Oregon Chapter of HFMA

PIPELINE

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In this issue

President's Message

Are you ready for change?

As I type this on Aug. 1, the first day of coordinated care organizations (CCOs) in the state of Oregon, are you and your organization prepared for today? Or how about for Jan. 1, 2014, the first day of the Oregon Healthcare Exchange?

While change has become the norm in business today, the speed in which change will happen in the next year will be significant. CCOs, something we did not even know about a year ago, are now live in many Oregon communities. What does this mean for you and your organization? What action should your organization taking today, or maybe more importantly, what should your organization be doing to best position itself for next year? What future changes are coming with Oregon CCOs? Will the Public Employees' Benefit Board and/or the Oregon Educators Benefit Board become part of the CCOs? At the same time we are learning about CCOs, Oregon's filing for the 2014 Oregon Healthcare Exchanges is due in May 2013. What is your organization doing to best position itself for January 2014?

There are many significant changes coming in health care, and some very specific changes unique to Oregon. Oregon HFMA will continue to be your source of educational information for Oregon healthcare providers.

Our next meeting is a joint meeting with the Alaska/Washington chapter Sept. 19–21. Not only can you learn about Oregon CCOs, you can also work with your counterparts in Alaska and Washington to understand why those states are not doing CCOs and what action they are taking instead.

I look forward to seeing you all this fall.

Respectfully yours,
Dustin Taylor
Oregon President 2012–13

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STEP Up

Supreme Court rules on health care reform law

By Jeffrey A. Lampman, Beseler Consulting

On June 28, in one of the most anticipated decisions in years, the United States Supreme Court voted 5–4 to uphold major provisions of The Patient Protection and Affordable Care Act of 2010 (PPACA). Led by Chief Justice John Roberts, the Supreme Court concluded that the "individual mandate," one of the most controversial aspects of the law, was constitutional as a valid exercise of the federal government's taxing power. In addition to upholding the requirement that all individuals maintain some sort of insurance coverage, the court also sanctioned the expansion of Medicaid provided under the PPACA. Importantly, however, the court held that the federal government could not withhold Medicaid funds from states that choose not to expand Medicaid coverage pursuant to the PPACA. How that aspect of the court's ruling impacts Medicaid expansion will likely be a state-by-state issue. The stage is now set for the PPACA to continue to be one of the key issues in the upcoming presidential and Congressional elections.

Chief Justice John Roberts cast the deciding vote and wrote the majority opinion on the Affordable Care Act.

In upholding the PPACA, the court ensured that health care reform under the act will continue, at least until the federal elections in November. This removes some of the uncertainty under which health care providers have been acting while the legal challenge was pending.

Health care providers should now proceed with the expectation that the PPACA will be implemented according to schedule. While the upcoming election could change things, it would take a Republican sweep of the presidency and both houses of Congress to even begin the process of repealing provisions of the PPACA.

In order to best prepare financially, hospitals should pay special attention to the following areas as the PPACA is fully implemented. Now is the time for improved clinical and financial collaboration to be proactive in improving patient care delivery models while minimizing financial penalties today and in future years.

- The Hospital Readmission Reduction Program begins Oct. 1, 2012. The initial focus will be on readmissions related to heart attack, heart failure and pneumonia. Hospitals with higher than expected readmission rates will experience reductions in their Medicare rates. It is expected that the federal fiscal year (FFY) 2013 financial impact of the Readmission Reduction Program will total $300 million nationally. Hospitals can also expect up to a 2 percent reduction in base DRG rates in 2014 and up to a 3 percent reduction in base DRG rates in 2015. CMS will expand the program to include COPD, CABG, PTCA and other vascular procedures. It is estimated the readmission payment reductions will total $7.1 billion over 10 years. There are very few hospitals nationally that will not experience a payment reduction. Hospitals focused on the reduction of readmissions are best positioned to limit the financial impact of this program.
- The value-based purchasing (VBP) program will reward hospitals that deliver high quality care with value-based incentive payments to hospitals that meet specified performance standards. These standards will begin with a subset of the measures in the current pay for reporting program but will be expanded to include efficiency and outcome measures. Effective Oct. 1, 2012, all hospitals will experience a 1 percent reduction in base DRG rates. Incentive payments will then be made to the qualifying providers. In other words, hospitals will need to "earn their money back."
- Beginning in FFY 2012, CMS publically reported the first eight hospital-acquired conditions under the inpatient quality reporting program. Beginning Oct. 1, 2014, hospitals in the top quartile with respect to national HAC rates will experience a 1 percent payment reduction in base DRG rates.
- Hospitals should prepare for changes to Medicare Disproportionate Share Hospital Reimbursement, which under the PPACA is set to begin on Oct. 1, 2013. Those changes will reduce Medicare DSH payments to 25 percent of their current levels.

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Supreme Court ruling

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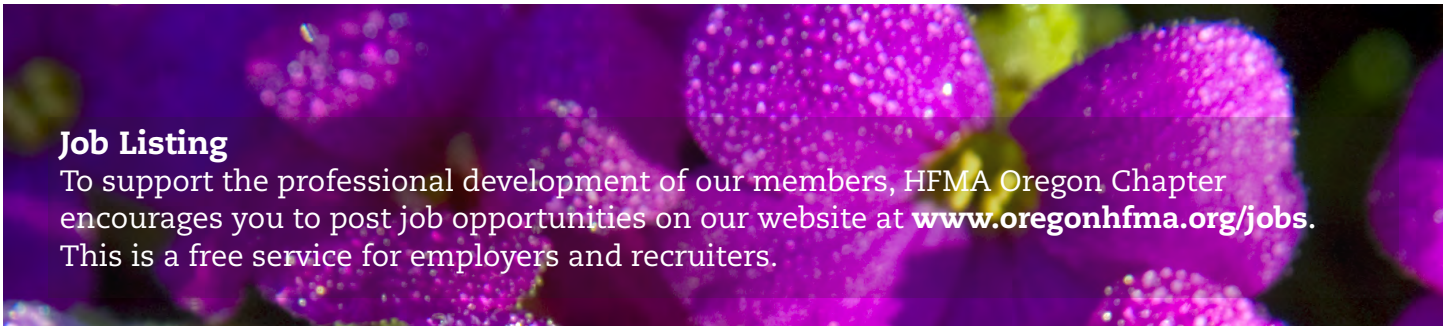
- Hospitals should pay greater attention to the Medicare Cost Report Worksheet S-10, which reflects uncompensated care provided by a hospital. In conjunction with the decrease in Medicare DSH payments, an uncompensated care fund is being created. Although it is unclear exactly how the Centers for Medicare and Medicaid Services will determine how to allocate that fund, it is likely that the S-10 will pay a role in that allocation. The S-10 also is a significant determinant of electronic health record payments to hospitals. *(For more information about Worksheet S-10, see the article on page 6.)*
- State-by-state changes in Medicaid will likely accelerate following the Supreme Court's decision. Many states had held up implementing Medicaid changes and expansion until a final decision on the PPACA's constitutionality was issued. Now that the constitutionality has been settled, expansion measures will become more prominent. Hospitals should work with their Associations and other advocates to attempt to shape these expansion efforts to ensure that providers' views are considered in the expansion. Once the specifics of each state's expansion become clearer, hospitals will have to work with consultants and internal staff to adjust to those changes.
- Some states have stated that despite the Supreme Court's ruling, the state will not implement various provisions of the PPACA. This puts hospitals in a very precarious position. With DSH funding scheduled to be reduced, if a State does not take steps to implement the PPACA, it is possible that hospitals in such a State will also be excluded from the new uncompensated care pool. The impact on hospital funding could be substantial. Hospitals should work closely with their advocates to ensure that any State that wants to register its continuing objection to the PPACA does so in a manner that does not hurt hospitals and other providers in the State.

Hospitals will experience Medicare payment reductions in just a few months. Additional reductions will continue over the next few years. It will imperative for hospitals to focus on these areas to minimize the financial impact wherever possible.

Besler Consulting offers a variety of customized services that can provide the appropriate mix of expertise to conduct a health care reform impact analysis for your hospital. For more information contact Jeffrey A. Lampman at 609-514-1400 or jlampman@besler.com.



Recent changes to Worksheet S-10:

Exploring the impact on reimbursements

By David Verbaro

July is over and the summer is nearly gone. By now, all hospitals will have had their first encounter with the new 2552-10 Medicare cost report forms. Although the cost reports have been submitted, what remains to be seen is the impact these changes will have on a hospital reimbursement. No worksheet has had more alterations than Worksheet S-10. Hospital CFOs and reimbursement directors should understand how the changes to this worksheet will influence the reimbursement they receive.

Impact of the new S-10 on hospital reimbursements

Until recently, the S-10 form had no reimbursement impact, and, in fact, the Centers for Medicare and Medicaid Services (CMS) did not even require that hospitals complete the form. Starting in 2010, CMS instructed all acute care and critical access hospitals to complete the form to calculate the cost of providing care for which they are not compensated. Going forward, Worksheet S-10 will play a vital role in the distribution of a hospital's electronic health record (EHR) incentive payments and may be used in the calculation of future disproportionate share (DSH) payments.

To determine a hospital's uncompensated care costs on Worksheet S-10, a hospital records charges and payments, and calculates costs (using the cost-to-charge ratio [CCR] from Worksheet C) for:

- Services to Medicaid patients
- Services to SCHIP patients
- Services to patients covered by a state or local government indigent-care program
- Services to patients who are given a discount under a hospital's charity care policy

In addition, Worksheet S-10 includes costs (again, using the CCR from Worksheet C) for non-Medicare and non-reimbursable Medicare bad debt.

Impact on EHR payments

A hospital's EHR payment is driven by the amount of charity care it provides. Higher documented charity care will result in a more substantial EHR payment. The hospital's uncompensated care amount consists of charity care and bad debt, both non-Medicare and non-reimbursable. This amount of uncompensated care is now calculated on line 20 of the 2552-10 Worksheet S-10. A hospital's individual charity care policy will determine what services are eligible for line 20. A less stringent charity care policy will most likely result in a higher amount of reported charity care. Accordingly, hospitals should continue to review their charity care policy, which are usually governed in part by State regulations. If a hospital fails to submit any information on the S-10, it may put EHR payments at risk. This omission could jeopardize millions of dollars in payments. Calculating EHR payments may not be the sole purpose of the Worksheet S-10.

Possible impact on DSH payments

Beginning in federal fiscal year (FFY) 2014 (October 2013), hospitals will receive only 25 percent of their current DSH payments. The remaining 75 percent, or most of it, will be included in an uncompensated care pool. A hospital will receive funding from this pool based upon its ratio of uncompensated care provided compared to the ratio of

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Worksheet S-10 changes

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uncompensated care provided by all hospitals. The Medicare statute [42 U.S.C. §1395ww(r)(2)(C)(i)] states that "appropriate data" will be the basis for a hospital's amount of uncompensated care. CMS has not issued a rule specifying the specific data it will use. It seems very likely, however, that CMS will use data on Worksheet S-10 to calculate the amount of a hospital's payment from the uncompensated care pool. Regardless of the specific source of data, hospitals should begin to shift their focus from the current DSH methodology to refining their methods of capturing uncompensated care payments.

Hospitals will soon have to contend with an increased amount of hospitals eligible for these payments. Now is the time for hospitals to evaluate their charity care policies to determine they are in accordance with CMS regulations. Hospitals should ensure they have included all of the proper documentation to support their amounts, while also trying to maximize their share of the uncompensated care pool.

Conclusion

Hospitals have a significant number of issues to consider when completing their Worksheet S-10. These considerations include data collection, classification of uncompensated care, and various reporting requirements. With regards to data collection, hospitals will now have to determine who is responsible for obtaining the necessary information to support their amounts. Each line of the Worksheet S-10 may have its own interpretation. For example, hospitals will need to determine how they will record partial payments from charity care patients. Data collection will be a key factor in completing this form. Understanding the impact that this data will have on your reimbursement will be critical to maintain your current level of payment. Hospitals may have an additional opportunity to review their submission, but it is not certain, so careful preparation and review is essential.

For more information about the changes to the Worksheet S-10 and the impact on reimbursement, contact David Verbaro at dverbaro@besler.com or 732-92-8242.

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Hospital Readmission Reduction Program begins

By Kathy Ruggieri, Beseler Consulting

The Patient Protection and Affordable Care Act of 2010 (Section 3025 of the Affordable Care Act added section 1886(q)) mandates that the Centers for Medicare and Medicaid Services (CMS) implement a program in which hospitals with higher-than-expected readmission rates for certain designated conditions will experience reductions in their Medicare payments. The initial focus will be on readmissions related to heart failure, heart attack and pneumonia.

The implementation of this program and these reductions begins for fiscal year 2013 discharges. It is expected that the federal fiscal year (FFY) 2013 financial impact of the Readmission Reduction Program will total $300 million nationally. Hospitals can also expect up to a 2 percent reduction in base DRG rates in 2014 and up to a 3 percent reduction in base DRG rates in 2015. CMS will expand the program to include COPD, CABG, PTCA and other vascular procedures. It is estimated the readmission payment reductions will total $7.1 billion over 10 years. There are very few hospitals nationally that will not experience a payment reduction.

If predicted estimates come to pass, there are very few hospitals nationally that will not experience a payment reduction.

In the 2013 IPPS Proposed Rule, the CMS have given hospitals 30 days to review and submit corrections on information used to calculate their excess readmission ratios in conjunction with the Hospital Readmission Reduction Program. On June 20, hospitals received access to their hospital-specific readmission reports and had until July 19 to review their data and report any errors to CMS.

The FY 2013 Hospital Readmissions Reduction Program implementation timeline is (all dates are 2012):

- June 20 — Hospitals receive hospital specific reports and discharge level data with results for the FY 2013 program for review, as proposed in the FY 2013 IPPS Proposed Rule
- July 19 — Deadline for hospitals to notify CMS of any concerns about their excess readmission ratio calculation
- Aug. 1 — CMS publishes excess readmission ratio results in FY 2013 IPPS Final Rule
- Oct. 1 — FY 2013 readmission adjustment goes into effect
- Oct. 11 — CMS reports FY 2013 excess readmission ratio results on its Hospital Compare website

There is a strong disagreement to the manner in which CMS implemented its readmission program. The statute mandates that CMS adjust the readmission measures to account for readmissions that are planned and unrelated to the initial admission. For FY 2013, CMS previously finalized that it will use the three existing 30-day readmission measures for heart attack, heart failure, and pneumonia patients. However, CMS has not excluded all planned and unrelated readmissions from these measures, despite ongoing feedback from AHA and other advocacy groups. Several advocacy groups have communicated their concerns regarding the inclusion of planned and related admissions and have memorialized these concerns during the 2013 final rule comment period.

Besler Consulting believes that hospitals should analyze their readmission reports by validating their data. It is unknown whether a change will be made related to planned and unrelated readmissions once the 2013 IPPS rule is finalized. Hospitals need to gain a detailed understanding of their readmission trends in order to prepare for these reduced payments. Although the Readmission Program initiative begins with a 1 percent reduction for 2013, further reductions are anticipated for 2014 and 2015. There is also the potential of an expansion to the current program over and above the three core measures. Besler Consulting also recommends that hospitals identify all planned and unrelated readmissions and identify these cases as errors during the 30-day comment period. It is unclear what appeal rights may apply outside of this 30 day review period, so hospitals should take the opportunity to raise any concerns now. Hospitals focused on the reduction of readmissions are best positioned to limit the financial impact of this program.

Besler Consulting has been monitoring the readmission reduction program and we are prepared to assist you in the analysis and validation of your data. If you need assistance or have questions in general, please contact Kathy Ruggieri at 732-392-8227 or kruggieri@besler.com.

Charge Description Master maintenance; highlights of OPPS Update

By Elizabeth Schaub-DeBlock, Beseler Consulting

Since the implementation of Medicare's Outpatient Prospective Payment System (OPPS) in August 2000, we have come to understand the significant role the Charge Description Master (CDM) plays within this payment structure to ensure appropriate payments for hospital services. Constant changes, including Healthcare Common Procedure Coding System (HCPCS) updates, changes in procedures being performed throughout the hospital and changes in reimbursement guidelines highlight the importance of maintaining the CDM.

In January 2005, the Office of the Inspector General (OIG) released the Supplemental Compliance Program Guidance for Hospitals, which emphasizes the importance of maintaining the CDM.

Because HCPCS codes and Ambulatory Payment Classifications (APCs) are updated by CMS regularly, hospitals should pay particular attention to the task of updating the CDM to ensure assignment of correct codes to outpatient claims. This should include timely updates, proper use of modifiers and correct association between procedure and revenue codes. *(Source: OIG Supplemental Program Compliance Guidance for Hospitals, January 2005)*

This guidance underscores that an outdated CDM poses a significant compliance risk for hospitals.

A representative from the Corporate Compliance Department should be included on the hospital's CDM Team for oversight and compliance documentation purposes. Ongoing CDM maintenance is an important compliance monitoring activity and should be documented to demonstrate the hospital's ongoing compliance efforts.

As comprehensive, annual and quarterly updates to the CDM are made, the Compliance Officer will want to evaluate and assess the CDM review and maintenance function. One way to do this is to perform a CDM gap analysis. The gap analysis should include the following steps:

- Validation of the CDM
- Validation of the charge capture process
- Interviews with staff members responsible for charge capture to assess their knowledge of the process
- A review of the CDM maintenance policies and procedures
- A chart to bill coding and billing assessment

Additionally, staff members who are is involved in the ongoing maintenance of the CDM should receive annual instruction about how to comply with federal, state and local claims submission guidelines for correct selection of charges relevant to actual services being provided.

CDM compliance

An example of a compliance issue would be coding for drugs, biological or radiopharmaceuticals with the incorrect number of units. When billing for these items the number of units should reflect the units referenced in the HCPCS and CDM descriptions of that drug, as well as the documented number of units administered. CMS guidance states that:

Hospitals are strongly encouraged to report charges for all drugs, biological and radiopharmaceuticals, regardless of whether the items are paid separately or packaged, using the correct HCPCS codes for the items used. It is also of great importance that hospitals billing for these products make certain that the reported units of service of the reported HCPCS codes are consistent with the quantity of a drug, biological, or radiopharmaceutical that was used in the care of the patient. *(Source: CR 7847, July 2012 Update of the Hospital Outpatient Prospective Payment System)*

As you can see, the accuracy and appropriate use of the CDM is a significant billing compliance risk that requires oversight by the compliance department. The CDM review and maintenance procedures conducted as part of hospital operations are critical to a hospital's billing compliance program.

Highlights of June update of Hospital OPPS*

- HCPCS code C1882, *Cardioverter defibrillator, other than single or dual chamber, implantable*, has been reinstated as a device code that can satisfy the edit for CPT code 33249, retroactive to Jan. 1, 2012.
- CMS is implementing in the OPPS the seven Category III CPT codes that the AMA released in January 2012. Codes 0302T to 0308T, along with their status indicators, APCs

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*Source: MLN Matters, MM7847

CDM maintenance

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and payment rates, can be found in Addendum B of the July 2012 OPPS Update on the CMS website at **http://tinyurl.com/PipelineCMSupdate**.

- As of July 1, HCPCS code C9732 has been deleted. CPT code 0308T should be reported in its place, and should be reported with device C1840.
- There are two new drugs and biological that have been granted pass-through status as of July 1, 2012:
  - — C9368, *Grafix core, per sq. cm*
  - — C9369, *Grafix prime, per sq. cm*
- Six new HCPCS codes have been created for reporting certain drugs and biological (in addition to those listed in the preceding paragraph):
  - — Q2047, *Injection, peginesatide, 0.1 mg (for ERSD on dialysis)*
  - — Q2049, *Inj, doxorubicin hydrochloride, liposomal, imported lipodox, 10 mg*
  - — Q2034, *Influenza virus vaccine, split virus, for intramuscular use (Agriflu)*
  - — Q2045, *Injection, human fibrinogen concentrate, 1 mg* (this replaces J1680 which changed to SI E, as of July 1, 2012)
  - — Q2046, *Inj, aflibercept, 1 mg* (this replaces C9291, which was deleted as of July 1, 2012)
  - — Q2048, *Inj, doxorubicin hydrochloride, liposomal, doxil, 10 mg* (this replaces J9001 which changed to SI E as of July 1, 2012)

Remember to update your CDM to ensure compliance.

Besler Consulting provides a variety of customized services that can provide the appropriate mix of experience and audits to help with your CDM review. For more information contact Laureen A. Rimmer at 732-839-8226 or lrimmer@besler.com.

UPCOMING EVENTS

Fall Meeting 2012 *(11 hours CPE)*
A joint meeting with Washington-Alaska HFMA
September 19–21
The Heathman Lodge
7801 N.E. Greenwood Drive
Vancouver, WA 98662

Winter Meeting 2013
February 20–22
Embassy Suites Portland — Washington Square
Tigard, Ore.

Spring Meeting and Annual Banquet 2013
May 15–17
Salishan Spa & Golf Resort
Gleneden Beach, Ore.

Summer Meeting 2013
July 17–19
Mount Bachelor Village Resort
Bend, Ore.

Military treatment facilities and their right of first refusal

Like civilian physicians and other providers, military treatment facility (MTF) physicians and providers need to see a variety of patients and diagnoses, perform the full range of services within their specialty when in medical training, and maintain proficiency in their specialty. MTF resources, such as buildings and equipment, also need to be optimized to save taxpayer dollars. Those are some of the reasons MTFs are given the right of first refusal for Tricare Prime beneficiaries residing in a Tricare prime service area for inpatient admissions, specialty appointments and procedures requiring prior authorization.

The MTF staff will review the referral to determine if they have the specialty capability and an available specialty care appointment within Tricare access standards. If the MTF accepts the care, the beneficiary must obtain these services at the MTF or they would be using their point of service option with higher copays and deductible. If the service is not available at the MTF within the appropriate access standards, the beneficiary is referred to a civilian network provider.

Please note: It is very important to include clinical information in all referral or authorization requests. Doing so enables MTF providers to make an informed decision about whether they can accept the patient or will approve use of a network servicing provider.

How the ROFR process works

When you determine a referral request is required and submit it to TriWest Healthcare Alliance, the request will be forwarded to the MTF, based upon an MTF capability report, to determine if the MTF can provide the service.

If the MTF can provide the service, TriWest will complete the referral to the MTF and inform the beneficiary to schedule an appointment. If the MTF declines the referral request, TriWest will complete the referral to a civilian network specialist and notify your patient to schedule an appointment.

Prime beneficiaries should have access to a primary care manager whose office is within 30 minutes of home under normal circumstances. Specialty care should be available within one hour of home.

Important points to remember

- An MTF has the right of first refusal for specialty care and other services they can provide for Tricare Prime beneficiaries living within a 60-minute drive of the MTF.
- Care may be provided by the MTF if the service or care is available, even if you request, or the Prime beneficiary prefers, a civilian specialist.
- If the MTF accepts the referral, a Tricare Prime beneficiary may choose to use their point-of-service benefit and seek care with a civilian provider.
- All requests must include clinical information. When submitting a referral or authorization request online, pertinent clinical information may be attached electronically and notes may also be copied from your medical management system.
- If the MTF accepts the referral, it will call the beneficiary directly to schedule an appointment within the MTF.
- The beneficiary should not schedule an appointment with a civilian network specialist until he or she receives approval from TriWest.

Visit the referrals/authorizations section at **www.triwest.com/provider** for more information.

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Make social networking count: Connect with HFMA National

Social networking continues to increase in popularity and importance. You may have a Facebook profile, a LinkedIn page, or a Twitter account — and so does HFMA National.

Whether you want to connect with a specific HFMA forum group or need general information, use HFMA National's official social networking site at **www.hfma.org/chapter_resources/socialnetworkinglinks.htm** to make your social networking profile count, and get connected with us!

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