To Our Healthcare Clients and Friends:

This issue of *IMA Insights* seeks to provide a comprehensive discussion of how “shadow billing”, by hospital providers, for their Medicare Advantage patients, can provide incentive payments to hospitals for the "meaningful use" of certified EHR technology.
BACKGROUND

“Shadow billing”, synonymous with “no pay” or “information only” claims, is an unofficial term that refers to the process wherein hospitals submit claims to their Medicare Administrative Contractor (MAC) for inpatient services provided to Medicare beneficiaries who are enrolled in a Medicare Advantage (MA) plan. These claims are submitted, as per instructions from CMS through a series Transmittals, for the purpose of requesting supplemental Indirect Medicare Education (IME), Graduate Medical Education (GME), and Nursing Allied Health Education (NAHE) payments, and for the proper reporting of Medicare beneficiary days to be counted in the Medicare fraction of the Disproportionate Share Hospital (DSH) calculation. Shadow Billing for MA patients by hospitals began with the passage of Balanced Budget Act of 1997 (BBA’97), wherein sections 4622 and 4624 of the Act, provided hospitals with additional payments for IME and GME costs for their patients enrolled in a Medicare managed care program.

The American Recovery and Reinvestment Act of 2009 includes the Health Information Technology for Economic and Clinical Health Act, or the “HITECH Act,” which established programs under Medicare and Medicaid to provide incentive payments to hospitals for their meaningful use of Electronic Health Record (EHR). The Act will reward hospitals for adopting, implementing or upgrading to certified EHR in year one of the program and demonstrating meaningful use of the technology in the years thereafter. The Final Rule was released in July 2010 (75 Fed. Reg. 44314) and added to Title 42 of Code of Regulations: Part 495.

For Medicare purposes, an eligible hospital means: hospitals (acute care hospitals that are subject to PPS), critical access hospitals and Medicare Advantage hospitals. NIH Cancer Centers and Children’s hospitals are excluded. Hospital payments are based on the 12 – month federal fiscal year, from October 1 to September 30. After the first payment year, every subsequent year is treated as a payment year, even if no incentive payment is received. The implementation of a CMS certified EHR occurs in three stages: stage 1 including 2011 and 2012 payment years, stage 2 including 2013 and 2014 payment years and stage 3 2015 and 2016 payment years. There are no payments after 2016. The meaningful use must be demonstrated for each payment year by meeting 14 core objective and 15 clinical quality measures.

The meaningful use incentive payment can begin in 2011 and must begin in 2015. The amount decreases if the program begins in 2014 or 2015. Preliminary calculations are based on the latest submitted 12 – month hospital cost report with final payments determining at the time of settling the first 12- month hospital cost report for the hospitals fiscal year that begins on or after the first day of the payment year. The following is the calculation:

Incentive Payment = [Initial Amount] X [Medicare Share] X [Transition Factor]

The initial amount is a base payment of $2,000,000 and $200 per discharges between 1150th and 2300th. The Medicare share is a fraction where the numerator is the number of Medicare Part A + Medicare Advantage inpatient bed days while the denominator is the total number of inpatient days multiplied by Total Charges minus Charity Care and divided by Total Charges. Lastly, the transition factor is applied at a sliding scale depending on when the hospital qualified: 2011 is 100% and then 75%, 50% and 25% from 2012 through 2014. It should be noted that hospitals will lose the first or first and second payment if they qualify in 2014 or 2015 respectively.

There are penalties associated for failure to adopt an EHR and beginning in 2015 there will be a negative market basket adjustment of 331/3 %, in 2016 a 66 2/3 % reduction and in 2017 a 100% reduction.

The Medicare Administrative Contractor (MAC) will calculate the payments which will in turn be issued through a single contractor. The payment contractor will issue to qualifying hospitals a single initial payment per year within 4 to 8 weeks of a stated goal with the final payment being settled on the cost report period in which the provider was deemed a meaningful user.

CHALLENGES

As previously written, hospitals are under increased pressure to make sure that they identify and re-coup money that is rightfully theirs while balancing the challenges of dealing with a myriad of compliance issues. As discussed earlier, in order for hospital providers to submit shadow bills for their MA patients, they must submit a separate claim.
to their MAC (and not the MA plan). Accordingly this methodology places the onus on the hospital to ensure that the necessary information is provided on the claim, including specific information that must come from the beneficiary upon registration.

Often all of the information needed to submit a shadow claim is not obtained during the registration process causing large buckets of claims to never be submitted. Further, providers must ensure that the claim includes the applicable condition codes and other necessary information so that the claim can be properly processed. For many teaching facilities, this issue is likely to have been on their radar screen for a while. For the non-teaching facilities, that may not necessarily be the case. While many providers have addressed this issue by way of conducting retrospective reviews and incorporating internal processes to identify these claims prospectively, providers often fail to identify all of the eligible claims that they should be billing. Even in organizations that are doing retrospective reviews, simply missing 1% - 2% of these claims can result in significant lost revenues.

Missing these claims can result in a hospital not being able to capturing the associated Medicare Advantage days to be used in the incentive payment calculation. The incentive calculation for meaningful use uses inpatient Medicare day to total days which includes Medicare Advantage days. For the MA days to be included in the calculation the Shadow Bill must be processed and paid on the provider statistical and reimbursement report (PS&R).

There are a variety of factors that may contribute to this dilemma including the fact that the regulatory guidance is complex and sometimes unclear; hospitals sometimes lack proper internal resources; there is often miscommunication or a lack of effective communication among key hospital departments (i.e., patient accounting, reimbursement, managed care, compliance, decision support, and finance); disparate systems often make it difficult to obtain all of the required data; time and competing initiatives; and turnover of staff leading to gaps in processes. So the challenge for providers is to develop and maintain processes and controls to identify MA patients, ensure proper data is collected and successfully bill shadow claims.

With regard to filing shadow bill claims, the conventional belief in the industry is that these claims must be filed according to the timely filing rules. On May 7, 2010, CMS issued new timely filing guidelines in Change Request (CR) 6960, which went into effect on January 1, 2010. In that issuance, CMS instructed Medicare contractors (based on provisions of the Patient Protection and Affordable Care Act (PPACA) to adjust their system edits to ensure the following changes for the processing of claims. Beginning January 1, 2010, claims must be filed within 12 months from date of service. This change is significant and dramatically shortened the amount of time a provider has to file a claim. For those providers who rely on retrospective reviews to ensure that they have captured all of the monies to which they are entitled, this change dramatically shortens the window of time with which to get these reviews completed.

INSIGHTS

Despite the numerous challenges that exist surrounding the issue of shadow billing for MA patients, there are many things within the control of the provider in order to address these challenges. More importantly, given the upside for additional incentive payments as it relates to meaningful use, potential negative impact of not doing so, providers cannot remain complacent with this issue.

First, a comprehensive understanding and reconciliation to the PS&R report (both Report type 110 and 118. This will ensure that the MAC is capturing the correct claims. Second, the function of shadow billing should occur within a reasonable time frame and not be held up for the Medicare Advantage plan to pay the claim first. Third, conduct on-going reviews to ensure that you are capturing and shadow billing all MA patients you treat through automation and tracking. Fourth, based on the results of your reviews, you may need to tighten existing internal processes and controls and create new ones as needed based on the results of your review. Part of your review should include a retrospective assessment.

Finally, stay in touch with your peers and industry experts and continually look in areas where you didn’t look before (i.e., do you complete a 100% review of traditional HMO claims to look for misclassified MA patients – another opportunity to capture shadow bills).
SUMMARY

Opportunities exist for providers to re-coup additional reimbursement to which they are rightfully entitled and to make sure that they are in compliance with instructions set forth by CMS. Additionally, HITECH and the meaningful use requirement will allow providers to receive additional incentive payments. It is clearly demonstrated that a financial opportunity exists for teaching facilities to recoup additional dollars as well as non-teaching facilities to ensure they are to the best of their abilities are capturing and attesting to shadow billing requirements.

In our experience, providers are successfully capturing between 92% – 99% of the claims that should be shadow billed. This appears to be a strong success rate, but even a small percentage increase to your MA days can increase a meaningful use payment by $200,000 to $600,000 for the duration of the program.

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We are pleased to have the opportunity to provide this information to you. If you have any questions, need assistance with evaluating your shadow billing process, or need assistance recovering lost monies, please do not hesitate to contact me at (215) 514-0951.

Truly yours,

Mario Feher

Director