HEALTH FINANCIAL SYSTEMS

User' s Meeting – August 2015
Skilled Nursing Facility Issues and Update

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Topics

- Hot Topics
  - Trivia
  - Fraud Issues
  - RAC's, MAC's and ZPIC's
  - CMS 2016 SNF PPS Final Rule
  - Changes to SNF Requirements for Participation
  - Value Based Reimbursement
  - Affordable Care Act
- Bad Debt Issues
- Collection Efforts

Trivia!

- Using Florida as a benchmark:
  - The profit margins in SNF's has declined 65% in the past three years, form 6.7% in 2012 to the current 2.4% in 2015
  - A total of 601 nursing centers were reflected in the study's database
  - The study found that 216 facilities (35.9%) incurred negative margins, reflecting a combined negative margin of 4.8%
  - Another 69 facilities (11.5%) had margins less than 2.0%

FRAUD!

FRAUD!

- June 2015 – In the largest national crackdown on Medicare fraud ever, 243 people from coast to coast – including 46 doctors and nurses – were arrested for $712,000,000 in false billings.
- Charges included conspiracy to commit healthcare fraud, violations of the anti-kickback statutes, money laundering and aggrevated identity theft.

FRAUD!

- Medicare fraud enforcement has intensified since the passage of the ACA, which provided more funding to hire investigators and toughened sentencing for criminal activity.
- Higher losses now mean increased prison time for offenders.

FRAUD – Miami

- 73 Arrests in Miami –
  - 1 mental health center billed $64 million over a 6 year period for "Intensive psychotherapy treatments" that were basically just moving patients to different locations.
  - "Patients" were recruited from homeless shelters and off the streets, and were paid to share their Medicare numbers

FRAUD - Dallas

- 7 people were charged in healthcare schemes in which operators of a physician house call company exaggerated the length of visits and submitted $43,000,000 in billings under one doctor's name – regardless of who provided the service.

FRAUD - Detroit

- 16 arrested for $122 million in false claims for services that were medically unnecessary or were never rendered, including
  - Home health care,
  - Physician's visits,
  - Psychotherapy, and
  - Pharmaceuticals

FRAUD – Brooklyn

- 9 were charged in physical and occupational therapy schemes

FRAUD – New Orleans

- 11 were arrested for $110 million in
  - Home healthcare and
  - Psychotherapy schemes

FRAUD – Los Angeles

- A doctor was charged with false billings of $23 million for 1,000 power wheelchairs and other healthcare aids that were either
  - Not needed
  - Never delivered

FRAUD – MEDICAID

- The federal government expended approximately $310 Billion in 2014.
- CMS reported an estimated $17.5 Billion in potentially improper payments for the Medicaid program
- The GAO analyzed Medicaid claims paid in 2011 (most recent year available) for
  - Arizona
  - Florida
  - Michigan
  - New Jersey

FRAUD - MEDICAID

- The four states accounted for 13% of all Medicaid expenditures
- Audit outcome
  - 8,600 beneficiaries had payments made on their behalf concurrently by two or more states totaling $18.33 million,
  - The identities of about 200 deceased beneficiaries received about $9.6 million in Medicaid benefits,
  - About 50 providers were excluded from federal health care programs, including Medicaid, for
    - Patient Abuse Neglect Fraud
    - Theft Bribery Tax Evasion

RAC Audits

- Manual Medical Review (MMR) has commenced for Part B Therapy claims over the $3,700 threshold paid between March 1, 2014 and December 31, 2014
- According to CMS, claims will be reviewed in chronological order, based on the month in which they were paid.

RAC Audits (Cont.)

- The Medicare Audit Improvement Act of 2015 (H.R. 2156) was introduced to address the payment structure for RAC's in an effort to reduce inappropriate payment denials and burdensome medical records requests for providers
  - Current reimbursement: 9.0 – 12.5% commission
  - Proposed reimbursement: Flat fee with a potential for the fee to be lowered if the RAC performed poorly

MAC's, RAC's and ZPIC's

- MAC's will have only 30 days for a prepayment review
  - Does not include 3rd party liability claims for which they have 60 days
- RAC's will have only 30 days to cpmplete post-payment review and communicate the results to the provider
- ZPIC's will have 60 days to complete prepayment review and notify the MAC

MEDPAC Recommendations

- Recommendations for 2016
  - Eliminate the Market basket increase entirely,
  - Revise the prospective payment system,
  - Rebase payments beginning with a 4% reduction to the base rate

Medicare Advantage Plans

- CMS has proposed increasing Medicare Advantage payment rates by 1.05% for 2016,
- Any plan that earned at least four out of five stars will receive a 5% bonus payment in 2016.
- Any plans with a 0-3.5 stars will continue to get no additional payments.
- Star rating will make or break Advantage plans over the next few years

2016 SNF PPS Final Rule

- SNF Payments to increase $430 million
  - Equals about 1.2%
- This is 0.2% less than what was outlined in the April proposed rule
- CMS claims, "that if more recent data became available and was appropriate to consider, the agency would use such data to determine the final FY 2016 SNF rate."

Unadjusted Federal Rate Per Diem

Rate Component	Nursing Case Mix	Therapy Case Mix	Therapy Non Case Mix	Non-Case Mix
Urban Per Diem	$171.46	$129.15	$17.01	$87.50
Rural Per Diem	$163.80	$148.91	$18.17	$89.12

Requirements for Participation

- Proposed Rule (July 13th, 2015)
- Actual language is located on pages 42246-42269 of the Federal Register
- Significant proposed changes:
  - Quality Assurance and Performance Improvement Plans
  - Baseline care plan for each resident within 48 hours of admission
  - Compliance and ethics programs
  - Discharge planning

Requirements for Participation

- (Continued)
  - Facility assessment which aims to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies, and
  - A more comprehensive Infection Prevention and Control Program including an Infection Prevention and Control Officer
  - Comments on the use of arbitration agreements

Requirements for Participation

- Deadline for comments is September 14, 2015
- Send to:
  - Centers for Medicare and Medicaid Services
  - Department of Health and Human Services
  - Attention: CMS-3260-P
  - Post Office Box 8010
  - Baltimore, Maryland 21244-8010

Value Based Reimbursement

- DHHS released a timeline to fully transition to a "Value-based" system
  - Category one: Fee-for-service with no link of payment to quality,
  - Category two: Fee-for-service with a link of payment to quality,
  - Category three: Alternative payment models built on fee-for-service architecture, and
  - Category four: population based payment

Category 1	Category 2	Category 3	Category 4
Payments are based on volume of services and not linked to quality or efficiency	At least a portion of payments vary based on the quality or efficiency of health care delivery	Payments still triggered by delivery of services, but opportunities for shared savings or two-sided risk	Clinicians and organizations are paid and responsible for the care of a beneficiary for a long time
Limited in Medicare fee-for-service	Hospital value-based purchasing	Accountable care organizations	Eligible Pioneer ACO's in 3-5 years
Majority of Medicare payments now are linked to quality	Physician value-based modifier	Medical Homes, Bundled payments, Comp primary care	
	Readmissions/Hospital Acquired condition reduction prgrm	Comp ESRD, Mcare/Caid financial alignement	

Value Based Reimbursement

- Timeline for Transition:
  - End of 2016:
    - 85% of Medicare payments in Cat 2, 3, and 4
    - 30% in categories 3 and 4
  - End of 2018:
    - 90% of Medicare payments in Cat 2 – 4
    - 50% in categories 3 and 4

Value Based Reimbursement

- Alternative Payment Models
  - Accountable Care Organizations (ACO's)
  - Advanced Primary Care medical homes
  - Bundled payments or episodic payments
  - Integrated care demonstrations for dual eligible beneficiaries

Value Based Reimbursement

- Health Care Payment Learning and Action Network (HCPLAN)
  - The goal of this HHS plan is to drive greater collaboration between private payers, providers, large employers, consumers and state and federal partners
- The goal is no longer incentives for volume but in now incentives for VALUE

Value Based Reimbursement

- Translation:
  - SNF Quality Reporting Program (QRP)
    - The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires:
      - Beginning 2018 if a SNF fails to submit required quality data to CMS under the QRP then they will have their annual updates (rates) reduced by 2%
      - The three quality domains are:
        - Skin integrity and changes thereto;
        - Incidence of major falls; and
        - Functional status, cognitive function, and changes thereto

Affordable Care Act

- No one saw this coming…..
- Section 6106 of the ACA requires facilities to electronically submit direct staffing information (including agency and contract staffing) based on payroll and other auditable data.
- Hence, Payroll-Based Journal (PBJ)

ACA – PBJ

- CMS intends to collect staffing and census data through the PBJ system on a voluntary basis beginning October 1, 2015 and on a mandatory basis beginning July 1, 2016.
- Registration for voluntary submission will begin in August 2015 and CMS will communicate more information at that time.
- What follows is the first step in in implementing section 6106.

PBJ

- PBJ Policy Manual – available in draft form
- PBJ Technical Information
  - PBJ 1.0 Submission Specifications V 1.00.0 for October 1, 2015 release
    - PBJ data specs PDF files ZIP
    - PBJ data directory ZIP
    - PBJ data specs CSV files ZIP
    - PBJ data specs HTML files ZIP
    - PBJ data specs XML and XSD files ZIP
- Questions can be sent to: NursingHomePBJTechIssues@cms.hhs.gov

PBJ

- A conference call was held on June 22nd. This is a summary of the 1 hour conference call.
  - How will the system account for additional hours worked (over 40) by salaried/exempt staff?
    - CMS will only collect hours paid.
  - How will the system track a salaried employee "wearing multiple hats"/split time?
    - The primary function is what matters and what should be reported. We want to prevent workers from having to swipe in and out every time they change tasks related to different work areas.

PBJ

- CMS is 'laser-focused" on the best data they can obtain in an accurate way.
- It is not yet clear how this data will be used in a Five-Star

- Not all providers receive billing statements from contractors delineating the staff who have worked in a center by name, date and hours worked….How does CMS account for this additional financial burden?
  - CMS staff asserted that he did not fully understand this question

PBJ

- Providers may only submit staff hours for those individuals who are paid by the center (either as employees of through agency or contract). Hours worked by staff who are paid through other means (e.g., private pay, directly from Medicare or Medicaid, long-term insurance, etc.) may not be submitted by providers.

- How will the system track a Medical Director also serving as an attending physician?
  - These are difficult things but it is clear we have to know the hours of the staff that were allocated to nursing home residents or are billable to another payer. There should be a reasonable methodology to do this.

PBJ

- Documentation burden on Providers?
  - According to CMS staff, providers need to understand the CMS perspective. CMS will provide more clarity about what information will me looked at and how long it must be retained. It will be a burden in the beginning but CMS expects the burden to reduce over time. CMS anticipates the ability to quantify the burden during the voluntary submission period.
- CMS essentially cut & pasted the categories from the staffing form 671 – why are positions on the list that nursing homes don't typically use and also positions that do not necessarily fit into "direct care"?

PBJ

  - CMS staff believes most of the positions listed have some level of direct care in them
- Why does the system (CMS) need to know part-time vs. full-time staff?
  - CMS will figure this information out through data that providers submit. CMS will remove this requirement.
- Many concerns raised about the request for reporting one-day per month of resident census and daily for staff.
  - CMS is reviewing this and staff believes the voluntary submission period will "tell them more."

PBJ

- How will CMS address payroll corrections? For example, often the home is not made aware that an employee failed to clock in or out appropriately until the employee receives their pay check. Home make the correction manually and that may neve show up in payroll data nor in time and attendance data.
  - There will be 45 days after the end of the quarter to make corrections
- The table in the PBJ of labor/job codes/descriptions does not indicate which categories will be considered 'direct care.'

PBJ

- CMS staff stated, "we already talked about this." All categories are direct care.

Bad Debt Issues

- Provider must submit a bad debt list that, at a minimum, contains all data required per CMS Exhibit 2
- The Bad Debt list must agree with the amount claimed on the cost report.
- Provide listings in an electronic format (Excel is preferred.)

Bad Debt Issues

- The bad debt listing MUST contian the data elements listed:
  - Patient Name
  - HIC Number
  - Dates of Service
  - Indigency status and Medicaid number, if applicable
  - Date first b ill sent to beneficiary
  - Date Collection Efforts Ceased/Write off date
  - Medicare RA date
  - Deductible or Coinsurance
  - Total Medicare write off
  - Medicaid RA date

Collection Efforts

- Collection effort includes actions such as subsequent billings, collection letters and telephone calls or other contacts
- Collection effort may include using or threatening to use court action to obtain payment
- Collection effort is consistent between payer class
- Efforts must be genuine, not token

Collection Efforts

- Indigent Determinations
  - Patient's file must contain documentation of the method by which the patient was determined to be indigent
    - Patient's total resource analysis (Asset test)
      - Providers must use their customary methods for determining the indigence of Medicare patients; they cannot have a different resource and income analysis for determining the indigence of Medicare patients
      - Comparison of patient's income to the federal poverty guidelines is not sufficient
      - Determination should be made at time of admission or shortly thereafter

Collection Efforts

- Use of a Collection Agency
  - A bad debt cannot be claimed as worthless if it is referred to the collection agency for additional collection effort and has not been returned to the provider as uncollectable.
  - The bad debt can be claimed after the collection agency has deleted accounts from the patient's credit bureau file, ceased their efforts and informed the provider that the account was uncollectable.
  - NOTE: If the account was referred to the credit bureau by the provider and not the collection agency, the provider doe NOT have to ensure the account is deleted from the credit bureau file before claiming the bad debt

Collection Efforts

- Use of a Collection Agency (continued)
  - Review the provider's contract with the collection agency to ensure that it is not conflict with Medicare guidelines
  - If the provider uses multiple collection agencies, ensure amounts are not referred to different collection agencies based on financial class.

Collection Efforts

- Use of a Collection Agency (continued)
  - Obtain a copy of the collection agency report that should include
    - Patient name
    - Date placed with the agency
    - Amount placed with the agency
    - Current balance
    - Date account was returned to the provider from agency
  - Disallow the bad debt if the provider cannot supply documentation from the collection agency that the non-indigent account was turned over to the collection agency

Collection Efforts

- Disallow bad debts if the re is no clear evidence that the accounts were returned from collection
- Disallow the bad debts if the provider does not furnish documentation form the collection agency to support that the accounts were deleted from the patients credit bureau file by FYE
- An affidavit is testimonial evidence and is generally NOT sufficient documentation. The provider is responsible for obtaining and maintaining documentation form the collection agency at the time the account is returned
- Request account history transaction details

Collection Efforts

- Provider Responsibilities
  - Submit a complete and accurate bad debt list that agrees with the amount on the cost report
  - Ensure the amounts on the bad debt list are only for unpaid deductible and coinsurance. DO not include coinsurance for Part B professional fees or fee based services
  - Ensure that claims for bad debts have been reduced by patient and third party payments
  - Ensure that claims previously reimbursed have not been claimed against

Collection Efforts

- Provider Responsibilities (continued)
  - Ensure the bad debt list does not have duplicate current year or prior year write-offs
  - Submit a bill to the patient or responsible party shortly after discharge
  - Bill the state Medicaid agency timely for dual eligible beneficiary claims. Maintain a copy of the Medicaid remittance advice (RA)

Collection Efforts

- Provider Responsibilities (continued)
  - Maintain auditable records to support the collection efforts and/or indigent determinations. Ensure indigent determination considers total resources and is not based solely on income
  - Ensure collection agency maintains documentation of referral and request for removal of accounts from credit bureau files
    - Generally, the transaction details (history) list when the account was referred to the credit bureau and when it was deleted from the credit bureau file
  - Do not claim Medicare bad debts until after the collection agency returns the account to the provider as non collectible

Collection Efforts

- Provider Responsibilities (continued)
  - Maintain documentation of verification of no estate for deceased patients
    - County records Probate Court
  - Provide listing of Medicare recoveries and maintain audit trail to document accumulation of Medicare recoveries
  - Respond timely to requests from the Medicare contractor for bad debt documentation

Collection Efforts

- Provider Responsibilities (continued)
  - Ensure the bad debt can be completely documented before putting it on a bad debt listing.
  - Unusual circumstances do arise; document efforts to obtain information in the patient file.
  - Be proactive rather than reactive – contact your MAC for guidance if you are unsure as to whether the bad debt can be claimed and if alternative documentation would be sufficient.