601. Managed Care – How to Overcome the Operational Challenges within a Deep Managed Care Environment
Deep Managed Care Environment

Continuing Education

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- Nurse attendees may earn a maximum of 15.5 contact hours
- Accountant attendees can earn up to 18.9 CPEs

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Commercial Support provided by Brightree, Excel Health Group, Healthcare Provider Solutions, and Simione Healthcare Consultants.
Agenda

- Current Marketplace
- Enrollee: Why choose Medicare Advantage?
- Opportunities are everywhere
- Provider Perspective
- Recommendations

Current Marketplace

The Health Insurance Marketplace is OPEN for business!
Medicare Advantage (MA)

• MA enrollment has doubled over the past decade
• Between 2017 and 2018, MA enrollment rose by 8%
  • 1.5 M beneficiaries
• MA enrollment is projected to increase 11.5% in 2019
  • 20.2 M → 22.6 M
• New Medicare enrollees are choosing a MA plan (29%)

Medicare Advantage

• As of 2019, one-third (34%) of all Medicare beneficiaries are enrolled in MA plans
  • 22 M
• CBO projects that in 2029 47% of Medicare eligible will be enrolled in MA
Medicare Advantage

- 40%+ Medicare eligible chose MA in the below states
  - HI
  - FL
  - MN
  - OR
  - WI
  - PA
  - & Puerto Rico
- >20% Medicare eligible chose MA in 14 states

Medicare Advantage

- Higher percentage of MA enrollees live in large, urban areas
  - More than half of Medicare beneficiaries have chosen to enroll in MA
- In rural areas, around 10% of beneficiaries are enrolled in MA plans
Medicare Advantage Partners

- Managed Advantage plans are dominated by 3 payors
  - UnitedHealthcare (26%)
  - Humana (18%)
  - BlueCross BlueShield affiliates (15%)

Value Based Insurance Design (VBID)

- Modernize Medicare Advantage plans, including Dual Eligible clients
  - Special Need Plans (SNP)
- Goal of reducing overall Medicare expenditures
- CMS is encouraging plans to add complementary benefits
- Movement towards Value Based Contracts
- MA Hospice benefit in 2021
Why Choose Medicare Advantage?

- 90% of MA plans offer prescription drug coverage
- 56% of beneficiaries pay no premium other than the Medicare Part B premium
- Premiums paid by MA enrollees have slowly been declining since 2015
- MA enrollees have access to benefits not covered by traditional Medicare
Advantages for Beneficiaries

- Provide additional coverage and benefits to members
- Patients have a cap on out-of-pocket expenses
- Average out-of-pocket limit for in-network is $5,059 and $8,818 for out-of-network services (Kaiser 2019)

Additional MA benefits

- New benefits offered CY 2019
  - Non-skilled in-home care services
    - Chores, safety devices, respite for caregivers
  - In-home support system
  - Telehealth services
  - Home delivered meals
  - Social needs benefit
  - “Complementary” therapies
  - Adult day care
  - Transportation
Opportunities Are Everywhere in RCM

Traditional Medicare vs Medicare Advantage

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<th>Medicare Advantage</th>
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(MAC) – Medicare Administrative Contactor: private health care insurer that has been awarded a geographic jurisdiction to process Medicare Part A and Part B (A/B) medical claims or Durable Medical Equipment (DME) claims for Medicare Fee-For-Service (FFS) beneficiaries.

(QIO) – Quality Improvement Organization: group of health quality experts, clinicians, and consumers organized to improve the quality of care delivered to people with Medicare
Contracting

- Develop a payer profile before negotiating
- If you are part of a Healthcare System, leverage that in your negotiations
- Show your value to the payer
  - Turnaround time
  - Rehospitalization rate
- Competitive landscape
- Know what your contract payment terms are
  - Predetermined cost-of-living adjustments (COLA)
- Ask for details on how the contract will be operationalized
- Value based contracts

Contracting

- Verify that your EMR can support the requirements of the contract
  - If not, how can you operationalize?
- Ensure payor is setup correctly in EMR
  - Rates
  - Payer specific requirements
- Establish recurring calls with payer
Path to Reimbursement

- Medicare
- Medicaid

- Managed Medicaid
- Traditional Commercial Insurance
- Veterans Administration
- Contracts
- Private Pay

Obstacles in a transactional process

- Transparency
- Requires independent workers
- High level problem solving
- Identification of new issues can be challenging
- Have the right KPIs
- Reevaluate tools constantly
Intake

• When does it start?
  • Utilize your liaisons/ marketing team
  • Are you relying on calls to your branches/ call center
• List of contracted payers
• Areas of focus
  • Correct Payer
  • Certifying Physician
  • F2F physician
  • PECOS

Eligibility & Benefits

• Confirm patient coverage is active
  • Preferred method electronic
  • Often one must call to verify Home Health benefits
• Are you a participating provider?
  • If not, verify out of network benefits
• Verify, document & in EMR
  • Copay, coins, deductibles
• Communicate benefits before first visit
• Address coordination of benefits (COB) issues immediately
• Reverify eligibility monthly
Orders

• Days to approve and send
• Is your staff identifying the correct certifying physician?
• What is your average turnaround time?
  • By physician
  • By practice
• Communicate with challenging physicians/groups
• Try calling, don't just refax

Authorizations

• Requirements for initial authorization vs. continued authorization
• Initial request needs to be within 24 hours of first appointment
• Understand the payers utilization management practices
• Is the process following the operational process that was discussed upon contracting
• Capture reference numbers
Authorizations

- Double check:
  - Date range of authorized visits
  - Levels authorized
  - Units vs Visits
  - Codes authorized
- Identify expiring authorizations BEFORE they expire
- Know retro authorization guidelines
- Payors are starting to require completed OASIS in a .xml format

Claims Processing

- Frequency of billing
  - Recommended - monthly
- Monitor your clean claim rate
- Address pre-bill errors quickly
  - Understand timely filing guidelines
  - Communicate upstream
- Monitor electronic submission percentage
- Medicare Advantage
  - “Per Medicare Guidelines”
Cash Posting

- Ensure accuracy
  - Use Electronic Remittance Advice (ERA)
- Timeliness
  - Days to Post
- Post all $0.00 dollar remits
- How are you handling forward balances?
- Health of your accounts receivable
  - Source of truth

Denial follow up

- Prioritizing your accounts to be followed up
  - High dollar first
  - High patient balance
  - Timely follow up
- Work the payer escalation service model
  - Reconsideration vs appeals
  - Claims Supervisor
  - Payor projects
- What tools are you using?
  - Denial Management Tools
- Are you capturing data to share with the payor?
OIG Report on MA adjudication

Exhibit 2: During 2014–16, 75 percent of beneficiary and provider appeals to their MAOs were fully or partially successful.

- Unsuccessful appeals 25%
- Partially successful appeals 5%
- Fully successful appeals 70%


MAOs overturned more than a half million preauthorization and payment denials at the first level of appeal.

Key Takeaway
High numbers of overturned denials upon appeal, and persistent performance problems identified by CMS audits, raise concerns that some beneficiaries and providers may not be getting services and payment that MAOs are required to provide.

Third Party Auditors

- Many companies are contracting with auditing firms
- “Medicare Like” audits but with a twist
- Watch for these in the mail
- Look at coding, rendered services, non-medically necessary services, improperly supervised services, and low quality services
Overpayments / Credits

- **Definition**: Payment from Medicare exceeds amounts properly payable under Medicare statutes and regulations
- **Requirement**: Providers must report and return overpayment within 60 days of date received after being “identified”

- Do you have policies / best practices on resolving government and nongovernment fund source credits?

Provider Perspective
Provider Perspective

• Must pay attention to Payer Mix
  • It is shifting
  • Medicare payment policy for plans has shifted from producing savings to focusing on expanding access to private plans
• What can you do to address it?
  • Predictive analytics

Provider Perspective

• Commercial payer strategy
• Referral Management
• Discharge planning at admission
Provider Perspective

• Leveraging your position in the marketplace
• Multi State provider

Provider Perspective

• Negotiation vs. take it or leave it
• Creating that collaborative partnership with the payers
  • Do you have a shared vision?
Provider Perspective

- Attention to detail at admission
- Optimize
  - People
  - Process
  - Technology

Provider Perspective

- Making strategic business decisions
  - Terminating contracts
  - Not contracting
  - Remaining out of network
As leaders in your organizations….

Internal Monitoring

- BE PROACTIVE!
- Perform regular audits
- What are your internal QA & QC processes?
- What are your KPI’s / benchmarks
- Productivity Standards
Recommendations

- Cultivate your commercial payer strategy
- Conduct an impact analysis on an increasing commercial revenue mix
  - What can be applied as we adapt to PDGM
- Strengthen relationship with payers
- Practice continuous improvement
- Breakdown the silos
- Leverage technology
- Advocate

Questions?

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