CHA CONNECTICUT HOSPITAL ASSOCIATION

Thursday, December 15, 2011

In This Issue:

Connecticut Hospitals Facing Major Medicare and Medicaid Funding Cuts

On December 13, the US House of Representatives passed the Middle Class Tax Relief and Job Creation Act of 2011 (H.R. 3630) that would, among other things, cut more than $17 billion in hospital funding as part of a year-end tax and unemployment package that includes a two-year fix for physician payment under Medicare. CHA supports eliminating the scheduled reduction of 27.4 percent in Medicare payments to physicians set to begin on January 1, but not by reducing payments to hospitals.

H.R. 3630 would cut Medicare and Medicaid payments to Connecticut hospitals to achieve savings to partially offset the cost of the physician fix. Among other things, the bill would:

- Reduce hospital outpatient payments by drastically cutting payments for evaluation and management (E/M) services by $6.8 billion. These services are among the most common outpatient services provided in hospitals. Cuts would affect all hospitals, regardless of whether they employ their physicians.

- Cut Medicare bad debt payments, currently reimbursed at 70 percent, to 65 percent in 2013, 60 percent in 2014, and 55 percent in 2015, a cut across all provider types of over $10 billion over the next ten years. The reductions are phased in, beginning in 2013. These payments are essential to help hospitals care for low-income Medicare patients.

- Extend the therapy caps exceptions process, which places an annual limit on covered therapy services; however, it would for the first time apply the annual therapy cap to therapy provided in the outpatient hospital setting, reducing Medicare spending to hospitals by more than $2.5 billion over 10 years.

- Not extend a number of Medicare payment provisions supported by CHA, including the section 508 wage index reclassification.

CHA and Connecticut hospitals have been actively seeking the support of the Connecticut Congressional Delegation to defeat these proposed cuts because:

- This House bill includes major additional cuts to hospitals, including considerable reductions to outpatient services and bad debt relief.

- Connecticut hospitals are facing significant financial pressures due to the Patient Protection and Affordable Care Act (PPACA), the stagnant economy, the growing number of uninsured and residents losing employer-sponsored health insurance, and recent state budget actions that imposed a hospital tax and cut disproportionate share funding.

- Connecticut hospitals will also experience an additional $62 million reduction as a result of triggering the automatic sequestration due to the failure of the deficit reduction "super committee."

- Connecticut hospitals play a significant economic role. They contribute nearly $17.6 billion to the state and local economies, provide 97,000 jobs in our communities, and serve as a magnet for other healthcare businesses and a stimulus for new businesses, such as retail stories, banks, grocery stores, and restaurants.

The Senate is now expected to take action on the House bill, H.R. 3630. However, Democratic leadership in the Senate is developing its own proposal and there will be further negotiations to follow with the House.

State Medicaid Plan Amendment For Transition to ASO Addresses Key Hospital Concerns

The Connecticut Department of Social Services (DSS) explained in a recent provider bulletin its plans for implementing a new HUSKY Health program, which eliminates Medicaid Managed Care Plans and establishes a new model of care management for all Medicaid recipients. Under this new model, the Department will contract with a single entity to provide a broad range of member and provider services and support. Beginning January 1, 2012, the administrative services organization (ASO) will authorize and manage the medical health services for all Medicaid beneficiaries.

CHA has been working with DSS over the last several months to ensure a smooth transition to the new HUSKY Health Program. Key CHA objectives for this transition were to: 1) make sure that this was budget-neutral for every hospital, and 2) modernize the Medicaid payment system by replacing Connecticut's outdated TEFRA target system with a DRG system. Adopting a DRG system creates the foundation for a system that can reliably measure quality, efficiency, and safety, as detailed in CHA's Medicaid Modernization plan. Both of these recommendations were incorporated into the State Medicaid Plan Amendment filed by DSS.

Governor Malloy Names Mark Ojakian Chief of Staff

Photo courtesy www.courant.com

Governor Dannel P. Malloy today announced he has named Mark Ojakian to serve as Chief of Staff in the Governor's Office. Mr. Ojakian, who currently is the Deputy Secretary of the Office of Policy and Management, will replace outgoing Chief of Staff Tim Bannon, who announced in November his impending plans to depart the position. According to Governor Malloy, Mr. Ojakian was "a big part of the reason we reached an historic agreement with our state employees that will save taxpayers $21.5 billion over the next 20 years."

Prior to joining the administration earlier this year, Mr. Ojakian served as Deputy Comptroller under Lieutenant Governor Wyman for 16 years when she headed that office. In his role as Deputy Comptroller, Mr. Ojakian acted as senior policy advisor, had administrative responsibility for over 250 employees, and fiscal responsibility for over $1 billion in state accounts. He has served in a number of roles on a variety of boards and commissions throughout his career and has been an integral part of several large public policy initiatives, including implementation of Core-CT, the state's computerized financial, human resource and payroll software system aimed at modernizing outdated financial reporting functions.

He will transition into the role by working alongside Mr. Bannon, whose final day with the Office of the Governor will be on January 5. CHA looks forward to working with Mr. Ojakian to advance hospital and healthcare related issues during the upcoming session.

CHA Diversity Collaborative to Hold First Team Meeting on January 11, 2012

On Wednesday, January 11, 2012, CHA will hold the first team meeting for the CHA **Diversity Collaborative: *From Intent to Impact***. Developed to support the hospitals' Diversity Collaborative teams, this meeting will include a review of the Diversity Collaborative structure, program elements, calendar of events, metrics, interventions, strategies, and team action plans. It will include an educational session, *Exploring the Four Practice Areas of Diversity and Defining Your Action Plan*, presented by Brenda Oneal and Carlton Oneal of **Light Speed**.

Teams from Connecticut hospitals are working together through the Diversity Collaborative, multi-year statewide initiative that will:

- Increase diversity in hospital governance and management;
- Improve the cultural competence of care delivery; and
- Increase supplier diversity.

For further information about the meeting, contact Margi Brault at Brault@chime.org or at (203) 294-7301.

Education Updates

The ICD-10 Impact on Hospitals and Transition Strategies to Meet the Deadline—Webinar Series: January 18, 2012, and February 15, 2012, 1:00 p.m. - 2:00 p.m.

Two years and counting… is your hospital on its way to ICD-10-CM/PCS implementation by the October 1, 2013 deadline? Are you planning for the significant financial and clinical impact this will have on your organization? Do you have a strong inter-functional team and timeline in place to achieve "ICD-10 readiness"?

This webinar series, begun in November, focuses on helping hospital leaders and their ICD-10 implementation leaders and

teams. The next program in the series is:

Webinar: The Value of Strategic Planning for ICD-10 Readiness, January 18, 2012, 1:00pm - 2:00pm

Scuba divers, when undertaking a risky dive, are told to "plan your dive" and "dive your plan." Undertaking the ICD-10 transition is just as risky for your institution; therefore, you should "plan your transition" and "transition with a plan." This session will share lessons you can learn from other providers who have developed a transition plan and what the key points should be for your own organization's strategic plan for ICD-10 readiness. Even if you already have developed a transition plan, participation in this webinar will be a good double-check to ensure your plan's thoroughness.

Speakers for this webinar series include Andrea Clark, RHIA, CCS, CPC-H, President and Founder of Health Revenue Assurance Associates (HRAA) and a past presenter at CHA, and Keith Siddel, MBA, PhD(c), Chief Marketing Officer at Health Revenue Assurance Associates, Inc. Ms. Clark, a nationally prominent health information management expert, will focus specifically on revenue integrity of outpatient coding and billing systems; charge capture; coding and billing; data transference, and outpatient compliance training services. Mr. Siddel has more than 25 years of experience in healthcare finance, information systems, operational, and compliance training expertise, which includes hospital-based and free standing day surgery sites, emergency room, hospital-based clinics, and ancillary diagnostic services areas.

For more information, click here. To register, email educationservices@chime.org.

Save the Date - Changes in CPT/HCPCS for 2012, Wednesday, January 11, 2012, 8:00 a.m. - 12:00 p.m.

CPT and HCPCS codes are the primary codes that describe individual hospital services that are billed to all payers. These code sets go through annual revisions with codes that are added, deleted, or revised. For 2012, over 800 codes will change inclusive of new and deleted codes, and those with revised descriptions.

The workshop will emphasize coding changes in skin replacement surgery, imaging guidance changes, and new preventive service HCPCS codes.

Save the Date - OPPS Final Rule for 2012, Wednesday, January 11, 2012, 12:45 p.m. - 4:15 p.m.

The Centers for Medicare and Medicaid Services (CMS) has published the Outpatient Prospective Payment System (OPPS) Final Rule for 2012, defining what CMS will be implementing for OPPS in 2012. The Final Rule documents changes in composite Ambulatory Payment Classifications (APCs), drug administration, visits, partial hospitalization, implantable biologicals, Composite APCs (there's a new one), pulmonary rehabilitation, and new codes for 2012. In addition, the Final Rule continues to address quality reporting.

Update On Hiatus

This is the last edition of Update for 2011.
Our regular schedule will resume on Thursday, January 5, 2012.
Warm wishes for a happy, healthy 2012.