As we all know, in today’s healthcare environment, regulations are becoming increasingly more complex and the consumer is becoming more demanding. Today’s revenue cycle staff is more accountable than they have been in the past and therefore must have a broader understanding of the entire revenue cycle and how it influences the financial outcomes of the healthcare organization.

That is why HFMA created the CRCR Certification Program. It was designed as a standardized measurement for performance for revenue cycle professionals. It provides the healthcare organization with the means to ensure that their revenue cycle staff has the knowledge to meet today’s demands.

So, earlier this year, when Travis Boucher, Revenue Systems Lead at Elliot Hospital, and NH/VT Chapter Certification Committee member, was looking for a nationally recognized program in which the Revenue Cycle Team at Elliot could gain the knowledge needed to become experts in their field, he immediately thought of HFMA’s CRCR Certification Program. He brought his proposal to Senior Leadership and, after a solid presentation showing the value in the program; Travis was able to get full buy-in from Elliot.

Overall, sixty-nine staff members participated in this program. This included both HFMA and non-HFMA members. It was determined that approximately 16 hours would be needed for successful completion. This time was provided and facilitated by Elliot in one week blocks for a period of nine weeks. Each participant would sign up for a particular block with the expectation that Monday-Thursday from 12:30-4:30 would be their study time and on Friday they would take the exam.

After the completion of the nine weeks, the statistics from the program show there was an 80% first-time pass rate for the group. This is compared to the HFMA national statistics that show a 50% first-time pass rate.
Overall, this has been deemed as a success. Congratulations to Travis and the folks at Elliot for a job well done.

Since HFMA launched the CRCR program four years ago, there has been approximately 5,000 revenue cycle staff members 3,000 in the last year alone, that have successfully passed the exam. If you or your organization would like more information about this program, or any other certification program, please feel free to reach out to any of the NH/VT Chapter Certification Committee members. They would be more than happy to help you determine what best fits your needs.

Welcome New Members

Evan Dressel
Wentworth-Douglass Hospital

Mike Grube
Dartmouth-Hitchcock

Lisa Hull
Monadnock Community Hospital

PARRISH-SHAW

Medical Claim Insurance Recovery
- Out of State Medicaid - Workers’ Compensation - Low Dollar -
- Aged Follow-Up - Legacy System Run Out -
(800) 872-1818
www.parrishshaw.com

Your Career. Your Future.

HFMA Certification Programs
Excellence at every level.
In Memoriam
by Jeff Walla, CPA, FHMA

Robbin R. Grill, past-president of our chapter, died on December 1st after a period of declining health. Robbin had a long connection with our chapter, with the most active period of involvement in the 1980s through the mid-1990s. She served as chapter president from 1991-1992. She worked through all the chair positions and served as a board member prior to becoming an officer of the chapter. After her service as our chapter president she was appointed to the National HFMA Principles & Practices Board from 1993-1998. Robbin was involved in establishing the current Christopher Weinheimer Scholarship Fund in 1993, the year Chris served as the National Chairman for HFMA. Robbin, always a strong supporter of service to the chapter, received numerous awards recognizing her service through the Founders Recognition Awards. She received the William G. Folmer Bronze award in 1984, Robert H. Reeves Silver award in 1989, the Frederick T. Muncie Gold award in 1992, and the Medal of Honor in 1997. Many of us were fortunate to have known Robbin and served with her or worked with her as a co-worker, client, chapter board member or chapter officer. Robbin was well known in the healthcare industry and had the ultimate respect of her peers. At professional meetings she was always surrounded by colleagues eager to gain new insight from Robbin. She would often bring her husband of almost 50 years, Alan, to chapter or regional events and many of us recall the way they both enjoyed a good party and laughter. An appropriate final memory for this larger than life woman.
Interview with a Fellow of the Healthcare Financial Management Association

by Robin Fisk

We asked Eric Walker, the Finance Manager at New Hampshire Healthy Families, to answer several questions about becoming a certified Fellow of the Healthcare Financial Management Association (FHFMA). Here are his responses.

I decided to take the exam because it was a great opportunity to validate my career path. I felt my experiences in public accounting, hospital accounting, and insurance finance tremendously prepared me for the CHFP exam. I have been involved with HFMA in some capacity for nine years. I was overdue to take this exam.

What do you hope to achieve by becoming a certified member of HFMA?

The CHFP and FHFMA designations are important to me and demonstrate my well rounded knowledge of the industry. It is a benchmark of achievement in Healthcare Finance.

Becoming a certified HFMA member is valuable for making professional connections. A CFO of a pharmaceutical company contacted me shortly after the exam on LinkedIn after seeing through a friend my FHFMA designation. I told him of my experience and how the test was geared towards that point in my career and gave him some areas to gather study materials. He wrote back to me a few months later to tell me he passed and my advice was helpful.

What one piece of advice would you give to someone who was preparing to take the certification exam?

Anyone that takes this exam needs to study and be prepared. The NH/VT chapter brought in an outside expert (Christoph Stauder) and offered a free eight-hour course that also allowed for CPE credits for my CPA license. I studied for an additional month using the notes from that course and was able to pass on my first try. Take advantage of programs your state may be offering. [Editor’s note: The New Hampshire – Vermont Chapter is in the process of developing additional resources for preparing for the Certification Exam.]

What aspect of the certification exam process was the most surprising to you?

In the version of the exam I passed, the process that most surprised me was that I received my results immediately. I am used to having to wait a few days at the very least for any results dating back to my CPA exam and college days. Technology has caught up quite a bit.
CERTIFICATION CORNER

As we start another new year, think about making CHFP Certification your professional goal for 2016. The NH/VT Chapter Leaders are encouraging our members to become certified and be recognized as a Certified Healthcare Financial Professional (CHFP). What are we doing to encourage and “Support Your Efforts to Get Certified”? Watch for chapter announcements about our new coaching format and the coaching material available 24/7.

We are joining forces again with the certification leaders of AZ, CT and WI chapters to organize a new joint educational program using an innovative approach to teaching the certification material. This newly designed Joint Program is planned and will be available March 2016.

Our Chapter will inspire you by:

► Providing FREE coaching lessons; speakers are “subject matter experts” presenting test topics
► Providing 6 pre-recorded YouTube coaching sessions for the Module 1 lessons
► Providing members $250 incentive payment to help defray your cost

(Note: You must be a current and active member of NH/VT Chapter when you request your $250 incentive reward and when you take the exams.)

Members considering sitting for the CHFP exam should visit www hfma.org/certification and read the entire FAQ section. The online study material cost $700. A more expensive iPad version of study materials is available as well. The fee includes both exams.

The members of the Certification Committee will help and coach you on how to take the examinations. Help from the Certification Committee is a phone call and/or an email away.

If you have questions about certification, please do not hesitate to contact one of our Certification Co-Chairs:
Diane Blaha @ diane.blaha@gmail.com
Peter Smith @ Peter.Smith@wdhospital.com
Compliance remains a major focus of the Department of Health and Human Services. Through CMS, the OIG and others, oversight of Medicare and Medicaid reimbursement continues to expand. This article summarizes and provides an overview of the recently released 2016 Office of Inspector General (OIG) work plan.

The 2016 OIG work plan relative to possible healthcare fraud and abuse was published in October 2015. The document is filled with new topics and proposed audit activities as well as continuation of audit activities on subjects from years past.

The objectives related to the plan are fairly straightforward:

► Investigate entities that bill or allege to have billed for services not rendered
► Identify providers that manipulate payment by claim coding in an effort to inflate reimbursement
► Identify false claims violations, including billing for unnecessary services
► Identify improper incentive and/or bonus payments realized from quality reporting

Hospital Concerns and Guidance

Provider-Based Entities

This is the new “bottomless pit” for the OIG, given the potential for non-compliance with eligibility requirements and billing related issues and opportunities. On the table for review in this work plan are:

► Payment differences between provider-based entities and free standing clinics, especially with the recent passage of the 2016 Budget deal, whereby off-campus provider-based payment differences have been eliminated for new entities.
► Additional beneficiary payment liability

Review of Inpatient and Outpatient Payments (PPS)

The OIG proposes to use their sophisticated data mining tools as well as computer system matching programs to select claims failing to conform to specific CMS billing requirements. They will focus on those failures to comply with billing instructions that result in hospital overpayments.

This type of review is broad and, without more specific criteria, hospitals will be open to an aggregate of potential review issues. Hospitals are advised to monitor and review billing requirements as published in the Internet Only Manuals.

Under OIG review are:

► Overall billing complexity
► Medical necessity and coverage issues
► Coding accuracy
► National correct coding initiatives rules
► Use of Outpatient PPS modifiers

Hospitals should consider the following:

► Ensure staff have the necessary skills and knowledgebase
► Perform self-audits
► Formalize a CMS change management process
► Ensure timely charge master maintenance
► Purchase of software claim scrubbers that mimic Medicare code editors to prevent payment related errors in advance of claim submission

Cost Outliers

The OIG plans to review outlier payments to hospitals to ensure CMS performed necessary reconciliations. These payments are based on hospital cost-to-charge ratios and may also reflect the time value of money, so under scrutiny will likely be the policies and procedures related to price setting along with the medical necessity of services billed.

Outpatient Hospital Dental Claims

Medicare considers dental services to be excluded from Medicare coverage. The plan is to investigate hospital outpatient claims adjudicated to payment for dental related services and possible provider overpayments.

Hospitals should ensure procedures are in place in the billing office to prevent claim submissions to Medicare for non-covered statutory excluded services. This process should include screening for non-covered services but also related and incidental services associated with these non-covered services.

Medicare 72-Hour Window

Certain items, supplies, and services furnished to inpatients are covered under Part A and should not be billed separately to Part B. Commonly referred to as the 72 hour
window, certain services billed within three days of an inpatient admission (or 1 day in the case of inpatient psychiatric or rehabilitation) must be bundled on the inpatient claim. The OIG will be reviewing these situations to ensure compliance with the bundling provisions.

Two-Midnight Rule
The OIG will review hospital compliance with the two-midnight rule when admitting and billing the inpatient Part A stay. Of particular interest will be the use of observation bed services as well as physician certification and their explicit orders and signature.

Mandated Quality Reporting
The OIG will be reviewing the extent to which CMS validated hospital inpatient quality reporting data in the areas of meaningful use, PQRS, quality reporting, HPSA, primary care bonuses, etc. Hospitals should consider validation audits to assure the accuracy of reporting based on their documentation.

Anesthesia Professional Billing
The OIG has a concern that anesthesia services are being reported as personally performed when, in fact, they are only medically directed. The improper use of modifiers may inappropriately increase payment. Hospitals should perform an internal review of their use of anesthesia modifier reporting and also ensure appropriate identification of the actual provider rendering the service.

Other OIG Concerns
There are many other topics and items of interest to the OIG, including, but not limited to, the following:
- Outpatient physical therapy
- Hospital wage data
- Laboratory services
- Radiation therapy
- IME/GME
- Ambulance services
- Medicare payment for drugs – Part B vs Part D
- DME
- And so much more......

Summary of the OIG Work Plan
The OIG reported expected recoveries of approximately $3 billion for FY 2015 related to investigative recoverables. Another $20.6 billion in savings was identified related to legislative, regulatory or administrative actions that were supported by OIG recommendations. It further accomplished 4,112 individual/entity exclusions from participation, 925 criminal actions and 682 civil actions. It is increasing its use of its extensive database to data mine for more efficiency and effectiveness in pinpointing its oversight efforts.

It is clear, based on the successes described in its semi-annual report to Congress and on its website, that the OIG will remain extremely active in its audit and review activities of all provider types.

CONCLUSION
The Department of Health and Human Services, through its agencies, continues its oversight of Medicare and Medicaid payments to healthcare providers across the continuum of care. The future appears no different and, in fact, appears to include even more oversight than currently exists. Providers should carefully review and analyze each of the many work plans and rules that have been published in the past few months and incorporate review and analysis into their compliance plans.

Barbara Lynch
Sr. VP Account management
blynch@bhrlc.com
D:603-546-4085  C:978-831-7800
Top Considerations to Develop a Defensible Pricing Strategy

By: Cheri S. Kane, Managing Director; Joseph Sabatina, Director; Kim Carlozzi, Manager

In today’s new healthcare economy, payment methodologies are changing rapidly and the pendulum of payment responsibility is shifting to the consumer. For patients and employers, high deductible health plans (HDHPs) are now the norm. Legislative changes required by the Affordable Care Act and 501(r) are forcing healthcare leaders to reconsider charging practices and long-term strategies for their respective organizations.

The long standing charge structures and their routine maintenance are being called into question, and rightfully so, given the financial, operational, and regulatory challenges that leadership faces. Market pressures from free-standing healthcare facilities and increasingly selective patients are forcing the industry to respond.

Regulatory implications regarding price transparency are also being imposed. Requirements for charges to be aligned with amounts generally billed (AGB) to payers for select patients meeting certain financial assistance criteria also play a significant role in how financial leaders view the relevance with which they set their charge levels. Organizations are being challenged to adapt to these forces, particularly given the potential financial and operational impact, due to shifts in demand for services and potential loss of market share.

With all of these variables being faced by healthcare leaders in the industry, there are still a large number of organizations that continue to charge patients without regard for the competitive market, costs of services, impact on patient volumes, and last but not least, the consumer. One can clearly see why sweeping healthcare change is often tempered with the reality of implementing change across an industry that is, at times, resistant to such change, all the while leaving our patients confused and concerned.

To revisit a well-storied history, health care providers typically increased charges annually to obtain the maximum payment from payers reimbursing services at a percentage of billed charges. With minimal regulatory guidance established to govern hospital charging practices and the cumulative impact of increasing billed charges year over year for decades, many health care providers have charge description masters (CDMs) that are excessive and no longer meaningful to those purchasing care.

Continued, next page
Is it now time for health care providers to consider reducing billed charges to more closely align with the market, cost for services, and to have the overall goal be a defensible pricing structure. Even further, now is the time to consider long-term strategies that will drive charge levels down to closely align to payers’ negotiated rates.

Patient consumer advocacy groups, payers, and legislators have pushed for health care price transparency. As a result, this is a top priority to many leading healthcare provider organizations. Legislators and patient advocacy groups are demanding hospitals provide patients estimates prior to performing healthcare services. In some states, legislation is now requiring health care organizations to complete these requests for estimates.

For hospitals, it is often complicated and difficult to provide an appropriate patient estimate, particularly for self-pay patients. Clinical protocol for patients with similar ailments or illnesses is not always consistent from patient to patient. Hospital prices, service provided, venue, and length of stay may vary widely by physician providing the service, location, patient’s comorbidities, etc.

For patients covered by insurance, the process may be somewhat easier; however, the provider must have a “live” insurance verification process since the patient’s balance will be based on the patient’s co-payment, deductible met, and/or co-insurance for the service based on the payer’s negotiated rate. Even though the process for developing the estimate may be easier than estimating a self-pay patient’s balance, it is still complex and requires a database of common procedures and services in order to calculate the patient’s estimated self-pay amount.

Massachusetts passed a law requiring payers and providers to estimate patient balances within forty-eight hours of a patient’s request. Almost two years since the law was passed, the media is reporting that some providers are not able to comply with the new regulation and Massachusetts may be considering additional legislation to drive results. Other states have varying price transparency legislation that focus on different issues – publicizing the CDM prices, providing a reasonable estimate of total charges for a given service, providing estimated out-of-pocket costs for the patient, etc.

Part of the challenge is the lack of consistency in charges prices for services from provider to provider, which is compounded by the decades old practice of raising charges. In some cases, inflated CDMs have diminished the relationship between service charges and the costs for providing those services to the extent that it complicates the creation of patient estimates for services, particularly for those patients without insurance.

The current state of many organizations’ CDMs has resulted in healthcare leaders considering the reduction of their charge structures, with the goal of developing a defensible pricing strategy. This effort requires the ability to determine the financial, operational, and regulatory implications of developing such a defensible pricing structure. Of utmost importance to financial leaders is the organization’s accuracy in estimating and monitoring the potential negative impact to the bottom line.

In essence, this is “strategic pricing” with the goal of reducing the overall charge structure based on the market and cost related benchmarks by accurately estimating, monitoring, and minimizing the adverse impact to net revenue streams. With a defensible pricing structure in place, it will be important to determine how your billed charges and negotiated rates compare with your competitors’, particularly given the demand for pre-service price estimates. Otherwise, after your team calculates and provides the estimate to your patients, patients may decide to shop online or call your competitors, and choose another provider.

You may be wondering how do I compare my payer reimbursement and billed charges against my competitors, legally? Billed charge information and payer reimbursements are available through a variety of sources. This information is probably best obtained from an independent third party to perform blinded analytics and provide a solid comparison.
of your billed charges and payer reimbursement levels as compared to your market competitors.

Some key considerations are described below to assist you in identifying next steps for considering CDM reductions, developing a defensible pricing strategy, and preparing your organization for price transparency:

► **Competitor Charge Comparison**
You will need to perform a comparison of your billed charges vs. those of the market to determine if your fees are above and/or below market. For an adequate market comparison, obtain comparative charge information from an independent third party. This analysis will provide you information by service category related to whether your organization's charges are higher or lower than the competition. Often you are able to select locations by city, core-based statistical area (CBSA), specific demographic differentiators or by specific provider(s) for an appropriate comparison.

► **Payer Reimbursement Comparison**
Your organization will want to confirm that negotiated payer reimbursement rates / levels are competitive with your market competition. Paid claims data is available by Metropolitan Statistical Area (MSA) from vendors and/or consultants allowing for a solid comparison of payer reimbursement by service – i.e., MS DRG, HCPCS code, etc. This will allow your organization to understand areas where your reimbursement, particularly for managed care payers, may be lower or higher than your competitors’, identifying areas for potential adjustment in upcoming negotiations.

► **Renegotiation of Payer Contracts**
As you consider charge / price reductions, it will be important to talk to your payers and discuss the potential need of renegotiating your agreements to maintain revenue neutrality. For example, if your organization identifies a need to reduce radiology reimbursement to be competitive in the market and the current reimbursement is based on fee for service, it may be necessary to renegotiate your payer reimbursement to a case rate or different methodology to reduce the net reimbursement impact for select managed care payers.

► **Create a Market Position**
From a hospital perspective, reducing your organization’s charge structure may have significant positive results from a competition perspective, including the creation of patient market leverage. Patients want a trusted provider. Legislators and patients are demanding price transparency and they do not want to perform an extensive price analysis each time they seek services. If your hospital is able to provide a patient with a firm estimate prior to service, patients will likely return. Patient volume may increase as patients become more aware of your organization’s ability to work with them on payment arrangements creating a positive patient experience and fostering trust between your organization and the patient / community.

► **Patient Estimates**
- Providing patient estimates may be risky, if the hospital has not performed an extensive analysis of fees based on service, physician and venue. Recent legislation, 501(r), requires hospitals bill patients eligible for financial assistance, the amounts generally billed (AGB) to other payers. Analyzing average fees and knowing where and why service cost outliers exist is key. Overall, providing estimates to patients without insurance is low risk, given self-pay collections are often a mere 10% to 15% of the amount billed. Estimating the patient's balance and solidifying the patient's ability to pay prior
to the service may substantially increase self-pay collections and reduce bad debt. However, it will be important to ensure self-pay patients are thoroughly evaluated for their ability to pay prior to service. This process will assure the hospital is not pulling self-pay patients from other providers, increasing their self-pay population, and potentially increasing bad debt.

► **Total Reimbursement Impact** - Your organization will need to carefully evaluate the short and long term impact of a potential charge structure reduction. These reductions may have a substantial impact on your provider’s Medicare cost report, Medicare outliers, and disproportionate share payments. Evaluating the financial impact of these changes will be key to limiting potential adverse financial impact to your organization’s operating results.

► **Insurance Verification / Price Estimator Tools** – It will be necessary to purchase an automated price estimator tool and/or capabilities that will assist your staff in developing a price estimate. These systems require real-time insurance verification, real-time patient responsibility data, (e.g. what portion of deductible has been met) and accurate negotiated rates interfaced and/or loaded into the system to ensure an appropriate calculation. These tools will be key to successful implementation.

► **Payer Perception** – Reductions in your CDM may result in the payer’s “illusion” your organization’s costs have decreased. Decreases in the CDM may or may not actually correlate to a cost reduction.

However, if payers are not well informed prior to the reduction and understand the price reduction impact, payers may believe your organization’s costs are reduced when compared to your competition, resulting in the payer pushing to lower negotiated rates at the time of the next contract renewal.

► **Long-Term Strategic Positioning** – As organizations are reducing their charge structures, several cutting edge organizations are implementing a longer-term strategy whereby the goal is to align charges to the levels of the negotiated rates to essentially eliminate the mystery of healthcare pricing and streamline many processes which are also aimed at fully embracing the price transparency objectives and simultaneously creating organizational distinction within the marketplace and within the industry itself.

As your organization considers developing and implementing a defensible pricing strategy, it will be important to consider the impacts on all stakeholders including the employers, patients, and payers to develop an implementation strategy that will positively impact your organization for the long term, creating organizational distinction and positioning your organization as an industry leader.
INTRODUCING

HFMA CERTIFIED TECHNICAL SPECIALIST PROGRAMS

TECHNICAL EXPERTISE FOR MANAGERS AND DIRECTORS

Never has technical expertise been more important than in today’s complex healthcare operating environment. With the rapid pace of change, it’s critical to keep skills sharp and stakeholders aligned. So HFMA’s made it easier...with three on-line, self-paced comprehensive certification programs to earn the CTS designation and CPE credit. No prerequisites required.

Get certified. Earn your CTS designation today.

To learn more about these new HFMA certification programs, contact HFMA’s Career Services Dept. at careerservices@hfma.org.

GROW YOUR CREDIBILITY. ADVANCE YOUR CAREER. CHOOSE FROM:

Accounting & Finance
Gain critical technical competencies for effective decision support in all areas of healthcare management, compliance, and development. Designed for accounting professionals in healthcare finance. (CPE credits: 15)

Managed Care
Learn the “nuts and bolts” of managed care with a thorough primer on challenges posed by healthcare reform. Designed for managed care professionals as well as hospital or health system-based managers and clinicians. (CPE credits: 12)

Physician Practice Management
Explore best practices for hospital–physician practice alignment to excel in a value-based payment and population health management structure. Designed for financial professionals in both independent or integrated healthcare delivery system group practice settings. (CPE credits: 12)

Visit hfma.org/cts for more details.
Accounting Corner

Written by W. Kari Baker, CPA, CliftonLarsonAllen LLP and
Joseph Lopatosky, CPA, CliftonLarsonAllen LLP

Proposed Updates to Fair Value Measurement Disclosures

It was only in the last issue that we discussed the efforts of the Financial Accounting Standards Board (FASB) to make financial statement disclosures more effective and coordinated, as well as reducing redundant disclosures, as part of its disclosure framework project. In coordination with this project, FASB previously issued a proposed FASB Concepts Statement, Conceptual Framework for Financial Reporting – Chapter 8: Notes to Financial Statements. The proposed Concept Statement is more so intended to identify a broad range of possible information for FASB to consider than to provide guidance on disclosure requirements for particular topics.

Following up September’s Proposed Accounting Standard Update Notes to Financial Statements (Topic 235) Assessing Whether Disclosures are Material, FASB issued the exposure draft Proposed Accounting Standard Update Fair Value Measurement (Topic 820) on December 3, 2015. September’s proposed update is intended to guide all reporting entities to use discretion when evaluating disclosure requirements, including the option of excluding immaterial information. The most recent update builds upon that, proposing that, among other things, an entity shall provide required disclosures if they are material to them.

Changes in Disclosure Requirements

Current fair value measurement disclosure requirements have been developed through numerous projects over the past decade, dating back to the issuance of FASB Statement No. 157, Fair Value Measurements in September of 2006, and modified through the issuance of several accounting standards update since. FASB Statement No. 157 introduced us to the expanded disclosures for the fair value hierarchy. FASB has been working with the Private Company Council in determining whether and in what circumstances to provide alternative disclosure requirements for private companies who report under GAAP.

Additionally, FASB has worked extensively with stakeholders, which include financial statement preparers and users, as part of the disclosure framework project. Much of this proposed update is a result of these ongoing collaborations. Although the proposed amendments would apply to all entities that are currently required to make fair value measurement disclosures under existing GAAP, certain disclosures would not be required for private companies.

The amendments of this proposed update would modify the requirements on fair value measurement disclosures. The proposed update would eliminate the following disclosure requirements from Topic 820, Fair Value Measurement, due to the fact that they would not be consistent with the concepts in the proposed Concepts Statement or because they would no longer be considered to offer useful information:

► The amount of and reasons for transfers between Level 1 and Level 2 of the fair value hierarchy
► The policy for timing of transfers between levels
► The valuation policies and procedures for Level 3 fair value measurements
► The change in unrealized gains and losses included in changes in net assets on recurring Level 3 fair value measurements held at the end of the reporting period (for private companies only).

Certain disclosure requirements would be modified as follows to align with the proposed Concepts Statement:

► For investments in certain entities that calculate net asset value, disclosure of the timing of liquidation of an investee’s assets and the date when restrictions from redemption will lapse will be required only if the investee has communicated the timing to the entity or announced the timing publicly
► Clarify the measurement uncertainty disclosure to communicate information about the uncertainty in measurement as of the reporting date rather than information about sensitivity to changes in the future

Continued, next page
Leaving 30% of your Medicare post-acute transfer revenue on the table doesn’t make much sense either. On average, BESLER Consulting can identify 30% more post-acute transfer revenue than a hospital’s internal process or primary review vendor. This could mean realizing hundreds of thousands of dollars in additional revenue simply by asking us to take a second look. Watch a short video now at www.drgtransfer.com to see how you can get on the road to a bigger underpayment recovery.

©2015 BESLER Consulting

*HFMA staff and volunteers determined that Transfer DRG Revenue Recovery Service has met certain criteria developed under the HFMA Peer Review Process. HFMA does not endorse or guarantee the use of this service.

(877) 4BESLER | www.besler.com |
@BeslerDotCom

Enhancing and protecting Medicare revenue for hospitals

Estimates show hospitals underpaid $330M each year Medicare transfer revenue.

Gragil Associates, Inc. is a full service accounts receivable management firm with 42 years of experience providing bad debt collection services to over 100 New England Hospitals and Physicians.

Contact: Jackie Gruel, Client Services 800-462-0282

What are you reflecting on? In an industry filled with changing regulations and increased demand, BKD can help provide the knowledge you need to manage change, make wise decisions and stay compliant.

The proposed amendment will apply to all entities, with the specific exceptions note for private companies. There is no proposed effective date, as it will be determined based upon consideration of feedback received. Feedback being solicited includes whether or not these changes will result in more effective and useful disclosures, the proposed exemptions for private companies, and whether other business entities should be exempted (such as not-for-profit organizations). The exposure draft is currently open for comments, with a deadline of February 29, 2016. The exposure draft may be revised based upon the responses received before being finalized.

Contact us with questions about these or any other accounting matters you may have.

W. Karl Baker, CPA, is a principal in the New England health care practice at CliftonLarsonAllen LLP. He can be reached at karl.baker@CLAconnect.com or 617-984-8162.

Joseph Lopatosky, CPA, is a manager in the New England health care practice at CliftonLarsonAllen LLP. He can be reached at Joe.Lopatosky@CLAconnect.com or 617-984-8138.
First Annual HFMA Region 1 Provider Poster Celebration
HFMA Region 1 Conference - Mohegan Sun, CT - May 25, 2016

Ever wanted to present one of your achievements in front of your colleagues but were afraid to take the plunge?

Concerned that writing a long presentation would be too much pressure?

Stressed by the idea of presenting in front of a large group?

Consider presenting your idea at the first annual HFMA Poster Celebration!!!

The Region 1 meeting is the perfect opportunity to exhibit your idea, practice your skills in a safe environment with other members of HFMA.

Read our Poster Celebration Details article in this newsletter for more information!!!

For more details, check out www.hfmaregion1.org
First Annual HFMA Region 1 Provider Poster Celebration

HFMA Region 1 Conference – Mohegan Sun, CT
May 25, 2016

Poster Celebration Details:

HFMA Region 1 would like to encourage more active involvement of provider staff in the program for its Annual Conference. The Poster Celebration is open to provider staff only, including employed staff of hospitals, health systems, physician offices or organizations, other direct provider organizations and managed care organizations.

Abstract:
To be considered to present a poster an author must submit a one page abstract in the format defined at www.hfmaregion1.org by March 18, 2016 at 5:00pm.

Posters:
Authors whose abstracts are accepted must prepare and present a poster at the Annual Conference on May 25th. Judging and presentations will take place on May 26th. The Author must be present at the conference to be eligible for recognition and awards. The poster must be a single panel no smaller than 30”x36” nor larger and 36”x48”. The author must provide a PDF or a JPG picture of the poster by April 29, 2016 by 5:00pm to be considered for awards.

Judging:
Abstracts will be assessed for participation in the Poster Celebration based on completeness and applicability to the review categories. Posters will be judged on site by a panel of our sponsors and in addition there will be community popular vote.

Recognition and awards:
The authors of all abstracts accepted for presentation will receive a certificate of participation and be listed on the Region 1 website. Up to 4 posters will receive designation of Region 1 Exemplar for one or more of the designated categories. One poster will receive designation of Member Model by popular vote of the participants at the conference. The authors of the 5 winning posters will receive a certificate designating their achievement and a non cash award for the attendance fee in order that the can participate in a future Region 1 annual conference that must be used within 2 years. All designations are final and there is not appeals process. There is no cash substation for the awards and they are not transferable.

Participants and awardees will be recognized during the 7:45am meeting in the main ballroom.

For more details, check out www.hfmaregion1.org. Please join us in celebrating the great ideas and accomplishments you and your coworkers have achieved at your organization!
Get Involved!

Get the most out of your membership by volunteering. We have openings that will give you more networking opportunities and help you develop leadership skills.

Volunteer Opportunities

Annual Meeting – Day 1
Meredith, NH, March 17, 2016
For 1st time Volunteers only
Waived Registration, 2 Founders Points

Social Committee
► Member

Physician Practice Management Committee
► Committee Chair
► Member

Membership Committee
► Volunteer Coordinator
► Member Liaison
► Student Member Sub-committee member

Committee members earn 2 Founders Points.
Check our website for descriptions of these committees at http://www.nhvthfma.org/CommitteeOpportunities.

To learn more about these opportunities, email judith.a.deavers@hitchcock.org.

May 25-26, 2016 | Mohegan Sun Resort, CT
Save the Date
HFMA Region 1
15th Annual Healthcare Conference

CBCS WE DO THAT!
CBCS is a full service accounts receivable management company. Our goal is to increase recoveries for our customers at all levels of delinquency.

You NEED SERVICES THAT DELIVER RESULTS. WE DO THAT.

WHAT DO YOU EXPECT FROM YOUR COLLECTION AGENCY?
COLLECT MORE MONEY | TAILORED SOLUTIONS | TOOLS
WE DO THAT!

My patients don’t understand their bills, and I can’t easily customize them. They also want a secure way to pay online, and want options like monthly payment withdrawals. I’m not getting that now.

Have you tried EMA?

Today 2:14 PM
EMA MANAGEMENT ASSOCIATES
www.emamng.com
800-639-3129
# HFMA Calendar

<table>
<thead>
<tr>
<th>DATE</th>
<th>TOPIC</th>
<th>LOCATION</th>
<th>POTENTIAL CO-SPONSOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/4/2016</td>
<td>Responding to Patient Bill Estimation Requests</td>
<td>Webinar</td>
<td></td>
</tr>
<tr>
<td>2/11/2016</td>
<td>Excel Series - Pivot Tables Part 1</td>
<td>Webinar</td>
<td>Maine HFMA</td>
</tr>
<tr>
<td>2/25/2016</td>
<td>Excel Series - Pivot Tables Part 2</td>
<td>Webinar</td>
<td>Maine HFMA</td>
</tr>
<tr>
<td>3/9/2016</td>
<td>Health Plan Leadership Perspectives on the NH Exchange of the Premium Assistance Program</td>
<td>Executive Courtyard Banquet Facility Manchester, NH</td>
<td>NHMGMA</td>
</tr>
<tr>
<td>3/10/2016</td>
<td>Accounting Update/Ethics</td>
<td>Portland, ME</td>
<td>Maine HFMA</td>
</tr>
<tr>
<td>3/17-18</td>
<td>Innovations in Population Health and the Reality of Retail Medicine and Annual Meeting</td>
<td>Inn at Mills Falls Meredith, NH</td>
<td></td>
</tr>
<tr>
<td>4/8/2016</td>
<td>Breaking the Glass Ceiling: Leadership Skills for Women</td>
<td>Manchester Country Club Manchester, NH</td>
<td></td>
</tr>
<tr>
<td>4/21/2016</td>
<td>Legislative Update</td>
<td>Webinar</td>
<td>NNEAHE</td>
</tr>
<tr>
<td>5/24-26</td>
<td>HFMA Region I Conference</td>
<td>Unscaville, CT</td>
<td>Region I Chapters</td>
</tr>
</tbody>
</table>
Health care is changing – and so is the Certified Healthcare Financial Professional (CHFP) designation.

The new CHFP from HFMA prepares finance professionals, clinical and nonclinical leaders, and payers to address the continually evolving healthcare business environment. Multidisciplinary courses focus on providing today’s essential skills: business acumen, strategy, collaboration, and leadership.

Course modules include:

**The Business of Healthcare**
Healthcare finance overview, risk mitigation, evolving payment models, healthcare accounting and cost analysis, strategic finance, and managing financial resources

**Operational Excellence**
Exercises and case studies on the application of business acumen in health care

Take the next step in your professional development – check out the new CHFP at [hfma.org/chfp](http://hfma.org/chfp).
You know – more than anyone – the value of belonging to HFMA.

Invite your peers, your staff, and your colleagues to join you – and join HFMA.

Find out more information at 
HFMA.ORG/MGAM
CMS Audit Update

By Erin Brearley

Two-Midnight Rule Changes

Finalized Policy Changes

CMS finalized the proposed updates to the two-midnight policy, outlined in the OPPS Final Rule. The previous policy stated that if a physician expects the patient will remain in the hospital for two or more midnights, the patient is generally appropriate for inpatient status. Conversely, in the absence of a two-midnight stay or longer, an inpatient admission would not be reasonable and necessary except for inpatient only procedures, and in rare and unusual circumstances.

CMS proposes to modify its “rare and unusual” exceptions policy so that certain hospital inpatient services that do not cross two midnights may be appropriate for inpatient admission if the physician determines and documents that the patient requires reasonable and necessary admission to the hospital as an inpatient (less than two-midnights).

Relevant factors:

► The severity of signs and symptoms
► The medical predictability of something adverse happening to the patient
► The need for diagnostic studies that appropriately are outpatient services

Cases that fall under this new exception will be prioritized for medical review. CMS also clarified that minor surgical procedures with stays less than 24 hours would need to be “rare and unusual” to require inpatient admission.

CMS Clarification: “Rare and Unusual”

In the OPPS final rule, CMS clarified some confusion about their modification to the rare and unusual policy:

“We would like to clarify that our proposed modification to the current exceptions process does not define inpatient hospital admissions with expected lengths of stay less than 2 midnights as rare and unusual. Rather, it modifies our current ‘rare and unusual’ exceptions policy to allow Medicare Part A payment on a case-by-case basis for inpatient admissions that do not satisfy the 2-midnight benchmark. This modification acknowledges other patient-specific circumstances where certain cases may nonetheless be appropriate for Part A payment, in addition to continuing to provide an opportunity for Part A payment in ‘rare and unusual’ circumstances for which there is a national exception.”

In other words, if the physician expects the patient will need two midnights of medically necessary hospital care, but the patient recovers faster than expected, this qualifies for inpatient payment under the two-midnight benchmark, which has been part of the two-midnight rule all along. However, if the physician expects the patient will need fewer than two midnights of medically necessary hospital care, but still believes the patient requires inpatient admission, this may qualify for inpatient payment under the revised “rare and unusual” exceptions policy. However, these cases will be prioritized for review and the documentation will need to support the rare and unusual situation that caused this patient to need inpatient care.

Two-Midnight Rule Enforcement Changes

The historic process for reviewing patient status decisions and enforcing policy was pre and post-payment reviews completed by the MACs and RACs.

CMS will now use Quality Improvement Organizations (QIOs) rather than MACs and RACs, to conduct first-line reviews of short inpatient stays. The QIO for New Hampshire and Vermont is Livanta.

Continued, next page
QIO Audit Process:

► Twice a year the QIO reviews 25 charts for “large” hospitals, and 10 for other size hospitals. Reviews exclude inpatient only procedures, already-reviewed claims, and certain discharge disposition codes (e.g. AMA, death, transfer). The QIO denies or approves these cases.

► The QIO calls the hospital to set up the review. The hospital will have a specific contact at the QIO to request an education session.

► The QIO tells the MAC to recoup denied claim(s).

► The MAC sends a Demand Letter with information about appeal rights.

► The appeal process is the same as other Medicare denials.

► RACs are not involved until a hospital is referred by the QIO for “high denial rates”. The number of denials determines whether hospital will be referred to RAC, but the threshold has not yet been defined by CMS.

So, what about the RACs?

Even if a hospital is not referred to the RAC for high QIO denial rates, RACs will still be auditing hospitals for:

► Medical necessity for procedures
► Canceled inpatient surgeries
► MS-DRG validation
► Other hot topics such as cataract surgery

RAC Contracts

In February 2014, the existing RAC contracts were scheduled to end. Pre-award protests were filed by some of the bidders, and legal proceedings invalidated a portion of the initial proposed scope of work. Therefore awards have been delayed. CMS has allowed the existing RACs to audit under contract extensions; currently through June 30, 2016.

In November 2015, CMS issues new RFPs for the long-term RAC contracts.

RAC Program Improvements

CMS has made improvements to the RAC program in an effort to “reduce provider burden, enhance CMS oversight, and increase program transparency”. There are twenty new improvements, a few of which are outlined below. To see the full list, visit CMS’s RAC webpage.

ADR Limits

Effective 1/1/16, a hospital’s annual ADR limit is 0.5% of the provider’s total number of Medicare claims from their previous year.

► The annual ADR limit will be divided by 8 to determine the maximum number of claims that can be audited every 45-day cycle.

► ADR limits will be diversified across all claim types of a facility, based on the types of bills (TOB) that the provider was paid for in the previous year.

► CMS will “adjust a provider’s ADR limit based on the provider’s compliance with Medicare rules. Providers with low denial rates will have ADR limits decreased, which providers with high denial rates will have their ADR limits increase.” CMS has not defined how they will determine the increase and decrease amounts.

Look-back Period

Effective 5/15/15, RACs can only look back 6 months for patient status reviews from the date of service provided the hospital submits the claim within three months of the date of service. This allows for rebilling while still in the one year timely filing window.

For all other types of audits, the look back period is still a rolling 36 months from the paid date.

Discussion Period

Effective 1/1/16, The RAC must wait 30 days to allow for a discussion request before sending the claim to the MAC for adjustment. The RAC must confirm receipt of the discussion request within three business days.

Contingency Fee

Effective TBD, the RAC will not receive a contingency fee until after the second level of appeal is exhausted. Previously, RAC was paid immediately upon denial and recoupment of the claim.

Overturn Rate

Effective 5/15/15, the RAC must maintain an overturn rate of less than 10% at the first level of appeal, excluding claims that were denied due to no or insufficient documentation or claims corrected during the appeal process.

References:
Recovery Audit Program Recent Updates: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Recent_Updates.html
Chapter Officers

President
ROBERT M. GILBERT, FHFMA
(603) 740-6562 | Robert.Gilbert@wdhospital.com

President-Elect
DIANE L. MAHEUX, FHFMA
(603) 356-5461 | dmaheux@memorialhospitalnh.org

Immediate Past President
AMY VAUGHAN
(802) 847-7809 | amy.vaughan@UVMHealth.org

Secretary
AMY BETH MAIN, MBA
(802) 257-8382 | amain@bmhvt.org

Treasurer
WENDY DUMAIS
(802) 257-8382 | wdumais@crhc.org

The New Hampshire/Vermont Chapter of the Healthcare Financial Management Association (HFMA) is a professional membership organization for individuals in financial management of healthcare institutions and related patient organizations.