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Advomas Quarterly Newsletter | 3rd Quarter | Volume 74

APPLYING FOR MEDICAID
What You Need to Know

PE CLASS IN SESSION
A Presumptive Eligibility Primer

MICHIGAN NO-FAULT DECISION
What it Means for Providers

advomas®
Healthcare Eligibility Advocates

Knowledge is Power

After a 5-year hiatus from publishing our quarterly newsletter, we are BACK!

The decision to shift gears away from social media is not one we've made lightly. The world is undoubtedly hooked on social media. However, instant feeds with constant updates frequently bombard us with information that isn't critical to (and often distracts us from) the tasks at hand. Turning our focus back to a semi-permanent quarterly newsletter allows us to provide the most important eligibility information for revenue cycle professionals in a concise, direct manner. While we had significant engagement from Facebooking and Tweeting, we ultimately decided to revive the newsletter based on listening to your feedback.

This year Advomas celebrates 30 years of helping providers reduce uncompensated care and resolve complex payer claims. Our partnerships have allowed us to change the lives of millions of underserved Michigan residents. Thank you for your loyalty and trust in Advomas to take care of your most complicated claims cases while you focus on providing the care.

Our intent is to provide a publication founded on 30 years of experience resolving difficult claims issues. Our pages will be filled with relevant healthcare eligibility information with our perspective as it relates to Michigan's uninsured and underinsured. We will also throw in some "fun stuff" to keep you all awake.

We look forward to continuing to serve your organization and welcome your feedback.

Jennifer K. Rakolta
President

URGENT! *MEDICAID billing rules change effective 1/1/2017.*

The Change:

The Michigan Department of Health & Human Services (MDHHS) has updated the billing limitation policy to now require that all FFS claims must be filed and resolved no later than one year from the date of service (DOS).

What this Means for Providers:

Providers must now bill and resolve all claims within 1 year from date of service; they will no longer be able to keep a claim active in the system every 120 days after the year time frame. In addition, the new policy requires that any old claims providers have been keeping active for services rendered prior to 1/1/2017 must be submitted for payment and resolved no later than 12/31/2017. There are exceptions, but all exceptions must have a 1038 authorized by the MDHHS.

Since this policy was released, Advomas, the Michigan Patient Accounting Association (MPAA), and the Michigan Health & Hospital Association (MHA) have presented an array of concerns to the state as to why this new policy is detrimental to the provider community, and have offered suggested changes, many of which are still under consideration. For example, FFS Medicaid cases are those where the patient presents to the provider as uninsured and has to apply for Medicaid coverage. Delays in processing of applications by MDHHS may cause coverage activation to occur within the year, but long enough after the date of service that it only allows a short window for submitting a claim, not allowing the provider any opportunity to resubmit if it should be rejected for some reason. It has been proposed that the state consider following Medicare rules, allowing providers to bill from coverage activation rather than from date of service. This would allow for a better window of opportunity for providers to bill and, at the same time, relieve the state and providers of all the work involved in the securing of 1038 exceptions.

Meetings on this policy are still underway at the present time. Advomas will keep you abreast of any news on this matter as it occurs.

Attached Bulletin

http://www.michigan.gov/documents/mdhhs/MSA_16-37_543830_7.pdf

The American Health Care Act (AHCA) Passes the U.S. House – NOW WHAT?

By Jennifer Young, J.S. Clark Corporate Compliance Director

The Trump administration is taking the bull by the horns in pursuit of the Republican seven-year promise to repeal the Affordable Care Act (ACA). On May 4, 2017, the House of Representatives passed the American Health Care Act (AHCA) by a narrow margin with a vote of 217-213.

The AHCA is a budget reconciliation bill designed to repeal significant sections of the ACA. The primary focal points include the repeal of Medicaid expansion, the shift of power back to the States, replacement of individual subsidies with tax credits and multiple tax repeals.

The AHCA retains some of the ACA's more popular reforms, such as protections for enrollees with pre-existing conditions and the requirement that adult children can stay on their parents' plans until age 26.

Highlights include:

- Repeal of the individual and employer mandate penalties
- Repeal of the majority of ACA's taxes
- Delay of the Cadillac Tax until 2026
- Increased maximum deposits to health savings accounts (HSAs) and flexible spending accounts (FSAs)
- Replacement of income-based subsidies with age-based tax credits
- Increase the age-banded ratio insurance companies can charge older enrollees for premiums compared to younger enrollees from 3:1 to 5:1
- Establishes a Patient and State Stability Fund
- Repeal of the funding for the Prevention and Public Health Fund by the end of 2018
- Restructure Medicaid funding and repeal enhanced funding for Medicaid expansion
- Prohibit federal funding for Planned Parenthood clinics, and prevent premium tax credits from being applied to any insurance plans that provide coverage for abortions, with certain exceptions
- Allow states to apply for waivers to:
- Redefine Essential Health Benefits
- Vary premiums by health status with participation in the Federal Invisible Risk Sharing Program
- Increase age band ratios above 5:1

The bill was presented twice and pulled before debate in the House, finally put to full vote on May 4, 2017. Between March 23 and May 3, several amendments were included to ensure the necessary votes to pass in the House.

The final Congressional Budget Office (CBO) cost analysis of the AHCA estimates a reduction to the federal deficit of $119 billion during the period of 2017 – 2026 ($32 billion less than initially estimated). This is the targeted savings for the Senate Republicans as they draft their own bill. Staying on target is crucial to the Republicans to be able to take advantage of the 50 vote requirement under the budget reconciliation process.

The CBO analysis estimates 14 million people will lose coverage under the AHCA and by 2026 an estimated 51 million would be uninsured. Nearly half of those with incomes below 200% of the federal poverty level and about 17% fewer Medicaid enrollees would lose coverage due to the end of the enhanced funding and Medicaid expansion. This is compared to the estimated 28 million uninsured by 2026 under the ACA.

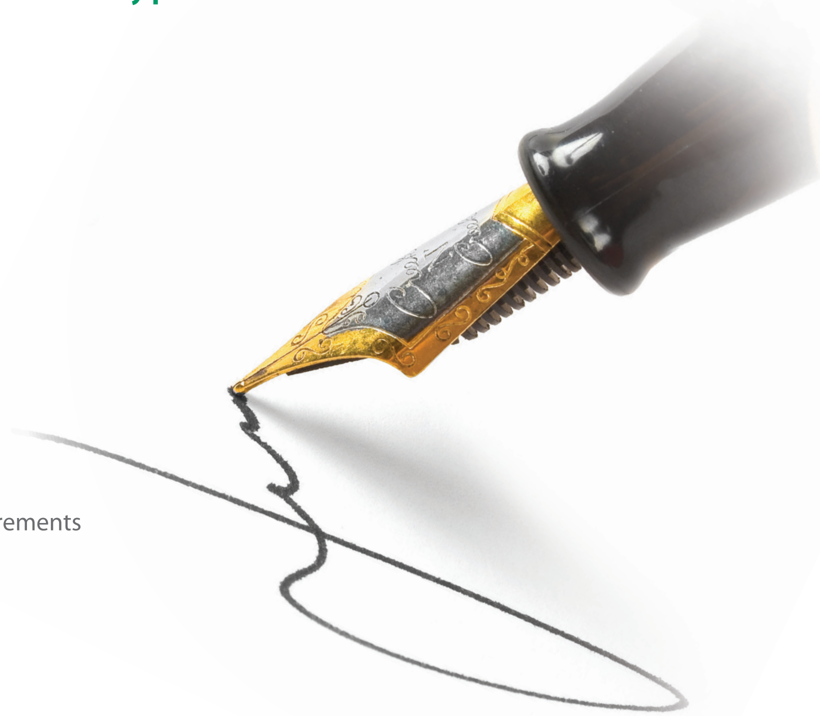
The passage of the bill in the House is just the beginning of what promises to be a long process. Identical versions of the upcoming Senate bill must pass both chambers before being signed by the President and becoming law. With expected major changes in the Senate, the bill could lose support in the house.

ACA compliance remains the law of the land – for now

Health care reform remains one of the hottest topics on Capitol Hill. As we ride out the debates and controversy it is most important employers keep in mind that nothing has yet changed!

Until a repeal and replacement bill is signed into law by the President, employers should continue to comply with all aspects of the ACA. Some of these ACA key provisions include:

- Exposure to all penalties
- Employer shared responsibility requirements
- Employer reporting requirements
- Tracking and verifying eligibility
- Summary of Benefits & Coverage requirements
- Advance Notice of Material Changes requirements
- Marketplace Notice requirements
- PCORI Fees
- Waiting period requirements
- Offer of affordable and minimum value coverage requirements



Jennifer Young *is the Corporate Compliance Director for the J.S. Clark Agency. Located in Southfield, Michigan, the J.S. Clark Agency provides benefits strategy, management and administration to more than 300 corporate clients, of which Advomas is pleased to be one. Please feel free to contact Jennifer at* ***jennifer@jsclarkagency.com*** *to discuss your organization's benefits compliance needs, or view the agency's full range of services at* ***jsclarkagency.com****.*

New Medicare Card (formerly called the Social Security Number Removal Initiative, SSNRI)- APRIL 2018

CMS is removing Social Security Numbers from Medicare cards to fight fraud, identity theft and protect your taxpayer dollars. Providers must be ready by April 2018 for the change from the Social Security Number based Health Insurance Claim Number to the randomly generated Medicare Beneficiary Identifier (the new Medicare number).

Be sure to visit CMS: https://www.cms.gov/medicare/new-medicare-card/nmc-home.html

Advomas is a member of the Michigan Patient Accounting Association (MPAA). The following are billing updates from the last meeting:

Predictive Modeling: When the Predictive Modeling edit hits the claim, a letter is generated to the provider. A paper copy is mailed and now a link to the letter will be attached to the claim information in the CHAMPS system. The provider has **45 days** to upload the documentation to the Document Management Portal (DMP). If any further info is requested, a message will be sent via the DMP explaining hat is needed, and the provider will have **10 days** to upload the additional documentation. If the additional information is not received in given time frame, the claim is denied and the entire process will need to be started over. (A new claim will need to be sent until it suspends for Predictive Modeling, then records can be uploaded to DMP…etc.)

Further info on this matter can be found via the link below:
http://www.michigan.gov/documents/mdhhs/Insti_Billing_Tip_Predictive_Modeling_01_05_2017_548309_7.pdf

Champs Enrollment

Bulletin Number: MSA 17-04

Beginning in 2018, Medicaid Health Plans (MHPs) and other managed care plans and organizations will be required to ensure all providers submitting Medicaid claims are enrolled in CHAMPS

- All providers servicing Medicaid beneficiaries will be required to enroll in CHAMPS as a requirement for reimbursement

Note: Enrolling in CHAMPS does not require you to be a Medicaid FFS Provider

To PE or not to PE? A Question for Providers, and Advomas Can Help.

Presumptive Eligibility (PE) allows staffs of qualified providers to make eligibility decisions based on preliminary information obtained through patient's attestation of their circumstance. If the applicant appears to be below the income threshold at the time of PE application, they can be enrolled for temporary coverage with the expectation that a full Michigan Medicaid application will be submitted following the PE application.

Benefits are mostly the same as those provided under full Medicaid, but only from the date of PE application through the end of the following month. Patients can only receive PE coverage once per year. While PE has been around for several years in other states for certain individuals, its full utilization has been somewhat limited in Michigan.

Advomas recently piloted one of two PE launches in Michigan with our client. The State initially set some guidance to measure performance of a hospital using the program. One benchmark established that a minimum of 60% of PE-approved cases thereafter need be approved for full Medicaid. Thanks to a well-designed joint process with our client and through the hard work of our staff, we are running above 90% for the initial 6-month period.

Over the course of launching this program we had some favorable surprises, including PE applications well above projections, and the expedient manner by which PE is approved, allowing us to notify patients almost immediately of their coverage, before they left the hospital.

Although some health systems are cautious to apply and implement PE, it has been a big success so far, offering peace of mind to a few early adopters and their patients.

For more information and questions please contact **Cheryl Korpela** at **ckorpela@advomas.com**

LOOK OUT! Top proposed changes in the AHCA could impact Michigan Medicaid

- **Elimination of 3-month retroactive coverage requirement (start eligibility "in or after" the month of application) beginning as soon as October 1, 2017**

  For clients that do not use Advomas in their emergency centers this change could be even more dangerous for your reimbursement. Ensuring that your facility's eligibility process occurs at the earliest point in a patient's usage cycle will be key to combatting the negative consequences of a reduced retro eligibility period.

- **Require eligibility redeterminations every 6 months for expansion enrollees beginning as soon as October 1, 2017**

  We checked in with our on-site DHHS workers and they are hopeful that a redetermination will not require substantial effort on Advomas or on providers. This more frequent redetermination process could result in more case closures and loss of Medicaid coverage, causing an increase in uninsured patients pursuing services and increased need to reapply for coverage.

- **Expanded Medicaid through the Healthy Michigan Plan could be eliminated as of 1/1/2020, causing loss of coverage to more than 600,000 Michigan residents**

- **Presumptive Eligibility could be eliminated as of 1/1/2020 as well.**

Advomas will notify its clients of policy changes as they occur…

Advomas HR Tip

"Hire slow and fire fast" is a phrase that most HR leaders have heard. Implementing this practice into your hiring process means you have taken the time to ensure you are hiring the right person. When you hire the right person based on cultural fit as well as experience and skill set, the overall transition for both the new hire and your organization is smoother. Both management and the employee struggle less during training, are more efficient, and can make a greater impact overall. Once an employee has been identified to no longer be a good fit for your company, do yourself and the employee a favor by letting them go as quickly as is practical. When you continue to keep a person who just isn't working out, you are actually causing more damage than good to the overall organization's mission.

Penni Roberts
VP Human Resource

Community Connections

Advomas culture is strongly rooted in helping people. This doesn't just mean through the work we do for our clients. We make it our mission to find innovative ways to give back as a team. Since January we have donated more than $150,000 dollars to local charities that benefit Michigan residents and local health systems… with our latest initiatives, we are on track to give back another $50,000 by year's end.

Applying for Medicaid - Income Type Reminder

Advomas onsite MARA worker, Susan Woonton, provided detailed training at our June staff meeting for our eligibility specialists. Below are a few highlights/reminders when applying patients for Medicaid:

MAKE SURE YOUR INCOME TYPES (EMPLOYED, SELF-EMPLOYED, COMPANY OWNER) ARE ACCURATE TO AVOID BRIDGES PENDING.

Bridges pends for verifications that do not exist causing:

- Denials for verification not being returned
- Denials due to rejection of returned verifications DHS/Bridges believes are incorrect
- Incorrect processing of returned verifications
- Difficulty in appealing a denial
- Reapplication
- Possible loss of a retroactive month

DEFINITIONS TO REMEMBER WHEN APPLYING:

1. "Employed"= Receives wages from another individual, organization or LLC/Corporation

   Verification Sources to pursue:

   - Verification of Employment (DHS-38)
   - Paychecks, Payroll Register
   - IRS 1099 or W-2
   - Electronic Verification (The Work Number)
   - Letter or document from person making the payment
   - IRS 1040 and applicable IRS Schedules

2. "Self Employed"= Runs own business (selling goods, farming, direct services, operating adult foster care home, or room and board); provides child care in his/her OWN home; sets own work hours; provides own tools used on the job; rental income (counted as either self-employment or unearned); NOT an owner of an LLC or Corp, S Corp (BEM 502); NOT an individual who provides child care in the CHILD'S home (BEM 502)

   Verification Sources to pursue:

   - IRS Schedule C, even if client did not file taxes, representing YTD income or anticipated future income
   - If an IRS 1040 is provided, the IRS Schedule C must also be provided.
   - NOT a DHS-431, 1099, W-2 or written statement

3. "Company Owner"= Individual is registered under the LLC or S Corp (Sole Proprietorship, Partnership or Corporation)

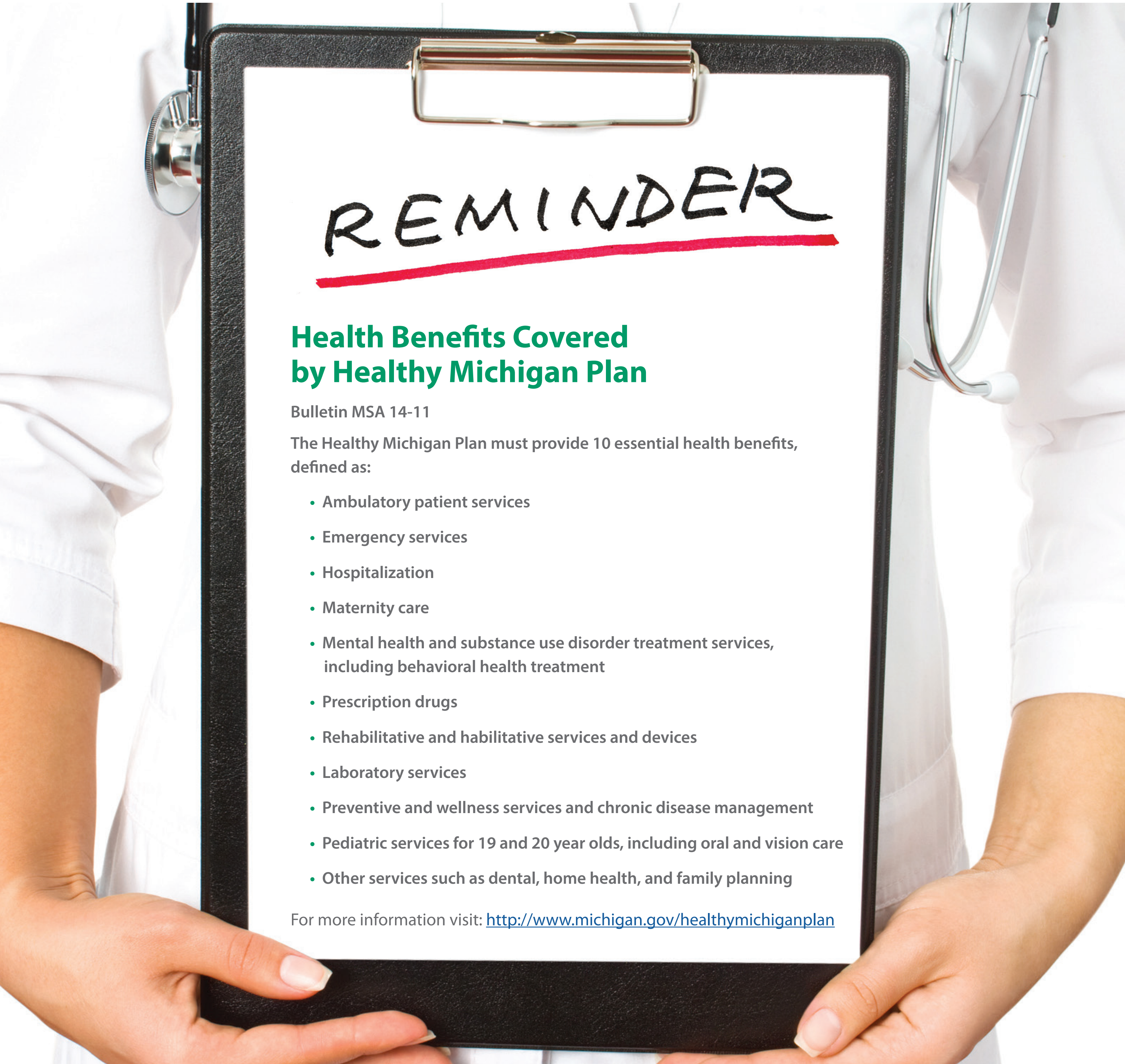
   - Business income is not used
   - DHS only counts the wages or salary the business owner pays himself (BEM 501)
   - Expenses to run/operate the business are not deducted (BEM 503)
   - As of 07/1/2017 enter income as earned income (BEM 501)

   Verification Sources to pursue:

   - Enter the company name in the search box on the Department of Licensing and Regulatory Affairs website, **dleg.state.mi.us**
   - Displayed results show registered type
     - Enter earned income from IRS 1040
     - Enter unearned income (shareholders or partner dividends/interest) from IRS Schedule K-1 (BEM 503)
     - Limited Liability Company (Sole Proprietorship)
     - Limited Partnership
     - Corporation

Opportunity for Medicare when No Auto Benefits Available:

Dialysis for Acute Kidney Injury is now a covered benefit thru Medicare just like ESRD as of January 1, 2017! Please be sure to question anyone who has been injured, especially in an auto accident, if they are receiving dialysis due to an injury to their kidneys so that the patient can be evaluated for Medicare coverage, especially if they are driving their own uninsured vehicle and not eligible for no fault benefits.



Health Benefits Covered by Healthy Michigan Plan

Bulletin MSA 14-11

The Healthy Michigan Plan must provide 10 essential health benefits, defined as:

- **Ambulatory patient services**
- **Emergency services**
- **Hospitalization**
- **Maternity care**
- **Mental health and substance use disorder treatment services, including behavioral health treatment**
- **Prescription drugs**
- **Rehabilitative and habilitative services and devices**
- **Laboratory services**
- **Preventive and wellness services and chronic disease management**
- **Pediatric services for 19 and 20 year olds, including oral and vision care**
- **Other services such as dental, home health, and family planning**

For more information visit: http://www.michigan.gov/healthymichiganplan

Call to Action!

Covenant V. State Farm

On May 25, 2017, the Michigan Supreme Court issued a landmark decision in the case of *Covenant Medical Center, Inc., v. State Farm Mutual Automobile Insurance Company*. In a 5-1 decision, the Court took away significant legal rights of healthcare providers who care for auto accident victims. The Court held that healthcare providers do not have a right under the No-Fault Act to sue no-fault insurers directly for services rendered to patients injured in auto accidents. As the Court stated: "*We therefore hold that healthcare providers do not possess a statutory cause of action against no-fault insurers for recovery of personal protection insurance benefits under the no-fault act.*"

The *Covenant* decision marks a radical departure from over 20 years of case law from the Michigan Court of Appeals, which repeatedly held that healthcare providers had a statutory cause of action against no-fault insurers. Yet the *Covenant* Court called such longstanding decisions "*unconvincing*" and "*devoid of the statutory analysis necessary to support that premise.*" Since hospitals can no longer sue no-fault insurers directly, what can they do? *Covenant* did leave other options open for pursuing payment:

- **Assignment of Benefits from Patient to Provider.** In an important footnote, the Court stated: "*[O]ur conclusion today is not intended to alter an insured's ability to assign his or her right to past or presently due benefits to a healthcare provider.*" However, Section 3143 of the no-fault act prohibits the assignment of **future** benefits. These Assignments must be carefully worded to comply with the statute. Also, many auto insurers are already seeking to bar this avenue by asserting that their policies contain "anti-assignment" clauses. Typically, those clauses have been interpreted as "anti-transfer" clauses, not as a bar to assign the right to pursue payment. There will be some uncertainty, and no doubt litigation, as insurance companies try to challenge the validity of assignments.
- **Third-Party Beneficiary Status.** In another footnote, the Court indicated that a medical provider *may* be able to bring a claim based on the argument that it is a third-party beneficiary to the insurance contract, if the terms of the insurance contract lend themselves to that argument. This is a weaker argument, though, and only applies in situations where the patient has a contracted insurance policy. It would never apply to insurers assigned by the Michigan Assigned Claims Plan.
- **Seeking payment from the patient.** The Court held that a healthcare provider's ultimate recourse is to "*seek payment from the injured person for the provider's reasonable charges*." Thus, healthcare providers will now be forced to sue their patients for unpaid balances. This will mean more auto accident victims retaining more lawyers and more lawsuits filed – all of which our no-fault system was designed to avoid.

Best practices for medical providers may now include working closely with car accident victims so that they better understand the billing process, and obtaining signatures for assignments of **rights** after treatment is provided, to permit the medical provider to litigate against no-fault insurers directly for unpaid medical bills. Questions? Contact the expert attorneys at Knight & Firth P.C., 248-928-8100.

To see the full opinion visit: http://courts.mi.gov/Courts/MichiganSupremeCourt/Clerks/Recent%20Opinions/16-17%20Term%20Opinions/152758.pdf

Advomas Employee Spotlight - *Brittany Harris*

Our team of experts is the reason we are so effective at securing the highest payer source. With their compassion and dedication we have remained a strong and resilient company. This quarter we thank Brittany Harris for her support as a human resources assistant. Our people aren't just making a difference at Advomas, they're positively helping in the community. Here's how:

"My community involvement is through my church. I'm a part of a group that goes out into the community to do "Random Acts of Kindness," such as passing out $10.00 movie theater gift cards in three surrounding cities of my church, paying for people to wash and dry their clothes at the laundrymat, and filling up 40 cars at a local gas station.

I'm a firm believer that life is not only about building relationships with people but also maintaining those relationships; this is what Advomas does with their patients and clients. I'm happy to be a small piece that helps the company operate and continue to build on those relationships in our community."

Brittany was born in Michigan and spent her childhood in Texas, Germany and California; her father is a United States Army member. Brittany will complete her MBA from University of Detroit Mercy this summer with a focus on Forensic Accounting.

Cheryl Korpela,

Chief Administrative Officer at Advomas, anticipates walking 60 miles in Susan G. Komen Cure for Cancer.

Support Cheryl as she walks 60 miles in California on November 17-19, 2017. Cheryl and her team are raising $2,500 for the walk.

Visit her site at **the3day.org/goto/korpela2017** to donate towards a truly worthy cause!

Susan G. Komen for the Cure®

MARK YOUR CALENDAR!

MDHHS OFFICE CLOSED:

September 4

November 10, 23, 24

December 22, 25, 29

The Michigan Patient Accounting Association (MPAA) & Michigan Association of Healthcare Access Professionals (MAHAP) will be merging into one organization in **September 2017** and will be called "The Michigan Revenue Cycle Association" (MRCA)

MAHAP-MPAA-HFMA Michigan Revenue Cycle Conference
Wednesday-Friday, September 20-22, 2017
Soaring Eagle, Mt. Pleasant, MI
888-732-4537

Webinar regarding the new Michigan Medicaid application and other MiBridges changes will be repeated on **9/21/17** at **11:30 a.m.**

November 2017 - Training sessions will be starting on how to enroll in MiBridges as a Community Partner, along with training on the new application

January 22, 2018 - NEW Medicaid APPLICATION rollout date statewide

January 2018 - New MiBridges access for Community Partners assisting people with applying for assistance, to include access to view active benefits received by applicants

5/4/2017

House Republicans approved their plan to replace the Affordable Care Act in a 217-213 vote.

5/26/2017

Michigan Supreme Court Ruling on MVA- Provider loses to Insurance Company for over $40,000 in medical care.

7/28/17

ACA Repeal Fails in Senate

NOTES

A MESSAGE FROM OUR FOUNDER & CEO

The only thing wrong with the word, "Change", in this instance, is that when you have been around the block, the term often should be, "Change back."

That's what we are seeing today from our Supreme Court and Lansing (and Washington will likely follow).

The Michigan Supreme Court has delivered a blow with the elimination of provider's ability to sue an insurer directly without an assignment given after the service is rendered.

Some of you may remember, this is where we were about 12 years ago. Like I said, change back…

The fact is, we didn't die and the world didn't come to an end; but we did things differently and now, all our clients are on track to "change back" and reinstitute the procedures and processes we used a decade ago. The "change back" in the law isn't good and it will impact our clients negatively but we can fix much of it…specifically, we've begun working with clients to ensure that an assignment will be signed after services are rendered. There is an advantage of being long in the tooth and in being in this business for 40 years... we've seen it all...almost. From my personal standpoint, when I watch my young managers quasi-panic with the changes and proposed changes, I can simply lean back and say, "We've done that before and this is how we cope with it."

Unfortunately for me (and fortunately for you), we've got a team that always manages to improve on my old solutions – either with new technology or some other newfangled tweak in our processes. It's amazing what you come up with when you have a solid base of information, experience, and knowledge enhanced by young whippersnappers.

W. Bruce Knight

W. Bruce Knight
Founder & CEO

Advomas is a proud member of

MHA Michigan Health & Hospital Association

hfma

MPAA Michigan Patient Accounting Association

MAHAP

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