

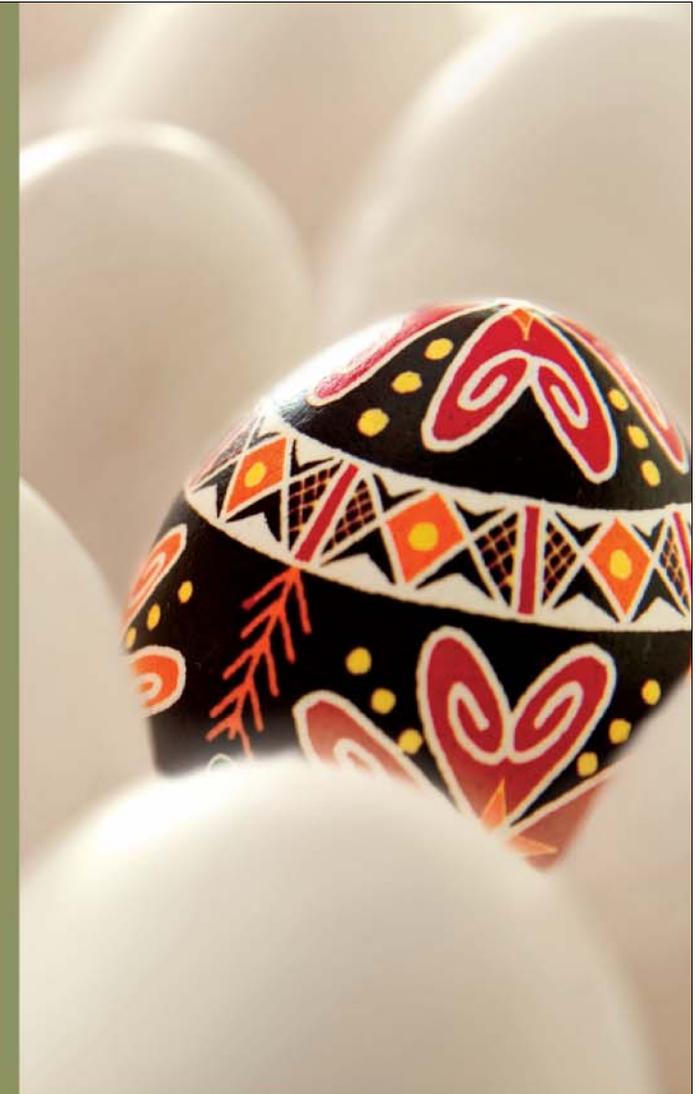
Watching Your Bottom Line Key LTC Reimbursement Updates and Trends

MHHA Institute for Older Adult Services
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**NOTICEABLY
DIFFERENT**

Reimbursement Challenges

Clinicians continue to be the drivers of reimbursement

- RAI staff turn-over and training issues
- Understanding MDS coding
- Understanding the RUG payment systems
- Multiple Payer Sources/Plans



The Last Year

- Multiple New Interpretive Guidelines with more on the way
- Report Cards
- QI/QM's
- Updates to the RAI Manual June 2006
- MSHO/Other Insurances
- All Quarterly Assessments Payment Assessments as of October 2006



New Interpretive Guidelines

- Pressure Ulcer
- Urinary Incontinence
- Psycho-social Needs
- Unnecessary Medications
- POCs and Unsuccessful Resurvey Process



Report Cards and QI/QM

- Understanding where the data is obtained from and impact to Pay for Performance
- Public Information
- Individual Resident Review is important but systems to evaluate and correct are equally important moving forward



RAI Manual Updates

- March 2006
 - Section W
 - Multiple changes in moving text and typos



RAI Manual Updates

- Posted Update of May 2006 has been removed as it was intended as a DRAFT
- June 2006 Update
 - P1a-k changed to P3a-k (nursing rehab must be in 15 minute blocks)
 - If therapy is not scheduled skip to T3 changed to T2 (performance section)
 - Page correction for the index for the Respite Resident
 - Update to state agency contacts and MDS RAI Coordinators



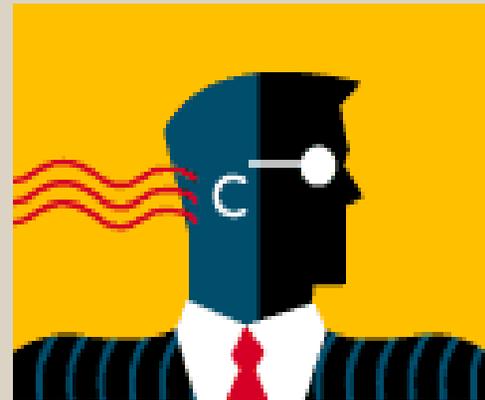
MSHO/Other Insurances

- While most plans have a case manager role in place, it is important that the facility also case manage to ensure proper coverage and maximum benefit utilization
- Understand each of the plans
 - Days of utilization
 - Updates required
 - Forms required
 - Schedule of MDS's
 - Levels of coverage
 - Inclusions/Exclusions



MSHO/Other Insurances

- Compliance with Plans
 - Audits
 - Future Incentives



Medica Dual Solutions

- Requires referrals for SNF admissions from “Care System”.
- First five digits of Medica subscriber number identifies the care system i.e. Evercare, Fairview Partners, HealthEast, etc.
- Care System contracts supersede Medica contracts.
- New mailing address: Medica, P.O. Box 30990, Salt Lake City, UT 84130.
- MSHO Staff: Ann Keefe, Operations Manager (952) 992-2874 and Sarah Keenan RN, Clinical Liaison (952) 992-2041.
- Timely filing of claims is 180 days.
- Website www.medica.com – Provider Resources



SecureBlue- BCBS

- Requires Nursing Home Communication Form to notify BCBS of admission and changes in condition.
- Some Part B services require prior authorization.
- Requires Medicare MDS to determine payment level.
- Mail paper claims that are not passing scanner to the attention of Vicki Vesey.
- Timely filing of claims is 15 months.
- Website www.bluecrossmn.com



UCare MSHO

- Requires prior authorization for SNF admissions and therapy.
- Telephone number for authorizations 1-877-447-4384 or 612-66-6705.
- Call 612-676-6622 to find out who Care Manager is for a particular resident.
- Do not put assessment dates on claims.
- 5-tiered contract.
- Evercare and Fairview Partners contracts supersede UCare contract.
- Timely filing for claims is 12 months.
- Website www.ucare.org



Senior Care Complete South Country Health Alliance

- Requires Nursing Home Communication Form for admissions and changes to condition.
- Also requests that local county CRMT is notified when skilled care is required.
- Contracts with Blue Plus for network and claims processing.
- Requires Medicare assessment to determine payment levels.
- Timely filing for claims is 12 months.
- Website mnscha.org



MDS Assessments

- Assessment cycles
 - Managing the assessments will impact revenues
 - Understanding of OBRA and PPS assessment cycles
 - Poor management can lead to major penalties
 - Double check your systems for:
 - ◇ Timely completion of assessments
 - ◇ Omissions of assessments



MDS Submission - Common Errors

- Assessments submitted out of sequence
- Inaccurate Reason Coding
- Discharge tracking form
- Example

Resident hospitalized and return anticipated.

Resident returns and Medicare covered

What is the reason for assessment?



Management of MDS Assessments

- Timing of Assessments
 - ARD scheduling to capture the highest number of index “drivers”; inclusion of the hospital look-back period for the 14 Day Medicare assessment
 - Payment Effective Date
 - Software scheduling mechanisms are static
 - Management of both Medicare and MA RUG system and assessment schedules
 - Understanding the RAI/MDS “rules”
 - Case Management of individual residents



Factors Which Affect Classification: Rehab

- Clinical Practice Changes
 - Nursing Rehab Programs
 - ◇ Formalize existing programs
 - Prioritize
- Continue to see errors in minute calculations
 - Mathematical errors
 - Inclusion of Evaluation time
- Evaluation of Part B utilization
- Billing remains the same



Factors Which Affect Classification: Clinical Indicators

- Common Omissions on the MDS
 - IV Medications (Extensive Care)
 - Transfusions (Clinically Complex)
 - Fever (Special Care)
 - Oxygen Use (Clinically Complex)
 - Respiratory Therapy (Special Care)
 - Depression Indicators (Clinically Complex)



Factors Which Affect Classification: Cognitive Status

- Understanding the Cognitive Performance Scale
- Important Cognition Questions
 - Short Term Memory
 - Daily Decision Making
 - Making Self Understood
- Higher Functioning Residents Only
 - ADL scores
 - ◇ 6-10
 - ◇ 4-5
- Highest revenue impact with Nursing Rehab Program implementation



Factors Which Affect Classification: Behavior

- Function of Frequency
- Ability to Quantify and Qualify
- Higher Functioning Residents Only
 - ADL scores
 - ◇ 6-10
 - ◇ 4-5
- Compliance still requires interventions



Factors Which Affect Classification: Nursing Rehab

- Nursing Function
- Ability to Quantify 15 minutes per day
 - Supporting Documentation
- Define into MDS categories in Section P
- Necessity based on evaluation
 - By virtue of good clinical practice all facilities should see some nursing rehab
 - Percentage will depend on client base
- Compliance issues



Managing of Multiple Priorities

An American Proverb

You can not leap a twenty foot chasm with two 10 feet jumps



Medicare Bad Debt

- Bad debt can be claimed on Medicare cost reports for dual eligible residents when coinsurance has not been paid by MA or PMAP plans.
- Coinsurance must have gone through the entire payment process and DHS has sent a “Paid Secondary” remit to the facility.
- Medicare will disallow bad debt claims for a number of reasons.



Medicare Bad Debt

- Medicare will disallow bad debt where the:
 - MA remit is denied rather than paid secondary.
 - Write off date is before date of MC or MA remit.
 - Write off date is not in current year.
 - Date of MA remit is not in current year.
 - Bad debt is from a private Medicare Advantage Plan such as Humana Gold.
 - No proof of MA eligibility documented for PMAP plan.
 - No collection efforts were made.



Medicare Bad Debt

- If Medicare has disallowed bad debt due to denied MA remits, you can e-mail Greg Leahy at DHS greg.leahy@state.mn.us with the following information:
 - Provider name and MA #
 - Recipient name and MA #
 - 17 digit TCN (claim) #
 - Dates of Service
 - Amount Medicare paid including coinsurance



Medicare Bad Debt

- For PMAP residents, the documentation to support the bad debt must include:
 - Proof that the resident was eligible for Medicaid for the dates of service claimed on the bad debt report.
 - ◊ You can usually print this from the eligibility screen on MN-ITS.
 - PMAP remittance advice that shows non-payment.



Medicare Bad Debt

- If the disallowed bad debt is in prior year and you now have the paid secondary, you may need to ask for a reopening of a prior year cost report.
- However, Medicare just recently has been disallowing bad debt due to MA remits being dated after the fiscal year end.
- You can still claim the bad debt on your current year's cost report, but you may need to reverse the original write off and write them off in the current year. We have seen some disallowance of bad debt because it was written off in a different fiscal year.



Glucose Billing

- Rules for Glucose billing were clarified in the final rules for the 2007 Physician Fee Schedule.
- Tests must be ordered by physician who is treating the beneficiary.
- Physician must use the results promptly in the management of the beneficiary's medical condition.
- Physician must certify that each test is medically necessary.
- A standing order is not sufficient to order a series of tests.
- Applies to all providers of services.



Therapy Caps Exceptions

- Therapy cap amounts did not change for 2007. Still \$1,740 for combined PT and Speech and \$1,740 for OT annually.
- Legislation granted an extension to the therapy caps exception process to December 31, 2007.
- The manual process of asking for exceptions expired 12/31/2006.
- Therapy cap exceptions for 2007 will use the automatic process only.



Therapy Caps Exception

- Exceptions are granted for medically necessary services if conditions described in the Medicare Claims Processing Manual (100-04) Chapter 5, section 10.2 are met.
- ICD-9 codes describe the most typical conditions and complexities.
- Download MedLearn Matters article for table of ICD-9 codes by discipline.
www.cms.hhs.gov/MLNMMattersArticles/downloads/MM5478.pdf



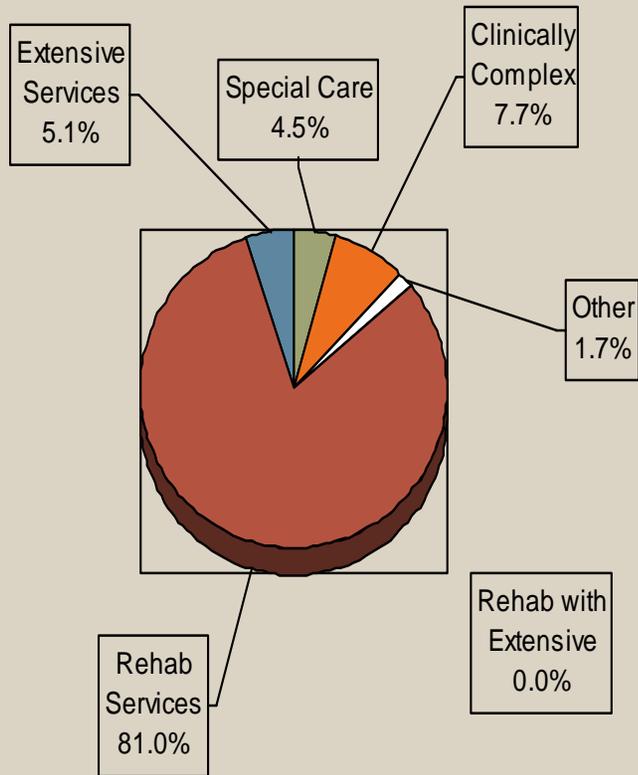
Rehab With Extensive Care

- In January, 2006, Medicare established 9 new RUGS codes in a category called Rehab With Extensive Care.
- What has been the effect of these new codes?
- We did a comparison of the census data from 18 facilities for the period of October 1, 2005 – September 30, 2006 to the average census data of all of our clients for 2005.
- The following chart shows the results of our comparison.

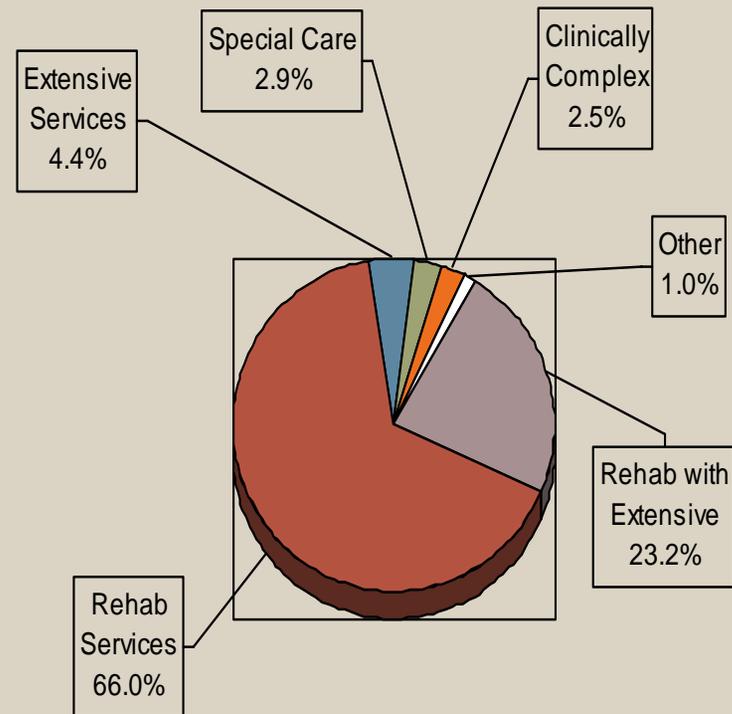


Rehab with Extensive Services Changes In Census Data

LarsonAllen 2005 Cost Comparison



Census Data 2006



Rehab with Extensive Services

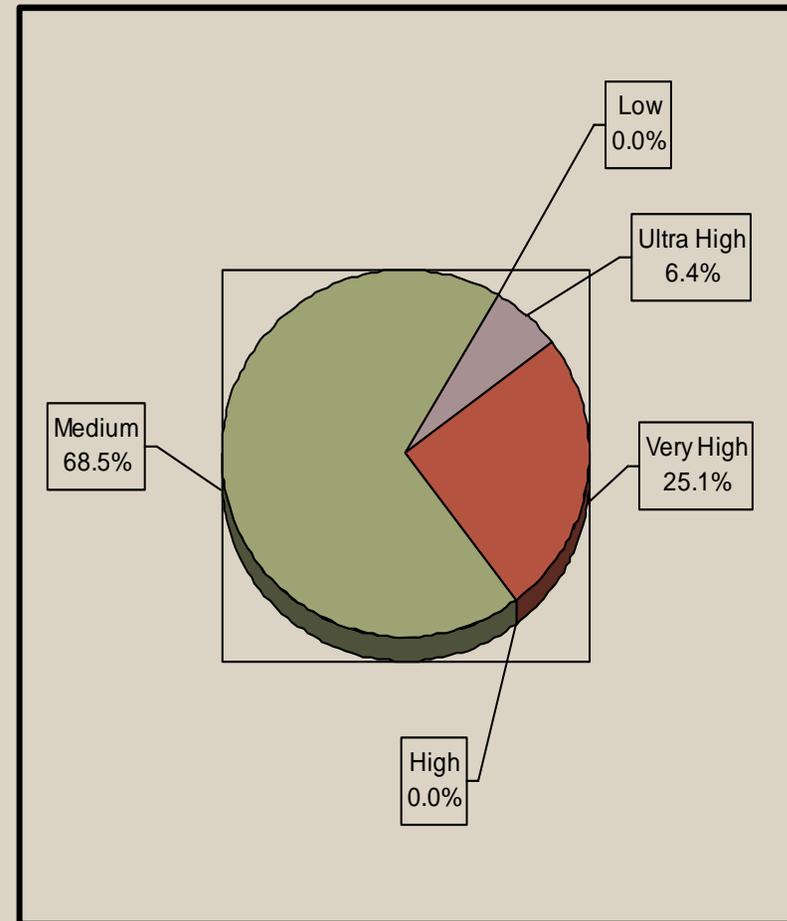
Results Of Comparison

- In this sample of facilities, overall therapy census increased from 81% to 89.2% of Medicare days.
- Rehab With Extensive Services accounted for 23.2% of the Medicare therapy days.
- The remaining RUGS categories all show a sharp decline in census days.



Rehab With Extensive Services

- No census days were recorded for the high or the low categories.
- Majority of the days in this sample were in the medium range at 68.5%
- Ultra high and very high account for the remainder of the days recorded in Rehab with Extensive Services.



Rehab with Extensive Services

Dollars and Cents

- What does this mean in dollars and cents?
- In this sample, the average payment per therapy day before January 1, 2006 was \$355.23.
- After January 1, 2006, the average payment per therapy day was \$354.99 for a difference of (\$.24) per day.
- Average annual loss on payment for Medicare therapy with the addition of the new codes calculated out to be \$409.48 per facility.
- Individual facilities annual losses ranged from \$1365 all the way down to \$34.50.



Medicare Updates 2007

- Pay For Performance
- STRIVE Project
 - Staff Time and Resource Intensity Verification Project



Medicaid Quarterly Assessments

- Prior to October 1, 2006, RUGS levels for payment purposes on MA and Private Pay residents were based on the assessments done at admission, 2nd quarterly and annually.
- Effective October 1st, 2006 every quarterly assessment changes the RUGS level for payment.
- What effective did this change have on facility's revenue?



Medicaid Quarterly Assessments

- We did an analysis of five facilities revenues for the period of Oct. 1 – Dec. 31, 2006 to attempt to answer that question.
- The method used was to calculate the percentage of days in each RUGS class before and after quarterly assessments were required using the old and new census days for MA and Private Pay residents from the Oct. 1, 2006 rate notice.
- We then applied those percentages to the actual census days for the three month period and calculated an “expected revenue” amount.
- The “expected revenue” amount was then compared to the actual revenue for the quarter.

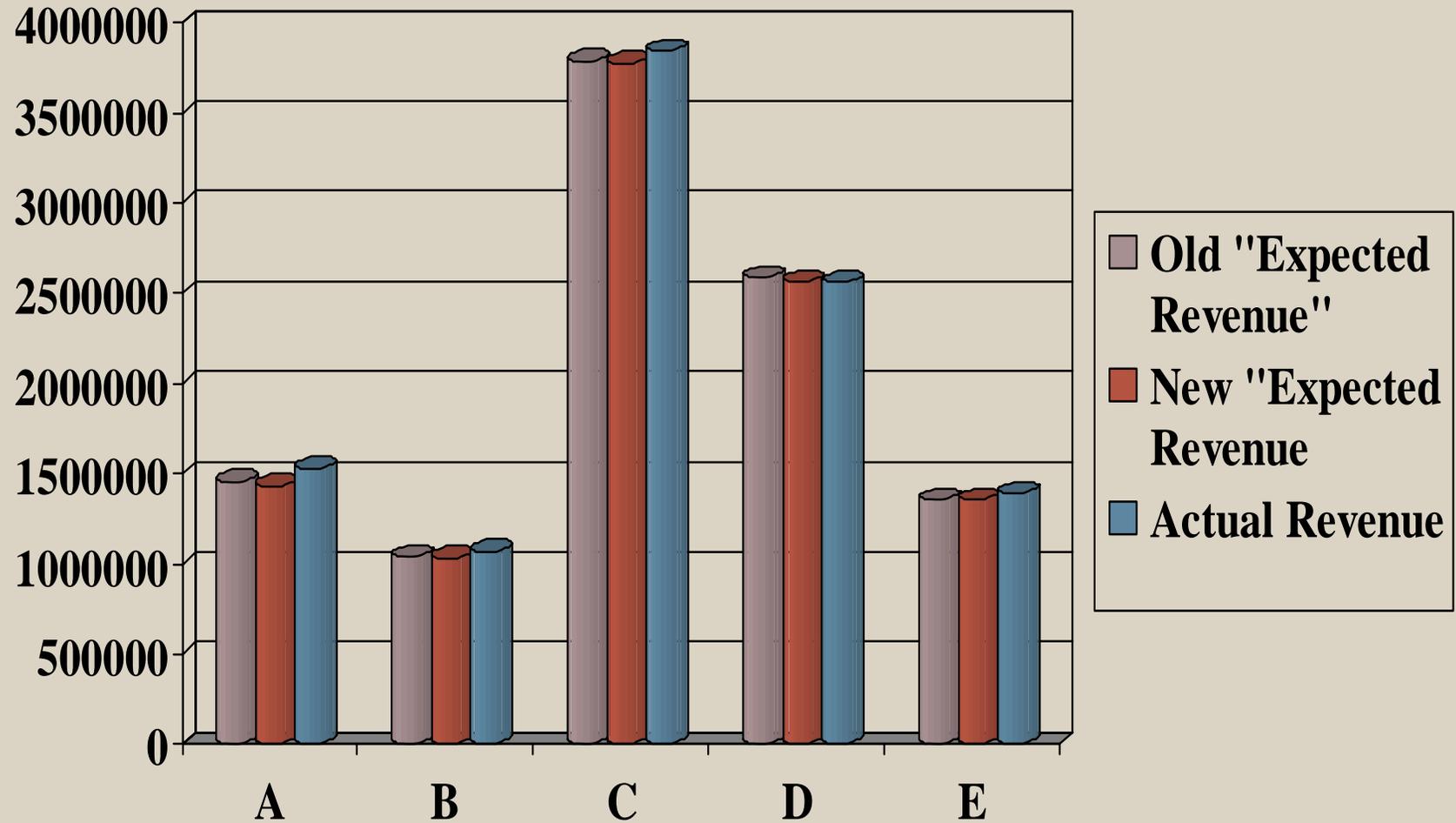


Quarterly Assessment Results

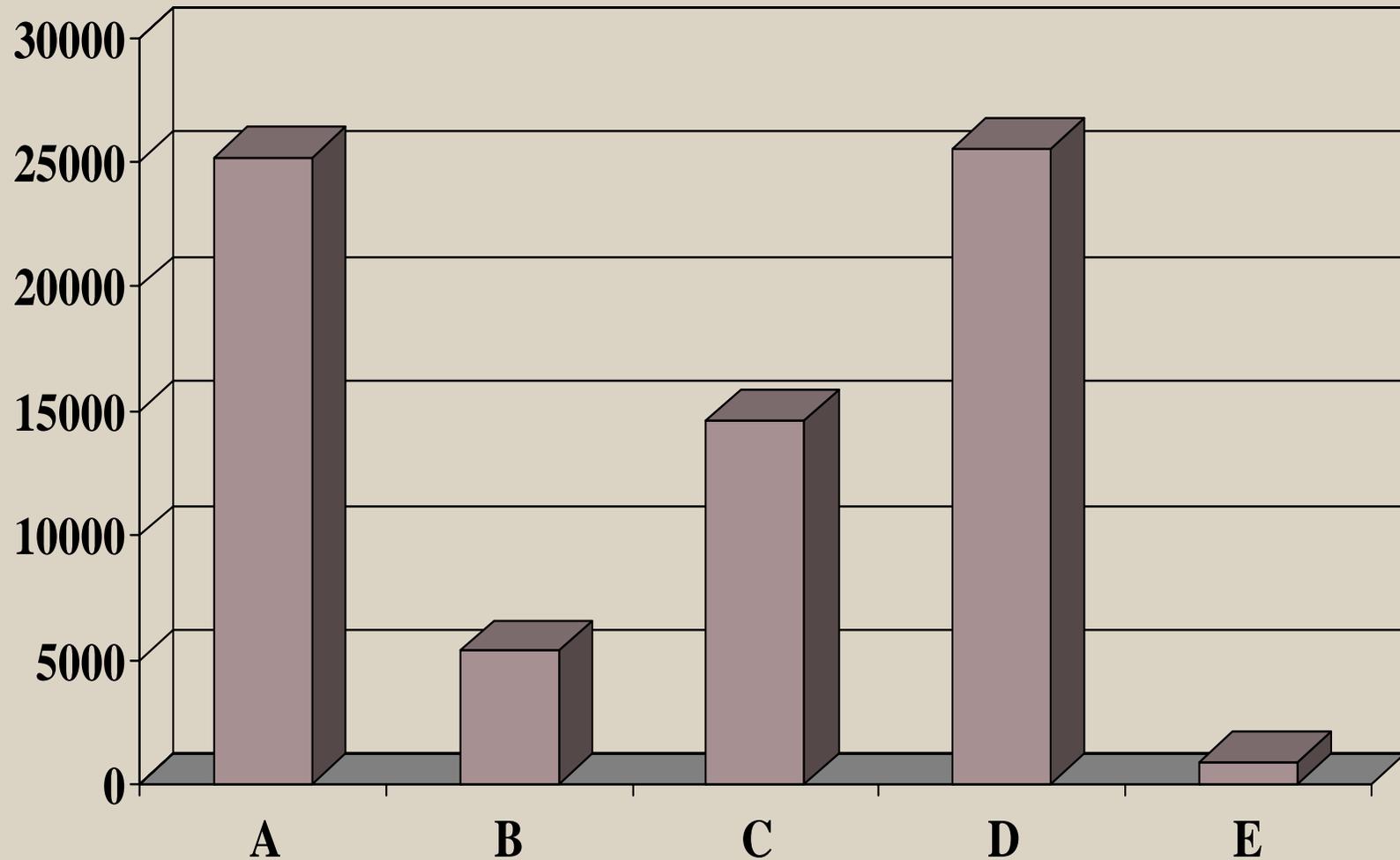
- Four of the five facility's actual revenue was higher than the "expected revenue" calculations.
- All five facilities experienced lower "expected revenue" results with quarterly assessments than the "expected revenue" results with the old assessment schedule.
- Four of those facility's "expected revenue" differences were significant.
- Will facilities generally be adversely affected by change in assessment schedule? Were the quarterly assessments sent in to DHS for the conversion not as accurate as they could have been? Or are the results due to other factors?
- See graphs on the next slides to view results.



Results Of Calculations



Differences Between Old and New Expected Revenue Calculations



Quality Add-On Payments

- Five areas are being measured for quality that can result in additional payments to facilities.
 - MDS Quality Indicators
 - Employee Turnover
 - Employee Retention
 - Use of Nursing Pool
 - MDH Surveys



Quality Calculations

- Quality Indicators are based on 23 areas of the MDS and are risk adjusted for the proportion of residents having health conditions putting them at risk for the outcome.
- Employee Retention is based on the number of direct care employees employed at the beginning and still employed at the end of the year divided by the number of direct care employees. A facility must fall within 60% and 85% retention for earn any points.



Quality Calculations

- Employee turnover is computed by the number of employees who left between the beginning and end of the year divided by the number of direct care employees. Only terminated employees count as turnovers. Transfers between jobs do not count in this calculation. Nor do employees in their probationary period. Facilities must fall between 21% and 69% to earn any points.
- Pool Use is based on the average percentage of pool hours used by those facilities reporting any pool utilization. Points are scored for any facility that has between zero and two times the average use of pool hours.



Quality Calculations

- MDH Surveys – 17 care related deficiencies were identified as most important in measuring quality of care. A facility will earn ten points if they do not receive any of the specified deficiencies or if they receive deficiencies in these areas but only with a scope and severity lower than level F.
- A facility will receive five points if they received one or more deficiencies in these areas determined to be at a scope and severity of a level F or G.
- If a facility received one or more of the specified deficiencies determined to be at a scope and severity of a level H or higher, no points will be awarded.



Quality Add-On Payments

- The maximum add-on payment available for October 1, 2006 rates was 2.4%.
- To receive the maximum add-on payment, a facility must have received a score of 100.
- Any facility receiving less than 40 points on the quality scores did not receive any add-on payment to their rates.
- Highest add-on received for any facility was 2.18%.



Quality Add-On Payments Average and Maximum Points

Quality Measure	Average Points	Maximum Points
Quality Indicators	24.1	40
Employee Retention	12.6	25
Employee Turnover	9.7	15
Pool Use	8.8	10
MDH Surveys	9.4	10
Total Quality Score	64.5	100



Quality Add-On Payments

Changes for October 1, 2007 Rates

- Customer satisfaction survey results will be added to the quality scoring.
- Employee turnover will be data will not be collected.
- Employee retention data will include employees still in their probationary period.



Nursing Facility Performance Based Incentive Payments

- Nursing facilities can contract with DHS to earn up to five (5%) of their operating rate by submitting projects that meet criteria outlined in DHS Bulletin 06-62-01.
- DHS received 155 applications and are currently negotiating with 19 of them.
- Payments for these projects would not begin until on or after October 1, 2007.
- \$1.2 million in state funds is available for 2007.
- Another round of applications is scheduled for 2008 where DHS expects to contract with another 140 facilities.
- \$6.7 million in state funds available for 2008.



Property Rate Adjustments as a Result of Remodeling

- Property rates are adjusted for cost of remodeling projects that are not subject to moratorium exceptions.
- Effective October 1, 2006, APS facilities are now eligible for changes in property rate for building projects.

Minimum Threshold
\$247,197

Maximum Threshold
\$1,264,751



Nursing Facility Planned Closure Rate Adjustments

- \$2,080 per bed limit on planned nursing home bed closures eliminated as of March 1, 2006.
- No cap except the proposal, along with the other approved proposals, cumulatively, has no cost to the state.
- “PCRA Pool” will be established.
- Rate adjustments can be assigned to your facility or to a different facility.
- Planned closures must meet all criteria established by MN Statutes. Resident relocation laws most important.
- More information can be found in DHS bulletins #01-62-04, #04-62-01, #05-62-03 and #06-62-01.



Bed Layaway

- Bed layaway plan is still available.
- Taking beds on and off layaway affect property rate.
- Beds on layaway for longer than 5 years will be permanently de-licensed.
- If the beds are not going to be returned to service, it may be a good time to submit a planned closure property rate adjustment proposal.



Questions?

- Contact information
- LarsonAllen 612/376-4642
- Augustana Care Corporation 612/238-5277

