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A Handy Guide to 5 of the Top Payers in the U.S.

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Working with payers is one of the most difficult parts of being a healthcare provider these days. It should be a relatively straightforward process: A healthcare provider gives patients a service up front, and their insurance company reimburses the provider for that service.

However, the reality of reimbursement is anything but straightforward. **There are more than 900 health insurance companies in the United States**, and each has their own set of rules for what services are covered, where patients can get care and from whom, how claims must be submitted, and more. Rules can vary by state or region, and they change all the time.

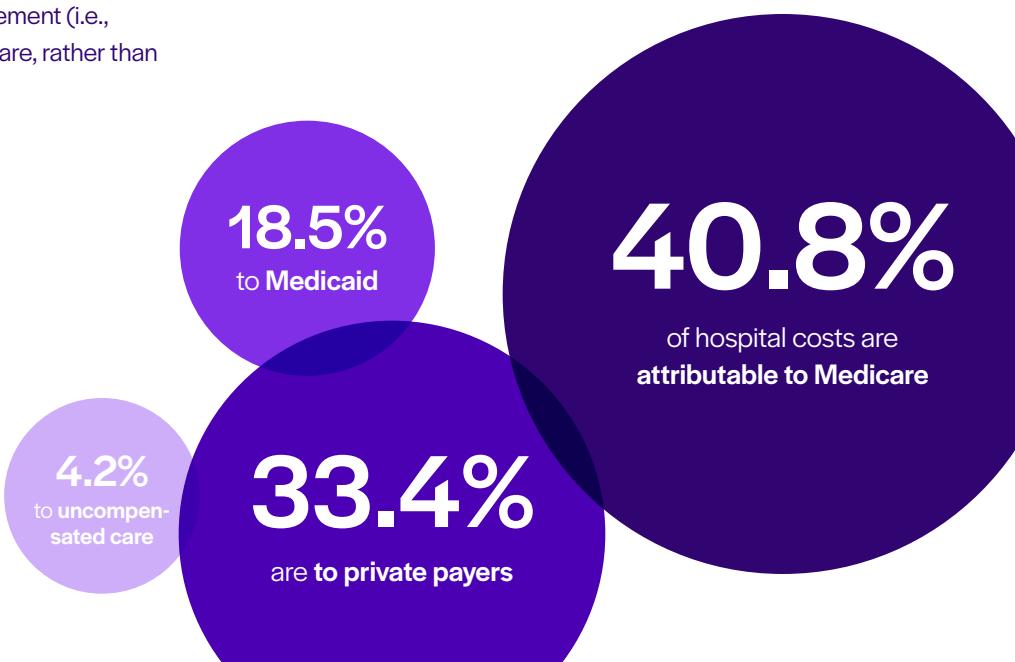
Payers also vary in how and when they reimburse the providers that they’re contracted with. They may pay different rates for the same service and have different reimbursement schedules. Others have different “timely filing” requirements, where a claim submitted later than a prescribed number of days or months won’t be paid. Some payers must file within 90 days of providing a service, while others might have a 180-day requirement.

There are also differences between how providers are reimbursed: While fee-for-service reimbursement is still the most common, some payers and services are increasingly using value-based reimbursement (i.e., reimbursement based on the quality of care, rather than the quantity of care).

Of course, not every healthcare provider contracts with every payer, and some providers have been known to terminate contracts with payers that are too difficult to work with. But in general, providers contract with a mix of public (Medicare and Medicaid) and private payers. According to the American Hospital Association data cited by the Center for American Progress, **“40.8% of hospital costs are attributable to Medicare, 33.4% to private payers, 18.5% to Medicaid, and 4.2% to uncompensated care.”**

Keeping up with all the rules as they change is nearly impossible for employees to do on their own without help from automated tools, and even the most well-versed CFO or revenue cycle executive doesn’t have each detail of their payer contracts and each of their payer’s rules committed to memory.

That’s why we’ve put together this handy guide to five of the top payer’s key statistics, website details, timely filing information, and more to get you started. You’ll also find examples for each of our featured payers about recent reimbursement, prior authorization, and other revenue cycle-related policies that have made waves, drawn ire, or are indicative of larger trends that you need to watch.



The Centers for Medicare & Medicaid Services (CMS)

The basics

CMS is the single largest payer in the United States. Medicare is a federal program that serves those 65 years and older, plus younger people with disabilities and dialysis patients. Medicaid serves low-income people of any age. It's run by state and local governments within federal guidelines.

There were 61,212,247 Medicare beneficiaries in 2020, according to the [Kaiser Family Foundation \(KFF\)](#). In addition, 81,698,467 individuals were enrolled in Medicaid and Children's Health Insurance Programs (CHIP) in the 50 states and the District of Columbia that reported enrollment data for March 2021, according to [Medicaid.gov](#).

CMS.gov outlines a [four-step enrollment guide](#) for hospitals, critical care facility, and other institutional providers that includes:

- 01) Getting a National Provider Identifier (NPI) number
- 02) Completing the Medicare enrollment application
- 03) Paying the Medicare application fee (it was \$595 in 2020)
- 04) Working with their Medicare administrative contractors and state agency

Although CMS coverage and policy often influence that of private payers, its reimbursement rates are typically much lower. [KFF research](#) from April 2020 shows that private insurers paid **an average of 199% of Medicare rates for all hospital services, and 143% of Medicare rates for physician services.**



Getting updates

Since CMS is a government agency, [its rulemaking process](#) follows very rigid guidelines. When it wants to change how its Medicare programs are administered, for instance, it issues a proposed rule outlining what it wants to change, which the public can comment on for a set number of days. After taking those comments and other information into account, the agency will issue a final rule. All CMS regulations and notices are published on the [Federal Register](#).

Examples of important, annual rules that affect payment policies and reimbursement are the [Inpatient Prospective Payment System \(IPPS\)](#) and the [Outpatient Prospective Payment System \(OPPS\)](#) rules.

Medicaid programs are administered by individual states. [Medicaid.gov](#) provides [state-by-state](#) overviews of each Medicaid program.

Timely filing for claims

[Timely filing](#) for Medicare claims is 12 months after the date of service. Timely filing for Medicaid claims varies by state program. For instance, it's six months from the date of service in California and 90 days after the date of service in Massachusetts.

Getting in touch

Medicare fee-for-service providers can contact their regional [Medicare Administrative Contractors](#) for questions about [claims or coverage issues](#). Each state Medicaid provider has its own customer service system.

In the news

On August 2, CMS issued the [final rule](#) for fiscal year (FY) 2022 Medicare Hospital Inpatient Prospective Payment System (IPPS). Two big pieces of news in that announcement were CMS's intention to repeal the collection of market-based rate information on the Medicare cost report and that Medicare IPPS rates are increasing by a net 2.5% in fiscal year 2022, compared to 2021.

UnitedHealthcare



The basics

UnitedHealthcare, based in Minnesota, is the health benefits business of UnitedHealth Group, a healthcare company that also includes Optum. According to ValuePenguin data, UnitedHealthcare is the largest payer after CMS by covered lives, with 70 million members. As of October 2020, the company says it partners with more than 1.3 million physicians and healthcare professionals, and 6,500 hospitals and other care facilities nationwide. It provides health and related benefits to people in all 50 states and Washington, D.C.

Providers who want to join the UnitedHealthcare network can get [started online](#) and must take a number of steps, including applying, verifying their experience and expertise, signing a participation agreement, setting up online tools and completing a training.

Its other provider education and training tools are extensive and comprise courses in nine different categories. One of them is the “coding corner,” which includes detailed courses aimed to “help decrease the number of claim denials caused by coding errors” on topics that currently include the 2021 changes for evaluation and management (E&M); cardiovascular and E&M unbundling, and a telehealth best practices interactive guide.

Getting updates

UnitedHealthcare’s website features a page containing [news for providers](#), practice managers, facilities, and hospitals where users can sign up for provider news email updates. They can also get the latest COVID-19 updates and read about “featured news” that UHC itself highlights, such as a late July notice notifying providers about a [new online location](#) for its peer-to-peer request form and submission instructions.

But perhaps the most crucial document for revenue cycle leaders to monitor is the monthly Network Bulletin, which contains updates about things like protocol and policy changes and administrative information for its Medicare Advantage, Medicaid, and Individual and Group Market plans. They include updates for pharmacy, medical policy, reimbursement, and prior authorization, with 30-, 60-, and 90-day notices.

Visiting the [Network Bulletin website](#) provides information for all of the current month’s notices, changes, and updates at a state and national level, as well as a link to archived PDFs of prior month’s Network Bulletins and related articles. Users can also sign up for email updates.

Timely filing for claims

According to the [2021 UnitedHealthcare Care Provider Administrative Guide](#), “timely filing limits vary based on state requirements and contracts.” It advises providers to refer to their “internal contracting contact or agreement for...specific timely filing requirements.”

Getting in touch

UnitedHealthcare has a dedicated website just for providers called [UHCProvider.com](#), and its homepage links to the latest news, its Network Bulletin, and other tools, resources, and information for providers.

Providers can also access [another webpage](#) to find state-specific information, service, support, and detailed contact information.

In the news

This summer, UnitedHealthcare made national news and angered provider groups, like the American Academy of Emergency Medicine and the American Medical Association, when it announced plans to retroactively deny commercial emergency department claims that it considered non-emergent.

Although the policy was supposed to go into effect July 1, [UHC quickly backed off](#) the policy after the outcry, saying it would instead “delay the implementation of our emergency department program until at least the end of the national public health emergency period.”

Providers argue, though, that merely delaying the policy isn’t good enough, since it appears to violate the “prudent layperson” standard for emergency care.

Anthem

The basics

Indianapolis, Indiana-based Anthem, Inc., serves more than 107 million people. The company says one-in-eight people get their medical care through Anthem's affiliated plans. It is an independent licensee of the Blue Cross and Blue Shield Association serving members in California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia, and Wisconsin, as well as specialty plan members in other states.

Its companies include Anthem Blue Cross and Blue Shield; Anthem Blue Cross; and Empire BlueCross BlueShield; as well as Anthem Life Insurance Company and several affiliated and specialty companies such as Amerigroup, CareMore, and UniCare.

For providers, joining the Anthem network varies by state. Providers are prompted to choose their state from a dropdown menu before accessing an [online application](#). Anthem uses [Availability](#), a free, full-service web portal, for this and other provider interactions, including submitting and monitoring claims, accessing patient coverage information, submitting authorizations for medical or behavioral health inpatient or outpatient services, and other tasks.

Its website, anthem.com/provider, features a repository of resources, including policies, manuals, guidelines, claims submission, prior authorization tools, and more.

Getting updates

Within the anthem.com/provider site is a section dedicated to news for providers, including updates that are tailored by state.

For instance, searching for news and information tailored to Colorado will yield CME webinars about specific topics (in August they included improving pharmacy quality measures and improving risk adjustment documentation accuracy). A section dedicated to Colorado-relevant policy updates is especially relevant to the revenue cycle. Updates in July and August included new clinical guidelines, reimbursement policy updates, and information about medical necessity reviews, among others.

Providers can also elect to receive state-specific provider updates by email. State-specific provider news is available for California, Colorado, Connecticut, Georgia, Indiana, Kentucky,

Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia, and Wisconsin.

Timely filing for claims

As of late 2019, Anthem changed its timely filing limit for professional claims to 90 days, according to state-specific announcements from several states, including [California](#), [Georgia](#), and [Virginia](#). It also lists reimbursement policies [by state](#).

Getting in touch

Anthem uses the [Availability](#) portal for basic provider relations needs, but also offers assistance via its Provider Experience team. Providers must fill out an [online form](#) and someone from the Provider Experience team will typically get in touch within two business days.

In the news

After months of negotiations Anthem in California and Nevada [reached a deal with Dignity Health](#), the largest not-for-profit health system in California, to allow Anthem-insured patients to maintain in-network access to Dignity Health services, facilities, and providers.

Anthem and Dignity Health had been in a contract dispute that briefly saw the payer's contract with Dignity Health's California facilities expire on July 15. "Because of Anthem's unwillingness to negotiate a new, responsible contract, more than 1 million patients lost in-network access to care at most of Dignity Health's California facilities on July 16, 2021," Dignity Health previously said in a statement.

Although Dignity Health in California experienced a brief out-of-network period, the health system says that the new agreement is retroactive to the date the contract expired. In addition, Dignity Health held Anthem claims during the negotiation process in "anticipation of reaching an agreement...so patients should not experience any impact on their bills." In Nevada, they reached the agreement before the previous contract expired on Aug. 1, preventing a lapse in in-network status.

The basics

Since 2018, Connecticut-based Aetna has been a subsidiary of CVS Health Corporation, and as of September 30, 2018, the company says it serves approximately 22.1 million medical members, 12.7 million dental members, and 13.1 million pharmacy benefit management services members. Its network consists of about 1.2 million healthcare professionals, including more than 700,000 primary care doctors and specialists, and more than 5,700 hospitals.

Providers that want to join the network can do so by accessing the online [Provider Onboarding Center](#), which includes a request for participation form and outlines next steps, which involve working with an Aetna Network representative and any applicable credentialing.

Another section of the website that's just for healthcare professionals has detailed sections covering information with overviews of claims, payment, and reimbursement; getting paid and submitting claims; disputes and appeals; fee schedules; and precertification.

Getting updates

Aetna releases a quarterly [OfficeLink Updates](#) newsletter (available online) which contains all relevant changes, including "changes to plans and procedures, behavioral health coverage, drug lists, and Medicare and state-specific information." A separate section highlights current 90-day notices and material changes. It also issues monthly "important reminders" documents in between quarterly newsletter releases. Its webpage links to each of those documents going back to December 2018, as well as an archive of older ones.

Timely filing for claims

According to its website, providers generally have 120 days from the date of service to file a claim with Aetna. However, providers can request [timely filing policy waivers](#) by showing proof that they tried to file the claim on time. When it comes to disputes and appeals Aetna has a 180-day dispute filing standard except for some state-specific exceptions which it lists online.

Getting in touch

Aetna has an [online form](#) for providers to use to get in touch with for questions, as well as general FAQs and COVID-19 specific FAQs.

In the news

Aetna's policy requires precertification for cataract surgery procedures as of July 1 has drawn the ire of physician organizations like the American Academy of Ophthalmology. Although [Aetna contends](#) that "placing cataract surgery on the National Precertification List (NPL) lets us review for medical necessity" and help "members avoid unnecessary surgery," physicians disagree saying that the policy takes "control of medical decisions from doctors and put them in hands of insurance company administrators who delay and disrupt, and sometimes deny medically necessary care."

In fact, the [American Academy of Ophthalmology](#) and the [American Society of Cataract and Refractive Surgery](#), representing 20,000 medical doctors in the United States, sent a [letter](#) to members of Congress, asking them to "protect patients" from "excessive prior authorization requirements imposed by insurers."

The organizations point out that Aetna's "egregious" new policy" applies equally among its members, from children born with cataracts, to adults whose cataracts interfere with their ability to drive, to people in need of emergency cataract surgery before vision-threatening retinal conditions can be treated."



The basics

Based in Connecticut, Cigna boasts 17 million global medical customers, 17 million global dental customers and more than 1.5 million relationships with healthcare providers, clinics, and facilities.

Providers who want to join the Cigna network can get more information about doing so [online](#), but the process actually starts with a pre-application phone call to Cigna's customer service about whether they meet the basic guidelines to apply for credentialing. Facilities or ancillary providers also need to start the process with a phone call. From there, applicants will get an email with an application packet.

Also, cigna.com/health-care-providers, links to several provider resources, including a link to sign up for Cigna's dedicated provider website, CignaforHCP.com, which includes information, tools, and resources for users to do things like check patient eligibility and benefits; check claims, payments, and fee schedules; and update their Cigna provider directory information.

For instance, CignaforHCP.com contains links to clinical reimbursement and payment [policies](#); [precertification guidelines](#); and a repository of [forms](#) and tools for tasks like filing certain claims, appealing claims, changing provider information, or receiving authorization for certain prescriptions.

Getting updates

Cigna publishes a variety of newsletters, [available online](#), but the one most relevant to revenue cycle professionals is its Network News, which is issued four times a year. It contains updates to Cigna's policies and procedures, along with other announcements like ones about new Cigna electronic tools and services, patient issues, and health trends.

Its [third quarter 2021 issue](#) of Network News, for instance, contains several updates in the areas of preventive care services policy; clinical, reimbursement, and administrative policy; and precertification policy.

Timely filing for claims

Cigna's timely filing for claims limits [are outlined online](#): They're 90 days after the date of service for in-network providers and 180 days after the date of service for out-of-network providers.

Getting in touch

Providers can use the CignaforHCP.com portal or call Cigna's customer service number: 1-800-997-1654.

In the news

Cigna [said this summer](#) that it's offering cash incentives for patients to switch from expensive biologic medicines to less-expensive biosimilars.

The payer said it will "offer all eligible customers the option to receive a one-time \$500 debit card for health care services and products if they decide to switch to a biosimilar or another preferred medication."

Biosimilars are clinically equivalent alternatives to biologic medicines like Remicade, which come with a huge price tag. In announcing the program, Steve Miller, MD, Cigna's chief clinical officer, pointed out that in "2019, biologics accounted for 43% of the total invoice-level medicine spending."

Offering this incentive for customers came as Cigna was moving two approved biosimilars for Remicade—Avsola and Inflectra—to preferred status.

Not everyone is pleased by such a policy. In April, the American College of Rheumatology (ACR) [wrote a letter](#) to Cigna's chief medical officer to express "serious ethical concerns about using money to persuade stable patients to switch treatment" after ACR members reported their patients being offered a "\$500 pre-paid medical debit card if they agree to stop taking Cosentyx (secukinumab) and switch to a preferred treatment."

With all of the payer information out there, it's easy to get overwhelmed.

As you use this information to help you navigate your relationship and understanding of payers you may also consider solutions to smooth out your payer experience. Rivet, for instance, is a modern revenue cycle product suite that gives you payer superpowers to unlock more revenue from patients and payers through underpayments and denials management, as well as patient eligibility and cost estimate tools.

Want to know more? Visit rivethehealth.com for more information or [schedule a Rivet demo here](#).

