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Summer Series

July 25, 2019

Date You To Move
HFMA Association 2019-2020 Theme

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Agenda

Time	Session	Speakers/Panelists
11:00AM	Registration & Lunch	
11:10AM	Welcome and Opening Remarks	**Mindy Scher** , President 2019-2020, HFMA San Diego
11:15 AM-12:15PM	Strategies for Improving Mental Health Services Delivery by the County of San Diego	**Dr. Luke Bergmann,** Behavioral Health Director **Dr. Nicole Esposito,** Assistant Clinical Director
12:15 PM-12:50 PM	Overcoming Mental Health Billing Complexities	**Joe McDowell**, Xtend HealthCare
12:50-1:00PM	Closing Remarks	

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hfma DY2M 2019-2020

County Of San Diego

Financial Strategies for Behavioral Health Population in San Diego County

Presented by:

Dr. Luke Bergmann, Director Behavioral Health

Dr. Nicole Esposito, Assistant Clinical Director

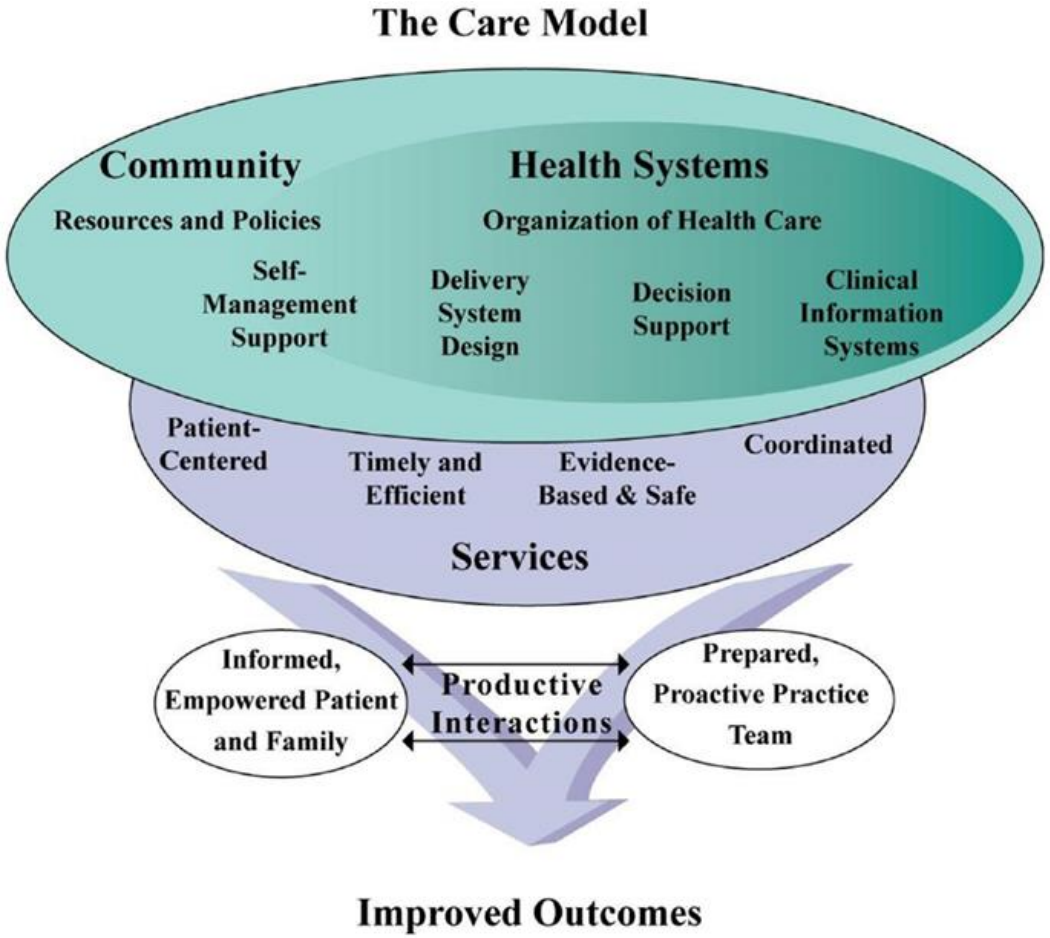
Behavioral Health Services
County of San Diego

Healthcare Financial Management Association Summer Series 7/25/19

Dr. Luke Bergmann, Director
Dr. Nicole Esposito, Assistant Clinical Director

LIVE WELL SAN DIEGO

Provider's Perspective: Finances & Collaborative Care



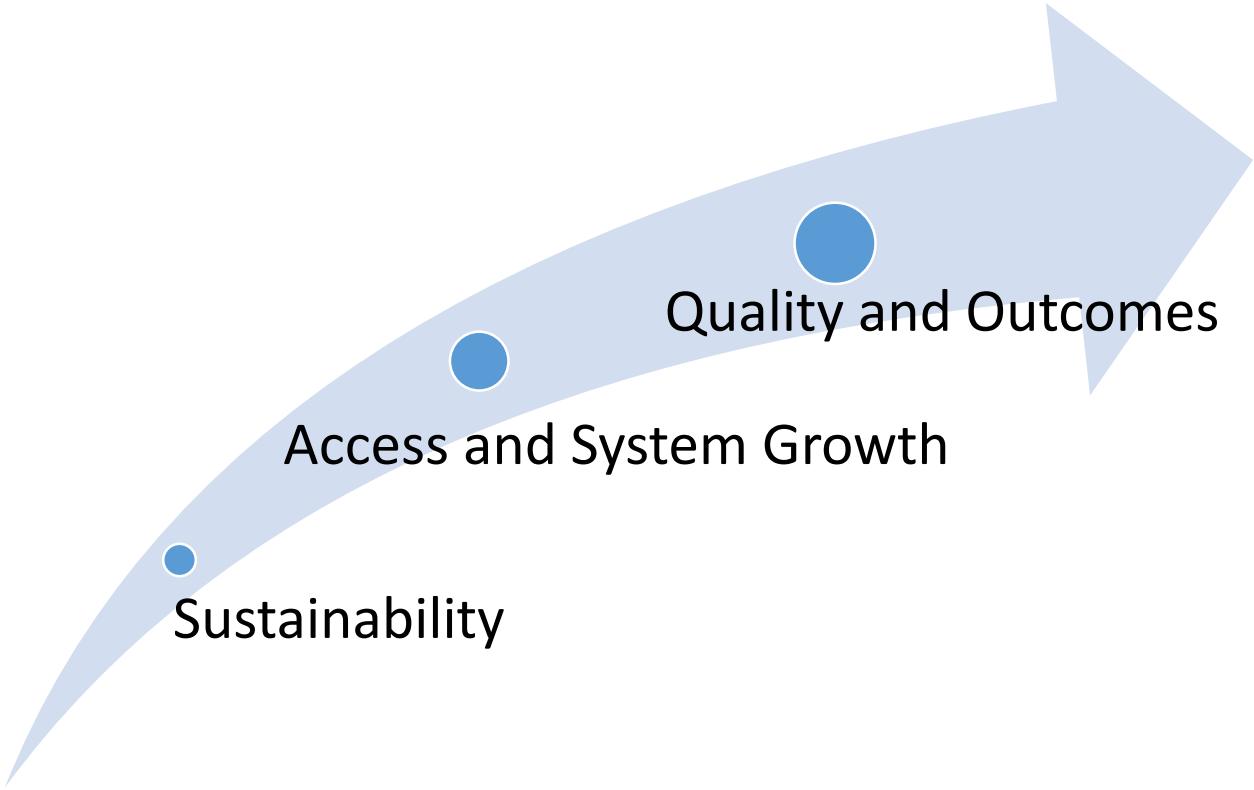
Drug Medi-Cal Organized Delivery System

SUD into Mainstream Healthcare

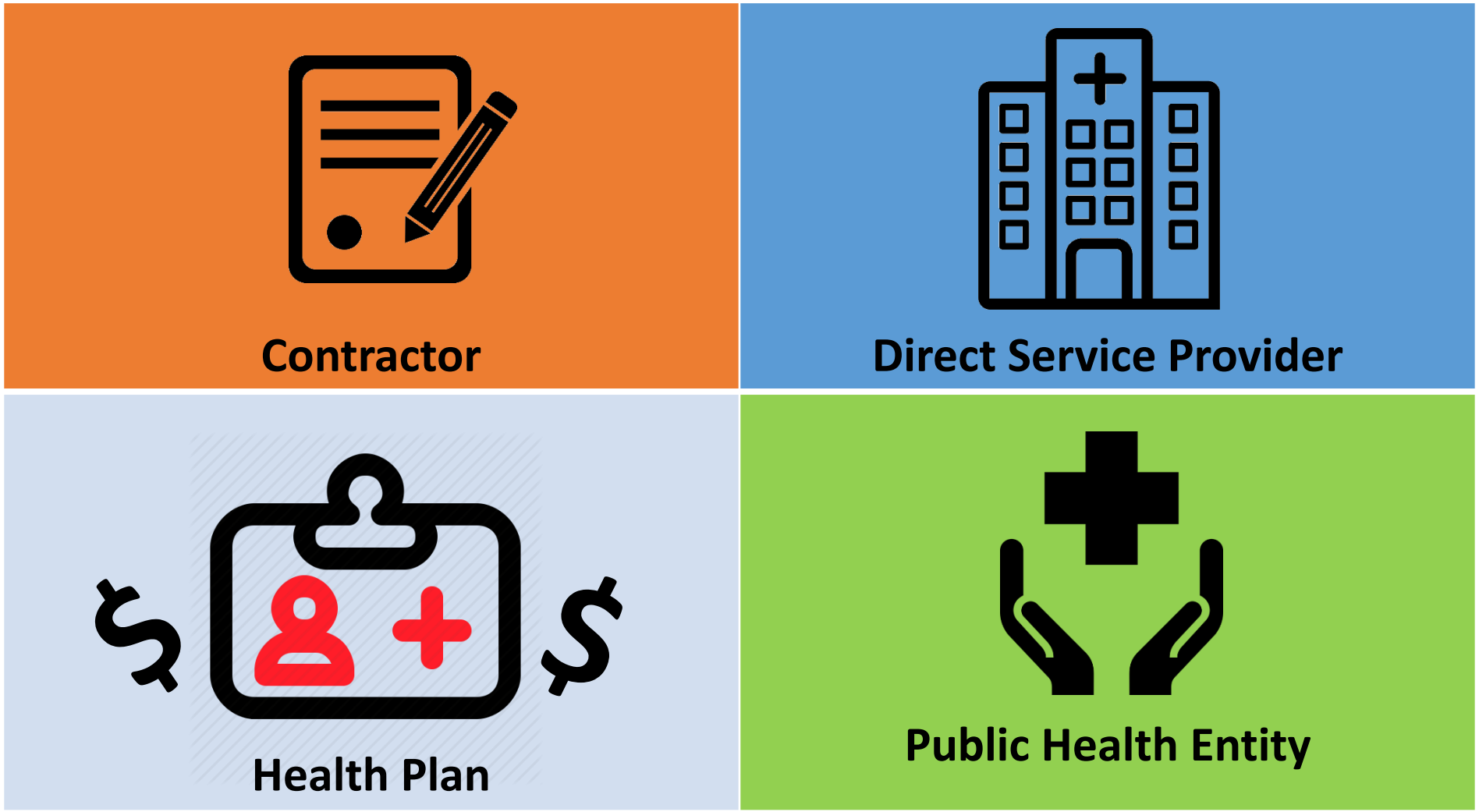
Chronic Care Management

EBP

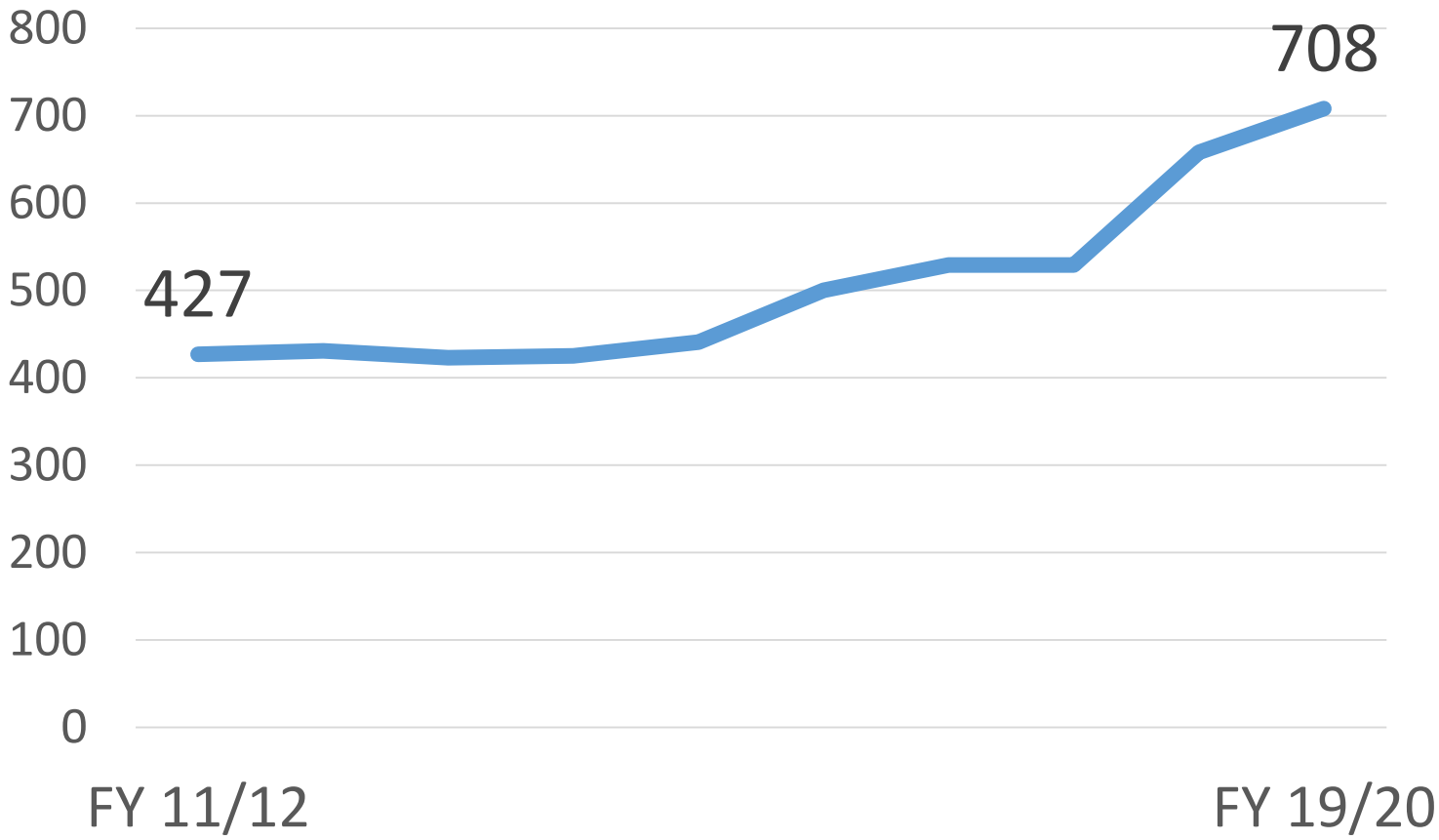
Evidence Based Practices



The County Has 4 Domains of Response

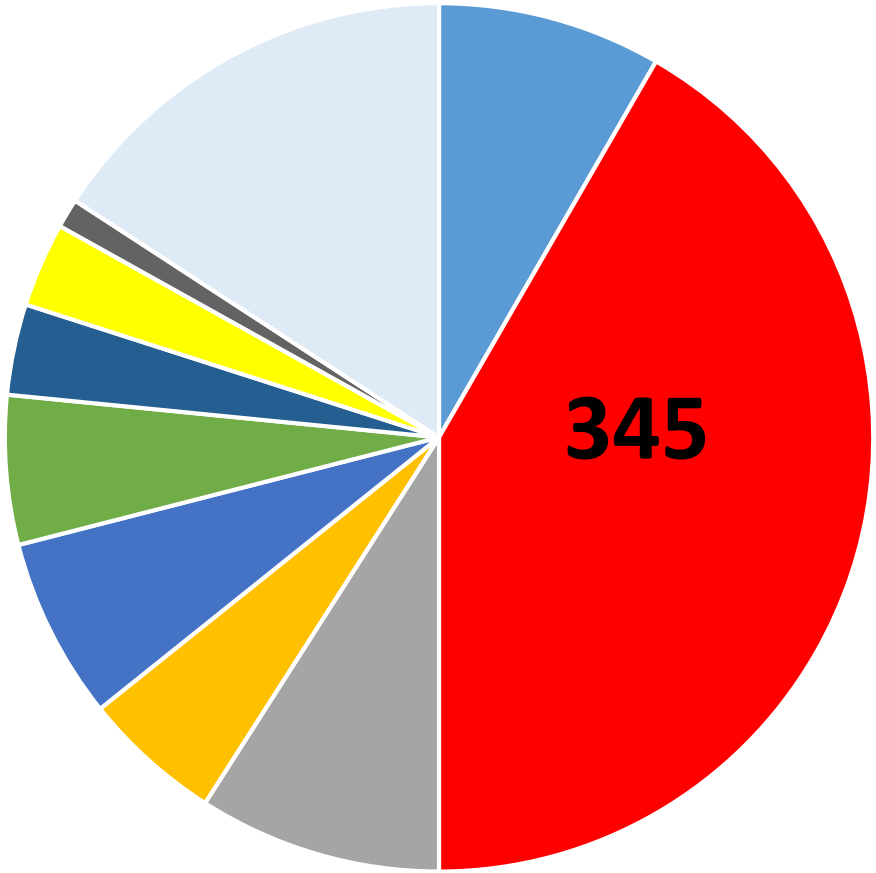


BHS Budget $ in Millions

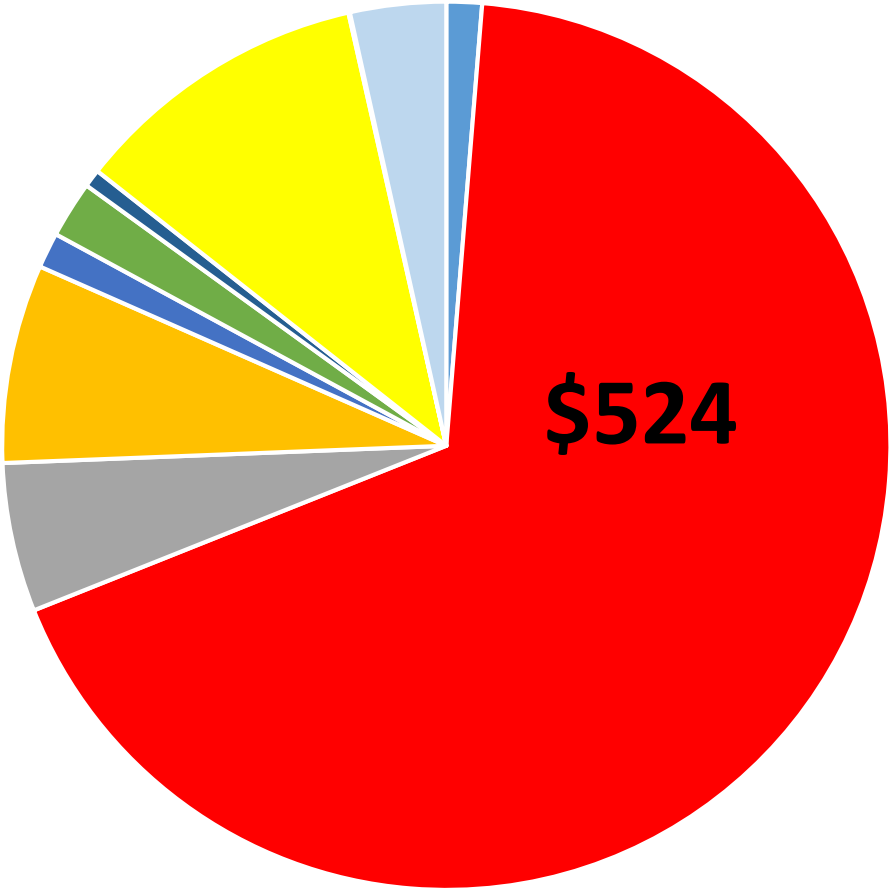


BHS is a Contractor

Number of Contracts



$ Value of Contracts, in Millions



ACS Report: HHSA Contracts Reference, April 2019

BHS is a Direct Service Provider

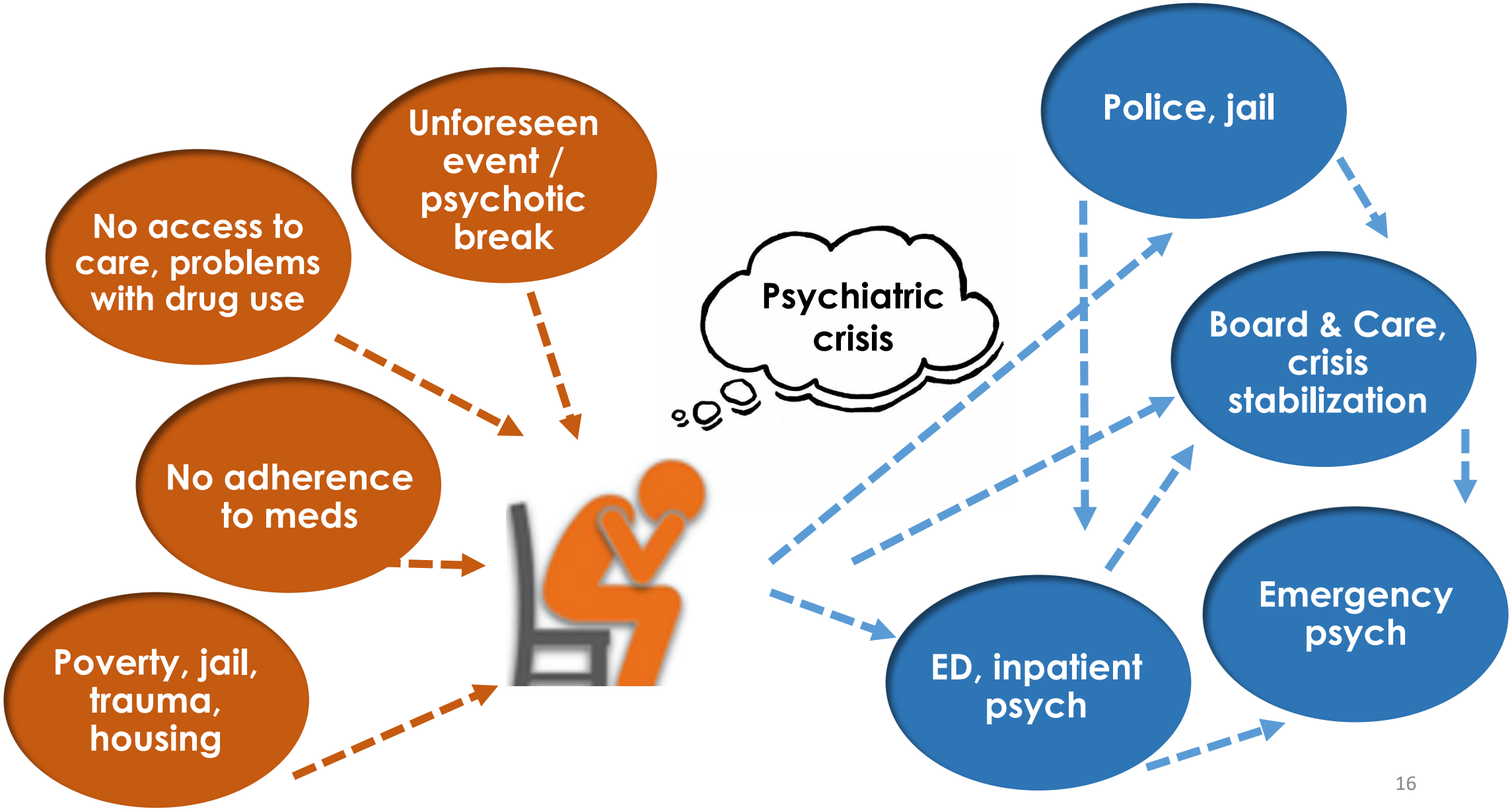
BHS is a Health Plan

BHS is a Public Health Entity:
Population Health and Integration

- Epidemiology and Public Health
- Behavioral and Physical Health Integration
- Health Equity

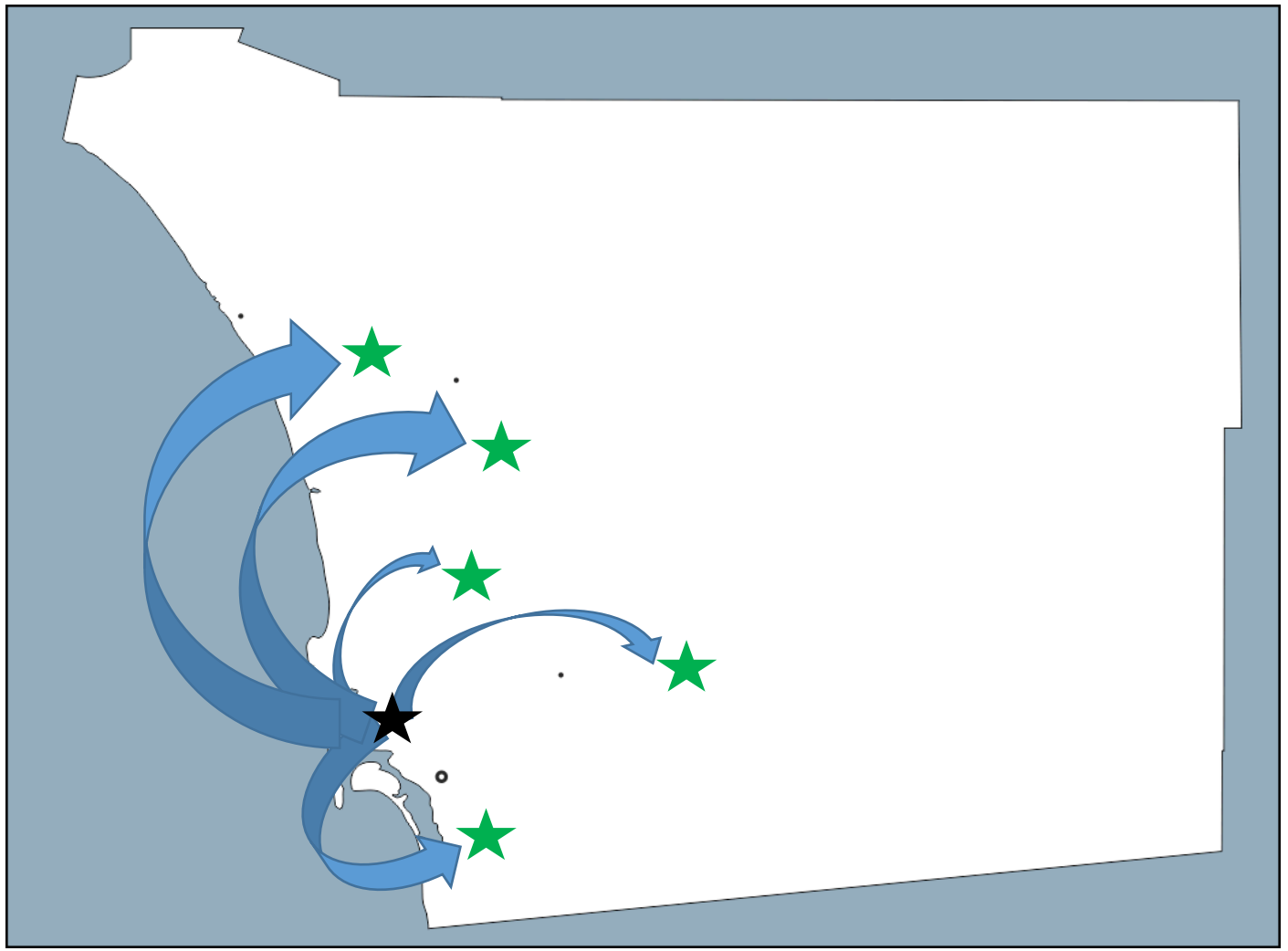
LIVE WELL SAN DIEGO

Psychiatric Crisis Care Continuum



Psychiatric Crisis Care Continuum

Regionally Distributed Model



-Thank You County of SD County Behavioral Health Services

For additional questions or comments please contact:

(619) 584-5049, Behavioral Health Services

Hot Topics in 2019 Reimbursement

Linda J. Corley, MBA, CPC, CPAR, CRCR
VP Compliance
706 577-2256
lcorley@xtendhealthcare.net

Agenda

2019 IPPS Updates

This presentation will review the following areas of the Inpatient Prospective Payment Systems (IPPS):

- **Specific inpatient order no longer required!**
- **List of charges posted on Internet . . .**
- **Disproportionate Share Calculation for Fiscal 2019**
- **Two Midnight Rule and ADRs**
- **Other Payment Polices Affecting Payment**
  - **Readmissions**
  - **Hospital Acquired Conditions / POAs**
  - **Quality Reporting Programs**

We will also review the current Mental Health services that generally are covered by insurance!

Why Discuss Reimbursement?

- Payment is more difficult to obtain in our current healthcare environment – patient owes more!
- Payor specificity has grown more important – one payment methodology does not collect optimum $$!
- Even after we get our claims paid, audit contractors may recoup payments!
- Revenue Cycle management is the all-inclusive process of documenting, charge capture, creating patient accounts, submitting claims, analyzing, and obtaining payment for health care – a very broad set of patient services – not directly related to medical care!
- Harvard Medical School estimates that 31% of our total health care costs result from these administrative activities.

FY 2019 Inpatient PPS Final Rule New!

No written Inpatient Admission Order required for payment!

42 CFR 412.3(a) Revised

- **CMS acknowledged that some otherwise medically necessary inpatient admissions are being denied payment due to technical discrepancies with the documentation requirements of inpatient admission orders.**

- **Common technical discrepancies, often deemed deficiencies, include missing physician admission signatures, missing co-signatures or authentication signatures and signatures occurring after discharge.**

- **These discrepancies have occasionally been the primary reason for denying Medicare payment of an individual claim.**

FY 2019 Inpatient PPS Final Rule

No Inpatient Admission Order Required!

- **CMS is revising 42 CFR 412.3(a) to remove the language stating that a physician order must be present in the medical record and be supported by the physician admission and progress notes, in order for the hospital to be paid for hospital inpatient services under Medicare Part A.**
- **Now relying on Medicare Benefits Policy Manual (MBPM), Chapter 1, Section 10.2.:**
- **"The order to admit may be missing or defective (that is, illegible, or incomplete, for example 'inpatient' is not specified), yet the intent, decision, and recommendation of the ordering practitioner to admit the beneficiary as an inpatient can clearly be derived from the medical record.**

FY 2019 Inpatient PPS Final Rule

No Inpatient Admission Order Required:

- **In these situations, contractors have been provided with discretion to determine that this information provides acceptable evidence to support the hospital inpatient admission.**

- **However, there can be no uncertainty regarding the intent, decision, and recommendation by the ordering practitioner to admit the beneficiary as an inpatient, and no reasonable possibility that the care could have been adequately provided in an outpatient setting."**

- **This guidance will remain in effect after this rule is finalized.**

FY 2019 Inpatient PPS Final Rule

No Inpatient Admission Order Required: ***Note!***

- **This policy proposal would not change the requirement that a beneficiary becomes an inpatient when formally admitted as an inpatient under an order for inpatient admission (nor that the documentation must still otherwise meet medical necessity and coverage criteria);**
- **only that the documentation requirement for inpatient orders to be present in the medical record will no longer be a specific condition of Part A payment.**
- **Accordingly, inpatient admission order documentation information should continue to be available in electronic health records.**

My advice . . . Don't even mention it unless asked!

May want to continue hospital policy for ALL payors – Inpatient order with diagnosis to meet medical necessity

FY 2019 Inpatient PPS Final Rule

Published Standard Charge Services and Rates

- *Beginning January 1, 2019 . . .*
- hospitals were **required to publish a list of their standard charges online in a machine-readable format,** and
- to **update this information at least annually.**
- Hospitals are currently required to make this information publicly available or available upon request.
- CMS requested information to better understand what stops providers from giving patients sufficient price information, and how price transparency can be improved.
- CMS highlighted concerns such as surprise out-of-network billing, particularly by radiologists and anesthesiologists, and unexpected facility fees.
- CMS said information and suggestions submitted will be considered for future rule-making.

FY 2019 Inpatient PPS Final Rule

Disproportionate Share Payments:

- The ACA mandated the implementation of new Medicare DSH calculations and payments in order to address the reductions to uncompensated care as coverage expansion was to take effect.
- By law, 25% of estimated DSH funds, using the traditional formula, must continue to be paid to DSH-eligible hospitals.
- The remaining 75% of the funds (referred to as the Uncompensated Care (UCC) pool, are subject to reduction to reflect the impact of insurance expansion under the ACA.
- This UCC pool is to be distributed to hospitals based on each hospital's proportion of UCC relative to the total UCC for all DSH-eligible hospitals.

FY 2019 Inpatient PPS Final Rule

DSH Payment Adjustment and Additional Payment

- Uncompensated Care Section 3133 of the Affordable Care Act modified the Medicare disproportionate share hospital (DSH) payment methodology beginning in FY 2014.
- Under section 1886(r) of the Act, which was added by section 3133 of the Affordable Care Act, starting in FY 2014,
- DSHs receive 25 percent of the amount they previously would have received under the statutory formula.
- The remaining amount, equal to 75 percent of the amount that otherwise would have been paid as Medicare DSH payments, is paid as additional payments after the amount is reduced for changes in the percentage of individuals that are uninsured.
- Each Medicare DSH will receive an additional payment based on its share of the total amount of uncompensated care for all Medicare DSHs for a given time period

FY 2019 Inpatient PPS Final Rule

DSH Payment Adjustment and Additional Payment

- We (CMS) are updating our estimates of the three factors used to determine uncompensated care payments for FY 2019.

- We are continuing to use uninsured estimates produced by CMS' Office of the Actuary (OACT) as part of the development of the National Health Expenditure Accounts (NHEA) in the calculation of Factor 2.

- We also are continuing to incorporate data from Worksheet S-10 in the calculation of hospitals' share of the aggregate amount of uncompensated care

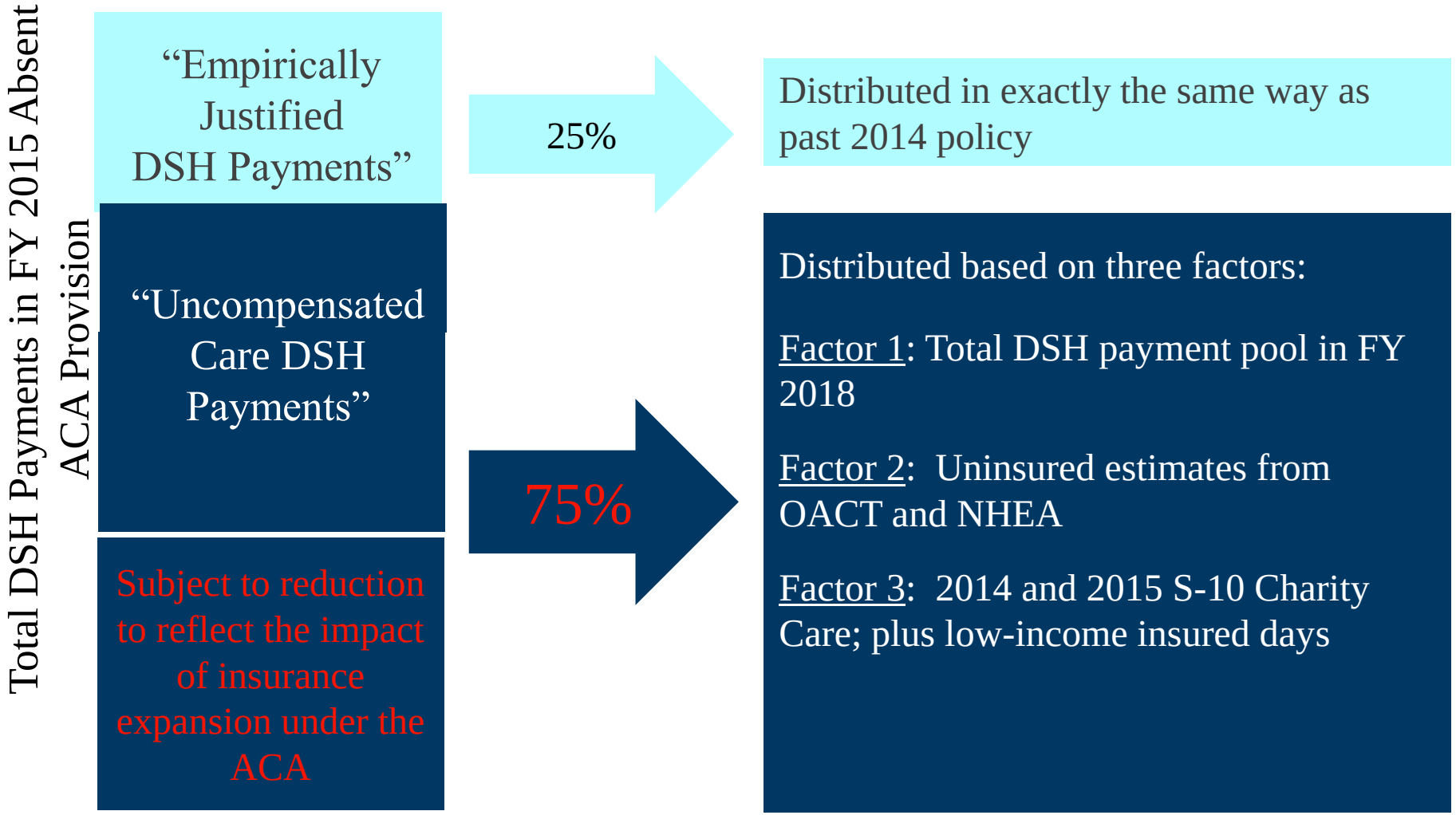
FY 2019 Inpatient PPS Final Rule

DSH Payment Adjustment and Additional Payment

- by combining data on uncompensated care costs from Worksheet S-10 for FYs 2014 and 2015
- with proxy data regarding a hospital's share of low-income insured days for FY 2013
- to determine Factor 3 for FY 2019.

CMS estimates uncompensated care for FY 2019 will increase by approximately $1.5 billion

2019 Medicare DSH: Uncompensated Care DSH Payment



Pro-active Tasks for Worksheet S-10

- Hospitals should review the uncompensated care data they reported in their 2014–2016 cost reports via the Worksheet S-10.
- If that data is not accurate (or nonexistent), hospitals should determine whether they can amend or adjust such data.
- A further step that hospitals should take is to re-examine their financial assistance policies and revenue cycle operations.
- CMS's comments make clear that the ultimate goal is to align the uncompensated care values that a hospital reports via its Form 990, Schedule H, with the uncompensated care values that a hospital reports via Worksheet S-10 of its Medicare cost report.
- Both of these reporting obligations require a hospital to report its amounts of charity care and bad debt.

Pro-active Tasks for Worksheet S-10

- The amount of reportable charity care and bad debt depends, in turn, on the terms of a hospital's financial assistance policies and the hospital's revenue cycle operations (including collections and accounting practices).
- Even longer-term actions that hospitals can undertake in this area would involve re-examining their community health needs assessments and any other community benefit and charity care obligations they may have (e.g., to maintain tax-exempt status, via consent agreements with their state attorneys general).
- The task may be daunting, but the benefits of aligning a hospital's community health strategy, financial assistance policies, revenue cycle operations, tax accounting and Medicare cost reporting are immense—for both hospitals and the communities they serve.

FY 2019 Inpatient PPS Final Rule

Coding Specificity

MS-DRG Refinements

- **Notable changes for major categories of Cardiovascular services for *FY 2018***
  Increases from 0.6% up to 3.7%
- **Weights based on 2016 FY MedPAR data**
- **Continued refinement of relative weights based on cost**
- **Included refinements for specificity of ICD-10-CM and PCS**

Compare Top Ten $$ MS-DRGs under ICD-9 to $$ paid under ICD-10 in 2018

Or – 2017 Top Ten to 2018

Behavioral Health

2019 Mental Health Services

Good news for 2019!

- **"Mental Health and Substance Use Disorder Coverage Parity" laws require most health plans *to apply similar rules to mental health benefits as they do for medical / surgical benefits.***
- **Health plans must have coverage of "essential" health benefits, which include 10 categories of benefits.**
- **One of those categories is mental health and substance use disorder services.**
- **Additionally, these plans must comply with mental health and substance use parity requirements, as set forth in MHPAEA, meaning coverage for mental / behavioral health and substance abuse services generally cannot be more restrictive than coverage for medical and surgical services.**

2019 Mental Health Services

- All state Medicaid programs provide some mental health services and some offer substance use disorder services to beneficiaries, and Children's Health Insurance Program (CHIP) beneficiaries receive a full service array.
- These services often include *counseling, therapy, medication management, social work services, peer supports, and substance use disorder treatment.*
- While states determine which of these services to cover for adults, Medicaid and CHIP requires that children enrolled in Medicaid receive a wide range of medically necessary services, including mental health services.
- Coverage for the Medicaid adult expansion populations is required to include essential health benefits, including mental health and substance use disorder benefits, and must meet mental health and substance abuse parity requirements.

2019 Mental Health Services

- Beginning in FY 2020, state Medicaid programs will be funded on a fixed per beneficiary amount (i.e. per capita cap).
- The per capita cap is calculated based on past expenditures, and in the long run is expected to cover medically necessary services.
- The bill also requires more frequent Medicaid eligibility redeterminations, and gives states the option of imposing work requirements as a condition for eligibility, with an increased federal match for administrative expenses.
- States would also have the option of applying to fund their Medicaid programs under a block grant known as the Medicaid Flexibility Program.
- States may also include inpatient psychiatric services as an optional benefit in their Medicaid plans, with a federal match of 50%.

2019 Mental Health Services

Medi-Cal coverage for adults is available through:

- **Long-term Care (Formerly Caregiver Resource Centers)**
- **Mental Health Services Act (MHSA)**
- **Project for Assistance in Transition from Homelessness (PATH)**
- **Community Mental Health Services Block Grant (MHBG)**
- **Network of Care for Mental Health is a great resource to obtain information about mental health issues and to search for a wide variety of mental health and other support services in your local community.**

- **mhsa@dhcs.ca.gov**

2019 Mental Health Services

Medi-Cal coverage for minors is available through:

- The Medi-Cal Specialty Mental Health Services (SMHS) program is "carved-out" of the broader Medi-Cal program and operates under the authority of a waiver approved by the Centers for Medicare and Medicaid Services under Section 1915(b) of the Social Security Act.
- DHCS is responsible for administering and overseeing the Medi-Cal SMHS Waiver Program, which provides SMHS to Medi-Cal beneficiaries through county mental health plans (MHPs).
- MHPs are required to provide or arrange for the provision of outpatient and inpatient SMHS to beneficiaries in their counties who meet SMHS medical necessity criteria, consistent with the beneficiaries' mental health treatment needs and goals, as documented in their client plans.
- In accordance with Medicaid Early and Periodic Screening, Diagnostic, and Treatment provisions, the intervention criteria for beneficiaries under the age of 21 are less stringent than they are for adults.

- mhsa@dhcs.ca.gov

2019 Mental Health Services

- Medicare covers a wide range of mental health services.
- Part A (Hospital Insurance) covers inpatient mental health care services in a hospital – room, meals, nursing care, and other related services and supplies.
- Part B (Medical Insurance) helps cover mental health services that are generally received outside of a hospital, including visits with a psychiatrist or other doctor, visits with a clinical psychologist or clinical social worker, and lab tests.
- Medicare Part D (Prescription Drug) helps cover drugs needed to treat a mental health condition.
    - Each Part D plan has its own list of covered drugs, known as formulary.
- Benefits are available through both traditional FFS Medicare and Advantage Plans. Specific benefits must be verified!

2019 Mental Health Services

Bottom line –

- **Coverage is expanding and improving!**
- **Only constant is that *each plan is different!***
- **Thoroughly review**
  - **contract or government coverage requirements,**
  - **appropriate setting for services needed (inpatient or outpatient),**
  - **authorization(s), and**
  - **billing / claim submission guidelines.**
- **Ensure patient financial responsibility is discussed with patients prior to services being provided!**
- **Analyze remit to evaluate appropriate payment receipt.**

Payment Updates

Proposed Changes

Admissions and Medical Review Criteria

- In FY 2014, CMS created the "2-Midnight" Rule for when a patient is expected (documented) to stay across two consecutive midnights (or has an "Inpatient only" service) will be presumed appropriate for Part A (Inpatient) payment.
- Less than 2-Midnights is presumed "inappropriate" for Inpatient stay, and would be reviewed for possible denial.
- Enforcement has been "on again" but "off again."
- Per the Medicare Access and CHIP Reauthorization Act of 2015, delayed until September 30, 2015.
- Although re-established October 1, 2015; but restarted on January 1, 2016, audits were delayed due to the QIOs varying interpretation of the guidelines.
- Began in earnest around July 1, 2016.

Admissions and Medical Review Criteria

Changes to the Two Midnight Rule:

- If physician expects stay to be less than two midnights:
  - Admission payable on a case-by-case basis based on the clinical judgment of the admitting physician.
  - Documentation in the medical record must support an inpatient admission is necessary, and is subject to medical review.
  - The following factors (among others) will be relevant:
    - Severity of the signs / symptoms exhibited by the patient.
    - Medical predictability of adverse occurrence to the patient.
    - Need for diagnostic studies that are more appropriately OP services (i.e., do not ordinarily require the patient to remain at the hospital for 24 hours or more).

Admissions and Medical Review Criteria

- While payment reduction may no longer be a factor, audits to continue for providers that have exhibited:
  - Persistent non-compliance with Medicare payment policies
  - High Inpatient denial rates
  - Failure to adhere to the Two-Midnight Rule after educational intervention from the QIO.
- Hospitals referred to the RACs for further evaluations.
- To avoid recoupments!
  - Ensure appropriate classification of patients as Inpatient or Observation upon initial status determination!
  - Ensure adequate Inpatient medical record documentation
  - Carry-out clinical review of one-day stays to check for "rare and unusual" exception policy

Admissions and Medical Review Criteria

- **Caution – follow your resolution of Medicare Additional Development Requests (ADRs) for Inpatient stays to determine if all claims are being paid by the MAC.**
- **May want to hold Inpatient stays of less than Two-Midnights for clinical review of documented medical criteria before filing an Inpatient claim.**
- **ALWAYS review one-day stays to ensure Inpatient criteria were met – or a "rare" exception occurred – prior to filing an Inpatient one-day stay claim to Medicare.**

Hospital “Pay for Performance” Quality Programs Updates

Here is where Clinical Care Affects Payment!

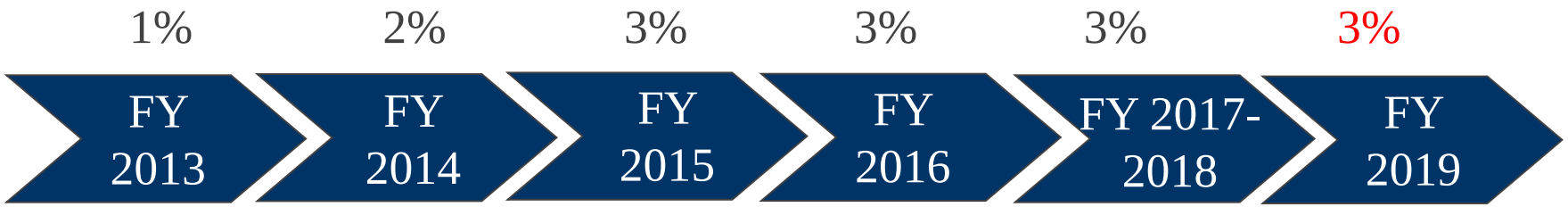
- **What is the one Department that can increase payment for all payors on a daily basis?**

- ***Patient Care Management***

• Case Management	→	Patient Status
• Utilization Review	→	Authorizations
• Discharge Planning	→	Approved days
• Clinical Docu. Review	→	Patient Acuity / Intensity of Services

Hospital Readmissions Reduction Program

- **Hospital-specific payment adjustment factors were applied to inpatient claims beginning Oct 1, 2012.**



- **For FY 2019 and subsequent years, the reduction is based on a hospital's risk-adjusted readmission rate during 3 year period**
- **AMI, HF, PN, COPD, and THA / TKA (Hip/Knee) and CABG**

- **Not "budget neutral." Hospitals can either maintain full payment levels or be subject to a penalty of up to 3.0% for 2019.**

HRRP: Expansion of Applicable Conditions

- For 2019, CMS estimated 2,610 hospitals (out of 3,300) will incur payment reduction of an estimated $566 M.

- Expand applicable conditions to include Coronary Artery Bypass Graft (CABG) for FY 2017 (finalized in FY 2015 IPPS rule)
- FY 2018 changed payment to include patients through "co-hart" diagnoses with:
  - Aspiration pneumonia
  - Principal diagnosis of sepsis or respiratory failure, and a secondary diagnosis of pneumonia present on admission
- Impact of expanding definition: major increase to number of cases (about 65%) and the number of hospitals meeting the minimum number of cases for this measure

HRRP: Review of Socioeconomic Factors

- Does HRRP disproportionately penalize hospitals that serve low-income and clinically complex patient populations?
- For several years, hospitals advocating for further adjustment based on socioeconomic status (SES).
- On 12/13/16, Congress passed 21st Century Cures Act which mandated HRRP begin to account for SES in its assessment of readmissions performance.
- 2018 IPPS Rule laid out plan for FY 2019.
- Sort hospitals into five (5) peer groups, according to dual-eligible IP stay rates
- Within each peer group, hospital's excess readmissions ratio for each of the program's six (6) conditions will be compared to the groups median excess readmission excess ratio for that condition.

Hospital-acquired Condition (HAC) Reduction Program

- **HAC Reduction program reduces total payments by 1% for worst performing quartile of hospitals as of FY 2018.**

  Example: Patient develops infection post-surgery – infection is coded but modifier required to be reflected on claim to indicate diagnosis was "not present on admission" – diagnosis (co-morbid condition) no longer raises MS-DRG payment.

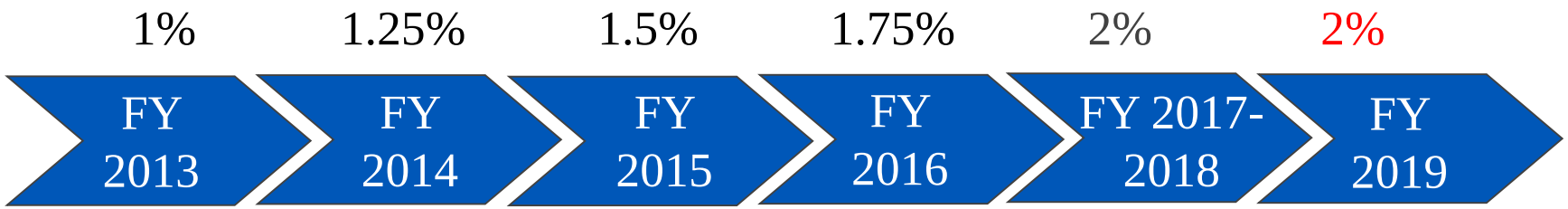
- **No changes to the ongoing policy where certain HACs can't qualify a case for a higher paying MS-DRG tier – *but CMS replaced the ICD-9-CM / PCS Version with 32 HAC list with the ICD-10-CM / PCS Version 33 HAC list***

- **FY 2018 findings, HAC reports released in late summer via Quality Net, hospitals have 30 days to review**

Hospital Inpatient Quality Reporting (IQR) Proposed Changes

Inpatient Value-Based Purchasing (VBP)

- **A percentage of inpatient base operating payments are at risk based on quality and efficiency metric performance**



- **For 2019, $1.9 B "redistributed"**
- **A budget neutral policy, where hospitals must fail to meet targets for bonuses to be generated for others**
- **Rewards for achievement or improvement**
- **Quality measures from Hospital Compare measure set**
  - **2019 Big changes – removing 21 duplicate measures, reassessing cost to collect data and report, 18 measures removed due to "topping out."**

Overlapping Medicare Policies – Triple Threat

Hospital-acquired conditions (HACs)	Not eligible higher payment (FY 08 ongoing)	IP VBP (FY 13 ongoing)	HAC Reduction Program (FY 2015 ongoing)
Catheter associated UTI	X	Finalized FY 16	Finalized FY 15
Surgical Site Infections	X*	Finalized FY 16	Finalized FY 16
Vascular cath-assoc. infections	X**	PSI-90/ CLABSI	PSI-90/ CLABSI
Foreign object retained after surgery	X		
Air embolism	X		
Blood incompatibility	X		
Pressure ulcer stages III or IV	X	PSI-90 FY 2015	PSI-90 FY 2015
Falls and trauma	X***	PSI-90 FY 2015	PSI-90 FY 2015
DVT/PE after hip/knee replacement	X	PSI-90 FY 2015	PSI-90 FY 2015
Manifestations of poor glycemic control	X		
Iatrogenic pneumothorax	X	PSI-90 FY 2015	PSI-90 FY 2015
Methicillin resistant Staph. aureus (MRSA)		Finalized FY 17	Finalized FY 17
Clostridium difficile (CDAD)		Finalized FY 17	Finalized FY 17

Changing Medicare Inpatient Reimbursement

Payment Reform for Hospitals

Fiscal Year	Value Based Purchasing	Hospital Readmission Reduction Program	Hospital Acquired Conditions (POAs)	Total
2013	1.00%	1.00%	0	2.00%
2014	1.25%	2.00%	0	3.25%
2015	1.50%	3.00%	1.00%	5.50%
2016	1.75%	3.00%	1.00%	5.75%
2017-2018	2.00%	3.00%	1.00%	6.00%
2019	2.00%	3.00%	1.00%	6.00%

What does the remainder of 2019 have in store for payment?

- Numerous regulatory changes – some still undefined!

- However – believe "quality" initiatives that focus on patient care outcomes will continue.

- Suggest process improvement in "patient care management."
  - Focus on case management, utilization review and discharge planning.
  - Although CDI has proven difficult, success = $$$
    - Supporting documentation to survive payor audits
    - Specificity of ICD-10 for diagnoses and procedures
    - Solid charge capture procedures to improve lost revenue and late charges

Questions?

- **Please telephone or e-mail with**
  coverage,
  coding,
  billing,
  reimbursement questions!

Joe McDowell
JMCDOWELL@XTENDHEALTHCARE.NET
209-829-9876

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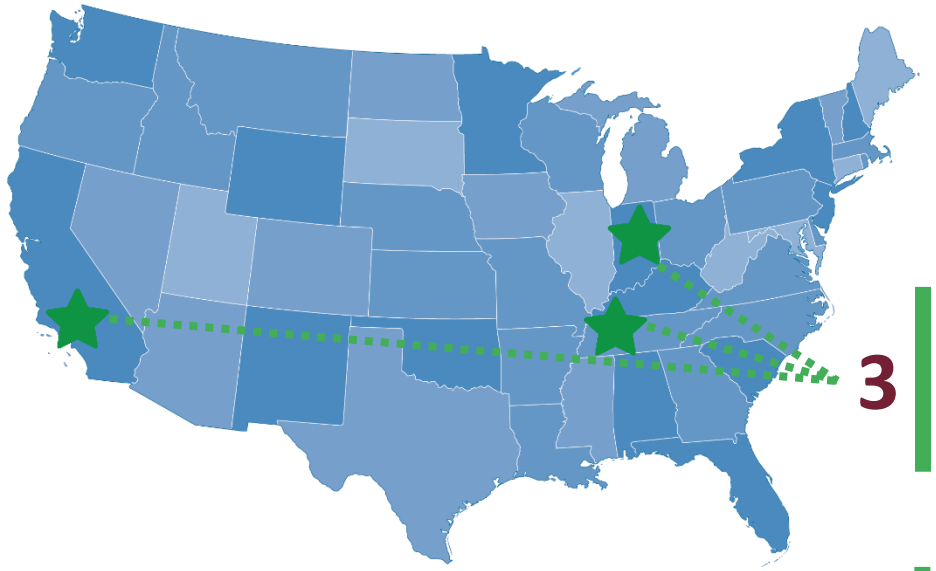
6 Time Zones with Clients

…including Alaska + Hawaii



84% Of the entire Xtend workforce is female

…including 67% Of leadership

3 Service Center Locations

FURTHEST CLIENT: HAWAII

4,300 MILES

$1.5 BILLION Third-party receivables

15 YEARS Longest Client Relationship

Revolutionize your revenue cycle

Extend your staff and IT assets

Improve your bottom line

-Thank You Xtend HealthCare

Upcoming Events

- **August 25th Day at the Races**
- **August 26th Summer Series**

Spotlight on the Homeless Crisis in San Diego presented by Councilman Chris Ward's Office

- **September 20th Fall Conference**

Join HFMA for a day of learning & networking

Featuring a keynote address by Dr. Jerry Teplitz providing an introspective on Self-Development and a comprehensive healthcare federal policy update delivered by Chad Mulvaney, HFMA Director, Healthcare Finance Policy, Strategy and Development

Upcoming Events

- SAVE THE DATE and Plan for Western Symposium, January 12-15, in Las Vegas at the Paris hotel.
  - First come first serve, if you are a Provider there are deep discounts available.
  - Room rates are down, keynotes are developing, Daniel Ruettiger, from the movie Rudy.
  - Need more information check our website soon www.hfmasandiego.org

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san diego-imperial chapter

Contact Us about Enterprise Membership for discounted group rates

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for joining us today!

hfma DY2M 2019-2020