HEALTH FINANCIAL SYSTEMS

User' s Meeting – August 2017
Skilled Nursing Facility Issues and Update

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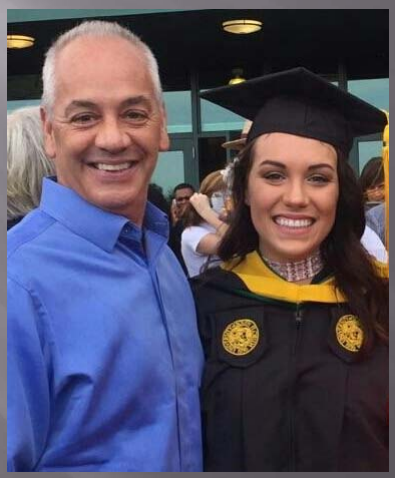

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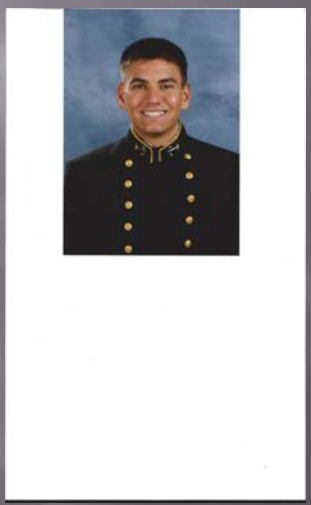

Topics

- Hot Topics
  - New Medicare ID Cards
  - IRS Issues
  - MEDPAC
- Bad Debt Issues
- Collection Efforts
- Medicare Appeals Process
- What's Next?

New Medicare ID Cards

- Affects 5.7 Million Americans
  - Fraud Prevention
    - The new cards remove the SSN
    - "Medicare Beneficiary Identifier"
  - Starts mailing out in April 2018 for Congressional mandated implementation date of April 2019
  - 21 Month transition period
    - Allows Beneficiaries and Providers time to phase in
    - CMS to provide a look-up tool

New Medicare ID Cards

- Folks 65 years old or older are victims of identity theft crimes
  - From 2012 to 2014 ID theft in the elderly increased from 2.1 million to 2.6 million individuals
  - 2/3rds of those affected experience both a
    - Financial loss
    - Emotional toll

Medicare and the IRS

- Can the IRS intercept Medicare payments from CMS to the Provider?
  - Yes – if the tax bill is significant and the owners are uncooperative.

MEDPAC

- Medicare Payment Advisory Commission
  - Letter dated June 21, 2017 – commenting on the Federal Register Volume 82, Number 85, page 20980 May 4, 2017
  - *Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities: Revisions to the Case-Mix Methodology*

MEDPAC

- MEDPAC suggests the following 'reforms'
  - Consider a single base rate with an empirically-based adjuster that targets payments to only isolated provides with low volume.
  - Classifying SLP and Non-therapy Ancillary Services as risk adjusters when related to medical necessity rather than part of the Case Mix
  - Adjust daily payments so that they are higher at the beginning of the stay rather than level throughout the stay

MEDPAC

- MEDPAC reforms – continued
  - Cap (at 25%) the share of therapy minutes furnished concurrently. CMS/MEDPAC is concerned that when therapy minutes no longer count in assigning patient days to a case-mix group for payment, providers will increase the use of concurrent therapy.

MEDPAC

- MEDPAC reforms – continued
  - Interrupted stays
    - About 25% of SNF stays involve multiple stays
    - Without a provision for interrupted stays the stay would start all over again at a higher rate
    - MEDPAC says if the resident returns within 3 days it is part of the same stay

MEDPAC

- MEDPAC reforms – continued
  - Currently Medicare requires assessments on days 5, 14, 60 and 90 of a resident stay
  - MEDPAC recommends fewer assessments but that the initial assessment occur with the first three days

MEDPAC

- MEDPAC reforms – continued
  - MEDPAC continues to believe that, "for the 16th consecutive year" the Medicare margin was over 10% (MEDPAC claims the Medicare margin in 2015 was 12.6%). Accordingly, MEDPAC suggests that payments to SNF's NOT be increased for the next two years and that any market basket updates be eliminated.

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 contain the data elements listed:
  - Patient Name
  - HIC Number (soon to be the MBI)
  - Dates of Service
  - Indigency status and Medicaid number, if applicable
  - Date first bill 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 there is no clear evidence that the accounts were returned from collection
- Disallow the bad debts if the provider does not furnish documentation from 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.

Medicare Appeals Process

- *Medicare Program: Changes to the Medicare Claims and Entitlement, Medicare Advantage Organization Determination, and Medicare Prescription Drug Coverage Determination Appeals Procedures* final rule
- Streamlines administrative appeal processes, increases consistency in decision making across appeal levels, and improves efficiency for both appellants and adjudicators, and in particular benefits Medicare beneficiaries by clarifying processes and adding provisions for increased assistance when they are unrepresented

Medicare Appeals Process

- Sustained increase in the number of appeals
- Modest increases in funding
- Significant backlog of appeals at the 3rd and 4th level
  - 3rd Level is administered by the Office of Medicare Hearing and Appeals (OMHA)
    - Conducts Administrative Law Judge (ALJ) hearings
  - 4th Level is the Department Appeals Board (DAB)
    - Medicare Appeals Council

Medicare Appeals Process

- 3 Prong strategy to address the backlog
  - Invest new resources at all levels of appeal to increase adjudication capacity and implement new strategies to alleviate the current backlog
  - Take Administrative actions to reduce the number of pending appeals and encourage resolution of cases earlier in the process
  - Propose legislative reforms that provide additional funding and new authorities to address the appeals volume

Medicare Appeals Process

- Changes to the Appeals Process
  - Permit designation of Medicare Appeals Council decisions as precedential
    - Provides more consistency in decisions at all levels,
    - Reduces the resources required to make decisions,
    - Possibly reducing the appeal rate by providing clarity to appellants and adjudicators

Medicare Appeals Process

- Changes to the Appeals Process
  - Expand OMHA's available adjudicator pool
    - Allow attorney adjudicators to decide appeals for which a decision can be issued without a hearing
    - Review dismissals
    - Issue remands to CMS contractors
    - Dismiss requests for hearings when an appellant withdraws the request

Medicare Appeals Process

- Changes to the Appeals Process
  - Simplify proceedings when CMS or CMS contractors are involved
    - Limit the number of entities (CMS or CMS Contractors) that can be a participant or party at the hearing

Medicare Appeals Process

- Changes to the Appeals Process
  - Clarify Areas of the Regulations
  - Create Process Efficiencies
    - Eliminate unnecessary steps
    - Streamline certain procedures (for example; using telephone hearings)
    - Require appellants to provide more information on what they are appealing and who will be attending the hearing

Medicare Appeals Process

- Changes to the Appeals Process
  - Address areas for improvement previously identified by stakeholders
    - Increase the quality of the process and responsiveness to customers
      - Establishing an adjudication time frame for remanded cases
      - Revising remand rules to help keep cases moving forward
      - Simplify the escalation process
      - Provide more specific rules on what constitutes good cause for new evidence to be admitted at appeal

Medicare Appeals Process

- Changes to Appeals Process
  for more information see:

- https://www.federalregister.gov/documents/2017/01/17/2016-32058/medicare-program-changes-to-the-medicare-claims-and-entitlement-medicare-advantage-organization.

What's Next?

RCS-1

- How about tossing the RUG IV Case Mix system and replacing it with
- Resident Classification Systems (version 1) [RCS-1]
  - Divorce therapy minutes from payments
  - Establish new case-mix components
  - Front load payments
  - Revise the assessment schedule

Medicare Cost Reports

- Now, more necessary than ever and more important that they are correct in order to set future rates.

THE END