AXIOM Healthcare Group

Puzzling Financial Issues for ICF/IID Providers
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Pieces of the Financial Issue Puzzle

Pieces of the Financial Puzzle

- Record Keeping
- Reimbursement Process
- State Budget/Rates
- Billing/Authorization
- Recovery
- Risk Avoidance

Record Keeping

It all begins with **'Good Record Keeping'**

Meeting the challenges in operating and achieving the goals established for any business are dependent on good record keeping. Unfortunately, the lack of good record keeping by Medi-Cal providers ultimately leads to problems with reimbursement. The fiscal management challenges related to reimbursement include frozen rates and potential rate cuts when policy makers are faced with budget deficits. Without good record keeping, providers have no basis to demonstrate the accurate and true costs of caring for California's most vulnerable citizens. Whether frozen rates or rate cuts, reduced reimbursement exacerbates the fiscal management challenges ICF providers face on a daily basis.

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Records - Why Necessary

EVERYONE IN BUSINESS MUST KEEP **RECORDS**. KEEPING GOOD **RECORDS** IS VERY IMPORTANT. GOOD **RECORDS** WILL HELP YOU DO THE FOLLOWING:

- **MONITOR THE PROGRESS OF YOUR BUSINESS**
- **PREPARE YOUR FINANCIAL STATEMENTS**
- **IDENTIFY SOURCES OF YOUR INCOME**
- **KEEP TRACK OF YOUR EXPENSES (COSTS)**
- **KEEP TRACK OF THE VALUE OF YOUR CAPITAL PROPERTY**
- **PREPARE REQUIRED GOVERNMENT REPORTS**
- **SUPPORT ITEMS REPORTED ON YOUR GOVERNMENT REPORTS**

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RECORD KEEPING SUPPORTING DOCUMENTS

- Supporting documents validate the entries to your accounting system and create the audit trail for information utilized to complete Government reporting forms.
- Supporting documents should be organized…
  - Simple - Manual or Computer
  - No Shoe or Amazon Boxes

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Audit Trail

An audit trail (also called audit log) is a security-relevant chronological record, set of records, and/or destination and source of records that provide documentary evidence of the sequence of activities that have affected at any time a sp procedure, or event. (Wikipedia)

What Is an Audit Trail?

Audit trails are the manual or electronic records that chronologically catalog events or procedures to provide support documentation and history that is used to authenticate security and operational actions, or mitigate challenges. (Smart sheet .com)

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Government Reporting Requirements

1. Payroll Tax
2. Medi-Cal and Medicare Cost Reporting
3. Medi-Cal Quality Assurance Fee Reporting
4. State Special Requests –

   Senate Bill (SB) 3 Minimum Wage Survey,

   Certification Document for ACA Mandate
5. Income Tax – FEDERAL and STATE
6. Client Trust
7. Other Compliance

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Failure to Submit Cost Reports

SPA - Will result in the facility receiving a rate set at the 2008-09 65th percentile and reduced by 10 percent. The rate may be adjusted further once the provider submits a cost report.

Medi-Cal Policy - Medi-Cal payment withhold or percentage payment reduction.

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The Puzzle's Main Piece

RECORD KEEPING IS THE MAIN PIECE THAT COMPLETES THE PUZZLE! ALTOGETHER.

- LEGAL AND REGULATORY COMPLIANCE
- FINANCIAL MANAGEMENT
- REIMBURSEMENT
  - FACILITY SPECIFIC
  - STATEWIDE
- GOVERNMENT REPORTING
- RISK AVOIDANCE

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Reimbursement Process

Recent News !

2018-19 Amended Rates

- The Department recently amended the 2018-19 reimbursement rates effective for dates of service on or after August 1, 2018, due to revisions made to the Minimum Wage add-on.
- Providers will continue to receive the initial 2018-19 reimbursement rates until the 2018-19 amended reimbursement rates are implemented in the system.
- Once the amended reimbursement rates are implemented, the Department will issue payments retroactive to August 1, 2018.
- Current estimated date for retroactive payments is ?

2018-19 Rates

2018-19 Amended Rates (For Facilities with No ACA)

Facility Type	LTC Accommodation Code	2018-19 Amended Rate	Supplemental Payment	2018-19 Total Reimbursement	2018-19 Total Reimbursement for BedHold ($7.92)
A	B	C	D	E=C+D	G = E - $7.92
ICF/DD	41 (1-59 beds)	$201.98	$15.47	$217.45	$209.53
ICF/DD	41 (60+ beds)	$188.19	$0.00	$188.19	$180.27
ICF/DD-H	61 (4-6 beds)	$224.19	$10.75	$234.94	$227.02
ICF/DD-H	65 (7-15 beds)	$240.66	$0.00	$240.66	$232.74
ICF/DD-N	62 (4-6 beds)	$250.42	$12.47	$262.89	$254.97
ICF/DD-N	66 (7-15 beds)	$257.21	$22.30	$279.51	$271.59

Reimbursement Past History

- **ICF rates frozen at 2009 levels on August 1, 2010 and remained in place until May 2014 (2013/14 Rates).**
- **New system implemented for 2013/14. Facility specific information used to determine rates. ICF providers without cost at or above rate threshold received the 2008-09 65th percentile rate reduced by 10%. Future rates impacted by facility-specific costs.**
- **Elimination of the cuts that were implemented pursuant to AB 97, effective August 1, 2016. (ABX2 1 (Thurmond).**

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Current Rate Methodology

- Facilities are peer grouped by level of care and bed size.
- Base rate is frozen at the 2008-09 65th percentile established for the facility's respective peer group increased by 3.7 percent, through the enabling legislation of Assembly Bill (AB) x21, and Welfare and Institutions Code Section 14105.075.
- The reimbursement rate also includes the projected cost of complying with any new State or federal mandates.
- Final rate includes a supplemental payment under proposition 56 (Tobacco Tax) for qualifying facilities.

Reimbursement Update

DHCS has confirmed the 2019-20 Rate Year rates will be calculated in the same way as the 2018-19 rates, with two separate rate components. First the base rate at the 08/09 65th percentile plus 3.7%, adjusted for add-ons. Second the Tobacco Tax Supplemental Payments.

CAHF will provide updates once DHCS finalizes the Add-On calculations.

Reimbursement
Current Perspective Issues

- **Prop 56 - Note that facilities in peer groups in which the unfrozen 2018-19 65th percentile rate was lower than the current reimbursement rate did not receive the supplemental payment.**
- **Future rates - Will be dependent on demonstrated cost information gleaned from audits of filed cost reports.**
- **Rate increases will be subject to the upper payment limit (i.e. reimbursement cannot exceed actual cost of services provided)**.

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Reimbursement Update

DHCS has confirmed the 19/20 Tobacco Tax supplemental payment rates will be the same as the 18/19 rates, pending CMS approval.

Peer Group	Tobacco Tax Supplemental Payment
ICF/DD – 1-59	$15.47
ICF/DD – 60+	$0.00
ICF/DDH – 4-6	$10.75
ICF/DDH – 7-15	$0.00
ICF/DDN- 4-6	$12.47
ICF/DDN – 7-15	$22.30

2019 - 2020
State Budget

Billing, Authorization, and Recovery

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For Medi-Cal providers that depend heavily on Government Funding, "Cash is King" .

Primary Sources of Cash

Medi-Cal
- Requires authorization
- Weekly billing and payment cycle
- End of Fiscal Year Payment Delay (June/July)

Medicare
- Billed as service is provided
- Generally paid within 14 days

Regional Center
- Varies consistent with vendor agreement

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Medi-Cal Authorization

- Medi-Cal Requires that a TAR be approved before service can be rendered and billed. TAR stands for Treatment Authorization Request.
- Client information is required to be submitted to support the request.
- Also when requesting approval of a TAR, you must attach a form called HS 231. This document is completed by the facility and signed off by the Regional Center Client Manager.
- HS 231's should also be maintained by the facility.
- TAR's can and should be approved for **2 years** at a time.

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Tips for Timely Tar Approval

Implement a TAR quality review process before submission!

- Ensure documentation is complete before submission.
  - Has the Regional Center completed the HS 231to include all required information?
  - Has the physician included sufficient medical information that justifies the need for the appropriate level of ICF/IID care being requested?

Tips for Timely Tar Approval

Don't delay followup with Medical Field Office When TARs are delayed!

- Identify key contacts for the Medi-Cal Field Office
- Submit TARs Timely (Before admission or sufficiently in advance for reauthorization).
- Identify any trends occurring with deferrals and correct
  - Missing documentation
  - Reviewers (Medi-Cal Consultant)
- When TAR approval is received, make sure all information is correct,TAR Control Number, level of care, time period of authorization, Medi-Cal ID, dates of service, etc.
- Notify CAHF of consistent or continuing problems.

Managed Care Disenrollment Process

The ICF Consumer in a Long Term Care Facility…To disenroll the consumer from a managed healthcare plan and return to fee for service (regular Medi-Cal), please follow these steps.

AUTHORIZATION:

- Screen to see if the facility representative has the authority to speak on the beneficiaries' behalf.
- To ensure smooth transitions for consumers and timely payment for the ICF, the ICF must first check the consumer's Medi-Cal eligibility. Use the AVES system available at www.medical.ca.gov/Eligibility/login.asp

PROCESS:

- Contact the Plan. The ICF must obtain authorization from the Plan to bill the Plan for services provided .
  - The ICF does not need to be contracted with the Plan.
  - Non-contracted ICFs can arrange a one-time financial agreement with the Plan.
  - During this disenrollment process, the Plan is responsible for the month of admission plus the following month (or a maximum of 62 days).
  - It is therefore critical that the Plan be advised of the admission **immediately** so the provider is not denied earned reimbursement.
  - To start the disenrollment process, provide the Plan with the face sheet containing the date of admission. The Plan will notify the ICF when the member has been accepted for disenrollment and the scheduled date.
  - The consumer will be disenrolled and will return to **Fee-For-Service Medi-Cal**.
  - When the Plan subcontracts with other health plans, the subcontracted plan authorizes and is responsible to pay for the ICF admission during the admission period. The Plan will instruct the ICF on how to obtain an authorization and where to bill for services.
  - For Continuing Problems - You may contact **Karen Widerynski M.P.H. CAHF Managed Care Specialist** at kwiderynski@cahf.org or 562-253-1445 for a list of Health Plan Contacts or assistance.

Reimbursement Recovery

First Step - Claims Inquiry Form (CIF) - The *Claims Inquiry Form* (CIF) is used to request an adjustment for either an underpaid or overpaid claim, request a Share of Cost (SOC) reimbursement or request reconsideration of a denied claim. The CIF can also be used as a tracer. See the Medi-Cal Provider Manual for details.

Second Step - An appeal is the final step in the administrative process and a method for Medi-Cal providers with a dispute to resolve problems related to their claims. Must Submit Appeal Form (90-1), attach necessary documentation. (Claim, TAR, RAD, Etc.). If more than one year, include proof of eligibility. Providers must submit an appeal in writing within 90 days of the the final action precipitating the appeal.

Third Step - Seek advice or guidance from Medi-Cal billing experts and/or legal counsel.

Risk Avoidance

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Medi-Cal Quality Assurance Fee Reporting

What is it?
The Quality Assurance (QA) Fee is a "provider tax" that is a vehicle used by California to increase general fund revenue. The dollars raised by the provider tax are matched with federal dollars, thereby increasing the benefit of the tax. ICFIID providers receive a rate add-on to their established reimbursement rates and pay back a portion of the add-on back to the State.

Reporting and Payment Requirements

DD Providers must complete a report on forms prescribed by DHCS on a quarterly basis.

Payments are due to DHCS on or before the last day of each calendar quarter for the previous calendar quarter gross receipts. The forms and instructions for completion at available on the DHCS website.

DHCS is taking a more rigid collection approach on delinquent accounts.

What happens if I don't Pay?

The state will "withhold" your Medi-Cal funds until the amount owed is paid in full.

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California Minimum Wage

Schedule for California Minimum Wage rate 2017-2023.

Date	Minimum Wage for Employers with 25 Employees or Less	Minimum Wage for Employers with 26 Employees or More
January 1, 2017	$10.00/hour	$10.50/hour
January 1, 2018	$10.50/hour	$11.00/hour
January 1, 2019	$11.00/hour	$12.00/hour
January 1, 2020	$12.00/hour	$13.00/hour
January 1, 2021	$13.00/hour	$14.00/hour
January 1, 2022	$14.00/hour	$15.00/hour
January 1, 2023	$15.00/hour	

There are also exceptions for employees who are mentally or physically disabled, or both, and for nonprofit organiz sheltered workshops or rehabilitation facilities that employ disabled workers. Such individuals and organizations m special license by the Division of Labor Standards Enforcement authorizing employment at a wage less than the leg Labor Code Sections 1191 and 1191.5

Medi-Cal Minimum Wage

Medi-Cal Wage Differentials

Non Administrative Employees

	DD	DD-H	DD-N
First 90 Days	$0.36	$0.21	$0.00
After 90 Days	$0.50	$0.21	$0.00

CNAs*

First 90 Days	$0.56	$0.41	$0.00
After 90 Days	$0.70	$0.41	$0.20

* Performing CNA Duty Requirements

Audits

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Audits?

- Due to the rate setting freeze the Department of Health Care Services has not been preforming rate setting audits of ICF DDH/N providers.
- Other Audits of ICF DDH/N providers have continued
  - Wage Pass-Through Audits
  - Affordable Care Act Certification Audits
- A unfrozen rate setting system will likely mean the return of rate setting audits.
- Comprehensive records make audits go smooth.

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Questions

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Thanks for allowing Axiom to participate with you at today's meeting.

- ✓**Accounting**
- ✓**Cash Flow Management**
- ✓**Financial and Business Operations Reporting**
- ✓**Government Reporting Requirements and Communications**
- ✓**Assisting Clients With Keeping Current**

To learn more about how Axiom can relieve the stress of managing the financial side of your business, call or email Axiom today to schedule an individual provider assessment.

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