CMS’ Progress Toward Implementing Value-Based Purchasing

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CMS’ Quality Improvement Roadmap

- Vision: The right care for every person every time
  - Make care:
    - Safe
    - Effective
    - Efficient
    - Patient-centered
    - Timely
    - Equitable
CMS’ Quality Improvement Roadmap

- Strategies
  - Work through partnerships
  - Measure quality and report comparative results
  - Value-Based Purchasing: improve quality and avoid unnecessary costs
  - Encourage adoption of effective health information technology
  - Promote innovation and the evidence base for effective use of technology

VBP Program Goals

- Improve clinical quality
- Reduce adverse events and improve patient safety
- Encourage more patient-centered care
- Avoid unnecessary costs in the delivery of care
- Stimulate investments in effective structural components or systems
- Make performance results transparent and comprehensible
  - To empower consumers to make value-based decisions about their health care
  - To encourage hospitals and clinicians to improve quality of care
What Does VBP Mean to CMS?

- Transforming Medicare from a passive payer to an active purchaser of higher quality, more efficient health care
- Tools and initiatives for promoting better quality, while avoiding unnecessary costs
  - Tools: measurement, payment incentives, public reporting, conditions of participation, coverage policy, QIO program
  - Initiatives: pay for reporting, pay for performance, gainsharing, competitive bidding, coverage decisions, direct provider support

Why VBP?

- Improve Quality
  - Quality improvement opportunity
    - Wennberg’s Dartmouth Atlas on variation in care
    - McGlynn’s NEJM findings on lack of evidence-based care
    - IOM’s Crossing the Quality Chasm findings
- Avoid Unnecessary Costs
  - Medicare’s various fee-for-service fee schedules and prospective payment systems are based on resource consumption and quantity of care, NOT quality or unnecessary costs avoided
    - Physician Fee Schedule and Hospital Inpatient DRGs
    - Medicare Trust Fund insolvency looms
Practice Variation

Map 2.5: Inpatient Hospital Services per Medicare Enrollee by Hospital Referral Region (1995)
- ≥2518 to <2723 (51)
- 2231 to <2518 (50)
- 2117 to <2231 (51)
- 1993 to <2117 (62)
- 1483 to <1993 (62)
- Not Populated

Practice Variation

Performance on Medicare Quality Indicators, 2000–2001

Support for VBP

- President’s Budget
  - FYs 2006-09
- Congressional Interest in P4P and Other Value-Based Purchasing Tools
  - BIPA, MMA, DRA, TRHCA, MMSEA
- MedPAC Reports to Congress
  - P4P recommendations related to quality, efficiency, health information technology, and payment reform
- IOM Reports
  - P4P recommendations in *To Err Is Human* and *Crossing the Quality Chasm*
  - Report, *Rewarding Provider Performance: Aligning Incentives in Medicare*
- Private Sector
  - Private health plans
  - Employer coalitions

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**Health-Care Spending, American-Style**

*Up, up and still up*

<table>
<thead>
<tr>
<th>Year</th>
<th>Spending, in trillions (left scale)</th>
<th>Spending, as pct. of GDP (right scale)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>1.0</td>
<td>10%</td>
</tr>
<tr>
<td>2005</td>
<td>1.5</td>
<td>15%</td>
</tr>
<tr>
<td>2010</td>
<td>2.0</td>
<td>20%</td>
</tr>
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</table>

*Where the money goes, in billions*

- Hospital care: 570.8
- Doctors, other professionals: $587.4
- Administration, insurance: 136.7
- Govt. public health, investment, other: 188.5
- Prescription drugs: 235.8
- Home health, nursing home: 158.4

Source: Centers for Medicare & Medicaid Services
VBP Demonstrations and Pilots

- Premier Hospital Quality Incentive Demonstration
- Physician Group Practice Demonstration
- Medicare Care Management Performance Demonstration
- Nursing Home Value-Based Purchasing Demonstration
- Home Health Pay-for-Performance Demonstration
- ESRD Bundled Payment Demonstration
- ESRD Disease Management Demonstration

VBP Demonstrations and Pilots

- Medicare Health Support Pilots
- Care Management for High-Cost Beneficiaries Demonstration
- Medicare Healthcare Quality Demonstration
- Gainsharing Demonstrations
- Better Quality Information (BQI) Pilots
- Electronic Health Records (EHR) Demonstration
- Medical Home Demonstration
VBP Initiatives

- Hospital Quality Initiative: Inpatient & Outpatient
- Hospital VBP Plan & Report to Congress
- Hospital-Acquired Conditions & Present on Admission Indicator
- Physician Voluntary Reporting Program
- Physician Quality Reporting Initiative
- Physician Resource Use
- Home Health Care Pay for Reporting
- Ambulatory Surgical Centers Pay for Reporting
- Medicaid

VBP Initiatives

Hospital Value-Based Purchasing
Hospital Quality Initiative

- MMA Section 501(b)
  - Payment differential of 0.4% for reporting (hospital pay for reporting)
  - FYs 2005-07
  - Starter set of 10 measures
  - High participation rate (>98%) for small incentive
  - Public reporting through CMS’ Hospital Compare website

- DRA Section 5001(a)
  - Payment differential of 2% for reporting (hospital P4R)
  - FYs 2007- "subsequent years"
  - Expanded measure set, based on IOM’s December 2005 Performance Measures Report
  - Expanded measures publicly reported through CMS’ Hospital Compare website

- DRA Section 5001(b)
  - Report for hospital VBP beginning with FY 2009
    - Report must consider: quality and cost measure development and refinement, data infrastructure, payment methodology, and public reporting
Hospital VBP Report to Congress

- The Hospital Value-Based Purchasing Report Congress can be downloaded from the CMS website at: http://www.cms.hhs.gov/center/hospital.asp

VBP Initiatives

Hospital-Acquired Conditions and Present on Admission Indicator Reporting
Value-Based Purchasing and Hospital-Acquired Conditions

- The Hospital-Acquired Conditions provision is a step toward Medicare VBP for hospitals
- Strong public support for CMS to pay less for conditions that are acquired during a hospital stay
- Considerable national press coverage of HAC has prompted dialogue on how to further eliminate healthcare-associated conditions, including infections

Statutory Authority:
DRA Section 5001(c)

- Beginning October 1, 2007, hospitals must begin submitting data on their claims for payment indicating whether diagnoses were present on admission (POA)
- Beginning October 1, 2008, CMS cannot assign a case to a higher DRG based on the occurrence of one of the selected conditions, if that condition was acquired during the hospitalization
- This provision does not apply to Critical Access Hospitals, Rehabilitation Hospitals, Psychiatric Hospitals, or any other facility not paid under the Medicare Hospital IPPS
Statutory Authority: DRA Section 5001(c)

- CMS is required to select conditions that are:
  1. High cost, high volume, or both
  2. Assigned to a higher paying DRG when present as a secondary diagnosis
  3. Reasonably prevented through the application of evidence-based guidelines

Inpatient Prospective Payment System (IPPS) FY2008 Final Rule

- Complications, including infections, acquired in the hospital can trigger higher payments:
  - MS-DRGs may split into three different levels of severity, based on complications or comorbidities (no CC, CC, or MCC—major complication)
    - The CCs and MCCs generate higher payment
    - The more severe the complicating condition, the higher the payment assigned to that CC or MCC DRG
Questions to Address

• Burden
  – Incidence, cost, morbidity, and mortality

• Preventability
  – Guidelines and interventions exist
  – Application can prevent these infections
    • Interpretation of “reasonably”

• Measurement
  – Events appropriately detected using ICD-9 codes

Hospital-Acquired Conditions

Selection of Conditions
Each condition considered was placed in one of three categories:

1. **Conditions selected for implementation** – These conditions will have payment implications beginning in October 1, 2008.
2. **Conditions being considered during FY2009 IPPS rulemaking** – These conditions raise one or more implementation or policy issues that need to be resolved before they can be selected. We will work to address these issues and propose to reconsider these conditions during the FY 2009 IPPS rulemaking process.
3. **Conditions needing further analysis** – After exhaustive consideration, we determined that further analysis is required before considering these conditions.

**HACs Selected for FY 2009 to Date**

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Catheter-associated urinary tract infection
- Pressure ulcers
- Vascular catheter-associated infection
- Surgical site infection – mediastinitis after CABG
- Falls – specific trauma codes
HACs Under Consideration for FY 2009

- Ventilator-associated pneumonia (VAP)
- *Staphylococcus aureus* septicemia
- Deep vein thrombosis (DVT)/ pulmonary embolism (PE)
- Methicillin-resistant *Staphylococcus aureus* (MRSA)
- *Clostridium difficile*-associated disease (CDAD)
- Wrong surgery

Present on Admission (POA)

CMS’ Implementation of POA Indicator Reporting
POA Indicator General Requirements

- Present on admission is defined as present at the time the order for inpatient admission occurs -- conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission.

- Phased implementation

POA Indicator General Requirements

- POA indicator is assigned to
  - principal diagnosis
  - secondary diagnoses
  - external cause of injury codes (Medicare requires reporting only if E-code is reported as an additional diagnosis)
## POA Indicator Reporting Options

### POA Indicator Options and Definitions

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<tr>
<td>N</td>
<td>Diagnosis was not present at time of inpatient admission.</td>
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<tr>
<td>U</td>
<td>Documentation insufficient to determine if condition was present at the time of inpatient admission.</td>
</tr>
<tr>
<td>W</td>
<td>Clinically undetermined. Provider unable to clinically determine whether or not the condition was present at the time of inpatient admission or not.</td>
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**POA Indicator Reporting**

**Successful Documentation of Present on Admission**
The Goal: Successful Documentation

“A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.”

ICD-9-CM Official Guidelines for Coding and Reporting

Opportunities for HAC & POA Involvement

- IPPS Rulemaking
  - Proposed rule in April
  - Final rule in August
- Hospital Listserv Messages
- Updates to the CMS HAC & POA website
- Hospital Open Door Forums
HAC & POA Indicator Reporting

- Further information about HAC & POA indicator reporting is available on the CMS website at:
  http://www.cms.hhs.gov/HospitalAcqCond/

Thank You

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Centers for Medicare & Medicaid Services
A Master Class in Hospital Reimbursement Compliance

Present on Admission and Hospital-Acquired Conditions

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Overview of POA
Technical Aspects
Quick Added History

• POA isn’t brand new?

  New York – 1994
  California – 1996 (fully implemented)
  Individual state initiatives underway prior to 10/01/07 in Florida through state reporting, as well as Maryland and Massachusetts

• DRA essentially nationalized POA

Official Coding Guidelines – POA Section

• Serves as a supplement to the ICD-9-CM Official Guidelines for Coding and Reporting to facilitate correct POA indicator assignment for each diagnosis and external cause of injury code reported on claim forms (UB-04)

• Not intended to replace any guidelines as otherwise reflected in the Official Guidelines

• Not intended to provide guidance on when a condition should be coded
Refresher on Indicators:

POA Indicator Options and Definitions

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Now let’s walk through examples of when the “Y” indicator would be assigned...
When to Assign the “Y” Indicator

- Condition is clearly documented by the provider
- Conditions diagnosed prior to inpatient admission, such as chronic, stable conditions
- Conditions diagnosed during the admission but clearly present before admission
  - Diagnoses subsequently confirmed following admission are considered POA if at the time of admission they are documented as suspected, possible, rule out, differential diagnosis, or constitute an underlying cause of a symptom that is present at the time of admission (best sources of documentation - ED physician note, admitting physician note or history & physical report)
- Conditions that develop during outpatient encounter prior to inpatient admission

Coding Specifics

- **Combination codes**
  - Identify all parts of the combination code as present on admission
    - Ex: Diabetic nephropathy is admitted with uncontrolled diabetes
  - One or more components of the combination code not present on admission
    - Ex: Gastric ulcer that does not start bleeding until after admission
    - Ex: Asthma patient develops status asthmaticus after admission
  - Identifies the chronic condition and not the acute exacerbation
    - Ex: Acute exacerbation of CHF
Other Coding Specifics

- **Impending or threatened diagnosis**
  - Based on symptoms or clinical findings that were present on admission
  - Based on symptoms or clinical findings that were not present on admission
- **Comparative or contrasting diagnoses**
  - Both present, or suspected, at the time of admission
- **Infection codes that include the causal organism**
  - Infection (or signs of the infection) present on admission, even though the culture results may not be known until after admission
    - Ex: Patient admitted with pneumonia and the provider documents pseudomonas as the causal organism a few days later

Coding Specifics: E-codes

- **External cause of injury or poisoning occurred prior to inpatient admission:**
  - Ex. Patient fell out of bed at home
  - Patient fell out of bed in emergency room prior to admission
- **External cause of injury or poisoning occurred during inpatient hospitalization**
  - Ex. Patient fell out of hospital bed during hospitalization
    - Patient experienced an adverse reaction to a medication administered after inpatient admission
Sources of Chart Documentation

- ED notes – condition(s) diagnosed or worked up
  - H&P – condition(s) diagnosed or worked up – past medical history, current medications, etc.
- Progress notes – follow-up on diagnosing initial condition – new findings of existing conditions
- Consults – for management of other conditions than that needing surgery
- Nursing admission, OR admission, & pre-anesthesia notes
- Lab and radiology reports

POA on the UB-04

Uniform Billing Claim:
- Implemented last year through the National Uniform Billing Committee (NUBC); replaced the UB-92.
- Revised partly due to increased need to examine public health reporting requirements and efforts to establish a national approach on research data (example was the added field/requirement for Present on Admission).
POA on the UB-04

A closer look:

67 - Required Principal DX Code & Present on Admission Indicator
Positions 1 – 7 are for the DX code(s), Position 8 (shaded area) are for POA Indicator’s

67 A-Q: Required Other Diagnosis
18 Total Dx’s (9 New)
Note the Shadowed Fields
Key Impact Considerations

• **Documentation evaluation**
  - Quality of current physician documentation to provide enough clinical information to correctly assign POA
  - Queries to obtain sufficiently detailed POA data
  - Education of medical staff & support for improved documentation
  - Auditing and monitoring of POA assignment accuracy

Coding process & Health Information Management Operations

• Additional time for POA data assignment/collection
• Study at Mayo Clinic hospitals in Minnesota = 2 minutes per record
• Impact to coder productivity and/or staffing
• Impact DNFB (Discharged but not Final Billed)

Key Date Considerations

• **October 1, 2007** – IPPS hospitals were required to begin submitting POA information on all primary/secondary diagnoses on Medicare claims*

• January 1, 2008 – CMS began processing POA data and providing feedback regarding POA reporting errors through Remark Codes on the Remittance Advice; hospitals were not subject to returned claims through March 31st

• April 1, 2008 – (TODAY!!) Claims submitted for payment that do not contain proper POA data will be returned to the provider for correct submission of POA information

*Direct Data Entry (DDE) screens could not be updated until January 1, 2008, so hospitals submitting claims via DDE were unable to submit POA until January 1, 2008
Compliance Officer Considerations

- Discuss POA with your HIM/coding professionals and business office to ensure appropriate mechanisms have been implemented
- Review findings from any internal evaluations performed of POA indicator claims feedback received between January and March 2008 – be aware of patterns which may reflect poor documentation patterns or lack of understanding about POA
- Facilitate corrective action where needed and/or if not addressed elsewhere through department heads
- Facilitate the monitoring plan to periodically assess accurate POA assignment, or review findings of established monitoring plan
- Confirm appropriate training is provided with appropriate resources for new coding, finance and billing, and other pertinent staff (and that it’s documented!)

Compliance Officer Considerations

- Confirm appropriate training resources are established and have been provided with existing coding, finance and billing, and other pertinent staff (and that it’s documented!)
- Team with HIM/coding to evaluate physician POA education to date and ensure that initial physician education has been provided
- Reinforce POA with physicians in “bite-sized chunks” through newsletters, department meetings, summarized reports of audit findings, etc.
- Incorporate findings from POA accuracy audits into Compliance Committee meetings for the first year and as appropriate thereafter
- Support internal initiatives related to POA with senior management and HIM/coding to further the importance of appropriate provider documentation to effect accurate POA assignment
- Ensure that all education, training, procedural and other documentation of POA compliance efforts are documented and appropriately retained for reference
POA Monitoring Efforts

- Determine if audits have been performed, and if so, review and evaluate findings along with HIM/coding and others involved
- Or, prepare and audit method to include time frame, record selection process, sample size, indicators, data analysis techniques or tools used, qualifications of individuals performing the audit, how results will be communicated and used, and; report formats for tracking and analyzing audit reports
- Sample should include inpatient Medicare claims between October 1, 2007 to present
- Evaluate feedback received through the business office on remittance advices for trends – perform further review as indicated
- Evaluate trends for potential overuse of the “U” and “W” POA indicators – focus on high risk or problem areas

POA Monitoring Efforts

- Facilitate focused audit of detected “U” and “W” overuse trends to evaluate documentation and individualize trends by provider
- Communicate all pertinent feedback with senior management and medical staff leadership, as well as in medical staff forums as appropriate
- Establish an organizational data integrity process to remedy POA indicator corrections, or, ensure that the current process is efficient
- Be sure to include evaluation of any contract coders and ensuring that appropriate POA education has been provided through the vendor or otherwise
Other POA Efforts

- **Establish a process** (or evaluate the effectiveness of an existing process) for clinical documentation improvement initiatives
- **Include evaluation** of an existing or develop/implement a new query process for inconsistent, missing, conflicting, or unclear documentation, and; a related auditing and monitoring process using audit methodology and tools, along with a process to monitor responses to queries as well as appropriateness of queries
- **Project financial impact** by analyzing ICD-9-CM code frequency from the 12 months prior to 10/01/07 for the nine CMS conditions; evaluate potential reimbursement impact of accurate physician documentation and correct POA assignment – share internally as appropriate
- **Provide education** and training for identified opportunities
- **Develop and implement** trending and reporting mechanisms

Bottom Line Considerations

- **Payment for the CMS designated conditions (hospital acquired or otherwise not identified as POA) will be adjusted** starting October 1, 2008:
  - Serious preventable event, object left in surgery
  - Serious preventable event, air embolism
  - Serious preventable event, blood incompatibility
  - Catheter-associated urinary tract infection
  - Pressure ulcers (decubitus)
  - Vascular catheter-associated infection
  - Mediastinitis after cardiac artery bypass grafting - surgical site infection
  - Hospital acquired injuries (fractures, dislocations, intracranial injury, crushing injury, burn, and other unspecified effects of external causes)
  - Not assigned to the higher-paying MS-DRG
Bottom Line Considerations

- Potential lost revenue for missing or inadequate physician documentation of conditions that were clinically present at time of admission
- Increase in accounts receivables days for returned claims and those resulting delays for needed corrections to POA indicator data (negative cash flow impact)
- Physician report card impact – POA can play a significant role in demonstrating why variations exist

Website Address:
Conclusions

- January to March has been the “training wheels” period
- 2008 claims data is now building the repository upon which CMS will draw in part to
  - determine POA success as well as
  - formulate 2009 considerations and beyond
- Anticipate increased POA awareness with claims return after April 1st – great opportunity for compliance to get involved (if not already)!

Website Address:
http://frwebgate.access.gpo.gov/cgi-bin/getpage.cgi?dbname=2007_register&position=all&page=48168
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