Disclosures

Dr. Gay has no COI disclosures.

Dr. Hain has no COI disclosures.

Dr. Shen has no COI disclosures.

We do not intend to discuss an unapproved or investigative use of a commercial product or device in this presentation.

VANDERBILT UNIVERSITY MEDICAL CENTER

MONROE CARELL JR. Children's Hospital at Vanderbilt

Beyond Patient Care: Broadening the Administrative Roles of Pediatric Hospitalists

Pediatric Hospital Medicine

July 22, 2017

VANDERBILT UNIVERSITY MEDICAL CENTER

MONROE CARELL JR. Children's Hospital at Vanderbilt

Workshop Faculty

James C. Gay, MD, MMHC
Professor of Pediatrics
Vanderbilt University School of Medicine
Medical Director, Utilization and Case Management
Monroe Carell Jr. Children's Hospital at Vanderbilt
Nashville, TN

Paul D. Hain, MD
Market President and Chief Medical Officer of Blue Cross Blue Shield of Texas' North Texas Region
Pediatric hospitalist and Associate Professor at UT Southwestern, Dallas, TX

Mark Shen, MD, MBA
President, Dell Children's Medical Center, and President and CEO, Dell Children's Health Alliance
Associate Professor of Pediatrics, Dell Medical School
Fellowship Director for Pediatric Hospital Medicine
Austin, TX

Our Goals

- Review compensable non-patient care roles for physicians at Children's Hospitals
  - Medical Directors
  - Physician Advisors
  - Quality Officers
  - Health Services Research
  - Credentials Comm. Chair
  - Chief of Staff
- Review the business aspects of running a children's hospital and medical center
  - Reimbursement
  - Day-to-Day operations
    - Utilization management

Learning Objectives

1. Name 5 compensable physician roles at children's hospitals which do not involve direct patient care .
2. Understand the basics of hospital finance, the role of Utilization Management teams in the missions of the hospital and the roles pediatric hospitalists can play in those missions.
3. Understand Observation vs. Inpatient status.
4. Understand how insurance companies apply policies and procedures to manage care and cost.
5. Learn and practice the "art" of conducting peer-to-peer discussions with insurance company representatives to provide the most useful clinical information to result in the most appropriate payment status for the patient's hospitalization.

Why Hospitalists?

- Uniquely positioned to understand and impact hospital processes and operations.
  - Clinical knowledge
  - Admission/discharge processes
  - Patient needs
  - Order entry
  - Consultations with other services

Reimbursement

History of Hospital Payments

Pre-1900 - Doctors and hospitals determined their own fees

1910-1930 - Need for services increase, charges are now more than the average family can pay

1930-1950 - Baylor University Hospital provides insurance to 1,500 local school teachers for $6 per year per person → Blue Cross is born.
Worker compensation increased by offering health insurance → employer sponsored health insurance is born.

1950-1970 - price of hospital care doubles; 1965 Lyndon Johnson signs Medicare and Medicaid into law; 1969 Richard Nixon proposes national health insurance and coins the phrase "HMO"

About this time…

- First generation "Diagnosis Related Groups" (DRGs) developed by 2 professors at Yale in the early 1970s for research use.
- Actually "Groups of Related Diagnoses" rolled up into buckets that are more manageable than 14,000 individual ICD-9 codes (or ~70,000 ICD-10).
- Original purpose – to classify hospital admissions by grouping patients with similar ICD-9-CM codes, thereby providing a means of relating the types of patients that a hospital treats to the costs that the hospital incurred.

Original DRGs

- Used: Principle diagnosis code, secondary diagnosis codes, procedure codes, age, gender, discharge disposition
- Divided all possible principal diagnoses into 23 mutually exclusive categories referred to as Major Diagnostic Categories (MDCs).
- Each MDC corresponded to a single organ system or etiology (e.g., Nervous System, GI) and contained 3-62 DRGs.

History of Hospital Payments

1980s - Enter: MEDICARE

- Pre-1983 – most hospitals paid "fee-for-service"
  - The more you did, the more you charged and the more you got paid
- 1983 –DRGs chosen by Medicare (Reagan administration) as the basis of its Prospective Payment System for hospitals.
- Now, hospitals were paid a set amount per type of patient (DRG), thereby providing incentives to control hospital and physician spending.

MEDICARE and DRGs

- Medicare DRGs (now called "MS-DRGs") now updated yearly, on October 1st but have focused on the >65 population almost exclusively.
- As a result, the Medicare DRGs do not describe all hospital populations well, especially neonates, obstetrical patients.
- However, subsequent to the enactment of the Medicare PPS, a number of states and large payors implemented DRG-based hospital payments for non-Medicare patients.

Overheard CFO

"Our ADC is actually slightly better than we thought, but our CMI is killing us. At this rate, we won't make budget."

What did she say?

Vocabulary Alert: Case Mix Index (CMI)

- A DRG relative value assigned to each inpatient. Most Children's Hospitals use the APR-DRG system and CMI
- A measure of "how sick on average" the patients in your hospital are.
- CMI usually measured for a floor, a service line, or a hospital

Overheard CFO Translation

"We have admitted slightly more patients than we expected, but the reimbursement per patient is lower than we expected because, on average, our patients aren't as sick as we thought they would be. The number of patients multiplied by the payments per patient is less than we thought. We may have allocated more money to be spent than we are going to take in."

Hospital Payment - 2017

- For children's hospitals, 3 general payor types *("Payor mix")*
  - Government ("Public")
    - Medicaid – traditional vs managed care
    - TriCare – Military
    - Medicare (chronic renal failure, a few chronically disabled patients)
    - Children's Health Insurance Program (CHIP)
  - Commercial
    - Examples: Blue Cross/Blue Shield, Aetna, United HealthCare, Cigna
  - Other
    - Self-pay

VANDERBILT UNIVERSITY MEDICAL CENTER

MONROE CARELL JR. Children's Hospital at Vanderbilt

Payment Methodologies

Per Diem	Percent of Charges	DRG (Diagnosis Related Groups)
Hospital gets a set fee per day that the patient is in the hospital (different for floor vs ICU)	Hospital gets a negotiated percent of the billed charges (chargemaster)	Hospital gets a bucket of money based on the diagnosis or surgical procedure of each admission
Incentives Admissions: Increase LOS: Increase Costs: Decrease	**Incentives** Admissions: Increase LOS: Increase Costs: Increase	**Incentives** Admissions: Increase LOS: Decrease Costs: Decrease

VANDERBILT UNIVERSITY MEDICAL CENTER

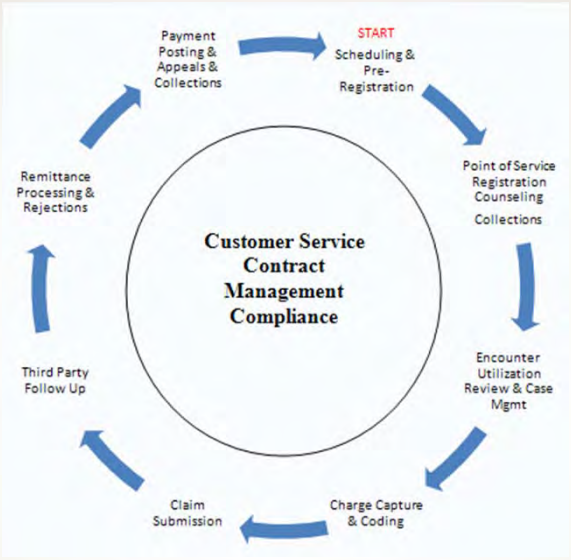
MONROE CARELL JR. Children's Hospital at Vanderbilt

How Hospitals Get Inpatient Revenue

- Patient Admitted to Hospital
- Care Given
- Patient Discharged
- Bill Sent
- Somebody Pays (*…or doesn't*)

Vocabulary Alert: Financial Terminology

- Revenue cycle - All administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue.
- In other words, it is a term that includes the entire life of a patient account from creation to payment.



The Revenue Cycle

VANDERBILT UNIVERSITY MEDICAL CENTER

MONROE CARELL JR. children's Hospital at Vanderbilt

REVENUE CYCLE TERMS AND PROCESSES

- Charge Capture
  - Documented services are manually or electronically translated into billable fees.
- Coding
  - The process of transforming descriptions of medical diagnoses and procedures into universal medical code numbers
- Claim Submission
  - Billable fees are submitted to the insurance company via a universal claim form for payment.
- Patient Collections
  - Collecting patient balances, making payment arrangements

VANDERBILT UNIVERSITY MEDICAL CENTER

MONROE CARELL JR. children's Hospital at Vanderbilt

REVENUE CYCLE TERMS AND PROCESSES Continued

- Pre-registration
  - Collection of all registration information, including eligibility, benefits and authorizations, prior to the patient's arrival for inpatient or outpatient procedures.
- Registration
  - Collection of a comprehensive set of data elements required in establishing a Medical Record Number and satisfying regulatory, financial and clinical requirements.
- Remittance Processing
  - Posting or applying payments/adjustments to the appropriate accounts, including rejects (denials).
- Third Party Follow-up
  - Pursue collections from insurers after initial claim filed.

How It Looks from the C-Suite

"Being a hospital CEO isn't all that hard in concept. You just have to make sure that you take in more money than you spend"

– Jeff Sperring

Vocabulary Alert: Contribution Margin

- Defined as the difference between the revenue and variable expenses
- It is the "profit" left over from a transaction that is available to be assigned to fixed costs

VANDERBILT UNIVERSITY MEDICAL CENTER

MONROE CARELL JR. children's Hospital at Vanderbilt

New Payment Structures

- Pay For Performance (P4P)
  - Negotiate targets for quality, efficiency or both
- Shared Savings
  - Set target goals based on actuarial assessments of populations, group gets a share of the amount of money below the target
- Accountable Care Organization (ACO)
  - Group of physicians/providers/facilities who agree to be responsible for the total care of a population
  - Incentives aligned so that spending less (fewer admissions) results in a gain to the group

VANDERBILT UNIVERSITY MEDICAL CENTER

MONROE CARELL JR. children's Hospital at Vanderbilt

Utilization Review

- Evaluation of the necessity, appropriateness, and efficiency of the use of medical services and facilities, which includes regular reviews of admissions, length of stay, services performed, and referrals.

Utilization (Resource) Management

- Regulates utilization review activities and ensures functioning within the Conditions of Participation for Medicare and Medicaid Programs and The Joint Commission (TJC) Standards for Utilization Review;
- Clearing house for Pediatric UM issues or processes
- Routinely evaluates UM processes and workflow for “bedded” patients
- Monitors UM outcomes and reports
- Monitors changes in health care regulations at State or Federal level
- Recommends hospital staff education regarding regulations and workflow as needed
- Manages payment denials and appeals

Utilization (Resource) Management

- Admission status reviews (Observation vs Inpatient) on all “bedded” patients
- Ongoing review of medical necessity
- Management of payment denials and appeals
- Some may do:
  - Pre-authorizations
  - Case-management

VANDERBILT UNIVERSITY MEDICAL CENTER

MONROE CARELL JR. children's Hospital at Vanderbilt

Utilization (Resource) Management

Key functions

- Facilitate optimal reimbursement
  - includes obtaining certification through processes determined by insurance co contracts, collecting clinical data and running it through criteria and communicating with them to obtain authorization
- Facilitate accurate billing
  - determine the status (observation vs inpatient) based on MD order and criteria, get the correct authorization from the insurance company
- Participate in discharge planning with Case Management, Social Work to facilitate discharge-supplying contacts, and identifying potential denials based on medical necessity
- Manage Denials
  - exhaust all efforts to overturn denials concurrently through communication with attending team, medical director and CM team. Assist with back end denials with criteria based post-billing appeal letters for insurance company chart review

VANDERBILT UNIVERSITY MEDICAL CENTER

MONROE CARELL JR. children's Hospital at Vanderbilt

Where did Observation Status Come From?
(in case you ever wondered)

- After DRG payments were instituted, hospitals who worried that payment for an admission would be denied for medical necessity or felt DRG payments too low, would admit patients in “observation status.”
- Keeping hospitalized patients in an “outpatient status” kept the DRGs from applying, outside the purview of medical review and reimbursed by fee-for-service
- Eventually, the government caught on to this and issued rules about who can and cannot be in observation status.

VANDERBILT UNIVERSITY MEDICAL CENTER

MONROE CARELL JR. Children's Hospital at Vanderbilt

Observation Status

- Considered by payors and administrative staff to be an “outpatient” status in contract to “Inpatient.”
- However, few children’s hospitals have a true observation unit and most “observation” patients are on the same wards, same rooms, covered by the same medical and nursing staff as so-called “Inpatients,” i.e., artificial distinction.
- Determination of “Observation Status” vs “Inpatient” depends on hospital contracts with individual insurance companies and other payors. Reimbursement for “Observation” – determined by an hourly rate - is much less than for and “Inpatient” DRG payment.

VANDERBILT UNIVERSITY MEDICAL CENTER

MONROE CARELL JR. Children's Hospital at Vanderbilt

Observation Status

- Criteria for “Observation” vs “Inpatient” based on published guidelines (e.g., Milliman or InterQual) that hospitals and payors use (and argue about) to support decisions on status.
- Mostly used for children admitted to VCH with the expectation of a brief hospital stay expected to improve in 24 hrs. However, length of stay (typically thought of as <48 hours) is not the sole determinant of “Observation Status.”
- Example: asthmatic admitted to the PICU on continuous albuterol, improves quickly, goes to floor, discharged home in 40 hours is “Inpatient.”

Observation

CMS Definition

OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS)

PURPOSE OF OBSERVATION: “DETERMINE THE NEED FOR FURTHER TREATMENT OR INPATIENT ADMISSION.”

Specific, clinically appropriate services which include:
* *Ongoing short treatment*
* *Assessment*
* *Reassessment*

Criteria for Observation (Interqual)

- Does not meet criteria for inpatient admission and any of the following apply:
  - Diagnosis, treatment, stabilization and discharge can reasonably be expected within 24 hours
  - Treatment and/or procedure will require more than 6 hours of observation
  - The clinical condition is changing and a discharge decision is expected within 24 hours
  - Complications of ambulatory surgery/procedure
  - Extended observation post anesthesia/surgery
  - Symptoms unresponsive to at least 4 hours ER Rx
  - Psychiatric crisis intervention/stabilization every 15 minutes
- At 24 hours, if the patient is not stable for discharge, apply acute care criteria, extend observation up to 48 hours, or refer for medical review

VANDERBILT UNIVERSITY MEDICAL CENTER

MONROE CARELL JR. Children's Hospital at Vanderbilt

So what happens when the payor doesn't think the patient meets medical necessity for admission?

- Payor may "deny" payment or offer a lower payment type (Observation vs Inpatient).
- Payor may offer a "Peer-to-peer" (P2P) between attending and payor medical director.
  - Opportunity for discussion, additional clinical information
- Even after an unsuccessful P2P, the hospital may submit a further written appeal for payment to justify the billing status.

VANDERBILT UNIVERSITY MEDICAL CENTER

MONROE CARELL JR. Children's Hospital at Vanderbilt

Other Physician Roles

- Medical Directors
  - Utilization Management
  - Case Management
  - Credentials Committee Chair
  - Coding Initiatives
- CEO – (i.e., the BIG TIME)
- Chief Medical Officer for the Center for Medicare and Medicaid Services (CMS)

  (i.e., the REALLY big time)

VANDERBILT UNIVERSITY MEDICAL CENTER

MONROE CARELL JR. children's Hospital at Vanderbilt

How Hospital vs Insurance Company Conflicts Start

- Either side can instigate
  - Issue a termination
- Hospitals looking for increased rates
  - High Overhead
  - Market has shifted
  - Offset other losses (like Medicaid)
- Insurance Companies looking to lower trend
  - Pressure from self-insured clients to lower total cost of care
  - May feel that other companies get a better deal

VANDERBILT UNIVERSITY MEDICAL CENTER

MONROE CARELL JR. children's Hospital at Vanderbilt

Things that Favor

- The Hospital
  - Niche Services
    - High End Pediatrics
    - Geographic Isolation
  - Halo Effect
    - Great PR team
    - Academic Medical Center
- The Insurance Company
  - High Market share
  - Viable 2nd Option
    - Steerage is easy
    - Halo effect small
  - High Hospital Charges
    - "Numbers Don't Lie"

Important Issues in a Conflict

- Communication
  - With Physicians often favors the Insurance Company
  - With Brokers often favors the Hospital
  - With insurance plan members is volatile
- At 30 days prior to going Out of Network
  - Members must have a communication
    - Often an impetus to settle
- At the drop dead date, things heat up even more
  - Cash flow issues for hospital
  - Out of Network charges for Insurance Company