2012 Alabama Rural Health Conference – May 2-3 - Prattville

Alabama State Office Rural Health Breakout Sessions

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Today's State of Affairs in Rural PPS Hospitals

Wednesday, May 2 (1:00 – 1:30)

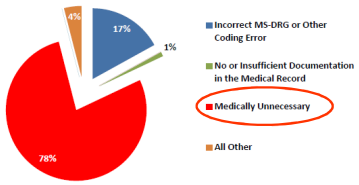
Are We Going at a Fast Enough Speed?

Increased Scrutiny

- Medical necessity documentation for both IP and OP

Percent of Participating Hospitals by Top Reason for Complex Denials by Dollar Amount for Medical/Surgical Acute Hospitals with RAC Activity, 4th Quarter 2011

Survey participants were asked to rank denials by reason, according to dollars impacted.

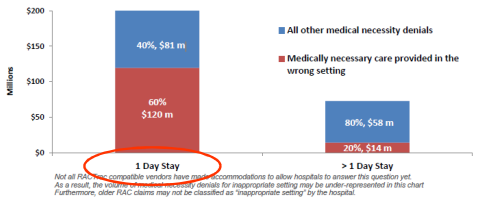


AHA RACTrack
http://www.aha.org/content/11/11Q4ractracresults.pdf

Increased Scrutiny

- One-day IP stay denials

Reason for Medical Necessity Denials by Length of Stay Among Hospitals Reporting Medical Necessity Denials, 4th Quarter 2011



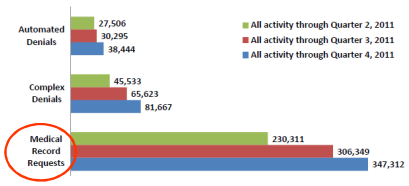
Not all RAC-doc compatible vendors have made accommodations to allow hospitals to answer this question yet. As a result, the volume of medically necessary denials for inappropriate setting may be under-represented in this chart. Furthermore, older RAC claims may not be classified as "inappropriate setting" by the hospital.

AHA RACTrack
http://www.aha.org/content/11/11Q4ractracresults.pdf

Increased Scrutiny

- RAC review
- Denials = not getting paid for the work done!!

Reported Automated Denials, Complex Denials and Medical Records Requests by Participating Hospitals, through 4th Quarter 2011



AHA RACTrack
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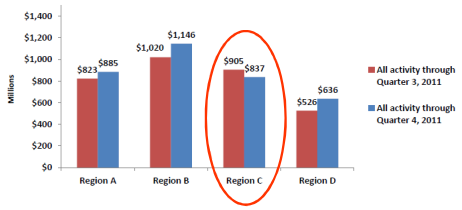
Increased Scrutiny

- RAC review

Medicare Payments Associated with Medical Records Requested from Participating Hospitals, through 4th Quarter 2011, in Millions



AHA RACTrack
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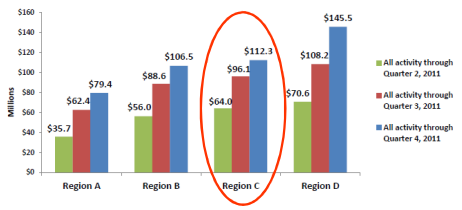
Increased Scrutiny

- RAC review

Dollar Value of Automated and Complex Denials by RAC Region for Participating Hospitals, through 4th Quarter 2011, Millions



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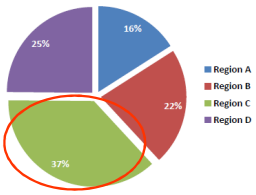
Increased Scrutiny

- RAC review

Percent of Automated and Complex Denials by RAC Region for Participating Hospitals, through 4th Quarter 2011



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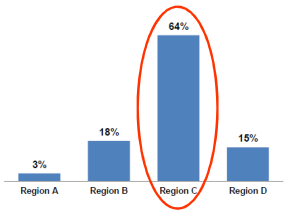
Increased Scrutiny

- RAC review

Percent and Number of Reported Automated Denials for Participating Hospitals, by Region, through 4th Quarter 2011

	Total Number of Automated Denials by RAC Region
Region A	1,288
Region B	6,787
Region C	24,667
Region D	5,702



AHA RACTrack
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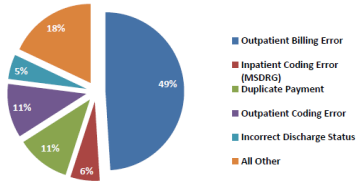
Increased Scrutiny

- RAC review

Percent of Participating Hospitals by Top Reason for Automated Denials by Dollar Amount for Medical/Surgical Acute Hospitals with RAC Activity, 4th Quarter 2011, Region C

Survey participants were asked to rank denials by reason, according to dollars impacted.



AHA RACTrack
http://www.aha.org/content/11/11Q4ractracresults.pdf

AHA RACTract - (You are encouraged to review)

http://www.aha.org/advocacy-issues/rac/ractrac.shtml

http://www.aha.org/content/11/11Q4ractracresults.pdf

Note: According to the Final Rule, States are required to implement their respective RAC programs by January 1, 2012

http://www.cms.gov/MedicaidIntegrityProgram/downloads/Scanned_document_29-12-2011_13-20-42.pdf

Decreasing Risk & Improving Outcome

- Registration to ensure that they have the patient registered at the correct level of care as intended by the physician
- Utilization review and medical necessity documentation
- Patient notification when not meeting IP or OP criteria
- Knowledgeable coders
- Acceptable diagnosis for OP services
- CDM updated and maintained

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Decreasing Risk & Improving Outcome

- Comprehensive encounter forms for all OP services (ED, Infusion, SDS/Proc, Observation….)
- Audit process
- Managing cost
- Ensuring that charges are all in
- Managing LOS
- Comprehensive data tracking – A MUST
- Process analysis and action planning
- All while maintaining physician and staff satisfaction

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Increasing Challenges

- Payment systems transitioning from volume based to value based yet we are still paid on a FFS system
- Keeping up with the multiple regulatory changes;
- Increased emphasis on quality as payment and market differentiator (IP, SB/SNF, OP, OR, ED, Clinics);
- Reduced payments for services;
- Physician recruitment in rural areas continues to be a challenge;
- Increased difficulty in meeting IP criteria
- Increased competition;

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Factors Impacting Rural Health

- Requirement that rural information technology is on par with urban hospitals;
- Rural hospital governance lacking the knowledge or understanding of their role regarding strategies, finances, and operations;
- Consumer perception that "bigger is better"; hospital being a "Band-Aid station"
- Quality indicators must be measurable, comparable and meaningful;
- Old facilities and true limitations to accessing capital
- Increased importance of patient satisfaction

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Factors Impacting Rural Health

CMS Innovation Center

Mission

- **Better health care** by improving all aspects of patient care, including Safety, Effectiveness, Patient-Centeredness, Timeliness, Efficiency, and Equity (the domains of quality in patient care as defined by the Institute of Medicine).
- **Better health** by encouraging healthier lifestyles in the entire population, including increased physical activity, better nutrition, avoidance of behavioral risks, and wider use of preventative care.
- **Lower costs through improvement** by promoting preventative medicine, improved coordination of health care services, and by reducing waste and inefficiencies. These efforts will reduce the national cost of health care and lower out-of-pocket expenses for all Medicare, Medicaid, and CHIP beneficiaries.

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CMS's Triple Aim Goal

Proposed in 2007 by Don Berwick, former CMS Administrator, which emphasizes the following

1) The simultaneous pursuit of improving the experience of care (quality driver),
2) Improving the health of populations (value based payment driver) and,
3) Reducing per capita costs of healthcare (reduced payment driver).

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Changes in Payment System

- *Payment systems will transition from volume based payment providing quality services while managing cost,*
  - Moving to pay-for-performance from being paid-for-volume
  - *Increasing volume to reduce unit costs and generate profit is no longer relevant*
- Bringing the old with the new is challenging
- Primary care physicians role with patients assigned to them and responsible to manage cost through quality
  - PCPs will be the revenue drivers
  - Will require increased involvement
  - All other cost, including in most cases specialists, technology, bricks and mortar, and staff, become costs in the new economic model

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Survival

- The delivery system must remain aligned with the current payment system while implementing programs and processes that will facilitate the transition to a new payment system
- Rural delivery systems must begin to prepare for the transition now
- Engage commercial payers in conversations about future changes in payment processes
- Do not hide your head in the sand
  - Have your ear to the ground
  - Know what is going on in your service area
  - Are there ACO like talks going on?

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Survival

- Rural hospitals will gain extraordinary value relative to costs, through alignment with PCPs
- Rural hospitals that closely align with employed and independent providers will enable medical staff interdependence and support clinical integration efforts
- Board of Directors education
  - This is not the time to "play politics"
  - Discussion regarding major strategic planning and decisions making, including affiliation strategies and medical staff alignment,
  - Time to shift the focus to increasing hospital efficiency
  - Engaged in quality management

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Quality Differentiator

- Beginning in 2012, hospitals will be scored based on quality measures from three domains compared against peers (outcome score) and themselves (improvement scores).
- These three domains include;
  - Clinical Process,
  - Patient Experience and
  - Outcomes (beginning in 2014).
- *Rural hospital leadership must become comfortable with the reality that quality data is already available publicly, and transparency will increase in the coming years.*
  - Some hospitals are still not transparent internally
  - Time to get on the band-wagon

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Quality Differentiator

- Determine what is to be tracked
  - Go beyond what CMS expects
  - Do it because it's the right thing to do
  - Culture change is a must
- Make health information technology work for you and not the other way around
  - Enhanced access to data allows hospitals to focus on improving outcomes
- Documented quality will increasingly become a differentiator in future provider recruitment
  - Will be easier for them to meet expectations
- Quality must be incorporated in the strategic plan
- Every employee must be involved – it cannot be an office job!

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Reduced Payments

- An unsettling future regarding funding for rural healthcare:
  - The move to a value based payment program will include a 1 percent maximum cut beginning in 2013, and 2 percent in 2017 and every year thereafter
  - 30 day re-admission payment reduction of 1 percent in 2013, and 3 percent in 2015 and every year thereafter
  - Potential physician payment cuts,
  - Reductions of the update factor for the Prospective Payment System (PPS) facilities and
  - The expansion of already underfunded state Medicaid programs,

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Recommended Strategies

- Increase the efficiency of revenue cycle function by
  - Adopting revenue cycle best practices,
  - Ensuring the hospital has an effective measurement system in place and "super charging" front end processes, including
  - Online insurance verification and point of service collections
  - All hospitals should ensure their chargemaster is up-to-date with appropriate pricing
- Know your community – what are their needs – what opportunities exists
- Review both profitable and non-profitable service lines to determine an appropriate fit with the hospital's mission and financial contribution to viability of the organization.

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Recommended Strategies

- Ensure a strong competitive skilled care program if you offer "swing bed"
  - Just having a service to manage MS-DRG LOS is no longer sufficient
  - Use it to manage readmissions
- Develop a strong discharge planning process
- Early patient education
- Efficient medication reconciliation process
- Efficient discharge planning instructions
- Strong transition of care process
- Meaningful follow-up system

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In Conclusion

- Rural providers can no longer remain on the sidelines
- Providers must actively position themselves for the transforming payment systems, competition over value and quality, and overall reductions in revenue
- Changes in Medicare and Medicaid payment and delivery systems will have the most direct impact on providers.
- Imperative to evaluate all opportunities to increase efficiency and improve quality
  - Be a partner in the future evolutions of healthcare

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