive – especially in the outpatient market
Strategies to Improve Quality Outcomes and Reporting

- Must have C-suite buy-in – lead by CEO
- Multi-disciplinary team – clinical, quality, financial and IT
- Promote a culture of transparency and integrity
- Two important areas to address:
  - Clinical data
  - Technology
Strategies to Improve Quality Outcomes and Reporting

- Assess inefficient areas of the hospital
- Cross organizational governance
- IT involvement is critical
- Investment in comprehensive data collection and reporting systems
- Patient satisfaction
- Sharing of quality scores (ongoing)
Strategies to Improve Quality Outcomes and Reporting

• Review of all reporting and audit mechanisms to assess for duplication of efforts and conflicting messages
• Focused review of cases with quality issues by an external auditor
• Development of multidisciplinary task force to develop workflow and shared processes with single point reference for providers
Strategies to Improve Quality Outcomes and Reporting

- Use of quality tracking tool
- Determine problem quality issues and develop a focused corrective action plan
- Education for entire multidisciplinary team
- Run, use and share reports – look at your data
  - Severity of Illness
  - Risk of Mortality
  - PSI (Patient Safety Data)
  - Length of Stay
  - Readmissions
Ensuring Clinical Documentation Integrity

- Accurate Clinical Documentation Impacts:
  - Coding
  - Severity of Illness (SOI)
  - POA/HAC
  - Case Mix Index (CMI)
  - Core measures
  - Patient safety
  - Outcome measures
  - Profiling
  - Compliance
  - Audits
  - And more......
CDI Program Impact

• A CDI Program should be viewed as a necessary aspect to the provision of patient care and overall operational performance resulting in:
  • Higher quality patient care
  • Better treatment outcomes
  • Higher quality scores and reporting
  • Better patient safety indicator scores
  • Accurate reimbursement (facility and Physician)
  • Sustained CMI
  • Decreased recovery audit contractor (RAC) denials
Role of Medical Staff

- CDI activities must resonate with all clinicians as an organizational strategy critical to the longevity and survival of the organization
- The physician concurrent query process is the core operational component of every CDI Program – key is timely query response
- Good documentation saves time and money, and improves communication among providers as well as the overall quality of care provided to the consumer
Recommendations for a CDI Program

• CDI Program Objectives:
  • Improve MS-DRG assignment to sustain Case Mix Index and prevent erosion due to regulatory changes
  • Improve SOI and ROM classifications
  • Maintain high quality clinical documentation
  • Support internal quality initiatives
  • Report valid and reliable data
  • Influence external quality measurements
  • Support ICD-10 implementation
“And then the documentation is gone, and all that is left is a set of numbers.”
Contact the Speaker:
Kim Charland
kcharland@panaceainc.com

QUESTIONS??????