MANAGING THROUGH THE MAZE OF CURRENT CHANGES:

The Impact From the ACA And ICD-10 on the Revenue Cycle

PART ONE

Introductions

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Agenda

- Affordable Care Act
  - Overview
  - Recent Statistics
  - Roll-Outs
  - Impacts
- ICD-10
  - Clinical Documentation
  - Medical Necessity
  - Present on Admission
  - Case Mix
  - Revenue Cycle Strategies
- Questions?

The Affordable Care Act

The Affordable Care Act includes a series of Medicare reforms that will generate billions of dollars in savings for Medicare and strengthen the care Medicare beneficiaries receive. The new law protects guaranteed benefits for all Medicare beneficiaries, and provides new benefits and services to seniors on Medicare that will help keep seniors healthy. The law also includes provisions that:

Increase Access

- Health Insurance exchanges are designed to cover half of the newly insured
- The newly insured will have different demographic attributes than the currently insured
- Health plans must guarantee issue and renewability of health insurance regardless of health status

Improve Affordability

- As online marketplaces, exchanges promote price and quality transparency to increase competition
- Exchange coverage is subsidized for those who earn between 100% and 400% of the federal poverty level

Improve Quality

- Reduces the number of hospital readmissions
- Reduces hospital acquired conditions
- Bundling payments for ESRD
- Improves physician quality reporting

Fight Waste, Fraud, and Abuse

- The Affordable Care Act includes a range of provisions to reduce waste fraud and abuse such as expanding Recovery Audit Contractors (RACs); requiring face encounters with physicians before receiving certain services and requiring greater data matching capabilities

Source: CMS Office of the Actuary, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," (2010).

ACA Updates

(Forbes March 2014)

6%

Received notice that their plan was cancelled for a non-ACA related reason

15.9%

Still uninsured which translates to 3-4 million people ~ down from 17.1%**

18.6%

Received notice that their plan would no longer be offered as of January 2014 due to ACA requirements

75.4%

Did not receive any notice

Full time employment grew by over 2 million while part-time declined by 230,000

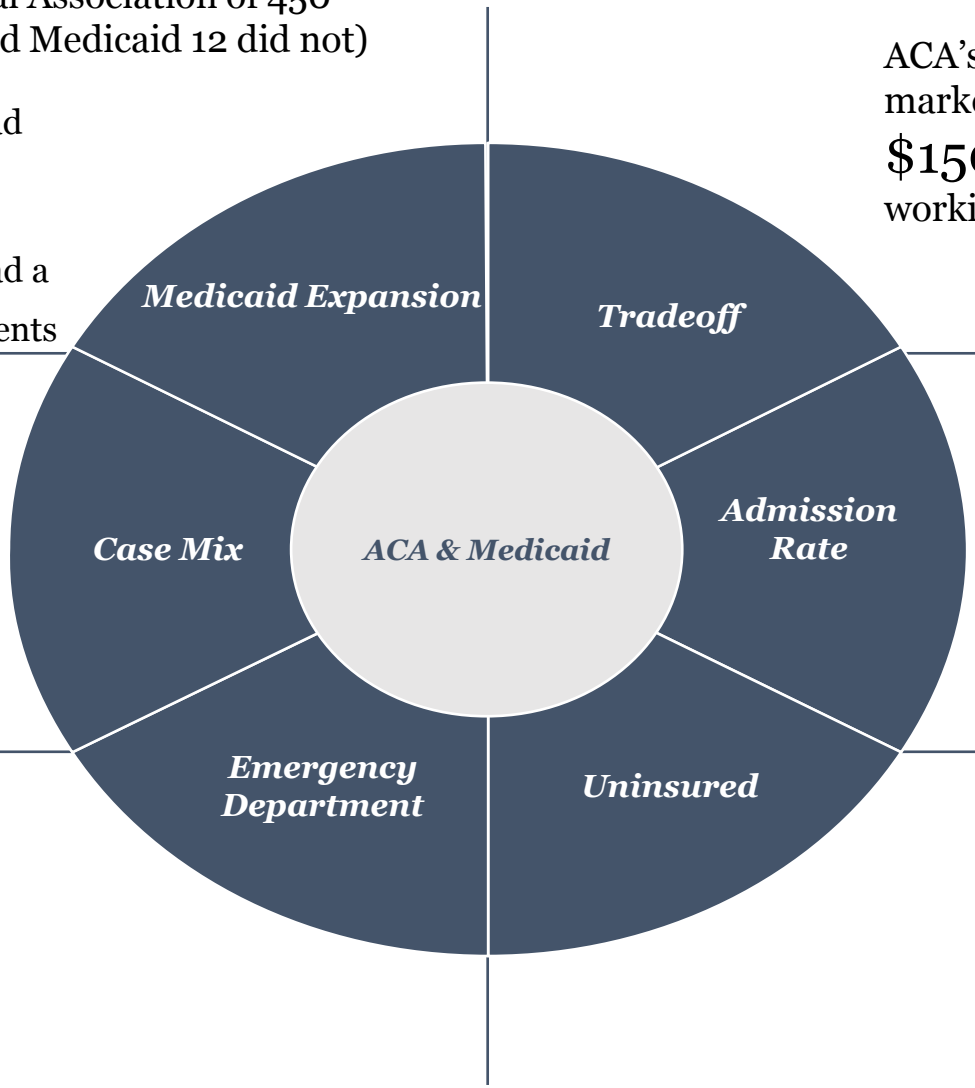
**estimates indicate that over half will be eligible for other coverage

Recent Medicaid Statistics

Recent study by Colorado Hospital Association of 450 hospitals in 25 states (13 expanded Medicaid 12 did not) found:

- States that expanded Medicaid had an increase of 4% in Medicaid patients
- Expanded Medicaid states also had a reduction of 2% in self-pay patients

ACA's trade off between Medicaid and marketplace coverage expansion and $150 billion in Medicare cuts is working



Medicaid admissions in expansion states ranged from 10.4% to 32%

Case Mix increased 10% for Medicaid patients first quarter 2014

ED usage increased by 5.6% in second quarter of 2014 compared to a 1.8% increase in non-expansion states

Uninsured self-pay admissions declined 47% first half of 2014

The Affordable Care Act Roll-Outs

2008 – "Never Events"

Never Events – As of 2008 the Centers for Medicare and Medicaid Services (CMS) no longer reimbursed a hospital for procedures which resulted in a "never event." A "never event" is an error that should never occur in a health care setting, such as surgery on the wrong patient or the wrong body part.

2011 – Market Basket Adjustment

Market Basket Adjustment: The ACA reduces market basket updates for inpatient and outpatient hospital services, as well as for Inpatient Psychiatric Facilities (IPF's), Inpatient Rehabilitation Facilities (IRF's) and Long Term Care Hospitals (LTCH's). Market basket reductions are estimated to save an estimated $112 billion over 10 years. These reductions are retroactive to January 1, 2010, and extend for a period of 10 years, and beyond.

The Affordable Care Act Roll-Outs

2012 – High 30-Day Readmission Rates for AMI, heart failure, pneumonia

30-Day Hospital Readmission Rates: Medicare will reduce payments to hospitals for potentially preventable readmissions for select conditions. Hospital readmission rates for these conditions will be published on the Center for Medicare/Medicaid Services' Hospital Compare Web site.

2012 – Value Based Purchasing

Hospital Value-based Purchasing program: Medicare will reward hospitals that provide higher quality or better patient outcomes. Under the Program, CMS will make value-based incentive payments to acute care hospitals, based either on how well the hospitals perform on certain quality measures or how much the hospitals' performance improves on certain quality measures from their performance during a baseline period. The higher a hospital's performance or improvement during the performance period for a fiscal year, the higher the hospital's value-based incentive payment for the fiscal year would be.

The Affordable Care Act Roll-Outs

2014 – Disproportionate Share payments cut

Disproportionate Share Payment (DSH): Under the ACA, Medicaid DSH payments will be reduced by $14.1 billion from FY 2014 through 2019, and Medicare DSH payments would be reduced by $22.1 billion from FY 2014 to 2019. In July 2013, CMS proposed reducing Medicare DSH spending by $1 billion in FY 2014, as part of its inpatient prospective payment system regulation for FY 2014. The agency has also proposed a methodology for reducing federal Medicaid DSH allotments to states by the ACA-mandated levels of $500 million in FY 2014 and $600 million in FY 2015. (Source: http://www.ahanews.com/ahanews/jsp/display.jsp?dcrpath=AHANEWS/AHANewsArticle/data/AHA_News_051713_dsh)

2015 – Hospital Acquired Infections – top quartile

Hospital Acquired Infections: In 2015, hospitals will face an additional 1% reduction in Medicare reimbursement payments if they fall into the top 25% of national risk-adjusted Hospital Acquired Conditions rates for all hospitals in the previous year.

ACA Impact – Bad Debt

Bad Debt Shifting

At a national level, uninsured individuals account for more than 2/3 of hospital Bad Debt; Balance after Insurance and Payor Disputes account for 1/3. This ratio is likely to shift significantly

This shift will require hospitals to change from a “wholesale” RCM model to retail model that focuses more energy on the collection from individual patients

Costs are higher to collect from individuals who also take significantly longer to pay their bills

It is crucial for Access/ Schedistration to collect the appropriate monies prior to services rendered and there are operational and technological challenges inherent with this internal mandate

Patient Advocacy programs can help reduce potential Bad Debt whether insourced or outsourced

ACA Impact – Clinical Revenue Cycle

Clinical

As reimbursement is moving away from fee-for-service to payment-for-value tighter integration of clinical records will be required- a task that has limited historical achievement

Keep in mind that with ACA, payors are no longer able to rely on risk selection as a lever, they are turning to Utilization and Care Management as key elements of their business model. Thus we are seeing increases in Authorization requirements (Primary & Secondary), Clinical Clearances and Retrospective payment take-backs through clinical audits for level of care

The next vital revolution for efficiency will be the Clinical Revenue Cycle- the process by which medical records for patient care are translated into billing and collection activity

- New Documentation Practices
- Defining new responsibilities for managing clinical denials
- Linking payments to quality

How ICD-10-CM Affects Clinical Documentation

1. The increased code detail contained in ICD-10-CM means that clinical documentation will need to change substantially. The ICD-10-CM includes a more robust definition of severity, comorbidities, complications, sequelae, manifestations, causes, and a variety of other important parameters that characterize the patient's conditions.

2. A large number of ICD-10-CM codes only differ in one parameter. For example, nearly 25 percent of the ICD-10-CM codes are the same except for indicating the right side of the patient's body versus the left. Another 25 percent of the codes differ only in the way they distinguish among "initial encounter," versus "subsequent encounter," versus "sequelae."

3. For example, even though there are more than 1,800 available codes for coding fractures of the radius, there are only approximately 50 distinct recurring concepts. The next slide shows the type of documentation the ICD-10-CM will require for a fracture of the radius and includes the following:

   Category: The category for the medical concepts that will need documentation
   Documentation Requirements: The list of individual concepts that should be considered in documentation to support accurate coding of the patient conditions

Source: CMS' ICD-10 Implementation Guide for payors

Under ICD-10… More Documentation

	Description
Disease Acuity	Will provide more accurate representation of the severity and urgency of the patient's condition; Example: Congestive Heart Failure |Better – Chronic diastolic congestive heart failure
Disease Type	Acute Renal Failure – Is it with tubular necrosis, acute cortical necrosis or medullary necrosis? • CAD – Is it without angina, with unstable angina, with spasm, with other forms of angina pectoris? • Hypertension, COPD, hyperlipedemia will require MORE
Disease Stage	Shows a relationship between the severity of a patient's condition and costs for the patient's encounter • Non-pressure skin ulcers need the level of tissue breakdown • There are stages to Chronic Kidney Disease (I-IV or ESRD); • Malnutrition – mild, moderate or severe
Site Specificity	Site specificity has been added to thousands of codes • UTI needs site (urethritis, cystitis, pyelonephritis) • Osteoarthritis – by joint(s) and if primary, secondary, or post traumatic

Myocardial Infarction: ICD-9 CM

Identify site of the MI

- Anterolateral wall
- Inferolateral wall
- Inferoposterior wall
- Subendocardial, ETC.

Identify episode of care

- Initial
- Subsequent, (less than 8 wks)
- unspecified

Identify any current complications

- Within initial Eight (8) week period

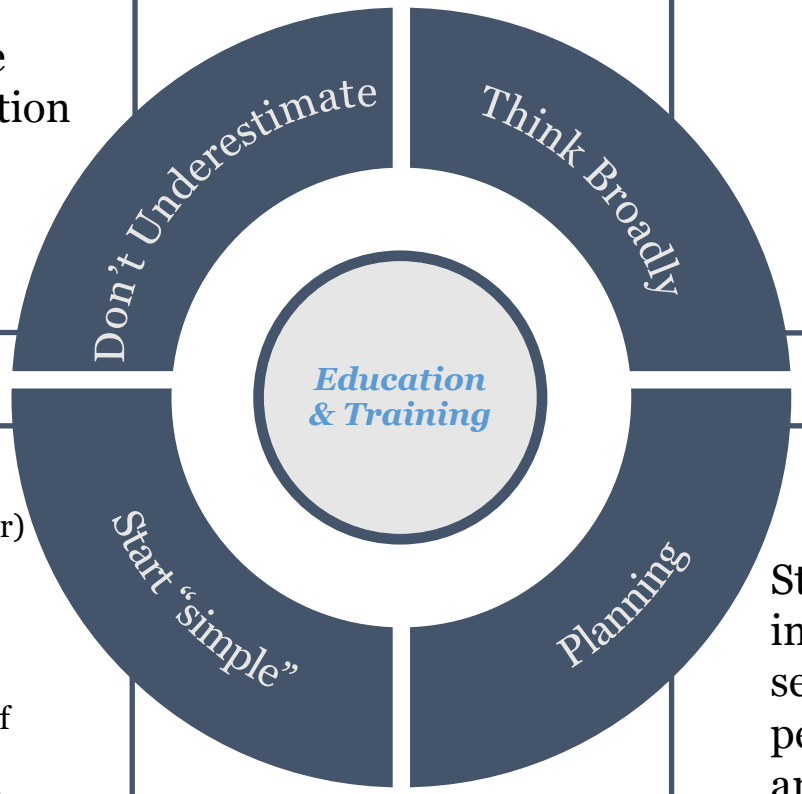
Myocardial Infarction – ICD – 10 CM

Identify episode of care	Identify type of MI	Identify site for initial episode	Identify site of subsequent	For NSTEMI	Identify any current complications
• Initial • Subsequent (< 4 wks)	• STEMI OR NSTEMI	•Anterior wall •Left main coronary artery •Left anterior descending artery •Other artery of Anterior •Inferior wall •Right coronary artery •Other artery of Inferior •Other specified site •Left circumflex coronary artery •Other specified site •Unspecified site	• Anterior • Inferior • Other	• No site specific required • Select code on episode only	•Within initial 28 day period •Hemopericardium; atrial septal defect; ventricular septal defect; rupture of …etc. •Use additional code to identify any “connection” to tobacco use

Clinical Quality Management

Education and Training will be BIGGEST situation for specificity requirements

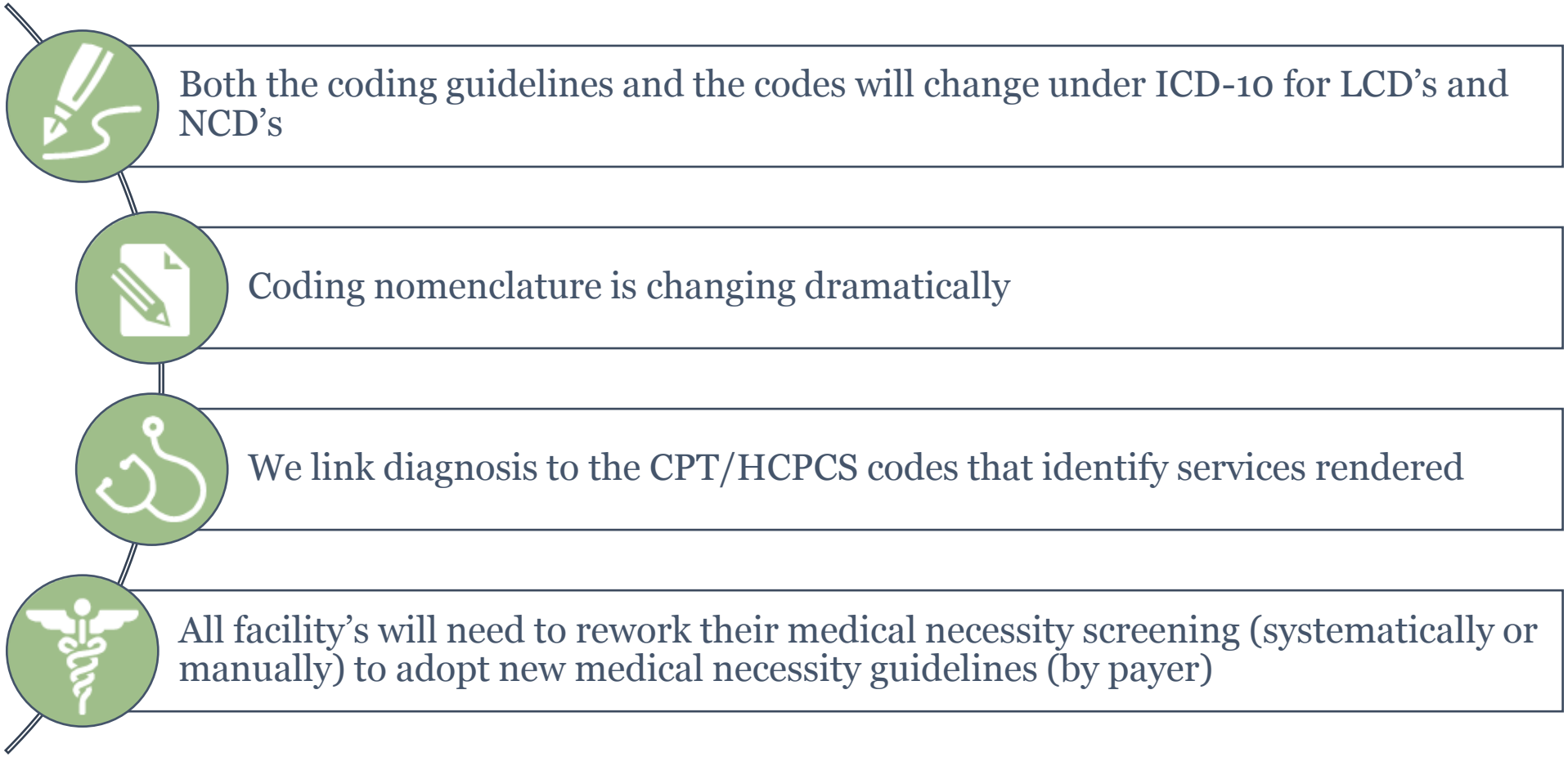
Not JUST providers, nurses and coders
- Physician office staff
- Patient/physician office medical record
- Hospital Electronic Medical Records (EHR)
- Practice Management systems
- "Outsourcing" Labs, Radiology, Oncology, etc.



- Choose a major specialty (volunteer)
- Transform a super bill as a specific example
- Physical "Body Sheets" for levels of specificity
- Complete and then get assessment

Start some informative sessions to discuss people, process and technology

Medical Necessity Changes for ICD-10



- Both the coding guidelines and the codes will change under ICD-10 for LCD's and NCD's
- Coding nomenclature is changing dramatically
- We link diagnosis to the CPT/HCPCS codes that identify services rendered
- All facility's will need to rework their medical necessity screening (systematically or manually) to adopt new medical necessity guidelines (by payer)

Changing the NDCs for Coding and Medical Necessity

Example – CPT Codes for lab tests

87086: Culture, bacterial; quantitative, colony count, urine

87088: Culture, bacterial; with isolation and presumptive identification of each isolates, urine

87184: Listed in manual only Susceptibility studies, antimicrobial agent; disk method, per plate (12 or fewer agents)

87186: Listed in manual only Susceptibility studies, antimicrobial agent; microdilution or agar dilution (minimum inhibitory concentration (MIC) or breakpoint), each multi-antimicrobial, per plate

Medical Necessity Changes

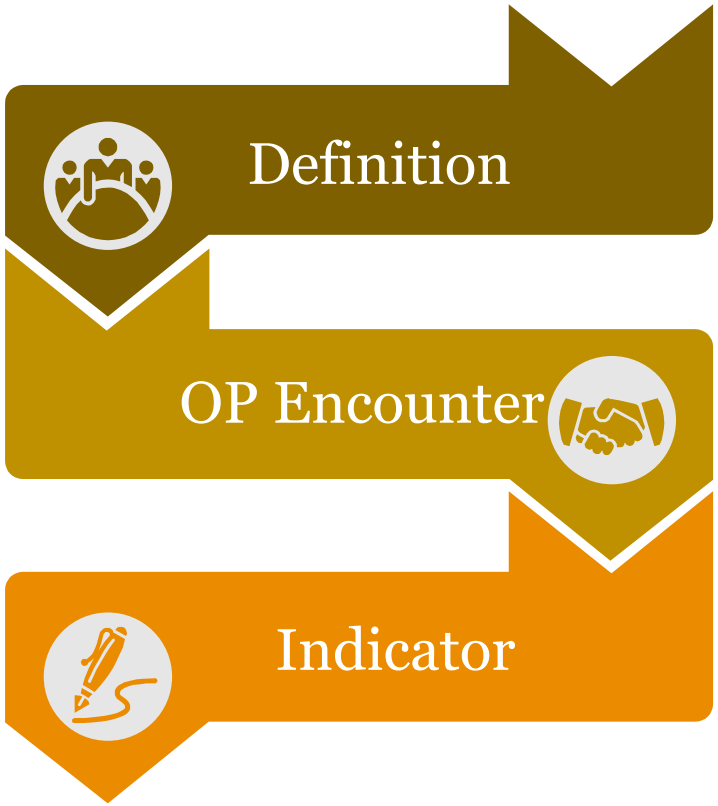
Link to these specific ICD-9 Diagnoses:

ICD-9-CM Codes Covered by Medicare Program:

- The individual ICD-9-CM codes included in code ranges in the table below can be viewed on CMS' website under:

Downloads - Lab Code List:
www.cms.gov/Medicare/Coverage/CoverageGenInfo/LabNCDs.

Present on Admission (POA)



POA is defined as present at the time the order for inpatient admission occurs

Conditions that develop during an OP encounter (including ED, Observation or OP surgery) are considered as POA

The POA indicator is assigned to principle and secondary diagnoses and external cause of injury codes (E-codes)

POA Examples

External Cause of Injury Codes

Y indicator is assigned to any E code representing an external cause of injury or poisoning that occurred prior to the inpatient admission (pt fell out of bed at home or in the ED prior to admission)

N indicator is assigned for any E code or poisoning that occurred during an inpatient stay (pt. fell out of bed in the hospital or had an adverse reaction to medication administered after inpatient admission

POA Impacts to Reimbursement

Payers such as CMS and others are emphasizing value-based purchasing and pay-for-performance

CMS has added to the list of HAC's and other payers have adopted POA into their reimbursement models

POA will impact the assignment for APR-DRG's due to the level of specificity that must be coded to reach the correct APR-DRG

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ICD-10 Effect on Payor Reimbursements

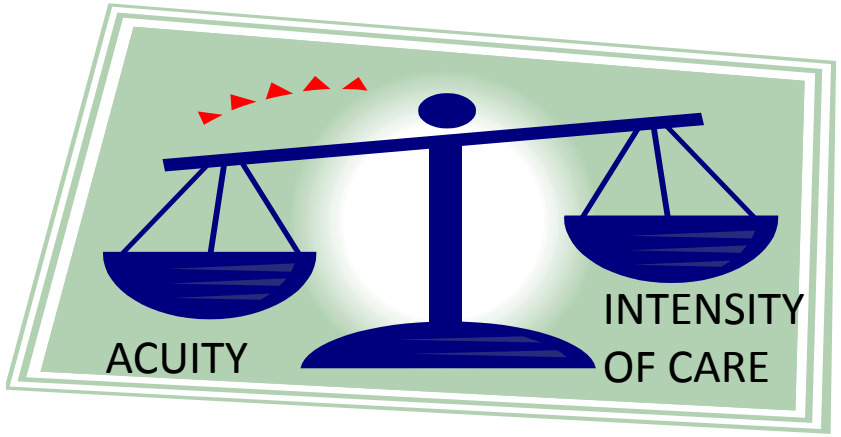
01 Independent analysis of some of the most common reimbursement arrangements identified conversion challenges that may modify some payor and provider reimbursement arrangements, while for others the effect will be minimal

02 Solutions to these situations need to be tailored to your specific environment; however, you will want to review the possibilities identified in the analysis outlined in the table below

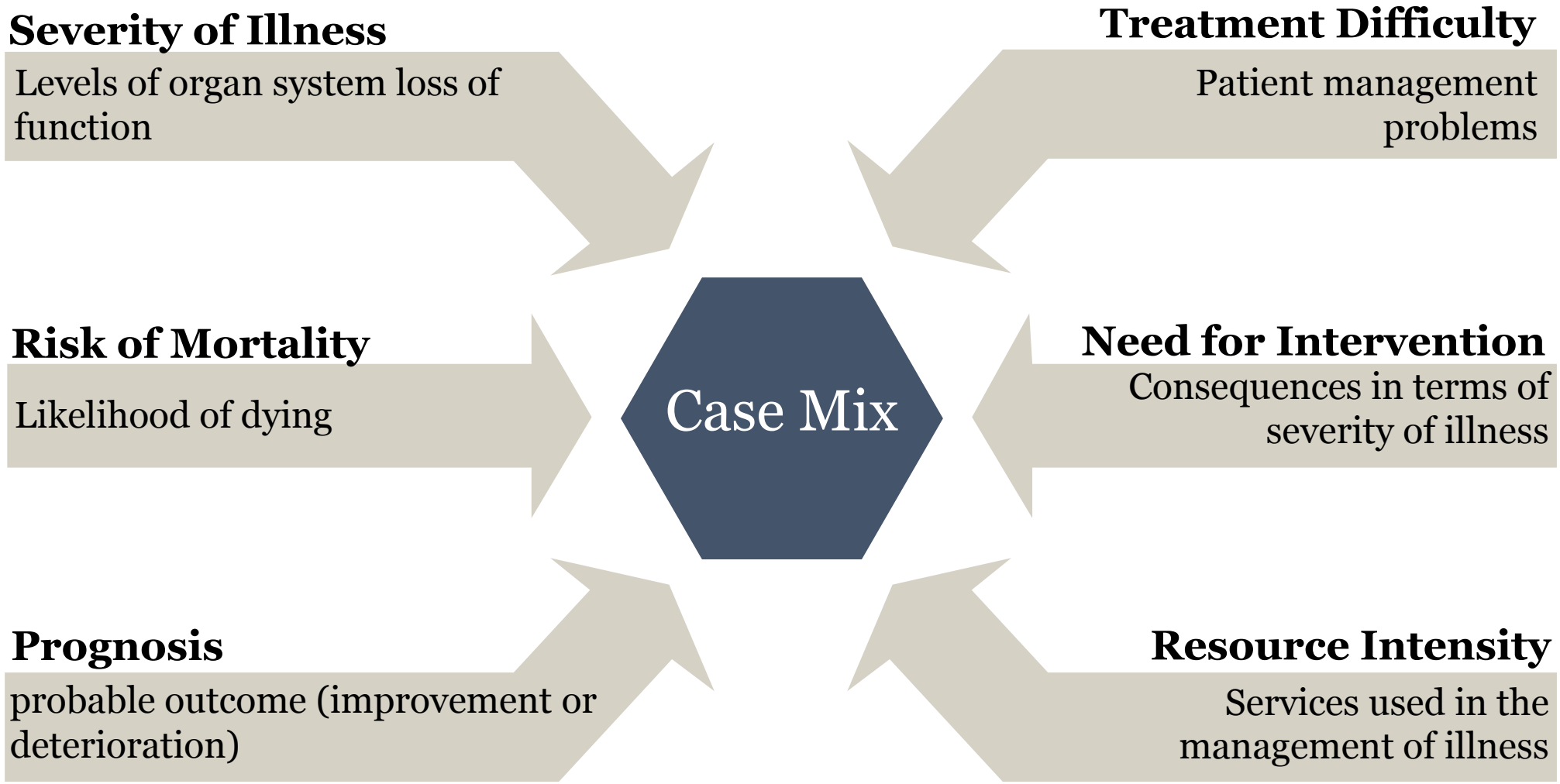
03 In cases such as diagnosis-related group carve outs where codes have a relatively small impact on reimbursement formulas, most payors will likely experience few conversion problems

Case Mix

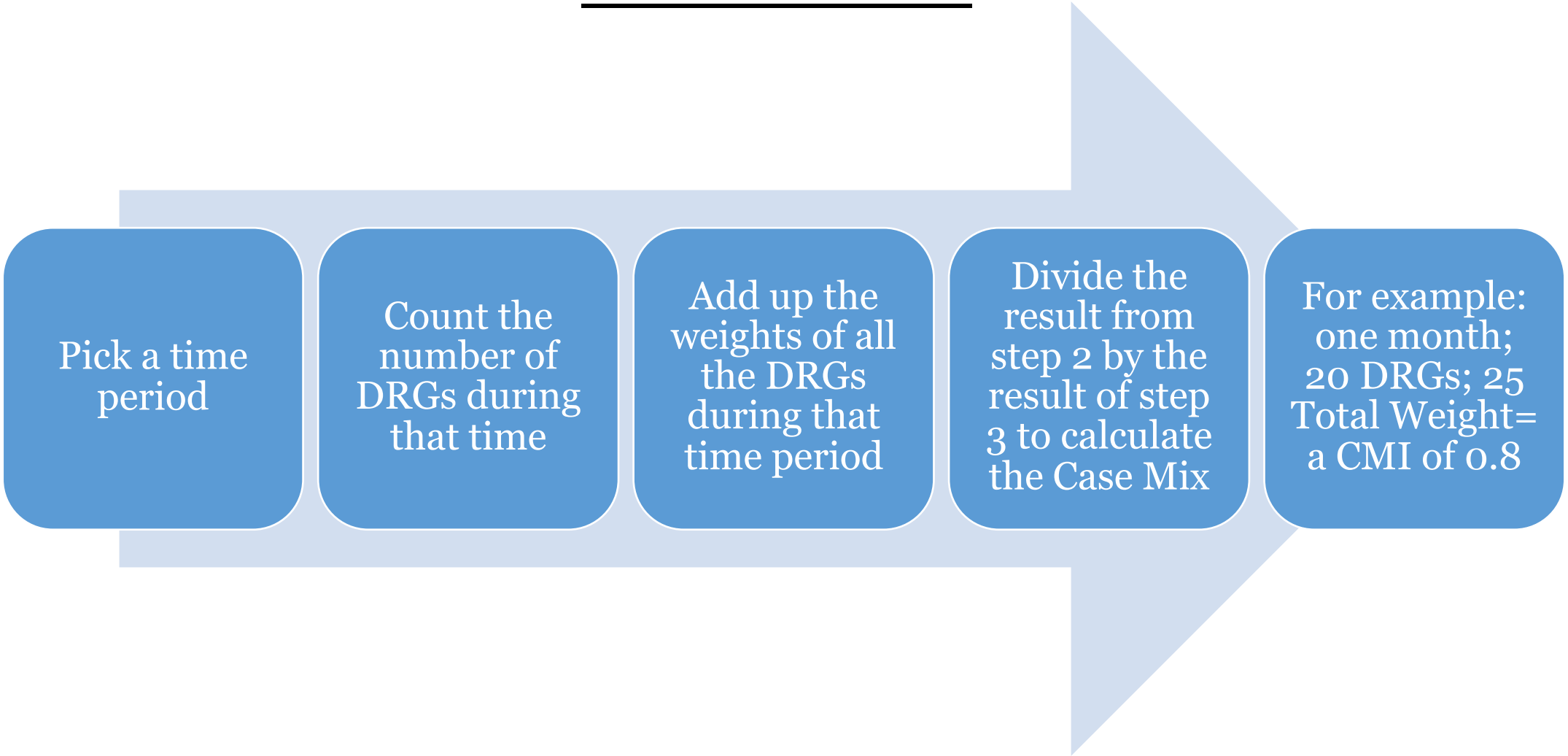
- Is the calculation that represents the level of acuity and intensity of care provided by a facility to the 'average' inpatient



Six dimensions for measuring Case Mix



Calculation



Case Mix Calculation

MSDRG	Description	Weight
470	Major joint replacement or reattachment of lower extremity w/o MCC	2.0613
313	Chest pain	0.5404
392	Esophagitis, gastroent & misc digest disorders w/o MCC	1.6921
247	Perc cardiovasc proc w drug-eluting stent w/o MCC	1.9121
885	Psychoses	0.8899
	TOTAL	7.0958

One Case of Each DRG gives a case mix of 9.7742

Future of Reimbursement Methodology

ICD – 10 Documentation Requirements

- Increased level of patient clinical condition
  - Acuity
  - Stages
  - Disease Type
  - Specific site
- POA and current Severity
- Secondary Diagnosis impact

APR-DRG Assignment Requirements

- DRGs have been re-allocated to APR-DRGs for distinct grouping
- Each APR-DRG has four sub-classes to it
  - Minor
  - Moderate
  - Major
  - Extreme
- Different weights for each sub-class

Documentation for the APR-DRGs

APR-DRGs	expand upon DRGs by also assigning to each case a severity of illness (SOI) subclass and risk of mortality (ROM) subclass
SOI	Severity of Illness (the extent of physiologic decomposition or organ system loss of function)
ROM	Risk of Mortality (the likelihood of dying)

Documentation Required for APR-DRGs

***The following discharge data elements are used for APR-DRG subclass assignment*:**

Principle DX coded in ICD-9 CM
Principle Procedure coded in ICD-9 CM (Vol 3)
Secondary DX coded in ICD-9 CM
Secondary Procedures coded in ICD-9CM (V 3)
Age
Sex
Birth weight (value or ICD-9 CM code)

Documentation Required for APR-DRGs

Discharge Date
Status of Discharge
Days on Mechanical Ventilator (value or ICD-9 CM code)
Documenting the presence of multiple co-morbid conditions in combination increases the severity of illness for a patient
The increase in severity accurately reflects the increased difficulty and costs involved in treating the patient

New Methodology of APR-DRGs

	Future Methodology						
				APRDRGs	Weights		
MSDRG		Weight	APR #	1	2	3	4
470	Major joint replacement or reattachment of lower extremity w/o MCC	2.0613	313	1.0621	1.6254	2.8176	7.0611
313	Chest pain	0.5404	203	0.3586	0.451	0.6973	1.9656
392	Esophagitis, gastroent & misc digest disorders w/o MCC	1.6921	220	1.2027	1.9353	3.4738	7.5539
247	Perc cardiovasc proc w drug-eluting stent w/o MCC	1.9121	175	1.4546	1.6351	2.4993	3.8994
885	Psychoses	0.8899	751	0.4768	0.5508	1.4403	1.4765

New Case Mix Potentials

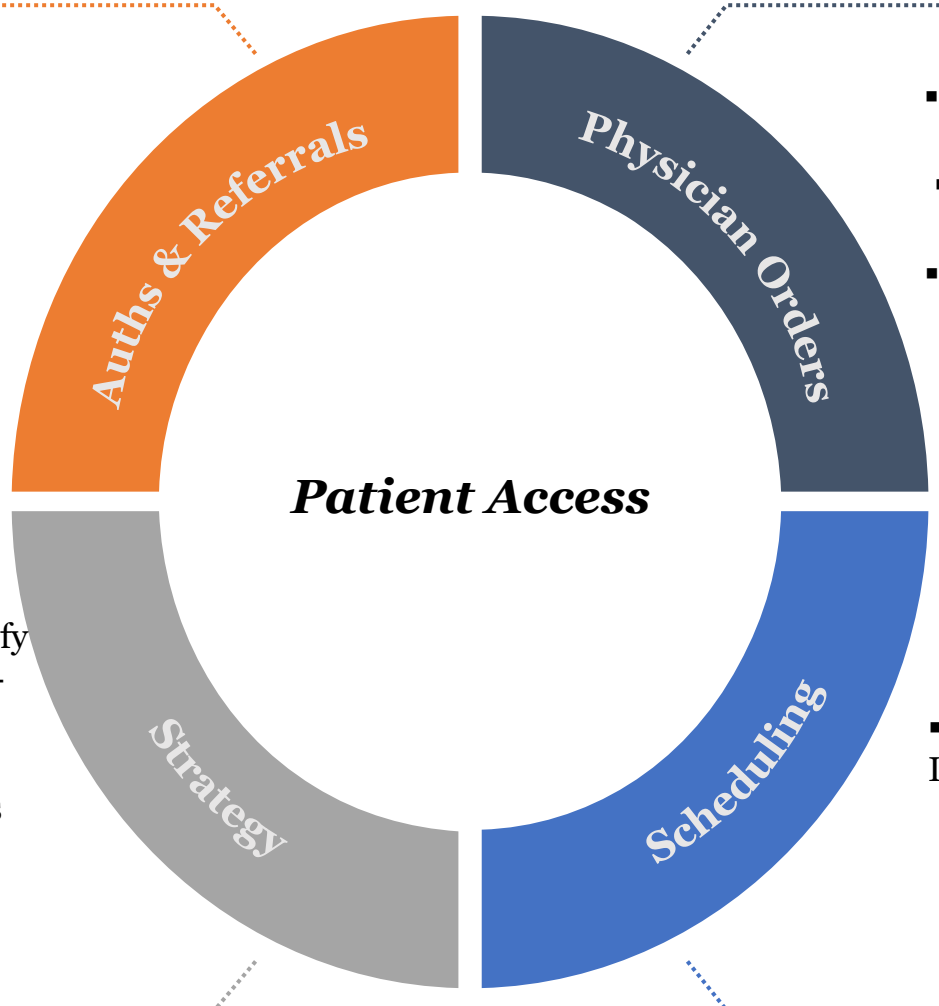
	Future Methodology							
					APRDRGs	Weights		
MSDRG		Weight		APR #	1	2	3	4
470	Major joint replacement or reattachment of lower extremity w/o MCC	2.0613		313	1.0621	1.6254	2.8176	7.0611
313	Chest pain	0.5404		203	0.3586	0.451	0.6973	1.9656
392	Esophagitis, gastroent & misc digest disorders w/o MCC	1.6921		220	1.2027	1.9353	3.4738	7.5539
247	Perc cardiovasc proc w drug-eluting stent w/o MCC	1.9121		175	1.4546	1.6351	2.4993	3.8994
885	Psychoses	0.8899		751	0.4768	0.5508	1.4403	1.4765
		7.0958			**5.5548**	**8.1976**	**13.9283**	**25.9565**

Case Mix now moves from 9.7742 to numerous possibilities!!!

ICD-10 Focus Areas: Patient Access

Authorizations & Referrals

- Triggers for evaluating prior authorizations and referrals are based on ICD-9 codes
- Expect changes in triggers or approvals as medical policies are refined



Physician Orders

- Risk that orders will not include necessary ICD-10 codes
- Hospital is "on the hook" if not mitigated at point of receipt
- Consider requiring OP orders to require ICD-9 and ICD-10 codes for a period of time

Strategy

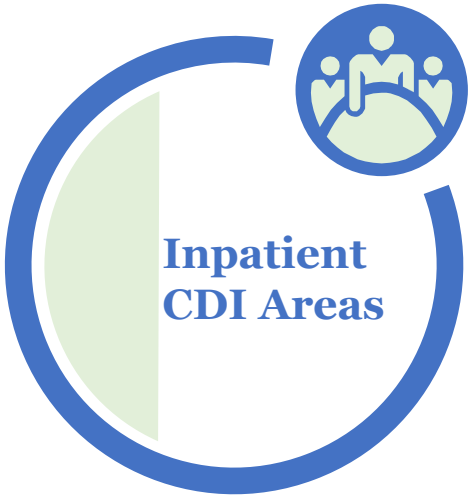
- Training – ensure staff can identify ICD-10 codes and screen for non-compliance
- Physician Outreach – adoption critical to minimizing bottlenecks and impacting patient care
- Make a Plan – develop plan to manage missing ICD-10 codes

Scheduling

- Policy consideration to require ICD-10 code in order to schedule non-emergent procedures
- Are your Scheduling staff adequately trained to screen for ICD-10 codes?

ICD-10 Focus Areas: CDI

Objectives	Benefits
▪ Establish a CDI operational model	▪ Increase in coding accuracy
▪ Focus on practice coding	▪ Decrease in denials and potential to increase reimbursements
▪ Improve documentation specificity and clinical quality data capture	▪ Potential for more accurate documentation and coding support for risk adjustment score ▪ Improves readiness for global payment models



Objectives	Benefits
▪ Improve clinical documentation to more accurately capture patient severity of illness and risk of mortality	▪ Achieve a more accurate representation of clinical mix ▪ Increases case mix index ▪ Improves accuracy of patient safety indicators (PSI), Potentially Preventable Readmissions/complications (PPR/PPC) ▪ Greater communication between physicians and UR/QM/HIM staff
▪ Enhance revenue capture opportunities	▪ Potential high return on investment ratio ▪ Appropriate and supportable reimbursement for patient care resources

ICD-10 Focus Areas: PFS

Contract Management:

- Determine contract renewal periods for Commercial payers
- Consider discussing the following:
  - Relaxation of timely filing limits
  - Inclusion of Periodic Interim Payments (PIP)
  - Ensuring financial neutrality

Strategy:

- Collaborate with payers to mitigate risk
- Decrease A/R and increase Cash on Hand
- Shifting A/R workloads may provide ability to reorganize PFS staff to address denial volumes

Accounts Receivable:

- Post ICD-10 implementation expected to impact A/R and slow cash flow
- Analyze A/R aging and determine areas to quickly liquidate
  - Internal SWAT teams
  - Outsource strategically
- Goal is to "clean" A/R and ready capacity for ICD-10 impact

Denials Management:

- Anticipated increase in denials due to coding challenges
  - May be result of remediation of medical policies or processing rules
- Consider run-down as part of A/R strategy

Questions?

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