E-BRIEF SERIES

What is Risk Value-Based Payment (VBP) and What Does it Mean for Our Healthcare System?

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The United States healthcare system is rapidly moving toward rewarding value.

Recent legislation, such as the Affordable Care Act and the Medicare Access and CHIP Reauthorization Act (MACRA), solidified the role of value-based payment in Medicare.

Value-based reimbursement is the payment model for medical services that will gradually replace the traditional fee-for-service model for payers and healthcare organizations. The goal is to cut rising healthcare costs by switching from a quantity-based model to value-based reimbursement, which is based on quality.

In contrast to the predominant fee-for-service model, in which payers reimburse providers a fixed fee for each service they provide from an approved list, value-based payment (VBP) models hold providers financially accountable for both the cost and the quality of care they deliver. VBPs reward providers financially for delivering better, more cost-effective care, and can penalize them for failing to do so.

Value-based payment model is one approach to achieving a balance between efficiency and effectiveness and comes in different forms, varying in the level of provider accountability they entail. The level of payment a provider receives is tied to cost and quality targets. These targets ensure that providers do not cut costs at the expense of patient outcomes. Examples of quality measures include post-hospitalization readmission rates, provider-to-patient ratios, and percentage of patients receiving preventative care (such as immunizations).

Value-based programs support a three-part aim:

- **Better care for individuals**
- **Better health for populations**
- **Lower cost**

What are CMS' value-based programs?

- **End-Stage Renal Disease Quality Incentive Program (ESRD QIP)**
- **Hospital Value-Based Purchasing (VBP) Program**
- **Hospital Readmission Reduction Program (HRRP)**
- **Value Modifier (VM) Program**
  (also called the Physician Value-Based Modifier or PVBM)
- **Hospital-Acquired Conditions (HAC) Reduction Program**
- **Skilled Nursing Facility Value-Based Program (SNFVBP)**
- **Home Health Based Program (HHVBP)**

Value-Based programs timeline

	2008	2010	2012	2014	2015	2018	2019
LEGISLATION PASSED	MIPPA	ACA		PAMA	MACRA		
PROGRAM IMPLEMENTED			ESRD-QIP HVBJ HRRP	HAC	VM	SNF-VS	APMs MIPS

LEGISLATION

ACA: Affordable Care Act

MACRA: the Medicare Access & CHIP Reauthorization Act of 2015

MIPPA: Medicare Improvements for Patients & Providers ACT

PAMA: Protecting Access to Medicare Act

PROGRAM

APMs: Alternative Payment Models

ESRD-QIP: End-Stage Renal Disease Quality Incentive Program

HACRP: Hospital-Acquired Condition Reduction Program

HRRP: Hospital-Readmissions Reduction Program

HVBP: Hospital Value-Based Purchasing Program

MIPS: Merit-Based Incentive Payment System

VM: Value Modifier or Physician Value-Based Modifier (PVM)

SNFVP: Skilled Nursing Facility Value-Based Purchasing Program

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs

Value-based payment calculation

Value-based programs reward healthcare providers with incentive payments for the quality of care they give to people with Medicare. Value-based reimbursements are calculated by using numerous measures of quality and determining the overall health of populations. Unlike the traditional model, value-based care is driven by data because providers must report to payers on specific metrics and demonstrate improvement. Providers may also have to track and report on hospital readmissions, adverse events, population health, patient engagement, and more.

Under the new models, providers are incentivized to use evidence-based medicine, engage patients, upgrade health IT, and use data analytics to get paid for their services. When patients receive more coordinated, appropriate, and effective care, providers are rewarded.

To participate in value-based care, CMS has developed several models for providers, such as the accountable care organization, bundled payments, and patient-centered medical homes.

Will value-based make a difference?

Value-based refers to the quality of the care patients receive, rather than the quantity. It takes into account access, price, efficiency, and alignment of incentives. In many cases, it is cited as one of the best ways to reform healthcare.

It is a catch-all term for Accountable Care Organizations (ACOs) and other ways of restructuring healthcare around a system that puts more weight on metrics of quality or the aggregate health of a population rather than how many visits someone makes to the hospital or how many procedures one has. The ultimate goal of the system is to maximize value for patients and define health outcomes achieved per unit of cost spent.

As we move forward, VBP model provides new opportunities for the development and participation of ACOs. The Affordable Care Act is promoting the use of ACOs and levies penalties for hospital readmissions — to encourage better follow-up care outside the hospital. It is a more data-driven vision of healthcare reform that not only improves quality and efficiency, but also reduces costs. As illustrated below, the new world of healthcare focuses exactly where it should — on quality outcomes that benefit the patient.

Value-Based Care

	Volume-Based	Value-Based
Payment	Fee-for-Service	Outcome-Based
Incentives	Pass-A-Tube-Get-A-Payment	Keep-Em-Healthy-And-Make-A-Living
Focus	Episodes	Populations
Role of the Provider	Interaction on Individual Interactions	Team-Based Care Continuum
Information	Retrospective	Predictive

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs

What is the role of a coder in VBP models?

Value-based models encourage a team-oriented approach to patient care. Under a value-based model, primary, specialty, and acute care specialties are integrated, and healthcare providers work as a team to deliver the best-coordinated care. For example, treatment plans may require the contributions of many specialists — pharmacists, behavioral health providers, social service professionals, etc. — where each contributing party shares in the incentives of a positive outcome.

One common element in many value-based programs is risk adjustment using Hierarchical Condition Categories (HCCs). HCCs can be used to classify patient conditions, and each has an associated Risk Adjustment Factor (RAF). The health risk of an individual is represented by the sum of RAFs for his/her conditions, typically calculated annually based on all the conditions in billed claims during a calendar year.
The HCC/RAF model assigns the highest scores to the sickest patients. Lower RAF scores suggest healthier patients.

To prepare for a successful VBP implementation, healthcare facilities and coders should consider the following:

- Create a multi-disciplinary team to ensure thorough oversight of hospital-acquired conditions and other issues relating to changing reimbursement.
- Adopt best practices through nationally recommended evidence-based medicine practice guidelines and monitor compliance.
- Take action based on data outcomes to protect patients, reduce adverse events, and increase efficiency.
- Perform patient population-level analysis of HCC and RAFs.
- Educate physicians about how their care decisions and documentation will impact reimbursement. Include education on:
    - Documenting diagnoses for HCCs and other value-based programs.
    - Think beyond Medical Necessity; encourage documentation of all comorbid conditions, documentation of manifestations which are due to an underlying etiology, and documentation of wellness measures such as screenings, interventions and social determinates.
- Ensure timely and ongoing education regarding VBP model changes associated with coding and reimbursement requirements.
- Review claims data prior to submission according to documentation standards and coding accuracy.
- Perform periodic clinical documentation and coding reviews including post-audit education with staff and physicians.

In summary, diagnostic precision for all conditions is desirable, and particularly necessary for the correct classification, risk adjustment, severity of illness, and quality of care reporting. Although VBP may initially require coders to meet even higher standards for data accuracy, the program has the potential to significantly improve healthcare, by better linking payment to performance.

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Navigating the Coding Proffession by Toni Elhoms, CCS, CPC, CRC AAFP
https://www.aafp.org/home.htm

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AUTHOR BIO

Viola began her career over 20 years ago as a medical biller in a small level 1 trauma and teaching community hospital in Ohio. She worked as facility coder, however, most of her experience entails providing coding and billing services to physician practices in freestanding as well as provider-based settings. Viola has played an important role in provider education as well as educating the office staff in coding and billing matters. She has assisted physician practices in a variety of specialities in new service lines as well as her team on learning a new system such as value-based payments and risk adjustment. Viola continues to conducted provider audits, coder audits, provider education as well as staff education on a variety of topics.

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