The Importance of Clinical and Financial Integration and Revenue Integrity

Michele Madison
mmadison@mmmlaw.com
404-504-7621
Quality vs Quantity
New Focus

- Reduce Costs
- Improve Outcomes
- Gain Efficiencies

- ACOs
- SGR
- Patient Centered Medical Home
Value Based Purchasing

• Required by the Affordable Care Act, which added Section 1886(o) to the Social Security Act
• Quality incentive program built on the Hospital Inpatient Quality Reporting (IQR) measure reporting infrastructure
• Next step in promoting higher quality care for Medicare; pays for care that rewards better value and patient outcomes, instead of just volume of services
• Funded by a 1% reduction from participating hospitals’ base operating diagnosis-related group (DRG) payments for FY 2013, increasing to 2% by FY 2017

• Uses measures that have been specified under the Hospital IQR Program and results published on Hospital Compare for at least one year
Metrics

2013 Measures
12 Clinical Process Measures
8 Patient Caregiver Experience Measures

2014 Measures
Add Efficiency and Outcome Measures
Value Based Purchasing

- Linking provider payments to improved performance by health care providers.
- This form of payment holds health care providers accountable for both the cost and quality of care they provide.
- It attempts to reduce inappropriate care and to identify and reward the best-performing providers

www.healthcare.gov
Metrics

• Acute Myocardial Infraction
  • Therapy within 30 minutes
  • PCI within 90 minutes
• Pneumonia
  • Blood Cultures in ED
  • Initial Antibiotic Selection for CAP
• Surgical Care Improvement
  • Received a Beta Blocker During the Perioperative Period
  • Prophylaxis Ordered
  • Ordered 24 hours prior to and following surgery

• Hospital Acquired Infections
  • Prophylactic Antibiotic Received Within 1 Hour Prior to Surgical Incision
  • Prophylactic Antibiotic Selection for Surgical Patients
  • Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery
  • Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose

• Heart Failure
  • Discharge Instructions
Metrics—Patient Caregiver

Communication with Nurses
· Communication with Doctors
· Responsiveness of Hospital Staff
· Pain Management
· Communication About Medicines
· Cleanliness and Quietness of Hospital Environment
· Discharge Information
· Overall Rating of Hospital
Hospital Acquired Infections

• Foreign Object Retained After Surgery
• Air Embolism
• Blood Incompatibility
• Pressure Ulcer Stages III & IV
• Falls and Trauma: (Includes: Fracture, Dislocation, Intracranial Injury, Crushing Injury, Burn, Electric Shock)
• Vascular Catheter-Associated Infections
• Catheter-Associated Urinary Tract Infection (UTI)
• Manifestations of Poor Glycemic Control
2014 Metrics

Mortality Rate

• Mortality-30-AMI: Acute Myocardial Infarction (AMI) 30-day Mortality Rate
• Mortality-30-HF: Heart Failure (HF) 30-day Mortality Rate
• Mortality-30-PN: Pneumonia (PN) 30-Day Mortality Rate
2015

- Fiscal Year (FY) 2015 Minimum Reporting Requirements
- Clinical Process of Care: 10 cases and 4 measures
- Patient Experience of Care: 100 completed surveys
- Outcome Measures: Hospitals must report the applicable case minimum for at least 2 of the 5 measures
2015

• Outcome domain.
  • AMI 30-Day Mortality: 25 cases
  • HF 30-Day Mortality: 25 cases
  • PN 30-Day Mortality: 25 cases
  • AHRQ (PSI-90): 3 cases for any one of the underlying indicators
  • HAI (CLABSI): 1 predicted infection
• Efficiency (Medicare Spending Per Beneficiary): 25 episodes of care
Fiscal Year (FY) 2015

12 Clinical Process of Care measures
8 Patient Experience of Care dimensions (HCAHPS)
3 - 30-Day Outcome Mortality measures:
   - Acute Myocardial Infarction (AMI)
   - Heart Failure (HF)
   - Pneumonia (PN)
1 Agency for Healthcare Research and Quality (AHRQ) Composite measure:
   - Patient Safety Indicator (PSI-90)]
1 Healthcare Associated Infection:
   - Central Line-Associated Blood Stream Infection (CLABSI)
1 Efficiency measure:
   - Medicare Spending Per Beneficiary (MSPB)
# 2015 Scoring

<table>
<thead>
<tr>
<th>Domain</th>
<th>Weight</th>
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<tbody>
<tr>
<td>Clinical Process of Care</td>
<td>20%</td>
</tr>
<tr>
<td>Patient Experience of Care</td>
<td>30%</td>
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<tr>
<td>Outcome</td>
<td>30%</td>
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<tr>
<td>Efficiency</td>
<td>20%</td>
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Clinical Integration
Clinical Integration

• The integration of clinical information and healthcare delivery services from distinct entities.
• Continuum of care, including preventative, outpatient, inpatient acute hospital and post-acute care to improve the value of care provided
Triple Aim

- Improving Population Health
- Reducing Costs
- Improving the Experience of Care
ACO

- Recognized under State Law as Legal Entity with a TIN.
- Governing Body must have 75% representation from ACO members.
- Financial and clinical integration.
- A leadership and management structure that includes clinical and administrative systems.

“Better health care for individuals” defined as health care that is safe, effective, patient-centered, timely, efficient, and equitable
Centers for Medicare and Medicaid Innovation

a model must either reduce spending without reducing the quality of care, or improve the quality of care without increasing spending, and must not deny or limit the coverage or provision of any benefits
Bundled Payment

1. Episode of care as the acute care hospital stay only (Model 1),

2. The acute care hospital stay plus post-acute care associated with the stay (Model 2),

3. Just the post-acute care, beginning with the initiation of post-acute care services after discharge from an acute inpatient stay (Model 3).

4. A single, prospective bundled payment that would encompass all services furnished during an inpatient stay by the hospital, physicians and other practitioners.
Comprehensive Primary Care

1. Commercial Payer Program
2. Involves 7 Primary Care Regions

Medicare will work with commercial and State health insurance plans and offer bonus payments to primary care doctors who better coordinate care for their patients. Primary care practices that choose to participate in this initiative will be given resources to better coordinate primary care for their Medicare patients.
FHQC Advanced Primary Care

- Goal is to show how the patient-centered medical home model can improve quality of care, promote better health, and lower costs.
- Participating FQHCs are expected to achieve Level 3 patient-centered medical home recognition, help patients manage chronic conditions, as well as actively coordinate care for patients.
- Paid a monthly care management fee for each eligible Medicare beneficiary receiving primary care services. In return, FQHCs agree to adopt care coordination practices that are recognized by the National Committee for Quality Assurance (NCQA).
Beyond Medicare/Medicaid

Third Party Payers are also supporting Clinical Integration

BCBS partnership with Emory for ACO

Changes in the payer marketplace

United Purchases Physician Practices
Humana Purchases Concentra
Cigna Opens Alternative Physician Practices
Legal Considerations

• **Federal Trade Commission and Antitrust considerations**
  - Oklahoma PHO Approved
  - St. Lukes vs. Saltzer

• **Civil Monetary Penalty**
  - Payments from a hospital that directly or indirectly induce physician to reduce or limit services to Medicare or Medicaid patients
Legal Considerations

• **Stark**—generally prohibits physicians from referring patients to an entity that bills M/M for DHS if there is a financial relationship unless an exception applies

• **Anti-kickback**—prohibits remuneration in exchange for inducing referrals for services billed to governmental healthcare programs

• **Medical Malpractice**—protocol based medicine
Lessons Learned

• Interdependence of Physicians is important
• Must include Quality Reporting/Metrics
• Independent Negotiation of Rates
• Reduction of Costs
• Joint Contracting is Subordinate
• Patient Satisfaction Improvement
Revenue Integrity
Controls and Policies

• Internal Process for Capturing
  • Clinical Documentation
  • Proper Coding
  • Avoid Recoupments (readmissions and lack of documentation)
• Contracting Controls and Education
• Clinical and Financial departments collaborate on Revenue Integrity
Clinical Documentation

- Critical to Support Billing
- Critical to Support Documentation of Acuity of Care
- Critical to Refute Recoupment Actions
- Foundation for the Clinical Integration of Providers
Coding

- Based Upon Medical Record
- Must avoid Copy and Pasting of Records
- Coding Compliance
- ICD-10 Conversion
- Testing and Preparation with Private Payers
- No Charge on Bundled Payment Programs
Managed Care Contracts

- Contract Management
- Contracting among providers
  - ACO
  - Bundled Payment
- Understanding Patient Centered Protocol Implementation
- Reporting on Metrics
Auditing

- Internal Contract Audit Controls
- Audit Clinical Performance on Protocols
- Audit Deficiencies in Patient Engagement
  - Patient Survey Scores
  - Challenges in Departments
- Track and Audit Denials
Questions
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