HealthSmart

Innovative Insights Into Modern Healthcare

2019 | Q4

Predictions 2020

OPPS/MPFS FINAL RULE

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ADVIS ANNUAL GOLF OUTING & SEMINAR WRAP-UP

SPOTLIGHT ON ADVIS SENIOR CONSULTANT, PRESTON SISLER

advis

YOUR SMART HEALTHCARE CONSULTANTS

A NOTE FROM LYNDEAN

As we near the end of 2019, and look back at this year's accomplishments, I couldn't be happier with team Advis. The innovation and thought leadership from our firm evolves constantly. Each person brings unique qualities and a well-honed skillset to the job at hand. I am elated to see team Advis and its many members flourish. In collaboration with our clients we continue to set the bar high for healthcare delivery. Thank you for an exceptional year!

We are excited to share some highlights from recent events like the Advis Seminar & Golf Outing, where 50 clients travelled from near and far to enjoy a few days of golf, networking and informative seminars. We are also extremely proud of our relationship with CASA, the Court Appointed Special Advocates, who provide children with a safe and healthy environment in temporary and permanent homes.

Advis threw its collective hat in the ring in several areas of event and media throughout 2019. Our consultants were busy with speaking engagements and webinars for both the Illinois and Texas Hospital Associations. This issue will include a snapshot of some of these topics: Change of Ownership Transactions, Healthcare Diversity and Inclusion, 2020 OPPS Final Rule, and 2020 Predictions for American Healthcare.

At Advis, consultants think outside the box. Know that you can continue to depend on us to answer your healthcare compliance questions and meet your operational requirements. From credentialing specialists to legal experts, our well-rounded staff will always provide you with practical, innovative solutions to your most pressing industry concerns. Enjoy our newsletter.

Lyndean

SPOTLIGHT ON PRESTON SISLER

To find Preston Sisler on the golf course is no surprise. Preston is a golf lover and avid Pittsburgh sports fan; but, more importantly from our point of view, he is a highly respected senior consultant for Advis and lead counsel for Advis Law. Preston is an expert in complex regulatory issues related to healthcare system operations and compliance, specifically regarding mergers and acquisitions. Preston is also a WWII history buff and amateur historian. He is an incredibly valuable asset at any coffee clutch or water cooler discussion. Clients love him because he knows what he's talking about.

Preston has advised providers across the care continuum on strategy, compliance, and reimbursement matters. He has assisted clients with facility development in several states.

Preston lives in Downers Grove, Illinois. When not working, he spends most of his free time with his wife, raising two boys, ages 6 months and 2½. The family stays busy with activities like skiing, spending time with friends, exploring, and always learning new things.

Quotes:

> "Preston has been instrumental in our success converting six clinics to Provider Based. He kept us focused, on-track and ensured follow-up on critical issues. As a result of his leadership, our implementation was flawless and actually uneventful which is a testament to his attention to detail and project management skills." **– Ed Bertels, CMPE, CHRISTUS Trinity Clinic**

> "Preston Sisler simply gets the job done. Quietly, efficiently, and with great expertise, Preston handles whatever challenge is sent his way. Preston cares. He cares about his work, about his colleagues and their work, and about the company he works for. His future is as bright as his past has been diligent. His clients are invariably complimentary in appreciation of a job well done." **– Rob Monroe, JD, Vice President, Advis**

ANNUAL ADVIS GOLF OUTING AND SEMINAR WRAP-UP

This year's Golf Outing was our best one yet! Over 50 clients from around the country joined us for two days of informative seminars, fun networking events, and, of course—golf at the renowned Olympia Fields Country Club.

The event started off with a fan favorite Chicago-themed welcome reception. Deep dish pizza from Lou Malnatis, Italian beef, Chicago hot dogs and Eli's cheesecake—just to name a few of the Chicago delicacies sampled. We also had a locally sourced salad and vegetable bar to represent Illinois' expansive farmland.

Advis leadership showcased informative presentations, highlighting current trends in healthcare, predictions for 2020, and meaningful, practical knowledge for our hospital executive attendees. Our CEO and President, Lyndean Brick, kicked off the seminar with a presentation about provider transformation and innovation that sparked intuitive and dynamic discussions.

SEMINAR TOPICS
2019

Future Cast:

An Examination of Regulatory & Reimbursement Trends for Today & Tomorrow

Topics Covered: 340B Update, National Reimbursement Trends & Strategies, and OPPS/IPPS Final Rule Updates

Data Analytics in Healthcare

Topics Covered: Revenue Cycle Compliance, Medical Record Documentation, Employee Oversight, Population Health, and Meaningful Use

Transformation & Innovation:

Lyndean Brick, J.D., President & CEO

Provider Strategies to Survive, Strive & Thrive

Behavioral Healthcare:

Key Strategies & Trends to Watch

Advis explored the key behavioral healthcare issues facing the nation and its providers. We offered insight and possible solutions regarding current market trends and opportunities.

Post-Acute Care Update

Key topics included: Opportunities available for Distinct Part Units within LTACHs, Changes to the Skilled Nursing Facility Reimbursement Structure, CMS' Efforts to Unify Post-Acute Care

AND GUEST SPEAKER

ANNE E. COLLIER, MPP, JD, PCC, CHIEF EXECUTIVE OFFICER AT ARUDIA

Embrace and Supercharge Your Leadership Style

Other topics included 340B Inform, key strategies and trends in behavioral healthcare, and data analytics in healthcare.

This year's theme was 'Sushi, Sake and Socializing'. Participants were invited to join veteran Chef John Daniel on a culinary journey through Japan. We watched as the chef created one of Japan's most beloved dishes: Sushi. Participants had an opportunity to create their own sushi rolls and were shown how to pair ingredients with an assortment of sakes. In all, we tasted six Sake.

Seminar participants were invited to a round of golf on the Olympia Fields North Course, ranked annually by Golf Digest as one of America's Top 100 Greatest Courses, and host to multiple US Opens, the women's 2017 KPMG PGA Championship, and the men's 2020 round of 70 FedEx Cup Championship.

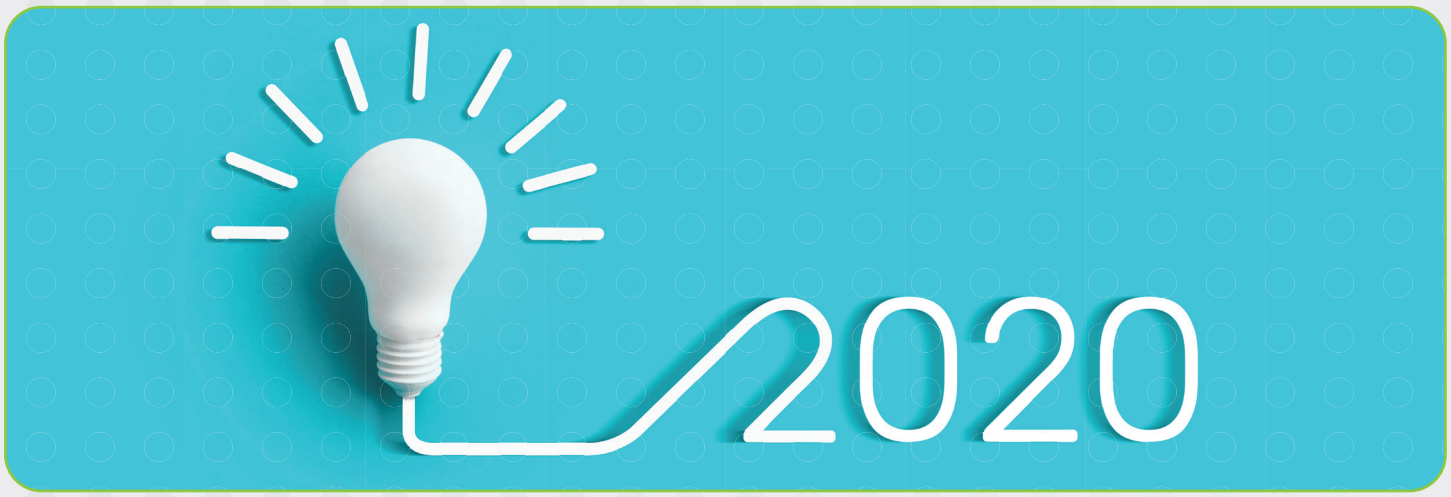
SAVE THE DATE

2020 Annual Golf Outing & Healthcare Seminar

September 30 – October 2

On The Cover (Left to right)
Ken Cunningham, CHRISTUS; Kurt Leifheit, The Carle Foundation; Preston Sisler, Advis; Billy Pennington

PREDICTIONS 2020:
Healthcare Changes Big And Small



1. Birthing Centers Will Replace Traditional Inpatient Labor & Delivery Units.

Birthing centers provide a more comfortable and holistic approach to childbirth. Here the well-being of the mother can be the primary focus of the institution; the mother's desires and needs are front and center. Furthermore, birthing centers have also proven to lead better delivery outcomes. Birthing centers target women with low-risk pregnancies. The costs are 50% lower than in hospitals. They improve maternity care. They are better equipped to meet patient needs during the pregnancy and birthing stages. And birthing centers support maternity bundled payment models feasible for both payers and beneficiaries. These centers are also responsive to managed Medicaid, which is why we will continue to see hospitals increasingly develop birthing centers in an effort to provide better service and control costs.

2. Payers Will Recognize the Importance of the Interrelation Between Healthcare Outcomes and Addressing the Social Determinants of Health.

We will begin to see payments to providers addressing the social determinants of health. As a first step in this direction, United Healthcare and the AMA presented a set of ICD-10 codes that would expand existing diagnostic codes to include social determinants of health. Consequently, hospitals would be reimbursed for those services rendered. Recognizing the social determinants of health further serves to institutionalize the hospital as the preeminent community safety net.

3. Physician Groups Will Continue to Expand Market Share.

In the past, physicians were part of small practices or largely self-employed. Over the past 20 years, individual practices or even two-physician practices have decreased significantly. Today, most physicians are employed by large healthcare organizations. Most physicians work in large group practice settings. As both payers and public continue to demand efficient, immediate, and cost-effective care, physician group practice will continue to grow larger. Large physician groups like DMG and Oak Street Health are going to see the continued expansion provided they remain responsive to value-based care. Whoever and whatever can provide quality patient care at significantly lower costs than hospitals is poised to grow larger.

4. Site Neutrality is Leveling the Playing Field.

Promoting site neutrality in an effort to level the playing field between hospitals and other healthcare providers will continue to cause headaches in hospitals. Specifically, with United Healthcare's recent push for outpatient surgical services outside of the hospital, and Anthem's push for imaging and MRI services in ambulatory settings, the trend to get away from the hospital will continue to accelerate in 2020. It is going to continue to accelerate for years to come.

5. C-Suites Will Shrink.

Currently, the United States spends more than twice as much on healthcare as other high income, developed countries. According to the Center for American Progress, in 2019 payers and providers will spend 496 billion dollars on billing and insurance related

administrative costs alone. In fact, the average salary for hospital administrators is $237,000; for an insurance chief executive officer it's $584,000; and for a hospital CEO it's $386,000. How do these salaries compare to those in the actual medical profession? The people with all the education and loans to pay? According to the New York Times, the average salary for a general practitioner is $185,000. The average salary for a surgeon is $306,000. Layers and layers of healthcare administration must collapse as demand for efficient, low overhead patient care increases. There's no other way. Hospitals and academic medical centers have to find ways to trim the high costs of administration.

6. Psychedelics and Marijuana Will Become Mainstream in Healthcare.

Maybe Baby Boomers just want to relive their youth. Or maybe they're on to something. Either way, with Medical Marijuana having gained almost universal acceptance (and recreational marijuana not far behind), Psychedelics now represent the final frontier for experimental behavioral science. As a result of recent studies successfully treating several psychiatric diagnoses, from depression to autism and substance abuse disorders, with psychedelics, combined with the recognition of the benefits of psychedelics and marijuana for behavioral health by several federal agencies, we predict seeing more of these substances utilized by conventional medicine and psychiatric care in the days and years to come. Numerous patients report benefits and attending physicians are encouraged by the results. Experimentation regarding the relationship between psychedelics and behavioral health will continue apace.

7. Pharmacists Will Join the Primary Care Team Across the Nation.

Some states have already recognized patient care by pharmacists and are mandating reimbursement for these services. Wellness and prevention are a significant part of primary care. Many people in the US suffer because of a dearth of preventative care. However, there's a light at the end of the tunnel. Pharmacists are trained in preventative care and medication management. Increasingly they're bridging the gap between the patient and circumstances where primary care is lacking or falls short. Improper medication usage is one of the reasons hospital readmissions are at an all-time high. Moreover, integrative pharmacies help reduce primary care provider burnout. Along with optimizing compliance with hospitals and medication management, the industry will see pharmacists emerge as a widely recognized and accepted part of the primary care team. With more states and payers recognizing the importance of the pharmacist to direct patient care, payers will increasingly allow for the reimbursement of their services.

8. Transparency Trends Persevere, Forcing Us into API and Cloud Based Systems.

The government continues to force transparency trends onto the industry. CMS will require standardized data formatting via API or cloud residing database use to allow open access to price transparency data. Patient-friendly price transparency tools that calculate individualized out-of-pocket cost estimates will become the norm. "There's an App for that" is the mantra of digital culture. Transparency rules will not apply on a per hospital basis; instead, they will be developed by software companies using the open API mandated by CMS. Hospitals that do not comply with exact data specifications will be at a severe disadvantage within the marketplace.

9. The Inpatient SNF Will Morph Into a Completely Transformed Venue of Care.

The Skilled Nursing Facility as we know it today will disappear. SNFs will disappear to allow room for service provision in a patient's home, or on an ambulatory basis, with the use of technology, telemedicine, and efficient SNF teams that travel to the patient. We know the service population is continuing to grow; but the push away from inpatient SNFs is unstoppable. Inevitably, this changing and highly fluid situation is going to evolve into a whole new model of care. That new model may allow SNFs to continue as the risk bearer and quarterback for services, or they may be entirely written out of the picture.

10. Healthcare Consumers Will More and More Gravitate Toward Telemedicine and Internet Apps for Their Healthcare.

With the internet bombarding us with trendy, efficient, and useful ways to meet our healthcare service needs, hospitals will need to jump into telemedicine and App utilization to avoid market share loss. Startups like Hims and Roman for erectile dysfunction, Nurx for prescribing oral contraception, Cove for migraines, and Zero to quit smoking capitalize on the younger consumer's internet-based marketing habits. Internet based healthcare services provide a solution for American health care frustrations. They provide a cheaper, more accessible means of primary care. These apps can connect users to a licensed professional who can then prescribe needed medications with no appointment or clinic visit required. Apps utilizing facetime, text messaging, and webcam monitoring efficiently and effectively diagnose symptoms and prescribe medications to patients at drastically reduced costs. These apps also work with a user's insurance and can work for people lacking insurance. In the future, there will be an App for that… and the future is now.

CMS ISSUES FINAL OPPS/MPFS RULES WITH PROPOSED PRICE TRANSPARENCY FOR HEALTH PLANS/INSURERS

The final CY 2020 Outpatient Prospective Payment System ("OPPS") and Medicare Physician Fee Schedule ("MPFS" rules were released by the Centers for Medicare & Medicaid Services ("CMS") this past fall.

CMS delayed their response regarding hospital price transparency, to the issuance of another forthcoming rule, which finally came out with a delay in implementation and the introduction of proposed rules for health plans. Addressing provider's comments, CMS clarified that all hospitals will be required to post standard charges as well as the payer-specific negotiated charges – now defined as any discount the patient receives for using an in-network provider – online in a single digital, machine-readable file. Hospitals must also post similar information for at least 300 "shoppable" items and services.

CMS extended the deadline for compliance to January 2021. CMS also proposed an additional rule that, if finalized, will require health plans to provide consumers with real-time, personalized access to cost-sharing information, including an estimate of their cost-sharing liability for all covered healthcare items and services. Most group health plans and health insurers will be required to provide this information through an online tool and in paper form at the consumer's request.

The final rules contain other notable changes, however, such as modifying office/outpatient Evaluation & Management (E/M) billing and coding, adding ASC and outpatient eligible surgical services, enhancing Part B opioid use disorder treatment benefits, and continuing site neutral provider-based and 340B payment changes.

CMS discussed the recent site neutral and 340B federal court rulings at length, both of which are adverse to the CMS authority. However, CMS again presented its arguments in support of its payment reduction policies, and signaled the possibility of additional appeals. This shows a likelihood of continuing court challenges where site neutral and 340B payment changes are concerned.

Key OPPS Proposed Changes

1. Continuing Site Neutrality Despite Recent Court Order

Despite the recent federal court ruling reversing the CY 2019 payment reductions, the CMS CY 2020 OPPS Final Rule completes the two-year phase-in of site neutral payments for hospital off-campus clinic visits. This action will result in payments of 40 percent of the OPPS rate for clinic visits coded with HCPCS G0463 at all off-campus provider-based departments in CY 2020, including "grandfathered" rates under the BBA of 2015.

CMS acknowledged that the most recent district court order closed the case and vacated the CY 2019 payment reductions at 70% of the OPPS rate. This would seemingly require CMS to adjust CY 2019 claims that received reduced OPPS reimbursement for HCPCS G0463 clinic visit services in "grandfathered" off-campus provider-based departments. However, CMS did not explain how it will do this. Instead, CMS stated it is "working to ensure affected 2019 claims for clinic visits are paid consistent with the court's order" while it evaluates whether to appeal the court's decision.

2. Changes to the Inpatient Only List

CMS changed the Inpatient Only (IPO) list by removing total hip arthroplasty, six spinal surgical procedures, and certain anesthesia services from the list. Removal make these procedures eligible to be paid by Medicare in the hospital outpatient setting and the hospital inpatient setting alike.

3. ASC Covered Procedures List

CMS added Total Knee Arthroplasty (TKA), Knee Mosaicplasty, six additional coronary intervention procedures, and twelve procedures with new CPT codes to the ASC covered procedures list.

4. Payment Methodology for 340B Purchased Drugs

CMS will continue to pay ASP minus 22.5% for 340B drugs for the time being, yet again acknowledged the on-going litigation and its current appeal of the recent covered entity-favorable decision. CMS summarizes potential remedies in the event that its appeal is denied; however, the agency has not yet selected which approach it will take in this event. Advis will continue to monitor this process and provide updates when available.

Key Points of Hospital Price Transparency

1. Types of Hospitals Required to Comply

CMS defines "hospital" for purposes of this price transparency rule to include all institutions licensed as hospitals under applicable state laws, regardless of whether the hospital is Medicare-certified. CMS did not provide exemptions for small or rural hospitals such as critical access hospitals or sole community hospitals.

2. Pricing Information Hospitals are Required to Make Public

CMS explains that it would essentially like to provide patients with the ability to create their own Explanation of Benefits ("EOBs") before the receipt of any items or services. Hospitals will therefore be required to make their "standard charges" public for patients, which CMS defines as "the regular rate established by the hospital for an item or service provided to a specific group of paying patients." CMS explains that "standard charges" goes beyond merely the hospital's chargemaster, and is requiring actual pricing data be made public.

CMS created four different types of "standard charges" that hospitals are required to make public so that patients can determine how much they will have to pay: Gross Charges, Payer Specific Negotiated Charges, De-Identified Minimum and Maximum Negotiated Charges and Cash Discount Charges.

CMS also clarified it will continue to use the terms "rate" and "charge" interchangeably, and cites to the Oxford dictionary definition of "rate" to support this assertion. Through this interpretation, CMS will be giving patients access to data that has typically been deemed confidential and proprietary between hospitals and third-party payers.

3. Requirements for Shoppable Services in a "Consumer-Friendly Manner"

In addition to pricing information for all items and services described above, CMS will also require hospitals to create and make public a list of "shoppable services" for consumers. CMS clarified that "shoppable services" are those that can be scheduled in advance by a healthcare consumer. CMS would like patients to be able to search through a hospital's list of "shoppable services" to better understand and compare pricing when selecting a provider.

4. Monitoring and Enforcement of Price Transparency Requirements

CMS will review and audit public hospital websites, and monitor patient complaints to enforce these rules. Additionally, if CMS determines a hospital is noncompliant with the price transparency rules, CMS may provide a written warning of the specific violations, request a CAP, or impose a civil monetary penalty of up to $300 a day and publicize the penalty on a CMS website.

Key MPFS Changes

1. Office/Outpatient Evaluation and Management (E/M) Services

CMS finalized E/M coding changes to align with the American Medical Association (AMA) for office/outpatient visits. The changes retain 5 levels of coding for established patients, reduce the number of levels to 4 for new patients, revise the times and medical decision-making process for all of the codes, and require performance of history and exam only as medically appropriate. Clinicians can continue to choose the E/M visit level based on either medical decision-making or time. CMS is also increasing payment for office/outpatient E/M visits, in line with the AMA Specialty Society Relative Value Scale Update Committee (RUC) recommended values.

2. Revisions to Physician Supervision of PAs

In the absence of any contradicting state rules, CMS finalized a revision to supervision requirements to clarify that physician supervision is a process in which a PA has a working relationship with one or more physicians to supervise the delivery of their health care services. Such physician supervision is evidenced by documenting the PA's scope of practice and indicating the working relationship(s) the PA has with the supervising physician(s) when furnishing professional services.

3. Part B Benefits for Opioid Use Disorder Treatment

CMS finalized plans to implement legislation that established a new Medicare Part B benefit for medication-assisted treatment of opioid use disorder, furnished by opioid treatment programs. CMS also finalized the creation of new coding and payment for a monthly bundle of services for the treatment of opioid use disorder that includes overall management, care coordination, individual and group psychotherapy, and substance use counseling, as well as an add-on code for additional counseling. The individual psychotherapy, group psychotherapy, and substance use counseling included in these codes could be furnished as Medicare telehealth services using communication technology where clinically appropriate. CMS also finalized new telehealth HCPCS codes G2086, G2087, G2088, which describe bundled episodes of care for treatment of opioid use disorders.

CHOW TIPS

In an era of industry consolidation, Advis is frequently engaged to provide regulatory guidance for health systems undergoing a change of ownership. With Medicare, CHOWs typically occur when a Medicare provider has been purchased by another organization. The change in ownership results in the transfer of the former owner's Medicare Identification Number and provider agreement (including any outstanding Medicare liabilities of the former owner) to the new owner. In addition to the required Medicare filings, a CHOW also triggers various other federal and state filings.

Advis has significant experience guiding health systems and other entities through the complexities of the change of ownership process. From start to finish, Advis services provide: transaction evaluation, due diligence, regulatory interpretation, preparation of necessary filings, coordination with federal and state agencies, and more. Tips to consider during the CHOW process from the experts at Advis' include:

Obtain New NPIs for the Buyer in a CHOW

Valerie Ford, Vice President, Enrollment

Many "Buyer" organizations believe that utilizing the "Seller" organization's NPIs after a CHOW has been approved by CMS is easier and less labor intensive. In fact, it is the opposite. In order for payer processing to be completed, the Legal Business Name and EIN on an NPI must match the Buyer's information. Since payers process CHOW applications and notifications within different timeframes, the NPIs would have to be updated upon first request by a payer. This will result in the holding of claims and potential cash flow issues until all payer enrollments are approved. Obtaining new NPIs for the Buyer allows for a seamless billing transition, tracking of receivables and avoids NPI crosswalk issues.

Third Party Pharmacy Agreements

Michael French, J.D., Senior Consultant

While the Medicare provider agreement and other payor contracts deservedly get a lot of attention during a CHOW, don't forget about pharmacy-related third-party agreements. Ensuring that pharmacy operations can seamlessly continue post-CHOW is crucial to maintaining high levels of patient care. These pharmacy-related agreements (such as switch vendor contracts, 340B TPAs, and equipment leases) can usually be assigned to the buyer, typically carry little risk of historical liability, and can act as a temporary bridge before new agreements can be negotiated. Temporary assignment of 340B contracts can also lead to uninterrupted realization of 340B drug cost savings for the new buyer. However, before accepting assignment of any contracts, the buyer should perform due diligence to confirm that doing so will not violate exclusivity clauses in existing system-level pharmacy agreements.

"Grandfathered" Off-Campus Provider-Based Sites

Ryan Bailey, J.D., CHC, Vice President

"Grandfathered" off-campus provider-based sites are those that were established by a hospital prior to 11/2/2015. These sites continue to receive traditional OPPS reimbursement for outpatient services by Congressional statute, despite CMS' continued push for "site neutral" payments. The buying entity must accept assignment of the selling entity's Medicare provider agreement in order for this financially beneficial status to transfer with these off-site departments. If the buying entity rejects such assignment, these sites will be paid at CMS' "site neutral" rates, e.g., 40% of OPPS. Furthermore, if the buying entity plans to incorporate the seller's main provider location as a remote campus, e.g., establishing a multi-campus hospital, only those off-campus provider-based sites within 35 miles of the buyer's main provider buildings will retain eligibility. Careful review of all practice locations is therefore required when considering a CHOW.

Interim Billing Services Agreement

Ryan Yokley, J.D., MHA, Vice President

A significant regulatory advantage of a CHOW transaction (as defined by Medicare), is the ability for the Buyer to continue billing under the Seller's provider enrollment information post CHOW and until which time CMS process and approves the transaction (issuance of tie-in notice). This allows for a seamless continuation of billing privileges and prevents a cash flow interruption. However, many logistical components need to be addressed to ensure this process is carried out smoothly. Advis has found, negotiation and execution of an Interim Billing Services Agreement in advance of the CHOW is the best way to ensure a seamless continuation of billing is realized.

Master Plan to Drive Necessary and Timely Filings

Preston Sisler, J.D., Senior Consultant

From a regulatory perspective, it is critical to allow for appropriate time for due diligence to identify and catalog all regulatory licenses, permits, registrations, etc. Once this has been completed, a work plan should be established to identify the timeline for regulatory filings, with particular attention paid to pre-closing filings. For example, pre-closing authorization must be obtained from the Federal Communications Commission ("FCC") for the transfer of control or assignment of FCC licenses to the acquiring entity. Identification of pre-closing activities is an essential step to ensure the targeted closing date is not delayed (or to ensure the acquiring entity does not subject itself to unnecessary post-closing regulatory risk).

Detailed Communication Plan

Jake Beechy, J.D., Senior Consultant

Advis finds that creating a simple but effective patient communication plan can tremendously help with the transition to a new owner. It is typically our recommendation to provide notice to patients in the months leading up to and for up to two months following the effective date of the change of owner. The notice should explain the change and describe any potential impact to the patient, such as from whom they will be receiving a bill. Advis also recommends providing training and scripting to staff and front-end staff who will field the majority of the patient inquiries. The communication plan and patient notice ultimately allows for a more seamless transition with little disruption to the patients' quality of care.

Supplemental Payments

Bryan Niehaus, J.D., CHC, Vice President

Supplemental payments are Medicaid payments to providers that are separate from and in addition to the payments for services rendered to Medicaid enrollees. States make supplemental payments through FFS, managed care, and waivers, but the payment mechanisms and qualifications vary greatly by state and provider type. If a provider is changing the type of ownership (Non-Profit/For-Profit/County), or the enrollment structure of a provider under Medicare/Medicaid, the supplemental payment may increase or decrease. Ensuring all team members (legal/finance/etc....) are aware of supplemental payment implications (and in communication with the State agencies) is critical to ensuring supplemental payments are maximized/protected during the CHOW process.

Protect Grandfathered Practice Locations

Monica Hon, J.D., Vice President & Director of Client Solutions

When acquiring a hospital with multiple off campus practice locations, review the Medicare certification record and related documentation closely to ensure all practice locations being acquired are reported appropriately to ensure a smooth transition of grandfathered hospital practice locations

Maintain Open Communication with Sellers

Robert Monroe, J.D., LL.M., Vice President

Communicated with non-government payers regarding the CHOW process and timelines. Medicare approvals, accreditation approvals and other recognitions of the "new owner" will take a period of time after the effective CHOW date to receive. To the extent that nongovernmental payers rely on CMS and/or accreditation documents, new owners should maintain communication with the payers to limit any interruption of enrollment with payers.

Transfer Documents are Often Needed Even with Internal Transactions

Andrea Graham, Senior Consultant

It is important to remember if a company with multiple EINs wants to consolidate down to 1 EIN, bills of sale or asset purchase agreements need to be prepared and executed in regards to each EIN change. Although the company may consider this transaction to be "internal," Medicare/Medicaid and various other state agencies consider it to be a complete Change of Ownership and will require an executed bill or sale or asset purchase agreement to process the EIN change. These documents can be signed by the same individual as the buyer and seller.

DIVERSITY SETS THE TONE FOR A SAFE & INCLUSIVE WORKPLACE

Have you ever witnessed a hospital staff member being harassed by a distraught patient hurling hateful slurs?

Do you remain silent when you see statements made to some of your colleagues that you know are culturally insensitive?

Have you observed a patient refuse treatment from a practitioner of color, demanding to see a white doctor?

Or have you overheard someone say, "Your English is so good!", upon learning their physician is from another country?

Each of these scenarios is problematic in its own way. More and more frequently, healthcare professionals are encountering challenging moral and ethical situations in the workplace that relate to diversity in the workplace. Whether from patients, colleagues, administrators or vendors, it is simply not enough to have anti-harassment and nondiscrimination policies in place. People must have the courage and foresight to act upon them. Diversity training and a solid plan can help. If discrimination, gender bias, sexual harassment, or other types of recurring actions detrimental to the workplace rear their ugly heads from time to time, then it's time to carve a path toward cultural change. It's time to move beyond the tutorials and policy reviews: provide your organization's membership with the practical tools necessary to have a voice, to feel included, to feel valued, and to have the courage to say so.

Bystander Intervention Strategies

Several proven methodologies may assist an individual in a discriminatory or bias situation they witness or uncover. In the healthcare setting, Advis advises focusing on five important strategies:

1. Interruption & Distraction;
2. Immediate Intervention;
3. Delegation;
4. Delay & Follow-Up; and
5. Documentation.

Interruption and Distraction

Due to sensitivities inherent to the healthcare facility environment and the presence of ailing patients, the distraction strategy is of real value. Simply interrupt the situation, ignoring the harasser, and engage directly with the targeted individual about something completely unrelated to the harassment witnessed. Any pretense can be used to interrupt and/or deflect negative actions. Take the first example of a patient using racial slurs against their nurse. To change the subject, you might ask the nurse for test results from another patient, or ask for the time, or express some other random thought that will hopefully interrupt or, better still, stop the harassment. The distraction strategy is extremely effective in many situations. It always deflects and deflates the harassment.

Immediate Intervention

This strategy can be risky, so caution is advised. Security and other policies may be necessary as well, but sometimes immediate intervention is all that's needed when witnessing harassment. Quickly assess your surroundings. Make certain you can ensure the situation's safety, because the harasser, once confronted, may turn on you. The harasser may state homophobic or culturally hateful language toward another person. You directly intervene by stating: "That's inappropriate. It's not ok. Stop it now". What's important is that you keep your interruption of the harasser short and to the point. Always refrain from debating the harasser. Knocking the harasser off stride is your goal.

Delegation

Again, in most healthcare venues security personnel and/or security procedures are in place to help staff battle harassment issues. Sometimes a situation calls for asking for assistance from a leader, manager, security personnel or other like person, especially if you already tried a distraction strategy and it proved insufficient to resolve the matter at hand.

Delay & Follow-Up

Sometimes you witness harassment situations in passing, or they happen so quickly that it's all over before you can jump in and apply one of the proven strategies. In this case, it is always good practice to follow up with the person who suffered the harassment and ask them if they are ok. Acknowledge that the incident took place. Reassure the victim that it was not ok. You can offer to accompany them to make a report. Always document the incident while its fresh.

Documentation

Most healthcare service venues have procedures and reporting methodologies for such incidents in place. Whether your healthcare facility has an organized reporting mechanism or not, it is important to document any and all incidents you witness so that leadership may address these issues in a timely manner.

Conclusion

Diversity Training and Policies of Inclusion are critical to the modern workplace. The healthcare environment is one of the most social workplaces to be found anywhere. Maintaining a healthy work environment based upon mutual respect and excellence is critical to the modern successful workplace. Advis specializes in assessing existing policy and in developing and implementing supplementary policies to assure that a diverse, inclusive, and thriving workplace is in place at your organization. Please be aware that every institution has its own approach to diversity and inclusion and bystander involvement. Please always follow the direction from your organization. To inquire about diversity training, policy review, or your workplace culture, contact Advis at 708.478.7030, and one of our experienced diversity trainers will be happy to assist you.

INSIDE ADVIS

Notes About Advis Staff and Activities

ADVIS GIVES BACK

Advis has long standing relationships with several charities and philanthropies that mean a lot to us. Catholic Charities, Guardian Angel Community Services, Bethany House of Hospitality, and the Will County chapter of CASA (Court Appointed Special Advocates) are all wonderful causes. Whether we are running races or ballroom dancing, Advis employees enjoy raising money year-round for vital causes.

But around the Holidays, we especially look forward to helping our friends at CASA. CASA is a national association with regional chapters that support and promote court-appointed advocates for abused or neglected children in the court system. CASA goes the extra mile to provide badly needed assistance for so many children in emergency situations. And so Advis likes to go the extra mile for CASA.

Over the years, the team at Advis has worked together to fulfill children's wish lists, to make sure they have a healthy and enjoyable holiday season. We enjoy the entire process. From reading the wish lists to gift-wrapping sessions, nothing is more fulfilling then letting children know that you care.

HALLOWEEN AT ADVIS

Chili cookoff, trick ‘r treating, and costume contests, oh my! Advis staff brought their children in to gather candy and toys around the festive decorated office. 6 competitors cooked their best chili recipes to see who would come out on top. Bob Krause was the winner of this one! Costume contestants battled it out for best guise. Ryan Bailey and his family grabbed the winning title with their Star Wars ensemble while group Sylvie Brick, Jordan Pfaff, Mary Hannosh, and Chris Cardullo came second as “The Gang” in Scooby Doo.

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