

2010 Nursing Facility Reimbursement Update

HFMA Southern California

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Educational Session

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Financial Challenges 2010 and Beyond

- Perspective
- Decreased Levels of Funding
- Cash Flow
- Changing Payment Methodologies
- Greater Levels of Scrutiny
- Transparency
- Ability to Compete

Perspective - State Expenditures

State and Federal Funds Expenditures

- 2007/08 Actual = \$129.6 Billion
- 2008/09 Estimated = \$118 Billion
- 2009/10 Enacted = \$109.7 Billion

Spending Decrease

- Amount = \$19.9 Billion
- Percentage = 15 %
- For 2008/09 - State expended \$ 4.5 Billion more than it took in from revenue.

Perspective - State Budget Solutions

- Summary – Solutions 2008/09 and 2009/10 totaled nearly \$60 billion.
 - February 2009 – \$ 35.9 Billion
 - July 2009 - \$23.7 Billion
- Fiscal Year Impact 2008/09 - \$15 Billion
 - \$10 Billion - spending reductions
 - \$ 1 Billion – new revenues
- Fiscal Year Impact 2009/10 - \$ 45 Billion
 - \$ 22 Billion – spending reductions
 - \$ 11 Billion – increased taxes

2010 State Budget Medi-Cal Impact

- AB 1629 Rates
- Other Long Term Care Rates
- Related Benefit Eliminations and/or Reductions
- State Services Impact

AB 1629 Rates

- AB 1629 rates for 2009-10, effective August 1, 2009, were released ?
<http://www.dhcs.ca.gov/services/medical/Pages/LTCAB1629.aspx>
- Rates will be recalculated for the 2009-10 year based on 2007 cost reports.
- Weighted average rates cannot exceed the 2008-09 rate year. Excess will be applied proportionately on a facility-specific basis to rate increases and decreases.

AB 1629 Rates – Zero Budget CAP

- What does it mean that the excess (beyond the 2008/09 weighted average) will be applied proportionately to 2009/10 rates, both increases and decreases?
- 2009/10 Budget CAP adjusted for increase in QAF and mandate add-ons = 2008/09 weighted average \$162 + QAF + Mandates = 2009/10 Adjusted Budget CAP = Est. \$164.50.

AB 1629 Rates – Zero Budget CAP

- Budget CAP overage applied equally to all rates.
- Overage = Difference between 2009/10 Actual Calculated Rates and Adjusted 2009/10 Budget CAP.
- Projected Overage = 9%
- Applied equally to both increased rates and decreased rates.

Provider Impact

- Provider concern higher spending (costs) over prior year = If 2009/10 cost base (2007 costs) are greater than 2008/09 cost base (2006 costs) , AB 1629 reimbursement will be less than expected.
- Provider concern lesser spending (costs) over prior year = If 2009/10 cost base (2007 costs) are less than 2008/09 cost base (2006 costs), will result in a greater rate decrease.

AB 1629 Budget CAP Calculation

Increased Cost/Rate Increase

- Current Rate = \$140 (2008/09 Rate)
- AB 1629 2009/10 Calculated Rate = \$150
- AB 1629 Rate Increase \$10 (\$150 - \$140).
- 2009/10 AB 1629 Rate to Be Paid = 91 % of \$150 = \$136.50 CAPPED Rate .
- Loss of Reimbursement = AB 1629 Calculated Rate \$150 less CAPPED Rate of \$136.50 = \$13.50 loss. Loss from prior rate = \$3.50.

AB 1629 Budget CAP Calculation

Decreased Cost/Rate Decrease

- Current Rate = \$140 (2008/09 Rate)
- AB 1629 2009/10 Calculated Rate = \$135
- AB 1629 Rate Decrease = \$5 (\$140 - \$135).
- 2009/10 AB 1629 Rate to Be Paid = 91% of \$135 = \$122.85 CAPPED Rate .
- Loss of Reimbursement = AB 1629 Calculated Rate = \$135 less CAPPED Rate of \$122.85 = \$12.15 loss. (Total loss = \$17.15 (\$5 + \$12.15))

Other LTC Rates

August 2009 Medi-Cal Bulletin Number 390 - Rates will remain at the rates in effect as of March 1, 2009, subject to pending judicial determinations for:

- ICF
- ICF/DD, ICF/DD-H, and ICF/DD-N
- DP NF/B, DP NF B Subacute
- All Pediatric Subacutes
- Rural Swing Beds
- Adult Day Health

FY 2010 PPS Rates

CMS Final Rule of July 31, 2009, effective October 1, 2009

- Market Basket Adjustment = 2.2 percent or approximately \$690 million for FY 2010.
- Forecast error adjustment and productivity adjustment = reduction of \$1.05 billion for FY 2010.
- Net Impact = reduction of \$360 million for FY 2010.
- Estimated California impact = \$26 PPD.
- PPS Tool kit and information on FY 2010 PPS rates on CAHF members only section of web.

FY 2010 PPS Rate Adjustments Estimated Impact to California

- Recalibration of Parity Adjustment - PPD Estimate – at \$ 20 PPD = \$89.6 million Total
- Incorrect Application of SNF Wage Adjustment – PPD Estimate at \$ 6 PPD = \$27.2 million.
- Related Economic Impact
 - Business Activity Loss - \$155.2 million
 - Labor Income Loss - \$77.1 million
 - Job Loss – 2000

Decreased Levels of Funding

Decreased Levels of Funding

- Fallout from Current Recession
 - State Funding
 - Occupancy
 - ARRA Federal Stimulus
- Future of AB 1629 (Governor's Budget Item)
 - Sunset Extension
 - Future Budget CAPs
- Impact of Health Reform

ARRA – Federal Stimulus

- Stimulus – Temporary bridge for State Budget Shortfalls
 - Medicaid Relief to States \$87 Billion
 - Covers 27 months from October 1, 2008 through December 31, 2010.
 - Paid through enhanced FMAP
 - CA FMAP at 61.59%
 - California estimated to receive \$11.23 Billion for Medi-Cal
 - California 2009/10 Budget assumes \$8 Billion from ARA, total funds.

Stimulus 2 ?

- ARRA Provides Temporary Bridge
- Budget Cliff for all States – January 1, 2011
- Recent GAO Report Concerning
 - California Budget Shortfall for FY 2009/10 could approach \$7 Billion.
 - Budget shortfalls likely to continue over next several years.
- Current push on the Governor and California's Congressional Delegation to push for Stimulus 2.

2011 Outlook

- State
 - LAO November Estimate
 - Governor's 2010/11 Budget
 - Special Session Outcome
- National
 - President's Budget
 - MedPAC Recommendation
 - Health Reform

LAO Report – November 2009

- General Fund budget problem of \$20.7 billion between now and the time the Legislature enacts a 2010–11 state budget plan.
- Budget problem consists of a \$6.3 billion projected deficit for 2009–10 and a \$14.4 billion gap between projected revenues and spending in 2010–11.
- Revenue growth flat until 2012-13.

Governor's 2010/11 Budget

- No additional cuts to long term care.
- Relies heavily on additional federal revenue.
 - ARRA FMAP Extension
 - Permanent FMAP Change
 - Repayment of State funds paid for Medicare.
- Medi-Cal cost saving strategies
 - Managed care, Eliminates ADHC, Reduces IHSS
- Other triggers

Budget Special Session

- Resolved \$ 5.1 billion of the budget problem.
- Did not address the tough decisions.
- Solutions
 - Revenue - \$1.1 billion shift in gas tax.
 - Cuts - \$ 4 billion
 - State employee compensation.
 - Prison health care cuts.
 - Continued Regional Center 3% cuts.

President's 2011 Budget

- No specific cuts for long term or post acute care.
- Budget assumes Health Reform becomes law.
- Health Reform includes cuts to long term and post acute care.
- Budget is only a recommendation.

MedPAC Report/Recommendation

- Zero market basket update for 2011.
- Rationale
 - Access remained good.
 - Quality mixed
 - Access to capital good.
 - Payments between 2007-2008 outpaced costs.
- Medicare Margin
 - 2008 = 16.5% Projected 2010 = 10.3%

Health Reform

- White House February Summit
- Senate Bill is Base Document
 - Medicare cuts
 - Payment methodology changes
 - Additional program integrity provisions
 - Employer mandates
- Reconciliation process a possibility

Cash Flow

Cash Flow

- Latest State Controller Data
 - Diminishing State Revenue
 - Bridge to April Tax Receipts
- 2009/10 AB 1629 Overpayment Collections
- 2009/10 QAF
- April 19 WPS to Palmetto Transition
- Governor's Budget Proposal
- Furlough Friday Impact

CASH Outlook

Latest Information
State Controllers Report

SCO Reports

- February Report
 - January Receipts exceeded budget estimate by \$ 1.28 billion or 18.6%.
- March Report
 - February Receipts
- LTC remains on priority payment list.

AB 1629 Rate Overpayment Collections

- Rates Adjusted 60 days after posting.
- HP Enterprises (or successor) to process Erroneous Payment Correction (EPC).
- EPC will reverse all payments for Dates of Service 8/1/09 through cut off at old rate and pay new rate. Many providers will have significant accumulated overpayments.
- Overpayments of \$35 k or more to be collected over 8 check writes.

2009/10 NF B QAF

The California Department of Health Care Services (DHCS) has announced the following Quality Assurance Fees (QAF) for the 2009/10 rate year:

- \$11.16 per resident day for FS/NF-Bs and FS/Adult Subacute Facilities, the 2008/09 QAF was \$9.05 per resident day.
- The \$2.11 Increase driven primarily by Medicare revenue add.
- Invoices should have been sent out – Unofficial – payment at prior rate until 2009/10 AB 1629 rates are in place without penalty.

J1 MAC Transition

- Effective April 19, 2010, most WPS providers in California will transition to Palmetto GBA.
- Some chain providers may not be transferred to facilitate the chain's ability to bill one MAC.
- Palmetto GBA has created two resources:
 - A dedicated Web site.
 - FAQs.
- Website accessed through Palmetto site.

Changing Payment Methodologies

Changing Payment Methodologies

- Medi-Cal
 - Managed Care Expansion
 - COHS
 - Long Term Care Integration (LTCI)
- Medicare
 - MedPAC Recommendations
 - Other Changes

Medicare

- MedPAC Recommendations
 - Medical Homes
 - Bundling
 - Accountable Care Organizations
 - Pay for performance (P4P)
- Other Changes
 - MDS 3.0/RUGs changes (RUGS IV)
 - Program Integrity Enhancements

**Greater Levels of Scrutiny
RACs, MICs, and Other Audit Programs**

State Audit Update

- CAHF Advocacy with Senior DHCS Leadership
 - Failure to follow law (Medi-Cal Bulletin 389)
 - Failure to adhere to Regulations
 - Failure to follow professional Auditing Standards
 - Operational inefficiencies
- 2010 Outlook - New Optimism
 - New leadership, Retirements, Collaboration
 - Staff Training/ Centralized review

Recovery Audit Contractors (RACs)

- Demonstration
 - Purpose of the pilot required by the MMA (2003)
 - To determine whether use of RACs is cost--effective
 - Identify and collect Part A and Part B Medicare claims overpayments and underpayments that were not previously identified by the MACs
 - Division of Work
 - Medicare Secondary Payer Overpayments
 - Non-MSP Claims review
 - The Demonstration in 3 States
 - California, Florida and New York (with responsibility for Arizona, SC and MA)
 - Selected because they are the largest states in terms of Medicare utilization
- Demonstration ended in March 2008
- Tax Relief and Health Care Act of 2006 – Expanded program to all states no later than January 1, 2010

Problems

- Bounty Hunters – seeking to recover what you've been paid on contingency basis.
- Many problems in the California Demonstration
- AHCA and California affiliate went to CMS and the Hill
- Changes made for the permanent program

CMS Improvements to the RAC Permanent Program

- Coding experts
- Physician reviewers
- RAC physician medical director
- Credentials of reviewers provided on request
- Limits on # of medical records requested – CMS to establish limits
- All new issues a RAC wishes to pursue for overpayments validated by CMS or an independent RAC Validation Contractor
- Contingency fees to be paid back by RACs when an improper payment determination is overturned at any level of appeal
- Changing from a 4-year look-back period to a 3-year look-back period
- Maximum look-back date of October 1, 2007
- Web-based application that will allow providers to look up the status of medical record reviews
- Reason for review listed on request for records letters and overpayment letters
- Public disclosure of RAC contingency fees

RAC Timetable

- The RACs have already started recovery audits in Summer/Fall of 2009.
- Likely to be only “automated reviews” at first and “complex reviews” likely not to start until late Fall 2009/early 2010.
- “Medical necessity” complex reviews likely to begin early 2010.

October 2008 Award to 4 RACs For Permanent Program

- **Region A** -- Diversified Collection Services, Inc. (DCS) of Livermore, California
- **Region B** -- CGI Technologies and Solutions, Inc. of Fairfax, Virginia
- **Region C** -- Connolly Consulting Associates, Inc. of Wilton, Connecticut
- **Region D** -- HealthDataInsights, Inc. (HDI) of Las Vegas, Nevada

RAC Review Process

- RACs review claims on a post payment basis
- RACs use the same Medicare policies as FIs, Carriers and MACs
 - NCDs, LCDs & CMS manuals
- Two types of review:
 - Automated (no medical record needed)
 - Complex (medical record required)
- RACs will NOT be able to review claims paid prior to October 1, 2007
 - RACs will be able to look back three years from the date the claim was paid
- RACs are required to employ a staff consisting of nurses, therapists, certified coders & a physician CMD

Automated Review Process

- Review claims data – “data mining”.
- All potential issues approved by CMS.
- Claim determinations made at system level without staff intervention.
- Library of CMS rules, regulations, guidelines, and coding policies maintained and updated.

Complex Review Process

- All potential issues approved by CMS
- Additional documentation requests
- Medical record chart reviews
- CMS record request limits – (10% of average monthly claims/up to 200 claims per month)
- Review Team:
 - Coding review determinations (RN, Certified Coders, Therapists)
 - Medical necessity reviews will be performed by RNs who have access to Physician Reviewers as necessary.
 - MD oversight of reviews
- Complete documentation maintained in automated system

Appeal Issues

- Strategic Appeal Issues - Redetermination
 - 30 days to stop recoupment
 - 120 days to request redetermination
 - 11.375% interest accrues from date of determination
 - Cash flow – can extend repayment for 90 days from the date of determination (includes 60 days for redetermination decisions to be issued)
 - Impact of “rebuttal period” - up to 30 days

Appeal Issues (cont.)

- Strategic Appeal Issues - Reconsideration
 - 60 days to stop recoupment
 - 180 days to request reconsideration
 - 11.375% interest accrues from date of determination
 - Cash flow – $90+60+60 = 210$ days (Includes 60 days for reconsideration decisions to be issued)

Appeal Issues (cont.)

- One strategy – appeal all claims within 30 days at first level and within 60 days at second level
- Advantages
 - Cash flow (for a maximum of 210 days from date of determination or 330 days, if reconsideration)
 - Opportunity to reverse decision without impact
- Disadvantages
 - Accrue interest at 11.375%
 - Frantic timetable to assemble appeals

Appeal Issues (cont.)

- A Second Strategy – appeal some claims within recoupment limits
 - Based on amount in question?
 - Based on review of the merits?
- A Third Strategy – appeal claims within appeal but not recoupment limits
- ALJ, Medicare Appeals Council and Court Appeals

Provider Preparation

- Know where previous improper payments have been found (OIG, CERT, Demo RAC Reports)
- New issues are posted to the web – CMS appeal process
- RAC claim status web interface (2010)
- Detailed review results letter and denial letter following all complex reviews – “discussion period” opportunity/does not impact appeal deadlines
- Prepare to respond to RAC medical record requests – 45 day window
- Keep/submit proper documentation – point of contact/team building/organizational issues resolved
- Appeal when necessary - know timelines for appeal AND timelines to stop recoupment (*e.g.*, 120 days v. 30 days for first level appeal and 180 days v. 60 days for second level appeal)

Program Safeguard Contractors

- Like RACs, PSCs are part of the Medicare Integrity Program
- Not contingency fee contractors
- Function like RACs in the area of “complex review”
- Requirements for Medical Records – 45-day window
- Ability to cause recoupments (like RACs)
- Organize like RAC activities
- Activities have focused on Part A and Part B (MDS and therapy)

Medicaid Integrity Program (“MIP”)

- Created by Deficit Reduction Act (“DRA”) in 2005
- Establishes the federal government’s role in combating Medicaid fraud, waste and abuse
- Effective support and assistance to States
- Formation of Medicaid Integrity Group (“MIG”)
- Creation of Medicaid Integrity Contractors (“MICs”)

Goal of the MICs:

- Identifying and recovering overpayments

MIC Audit Process

- ID of potential audits through data analysis by review MICs
- Vetting potential audits with State and law enforcement
- Audit MIC receive assignment
- Contact with provider and scheduling of the entrance conference
- Currently in 20 states – Florida, South Carolina, Pennsylvania, Delaware, Georgia, Alabama, North Carolina, District of Columbia, Virginia, Kentucky, Maryland, Texas, Arkansas, Louisiana, New Mexico, Colorado, Oklahoma, California, Nevada, Idaho

Timing of Audits

- Should be at least two weeks notice before audit to begin
- Records request/preparation time (all over the place - 10 to 45 days)
- Desk or field audit
- Entrance conference (phone or in-person)

Look-Back Period

- Not set by MIG
- Relates to maximum period under state law
- Not always clear under state law
- Need to know/analyze state law

Audit Process (cont.)

- Intake questionnaire (work in process)
- Entrance conference
- Audit
- Review of preliminary audit findings and tentative conclusions
- Opportunity for provider to comment and provide additional information

Audit Process (cont.)

- Draft audit report to CMS and State for review and comments along with provider
- If revised, further review with State
- Draft audit report finalized
- CMS issues final report to State
- State has 60 days to repay federal government for its share

Audit Process (cont.)

- State issues final report to provider and begins overpayment recovery process
- Provider rights of appeal are those available under State law
- Settlement made complicated by feds recoupment from states
- If provider wins, what happens to state loss?

Relevant Issues

- Standards applied – known?
- Audit according to General Accepted Government Auditing Standards (“GAGAS”)
- Adequate time to produce all records
- Ability to stay recoupment
- Payment plan available?
- Timely Appeal Process/Overburdened State Appeal Process/Due Process

MIC PROGRAM

No Record Request Limitations

- No Limits on the Number of Medical Records a MIC can Request per Month
- Unlike RAC program
- Basic problem with MIP/MICs – no formal structure to program
- Compare and contrast to RAC

MIC Application of Standards

- Uncertain
- Push MIC to identify substantive standards utilized

Identified Audit Process Issues

- Requests for information outside of the scope of the audit (intake questionnaire)
- Short timeframe
- Looking back up to 5 years
- Duplicative of other audits
- Federal/State conflicts

Areas of Focus in LTC

- Accuracy of patient responsibility/share of cost
- Deceased patients
- Duplicative payment issues/impact of retro Medicaid rate changes can make it look like duplicate claims
- Bed-hold rate limitations

Prepare for RACs/MICs

- Establish internal team
- Interdisciplinary Team: Legal, Finance, Clinical, Compliance, IT
- Identify point of contact for internal and external communications
- Develop central tracking mechanisms/database for all - Incoming and Outgoing
- Coordinate the tracking mechanism with communications structure – record reviews, and appeal of recoupment deadlines

Prepare for RACs/MICs (cont.)

- Conduct internal reviews and audits to identify potential problems.
- Participate in trainings and outreach.
- Monitor news sources, CMS, associations, and your own reports to stay abreast of trends.
- If desired, development of unique forms for appeal levels once issues identified.
- Outline specific process to follow for responding to record requests.

Transparency

- Data Reporting
 - OSHPD
 - OSCAR
- Licensing
 - Corporate Structure
- Public Exposure
 - Five Star
 - Public Websites

Ability to Compete

- Future Operational Model
 - Changing Demographics
 - Consumer Choice
 - Physical Plant and Infrastructure
 - Age and condition
 - Design to meet operational needs
- Quality
- Technology
- Marketing

Questions And Hopefully Answers?