How the Revenue Cycle Fits Into the Bigger Picture

Nebraska Hospital Association
Revenue Cycle Residency Program 2024-2025

September 10-11, 2024

Introductions

Martie Ross
Principal
mross@pyapc.com

Kathy Reep
Senior Manager
kreep@pyapc.com

pyapc.com
800.270.9629

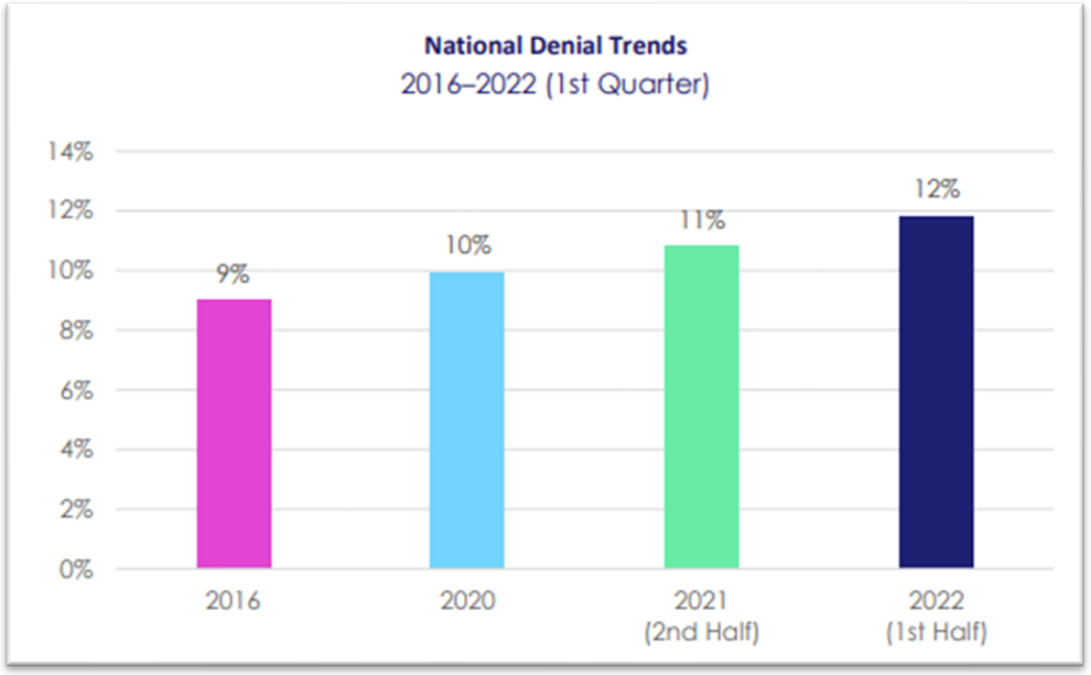
Why Revenue Cycle Matters

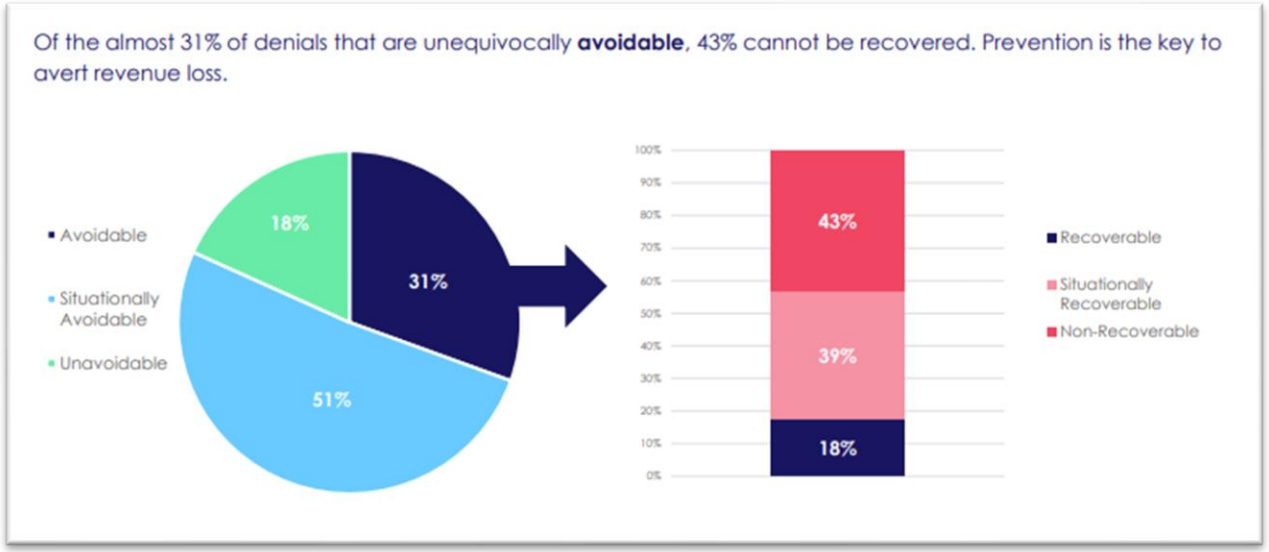
Denied claims = uncompensated care; most denied claims are avoidable

Revenue cycle staff have significant responsibility for regulatory compliance

Community's perception of its hospital based in significant part on interaction with revenue cycle staff

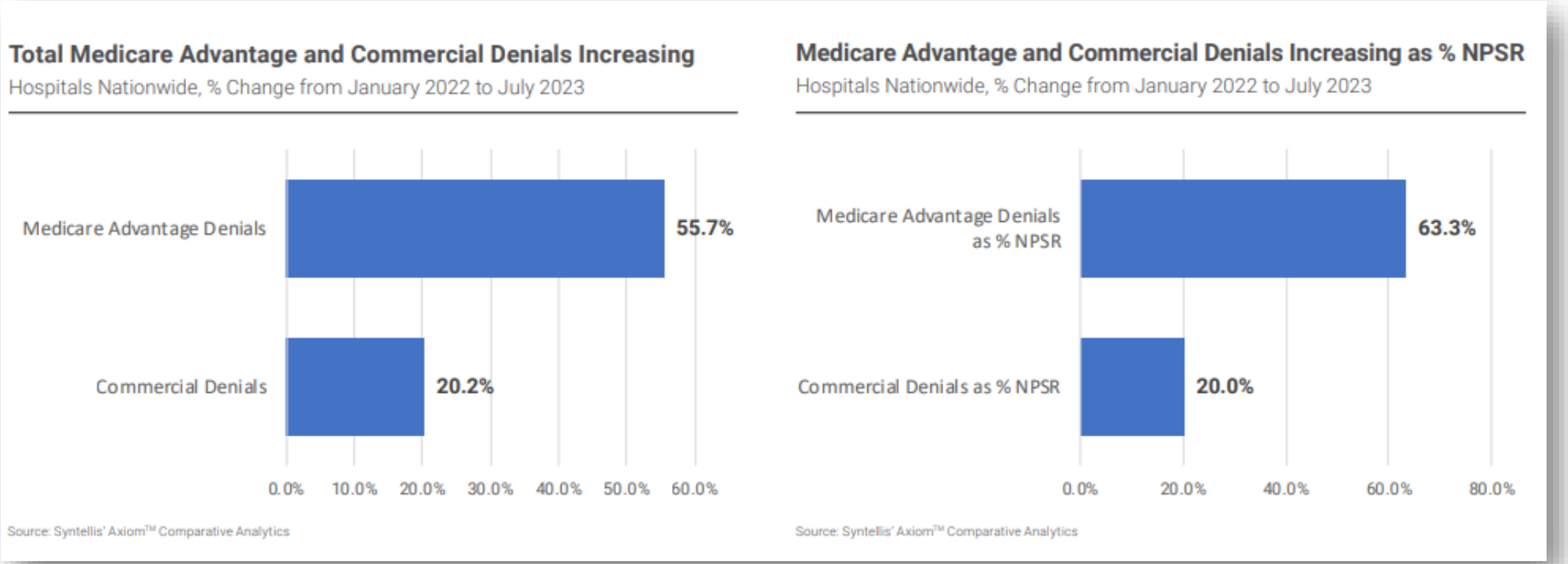
Change Healthcare
2022 Revenue Cycle Denials Index





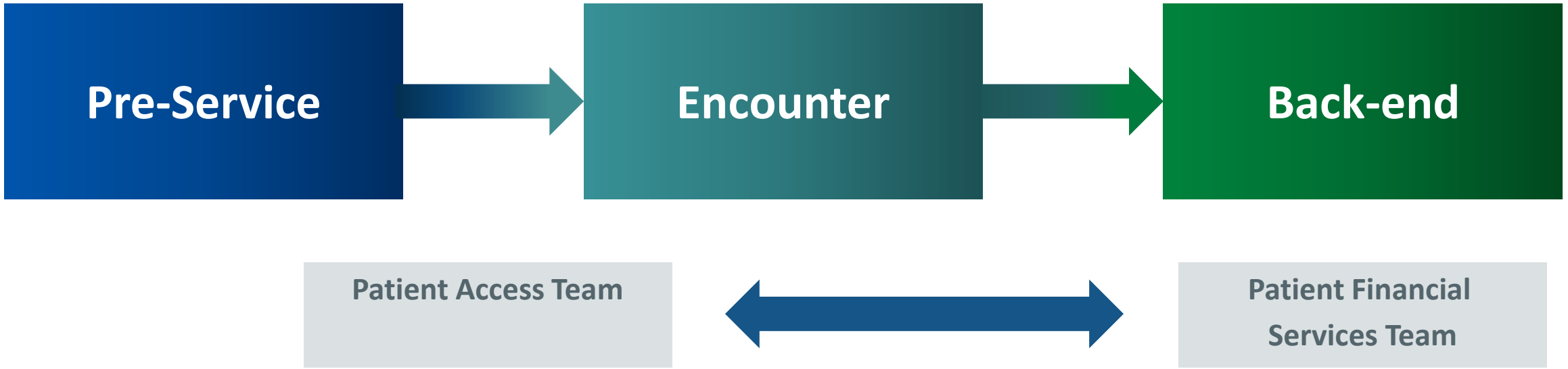
https://www.changehealthcare.com/insights/denials-index

Increased Denial Rates in 2023

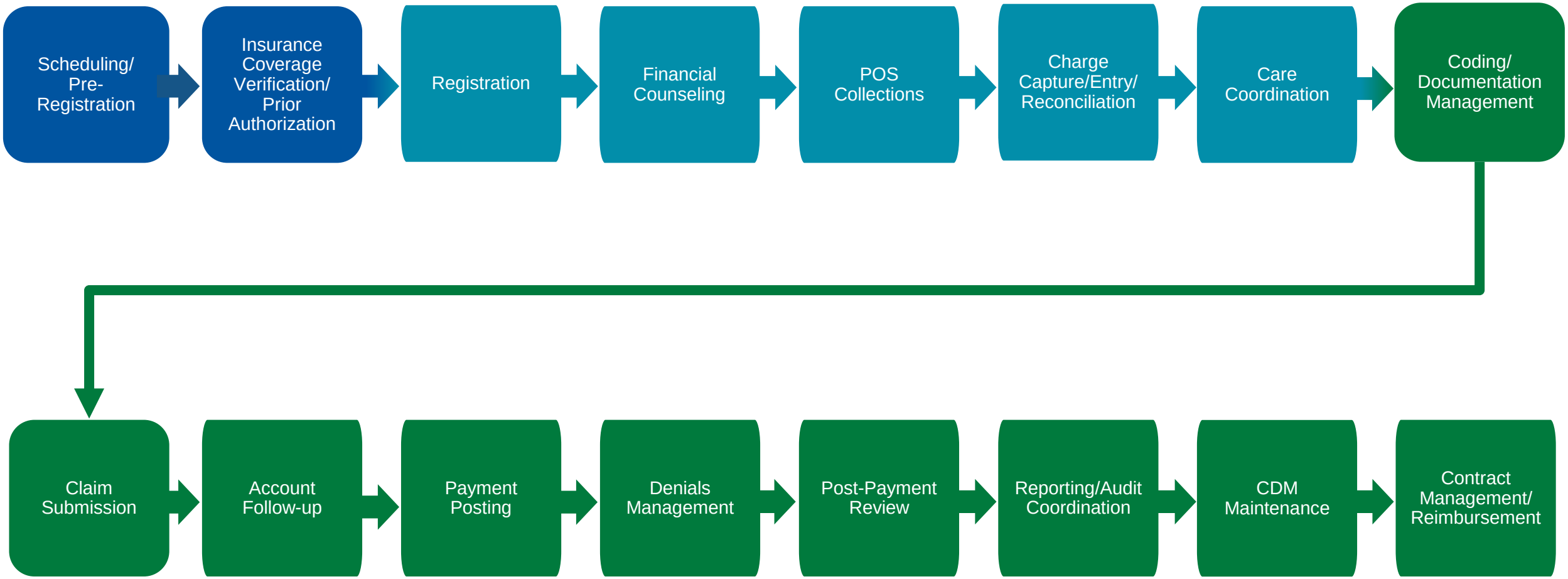


https://www.syntellis.com/sites/default/files/2023-11/aha_q2_2023_v2.pdf

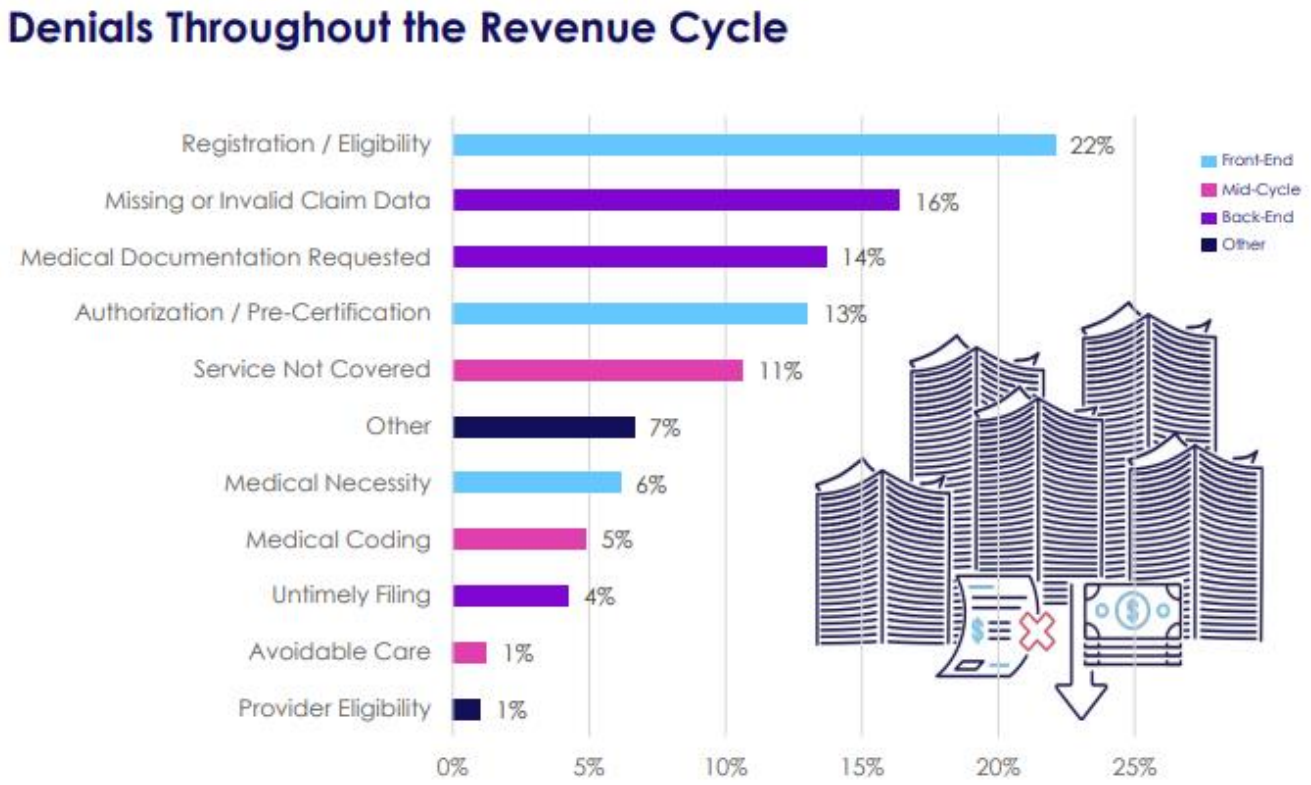
Three Phases of the Revenue Cycle



The Revenue Cycle



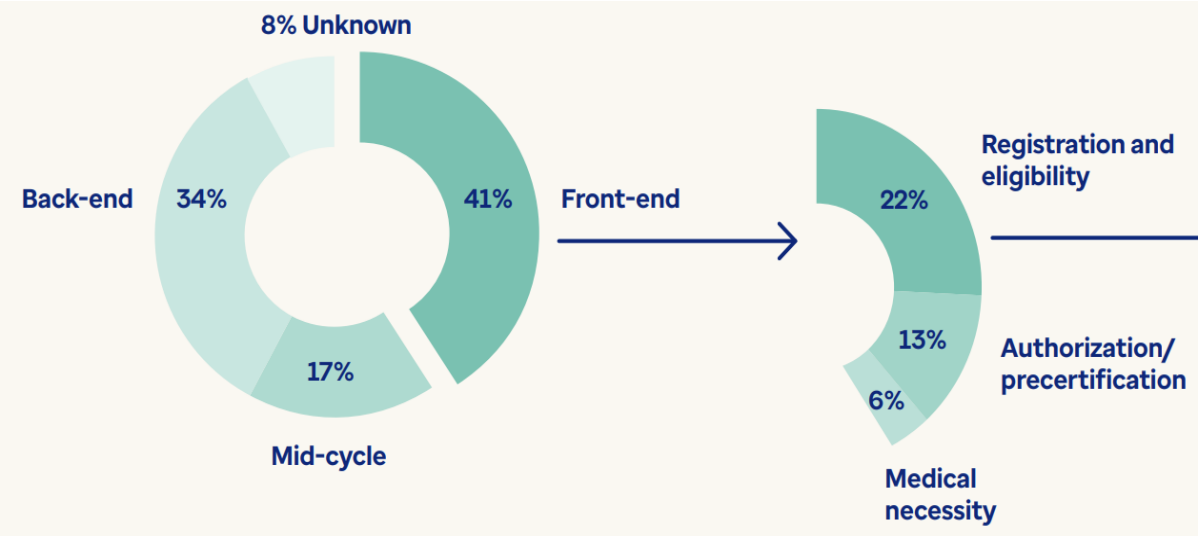
Change Healthcare
2022 Revenue Cycle Denials Index

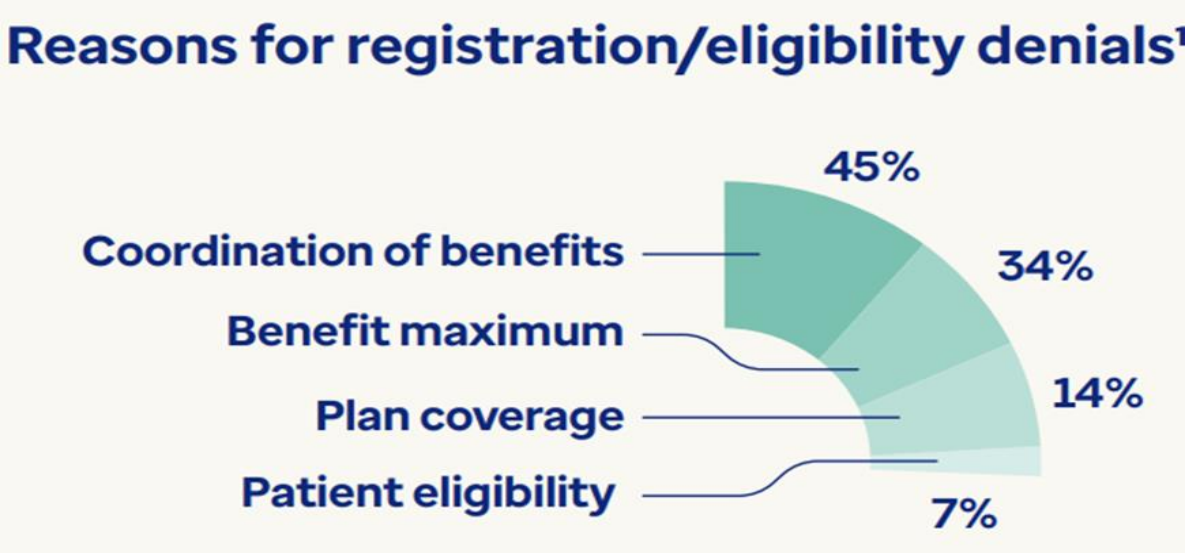


https://www.changehealthcare.com/insights/denials-index

Phase I:
Pre-Service

Change Healthcare
2022 Revenue Cycle Denials Index





https://www.changehealthcare.com/insights/decrease-denials-strategy

1. Scheduling/Pre-Registration

- Patient's initial contact with hospital/clinic staff – ***critical*** to obtain complete and accurate demographic and payer information, including verification of information previously obtained
- Coordination of benefits (~10% of all denials)
  - Other insurance coverage, e.g., worker's compensation, automobile injury
- ***New!*** Provision of Good Faith Estimate for scheduled self-pay patients
  - Also required for individuals who contact providers "shopping" for services

Good Faith Estimates

‘Convening provider’

- Provider responsible for scheduling primary item or service
- Includes clinic visits, diagnostic testing, procedures, etc.

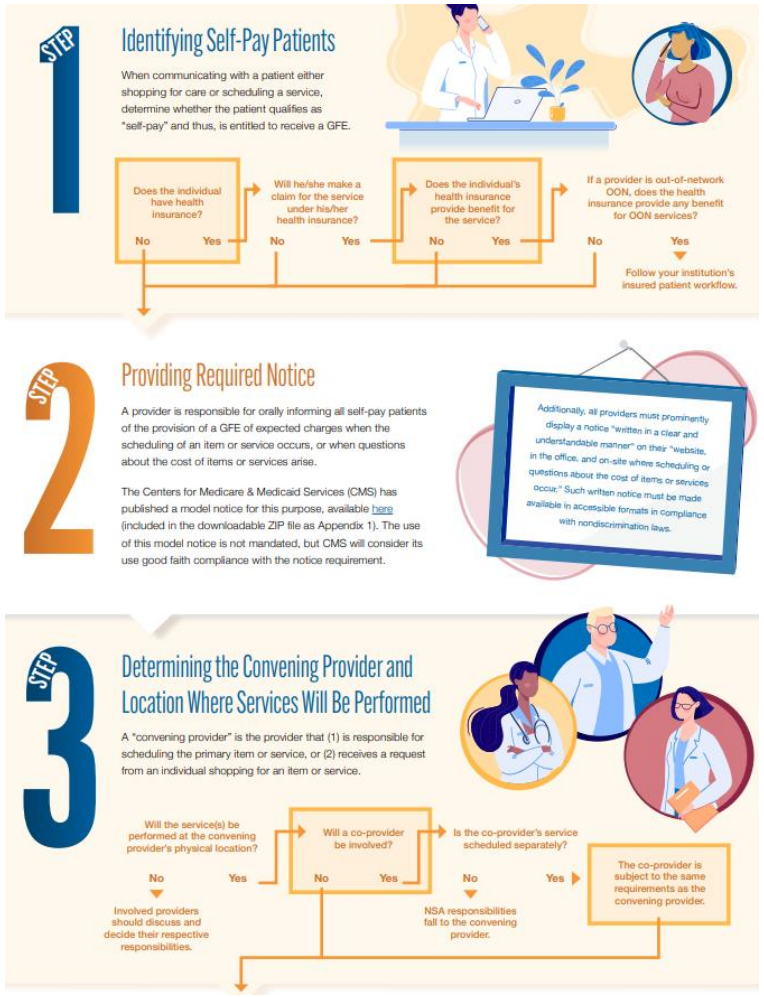
Must furnish good faith estimate of total expected charges when -

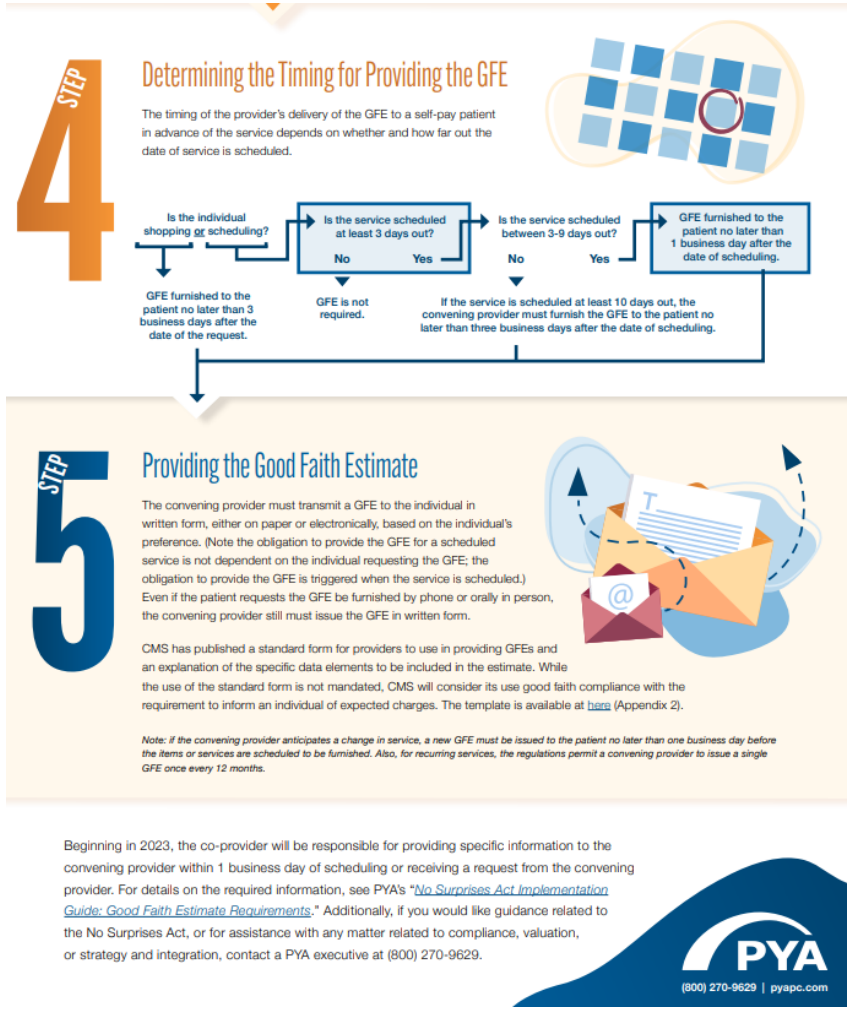
- Self-pay patient requests estimate (comparison shopping)
- Self-pay patient schedules item/service at least 3 business days in advance

Must include -

- Items and services to be billed by convening provider
- Requirement to furnish co-provider information delayed indefinitely

Good Faith Estimate Workflow





Available at https://www.pyapc.com/insights/no-surprises-act-good-faith-estimates-workplan-infographic/

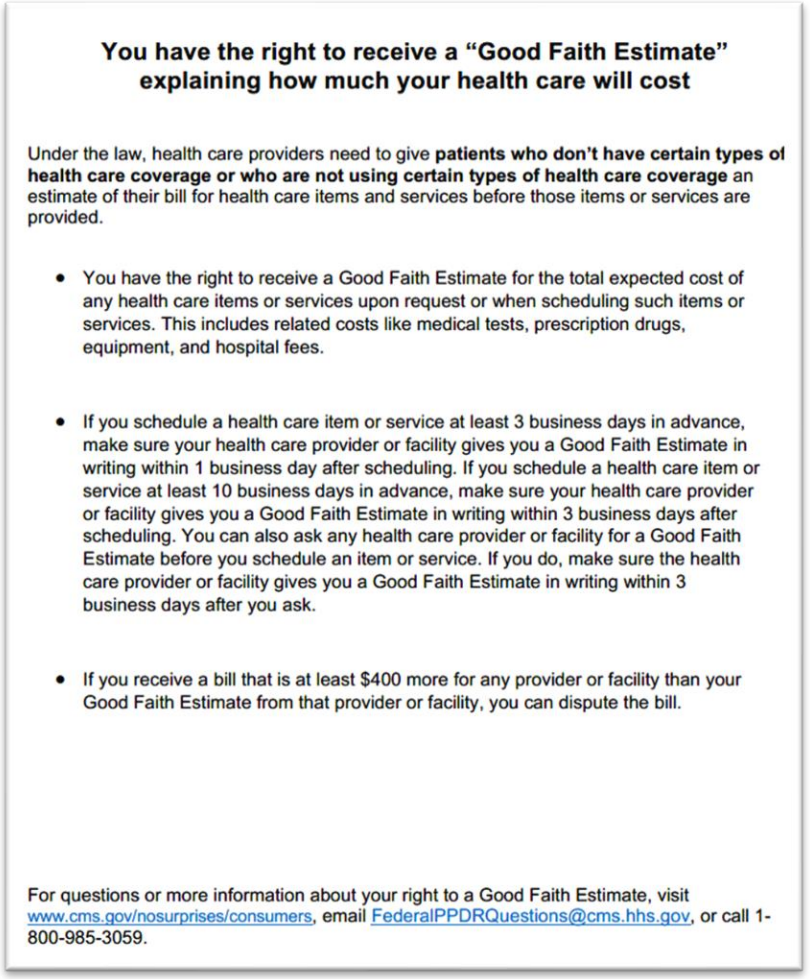
Step 1 - Determine If Self-Pay Patient

'Self-pay' includes -

- No insurance coverage
- Has insurance, but does not intend to submit claim for item/service
- Has insurance, but item/service is not covered
- Has insurance, but no coverage for OON items/services (vs. higher out-of-pocket)

Step 2 – Provide Required Notice

- Orally inform all self-pay patients of GFE availability when scheduling or when questions regarding cost arise
- Post GFE notice on website
- Post GFE notice at physical location
  - Next to Notice of Privacy Practices + Surprise Billing Notice



You have the right to receive a "Good Faith Estimate" explaining how much your health care will cost

Under the law, health care providers need to give **patients who don't have certain types of health care coverage or who are not using certain types of health care coverage** an estimate of their bill for health care items and services before those items or services are provided.

- You have the right to receive a Good Faith Estimate for the total expected cost of any health care items or services upon request or when scheduling such items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- If you schedule a health care item or service at least 3 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 1 business day after scheduling. If you schedule a health care item or service at least 10 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after scheduling. You can also ask any health care provider or facility for a Good Faith Estimate before you schedule an item or service. If you do, make sure the health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after you ask.
- If you receive a bill that is at least $400 more for any provider or facility than your Good Faith Estimate from that provider or facility, you can dispute the bill.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.

Model notice available at https://www.cms.gov/files/zip/cms-10791.zip

Step 3 – Provide Written GFE

[NAME OF CONVENING PROVIDER OR CONVENING FACILITY]

Good Faith Estimate for Health Care Items and Services

Patient			
Patient First Name	Middle Name		Last Name
Patient Date of Birth:	_____/_____/_____		
Account Number (last four digits) (optional):			
Patient Mailing Address, Phone Number, and Email Address			
Street or PO Box			Apartment
City	State		ZIP Code
Phone			
Email Address			
Patient's Contact Preference:	[ ] By mail	[ ] By email	[ ] By phone
Patient Diagnosis (if determined)			
Primary Service or Item Requested/Scheduled			
Patient Primary Diagnosis		Primary Diagnosis Code	
Patient Secondary Diagnosis		Secondary Diagnosis Code	
If scheduled, list the date(s) the Primary Service or Item will be provided: [ ] Check this box if this service or item is not yet scheduled			

Date of Good Faith Estimate: _____/_____/_____

Summary of Expected Charges
(See the itemized estimate attached for more detail.)

Provider Name	Estimated Total Cost
Provider Name	Estimated Total Cost
Provider Name	Estimated Total Cost
Total Estimated Cost: $	

The following is a detailed list of expected charges for [LIST PRIMARY SERVICE OR ITEM], scheduled for [LIST DATE[S] OF SERVICE, IF SCHEDULED] [[ADD IF ADDITIONAL ITEMS/SERVICES ARE BEING INCLUDED], as well as for items or services reasonably expected to be furnished in conjunction with the primary item or service as part of the period of care]. [Include if items or services are reoccurring, "The estimated costs are valid for 12 months from the date of the Good Faith Estimate."]

Template and instructions available at https://www.cms.gov/files/document/good-faith-estimate-example.pdf

Provide Written GFE

[Provider/Facility 1] Estimate

Provider/Facility Name		Provider/Facility Type	
Street Address			
City		State	ZIP Code
Contact	Person Phone	Email	
National Provider Identifier		Taxpayer Identification Number	

Details of Services and Items for [Provider/Facility 1]

Service/Item	Address where service/item will be provided	Diagnosis Code (if required for the calculation of the GFE)	Service/Procedure Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]	[Service/Procedure Code Type: Service/Procedure Code Number]		
Total Expected Charges from [Provider/Facility 1] $					
Additional Health Care Provider/Facility Notes					

Provide Written GFE

Abbreviated GFE for No-Cost Health Care Items or Services

This abbreviated GFE should **only** be used by a provider or facility that **does not expect to bill the uninsured (or self-pay) individual** for items or services furnished on the date the items or services are expected to be provided.

[*insert* NAME OF PROVIDER OR FACILITY]
Good Faith Estimate for No-Cost Health Care Items & Services

This provider/facility will not bill you for items or services scheduled to be provided on [*insert date(s)*] **[*If items or services have not been scheduled, replace with this:* This provider/facility will not bill you for items or services.]**		
Patient Name:	Patient Date of Birth:	
Patient Identifier (optional):		
Provider/Facility Name:		
Provider/Facility Street Address (where items or services are expected to be furnished):		
City:	State:	ZIP Code:
Provider/Facility Contact:	Phone:	
Email Address:		

Timing

- Initial GFE
  - If requested prior to scheduling – 3 days following request
  - If scheduled at least 10 but less than 4 business days in advance – 3 days before
  - If scheduled at least 3 business days in advance – 1 day before
  - No GFE required if scheduled less than 3 days in advance
- FAQ on updating GFE
  - If provider expects or is notified of changes to scope of GFE, must furnish updated GFE no later than 1 business day prior to scheduled date of service
  - Encouraged to review updated GFE with patient

Coming Soon? Advanced EOB

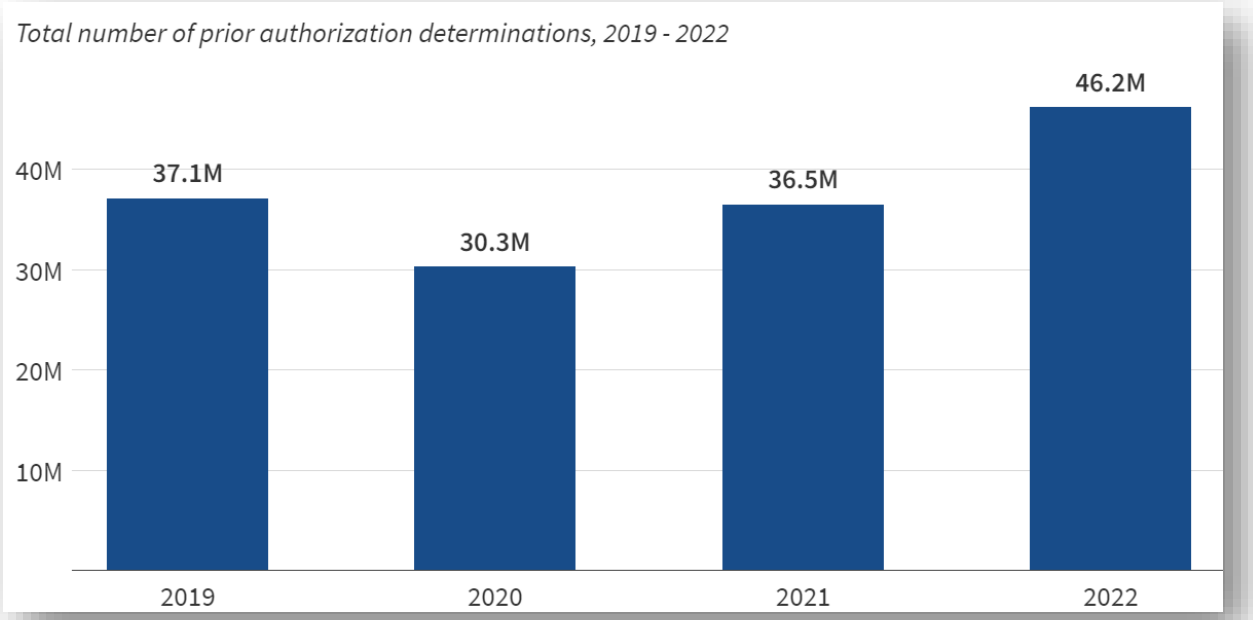
- Provider sends “insured GFE” to commercial payer
- Payer uses information to provide AEOB to patient
  - Provider’s expected charges
  - Portion payer expects to cover
  - Patient’s expected cost-sharing liability
- No ETA – presently developing processes for exchanging information between provider and payer

https://www.cms.gov/files/document/progress-aeob-rulemaking-implementation.pdf

2. Insurance Coverage Verification and Prior Authorization

- Use of on-line tools vs. telephonic communications
  - Patient follow-up, as necessary
- Initiate and follow-up on prior authorization process
- Identify necessary forms/notices to be furnished to patient (e.g., ABNs for Medicare beneficiaries)
- Calculate patient's out-of-pocket liability (if possible)

Medicare Advantage
2022 Prior Authorization Statistics



Medicare Advantage Insurer	Prior Authorization Requests per Enrollee	Share of Requests Fully or Partially Denied	Share of Denials Appealed	Share of Appeals that Overturned Initial Decision
Overall	1.5	6%	11%	82%
Anthem	2.9	3%	7%	75%
BCBS Plans	2.2	6%	7%	76%
Centene	2.6	10%	7%	94%
Cigna	1.3	8%	19%	80%
CVS	0.8	12%	20%	90%
Humana	2.8	3%	11%	70%
Kaiser Permanente	0.3	12%	1%	30%

https://www.kff.org/medicare/issue-brief/use-of-prior-authorization-in-medicare-advantage-exceeded-46-million-requests-in-2022/

2024 MA & Part D Final Rule (effective 01/01/2024)

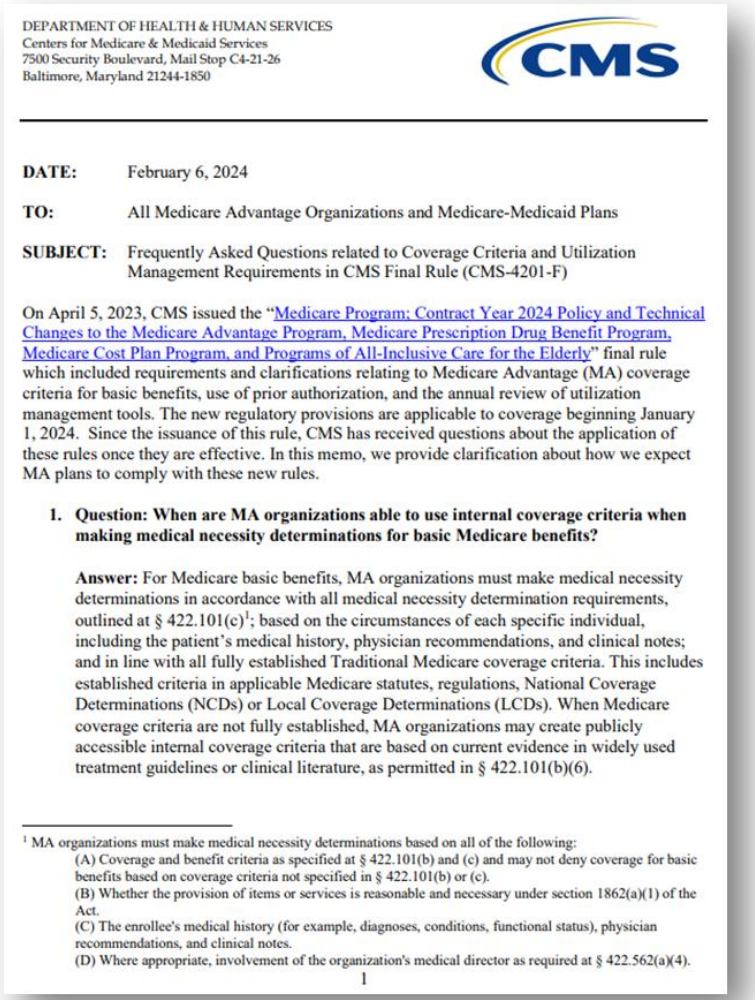
1. MA plan must comply with traditional Medicare NCDs, LCDs, and general coverage and benefit conditions
   - Including coverage criteria for inpatient, IRF, and SNF admissions and HHA services
   - Specifically, admissions for surgeries on inpatient only list and admissions meeting two midnight benchmark (but not the two-midnight presumption applied for medical review purposes)
2. If (and only if) coverage criteria not fully defined by above, may establish internal coverage criteria
   - Must be based on current evidence in widely used treatment guidelines or clinical literature
   - Must be publicly accessible (including summary of evidence)
   - Plan must demonstrate additional criteria provide clinical benefits highly likely to outweigh any harm (including delayed/decreased access to care)

2024 MA & Part D Final Rule

3. Must establish Utilization Management Committee led by Medical Director to review PA policies annually
   - Additional specifications listed in 11/15/2023 HPMS memo
   - 2025 MA & Part D Final Rule added new requirements
     - At least one committee member must have expertise in health equity
     - Committee must conduct annual plan-level health equity analysis of PA policies
4. Prior authorization must remain valid for as long as medically necessary to avoid disruptions in care; must provide minimum 90-day transition period when enrollee undergoing treatment changes coverage
   - Cannot be required for emergency, urgently needed, and stabilization services
   - Should not function to delay/discourage care

Additional Clarification

February 6, 2024, FAQs on coverage criteria and utilization management requirements



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C4-21-26
Baltimore, Maryland 21244-1850

CMS

DATE: February 6, 2024

TO: All Medicare Advantage Organizations and Medicare-Medicaid Plans

SUBJECT: Frequently Asked Questions related to Coverage Criteria and Utilization Management Requirements in CMS Final Rule (CMS-4201-F)

On April 5, 2023, CMS issued the "Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly" final rule which included requirements and clarifications relating to Medicare Advantage (MA) coverage criteria for basic benefits, use of prior authorization, and the annual review of utilization management tools. The new regulatory provisions are applicable to coverage beginning January 1, 2024. Since the issuance of this rule, CMS has received questions about the application of these rules once they are effective. In this memo, we provide clarification about how we expect MA plans to comply with these new rules.

1. **Question: When are MA organizations able to use internal coverage criteria when making medical necessity determinations for basic Medicare benefits?**

   Answer: For Medicare basic benefits, MA organizations must make medical necessity determinations in accordance with all medical necessity determination requirements, outlined at § 422.101(c)[1]; based on the circumstances of each specific individual, including the patient's medical history, physician recommendations, and clinical notes; and in line with all fully established Traditional Medicare coverage criteria. This includes established criteria in applicable Medicare statutes, regulations, National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). When Medicare coverage criteria are not fully established, MA organizations may create publicly accessible internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature, as permitted in § 422.101(b)(6).

[1] MA organizations must make medical necessity determinations based on all of the following:
(A) Coverage and benefit criteria as specified at § 422.101(b) and (c) and may not deny coverage for basic benefits based on coverage criteria not specified in § 422.101(b) or (c).
(B) Whether the provision of items or services is reasonable and necessary under section 1862(a)(1) of the Act.
(C) The enrollee's medical history (for example, diagnoses, conditions, functional status), physician recommendations, and clinical notes.
(D) Where appropriate, involvement of the organization's medical director as required at § 422.562(a)(4).

1

https://www.aha.org/system/files/media/file/2024/02/faqs-related-to-coverage-criteria-and-utilization-management-requirements-in-cms-final-rule-cms-4201-f.pdf

1. Two Midnights – Benchmark vs. Presumption

- MA plans must follow two midnights benchmark (42 CFR 412.3(d)(1))
  - Admitting physician expects patient to require hospital care that crosses two-midnights
- MA plans not required to follow two midnights presumption (CMS medical review instruction)
  - Any claim that crosses two midnights following inpatient admission order are presumed appropriate for payment
- MA plan may evaluate whether admitting physician's expectation was *reasonable* based on complex medical factors documented in medical record

2. Post-Acute Care

If physician orders post-acute care in specific type of facility (e.g., IRF, SNF, swing bed) and patient meets all applicable coverage criteria, plan cannot deny admission or re-direct care to different setting

- MA plan may discuss with enrollee treatment options (offer incentives?)

MA plan bears burden of proving services no longer reasonable and necessary when terminating post-acute care services

- Such action subject to expedited appeals process

3. Post-Claim Audits

If MA plan gave prior authorization, cannot later deny coverage for lack of medical necessity; cannot re-open its decision without good cause/reliable evidence of fraud

Any post-claim review that constitutes refusal to pay for services = ***organization determination*** that must be reviewed by physician/healthcare professional with relevant expertise (including knowledge of Medicare coverage criteria)

- Cannot characterize such action as “payment reviews” to which rules do not apply
- Must provide notice of revised determination, rationale, and appeal rights

4. Use of Algorithms/AI in Coverage Determinations

- Medical necessity determinations must be based on individual enrollee's circumstances (medical history, physician recommendations); use of algorithm/AI that determines coverage based on larger data set not permitted
  - Cannot use to predict post-acute LOS to terminate service
  - Cannot use to deny admission/downgrade to observation stay
- Algorithms/AI can only be used to ensure fidelity with posted coverage criteria; cannot be used to shift such criteria over time
- Plans must safeguard against use of algorithms/AI in manner that perpetuates or exacerbates discrimination and bias

5. Enforcement

"CMS will conduct both routine and focused program audits of organizations in 2024 to assess compliance with the coverage and UM requirements" in the 2024 rule

- Expect to evaluate UM-related performance of plans serving 88% of MA enrollees
- Will utilize physician reviewers to review denials and assess whether plan meeting new clinical coverage requirements

May impose civil money penalties + enrollment and/or marketing sanctions

Phase II:
Encounter

3. Registration

- Re-verification of information obtained at scheduling/pre-registration
  - *Key performance indicator* for front desk staff: complete and accurate information captured/verified
- Delivery of required notices
  - HIPAA Notice of Privacy Practices (secure acknowledgement)
  - Assignment of Benefits
  - Medicare MOON (outpatient observation notice)
  - Surprise Billing (commercially-insured patients only)
  - *Coming soon*! TEAM episode beneficiary notice (participating hospitals only)

Surprise Billing Notice

Facilities *and* providers who furnish services in facilities must provide notice to patients of NSA protections

- Post prominently at physical location (HIPAA Notice of Privacy Practices)
- Post on website (link from homepage)
- Facility must deliver to each commercially insured patient to whom services provided at facility in manner requested by patient no later than time at which request for payment made (or claim submitted, if no request)
  - Does not include Medicare Advantage, managed Medicaid, health reimbursement arrangements, health-sharing ministries, plans with reference-based pricing short-term limited-duration insurance, retiree-only plans
- Provider furnishing services in facility may enter into written agreement with that facility to rely on facility's notice to insured patients
  - Otherwise, provider responsible for delivering notice to patients (in addition to facility's notice)

Model Notice

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

[*Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed language as appropriate*]

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

[*Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed language regarding applicable state law requirements as appropriate*]

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact [*Insert contact information for entity responsible for enforcing the federal and/or state balance or surprise billing protection laws. The federal phone number for information and complaints is: 1-800-985-3059*].

Visit [*Insert website describing federal protections, such as www.cms.gov/nosurprises/consumers*] for more information about your rights under federal law.
[*If applicable, insert:* Visit [*website*] for more information about your rights under [state laws].]

https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf

Patient Complaints

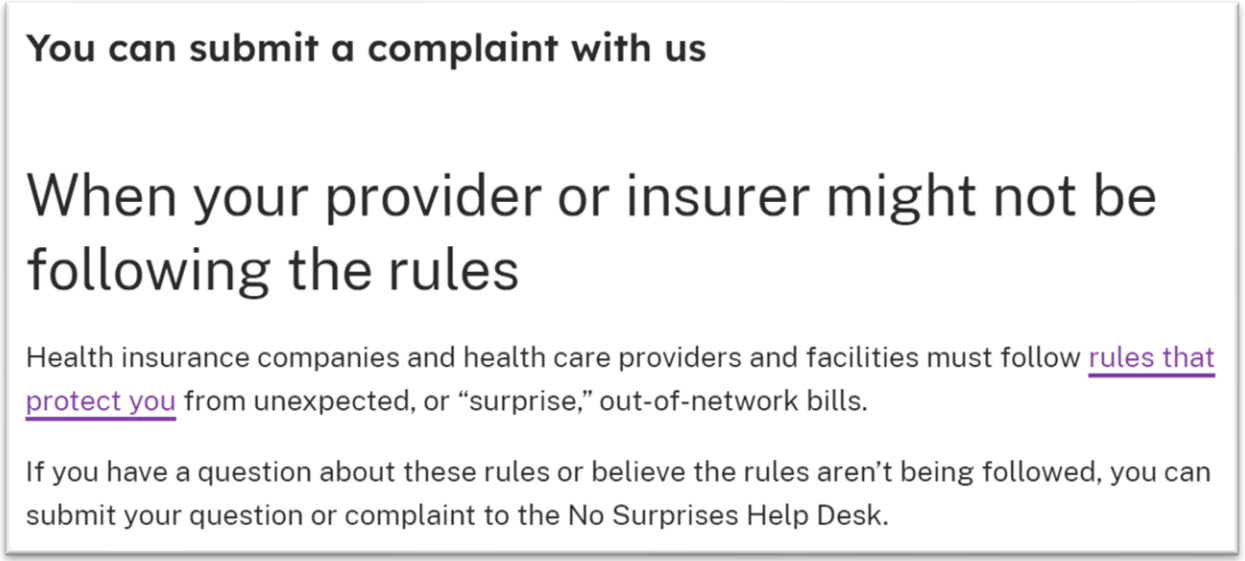
Know your rights

The No Surprises Act protects people who use private insurance or don't have or use insurance.

The No Surprises Act is a federal law that went into effect on January 1, 2022.

It protects people in the United States who:

- Use most types of private health insurance
- Don't use health insurance
- Don't have health insurance



You can submit a complaint with us

When your provider or insurer might not be following the rules

Health insurance companies and health care providers and facilities must follow rules that protect you from unexpected, or "surprise," out-of-network bills.

If you have a question about these rules or believe the rules aren't being followed, you can submit your question or complaint to the No Surprises Help Desk.

https://www.cms.gov/medical-bill-rights/know-your-rights

No Surprises Act Complaints

As of June 30, 2024

Top 3 most common complaints against non-federal governmental plans and issuers

Type of Complaint	Number of Complaints
Non-compliance with Qualifying Payment Amount (QPA) requirements	1,035
Late Payment after Independent Dispute Resolution (IDR) determination	675
Non-compliance with 30-day Initial Payment or Notice of Denial of Payment requirements	390

Top 3 most common complaints against providers, facilities, and providers of air ambulance services

Type of Complaint	Number of Complaints
Surprise Billing for non-Emergency Services at an In-Network Facility	4,286
Surprise Billing for Emergency Services	2,577
Good-Faith Estimate	1,922

https://www.cms.gov/files/document/august-2024-complaint-data-and-enforcement-report.pdf

4. Financial Counseling

- Board-approved written financial assistance policy
  - Posting on website
- Written policies on extended payment plans
- Written policies detailing financial counseling process
  - Staff training and tools (sensitivity of patient discussions, unwillingness to provide documentation)
  - Referral to third-parties to explore potential coverage (e.g., Medicaid, exchange plan) and follow-up
  - Review and approval process
  - Consistently applied with supporting documentation

Financial Assistance Policies

July 8, 2024, Fraud and Abuse Authorities FAQ Update

- Hospital may waive federal health program enrollees' cost-sharing amounts pursuant to financial assistance policy on two conditions:
  - Waiver is not advertised
  - Waiver based on good faith assessment of individual financial need
- Hospital can make patients aware of financial assistance policy that permits lawful waivers of Federal health care program enrollees' cost-sharing amounts, but only if "not offered as part of any advertisement or solicitation"
  - Hospital may disseminate message on its website, its public areas, and its billing materials
  - However, information on website related to "insurance only" billing for all patients considered advertisement/solicitation
- Neither AKS or CMP prohibits hospital from furnishing free or discounted services to uninsured or commercially insured patients
- Neither AKS or CMP prohibits hospitals from advertising about the availability of such assistance

https://oig.hhs.gov/faqs/general-questions-regarding-certain-fraud-and-abuse-authorities/

5. Point of Service Collections

- Address any outstanding balances from prior encounters
- Collection of patient coinsurance
  - Issue of high deductible plans/increasing patient out-of-pocket responsibilities
  - Card-on-file with authorization to bill?
- Lenient upfront collection practices leave significant patient responsible balances for back-end collection, which drastically reduces the likelihood of collecting
- Use of scripting

Upfront Collections

Implementation Tactics

Objectives/Primary Drivers Strategies to Achieve Business Aim	Tactics/Secondary Drivers
Evaluate upfront patient collections options	*Create a committee to develop content for a more robust upfront collections policy*
Approve new policy	*Establish a written upfront collections policy with approved parameters*
Train staff	*Define Patient Access team responsibilities; train team members on responsibilities*
Communicate new policy	*Communicate new policy to all supervisors; train supervisors and advise them to communicate to their staff*
Implement new policy and monitor progress	*Conduct weekly meetings with the Patient Access and Patient Financial Services teams over the first three months following implementation to receive feedback and discuss potential issues*

Credit Reporting of Medical Debt

- Proposed rule published on June 18 (final rule not at OMB)
  - Discontinue inclusion of medical debt in credit evaluations
  - Applies to reporting agencies –
    - *"… a consumer reporting agency generally would be prohibited from furnishing to a creditor a consumer report containing medical debt information in connection with a credit eligibility determination"*
    - *"… consumers would no longer be unfairly penalized in the credit market for having medical debt"*
- Impact on collection activities
  - Patient motivation to pay
  - Focus on upfront collections
  - Subsequent impact on revenue
  - Rule includes litigation as option for collections

6. Charge Capture/Entry/Reconciliation

- *Significant* opportunity to improve revenue
  - Educate clinical staff regarding importance of accurate charge capture; develop/distribute cheat sheets
  - Near real-time review and follow-up on incomplete charge information
- Documentation of diagnoses
  - Satisfy medical necessity requirements
  - Support accurate ICD-10 coding (HCC scores, Z-codes)

7. Care Coordination

- Utilization review and discharge planning (post-acute services)
- Screening for health-related social needs
- Schedule procedures, follow-up appointments prior to patient departure
- In appropriate cases, recommend ambulatory care management services
  - Transitional care management
  - Chronic care management
  - Remote patient monitoring
- Patient satisfaction surveys

Medicare Appeal Rights for Changes in Patient Status -- Proposed Rule

- Published December 27, 2023
  - Comments were due February 26
- Applies to Medicare patients initially admitted as inpatients but then reclassified to outpatient observation
  - Appeals would be allowed back to January 1, 2009
    - Patients not enrolled in Part B at time of stay, or stayed at hospital for 3 or more consecutive days with less than 3 as inpatient

Final Rule - Update

- Defendant's Status Report filed August 18
  - Required by court to report CMS' progress in complying with prior court order
    - Order had required final rule to be published on or before October 15, 2024
      - OMB review time not considered valid excuse for failure to comply with the deadline
  - CMS indicates it is on "track to meet this deadline"
    - Final Rule presently at OMB
    - Retrospective appeals process should be operational by January 1, 2025
      - CMS to post model appeal form, decision tree to help beneficiaries decide whether to submit an appeal, and appeals process flowchart
    - Prospective appeals process should be operational by February 15, 2025
      - CMS intends to require new notice called Medicare Change of Status Notice (MCSN)

Patient Access - Structure

- Define and standardize data elements collected throughout Patient Access processes (i.e., Minimum Data Set)
- Determine any IT system updates needed to optimize Patient Access processes
- Develop training materials to support initiative
- Document current state Patient Access processes across organization
- Work with RC leadership to develop recommended future state model
  - All information collected and verified prior to scheduled services
  - The direct impact on financial performance of the organization
  - Focusing on an enhanced and consistent patient experience
  - Optimizing organizational processes and resources

Patient Access - Structure

- Clearly document ownership of responsibilities across entire scope of work
- Ensure strategic span of control across department staffing
- Establish organizational consistency and key performance indicators (KPIs)
- Develop reporting package to effectively monitor scheduling KPIs
- Provide recommend training structure and materials (i.e., policies and procedures)

Key Performance Indicators

- Insurance verification rate
- Service Authorization Rate – Inpatient and Observation
- Service Authorization Rate- Outpatient
- Conversion Rate of Uninsured Patient to Payer Source
- Point of Service Cash Collection

Phase III:
Back-End

8. Coding/Documentation Management

- Accurate and complete coding supported by medical record documentation necessary for appropriate billing and payment
  - Establish processes for review and follow-up with physicians, clinical staff
  - Do it now, or do it later (denials)
- Key performance indicator for coding staff: ongoing education, internal reviews
- CAH Method II billing
  - Enhanced reimbursement for E/M services furnished in facilities

Clinical Documentation

- Vital opportunity to improve reimbursement capture and protect operating margins
- Accurate and timely documentation serves as foundation for several hospital initiatives including performance improvement, public reporting, and value-based purchasing

Clinical Documentation: The Physician

- Success hinges on hospital's ability to engage physicians in process and improve clinical documentation performance
  - Engaged physicians drive improvements
- Targeted individual physician education, focused on positive impact to care quality, their own practice reimbursement, and acuity of their patients – not the hospital's bottom line
- Engage physicians to correlate how clinical documentation provides opportunity to demonstrate high-acuity and quality of care provided

9. Claim Submission and Follow-Up

- Claim submitted to primary payer promptly
  - Submit to only one payer at a time (cross-over claims)
  - Management of patient payment plans
- Respond promptly to payer requests for additional information
  - Assign responsibility for receipt and response to all such requests
- Monitor timely payment/denial
- Timely submission of claim to secondary payer, any remaining patient responsibility
  - Compliance with Surprise Billing requirements
- Key performance indicator: gross time in A/R by payer
  - Establish baseline and improvement targets

No Surprises Act – Prohibition on Surprise Billing

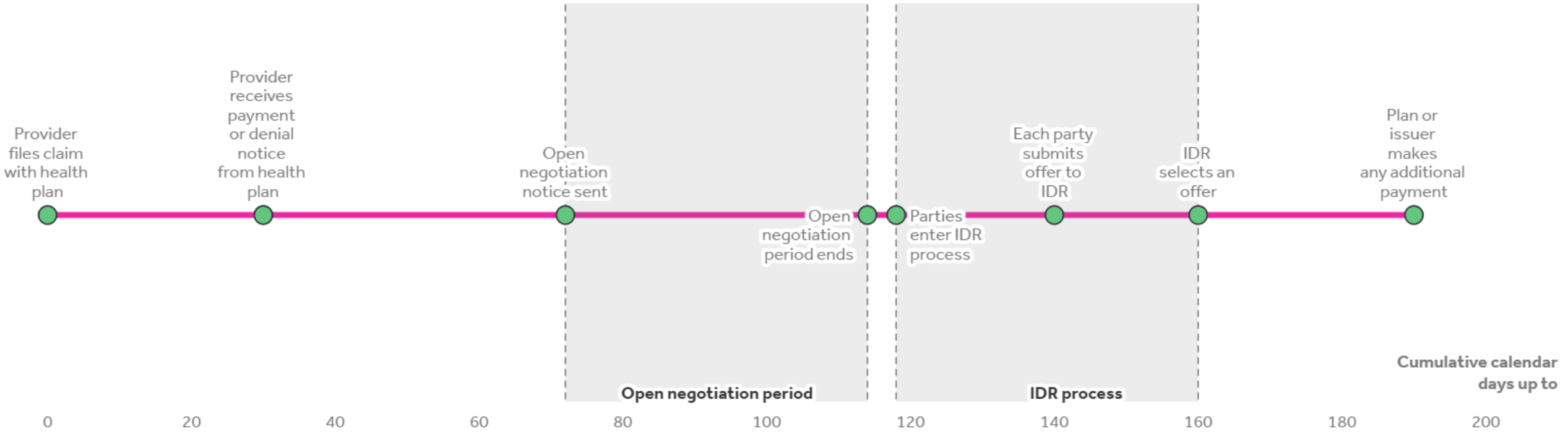
- Nebraska Out-of-Network Emergency Medical Care Act (2020)
  - Applies to state-regulated plans (175% Medicare rate assumed to be reasonable)
- Provider cannot charge patient more than in-network out-of-pocket amount for certain out-of-network services
  - Emergency services (broadly defined)
  - Specified non-emergency services furnished by OON provider at in-network facility
- Process to obtain qualified payment amount from payer for purposes of calculating patient's obligation
- Process for negotiating payment rate between payer and OON provider
  - All other disputes resolved through federal Independent Dispute Resolution process

Federal IDR Process

Step in the Process	Must Be Completed By
Following failed open negotiation, either party may initiate IDR process by sending Notice of IDR Initiation to the Departments through federal IDR portal and to other party (electronically or by paper if requested); use standard notice and list preferred certified IDR entity (CIDRE)*	**4 business days**, starting business day after the open negotiation period ends
Non-initiating party agrees or objects to preferred CIDRE (assume agreement if no response)	**3 business days** after IDR initiation date (i.e., date Departments received notice)
Initiating party notifies Departments of (a) selection of CIDRE, or (b) failure to agree to CIDRE; non-initiating party submits reasons claim not eligible for federal IDR process (if appropriate)	**4 business days** after IDR initiation date
Departments select CIDRE (if applicable)	**6 business days** after IDR initiation date
Selected CIDRE submits to Departments attestation that it does not have a conflict of interest and determines matter is eligible for federal IDR process	**3 business days** after date of CIDRE selection
Parties submit payment offers and required data elements to CIDRE with administrative fee and CIDRE fee; failure to pay fees results in CIDRE accepting other party's payment officer	**10 business days** after date of CIDRE selection
IDR entity issues written opinion accepting one party's offer	**30 business days** after date of CIDRE selection
Payment made to provider (if successful); CIDRE fee refunded to prevailing party	**30 business days** after payment determination
Cooling off period - initiating party cannot submit subsequent Notice of IDR Initiation involving same party with respect to claim for same/similar item or service that was subject of Notice of IDR Initiation.	**90 calendar days** after payment determination

*Departments have published standard forms/data elements (including Notice of IDR Initiation, Notice of CIDRE Selection, Notice of Offer, Notice of Agreement on Out-of-Network Rate) to be used by Federal IDR participants, as well as a form to request extension of time periods due to extenuating circumstances. These documents are available at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act)

Federal IDR Timeline



https://www.healthsystemtracker.org/brief/independent-dispute-resolution-explainer/

IDR Decisions Favor Providers

Table 12: Payment Determination Outcomes, 2023 Q2

	OON Emergency or Non-Emergency Items or Services	OON Air Ambulance Services	Total
Total Payment Determinations Made	53,806	3,321	57,127
Number of Payment Determinations where the Provider, Facility, or Air Ambulance Provider is the Prevailing Party	42,277	2,730	45,007
Number of Payment Determinations where the Health Plan or Issuer is the Prevailing Party	11,488	590	12,078
Number of Payment Determinations Resulting in Split Decisions	36	1	37
Number of Payment Determinations where Only One Party Submitted an Offer and Paid Fees	11,929	619	12,548
Number of Payment Determinations where the Prevailing Offer is Greater than the Qualifying Payment Amount (QPA)	41,058	2,710	43,768

Medicare Advantage - Coverage for OON Services

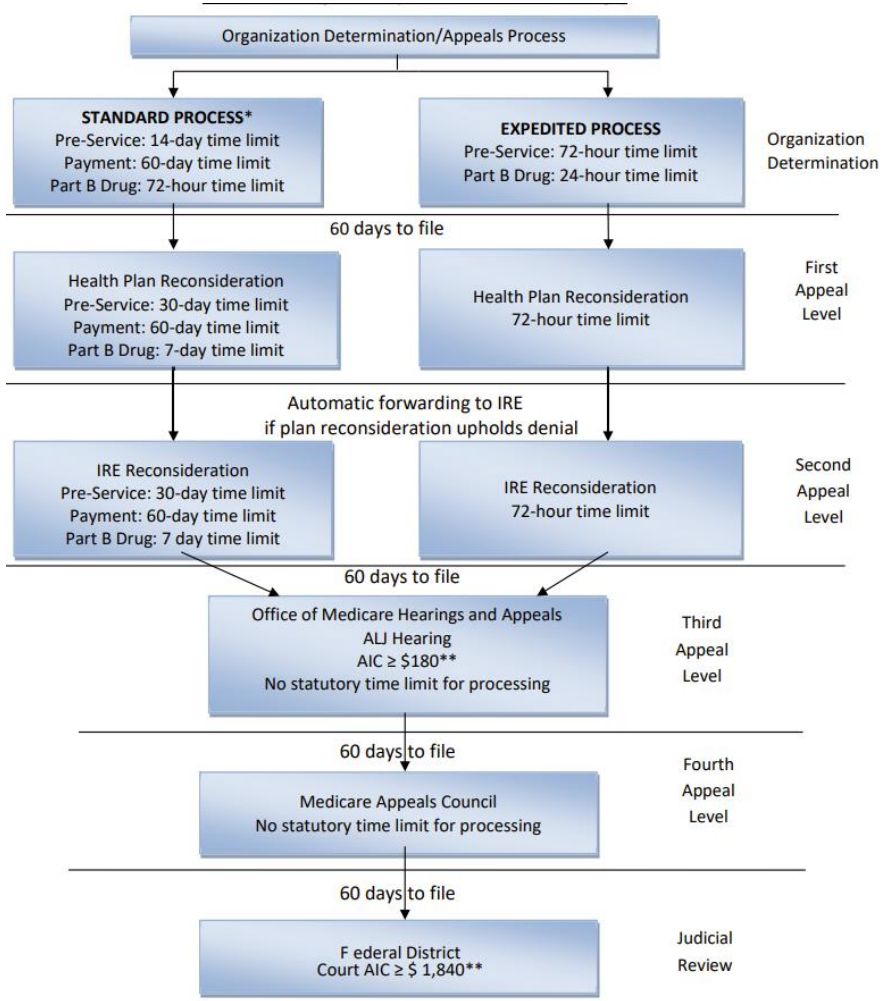
1. Ambulance services dispatched through 911 (or local equivalent) if other transport not reasonable
2. Emergency services
   - Apply prudent layperson definition of emergency medical condition (EMC) regardless of final diagnosis
3. Urgently needed services
   - Services required due to unforeseen illness, injury, or condition furnished to enrollee temporarily absent from plan's service area or for whom network provider temporarily unavailable/inaccessible if not reasonable to delay care
4. Post-stabilization care services (services related to EMC provided after enrollee is stabilized to maintain stabilized condition)
   - Administered within 1 hour of request to MA plan for pre-approval of services
   - Administered after unsuccessful attempt to contact MA plan for pre-approval
   - Plan rep and treating physician cannot agree on plan of care and plan physician not available for consultation
5. Renal dialysis services provided while enrollee temporarily outside plan's service area
6. Services for which MA plan denied coverage when such denial overturned on appeal

MA Plan Payments to OON Providers

- For covered OON services, MA plan (both HMO and PPO) must pay amount provider would have received under traditional Medicare (a/k/a Medicare Rate)
  - Defined in CMS' MA Payment Guide for Out of Network Payments (4/15/2015 Update)
  - Enrollee's liability limited to amount enrollee would have paid if received services from network provider (vs. what traditional Medicare beneficiary would owe); otherwise, plan pays full amount
- For all other services –
  - If HMO plan (~36% of MA beneficiaries), enrollee must pay provider Medicare Rate
  - If PPO or HMO-POS plan (~64%), plan pays Medicare Rate less applicable co-insurance (up to MOOP limit); enrollee pays co-insurance amount; PA requirements apply
- Prompt payment rules
  - Must pay 95% of "clean claims" within 30 days; must pay interest on claims not paid in 30 days
  - Must pay/deny all other claims from non-contracted providers within 60 calendar days from date of request for payment

https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/downloads/oonpayments.pdf

MA Organizational Determination/Appeals Process



- Applies to any decision made by MA plan regarding –
  - Authorization/payment for item or service
  - Amount MA plan requires enrollee to pay for item or service
  - Limit on quantity of items or services
- May be pursued by –
  - Enrollee/personal representative
  - Provider that furnishes, or intends to furnish, services to enrollee
- Updated guidance published in July 2024

https://www.cms.gov/medicare/appeals-and-grievances/mmcag/downloads/parts-c-and-d-enrollee-grievances-organization-coverage-determinations-and-appeals-guidance.pdf

10. Account Follow-Up

- Implement Standard Documentation Guidelines for staff to follow when noting account history
  - Inconsistent documentation creates delays when following-up on an account and limits coverage options when staff are absent
    - Accurate and timely completion of notes ensures everyone accessing account has information needed to complete their work
    - Quality system notes are important because they can serve as legal documentation
    - Consistency in how accounts are documented can increase quality of work, improve efficiency by eliminating “double work” due to incomplete notes, and reduce denials as a result of improved revenue cycle communication

Account Follow-Up: Policy Development

- *Prioritize Accounts* – sort by highest dollar, aged accounts to ensure staff are working accounts with the greatest financial impact
- *Stratify Similar Accounts* – group specific payer plans together to create greater efficiency when checking websites and calling payers
- *Tickle Accounts* – establish consistent timeframes for how accounts should be pended to create efficiency in how often accounts are being worked and to help establish exception-based workflow

11. Payment Posting

- Verify payment amount consistent with contract rates
  - Treat underpayments as denials, refund overpayments
  - Automated vs. manual process
- Track and report internally on amount billed/amount collected
- For OON claims subject to Surprise Billing rules, initiate Independent Dispute Resolution process

12. Denials Management

- Convene Denials Committee
  - Include representative from each phase of revenue cycle (including clinical staff)
  - Meet at least bi-weekly
  - Maintain complete list of unresolved denials categorized by payer and type
  - Identify specific reason for each denial (root cause analysis)
  - Pursue appeals when appropriate, take appropriate action to prevent future denials
  - Track and report internally on denials and appeals
  - Focus on root causes of initial denials (versus final denial write-offs)
    - Creates more transparency into specific staff, physicians, or departments causing the denials
    - Creates higher staff and department accountability
- Establish regular, ongoing communication with payer representatives
  - Standing list of issues to be addressed

13. Post-Payment Review

- Dashboards and user-level detailed adjustment reports can assist in –
  - Identifying root causes of errors resulting in write-offs
  - Tracking exact populations being written off
  - Communicating patterns of write-off root causes to teams responsible for developing and implementing appropriate corrective actions
- Consistently review all write-off/adjustment codes
  - Distinguish codes between avoidable vs. unavoidable and include definitions and usage guidelines for each

13. Post-Payment Review

- Contractual adjustments
  - Perform sampling to identify contractual allowances that are 90-100% of total charges
  - Sample the accounts to determine if the contractual allowance was appropriate, or if it represents a “hidden” administrative write-off
    - The most common hidden write-offs are taken as manual contractual adjustments by the staff - and usually do not represent any purposeful hiding of write-offs, but a lack of training
    - Contractuals that are taken systematically and are inappropriate might also be uncovered

14. Reporting/Audit Coordination

- Manage audit requests
  - Timely response to requested records
- Review audit results with Denials Committee (root cause analysis)

15. Charge Description Master (CDM)

- Determine reasonableness of charges for your market
- Impact on cost-to-charge ratio
- Impact of charge on patient liability
  - Medicare co-payments for CAH outpatient and RHC services based on 20 percent of **billed charges**
- Charges are more important than ever
  - Transparency requirements make charges visible to EVERYONE!
  - Payer blame game/turning public opinion against hospitals

Price Transparency

- Effective January 1, 2021, all hospitals (including CAHs) must post current information for all hospital inpatient and outpatient services -
  - Standard charges
    - Machine readable files
    - Consumer-friendly display of shoppable services (minimum 300 services)
  - Payer-specific negotiated rates
    - Name of third-party payer and plan

TABLE 151A: Implementation Timeline for CMS Template Adoption and Encoding Data Elements

Requirement	Regulation cite	Implementation (Compliance) Date
MRF INFORMATION		
MRF Date	45 CFR 180.50(b)(2)(i)(B)	July 1, 2024
CMS Template Version	45 CFR 180.50(b)(2)(i)(B)	July 1, 2024
HOSPITAL INFORMATION		
Hospital Name	45 CFR 180.50(b)(2)(i)(A)	July 1, 2024
Hospital Location(s)	45 CFR 180.50(b)(2)(i)(A)	July 1, 2024
Hospital Address(es)	45 CFR 180.50(b)(2)(i)(A)	July 1, 2024
Hospital Licensure Information	45 CFR 180.50(b)(2)(i)(A)	July 1, 2024
STANDARD CHARGES		
Gross Charge	45 CFR 180.50(b)(2)(ii)	July 1, 2024
Discounted Cash	45 CFR 180.50(b)(2)(ii)	July 1, 2024
Payer Name	45 CFR 180.50(b)(2)(ii)(A)	July 1, 2024
Plan Name	45 CFR 180.50(b)(2)(ii)(A)	July 1, 2024
Standard Charge Method	45 CFR 180.50(b)(2)(ii)(B)	July 1, 2024
Payer-Specific Negotiated Charge –Dollar Amount	45 CFR 180.50(b)(2)(ii)(C)	July 1, 2024
Payer-Specific Negotiated Charge – Percentage	45 CFR 180.50(b)(2)(ii)(C)	July 1, 2024
Payer-Specific Negotiated Charge – Algorithm	45 CFR 180.50(b)(2)(ii)(C)	July 1, 2024
Estimated Allowed Amount	45 CFR 180.50(b)(2)(ii)(C)	January 1, 2025
De-identified Minimum Negotiated Charge	45 CFR 180.50(b)(2)(ii)	July 1, 2024
De-identified Maximum Negotiated Charge	45 CFR 180.50(b)(2)(ii)	July 1, 2024
ITEM & SERVICE INFORMATION		
General Description	45 CFR 180.50(b)(2)(iii)(A)	July 1, 2024
Setting	45 CFR 180.50(b)(2)(iii)(B)	July 1, 2024
Drug Unit of Measurement	45 CFR 180.50(b)(2)(iii)(C)	January 1, 2025
Drug Type of Measurement	45 CFR 180.50 (b)(2)(iii)(C)	January 1, 2025
CODING INFORMATION		
Billing/Accounting Code	45 CFR 180.50(b)(2)(iv)(A)	July 1, 2024
Code Type	45 CFR 180.50(b)(2)(iv)(B)	July 1, 2024
Modifiers	45 CFR 180.50(b)(2)(iv)(C)	January 1, 2025

TABLE 151B: Implementation Timeline for Other New Hospital Price Transparency Requirements

Requirement	Regulation Cite	Implementation (Compliance) Date
Good faith effort	45 CFR 180.50(a)(3)(i)	January 1, 2024
Affirmation in the MRF	45 CFR 180.50(a)(3)(ii)	July 1, 2024
Txt file	45 CFR 180.50(d)(6)(i)	January 1, 2024
Footer link	45 CFR 180.50(d)(6)(ii)	January 1, 2024

New/Revised Requirements Effective 01/01/25

Report an “estimated allowed amount” when the payer negotiated rate is based on an algorithm or percentage

Estimated allowed amount: Average reimbursement in dollars previously received from payer for specific item or service

Drug unit and type of measurement

Modifiers impacting the “standard” charge, including a description of the modifier and how it would change the standard charge

Certify MRF Completeness and Accuracy

Compliance Statement

To the best of its knowledge and belief, this hospital has included all applicable standard charge information in accordance with the requirements of 45 C.F.R. §180.50 and the information encoded in this machine-readable file is true, accurate and complete as of the date indicated in this file.

Effective date **July 1, 2024**

Hospital enters value of “true” or “false”

Does this Look Right?


```
"description": "Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh ",
"code_information": [
  {
    "code": "43282",
    "type": "CPT"
  },
  {
    "code": "481",
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  }
],
"standard_charges": [
  {
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    "minimum": 4357,
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        "methodology": "case rate",
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      }
    ]
  }
-
```

What About This?


```
    "description": "Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh ",
    "code_information": [
      {
        "code": "43282",
        "type": "CPT"
      },
      {
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        "type": "RC"
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            "plan_name": "HMOPPO",
            "methodology": "case rate",
            "standard_charge_dollar": 4357
          }
        ]
      }
    ]
  },
```

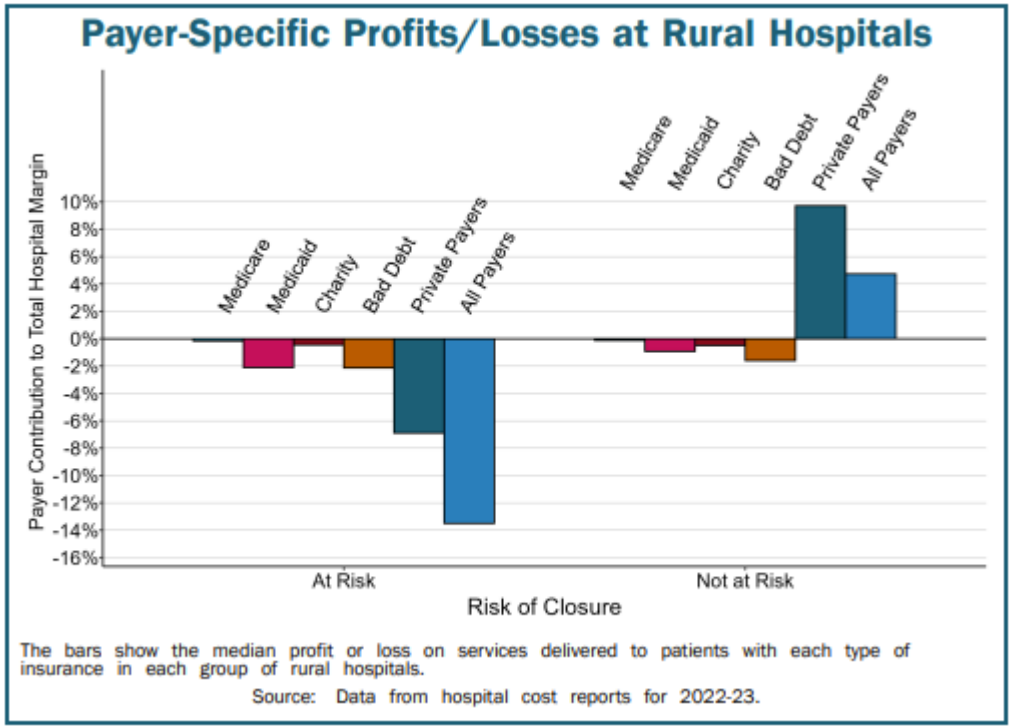

Enforcement Provisions

- Requires hospitals to acknowledge receipt of warning notices
- Requires hospitals to submit additional information including contracts to assist in assessing compliance
- CMS will work with health system officials to address noncompliance issues in one or more hospitals that are part of health system
- CMS will better publicize enforcement activities related to individual hospitals
  - To date, CMS has imposed civil monetary penalties on 15 hospitals (most recent in August)
  - According to latest enforcement update, CMS has issued more than 730 warning notices and 269 requests for corrective action plans

16. Contract Management/Reimbursement

- Prioritize and actively engage in payer negotiations
- Compare commercial rates to current Medicare inpatient and outpatient rates
  - Payments based on percentage of charges often less than Medicare reimbursement
- Calculate payer mix to prioritize contract negotiations (inpatient vs. outpatient)
- Compare commercial rates with current rates for surrounding facilities (posted machine readable files)
- Understand payer network adequacy requirements

National-Level Historical Data - Private Payers



Center for Healthcare Quality and Payment Reform, *Rural Hospitals at Risk of Closing* (July 2024), available at https://ruralhospitals.chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf.

Questions?