IN THE NEWS

HHS Ramps Up Value-Based Purchasing Plans

“Better, Smarter, Healthier” was the headline which topped a January announcement shifting value-based purchasing (VBP) goals and shortening implementation deadlines.

By 2016, 85% of all traditional Medicare payments will be tied to quality or value. By 2018, 90% of all payments will have some quality measures attached, according to Department of Health and Human Services (HHS) Secretary Sylvia Burwell.

What is VBP? Essentially, it’s an amalgamation of various government efforts tied together by a new payment methodology.

Congress authorized use of VBP under the Affordable Care Act. Signed into law in 2010, the program uses the hospital quality data reporting infrastructure developed for the hospital inpatient quality reporting (IQR) system that was created under the 2003 Medicare Prescription Drug, Improvement, and Modernization Act.

In fiscal year 2015, CMS funded the VBP by a 1.50% reduction from participating hospitals’ DRG payments. Hospitals have the potential to earn more than the 1.50% back, however, depending on their performance on VBP measures.

Measures are divided into four categories or domains, including:

1. Efficiency: Medicare spending per beneficiary
2. HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems): Includes patient perception of nurse/physician communication, hospital staff responsiveness, cleanliness, and other measures
3. Outcomes: Derived from mortality and patient safety indicators and currently focused on acute myocardial infarction (AMI), heart failure, pneumonia, central line–associated bloodstream infections, and patient safety indicator 90 composite
4. Process: Includes 12 clinical process care measures such as AMI treatment with fibrinolytic therapy within 30 minutes of arrival at the hospital

Each domain is weighted, and improvement (or negative progress) is measured against previously indicated benchmarks in time.

For CDI specialists, obtaining documentation of these conditions—which are often already top targets for CDI scrutiny—can not only help ensure that current reporting of hospital activities remains as accurate as possible, but also help ensure that baseline data is also true.

“We all hear the news every day about new government programs such as accountable care, gainsharing, bundled payments, value-based payments, and other initiatives that are really moving us away from fee-for-service models,” says Glenn Krauss, RHIA, BBA, CCS, CCS-P, CPUR, CCDS, C-CDI, PCS, C-CDAN, executive director for the Foundation for Physician Documentation Integrity, who spoke on the February 18 ACDIS Radio program “How CDI Must Adapt to Healthcare Reform.”

Although the idea of tying government healthcare reimbursement to efficiency and quality of care is nothing new, the aggressive plans outlined by Burwell and HHS are.

They call for a three-year plan boosting the percentage of fee-for-service Medicare reimbursements based on alternative payment models (APM) and increasing the percentage of all reimbursements linked to quality and value, HealthLeaders Media reports.
To oversimplify, if hospitals do a good job, then they receive additional funding: if they don’t do that well, then they lose funding. Although 55% earned higher payments for their VBP efforts, less than half of them actually received more money due to penalties associated with other related quality payment programs, according to a Kaiser Health News report.

CMS penalized more than 700 hospitals for hospital-acquired conditions, for an estimated $373 million, Kaiser Health News reported in December 2014. In October 2014, Kaiser Health News reported that three-quarters of hospitals subject to the Hospital Readmissions Reduction Program were penalized, resulting in fines/payment reductions of about $428 million.

Furthermore, preventive care, which aims to keep patients healthier and out of the hospital, reduces hospital volume. Coupled with the drop in payments, hospitals may really suffer, Greg Adams, MBA, FHFMA, senior vice president of Panacea Healthcare Solutions, said during a 2014 Talk Ten Tuesday broadcast.

“It’s a volume to value issue. These cuts may not seem like a lot, but it’s like having one foot on the deck and the other on the boat while hoping the boat doesn’t move until you can jump on board. There are parts of the country where operating margins are so low it will be difficult for them to survive,” he said.

The ripples from VBP and the government’s healthcare reform focus on payment for care quality touch all manner of healthcare providers—including physician practices and outpatient services, ACDIS Advisory Board member James P. Fee, MD, CCS, CCDS, vice president of Huff DRG Review told ACDIS’ February Quarterly Conference Call participants.

“We are moving to clinical integration and partnerships; physicians and CDI staff are increasingly involved in capturing true severity and complexity of patients across the continuum of care,” said Fee.

Of course, all these payment changes nevertheless rely on one significant factor—information—and that information is what gets captured in the medical record, says Krauss.

“That’s directly related to those of us who work in CDI,” he says. “It’s just that we need to expand the scope of CDI beyond the capture of the principal diagnosis and the secondary diagnosis to a much more holistic approach,” looking for any opportunity to improve the quality of the documentation and taking a focused look at some of the elements being targeted within the VBP program and healthcare reform.

“We need to maintain our awareness of these new concerns and look to obtain new levels of expertise and physician involvement if we (and our facilities) are going to be successful,” Fee agrees.

CDI programs may be wondering what steps they need to take to expand into these areas, says CDI Education Specialist Laurie L. Prescott, MSN, RN, CCDS, CDIP, with HCPro in Danvers, Massachusetts.

“Step one really is starting to educate yourself. Use CMS resources to identify target areas and look to see where your own facility’s documentation needs are. Then, reach out to leaders in quality and other departments to determine what we can pull to help support those quality of care measures,” says Prescott.

Krauss suggests explaining to physicians that neither CDI nor healthcare reform is really asking them to change how they practice medicine.

Instead, CDI specialists should focus on capturing:

- What the physician thinks
- Why the physician thinks diagnosis A or B
- Where the treatment or testing plan is headed
- What actions were taken and what actions are still needed
- How long it is going to take to plan for postacute care

“In a nutshell, this is what CDI specialists should be striving for in real CDI efforts. There’s a much better chance of engaging the physician in CDI with this message, and a much better chance of adapting to the increased emphasis on VBP and other healthcare reform measures,” Krauss says.

“This really is something we should embrace and be excited about,” says Prescott.