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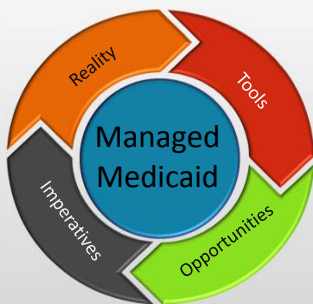
Arthur Krauss is Founder and President of Woodlyn Associates, LLC, the largest Revenue Cycle Management firm specializing in the senior care industry in New Jersey. Arthur was formerly a partner in a Philadelphia accounting firm specializing in Medicare and Medicaid reimbursement and spent twelve years as a founding partner of a crisis management firm that was retained by lenders and the courts to oversee distressed senior care institutions. Locally, Arthur serves on the HCANJ reimbursement committee and is a member of two of the task forces engaged in MLTSS implementation. Arthur holds a bachelor's degree from Dickinson College and a Masters in Business Administration from Temple University. He is licensed as a CPA in Pennsylvania.

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THE FUTURE OF MEDICAID How Will You Get Paid ?



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Our Goals Today



Framing the Reality

~~July 1, 2011~~
~~January 1, 2012~~
~~July 1, 2012~~
~~January 1, 2013~~
~~July 1, 2013~~
~~January 1, 2014~~



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Medical Day Care and PCA

Lessons Learned

Better Communication
 Better Planning
 Better Education
 Better Execution



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The Comprehensive Waiver

"Dear Commissioner Velez:

This letter is to inform you that New Jersey's request for a new Medicaid section 1115(a) demonstration, entitled "New Jersey Comprehensive Waiver" (NJCW) (Project Number 11-W-00279/2), has been approved by the Centers for Medicare & Medicaid Services (CMS) in accordance with section 1115(a) of the Social Security Act (the Act). This approval is effective from October 1, 2012 through June 30, 2017...."



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The March to July 1, 2014

- Steering Committee Meetings**
- Questions to the State**
- Sub-Committee Meetings**
- Tentative Decisions**
- Initial Roll-Out Delay**



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Big Picture Changes

Contract Uncertainty

Payment Uncertainty

Managed Care Focus

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Contract Uncertainty

- Today
 - License Permits (or Requires) Medicaid Participation
- June 14, 2013 Announcement
 - Commissioner Announced a Two Year “Any Willing Provider” Provision
 - Covers Skilled Nursing Facilities and Assisted Living Facilities

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Any Willing Provider

- Doesn’t Guarantee the Terms of Engagement
- May Also Require an “Any Available Payer” Provision

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Contract Uncertainty

- Today
 - License Permits (or Requires) Medicaid Participation
- June 14, 2013
 - Commissioner Announced a Two Year “Any Willing Provider” Provision
 - Covers Skilled Nursing Facilities and Assisted Living Facilities
- July 1, 2016
 - No Protection

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Payment Uncertainty - Timing

- Today – Bill by the End of Week 1
 - Get Paid the End of Week 2
- Tomorrow –
 - MCO Contract will require:
 - 30 Days for HCBS
 - 15 Days for SNFs and ALs(?)
 - Rules apply to “Clean Claims”

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Payment Uncertainty - Rates

- Today – Rates Set by State Budget Process
- July 1, 2014 –
 - State Rate Setting for Facility-Specific Rates
 - Inflation Factor (at Least for SNFs)
 - State Rates = Payment Floor

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Payment Uncertainty - Rates

- July 1, 2016
 - No State Guarantees
- No Uniformity Requirement Among MCOs

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Managed Care Focus

- Minimum Level of Care Assessments
 - NJ Choice Tool - Mandatory
 - Home and Community-Based Long Term Care Assessment – May Use

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Managed Care Focus

- Minimum Level of Care Assessments
 - State Approval Required When MCO deems that NF LOC is Met
 - Minimum Reassessments – Annually
 - MCOs May Assess More Frequently, but can't alter the NJChoice Tool

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Three Terms To Remember

Budget Control

Capitation

Managed Care

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The Tools For Tomorrow

Evaluate

Plan and Prepare

Execute

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Evaluate

- What Are Your Patient Sources ?
- What Are Your Financial Resources ?
- Is Your Staffing Correct for a Managed Medicaid Environment ?

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Evaluate

- What Type of Facility Are You
 - Focused on Short Term Rehab ?
 - Primarily Private or Medicaid ?

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Plan and Prepare

- Review Your Business Plan
- Arrange for Any Required Funding
 - Real or Contingent
- Train and/or Recruit Appropriate Staff

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Plan and Prepare


- Understand the Claims Process
- Understand your Ancillary Partners' Plans
- Determine a Method of Assisting your Current (and Future) Residents

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Funding Requirements

The Commissioner Says:


15 Days for SNFs
30 Days for HCBS



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Funding Requirements

**If The MCOs Pay
As Required –
How Much
Additional Cash
Will You Need?**




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Funding Requirements

The Good News

**Our Own Internal
Study Tells Us Most
MCOs Pay Far Better
Than Mandated**




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Funding Requirements

**Our Study:
(not a guarantee)**

**Horizon – 5 Days
Amerigroup – 8 Days
United – 13 Days
HealthFirst – 18 Days**



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Prepare Your Staff

Admissions and Case Managers – Learn to Work with HMOs

Business Office – Learn to Track Enrollments, Deal with Billing Requirements, Appeal Rules




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The Claims Process - Terms

A Few Critical Terms:

- Institutional Claims**
- UB-04 (837I)**
- Professional Claims**
- CMS-1500 (837P)**
- Remittances**
- RA/ERA (835)**
- Clearinghouses**




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The Claims Process – Why Electronic

Why Submit Electronically:

- Mandated**
- Faster Payment**
- Cleaner Process**



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The Claims Process - Clearinghouses

Clearinghouses – What They Do / Don't Do

- Routing
- Preliminary Screening
- Reporting Status



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The Claims Process – PreAuths/Enrollment

- May Become Mandatory, at least Enrollment Is
- No Retroactivity for ALs, etc.
- If A Medicaid Pending in a SNF is approved, SNF will bill under Fee-For-Service (as it stands now)



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The Claims Process – Timeframes

- Claims Don't Always Process Together
- Each HMOs Timeframe is Different
- Timeframes May Vary By HMO
- Timeframes Are Not Guaranteed



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The Claims Process – Consistency

- Will All Claims Look the Same?
- Required Fields
- Coding?
- Should You Include Optional Information?



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The Claims Process – Crossovers

- Requires Additional Information on Original Claim
- Currently - Inconsistent HMO Application



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The Claims Process – Follow Up

- Experience Says –
 - Long Periods on Hold
 - Inconsistent Answers
- Persistence Is Mandatory



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The Claims Process – Appeals

- TimeLines Are Critical
- Pay Attention to Details
- Distinguish Clinical vs. Financial Appeals
- Document, Document, Document



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The Claims Process – Appeals

- Appeals Within the HMOs
- Appeals to DOB
- Level Three Appeals – to an Independent Body



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The Claims Process – Appeals

- Waiver Mandates
 - Fair Hearing Access
 - Federal Guidelines
- IHCAP Appeals – Medical
- PICPA Appeals – Administrative
- Current PICPA Contractor – Maximus
- There Are Fees Involved
- Must file Internally First



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What Are Your Partners Doing?

Are the Patient Docs aligned with Your HMO Contracts ?

AL's – Do your preferred ancillary sources align well ?



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How About Your Patients

What Do You Say When They Ask You What To Do?

What Happens When They Change Plans?



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Execute

HMOs are Beginning To Reach Out – Time To Respond

Take a Look at Your Current Patient Population – SNF Patients – Are they aligned with a Medicare Advantage Plan? Others - Do they Have a Plan in Place?

Allocate Resources as Changes Occur

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Opportunities

Advocate

Plan

Position

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Advocate

Talk To Your Legislators

Talk to HCANJ

Talk to the HMOs

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Imperative


Evaluate – While You Have Time

Plan-While You Have Time

Make The Case


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Will This Be
Your Facility's
Tomorrow ?



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Or Will You Be
One of The
Winners ?



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The Best Plan For Success



Quality Speaks for Itself

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