Financial Disclosures

*Neu*Strategy®

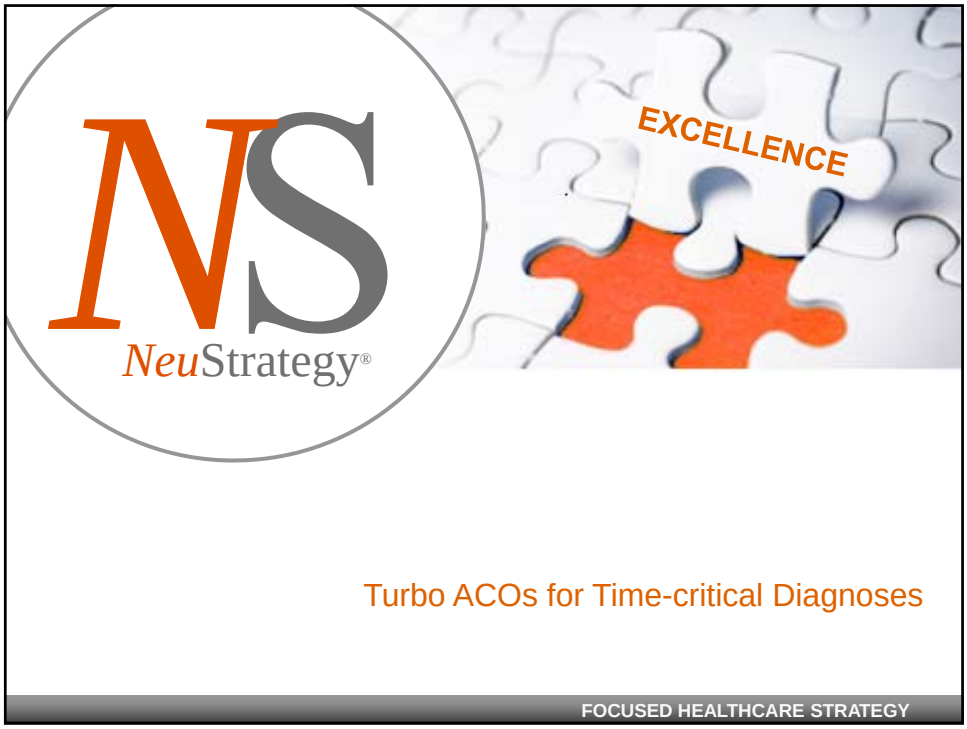
Partner, *Neu*Strategy, Inc.
Chicago, IL

*Neu*Strategy provides a broad spectrum of strategy, financial, operations and outcomes consulting services to enhance the market position of hospitals, health systems and physician practices.

Independent Contractor

American Heart Association | American Stroke Association

Greater Southeast Affiliate



"Turbo" ACOs for Stroke Systems of Care

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Accountable Care Organizations

Standard ACO model:

- Promotes value-based care delivery
  - Organized care
  - Performance management
  - Payment reform
- Ignores essential emergency systems
  - Sophisticated care
  - Time-critical diagnoses
  - Public health impacts

Stroke Systems of Care

Systems of Care model:

- Promotes value-based care delivery
  - Coordinated and timely care
  - Existing registries for performance
  - Efficiencies reduce cost of care

"Turbo" ACOs for Stroke Systems of Care

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Stroke Systems of Care

"Turbo" ACO model for stroke:

- Networks with extensive and integrated level of emergency stroke care
- Improved outcomes through enhanced regional collaboration
- Concentration on clinical and process performance and improvement
- Relationship building
  - Input from ALL optimizes system improvement
  - Cultivates formation of strong alliances
  - Combats fragmented care
- Concentration on fiscal stewardship - TBD

"Turbo" ACOs for Stroke Systems of Care

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- Would "turbo" ACOs accelerate existing efforts to create efficient and cost-effective regional networks for stroke?
- Some thoughts considered in a STEMI model:
  - State or regional ACOs would provide collateral benefit to all
  - Adds simplicity for CMS to attribute Medicare beneficiaries to a region-based ACO based on address
  - Shared savings plan = increased payments for episodes of care
    - Going to EMS and hospitals through existing mechanisms
    - Direct payments avoiding how to fairly divide earnings
  - Shared accountability and collaboration encouraged with bonus payments *only when entire turbo-ACO succeeds*
  - Integrated secondary prevention encouraged by long-term outcomes

Circ Cardiovasc Qual Outcomes. 2011;4:647-649

Why All The Attention from CMS?

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ALL DIAGNOSES

Short **Inpatient Stays**
(<2 nights)

Length of Stay	No. of Stays	%
1 night	1,032,233	90%
Less than 1 night	114,693	10%
Total	1,146,925	100%

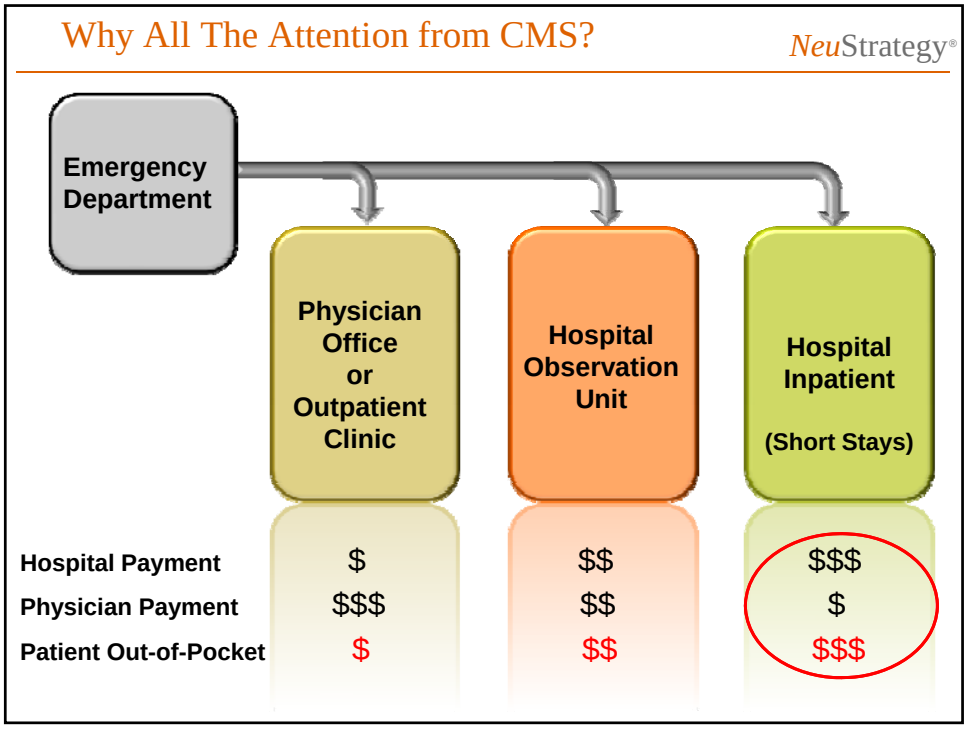
Observation Stays

Length of Stay	Observation Stays	%
0 nights	126,264	8%
1 night	833,583	55%
2 nights	385,830	26%
At least 3 nights	166,198	11%
Total	1,511,875	100%

Long **Outpatient Stays**

Length of Stay	No. of Stays	%
1 night	1,298,178	94%
At least 2 nights	87,912	6%
Total	1,386,090	100%

Source: OIG Report, 07-29-2013 Hospitals' Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries, Oel-02-12-00040


Why All The Attention from CMS?
NeuStrategy
Emergency Department
Physician Office or Outpatient Clinic
Hospital Observation Unit
Hospital Inpatient (Short Stays)
Hospital Payment
Physician Payment
Patient Out-of-Pocket
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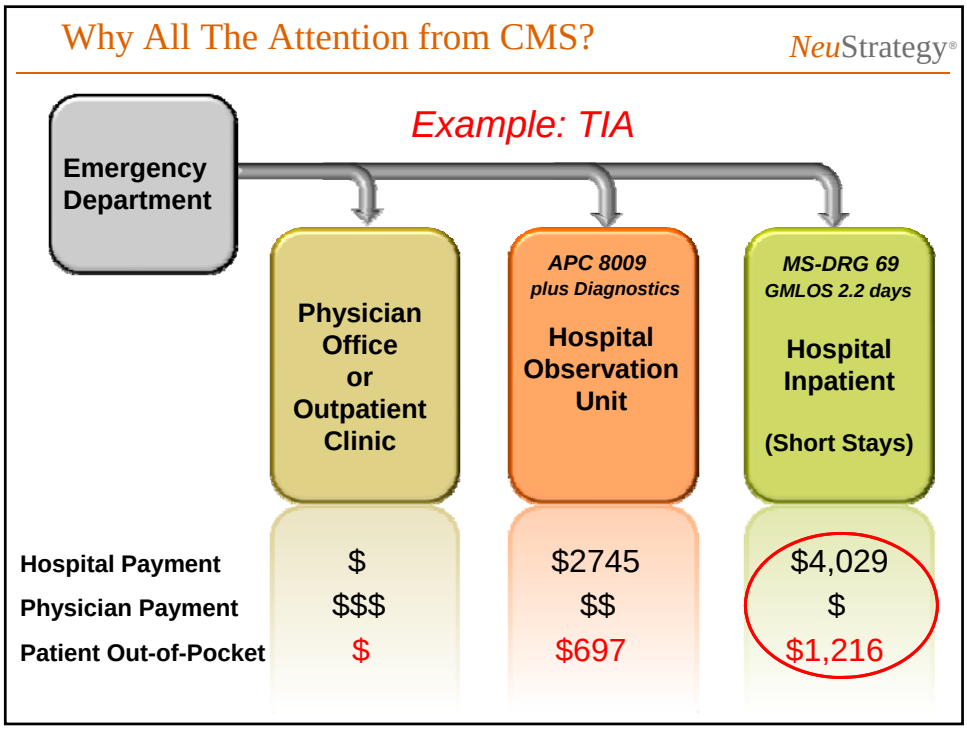
Why All The Attention from CMS?
NeuStrategy
Example: TIA
Emergency Department
Physician Office or Outpatient Clinic
APC 8009 plus Diagnostics
Hospital Observation Unit
MS-DRG 69 GMLOS 2.2 days
Hospital Inpatient (Short Stays)
Hospital Payment
Physician Payment
Patient Out-of-Pocket
$
$$$
$
$2745
$$
$697
$4,029
$
$1,216

CMS Two-midnight Rule

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What it says….

Surgical procedures, diagnostic tests and other treatments would be ***generally appropriate for inpatient admission*** and ***inpatient hospital payment*** under Medicare Part A…...

when the physician expects **the beneficiary** ***to require a stay that crosses at least 2 midnights*** and admits the beneficiary to the hospital based on that expectation.

Source: 2014 IPPS Final Rule, p. 50944

CMS Two-midnight Rule

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Conversely,

If a patient comes to the hospital for a surgical procedure, diagnostic test and/or other treatment and ***the physician expects*** **to keep the beneficiary for a limited time** ***not to cross 2 midnights…***

the services would ***generally be inappropriate for inpatient hospital payment*** under Medicare Part….regardless of the hour of arrival or whether a bed was used.

CMS Two-midnight Rule

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Emergency Department

Based on info available, **physician decides if patient will require 2 or more "midnights" of hospital services**

NO
Stroke OP Clinic
- No restrictions

NO
Observation Unit
- Must have a qualifying ED visit
- Must remain in unit for ≥ 8 hours *(to be paid for observation)*

YES
Inpatient Admission
- The clock for the rule starts when "care is initiated" after hospital arrival
- Prior time in ED, observation or procedure area counts

Frequently Asked Questions (FAQs)

FOCUSED HEALTHCARE STRATEGY

FAQs

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- What are documentation requirements of a two-midnight expectation?
  - **Expected length-of-stay**
  - Underlying need/complex medical factors
    - Patient history and comorbidities
    - Severity of signs and symptoms
    - Current medical need
    - Risk of an adverse effect
- Is bed location or monitoring justification for admission?
  - Two-midnight benchmark **not** based on level of care or placement of patient within the hospital
  - ICU or telemetry alone do not justify admission
- How are closed services on weekends considered?
  - Custodial care will not justify a two-midnight inpatient stay

FAQs

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- What if the physician is unable to determine the need for two-midnight, or longer stay, at time of patient presentation?
  - Admit for observation services and re-evaluate later
    - Observation time will count toward two-midnight benchmark if admitted later
  - For a rare and unusual circumstance, admit and THOROUGHLY document why it should be considered an exception
- Patient is admitted under a presumption of two-midnight stay but leaves earlier. Is it paid as inpatient admission or other?
  - Paid as inpatient if expectation of two-midnight stay is justified
    - Patient transferred, left AMA or expired
    - Symptoms resolved/clinical condition improved

FAQs

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- When does observation billing begin?
  - Outpatient billing for observation time begins *when patient is admitted to the observation unit/bed*
    - Not when care is initiated
      - *Only applies to when the two-midnight rule begins*

TIA Scenario #1

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- Patient presents at **10 am** with stroke symptoms
  - Care initiated at 10:10 am
  - By 11:30 am symptoms resolve
  - Symptoms return at 1:00 pm
  - ED physician re-evaluates; admitting physician agrees to admit for one day
  - LOS expectation based on condition, treatment and risk?
    - **1 midnight**
    - **Place in observation**
- Patient presents at **10 pm** with stroke symptoms
  - Care initiated at 10:10 pm
  - By 11:30 pm symptoms resolve
  - Symptoms return at 1:00 am
  - ED physician re-evaluates; admitting physician agrees to admit for one day
  - LOS expectation based on condition, treatment and risk?
    - **2 midnights**
    - **Admit as inpatient**

Same patient, same presentation, same expected LOS, different course

TIA Scenario

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- Patient presents at **10 am** with stroke symptoms
  - Care initiated at 10:10 am
  - By 11:30 am symptoms resolve
  - Symptoms return at 1:00 pm
  - ED physician re-evaluates; admitting physician agrees to admit for one day
  - LOS expectation based on condition, treatment and risk?
    - **1 midnight**
    - **Place in observation**
- Placed in observation, H&P done
- Echocardiogram, MRI, MRA done
- Next day, hospitalist busy with admissions, rounds at 8 pm, patient feels better but asks to stay the night
- Hospitalist agrees to discharge in am if stable
- 1st night – medically necessary
- 2nd night –medically unnecessary
- **Keep patient on observation status**
- **Write off medically unnecessary hours**

TIA Scenario

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- Patient presents at **10 am** with stroke symptoms
  - Care initiated at 10:10 am
  - By 11:30 am symptoms resolve
  - Symptoms return at 1:00 pm
  - ED physician re-evaluates; admitting physician agrees to admit for one day
  - LOS expectation based on condition, treatment and risk?
    - **1 midnight**
    - **Place in observation**
- Placed in observation, H&P done
- Echocardiogram, MRI, MRA done
- **Evening of first day, patient worsens**
- MD writes order to admit
- 1st night – observation counts toward two-midnight benchmark
- 2nd night – inpatient night counts as second night
- **Patient admission meets two-midnight rule and qualifies for inpatient reimbursement**

Compliance and Timing

FOCUSED HEALTHCARE STRATEGY

Compliance

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- Inpatient admissions –**Post-payment**
  - **≥ 2 midnights**
    - CMS "recovery auditors" WILL NOT review inpatient stays ≥ two midnights for medical appropriateness
      - For admissions between 10-1-13 and 10-1-14
  - **0-1 midnights (slight delay)**
    - CMS "recovery auditors" WILL NOT review 0-1 day IP stays for admissions between Oct. 1, 2013 and March 31, 2014
- CMS "Probe and Educate" Approach - **Pre-payment**
  - **Short IP stays**
    - CMS "administrative contractors" WILL review a sample of IP stays between Oct. 1, 2013 and ***Sept. 30, 2014***
      - Review is post-bill but pre-payment
      - Allows hospital to rebill as observation stay, if needed

What You Should Be Doing Now!

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- Internal focus
  - **Two-night benchmark**
    - Apply to decision-making AND documentation as of January 1, 2014

  - **Short inpatient stays (0-1 days)**
    - Audit documentation to support two-midnight stay expectation
  - **Orient staff to "midnight" clock**
    - Time in triage or ED waiting room doesn't count
    - Clock starts when services begin
      - Blood pressure check
      - Neuro assessment
      - Pulse oximetry, etc.
- Additionally……
  - *Check the ambulance bay and the waiting room at 11 pm!*


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THOUGHTS?
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