County of El Dorado

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Legislation Text

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Health and Human Services recommending the Board adopt **Resolution 186-2011** authorizing the Director to:
1) Execute in the name of the County of El Dorado all documents related to Medicare billing, including Medicare revalidation applications, agreements, amendments and requests for payment necessary to continually maintain Medicare billing privileges;
2) Execute in the name of the County of El Dorado all documents related to new Medicare enrollment applications, contingent upon concurrence from Chief Administrative Officer and the County Counsel;
3) Initiate payment of any fees required as a condition of submitting any Medicare enrollment or Medicare revalidation of enrollment documents.

FUNDING: Current application fee to be funded from Ambulance Billing Revenues.
BUDGET SUMMARY:

Total Estimated Cost	Current application fee	$505
Funding		
Budgeted	$	
New Funding	$	
Savings	$	
Other	$	
Total Funding Available	$505	
Change To Net County Cost		$0

Fiscal Impact/Change to Net County Cost:
No change in Net County Cost. Funds for the current application fee are available within the Health and Human Services FY 2011-12 Ambulance Billing program budget

Background:
The County has been routinely billing Medicare for various services, including ambulance services and annual flu shot clinics. Medicare is a critical funding source which offsets the cost to the County of providing these services. Revenues from annual Medicare billings are approximately $2.7 million for ambulance services and $10,000 for flu shot clinics.

Reason for Recommendation:
The Patient Protection and Affordable Care Act (PPAC) Section 6401 (Title 42 Code of Federal Regulations (CFR) Section 424.515), requires that all existing providers must be reevaluated under new screening guidelines specified in PPAC Section 6028 by no later than March 23, 2013. In addition Medicare requires that all Medicare providers revalidate enrollment information every five years. Failure to submit complete enrollment applications and all supporting material within 60 calendar days of the postmark date of the letter may result in Medicare billing privileges being deactivated.

A request has been received from Palmetto GBA, the third party Medicare administrator, for the County to submit a revalidation application for Ambulance Services. The request was dated September 26, 2011. In order to maintain the ability to bill Medicare, the Revalidation Application must be submitted by November 23, 2011, in order to meet the 60 day timeline of November 25, 2011, prior to the Thanksgiving holiday.

Due to the requirement that providers be revalidated every five years and the required 60 calendar day timeframe for the submittal of the revalidation application, Health and Human Services is requesting the Board adopt a Resolution delegating authority to the Director for all required Medicare billing documentation.

The application requires that a government entity submit an Attestation Letter, attesting to the fact that the government entity will be legally and financially responsible in the event that there is any outstanding debt owed to Medicare. The signed Resolution will serve as that Attestation Letter.

The application further requires that an Authorized Official be granted legal authority to enroll in the Medicare program, make changes or updates to the Countys status in the Medicare program and to commit the County to fully abide by the statutes, regulations and program instructions of the Medicare program. In the past the Chair of the Board of Supervisors was designated as the Authorized Official.

An Authorized Official is defined as an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board or direct owner) to whom the organization has granted legal authority to enroll it in the Medicare program, to make changes or updates to the organizations status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program.

Medicare requires that providers submit specific information about the Authorized Official anytime that individual changes. The additional information includes a copy of the place of birth, date of birth, copy of drivers license and social security number. Since the individual designated as the Chair changes on an annual basis, this would require an annual update to the Countys Medicare application. In order to alleviate the burden this would entail, the signed Resolution will delegate the role of Authorized Official to the Countys Director of Health and Human Services.

The Resolution requires that the Director obtain concurrence from County Counsel and the Chief Administrative Officer for any new Medicare enrollment applications.

Effective March 25, 2011 (Title 42 CFR 424.514), a fee is being imposed on all providers prior to filing an application with Medicare. The Resolution will further authorize the Director to initiate payment of any required fees associated with any applications.

Action to be taken following Board approval:
1) Upon execution by the Chair, the Board Clerks Office will forward a certified copy of the signed resolution to Health and Human Services for submittal with any Medicare applications.
2) Health and Human Services will submit the current Medicare revalidation application related to Ambulance Services.

Contact: Daniel Nielson, Director, Health and Human Services

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Concurrences: County Counsel has reviewed and approved the Resolution.

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