

Revenue Cycle
Impacts of Pandemic
&
Managed Care Updates/Trends

Presented by:
Shelly Cassidy & Hayley
Prosser
March 18, 2021



Who We Are

- **ruralMED Management Resources**
 - Based in Holdrege
 - Mission- We are a pool of resources to help keep rural healthcare strong
 - CEO-Rebekah Mussman
- **Revenue Cycle Service Line**
 - We are committed to helping Nebraska healthcare organizations have amazing Revenue Cycles.
 - Exciting things are coming!



Today's Topics

Virtual Service Update

- Reimbursement and Policy Changes

Emerging Service Lines

- Chronic/Principal Care Management & Remote Patient Monitoring

Managed Care Payor Contracting

- Updates and Trends

Medicare Advantage

- Contracts & Billing Pitfalls

Virtual Service Update *Reimbursement and Policy Changes*

Reduction of Flexibilities

- Video Component Waiver
- HIPAA Complaint Platform Waiver

Permanent Policies:

- Medicare, Cigna, and UHC
- Additional Commercial Payors to Follow

Cost Share Waivers

- Cost Share Waivers for COVID-19 Treatment Expiring
- Families First Coronavirus Response Act (FFCRA) Mandated Cost Share Waiver Still in Effect
- CS Modifier Compliance

Chronic Care & Principal Care Management (CCM/PCM)

Program Overview

- Patient Eligibility
- Documentation
- Identifying Eligible Patients
- Included Activities
- Eligible Payors

CPT	Description	Medicare Allowable
99490	Chronic care management services with the following required elements.....first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.	\$38.40
99491	Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements....	\$77.31
99439	Chronic care management services with the following required elements.....each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.	\$35.01
99487	Complex chronic care management services with the following required elements.....first 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.	\$85.36
99489	Complex chronic care management services with the following required elements:.....each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)	\$40.59
G0511	Rural health clinic or federally qualified health center (RHC or FQHC) only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner, per calendar month	Average of 6 Code 2020 Rate=\$66.77
G2064	Comprehensive care management services for a single high-risk disease, e.g., principal care management, at least 30 minutes of physician or other qualified health care professional time per calendar month with the following elements:	\$84.13
G2065	Comprehensive care management for a single high risk disease services, e.g., principal care management, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month with the following elements:.....	\$36.19

Remote Patient Monitoring (RPM)

- **Program Overview**
 - Patient Qualification
 - Allowable Providers
 - Device
- **Medicare**
 - 2021 Additional Flexibilities
- **Other Payor Coverage**
 - Nebraska Medicaid & Commercial

CPT	DESCRIPTION	MEDICARE ALLOWABLE
99453	Remote monitoring of physiologic parameter(s) initial; set-up and patient education on use of equipment	\$17.19
99454	Remote monitoring of physiologic parameter(s), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days	\$57.11
99091	Collection and interpretation of physiologic data digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days	\$53.77
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes	\$47.28
99458	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 min	\$38.40

RPM & CCM/PCM Considerations

Benefits

- Higher Quality Patient Care
 - 85% of Americans over the age of 65 have **one** or more chronic conditions
 - 56% of Americans over the age of 65 have **two** or more chronic conditions
- Reduction of Healthcare Costs
- Maximizes Value-Based Care Reimbursement
 - Accountable Care Organizations (ACO), Patient-Centered Medical Home (PCMH) models, and other alternative payment models.

Competition with Insurance Companies

- Care Coordinators, Navigators, etc.

Tips for Initiating CCM & RPM Programs

- Know what Activities Count Towards the Time
- EHR Selection
- Outside Vendor Consideration

Source: https://www.cdc.gov/nchs/health_policy/adult_chronic_conditions.htm

Managed Care Payor Contracting *Updates and Trends*

Medica/Midlands Choice

Nebraska Total Care- MA & Ambetter

Multiplan/PHCS

UCH Initiatives

United Healthcare Initiatives

Laboratory Test Registry Protocol

- Delayed effective date 1/1/2022
- Registration complete by 12/1/2021
- Unique “test code” assigned by UHC reported on UB04 in description field prefaced by “LAB”
- Will require billing system changes
- Claims without the unique UHC code will be denied as provider contractual adjustment
- Will apply to all lines of service: Commercial , Medicaid and Medicare Advantage

<https://www.uhcprovider.com/en/policies-protocols/lab-test-registry.html>

Triple Aim Explained: <https://newsroom.uhc.com/experience/preferred-lab-network.html>

United Healthcare Initiatives

In Network Referral Policy

- Effective with contract and UHC policy
- Providers required to refer to in-network providers
- “If you violate the protocol and do not confirm the member's consent for the referral, you will be in violation of your Agreement. As a result, we may, depending on state law”
 - Disqualify you from any rewards or incentive program
 - Decrease your fee schedule
 - Hold you financially responsible for any costs collected from a member by a non-participating care provider
 - Terminate your Agreement

<https://www.uhcprovider.com/en/admin-guides/administrative-guides-manuals-2021/ch6-referrals-2021/non-part-care-prov-ref-ch6-guide.html>

United Healthcare Initiatives

Non-patient Lab (Reference Lab)

- Effective 5/1/2020
- UHC not allowing reimbursement under hospital's Facility Participation Agreement (OP rate)
- Contact Network Representative to contract as reference lab

<https://www.uhcprovider.com/en/resource-library/news/2020-network-bulletin-featured-articles/0220-non-patient-lab-reimbursement.html>

United Healthcare Initiatives

Designated Diagnostic Provider program

- Effective 7/1/2021
- Deadline to apply 3/10/2021
- Summary from UHC

“In an effort to reduce member cost and improve transparency, we’ve created, **subject to state regulatory approval**, Designated Diagnostic Provider benefit designs. For fully insured commercial plan members, outpatient laboratory services will only be covered when delivered by freestanding or hospital lab providers who meet certain quality and efficiency requirements.”
- Lab performed at non designated providers will deny as non-covered service with 100% patient liability. (some outliers apply)
- How to become a Designated Diagnostic Provider
 - Meet *certain* quality and efficiency requirements.
 - Complete the Designated Diagnostic Provider lab quality questionnaire
 - If you meet the lab quality and efficiency requirements, you will become a Designated Diagnostic Provider for lab services and be notified accordingly
 - If you do not meet the lab Designated Diagnostic Provider requirements for lab services, a dedicated network representative will reach out to follow up and support the process

<https://www.uhcprovider.com/en/reports-quality-programs/designated-diagnostic-provider.html>

Is this

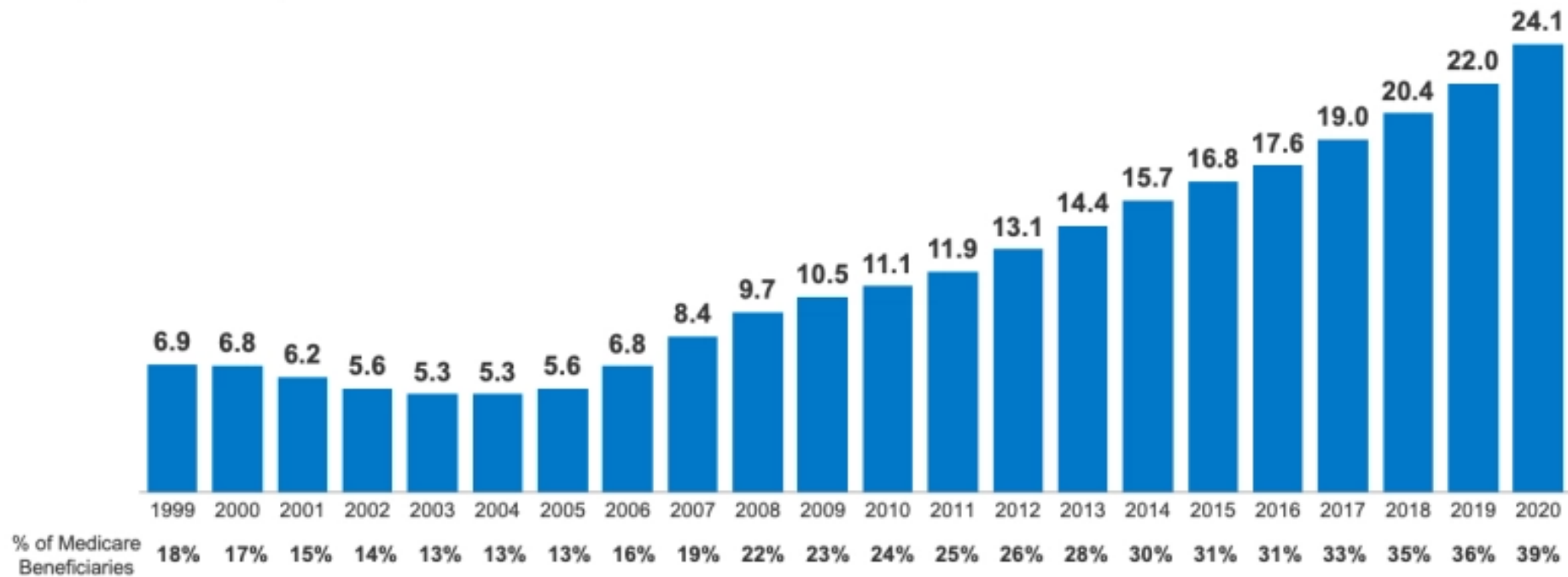


Really
happening

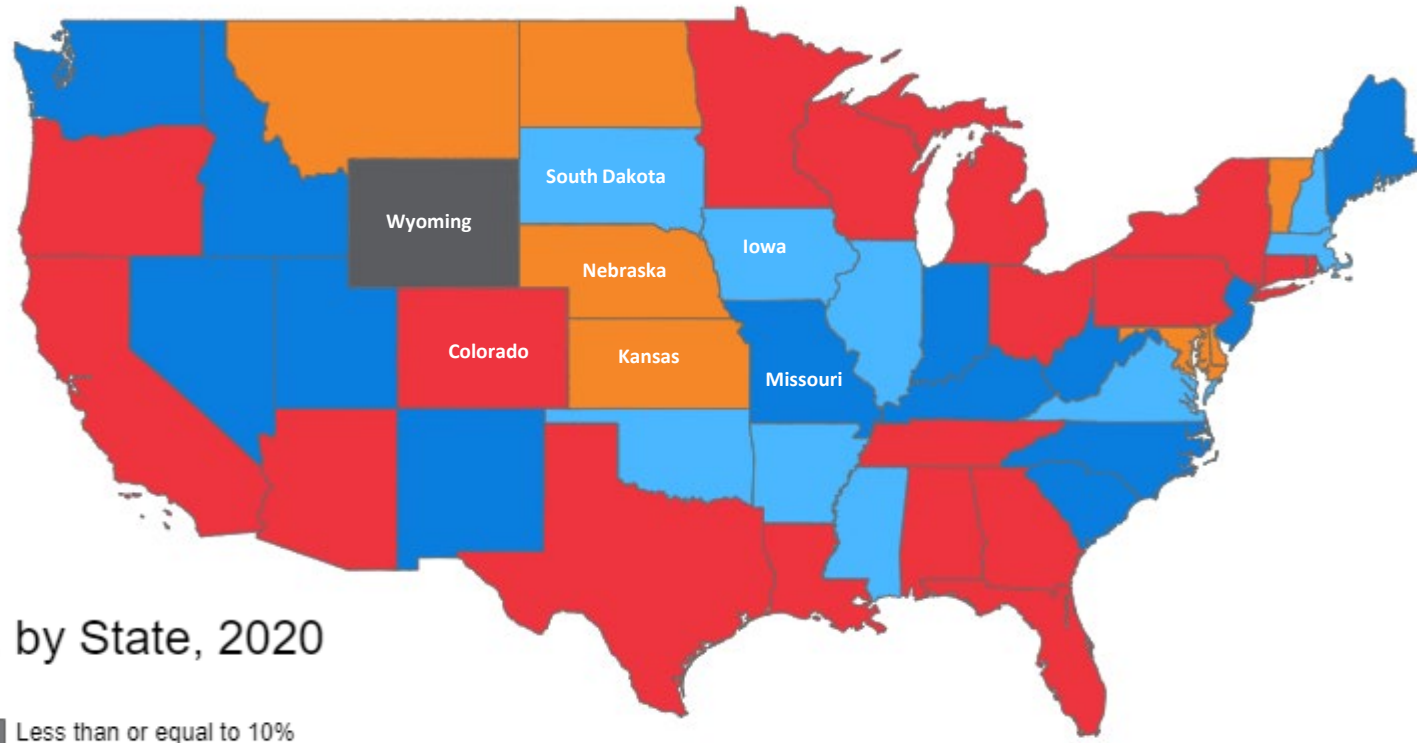
Medicare Advantage Trends

Medicare Advantage- The Trends

Total Medicare Advantage Enrollment, 1999-2020
(in millions)

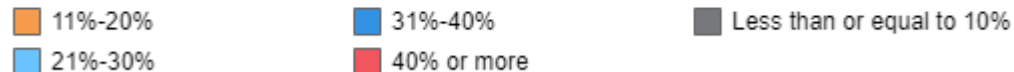


Medicare Advantage- The Trends

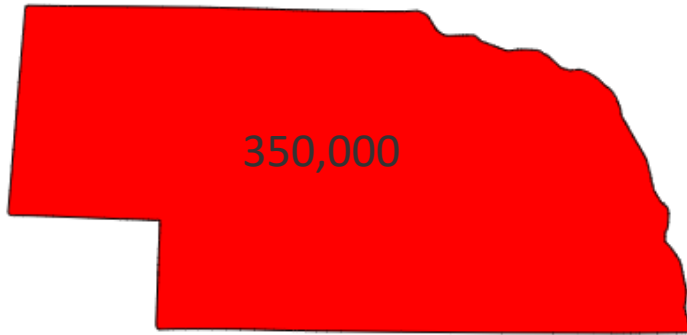


Medicare Advantage Penetration, by State, 2020

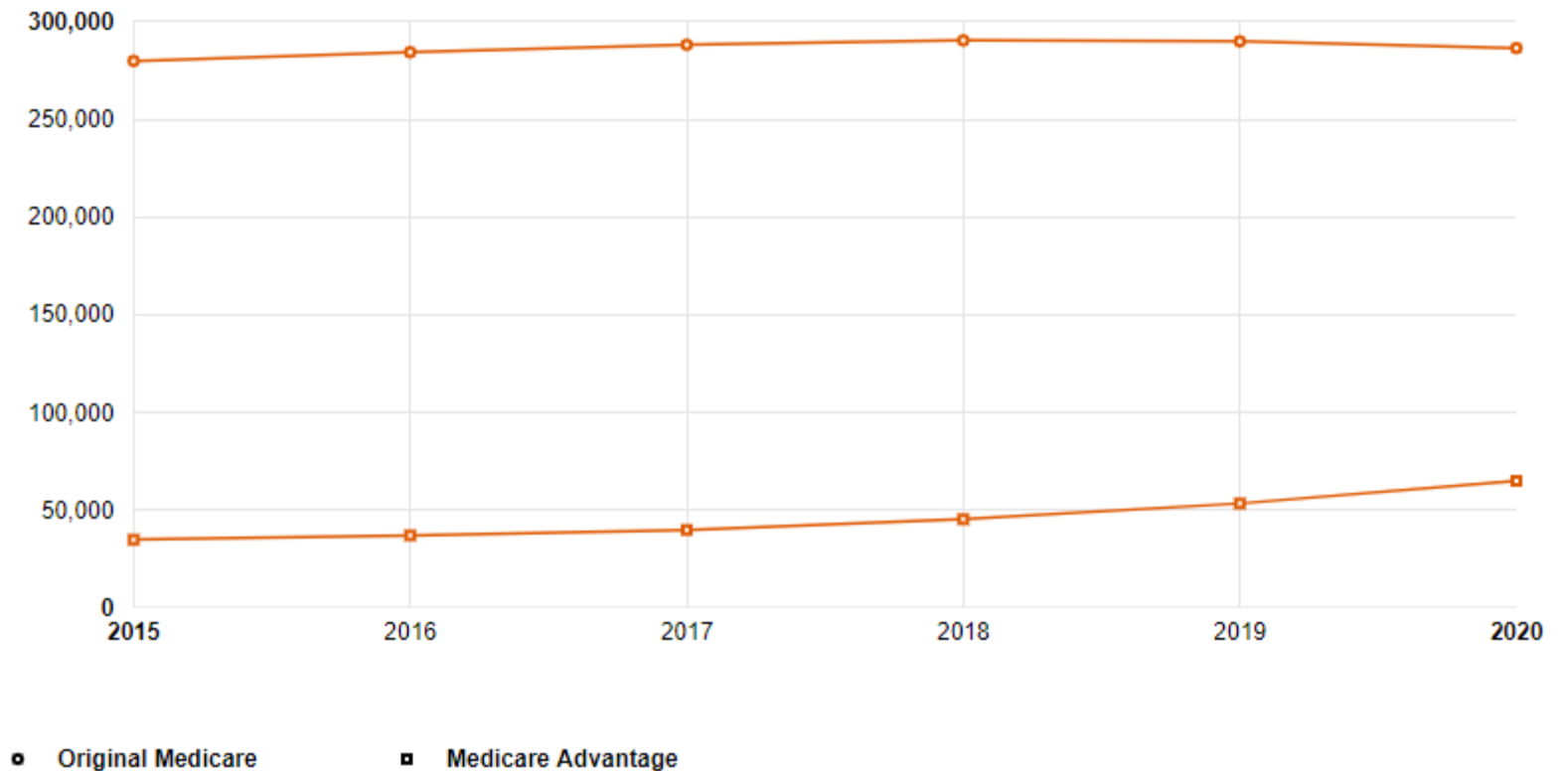
State Breakdown



Medicare Advantage- The Trends

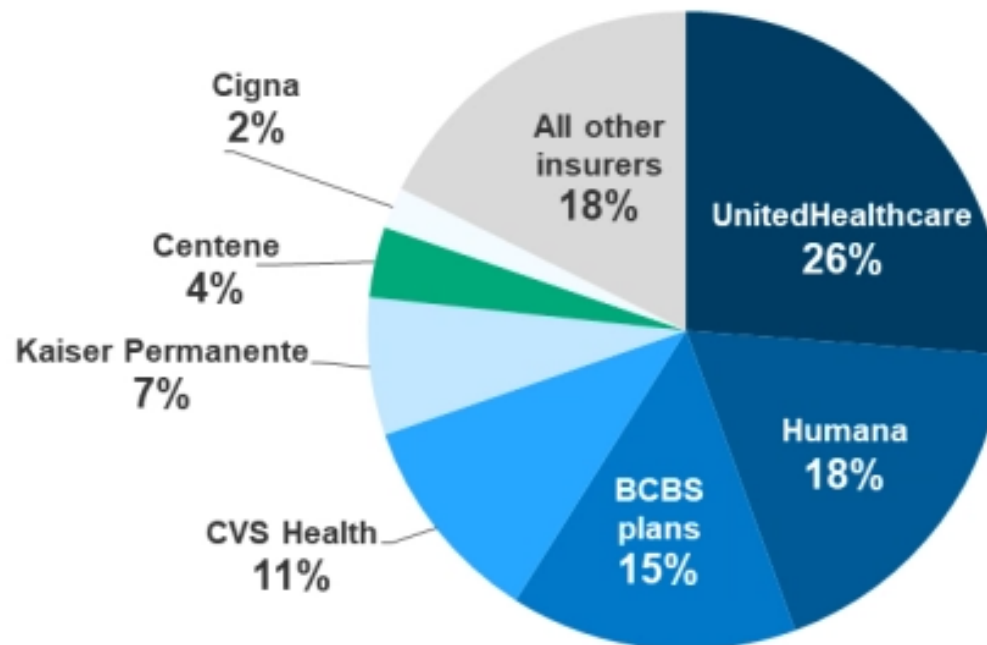


2020	
Original Medicare	Medicare Advantage
286,574	65,094



Medicare Advantage- The Trends

Medicare Advantage Enrollment by Firm or Affiliate, 2020



Total Medicare Advantage Enrollment, 2020 = 24.1 Million

Why Is This Happening?

Emerging Savvy Consumer Population

Plans Are Adding Perks & Getting More Attractive

- Dental, Vision, Hearing
- Transportation for Medical Visits
- Fitness Benefits
- Meals Benefits (Delivery, Classes, Education)
- Home Safety Devices
- Over-the-Counter Medications
- Adult Day-Care Services
- Overseas Travel Coverage

Financially Attractive to Patients

- Overall Premium Cost
- Statutory Annual Limit on Out-of-Pocket Expense

Medicare Advantage Plans

**Can You Avoid
Them?**

Do You Want To?

Payor Network Requirements

Payors Cannot Sell MA Product
Without Established Network

What If..... Your Neighbors Signs?

Negotiating Medicare Advantage

- Act Now! Timing = Leverage
- Address Details for Reimbursement Structure
 - Avoid “Paid According to Medicare Fees/Rates”
 - RHC Paid on per Visit Rate (Encounter) as Established by Medicare
 - Address Method II billing
 - CRNA Pass Through vs Fee Schedule
- Cost Report Settlement
- IP Surgery Consideration
- **Caution:** Inpatient Per Diem limitations
- Negotiate Above 100% of Medicare Rates
- Include Language Allowing For Separate Commercial, Medicaid, MA Terminations

Managed Care Contract/Billing Pitfalls

- Requirements to Send Medicare Rate Letters to MA
- Provider Requirements to Report to MA:
 - Chargemaster Increases
 - Offshore Activity
 - Adverse Events
 - Change of Liability Carrier
- CAHs- Medicare Professional Fees Billed on UB04 or 1500?
- RHCs - Ensure Professional Fees are Paid on Per Visit Rate Rather than Fee Schedule for MA Plans
- Primary Payor Requirements
- Secondary Allowance Calculation
- Complex Billing- Medica Example-Part A & Part B (Don't Write Off Claims Unnecessarily.)
- Provider-Based Billing Language
- The “we can put in the policy manual” Statement
- Communication Between Contract Negotiator & Billing Team

Contact Information

Hayley Prosser
*Director of
Revenue Cycle Services*

Cell:
720-361-9700

Email:
hprosser@ruralmed.net



Shelly Cassidy,
*Vice President of
Revenue Cycle Services*

Cell:
402-759-2823

Email:
scassidy@ruralmed.net

Wrap Up & Questions

