Medicare Advantage – Do I Want to be In Network?

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Melinda A. Gaboury, with more than 30 years in home care, has over 20 years of executive speaking and educating experience, including extensive day to day interaction with home care and hospice professionals. She routinely conducts Home Care and Hospice Reimbursement Workshops and speaks at state association meetings throughout the country. Melinda has profound experience in Medicare PDGM training, billing, collections, case-mix calculations, chart reviews and due diligence. UPIC, RA, ADR & TPE appeals with all Medicare MACs have become the forefront of Melinda's current impact on the industry. She is currently serving as Chair of the NAHC/HHFMA Advisory Board and Work Group and is serving on the board of the Home Care Association of Florida and the Tennessee Association for Home Care. Melinda is also the author of the Home Health OASIS Guide to OASIS-E and Home Health Billing Answers, 2024.

Melinda A. Gaboury, COS-C
Chief Executive Officer

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Staying Informed

Staying informed about home health regulations and managed care updates is crucial for healthcare organizations and providers to ensure compliance, adapt to changing requirements, and maximize reimbursement. It involves actively seeking information, engaging with industry resources, and staying educated on relevant updates.

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Staying Informed

Regularly check regulatory websites:

- Government entities such as the Centers for Medicare and Medicaid Services (CMS) regularly update their websites with information on home health regulations and managed care updates.
- Sign up for email subscriptions or newsletters to receive regular updates directly to your inbox.
- Visit websites, including the CMS website, state health department websites, and relevant managed care organization websites, to access the latest information and resources
- Add reminders to your calendar

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Staying Informed

Engage with professional associations:

- Joining and actively engaging with professional associations related to home health and managed care can provide access to a wealth of information and resources.
- These associations often have newsletters, webinars, and educational resources that keep members updated on the latest regulations and managed care updates. Including forums to ask questions
- They may also advocate on behalf of their members and provide opportunities for networking and collaboration.

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Staying Informed

Attend conferences and webinars: Healthcare conferences and webinars often feature sessions specifically focused on home health regulations and managed care

- Networking with other attendees can also provide valuable insights and information.

Utilize resources from managed care organizations: If your organization contracts with managed care organizations, take advantage of the educational resources, training opportunities, and updates they provide

- These organizations often have dedicated websites or portals for contracted providers that offer resources on billing and coding, compliance, and updates to their policies and procedures.

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Staying Informed

Follow industry publications and blogs

- Subscribe to industry publications and blogs that focus on home health and managed care. These sources often publish articles, opinion pieces, and updates on regulatory changes and managed care trends. They can provide valuable insights and analysis to help you understand the implications of these changes and how they may affect your organization.

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Gathering Data

Gathering data for negotiating managed care contracts is a critical step in the process of building a successful relationship with managed care organizations (MCOs) and ensuring favorable contract terms. By collecting and analyzing relevant data, healthcare organizations and providers can make informed decisions, demonstrate their value, and negotiate fair reimbursement rates. Here are some strategies for gathering data for negotiating managed care contracts

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Gathering Data

Analyze your organization's financial data:

- Start by examining your organization's financial data, including revenue, costs, and profitability
- Identify key metrics such as total costs per patient, average reimbursement rates, and profit margins
- This data will help you understand your organization's financial position and help determine your desired reimbursement rates and contract terms

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Gathering Data

Evaluate your organization's performance data:

- Assess your organization's performance data to highlight areas of strength and areas for improvement
- This may include metrics such as patient outcomes, readmission rates, patient satisfaction scores, and quality measures
- This data will help you demonstrate the value and quality of care your organization provides, which can be used as leverage during contract negotiations

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Gathering Data

Research market data and benchmarking:

- Gather market data and benchmarking information to understand the prevailing reimbursement rates and contract terms within your region or specialty
- Utilize industry resources, such as trade associations or consulting firms, to access data on average reimbursement rates, contract terms, and negotiation strategies
- This information will help you set realistic goals and expectations for your negotiations

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Gathering Data

Engage with managed care organizations:

- Engage with MCOs to gather data on their expectations, requirements, and reimbursement rates.
- Request information from the MCOs on their reimbursement methodologies, network criteria, and current provider discounts

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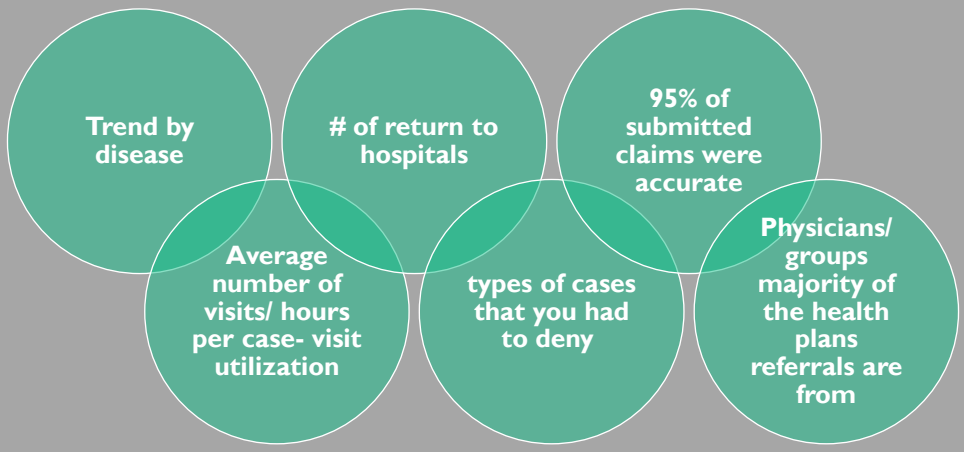
Gathering Data



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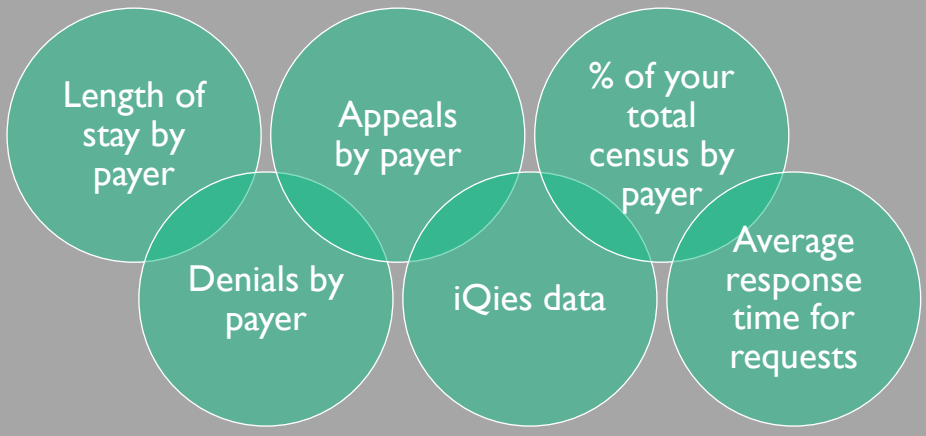
Gathering Data



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Building Relationships

Building relationships with managed care plans as a home health provider can lead to increased patient access, streamlined processes, access to resources, enhanced reimbursement opportunities, and collaboration on quality improvement initiatives. These benefits can help to strengthen the business and improve the overall quality of care provided.

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Building Relationships

Understand the managed care plan's goals and objectives:

- Take the time to research and understand the mission and objectives of the managed care plan to align your approach and objectives accordingly

Develop strong communication channels:

- Establish open and clear lines of communication with representatives from the managed care plan to ensure effective and efficient collaboration

Demonstrate value and cost-effectiveness:

- Highlight the value and cost-effectiveness of your services by providing evidence-based data on patient outcomes, cost savings, and quality improvements.

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Building Relationships

Collaborate on quality improvement initiatives

- Engage in joint quality improvement initiatives to enhance patient care and outcomes, demonstrating your commitment to providing high-quality services

Be responsive and proactive:

- Promptly respond to inquiries and requests from the managed care plan and be proactive in addressing any concerns or issues that may arise

Establish strong relationships with key personnel:

- Build relationships with decision-makers within the managed care plan, such as medical directors or network managers, to facilitate ongoing collaboration

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Building Relationships

Stay up to date with industry trends and changes:

- Continuously monitor and stay informed about changes in policies, regulations, and trends in the managed care industry to adapt your offerings and strategies accordingly

Advocate for patient needs:

- Advocate for your patients' needs within the managed care plan, ensuring their access to appropriate care and services

Strive for win-win partnerships:

- Seek mutually beneficial partnerships by finding common ground and shared goals with the managed care plan, fostering a relationship based on trust and collaboration

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Building Relationships

Regularly evaluate and report outcomes:

- Provide regular updates on clinical outcomes, patient satisfaction, and cost-efficiency metrics to showcase the positive impact of your services and justify continued collaboration with the managed care plan
- Schedule regular QI meetings with provider reps

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Contract Analysis

Evaluating and analyzing the performance of managed care contracts is essential for home health providers to ensure that they are maximizing their financial outcomes and delivering high-quality care. Here are some key steps to evaluate and analyze managed care contract performance:

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Evaluate Contract performance

Define performance metrics: Start by defining the performance metrics that are most relevant to your organization's goals and objectives. These may include :

- Financial metrics such as cost per patient, revenue generated, and patient satisfaction scores.
- Operational metrics such as claims processing efficiency, call center responsiveness, and network adequacy should also be considered.
- Clinical metrics, including quality of care measures such as readmission rates, preventive care compliance, and patient outcomes, should be included as well.

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Evaluate Contract performance

Regularly evaluating and analyzing managed care contract performance is an ongoing process. It requires consistent monitoring of key metrics, open communication with the managed care plans, and a proactive approach to identifying and addressing any challenges or opportunities.

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Offer Value

Home health agencies can offer value to managed care companies by demonstrating their ability to provide high-quality, cost-effective care that meets the needs of the managed care population. Here are some ways home health agencies can offer value:

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Offer Value

Quality outcomes: Home health agencies should strive to achieve and maintain high-quality outcomes, such as low hospital readmission rates, high patient satisfaction scores, and positive clinical outcomes. By consistently delivering on quality metrics, agencies can demonstrate their effectiveness in managing patient care and reducing healthcare costs.

Care coordination: Home health agencies can play a vital role in care coordination by closely collaborating with other healthcare providers involved in a patient's care, such as primary care physicians, specialists, and hospitals. Effective care coordination can lead to improved patient outcomes, reduced hospitalizations, and cost savings.

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Offer Value

Preventive care and early intervention: Identify and address health issues in their early stages, agencies can help prevent the need for more costly and intensive care down the line.

Technology and data capabilities: Invest in technology and data capabilities to improve care coordination, streamline workflows, and offer real-time insights into patient outcomes and care delivery. Managed care companies value agencies that can effectively utilize data to drive decision-making and improve care delivery.

Patient engagement and education: Focus on patient engagement and education to empower patients to actively participate in their own care. By providing patients with the necessary tools, resources, and education, agencies can improve patient outcomes and reduce healthcare costs

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Offer Value

Flexibility and responsiveness: Demonstrating a willingness to collaborate, address concerns, and adjust processes or services to meet the evolving demands of managed care plans can help agencies stand out

Strong referral relationships: Building and maintaining strong referral relationships with hospitals, physicians, and other healthcare providers can increase the perceived value of home health agencies to managed care companies. These relationships can help demonstrate a commitment to continuity of care and facilitate smooth transitions for patients.

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Understanding Contract Terms

Term and Termination: These provisions outline the process for contract termination or renewal. Including the initial term limits.

- Notice required to term agreement
- With or Without Cause
- Continuance of care

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Key Elements of a Contract

Network participation: This section defines the provider's participation in the MCO's network and the types of services they can offer.

HMO and which ones

PPO

POS

Exclusive Provider

Employer Direct

Medicaid/ CHIP

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Key Elements of a Contract

- Payment terms: This section outlines the reimbursement rates and payment mechanisms that the managed care organization will use to compensate providers
  - Per diem
  - Per Visit
  - Fee Schedule
  - Flat Rate
- Correct Billing form
- Timely filing

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Covered Services

Covered services: This section specifies the services and procedures that are covered and reimbursable under the contract. Including the specific codes.

- Only codes listed will be reimbursed
- Code listed in the agreement does not necessarily indicate coverage
- Confirm for each Line of business (HMO, PPO, Commercial, etc)

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Covered Services

Revenue Codes	Medicare Procedure Code	Category
550	G0299	RN Evaluation
551	G0299	RN Visit
552	G0299	RN Per Hour
551	G0162	RN HT Evaluation
551	G0299	HT IV Evaluation
552	G0162	RN HT Per Hour
559	G0494	LPN Visit
559	G0300	LPN Per Hour
571	G0156	Home Health Aide Visit
572	G0156	Home Health Aide Per Hour
560	G0155	MSW Visit
424	G0151	PT Evaluation
420	G0151	PT Visit
434	G0152	OT Evaluation
431	G0152	OT Visit
440	G0153	Speech Therapy (Including 92521-92524)
420	G0157	Physical Therapy Visit provider by a Physical Therapy Assistant (PTA)
431	G0158	Occupational Therapy Visit provided by an Occupational Therapy Assistant (OTA)

551.00 552.00	Skilled Nursing Skilled Nursina
571.00 572.00	Home Health Aide Home Health Aide
561.00 562.00	Medical Social Worker Medical Social Worker
421.00 422.00	Physical Therapy Phvsical TheraPv
431.00 432.00	Occupational Therapy Occupational Therapy
441.00 442.00	Speech Therapy Speech Therapy
410.00	Respiratorv Theraov
589.00 590.00	Registered Dietitian Reqistered Dietitian

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Utilization Management

- This component outlines the MCO's requirements for pre-authorization, utilization review, and other utilization management practices. Please also refer to the provider manuals & websites for updates.

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Additional Elements

- Members Right & Responsibilities
- Quality measures: This section may include performance standards, quality improvement initiatives, and reporting requirements that providers must meet.
- Health Plan Duties: What are they required to do
- Effective dates: This is an important factor with certain payers and their re-negotiation windows

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Administrative Process

Educate staff on managed care requirements:

- Train and educate your staff on the specific requirements, protocols, and expectations of managed care companies. This helps ensure that everyone understands their role in providing care and meeting managed care guidelines.
- Thoroughly review contracts and provider manuals
- Have all key staff attend provider trainings
- **MAKE THIS A PRIORITY**

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Enhance Communication

Establish clear lines of communication:

- Regularly communicate with managed care companies to ensure timely and accurate exchange of information. This can include phone calls, emails, or virtual meetings.

Utilize electronic health records (EHRs):

- Implement electronic health records to streamline documentation, track patient information, and share data with managed care companies when needed. This improves efficiency and accuracy

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Manage Cost

Improve operational efficiency:

- Streamline processes and workflows to eliminate waste and reduce costs. This can include optimizing scheduling, reducing paperwork, and automating repetitive tasks.

Work with Consultants:

- Let professionals handle some tasks

Supplies:

- Utilize MCO preferred providers
- Review agreements for carve outs and bill accordingly
- Have patient specific supplies sent to their home

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Manage Cost

Use technology and data analytics to track inventory levels and avoid overstocking or expiring supplies.

Explore group purchasing organizations (GPOs) to leverage collective buying power

Invest in staff training and development:

- Provide ongoing education and training programs to employees to enhance their skills and knowledge. Well-trained staff can deliver high-quality care more efficiently, reducing costs associated with rework or errors.

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Manage Cost

Optimize reimbursement practices:

- Stay up to date with reimbursement rules and regulations.
- Assign dedicated staff members to regularly review claims and address any denials or underpayments.
- Ensure contracts are loaded properly
- Ensure that EMRs are set up properly
- Utilize payer portals

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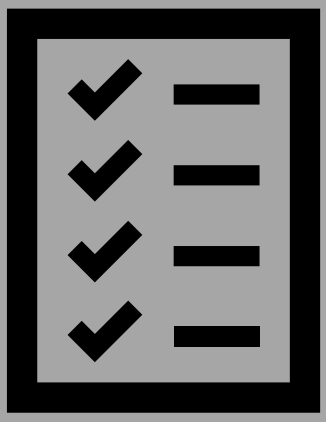
When You Receive the Referral

Verify eligibility

- Medicare verify- on every patient
- Medicaid verification- every patient
- Health plan verification



Verify benefits

- Confirm network status
- Determine if authorization is required
- Check for IPA/ MSO affiliation- primary care Dr.
- Utilize payer portals

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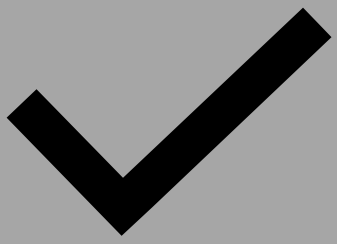
Verification

- Ensure policy is current
- Confirm services needed are covered
- Out of Network – check on cap of services
- Co-payments/ co-insurance
- Verify every client/ every time
- Check for open MSP (Medicare secondary payer)



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Authorization

- Use correct form/portal or EVV
- Prior authorization vs. Advanced Notification
- Confirm codes in your agreement with codes on authorization
- Confirm skill levels authorized
- If you have non-routine supply orders, request authorization

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Authorizations

- Track when re-authorizations are needed
- Receive authorization in writing
- Most require CPT/ HCPCS codes
- Ensure correct physician is identified (signing vs PCP)
- Confusing no prior auth required with no auth required

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Authorizations

- Fill in any forms or information required completely
- Advocate for your clients- bullet points as to why you are asking for visits
- Learn the sweet spot per payer.
- Build relationships when possible
- Track when re-authorizations are needed
- Understand how that particular payer handles retro auth

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Continuation of Care for Skilled

- Some require OASIS & initial therapy evaluation- often with in 7 days of SOC
- OASIS if not already provided- if skilled
- Last 2 visit notes for each discipline seeing the patient
- Relevant clinical documentation to support services
- Clearly outline why they NEED to stay on service

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Case Management Pro Tips

Team Collaboration

- Weekly case conference/ UR meetings
- Do not wait until last covered visit to re-auth
- If skilled patients- have systems in place for timely completion of clinician notes
- Utilize EHR
- Clear assignments to key staff

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Common Missteps

- Ensuring contracts are loaded properly
- EMR is set up properly (codes, plans, rates, timely filing etc.)
- Not doing a pre-bill review
- Not being organized with re-authorizations
- Clinicians not submitting clinicals in a timely manner
- Not attending provider training
- Not working with the provider engagement

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Common Missteps

- Not having accurate client demographics
  - Discuss with client/ POA
- Not identifying primary care physicians or IPA groups
- Not using correct form or portal
- Not reading provider manual
- Not verifying benefits monthly
- Analyze data every 6 months
- Clinical team needs to understand the contracts
- Request the health plan data

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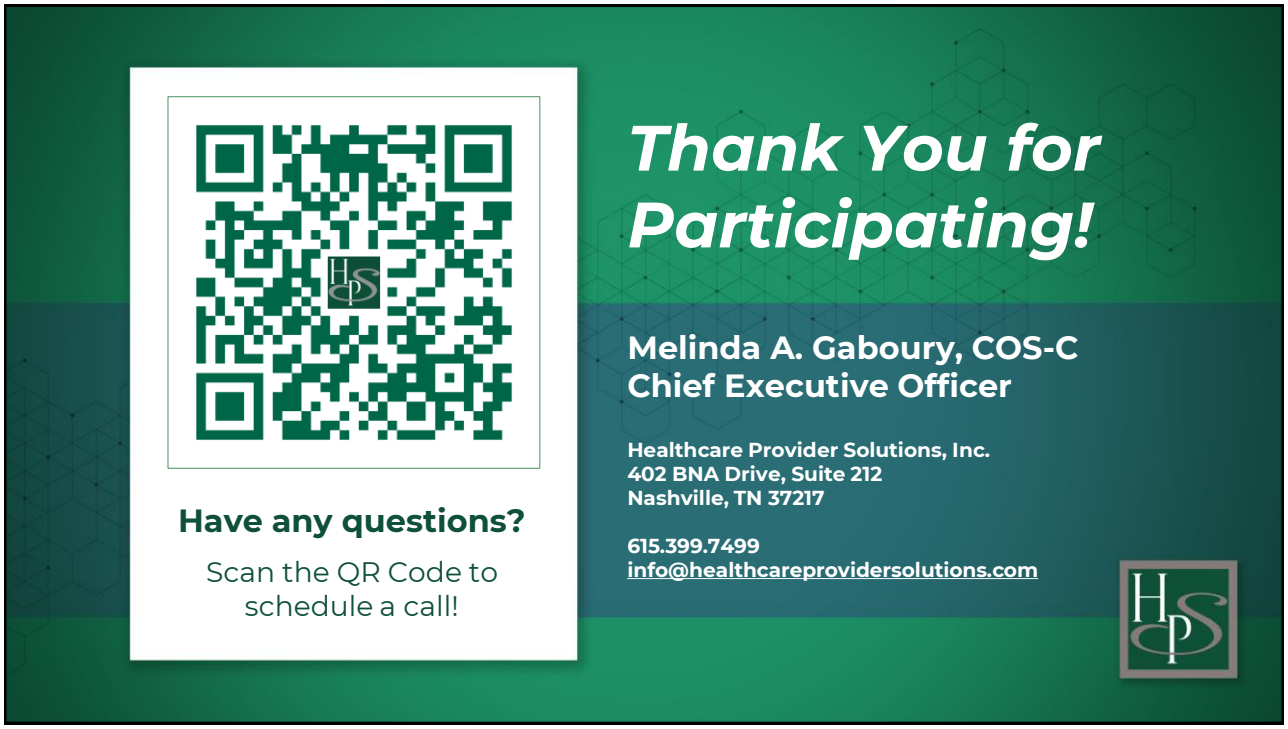
Have any questions?
Scan the QR Code to schedule a call!
Thank You for Participating!
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