CMS Administrative Agreement offers partial payment to hospitals: Hopes to ease ALJ log jam

Prepared by
Steven J. Meyerson, M.D.
Accretive Health, Inc.

© 2014 Accretive Health Inc.

Summary of CMS Administrative Agreement

- Hospital agrees to withdraw all pending Part A appeals of "denials on the basis that services may have been reasonable and necessary but treatment on an inpatient basis was not. "
- Applies to admissions prior to Oct 1, 2013
- Deadline for signed Agreement: Oct 31, 2014
- Hospital paid 68% of "net" DRG payment (after Part A copayment deducted)
- Hospital can't collect copay from beneficiary after effective date unless on "repayment plan"
- Hospital-submitted list of pending appeals reconciled with CMS records
- Payment within 60 days of effective date of agreement - then interest accrues at 1.0% per annum.
- Timeframe not specified for CMS to sign agreement or for final reconciliation

CMS is now offering hospitals an option intended to help clear the back log that has created a three to four-year delay in the appeals process. An **Administrative Agreement** will allow hospitals to withdraw all of their pending appeals of Part A "inpatient-status claim denials by Medicare contractors [that were denied] on the basis that services may have been reasonable and necessary but treatment on an inpatient basis was not." Denials for other reasons, such as lack of medical necessity for procedures and coding/DRG denials are not eligible. CMS is offering to pay hospitals 68 percent of the net Part A DRG (diagnosis related group) payment that they would be entitled to receive if the denial were to be overturned.

This paper is intended to explain the program, explore the issues, and offer assistance.

Only acute care hospitals need apply

The Administrative Agreement is open to all acute care hospitals (including partial interim payment (PIP) and Maryland waiver facilities) and to critical access hospitals but not to inpatient rehabilitation facilities or to psychiatric, long term care, children's, or cancer hospitals. Hospitals with pending False Claims Act litigation or investigations may also be declared ineligible.

It's all or nothing

The settlement offer applies to hospital admissions prior to October 1, 2013. CMS must receive the hospital's request by October 31, 2014, but will offer extensions if hospitals are unable to meet this deadline. The hospital cannot pick and choose which appeals it wishes to include or exclude. It's an all-or-nothing deal, making the

© 2014 Accretive Health Inc.

decision whether to participate both very difficult and very important as the financial implications can affect both the amount and timelines reimbursement.

Three step process

Here's how the program works: after downloading and printing the Administrative Agreement, the hospital will return the signed form to CMS along with a list of its eligible appeals using the Eligible Claim Spreadsheet. If this list matches CMS' record of pending appeals that meet criteria for the program, CMS will pay the hospital 68 percent of the net amount otherwise payable within 60 days of the effective date of the agreement - the date it is signed by CMS. Since there is no time frame defined for CMS acceptance of the Agreement we cannot say when the clock will start on the 60-day deadline for payment. If payment is not made by day 60, CMS will pay interest to the hospital starting on day 61 at “the Current Value of Funds Rate (“CVFR”) as promulgated by the United States Department of the Treasury” which is currently one percent.

When there are discrepancies between the hospital’s submission and CMS’ records (as there are bound to be) CMS will pay the hospital for those it agrees upon and the remaining appeals will be stayed. CMS gives the hospital two weeks to submit a revised list of pending appeals. It will compare this second list to its records and pay hospitals within 60 days for those that match up. If discrepancies persist, these will be resolved until all appeals have been accounted for and both parties are satisfied

The Medicare Administrative Contractor (MAC) will validate withdrawn appeals that were at level 1 and the Administrative Qualified Independent Contractor (AdQIC) will review those that were waiting for resolution at level 2. Due to the large number of claims "stuck" at the ALJ (level 3) and Department Appeals Board (level 4), these claims will initially be reviewed for appropriateness by statistical sampling and paid based on the sample but there will be a final reconciliation of all appeals by the ALJ and DAB in which hospitals will be paid for any appeals that were not included in the initial payment and overpayments due to inclusion of ineligible claims will be recouped. (No time frame for this final resolution was specified.)

“Net payment” = Part A copay deducted before adjustment

The settlement amount is calculated after the patient copayment is subtracted from the DRG payment to determine the “net payment”. Hospitals are not allowed to seek or collect copayments from beneficiaries unless there is a payment plan in place as of the effective date of the Agreement. Secondary payers are not required to repay the hospital if they recouped the Part A copayment when the claim was denied. Unless it has already been paid by the beneficiary or there is a payment plan in place, a hospital will have to write off the Part A copayment.

© 2014 Accretive Health Inc.

Collecting Part A copayment restricted

The settlement offer does not convert Part A claims to Part B billing and the patient's financial liability is limited to the Part A copayment. Furthermore, the Agreement does not allow the hospital to "seek" any payments from beneficiaries for copayments or deductibles "that is not subject to a repayment plan existing as of the effective date of this Agreement." For beneficiaries who have Medicare supplemental insurance, this amount has most likely already been paid but "self-pay" patients may still have a balance outstanding. The hospital may keep any out of pocket payments it has received prior to the effective date of the Agreement, but given this restriction, hospitals planning to use the Settlement Agreement should consider trying to collect outstanding balances or establish payment plans prior to submitting their request for settlement.

For example, for a $5,000 2012 Part A claim the "net amount" is $5,000 minus $1,156 (the Medicare Part A copayment in 2012) = $3,844. CMS will pay 68% of that amount, or $2,613.92.

If the hospital had decided to avoid recoupment and held onto its money when it appealed the denial, the MAC will recoup the difference, i.e., up to 32 percent of the initial payment. Any interest the hospital has paid will be refunded.

A complex hospital decision

Hospitals are now faced with making a difficult financial decision on whether to accept the partial payment or to continue to pursue their appeals. Accretive can help you make an informed decision by using clinical criteria to conduct an appeals viability analysis. The first step is to determine how many appeals a hospital has at each level and to consider its record of success in overturning denials at each level. Accretive can do an analysis of a hospital's appeals and advise on "appeal viability," i.e., the likelihood that the hospital will be able to overturn the denial. This is a critical factor in comparing options.

Part B Rebilling Option

A hospital may withdraw selected appeals prior to submitting the Settlement Agreement and use Part B rebilling once the withdrawal has been acknowledged. The hospital should decide whether the potential reimbursement for Part B rebilling will be more or less than the amount CMS has offered with the Settlement Agreement. The hospital should factor in the administrative cost of rebilling and consider that it must bill the patient for any Part B copayments or deductible they owe and refund any overpayment resulting from previously collected copayments. Again hospitals will need to look at their own track records and payment rates to make this complex decision. Accretive can provide the data and guidance in comparing these options and making the decision that is best for you.

© 2014 Accretive Health Inc.

Time value of money and uncertain time frame for payment

There are additional considerations besides comparison of payment rates. There's the time value of money, or course. If a hospital has a lot of appeals in the lower levels, it will take more time to resolve them and faster payment from the Administrative Agreement will be more attractive. How much more is 68 percent in the bank worth now compared to the potential of 100 percent in 3 years? For very strong appeals (such as denial of an inpatient only procedure because it was done as an inpatient) the answer is simple, but how many of a hospital's appeals are such "slam dunks"? Taking into account the denials that will not be overturned, 68 percent may look more attractive. This is where an Accretive appeal viability analysis can really pay off.

Another unknown is how the various efforts to clear the backlog will affect time to final adjudication of the appeals that remain in the system. If the program is widely accepted, that time frame can be expected to drop and a hospital may receive payment on overturned denials in a timelier manner than expected. This will remain an unknown until we see how many hospitals opt in and how many claims are removed from the backlog.

Time is of the essence

There are a number of questions about the program still to be answered, but now is the time for hospitals to review their pending appeals and decide which if any of the CMS initiatives will benefit them most. The window for preparing and deciding on participation is short and once the RACs and MACs are back in the business of issuing denials and recoupments, the flood of appeals will likely begin anew and the backlogs may be back. Accretive Health is ready to assist you in that process. Contact your Account Manager to get the ball rolling. There is very little time and a lot to do.

CMS has created a mail box for hospitals to submit questions about this new policy: MedicareSettlementFAQs@cms.hhs.gov. It is not offering personal responses, however but says it will use the questions to develop an FAQ document.

More details and the forms required to withdraw appeals and request an Administrative Agreement can be found on the Inpatient Hospital Reviews CMS webpage here: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html.

CMS will be holding a teleconference on the new program on September 9 at 1 PM ET. Register at http://www.eventsvc.com/blhtechnologies.

© 2014 Accretive Health Inc.

Although this offer seems enticing, hospitals need to consider numerous factors to arrive at an informed decision.

Some of the key questions to consider are:

1. What is the total expected Part A reimbursement for all qualifying pending Medicare appeals?
    a. What is the percentage and amount of expected reimbursement at each appeal level?
    b. What is the hospital's appeal success rate?

2. What is the probability of success for your current pending appeals?
    a. How many have a high, medium or low probability for success?

3. How does your expected reimbursement from completing the appeals process differ from a 68 percent settlement?
    a. Does the statistical sampling at level 3 affect the 68 percent settlement amount?

4. Should you withdraw some appeals and rebill Part B?
    a. How does potential Part A payment compare to guaranteed Part B?
    b. Is the rebilling process worthwhile?

5. How important is cash flow to your facility?
    a. When will Medicare actually pay for settled claims?
    b. How long will it be from settlement submission to CMS reconciliation to CMS counter signature to actual payment? Can you afford to wait?

Accretive Health can assist you in determining whether to accept the 68 percent settlement or continue with the appeals process!

Accretive clients: Contact your account manager to discuss your particular concerns and needs.

Contact Accretive Health, Inc. at
231 S. LaSalle St, Ste 1600
Chicago, IL 60604
(312) 931-3007
pas.info@accretivehealth.com
www.accretivehealth.com

© 2014 Accretive Health Inc.