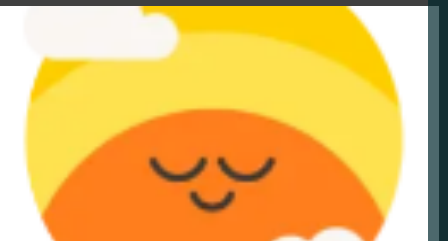
FUTURE TRENDS UIHP

BUSINESS OFFICE 3PB

Opportunities

WHATEVER WORK WE DO, RAISING OUR GAME OFTEN MEANS RAISING OUR MENTAL GAME

Mindful Moment from Headspace

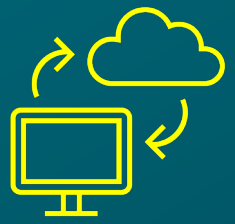


THE TEAM

Patients

Clinical Staff

Coders & Billers



Technology

Administrative Requirements

MAJOR CONSIDERATIONS

Medicaid

Bulk of Revenue

Enrollment losses

Managed Care Billing

Capitation

Reconciliation

Electronic Records

RPMS or COTS

Configurability

P4P data collection and extraction

Enhancement v Requirement

Medicare

2nd highest revenue source

Complex compliance

Aging population

Managed care

Untapped revenue (APM?)

P4P

Collecting and extracting codes

Documentation burden for clinical staff

Commercial

Requirements differ for each payer

PPO-EPO-POS-HMO

Participation and Enrollment burden

Artificial Intelligence & Tech

Accuracy

Unique FQHC regulations

Compliance

Integration

MAJOR CONSIDERATIONS

Environmental

SDOH

Climate Change

Power Grids

Legislative Reforms

Telephone/Telehealth regulation changes

Whole Person & Equitable Care

Population Shift

R76 million baby boomers born between 1946 and 1964 come to retirement age increasing federal spending

Technology

Patient empowerment with wearables and virtual services

Illness Trends

Double Digit increases

STI

Obesity

Autism

E-Coli

Liver Cancer

Kidney Cancer

Colon Cancer

Whooping Cough

THE WORKFLOW TODAY

Are we just trying to keep up? Could AI Help?

Reviewing Chart Notes

- **Always a vital but time-consuming task**
- **Focus on the basic revenue and compliance requirements**

Provider Inquiries

- **Missing or incomplete notes**
- **Unspecific Diagnoses**
- **Monitoring for responses**

Processing Claims

- **Review documentation**
- **Process corrections**
- **Adapt to payer requirements**
- **Created & submit claims**
- **Start again**

When to follow up?

THE WISH

Someday?

Additional Revenue

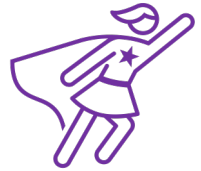
- **APM**
- **Fee Schedule Analysis**
- **Incentive Programs**
- **Reduced denials and corrections**
- **Care Management**

Workflow Improvement

- **Capture more at the encounter**
- **Reduce missed opportunities**
- **Capture and use SDOH Data**
- **Automate recall reminders**
- **Trigger orders for routine services automatically**

Audits

- **Audit & Educate**
- **Work the Aging**
- **Detect trends earlier**
- **Reduce losses & frustration**



WHAT'S NEXT

The business of healthcare never stops evolving. Change does not stop changing…

THE PLAN

Conference thinking hats

Education & Training

- **Invest in education & training**
- **Certification**
- **Collaboration**
- **Engage with payers**

Technology

- **AI is going to change but not take your job**
- **Get involved**
- **Embrace change**

Look ahead

- **Remain curious**

CONTINUED…

Education & Training

- AAPC – AHIMA – NACHC – MGMA
    1. Certified Coder
    2. Certified Biller
    3. Certified Auditor

Technology

- RPMS – Nextgen – eClinical Works – Greenway – Athena – Other
- We cannot be an after-thought
- IHS & FQHC needs are not typical
- Be heard and understood

Look ahead

- Missed revenue opportunities
- Credentialing-Privileging & Enrollment
- Wearable technology
- Data analysis and management beyond claims
- New outpatient services
- Your agencies strategic plan

3 OF 30 OF AAPC CERTIFICATIONS

Certified Professional Biller CPB

The revenue cycle from front desk to claim payment

Overview of Coding (ICD/CPT/HCPC)

NCD/LCD's – HIPAA – False Claims Act

Differences in payer requirements including (Medicare, Medicaid, Commercial, Tricare

Fair debt collections act

Appeals & Denial management

Certified Professional Coder CPC

Expert level knowledge of ICD, CPT and HCPC code sets

Compliance & Regulatory requirements such as documentation, medical necessity, and bundling/unbundling.

17 areas of knowledge

Certified Professional Medical Auditor CPMA

Use CPC & CPB knowledge to avert liability and secure proper maximum reimbursement

Advanced compliance, fraud/abuse, record auditing and abstraction, and perform QA risk analysis.

Scope and statistical sampling methodologies

- ✓ About 40 hours of preparation and the exam.
- ✓ 100-135 Questions in 4 hours.
- ✓ In person – Online – Hybrid.

ADDITIONAL RESOURCES

CMS.GOV

Medicare Learning Network (MLN) free educational materials for healthcare providers on CMS programs, policies and initiatives.

NACHC

Founded in 1971 to promote efficient, high-quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all.

PRIMARY CARE ASSOCIATIONS

State or regional nonprofit organizations offering training and technical assistance to safety-net providers..

NEWS YOU CAN USE

More specifics

2024 MEDICARE ADVANTAGE RULE

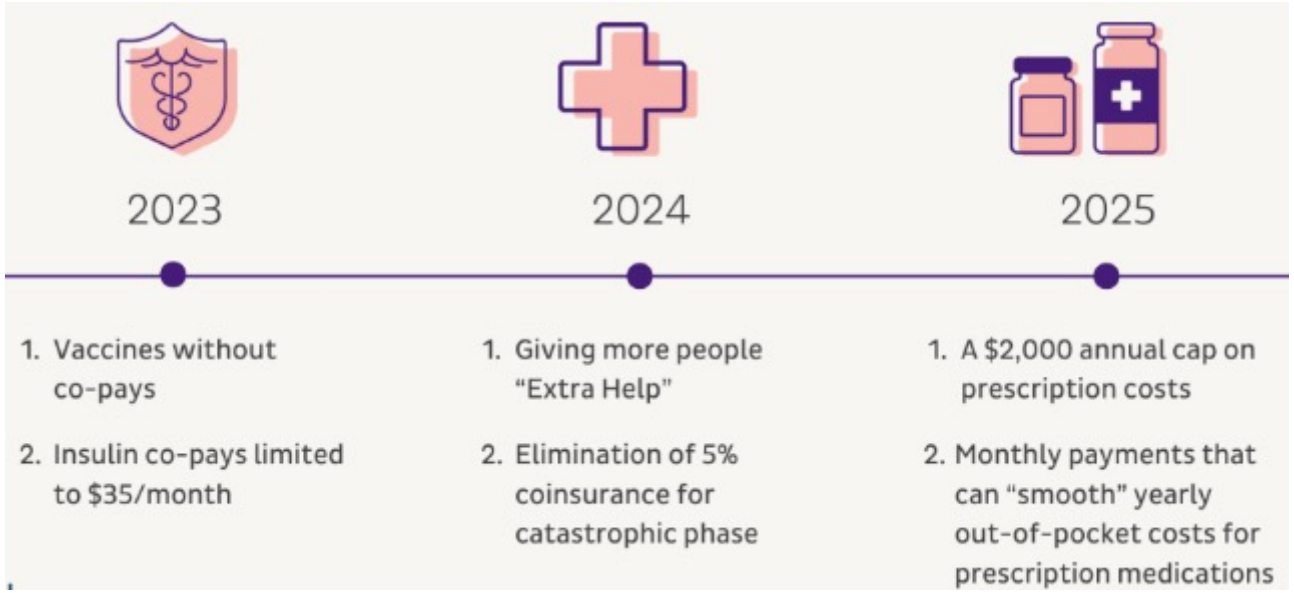
April 2023

https://www.federalregister.gov/documents/2023/04/12/2023-07115/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program

Key Highlights:

- Prohibit MA plans from limiting or denying coverage for a Medicare-covered service based on their own internal or proprietary criteria if such restrictions don't exist in traditional Medicare;
- Limit MA plan ability to apply site of service restrictions not found in traditional Medicare;
- Require health plan clinicians reviewing prior authorization requests to have expertise in the relevant medical discipline for the service being requested;
- Require prior authorizations to be valid for an entire course of approved treatment and to be valid through a 90-day transition period if an enrollee undergoing treatment switches to a new MA plan;
- Establish additional processes to oversee MA plan utilization management programs including an annual review of policies to ensure consistency with federal rules;
- Strengthen behavioral health network adequacy requirements;
- Tighten MA marketing rules to protect beneficiaries from misleading advertisements and pressure tactics;
- Expand requirements for MA plans to provide culturally and linguistically appropriate services;
- Establish a new Health Equity Index to be incorporated into MA plan Star Ratings beginning in 2027;
- Implement statutory provisions of the Inflation Reduction Act and the Consolidated Appropriations Act of 2021 related to prescription drug affordability and coverage for eligible low-income individuals.

MEDICARE REFORMS



Part D plans and Advantage will no longer require a deductible, coinsurance or other cost sharing for adult vaccines recommended by CDC. This includes the shingles vaccine.

As of January 1, 2023, cost-sharing for insulin products is limited to no more than $35 per month for people with Medicare insurance, including insulin covered under both Part D and Part B. No deductibles apply. Medicare has also started a special enrollment period that will allow people who use a covered insulin product to add, drop, or change their Part D coverage one time between now and December 31, 2023.

LOW-INCOME SUBSIDY PROGRAM

2024

Beginning in 2024, there will no longer be a partial program in the Low-Income Subsidy program. Full benefits will be offered to people with Medicare with limited resources and incomes up to 150 percent of the federal poverty level, which in 2023 is $21,870 per year for an individual. With full benefits, the majority, if not all out-of-pocket costs for prescription medications will be covered. People who qualify for Extra Help will pay:

- No deductible
- No premium
- Fixed lower copays for certain medications

If your income for 2023 is below $22,000 ($30,000 for married couples), you may qualify for lower prescription drug costs. Many people qualify for "Extra Help" with Medicare Part D (drug coverage) and don't even know it.
Medicare.gov has a resource to help you quickly see if you qualify for Extra Help.
You can visit PAN's Extra Help education hub to learn more about this program and see if you qualify.
You can enroll in the Extra Help program by visiting SSA online at ssa.gov/extrahelp or call 1-800-772-1213.
For one-on-one assistance with Extra Help, contact your State Health Insurance Assistance Program (SHIP) at ShipHelp.org or call 1-877-839-2675 to get the number for your local SHIP.

MEDICARE REVENUE

FQHC Qual Enc

G0466 New Patient

G0467 Established Patient

G0468 IPPE/AWV

G0469 New Mental Health Patient

G0470 Established Mental Health Patient

Additional $

Laboratory Services to Part B MAC

Chronic Care Management

Medical & Mental Health same day

Hospice G0466-G0470 GV or TC Modifier)

DSMT / MNT PAP/Pelvic, Prostate, Glaucoma screening enc

PPS Annual Rate Adjustment

2019 PPS Base Rate $169.77 * GAF

2020 PPS Base Rate $173.50 * GAF

2021 PPS Base Rate $176.45 * GAF

2022 PPS Base Rate $180.16 * GAF

Lesser of charge or base rate

Care Management

Transitional Care Mgmt (TCM)

Chronic Care Mgmt (CCM)

Principal Care Mgmt (PCM)

Chronic Pain Mgmt (CPM)

General BH Integration (BHI)

Virtual Check Ins

Communications-based technology remote evaluation, established pt. At least 5-minutes. Medical discussion or eval is not for condition provided in recent 7 days or lead to appt in next 24 hours/soonest available. G0071 (MM10843)

SE22001-01 Revised

Audio Visual modifier 95

Audio only Modifiers 93, FQ

Annual in-person BH requirement postponed to 1/1/25

Warning: Always verify codes are active and accurate before using. Data on slides will age….

EXAMPLE BENCHMARKING STAFFING

https://data.hrsa.gov/tools/data-reporting/program-data/state/CA/table?tableName=5

Medical, Dental, Behavioral

- **22,675.17 FTEs in 174 awardees**
- **6,372.76 Vision, SUD, Pharmacy, Case Managers, Education and Outreach, Other**
- **=29,047.93 FTE Clinical Staff**
- **~26,122,271 Visits**

Fiscal and Billing

- **2,481.92 FTEs Fiscal & Billing**
- **~12 FTE clinical per Fiscal/Billing FTE**
- **~10,525 visits per FTE Fiscal & Billing**
- ***Fiscal will include finance, accounts payable, payroll etc…***

Other

- **15,764.36 FTEs Enabling, Quality Management, Administration, Front desk, Facilities Information Technology, other**

REMEMBER THE 7 ELEMENTS (CPG)

Of an effective Compliance Program (*1998…25 years ago*)

1. Conduct internal monitoring and auditing.
2. Implement compliance and practice standards.
3. Designate a compliance officer or contact.
4. Conduct appropriate training and education.
5. Respond appropriately to detected offenses and develop corrective action.
6. Develop open lines of communication with employees.
7. Enforce disciplinary standards through well-publicized guidelines.

https://oig.hhs.gov/documents/compliance-guidance/801/physician.pdf

COMPLIANCE

OIG announces upcoming changes to guidance 4/23

1998	New CPG	Industry Specific CPG	OIG not Federal Reg
CPGs have not sufficiently kept up with the innovations and growth of the healthcare industry. The new CPGs will impact compliance program requirements for all healthcare industry participants and organizations will need to incorporate the resulting changes into compliance plans, operational policies and procedures, and audit protocols.	The OIG will issue a new general CPG (GCPG) that will apply to all individuals and entities in the healthcare industry. The GCPG will address overarching compliance elements regarding federal fraud and abuse laws, compliance program basics, compliance program effectiveness, and general process and procedures. The OIG intends to publish the GCPG by December 31, 2023.	The OIG will also issue new industry-specific CPGs (ICPGs) which will apply to different types of providers, suppliers, and healthcare industry participants that participate in federal healthcare programs. The first two ICPGs are expected to cover Medicare Advantage and nursing facilities and are anticipated to be issued in 2024.	The new CPGs will no longer be published in the Federal Register, but the CPGs, and any future related guidance will be available on the OIG's website. The OIG intends to update the CPGs periodically as compliance practices, legal requirements, and risks evolve with the industry, and will notify interested parties through the OIG public listserv[2] as well as through other publicly available communication platforms.

COMPLIANCE

HIPAA Violation Structure (*annual increases*)

Tier 1- Lack of Knowledge	Tier 2 – Reasonable Cause	Tier 3 – Willful Neglect	Tier 4 – Willful Neglect excess 30 days to correct
A violation that the covered entity was unaware of and could not have realistically avoided, had a reasonable amount of care been taken to abide by HIPAA Rules	A violation that the covered entity should have been aware of but could not have avoided even with a reasonable amount of care. (but falling short of willful neglect of HIPAA Rules)	A violation suffered as a direct result of "willful neglect" of HIPAA Rules, in cases where an attempt has been made to correct the violation	A violation of HIPAA Rules constituting willful neglect, where no attempt has been made to correct the violation within 30 days
Fine of $127 per violation up to $31,987	$1,280 per violation up to $63,973	$12,794 per violation up to $63,973	$63,973 per violation

THANK YOU

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