# REVENUE CYCLE – BILLING STRATEGIES FOR MCOS

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## PA Medicaid Managed Care

1. Framework
2. Insurers
3. Rates
4. Outliers
5. Billing
6. Other

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# PA Medicaid Managed Care - Framework

1. DHS pays MCOs a capitated per member per month rate
2. Implementation – SW – 1/1/2018, SE – 7/1/2018, Rest of PA – 1/1/2019
3. Enrollment: All current Medicaid SNF residents and adults over 21 who need SNF care
4. Clinical and Financial Eligibility Requirements remain status quo



# PA Medicaid Managed Care - Framework

5. MCOs must contract with "any willing provider" within 18 months of implementation
6. Be aware of your total Medicaid rate:

   Base (Floor) Rate + MDOI + DSH + NF Assessment = Target Rate
7. Cost Reports and CMI Reports will continue under the CHC Program

# PA Medicaid Managed Care - Insurers

1. AmeriHealth Caritas
2. Pennsylvania Health and Wellness (Centene)
3. UPMC for You



# PA Medicaid Managed Care - Rates

1. Rate Floor – During first 36 months, the MCO rate must not be less than the average of the four Case-Mix rates prior to implementation (higher rates can be negotiated)
2. DHS will continue to calculate and publish rates using the state mandated Case-Mix system to ensure the acuity of nursing residents is considered

# PA Medicaid Managed Care - Outliers

Additional payments will continue to be made to SNFs similar to current incentive based payments

1. MDOI (NonPublic SNFs): >85% Total, >65% MA Occupancy
2. DSH: > 90% Total, 80% MA Occupancy
3. Nursing Facility Assessment Program
4. HAI (Health Associated Infections): Annual Fee * Medicaid occupancy rate



# PA Medicaid Managed Care - Outliers

5. Ventilator/Tracheostomy Care Grants
6. EDME Grants
7. P4P Incentive Payments (County) – MA CMI > Total CMI – Quarterly payment based on prior quarter's CMI scores
8. MDOI (County) – Appropriation / Total MA Days for all County Homes * Facility Specific County Home days

# PA Medicaid Managed Care - Billing

1. Process
2. Results



# PA Medicaid Managed Care – Other

1. NF Assessment Supplemental payments are expected to be paid as an add-on to the daily rates BEFORE the Assessment payments are made
2. SNFs shall continue to collect PL and deduct those payments from the monthly billed amounts to the MCOs
3. SNFs need to check EVS to determine a resident's MCO

## NY and NJ Managed Care implementation Lessons

1. Medicaid Eligibility
2. Medicaid Billing/Payments
3. Patient Liability



## Helpful Hints to Succeed in MCO Environment

1. Negotiate a Fair Rate with MCOs
2. Keep ALOS down
3. Limit Rehospitalizations
4. Increase CMS Star Ratings
5. Contain costs
6. Expand service lines (IV, Trach, Wound Care)

## MONTH END CLOSE PROCESS

- Reconcile census for all payers
- Post/reconcile cash payments
- Post ancillaries: RX, therapy, etc.
- Complete Month End Recon
- Triple Check claims
- Run private pay statements



## PRE-AUTHORIZATIONS

- Process on admission
  - Admission source obtains auth
  - If no auth on admission, facility attempts to obtain
- Internal communications to therapy dept., RNAC, BO, etc.
  - Recertification of auth as needed.
  - Notification of LCD

## PRE-AUTHORIZATIONS (CONT)

- Billing Process
  - Biller verifies insurance eligibility & verifies valid auth is on claim for billing
  - Request auth from appropriate dept. if auth not found for claims



## BILLING FOLLOWUP PROCESS

- Run current aging
- Utilize online payor websites & telephonic automated response system.
- Call customer service to request reconsiderations & do appeals if no satisfactory payment response.

## What is Managed Care?

- "Managed care" encompasses programs:
  - ...intended to control the financing and delivery of health services to members enrolled
- Goals of Managed Care:
  - Providers deliver high-quality care in an environment that manages or controls costs
  - Care delivered is medically necessary and appropriate for the individual's condition
  - Care is rendered by the most appropriate provider.
  - Care is rendered in the most appropriate, least restrictive setting



## Medicare Advantage

- Beneficiaries will have additional choice of plan options-regional PPO Plans
- All beneficiaries have the opportunity to switch among plans or back to original Medicare during the annual election period in November or December
- Participating plans will be under continued pressure to improve benefits, reduce premiums, and improve networks and services.

## 3 Medicare Advantage Plan Types

1. Health Maintenance Organization (HMOs)
2. Preferred Provider Organizations (PPOs)
3. Private Fee-For-Service (PFFS)



## Medicare Advantage Reimbursement

- Paid a capitated amount for all services
- Capitated amount is based on county where the enrollee lives
- Risk based rate ( based on resources used)

## Why?

- Assumptions:  Managed Care will continue to be important and may expand in both Medicare and Medicaid
  - There is too much enrollment to ignore
  - The Federal government will continue to seek use of private insurers to shift risk and will seek to managed care



## Managed Care Contracting Issues

- Compliance with Plan Policy and Procedures
  - Review  Plan Policy and Procedures prior to executing a contract
  - Health Plan Policy and Procedure Manual more informative then contract itself
    - Credentialing Requirements
    - Claims Submission
    - Coding Policies
    - Appeal and Grievance Procedures
    - Referral and Prior Authorization Requirements
    - Quality and Utilization Management Program

# Managed Care Contract- What to ask?

1. What does the contract mean in terms of revenue and expenses?
2. How does the contract define "medically necessary"?
3. How does the MCO verify that a patient is enrolled in a plan?
4. How do you determine whether medically necessary services are covered by a patient's benefit plan?
5. Does the contract clearly designate services subject to prior authorization ?
6. What is your reimbursement under this contract?

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# Managed Care Contract- What to ask?

7. Is reimbursement sufficient?
   - What are your costs to provide the services required under the contract?
8. What are your rights to appeal a reimbursement decision?
9. Can the MCO change reimbursement terms unilaterally?
10. Does the contract include a specific payment time period, and does the MCO agree to pay interest if it delays payment beyond that time period?
11. In what programs are you required to participate?
12. How can you terminate the contract?

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## Ongoing Coverage Criteria

- What is Utilization Review?
- How often is Utilization Review conducted?
- What is "Medically necessary care"?
- When would you need to appeal a utilization review decision instead of filing a grievance?
- How can you appeal your managed care plan's adverse determination?



## Top 10 Denial Reasons

1. Not eligible
2. No qualifying stay
3. Benefits exhausted
4. No authorization
5. Authorization does not match

## Top 10 Denial Reasons

6. Request for Medical Records
7. Missing or Invalid Diagnosis
8. Past timely filing
9. Information provided does not support the medical necessity for this service
10. Medical records not received



## Denial Prevention

- Who is verifying coverage?
- Who is verifying prior stay information?
- Who is obtaining the authorizations?
  - At admission?
  - Weekly?
- Is there an effective Triple Check Proces in place?

## Denial Prevention

- Managed Care Contracts?
  - Are they on file?
  - Does ALL pertinent staff know the contractual obligations?
    - Timely filing guidelines
    - Revenue Codes/Rates/Reimbursement structure
- Web portal Access?



## Electronic Data Interchange/Direct Data Entry

- Provides rapid notification of claim receipt, status and payment
- Reduces clerical paperwork
- Less time on follow up/tracking
- Reduce denials
- Increase revenue

## Triple Check Process

- ✓ Why is Triple Check important?
- ✓ Who needs to be involved?
- ✓ What information do you need?
- ✓ When and how should it be completed?



## Triple Check Process-Importance

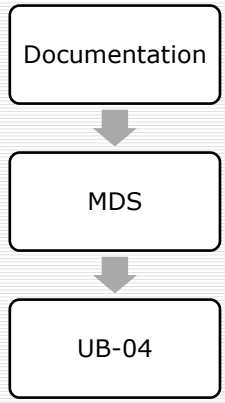
- ✓ Ensures the accuracy of skilled services from admit through discharge
- ✓ Reduces audit risks
- ✓ Reduce rework
- ✓ Improve cash flow
- ✓ Clinical and financial data should agree

# Triple Check Process-Team Members

- ✓ Business Office/Billing Manager
- ✓ RNAC/MDS Assessment Coordinator
- ✓ Therapy Staff/Director
- ✓ Medical Records Representative
- ✓ Social Services Representative



# Triple Check Process




Clinical notes and documentation support the MDS which supports the "bill" to Medicare.

All three components must agree!

# Triple Check Process-Documents

- ✓ Three-digit RUG taken from the validation report received upon acceptance of the MDS into the state database
- ✓ Assessment modifier for billing purposes
- ✓ Assessment reference date (ARD)
- ✓ Date MDS transmission was accepted by the state database
- ✓ Date span covered by the RUG and number of billable days



# Triple Check Process-Documents

- ✓ Verification of the following signatures and/or completed forms:
  - ✓ Physician orders
  - ✓ Physician certification and recertification
  - ✓ Therapy plans of treatment
- ✓ Review of the following documentation to support skilled services:
  - ✓ Nurses notes
  - ✓ Therapy notes
- ✓ Therapy ARD, days, and minutes reviewed

# Triple Check Process-Documents

- ✓ Diagnosis from the MDS
- ✓ Ancillary Provider Invoices
- ✓ Confirmation that the MDS has been signed
- ✓ Notice of Medicare Non-Coverage (if applicable)



# Triple Check Process

- ✓ Review of the documents to MDS should be verified prior to the start of the meeting.
- ✓ Claim Review
  - ✓ Verify demographic information
  - ✓ Type of bill
  - ✓ Date of admission
  - ✓ Qualifying stay
  - ✓ Date span of claim

## Triple Check Process

- ✓ Claim Review
  - ✓ Diagnoses as supported by MDS, Physician Orders and Therapy Plan of Care
  - ✓ Assessment Reference Date and RUG level from MDS
  - ✓ Review for ancillaries provided (ie lab, xray)



## Triple Check Process

- ✓ Claim Review
  - ✓ Check rehabilitation therapy visits to the claim (minutes to the MDS should have been verified prior to meeting)
  - ✓ Assessment Reference Date and RUG level from MDS
  - ✓ Review for ancillaries provided (i.e., lab, x-ray)
  - ✓ Check rehabilitation therapy (Review minutes to MDS and visits to claim)

## Triple Check Process

- ✓ Claim Review
  - ✓ Confirm support for skilled services
  - ✓ Review for outside appointments and Consolidated Billing Charges



## Characteristics of an Efficient Business Office

1. Admissions Packet
2. Timely Social Security Representative Payee Applications
3. Medicaid Application Filing Process
4. Take a Proactive Approach Towards Managing a Residents Needs
5. Maintain Good Recordkeeping

## Characteristics of an Efficient Business Office

6. Follow-up on unpaid Patient Liability amounts immediately
7. Quickly assess a resident's ability to pay on overdue balances



## QUESTIONS?