Managed Care Update

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Agenda

- Managed Care – Background
- Value Based Payment Model – What’s it Going To Look Like?
- Managed Care – What are we seeing?
- Strategic Positioning Questions to be Asked and Answered by Your Organization
- Considerations of IPA’s
Managed Care – Background

• Implemented in Upstate NY July 1, 2015. We are currently in a transition period until 2017
  
  − Most providers have contracts with plans at a rate at or above Medicaid benchmark rate

• By 2019, 80-90% of total managed care payments to PPSs/providers must be made via at least Level 1 (upside shared Savings) value based payment.
  
  − Part of DSRIP Initiative
  
  − Moves Medicaid payment from current fee-for-service system to alternative payment arrangements (i.e. bundling, risk sharing, capitation)
Value Based Payment

- **Levels**
  - Level 0 VBP – FFS w/ Quality Bonuses
  - Level 1 VBP – FFS w/ Upside Shared Savings
  - Level 2 VBP – FFS w/ Risk Sharing (Upside, Some Downside)
  - Level 3 VBP – Full Capitation & Risk (Full Upside and Downside Risk)
Value Based Payment

• How does this impact long-term care providers?
  - Many homes are not positioned to take the risk required with value based payment models
  - Homes that are capable of reporting quality statistics stand a chance of benefiting from the upside shared savings
  - Expected that most homes will only be able to accept and move to Level 1 VBP arrangements
Value Based Payment

- What will these VBP contracts look like?
  - Pilots
  - Plans in the early stages of developing these contracts
Managed Care – What are we seeing?

- Plans behaving different
  - Plans less eager to contract with LT providers
  - Plans not willing to negotiate above benchmark
  - Plans attempting to amend contracts

- Plans are finding that the payment model that they are receiving from NYS is unsustainable.

- Under current payment model, plans will be tempted to contract with providers that have the lowest cost.
  - “race to the bottom”???
Managed Care – What are we seeing?

- Contract language is changing
  - NAMI
  - The right to amend contracts
  - Contract terms
  - Definition of patient co-pay or customer expense
  - More specifications related to revenue codes, and electronic claim submissions
Managed Care – What are we seeing?

- **Net Available Monthly Income (NAMI)**
  - As part of the NH transition policy, the responsibility to collect NAMI amounts is being assumed by the plans. Plans may delegate the collection of NAMI to the NH, but this must be expressly agreed to by the provider in the participating provider contract. Monthly premium payments to the plans will reflect an offset for NAMI amounts.
  - If the plan retains responsibility to collect NAMI, it should pay the facility the full contract rate multiplied by the days of care provided. If the plan delegates NAMI collection to the facility, the NAMI amount should be deducted from payments to the NH for those time periods during which the NAMI is collected by the NH.
  - *Source: June 2015 Benchmark Letter*
Strategic Positioning Questions to be Asked and Answered by Your Organization

- NYS has made it quite clear, with the Department of Health (NYS DOH) now driving the bus, that fewer health and human service providers with reduced administrative costs will be one of the sources of achieving efficiency and reduced costs for services. What is the provider doing proactively to address its administrative cost efficiency and, more broadly, the State’s desire for mergers, affiliations, and shared service organizations to achieve a more efficient delivery system?

- Evaluate the merits of joining a Regional IPA and/or MSO. If you don’t know what those acronyms mean, consider yourself to be in trouble!
Strategic Positioning Questions to be Asked and Answered by Your Organization

• The following areas are of highest priority in evaluating the question above:
  
  a) Partnering/merger/affiliation with other service providers
  
  b) Participation in regional provider networks
  
  c) More sophisticated cost accounting and electronic records for all program components
  
  d) Restructuring your billing and accounts receivables systems to accommodate revised contract payment methodologies (e.g. incentive payments for achieving performance goals, P4P)

  e) Incremental cost structures on administrative infrastructure (technology, compliance, etc.) will be a significant challenge in assessing your organization’s future services and structure.

Ask yourself the question, are we sophisticated enough to survive in a Value Based Payment reimbursement environment that demands high service quality and desirable outcomes?
Considerations of IPA’s

• The formation of an Independent Provider Association (IPA) is a viable strategy to address the dramatic shift in how services will be managed and paid for in New York State through the MCO / Managed Care Plan structure.

• Advantages are considered as follows:
  • Critical Mass Creates Leverage
  • The structure of an IPA can provide an effective alternative to merger or sale
  • Potential for Savings from Shared Services
Considerations of IPA’s

• Possible Risks / Disadvantages of IPA Formation

  • MCOs/PPSs refuse to negotiate with the IPA. This is not likely based on discussions to date.

  • The IPA Board and its provider members cannot effectively agree and govern the organization to achieve the desired advantages listed above.

  • The risk of individual provider members defecting from the IPA commitment to satisfy their own individual objectives.

  • An IPA structure does involve additional costs. However, many of these costs of an IPA structure are substantially offset by individual providers devoting time and effort to MCO contract negotiation and reporting.
Is Your Revenue Cycle Under Attack?
Revenue Cycle Under Attack

• Medicaid Managed Care
  ✓ NAMI Management
  ✓ Part A Denial – NOMNC
  ✓ Authorizations and LOC
  ✓ Claims Submission Schedule

• Staffing
  ✓ Shortage of Trained Nursing Home Billers
  ✓ Department Redesign/Restructure
  ✓ Outsourcing

• Accounts Receivable Management
  ✓ % of AR >90 days
  ✓ Denial Management Program
  ✓ Revenue Cycle Benchmarking
Medicaid Managed Care – NAMI Management

- Pending Medicaid residents
  - Estimate NAMI and attempt to collect

- Can be difficult to oversee
  - Not all banks make it easy to manage “rep payee” EFTs
  - National Datacare Corporation
    - Manage direct deposit
    - Automated care cost payments and resident allowance retention
    - Automatic return of direct deposits when expire/transfer

- Initial MLTC implementation shifts responsibility to MCO and MCO may delegate it to nursing home or other entity
  - Should be outlined/agreed to during contracting
  - Make sure you have an internal process in place if agreement is different than your current norm
Medicaid Managed Care – NAMI Management

• Four important questions
  ✓ Who manages Social Security and other income?
  ✓ Does nursing home manage a resident fund of PNA money?
  ✓ When does payer collect NAMI – all residents, short term or long term?
  ✓ Are you confident payer will pay correctly?
Medicaid Managed Care – NAMI Management

• If nursing home is rep payee it will NEVER escape NAMI responsibility
• Develop a tracking tool to ensure accurate payment from payer

$1,000 income (Social Security)
- Resident = $1,000
- Plan collects from resident = $950
  - Resident give NH $50 PNA (or keep)
  - Plan pays NH $950

$1,000 income (SS and pension)
- NH Social Security Rep Payee = $600
- Plan collects pension from resident = $400
  - NH keep $50 PNA from SS
  - NH keep $550 of NAMI
  - Plan pay NH $400
Medicaid Managed Care – Part A Denial – NOMNC

- Does MLTC payer require a denial from Part A?
  - ✓ If so, will result in slow down of revenue cycle
- Submit No Pay Claim to Medicare
  - ✓ Submit copy of EOB with MLTC claim
- Will payer accept a NOMNC in lieu of a Part A denial?
  - ✓ Develop internal process for issuance of NOMNC
  - ✓ Submit copy of NOMNC instead of Part A denial
- Rumor has it: For Fidelis, if only R&B on claim Part A denial not needed
Medicaid Managed Care – Authorizations

- Authorization will generally be required
- Authorization for bed hold may be required
- Verify if the authorization is tied to a LOC
  - LOC must be accurately reflected (revenue code) on claim
- Authorization period will vary based on expected LOS
Medicaid Managed Care – Authorizations

- UAS-NY assessment completed by Medicaid MCO – required when individual enrolls in a plan and every 6 months thereafter or when significant change in condition occurs – *in person* (*per* MLTC Policy 16.01: UAS-NY Assessment Requirements)
  - MCO required to compare the UAS-NY assessment needs with the MDS assessments conducted by NH and consider both when authorizing services, equipment and supplies
  - The care plan, MDS, UAS-NY, medical record and input from care management team will provide the MCO with the information needed for authorization of services
  - Although reassessment using UAS-NY is required at above schedule, MCOs *may* authorize for shorter time periods
    - daily, several times each week, weekly and monthly
Medicaid Managed Care – Billing Schedule

• Payers are willing to accept claims twice a month
  ✔ Not mentioned in provider/billing manuals
• Will need to change current billing processes
  ✔ Currently used to billing only Medicaid more frequently than monthly
• Need to keep cash flow moving since payment cycles are generally slower
Staffing – Shortage of Trained Nursing Home Billers

• Reasons
  ✓ Small industry
  ✓ Billers tend to leave nursing home niche for higher paying opportunities (hospitals, physician offices)

• Inadequate training
  ✓ Lack of well-rounded “in-house” knowledge base
  ✓ Not all good billers are good trainers
  ✓ No time to develop comprehensive training program
  ✓ Lack of sufficient cross-training
  ✓ Consider outsourcing new hire and skills development training
Staffing – Department Redesign/Restructure

• Why restructure?
  ✓ Shift to MLTC – more difficult and time consuming
  ✓ New technology – improved billing systems, clearinghouses
  ✓ Change in roles and responsibilities

• Small homes: one biller may no longer be adequate

• Current silo structure may become ineffective
  ✓ Medicaid Managed Care
    o May be too much work for one person to handle
    o Medicare Advantage/Commercial blurring into Medicaid Managed Care
  ✓ Alpha-split, unit-based, additional FTE assigned to MLTC
Staffing – Outsourcing

• Outsourced billing
  ✓ Entire billing function
  ✓ Specific payors
  ✓ On-site or remote access

• Higher costs generally are offset by better results

• Will still need:
  ✓ In-house liaison
  ✓ Someone to monitor overall performance of billing service
  ✓ Willingness to modify operations to improve processes
AR Management – % of AR > 90 Days

- **Goal**
  - ✓ AR >90 days should not exceed 25%
  - ✓ Look at each payer individually
    - o Issue with one payer could be masked by results in others
  - ✓ Conduct focused recovery project
    - o In-house with current staff (but don’t fall behind on current)
    - o Outsource clean up to experts
    - o Outsource but involve current staff to teach them effective follow up techniques and provide cross-training opportunities
AR Management – Denial Management

• Per AMA 1.38% – 5.07% of claims are denied on 1st submission
  ✓ Aetna – 6.00%  UHC – 4.30%  Cigna – 3.80%  Medicare – 2.30%

• Less than 40% chance of denied claim getting paid

• Need to work electronic rejection/acceptance reports
  ✓ Must review 999 and 277CA
    o 999 confirms that a file was received. However, the 999 includes additional information about whether the received transaction had errors. Accepted (A), Rejected (R), Accepted with errors (E)
    o 277CA acknowledges all accepted or rejected claims in the file

• Work payor denials/remits in timely manner (< 5 days)
AR Management – Denial Management

• Cost to re-work a claim
  Staff time $10.67
  Supplies $  1.50
  Interest $  1.75
  Overhead $  1.00
  TOTAL $14.92

• Key Performance Indicators (KPIs):
  ✓ % of denied claims <5%
  ✓ % of EDI denied claims <1%
  ✓ % of paid after 1\textsuperscript{st} appeal >75%
  ✓ Lag time to work denial < 5 days
AR Management – Denial Management

- Track by payor
- Track documentation deficiencies (make improvements going forward)
- Learn your weaknesses
  - Therapy minute discrepancy
  - ADL documentation
- Submit summary page with records that shows how/where RUG/level is supported
- Perform documentation audit and CDI project

- Win… Lose…
- OR Give Up Trying

- Claim Billed and Paid
- Records Requested
- Follow Appeal Process
- Records Not Support RUG – Payment Retracted

- Track by payor
- Track documentation deficiencies (make improvements going forward)
- Learn your weaknesses
  - Therapy minute discrepancy
  - ADL documentation
- Submit summary page with records that shows how/where RUG/level is supported
- Perform documentation audit and CDI project
AR Management – Denial Management

• Industry shift toward managed care requires SNF to focus on denial management

• Denial management is “old news” to physicians and hospitals
  ✓ Long ago addressed in their billing systems and processes (payment posting and reporting)

• SNF billing systems and SNF process deficiencies
  ✓ Many billing systems don’t capture payment codes
  ✓ Many billing systems can’t generate denial management reports
  ✓ Minimal use of clearinghouses and available denial-related reports
  ✓ Many SNFs don’t post zero payments
  ✓ Most SNFs do not have a robust denial management program

• Consider additional report writing add-on software or programming
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