Course Goal Summary

What can affect revenue even after a “clean bill” is submitted?

- Current federal rules and their affect on the Revenue Cycle
- The new Value Based Purchasing Guidelines – Pay for Quality or Stats?
- What are the Metrics?
Course Summary: What will we cover?

Those measures that reduce payments AFTER billing is complete
- HCAHPS
- Core Measures
- Other metrics that Reduce Net Revenues after billing has occurred

Metrics and tools to understand non-revenue cycle issues that can reduce revenue

Some predictions of how the business office or revenue cycle process could change

The Ever Evolving Alphabet Soup

**ARRA**
- MU
  - EH / EP objectives
    - HITECH

**Core Measures**
- VTE, DVT, NQF

**HCAPS**
- Patient Satisfaction
First, the definitions

Definitions

ARRA

American Recovery and Responsibility Act

– Passed 13 February 2009
– Commonly known as the ‘stimulus package’
– Originally funded with $787B which was increased to $840B in 2011
– The three immediate goals of the Recovery Act:
  – Create new jobs and save existing ones
  – Spur economic activity and invest in long-term growth
  – *Foster unprecedented levels of accountability and transparency in government spending*
Healthcare’s Portion of ARRA

• Medicare and Medicaid: $98,098,882,278
  – HHS-Center for Medicare & Medicaid Service includes
    Grants to States for Medicaid: $90,633,606,944
  – Medicare HITECH Incentive Payments: $7,133,677,289
  – Medicare – Program Management: $327,318,073
  – Medicaid – General Dept Management: $4,279,972

Reductions due to non-Revenue Cycle Metrics

• HHS-Center for Medicare & Medicaid $90.6B can be reduced by Lowered Quality Measured by:
  • Core Measures
  • HCAPS
  • Etc.

• Medicare HITECH Incentive Payments $7.1B can be reduced by:
  • Not Installing an Approved EHR
  • Not Meeting Meaningful Use Standards
The Medicare EHR Incentive Program

- The Medicare EHR Incentive Program provides incentive payments to eligible professionals, eligible hospitals, and CAHs that **demonstrate meaningful use of certified EHR technology.**

- Eligible professionals can receive up to **$44,000** over five years under the Medicare EHR Incentive Program. There's an additional incentive for eligible professionals who provide services in a Health Professional Shortage Area (HSPA).

- **To get the maximum incentive payment, Medicare eligible professionals must begin participation by 2012.**


The Medicaid EHR Incentive Program

Provides incentive payments to eligible professionals, eligible hospitals, and CAHs as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology in their first year of participation and demonstrate meaningful use for up to five remaining participation years.
Medicaid Incentive Program continued

• Eligible professionals can receive up to $63,750 over the six years that they choose to participate in the program.

• Provides incentive payments for eligible healthcare providers to use EHR technology in ways that can positively impact patient care.

• The Medicaid EHR Incentive Program is voluntarily offered by 43 individual states and territories.

Medicare versus Medicaid

<table>
<thead>
<tr>
<th>Medicare EHR Incentive Program</th>
<th>Medicaid EHR Incentive Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Run by CMS</td>
<td>Run by Your State Medicaid Agency</td>
</tr>
<tr>
<td>Maximum incentive amount is $44,000</td>
<td>Maximum incentive amount is $63,750</td>
</tr>
<tr>
<td>Payments over 5 consecutive years</td>
<td>Payments over 6 years, does not have to be consecutive</td>
</tr>
<tr>
<td>Payment adjustments will begin in 2015 for providers who are eligible but decide not to participate</td>
<td>No Medicaid payment adjustments</td>
</tr>
<tr>
<td>Providers must demonstrate meaningful use every year to receive incentive payments.</td>
<td>In the first year providers can receive an incentive payment for adopting, implementing, or upgrading EHR technology. Providers must demonstrate meaningful use in the remaining years to receive incentive payments.</td>
</tr>
</tbody>
</table>
### Table 1: Maximum Incentive Payments Based on the First CY in Which an EP Participates in the Program

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>$18,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>$12,000</td>
<td>$18,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>$8,000</td>
<td>$12,000</td>
<td>$15,000</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>$4,000</td>
<td>$8,000</td>
<td>$12,000</td>
<td>$12,000</td>
</tr>
<tr>
<td>2015</td>
<td>$2,000</td>
<td>$4,000</td>
<td>$8,000</td>
<td>$8,000</td>
</tr>
<tr>
<td>2016</td>
<td>$2,000</td>
<td>$4,000</td>
<td>$8,000</td>
<td>$8,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$44,000</td>
<td>$44,000</td>
<td>$38,000</td>
<td>$24,000</td>
</tr>
</tbody>
</table>

### Medicare EP in a HPSA

Table 2 shows the maximum incentive payments for EPs who qualify for the higher HPSA limit.

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>$19,800</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>$13,200</td>
<td>$19,800</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>$8,800</td>
<td>$13,200</td>
<td>$16,500</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>$4,400</td>
<td>$8,800</td>
<td>$13,200</td>
<td>$13,200</td>
</tr>
<tr>
<td>2015</td>
<td>$2,200</td>
<td>$4,400</td>
<td>$8,800</td>
<td>$8,800</td>
</tr>
<tr>
<td>2016</td>
<td>$2,200</td>
<td>$4,400</td>
<td>$8,800</td>
<td>$8,800</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$48,400</td>
<td>$48,400</td>
<td>$42,900</td>
<td>$26,400</td>
</tr>
</tbody>
</table>

*Note: (1,406 increase)*
If the Revenue Cycle does everything correct, you will still lose revenue!

Payment Adjustments Beginning in 2015
If an EP does not successfully demonstrate meaningful use of certified EHR technology, the EP’s Medicare physician fee schedule amount for covered professional services will be adjusted by the applicable payment adjustment specified in the Recovery Act beginning in 2015. The payment adjustments will be as follows:

- 2015—99 percent of Medicare physician fee schedule covered amount
- 2016—98 percent of Medicare physician fee schedule covered amount
- 2017 and each subsequent year—97 percent of Medicare physician fee schedule covered amount

If it is determined that for 2018 and subsequent years that less than 75 percent of EPs are meaningful users then the payment adjustment will change by one percentage point each year until the payment adjustment reaches 95 percent.

Medicare Incentive Payment Calculation
Regardless of the payment year, the Medicare incentive payment is the product of three factors:

1. An Initial Amount
2. The Medicare Share
3. A Transition Factor applicable to the payment year
**Medicare Hospital Payments**

**Table 1: Initial Amount Calculation**

<table>
<thead>
<tr>
<th>Type of Hospital</th>
<th>Hospitals with 1,149 or fewer discharges during the payment year</th>
<th>Hospitals with at least 1,150 but no more than 23,000 discharges during the payment year</th>
<th>Hospitals with 23,001 or more discharges during the payment year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Amount</td>
<td>$2,000,000</td>
<td>$2,000,000</td>
<td>$2,000,000</td>
</tr>
<tr>
<td>Discharge-Related Amount</td>
<td>0</td>
<td>$200 x (n - 1,149)</td>
<td>$200 x (23,001 - 1,149)</td>
</tr>
<tr>
<td>Total Initial Amount</td>
<td>$2,000,000</td>
<td>Between $2M and $6,370,400 depending on the number of discharges</td>
<td>Limited by law to $6,370,400</td>
</tr>
</tbody>
</table>

**The Transition Factor [Reduction in $]**

**Table 2: Fiscal Year That Eligible Hospital First Receives the Incentive Payment**

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>0.75</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>0.50</td>
<td>0.75</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>0.25</td>
<td>0.50</td>
<td>0.75</td>
<td>0.75</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td></td>
<td>0.25</td>
<td>0.50</td>
<td>0.50</td>
<td>0.50</td>
</tr>
<tr>
<td>2016</td>
<td></td>
<td></td>
<td>0.25</td>
<td>0.25</td>
<td>0.25</td>
</tr>
</tbody>
</table>
So how are these non-Revenue Cycle Dollars given....

A. Adopt, implement or upgrade a Certified EHR per the ONC’s requirements

B. Demonstrate Meaningful Use of the EHR
   14 Core Objectives
   5 of 10 Menu Objectives
   15 Clinical Quality Measures

Meaningful Use is NOT Quality Measures

EHR incentive payments are issued after an EH or EP can show or prove that they have used certified EHR technology in ways that can positively impact patient care.
Clinical Quality of Care Measurements

Easy one for physicians:

Submit Prescriptions Electronically.

1% Increase for compliance
1% Decrease for non-compliance

NOTE: An EHR can make this happen easier.

Clinical Quality of Care Measurements

- Hospital Inpatient Quality Reporting
  - Public Reporting (Transparency)
  - Pay for Reporting (Accountability)
    - Deficit Reduction Act increased the penalties to 2% percentage point reduction in the annual market basket update for hospitals that did not successfully report
    - All Data made available to the public which does affect admission rates
Clinical Quality of Care Measurements

- Data Source:
  - HCAHPS
  - Medical records
  - Claims
  - Web-based tool
  - NHSN

- Measures:
  - Outcome
  - Process
  - Patient experience
  - Cost/resource use

Medicare’s Hospital VBP Program

Medicare will make incentive payments to hospitals beginning in Fiscal Year (FY) 2013 based on either:

1) How well they perform on each measure,
   or

2) How much they improve their performance on each measure compared to their performance during a baseline.
VBP Program Scoring

• Hospitals will earn scores for their performance on measures and dimensions in two domains during the performance period of July 1, 2011, to March 31, 2012.

• The FY 2013 Baseline Performance Period is July 1, 2009 to March 31, 2010.

Value Based Purchasing

• Data Sources:
  - Medical records
  - Claims
  - Survey (HCAHPS)

• Measures:
  – Outcome
  – Process
  – Patient experience
  – Cost/resource use
Quality Reporting for PPS

- Not later than October 1, 2012, the Secretary shall publish the measures selected that will be applicable with respect to fiscal year 2014.
  - Data Source: Medical records, NHSN
  - Measures: Process, outcome

Hospital Re-admission Reductions

- Requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012.

- Readmission measures for AMI, HF, and PN and the calculation of the excess readmission ratio was established to calculate (in part) the readmission payment adjustment under the Hospital Readmissions Reduction Program.
Shared Savings Program (ACOs)

Value-based purchasing, public reporting, voluntary participation

- The final rule requires ACOs to publicly report certain aspects of their performance and operations and CMS to publicly report certain quality data.

Established quality performance measures and a methodology for linking quality and financial performance that will:

- set a high bar on delivering coordinated and patient-centered care by ACOs,
- emphasize continuous improvement around the three-part aim of better care for individuals, better health for populations, and lower growth in expenditures.
Rough Approximation of the Payment

Current Average CMS cost of a beneficiary
Minus
The cost incurred by the ACO population
Times a CMS factor
Equals amount to be sent back to the ACO

Shared Savings Program Issues

- Who to include in the program
  - Surg centers, physicians, non-physician providers
  - Hospitals, Payors
- Who pays for the infrastructure
- How to coordinate the care of each patient within the ACO
- Penalties for non-compliant behavior?
- How will Shared Savings Payment be split between provider members of the ACO
- How to avoid the pitfalls of HMOs?
Bringing the pieces back together

How to Coordinate All these Efforts?

- Electronic Medical Record
- Electronic Health Record
- Quality Management
- HCAHPS
- Close Alliance between Finance AND Operations
2/22/2013

The difference between EMR & EHR

**Electronic Medical Records**
- The legal record of the CDO
- A record of clinical services for patient encounters in a CDO
- Owned by the CDO
- These systems are being sold by enterprise vendors and installed by hospitals, health systems, clinics, etc.
- May have patient access to some results through a portal – but is not interactive
- Does not contain other CDO encounter information

**Electronic Health Records**
- Subset (i.e., CCR or CCD) of information from various CDOs where patient has had encounters
- Owned by patient or stakeholder
- Community, state, or regional emergence today (RHIOs) - or nationwide in the future
- Provides interactive patient access as well as the ability for the patient to append information.
- Connected by NHIN

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**Quality Integration / Activation**

- Best Practice for Quality Patient Outcomes and Revenue Integrity **IS** Integration / Activation
- Revenue Integrity / Health **IS** second to Quality Patient Outcomes
- So, how **DO** we connect the dots between Clinical Operations and Financial Operations?
HCAHPS

The HCAHPS survey contains 18 patient perspectives on care and patient rating items that encompass eight key topics:

- Communication with doctors, nurses
- Responsiveness of hospital staff
- Discharge information
- Pain management
- Cleanliness and quietness of the hospital environment

HCAPHS Penalties

- **2% reduction for not Participating**
- The Hospital VBP Total Performance Score (TPS) for FY 2013 has two components:
  - the Clinical Process of Care Domain, which accounts for 70% of the TPS;
  - and the Patient Experience of Care Domain, 30% of the TPS. The HCAHPS Survey is the basis of the Patient Experience of Care Domain.
ICD-10

Will give that granularity of information needed for the quality measures.

Citations from ...

CMS EHRs

Clinical Measures

HCAHPS
• http://www.hcahpsonline.org/files/HCAHPS%20Fact%20Sheet%20May%202012.pdf