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FALL 2019

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Heartbeat of Progress

IN THIS ISSUE:

President, Central Ohio HFMA, John Ziegler

Dear Members,

Finally, a bit of Fall temperatures. Although, I admit I did not mind Summer clinging on to us for a bit longer. But, Fall is here and we all begin to put more time in on our routines, school activities, work year-end preparations and looking to see that our sweaters are moth-hole-free.

The Central Ohio HFMA chapter is also diving into the routine of putting the details together for our busy year of outstanding programs. While the calendar is set for the year, the elements that make the planned events outstanding are being honed now. As part of our planning goals the words "engagement" and "value" are omnipresent. So far, focusing on these two words is delivering the hoped for results. The New Member Reception provided an outstanding opportunity for new members to meet other new members and existing members who show how they really enjoy being with the HFMA. In September we had our 6th biennial Tri-State Conference that set records for attendance, included golf, wine and paint, spa sessions and had two great evening networking events.

This Fall we have our annual Accounting and Auditing Update in November, a Roadshow at OhioHealth in December and our Holiday Gala (a.k.a. Jeffrey's Prom) that is extravagant and our Social Czar, Jeffrey Carranza, makes sure that it is a not-to-be-missed event. That will lead us into the new year with more great events.

"Engagement and Value"

In September, I attended the Fall Presidents Meeting along with our President-elect James Monroe. The meeting is our opportunity to have direct access to the Association national leadership, learn what is happening on the national front, interact with our Regional counter parts in a great city (Denver this year) and have fun. Two important themes came out of the meeting. First, the Association is looking to the chapters to collaborate more; collaborate on events, idea sharing and resources. I am happy to say we are already on that one. We have Tri-State, Webinars with Michigan and All-Ohio already. Look to the National Newsletter as there will be a write-up on Tri-State. We are going to try something new at All-Ohio to enhance collaboration. We will be live-streaming Joe Fifer's keynote address to Michigan during their statewide conference. If successful, we will look to collaborate more like pulling resources to bring nationally recognized speakers to our events physically and virtually.

The second takeaway was that we have one great chapter. Many of the concerns that other chapters have are ones that we long ago addressed and solved. The past leadership teams have set the stage wonderfully and this group of leaders is carrying that torch to new heights. We all enjoy working together and we continuously bring new ideas and methods of delivering value.

Finally, I want to encourage everyone to take as active a roll in our chapter as you can. Your participation, from attending events to signing up to volunteering, is truly the lifeblood of our chapter's success. Plus, volunteering is a great way to see where you can easily affect change. Presently, we are creating new ways to make it easier for all to participate in volunteering.

-John

The Medicare IPPS rule changes are here. Are you taking action?

The 2020 Medicare IPPS rule changes are creating millions of dollars in adjustments to reimbursements nationwide. Do you understand the impact the final rule has on hospitals within your system? Here are some action steps to take now.

On Aug. 2, 2019, the Centers for Medicare & Medicaid Services (CMS) released the Medicare Inpatient Prospective Payment System (IPPS) 2020 Final Rule. The rule ushers in important changes to reimbursement rates for hospitals and the methodology used to distribute the Medicare Disproportionate Share Hospital (DSH) uncompensated care pool.

Changes to reimbursement rates
The CMS estimates reimbursement rates to hospitals will increase by approximately 3.1 percent on average; however, the actual change for individual hospitals will vary significantly due to:

- The impact of various elements of reimbursement, such as medical education and Medicare DSH.
- Year-over-year changes to an individual hospital's wage index and expected case-mix index.

Action steps to take now
Since all IPPS hospitals are impacted, you should calculate or seek out an individual impact analysis for each hospital within your health system.

Distribution of the DSH uncompensated care pool
CMS has made significant changes to the distribution of Medicare's $8.4 billion DSH uncompensated care pool. CMS had previously distributed this pool using a three-year average of a combination of Medicare and Medicaid indigent days and information from the Medicare cost report Worksheet S-10 data. However, for FY2020 CMS has distributed this pool using one-year of 2015 Medicare S-10 data. This change in allocation methodology has created significant shifts in the allocation of the pool among providers.

Action steps to take now
You should conduct a full analysis of the impact changes in reimbursement methodology will have on your facilities for the upcoming federal fiscal year. Many hospitals are receiving millions of dollars – more or less than – they had in the past. The analysis should include looking at what your facility filed on the Medicare Worksheet S-10 in 2015 and in subsequent years. To ensure your hospital receives its full portion of the $8.4 billion pool, it's important to look at the entire patient population. While the majority of the claim amounts on the Medicare Worksheet S-10 may come from a handful of charity care, financial assistance, or bad debt adjustment codes, opportunities could be missed if your hospital isn't looking at all the adjustment codes and certain populations that would have a high likelihood of being included.

Changes for rural providers
The final rule also includes changes that affect many rural providers across the country, including an adjustment for hospitals with wage index values below the 25th percentile and a revised wage index rural floor calculation to exclude urban-to-rural reclassifications. If you're a rural provider, these adjustments should also be considered in your analysis.

Action steps to take now
It's imperative that you understand the impact the 2020 Medicare IPPS changes will have on your facilities and what you need to do to stay ahead of changes and plan for the upcoming federal fiscal year.

-**Christopher Walski**, Plante Moran

HFMA Central Ohio Member Spotlight.
Suzanne B Griffin

Name: Suzanne B. Griffin
Organization: Huntington Bank
Position: Senior Vice President, Treasury Management
Hometown: Newark, Ohio
College: Ohio University

First Post-Collegiate Job: Working at a large corporate company as an accounting, A/P, A/R specialist.

HFMA Experience: Currently on the membership committee with Lauree Handlon.

Great HFMA Memory: Attending great conferences, Fall and Women's conference and New Member Mixer a month ago.

If someone wrote a biography about you, what do you think the title should be?
The Fabric of her Life -Yes, she quilts too!

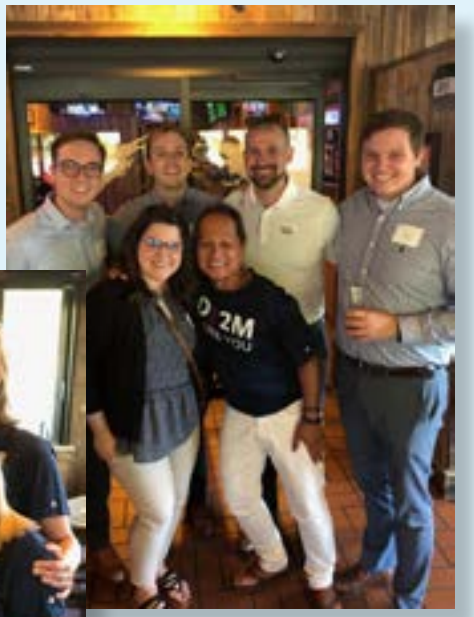
What do you enjoy most about working in healthcare? I love the aspect that while a bank receives a payment, there is so much more (in terms of technology and data matching) that a bank handle to create efficiencies for organizations.

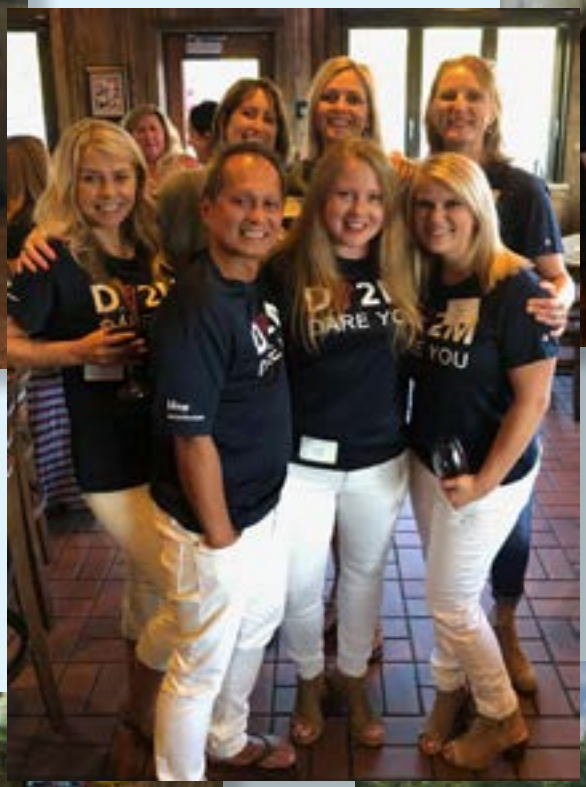
Aside from his busy work schedule, what else keeps you busy? Quilting, volunteering with Central Ohio Association Financial Professionals, and other nonprofit organizations including my church, St Francis de Sales.

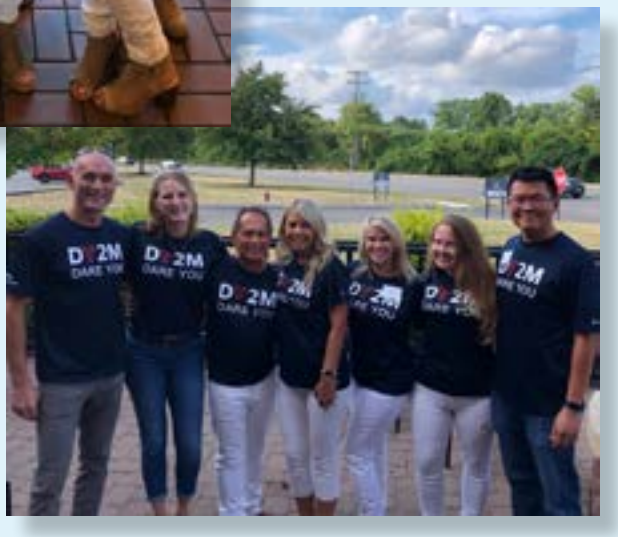
What is your favorite vacation spot? Goodyear Arizona for spring training for the Reds!

Huntington Welcome.

Event Recap
New member Reception







We had a great time at the Central Ohio HFMA New Member Reception!
Thank you, everyone, for attending the event and making our chapter such a special place to be a part of! Over 60 people attended the event to kick off our new HFMA year.

3 Key Summer Updates to Know for VA Claims Processing

The Veterans Administration had a busy summer in 2019. First, the Veteran Integrated Service Network allowed all facilities within their network to work claims regardless of where they originate within the network. The VISN map can be found here and select Region. Second, the VA began their Cerner implementation, which is scheduled to take 10 years. The Senate requested oversight to make sure the implementation does not go over budget or take an unnecessary amount of time. Keep in mind, the original implementation budget allotted $10 billion, before ballooning to $16 billion. The requested oversight would cost an additional $890 million. But the VA saved their most expansive change for June 6th, when the Maintaining Internal Systems and Strengthening Integrated Outside Networks Act, otherwise known as the MISSION Act, became effective under 38 C.F.R. § 17.4000 (2019). We're going to take an opportunity to break down how the MISSION Act changed eligibility criteria, the authorization procedure, and the claim submission process.

The MISSION Act repelled the Veterans Choice Program and replaced it with the Veterans Community Care Program. Under the new Veterans Community Care Program, the old five eligibility conditions were altered. The old criteria would allow a Veteran to seek outside treatment when: the VA cannot provide the services, an appointment could not be made in 30 days, the Veteran lived more than 40 miles from the nearest VA, the Veteran must travel by extraordinary means, and the Veteran faced an excessive burden in traveling. Of the original criteria, four are objective and one is subjective. The MISSION Act changed the criteria to basing it on a multiple factor analysis. Those factors include: the distance between the veteran and the facility that provide potential services, nature of the care or services, the frequency of care, the potential improved continuity of care, quality of care, or whether the veteran faces an excessive burden in accessing care based on driving distance, alternative VA facilities, travel, compelling reason for alternative treatment, and the need for an attendant. The new factors should allow the VA more latitude in granting alternative care, but there are more subjective factors that could be decisive in the VA disallowing outside care.

Under the new Veterans Community Care Program, TriWest serves as the authorizing agency. TriWest is responsible for authorizing all inpatient care along with all known outpatient encounters. As it concerns emergency outpatient, transfers, and emergency inpatient claims, hospitals should attempt to acquire an authorization within 72 hours of admission and see if the VA hospital has an available bed. If there is a bed available, the Veteran must be transferred. If no bed is available, the hospital can continue to treat the Veteran while a treatment plan is authorized. The authorization guidelines remained the same but added a new wrinkle with the TriWest requirement. The MISSION Act attempts to centralize authorization functions with one entity, but it does not address the main issue of responsiveness from a VA facility regarding bed availability.

Continued on page 8

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Finally, the last change deals with claim submissions under the Veterans Community Care Program. For claims that are authorized, a hospital must submit the UB to TriWest with the authorization number. The timely filing deadline is 120 days from the date of discharge. However, TriWest requests the bill within 30 days. At the same time, the hospital, at a minimum, must send the medical records to the VA within 30 days of discharge. The VA suggests that the claim be placed with the medical records so the VA will not waste time trying to marry the authorization and the medical records together. When both agencies have their respective documentation, the VA will review the medical records to confirm that the authorization matches services performed. If the VA confirms the services match the authorization, TriWest will process and pay the bill to the hospital. If the VA denies the authorization, TriWest will send a denial to the hospital.

In cases where there is no authorization on file, the previous claim submission process of submitting the UB and medical records to the local VA for review and processing.

In summary, the VA made a significant regulatory change this year. First, the MISSION Act changed their program criteria for veteran eligibility to receive care from non-VA facilities. Second, the MISSION Act shifted a significant amount of the authorization responsibilities to TriWest. Finally, the MISSION Act changed the submission process for VA claims.

While veterans deserve great care, hospitals should not be left holding the bag to cover those costs. If your hospital needs assistance resolving aging A/R or reducing days to pay, consider the idea of finding a partner whose sole focus is managing these difficult claims. Review their process and be confident that the outstanding care you're providing to our veterans is also extended to the health of your revenue cycle.

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Fall 2019

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Pharmacy Site Manager
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Jennifer Smith
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Annete Solomon
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Fall 2019 (continued)

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Brandon Wheeler
Sr. Accountant
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Shannon Wood
Education & Training Coordinator
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Allie Zervos
Student
WLU

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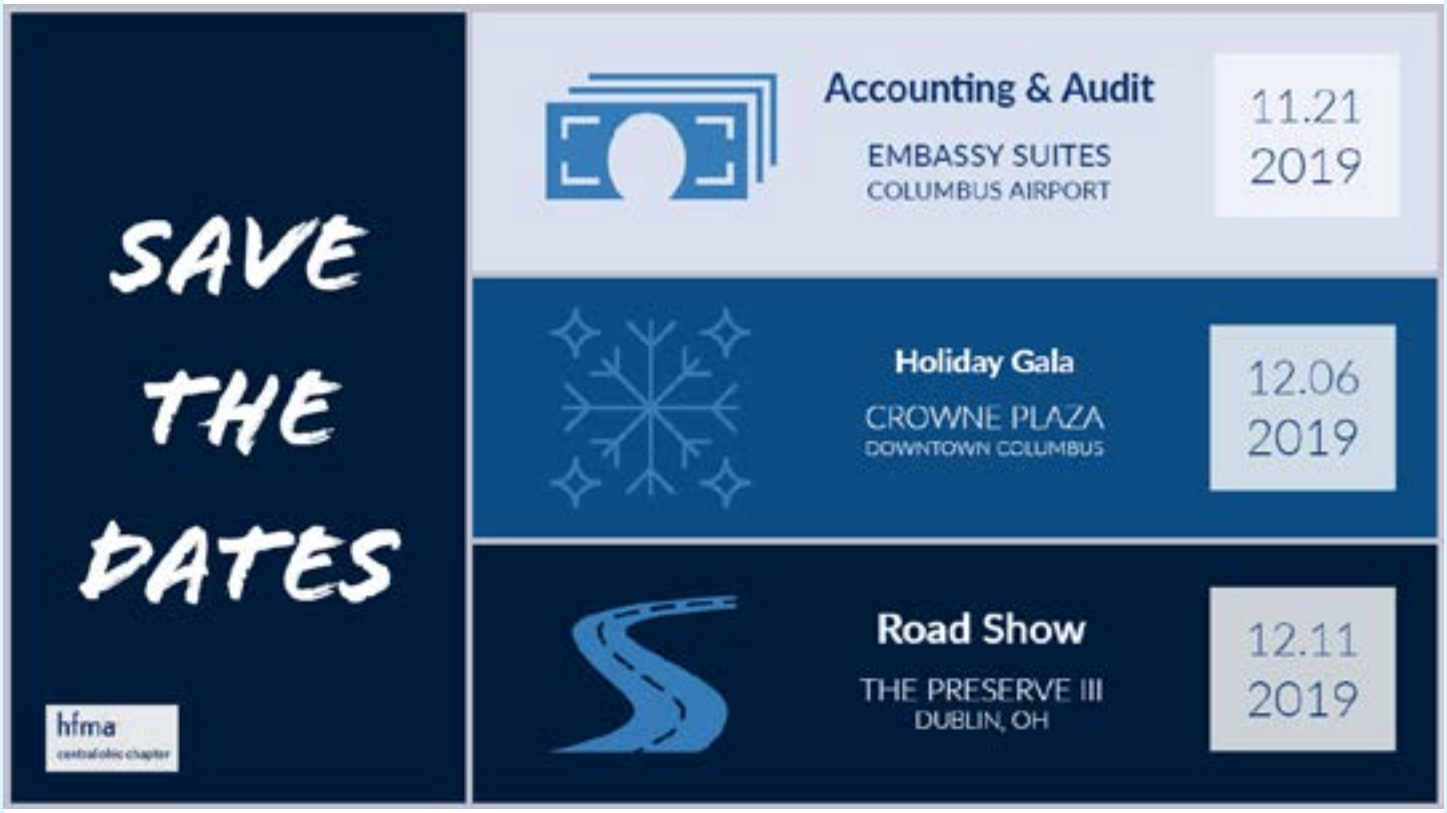

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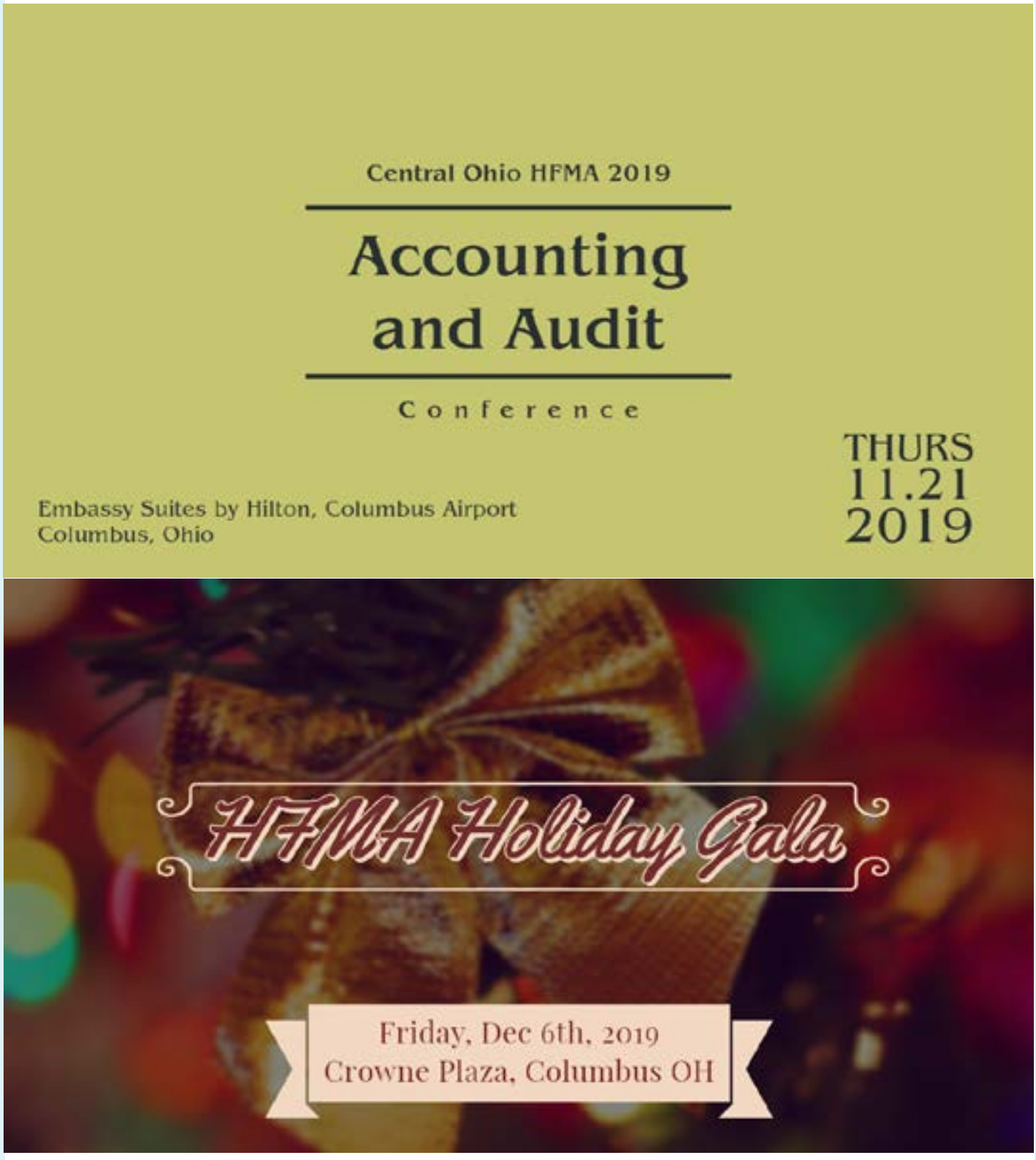

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Comments, Suggestions, Articles?

Do you have comments or suggestions regarding the Central Ohio HFMA newsletter, programming ideas or other chapter matters? Have an article you would like to see published in a future newsletter? We would love to hear from you! Please send all correspondence to Stephen Saputra at stephen.saputra@ohiohealth.com

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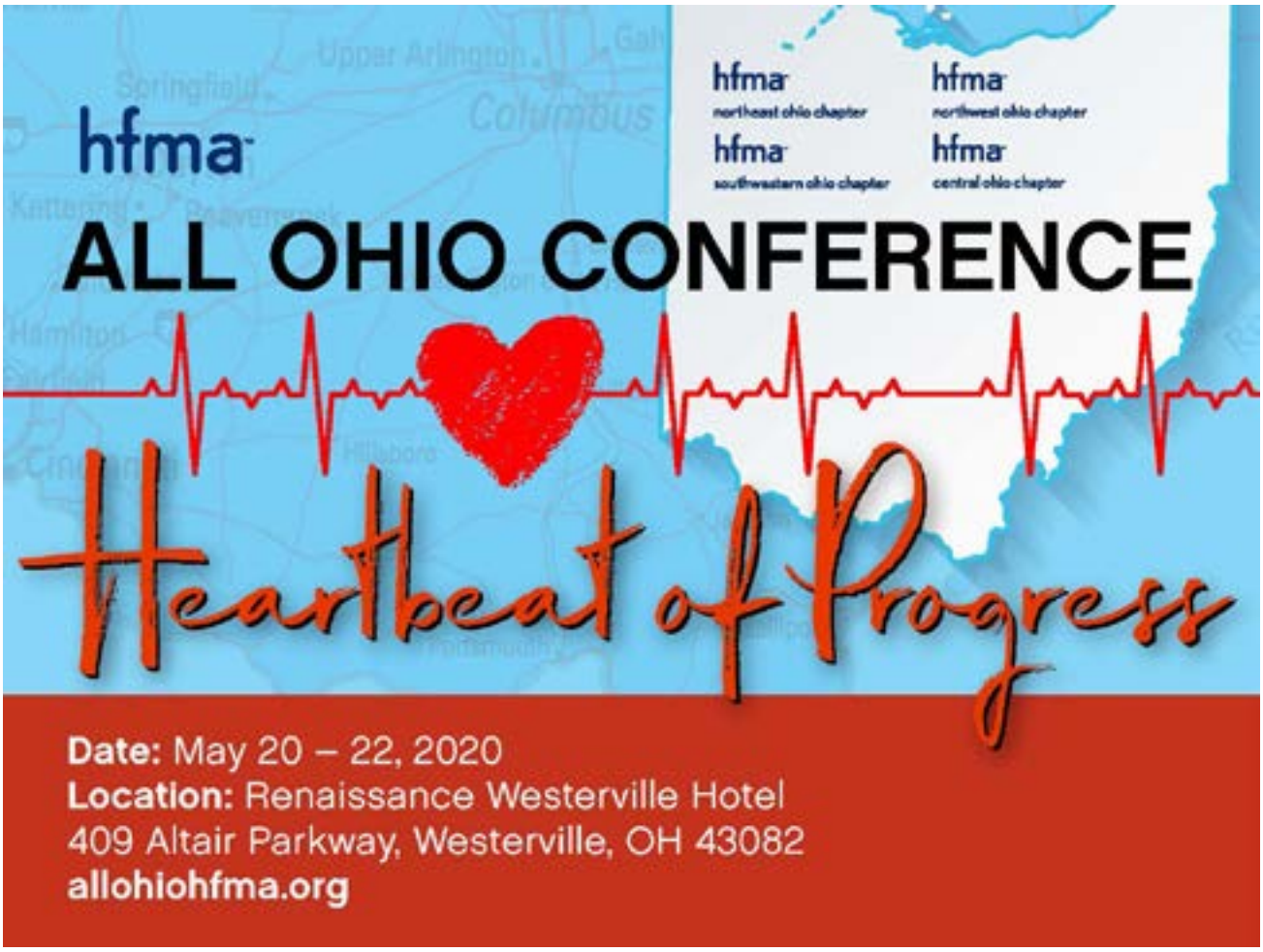

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