ACMESA

Atlantic Coast Medical Equipment Services Association

2024 Winter Meeting and Exhibit Show

Feb. 20 - 21, 2024

Grandover Resort & Spa
Greensboro, NC

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Allegiance Group, Brightree, Compass Health Brands, McKesson, MedBill, Medline

Bronze

ACHC, Cleanwaste, GEMCO, HQAA, Nonin, O2-Concepts, Pharmacists Mutual
Pride Mobility, Prochant, React Health
Strategic Office Support, Wellcare

Next ACMESA 2024 Meeting & Exhibits:

AUGUST 15-16 - Holiday Inn Resort - Lumina, Wrightsville Beach

ACMESA Winter Meeting
Tues/Wed - February 20 - 21, 2024

Grandover Resort & Conference Center - 1000 Club Road, Greensboro, NC 27404 (336) 834-4839; Rooms $223 expired 1/22/24

2024 SPONSORS

PLATINUM: Philips Respironics, VGM

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SILVER: Allegiance Group, Brightree, Compass Health Brands, McKesson, Medbill, Medline

BRONZE: ACHC, Cleanwaste Medical, Gemco, HQAA, Nonin, O2 Concepts, Pharmacists Mutual, Pride Mobility, Prochant, React Health, Strategic Office Support, Wellcare

Tuesday, February 20 (Meeting - Carlisle Ballrooom; Exhibits - Griffin B & Payers in Ballroom)

9:00 am — Board Meeting - Open to Membership (Beaumont Room - 2nd Floor) Open to Membership

10:00 am — Exhibitor Set Up Begins (Griffin B)

12:00 noon — Meeting Registration Open - Pick up Meeting Materials

12:30 pm — President's Welcome, General Meeting, Presenting 2024 Slate & Committee Reports (Carlisle Ballroom)

1:00 pm — Sarah Hanna, ACU-Serve SPONSOR ACU-SERVE

Customizing KPIs for Your Business: A Tactical Approach

This seminar will delve into the criticality of customizing Key Performance Indicators (KPIs) to suit your company's unique goals and nuances, challenging the one-size-fits-all approach often seen in the industry. Attendees will be guided through a series of essential topics, such as the origins and definitions of industry metrics, and how they might differ from your company's specific calculations. This presentation provides a comprehensive framework, empowering businesses to evaluate and choose metrics that align with their specific objectives, thereby setting their own standards for measurement and goal attainment.

2:00 pm — Laura Williard VP Payer Relations - AAHomecare & Craig Douglas, VP Payer & Member Relations - VGM

Payer Relations in Focus with ACMESA: Updates & Trends

Laura & Craig tag team to inform us of the many payer initiatives and opportunities with commercial, Medicare Advantage, and Medicaid payers - especially in NC, VA & WV…followed by Q&A. Grab a seat to hear **in depth Medicare Advantage updates** and a detailed discussion around the Transparency in Coverage Final Rule rollout.

3:30 pm — Dessert Break in Meeting Room

NEW 3:45 pm — Steve Cela, Strategic Office Solutions

HME Paradigm Shift: Change to Survive!

Steve shares his passion for this topic with solutions! HME companies have sold ourselves short knowing our worth and what we deserve. The days of balanced billing and not collecting upfront from the patient must end. Documentation requirements need to occur before the service is rendered. The consequences of a denial or nonpayment must be understood by everyone in the business. For every denied and nonpaid claim, the company must sell 10 more to make up for that one loss and this cannot be. The margins are too tight to allow this and this must stop or the patient or referral source should seek services elsewhere. The industry is growing at 400% per year and there are less providers - those providers who can maintain their margin and thus their services will be around long term. There is a plenty of business and those needing services. We must be sure to maximize profitability so you can continue to serve those customers and referral sources that really appreciate it.

5:00pm — John Gallagher, VP Government Relations - VGM SPONSOR VGM

Federal Washington Update

John give us the Federal Legislative update with focus on what's going on in Washington, our state delegations, HHS & CMS and what to expect in 2024.

SPECIAL! 5:45 pm — NC Legislators invited as Guest Speakers

6:00 pm — (Griffin B Room) Exhibit Reception: Cocktails & Heavy Hors-d'oeuvres - SPONSOR VGM

FUN!! — Joel Givens, MAGICIAN until 7pm **SPONSOR VAN PRODUCTS MOBILITY/COMMERCIAL UPFIT**

Dinner on your own - Enjoy your Evening!

Wednesday, February 21 (Meeting - Carlisle Ballrooom; Exhibits - Griffin B & Payers in Ballroom)

8:00 am — (Griffin B Room) Continental Breakfast with Exhibitors

8:45 am — Ronda Buhrmester & Kim Cuce, VGM SPONSOR VGM

Revolutionize Your DME Game: Unveiling the Latest Industry Secrets!

Embark on a journey of innovation and success in the durable medical equipment (DME) realm! Our exclusive session unveils the latest industry updates regarding policies and reimbursement, game-changing technologies, and strategic insights that can transform your business. Don't just keep up—lead the pack! Join us for a dynamic experience that promises to elevate your DME venture to new heights. Seize the future of healthcare equipment—your success story starts here!

9:45 am — Break with Exhibitors

NEW 10:30 am — Sarah Newby & Steve Cela - Strategic Office Solutions

Leadership: Expert Tips that Give Actionable Items for Business Growth

Are you frustrated that your company isn't growing to plan? Does your team always miss their targets? Do you feel like you're the one doing all the work? As business owners and managers, we agonize over the bottom-line, spend hours planning goals, and try to coach our teams to greatness. But, we often neglect the most important lever… improving our ability to influence and lead the organization. It is **your** leadership that is the lid on your organization's success. Elevate yourself, and everyone will follow you to new heights. Stay stagnant, and those around you will as well. In this session, earn how to break free of mediocrity and develop a new definition of leadership. You will learn how to attract better leaders to work for you and what are the breaking points in business, and how to smash through those breaking points. If studied and applied, the lessons in this session will allow you to unlock the potential of your people and your organization

11:45 am — Judie Roan, CGS Jurisdiction C DME MAC

Medicare Update & Q&A

Judie from CGS gives updates and answers questions regarding Medicare program participation.

12:45 pm — (Griffin B Room) Lunch with Exhibitors SPONSOR: Drive/DeVilbiss

1:30 pm — NC Medicaid Presentations - Jay Ludlam (Dept. Secretary) John Vitiello (Medicaid Manager) & Sheri Spainhour

Medicaid Update, Managed Care Expansionin NC & More

DMA & Management staff gives an overview of the program updates, in-depth look at current issues plus Medicaid Managed Care with Q&A Session to follow.

2:15 pm — NC Medicaid MCO Plan Presentations (Confirmed: CCH, UHC, Wellcare. Healthy Blue & Amerihealth Caritas TBD)

BREAKOUTS - 2:45pm - VA Medicaid with Elizabeth Flaherty - Breakout Meeting Room (Regents Boardroom - 2nd Floor)

VA DMAS - Elizabeth gives updates and answers questions regarding Virginia Medicaid and reports on ACMESA monthly payer meetings benefits and progress..

4:00 pm — Adjourn

Note**: ACMESA reserves the right to change agenda/meetings due to emergencies, insufficient registrations, etc. ACMESA takes pride in presenting speakers on topics of interest and the speakers we offer are widely recognized as experts in their field. However, the ACMESA staff and its officers and board of directors are not able to evaluate the accuracy and content of their presentations which are highly technical in nature and often require professional judgments. For this reason, ACMESA and its staff, officers, and directors assume no liability growing from the advice and information such speakers present.* ***Email beth@AtlanticCoastMESA.org

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ACU-SERVE
Collecting More, Faster.

Customizing KPIs for Your Business: A Tactical Approach

Presented by:
Sarah Hanna
VP of Consulting Services

Email: shanna@acuservecorp.com
Mobile: 843-697-7562 (text or call)

ACMESA
Atlantic Coast Medical Equipment Services Association

ACU-Insight

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Overview:

ACU-Insight

- Benchmarking against industry "standard."
- Setting your own "standard."
- OKRs vs. KPIs
- Creating goals and the **RED, YELLOW, GREEN** method.
- Quick wins and overall improvement

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Objective Key Results: OKR
An effective goal-setting and leadership tool for communicating what you want to accomplish and what milestones you'll need to meet in order to accomplish it.

Benchmarking
A process of measuring the performance of a company's products, services, or processes against those of another business considered to be the best in the industry, aka "best in class."

Source: Google

Key Performance Indicator: KPI
A quantifiable measure of performance over time for a specific objective. KPIs provide targets for teams to shoot for, milestones to gauge progress, and insights that help people across the organization make better decisions.

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ACU-Insight
BENCHMARKING
The Industry Standard
• Understanding and having access to industry information sets a point of reference for your company.
• It provides a baseline for companies to identify shortcomings in performance and opportunities for improvement.
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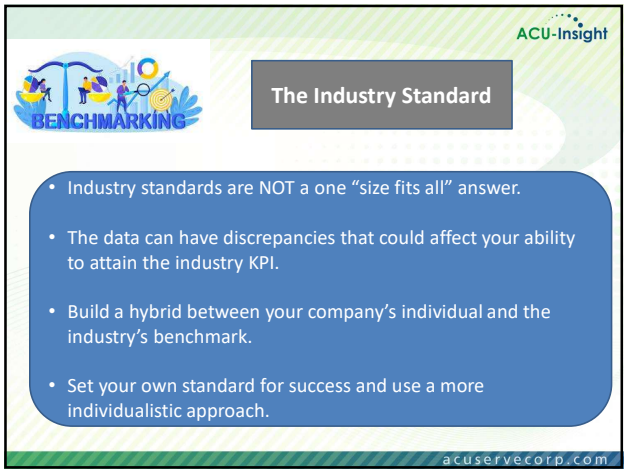
ACU-Insight
BENCHMARKING
The Industry Standard
• Industry standards are NOT a one “size fits all” answer.
• The data can have discrepancies that could affect your ability to attain the industry KPI.
• Build a hybrid between your company’s individual and the industry’s benchmark.
• Set your own standard for success and use a more individualistic approach.
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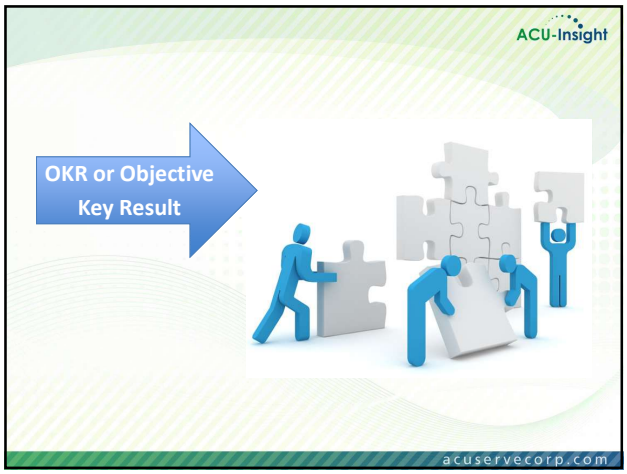
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OKR or Objective Key Result
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The History of OKR

1954

- Peter Drucker formed the technique Management by Objectives in his book, *The Practice of Management*.
- MBO grew in popularity due to its success in helping businesses.

1970

- Andrew Grove, CEO of Intel, took the idea of Objectives and merged it with Key Results to create OKR.
- He called them iMBOs (Intel Management by Objectives.
- During his tenure, objectives were never discussed without mentioning key results.

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The History of OKR

1999

- John Doerr learned the methodology from Andrew Grove while working at Intel.
- Introduces the approach to Google.

Today

- Leaders of LinkedIn, Twitter, Slack, Spotify, Uber and Microsoft use the OKR approach.
- It is used to communicate improvement priorities across the companies and align teams to move in the right direction.

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OKRs Encompass KPI's

For Example: You have an objective pertaining to new customer acquisition. You might have the key result: **Grow new customer acquisition by 50% by the end of Q1.**

"New customer acquisition" represents the KPI for this specific KR.

New customer acquisition is one factor that could determine the success of your company.

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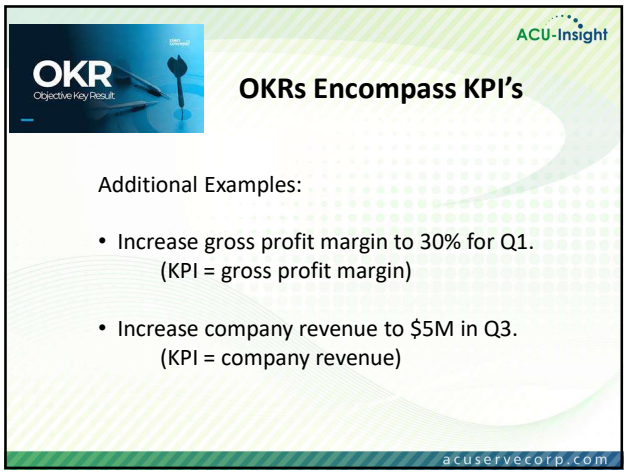
OKR
Objective Key Result
ACU-Insight
OKRs Encompass KPI's
Additional Examples:
• Increase gross profit margin to 30% for Q1.
(KPI = gross profit margin)
• Increase company revenue to $5M in Q3.
(KPI = company revenue)
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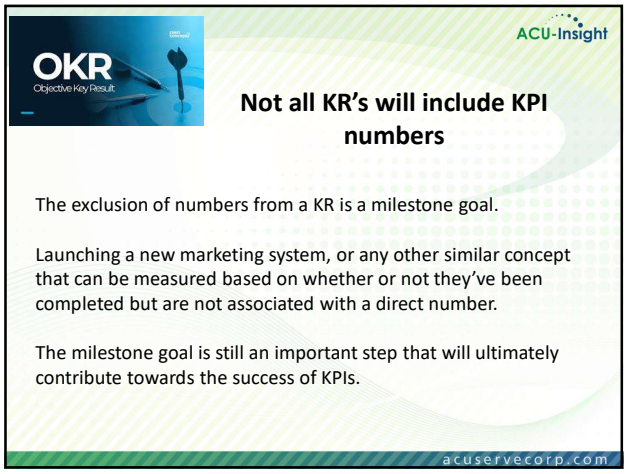
OKR
Objective Key Result
ACU-Insight
Not all KR's will include KPI numbers
The exclusion of numbers from a KR is a milestone goal.
Launching a new marketing system, or any other similar concept that can be measured based on whether or not they've been completed but are not associated with a direct number.
The milestone goal is still an important step that will ultimately contribute towards the success of KPIs.
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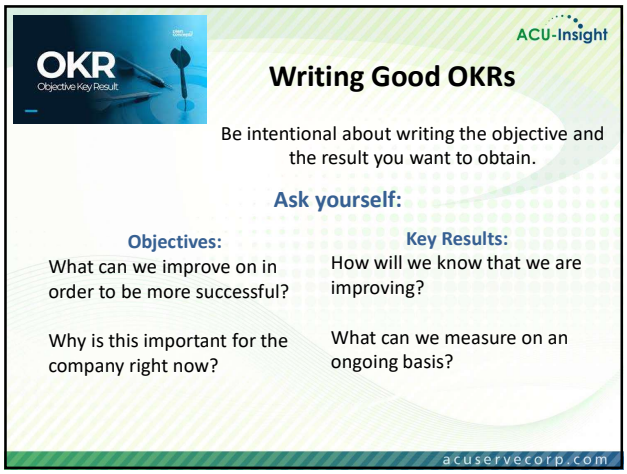
OKR
Objective Key Result
ACU-Insight
Writing Good OKRs
Be intentional about writing the objective and the result you want to obtain.
Ask yourself:
Objectives:
What can we improve on in order to be more successful?
Why is this important for the company right now?
Key Results:
How will we know that we are improving?
What can we measure on an ongoing basis?
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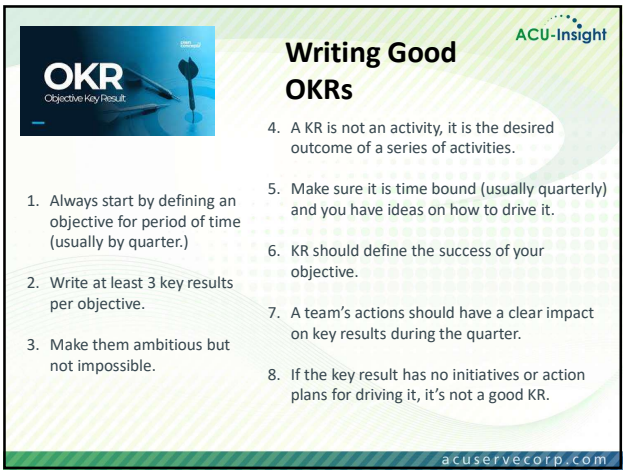
OKR
Objective Key Result
ACU-Insight
Writing Good OKRs
1. Always start by defining an objective for period of time (usually by quarter.)
2. Write at least 3 key results per objective.
3. Make them ambitious but not impossible.
4. A KR is not an activity, it is the desired outcome of a series of activities.
5. Make sure it is time bound (usually quarterly) and you have ideas on how to drive it.
6. KR should define the success of your objective.
7. A team's actions should have a clear impact on key results during the quarter.
8. If the key result has no initiatives or action plans for driving it, it's not a good KR.
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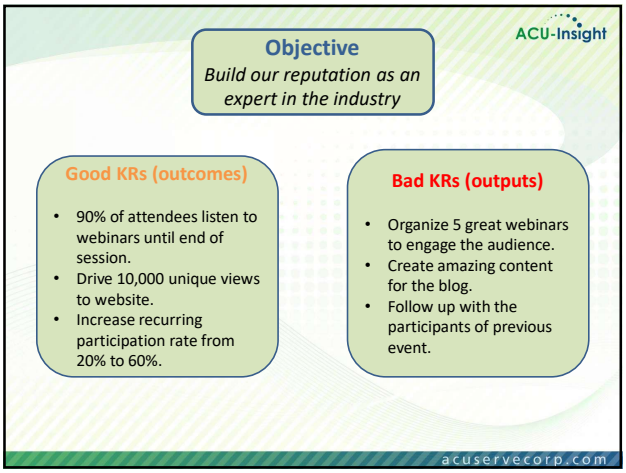
ACU-Insight
Objective
Build our reputation as an expert in the industry
Good KRs (outcomes)
• 90% of attendees listen to webinars until end of session.
• Drive 10,000 unique views to website.
• Increase recurring participation rate from 20% to 60%.
Bad KRs (outputs)
• Organize 5 great webinars to engage the audience.
• Create amazing content for the blog.
• Follow up with the participants of previous event.
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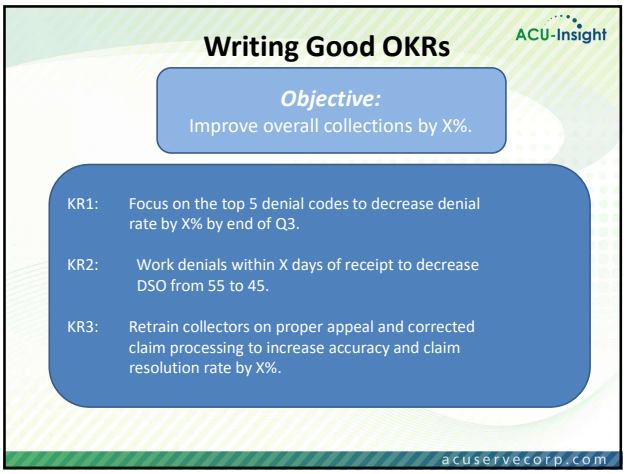
Writing Good OKRs
ACU-Insight
Objective:
Improve overall collections by X%.
KR1: Focus on the top 5 denial codes to decrease denial rate by X% by end of Q3.
KR2: Work denials within X days of receipt to decrease DSO from 55 to 45.
KR3: Retrain collectors on proper appeal and corrected claim processing to increase accuracy and claim resolution rate by X%.
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Writing Good OKRs

ACU-Insight

Objective:
Personalize sales approach and nurture potential customers better.

KR1: Improve conversion % from trial to paid from 20% to 35%.

KR2: Increase follow up email open rate from 14% to 45%.

KR3: Obtain 8/10 average score on customer satisfaction with at least 100 responses.

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Common Benchmarking Slip-Ups

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1. Skipping the defining of clear objectives

Without a clear purpose, benchmark analysis fails to meet expectations.

Define why you are benchmarking an area, what you really want to know, and decide the KPIs that are required to succeed.

2. Choosing the wrong benchmark

Using benchmarks to compare peers within groups/units.

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3. Benchmarking too many KPIs

- Avoid choosing KPIs as "that would be nice to know."
- Too many KPIs will distract from the critical factors.
- **Choose wisely!**

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4. Assuming that numbers and performance stay stable for long periods

Numbers constantly change.

Continue to monitor on a regular basis to ensure best performance remains after the spotlight has faded on that area of focus.

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Key Performance Indicators

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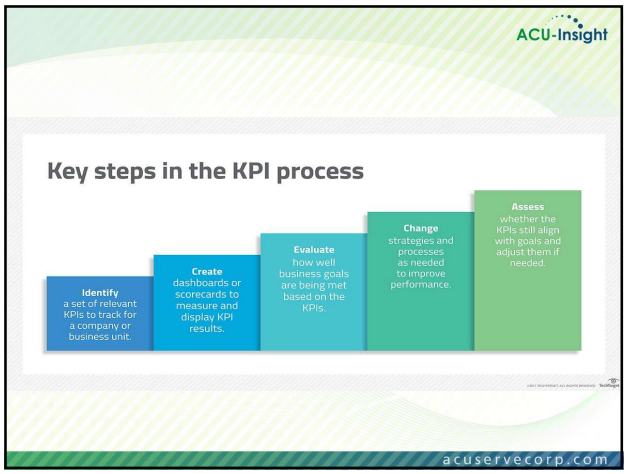
ACU-Insight
Key steps in the KPI process
Identify
a set of relevant KPIs to track for a company or business unit.
Create
dashboards or scorecards to measure and display KPI results.
Evaluate
how well business goals are being met based on the KPIs.
Change
strategies and processes as needed to improve performance.
Assess
whether the KPIs still align with goals and adjust them if needed.
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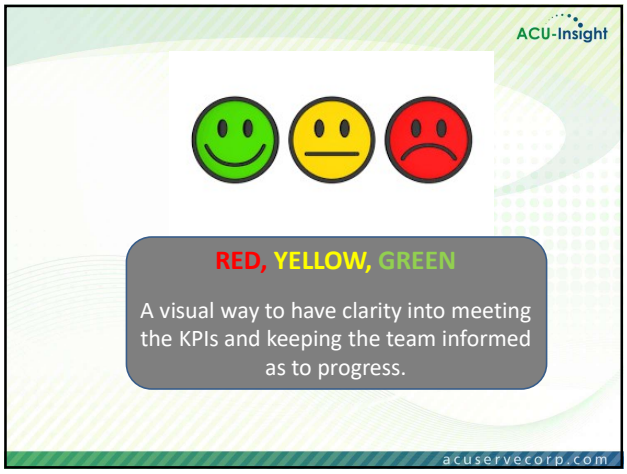
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RED, YELLOW, GREEN
A visual way to have clarity into meeting the KPIs and keeping the team informed as to progress.
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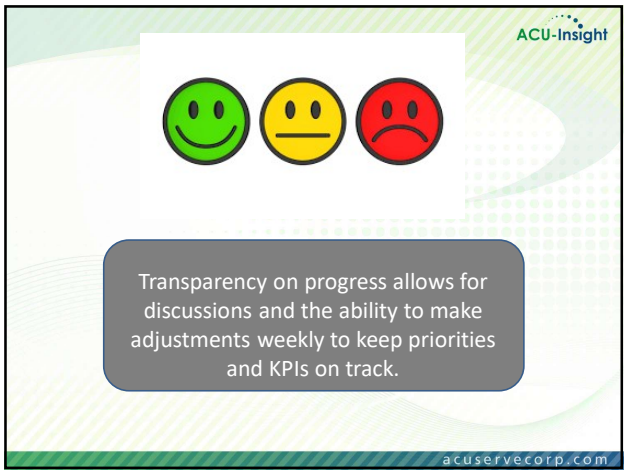
ACU-Insight
Transparency on progress allows for discussions and the ability to make adjustments weekly to keep priorities and KPIs on track.
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Determining the Success Criteria

1. Be sure the goals are realistic.
2. Determine the successful outcome you want to attain and set that as your GREEN goal.
3. You can set a SUPER GREEN goal to stretch your A-Team.
4. Define your minimum level of acceptable performance and any result below that is considered **RED**.
5. This means YELLOW is any result between **RED** and GREEN.

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Setting the Standard

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Quick Wins

- When developing your benchmarks, look for areas within that category that can provide "quick wins."
- This helps to motivate the team to keep moving forward and not become overwhelmed with the task at hand.
- Recognize the little wins. This drives performance.

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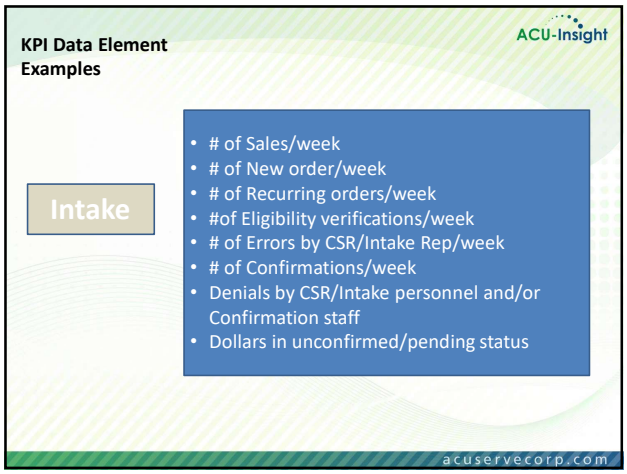
KPI Data Element Examples
ACU-Insight
Intake
of Sales/week
of New order/week
of Recurring orders/week
#of Eligibility verifications/week
of Errors by CSR/Intake Rep/week
of Confirmations/week
Denials by CSR/Intake personnel and/or Confirmation staff
Dollars in unconfirmed/pending status
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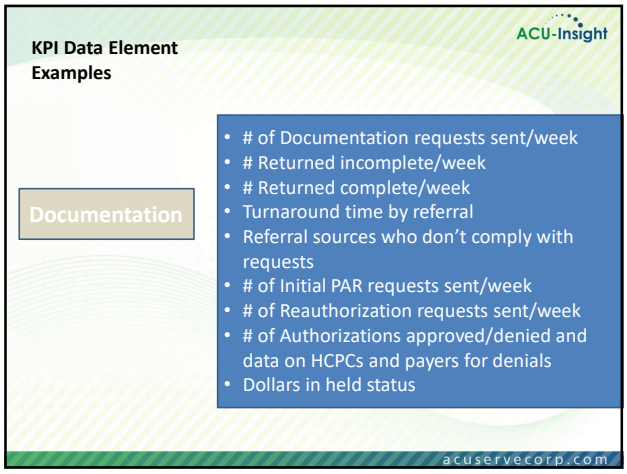
KPI Data Element Examples
ACU-Insight
Documentation
of Documentation requests sent/week
Returned incomplete/week
Returned complete/week
Turnaround time by referral
Referral sources who don't comply with requests
of Initial PAR requests sent/week
of Reauthorization requests sent/week
of Authorizations approved/denied and data on HCPCs and payers for denials
Dollars in held status
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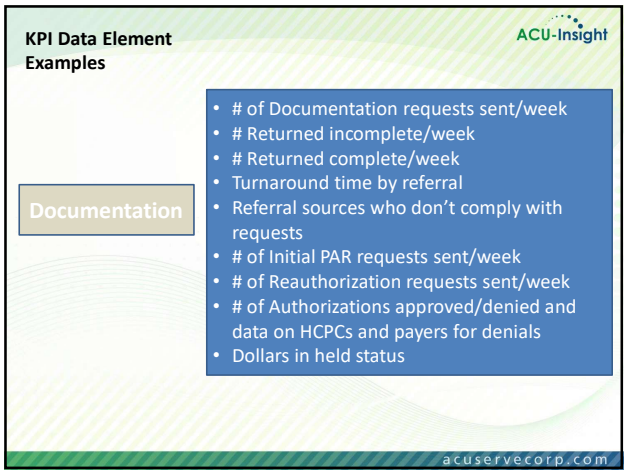
KPI Data Element Examples
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Dollars in held status
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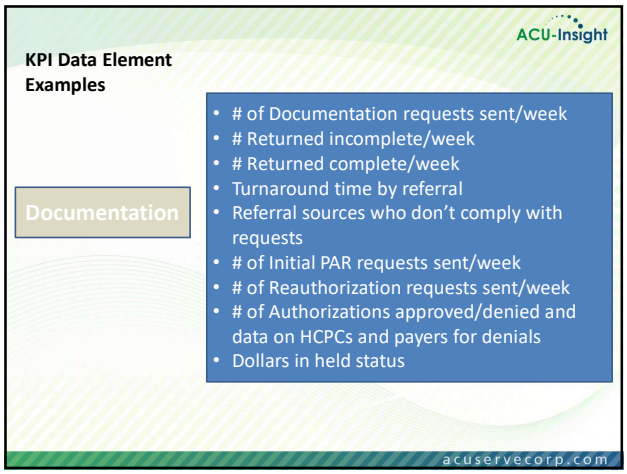
ACU-Insight
KPI Data Element Examples
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Dollars in held status
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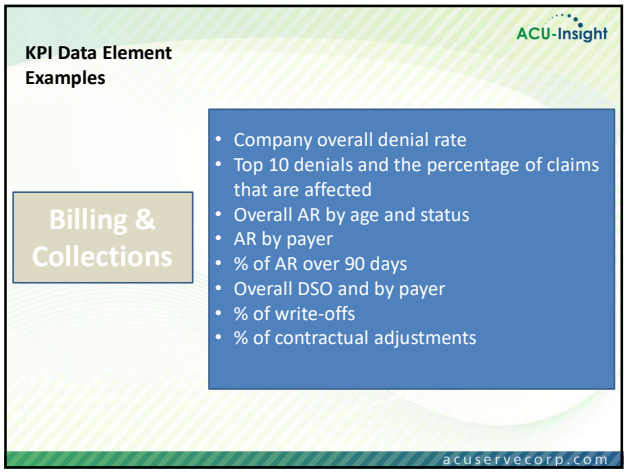
ACU-Insight
KPI Data Element Examples
Billing & Collections
Company overall denial rate
Top 10 denials and the percentage of claims that are affected
Overall AR by age and status
AR by payer
% of AR over 90 days
Overall DSO and by payer
% of write-offs
% of contractual adjustments
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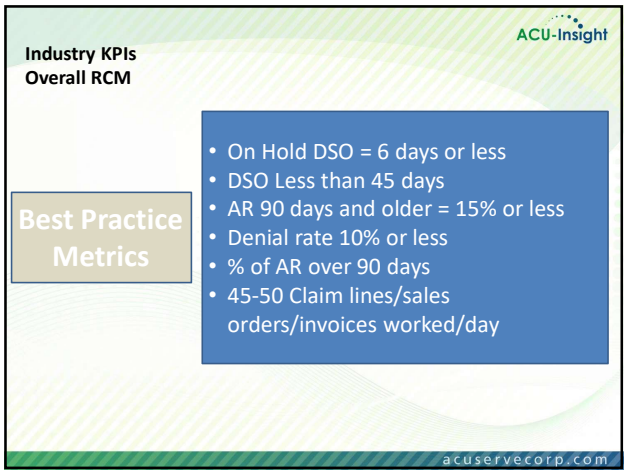
ACU-Insight
Industry KPIs Overall RCM
Best Practice Metrics
On Hold DSO = 6 days or less
DSO Less than 45 days
AR 90 days and older = 15% or less
Denial rate 10% or less
% of AR over 90 days
45-50 Claim lines/sales orders/invoices worked/day
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Conclusion

- Use the industry "standard" benchmarks as guideposts but evaluate your company to create your own.
- Be intentional about setting your OKRs and KPIs.
- Clearly communicate, monitor, report feedback and track results. Share openly with all stakeholders in the process.
- Provide a "grading" system that is visual so your team can see their progress: **RED, YELLOW, GREEN**.
- Use the data to find quick wins that motivate your team by seeing progress that leads to overall improvement.

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Resources

https://business.adobe.com/blog/basics/okr-vs-kpi
OKRs vs. KPIs
Adobe Communications Team
3/18/2022

https://www.rhythmsystems.com/blog/how-to-win-with-red-yellow-green-slideshare
How to Win with Red-Yellow-Green
Jessica Wishart
RHYTHM SYSTEMS
12/8/2019

https://weekdone.com/resources/objectives-key-results
What is OKR? Everything to Know
WEEKDONE

- https://www.costengineering.eu/blog-article/5-common-pitfalls-in-benchmarking
5 Common Pitfalls in Benchmarking
7/25/2022

https://people.ai/blog/how-to-develop-kpis/
How to Develop KPIs In 7 Steps
People ai

https://quantive.com/resources/articles/okrs-vs-smart-goals?utm_campaign=engage-t3-goal-mgmt-pillar-pages-12-22-v1-emea-apac-google-search&utm_adgroupid=142135862102&utm_term=i&utm_source=google&utm_medium=cpc&hsa_acc=8866348274&hsa_cam=19422939582&hsa_grp=142135862102&hsa_ad=643214566062&hsa_src=g&hsa_tgt=dsa-1932589292306&hsa_kw=&hsa_mt=&hsa_net=adwords&hsa_ver=3&gclid=EAIaIQobChMIlPW-09fP_QIVnG5vBB2-3gzmEAAYAiAAEgKAE_D_BwE
OKRs vs. SMART Goals: Similarities, Differences, and Uses
Quantitative

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ACU-Insight

ACUSERVE Collecting More, Faster.

Sarah Hanna,
VP of Consulting Services

Email: shanna@acuservecorp.com
Phone: 800-887-8965 ext. 102
Mobile: 843-697-7562

Service Offering Overview:

- HME/DME Billing and Collections
- Home Infusion Billing and Collections
- Intake Optimization
- Documentation Retrieval
- Prior Authorization Retrieval
- Business Operations and Revenue Cycle Management Consulting
- Audit and Compliance Consulting
- Special Projects

ACMESA
Atlantic Coast Medical Equipment Services Association

acuservecorp.com

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Payer Relations and Managed Care: Updates and Trends

Presented by:

Laura Williard, AAHomecare

Craig Douglas, VGM

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• Medicare Advantage 2023 Environment

- >30.8 Million enrolled in Med Advantage
- >51% of Medicare beneficiaries enrolled in Med Advantage
- More than doubled since 2007, CBO estimates 61% by 2032
- $454 billion of total federal Medicare spending (54%)
- 3,998 plans available nationwide in 2023 (6% increase over 2022)
- 59% HMO, 40% PPO, 1% PFFS
- 99.7% of Medicare beneficiaries have access to Med Advantage
- The average Medicare beneficiary has the choice of 43 plans by 9 firms in 2023
- 7 out of 10 MAP enrollees with Prescription Drug Coverage have no additional premium

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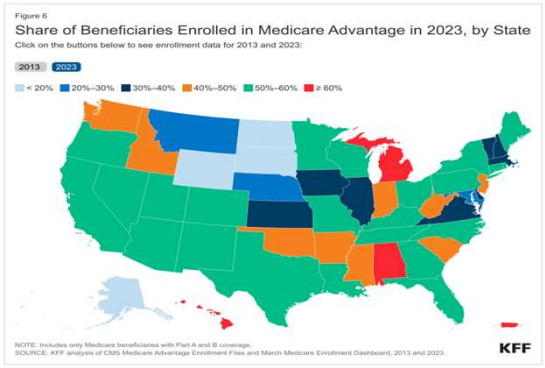

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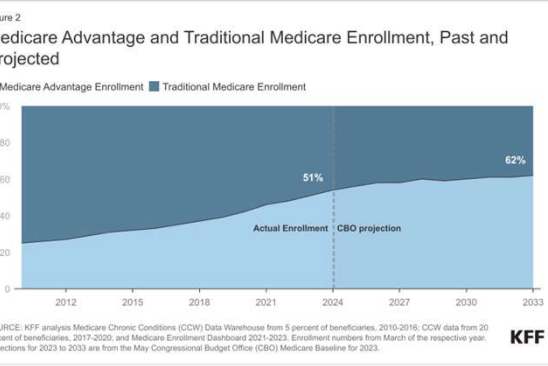

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• Medicare Advantage Bonus Payments

- Established by the Affordable Care Act
- *"A key feature of the quality bonus program is the **star rating systems**. Star ratings are used to determine two parts of a Medicare Advantage plan's payment: (1) whether the plan is eligible for a bonus, and (2) the portion of the difference between the benchmark and the plan's bid that is paid to the plan. The benchmark is the maximum amount the federal government will pay for a Medicare Advantage enrollee and is a percentage of estimated spending in traditional Medicare in the same county, ranging from 95 percent in high-cost counties to 115 percent is low-cost counties. The bid is the plan's estimated cost for providing services covered under Medicare Parts A and B."*
- Plans may but are not required to use bonus payments to cover the cost of supplemental benefits.
- $12.8 Billion bonus in 2023 is 28% higher than 2022 ($2.8 billion)
- Average Bonus Per Enrollee in 2023 is $417
- Increase of 126% since 2015

KFF The independent source for health policy research, polling, and news. AAHOMECARE

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MAP Bonus/Enrollment Summary

Health Plan	% of Enrollment	2023 Bonus Payment	% of Bonus Payments
United HealthCare	29%	$3.9 Billion	30%
Humana	18%	$2.3 Billion	18%
BCBS Plans	14%	$1.7 Billion	13%
CVS Health	11%	$1.3 Billion	10%
Kaiser Permanente	6%	$966.8 Million	8%
Centene	4%	$321.6 Million	2.5%
Cigna	2%	$247.3 Million	1.9%

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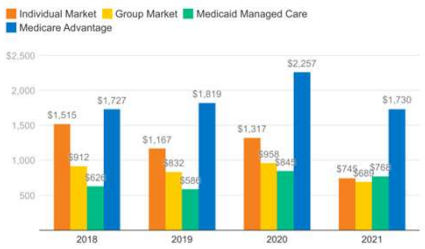
Figure 1

Gross Margins Per Enrollee, 2018-2021



NOTE: Gross margins per enrollee are the amount by which total premium income exceeds total claims costs, divided by the number of enrollees. Gross margins include administrative costs, tax liability, and profits.
SOURCE: KFF analysis of data from Mark Farrah Associates Health Coverage Portal TM.

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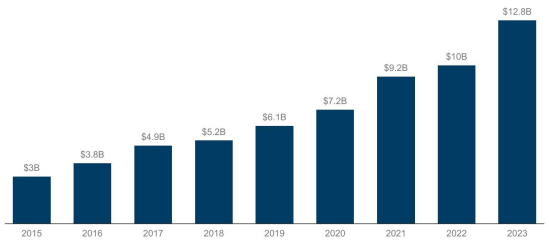
Figure 1

Total Spending on Medicare Advantage Plan Bonuses More Than Quadrupled Between 2015 and 2023



SOURCE: KFF analysis of CMS Enrollment and Plan Quality and Performance Ratings Files, 2015-2023

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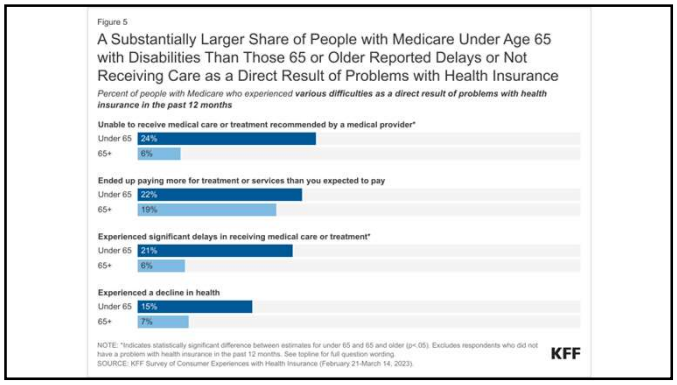


10

Considerations for Providers:

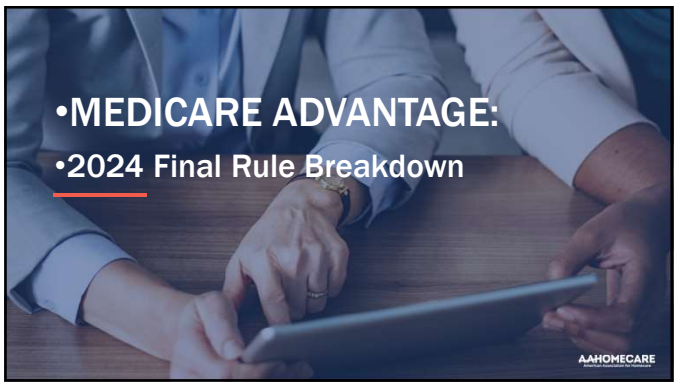
What percentage of your business is Medicare Advantage?

How has it grown over the last 5 years?

What education can you give your customers on how to choose the best MAP for them?

What processes can you implement to improve interactions with MAPs?

11



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Main Objectives of Final Rule for 2024

- Prior authorization policies for coordinated care plans may only be used to confirm the presence of diagnoses or other medical criteria and/or ensure that an item or service is medically necessary
- Approval granted through PA must be valid for as long as medically necessary; 90-day transition grace period
- MA plans must comply with NCD/LCD, and general coverage and benefit conditions included in Traditional Medicare.
- MA plans establish a Utilization Management Committee to review all UM/PA policies annually
- Cracking down on misleading marketing tactics
- Strengthening Star Ratings/Health Equity

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CMS: 2024 Medicare Advantage and Part D Final Rule (CMS-4201-F)

- ***Prior Authorization***
  - ***Prior authorization policies may only be used to confirm the presence of diagnoses or other medical criteria and/or ensure that an item or service is medically necessary.***
  - ***Codifying sub regulatory guidance that indicates prior authorized equipment cannot be later denied for medical necessity.***
  - ***Requires that approval of a prior authorization request for a course of treatment must be valid for as long as medically reasonable and necessary.***
  - ***Minimum 90-day transition period when an enrollee switches to a new plan, new plan may not require prior authorization for an active course of treatment.***

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AAHomecare Asked Med Adv Plans:

Regarding Prior Authorization: The rule stipulates that a prior authorization request for a course of treatment must be valid for as long as medically reasonable and necessary. Please clarify how this will impact lifetime prior authorizations for treatment, such as oxygen therapy? When a prior approval is in place, what will be the expectation for medical necessity documentation?

Regarding the 90-Day Transition Period: How will your plan implement the requirement for a 90-day transition period without prior authorization for active treatment?

15

Considerations for Providers:

- What are the claims review protocols for your MAP contracts?
- Do they look to determine medical necessity before claims payment even when no auth is required?
- Are the published coverage criteria and medical documentation rules clear for the products you provide?
- What tools/resources can you use to speed up PA review & take advantage of the 90-day transition requirement?

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XYZ Company 111 Maple Ave. Anytown, ST 00000 111-1111 www.xyzcompany.com	**To:** ABC Payer **Fax number:** 555-5555
	From: XYZ Company **Fax number:** 111-1111
	Date: 1/1/0001
	Regarding: 90-day transition authorization for Jane Doe
	Phone number for follow-up: 111-1111
New enrollee for ABC Medicare Advantage Plan. This is a new auth request to put an existing auth that is within the 90-day transition period in ABC payer's auth format. Please process this quickly per the 90-day transition Medicare final rule. Jane Doe is waiting for delivery of their DME which was already prior authorized and reviewed for medical need by 123 Medicare Advantage plan (previous Medicare payer for this member).	

• SAMPLE COVER SHEET

- Call out as new enrollee
- Reference 90-day transition rule
- Reference previously authorized

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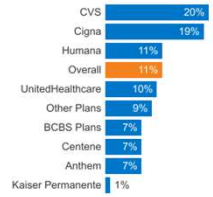
Figure 3

About 1 in 10 (11%) Prior Authorization Request Denials Were Appealed

Share of adverse and partially favorable prior authorization determinations that were reconsidered in 2021



NOTE: Anthem BCBS plans are not included in the analysis because of data quality issues.
SOURCE: Technical Specifications Public Use File of Contract Year (CY) 2021 Part C and D Reporting Requirements Data

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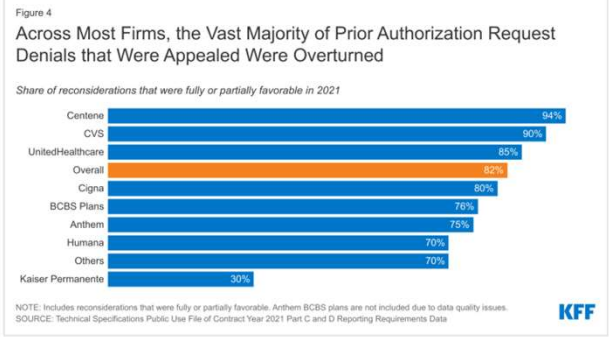

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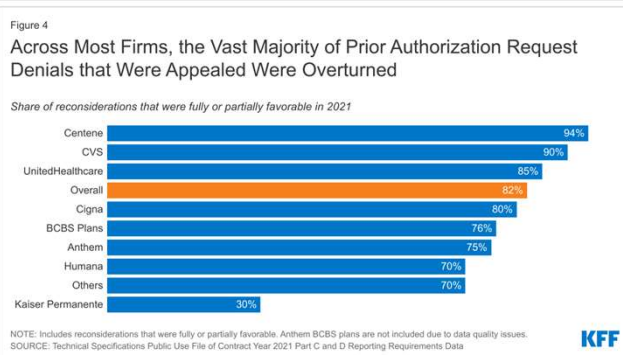

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• CMS: 2024 Medicare Advantage and Part D Final Rule (CMS-4201-F)

- ***Strengthening Quality: Star Ratings Program***
  - ***CMS finalizes a health equity index (HEI) reward, beginning with the 2027 Star Ratings, to further encourage MA and Part D plans to improve care for enrollees with certain social risk factors.***
  - ***CMS also reduces the weight of patient experience/complaints and access measures to further align with other CMS quality programs and the current CMS quality strategy.***

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AAHomecare Asked Med Adv Plans:

Hospital Avoidance and Star Ratings: How can we collaborate and assist in efforts to keep beneficiaries out of the hospital and improve Star Ratings?

22

• CMS: 2024 Medicare Advantage and Part D Final Rule (CMS-4201-F)

- ***Advancing Health Equity***
  - ***CMS clarifies current rules, expanding the example list of populations that MA organizations must provide services to in a culturally competent manner.***
  - ***Requirements for MA organizations to develop and maintain procedures to offer digital health education to enrollees to improve access to covered telehealth benefits.***
  - ***Requires MA organizations to include providers' cultural and linguistic capabilities in provider directories.***
  - ***MA organizations' quality improvement programs must include efforts to reduce disparities.***

23

AAHomecare Asked Med Adv Plans:

How will these Medicare policy changes be communicated to your network DMEPOS suppliers? When a Medicare coverage policy is not in place and you create a new policy specific to your plan, how are those policies communicated to DMEPOS suppliers?

24

Considerations for Providers:

How can we as an industry work on advancing health equity and use that in partnership with the payers?

Is this an opportunity for providers to partner with MAPs on things like shared community events/outreach?

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CMS: 2024 Medicare Advantage and Part D Final Rule (CMS-4201-F)

Utilization Management

- ***MA plans must comply with national coverage determinations (NCD), local coverage determinations (LCD), and general coverage and benefit conditions included in Traditional Medicare regulations.***
- ***When coverage criteria are not fully established, MA organizations may create internal coverage criteria based on current evidence in widely used treatment guidelines or clinical literature made publicly available to CMS, enrollees, and providers.***
- ***MA plans establish a Utilization Management Committee to review policies annually and ensure consistency with Traditional Medicare policies.***

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AAHomecare Asked Med Adv Plans:

Regarding Your Utilization Management Committee: What's your plan for establishing this committee, and what will its composition and responsibilities be?

Regarding UM Annual Reviews: How will the committee conduct annual reviews of utilization patterns?

Regarding HME Industry Involvement: Can a representative from the DMEPOS industry, like AAH, participate in or meet with the Utilization Management Committee?

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Considerations for Providers:

Make sure NCDs and LCDs are regularly reviewed to ensure consistency.

If no active NCD or LCD be sure you are aware of the payer's coverage criteria.

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CMS: 2024 Medicare Advantage and Part D Final Rule (CMS-4201-F)

- ***Marketing Requirements***
  - ***CMS is prohibiting ads that do not mention a specific plan name as well as ads that use works and imagery that may confuse beneficiaries or Medicare logos in a way that is misleading, confusing, or misrepresents the plan.***
  - ***CMS also reinstates important protections that prevent predatory behavior and finalized changes that strengthen the role of plans in monitoring agent and broker activity.***
  - ***Protecting Medicare beneficiaries by ensuring they receive accurate information about Medicare coverage and are aware of how to access accurate information from other available sources.***

29

Considerations for Providers:

What types of marketing issues are you seeing with the Medicare Advantage Plans?

Have you noticed any changes in the wording/tactics used in MA marketing efforts?

What questions or suggestions do you have on this regulation?

30

2024 Coverage Requirements for MAPs – Denials

- MA organizations must cover all Part A and B benefits, excluding hospice services and the cost of kidney acquisitions for transplant, on the same conditions that items and services are furnished in Traditional Medicare. This means that MA organizations may not limit coverage through the adoption of policies and procedures—whether those policies and procedures are called utilization management and prior authorization or the standards and criteria that the MA organization uses to assess and evaluate medical necessity—when those policies and procedures result in denials of coverage or payment where the Traditional Medicare program would cover and pay for the item or service furnished to the beneficiary.

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

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Previous Language

- If the MAO expects to issue a partially or fully adverse medical necessity decision based on the initial review of the request, the organization determination must be reviewed by a physician or other appropriate health care professional with sufficient medical and other expertise, including knowledge of Medicare coverage criteria, before the MAO issues the organization determination decision.
- Must make determinations based on: (1) the medical necessity of plan-covered services - including emergency, urgent care and post-stabilization - based on internal policies (including coverage criteria no more restrictive than original Medicare's national and local coverage policies) reviewed and approved by the medical director

https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c04.pdf

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More Changes Coming?

- Increased Costs & Decreased Payments from CMS
- Tighter scrutiny on operations and accountability
- How will MAPs respond?
  - Fewer "Add-On" Services Offered?
  - Increased Premiums?
  - Higher Deductibles?
  - Lower Reimbursements to Providers?

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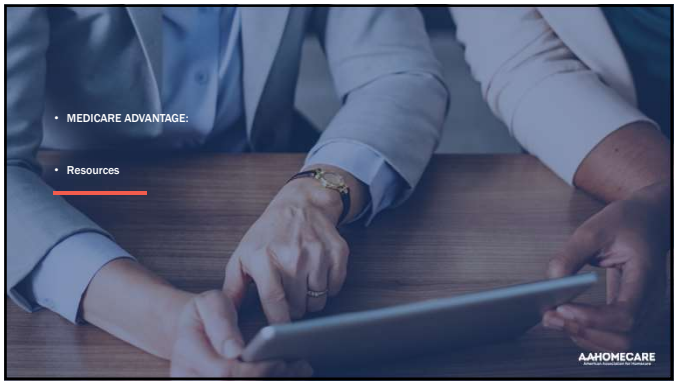

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Medicare Advantage Resources

https://aahomecare.org/medicare-advantage

- Brown & Fortunato Medicare Advantage. . .Plans Overview:
  - Rights of DME Supplier Under a . . .Medicare Advantage Plan
  - Medicare Advantage Plans. . . Access to Care Requirements
  - Overview of Federal Statutes and Regulations Governing Medicare Advantage Plans. . .
  - Medicare Advantage Plans. . . Minimum Level of Service
- AAHomecare Summary on 2024 Medicare Advantage and Part D Final Rule
- Template Letter to Payers on 2024 Final Rule

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Evaluating MAP Plans In Your Service Area

Explore your Medicare coverage options www.medicare.gov/plan-compare

- Enter Zip Code
- Recommend zip code with highest population for high volume cities
- Select Medicare Advantage Plan (Part C) and Click Find Plans
- "Help with your costs" Select "I don't get help from any of these programs"
- "Do you want to see your drug costs when you compare plans?" Select No and Next
- Plans will be sorted from Lowest drug + Premium Cost

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• Evaluating MAP Plans In Your Service Area

1 HealthPartners Journey Pace (PPO)
HealthPartners | Plan ID: H4882-009-1
This plan got Medicare's **highest rating** (5 stars)

MONTHLY PREMIUM
$0.00
Includes: Health & drug coverage
Doesn't include: $164.90 Standard Part B premium

TOTAL DRUG & PREMIUM COST (for the rest of 2023)
$0.00
Only includes premiums for the months left in this year when you don't enter any drugs

OTHER COSTS
$0
$3000.00
$8,950 in and Out-of-network
$5,200 in-network
Plan Details
Add to compare

PLAN BENEFITS
- Vision is available
- Dental is available
- Hearing is available
- Transportation is not available
- Fitness benefits is available
- Worldwide emergency is available
- Telehealth is available
- Over-the-counter drugs is available
- In-home support is not available
- Home safety devices & modifications is not available
- Emergency response device is not available

COPAYS/COINSURANCE
Primary doctor: $0 copay
Specialist: $40 copay per visit

DRUGS
Add your prescription drugs
Enter drugs you take regularly (if any) to see your estimated drug + premium cost

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CMS Monthly Report: MA Enrollment by State/County/Contract

https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/monthly-ma-enrollment-state/county/contract

Monthly Link to MAP enrollment by State/County/Contract

- Filter by State
- Lists by:
  - Counties
  - Organization Name
  - Organization Type
  - Plan Type

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Medicare Advantage Resources

https://aahomecare.org/medicare-advantage

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  - Rights of DME Supplier Under a . . .Medicare Advantage Plan
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Evaluating MAP Plans In Your Service Area

1.HealthPartners Journey Pace (PPO)
HealthPartners | Plan ID: H4882-009-1
This plan got Medicare's **highest rating** (5 stars)

MONTHLY PREMIUM
$0.00
Includes: Health & drug coverage
Doesn't include: $164.90 Standard Part B premium

TOTAL DRUG & PREMIUM COST (for the rest of 2023)
$0.00
Only includes premiums for the months left in this year when you don't enter any drugs

OTHER COSTS
$0
$300.00
$8,950 In and Out-of-network
$5,200 In-network
Plan Details
Add to compare

PLAN BENEFITS
- Vision is available
- Dental is available
- Hearing is available
- Transportation is not available
- Fitness benefits is available
- Worldwide emergency is available
- Telehealth is available
- Over-the-counter drugs is available
- In-home support is not available
- Home safety devices & modifications is not available
- Emergency response device is not available

COPAYS/COINSURANCE
Primary doctor: $0 copay
Specialist: $40 copay per visit

DRUGS
Add your prescription drugs
Enter drugs you take regularly (if any) to see your estimated drug + premium cost

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CMS Monthly Report: MA Enrollment by State/County/Contract

https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/monthly-ma-enrollment-state/county/contract

Monthly Link to MAP enrollment by State/County/Contract

- Filter by State
- Lists by:
  - Counties
  - Organization Name
  - Organization Type
  - Plan Type

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Do You Have a Process to:

- ❑ Verify customer benefits after re-enrollment
- ❑ Confirm prior authorizations are moved to new MAP during 90-day transition period
- ❑ Evaluate for new MAPs in your coverage area
- ❑ Make sure you are contracted with all MAPs in your coverage area
- ❑ Appeal denied prior authorizations
- ❑ Review LCDs, NCDs, other Medicare coverage docs & MAP coverage criteria
- ❑ Educate your customers about MAP benefits, coverage, & the appeals process
- ❑ Leverage importance of Star ratings to demonstrate how your business benefits MAPs

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Key Takeaways

- Patient complaints – **1-800-MEDICARE**
- Stakeholder complaints – Regional Office Contacts and https://dpap.lmi.org
- AAHomecare continues to provide global industry feedback and proposed solutions directly to CMS Part C leadership
- AAHomecare Payer Relations team meeting with top 6 health plans
- Educate payers/request their implementation plans
  - Utilize AAHomecare Summary of 2024 MA Final Rule
  - Utilize template letter with questions in your outreach to MA plans
- Check out our new website and resources available: www.AAHomecare.org

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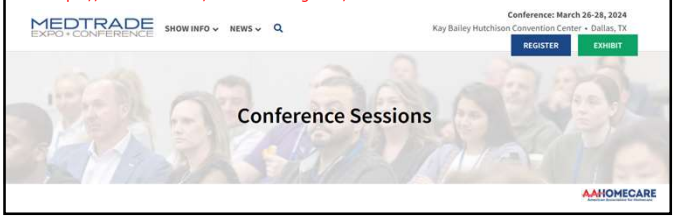
Medtrade March 26th through March 28th

Payer Relations Courses on Medicare Advantage and more!

https://medtrade.com/conference-agenda/



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Transparency in Coverage

Your "Private" rates with Payers are Now Public Information

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Transparency in Coverage Helpful Links

https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS-Transparency-in-Coverage-9915F.pdf
https://www.federalregister.gov/documents/2020/11/12/2020-24591/transparency-in-coverage
https://www.cms.gov/files/document/hospital-price-transparency-frequently-asked-questions.pdf
https://www.cms.gov/newsroom/press-releases/cms-completes-historic-price-transparency-initiative
https://www.cms.gov/healthplan-price-transparency/plans-and-issuers

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Price Transparency Requirements (Payer)

- Beginning in 2022, insurers must post online machine readable files that include their in-network negotiated provider rates, out-of-network coverage rates and in-network drug pricing. The following year, in 2023, insurers must offer an online shopping tool or similar platform that includes an out-of-pocket cost estimate and negotiated prices for 500 of the "most shoppable" services. By 2024, the requirement will be extended to all services.

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Standard Charges To Be Posted in 2 Ways:

- **1) Machine Readable File**
- Single machine-readable file containing the following standard charges for all items and services provided by the hospital: gross charges, discounted cash prices, payer-specific negotiated charges, and de-identified min/max negotiated charges (NPI, TIN, POS.)
- Additional details at 45 CFR §180.50.
- **2) Consumer-friendly Display of Shoppable Services**
- Display of at least 300 "shoppable services" that a consumer can schedule in advance. Must contain plain language descriptions of the services and group them with ancillary services, and provide the discounted cash prices, payer-specific negotiated charges, and de-identified min/max negotiated charges.
- Additional details at 45 CFR §180.60.

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Health Plan Requirements

Starting on January 1, 2023 the rule will require health plans to offer an online shopping tool that will allow consumers to see the negotiated rate between their provider and their plan, as well as a personalized estimate of their out-of-pocket cost for 500 of the most shoppable items and services.

Then starting on January 1, 2024, these shopping tools will be required to show the costs for the remaining procedures, drugs, durable medical equipment and any other item or service they may need

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Transparency in Coverage (Payer)

- pricing information for all covered items and services should be available, including pricing for durable medical equipment (DME) or other medical devices that are supplied to a participant, beneficiary, or enrollee by a provider under a contract with a plan or issuer.
- in-network provider to mean any provider of items and services with which the plan or issuer, or a third-party for a plan or issuer, has a contract setting forth the terms under which a covered item or service may be provided to a participant, beneficiary, or enrollee.
- the pricing information for the specific covered items or services subject to that contract or payment arrangement are required to be disclosed as part of the internet self service tool and machine-readable files.
- https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS-Transparency-in-Coverage-9915F.pdf
- https://www.cms.gov/newsroom/fact-sheets/transparency-coverage-final-rule-fact-sheet-cms-9915-f

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Health Plan Requirements

Group health and marketplace plans must disclose cost-sharing information upon request to a participant, beneficiary, or enrollee including an estimate of the individual's cost-sharing liability for covered items or services

Health plans must make this information available on an internet website and, if requested, in paper form

The final rules require plans and issuers to disclose in-network provider negotiated rates, historical out-of-network allowed amounts, & drug pricing information through 3 machine-readable files posted on a website, allowing the public to have access to health coverage information used to understand health care pricing and dampen the rise in health care spending.

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Health Plan Requirements

Pricing information for all covered items and services should be available, including pricing for durable medical equipment (DME) or other medical devices that are supplied to a participant, beneficiary, or enrollee by a provider under a contract with a plan or issuer…

Plans and issuers are required to disclose "negotiated rates" for encounters, procedures, medical tests, supplies, prescription drugs, durable medical equipment, and fees through the internet-based self-service tool as well as to the public through a machine-readable file…

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Hospital Compliance

- Very slow at first
- Unclear about expectations and enforcement
- "I'll just pay the fine" rather than comply

- https://revcycleintelligence.com/news/more-hospitals-complying-with-price-transparency-rule-requirements
  - 2/3 of all hospitals now compliant

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Penalties for Non-Compliance

- https://www.cms.gov/hospital-price-transparency/hospitals
- **For hospitals that do not comply, we may issue a warning notice, request a corrective action plan, and impose a civil monetary penalty and publicize the penalty on a CMS website.**
- 2021 Max daily fine: $300
- 2022 Max daily fine: $300/day if under 30 beds, otherwise # of beds x $10, cap at $5500 (avg 150 beds per hospital)
- Max fine of $110,000 / $2M/year

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Penalties enforced

- https://www.fiercehealthcare.com/providers/after-months-warnings-cms-begins-handing-out-fines-hospitals-failing-price-transparency
- June 2022
- CMS issued 350 warning letters. 170 addressed citation satisfactorily,157 remain non-compliant
- Northside Hospital Atlanta $880,000 fine
- Northside Hospital Cherokee $214,000 fine
- Rochester, N.H.- Frisbie Memorial Hospital $102,660
- Wichita Falls, Texas- Kell West Regional Hospital $117,260

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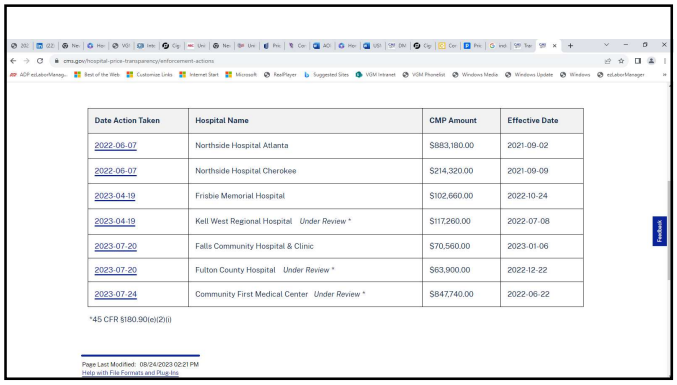


Date Action Taken	Hospital Name	CMP Amount	Effective Date
2022-06-07	Northside Hospital Atlanta	$883,180.00	2021-09-02
2022-06-07	Northside Hospital Cherokee	$214,320.00	2021-09-09
2023-04-19	Frisbie Memorial Hospital	$102,660.00	2022-10-24
2023-04-19	Kell West Regional Hospital *Under Review* *	$117,260.00	2022-07-08
2023-07-20	Falls Community Hospital & Clinic	$70,560.00	2023-01-06
2023-07-20	Fulton County Hospital *Under Review* *	$63,900.00	2022-12-22
2023-07-24	Community First Medical Center *Under Review* *	$847,740.00	2022-06-22

*45 CFR §180.90(e)(2)(i)

Page Last Modified: 08/24/2023 02:21 PM
Help with File Formats and Plug-Ins

58

Spinoff Legislation

Colorado bill - hospitals can't pursue debt collections with patients if the facility is non-compliant

https://revcycleintelligence.com/news/colorado-bill-aims-to-limit-debt-collections-boost-price-transparency

59

Payer Example – CIGNA

CIGNA - https://www.cigna.com/legal/compliance/machine-readable-files

The machine readable files contained in the table of contents below are made available in response to the Federal Transparency in Coverage Rule and include negotiated service rates and out-of-network allowed amounts between health plans and healthcare providers.

Important note: Each of the files accessible through the Table of Contents is in JSON format and may be as large as one Terabyte (TB) in file size, which has significant system requirements for use. Please ensure you have the required memory capacity, hardware, and software capabilities before attempting to download.

60

Companies Offering TIC Data

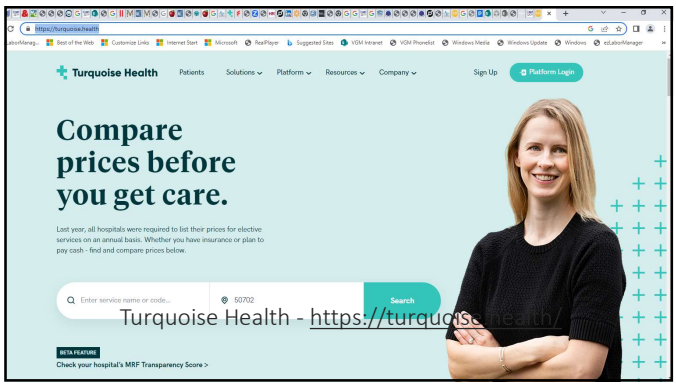
- Turquoise Health
- Clarify Health
- Zelis/Health Insights 360
- Medlyze
- Amino Health

61

Turquoise Health

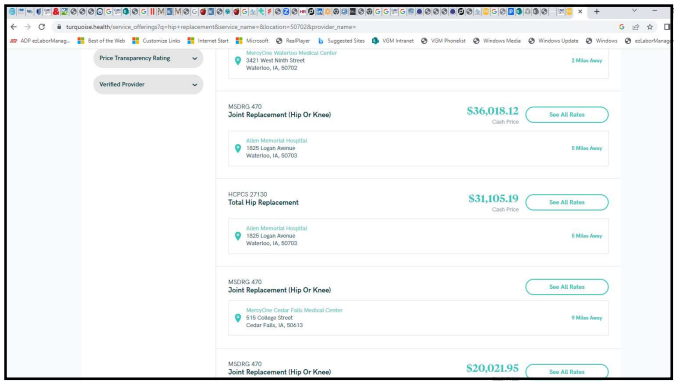
- https://turquoise.health/
- Enter service name or code
- Enter zip code
- Shows list of providers by name
- Shows prices for procedure selected
- Select specific insurance to see rates for that payer

62

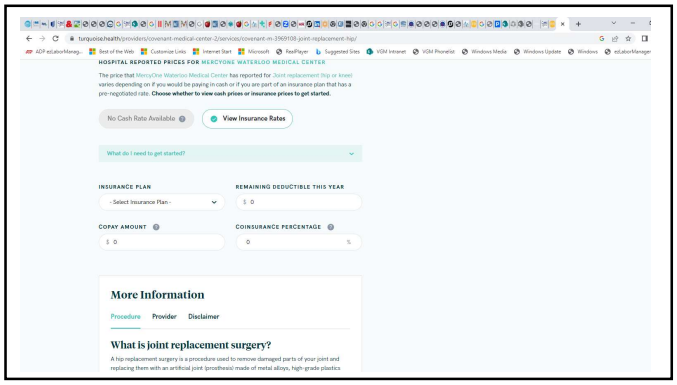


Turquoise Health - https://turquoise.health/

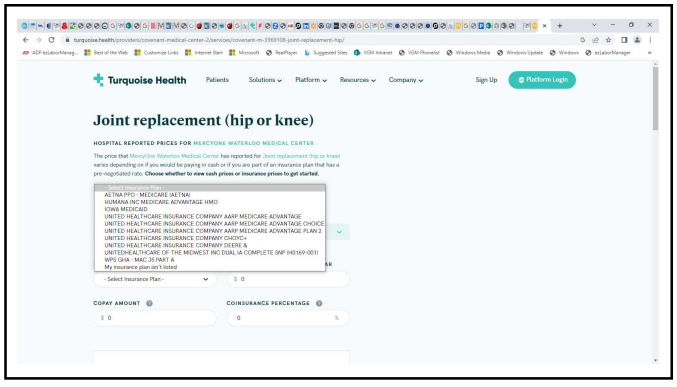
63


Price Transparency Rating
Verified Provider
MercyOne Waterloo Medical Center
3421 West Ninth Street
Waterloo, IA, 50702
2 Miles Away
MSDRG 470
Joint Replacement (Hip Or Knee)
$36,018.12
Cash Price
See All Rates
Allen Memorial Hospital
1825 Logan Avenue
Waterloo, IA, 50703
5 Miles Away
HCPCS 27130
Total Hip Replacement
$31,105.19
Cash Price
See All Rates
Allen Memorial Hospital
1825 Logan Avenue
Waterloo, IA, 50703
5 Miles Away
MSDRG 470
Joint Replacement (Hip Or Knee)
See All Rates
MercyOne Cedar Falls Medical Center
515 College Street
Cedar Falls, IA, 50613
9 Miles Away
MSDRG 470
Joint Replacement (Hip Or Knee)
$20,021.95
See All Rates

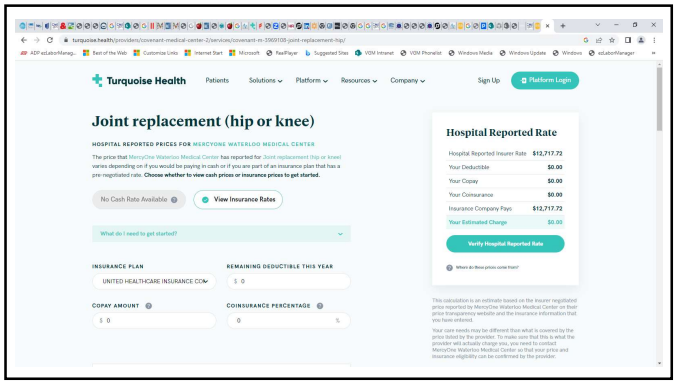
64


HOSPITAL REPORTED PRICES FOR MERCYONE WATERLOO MEDICAL CENTER
The price that MercyOne Waterloo Medical Center has reported for Joint replacement (hip or knee) varies depending on if you would be paying in cash or if you are part of an insurance plan that has a pre-negotiated rate. Choose whether to view cash prices or insurance prices to get started.
No Cash Rate Available
View Insurance Rates
What do I need to get started?
INSURANCE PLAN
- Select Insurance Plan -
REMAINING DEDUCTIBLE THIS YEAR
$ 0
COPAY AMOUNT
$ 0
COINSURANCE PERCENTAGE
0
%
More Information
Procedure
Provider
Disclaimer
What is joint replacement surgery?
A hip replacement surgery is a procedure used to remove damaged parts of your joint and replacing them with an artificial joint (prosthesis) made of metal alloys, high-grade plastics

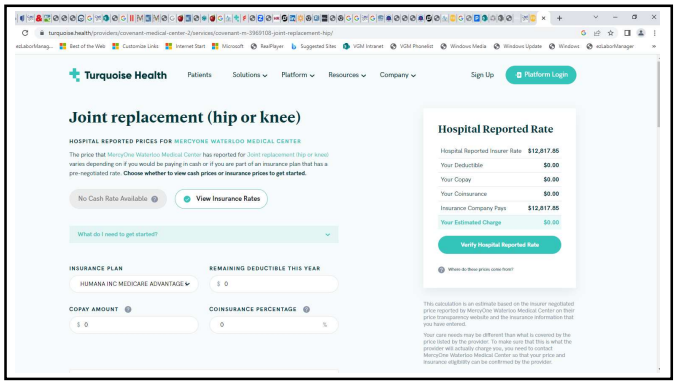
65


Turquoise Health
Patients
Solutions
Platform
Resources
Company
Sign Up
Platform Login
Joint replacement (hip or knee)
HOSPITAL REPORTED PRICES FOR MERCYONE WATERLOO MEDICAL CENTER
The price that MercyOne Waterloo Medical Center has reported for Joint replacement (hip or knee) varies depending on if you would be paying in cash or if you are part of an insurance plan that has a pre-negotiated rate. Choose whether to view cash prices or insurance prices to get started.
AETNA PPO - MEDICARE (AETNA)
HUMANA INC MEDICARE ADVANTAGE HMO
IOWA MEDICAID
UNITED HEALTHCARE INSURANCE COMPANY AARP MEDICARE ADVANTAGE
UNITED HEALTHCARE INSURANCE COMPANY AARP MEDICARE ADVANTAGE CHOICE
UNITED HEALTHCARE INSURANCE COMPANY AARP MEDICARE ADVANTAGE PLAN 2
UNITED HEALTHCARE INSURANCE COMPANY CHOICE+
UNITED HEALTHCARE INSURANCE COMPANY DEERE &
UNITEDHEALTHCARE OF THE MIDWEST INC DUAL IA COMPLETE SNP (H0169-001)
WPS GHA - MAC JE PART A
My insurance plan isn't listed
- Select Insurance Plan -
$ 0
COPAY AMOUNT
$ 0
COINSURANCE PERCENTAGE
0
%

66



67

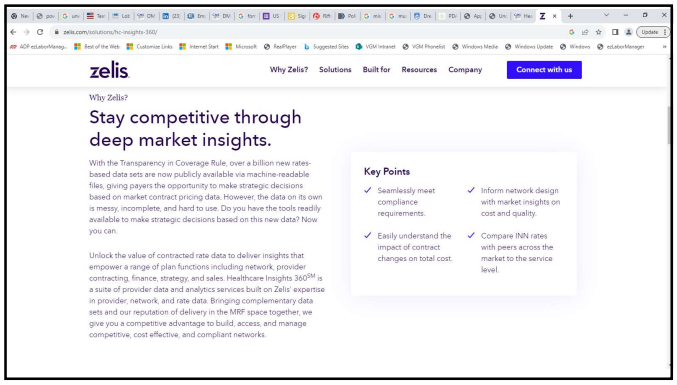


68

Blog Post from Turquoise Health

- Miss us? We were busy guzzling payer data the past few days, but now we're back with updates. This week and next, we'll be chiming in on what we're seeing *in* the data now that we have 500TB (uncompressed) in payer data sitting in our cloud, waiting to rock and roll American healthcare. That's right - even the BUCAHs + Centene are all online, and that's big.

69

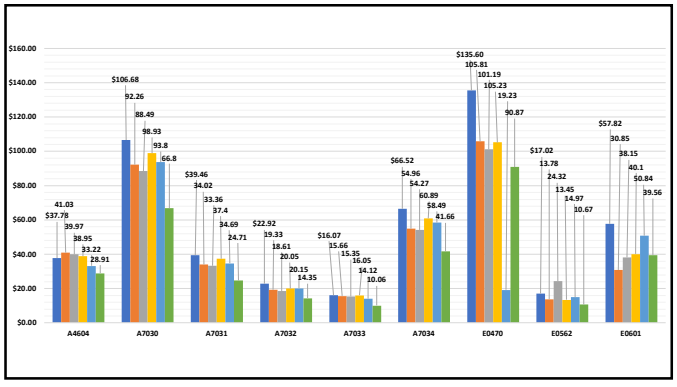


70

Healthcare Insights 360 https://www.zelis.com/solutions/hc-insights-360/

- With the Transparency in Coverage Rule, over a billion new rates-based data sets are now publicly available via machine-readable files
- the data on its own is messy, incomplete, and hard to use.
- Unlock the value of contracted rate data to deliver insights that empower a range of plan functions including network, provider contracting, finance, strategy, and sales.
- Unlock the value of contracted rate data to deliver insights that advance your market position

71



72

Range in payments from a single payer

Anthem commercial K0861 - $5136 - $10,598	Humana commercial K0861 - $4619 - $5421	Aetna commercial K0861 - $3863 - $6249
UHC Commercial - $3936 to $9501	TriCare - $8800 - $10,003	BCBS of TX – No range…all providers at $5750.69

73

Questions to ask yourself:

- How can I use this data?
- How will others use this data?
  - Consumers
  - Competitors
  - Health plans
  - Referral sources

74

Questions?

- Craig Douglas
- VP of Payer and Member Relations
- VGM & Associates
- craig.douglas@vgm.com
- 877-218-2825

- Laura Williard
- VP of Payer Relations
- AAHomecare
- LauraW@aahomecare.org
- @WilliardLaura

75

HME Paradigm Shift:
Change to Survive!

Steve Cela
President, Strategic Office Support

ACMESA Winter Meeting 2024

1

Steve Cela

President, Strategic Office Support

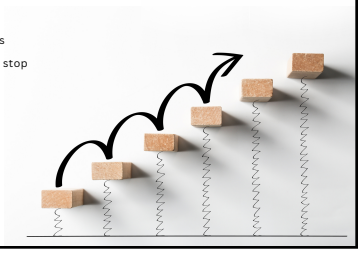
Steve Cela, President of Strategic Office Support, brings over two decades of experience in owning and operating DME companies and diagnostic centers. He is the owner and co-founder of Aprix Sleep Diagnostics, as well as Aprix CPAP Equipment and Supplies. He also owns a manufacturing business in Houston, Texas. Steve holds degrees in Biology and Business from Baylor University and the University of Texas in Dallas, respectively. A speaker, business owner, and consultant, he is renowned for transforming business operations and strategy, leveraging his extensive expertise in efficiency optimization. His practical insights and strategic management advice have shaped the growth trajectories of numerous businesses in the healthcare sector.

Steve founded Strategic Office Support, a revenue cycle management and remote staffing company, specifically to help HME and DME providers become more efficient, more profitable, and more patient-focused. Together with Strategic Office Support, Steve is on a mission to help all clients reclaim their time and focus on growth!

2

AGENDA

- Demonstrate HME is unlike any other business
- Establish the goal of business
- Present the case for an optimal process
- Identify legacy inefficiencies that must stop
- **Action steps: Change to survive!**



3

HME is unlike any other business.

In our industry, increasing the value that we provide to the patient does NOT give us the ability to increase prices.

There are forces at play working against HME profitability.

4

Who is our customer?

Who are we creating value for?

- *The patient?*
- *The referral source?*
- *The payor?*

5

There is no industry like ours.

The force that sets your worth is negatively impacted by paying you your worth.

You must accept the game and play it well to survive.

6

Let's talk business.

Milton Friedman

Shareholder Theory

"The social responsibility of business is to increase its profits."

Peter Drucker

Innovate or Die

"The purpose of the business is to create a keep a customer."

7

Creating value

$$\frac{\left(\frac{Dream\ Outcome}{Time\ Delay}\right) \times \left(Perceived\ Likelihood\ of\ Achievement\right)}{(Effort\ and\ Sacrifice)} = \text{VALUE}$$

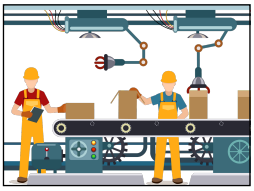
8

How do we maximize profit in this game?
How do we not just stay alive, but thrive?

Optimize your process.

9

Henry Ford: Specialization of labor



- Each individual in the line can be **managed for productivity** because they are doing one function
- Each individual **will become extremely good** at doing their one task
- The **onboarding of the position is much quicker** and more simple than a person that makes an entire car

10

The case for optimization in HME

- ☑ With specialization of labor, you know the optimal staffing per department.
- ☑ With defined KPIs, you can manage each person from a scorecard on a daily or weekly basis.
- ☑ With simplification, your onboarding process is more efficient and less costly.
- ☑ With standardization, you can capture the 400% growth of this industry.

11

Put yourself in position to capture the market growth!

There are 30% less rooftops today than a decade ago.

For every $1 spent per rooftop pre-consolidation:
- $2.50 is spent today
- $10 is projected by 2040

For every senior each rooftop cared for a decade ago:
- Today's locations care for 1.85 seniors
- And nearly 4 seniors per location projected by 2040

12

Put yourself in position to capture the market growth!

In 2023, more than half of companies experienced revenue growth, with nearly 30% of you in this room experiencing double-digit growth…

Which means 40% of you were flat or declined!!

> **"When opportunity comes, it's too late to prepare."**
> *- John Wooden*

13

The HME Process

- Receive an order
- Enter order into system to start tracking it
- Validate the order
- Patient eligibility and payor requirements
- Ensure the patient wants the service
- Collect patient portion
- Schedule service
- Render the service
- Confirmation
- Monitor rejection reports
- Post payment
- Work any denial
- Manage the AR

14

Each step requires a distinct skillset

- Receive an order
- Enter order into system to start tracking it
- Validate the order
- Patient eligibility and payor requirements
- Ensure the patient wants the service
- Collect patient portion
- Schedule service
- Render the service
- Confirmation
- Monitor rejection reports
- Post payment
- Work any denial
- Manage the AR

15

Process Optimization Framework

Optimizing a process is a process!

- An **as-is process** is the existing way of doing things; it describes the current tasks and procedures in the process you're study.
- **Key performance indicators** (KPIs) quantitatively describe the improvement you'd like to see. There's no room for vagueness in business process optimization; KPIs give you the metrics you need to evaluate success.
- The **to-be process** is the new way of doing things. It's your end goal, an optimized process, and you reach this state by implementing the process improvements you uncover during an optimization exercise.

16

Process Optimization Framework

STEP ONE: Document the existing process

Start by analyzing the structure of your "as-is" process in detail.

- **Tasks:** What's each step in the process? Create a workflow map to organize tasks into broader processes.
  - Example: Intake, order validation, eligibility, PAR check, etc.
- **Procedures:** For each task on your list, how does the work get done? Be as granular as series of keystrokes or mouse clicks that move data throughout the process.
  - This is key as it will shed first light onto cumbersome and convoluted steps being used, as well as the huge possibility that people are doing it differently.

17

Process Optimization Framework

STEP ONE: Document the existing process

- **Systems:** You need to know what tools your team uses to complete each task in the process, and how those tools work with each other. For most processes today, these will be digital: web-based applications or portals, desktop applications like Excel or Outlook, EMRs, accounting software, etc.
- **People:** Who's completing each task? What sorts of verifications are in place at each step? How many Full-Time Equivalent (FTE) hours do you spend on each step? Are all staff following the exact same procedures, or is there a lot of variance?
- **Visibility:** How does reporting work at every stage of the process? Are you able to collect the data you need to evaluate success or reveal inefficiencies?

18

Process Optimization Framework

STEP TWO: Process Analysis

- **Identify target KPIs:** You probably have an idea of the ares you would like to improve. No we zero in on the KPIs you can adjust to improve the process outcomes. It could be productivity or throughput, error rates or defects, FTE hours, process turnaround time, and operational cost, just to name a few.
- **Identify model process:** Study your "as-is" report to see which elements of the process are affecting your chosen KPIs. Establish ideal goals for adjusting these KPIs by modifying discrete elements of the process. It helps to have standard productivity measures or time analysis on each process when evaluating your processes.

19

Process Optimization Framework

STEP THREE: Raise your belief lid

- Belief is a powerful source of company that your entire company can feel.
- Amplify and elevate your own level of thinking.
- Create ambitious goals and have a high level of expectation for achieving them.
- Raise the bar for what's possible within your organization.

20

Legacy inefficiencies must end!

- Do not give away for free. Do not overlook errors.
- Set up your system correctly so you know your margins.
- Always collect the patient portion.
- Reject orders at the earliest possible step & educate referral sources.
- Do not be penny-wise and pound-foolish.
- Do not let the good times spoil you.

21

Legacy inefficiencies must end!

1. **Do not give away for free. Do not overlook errors.**
   - Do not write off due to timely filing. Keep your AR tight.
   - Feed denials back to operations so swift action can be taken.
   - Error example:

   The average HME company net margin is 10% to 13%. Your staff makes an error and sends out a $120 mask that you won't get paid on. For that mask, your net margin is $12. You now need to sell 10 more masks to get back to break even. The margin is so slim, you must process orders without error.

22

Legacy inefficiencies must end!

2. **Set up your system correctly so you know your margins.**
   - You must know what is making you money and what is losing you money.
   - Your EMR/Billing system needs to be setup properly. Then, you can regularly run a report to show what you are getting paid and what your cost is. If you are losing money, you have four choices:
     - You can stop selling it because you are losing on every sale of that item
     - You can find an alternative that is more cost effective
     - You can go to the payor and attempt to get higher reimbursement
     - You can go to the vendor and negotiate lower pricing

23

Legacy inefficiencies must end!

3. **Always collect the patient portion**
   - All of your profit lies in the patient portion. You must collect it.

4. **Reject orders at the earliest possible step & educate referral sources.**

> "There is nothing so useless as doing efficiently that which should not be done at all. "
>
> *Peter Drucker*

24

Legacy inefficiencies must end!

5. Do not be penny-wise and pound-foolish.

- Utilize technology to reduce human error and reduce processing times.

6. Do not let the good times spoil you.

- Remember the good ol' times of uncapped rentals on CPAP and O2? When then the sun is shinning, put your focus on optimization because the cut is coming.

25

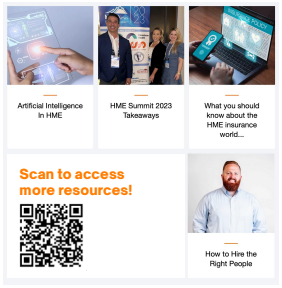
Actions you can take TODAY!

- **Time study**: How long does it take to do a type of task?
- **Productivity study**: How many orders per person are getting completed?
- **Sales training** for everyone that is in contact with a patient
- **Setup system** to accurately calculate gross margin
- **Educate your referral sources** on order requirements
- **Train your staff** and build into your process to always collect the patient portion

26

Thank you!

Steve Cela
President, Strategic Office Support
stevec@strategicofficesupport.com



27

Government Relations

A Government Divided: The Good, The Bad, and The Helpful

1

YOU MAY HAVE HEARD THE NEWS?

2

THANK YOU FOR YOUR INDULGENCE

NORTHWEST MISSOURI STATE BEARCATS

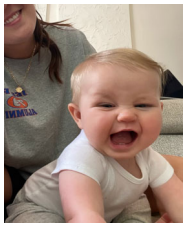
3

THANK YOU FOR INDULGING ME ☺

QUINN LOUISE HERMSEN
Feb 17th 2023
9 Lbs 20.5 inches

4

LOVE BEING A GRANDPA!



5

Key Meetings during the SPRING / SUMMER 2024

MIKE ISAACSON
SVP – VGM Government Relations

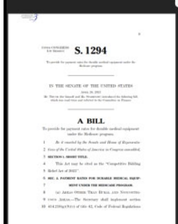
6

Discussions today include:

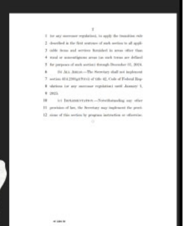
- FY 2023 Continuing Resolution "CR" Bill (End of Year Package)
- Success of Industry Relief Efforts ~ HR.5555 / S.1294
- Political Landscape for 118th Congress / 2nd Session
- 2024 Federal Legislative Priorities & Focus
- Non-bid/non rural area relief for 2025

* Competitive Bidding Program = 2025 /2026

7



S. 1294 – Non-CBA Relief – 75/25



8

S. 1294 -Legislation to Extend the 75/25 Relief

9

HR. 5555
Rep. Miller-Meeks (R-IA) & Rep. Paul Tonko (D-NY)



10

2024 Legislative Priorities •

S. 1294 Further extending 75/25 blended non-rural, non-CBA Medicare reimbursement rates. These rates influence other payers who peg reimbursements based on these rates, including Medicaid rates in 21 states as well as TRICARE rates.

HR.5555 Futher extending 75/25 blended Non-Rural, Non-CBA rates

•Work with Congress to encourage CMS to provide clarity on their plans for the Competitive Bidding (CB) program. If CMS indicates it plans to move forward, we will work with Congress on legislation that would codify into law important guardrails that are currently in place, including clearing price methodology and us ing the unadjusted fee schedule as bid ceiling. If the CB moves forward, we will work with Congress to re quire CMS to accept higher rates if that is the result of the bidding process.

11

2024 Legislative Priorities - Continued

- Work with Congress on oversight and transparency of Medicare Advantage plans to ensure Medicare beneficiaries have to the same access to care as in Part B.
- Work with Congress and industry stakeholders on legislation to establish oxygen criteria via critical d ata elements (CDE).
- Work with CMS and Congress to prevent competitive bidding program from expanding to include CGM, ostomy, and urological products.
- HR. 5372 – Legislation to allow within code for titanium/carbon fiber upgrades for mobility products as a Medicare benefit.
- Monitor Federal legislation on "right to repair" issues and potential impacts on mobility providers, ma nufacturers, and patients

12

Future of Competitive Bidding

The Competitive Bidding Program (CBP) was paused in 2018 to address fundamental design flaws that created unsustainable payment rates and jeopardize patient access to care.

- **The Ask: Ask Members of Congress to require that should CMS move forward with additional rounds of Competitive Bidding, it must:**
  - **Preserve existing safeguards added to the program:**
  - **Use clearing price methodology**
  - **Keep the unadjusted 2015 fee schedule as the ceiling**
  - **Preserve the surety bond requirement**
- **Ensure that CMS move forward with CBP rates if they are higher than 2016 rates and set the Single Payment Amounts accordingly**

13

INDUSTRY Focuses for 2024

Grassroots Activities and Opportunities

- Meetings with Incoming Congressional Freshman - 80+
- Build relationships with new and returning Congressional members and staff on Key Committees
- GAP (Grassroots Accountability Project) we need you!
- Press Opportunities
- SPRING / SUMMER / August of Action!
- 2024 Elections are 8 Short Months Away!

14

RELATIONSHIPS….

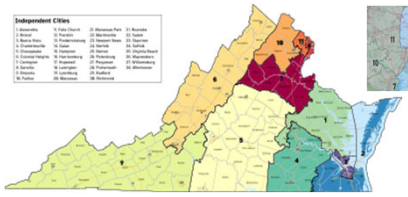
15

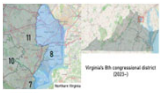
VIRGINIA CONGRESSIONAL DELEGATION
118th Congress

Office	Name	Party	Date assumed office	Date term ends
U.S. House Virginia District 1	Robert J. Wittman	Republican	January 3, 2007	January 3, 2025
U.S. House Virginia District 2	Jennifer Kiggans	Republican	January 3, 2023	January 3, 2025
U.S. House Virginia District 3	Robert C. Scott	Democratic	January 3, 1993	January 3, 2025
U.S. House Virginia District 4	Jennifer McClellan	Democratic	March 7, 2023	January 3, 2025
U.S. House Virginia District 5	Bob Good	Republican	January 3, 2021	January 3, 2025
U.S. House Virginia District 6	Benjamin Lee Cline	Republican	January 3, 2019	January 3, 2025
U.S. House Virginia District 7	Abigail Spanberger	Democratic	January 3, 2019	January 3, 2025
U.S. House Virginia District 8	Donald Sternoff Beyer Jr.	Democratic	January 3, 2015	January 3, 2025
U.S. House Virginia District 9	H. Morgan Griffith	Republican	January 3, 2011	January 3, 2025
U.S. House Virginia District 10	Jennifer Wexton	Democratic	January 3, 2019	January 3, 2025
U.S. House Virginia District 11	Gerald Edward Connolly	Democratic	January 3, 2009	January 3, 2025

16

VIRGINIA CONGRESSIONAL DISTRICTS
Virginia's congressional districts for 2024





Don Beyer
W & M

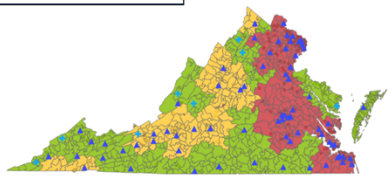
Morgan Griffith
E & C

17

Virginia Geographical Classification

State	Rural vs. Non-Rural	Population	% of Total Population
VA	CBA Zip	6,131,124	71.03%
	Non-Rural Zip	1,432,887	16.60%
	Rural Zip	1,067,626	12.37%

Classification	Oxygen concentrator reimbursement rate in 2015	Oxygen concentrator reimbursement rate during PHE	Percentage change
Rural	$180.92	$136.22	-24.7%
Non-rural	$180.92	$103.86	-42.6%
CBA	$180.92	$74.55	-58.8%



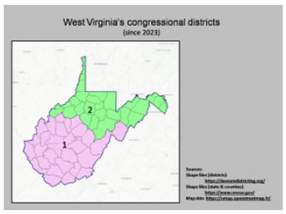
18

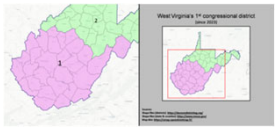
WEST VIRGINIA CONGRESSIONAL DELEGATION
118th Congress

Office	Name	Party	Date assumed office	Date term ends
U.S. House West Virginia District 1	Carol Miller	Republican	January 3, 2023	January 3, 2025
U.S. House West Virginia District 2	Alexander Mooney	Republican	January 3, 2015	January 3, 2025

19

WEST VIRGINIA CONGRESSIONAL DISTRICTS
WV's congressional districts since 2023





Carol Miller
Ways & Means

20

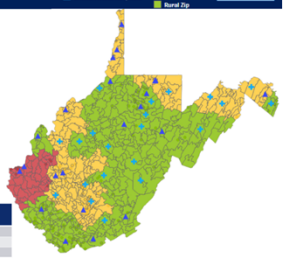
West Virginia Geographical Classification

Hospital Type
Acute Care Hospitals
Critical Access Hospitals

Rural vs. Non-Rural
CBA Zip
Non-Rural Zip
Rural Zip

FILTERS

State	Rural vs. Non-Rural	Population	% of Total Population
WV	CBA Zip	211,964	11.58%
	Non-Rural Zip	938,905	51.29%
	Rural Zip	679,708	37.13%

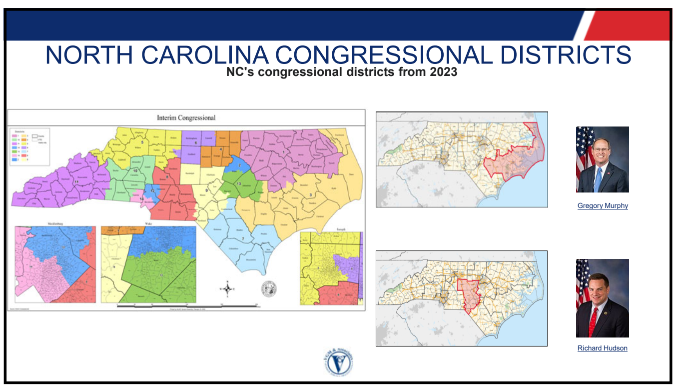


Classification	Oxygen concentrator reimbursement rate in 2015	Oxygen concentrator reimbursement rate during PHE	Percentage change
Rural	$180.92	$136.22	-24.7%
Non-rural	$180.92	$102.73	-42.6%
CBA	$180.92	$74.16	-59.0%

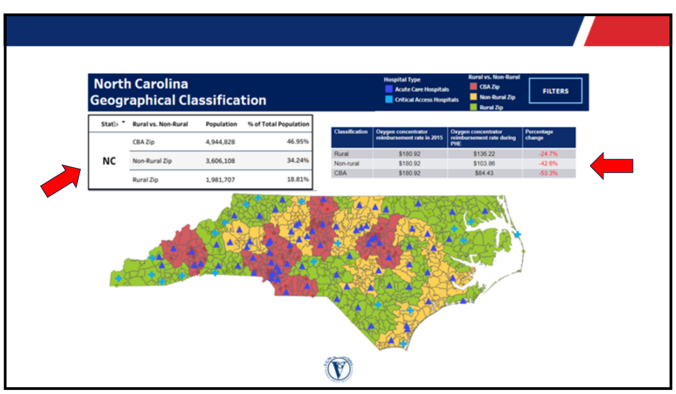
21

Office	Name	Party	Date assumed office	Date term ends
U.S. House North Carolina District 1	Donald Davis	Democratic	January 3, 2023	January 3, 2025
U.S. House North Carolina District 2	Deborah Ross	Democratic	January 3, 2021	January 3, 2025
U.S. House North Carolina District 3	Gregory Murphy	Republican	September 17, 2019	January 3, 2025
U.S. House North Carolina District 4	Valerie Foushee	Democratic	January 3, 2023	January 3, 2025
U.S. House North Carolina District 5	Virginia Foxx	Republican	January 3, 2005	January 3, 2025
U.S. House North Carolina District 6	Kathy Manning	Democratic	January 3, 2021	January 3, 2025
U.S. House North Carolina District 7	David Rouzer	Republican	January 3, 2015	January 3, 2025
U.S. House North Carolina District 8	Dan Bishop	Republican	January 3, 2023	January 3, 2025
U.S. House North Carolina District 9	Richard Hudson	Republican	January 3, 2023	January 3, 2025
U.S. House North Carolina District 10	Patrick T. McHenry	Republican	January 3, 2005	January 3, 2025
U.S. House North Carolina District 11	Chuck Edwards	Republican	January 3, 2023	January 3, 2025
U.S. House North Carolina District 12	Alma Adams	Democratic	November 12, 2014	January 3, 2025
U.S. House North Carolina District 13	Wiley Nickel	Democratic	January 3, 2023	January 3, 2025
U.S. House North Carolina District 14	Jeff Jackson	Democratic	January 3, 2023	January 3, 2025

22



23



State	Rural vs. Non-Rural	Population	% of Total Population
NC	CBA Zip	4,944,828	46.95%
	Non-Rural Zip	3,606,108	34.24%
	Rural Zip	1,981,707	18.81%

Classification	Oxygen concentrator reimbursement rate in 2015	Oxygen concentrator reimbursement rate during PHE	Percentage change
Rural	$180.92	$136.22	-24.7%
Non-rural	$180.92	$103.86	-42.6%
CBA	$180.92	$84.43	-53.3%

24

VIRGINIA Senate Delegation
118th Congress

Office	Name	Party	Date assumed office	Date term ends
U.S. Senate Virginia	Tim Kaine	Democratic	January 3, 2013	January 3, 2025
U.S. Senate Virginia	Mark Warner	Democratic	January 3, 2009	January 3, 2027

25

WEST VIRGINIA Senate Delegation
118th Congress

Office	Name	Party	Date assumed office	Date term ends
U.S. Senate West Virginia	Shelley Moore Capito	Republican	January 3, 2015	January 3, 2027
U.S. Senate West Virginia	Joe Manchin III	Democratic	November 15, 2010	January 3, 2025

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NORTH CAROLINA Senate Delegation
118th Congress

Office	Name	Party	Date assumed office	Date term ends
U.S. Senate North Carolina	Ted Budd	Republican	January 3, 2023	January 3, 2029
U.S. Senate North Carolina	Thom Tillis	Republican	January 3, 2015	January 3, 2027

27

SENATE DELEGATION - Freshman
118th Congress

Alabama		Katie Britt (R)	7th (100th overall)	No Open seat; replaced Richard Shelby (R)	CEO of the Business Council of Alabama Chief of staff to Senator Richard Shelby	1982	[2]
Missouri		Eric Schmitt (R)	6th (96th overall)	No Open seat; replaced Roy Blunt (R)	Missouri Attorney General State Treasurer of Missouri Missouri Senate	1975	[3]
North Carolina		Ted Budd (R)	3rd (93th overall)	No Open seat; replaced Richard Burr (R)	U.S. House of Representatives[4]	1971	[4]
Ohio		J. D. Vance (R)	5th (95th overall)	No Open seat; replaced Rob Portman (R)	Venture capitalist U.S. Marine Corps Corporal	1984	[5]
Oklahoma		Markwayne Mullin (R)	2nd (95th overall)	No Open seat; replaced Jim Inhofe (R)	U.S. House of Representatives[6]	1977	[6]
Pennsylvania		John Fetterman (D)	4th (97th overall)	Yes Open seat; replaced Pat Toomey (R)	Lieutenant Governor of Pennsylvania Mayor of Braddock	1969	[7]
Vermont		Peter Welch (D)	1st (94th overall)	No Open seat; replaced Patrick Leahy (D)	U.S. House of Representatives[8] President pro tempore of the Vermont Senate	1947	[9]

28

NEW COMMITTEE ASSIGNMENTS
House Ways & Means

House Republicans tapped ten new members to join the Ways and Means Committee this year

These committee members have significant influence over the tax code, trade policy, Medicare, Social Security and social services programs

Rep. Mike Carey (R-OH)
Rep. Randy Feenstra (R-IA)
Rep. Michelle Fischbach (R-MN)
Rep. Brian Fitzpatrick (R-PA)
Rep. Nicole Malliotakis (R-NY)
Rep. Blake Moore (R-UT)
Rep. Michelle Steel (R-CA)
Rep. Greg Steube (R-FL)
Rep. Claudia Tenney (R-NY)
Rep. Beth Van Duyne (R-TX)




29

WAYS AND MEANS COMMITTEE

Majority

- Jason T. Smith, Missouri, *Chair*
- Vern Buchanan, Florida, *Vice Chair*
- Adrian Smith, Nebraska
- Mike Kelly, Pennsylvania
- David Schweikert, Arizona
- Darin LaHood, Illinois
- Brad Wenstrup, Ohio
- Jodey Arrington, Texas
- Drew Ferguson, Georgia
- Ron Estes, Kansas
- Lloyd Smucker, Pennsylvania
- Kevin Hern, Oklahoma
- Carol Miller, West Virginia
- Greg Murphy, North Carolina
- David Kustoff, Tennessee
- Brian Fitzpatrick, Pennsylvania
- Greg Steube, Florida
- Claudia Tenney, New York
- Michelle Fischbach, Minnesota
- Blake Moore, Utah
- Michelle Steel, California
- Beth Van Duyne, Texas
- Randy Feenstra, Iowa
- Nicole Malliotakis, New York
- Mike Carey, Ohio






Minority

- Richard Neal, Massachusetts, *Ranking Member*
- Lloyd Doggett, Texas
- Mike Thompson, California
- John B. Larson, Connecticut
- Earl Blumenauer, Oregon
- Bill Pascrell, New Jersey
- Danny K. Davis, Illinois
- Linda Sánchez, California
- Brian Higgins, New York
- Terri Sewell, Alabama
- Suzan DelBene, Washington
- Judy Chu, California, *Vice Ranking Member*
- Gwen Moore, Wisconsin
- Dan Kildee, Michigan
- Don Beyer, Virginia
- Dwight Evans, Pennsylvania
- Brad Schneider, Illinois
- Jimmy Panetta, California



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NEW COMMITTEE ASSIGNMENTS
House Energy & Commerce

House Republicans added nine new members to the powerful Energy and Commerce Committee, including a handful of members with significant health policy experience.

This committee has broad jurisdiction over telecommunications, consumer protection, environmental quality, energy policy and interstate and foreign commerce. It's also one of the main health care committees in the House, with jurisdiction over Medicaid, mental health, substance abuse, health insurance, medical research, the FDA and pandemic preparedness issues.

Rep. Randy Weber (R-TX)
Rep. Rick W. Allen (R-GA)
Rep. Troy Balderson (R-OH)
Rep. Russ Fulcher (R-ID)
Rep. August Pfluger (R-TX)
Rep. Diana Harshbarger (R-TN)
Rep. Mariannette Miller-Meeks (R-IA)
Rep. Kat Cammack (R-CA)
Rep. Jay Obernolt (R-CA)

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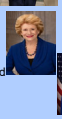
ENERGY & COMMERCE COMMITTEE

32

NEW COMMITTEE ASSIGNMENTS
SENATE FINANCE

Majority[14]	Minority[15]
•Ron Wyden, Oregon, *Chairman*	•Mike Crapo, Idaho, *Ranking Member*
•Debbie Stabenow, Michigan	•Chuck Grassley, Iowa
•Maria Cantwell, Washington	•John Cornyn, Texas
•Bob Menendez, New Jersey	•John Thune, South Dakota
•Tom Carper, Delaware	•Tim Scott, South Carolina
•Ben Cardin, Maryland	•Bill Cassidy, Louisiana
•Sherrod Brown, Ohio	•James Lankford, Oklahoma
•Michael Bennet, Colorado	•Steve Daines, Montana
•Bob Casey, Pennsylvania	•Todd Young, Indiana
•Mark Warner, Virginia	•John Barrasso, Wyoming
•Sheldon Whitehouse, Rhode Island	•Ron Johnson, Wisconsin
•Maggie Hassan, New Hampshire	•Thom Tillis, North Carolina
•Catherine Cortez Masto, Nevada	•Marsha Blackburn, Tennessee
•Elizabeth Warren, Massachusetts	



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COMMITTEE ASSIGNMENTS
SENATE HELP Committee
118th Congress

Majority[4]	Minority[5]
•Bernie Sanders, Vermont[6] *Chairman* •Patty Murray, Washington •Bob Casey Jr., Pennsylvania •Tammy Baldwin, Wisconsin •Chris Murphy, Connecticut •Tim Kaine, Virginia •Maggie Hassan, New Hampshire •Tina Smith, Minnesota •Ben Ray Luján, New Mexico •John Hickenlooper, Colorado •Ed Markey, Massachusetts	•Bill Cassidy, Louisiana, *Ranking Member* •Rand Paul, Kentucky •Susan Collins, Maine •Lisa Murkowski, Alaska •Mike Braun, Indiana •Roger Marshall, Kansas •Mitt Romney, Utah •Tommy Tuberville, Alabama •Markwayne Mullin, Oklahoma •Ted Budd, North Carolina

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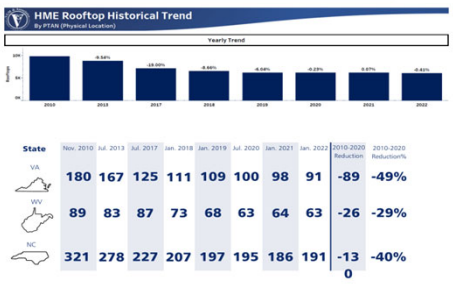
35

Nationally, the number of DME brick-and-mortars have dwindled in the past decade, 41% of which have left the business.



State	Nov. 2010	Jul. 2013	Jul. 2017	Jan. 2018	Jan. 2019	Jul. 2020	Jan. 2021	Jan. 2022	2010-2020 Reduction	2010-2020 Reduction%
VA	180	167	125	111	109	100	98	91	-89	-49%
WV	89	83	87	73	68	63	64	63	-26	-29%
NC	321	278	227	207	197	195	186	191	-130	-40%

36

Summary for 2024:
What needs to happen this year

1) Passage of S.1294 & HR. 5555 - Extension of Non-Rural rates (75/25 Blend) January 1 - Dec 31, 2024.. Currently in Continuing Resolution (CR) – votes on March 1st & March 8th.

2) Sequestration 2% and potential for additional "Pay Go" cuts of an additional 4% in 2025

3) Push for CMS Announcement on a CBP 2024/25?

4) CRT – HR.5371 – Titanium & Carbon Fiber Wheelchair Upgrades & Right to Repair

5) AUDITS

6) Medicare Advantage Plans

7) MCO's & State Issues

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Bipartisan Efforts

Our efforts must be supported by both Democrats and Republicans







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Old Soldiers Never Die…..




….They Just Fade Away!!



39

This old soldier Continues to work for you!

At your service,

John Gallagher

VP, VGM Government Relations

john.gallagher@vgm.com

www.vgmgov.com

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Additional Resources

vgm.com/industrymatterspodcast (Podcast)

vgm.com/news (Blog)

Legislative, Regulatory, Reimbursement, and Payer Updates from VGM Government

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- Exclusive Content
- Playbooks

VGM & Associates Communications

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"REVOLUTIONIZE YOUR DME GAME: Unveiling the Latest Industry Secrets!"

Ronda Buhrmester and Kim Cuce'

Embark on a journey of innovation and success ! Our exclusive session unveils the latest industry updates regarding policies and reimbursement, game-changing technologies, and strategic insights that can transform your business. Don't just keep up—lead the pack! Join us for a dynamic experience that promises to elevate your DME venture to new heights. Seize the future of healthcare equipment—your success story starts here!

2/20/2024

1

"CHALLENGES"

Challenges are inherent in almost every aspect of our every changing world, and they require thoughtful analysis, education, proactive solutions and monitoring to overcome.

Successfully navigating the challenges and getting to the root cause often leads to excellent outcomes and improved financial stability.

- **Enrollement Contractor Issues**
- **TPE - Oxygen**
- **Teleheatlh**
- **SWO Changes for PAP Supplies**
- Maximize your operating system
- Patient Pay Policy
- Insurance Eligibility
- Managing your Stop/Hold Reasons

2

UPDATES !!!

3

4

Enrollment Contractor (PTAN) Update

- NPE West
  - States West of Mississippi River
  - Palmetto GBA contractor
- NPE East
  - States East of Mississippi River
  - Novitas Solutions

- General liability insurance
- Surety bond renewal
- Changes to business address
- Change to store hours
- License, certificates updates
- Adding or removing a service/product
- AO or DO changes/updates
- Notify of any changes within 30 days
- Revalidations

Important to stay current –involved with PTAN changes, updates to avoid revocation

5

Telehealth Flexibilities

- Telehealth flexibilities have been extended through Dec 31, 2024 because of Consolidated Appropriations Act
- Virtual has NOT been extended for the ATP, home assessment
- PAP and RAD policies specifically state “in-person" -however telehealth flexibilities apply
- May be audio or audio/video
- Be sure it's a valid telehealth with known practitioner

6

Oxygen - Top Error Reason in TPE Audits

The medical record documentation does not support the treating practitioner has evaluated the results of a qualifying blood gas study performed.

From the Oxygen Policy Article (attached to LCD)

- **Evidence of qualifying test results at the time of need; and,**
- **Evidence of an evaluation of the qualifying test results by a treating practitioner**

7

How to Prove "Evidence" for Oxygen Test Results

The NP, PA, or MD should do the one of following:

- Mention the test results in the current chart note, or
- Add a new chart note (does not require a new visit), or
- Co-sign the actual test results

8

PAP SWO CHANGES

Effective Feb. 1, 2024

In order to promote patient adherence to PAP or RAD therapy, the treating practitioner may list the mask(s) in the "General Description of the Item" on the SWO as (not all-inclusive):

- CPAP Mask
- Mask of Choice
- Mask – Fit to Comfort
- Mask – one per three months

Use of these general descriptions on the SWO, as opposed to a specific mask type (i.e., full face mask), will eliminate the need for a new SWO each time a patient switches their mask type. In situations where the mask type is specified on the SWO and the patient needs to change mask type, a new SWO would be required since this would be considered a change to the SWO.

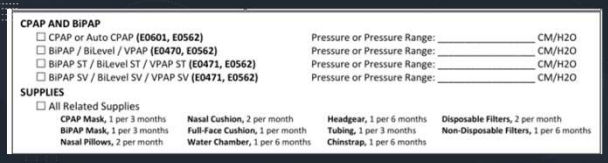
Alternatively, the treating practitioner may indicate multiple mask types on the SWO, so that DMEPOS suppliers are able to provide the mask that works best for the patient.

Dear Physician Letter –Masks: Positive Airway Pressure Devices

9

The Best News- CPAP Supplies

THIS IS A VALID ORDER



CPAP AND BiPAP

- ☐ CPAP or Auto CPAP **(E0601, E0562)** — Pressure or Pressure Range: _____ CM/H2O
- ☐ BiPAP / BiLevel / VPAP **(E0470, E0562)** — Pressure or Pressure Range: _____ CM/H2O
- ☐ BiPAP ST / BiLevel ST / VPAP ST **(E0471, E0562)** — Pressure or Pressure Range: _____ CM/H2O
- ☐ BiPAP SV / BiLevel SV / VPAP SV **(E0471, E0562)** — Pressure or Pressure Range: _____ CM/H2O

SUPPLIES

☐ All Related Supplies

CPAP Mask, 1 per 3 months	**Nasal Cushion,** 2 per month	**Headgear,** 1 per 6 months	**Disposable Filters,** 2 per month
BiPAP Mask, 1 per 3 months	**Full-Face Cushion,** 1 per month	**Tubing,** 1 per 3 months	**Non-Disposable Filters,** 1 per 6 months
Nasal Pillows, 2 per month	**Water Chamber,** 1 per 6 months	**Chinstrap,** 1 per 6 months	

10

Successful Reimbursement STARTS with system set up

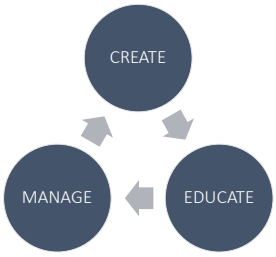
"root cause issue"

- Understand how your system is set up
  - MORE, importantly who is maintaining it?
- Know your payor contracts – are your price tables ser up correctly? – This controls your system
  - Fee Schedules
  - Coverage Limits
  - Auth Requirements

Establishing a proactive approach- STOP the cycle of putting yourself in the position to be reactive

11

PATIENT PAY POLICY.... YOUR SECRET WEAPON



- Create a policy that promotes transparency, reduces disputes and enhances overall patient satisfaction.
- Educate your team
- Monitor the success of the policy

12

Benefits of a properly executed PFP

- Educates the patient about their financial responsibilities upfront, allows them to make informed decisions.
- Creates positive patient outcomes - don't be the bad guy for attempting back-end collections
- Creates financial stability for the patients and the DME provider
- Save backend expenses chasing your money
- Eliminates unnecessary disputes and bad patient outcomes

13

CREATE a Policy that works for your company!

1

Understand your operating software and payor policies

- Do you have the allowables loaded correctly in your software?
- Can you determine accurate patient responsibility upfront?
- Consider additional expenses if your operating system is not set up properly!

2

Outline the PFP based on set up

- Is this for specific insurance policies? Determine pros and cons
- If you don't have an exact fee schedule, you may not require them to follow PFP to eliminate disputes and the costs of handling refunds.
- Specific products?

3

Determine acceptable payment plans

- Give your team the confidence to speak to patients

14

PAYMENT PLANS

Patient Resp	Required 25%	Balance for PP	6 month term	12 month term
$100.00	$25.00	$75.00	$12.50	$6.25
$250.00	$62.50	$187.50	$31.25	$15.63
$500.00	$125.00	$375.00	$62.50	$31.25
$750.00	$187.50	$562.50	$93.75	$46.88
$1,000.00	$250.00	$750.00	$125.00	$62.50

Payment Plan Options

- Determine the time frame
- Consider different time frames for different balance amounts
- What percentage will be required upfront?

15

Throwing money away- Statement Costs

STATEMENT COSTS			
CURRENT STATE			
# OF MONTHLY STATEMENTS	UPS	E-DELIVERY	
	$ 1.20	$0.48	
	99%	1%	
10000	$ 11,880.00	$100.48	
YEARLY COSTS	$ 142,560.00	$1,205.76	$ 143,765.76

GOAL - 30% on E-DELIVERY			
% TO SET UP ON E-DELIVERY	70%	30%	
5000	3500	1500	
	$ 4,200.00	$720.00	
YEARLY COSTS	$ 50,400.00	$8,640.00	$ 59,040.00
YEARLY SAVINGS			$ 84,725.76

GOAL - 50% on E-DELIVERY			
% TO SET UP ON E-DELIVERY	50%	50%	
5000	2500	2500	
	$ 3,000.00	$1,200.00	
YEARLY COSTS	$ 36,000.00	$14,400.00	$ 50,400.00
YEARLY SAVINGS			$ 93,365.76

16

EDUCATE YOUR TEAM

1. Evaluate your current processes and determine at what point in the process will the financial discussion occur.
   Who's responsible to have these discussions?
2. Educate them to understand the importance for both the company and the patient to have complete transparency PRIOR to delivery on the financial responsibility.
3. Create dictated responses to give your team the confidence to effectively explain how and why payment is required upfront and how the capped rental process.
4. Educate your sales team and referral source - avoid the "other providers arent requiring this"

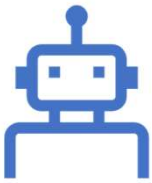
17

EDUCATE YOUR TEAM

- **THINGS I'VE HEARD FROM CSR's**
  - " Its not fair to collect additional money from the patient"
  - "The company already makes enough money"
  - "The patient really needed it"
- **RESPONSES to the CSR's**
  - The patient pay portion is often the profit margin
  - Almost all medical providers require the co-pays or co-insurance upfront. Why should DME?
  - You don't go to the grocery store, pick all your items, go to checkout, pay 80% of the total, get the items home then pay the 20% after you like your meal

18

MONITOR



- If this is a completely new process – monitor daily and provide results of the program. Create new habits based on the process change.
- Determine what is considered a "qualifying order" (based on your individual programs)
  - If the order has a primary and secondary insurance – autopay not be required/not a qualifying order?
- Set benchmarks on what percentage of qualified order needs to be set on autopay
- Monitor the team and the individuals
- Create incentives or contests
  - Recognize the Top 3 based on percentage
  - Put them in a drawing for a gift certificate or earned PTO

19

Insurance Eligibility

Electronic Eligibility
Auto Eligibility

" I am not paying $0.25 per check that's absurd !!! "

"It will cost way too much money on a monthly basis and Im already paying for the software"

20

TIME STUDY – Employee Costs

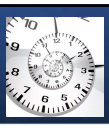
BUT it costs me $0.23 every single time I check Eligibility and that's too expensive !!!!!!

STEPS:

1. Log into another system (availity)
2. Re-type patient information
3. Print/Print to PDF / Scan into System
4. Add Notes

EMPLOYEE COSTS				
Hourly Rate	Cost per minute	5 min	6 min	10 min
$15.00	$0.25	$1.25	$1.50	$2.50
$16.00	$0.27	$1.33	$1.60	$2.67
$17.00	$0.28	$1.42	$1.70	$2.83
$18.00	$0.30	$1.50	$1.80	$3.00
$20.00	$0.33	$1.67	$2.00	$3.33
$22.00	$0.37	$1.83	$2.20	$3.67

21



AUTOMATION VS. MANUAL

CSR making $17.00 hour - average time to complete eligibility is 5 minutes

AUTOMATION			Manually	Cost Difference
# of monthly orders	Cost @ $0.23		*$17.00 - on average takes 5 min	Cost Difference
300	$69.00		$425.00	$(356.00)
500	$115.00		$708.33	$(593.33)
750	$172.50		$1,062.50	$(890.00)
1000	$230.00		$1,416.67	$(1,186.67)
5000	$1,150.00		$7,083.33	$(5,933.33)
10000	$2,300.00		$14,166.67	$(11,866.67)
15000	$3,450.00		$21,250.00	$(17,800.00)
20000	$4,600.00		$28,333.33	$(23,733.33)
10000	$2,300.00		$14,166.67	$(11,866.67)
ADDITIONAL MONEY SPENT				$(142,400.00)

CSR making $20.00 hour - average time to complete eligibility is 6 minutes

AUTOMATION			Manually	Cost Difference
# of orders	Cost @ $0.23		*$20.00 - on average takes 6 min	Cost Difference
300	$69.00		$600.00	$(531.00)
500	$115.00		$1,000.00	$(885.00)
750	$172.50		$1,500.00	$(1,327.50)
1000	$230.00		$2,000.00	$(1,770.00)
5000	$1,150.00		$10,000.00	$(8,850.00)
10000	$2,300.00		$20,000.00	$(17,700.00)
15000	$3,450.00		$30,000.00	$(26,550.00)
20000	$4,600.00		$40,000.00	$(35,400.00)
10000	$2,300.00		$20,000.00	$(17,700.00)
YEARLY COSTS				$(212,400.00)

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Don't be Penny Wise and Dollar Foolish

- Seamless
- You don't need to log into another system
- The eligibility check saves in the patient files automatically
- You can view historical eligibility checks
- If the insurance allows it, the total deductible and how much has been met auto populates
- You don't have to add a note about what the other system returned as eligibility results
- Gives alerts immediately on the following:
  - Date of Death
  - Insurance is a secondary
  - QMB
  - Any SNF visits

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Eligibility on Steroids... AUTO ELIGIBILITY

- Auto Eligibility can be set up several ways and can be insurance specific.
- You can set systems to automatically do an eligibility every time an invoice is generated on the capped rental items. If it doesn't have the same insurance as the prior month, it puts it on hold for you to work – eliminating unnecessary denials and increased work on the back end.

IMAGINE the time saved on the back end having to work denials.

Immediately improves your denial rate!

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Managing STOP/HOLD

Understand the different reasons and the process to get to the ROOT CAUSE of the issue.

Benchmarking should be different for each reason type.

Assign responsibility to manage each component.

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STOP/HOLD REASONS
Review your system set up

HOLDS – GENERATES REVENUE	STOPS- DOES NOT GENERATE REVENUE
MANUAL	MANUAL
CMN/LMN/SWO MISSING	NO PRICING
CMN/LMN/SWO EXPIRED	MULTIPLE PRICE OPTIONS
PAR/AUTH MISSING	PENDING PICK UP
PAR/AUTH EXPIRED	POLICY EXPIRED/INELIGIBLE

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STOP/HOLD..... TIDBITS

- MANUAL – some use manual holds on top of the system holds. Understand the difference. Even if you remove the system hold/stop, you still have to go back and manually remove the hold/stop. i.e.
- CMN – have been simplified, train your intake team to understand what is required on an SWO vs. letting it flow to another team to have to touch again
- No Pricing/Multiple Pricing – DON'T OVERRIDE or use special pricing. It will happen again, fix it at the price table level. Don't let it repeat for the next person.

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DOCUMENTATION HOLDS

STANDARD WRITTEN ORDERS

Educate referral sources to send a completed SWO.

Train intake to send a system generated immediately.

Train your intake team on what is a complete SWO and how to log them. This will drastically decrease your hold and eliminate multiple touches for the same document.

MEDICAL DOCUMENTATION

Don't gamble – get as much up front as possible – keep your money

PRIOR AUTHORIZATIONS

You have less control on the expected hold days and may increase your on hold percentage more so than other hold types

Factors to consider prior to setting benchmarks:

- How long do different insurances take to give an approval or denial?
- Does the insurance backdate from submission date

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Hold/Stopped Days & Management

Management of Hold Days – What needs adjusting?

- Knowing what is including with holds: Orders, Authorizations, manual holds and system stops
- Break down the categories and separate days on hold. Assigning responsibility to manage – by category
  - Different hold types can change the "acceptable hold days" for benchmarking
- Assigning accountability based on workflow – being worked regularly, reporting to management.

BENCHMARK
❑ Not Good > 8 days
❑ Acceptable 4-8 days
❑ Goal < 4 days

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WHAT ARE YOUR TOP CHALLENGES?

FIND THE ROOT CAUSE

- My Patient AR is out of control !
  - – Implement a strict Patient Pay Policy, **Educate** and Monitor it. Eliminates the problem and saves on invoices fees to chase the money
- Denials are high due to wrong insurance!
  - switch to electronic eligibility. Eliminate the human error and give your team back the time to focus on patients
- I have too much money on the Stop/Hold Report!
  - evaluate your workflow and reassign specific processes, i.e. educate your team on what is needed for an SOW.

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THANK YOU !

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CGS
A CELERIAN GROUP COMPANY

Medicare Updates

ACMESA

February 21, 2024

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Disclaimer

This presentation was current at the time it was published or uploaded onto the CGS website. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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Agenda

- New and Noteworthy Updates
- Policy and Documentation Requirements Updates
- Prior Authorization Updates
- GW Modifier Usage – Hospice Beneficiary
- myCGS Updates

3

New and Noteworthy Updates

Updates

4

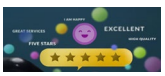
New Updates

- New authentication update when calling the Provider Contact Center
  - https://www.cgsmedicare.com/jc/pubs/news/2023/11/cope146616.html
  - Effective March 1, 2024
    - Provider National Provider Identifier (NPI)
    - Provider Transaction Access Number (PTAN)
    - The last five digits of the provider Tax Identification Number (TIN)
    - Medicare Beneficiary Identifier (MBI)
    - Beneficiary's first initial
    - Beneficiary's last name – Enter up to six letters followed "#" sign (ignore any spaces)
    - The beneficiary's date of birth.

5

MAC Customer Experience (MCE) Survey

- Tool for CMS to measure your satisfaction with our performance
- Helps to improve processes and procedures within the MACs and CMS
- Let us know what works well and where we have room for improvement
- Leave your contact information if you'd like us to reach out to you personally
- QR codes and links for surveys are being shared in communications from:
  - *myCGS* Portal
  - Prior Authorization (PA)
  - Provider Outreach and Education
  - Redeterminations
  - Targeted Probe and Educate (TPE)
  - Website
  - Written Inquiries in the Provide Contact Center



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In-Person Workshops

DME Provider Outreach & Education In-Person Workshops
Visit the In-Person Workshops page for more details about the upcoming educational events!
JB: https://cgsmedicare.com/jb/education/workshops.html
JC: https://cgsmedicare.com/jc/education/workshops.html

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Policy and Documentation Requirements

Updates

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Power Mobility Devices – Coding Update

- December 28, 2023 – The related Policy Article for Power Mobility Devices (A52498) revised the "No Power Options" definition:
- New language: "No Power Options – A category of PWCs that is incapable of accommodating a power tilt, recline, or standing system. If a PWC can only accept power elevating legrests and/or seat elevation, it is considered to be a No Power Option chair"
- Changes made to accommodate the seat elevation language.

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Lymphedema Garments

- Lymphedema Compression Treatment Items (new benefit)
  - Joint coding and billing article published December 8, 2023
    - https://www.cgsmedicare.com/jc/pubs/news/2023/12/cope147943.html.
- Effective for dates of service on/after January 1, 2024.
  - List of applicable HCPCS codes in the published article (approximately 80)
  - Diagnosis-driven policy (four lymphedema ICD-10 diagnosis codes)
  - Three (3) day garments per body area – RUL is six months
  - Two (2) night garments per body area – RUL is two years
  - Custom fitted if applicable per the medical record
  - Accessories (zippers, lining, padding) are covered if medically necessary
  - Appropriate modifiers: LT, RT, and RA (at replacement)

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Refill Documentation Requirements

Refill Documentation Requirements for dates of service before January 1, 2024

Obtained In Person @ Retail Store	Written Request From Beneficiary	Telephone Contact Between Supplier and Beneficiary
Signed delivery slip or copy of itemized sales receipt	Beneficiary name and/or authorized rep *(indicate relationship)*	Beneficiary name and the name of person contacted *(if someone other than the beneficiary include this person's relationship to the beneficiary)*
Delivery slip/receipt should indicate items were picked up		
	Date of Request	Date of contact
	Description of each item requested	Description of each item requested
	Quantity/functional condition of each item still remaining	Quantity/functional condition of each item still remaining
	Contact no sooner than 14 calendar days prior to delivery/shipping	Contact no sooner than 14 calendar days prior to delivery/shipping
	Shipment/delivery occur no sooner than 10 calendar days prior to current supply exhausting	Shipment/delivery occur no sooner than 10 calendar days prior to current supply exhausting

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Refill Requests: Final Rule CMS1780-F

Final Rule CMS1780-F: https://www.cms.gov/medicare/medicare-fee-service-payment/homehealthpps/home-health-prospective-payment-system/cms-1780-f.

- For refill requests for dates of service on or after January 1, 2024:
  - Suppliers must obtain documentation of beneficiary's affirmative response indicating a need for the refill
    - Removed: Suppliers must document quantity/functional condition of each item remaining
  - Suppliers must document the beneficiary has confirmed their need for refill no sooner than 30 calendar days prior to the expected end of the current supply
    - Removed: Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date

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Refill Documentation Requirements: Final Rule CMS1780-F

Refill Documentation Requirements **on or after** January 1, 2024

Obtained In Person @ Retail Store	Delivered Refill Communications
Signed delivery slip or copy of itemized sales receipt	Beneficiary name and/or authorized representative *(Suggested: if someone other than the beneficiary include this person's relationship to the beneficiary)*
Delivery slip/receipt should indicate items were picked up at store front	
	Date of Request
	Description of each item requested
	Documentation of affirmative response indicating a need for the refill
	Contact must occur no sooner than 30 calendar days prior to the expected end of the current supply
	Shipment/delivery occur no sooner than 10 calendar days prior to expected end of current supply

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Refill Requirements Information Changes(1)

- Removed: "either a written document received from the beneficiary or a contemporaneous written record of a phone conversation/contact between the supplier and beneficiary"
- Replaced: "individualized to the beneficiary (i.e., the beneficiary or their caregiver/designee affirms the need for refill) and documented in the record. Medicare does not prescribe the mode of communication used to gather the information. For example, the refill request communication may be performed via automated text messaging or email as long as each required aspect of the refill request is captured."
- Explicitly stated for clarification purposes; no change from current processes for the DME supplier community

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Refill Requirements Information Changes(2)

- DME suppliers must obtain documentation of beneficiary's (or caregiver/designee) affirmative response indicating the need for the refill
  - Removed: Suppliers must document remaining quantity or functional condition of each item remaining
- Suppliers must document the beneficiary has confirmed their need for refill no sooner than 30 calendar days prior to the expected end of the current supply
  - Removed: Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date
  - Replaced "approaching exhaustion" with "expected end" language

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Continuous Glucose Monitors (CGMs) 90 Day Supply

- Effective for dates of service on and after January 1, 2024
- For the CGM Up to a maximum of three (3) months, ninety (90) days of the supply allowance may be billed for code A4238 or A4239 to the DME MAC at a time and suppliers may not dispense more than a ninety (90) day supply.

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Oxygen Modifier Reminder - KX or N1, N2, N3

- For initial claims for oxygen or new 36-month oxygen rental periods with dates of service on or after April 1, 2023, suppliers must use the N1, N2 or N3 modifier:
  - N1 - Group I oxygen coverage criteria met
  - N2 - Group II oxygen coverage criteria met
  - N3 - Group III oxygen coverage criteria met
    - Group III criteria:
      1. Absence of hypoxemia defined in Group I and Group II above; and,
      2. A medical condition with distinct physiologic, cognitive, and/or functional symptoms documented in high-quality, peer-reviewed literature to be improved by oxygen therapy, such as cluster headaches (not all inclusive).
- For oxygen claims covered by Medicare prior to April 1, 2023, suppliers may continue to use the KX modifier or may use the N-modifiers for claims with dates of service on or after April 1, 2023.
  - KX - Requirements specified in the medical policy have been met

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Home Assessment for Manual Wheelchairs – Reminder

- The home assessment, must be fully documented in the beneficiary's medical record or the supplier's records. The home assessment may be done directly by visiting the beneficiary's home or indirectly based upon information provided by the beneficiary or their designee.
- When performed indirectly the supplier must still confirm in person at the time of delivery that the item delivered meets the requirements specified in Criterion C. Issues including, but not limited to, the physical layout of the home, surfaces to be traversed, and obstacles must be addressed by and documented in the home assessment to support medical necessity.
- The confirmation of the home assessment may not be met by indirect methods such as telephone or virtual conversations with the beneficiary or their caregiver, regardless of where or by whom the wheelchair is delivered.

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Prior Authorization Updates

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Competitive Bidding Temporary Gap

All contracts expired on December 31, 2023; the gap began January 1, 2024

- Any Medicare-enrolled DMEPOS supplier can provide the orthotics included in Round 2021:
  - Spinal orthoses: L0648 & L0650
  - Knee orthoses: L1833, L1851
- Practitioner modifiers KV, J4, and J5 No longer acceptable for dates of service on and after January 1, 2024

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Prior Authorization for Orthoses

- Required nationwide as of October 10, 2022
  - Spinal orthoses: L0648 & L0650
  - Knee orthoses: L1832, L1833, L1851
- Acute situations – ST modifier
- Orthoses Prior Authorization
  - https://www.cgsmedicare.com/jc/mr/orth_prior_auth.html

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Prior Authorization Information

- Other Required Prior Authorization programs:

Prior Authorization Additional Resources	HCPCS Codes
Lower Limb Prosthetics (LLP)	L5856, L5857, L5858, L5973, L5980, L5987
Power Mobility Device (PMD)	K0800-K0802, K0806-K0808, K0813-K0829, K0835-K0843, K0848-K0864
Pressure Reducing Support Surfaces (PRSS)	E0193 E0277, E0371, E0372, E0373

- Dedicated pages on the CGS Website in the Medical Review section
  - https://www.cgsmedicare.com/jc/mr/condition_of_payment_prior_auth.html

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Voluntary Prior Authorization Required Documentation & Timeframe for Review Decisions

- Documentation required for the voluntary accessories:
  - Same documentation required for the prior authorization of Power Mobility Device(PMD)
  - Documentation from the medical record to support medical necessity of the PMD and accessories
- The following codes can obtain voluntary prior authorization when submitted with PMDs that require prior authorization
  - E0950, E0955, E1002-E1010, E1012, E1029, E1030, E2310-E2313, E2321-E2330, E2351, E2373, E2377, E2601-E2608, E2611-E2616, E2620-E2625, K0020, and K0195
- Timeframe for review decisions are the same as for the PMD base:
  - 10 business days
  - Expedited: 2 business days
- Decision remains valid for 6 months following the provisionally affirmed review decision

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Do You Have Questions About Prior Authorization?

Prior Authorization (PA)

- Inquiries Email Box JC.PA.INQUIRY.MAILBOX@cgsadmin.com
  - Available to suppliers for questions related to Prior Authorization decisions
  - Please refrain from submitting duplicate emails
  - Please do not submit PHI through email – UTN is acceptable
  - Not intended for Non-Prior Authorization related issues
    - i.e., Redetermination, Claims, Written Reopenings, TPE, etc.

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myCGS Portal Updates

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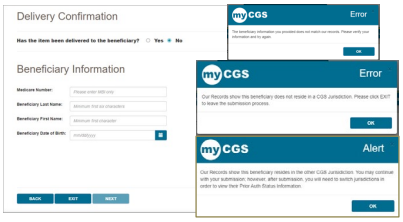
myCGS PASS: Up-Front Editing



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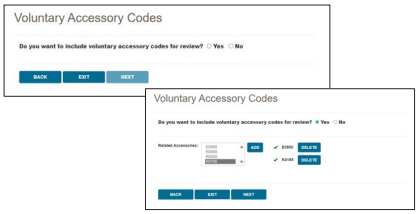
myCGS Pass: Voluntary Accessory Codes



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myCGS PASS: Dynamic Resource Links

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Auditing Entities Top Errors and Resolutions

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Comprehensive Error Rate Testing (CERT)

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CERT (1)

2023 Improper Payment Rates and Projected Improper Payment

https://www.cms.gov/files/document/2023medicarefee-servicesupplementalimproperpaymentdatapdf.pdf

Service Type	Improper Payment Rate	Projected Improper Payment Amount
Overall	7.4%	$31.2
★DMEPOS	★22.5%	★$1.9 B
Part A (excluding Hospital Inpatient Prospective Payment System (IPPS)	7.8%	$14.2 B
Part A (Hospital IPPS)	3.4%	$4.1 B
Part B Providers	10.0%	$11.0 B

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CERT (2)

2023 Top Policies with errors

DMEPOS (Policy Group)	Improper Payment Rate
Surgical Dressings	62%
Diabetic Shoes	51%
Commodes	48%
Wheelchairs Manual	43%
Parenteral Nutrition	37%
Spinal Orthoses	36%
Repairs/DMEPOS	33%
Hospital Beds/Accessories	30%
Wheelchairs Seating	29%
Enteral Nutrition	29%

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CERT (3)

2023 Improper Payment Rates by State

State	Improper Payment Rate
North Carolina	21.9%
Virginia	20.7%
West Virginia	12.9%

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CERT(4)

2023 Improper Payment Details by State

State	Improper Payment Details
North Carolina	• Policies with the top errors: CPAP, TPN, Lower Limb Orthoses • Top denial reason: Insufficient documentation • High number of "Submitted order not written by provider listed on the claim as ordering/referring provider"
Virginia	• Policies with the top errors: External Infusion, Lower Limb Orthoses, CPAP • Top denial reason: Insufficient documentation • High number of "Documentation to support coverage criteria - Inadequate"
West Virginia	• Policies with the top errors: CPAP and Surgical Dressings • Top denial reason: "Proof of delivery – Inadequate"

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CERT Contact Information

- Empower AI, Inc. is the CERT Documentation Center
- CERT Resources and Contacts
  - Customer Service: 1.888.779.7477
  - Fax: 1.804.261.8100
  - E-mail: certprovider@empower.ai
  - Website: https://c3hub.certrc.cms.gov/

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Responding to a CERT Request

- There are five ways to respond to a request from the CERT contractor.
  - Fax: 1.804.261.8100
  - Mail: CERT Documentation Center
    8701 Park Central Drive, Suite 400-A
    Richmond, VA 23227
  - esMD: https://www.cms.gov/esMD
  - Encrypted CD: Must be in TIFF or PDF format
  - Encrypted email: Attachment must be in TIFF or PDF format

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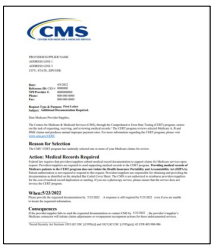
CERT Letter



Reason for Selection

Action: Medical Records Required

When/9/23/2022

Consequences

Created February 2024

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CERT Reminders

- Implement a thorough intake procedure
- Ensure that all documentation requirements are met
- Reply to all CERT documentation requests to avoid recoupment of payments
- Submit documentation to the CERT Documentation Contractor within the requested timeframe
- Use the bar code sheet as the cover letter to all documentation submissions

Created February 2024

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Targeted Probe and Educate (TPE)

Created February 2024

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Targeted Probe and Educate (TPE)

- TPE goal is to improve claims payment error rate
  - Reduce volume of appeals
- Existing data analysis determines suppliers to review
  - High claim error rates or unusual billing practices
  - Claims with greatest financial risk to Medicare
- Initial TPE review consists of 10 claims
  - Review of 20-40 claims, if errors are found in the initial 10
- One-on-one education to address errors
- Up to three rounds of probe reviews
- Jur C: https://www.cgsmedicare.com/jc/mr/tpe.html

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Targeted Probe and Educate (TPE) Common Errors

- The documentation does not contain a valid Standard Written Order (SWO).
- No medical record documentation was received.
- The documentation submitted is incomplete.
- The medical records received lack sufficient information concerning the beneficiary's condition to determine if medical necessity coverage criteria were met.
- The medical record documentation is not authenticated (handwritten or electronic) by the author.
- The medical record documentation is illegible.
- The treating practitioner's order, supplier prepared statement, or the practitioner's attestation, by itself, does not provide sufficient documentation of medical necessity.

CGS TPE Quarterly Reports https://www.cgsmedicare.com/jc/mr/reports.html

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Audit Preparation and CGS Resources

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Role of the Supplier

What can suppliers do for audit preparation?

- Have an audit response strategy in place for your business
  - Create a thorough intake process in place
  - Collect and maintain correct documentation
  - Utilize the documentation checklists
    - https://www.cgsmedicare.com/jc/mr/documentation_checklists.html
- Maintain documentation on file for seven (7) years
- Determine the root causes of denial problems or issues. This promotes compliance and identifies corrective actions needed.
- Conduct internal audits

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CGS Dear Physician Letters

We have over 30 "Dear Physician Letters" available!

- Authored by the medical directors of all four DME MACs
  - Documentation requirements
  - Specific DMEPOS items or LCDs
  - Informational/Reminders
- https://www.cgsmedicare.com/jc/mr/doc_reg.html

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CGS Connect® Program Educational Feedback

- Pre-review of your documentation to provide educational feedback
  - **Clinical Reviews - Voluntary Program**
  - **Estimated MR Response Time: 10-15 Days**
- Jurisdiction C: https://www.cgsmedicare.com/jc/mr/cgsconnect.html

Ankle Foot Orthosis & Knee Ankle Foot Orthosis L1902, L1906, L1930, L1971, L4360, L4361, L4396, L4397	Commodes E0163 and E0165	Continuous Glucose Monitors (CGMs) E2103, A4239	Continuous Positive Airway Pressure (CPAP) E0601	CPAP Accessories A7030 and A7034
Enteral Nutrition B4035	External Infusion Drugs/Pumps J2260, J1559, J3285	Glucose Testing Supplies A4253, A4256, A4258, A4259	Hospital Beds E0260, E0261, E0294, E0301, E0303	Immunosuppressive Drugs J7507, J7518
Manual Wheelchairs K0001, K0002, K0003, K0004	Nebulizer and Related Drugs J7605, J7606, J7686	Oxygen E1390 *initial beneficiary claims only	Respiratory Assist Devices E0470, E0471	Spinal Orthosis L0450-L0647 and L0651
Surgical Dressings A6196, A6197, A6021, A6212, A6010	Therapeutic Shoes for Persons with Diabetes A5500 (inserts provided with the A5500)	Urological Supplies A4351, A4352, A4353		

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Thank You For Attending!
What Questions Do You Have?
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DME Manual & Appendix B

January 1, 2024 – Updates

- CRT (Wheelchairs) for members in a nursing facility
- Incontinence products section
- Enteral Nutrition
  - Carve out removed for MCO members
  - Substitutions
- Respiratory section updates
  - Updates to policy on ventilators rental vs purchase
  - Service and maintenance agreements

2

CRT (Wheelchairs) for Members in a Nursing Facility

Medicaid members who are in a nursing facility can now get CRT wheelchairs and the accessories for these chairs through the DME benefit.

The chair must fall within the set list of codes spelled out in the manual.

The DME provider will follow the same rules as if the member is at home and submit for authorization through the MCO or FFS contractor.

All other custom or high dollar items must still use the patient pay adjustment process.

3

Incontinence Products Section

- DMAS provided additional information on size for incontinence products.
- Additional information on Degree of Incontinence for documentation purposes

CardinalCare

4

4

Enteral Nutrition

Carve out removed for Medallion 4 members

- Enteral nutrition for members under the age of 5 are no longer carved out of the Medallion 4 contract.
- All of the MCOs have confirmed they have systems updated for this change

Substitutions

- Due to ongoing formula shortages DMAS will allow the DME provider to substitute an equivalent formula as long as it falls under the same HCPCS code being requested. The DME provider must document equivalent substitute on the order line of the CMN and will need to get substitution written or verbal order form the ordering practitioner.
- Additional information on substitutions can be found in the DME manual, Chapter 4.

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5

5

Respiratory Section Updates

- DMAS made updates to the Ventilator section related to rental vs. purchase.
- DMAS will allow the provider to choose between a continuous rental or purchase for vents.
  - If a continuous rental is chosen the provider cannot bill for the service and maintenance agreement.

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6

DME Appendix B

Annual Appendix B updates

https://www.dmas.virginia.gov/for-providers/long-term-care/services/durable-medical-equipment/

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Provider Updates and Questions

- Any updates on supply chain issues/formula shortages
- Federal updates
- Questions or Concerns

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Helpful Links

- Appendix B Listing – www.dmas.Virginia.gov/#/ltssservices, click on Durable Medical Equipment tab on top of page.
- DME Manual Chapter IV and VI – covered services and limitations (can be found on the DMAS portal) https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual

CardinalCare 9

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Questions

- Contacts for MCO questions
  - Care Coordinator assigned to the member or
  - cccplus@dmas.virginia.gov
  - cccpluscarecoordination@dmas.virginia.gov
- Contacts for FFS questions
  - dme@dmas.virginia.gov

CardinalCare Virginia's Medicaid Program

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Thank you for letting me join your meeting today!!

CardinalCare Virginia's Medicaid Program

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UHC NC Community Plan

ACMESA Conference

2024

United Healthcare

NC Community Plan Provider Enablement Team

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P 952-324-4598

UHC Community Plan DME concerns: NC_ancillary_healthplan@uhc.com

Our team directly supports:

NC Community Plan (C&S) Line of Business for the following providers:

- Home and Community Based Services (HCBS)
- Long-Term Services and Support (LTSS)
- Home Health
- Home based DME (retail)
- In home PT, OT, SLP
- Ambulance/EMT (alongside Ben Pinault, Transportation Coordinator)
- Electronic Visit Verification (EVV) processes

Claim resolution service model

Quick reference guide

Step 1

Submit your claim reconsideration online or by phone.

- Obtain the online ticket or call reference number of your original claim
  - **Online (preferred method):** Sign in to the Provider Portal at **UHCprovider.com/claims**
  - **Phone:** Call Provider Services at **877-842-3210**
- Allow up to 30 days for processing

Step 2

Check the status of your reconsideration request.

- You should receive notice of our decision within 30 days
- If you haven't received a notice, check its status at **UHCprovider.com/claims**

Step 3

Don't agree? Contact Provider Relations via chat function.

- Get real-time answers to your questions about your claim reconsideration. To chat with a live advocate, go to **UHCprovider.com** and click Sign in at the top-right corner. Chat is accessed from the Contact Us page and is available 6 a.m.–6 p.m. MT, Monday–Friday.
- Please have the following information ready for the chat:
  - Member name, date of birth, ID number and plan name
  - Claim number, date of service and billed amount
  - Reason for escalation
  - Rendering care provider name, tax ID number
  - Call reference or online ticket number
- Allow up to 30 days for processing

Step 4

Don't agree? Submit a final appeal.

- If you don't agree with the response from Provider Relations, you may submit a final appeal
  - Use the File Appeal button in the Claims tool at **UHCprovider.com/claimsportal**
  - Attach all supporting materials
- Allow up to 60 days for processing

Our chat function can also address questions in real time regarding:

- Eligibility and benefits
- Prior authorization
- Onboarding processes
- Technical support

For more information

Please consult our Self-Paced User Guide at **UHCprovider.com/claimsportal.**

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How to Reach Us:

General Contacts:

- Provider Services Call Center: **800-638-3302** Community & State (Medicaid)
- Visit: UHCprovider.com
- Click to Chat- review details on next slide

Contracting Contacts:

- DME Contracting questions: DMEPOS@uhc.com

UHC Community Plan DME contacts: NC_ancillary_healthplan@uhc.com

UnitedHealthcare® Community Plan

Doc#: PCA-1015329102702192019_Y0_4M2M62D0D1Y9YYY

Do you need answers quickly but not sure where to find them? Are you looking for a way to lessen the time you spend on administrative tasks, so you can free up more time to focus on your patients? Our chat feature in the UnitedHealthcare Provider Portal has you covered.

Our knowledgeable advocates are ready to offer support when you're not sure of your next steps or need help finding information. When you pop into chat, not only will you get the support you need, you also may streamline your administrative processes.

Our chat feature currently offers support on the following:

Claims
Eligibility & benefits
Prior authorization
Credentialing
Technical support

How and where to access chat

To sign in to the portal, go to **UHCprovider.com** and click Sign In at the top-right corner. Then, enter your One Healthcare ID. Have a team member who doesn't have a One Healthcare ID yet? Have them go to **UHCprovider.com/access** to get started.

After signing in to the portal, chat can be accessed on the Contact Us page, 7 a.m.–7 p.m. CT, Monday–Friday.

Support is just a click away at **UHCprovider.com/chat**.

UnitedHealthcare® Community Plan

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Thank you!

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