**April 2019 Infoline**

**\*\* The 7th National Physician Advisor and Utilization Review Bootcamp is INKED in and Ready for Registration!  YAHOO!  \*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

EARLY BIRD DISCOUNT EXPIRES ON MAY 31st.  Both for Live webstreaming and onsite discounting.   Go to RAC SUMMIT to register or thru the Boot Camp page of our webpage.

**2019 Boot Camp:**

    **Medicare Advantage:  Building Blocks of Contracting, Provider-Sponsored MA Plans and the Ongoing Denial Challenges.**

    **Pre-Con:  "The Basics:  Medicare 101, CDI 101, P2P 101, and Denials/Appeals 101."**

**Yep, the title outlines the 3 major focus areas that will be taught in a 'how to' format= a BOOTCAMP.     \*\*Check out the ALL THINGS MA including CMS oversight &  Risk Adjustment Audits - both topics taught by long time MA experts...  WOW!**

**When:   Mon-Weds, July 29-31st   (Mon/pre con; Tues and 1/2 day Weds/general sessions)**

**Where:  Washington, DC**

**Same price as in all previous years; same option of live webstreaming or in person/only conference offering both for all sessions- so it is like being with us.**

**We would love to have you join us as we continue our MA journey together.  \*By 2020, it is forecast that close to 50% of all Medicare pts will be in a MA plan. \* Time to get our A game on plus explore pro-active options... if you can't beat them, be one!  Love it!**

SPEAKERS:   We are thrilled and honored to have multiple returning faculty, new subject experts, and dynamic networking opportunities with the faculty...Take a look at the full agenda as it is now ready.  Racsummit.com  YAHOO!

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HEY - all historical **Info Lines are on ARS's Webpage**.  They and all the classes are FREE... Get them and share the knowledge.

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**\*\*\*\*NEED HELP WITH CODING BACKLOGS?  ANY PATIENT TYPE -ALL OR JUST -IN -TIME CODING?  STAFF TURNOVER?  COMPUTER ANGUISH?  Let me know and we will get connected to provide 24-48 hr guarantee remote coding timeline with no minimum required.  Love it!\*\***

**Hot Spot Updates**

* **Medicare Advantage** - HUGE GROWTH AND ENHANCED SCOPE OF SERVICES.  Why did we dedicate this year's boot camp to "All Things Medicare Advantage?"  As an industry of healthcare providers, there is significant lack of coordinated information as to the "MA MARKET.'  The silos of contracting/sometimes in a diffferent location, unaware of what is even in the contract, impact to operations/coverage limitations, disputes/loss of inpt & downgrades of stripped dx & 'related' readmissions - with limited tracking and trending by payer are compounding the 'at risk' with the MA plans.  And the list goes on ..   Plus the industry has a limited knowledge of how MA plans are paid - not on a per claim /per provider/per patient basis.  As we continue to see a massive rise in MA enrollees - here are some key areas of challenge to help providers in this new 'payer battlefield."

            1)  MA plans are primarily insurance companies -but others are popping up - like PROVIDER-SPONSORED plans.  Growth in enrollees:  2010  11.1 M to  2016  17.6 M to 2019  22.6M which represents 1/3 of all Medicare beneficaries.  (Kaiser Family Foundation)   Additionally, 3700 MA plans that will be available in 2019... all with their own set of rules!    GADS!!  (Modern Healthcare)

            2)  If you are not contracted with the MA plan - then traditional Medicare rules apply.  YES!  CMS has stated same and we will discuss this further at the boot camp. (Thanks, Dr Baker/So Carolina for spearheading this and continuing to be part of the dynamic faculty at the boot camps)    AND the plans must have a provider contracted directory - so the healthcare provider has more 'power' to negotiate as they do need you to be able to sell in your community.  Yep!

            3)  Program Integrity Manual, Chapter 6, Section 6.1.3 A. ... HUGE WIN for clarity.  'Furthermore, if the plan approved the furnishing of a service through an advance determination of coverage, it may NOT deny coverage later on the basis of a lack of medical necessity."  YAHOO!  What are we seeing?   Approved, then MA hires an auditing company, and suddenly denied as 'not medically necessary' 2 or 3 years later.  Nope- can't do it.  Utilize direct payer contact but if they recoup the payment or continue - use the CMS COMPLAINT NOTIFICATION to report the MA plan plus Track and Trend (TNT) and involve legal if necessary.  (Go to our webpage page/below to get the contact list.)

            4)  Another problematic trend:  When requesting a conversion to inpt after failed outpt observation care, the MA plan is going back to 'day 1 of the clinical guidelines and requiring the patient meet THOSE requirements...not the 'failed outpt ' provision.  Wrong.  Again, work directly with the payer but if abusive, file a complaint.  Unfortunately, the healthcare community is not making CMS/who oversees all MA plans aware of the ongoing anguish and possible abuse of the MA plans.   SQUEEK!

             5)  Ensure all Traditional Medicare stats are separated from Medicare Advantage stats.  Unfortunately, when routinely asking for the two sets of stats separated by payer - it is not available.  It begins with registration- build unique pt types attached to the different "Medicares.'  Then ensure it is able to reported separately within "Medicare"  or  build a commerical data base/dictionary for "Medicare-Humana, Medicare-United,  etc.  This will ensure Traditional Medicare is not mingled with MA data. (EX:  One CFO said - I have had a growth of 20% in obs. I hate the 2 MN rule."  Are you really sure this growth is from Traditional or from one or multiple of your MA plans?  Outcome:  Still problems with converting to inpt after the first outpt MN but 44% obs rate for their two largest MA plans.  Shoot me now!)

            6)   Payer Employed Hospitalists who follow their own insurance covered pts. (Thanks, RAC RELIEF)  These payer-employed providers are being hired by the hospital , only to see long lengths of stay in observation and limited number of patients eligible for inpt.  WHY is this occuring?  Additionally, some hospitals are having the payer's Care Managers onsite to 'help with determining' if they are inpts or obs.  Same question - WHY?  Regardless of how clinically knowledgable they are - the insurance plan is their boss, paying their salary.  Rough relationship and one where TNT must be occuring with direct feedback to the CMO, CFO, CEO, pick one!

* **Short Term Health Plans - 'junk insurance**."  Yes, once again, we are sharing the extremely concerning executive order that allows states to sell "short term/up to 3 years" plans as long as there is 1 plan on the exchange that has all elements of the Affordable Care.  The 10 essential benefits, protection from caps, pre-existing, children up to 26/married or not...  BUYER BEWARE!  When you hear DC talk about  'the best, cheaper healthcare' - these are the plans in this conversation.  Do an internet search but each plan being sold can create any package of coverage = so no protections, limits on coverage=lots of them, no essential benefits, etc.   Two recent examples:  ND employee laid off.  Told she could get COBRA -which means she paid the entire premium --and just laid off???  So she went to the exchange to see if she could find an individual /family package she could afford.  She did not qualify for subsidies but her insurance told her about the new 'STHPs.'  The agent walked thru a ton of options (think cafeteria plans/old days) including her picking the prescriptions she 'thought they would need' and very narrow package but at least she had something.    MT man purchased STHP he 'thought provided full coverage." The man was denied care for testicular cancer. The plan eventually moved to drop his coverage due to pre-existing conditions.  (Becker's Hospital Review)

             What is the message?  1) Hospitals/providers - Immediately train your insurance verification team - look deeper for coverage as we now have 'state waivers' that allow for much lower coverage packages.  No longer look at "Blue Cross' and think - yep, they have to have all 10 essential benefits.  Check with the insurances in your community - are they selling these and how will you be able to spot them.   2)  Does your community understand these are very different than the last 8+ years with the ACA?   Time to do some community education.  3) Do your patients even understand what they are purchasing?  It has been 8+ years ...and since we are still experiencing significant premiums and deductibles --everyone is looking for 'cheaper' and still full coverage.  PS Let me know if you find that as 92% of all employers are under 50...how can they afford healthcare?  Many are sending their employees to the state EXCHANGES which is an excellent option...           If it sounds too good to be true--it usually is.  Educate your leadership teams!

**Last thoughts:**

* Cost Efficiencies- ER:  Hospital does all billing for the ER providers.  All documentation is accessible to the hospital coders -who are coding the ER facility visit.   But the hospital is still using a separate set of coders to do the ER Provider's 1500 (or method 2/CAH's UB) coding.  Same dx, but different E&M criteria.  Why isn't this consolidated under 1 coder doing all coding - sending to the correct claim:  UB/hospital; 1500/Pro side.  Crazy wasted cost...  Our EHR systems allow for exactly this cost saving option.
* Revise a common theme: Some conversations between finance/Rev Cycle and the clinical team include this recurring message:  "No margin, no mission."  Could I suggest a new, improved version?  "**Mission Drives Margin**.'   Hospitals are in the business of 'unsecure loans.'   Why do patients pay?  It is DEMONSTRATING the mission, beyond money, that people respond to.
* What three C's keep CFOs up at night?  With a bit of humor -as otherwise things get a bit too much - when I hear all the things that keep CFOs up at night- here are the Cs.  Cybersecurity, consumerism, cost, current politics, cash, compliance... did I miss any?  HERE ARE MINE:  Cash flow, Cost and just CRAP.  Yep, CRAP.  Then when a payer does something outrageous - it was just CRAP.  Nothing fancy...  love it!

**\*\*\*\*Hey, come and say hi when I have the privilege to particpate in one of the below conferences...or shout out a HI when doing an audio.  It is a joy for me ...anytime!\*\*\***

    **HEY NEW CLASS:  "Revenue Cycle Payer Impacts of Disruption."   We are teaching this to professional associations, groups or individual hospitals or onsite.  Let me know if you would like to discuss.  (After 40 years doing this fun work, I am definitely not bored.  HA)**

    May 2nd        WA HFMA                Attacking Mgd Care Denials   &   What does disruption look like - patient, provider, payer and nation

    May 17th        PA AAHAM              Finding lost revenue thru charge capture   &  Distruption  (Keystone chapter)

    May 21-22      CO HFMA                 2 part webinar - Payer challenges with CO sites telling their stories

    June 18th       Compliance 360        **FREE Webinar:  What is hot with payer denials -especially Medicare Advantage**

PS  Plus 2 grandchildren high school seniors graduating and 1 granddaughter graduating in Nursing.  WOW!   Way cool...

BOOTCAMP:  July 29-31st    In person or live webstreaming/like being with us!   Hope to see you there.

    Thanks to each of you for allowing us to continue to be a part of your professional life.  It does take a village and we are so grateful for your willingness to share...

    "The Shortest Distance Between Two People is LAUGHTER! -Victor Borge