

STATE OF CALIFORNIA
Budget Change Proposal - Cover Sheet
 DF-46 (REV 08/15)

Fiscal Year 16-17	Business Unit 4440	Department State Hospitals	Priority No.
Budget Request Name 4440-00-BCP-BR-2016-GB		Program Program Administration In-Patient Services Legal Services	Subprogram 4380010, 4380019, 4390

Budget Request Description
 Third Party Patient Cost Recovery

Budget Request Summary

The Department of State Hospitals requests \$3.2 million (\$2.8 million ongoing and \$400,000 one-time) in General Fund authority to transition 15.0 limited-term positions to permanent full-time positions to continue improvements to the patient cost recovery system, including accounts management, billing and collection, litigation and court appearances, assets determination, policies and procedures, compliance and auditing as well as oversight functions.

Requires Legislation <input type="radio"/> Yes <input checked="" type="radio"/> No	Code Section(s) to be Added/Amended/Repealed
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Does this BCP contain information technology (IT) components? <input type="radio"/> Yes <input checked="" type="radio"/> No <i>If yes, departmental Chief Information Officer must sign.</i>	Department CIO	Date
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For IT requests, specify the date a Special Project Report (SPR) or Feasibility Study Report (FSR) was approved by the Department of Technology, or previously by the Department of Finance.
 FSR SPR Project No. Date:

If proposal affects another department, does other department concur with proposal? Yes No
Attach comments of affected department, signed and dated by the department director or designee.

Prepared By Christina Edens Chief Financial Officer (A) <i>[Signature]</i>	Date 1/5/2016	Reviewed By Lupe Alonzo-Diaz, Deputy Director - Administrative Services <i>[Signature]</i>	Date 1/5/16
Department Director Pam Ahlin <i>[Signature]</i>	Date 1/5-16	Agency Secretary Kris Kent <i>[Signature]</i>	Date 1-5-16

Additional Review: Capital Outlay ITCU FSCU OSAE CALSTARS Dept. of Technology

Type: Policy Workload Budget per Government Code 13308.05

PPBA <i>Carla Custard</i>	Date submitted to the Legislature 1-7-16
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Analysis of Problem

A. Budget Request Summary

The Department of State Hospitals requests \$3.2 million (\$2.8 million ongoing and \$400,000 one-time) in General Fund authority to transition 15.0 limited-term positions to permanent full-time positions to continue improvements to the patient cost recovery system, including accounts management, billing and collection, litigation and court appearances, assets determination, policies and procedures, compliance and auditing as well as oversight functions.

B. Background/History

The DSH manages the nation's largest inpatient forensic mental health hospital system. Its mission is to provide evaluation and treatment in a safe and responsible manner, seeking innovation and excellence in state hospital operations, across a continuum of care and settings. The DSH is responsible for the daily care and provision of mental health treatment of its patients. In FY 2014-15, the DSH served almost 13,000 patients and on average the inpatient census was approximately 6,700 in a 24-hours-a-day, seven-days-a-week hospital system and approximately 600 outpatient census in its conditional release program. The DSH oversees five state hospitals and three psychiatric programs located in state prisons, employing approximately 12,000 staff. Additionally, the DSH provides services in jail-based competency treatment programs and conditional release programs throughout the 58 counties. The DSH's five state hospitals are Atascadero, Coalinga, Metropolitan – Los Angeles, Napa and Patton. The three psychiatric programs are through an interagency agreement with the California Department of Corrections and Rehabilitation (CDCR), treating inmates at prisons in Vacaville, Salinas Valley and Stockton.

In recent years, the state hospitals have seen a significant growth in population levels as noted in the following table. The DSH served 12,936 patients in FY 2014-15, over 14 percent higher than FY 2012-13. Further, the rate of admissions has grown with approximately 6,281 new patients admitted in FY 2014-15, 26 percent higher than FY 2012-13.

Table 1: Patients Served and Admitted, FY 2012-13 to FY 2014-15

	2012-13	2013-14	2014-15
Patients Served	11,304	12,295	12,936
Patients Admitted	4,990	5,971	6,281

To offset pressures to the General Fund, the DSH researches and coordinates avenues to support third party reimbursement including Medicare Parts A, B and D; private insurance; private pay; private trust accounts; and legal settlements.

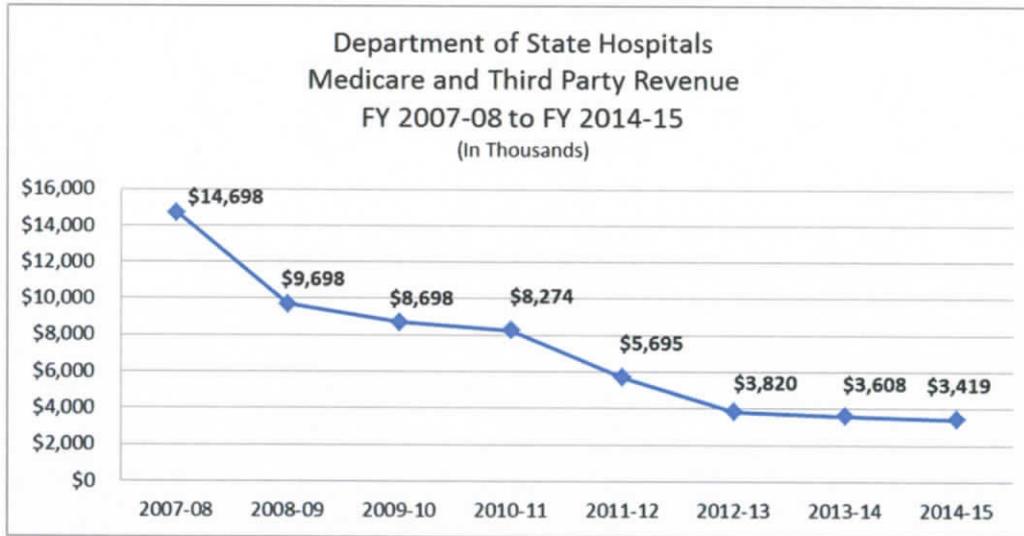
Transition from the DDS to the DSH

The Department of Developmental Services (DDS) was traditionally responsible for administering DSH's third party billing system. In the 1980s, the DDS and the then-Department of Mental Health (DMH) entered into a Memorandum of Understanding (MOU) agreement to identify its respective roles. The DMH would provide administrative services regarding State Hospital Cost Reporting, Patient Trust, Patient Billing for Third Party Payers, Conservatorship and Collection Services and the DDS would be responsible for developing hospital billing rates, compliance services, claims resolutions and risk management. The DMH would be responsible for the accuracy of data submitted to the DDS for Medicare billing and rate development, respond timely to audit inquiries, perform quarterly internal audits and quality control reviews of state hospital records.

When the DDS stopped performing the services outlined in the MOU, and as the population served by the DSH increased, the DSH did not have sufficient staff to perform the functions formally performed by the DDS. As such, quality control reviews, audits, claim corrections, trust functions and private pay collections were not being performed which resulted in the decline of revenue.

The following graph illustrates the significant decline in third party revenue since FY 2007-08.

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Implementation

With the approved 15.0 two-year LT positions, the DSH began the process of assuming the third party billing responsibilities from the DDS with the goal of maximizing revenue from Medicare, private pay and insurance collections by providing technical assistance to the state hospitals regarding billing; Medicare compliance reviews; managing patient trust accounts; performing patient benefit and insurance enrollment; provider enrollment, hospital certification, asset determination and pursuing legal efforts in private payer collections.

The DSH Established the PCRS

The FY 2014-15 Budget Act authorized the DSH to create a Patient Cost Recovery Section (PCRS) that included 15.0 full-time limited term (LT) positions to develop and implement a standardized and streamlined third party billing system that would include accounts management, billing and collection, assets determination, policies and procedures, compliance and auditing as well as oversight functions. The intent was for the DSH to assume the responsibility for all billing and collections functions previously performed by DDS for the DSH.

Provider Enrollment and Hospital Certification

The PCRS ensures accurate and timely enrollment of its providers by the Centers for Medicare and Medicaid Services (CMS) and hospitals by the California Department of Public Health (CDPH) and Joint Commission (JC) so that the DSH may seek reimbursement from Medicare Parts A, B and D.

Eligible providers include doctors of medicine, dental surgery or dental medicine, podiatry, optometry and chiropractors. The PCRS provides technical assistance to the hospital staff and providers to assist with enrollment with CMS. The PCRS submits applications for new providers during the initial hire and revalidates certification every five years. Ongoing, PCRS tracks provider staffing changes to update their hiring status with CMS.

The PCRS is responsible for securing and maintaining inpatient and outpatient Medicare certification which determines the Department's ability to seek reimbursement for Medicare Part A and B services. The California Department of Public Health (CDPH) licenses facilities to ensure facilities comply with state laws and regulations. CDPH has a cooperative agreement with CMS to ensure that facilities accepting Medicare payments meet federal requirements. Once certified, the DSH staff monitors the services provided at the five state hospitals to maintain compliance with federal regulations and CMS certification. Because each hospital may render varying services, each hospital has a unique formula for certification. For each hospital certification application, the CMS survey process may take up to a year to complete.

The following table shows the licensed status of each facility:

Analysis of Problem

Table 2: The DSH Hospitals and the CDPH Certification Renewed Annually

	Hospital Bed Licenses		
	Acute Psychiatric Facility	Intermediate Care Facility	Skilled Nursing Facility
Atascadero	x	X	
Coalinga	x	X	
Metropolitan	x		x
Napa	x	X	x
Patton	x	X	

Patient Account Management, Asset Determination and Collections

Upon admission, each state hospital Trust Office provides management and protection of patient property including mail, purchases of goods and personal funds – known as patient trust accounts – as well as insurance verification, establishing and maintaining cost of care accounts and collections.

Trust Office functions have been independently operated at each state hospital and technical assistance and guidance was previously provided by the DDS. DSH will determine how to support an enterprise-wide Trust Office function via functional oversight and centralized policy and procedure development. This will also include the management and oversight of patient cost of care accounts for the purposes of collections which may require legal assistance.

Patient-Generated Collections

California Welfare and Institution Code (WIC) Sections 7275-7295 define the DSH's responsibility for the collection of third-party payments to support a patient's costs for care and treatment services received in a state hospital. The DSH is required to assess, upon patient admission, the availability of money, property, or interest in property, and collect payment for a patient's cost of care from public and private health insurance as well as private pay. Collection for cost of care is complicated as it includes evaluating patients' health insurance and/or eligibility based on their commitment type, enrolling them if eligible into a public insurance program, and evaluating personal assets for billing and collection purposes. All functions performed by the PCRS will establish the ongoing framework to provide oversight of the five hospitals' collection processes required by WIC 7275-7295.

Table 3: Common Third Party Revenue Sources

Source	Can the DSH Bill?	Note
Medicare Part A	yes – if patient is eligible and enrolled	Includes hospital insurance such as inpatient care at a hospital, skilled nursing facility (SNF), and hospice
Medicare Part B	yes – if patient is eligible and enrolled	Includes medical insurance such as doctor and other health care providers' services, outpatient care, durable medical equipment, etc.
Medicare Part D	yes – if patient is eligible, enrolled and gives consent	Includes prescription drug coverage
Private insurance	yes – if patient is enrolled	For External Medical
Private payers ¹	yes	Based on individual or family's ability to pay for services rendered

Third party revenue collection can also be impacted by the patient's commitment type. The following table provides information on the patient types for which the DSH can collect.

Table 4: Commitment Types, Percentage of Daily Census and Billable Types

Commitment Type	Percent	Can the DSH Bill?
Not Guilty By Reason of Insanity (NGI) ²	21%	Yes
Incompetent to Stand Trial (IST) ³	20%	Yes

¹ Collections for monthly cost of care expenses from the patients benefit fund require the consent of the patient. Certain costs are claimable against the patient regardless of their consent to bill.

² As of January 1, 2016, NGIs are eligible for Medicare parts A and B only.

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Mentally Disordered Offender (MDO)	19%	No
Coleman/CDCR (PC 2684)	18%	No
Sexually Violent Predator (SVP)	13%	Yes
Lanterman-Petris Short (LPS)	9%	Yes

Compliance and Risk Management

The DSH is at a higher risk for an audit by the Office of Inspector General (OIG) and the CMS as it relates to Medicare Parts A, B and D claiming processes. In July 2000, the OIG audited Medicare Part B payments billed by California's developmental centers and state hospitals. The audit examined Medicare B payments for services over a four and a half year period (January 1, 1993 through June 30, 1997) to determine if the payments were appropriate for the services that were billed. Based upon OIG's random sample, there was \$13,046,880 in overpayments for services provided by the state hospitals. The report found 73 of 100 claims sampled to be in error. The error rate for the DSH specifically was 82% (19 of 22 claims).

Inaccuracies of submitted claims may be construed as false claims. This is of significant concern as there is a large volume of claims that need to be corrected for a variety of technical errors. Claims may contain multiple errors and the backlog of errors currently stands at approximately 60,000. The table below reflects the magnitude of claims and claims with errors in FY 2014-15.

Table 5: FY 2014-15 Medicare Claims and Claim Errors

Medicare Program	Number of Claims Submitted	Number of Claims with Errors ⁴	Error Rate (CMS Standard = 3% Error Rate)
Medicare Part A and Part B	13,308	9,663	73%
Medicare Part D	25,423	14,316	56%
Totals	38,731	23,979	62%

The False Claims Act (FCA) poses civil liability on any person who knowingly submits, or causes to be submitted, a false or fraudulent claim to the federal government. Civil penalties for violating the FCA may include fines up to three times the amount of the damages sustained by the government as a result of the false claims plus \$11,000 per claim filed. Further, the Social Security Act (Section 1848) (g) (4) requires that claims be submitted for all Medicare patients for services rendered. Compliance to mandatory claim filing requirements is monitored by the CMS, and violations of the requirement may be subject to a civil monetary penalty of up to \$2,000 for each violation.

The PCRS will be responsible for creating a compliance program that will standardize policies and procedures and manage risks. Responsibilities will include serving as a liaison to the DSH legal department, developing business process re-engineering initiatives, developing standards of operation as well as policies and procedures, training, auditing programs and services, and creating internal controls.

Renewed and Expanded Focus

The original BCP assumed an established and standardized patients account management system. Via site visits and precursory assessments of pharmacy billing practices, the DSH discovered system-wide Medicare compliance issues. Through other initial assessments, the DSH has also found lack of standardized systems for the Trust Offices. Trust Offices currently do not have a uniform billing and collections system for cost of care. The current Cost Recovery System (CRS), used for data entry, is an antiquated system requiring manual workload for review, updates to data, and reporting.

The DSH in the short-term must actively work on correcting claim errors and resubmitting them back to CMS. The DSH must also focus on long-term development of policies and procedures, standardizing systems, augmenting compliance and audit efforts in Medicare Parts A, B, and D as well as private insurance and pay otherwise the number of erred claims will continue to rise with the increasing DSH

³ As of January 1, 2016, ISTs are eligible for Medicare parts A and B only.

⁴ One claim may contain multiple errors.

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population and the DSH will not realize increased revenues. On the non-claims side, the DSH must focus on developing accurate cost of care accounts, creating oversight of Trust Office functions, and enrolling patients in private or federal insurance.

The implementation of the DSH cost recovery effort has taken longer than expected due to:

- Positions not being filled until December 2014 as a result of difficulty finding qualified candidates
- More Medicare training was required than originally anticipated. The DDS training of Medicare Part A, B and D occurred in March 2015 with additional Part B training in May 2015 and Trust training in April 2015
- Transition time to access to the DDS Medicare billing system and its associated training
- Delays in beginning corrections of claim errors
- PCRS identified a significant number of systemic issues resulting in prioritization of workload
- Extended site visits confirming lack of business process uniformity system-wide
- Greater than expected complexity of Medicare billing process, lack of standardized systems, and varying degrees of compliance
- Longer than anticipated process to correct Medicare Part D billing

Resource History (Dollars in thousands)

Program Budget	2011-12	2012-13	2013-14	2014-15	2015-16
Authorized Expenditures	N/A	N/A	N/A	1,893	1,878
Actual Expenditures	N/A	N/A	N/A	927	N/A
Revenues	\$5,695	\$3,820	\$3,608	\$3,419	N/A
Authorized Positions	N/A	N/A	N/A	15.0	15.0
Filled Positions (partial year value)	N/A	N/A	N/A	8.0	15.0
Vacancies	N/A	N/A	N/A	7.0	0

Workload History

Workload Measure	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
Medicare Parts A and B						
Claim errors corrected	N/A	N/A	N/A	N/A	8,140	44,770
Claims transmitted to the CMS	N/A	N/A	N/A	N/A	569	3,130
Medicare Part D						
Claim errors corrected	N/A	N/A	N/A	N/A	0	31,195
Claims transmitted to PDP	N/A	N/A	N/A	N/A	25,423	47,275
Trust and Collections						
Account reviews ⁵	N/A	N/A	N/A	N/A	200	684
Medicare line-item adjustments	N/A	N/A	N/A	N/A	900	6,840
Adjustments to patient accounts ⁶	N/A	N/A	N/A	N/A	540	1,026
Accounts for legal review	N/A	N/A	N/A	N/A	3	31
Individual asset determinations ⁷	N/A	N/A	N/A	N/A	0	684
Legal						
Private payer cases requiring litigation support per month ⁸	N/A	N/A	N/A	N/A	8	35

⁵ Reviews require determination of commitment type, assessment of Medicare eligibility, review of debit postings, etc.

⁶ Adjustments to add deposits and correct patient bill for non-billable items, Medicare eligibility, etc.

⁷ Patients for which a review of their accounts has determined they have holdings applicable to private pay collections.

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Patient Trust accounts requiring legal research and counsel (number of projects).	N/A	N/A	N/A	N/A	2	120
Medicare accounts requiring legal research and counsel (number of projects).	N/A	N/A	N/A	N/A	1	60
Patient Rights accounts requiring legal research and counsel (number of projects).	N/A	N/A	N/A	N/A	2	180

C. State Level Considerations

Supporting the continuation of the PCRS will result in a streamlined and standardized third party billing, collections and claims resolution process that will ultimately result in increased revenue collections to offset General Fund costs. Furthermore, these activities are in alignment with the Department's goals regarding fiscal responsibility and excellence in hospital operations.

D. Justification

The permanent positions are necessary to continue immediate and ongoing efforts to reduce the risk for Medicare audits, reduce the high volume of errors in Medicare claims submitted, and pursue third party claims.

The Patient Cost Recovery Section has focused its efforts on discovery and claims corrections. Discovery has included documenting the respective roles, functions and variances of the multiple parties – the DDS, the DSH-Sacramento and the hospitals. While this approach may not garner immediate revenue generation, it is necessary to re-engineer billing and collections systems, develop quality assurance and control measures as well as streamline and standardize procedures. Activities to date have included:

- developing a basic knowledge regarding billing and collection practices
- developing charters, workgroups and work plans to plan and implement high-priority projects
- researching applicable state and federal guidelines regarding billing and collections, CMS certification and compliance
- correcting billing errors within CRS and DSG
- conducting site visits at all state hospitals to document the hospital's functions and systems as they relate to Medicare billing and private pay functions
- assessing hospitals' trust, HIMD office, diagnosis and service coding and pharmacy billing processes
- training on functions previously performed by the DDS such as the Cost Recovery System (CRS)⁸ and Data Systems Group (DSG)
- training staff on claims processing, quality assurance regarding patient account accuracy, automated billing system and private pay collections

The DSH is also in the process of engaging in business process re-engineering to evaluate and standardize Medicare Part D pharmacy billing system and related processes. The DSH is pursuing implementing additional modules to the DSG software used to identify claim errors and installation of claim review software. Finally, the DSH is establishing project teams with hospital staff to address deficiencies and develop a corrective action plan to ensure accurate billing, collections and claims processing.

Through its discovery phase, the PCRS has prioritized the following functions to make significant progress in balancing its competing priorities:

- Provider Enrollment and Hospital Certification
- Patient Account Management

⁸ Legal staff will be working on an average of 35 cases in a given month, of which, some cases will take longer than others.

⁹ System administered by the DDS that records all DSH patient service costs

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- Patient Trust Support
- Private Payer Asset Determination and Collections
- Medicare Billing, Claims Resolution and Compliance
- Quality Control/Quality Assurances
- Admission Discharge Transfer (ADT) records and patient Cost Recovery System (CRS) reconciliation
- Ongoing collaboration with the DSH Technology Services Division for system improvements
- Legal Services and Support to Medicare, Patient Trust and Private Payer Assets and Collections
- Ability to directly submit Medicare billing to the CMS (previously handled through the DDS)
- Exploration of other public insurance programs beyond Medicare

Provider Enrollment and Hospital Certification

The focus on Provider Enrollment and Certification includes discovery and documentation of hospitals current certifications and potential for increased revenue once certification of each hospital is complete. This approach may not garner immediate revenue generation, however, is necessary for maximum revenue generation from Medicare billing.

Patient Account Management

Functions for account review and reconciliation include the following:

- Conversion of account from outdated system to electronic format
- Average account averages 200-300 pages (approximately 3000 lines of data)
- Verifying all charges/patients of patients
- If Medicare charges, make contractual adjustments (approximately 30 min per Medicare service)
- Make Medicare line adjustments as well as overall account adjustments to provide to Legal for litigation processes.

Establishing and implementing processes for reconciling accounts and collections will generate the quickest revenue and will assist with efforts for maintaining revenue in future fiscal years.

Approximately 17 percent of the DSH patient population is Medicare-eligible. As the patient population ages, it is expected that this number will increase significantly.

The PCRS focus on claims resolution will yield revenue as errors are corrected and claims submitted are processed for payment.

With training in April 2015, the DSH started the process of correcting errors in May 2015 and has prioritized old claims based on the claim's age and dollar value. Currently, there are approximately 60,000 errors that need to be corrected in the Medicare billing system which are the equivalent of nearly 6,000 claims. The table below illustrates the claims and errors corrected by the DSH to date:

Table 8: Actual Claims and Errors Corrected by the DSH

Timeframe	Number of Errors Corrected	Number of Claims	Average Number of Errors per Claim	Total Dollar Value of Claims
May – October 2015	16,032	2,826	5.67	\$3,162,938

As noted in the following table, in FY 2014-15 nearly 24,000 claims were submitted that contained errors. Assuming the workload data reflected above, the calculations below demonstrate the number of PYs that would be required to only process corrections to Medicare claims if the current business model is not improved.

Table 9: Workload Calculations – Medicare Billing and Claim Corrections

Annual Number of Erred Claims	24,000
Average Number of Errors per Claim	16
Total Annual Errors	384,000

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Number of Errors per day based on 250 work days (less weekends and holidays)	1,536
Average Number of Errors corrected per PY per day	95
Total PYs Needed	16.2

Assuming that business process improvements yield a reduction in the error rate for each claim by 60 percent and claims processors will increase workload capacity by 30 percent through proficiency in operating systems, the DSH will continue efforts to manage this workload. To continue efforts, the permanent 5.0 PYs shown below will be utilized for claim error specific workload. The table below reflects the workload calculations.

Table 10: Workload Calculations – Revised Workload for Medicare Billing and Claim Corrections

Annual Number of Erred Claims	24,000
Average Number of Errors per Claim - Assuming 60% Reduction in Errors	6
Total Annual Errors	153,600
Number of Errors per day based on 250 work days (less weekends and holidays)	614
Average Number of Errors corrected per PY per day - Assuming 30% Increase	124
Total PYs Needed	5.0

While the occurrence of errors in new claims is unavoidable, it can be reduced significantly with proper policies, procedures and training. The PCRS will provide consistent oversight, standardization of policies and procedures, and technical assistance to reduce the number of errors generated from new claims, particularly during the period of procedure development.

Interface with Data Systems

In addition to setting up patient accounts, billing and creating claims, staff are necessary to further perform quality assurance/quality control functions within those accounts. This includes reviewing and reconciling patient accounts, and adjusting accounts as well as generating the following reports:

- Discharge Report
- Room and Bed Charge Error Report
- Room and Bed Synchronization Report
- Error Correction Private Payer or Commercial Payments Report
- Listing of Pre-Admit Status Clients

Rate Development/Cost Reporting

Upon full transition from the DDS, the DSH will assess and develop cost reports and annual billing rates. Billing rates will be developed in accordance with WIC section 4025; to ensure that charges made by the DSH for the care and treatment of each patient in a facility shall not exceed the actual cost of their treatment. The workload to support this function was greater than anticipated due to the number of reports and frequency of establishing billing rates, particularly those established for Medicare. The PCRS must work with all five hospitals to develop billing rates three times per year including the 1) Estimated Rates; 2) Mid-Year Rates (around January); and 3) Actual Year End Rates. The process to establish these rates requires coordination with each hospital's Trust, HIMD and Accounting offices, along with DSH-Sacramento Accounting for the headquarters portion of the rates. The PCRS will assume full responsibility from the DDS for developing the survey materials to hospitals, providing technical assistance to the hospitals in completing the documentation, consolidating the data for submission to the CMS and the Office of Statewide Health Planning and Development (OSHPD), responding to inquiries from the CMS, the OSHPD and management regarding the rates, publishing the rates and coordinating with the DSH Technology Services Division to update the rates within CRS. Additionally, there are multiple required cost reports that have been managed by the DDS that will need to transfer to the DSH. Reports include:

- Medicare Home Office Cost Statement
- Medicare Cost Report
- OSHPD Hospital Annual Disclosure Report
- OSHPD Quarterly Financial Utilization Report

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Asset Determination and Collections

The DSH is required by statute to conduct an investigation to determine the monies, property or interest in property a patient or his/her relatives have to pay for the patients' cost of care. Currently, the hospital Trust Office staff do not have the capacity and tools to conduct a thorough search of assets that may be available for collection to offset a patient's cost of care. The Trust Office staff currently conduct an initial assessment of each patient's assets, based on information readily provided by the patient and/or the information that accompanies the patient upon admission. When information is available, the Trust Office may prepare a collection letter requesting payment for cost of care. However, the follow up on collection of funds are inconsistent by the hospitals. The PCRS will establish procedures that will allow the trust offices to send potential collection information to the PCRS. The PCRS will verify certain types of assets or available funds through a guardian or relative via skip tracing tools such as Lexis-Nexis and Department of Motor Vehicles information. The PCRS will then prepare collection letters and follow up on the status of response. If settlements or payment terms are requested, options will be identified, referred to Legal for consultation and finalized for decision by the Directorate. In the FY 2014-15 BCP, the asset determination and collections was specifically identified for the Legal Services Division (LSD). However, the workload described above is required prior to a collections case being referred to Legal. A number of collection cases may be resolved without requiring legal action. This high workload was unknown to the DSH at the time of initially requesting resources, therefore with the approved permanent positions, the DSH will continue efforts to increase revenue with collections and settlements for cost of care. Establishing and implementing processes for determining and verifying assets will assist the DSH with collection efforts, generating the quickest revenue and will assist with efforts for maintaining revenue in future FYs.

Compliance and Risk Management

Future risk management efforts will include keeping the Department up to date with rigorous federal regulation changes avoiding violations and reduce the likelihood of CMS penalties in the future. Additionally, proper training is essential to reducing error rates, claim rejection rates and decreasing the risk for CMS audits.

The development of standardized policies and procedures will take a concerted effort involving multiple stakeholders across the Department including: the PCRS, Legal, Medical/Clinical Leadership, Nursing, Pharmacy, Health Information Management staff, Trust Office staff and Accounting from all hospitals and headquarters. Priorities will include:

- Developing a standard review protocol in adjudicating Medicare Part A, B and D claims
- Conducting annual and ad hoc reviews with DSH hospitals to ensure hospital claim processes are in accordance with CMS regulations
- Developing and implementing Plans of Correction to address deficiencies found in reviews
- Providing ongoing internal claims reports to call out recommended corrections needed in an effort to meet the CMS reimbursement rules
- Training hospital staff involved with the cost accounting function on appropriate coding
- Coordinate ongoing trainings to provide Medicare education to the DSH staff
- Collect and distribute all Medicare related bulletins and special notices to the DSH staff to establish and maintain an internal library
- Developing training material and written instructions that are in agreement with Medicare rules and regulations
- Provide ongoing Medicare direction and advice as it relates to Medicare billing corrections
- Contracting with a consultant to document and assess hospital operations as well as develop business process re-engineering recommendations to establish the framework for policies and procedures

To begin addressing the immediate workload, the PCRS will prioritize procedures and standardized practices based on the greatest risk level. Once procedures are in place, the increased ongoing workload for this function involves comprehensive risk management, quality assurance and quality control to ensure that governing laws and regulations are adhered to. Further, evaluating and re-engineering existing procedures will further support the introduction to an electronic health record

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standard. The complexity of the workload requires development of expertise in the specialized areas contained within the overall PCRS function: Pharmacy Operations (Medicare Part D); Medical/Ancillary Services (Medicare Part A/B) and all other Trust functions. The focus on risk assessments, compliance reviews, developing standardized procedures and training all staff supports does not generate immediate revenue but supports a robust third party billing system in the long term.

Oversight of Patient Trust Functions

The PCRS will provide oversight, guidance and technical assistance to the hospital Trust Officers. Hospital trust officers have the fiduciary capacity to assume responsibilities similar to a guardian or conservator of a patient's property of assets. Staff supporting this function will serve as a primary point of contact to address issues within the hospital trust offices as well as coordinate the development and provide ongoing maintenance of standardized policies and procedures. Guidance and technical assistance in supporting the accounting and reporting of patient funds will also require coordination with DSH-Accounting.

In addition to the areas above, the staff supporting this function will need expert knowledge in insurance enrollment and benefit eligibility. Trust oversight staff will provide the technical assistance and guidance to cover this workload. As the PCRS has further defined the scope of trust office responsibilities, permanent staff will directly support the Asset Determination and Collections function and support the oversight of all other trust functions increasing the potential for quicker revenue.

Legal Services Division (LSD) and Support to Medicare, Patient Trust and Private Payer Assets and Collections

The LSD currently has 17 open cases at various stages of litigation regarding the collections process. When the DSH PCRS begins referring collection cases to the LSD for litigation, this workload is expected to increase.

Third-party billing activities to be performed by the attorneys include litigating and settling collections cases, and providing legal counsel on various PCRS issues to avoid or minimize liability. Such issues include the handling of patient trust accounts, personal property, and funds under state statutes, federal statutes, and controlling case law, Medicare compliance, Patient Rights, and Privacy Laws, including the Lanterman-Petris Short Act, Health Information Portability and Accountability Act (HIPAA), the California Medical Information Act (CMIA), and Information Practices Act (IPA).

The permanent positions are necessary to perform duties associated with patient collections cases in various stages of litigation in coordination with the PCRS activities by the Administrative Services Division. This includes support for the attorneys in performing the PCRS activities such as research on available and existing liens against specific debtors and lien/garnishment process and procedures in each of the 58 counties, managing and tracking cases in litigation, preparing filings regarding conservator, titles, trust and bankruptcy, and communicating with the court and other stakeholders when necessary. PCRS activities to be performed by the analysts include case intake from the PCRS, managing and tracking litigated cases, researching liens and available assets, assisting the attorney in communicating with stakeholders, preparing filings, managing process services, documenting evidence and witnesses, monitoring case post-litigation, and preparing cases for appeals.

Medicare Premiums

The DSH is responsible for funding premiums required to enroll patients into the Medicare Part A, B or D programs. A premium is the monthly amount paid for Medicare coverage and can change each year. DSH's eligible population and subsequent Medicare premium payments have increased, due to an aging population and the implementation of Medicare Part D in 2006. Since FY 2012-13, the Medicare premiums paid exceeds \$800,000 with more than 1,000 patients currently enrolled in these programs. As the current population ages, the DSH anticipates continued growth in the number of Medicare eligible patients it serves, increasing the amount that will be paid in premiums. The DSH will continue to monitor premium costs and will request additional funding as necessary in future budget years.

Analysis of Problem

The table below displays the number of the DSH Medicare-enrolled individuals and the amount the DSH pays for their Medicare premiums annually. In FY 2014-15, the Department paid approximately \$840,000 in Medicare premiums.

Table 11: DSH Medicare Enrollees and Premiums, FY 2014-15

	Number of Medicare Enrollees	Premiums Paid
Atascadero	75	\$36,129
Coalinga	47	\$82,459
Napa	415	\$325,128
Metropolitan	214	\$110,749
Patton	252	\$283,435
Total	1,003	\$839,898

Contracted Vendor to Assess Billing Practices

\$400,000 is requested to fund a contractor to assess billing practices in the hospitals and recommend corrective actions. This will ensure the DSH is able to implement Medicare billing and private pay processes that are best-practice, address Medicare compliance, and stabilize and improve revenue. The recommendations will establish the framework for policies and procedures.

E. Outcomes and Accountability

As a result of the PCRS' continued efforts, the Department expects the following outcomes:

- Evaluation of its existing third party revenue billing, collections and claims resolution processes across the five hospitals
- Enterprise-wide standardized and streamlined third party revenue billing, collections and claims resolution processes
- Development and implementation of policies and procedures including compliance review processes
- Ongoing and consistent training of billing, collections and health information staff
- Initiatives aimed at quality assurance/quality control
- Continuous process improvements and business process re-engineering including risk management
- Elimination of gaps in Medicare provider and hospital certifications
- Increased Medicare compliance and private pay cases
- Resolution to Medi-Cal and Veteran's Administration as potential sources of reimbursement
- Reduction in potential audits with accompanying findings

Potential increase in revenue collection

The Medicare and third party collection revenue averaged \$6,664,883 between FY 2008-09 and FY 2010-11. The revenue in FY 2014-15 was \$3.4 million, yet the goal is to collect \$5.5 million by FY 2017-18. Once standardized systems are in place, there is a potential for the DSH to collect more revenue. This goal is based on historical revenue collections, a growing DSH population of Medicare eligible age (approximately 12% annually, representing about 10% of DSH total population), and the growth in private pay cases possible with the permanent staffing requested.

Projected Outcomes

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Medicare Parts A and B						
Claim errors corrected	44,770	48,840	48,840	48,840	48,840	48,840
Claims transmitted to CMS	3,130	3,414	3,414	3,414	3,414	3,414

Analysis of Problem

Dollar value of claims submitted to CMS ¹⁰	3,770,459	4,113,228	4,113,228	4,113,228	4,113,228	4,113,228
Medicare Part D						
Claim errors corrected	31,195	34,315	41,177	49,413	59,295	71,155
Claims transmitted to PDP	47,275	63,033	66,185	69,494	72,968	76,617
Claims rejected by PDP	28,365	31,516	26,474	20,848	14,594	7,662
Dollar value of claims submitted to CMS ¹¹	3,578,314	4,472,893	4,696,537	4,931,364	5,177,932	5,436,829
Trust and Collections						
Account reviews	684	684	684	684	684	6846
Page conversions	6,840	6,840	6,840	6,840	6,840	6,840
Adjustments	1,026	1,026	1,026	1,026	1,026	1,026
Accounts reconciled for legal department	31	31	31	31	31	31
Patient asset determination	684	684	684	684	684	684
Legal Office Workload						
Number of legal cases	420	420	420	420	420	420
Trust Research projects	120	120	120	120	120	120
Medicare Research projects	60	60	60	60	60	60
Patient Rights Issues Research projects	180	180	180	180	180	180

Analysis of All Feasible Alternatives

Alternative 1 - Approve Permanent Status of the 15.0 Limited-Term Positions

Pros

- Supports the development and implementation of more robust DSH billing, collections and claims resolution process for third party billing
- Explores other revenue sources such as Medi-Cal and private pay
- Generates additional revenue sources and relieves pressure from the General Fund
- Reduces the risk of an OIG and/or CMS audit
- Maintains and enhances the current baseline of billing, collections and claims resolution
- Supports the oversight of the five state hospitals' patient cost recovery efforts
- Supports the development of standardized enterprise third party billing policies and procedures

Cons

- Results in initial General Fund costs not offset by additional revenues as the DSH implements improvements.

Alternative 2 – Extend the Approval of This Proposal for an Additional Two Years on a Limited Term Basis

Pros

- Generates additional revenue sources and relieves pressure from the General Fund
- Reduces the risk of an OIG and/or CMS audit

Cons

- Reduces staff expertise as the DSH would need to hire new staff as existing staff would no longer be eligible for employment beyond their two-year term

¹⁰ Billable not collectable

¹¹ Billable not collectable

Analysis of Problem

- Creates gaps in institutional knowledge and limits ongoing ability to meet deadlines
- Results in additional General Fund expenditures

Alternative 3 - Allow Positions to Expire Effective June 30, 2016

Pros

- Saves General Fund expenditures for those 15 PYs
- Eliminates positions

Cons

- Eliminates reimbursement of Medicare Parts A, B and D as well as private pay as there is no centralized body to oversee this function
- Eliminates oversight of the five state hospital's patient cost recovery efforts
- Eliminates the ability of the DSH to develop and implement a more robust DSH billing, collections and claims resolution process for third party billing
- Eliminates the ability to explore other revenue sources such as Medi-Cal and private pay
- Limits third-party revenue sources
- Increases the risk of an OIG and/or CMS audit

G. Implementation Plan

The estimated implementation plan assumes a July 1, 2016 start date as follows:

FY 2016-17

- Ongoing training
- Continue business process re-engineering for Medicare Part D
- Request contract for HIPAA compliance and claim development
- Continue providing technical assistance to hospitals
- Perform compliance reviews
- Site visits
- Develop methodology for billing rates and cost reports
- Begin transition of Medicare, private insurance, and private payer to the DSH

FY 2017-18

- Ongoing training
- Implement HIPAA compliance and claim preparation contract
- Participate in development of system for processing Medicare, private insurance and private payer billing
- Site visits
- Request contract for business process re-engineering for Medicare Parts A and B
- Continue transition of Medicare, private insurance, and private payer to the DSH

H. Supplemental Information

The contracts listed below will ensure the DSH has the necessary tools needed for the transition from the DDS. Specifically, external contracts are needed for the assessment of billing and claims processing at the hospitals, increasing the functional capacity of the existing systems, and providing training:

- MyAbility – verification of eligibility of benefits
- Claim Shuttle – ability to track claims individually through Noridian
- Claim Editor – DSH claim scrubber
- Experian – identity verification and credit tracking software for asset determination
- Lexis-Nexis – Property and asset determination tool
- Encoder Pro – Medical coding tool
- DSG – HIPAA compliant for submission to the CMS
- DDS – Intradepartmental contract for continuing limited DDS support

Analysis of Problem

- Process Servers – Serving legal paperwork for collections of patient accounts
- One-time assessments for Medicare Parts A and B processes (\$400,000)

Recommendation

The Department of State Hospitals recommends the approval of Alternative 1 to ensure that the DSH has the ability to continue billing, collections and claims resolution process for third party billing. Other alternatives will limit the DSH's ability to streamline and standardize third party billing processes and reduce the potential for relieving the General Fund of fiscal pressures.

PATIENT COST RECOVERY TIME STUDY Staff Services Manager II'S (SSMII's)		
CATEGORY	TOTAL HOURS PER YEAR	PERSONNEL YEARS
Medicare Billing, Claim Errors and Resolution		
Basic supervision	300	0.2
Provide office oversight, planning, management liaison, process and procedure development, etc.	300	0.2
Review staff work including claims, billing process instructions, issue papers, compliance reports, etc.	300	0.2
Oversight of billing rate processes	120	0.1
Oversight of OSHPD and CMS reports	120	0.1
Oversight of billing processes and resolution of complex issues with hospitals	120	0.1
Answer questions from Noridian	60	0.0
Assist with most complex Claim error review and resolution. Liaison with hospitals, DDS, and CMS.	180	0.1
Assist with and review Claim error research	180	0.1
Resolve most complex CRS billing and posting issues	180	0.1
CMS Compliance issues, liaison with hospitals	120	0.1
Part D issue resolution and liaison	120	0.1
Total Medicare Billing, Claims Errors and Resolution	2,100	1.2

CATEGORY	TOTAL HOURS PER YEAR	PERSONNEL YEARS
Trust Office Oversight		
Basic supervision	180	0.1
Provide office oversight, planning, management liaison, process and procedure development, etc.	240	0.1
Review, and assist with most complex Provider enrollment application processing	96	0.1
Oversight and issues resolution with Noridian or CMS	72	0.0
Review corrections in ADT, CRS, and DSG for patient account statements	96	0.1
Review of weekly census reports	60	0.0
Oversight, review of LPS billing and resolution of patient placement issues, and MOU development and oversight.	180	0.1
Resolve issues regarding insurance support to hospitals	120	0.1
Resolve issues regarding benefit eligibility support to hospitals	120	0.1
Oversight of Collections operations: including asset determination, billable status, legal processing, patient account oversight, etc.	360	0.2
Review Patient account corrections, i.e. LPS collections, non-claimables, invalid cost of care, incorrect payments, etc.	300	0.2
Review of Patient Account Requests	120	0.1
Total Trust Office Oversight	1,944	1.1
Grand Total SSMIs	4,044	2.3

PATIENT COST RECOVERY TIME STUDY Staff Services Manager I'S (SSMIs)		
CATEGORY	TOTAL HOURS PER YEAR	PERSONNEL YEARS
Asset Determination and Collections		
Basic supervision	480	0.3
Develop processes and procedures	150	0.1
review of patient account corrections, i.e. LPS collections, non-claimables, invalid cost of care, incorrect payments, etc.	400	0.2
Review of investigations to determine assets, property or interest	400	0.2
Oversight of Collections processes	400	0.2
Total Asset Determination and Collections	1,830	1.0
Medicare Billing, Claim Errors and Resolution		
Basic supervision	500	0.3
Develop processes and procedures	200	0.1
Oversight of OSHPD and CMS reports	200	0.1
Review staff work including claims, billing process instructions, issue papers, compliance reports, etc.	350	0.2
Oversight of billing processes and resolution of complex issues with hospitals	250	0.1
Assist with most complex Claim error review and resolution. Liaison with hospitals, DDS, and CMS.	350	0.2
Total Medicare Billing, Claim Errors and Resolution	1,850	1.0
Compliance Review and Risk Management		
Basic supervision	300	0.2

CATEGORY	TOTAL HOURS PER YEAR	PERSONNEL YEARS
Develop processes and procedures	90	0.1
Oversight of OSHPD and CMS reports	90	0.1
Answer questions from Noridian	30	0.0
Assist with and review Claim error research	90	0.1
Resolve most complex CRS billing and posting issues	120	0.1
CMS Compliance issues, liaison with hospitals	90	0.1
Part D issue resolution and liaison	90	0.1
Liaison with DSH and DDS IT regarding billing system issues.	90	0.1
Total Compliance Review and Risk Management	990	0.6
Grand Total Patient Cost Recovery SSMs	4,670	2.6

**PATIENT COST RECOVERY TIME STUDY
SSA/AGPAs**

CATEGORY	NUMBER OF STAFF	HOURS PER MONTH EACH	TOTAL HOURS PER YEAR	PERSONNEL YEARS
Medicare Billing, Claims Errors and Resolution; Compliance and Risk Management				
Develop processes and procedures	3.5	10	420	0.2
Answer questions from hospitals	3.5	20	840	0.5
Answer questions from Noridian	3.5	5	210	0.1
Claim Editor analysis	3.5	10	420	0.2
Claim error review in DSG	3.5	40	1680	0.9
Claim error research	3.5	30	1260	0.7
Part A/B/D Claim error correcting entry in CRS and/or DSG	3.5	40	1680	0.9
Maintain and update as needed, standardized policies and procedures for review protocol in adjudicating Medicare parts A, B and D	1.5	25	450	0.3
Conducting annual and adhoc reviews of hospitals	1.5	40	720	0.4
Identifying issues requiring corrective action, developing plans of corrections and coordinating the implementation of corrections	1.5	25	450	0.3
Providing ongoing claims reports for recommended corrections	1.5	10	180	0.1
Coordinating and conducting training regarding billing, coding, standardized practices to hospital staff	1.5	40	720	0.4
Provide technical assistance to hospitals related to Medicare billing	1.5	15	270	0.2
Total Compliance and Risk Management; Compliance and Risk Management	5.0	310	9300	5.2

Interface with Data Systems, Rate Development and Cost Reporting				
Develop processes and procedures	0.25	20	60	0.0
Research and correct most complex discrepancies between CRS and ADT	0.25	60	180	0.1
Answer questions from hospitals	0.25	15	45	0.0
Corrections to hospital admissions and establishment of patient accounts	0.25	40	120	0.1
Post service charges, diagnosis, detailed memos to the patient accounts and correct any discrepancies	0.25	40	120	0.1
Assess and develop processes for cost reports and billing rates	0.25	10	30	0.0
Provide technical assistance to the hospitals	0.25	15	45	0.0
Develop Billing rates	0.25	50	150	0.1
Coordinate data for frequent reports due to CMS and OSHPD	0.25	40	120	0.1
Respond to report inquiries	0.25	10	30	0.0
Ensure rate information is updated in CRS	0.25	40	120	0.1
Total Interface with Data Systems, Rate Development and Cost Reporting	0.5	340	1020	0.6

Patient Account Management; Asset Determination and Collections; Trust Office Oversight				
Provide cost of care technical assistance to hospitals	0.5	10	60	0.0

CATEGORY	NUMBER OF STAFF	HOURS PER MONTH EACH	TOTAL HOURS PER YEAR	PERSONNEL YEARS
Develop processes and procedures	0.5	10	60	0.0
Reconcile patient accounts, correct errors in CRS, etc.	0.5	50	300	0.2
Patient account review and corrections, i.e. log LPS collections, remove non-claimables, correct cost of care, etc.	0.5	75	450	0.3
Respond to patient's account requests and inquiries	0.5	5	30	0.0
Develop and maintain processes and procedures for verification of patients' assets	0.5	15	90	0.1
Post collections, reconcile with Accounting, CRS, and internal reports for CMS.	0.5	25	150	0.1
Run asset determination reports/software, review property reports, miscellaneous assistance with legal actions.	0.5	75	450	0.3
Preparation and follow up of cost of care collection correspondence to payors	0.5	15	90	0.1
Posting settlements to CRS accounts	0.5	10	60	0.0
Prepare collection information for accounts referred to litigation	0.5	15	90	0.1
Develop and maintain standardized processes and procedures for patient trust accounts, benefit eligibility protocols	0.5	20	120	0.1
Provide oversight, guidance and technical assistance to the trust offices at the hospitals	0.5	40	240	0.1
Assist hospitals with patient benefit enrollment	0.5	35	210	0.1
Assist with reconciling patient cost of care accounts	0.5	35	210	0.1
Researching insurance and benefit issues	0.5	10	60	0.0
Responding to adhoc requests and developing reports to management and hospitals	0.5	20	120	0.1
Total Patient Account Management; Asset Determination and Collections; Trust Office Oversight	1.5	465	2790	1.6
Grand Total SSA/AGPA	7.0	1115	13110	7.3

BCP Fiscal Detail Sheet

BCP Title: Third Party Patient Cost Recovery

DP Name: 4440-020-BCP-DP-2016-GB

Budget Request Summary

	FY16					
	CY	BY	BY+1	BY+2	BY+3	BY+4
Positions - Permanent	0.0	15.0	15.0	15.0	15.0	15.0
Total Positions	0.0	15.0	15.0	15.0	15.0	15.0
Salaries and Wages						
Earnings - Permanent	0	990	990	990	990	990
Total Salaries and Wages	\$0	\$990	\$990	\$990	\$990	\$990
Total Staff Benefits	0	505	505	505	505	505
Total Personal Services	\$0	\$1,495	\$1,495	\$1,495	\$1,495	\$1,495
Operating Expenses and Equipment						
5301 - General Expense	0	125	125	125	125	125
5304 - Communications	0	15	15	15	15	15
5320 - Travel: In-State	0	105	105	105	105	105
5340 - Consulting and Professional Services - Interdepartmental	0	300	300	300	300	300
5340 - Consulting and Professional Services - External	0	639	239	239	239	239
5346 - Information Technology	0	15	15	15	15	15
539X - Other	0	475	475	475	475	475
Total Operating Expenses and Equipment	\$0	\$1,674	\$1,274	\$1,274	\$1,274	\$1,274
Total Budget Request	\$0	\$3,169	\$2,769	\$2,769	\$2,769	\$2,769
Fund Summary						
Fund Source - State Operations						
0001 - General Fund	0	3,169	2,769	2,769	2,769	2,769
Total State Operations Expenditures	\$0	\$3,169	\$2,769	\$2,769	\$2,769	\$2,769
Total All Funds	\$0	\$3,169	\$2,769	\$2,769	\$2,769	\$2,769
Program Summary						
Program Funding						
4380010 - Program Administration	0	3,169	2,769	2,769	2,769	2,769
Total All Programs	\$0	\$3,169	\$2,769	\$2,769	\$2,769	\$2,769

