

Are **YOU** ready?

MANAGED MEDICAID: A BRIEF OVERVIEW OF THE PROCESS

HCANJ 20-HOUR SYMPOSIUM MARCH 19-21, 2013

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Arthur Krauss Woodlyn Associates, LLC



The Panel

- Sylvia Allen-Ware, JD, MT (ASCP)
 - Chief, Office of Managed Care, NJ State
 Department of Banking and Insurance
- Michelle Palko
 - Regional Collections Specialist, Hospicomm, Inc.
- Arthur Krauss, MBA, CPA, CGMA
 - President, Woodlyn Associates, LLC.

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Today's Goals

- Get you Up to Date
- Help You Prepare
- Give you Some Comfort

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What and When

- A Sea Change It's Not Just a New Payer
- Latest Date Estimate-
- Assisted Living January 1, 2014
- Skilled Nursing July 1, 2014

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What and Why - You Decide

- From the Public to the Private Sector
- Insurance Sector is a Better Manager
- Comprehensive Care Management
- Healthcare Cost Inflation will Moderate

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What Does It Mean?

- Managed Care
- Capitation and All It Implies
- For-Profit Care

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When did this all begin?

o July 1, 2011 − Medicaid only

o October 1, 2011 – Dually eligible

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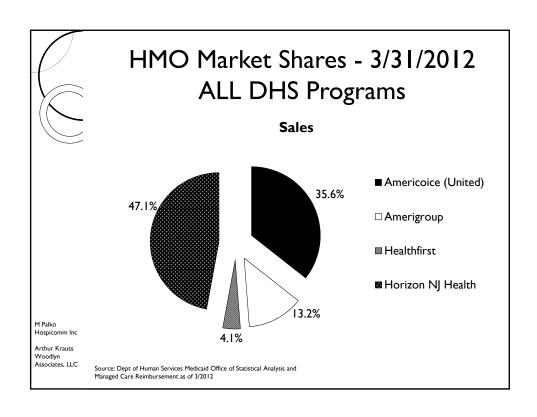
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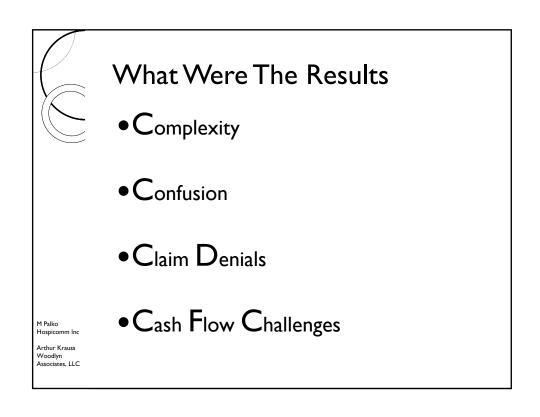


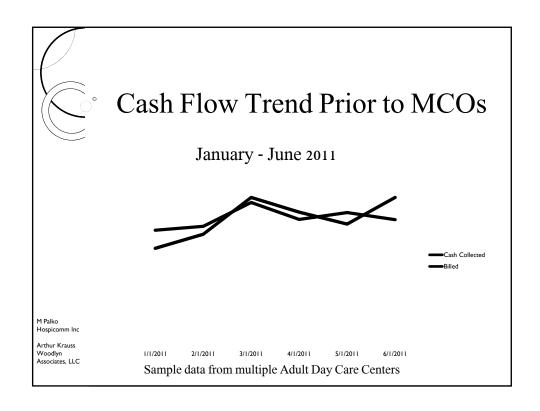
New Jersey Contracted Managed Care Organizations (MCO)

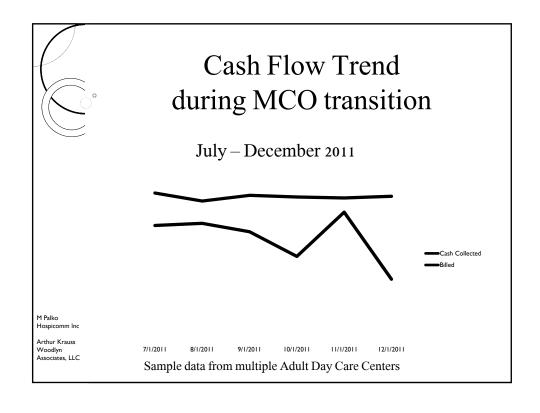
- o Amerigroup
- o Healthfirst NJ
- o Horizon NJ Health
- o United Healthcare Community Plan
- o New Payers in the Future?

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Cash Flow Trend first full year of MCOs

Calendar Year 2012



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Sample data from multiple Adult Day Care Centers



Why Did This Happen

- First Lack of Preparation
- Second Lack of Proper Protocols
- Third Lack of Complete Systems
- Fourth Lack of Proper Training

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As Managers –Basic Steps

Assess

Adapt

Acclimate

Advocate

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Step One - Assess

- Financial Ramifications
- Staffing Ramifications
- Operations Ramifications

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Step Two - Adapt

- Financial
- Staffing
 - Review your Organization Chart
 - Assess the Strengths of the Current Staff
 - Engage and Train Tomorrow's Team
- Operational
 - Consider your Delivery Care Model
 - Explore Strategic Partnerships

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Step Three - Acclimate

- Financial
- Staffing
- Operational

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Step Four - Advocate

The Working Committees are Meeting

Existential Issues Are On the Table

How Much and How When

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Financial

- Cash Flow Issues
- Rate Issues
- Eligibility and Coverage Issues?

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Cash Flow Impact

- Assumptions:
 - ∘ 120 Bed Facility
 - 85% Medicaid
 - 25% of Medicaid have Medicare Advantage
 - ∘ 5% Interest Rate
 - Claims Pay in 30 Days / 70 Days

Financial Cost:

\$30,603

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Addition to Days Outstanding:

30



Other Possible Financial Costs:

- Additional Staffing (Billing, Case Mgmt, Etc)
 - ∘ I FTE \$35,000
 - ∘ 2 FTEs \$70,000
- Rate Reduction Costs:
 - ∘ 1% \$ 75,000
 - · 5% \$372,000
 - · 10% \$745,000

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STAFFING Build the Teams

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What teams will this effect?

- o External Case Managers & Admissions
- o Social Services
- $\circ \, Billing$
- o Collections

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Make your own "MCO" for your teams!

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How do I make my own "MCO"?

Manage

Communicate

Organize

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Case Managers & Admissions

 $M \\ and \\ accurate information from the \\ referral$

Confirm coverage

- oWhat does the plan cover?
- oHow many days are covered?
- oWhat is the reimbursement rate?
- oIs disenrollment automatic or is follow up needed?

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Arthur Krauss Woodlyn Associates, LLC Obtain authorization number PRIOR to admit

MCO Contact Information

	Amerigroup	Healthfirst NJ	Horizon NJ Health	United Healthcare Community Plan
	www.myamerigroup	www.healthfirstni.o	www.horizonnihealth	www.uhccommunityp
	.com	rg	.com	an.com
Main Number	800-452-7101	888-GO4-NFNJ 888-464-4365	877-765-4325	973-297-5500
Member Servcies	800-600-4441	888-GO4-NFNJ or 888-464-4365	800-637-2997	800-941-4647
Prior Authorization	800-600-4441	866-467-7178	800-682-9094	888-362-3368
Provider Network	800-454-3730	888-801-1660 866-889-2523	800-682-9091	888-362-3368 973-297-5635
Fax	877-244-1724	866-506-7060	609-583-3025	855-551-5912

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Social Services

Manage the enrollment process

Communicate benefit utilization upon discharge

- o Upon discharge to the hospital services are suspended and continue on readmit
- Upon discharge to community a new authorization will need to be obtained at readmit, and they should get a new benefit period

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Arthur Krauss Woodlyn Associates, LLC Orchestrate the discharge re-enrollment process

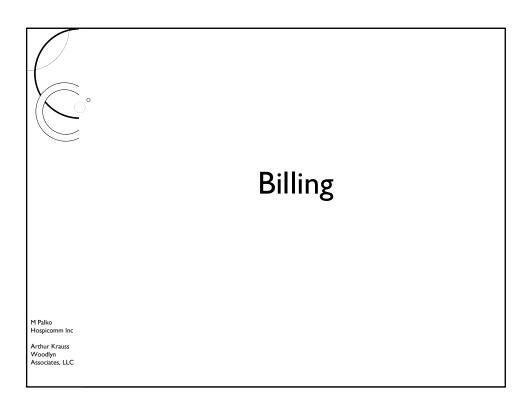


Social Services

Enrollment / Re-Enrollment in a MCO Contact Adult Client Services (ACS)

1-866-472-5338

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The Path Has Changed

- Today Direct to the Payer
- Tomorrow Direct or Indirect Options

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Critical Points

- Payer One is Not Payer Two (or three or four.....)
- HMOs are Much Less Forgiving
- Timelines are Tight

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Arthur Krauss Woodlyn Associates, LLC • Bills are More Complex



Direct Billing

- Electronic On-Line Claim Entry
 - Similar to Molina Option
 - Logical only for Very Small Facilities
 - No tie-in to any Financial System
- Manual Paper Claims
 - How You Do It
 - $^{\circ}$ What You Give Up
 - $^{\circ}$ When it's Required

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Indirect Billing

- Meaning and Use of a Clearinghouse
 - Who they Are
 - What they Do and Don't Do
 - What they Cost
- Certifiers and Scrubbers
 - Who they Are
 - What they Do and Don't Do
 - What they Cost

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Electronic Claims – Key Points

- 837's, 835's, HIPAA What Does it All Mean?
- Who Set the Rules and Why are they So Complex?
- Claims Aren't they all the Same?
- Clean Electronic Claims Pay Faster than Paper Claims

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Billing Electronically –What You Need to Know

- HMOs have a lot of Wiggle Room
- Changes seem to occur without warning
- Tracking is Critical

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Clean Claims – The Keys to Success

- 1) Know the Payer's Requirements
- 2) Accuracy It's a world of bits and bytes
- 3) Tracking You Need to Follow the Trail when Something Goes Wrong

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Arthur Krauss Woodlyn Associates, LLC 4) Know your Clearinghouse's Limitations



Billing

Make sure required insurance information is entered into your billing system correctly

Confirm the authorization number is on the claim

Overcome delay by assuring the claim is clean

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What Is A Clean Claim

- Correct Insured
- Coverage is in Force
- Authorizations are Current
- Referring Providers are Authorized
- Diagnoses, Revenue Codes, Types of Bill, etc. are all Valid
- Claim is Complete in Every Respect
- Claim is Timely

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According to the State of NJ Department of Banking & Insurance

*NOTE

Carriers may change the information, and documentation they require as long as participating providers are given 30 days notice

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Collections

Meeting your filing timeline

Correction or follow up to claim

Offset denials by understanding their meaning

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Collections

Common Denial codes

- o CBP = EOB needed from the members primary carrier
- O22= Secondary payment can't be considered without primary payor information
- o X16 = Resubmit with EOB from Medicare and PAKcharges exceed contracted amount for service

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Collections

What do these codes mean?

- o The insurance companies are requesting you bill Medicare

 Part A for denial before they pay your pre authorized claim
- Recently the MCOs have agreed that if you have a straight Medicaid admit from the community or an admission that does not qualify for Medicare they will waive the primary denial process listed above

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Appeals – The Regulatory Framework

An Update from Sylvia Allen-Ware, JD, MT (ASCP)

Chief, Office of Managed Care

NJ State Department of Banking and
Insurance

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How can we get ahead and stay on track?

Build your teams

Manage

Communicate

Organize

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Make "MCO" work for you!

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In the End

Assess

Adapt

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