# OPERATOR INSIGHTS

*presented by* ENSEMBLE HEALTH PARTNERS

# PUSH THROUGH THE PANDEMIC

## COVID-19 Underpayments and Denials Avoidance through Law and Policy

There is no doubt that hospitals and health systems are suffering financially amid the burden of COVID-19. **Patient volumes are down, and already slim operating margins have shrunk**, while labor, supply and medical equipment expenses continue to grow. According to the **American Hospital Association (AHA)**, hospitals and health systems stand to lose $202.6 billion from March through June, averaging $50.7 billion per month, with some hospitals **forced to close** or file for bankruptcy protections. For those that remain, it could take **years** to financially bounce back.

As healthcare organizations strive to navigate the many unknowns of this crisis, we are seeing a few key trends emerge that can impact provider revenue. When health systems are aware of these dynamics and have processes in place to respond to them, they can increase the likelihood their balance sheets will successfully weather this unprecedented time.

> **"IT'S ESSENTIAL TO REVIEW COVID-19 RELATED REIMBURSEMENTS"**

## Policy Equals Payment

While providers are struggling, payors are reporting record earnings due to declining patient volumes that it is projected that across all markets payors will be refunding or crediting members $2.7 billion in order stay in compliance with the Medical Loss Ratio provision of the Affordable Care Act†. While everyone is aware of the passing of the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security ("CARES") Act, there has been a flurry of law and policy coming down from all levels of government that impact providers and payors including the Centers for Medicare & Medicaid Services (CMS), the Department of Health and Humans Services (at both the state and federal level), as well as state departments of insurance, state departments of Medicaid and many Governors, all of which are issuing new policies, regulations, or guidelines daily.

This flurry of legislation was created with the intent of insuring that every American can get the treatment they need during the public health emergency due to COVID-19 and to support the providers on the front lines of the pandemic. Accordingly, to come into compliance, insurers have come out with a deluge of policies and near daily updates related to requirements to reduce administrative burdens on providers, increase payments, and remove barriers to payment such as suspension of pre-payment audits. If some form of the Health and Economic Recovery Omnibus Emergency Solutions ("HEROS") Act passes in the Senate, providers will likely see an increase in the already overwhelming number of payor policies and updates

The speed and complexity of COVID-19 reimbursement changes can easily lead to underpayments and erroneous denials. It's essential to review COVID-19 related reimbursements to make sure payors aren't just updating their policies and forgetting to modify their systems to comply with them.

For example, healthcare organizations are seeing somewhat of an underpayment trend around cost-sharing. The FFCRA requires almost every type of health plan to cover COVID-19 visits and testing without the application of cost-sharing, including plans traditionally not impacted by federal mandate, such as church plans and ERISA plans. However, sometimes commercial payors are simply not

†Kaiser Family Foundation, Data Note: 2020 Medical Loss Ratio Rebates, available at, https://www.kff.org/private-insurance/issue-brief/data-note-2020-medical-loss-ratio-rebates/ (last visited June 6, 2020).

applying the patient portion of the reimbursement to the insurance portion. In other cases, they are removing the patient portion by lowering the total allowed amount. For example, a health system is supposed to be reimbursed $100. The payor apportions $10 to the patient and the health system's payment is $90 rather than the full $100 per contract or statute. Here, if it is a COVID-19 patient, the payor should have remitted the full $100 to the provider with no apportioning to their member. Sometimes, payors have not updated their systems and the health system only receives $90. Not only is this an underpayment, but the $10 sent to the patient could also impact bad debt down the road.

Another area of underpayments relates to the DRG weight increase. The CARES Act increases the weighting factor that will be applied to inpatient DRGs for patients whose primary or secondary diagnosis is COVID-19. This will affect payments to providers rendering services to patients covered under original Medicare, as well as payments for patients covered by Medicare Advantage plans and certain state Medicaid programs that have issued policies indicating they will pay for COVID-19 patients at the Medicare rate.

Per the coding guidance issued by the Centers for Disease Control and Prevention (CDC), providers should use the code U07.1 (COVID-19) for discharges occurring on or after April 1, 2020 and B97.29 (other coronavirus as the cause of diseases classified elsewhere) for discharges occurring between January 27, 2020 and March 31, 2020.

Organizations need to hold payors to those guidelines and ensure Medicare-based claims were appropriately reprocessed back to January. Hospitals may also want review for accounts where the patient was pending a test result or other intervention to make sure they are capturing all diagnoses and ensuring corrected claims are submitted where necessary to capture the increase.

The CARES Act also temporarily suspended the 2% sequestration payment adjustment; this suspension applies to Medicare fee-for-service claims, non-contracted Medicare Advantage claims, and some contracted Medicare Advantage payors based on independent contract language‡. The suspension is in effect from May 1 through December 31, 2020. This may result in underpayments if managed Medicare payors are not following Medicare guidance or don't update their systems to compliantly handle these claims.

"FOR THE FIRST TIME, LEGISLATION DICTATES REIMBURSEMENT AND BILLING FOR EMPLOYER-BASED GROUP HEALTH PLANS"

## Different Definitions Regarding Who is Considered a COVID-19 Patient

Under the cost-sharing provision of the CARES Act, health plans are not required to absorb the cost-sharing amount unless the patient has an actual diagnosis of COVID-19 or the visit resulted in an order for or the administration of a COVID-19 diagnostic test. However, the provider relief fund portion of The CARES Act defines who a COVID-19 patient is a little bit differently. To obtain funds, providers are required to sign attestations regarding surprise and balance billing. Here, the Department of Health and Human Services ("HHS") stated it broadly views every patient as a COVID-19 patient.

The challenge with the dual definitions is that they keep providers from being able to issue balance or surprise bills to affected members if they have received monies under the provider relief grant. This creates a unique circumstance where, for the first time, legislation dictates reimbursement and billing for employer-based group health plans governed by the Employee Retirement Income Security Act of 1974 ("ERISA").

## Ensuring Full Reimbursement While Accelerating Cash

During this time, providers must make sure they are receiving reimbursement on time and in full, and if they are not, take action. To do this, a provider must know the level of reimbursement to which it is entitled and the time frame in which payors are obligated to remit that reimbursement. There are traditional prompt-pay statutes, and providers should always be seeking interest if there is a late payment under these statutes. Moreover, certain

‡King and Spalding, Suspension of the 2% Sequestration Reduction May Affect Commercial Payer Reimbursement, available at, https://www.jdsupra.com/legalnews/suspension-of-the-2-sequestration-66686/#:~:text=The%20suspension%20of%20sequestration%20in,Organizations%20(%E2%80%9CMAOs%E2%80%9D) (last visited June 2, 2020).

states and payors have changed their policies to expedite payment or increase rates of payment during the crisis. Providers should closely monitor these time frames to ensure timely and correct payment to accelerate cash, where possible. If a hospital is not familiar with its reimbursement rates and time frames and does not use prompt pay statutes to push for cash, it is going to struggle more with liquidity than necessary. Ultimately, providers must walk the line between maintaining a positive relationship with payors and seeking statutory rates of interest if payors are not adhering to prompt pay rules.

Since COVID-19 treatment is constantly evolving, a claim that was denied two weeks ago may be considered appropriate in a month or two. Where there is no standard treatment protocol with respect to drugs or devices used for COVID-19-19 treatment, hospitals should know what devices or tests have been given an emergency use authorization by the Federal Drug Administration (FDA), as well as what drugs are being tested in trials or are tied to studies that report potential efficacy. Providers will likely encounter experimental and investigational denials for a lot of drugs, and they need to keep informed of agency statements and studies to fight those denials. Keeping information on these claims is going to be crucial as denials management strategies evolve.

In addition to optimizing current reimbursement, it can be helpful to seek sources of additional funds during this time. New funding could come from a state's department of insurance or department of Medicaid, the Office of the Governor or the state legislature. For instance, during the outbreak, many state workers' comp programs are allowing additional coverages for different services or sites of services than they would traditionally permit. Opportunities like this one relate to COVID-19 while others exist separately. For example, the Massachusetts health physician program is increasing a number of CPT codes by 15%, and the decision to offer this increase is not related to COVID-19 care. When seeking new avenues to cash, providers should capture payment increases for both facilities and physicians.

## Out-of-network Considerations

Under the CARES Act, health plans must reimburse out-of-network providers for testing and/or treatment based on 1.) the previously negotiated rate in effect before the crisis 2.) an amount that equals the cash price for such services as listed by the provider or a public website, or 3.) another negotiated rate with the provider for less than the cash price. The key takeaway here is to access the accuracy of a cash price published if it is less than the updated Medicare rate.

## Prepare for a Marathon, not a Sprint

Unfortunately, all indicators suggest that COVID-19 is not going away any time soon and there is a strong chance of a resurgence in the fall and winter. However, if organizations are staying on top of the evolving legislation and payor policies and proactively developing strategies to fight underpayments and denials, they can reduce the risk of negative financial impacts or compliance shortfalls and emerge stronger in the long run.


To help our clients through the pandemic, Ensemble Health Partners has created this comprehensive revenue cycle resource library that includes information on the latest updates regarding COVID-19-19 coding, documentation, compensation and billing changes.

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