Online presentation Aug. 20, 2014

60 days of uncertainty:

Understanding the Affordable Care Act

90 Day Grace Period

This webinar is provided for discussion and informational purposes only. Participants are encouraged to discuss the requirements and/or their obligations related to the Affordable Care Act with their attorneys or other advisors.

About SCG Health

The Searfoss Consulting Group, LLC opened in 2011 and is focused on revenue cycle management and strategic planning in this post-health reform world.

Services support the business of medicine with providers, associations, health plans and vendors.

Advocacy ◆ Communication & Engagement ◆ Education ◆ Provider satisfaction driver evaluation◆ Strategic Planning

Objectives

Financial management

Understand the 90 day grace period policy under the Affordable Care Act

- Identify which patients the policy applies to and who it does not
- Outline practical solutions to implement in your medical practice to identify the patients and ways to mitigate retroactive denial

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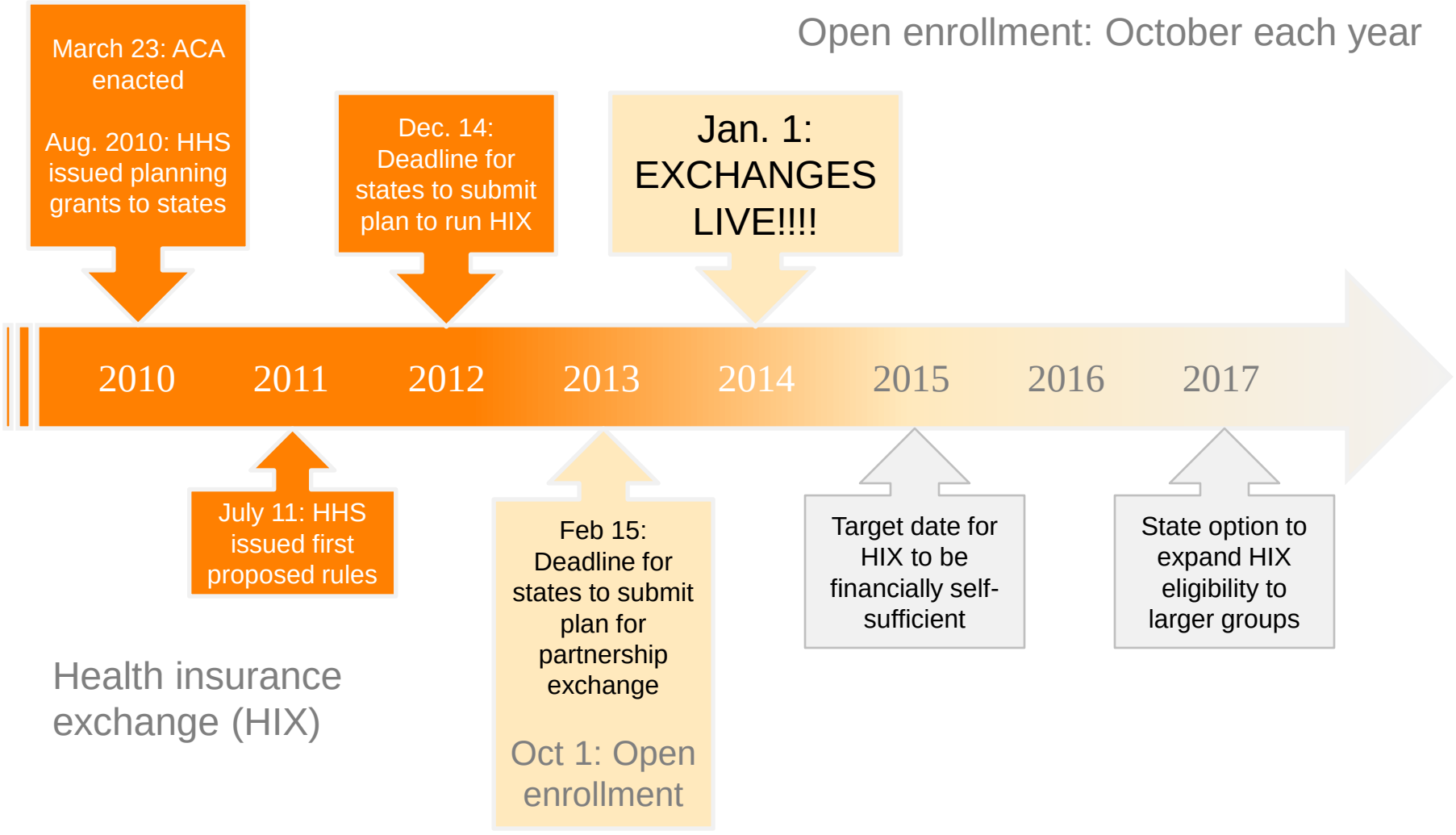
ACA refresher

Timeline



ACA language

P.L. 111-148, Section 1412

ADVANCE DETERMINATION AND PAYMENT OF PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS

(c) PAYMENT OF PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS

(2)(B)(iv)(II) “allow a 3-month grace period for nonpayment of premiums before discontinuing coverage.”

Categories of beneficiaries

HIX beneficiaries

Federal subsidy = Advanced Premium Tax Credit (APTC)

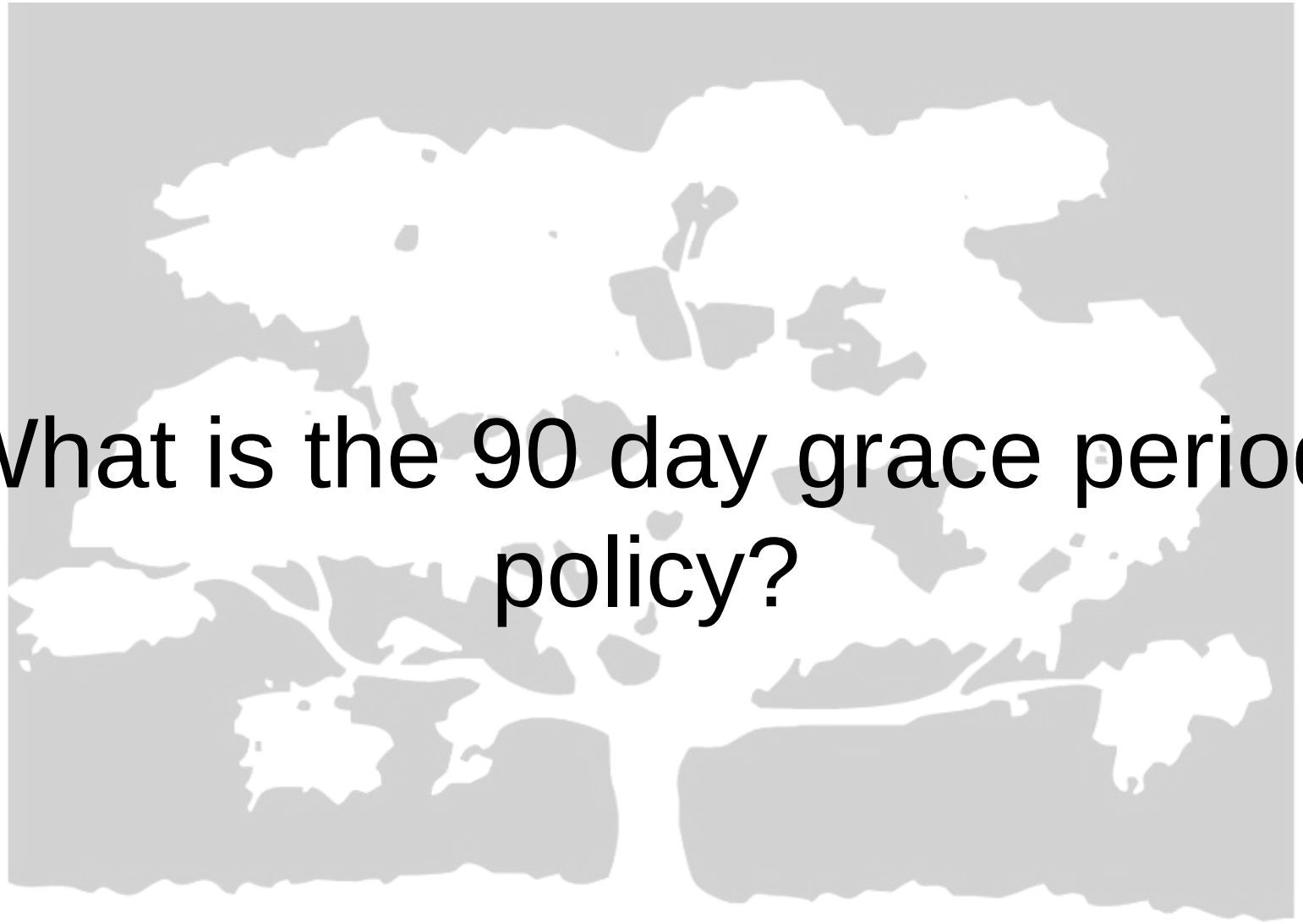
(a) Medicaid expansion
(b) qualified health plan product

No subsidy = marketplace purchaser

Non HIX beneficiaries

Fully-insured (FI): Grandfathered self-insured and small business policies where the insurance company bears the risk. State law applies.

Administrative Services Only (ASO): Employer-based coverage where the employer bears the risk. Insurance companies only administer the network and process claims. This falls under federal jurisdiction. State law does not apply.



What is the 90 day grace period policy?

Rulemaking finalized 7/15/2013 (on this provision)

45 C.F.R. § 156. 270(d)(3)

"(d) Grace period for recipients of advance payments of the premium tax credit.

- "A QHP issuer must provide a grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year. During the grace period, the QHP issuer must:
  - "(1) Pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period;
  - "(2) Notify HHS of such non-payment; and,
  - **"(3) Notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period."**

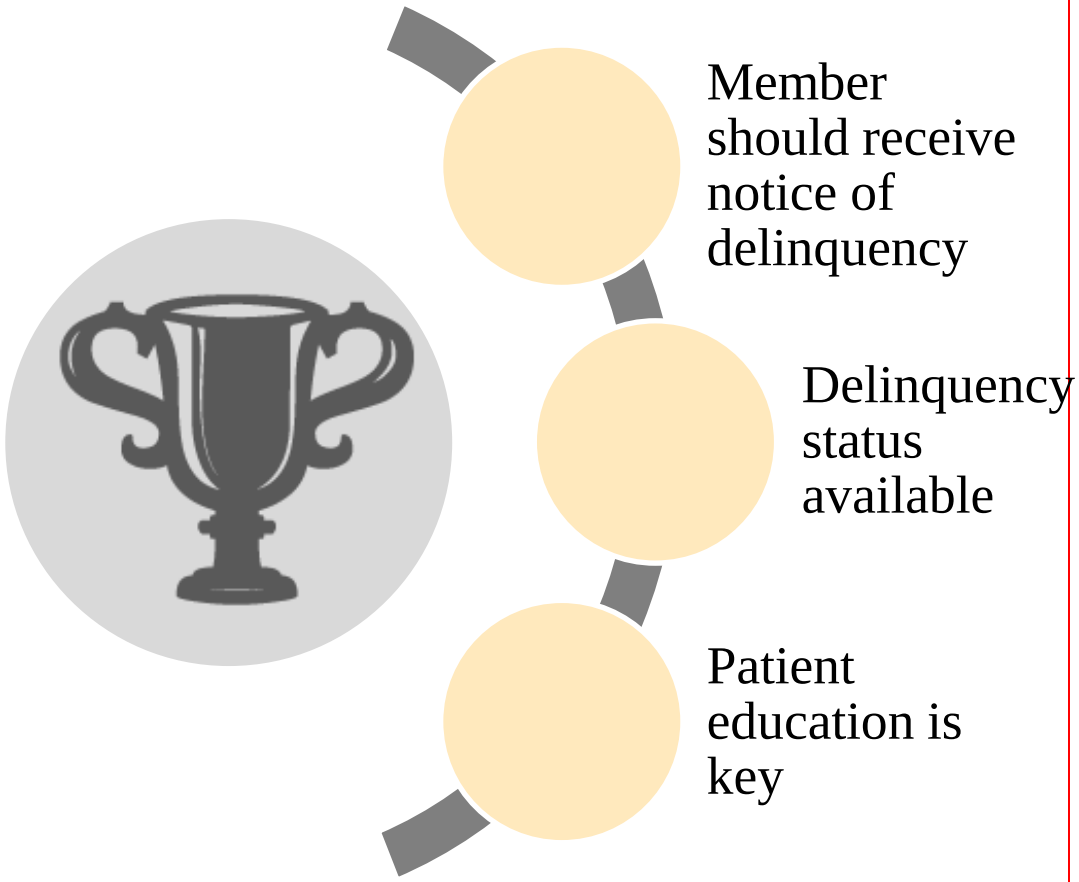
The policy in plain language

- Applies to HIX beneficiaries
- Must have received tax credit
- Must have paid one month or more in premium
- Health plan pays for services rendered during first month of non-premium payment
- Health plan must notify providers of possible non-payment for services rendered between days 31-90 of premium non-payment
  - No standard on how notification is provided

Practical implications

Member and provider notice mandatory
For APTC beneficiaries, they are to receive notice upon delinquency (usually before day 30) with pending grace period end date. Once hit day 31, information is available to provider.

Patient education necessary
As newly insured patients, they may not understand the importance of paying premiums.



End-game

APTC delinquency premium is not paid within 90 days

- Beneficiary liable for any provider charges during period
- Beneficiary liable to health plan for first month's premium of grace period
- Beneficiary liable to federal government for subsidy

Beneficiary is still on the hook for health insurance and services

Reality by insured type

State law:
- Recoupments
- Binding verification

APTC beneficiaries

- 90 day grace period
- Services rendered in first 30 days of delinquency paid
- Notice required of possible non-payment of services rendered during 31-90 days
- If health plan does pay, recoupment request.

Marketplace purchaser

- 30 day delinquency
- No requirement to pay services after payment
- No requirement for notice
- Payments made by health plan reversed by recoupment

Non HIX beneficiaries

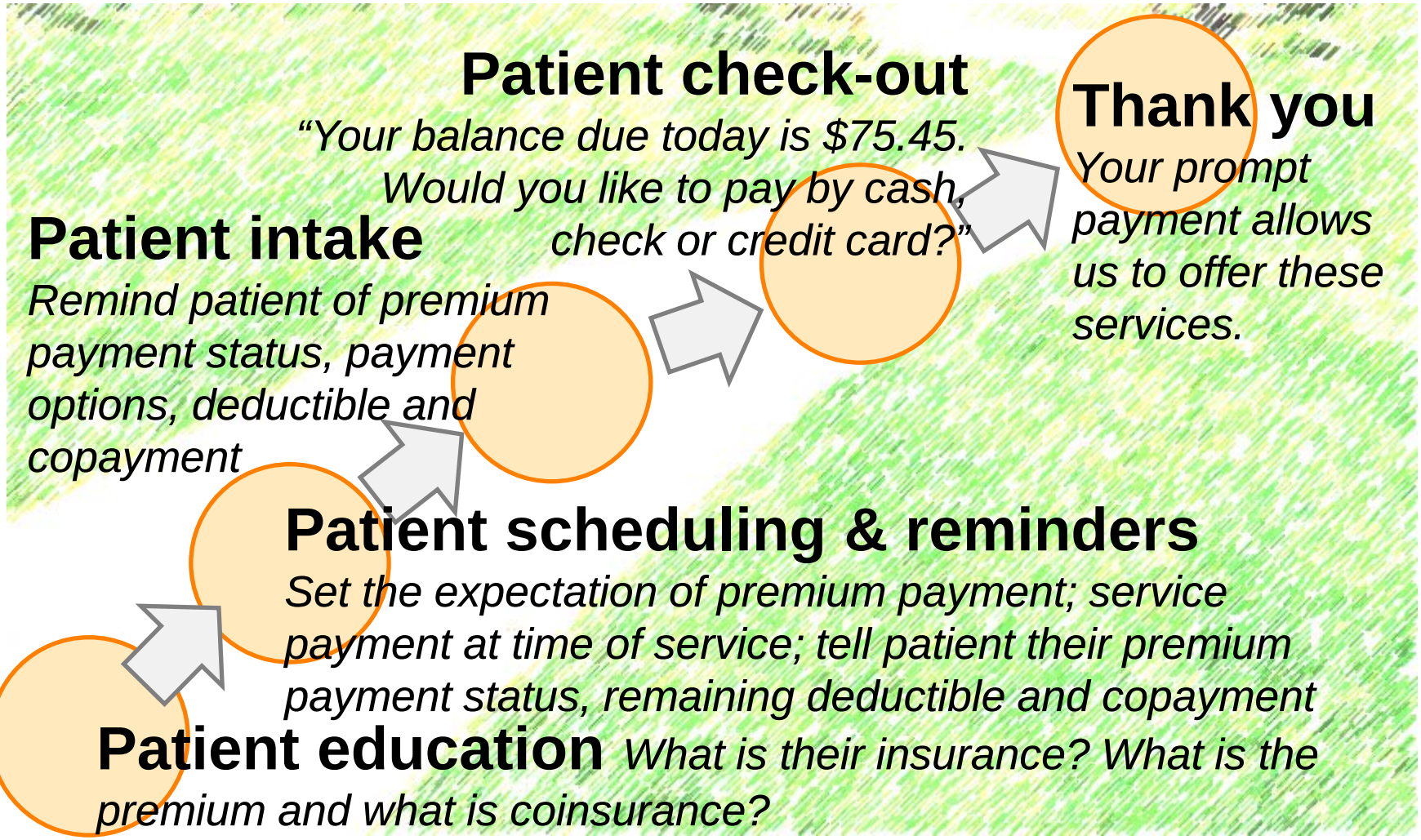
- **FI beneficiaries**: state law applies, if any
- **ASO beneficiaries**: wild west; retroactive take-backs well documented


Best practices

Best practices

1. Patient education
2. Office policies: eligibility, documentation and liability workflow
3. Patient engagement (statements, calls)

Patient work flow



Patient education

New patient forms!

Direct counseling

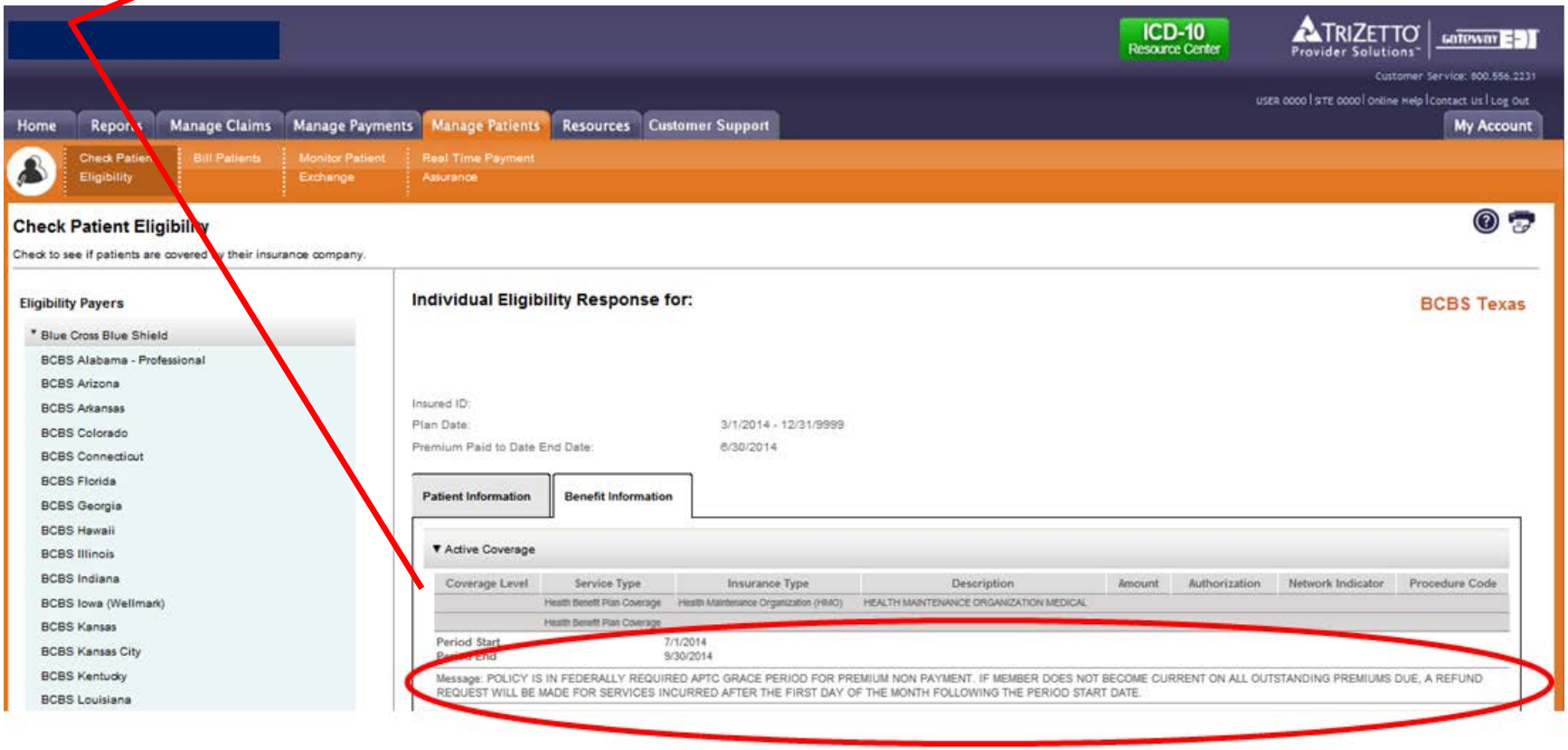
Waiting room brochures

Welcome insurance kit

I (*the patient*) also understand and acknowledge that I am personally responsible to pay (*the name of the practice*) in full for services that my health insurer will not cover due to non-payment of my health insurance premiums.

Validate eligibility

Message: POLICY IS IN FEDERALLY REQUIRED APTC GRACE PERIOD FOR PREMIUM NON PAYMENT. IF MEMBER DOES NOT BECOME CURRENT ON ALL OUTSTANDING PREMIUMS DUE, A REFUND REQUEST WILL BE MADE FOR SERVICES INCURRED AFTER THE FIRST DAY OF THE MONTH FOLLOWING THE PERIOD START DATE.



Validate eligibility/prior-auth

Electronic

By health plan

Document

Document

Document

Phone

By health plan

"Is this account in delinquency?"

"When was the last premium paid?"

Documentation

By PMS

Copy of patient ID card at each visit

Copy photo govt. issued ID

Date of inquiry

Time of inquiry (can pull call record)

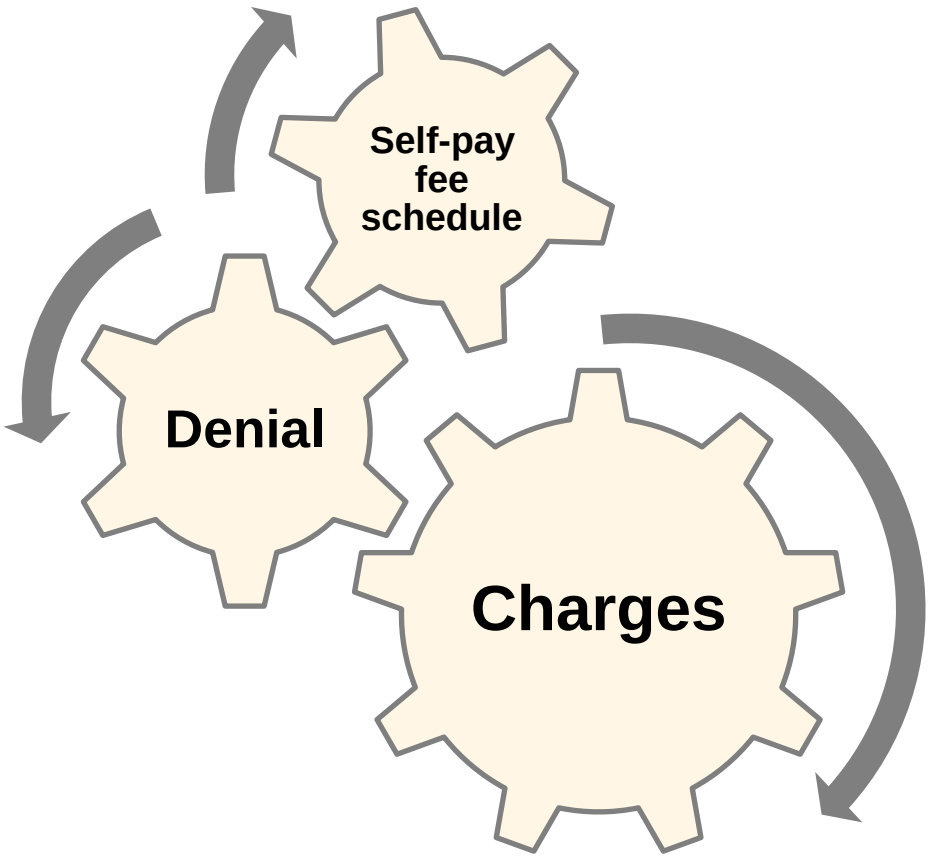
Name of representative

Question asked and answer provided

Staff training is essential for success!

- Front office staff.
- Back office staff.
- Clinicians too.

Patient engagement



Charges & self-pay

If patient is delinquent, then they
are uninsured. What is your policy? Generally, self-pay rates will apply.

Best practices:

- Claim shows charge rate
- Once denial for delinquency post-90 days, follow your policy for patients in this situation.
- **Be consistent!**
- For example: show the charged and “discount” to self-pay with full payment expected within 30 days.

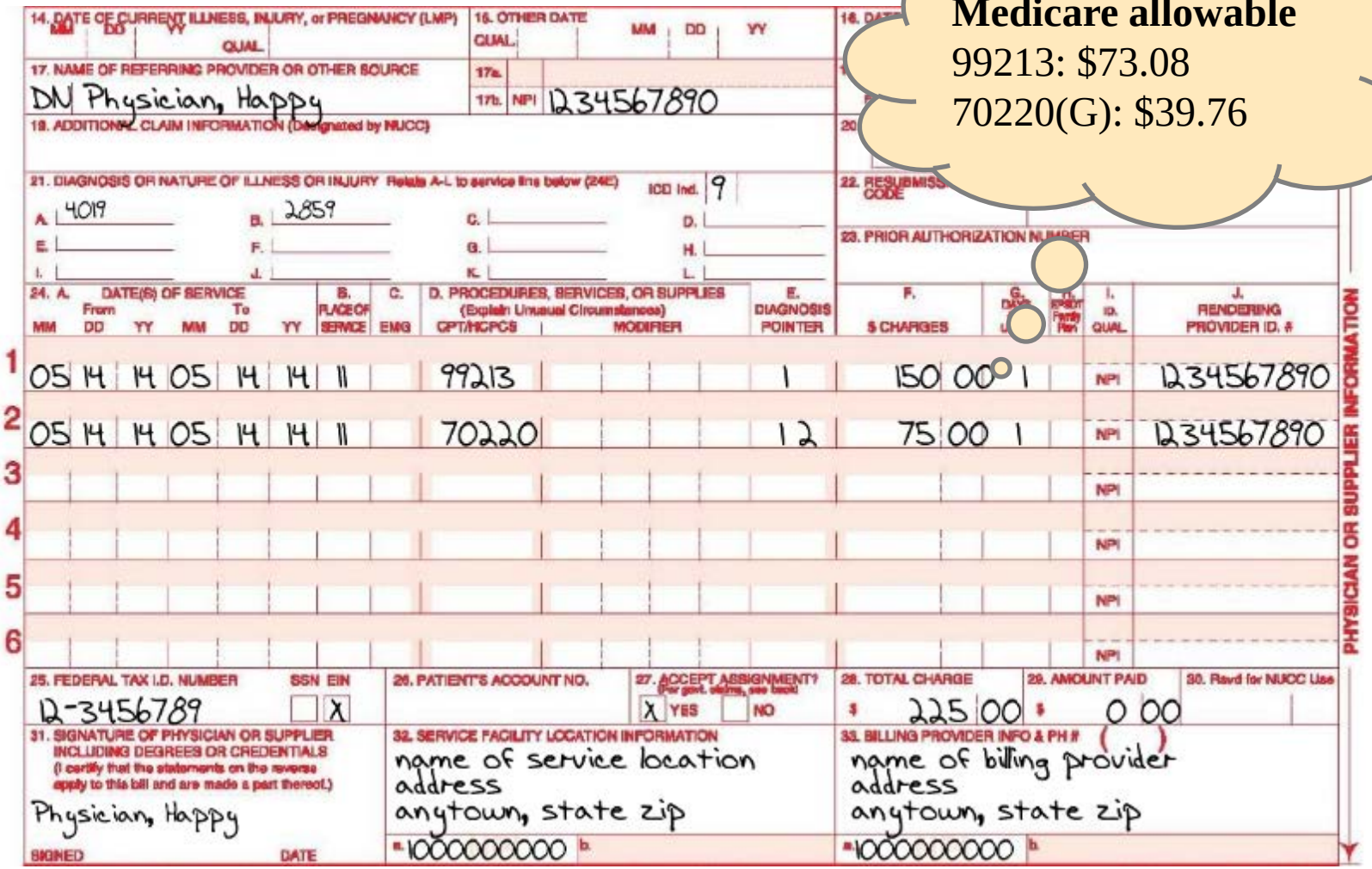
Premium payment assistance

Interim final rule for Third Party Payment of Qualified Health Plan Premiums published on 3/14/2014

- Both categories of HIX beneficiaries
- Certain organizations may pay a portion or all of premium to qualified health plans (FAQ clarification 2/7/2014)
  - Ryan White HIV/AIDS programs
  - Indian tribes, tribal organizations and urban Indian organizations
  - Private charitable
- Qualified health plans do not have to accept (and are encouraged to do so) premium payments made by hospitals, other health care providers and commercial entities

Example claim

Medicare allowable
99213: $73.08
70220(G): $39.76



14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL
15. OTHER DATE QUAL MM DD YY
16. DATE
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN Physician, Happy
17a.
17b. NPI 1234567890
18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
19.
20.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9
A. 4019 B. 2859 C. D.
E. F. G. H.
I. J. K. L.
22. RESUBMISSION CODE
23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	05	14	14	05	14	14	11		99213		1	150 00	1		NPI	1234567890
2	05	14	14	05	14	14	11		70220		12	75 00	1		NPI	1234567890
3															NPI	
4															NPI	
5															NPI	
6															NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 12-3456789 SSN [ ] EIN [X]
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO
28. TOTAL CHARGE $ 225 00
29. AMOUNT PAID $ 0 00
30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.): Physician, Happy
SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION: name of service location / address / anytown, state zip
a. 1000000000 b.
33. BILLING PROVIDER INFO & PH #: ( ) name of billing provider / address / anytown, state zip
a. 1000000000 b.

Example: self-pay

Service	Medicare	Charges	Band	Self-Pay	Band
99213	$73.08	$150.00	Double	$110.00	Quarter
70220	$39.76	$75.00	Double	$60.00	Quarter

If a patient can't pay their premium due to financial need, how do you know? Would your policy on discounting services for financial need apply?

Establish your policy for all patients that change insurance status
Review every three years

Discounting policy

- In clear terms, the government reiterated that federal law does not prohibit Medicare, Medicaid and state children's health insurance programs (SCHIP) providers from discounting services to the uninsured.
- The government, however, remains suspect of waiver and discount policies that fail to determine a patient's financial need.

Applicable laws

- The Medicare Exclusion Statute – civil only
- The federal Civil Monetary Penalty Law – civil only
- The federal Anti-kickback Statute – criminal only
- The federal Stark Law – civil or criminal
- The federal False Claims Act – civil or criminal

Discounting of services

- Practices may waive coinsurance on an individual-review basis.
  - Remember to continue to evaluate even for the same patient.
- Discounts may not directly or directly relate "to the furnishing of items or health services payable" by Medicare, Medicaid or SCHIP.
- Demonstrated financial need.
- Not a routine policy.
  - Special circumstances of patient only.

The government provides no universal definition of financial hardships.

- Practices must establish a reasonable designation and policy for **all patients** and then review and verify the status of each patient who may qualify.
- Not enough to have a form.

Special fraud alert states that practices must make a good faith effort to verify financial need.

- This could include requesting a copy of the patient's latest tax return or pay stub.

Checklist of key policy elements

In writing!!!	Consistency across all payer types	Establishes period for re-evaluation of status, documentation retention and confidentiality policy
Identifies what financial information is required and the financial qualifications for consideration	Specifies who in the office makes final determination of whether the patient qualifies	States how denied applications will be handled

What to ask for from patients: ◆ Copy of the latest W2, tax return, pay stub, bank statement, etc. ◆ Were you considered for the Medicaid program? You may request copy of Medicaid denial letter. ◆ Could you accept a payment plan?

Your homework

1. Review intake procedures.
   - Is the front desk able to identify patients?
   - Are patients aware of their premium payment status and financial liability?
   - Are you running and documenting eligibility for every encounter?
2. Review billing practices?
   - How does your software identify claims for these patients?
3. Review your policies.
4. Know your resources.

Resources

American Medical Association

http://www.ama-assn.org/ama/pub/advocacy/topics/affordable-care-act/aca-grace-period.page

Medical Group Management Association

State Medical Societies

Questions

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