HealthTech Management Services

CEO Update

July 2015

Context of the Organization

Special points of interest:

- What is Context of the Organization
- From the Hill: Budget Showdown; Medicare Audit & Appeals Bill; Critical Access Hospital Relief Act
- Proposed Medicaid Managed Care Rules
- Two-Midnight Rule Modification
- Baldrige Leadership Award

The new ISO 9001:2015 standards will be released soon, and one of the interesting concepts proposed in the new standards is understanding the **context of the organization**. The terminology is new therefore it seems important to share how healthcare organizations can incorporate the process regardless of whether one is DNV accredited, one that uses the ISO standards or one may be interested in contemporary vernacular.

The notion behind "context of the organization" is that an organization must fully explore and understand the internal and external conditions under which it operates. This is like a football team understanding the rules of the game, the nature of the playing field, and the strengths and weaknesses of its own team and the competition.

It is a simple concept, but in reality, it is an ongoing enterprise challenge. In today's world, organizations must understand the changes that occur all around them. This is a significant advancement in thinking.

The starting point for understanding the **context of the organization** should be the strategic direction, and the effect it has on the organization's ability to achieve the intended results of its quality management system.. A couple ways that this can be done is through the strategic planning process and a community health needs assessment.

The next step includes "understanding the needs of interested parties." Interested parties might include regulatory agencies, suppliers and even society in general, especially if environmental implications are related to the realization or use of an organization's products and services. CMS has directed healthcare organizations to improve the patient experience, and involve the patient in their care. The ISO standard maintains the importance of keeping the "customer" and their needs in mind when assessing the external conditions which affect the organization's operations.

If organizations have a fluid set of uncoordinated strategies without a clear direction, nothing will be accomplished. There are always issues that will affect the strategic direction of any organization. Those issues must be determined, and knowledge about them must be used in planning.

Leaders at all levels must establish unity of purpose and direction, and create conditions in which people are engaged in achieving the quality objectives of the organization. Creation of unity of purpose, direction and engagement enable an organization to align its strategies, policies, processes and resources to achieve its objectives., thus determining the **context of the organization.**

From the Hill

Budget Showdown Likely

Sequestration cuts have caused an uproar with many on the Hill. The two-year deal that was proposed by Paul Ryan and Patty Murray to ease the cuts occurred after sequestration had started. At this point, Medicare providers will realize a 2% cut.

Congress has until September 30 to come up with a spending plan for FFY 2016 that will address sequestration and discretionary spending since the Federal fiscal year begins October 1, 2015. Once again, without a plan, there is speculation that another government shutdown could occur. Potentially, a last minute plan could affect Medicare providers by increasing the percentage of cuts as a means of decreasing cuts to others.

Medicare Audit and Appeals Bill

The Senate Finance Committee recently approved the Audit and Appeal Fairness, Integrity, and Reforms in Medicare Act (AFIRM) which addresses the problems associated with the Medicare audit and appeal process. The goal is to reform the Medicare appeals system in an effort to ease the significant backlog of appeals. Other provisions of the bill include:

- Limit the period during which a RAC may conduct patient status reviews to ensure that certain hospitals have the ability to rebill under Medicare Part B
- An exemption for one year for providers who have low error rates from RAC and MAC audits while tying the ability of review contractors to request medical records to determine their accuracy rates
- Require CMS to approve methodologies and review guidelines for Medicare contractors, adjust conflicting local or national policies as needed, and establish an ombudsman program for reviews and appeals
- Reform the Medicare appeals system in part to address the significant backlog in appeals at the administrative law judge level by streamlining processes and increasing resources for the Office of Medicare Hearings and Appeals to conduct reviews, hearings, and appeals. (Source: Medicare Audit Improvement Act of 2015 (H.R. 2156). HANYS Report. June 2015)

Critical Access Hospital Relief Act

The Critical Access Hospital Relief Act (S. 258/H.R. 169) would remove the 96-hour certification requirement as a condition of payment for cahs, but keep the CoP requiring a 96-hour annual average length-of-stay. Additionally, the Protecting Access to Rural Therapy Services Act (S.257/H.R. 1611) would adopt a “general supervision” standard rather than the current direct supervision requirement to allow supervision by a physician or non-physician practitioner for many outpatient therapeutic services.

Centers for Medicare and Medicaid Services (CMS)

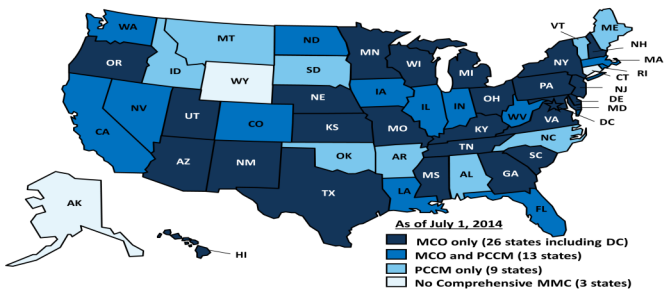
Proposed New Medicaid Managed Care Rules

The proposed changes apply to Medicaid and Children's Health Insurance Program (CHIP):

- Providers would have the right to file an appeal on the enrollee's behalf with or without their written consent.
- The timeframe for plans to respond to appeals would be 30 calendar days with expedited appeals having a timeframe of 72 hours.
- Establishment of a Medical Loss Ratio of 85% for Medicaid Managed Care products for contracts that begin on or after January 1, 2017.
- Managed care plans that cover dual eligible individuals and are responsible for coordination of benefits in states that use the automated process for fee-for-service claims would be required to sign a Coordination of Benefits Agreement and participate in the automated crossover process administered by Medicare
- Provides clarification for managed care plans that they could receive a capitation payment for enrollees aged 21 to 64 who have a short-term stay of no more than 15 days in a facility for mental illness provided the facility is an inpatient hospital or a subacute facility providing short-term crisis residential services
- Proposes to implement a six-step process that managed care plans will use to determine if capitation rates are actuarially sound which suggests that states must provide greater documentation and detail in setting rates
- States would be encouraged to use managed care plans as partners to assist states in achieving delivery system and payment reform along with performance improvements
- Suggests strengthening quality measurement and improvement efforts by establishing a quality framework built upon the principles established in the DHHS National Quality Strategy and the CMS Quality Strategy
- All network providers would have to enroll in the state Medicaid providers list yet the providers would not have to accept fee-for-service Medicaid
- Proposed would allow state's flexibility in the design and administration of managed long-term care services and supports to include community-based services as well as institutional-based services provided through managed care
- Build a more comprehensive system for monitoring and reporting program integrity issues
- Establishment of minimum standards for provider network adequacy requirements and strengthen beneficiary protections.

For further proposal descriptions, please refer to http://www.gpo.gov/fdsys/pkg/FR-2015-06-01/pdf/2015-12965.pdf

Comprehensive Medicaid Managed Care Models in the States, 2014



NOTES: ID's MMCP program, which is secondary to Medicare, has been re-categorized by CMS from a PAHP to an MCO by CMS but is not counted here as such. CA has a small PCCM program operating in LA county for those with HIV.
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2014.

Two Midnight Rule Modification

The Centers for Medicare and Medicaid Services in a proposed payment rule will ease requirements for the controversial "two-midnight" rule governing inpatient admissions. The new rule will allow physicians to use their judgment on a case-by-case basis when admitting patients for short hospital stays.
CMS said it will remove oversight of admitting decisions from its administrative contractors, instead asking quality improvement agencies to enforce the rule. RACs will be directed to concentrate only on facilities with unusually high claim denial rates.
Providers and policy experts alike have been calling for the repeal of the two-midnight rule in its entirety, but CMS is standing firm in its support of the policy. The agency said that it hasn't received any viable alternatives to the rule, despite three separate requests for public comment.
Under the proposed rule, if a physician admits a patient for an expected short stay, he or she must document evidence supporting the decision, including symptom severity and the risk of an adverse medical event while the patient is hospitalized.

2016 Baldrige Award for Leadership

The Baldrige Foundation is now accepting nominations for the 2016 Harry S. Hertz Leadership Award (HSHLA). The award is presented annually at the Quest for Excellence conference. The Foundation is seeking nominations to identify exemplar leaders for recognition with this prestigious award. A description of the award, the award criteria and nomination process, and the members of the selection committee can be found at:

http://www.baldrigefoundation.org.

The HSH Leadership Award will bring recognition to a deserving individual and provide leadership best practices to many. **Nominees do not need to have any prior association with the Baldrige process**; they should be exemplars of the leadership criteria described on the referenced web site. The deadline for nominations is September 20, 2015. For further information, please send your query to hshla@baldrigefoundation.org.