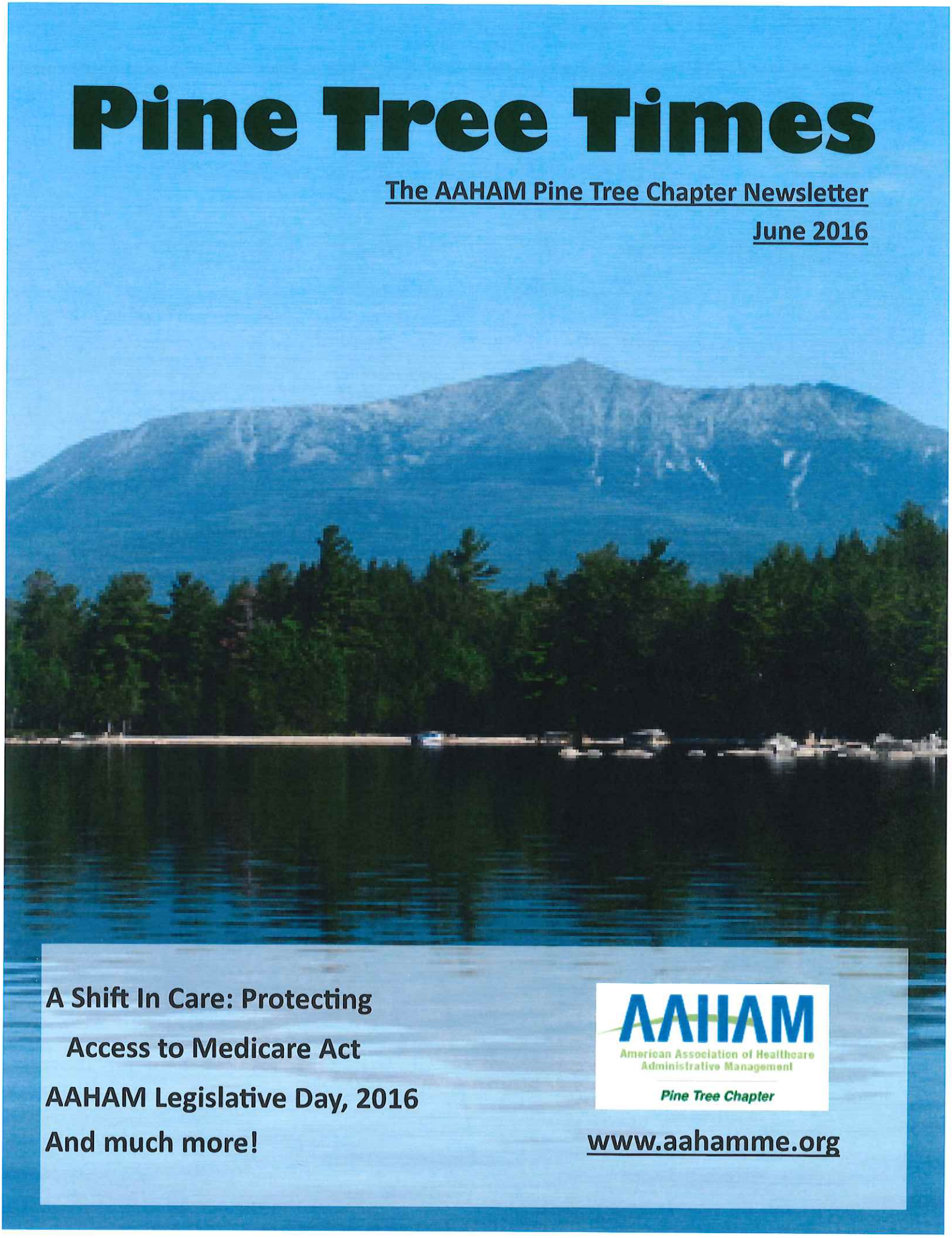
Pine Tree Times

The AAHAM Pine Tree Chapter Newsletter

June 2016



A Shift In Care: Protecting Access to Medicare Act

AAHAM Legislative Day, 2016

And much more!

AAHAM
American Association of Healthcare Administrative Management
Pine Tree Chapter

www.aahamme.org

President's Message

Dear Friends and Colleagues,

Happy Spring! Hopefully warmer weather and beautiful sunny days are right around the corner!

This past quarter has been a busy time for AAHAM and the Board. We have held 2 educational sessions, as well as planning for our ANI event scheduled for May 5-6, 2016. In addition, we completed our Chapter Operations Report for National AAHAM (and scored a 93 out of 100 points)!!! We are also revamping our website. This should be completed in the next several weeks and will have a brand new face and be much more user friendly! Next on the plate, will be submitting for Chapter Excellence, in which the Pine Tree Chapter has placed every year, since I can remember. Here's to another great year of Excellence!

I recently attended the National AAHAM Board Meeting in Washington DC and our local VP, Natashia Nile joined me for the 12th Annual Legislative Day, immediately following the Board Meeting. It was a very educational 2 days and we were very fortunate to attend on behalf of the Pine Tree Chapter. We had appointments with all four offices of Maine's Congressional Delegation:

Senator Susan Collins
Senator Angus King
Congresswoman Chellie Pingree
Congressman Bruce Poliquin

There were 2 pieces of legislation that AAHAM was promoting awareness for:

The Hospital Improvements for Payments (HIP) Act of 2014 (HAS NOT BEEN PRESENTED)
http://www.aaham.org/Portals/5/Files/LegislativeDay/2015HIPActPositionpaper.pdf

H.R.2156 – Medicare Audit Improvement Act of 2015
https://www.congress.gov/bill/114th-congress/house-bill/2156/text

Under former Pine Tree Chapter President, Paul Fitzpatrick's lead, he was clearly a veteran Leg Day attendee and self-professed "political geek", we visited with staff from each congressional office to provide awareness of both AAHAM as a national and local association, as well as the 2 pieces of legislation noted above. It was incredibly educational and Paul did a fantastic job teaching us how this event worked as well, as well as our role of representing and promoting AAHAM and the Maine healthcare providers. Congress was in session, so there were many sightings of notable faces (McCain and Rubio, just to name a couple) and we were even lucky enough to actually meet Congressman Poliquin, as he was in the office when we arrived and he was kind enough to make time to sit down with us and chat as well as pose for a pic!

It was a very exciting event, and I encourage anyone who has the opportunity to attend future Leg Day events, to do so. It is a great way to meet your legislators, help promote legislation that is critical to your facilities and network with fellow AAHAM members across the country.

Respectfully submitted,
Nicole Bishop, Chapter President

In This Issue

Healthcare Humor

"First we're going to run some tests to help pay off the machine."

Pine Tree Chapter Board

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Upcoming Meetings

September 23, 2016	**Revenue Cycle Meeting**	**Portland**
November 18, 2016	**Third Party Payer Meeting**	**Augusta**

A Shift in Care: Protecting Access to Medicare Act

The Protecting Access to Medicare Act (PAMA), like a lot of legislation, is based on a noble intention and is full of trade-offs, benefits and drawbacks. Overall, the Act aims to move the health care industry toward one that pays for results as opposed to services. Getting there, of course, is the tricky part.

Since the PAMA was signed into law on April 1, 2014, it has been a source of conversation among health care providers, lenders and beneficiaries. While there are many important components to this multifaceted legislation, this article will focus on the key components pertinent to senior living and health care providers. Perhaps most noteworthy for providers is the introduction of a value-based payment system for skilled nursing facilities (SNFs) that is based on individual SNF performance on a hospital readmission measure.

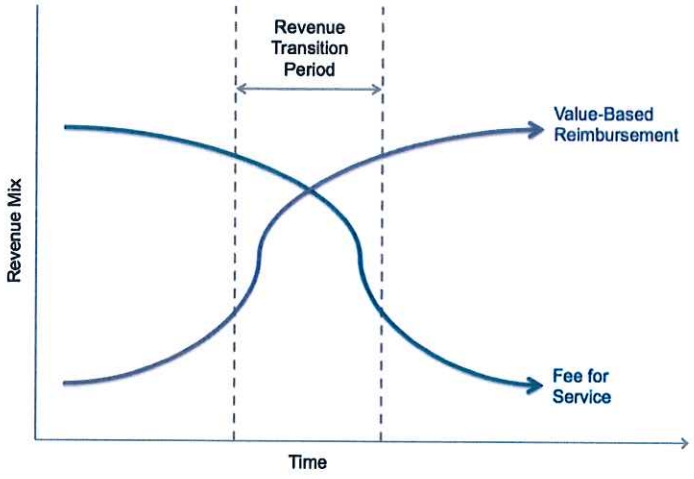
In the spirit of transparency and clarity, the goal of PAMA is to further define the terms, expectations and limitations of the Medicare Act pertaining to Medicare providers, beneficiaries and legislative branches. When it was signed into law in 2014, one of the key provisions was a delay in any cuts in the Medicare reimbursement rate until 2015. These cuts were originally scheduled to go into effect April 1, 2014, and have traditionally been delayed each year for more than a decade. This time, the cuts went into effect with no legislation in sight to change that. Many groups, such as the American Medical Association (AMA), were disappointed in this aspect of PAMA and continue to push for a permanent fix to the Medicare cuts. It remains to be seen whether those efforts will prove to be fruitful.

For now, PAMA is garnering attention not for the highly discussed Medicare cuts, rather for other provisions that are beginning implementation.

Paying for Performance

One of the core sections to come from the PAMA is section 215 which discusses the shift to a value-based purchasing (VBP) system. VBP is a demand side strategy to measure, report and reward excellence in health care delivery.[1] The transition to a VBP system typically occurs over many years with a transition period during which revenue decreases (Figure 1).

Figure 1:



https://www.healthcatalyst.com/hospital-transitioning-fee-for-service-value-based-reimbursements

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A Shift in Care: Protecting Access to Medicare Act

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In order to create the incentive pool, SNF's Medicare per-diem payments will be reduced by 2%. Out of the money collected, 50 -70% of it will be available for the incentive pool. Not all of the 2% reduction is going back to SNFs, as it is also a means to save Medicare money, a projected $2 billion over 10 years. Top performing SNFs will see most, if not all, of their 2% withhold returned through incentive payments, and possibly more. SNFs that perform in the middle level are expected to see a portion of their 2% than their withholding or nothing.

To quantify a SNF's performance in the VBP program, HHS will use one of two quality measures: a hospital readmissions measure based of all causes and conditions, or a "resource use" measure of "all-condition risk adjusted potentially preventable hospital readmissions" for SNFs. Initially, the VBP performance will be measured using the all-encompassing readmission measure, however, the PAMA requires that the more specific "resource use" measure be implemented as soon as possible.

HHS will provide SNFs with confidential feedback on the initial results from both measures in 2016 and will publicly report data on both measures by Oct. 1, 2017. The proposed VBP rule will be published in 2018 and the first adjustments to a SNF's payments will begin in 2019.

Ultimately, the VBP program should affect providers, beneficiaries and lenders in a positive way. The programs afford health care providers the opportunity to stand out from a quality of care, service and hospitality perspective by making global initiatives to enhance their operations. This methodology forces health care providers to refocus and reconsider their why statement ("why we are here and why are we doing this?") Hospitals and other health programs were created to care for the sick by those who had a passion for helping others. Effectively implementing a VBP program within a health care organization returns to the original principals that guided the creation of health care in society today.

Hospitals Feel the Effects

The changes in the PAMA affect hospitals in a variety of ways. Typically, Medicare sets annual beneficiary payment limits for outpatient therapy services. The PAMA allowed the temporary expansion of the cap on outpatient therapy services provided in Hospital Outpatient Departments (HOPDs) if the therapy is deemed medically necessary. The extension of the therapy cap was permanently extended by the Centers for Medicare & Medicaid Services (CMS) for Critical Access Hospitals (CAHs). From both an operational, beneficiary, and financial perspective, this is key as it drives additional patients to hospitals to supplement Medicare revenue and it allows patients to receive higher quality care for longer time periods through what is likely to be a better therapy program.

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A Shift in Care: Protecting Access to Medicare Act

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Concentrating more on rural hospitals, Section 106 details plans to spend $100 million over 10 years, focusing on extending the Medicare-Dependent Hospital (MDH) program. Established in 1987, the MDH helps support small rural hospitals for which Medicare patients make up a majority of their inpatient days or discharges. To qualify as an MDH, the hospital must be located in a rural area, have 100 beds or less, not be classified as a sole community hospital, and have at least 60% of discharges or inpatient days covered by Medicare. These hospitals are able to receive the inpatient price per service (PPS) rate plus three-quarters of the amount by which their costs per discharge exceed the (PPS) rate.

For example: ABC hospital discharges Patient X who had a one night stay. Patient X had a PPS rate of $150. The cost to discharge Patient X is $300. The hospital will receive $262.50. This is determined by taking the difference between the PPS rate and the discharge cost ($300-$150), multiplying it by .75 and adding it to the PPS rate which amounts to $112.50. This boost in rates is invaluable to operators as it helps to bridge the gap between costly discharges and low PPS rates. Additionally, MDH will help decrease expense margins and boost Medicare revenue.

Section 212 has received a lot of attention due to its focus on technology and effect on monetary means of providers. HHS Secretary Sylvia Burwell delayed the adoption of ICD- 10 as the standard code for medical data from Oct. 1, 2014 to Oct. 1, 2015. There was significant opposition regarding the delays in implementing the ICD-10 coding system. Many hospitals had incurred substantial financial obligations in implementing ICD-10. This delay ultimately slowed down the transition to value-based payment in the health system.

A Clear Shift

The PAMA has noble goals but is imperfect. While some sections in the PAMA are steering health care in the direction of realizing a true value-based payment system, some components of the legislation such as the ICD-10 coding have slowed down this process. Overall, however, the trend is clear; health care is moving towards a pay-for-performance model and PAMA represents a significant step in that direction.

Source: American Hospital Association, "Legislative Advisory, The Protecting Access to Medicare Act of 2014," April 2014.

Jessica Rosenberg is an associate with Lancaster Pollard in Columbus. She may be reached at jrosenberg@lancasterpollard.com.

1. http://www.nbch.org/Value-based-Purchasing-A-Definition

New Job!

The Pine Tree Chapter would like to congratulate Sherry Van Joolen, formerly of Maine General Medical Center, for accepting a new job.

Sherry is now a Billing Compliance Specialist with MaineHealth. Congratulations and best of luck in your new position!

Newsletter Content Wanted!

Have a great article that you want to share with the chapter? Any exciting updates or news - birthdays, job changes, births, graduations, etc.? We want to here from you!

If you would like to provide content for consideration in the next Pine Tree Times Newsletter please email Barbara Lynch at blynch@bhrllc.com

"In the News"

The superbug that doctors have been dreading just reached the U.S.

Lena H. Sun — The Washington Post, May 27, 2016

For the first time, researchers have found a person in the United States carrying bacteria resistant to antibiotics of last resort, an alarming development that the top U.S. public health official says could mean "the end of the road" for antibiotics.

The antibiotic-resistant strain was found last month in the urine of a 49-year-old Pennsylvania woman. Defense Department researchers determined that she carried a strain of *E. coli* resistant to the antibiotic colistin, according to a study published Thursday in Antimicrobial Agents and Chemotherapy, a publication of the American Society for Microbiology. The authors wrote that the discovery "heralds the emergence of a truly pan-drug resistant bacteria."

Colistin is the antibiotic of last resort for particularly dangerous types of superbugs, including a family of bacteria known as CRE, which health officials have dubbed "nightmare bacteria." In some instances, these superbugs kill up to 50 percent of patients who become infected. The Centers for Disease Control and Prevention has called CRE among the country's most urgent public health threats.

Health officials said the case in Pennsylvania, by itself, is not cause for panic. The strain found in the woman is still treatable with other antibiotics. But researchers worry that its colistin-resistance gene, known as mcr-1, could spread to other bacteria that can already evade other antibiotics.

Read the rest of the article here

AAHAM Legislative Day, 2016

AAHAM Legislate day took place in April of this year. What an incredible event. Over 80 AAHAM members from across the United States came to Washington DC to help support AAHAM and all of us working in the Healthcare Administrative Management arena. Each of us had the opportunity to meet with our own state representatives to help them understand what we are seeing in our hospitals.

We took two very important topics to our representatives this year.

The HIP act:

The HIP Act aims to fix the issues between payment systems. There are currently 2 regulatory proposals used by the Centers for Medicare and Medicaid Services (CMS) for reimbursement; the inpatient prospective payment system (IPPS) and the outpatient prospective payment system (OPPS).

- o Each of these systems reimburses in different ways, using different code systems that cannot be interchanged.
- o Therefore, hospitals must know both coding systems and both payment systems in order to receive Medicare reimbursement.
- o This system is inefficient for hospitals and leads to potential misleading incentives between programs.

• The HIP Act addresses problems associated with Medicare's Two-Midnight policy.

- o The Two-Midnight policy was created by the CMS in 2014 to clarify the previous Medicare short stay policy.
- o To replace the Two-Midnight rule, the HIP Act would create a transitional policy for 2016-2019 and then a new hospital prospective payment system (HPPS), a long-term short stay policy to be established by 2020. With this replacement, the 0.2% reduction by the CMS to the IPPS baseline would be repealed.

• The definition of a "short-stay" would be redefined as an actual length of stay less than 3 days that is classified to an MS-DRG with a national average length of stay which is less than 3 days, and an MS-DRG that is among the most highly ranked discharges that have been denied for reasons of medical necessity by RACs.

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• The policy defines an inpatient stay that is "reasonable and necessary" when a patient is treated in a hospital for two or more midnights. The problem with this is that there are instances in which a stay is mischaracterized causing issues to payments received.

• The Secretary of Health and Human Services (HHS) can expand this definition to include a larger subset of inpatient short-term discharges after 2017.

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• In response to the issues regarding the RAC system; the Act extends the current moratorium for RAC audits of short inpatient stays, requires the Secretary of Health and Human Services (HHS) to report all RAC data to the public and create a RAC compare website, and it reduces the RAC look back period from four to three fiscal years and gives providers and suppliers 30 days to discuss any reviewed claim before a denial is issued.

• The HIP Act includes a voluntary opportunity for providers to settle claims that are pending at the Administrative Law Judge (ALJ) level and it mandates hospitals provide financial information with respect to what coinsurance and copayments are collected for the 50 most common Diagnosis Related Groups (DRGs).

• The HIP Act requires hospitals (starting Oct. 1, 2018) to report to the HHS Secretary standardized patient assessment data, including information regarding medical conditions and functional status, comorbidities, cognitive function, and their living situation and access to family caregivers at home, any hospital that does not report the required data will have its payments reduced by 2%.

• Section two of the Act contains 19 individual legislative proposals. o Such proposals include a repeal of the current moratorium on physician-owned hospitals; o The creation of a voluntary demonstration program for hospitals to study ways to improve hand sanitation and calls for reporting of a new national hand sanitation quality measure; o A requirement that hospitals inform Medicare beneficiaries, who are on outpatient observation status, that they are not being treated as inpatients and their time in the hospital may not qualify them for Skilled Nursing Facilities (SNF) care, among others.

The Medicare Audit Improvement Act:

HR 2156 - The Medicare Audit Improvement Act The Medicare Modernization Act of 2003 first created the Recovery Audit Contractor (RAC) program to identify and recover improper Medicare overpayments and underpayments to healthcare providers. The program is overseen by CMS with RACs performing the actual work of reviewing, auditing, and identifying improper Medicare payments. Hospitals have been seeing a large increase in the amount of documents being requested. When a Medicare contractor detects the possibility of an improper payment they will contact the hospital and request additional documentation, referred to as an Additional Document Request (ADR).

• HR 2156 establishes a combined maximum amount of medical record requests for hospital Part A audits by Medicare Recovery Auditors (RACs) and Medicare Administrative Contractors (MAC).

o For complex, pre-payment and post-payment hospital audits, the maximum number of medical record requests may not exceed an amount equal to 2.0% of hospital Part A claims submitted for the previous calendar year, with a maximum of 500 additional document requests (ADRs) per 45 days for each of these audits.

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• HR 2156 implements financial penalties for RACs that have a pattern of failure to comply with these and other basic program requirements. Penalties will be paid to the Medicare program.

o Complete audits within the required deadlines;

o Timely issuance of "demand letters" per CMS's guidelines, to inform hospitals of the denial and related appeals rights;

o The HHS Secretary shall establish the frequency and amount of these penalties.

• HR 2156 makes clear that for appeals decided in favor of the provider, a RAC must pay a penalty to providers to offset the cost of the appeal. This amount will be established by the HHS Secretary.

• HR2156 states medical necessity audits by RACs are to be focused on widespread payment errors.

o CMS must identify patterns of payment error using a statistically significant sample of claims;

o CMS may approve medical necessity audits for widespread errors with at least a 40% error rate. This error rate must be adjusted to account for denials overturned through the appeals process;

o CMS will review this rate annually to adjust, when necessary, for improvements in billing practices; o This applies to both pre-payment and post-payment audits.

• HR 2156 requires CMS to establish consistent criteria for pre-payment audits by RACs and MACs.

• HR 2156 requires CMS to annually publish the following auditor information for each of these categories of audits: by automated, complex, and medical necessity review; Part A, Part B, DME; Part A medical necessity);

o For each of these data categories, report the following:

§ Number of denials;

§ Number of appeals;

§ Net denials; (Total denials minus denials overturned on appeal)

§ Appeal Rate

• HR 2156 allows hospitals to be paid the full Part B payment for inpatient claims denied by a RAC or MAC since the care was found to be appropriate at the outpatient level.

• HR 2156 states all claims audited by a RAC, MAC, or CERT contractor are considered to be "reopened," which means that Medicare timely filing limit does not apply to claims by CMS or other auditors.

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• HR 2156 requires that a RAC, MAC and CERT physician validate whether a denial is warranted when a medical necessity audit by a non-physician auditor indicates that a denial may be appropriate.

• HR 2156 establishes that the existing reopening standards can be enforced through an appeal by a hospital if a Medicare contractor violates them.

• HR 2156 restores the right of providers and patients to seek enforcement of the reopening deadlines in the Medicare appeals process and federal courts.

As you can we see we did a ton of work over the course of one full day on Capital Hill. If you have not been to an AAHAM legislative day, make sure you attend next year. It's truly inspirational to see how the American legislative system works.

Should you have any questions on any of these topics, upcoming legislative days, or just about anything AAHAM, feel free to email me at tmoore@marcamassociates.com.

Tim Moore
Chapter Development Committee Chair
AAHAM

National President's Award

This award is presented to an individual National AAHAM member for their exceptional contribution made at the national level, both to our organization and toward furthering the profession of healthcare administrative management.

This year, one member stood out as most deserving of this very prestigious award.

The member I have chosen has consistently shown great dedication to our organization. Commitment to the cause has been evident time and time again.

Attitude is so important when you work so hard in a volunteer capacity. This member always has a smile on his face and a positive outlook on life.

He has helped us grow – simply by convincing others that they could not – would not - be successful unless they were part of this great organization. And how could anyone say no to someone whose motto is "We will not quit – and Semper Fi."

That's right – It is my extreme pleasure to announce that this year's National Presidents Award goes to the amazing, energetic, rocking – – **Tim Moore**!

More About Lean Healthcare from the Annual Conference

Speaker Steve Musica, Principal of the Maine-based consulting firm Lean Healthcare East, provided an engaging 90 minute introduction to Lean healthcare. Steve reviewed the five principles of Lean and shared a case study from a recent hospital improvement project. AAHAM Pine Tree chapter members had great questions and left with a new way of looking at their work.

All organizations are composed of a series of processes intended to create value for customers. Lean is a management strategy that seeks to distinguish value added work from non-value added work and eliminate what is non-value added. The focus is on patient processes rather than functional departments. Hospitals continuous improvement projects based on Lean thinking have led to huge reductions in cost, inventories and patient wait times while improving patient outcomes. Lean also leads to increased job satisfaction and team growth. Contact Steve at Steve@LeanEast.com for a copy of the AAHAM presentation and more information.

Lean Healthcare East consists of experienced leaders and Lean experts offering strategic consulting, training and coaching to help organizations implement Lean improvements that improve patient outcomes and reduce costs. Improvement projects typically have a 10x ROI (return on investment) for the organization and provide increased value to patients and staff by reducing overburden, inconsistency and operational wastes. We are based in Maine and love to help our local hospitals!

2016 Pine Tree Chapter Membership

AAHAM is having a membership drive in 2016 and invites all members to encourage their peers to join our organization. If you are responsible for recruiting a new member, please, have the new member list your name on their membership form. The AAHAM member that recruits the highest number of AAHAM members will be eligible for a free 2017 Registration for The Pine Tree Chapter of AAHAM Annual Meeting or the Pine Tree Chapter of AAHAM will pay your national dues for 2017.

When you renew your dues, you will have the tools to lean how to work smarter, advance in your career and have access to a wealth of revenue cycle information. AAHAM is the only national organization dedicated to the revenue cycle, both management and the front line staff. We provide education and training for staff and managers, as well as offer a nationally recognized certification program.

Renewing your membership in AAHAM, provides the necessary tools to deal with the serious issues facing hospitals today. Some of the valuable benefits of membership are:

⇒ Access to Member's Only Section of AAHAM's website

⇒ Timely legislative and government updates to help stay in compliance-The latest networking on information systems, regulations, managed care, payer issues and more

⇒ Local and national education meetings-including the AAHAM Annual National Institute

⇒ Comprehensive certification programs for executives (Certified Revenue Cycle Executive-CRCE), for managers (Certified Revenue Cycle Professional-CRCP) and front line staff (Certified Revenue Cycle Specialist-CRCS and Certified Compliance Technician Exam-CCT). By ensuring your competency in Registration, Billing, Third Party Recovery and AR Management, you can demonstrate functional knowledge of the day to day operations of your facility.

Please, renew today and continue to build your valuable relationships with other Healthcare Professionals as you gain essential knowledge. Renewing your membership in AAHAM is an investment in your professional career and personal growth.

The dues for 2016 are $25.00. See the 2016 membership application and dues form at the end of this newsletter.

If you have any questions, please, contact me.

Sincerely,

Bonnie Richards

Membership Chair

207-907-1850

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American Association of Healthcare Administrative Management

Pine Tree Chapter

Renewal/Application Form

The Maine Chapter of AAHAM is pleased to welcome you as a member. Annual dues for 2016 are $25.00 per person. Membership runs from January to December. Local dues cannot be prorated during the year.

To ensure that you are a recognized member for the Chapter year and receive all notifications of educational sessions, please submit your payment of $25.00, made payable to "Pine Tree Chapter of AAHAM" to:

Karen Clark
Patient Accounts
Redington Fairview General Hospital
P.O. Box 468
Skowhegan, Maine 04976

If you are a member of National AAHAM and choose to pay your local dues through them, it is important that you still send this form (without payment) to the above address so that our records will correctly reflect your membership.
Please complete the following:

Name and Title: _____

Certification: _____

Organization: _____

Address: _____

Daytime Telephone: _____ Fax: _____ Email: _____

Check all that apply:
_____ This is a new application
_____ ***I was referred to AAHAM by*** _____
_____ I am renewing my application
_____ I have paid my local dues through National AAHAM

Please send checks to the attention of Karen Clark as close to the start of the new Chapter year as possible.

For Treasurer's Use Only:
Check No. _____
Date Received: _____