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Billing Alert for Long-Term Care

Excerpted from Volume 18 Issue No. 11 NOVEMBER 2016

Medicare's open enrollment period: What does it mean for the business office?

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Each year, Medicare's open enrollment period begins October 15 and ends December 7. The open enrollment period allows Medicare plan beneficiaries to review their current plan coverage and make changes to their plan selections. During the course of a year, details within the plans can change, such as provider and pharmacy network status, cost sharing requirements, and prescription drug coverage. In addition, as beneficiaries experience changes in their health, they may find that the benefits offered by their current plan no longer meet their needs. For this reason, CMS encourages beneficiaries to review their selections annually, including reviewing the documents that are sent during open enrollment, such as Evidence of Coverage and Annual Notice of Change. Changes made during open enrollment will take effect January 1 of the following year.

During the open enrollment period, beneficiaries may receive marketing materials from a variety of companies; they may also see advertisements that promote certain plans as cost-saving measures. These ads are designed to appeal to seniors, many of whom are on a fixed income dependent on their Social Security benefits. And, in 2016, beneficiaries did not receive a Cost of Living Adjustment (COLA) because the inflation rate had fallen. For 2017, the estimated COLA for Social Security beneficiaries is projected to be 0.03%—around $5 for the average beneficiary—and with insurance premiums on the rise, seniors are looking to save money.

During open enrollment, Medicare beneficiaries satisfied with their current plans can choose to not make any changes. Alternatively, they can change from traditional Medicare to Medicare Advantage or vice versa, or they can change from one Medicare Advantage policy to another Medicare Advantage policy. In addition, beneficiaries can make

changes to their Medicare Part D enrollment, choose a new prescription drug plan, or make an election if they were not previously enrolled in a Part D plan, although a late penalty may apply. That is a lot of payer changes in a short time frame.

Medicare beneficiaries may choose to transition from a traditional Medicare fee-for-service (FFS) plan to a Medicare Advantage plan as the premiums or cost of services may be lower than original Medicare or Medicare with a supplement. Many Medicare Advantage plans include a drug benefit, making the cost lower than traditional Medicare with a Medicare prescription drug plan. Another possible cost-saving advantage is the additional benefits some Medicare Advantage plans offer, such as eye exams, dental benefits, and health and wellness programs. Changing from FFS to Medicare Advantage plans is not without its pitfalls, however; plans may have in-network requirements that FFS Medicare does not. There may be referral and prior authorization requirements to see specialists, and beneficiaries may not be able to receive care at locations nearest to their homes, such as their hospital or nursing facility.

Starting January 1, it is important for skilled nursing facilities (SNF) to re-verify benefits for their entire census. Although this will take time for the staff to perform, it may lead to an overall cost-saving benefit. When payer changes are not properly detected, two things can happen. First, the facility's cash flow can be negatively impacted as the result of submitting claims to incorrect payers; when a payer change is not detected timely, a payment delay occurs, and additional staff time is spent resubmitting claims and working denials. Second, starting January 1, if a beneficiary transitions from Medicare FFS to Medicare Advantage, and the provider is not within the plan's network or did not perform a required authorization, the provider may receive a payment denial, which could lead to losing reimbursement or receiving a payment penalty from that resident's stay. It is also important to detect a Medicare Advantage enrollment because if your facility is out of network with the plan, this must be communicated to the beneficiary as he or she may be subject to increased financial obligations.

Performing benefits verification during the month of January is essential, but it is just as essential to perform

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it monthly throughout the individual's stay in the facility. During a beneficiary's lifetime, he or she may qualify for plan enrollment and disenrollment changes as a result of specific events. Special election periods (SEP) are a change most often seen by long-term care providers.

Special election periods

Medicare beneficiaries fall into SEPs when they reside in an institution. By Medicare's definition, an institution can be a SNF, a nursing facility, a psychiatric hospital or unit, an Immediate Care Facility for the Mentally Retarded, a rehabilitation hospital, a long-term care hospital, or a swing bed hospital. Once a beneficiary resides in one of these qualified institutions, he or she can transition between Medicare Advantage and Medicare FFS once a month, or switch from one Medicare Advantage plan to another. What that means for the business office is that upon admission, a resident can enter as Medicare Advantage and switch to Medicare FFS, or enter as Medicare FFS and switch to Medicare Advantage. In addition, for a beneficiary who moves out of one of the facilities listed above, that beneficiary will have an SEP for two full months after the month he or she leaves the facility. The effective date of the SEP is the first of the month following the month in which the enrollment/disenrollment request is received, but not prior to the month residency begins.

It is therefore vital to your facility's financial health to establish an ongoing process to verify resident benefits at the beginning of every month.

In addition, for those Medicare beneficiaries who reside on a campus, but not in a qualified institution (such as an assisted living facility or independent living apartment), there is one SEP that can be used if the resident changes his or her mind after enrolling in a Medicare Advantage plan. For the period January 1 through February 14, a beneficiary may transition from Medicare Advantage back to traditional Medicare FFS without penalty.

Additional election periods may occur when a beneficiary is a dual eligible, when he or she moves out of the plan area, or when the plan terminates. There is also an option to make a one-time change to a five-star Medicare Advantage plan.

It's important to evaluate your facility's procedures for benefits verification during open enrollment and beyond. If you do not have a process in place to do this, your facility is at risk for revenue loss and reduction of payments from payers. It is no longer acceptable to rely on the beneficiary or the beneficiary's power of attorney (POA) to communicate changes to the business office—staff must perform benefits verification on a monthly basis.

Equally imperative, your business office staff must understand *what* they are reviewing when the benefits verification comes back. The business office needs to communicate to the beneficiary (or POA) any coverage or network status changes that may financially impact the beneficiary. The office will also need to carry the updated benefits informationforward to ensure the payer tree is set correctly and confirm that information is properly reflected on your receivables. Finally, appropriate clinical staff will need to be informed of changes to ensure necessary authorizations are completed and coverage criteria are met and properly documented.

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