2024
Five Strategies for Patient Care Management Improvement – Inpatients and Outpatients

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Five Strategies – Patient Care Mgt.

2024 Reimbursement Healthcare Operational Practices:

In addition to the automatic reductions in payment:

- **What four (4) Medicare initiatives may lower your payments for FY 2024?**

- **Can your hospital Revenue Cycle team produce a positive affect on all four of these?**
- **What long-term reimbursement methodologies should your facility address every month?**

- **Rate your "patient care management" (CM, UR, CDI, DC Planning) program on a 1 (poor) to 5 (excellent) scale.**
- **What $$ amount was written-off at your hospital last month (and YTD) due to services provided in "wrong setting," that were "not medically necessary," or were "unauthorized" (including number of inpatient days)?**

FOCUS

For 2024

IPPS and OPPS

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Payment Reform for Hospitals

Fiscal Year	Value Based Purchasing	Hospital Readmission Reduction Program	Hospital Acquired Conditions (POA)	Total
2013	1.00%	1.00%	0	2.00%
2014	1.25%	2.00%	0	3.25%
2015	1.50%	3.00%	1.00%	5.50%
2016	1.75%	3.00%	1.00%	5.75%
2017 - 2024	2.00%	3.00%	1.00%	6.00%

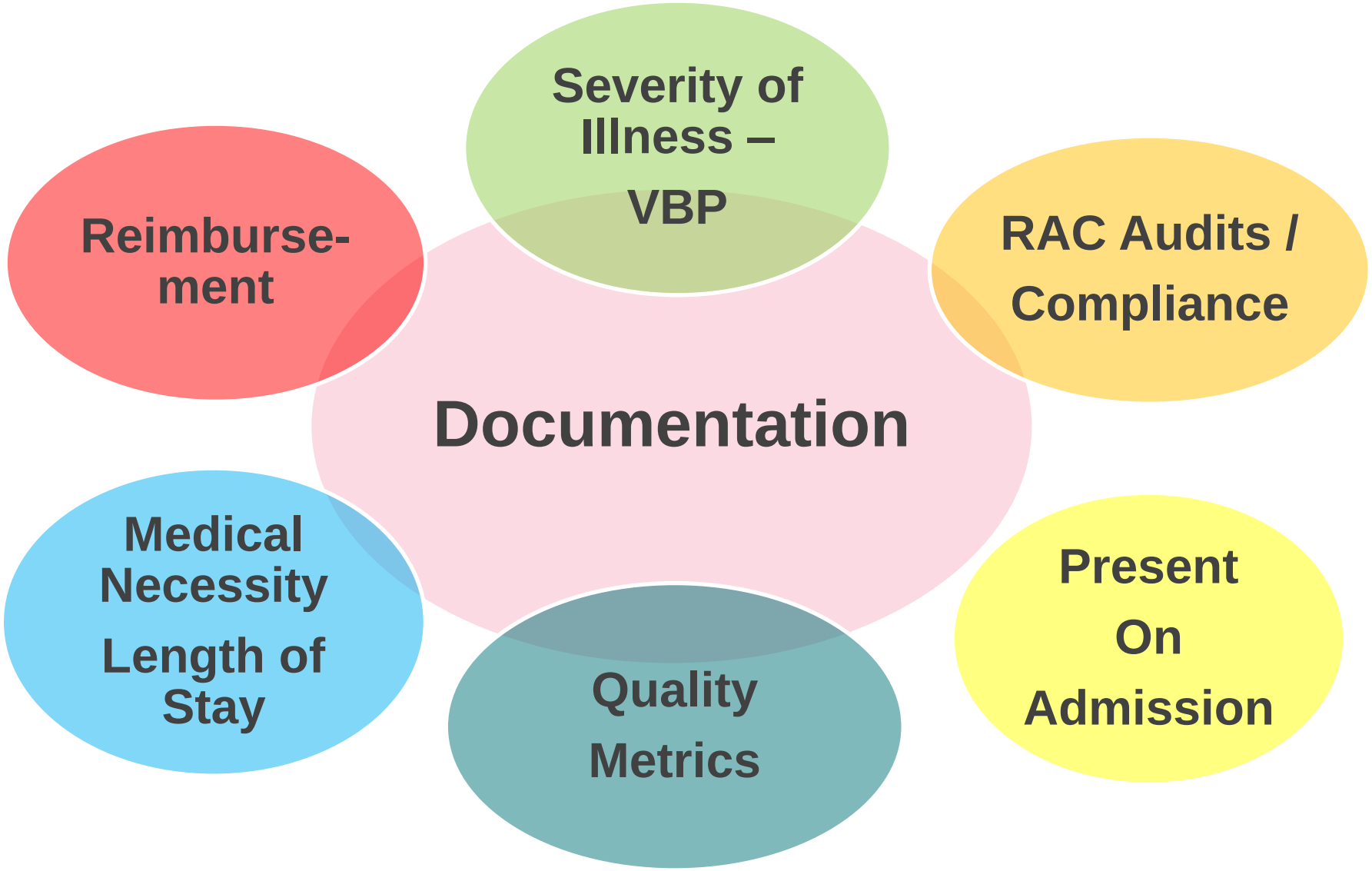
Alexander, K.,LHA Legislative & regulatory Update.
LA Assn for Healthcare Quality Annual Education Conference, April 2015

“Pay for Performance” Dichotomy

Problematic challenge:

- Past challenge for hospitals has been dichotomy of clinical “care plans” and/or “protocols” (patient care) versus “coverage, coding and billing” (financial) guidelines.
- The two are not the same – but they do overlap!
  - The overlap is where “pay-for-performance” and value-based purchasing of medical services will be resolved.
- Hospital practice has been for “clinical” operations to be separated from “financial” operations – although the two are interdependent and both are needed for successful longevity!
- The current challenge: two operational perspectives representing ALL care and payment requirements must be merged! How are you “leading” for success?

Effects of “Good” or “Poor” Documentation



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Key financial indicators that trigger a need for a Patient Care Improvement Mgt. and / or CDI program:

- **Lower paying MS-DRGs under ICD-10-CM and PCS**
- **Primary diagnosis = "unspecified" ICD-10-CM code**
- **Decreasing or low case mix index (CMI) compared to high inpatient length of stay (LOS)**
- **Denials for lack of medical necessity or pre-authorization for number of days approved for inpatient stay**
- **Medicare ADR requests that are denied pre-payment**
- **Medicare "Two-Midnight Rule" denials**

- **Increasing number of core measure reporting requirements**

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Patient Care Mgt. improvement "bridges the gap" between clinical language and technical (ICD-10, NCD, LCD) language

Patient Care Mgt. Goals			
Accurately reflect the severity of illness	Improve physician and hospital profiles	Increase case mix index / DRG	Retain maximum compliant reimburse-ment

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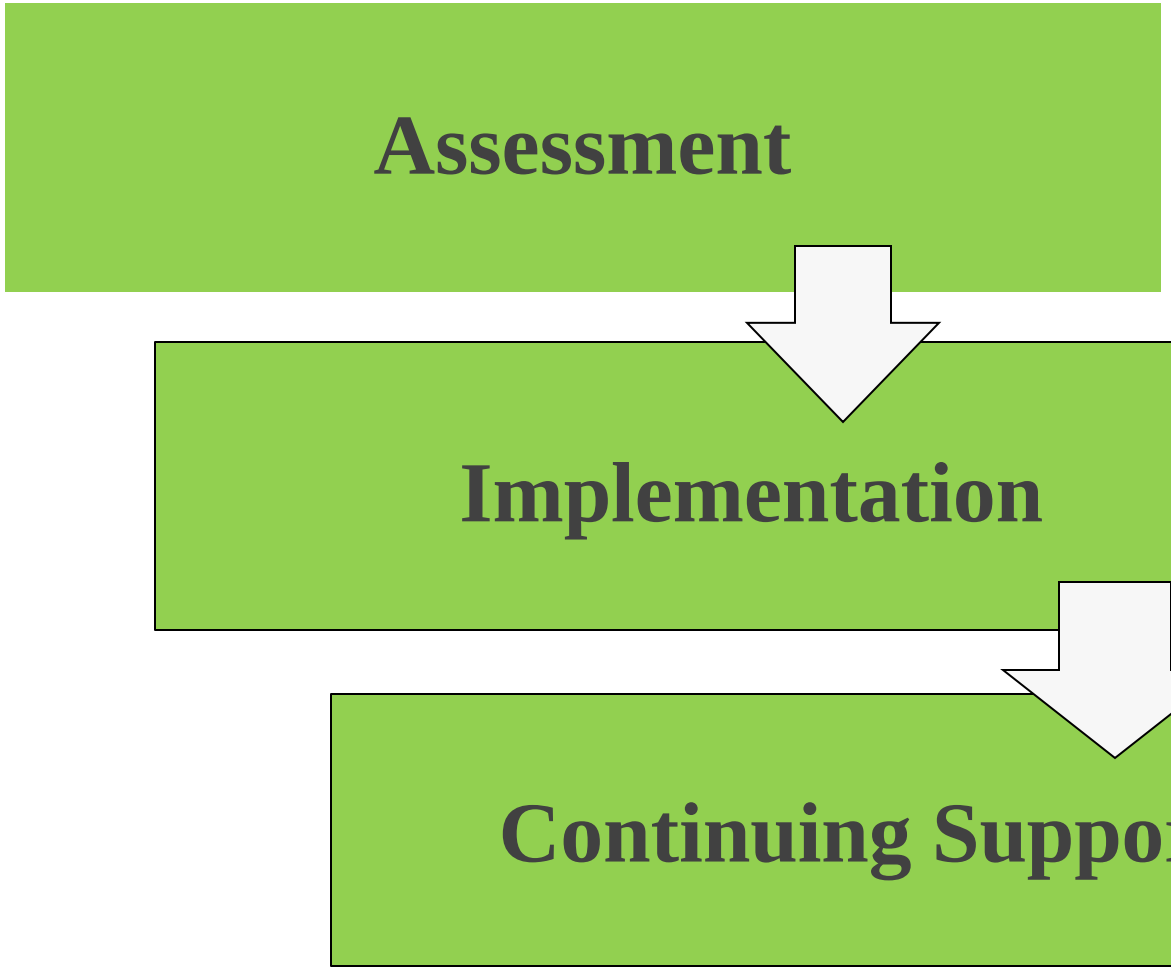

Evaluate strengths – deficiencies – resources needed

Pinpoint specific changes

Audit – Educate – Audit – Educate . . .

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Reimbursement challenge!

Each hospital / facility location is different –

- **Must perform "risk" analysis to identify specific strengths and weaknesses for collaboration of clinical and revenue cycle staff members.**
- **Clinical reporting translated into financial results such as**
  - **Medicare's identified hospital specific "payment reductions"**
  - **Payor specific denials and root causes**
  - **Medical necessity write-offs**
  - **Bundling and/or packaging of services, and**
  - **Key quality benchmarks correlated to department, physician or specialty service**
- **Tracked, shared, evaluated, *MAP for improvement***

Five Strategies – Patient Care Mgt. – Evaluate

Concurrent, but Multi-Disciplinary
Rev Cycle TEAM Approach

Patient Admitted — **PAS, CM, Clinical Services (CS)**

Concurrent Medical Record Review — **Physician, CM, CS, Coder**

Patient Discharged — **Physician**
CS
CM (DP) Goals:

Coder Receives Complete "well-documented" Record for Review

Magic Word? — **Specificity**

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Combine clinical review of "teams" with quality imperatives from CMS:

- VBP = Inpatient criteria vs. Observation; quality indicators
- Present-on-Admission = Physicians (Hospitalists), CM and clinical services
    - Also called **"hospital acquired conditions"**
- Re-admissions = CM (Discharge planning) / follow-up care
- CDI Specialists =
    - Patient Acuity + ICD-10-CM and PCS Coding requirements

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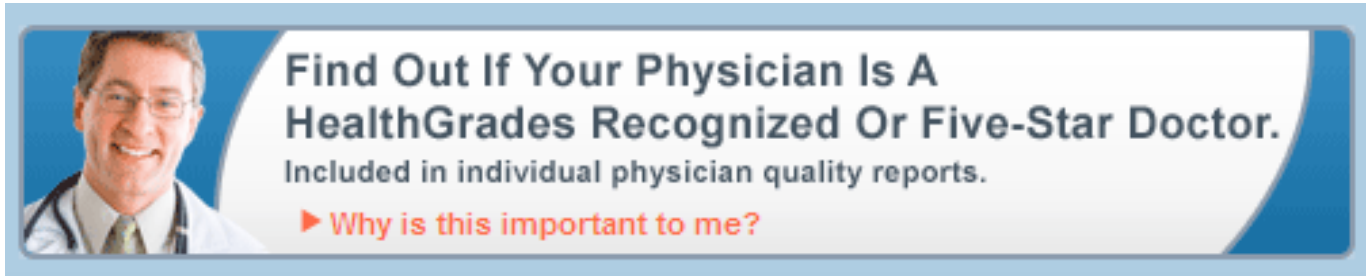

Data utilized for physician profiling:

- Length of stay
- DRG Assignment
- Evaluation and Management (E&M) – physician service
- Mortality and Morbidity rates

Documentation improvement assists with creating accurate profiles

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Patient Care Mgt. Team Members

- Patient Access Representatives (PAS) – Registrars
- Physicians
  - Include ED physicians and Hospitalists
- Patient Care Managers – Case Manager, UR, Discharge Planner
- Clinical Care Providers – Nurses, therapists, technicians
- HIM – Coders
- Clinical Documentation Specialists (CDS)
- Healthcare Quality Reporting team members

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The Role of the Clinical Documentation Specialist:

- Monitor the clinical documentation so that it accurately demonstrates the intensity of service and level of care provided for the patient.
- **Review all Medicare admissions after the first 24 hours** to ensure comprehensive documentation outlining the reason for admission, the patient's treatment, and any POA indicators.
- Review medical records for accuracy and **compliance by payor!**
- Clarify all documentation for accuracy of severity of illness and resource consumption.
- **Review high-cost Outpatient services at scheduling for medical necessity;** surgical report for appropriate language / implants

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The Role of the Clinical Documentation Specialist *(continued)*:

- **Provide ongoing education regarding clinical documentation for the multidisciplinary team.**
- **Query the physicians for clarification of diagnoses.**
- **Adhere to metrics established by your specific facility:**
  - **Daily caseload (new admissions and follow-up queries)**
  - **Number of queries per day**
  - **Physician query rate (verbal and written)**
  - **Physician response rate**

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Medical Staff (Physician or Hospitalist) Responsibilities:

- **Respond to the CDS queries prior to discharge.**
- **Provide accurate and timely documentation in order to:**
  - **Assist in assignment of the proper codes for hospital and physician billing**
  - **Assist in the planning, evaluation and delivery of patient care resulting in the best outcome**
  - **Provide other physicians in the organization clear opinions regarding the patient's condition, treatment options and response to the prescribed care**

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Medical Staff (Physician or Hospitalist) Responsibilities:

- **Provide accurate and timely documentation in order to:**
  - **Result in fewer payment denials and facilitate the overturn denials**
  - **Improve results in the areas of strategic planning, quality measures, outcomes and physician profiling**
  - **Lower potential litigation with focused and accurate documentation to support the appropriate, best practice care**

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The Role of the of the Professional Coder

- Continue retrospective review and coding of records
- Review record for any CDS query
- Determine if retrospective query is needed
- Ensure co-morbid conditions, if present, are accurately coded
- Assign DRG appropriately
- Explain Coding Clinics to CDS, if helpful

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Clinical Documentation for RAC and Revenue Integrity Audits

- A good Clinical Documentation Improvement program protects the hospital's resources
  - Accurate and complete documentation in the chart ensures accurate coding practices
    - Principle diagnosis
    - Secondary diagnoses
    - Appropriate capture of co-morbidities
    - Appropriate capture of major complications

Hospital Value-Based Purchasing Program

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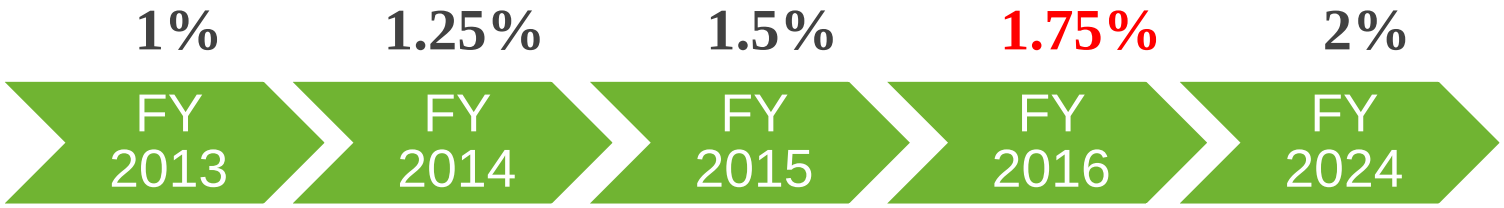
Inpatient Value-Based Purchasing Metrics

- Requires portion of Medicare operating **reimbursement to be withheld and returned proportionate to how the Hospital performs** based on quality and efficiency metric performance



- A budget neutral policy, where hospitals must fail to meet targets for bonuses to be generated for others.
- Rewards hospitals for achievement or improvement in metrics.
- **For 2024, CMS will keep 2.00 percent of Medicare reimbursements, resulting in about $1.6 billion in value-based incentives**

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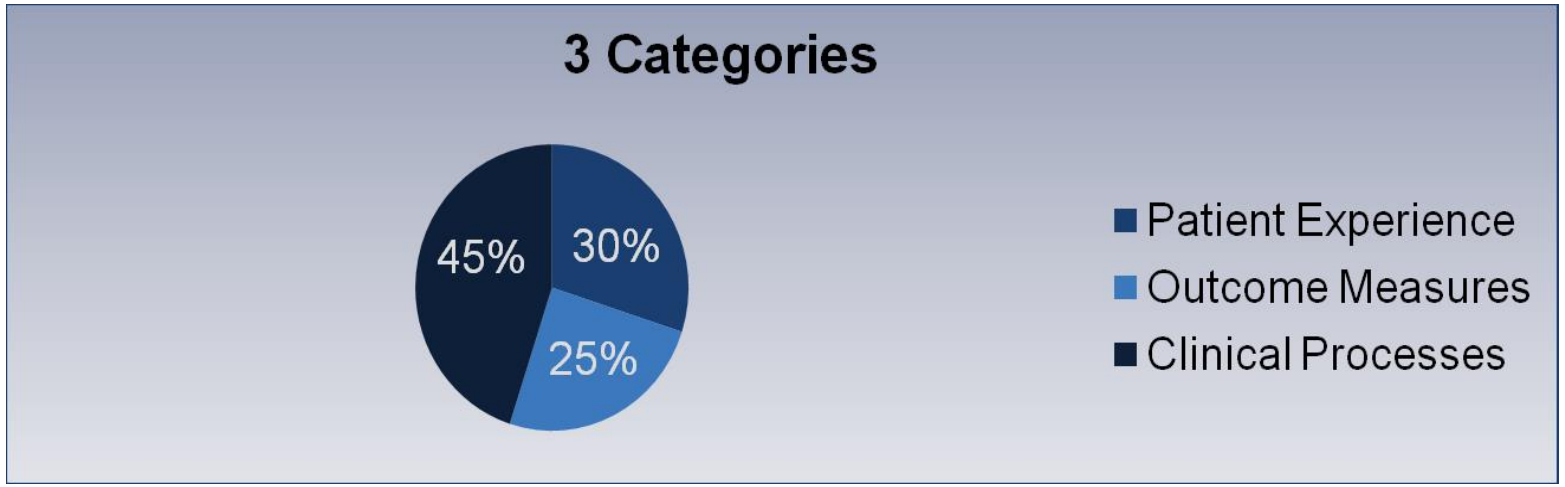
- **2024 = 2.00% withheld!**



Evaluating Hospital Performance – Quality measures from "Hospital Compare" measure set

20 measures (12 process / 8 HCAHPS) in FY 2013,
Added 3 outcome measures (3 mortality) in FY 2014, and
Added 2 outcome measures and1 efficiency measure in FY 2015
Removed 5 process and added 1 process, 2 outcome measures in FY 2016
Will remove 6 process and add 1 process, 2 "safety" measures in FY 2024

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HCAHPS Survey = 27 Questions divided into 4 scales

Evaluative Questions

YOUR CARE FROM NURSES

1. During this hospital stay, how often did nurses treat you with courtesy and respect?
   - ○ Never
   - ○ Sometimes
   - ○ Usually
   - ○ Always

"About You" Patient Questions

27. What language do you mainly speak at home?
   - ○ English
   - ○ Spanish
   - ○ Some other language (please print):

Global Rating Questions

22. Would you recommend this hospital to your friends and family?
   - ○ Definitely no
   - ○ Probably no
   - ○ Probably yes
   - ○ Definitely yes

Screening Questions

YOUR EXPERIENCES IN THIS HOSPITAL

10. During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a bedpan?
   - ○ Yes
   - ○ No → **If No, Go to Question 12**

Hospital Readmissions Reduction Program

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Hospital Re-admission Reduction Policy:

- **A reimbursement penalty (applies to total MS-DRG payment) approach for general acute care hospitals that have readmissions deemed "excess" by CMS**
  - **Reduction was capped at 1% in 2013, was 2% in 2014 and will be 3% in 2015 and beyond**
- **2024 Using refined 30-day re-admissions data for:**
  - **AMI Acute Myocardial Infarction**
  - **HF Heart Failure**
  - **PN Pneumonia**
  - **COPD Chronic Obstructive Pulmonary Disease**
  - **THA/TKA Total Hip and Total Knee Arthroplasty**
- Measures based on 3 years of data (July 1, 2021 - June 30, 2023) for FY 2024 payment.

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Compare Your Hospital's Re-admission Rate
www.whynotthebest.org

This is the way to find out how your hospital compares to other hospitals in the U.S. and to top performers:

Clinical Conditions	Top Performers	US National Average	What is your Re-admission Rate?
Heart Failure	17.3%	24.73%	?
Heart Attack	15.2%	19.97%	?
Pneumonia	13.6%	18.34%	?

- **If you don't already know – find out your 2024 penalty Rate!**

Hospital-Acquired Condition (HAC) 2024 Reduction Program

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Hospital Acquired Condition(s)

- **Also known as "Present-on-Admission"**
- **CMS has implemented the HAC Reduction program, part of the PPACA.**
- **Until now, if a patient's complication was acquired after admission, *the diagnosis has been excluded from raising the MS-DRG to be paid for the inpatient stay.***
- **Starting several years back, hospitals with the poorest performance in reducing HACs, specifically those in the lowest quartile, would have their Medicare pay docked by 1 percent.**
- **CMS estimated about 753 hospitals would lose that 1 percent, and overall payments would decrease $330 million, or more than $438,000 per affected hospital.**

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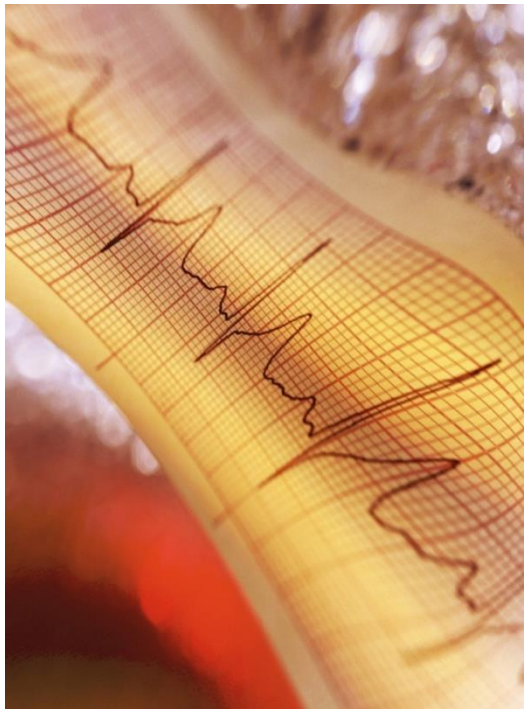
- Quarterly monitoring of the program to ensure the long-term success
    - Clinical Record Review
    - Compliance Evaluation
    - Analysis of data ongoing and reporting
    - Communication with the leadership team
- Monitoring of CMI and MS-DRG trends
    - Educational sessions
    - Coding guideline updates
    - Clinical and technological reviews



Sustaining the CDI Program

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Good news!

- CDI performance is directly tied to appropriate “optimum” in these five strategic areas of reimbursement!
  - Although RACs are Medicare fee-for-service – keep in mind:
  - Medicaid and Advantage Plan (Medicare)Integrity Audits recouping increased amounts
  - Commercial payer reviews of inpatient days and documentation to support diagnosed condition, illness, injury
  - Correlation of ED physician order with attending PCP or hospitalist
  - Most important initiative – **collaboration of clinical staff TEAM members with revenue cycle staff TEAM members** – and exchange of information!

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- **Keys for successful performance with Patient Care Management:**
- Clinical intervention and interaction with the following critical patient care decisions:
    - Patient status – Inpatient, Observation, Outpatient
    - Physician (provider) documentation
    - Length of stay
    - Assignment of optimum DRG
    - Discharge Planning
- Simply – signed physician order with date and time?
- Most important initiative **– collaboration of clinical staff TEAM members with revenue cycle staff TEAM members** – and exchange of information!

QUESTIONS

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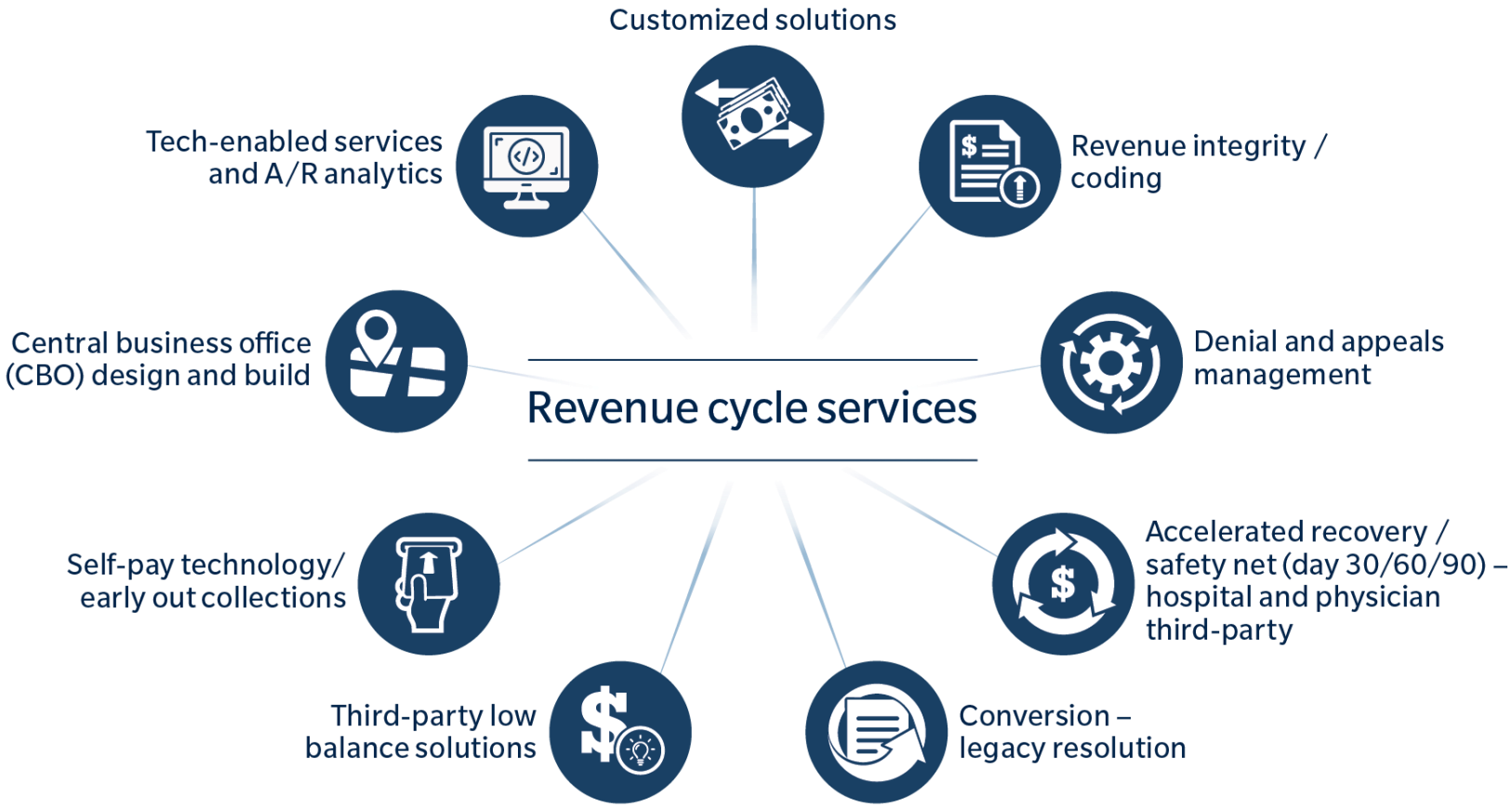
Our Mid Revenue Cycle Presence (June 5, 2023)

Our Solutions



Revolutionize your revenue cycle

Extend your staff and IT assets

Improve your bottom line

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