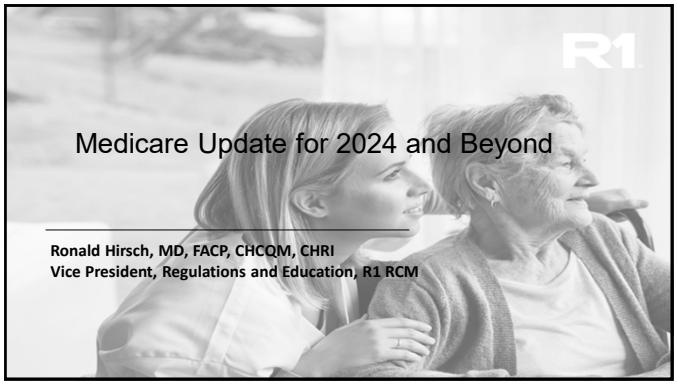


Late Breaking News

CMS proposed new appeal rights! CMS-4204-P

Don't panic- very limited
Can appeal Condition Code 44 change inpatient to outpatient
Two eligible populations-
- -Part A but not B, CC44 done, MOON given, receives Obs service
- -CC44 done, MOON given, receives Obs, stays 3 plus days

New notice won't be adopted before late spring/summer

Discharge Planning

Discharge planning begins on admission

Discharge planning does not end at discharge

Thanks for inviting me
Be sure to complete your survey to get CEUs

New Conditions of Participation

Released September 2019

Require choice lists for SNF, HHA, IRF and LTACH

Include data on quality and resource use

Can label facilities as “Preferred” but only if all applicable facilities are on the list

Address the patient’s “treatment preferences and goals of care”

How Does Choice Work?

Must offer choice of facilities in patient’s preferred geographic area – they set the range of search

Can limit to those that can fulfill patient’s care needs

Can exclude facilities without open beds

Home care agencies can be limited to those that serve geographic area where patient will go

- Can limit to HHAs that ask to be listed

What About other Post-Acute Care?

“We expect discharge planning to facilitate patient choice in any post-hospital extended care services, even though the statute does not require a specific list beyond HHAs, SNFs, IRFs, and LTCHs.”

Dialysis providers? DME? Infusion?
Outpatient therapy? Hospice?
Physicians?

Preferred Providers

Not forbidden from sorting list as you see fit

Not forbidden from indicating partner providers

Not forbidden from indicating where specific doctors go

Doctors can recommend a patient select a facility

Hospital financial interest must be disclosed, but not doctor's interest (Self-referral laws apply here)

Alternative Payment Models

Still must offer full choice to patients

Cannot require they use specific agency or facility

Sales/marketing opportunity for non-model participants?

Ensuring Compliance

No requirement to keep copy of list provided to patient

No need for patient to sign choice form

Must be able to show surveyor how you produced list for the patient if asked

How Far Does Patient Choice Go?

The list you provide does not need to include facilities without an open bed.

Can you give IMM if you have a SNF with an open bed but not their first choice?

What will QIO say?

Does a low star rating matter?

Goals of Care and Treatment Preferences

How are you assessing this?

How are you documenting this?

Someone Violated The Rules

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-23-16-Hospitals

DATE: June 6, 2023

TO: State Survey Agency Directors

FROM: Director, Quality, Safety & Oversight Group (QSOG)

SUBJECT: Requirements for Hospital Discharges to Post-Acute Care Providers

Memorandum Summary

CMS is committed to ensuring that the health and safety of patients are protected when discharges from hospitals and transfers to post-acute care providers occur. Therefore, we are providing the following information:

- Reminding state agencies (SAs), accrediting organizations (AOs), and hospitals of the regulatory requirements for discharges and transfers to post-acute care providers.
- Highlighting the risks to patients' health and safety that can occur due to an unsafe discharge.
- Recommendations that hospitals can leverage to improve their discharge policies and procedures to improve and protect patients' health and safety.

What's Happening Out There?

CMS has identified areas of concern related to missing or inaccurate patient information when a patient is discharged from a hospital. These areas of concerns include missing or inaccurate information related to:

AKA – Who would do this??? How dare they!

#1

Patients with serious mental illness (SMI), complex behavioral needs, and/or substance use disorder (SUD). Information related to patient's acute condition may be included, but information related to the patient's underlying diagnoses of SMI and/or SUD is not included.

Additionally, specific treatments that were implemented to help manage these conditions while in the hospital are omitted from patient information upon hospital discharge and transfer to the PAC provider, such as additional supervision that was provided throughout the patient's hospital stay (or was provided for some of the hospital stay, but discontinued prior to discharge (e.g., 24-48 hours before discharge))

#2

Medications, such as an incomplete comprehensive list of all medications that have been prescribed to a patient during, and prior to, their hospital stay.

Common omissions also include patient diagnoses or problem lists, clinical indications, lab results, and/or clear orders for the post-discharge medication regimen.

Medication information omissions have been most commonly reported for psychotropic medications and "hard" prescriptions for narcotics (i.e., provided on paper, not electronic, as required by law)

#3

Skin tears, pressure ulcers, bruising, or lacerations (e.g., surgical site(s), skin conditions noted upon hospital admission and/or acquired during hospitalization), including orders or instructions for cultures, treatments, or dressings

#4

Durable Medical Equipment, such as Trilogy, CPAP/BiPap or high-flow oxygen which are used for respiratory treatments and skin healing equipment for example mattresses, wound vacuum machine for treatment of a variety of wounds including surgical wounds, pressure ulcers, diabetic ulcers, etc.

#5

A patient's preferences and goals for care, such as their choices for treatment or their advance directives for end-of-life care

#6

Communication (with PAC providers and/or caregivers) about a patient's needs at home, or how their home environment may impact their ability to maintain their health and safety after discharge from the SNF (e.g., risk of falls, family or caregiving involvement/availability, homelessness, etc.)

Don't Do This

Discussion:
When the above issues occur, PAC providers are not properly prepared to care for new admissions, and caregivers are not properly prepared to care for their loved ones at home. Also, PAC providers may not be equipped or trained to care for certain conditions that apply to patients whose information they were not previously informed of by the hospital and have accepted for transfer and admission. Not only can this place the patient's health at risk, it can also put the health and safety of other residents (in the patient's home or in a SNF), as well as provider staff, at risk. These situations can cause avoidable readmissions, complications, and other adverse events. Finally, when an individual's preferences for end-of-life care are not known, they may receive treatments that are unnecessary or inconsistent with their wishes.

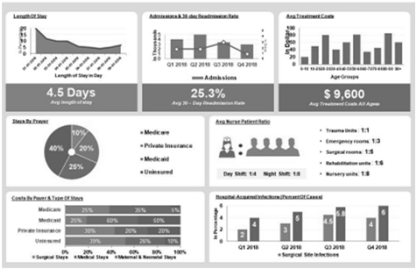
Key Performance Indicators

Demings - "Without data, you're just another person with an opinion."

Hirsch – "No data is better than bad data."

Everyone Has a KPI Scorecard

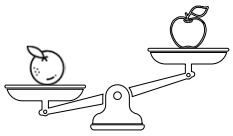
Health & Safety KPI Dashboard Showing Length …



Common UR KPIs Length of Stay

Medicare reported LOS – date of inpatient admission to discharge

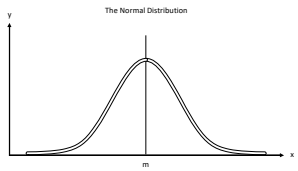
Hospital reported LOS – likely includes ED and Observation days



Length of Stay

Benchmark LOS – often uses Medicare Geometric mean LOS

That's thousands of patients not your patient in that bed



Length of Stay – FORGET IT!

What you want – how many days in the hospital were not medically necessary?

Find your avoidable days and reduce them.

Length of Stay - Just Say No

Is Overall LOS of use?

Only if you can compare to a hospital that is

- same service lines and same percentages
- same physician behaviors
- same patient demographics
- same SDoH in community

Common UR KPIs

Case Mix Index – average weight of all DRGs

TABLE 5.—LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS-DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—FY 2024 Final Rule

MS-DRG	FY 2024 Final Post-Acute DRG	FY 2024 Final Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
190	Yes	No	04	MED	COPD WITH MCC	1.1020	3.5	4.4
191	Yes	No	04	MED	COPD WITH CC	0.8490	2.7	3.4
192	Yes	No	04	MED	COPD WITHOUT CC/MCC	0.6418	2.2	2.7
329	Yes	No	06	SURG	MAJOR BOWEL PROCEDURES WITH MCC	4.5168	9.8	12.7
330	Yes	No	06	SURG	MAJOR BOWEL PROCEDURES WITH CC	2.3721	5.1	6.4
331	Yes	No	06	SURG	MAJOR BOWEL PROCEDURES WITHOUT CC/MCC	1.6720	2.9	3.4

Case Mix Index – Fatally Flawed

Most common message from leadership – "Find more inpatients!"

Guess what most common observation patients with potential for inpatient "upgrades" are --- low weighted DRGs!

What do low weighted DRGs do? Lower your CMI!

MS-DRG	FY 2024 Final Post-Acute DRG	FY 2024 Final Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights - Before Cap	Weights - 10% Cap Applied	Geometric mean LOS	Arithmetic mean LOS
310	No	No	05	MED	CARDIAC ARRHYTHMIA AND CONDUCTION DISORDERS WITHOUT CC	0.5530	0.5530	1.8	2.1
390	Yes	No	06	MED	GASTROINTESTINAL OBSTRUCTION WITHOUT CC/MCC	0.5590	0.5590	2.3	2.7
293	Yes	No	05	MED	HEART FAILURE AND SHOCK WITHOUT CC/MCC	0.5615	0.5615	2.1	2.6
894	No	No	20	MED	ALCOHOL, DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.5745	0.5745	2.1	2.9
951	No	No	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	0.5900	0.5900	1.8	2.8
761	No	No	13	MED	MENSTRUAL AND OTHER FEMALE REPRODUCTIVE SYSTEM DISORDER	0.6056	0.6056	1.8	2.1
684	Yes	No	11	MED	RENAL FAILURE WITHOUT CC/MCC	0.6085	0.6085	2.2	2.7
440	No	No	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY WITHOUT CC/MCC	0.6156	0.6156	2.4	2.8

What Do They Want?

Higher Case Mix Index (a pretty number)

- fewer inpatients but higher CMI
- Observation stays paid $2,611

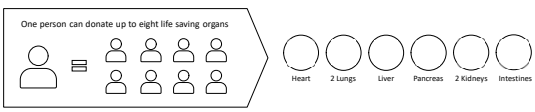
or

More Money (real revenue)?

- more inpatient with DRGs
- DRGs paid $7,000+

Want a Higher CMI?

MS-DRG	FY 2024 Final Post-Acute DRG	FY 2024 Final Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights - Before Cap
018	No	No	PRE	MED	CHIMERIC ANTIGEN RECEPTOR (CAR) T-CELL AND OTHER IMMUNOTHE	36.8427
001	No	No	PRE	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM WITH MCC	27.0986
927	No	No	22	SURG	EXTENSIVE BURNS OR FULL THICKNESS BURNS WITH MV >96 HOURS W	26.3587
003	Yes	No	PRE	SURG	ECMO OR TRACHEOSTOMY WITH MV >96 HOURS OR PRINCIPAL DIAGN	21.3203
004	Yes	No	PRE	SURG	TRACHEOSTOMY WITH MV >96 HOURS OR PRINCIPAL DIAGNOSIS EXCE	14.7000
007	No	No	PRE	SURG	LUNG TRANSPLANT	12.2664
002	No	No	PRE	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM WITHOUT	12.2441
014	No	No	PRE	MED	ALLOGENEIC BONE MARROW TRANSPLANT	11.4609
212	No	No	05	SURG	CONCOMITANT AORTIC AND MITRAL VALVE PROCEDURES	10.7707
005	No	No	PRE	SURG	LIVER TRANSPLANT WITH MCC OR INTESTINAL TRANSPLANT	10.3500



The Right Observation Rate?

1. If every patient is reviewed by case management with the use of a secondary physician review as appropriate for proper admission status,
2. Every patient is placed in the right status,
3. Observation is only ordered on the proper patients,
4. Every patient goes home as soon as their need for hospital care has finished, and
5. Every patient who has medical necessity for a second midnight is admitted as inpatient, then your observation rate is exactly where it should be.

Hirsch's Law

Looking at Readmissions

CMS Hospital Readmission Reduction Program

- calculates observed v expected rate, possible penalty incurred
- readmission cause not a factor

Cause of most readmissions not bad care, bad discharge but social determinants of health

What Can You Look At?

Your PEPPER!!!!

30-Day Readmissions to Same Hospital or Elsewhere	73
30-Day Readmissions to Same Hospital	57

Readmission back to you – second DRG (ca ching!)
Readmission elsewhere – you may get penalty (not good)
Look at percentage – 57/73= 78% came back

Unofficial average return = 75-80% (they like you, they really like you)

2024 Regulatory Changes

MA plan required to recognize

- 2 midnight expectation
- unplanned mechanical ventilation
- case-by-case exception
- unplanned occurrences-AMA, death, transfer, hospice
- unexpected rapid recovery
- inpatient only list
- HHA, SNF, IRF qualifications

Case-by-Case Exception

STEP 6 - for claims with a Date of Admission on or after January 1, 2016
Does the medical record support the admitting physician's determination that the patient required inpatient care despite not meeting the two midnight benchmark, based on complex medical factors such as:

- Patient history and comorbidities and current medical needs
- Severity of signs and symptoms
- Risk of an adverse event

Livanta says "Good medical practice includes documentation of specific reasons that inpatient care is required. In the case of increased risk, it is best to specify the nature of the increased risk and the need for inpatient care required for detection and treatment."

Case-by-Case Exception

When to use?

- Non-inpatient only surgery with operative high risk
- Medical patients with expected one day LOS but life-threatening illness

Be sure documentation addresses risk

For surgery, get inpatient order pre-op

Unexpected Rapid Recovery

Not a dot phrase

It's a patient whose clinically valid expectation was a two midnight stay but who was stable to go home the next day

SNF, IRF, HHA

Know the Medicare criteria

Don't let your therapists make promises to patients prior to meeting with you

Enlist the family to call the insurer if they won't approve and patient meets criteria

2024 Regulatory Changes

MA plan not required to follow/require

- LTACH admissions
- ASC Covered Procedure List
- Use of Condition Code 44
- Self-denial and rebilling process
- CMS Readmission payment rules

Let's break this down

Long Term Acute Care Hospital

Just like you, an acute care hospital

Accepts patients with estimated LOS of 25+ days

Medicare site neutral payment structure

lower rate if not ICU for 3 days or vent 96 hours

Long Term Acute Care Hospital

So why send a patient to an LTACH?

Your hospital “used up” the DRG payment so someone else can have the patient

or

The LTACH provides specialized care you cannot provide

Long Term Acute Care Hospital

If the latter…

Make the argument that you are really transferring for a “higher level of care”

Enlist the family to contact the payer

If the former, you have no valid argument to fight a payer refusal

ASC Procedures

Medicare has a list ASC-CPL for surgeries allowed at ASC

ASC provisions are not part of CMS-4201-F – MA Rule

Surgeries not in Inpt Only list but not allowed at ASCs for FFS Medicare can be done at ASCs for MA patients if surgeon agrees and MA plan approves

Condition Code 44

NUBC explanation of CC44

Inpatient admission changed to outpatient – For use on outpatient claims only, when the physician ordered inpatient services, but upon internal review performed before the claim was initially submitted, the hospital determined the services did not meet its inpatient criteria.

Condition Code 44

What does that mean?

If your UR process determines the doctor make a mistake admitting as inpatient for Medicare or MA, follow the process.

If MA plan refuses to approve inpatient and you agree to change, then no formal UR process is necessary nor is patient notification.

but the patient got the IMM so you probably should tell them their status has changed (and give MOON if >24 hours more planned)

Self-Denial and Rebilling

Medicare requires

- follow 42 CFR 482.30(d) to determine if inpatient incorrect
- then submit 110 claim then 121 and 131 claims
- get paid part B for payable services
- unlikely to get Obs C-APC unless 8+ hrs obs prior to change
- average payment ~$1,500 v $2,600 for Obs C-APC 8011

Medicare Advantage Inpatient Non-Approvals

If you agree with Medicare Advantage plan that In was wrong

- This is a payment issue so they can pay you what they want
- "You can bill Observation" = you may add observation hours to claim even without physician order
- Count inpatient hours, bill those as Observation hours, get paid the Observation contracted rate

Readmission Rules

Medicare Hospital Readmission Reduction Program

- Every admission except same day, same reason is paid a full DRG
- Observed v expected readmission rate calculated to determine if readmission penalty applied over next 3 years

If you have capacity, readmissions are financially good

Most readmissions are totally out of your control so why should you "pay the price"?

Medicare Advantage Readmissions

CMS allows the MA plans to do what they want with readmission payment

7 day, 14 day, 30 day…all, related, preventable…same hospital, system

You still send in shadow claim so you get CMS add-on money but not base payment from MA Plan

This is a contractual issue for now; CMS aware of MA malfeasance

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