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Payment Modifications and DRG Impacts

JULY 2023

Foreword

It is important for health plans and providers to stay updated with payment modifications and understand their implications in payment integrity. Keeping abreast of annual CMS IPPS rule changes, advancing Value Based Care and risk-sharing contracts, and updates to fee schedules are important payment modifications that require changes in DRG Validation. Understanding and implementing these changes is essential to ensure accurate coding, appropriate DRG assignment, and proper reimbursement for inpatient services.

At CERIS, we continually make significant investments in DRG audits, focusing on enhancing clinical and coding expertise. Modifying DRG Validation to keep up with payment modifications has become an important priority as healthcare payment models continue to undergo significant transformation in response to the evolving healthcare regulatory landscape.

The following article addresses three key payment modifications and their impacts:

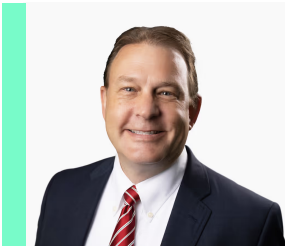
1. **CMS FY 2024 Inpatient Prospective Payment System (IPPS)** calls for a nearly 3% increase for general acute care hospitals successfully participating in the Hospital Inpatient Quality Reporting program that use meaningful electronic health records. The final rule has an anticipated effective date of October 1. This annual update continually impacts DRG Validation as final rulings are announced each year.

2. **Value-Based Care and Risk Based Contract Adjustments** tie reimbursement to quality over quantity and involve performance metrics such as clinical outcomes, patient satisfaction, or adherence to quality measures. These evolving payment models can also involve shared savings or shared losses based on performance against predetermined targets. These factors impact DRG Validation as they require providers to demonstrate contract required performance criteria.

3. **Fee Schedule Updates** can include changes to the Relative Value Units (RVUs) assigned to procedures, conversion factors, and other components that determine final payment amounts. Fee schedule updates may be influenced by inflation, changes in the cost of providing services, and updates to coding and documentation guidelines. While the focus of DRG Validation is primarily on the accuracy and appropriateness of DRG assignment, the review of fee-for-service (FFS) claims and documentation is an integral part of the audit process to ensure compliance with coding and billing guidelines.

CERIS remains committed to generating new ideas and improving solutions for DRG Validation and overall payment integrity. We are always here to discuss how to stay ahead of the payment accuracy curve.

Greg Dorn
President



Mark Johnson
SVP, Product Management

1. Payment Modification – CMS FY 2024 Inpatient Prospective Payment System

CMS FY 2024 Inpatient Prospective Payment System's (IPPS) proposed rule outlines various payment updates and initiatives with a focus on advancing health equity. The 2.8% increase in inpatient payments to eligible hospitals is estimated to provide an overall $3.3B boost for facilities.

In addition to increased payments, the ruling is focused on incentives to tackle health equity gaps through methods such as changing the severity of diagnosis codes that describe homelessness and other social challenges. These modifications allow hospitals to capture higher resource costs compared to similar cases without these challenges.

There are also incentives for hospitals that care for high portions of underserved individuals in an effort to enable the collection of health-related social needs (HRSNs).

With a continued focus on equity efforts, regulations continue to provide incentives for hospitals to deliver excellent care for underserved populations - laying the foundation for a safer, more equitable health system.

Proposed IPPS coding changes suggest additional codes to document factors such as:

- Abuse, maltreatment, and neglect of various populations
- Basic services being unavailable
- Inadequate housing or other environmental factors
- Treatment non-compliance due to financial hardship

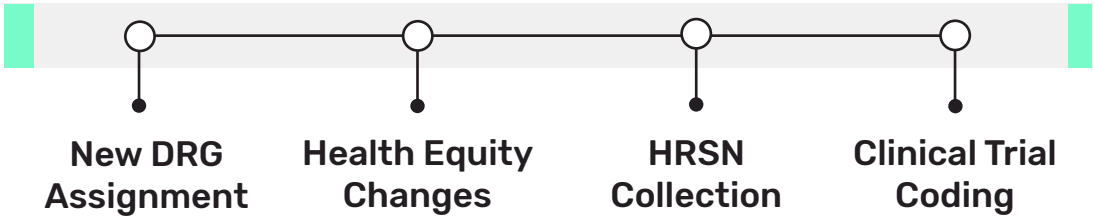
The ruling also proposes modifying several Medicare Severity Diagnosis Related Groups (MS-DRGs) that are subject to post-acute care transfer policy and MS-DRG special payments policies, including reassignment, creation, and deletion of MS-DRGs. Additionally, technical changes are proposed to modify the methodology for identifying clinical trial claims.

View the Proposed Rule and a CMS fact sheet with the final rule expected in August with implementation on October 1.

DRG Validation Impacts

Overall, the CMS FY 2024 IPPS proposed rule and payment updates focus on health equity, coding changes, and MS-DRG modifications that introduce various impacts to DRG Validation.

Payers should closely review and incorporate these changes into their validation processes to ensure accurate coding, proper DRG assignment, and appropriate reimbursement:



1. Audits should be updated to review the impact of payment modifications on assigned DRGs and ensure DRG assignments align with updated rates in the final ruling.

2. The ruling's focus on health equity and changes in severity of diagnosis to capture higher resource costs require DRG assignments to appropriately capture the complexity and resource utilization.

3. Collection of HRSNs also has implications for DRG Validation with additional documentation around factors such as abuse, unavailability of basic services, inadequate housing, and treatment non-compliance due to financial hardship affecting DRG assignment.

4. Proposed coding changes and modifications will additionally require audits to be updated on the technical changes in coding methodologies and the impact on identifying clinical trial claims.

2. Payment Modification – Value-Based Payment and Risk-Based Contract Adjustments

The potential of value-based care (VBC) models continues to remain unrealized. As the VBC landscape evolves, industry analysts expect the transition to risk-bearing reimbursement models to continue.

Ongoing focus points in VBC and risk-sharing models align incentives, improve quality outcomes, enhance care coordination, and reduce healthcare costs - ultimately aiming to deliver patient-centered and efficient care.

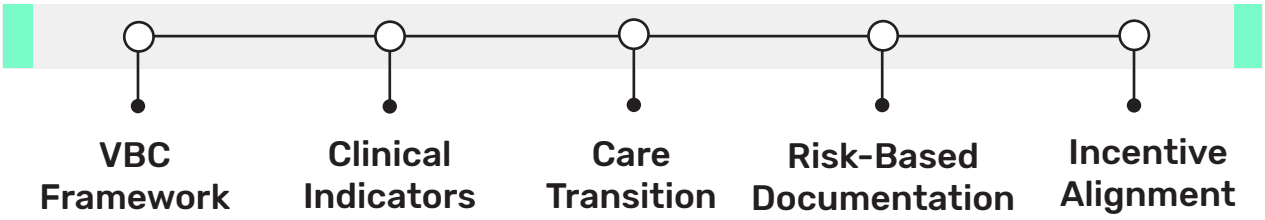
Current models center around several factors, including:

- Quality outcomes and performance measures, such as patient satisfaction and clinical quality metrics
- Various Alternative Payment Models (APMs) encouraging providers to move away from fee-for-service
- Population health management facilitated by data sharing and interoperability to improve preventative care, care coordination, and chronic disease management
- Accurate risk stratification and risk adjustment methodologies to ensure fair reimbursement based on patient complexity and health status
- Effective care coordination and transitions across settings, along with patient engagement and shared decision making

DRG Validation Impacts

VBC and risk-based payment arrangements can influence the focus and evaluation criteria of DRG Validation. Reviews may assess the accuracy of DRG assignment in reflecting the quality of care, care coordination efforts, performance metrics, coding accuracy, and financial implications within these models.

Payers should review VBC and risk sharing arrangements during the audit processes to ensure accurate coding, proper DRG assignment, and appropriate reimbursement. Some of the key areas of impact include the following:



1. DRG Validation within a VBC framework may include an assessment of whether assigned DRGs accurately reflect the severity of a patient's condition and quality of care.

2. Validations in VBC models should evaluate if documentation supports appropriate DRG assignments based on a patient's clinical indicators and quality outcomes. Audits may evaluate documentation such as patient satisfaction and clinical quality metrics.

3. Continuity of care and transitions between different providers and care settings should be evaluated to determine if assigned DRGs accurately reflect coordinated care efforts.

4. Risk-based model audits should focus on documented clinical and coding information to identify errors or omissions that impact risk adjustment and payment calculations.

5. Validations in risk-based models may also assess the financial impacts of assigned DRGs within the context of the risk-based arrangement to determine alignment with incentives or penalties.

3. Payment Modification – Fee Schedule Updates

Fee-for-service (FFS) models are undergoing significant changes and transformations in response to the evolving healthcare landscape. Some of the most notable changes (VBC models and Risk-Based contracting) are outlined in the previous section, but additional shifts include:

- Integration of Technology and Data: Integrating electronic health records (EHRs), health information exchange (HIE) platforms, and advanced analytics is transforming FFS models. These technologies enable better care coordination, data sharing, and insights to drive informed decision-making and improve patient outcomes.

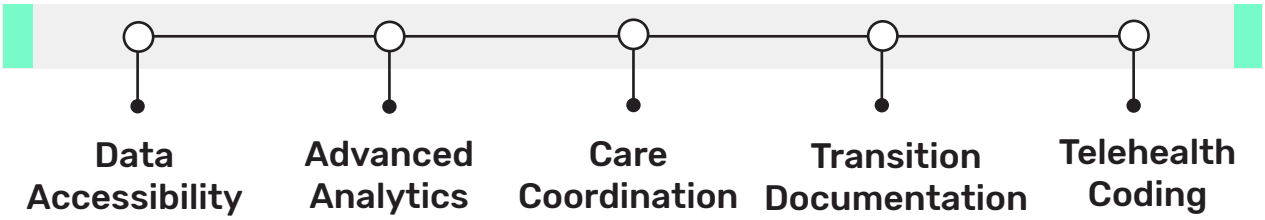
- Emphasis on Care Coordination: FFS models are evolving to prioritize care coordination and care management, aiming to improve patient experiences and outcomes while reducing unnecessary utilization and costs. Coordinated care models involve collaboration among different providers and settings to ensure seamless transitions and continuity of care.

- Telehealth and Remote Care: The expansion of telehealth and remote care services has influenced FFS models. Telehealth visits and remote monitoring have become reimbursable services, enabling greater access to care and reducing the reliance on traditional in-person visits.

While FFS and DRG are distinct concepts, they work together to determine the reimbursement hospitals receive for inpatient services. Under the FFS model, hospitals receive payment for each individual service provided, such as tests, procedures, and medications. However, when it comes to inpatient care, reimbursement is often determined using the DRG system.

DRG Validation Impacts

Changes in FFS models influence DRG Validation audits by placing emphasis on accurate documentation, care coordination, and adaptability to evolving healthcare delivery methods. Payers should consider the impact of technology integration, care coordination efforts, and the expansion of telehealth services when evaluating the appropriateness and accuracy of DRG assignments:



1. The integration of technology and data in FFS models enhances the availability and accessibility of patient information which enables more comprehensive and accurate data for assessing the appropriateness of DRG assignments.

2. Advanced analytics and data-driven insights support DRG Validation by identifying patterns, trends, and anomalies in DRG coding and documentation.

3. The focus on care coordination in FFS models can influence DRG Validation by highlighting the importance of accurate and complete documentation of care coordination efforts. Auditors may assess whether the assigned DRGs accurately reflect the coordination of care across providers and settings.

4. Auditors may also evaluate the documentation supporting transitions to ensure assigned DRGs align with the level of coordination involved.

5. The expansion of telehealth and remote care services within FFS models introduces new considerations for DRG Validation audits. Appropriateness of DRG assignments for virtual encounters and remote monitoring services is a new challenge. Documentation and coding should accurately reflect the nature and complexity of the telehealth visits and remote care provided.

Summary

This article focuses on the impacts of payment modifications on DRG Validation by highlighting three key components: CMS FY 2024 Inpatient Prospective Payment System (IPPS), Value-Based Payment and Risk-Based Contract Adjustments, and Fee Schedule Updates.

1. The CMS FY 2024 IPPS proposed rule impacts DRG Validation by requiring audits to take into consideration new reimbursement, resource costs, and health equity initiatives.

2. Value-Based Payment and Risk-Based Contract Adjustments impact DRG Validation by requiring audits within these models to review documentation around the quality of care, financial performance metrics, and coding accuracy.

3. Fee Schedule Updates impact DRG Validation by requiring audits to take into consideration of the impact of digital health and technology as well as care coordination and transition efforts.

Payers should incorporate each of these payment modifications into their validation processes to ensure accurate coding, proper DRG assignment, and appropriate reimbursement.