Mastering Managed Care Key Components to Success

MHCA Missouri Health Care Association

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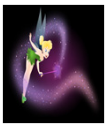
Mastering Managed Care
Key Components to Success

No magic pixy dust



No more "head in the sand"

It's GAME ON with Managed Care!

WINNING with Managed Care is essential for viability, operability and sustainability.

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Great Shift

- What Does this Really Mean?
- Why Do We Care?
- How Does This Make Things Different?
- Will This Affect Me?

Relevant 7 – Best Practices & "Must Knows"

- Contracting
- Case Management
- Billing
- Do You Know You?
- Grandma Alice – Show Me the Money!

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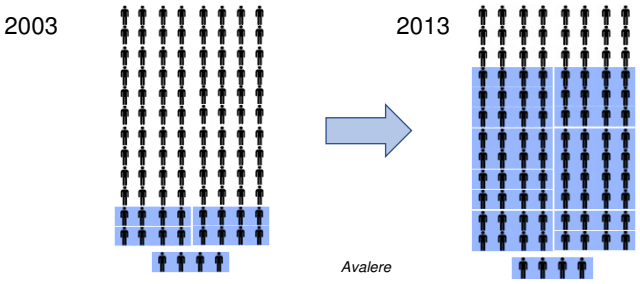
- **"GREAT SHIFT" - Skilled Nursing Facility landscape transformation**
  - Move from Traditional FFS to Managed Care



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- **"GREAT SHIFT"** - Skilled Nursing Facility landscape is transformation:
  - Move from traditional FFS to managed care

Federal and state legislation, programs, initiatives are pushing managed care members into our doors…

ACA

CFAD

MA

ME

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FFS to ➡ **Managed Care**

What does this really mean?

- Increase in managed care case mix
- Change in payer sources
- Change in facility systems
- Change in business office systems

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	Medicare Patient FFS	Managed Care Patient	HMO Patient w/o 100% of RUGS
Reimbursement per day	$500	$500	$300
Receive Payment	21-30	45-60*	45-60*
Length of Stay	30	15	15
Payment Received	$15,000	$7,500	$4,500

Why do we care?

DSO went from 21 days to 45 working days (60 calendar days)

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What can shrink $4,500 reimbursement?

Payment Received	$15,000	$7,500	$4,500

- **Incorrect payer identified - No authorization** **-$4,500**
- **Uncaptured high-cost medication** **-$1,700**
- **Use of facility DME company – not health plan contracted DME company** **-$ 900**
- **Change of Condition leading to higher acuity of care and higher reimbursement based on LOC** **-$2,250**
- **Take back because documentation lacked information to support "medical necessity"** **-$3,600**
- **Not contracted for line of business** **-$4,500**

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Managed Care Patient vs Medicare Patient

Differences & Implications

- Revenue Changes
- Cash Flow
- Functional and Operational Changes – Managed Care Systems
- Additional Hands in the Pot- MCO is Directing Stay, Not You! Is that true?
- New Folks to Market to
- Revenue generation begins with accurate identification and verification of the payer *PRIOR TO* Admission
- Profit projection begins with an effective patient cost-out strategy
- 12%- 19% of revenue is lost during the admissions process due to incorrect or unverified information

How does this make things different?

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CURRENT TRENDS IDENTIFIED: PROVIDER MANAGED CARE SYSTEM AUDITS

1. Review of "old" managed care contracts
2. Acquisition: contracts never assigned/assumed – previous agreements termed
3. Missing authorization, extended authorization
4. No exclusions being captured
5. Patient not being properly managed
6. Lack of system to capture high-cost services/medications

And more……..

Will this affect me?

Owners
Operators
Administrators
Case Manager
BOM
Managed Care Team
and more……

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CURRENT TRENDS IDENTIFIED: PROVIDER MANAGED CARE SYSTEM AUDITS

7. Therapy overutilization as minutes are not known because there is no communication system established to inform therapy of patient/insurer contract limits on LOC
8. Incomplete concurrent reviews = AUDITS
9. No triple check to check accurate information on patient claims
10. Billing per health plan contract when IPA/Med Group is at RISK for skilled stay in nursing facility
11. Medicare Assessment does not match your approved level of care
12. Incorrect Rev Code on claims
13. Patient co-pays not identified
    - Not Identified = Not Collected

And more……

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Missouri: Trends

- Medicare Advantage Growth
- Managed Medicaid (Expansion)
- Duals Programs

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Missouri

National Trends: Medicare Advantage Enrollment

1 in 3 beneficiaries now in Medicare Advantage program

Enrollment has increased 71% since Obamacare was passed in 2010

Kaiser Foundation

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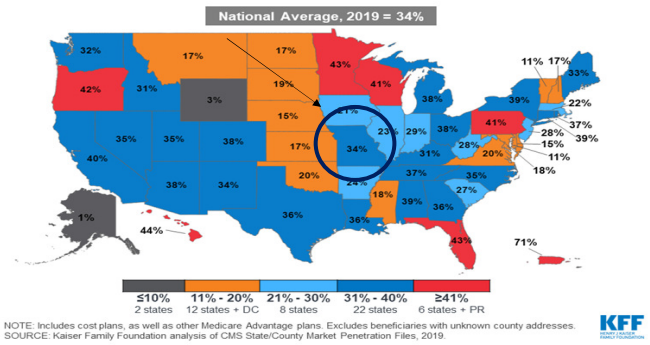
Missouri State Trends: Medicare Advantage Enrollment

Medicare Advantage Penetration, by State, 2019



1,350 different Missouri Medicare Advantage plans in 2019.[1]

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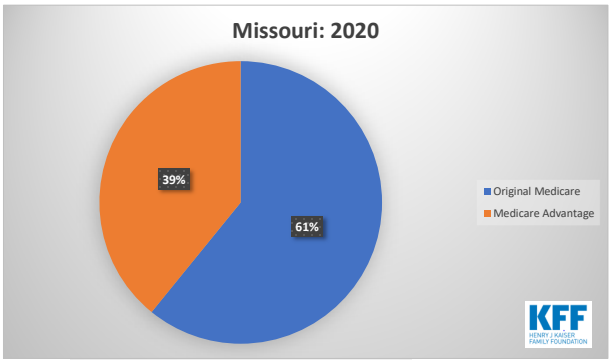
Missouri State Trends: Medicare Advantage Enrollment

Location	Original Medicare	Medicare Advantage	Total
Missouri	756,377	486,636	1,243,013



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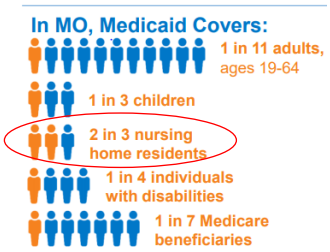
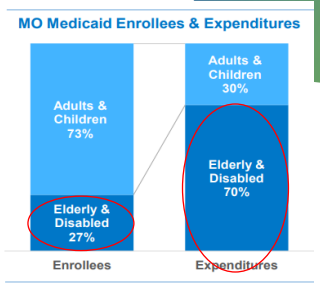
Missouri State Trends: Medicaid





Managed Medicaid: **MO HealthNet*** *all counties*

home state health. | HealthyBlue | UnitedHealthcare

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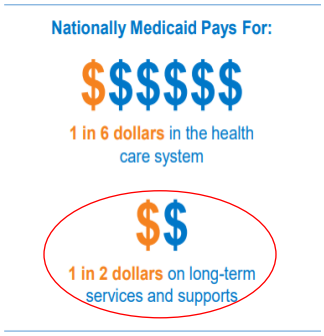
Missouri State Trends: Duals

Location	Dual Eligible Enrollees	Total Medicare Enrollees
Missouri	176,708	1,227,462

Duals:
- UHC Dual Complete (HMO D-SNP)
- UHC Dual Complete Choice (Regional PPO D-SNP)
- BCBS Healthy Blue (D-SNP)

MLTSS* in discussion as a MO program



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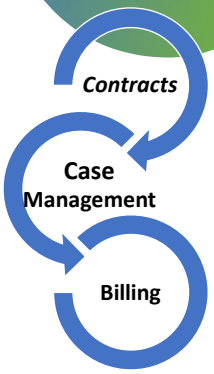
The Relevant 7:

*Succeeding with Managed Care begins with a well-developed **managed care system (best practices & "must knows")** operating efficiently, cohesively between departments and providing all necessary managed care data to bill claims timely and with accuracy.*



SUCCESS with Managed Care is essential for viability, operability and sustainability.

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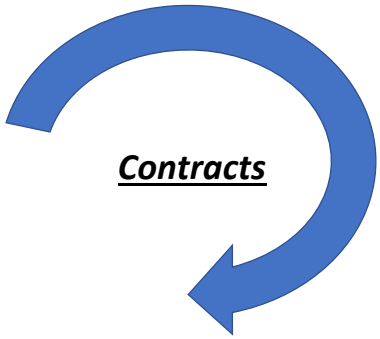

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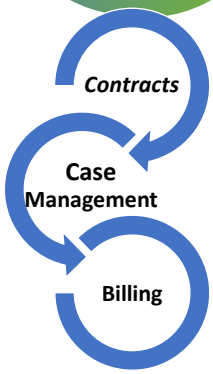
Managed Care contracts:

- ***Complete***
- ***Current***
  - Do we have copies of each contract?
  - Who has copies?
  - Effective dates [amendments]?
  - Lines of business – What does that mean and why is it important to know?
  - Exclusions – What does this mean?
  - Do we have a matrix/cheat sheets?
  - Mergers/Acquisitions



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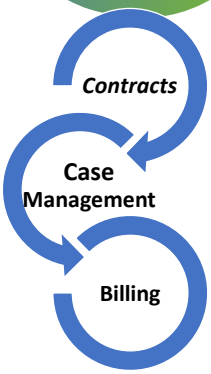
2 ***Managed Care contracts***

- ***Understood***
- ***Accessible***

  - Organized via electronic file or binder?
  - Managed care team
  - Cheat Sheets available?
  - Clear understanding of Current Language/Terms/Definitions
    - Rates/auto-increases
    - Term of contract
    - Take Back terms
    - Retrospective Language
    - Submission Timeline
    - Appeals Timeline
    - Medicaid Ancillary Reimbursement



****If we don't know our contracts we will not properly admit, manage or bill!***

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ANTHEM BLUE CROSS CONTRACT SUMMARY

Managed Care Contract Consulting

CONTRACT TERMS	SECTION	PAGE	COMMENTS
Effective Date		22	7/1/15
Initial Term	VIII 8.1	15	From the effective date until the agreement is terminated
Termination without Cause	VIII 8.2	15	With one hundred eighty (180) days prior written notice

CLAIMS	SECTION	PAGE	COMMENTS
Claims Submission	II 2.5 II 2.8.1	5 6	Provider will bill the Plan within 150 days from the date of services for Commercial and Medicare claims. Within 180 days for MediCal claims
Claim Forms	II 2.5	6	Facility shall submit claims, subject to applicable HIPPA requirements, on the UB-04 form
Claims Submission Address			Not Stated
Claims Instructions	II 2.5.2	6	Hard copy claims submission or electronic Claim Submission

CLAIMS	SECTION	PAGE	COMMENTS
Payment of Claim	II 2.6	6	Within 30 working days for PPO Plan claims and 45 working days for HMO and a majority of Medicare claims (remaining Medicare claims paid within 60 dyas)

APPEALS	SECTION	PAGE	COMMENTS
Days facility has to appeal	II 2.5	5-6	365 days the date of the Plan's adjudication of the original claims submission or the date of the Plan's request for information in response to a claim submission-- whichever was first
Days HMO has to respond to appeal			Not Stated

OVER/UNDER PAYMENT	SECTION	PAGE	COMMENTS
Notification	II 2.8	7	Plan will notify the Provider of the amount of the overpayment or amount owed and request a refund in accordance with applicable laws and regulations
Determination	II 2.8	7	Plan will deduct from and sett off any amount or amounts due and payable from the Plan to the Facility at any time under this agreement

Business Office Comments / Other Notes:

see page 2 for Rates, Levels, and Exclusions

****If we don't know our contracts we will not properly admit, manage or bill!***

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ANTHEM BLUE CROSS CONTRACT SUMMARY CONT.

Managed Care - Contract Consulting

RATES/LEVELS/EXCL Commercial and Medicare	EXHIBIT	PAGE	RATE
Level 1 • Nursing services up to 3 hrs per day, including 1 or more of the following: wound care stage 1, routine tracheostomy care, peripheral lines for hydration, and nebulizer treatments. • Rehab (PT/ST/OT) les than 90 min, no less than 3 times per week • Oral, IV, or subcutaneous drugs prescribed in conjunction with the diagnosis requiring admission to a SNF (up to $100 per day priced by Medicare's allowances)	PCS	3	$300/day
Level 2 • Nursing services up to 5 hrs per day, including 1 or more of the following: wound care stage 2 and 3, peripheral and central lines (complex and multiple), colostomy/ileostomy care, and respiratory therapy (suctioning, oxygen, tracheostomy care, etc.) • Rehab (PT/ST/OT) les than 90 min, no less than 3 times per week • Oral, IV, or subcutaneous drugs prescribed in conjunction with the diagnosis requiring admission to a SNF (up to $110 per day priced by Medicare's allowances)	PCS	3	$450/day
Level 3 • Nursing services up to 7 hrs per day, including 1 or more of the following: wound care stage 4 and 5, and peritoneal dialysis • Rehab (PT/ST/OT) les than 90 min, no less than 5 times per week • Oral, IV, or subcutaneous drugs prescribed in conjunction with the diagnosis requiring admission to a SNF (up to $115 per day priced by Medicare's allowances)	PCS	3	$600/day
Level 4 • Nursing services up to 7 hrs per day, including 1 or more of the following:ventilator weaning, tracheotomy care, mist treatments, complex tracheostomy care, suctioning, and ventilator dependent.	PCS	3-4	$750/day

RATES/LEVELS/EXCL MediCal	EXHIBIT	PAGE	RATE
Level A Most basic level of care (room and board, nursing care, ancillary services, supplies, medication equipment, etc.) required by a patient who no longer requires general acute care as provided in an Inpatient Acute Care setting but who does require documented, continuous skilled nursing care. Care must be Medically Necessary and the services must be authorized by Anthem. Level A includes: PT/ST/OT at least three (3) days per week with each session lasting less than ninety (90) minutes; orthopedic or neurological therapy; or positional splints.	A	A-1	$245/day
Level B Level A services, plus the following: 1.Wound Care 2. Respiratory Therapy 4 times a day or greater 3. Rehabilitation Services rendered by a licensed occupational therapist, speech therapist and/or physical therapist at least ninety (90) minutes and up to three (3) hours per day, at least five (5) days per week. 4.Nasogastric or Gastrostomy Tube Feedings. 5.Total Parenteral Nutrition (TPN) 6. Continuous IV therapy 7.Colony Stimulating Factors 8.Ostomy Care 9.Tracheostomy Care 10.Special Beds (e.g., KinAir, Clinetron) 11.Continuous passive motion machines 12.TENS/MENS units	A	A-1	$400/day
Level C **C-1:** Patient requires Level A, plus one of the following: 1. Hemodialysis 2.Ventilator Care 3. Expanded Spectrum IV Antibiotics 4.If applicable, rehabilitation residential transitional living centers for post acute rehabilitation services which must include four (4) to six (6) hours per day of skilled physical, occupational, speech or neuropsychological therapy **C-2:** Patient requires Level A, three or more of Level B fist seven services (1-7)	A	A-1	$540/day

RATES/LEVELS/EXCL Cal MediConnect	EXHIBIT	PAGE	RATE
Inpatient Care – All Levels, PT/ST/OT, Inpatient Room and Board, Leave of Absense, and all other covered services	F	F-1	100% CMS fee schedule

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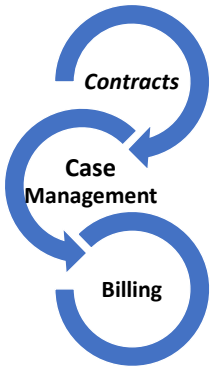
Managed Care Case Management

Systematic approach to actively and accurately assess potential admission & manage a managed care patient stay

- **PRE-ADMISSION**
- **ADMISSION**
- **MANAGING PATIENT**
- **DISCHARGE**



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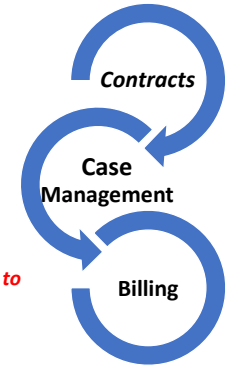
Accurately identifying & verifying

- ***Insurer***
- ***UM***
- ***Benefits***
- ***RISK payor along with obtaining complete AUTH***



****12%- 19% of revenue is lost during the admissions process due to incorrect or unverified information***

****AUTH is no guarantee of payment but without it, there is NO payment***

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- **PRE-ADMISSION**
- **ADMISSION**

Inquiry Evaluation & Decision

- Cost-out system
- Decision makers
- LOA negotiations – OON / Single carve-outs

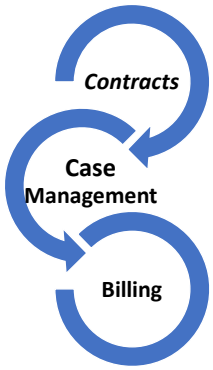
Benefit Verification Mastered

- Who does it? Appropriate training? Back-up
- Standard form - Thorough in its completion
- Who is this information shared with?

Authorization

- Obtained
- Accurate

What is our system of communication to business office?



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HealthRight Health Plan

Commercial	Medicare	Medi/Medi	Medicaid	Medicaid (Skilled)
Level I $290 •Ostomy Care •G-tube/NG tube •Routine Lab & X-ray •Wound Care Stage I & II Level II $345 •IV Hydration •Up to 1 hr. therapy (PT,OT,SP) •Wound Care Stage III Level III $440 •Isolation patients •Up to 1.5 hrs. therapy per day (PT,OT,SP) •IV Medication Administration-single •Wound Care Stage IV Level IV $490 •TPN administration •Multiple IV administration •Up to 2 hrs. therapy per day (PT,OT,SP) EXCLUSIONS Vancomycin, Lovenox, Procrit, Epogen, Neupogen, Rocephin,TPN, Zosyn, Specialty beds, Wound Vac, CPM Machine, Transportation	100% PDPM	90% PDPM	(Custodial) 100% Medicaid	Level I $215 •Ostomy Care •G-tube/NG tube •Routine Lab & X-ray •Wound Care Stage I & II Level II $300 •IV Hydration •Up to 1 hr. therapy (PT,OT,SP) •Wound Care Stage III Level III $365 •Isolation patients •Up to 1.5 hrs. therapy per day (PT,OT,SP) •IV Medication Administration- single •Wound Care Stage IV Level IV $425 •TPN administration •Multiple IV administration •Up to 2 hrs. therapy per day (PT,OT,SP) EXCLUSIONS TPN, Specialty beds, Transportation

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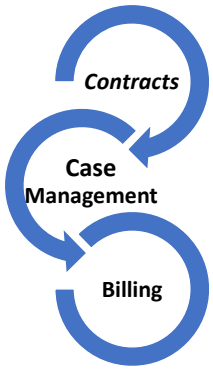
Daily managing of patient stay utilizing case management best practices with accurate communication and documentation is a MUST

****Without proper case management and established system for a line of communication the maximization of managed care contract is impossible – is this true?***



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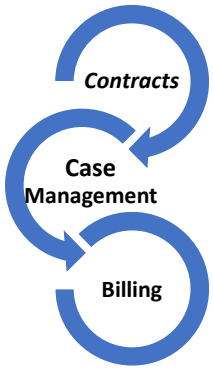
- **MANAGING PATIENT**
- **DISCHARGE**

Daily Management

- Contract management
- LOC / COC
- Authorizations
- Medical Necessity – Skilled Stay
- Team Communication
- Concurrent Reviews
- Exclusions
- Advocacy

Discharge

- MCO goal
- Documentation



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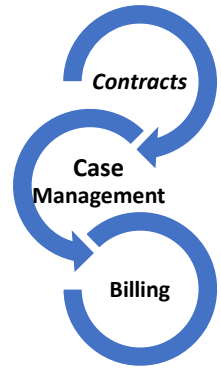
- **MANAGING PATIENT**
- **DISCHARGE**

Daily Management

Discharge

What is our system of communication to business office?



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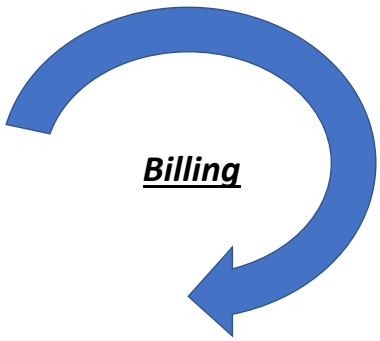

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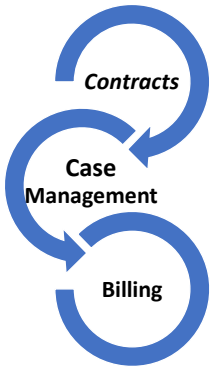
The use of Payor cheat sheets that accurately identify Payor needs of claims submitted



****All MCOs operate differently and any assumption that is made that information from one is equivalent to another – cause for MAY DAY!!***

****If we don't know our contracts we will not properly admit, manage or bill!***

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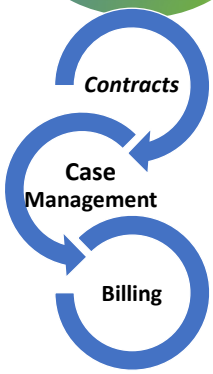
Business Office Systems

MCO knowledge for Billing

- Submission timelines
- REV Codes
- Clearinghouses
- Forms to bill claims
- Additional documentation required with claim
- Bed holds, SOC
- Where to send claim
- RISK grids
- Managed Medicaid long term authorization process



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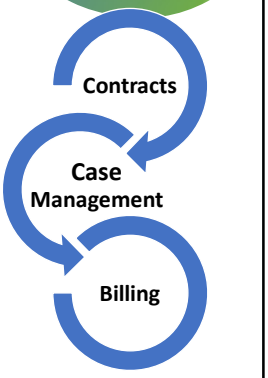
Goal = Clean Claim Billing

- Authorization
- Rev Code
- Correct diagnosis code
- Correct level
- Correct rate and description
- Modifiers (if applicable)
- Correct payor
- Correct dates of service



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ABC HEALTH PLAN CONTRACT SUMMARY

RATES/LEVELS/EXCL	EXHIBIT	PAGE	REV CODE	RATE
MEDI-CAL /HEALTH BENEFIT EXCHANGE				
Level I – Skilled Nursing Care *Moderate nursing intervention. Active treatment of comorbidities and assessment of vitals and body systems 2-3 times/day is required* •All intermediate care services listed •Nursing care, including skilled observation per Medicare guidelines •Oxygen services and supplies •Enteral nutrition services and supplies •Wound care for Stage I and II dermal ulcers and post-surgical wound care required once per day simple dressing changes •Case management, social services and discharge planning •Care of colostomy/ileostomy •OT/PT/ST services up to a total of 1 hour or modules/day •IV hydration, pain management, and antibiotics •Central and peripheral IV line care (including Hickman Catheter and Porta Cath)	D	28 31	191	$265
Level II – Skilled Nursing Care *Moderate-extensive nursing intervention. Active care and treatment of comorbidities (with potential to affect treatment plan) and assessment of vitals and body systems 3-4 times/day is required* •All intermediate and Level I services •PT, OT, ST up to a total of 2 hours or 8 modules/day •Isolation techniques •IV therapy	D	28, 31- 32	192	$365
Level III– Skilled Nursing Care *Extensive nursing and technical intervention. Active medical care and treatment of comorbidities (with potential to affect treatment plan) and assessment of vitals and body systems 4-6 times/day is required* •All intermediate, Level I and II services •Isolation patients, not including universal precautions •PT, OT, ST services up to a total of 2.5 hours •IV medication administration via peripheral lines up to 2x/day •Care of two or more Stage III and/or IV dermal ulcers •TPN and TPN management •Tracheostomy with Inner Cannulas requiring suctioning or mist, oxygen, aerosolization and supplies •Respiratory Therapy by a Respiratory Therapist a minimum of 2x/day for pulmonary toilet	D	29, 32	193	$440
Level IV – Skilled Nursing Care *Extensive nursing and technical intervention. Active medical care and treatment of comorbidities (with potential to affect treatment plan) and assessment of vitals and body systems 4-6 times/day is required* •All Intermediate, Level I, II, and III Services •PT, OT, ST services up to a total of 3 hours	D	29 32	194	$490

Mix Solutions

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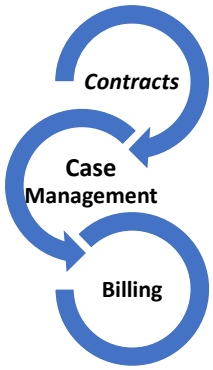
Mastering Managed Care
Key Components to Success

6

Efficiently running an effective monthly Triple Check Meeting for checks and balances to properly bill a Clean Claim



***The creation of the Triple Check Checklist is to ensure all information is accurate and correct**

SUCCESS with Managed Care is essential for viability, operability and sustainability.

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Mastering Managed Care
Key Components to Success

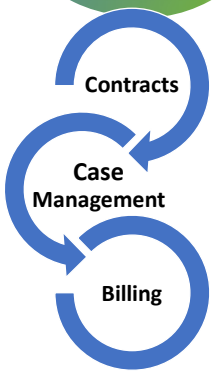
Business Office Systems

Triple Check Efficiency

- Clean Claim
  - Health plans needs/wants
- Prep Tool
- What to confirm prior to meeting
- Items to review during meeting
- Communication

Tracking and Follow-up System

- Proper posting
- Clean books
- Accurate picture of financials



***If we don't know our contracts we will not properly admit, manage or bill!**

SUCCESS with Managed Care is essential for viability, operability and sustainability.

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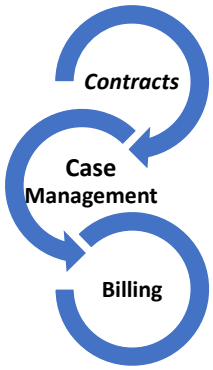
Mastering Managed Care
Key Components to Success

7

Systemic approach to Aging Review with accurate EOB assessment leading to tracking trends for non-payment of claims

****The identification of trends leading to non-payment of claims should yield change in managed care systems resulting in quicker case flow***



SUCCESS with Managed Care is essential for viability, operability and sustainability.

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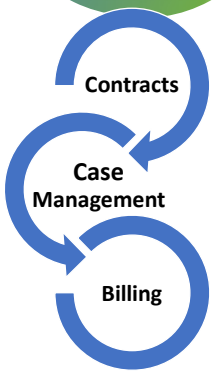
Key Components to Success

Business Office Systems

Aging Review

- **Trends/Reasons for Nonpayment**
  - **Reimbursement**
  - **Payor**
  - **Authorization**
  - **Rev codes**
  - **Timeliness**



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Billing – Claims - Revenue

Aging Review

Days MCOs	30	60	90	120	150	180	210+
BCBS	$9,898	$0	$68,422	$41,424	$2,369	$1,824	$6,300
Humana	$10,980	$9,430	$43,495	$26,531	$4,682	$3,348	$89,595
Coventry	$0	$9,455	$21,768	$34,889	$0	$0	$1,350
United	$19,769	$22,475	$53,965	$37,654	$36,598	$27,096	$75,789

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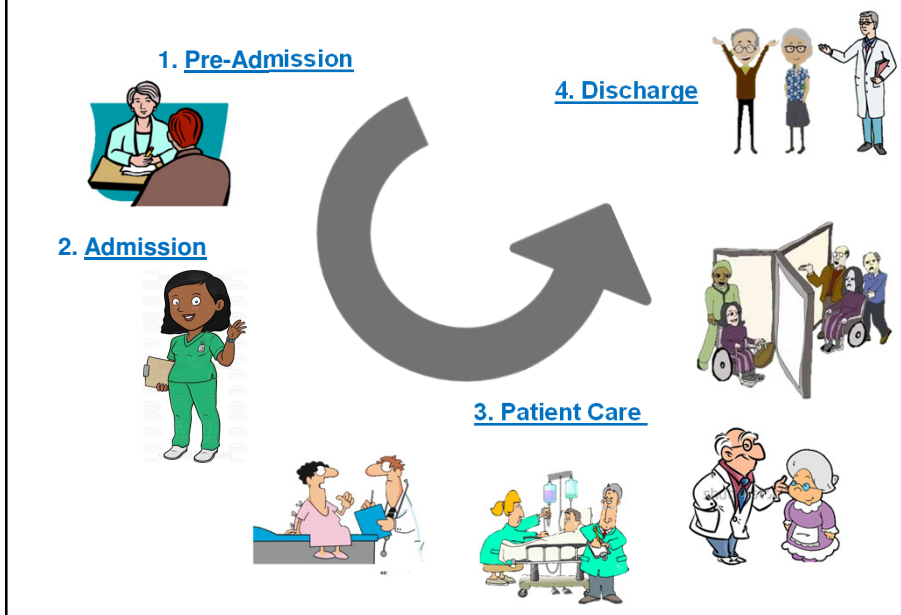
DO YOU KNOW YOU? "A Day in the Life of SNF"



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DO YOU KNOW YOU?

Managed Care Reality?

SNF 1

- **Patient Admitted**
- **Length of stay "X" number of days**
- **Business office submits claim to insurer for inpatient days**

SNF 2

- **Insurance Verification**
- **Authorization/Extended Authorization**
- **Communication on LOC, changes in LOC**
- **Communication on exclusions**
- **Triple Check meeting**
- **Business office submits claim to insurer for inpatient days**

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DO YOU KNOW YOU?

VALUE and IMPACT: INVEST in MASTERING!

- *Are you capturing all contract exclusions? (Meds, DME, Transportation)*
  If no, what is that cost each month?
- *Is facility tight in monitoring approved therapy limits of managed care contract?*
  If no, what is the cost of therapy services vs what is reimbursed by plans?
- *Is there an authorization for each managed care patient? An extended authorization?*
  If no, how much money is sitting in billing buckets (unpaid claims) due to no auth?
- *Are patients being managed daily for change of condition?*
  If no, what is loss in increased reimbursement for an increased level of care? Yet we are providing services to patient at higher acuity
- *Do you know your contracts? Does appropriate staff have access to them?*
  If no, what is the price of not being aware of contract rates, exclusions, business terms,

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SHOW ME THE MONEY!

Health Plan Contract

Custodial Rate $185
Level 1 $290
•Ostomy Care
•G-tube/NG tube
•Routine Lab & X-ray
•Wound Care Stage I & II
Level 2 $345
•IV Hydration
•Up to 1 hr therapy (PT,OT,SP)
•Wound Care Stage III
Level 3 $440
•Isolation patients
•Up to 1.5 hrs therapy per day (PT,OT,SP)
•IV Medication Administration-single
•Wound Care Stage IV
Level 4 $490
•TPN administration
•Multiple IV administration
•Up to 2 hrs therapy per day (PT,OT,SP)
EXCLUSIONS
Vancomycin, Lovenox, Procrit, Epogen, Neupogen, Rocephin,TPN, Zosyn, Specialty beds, Wound Vac, CPM Machine

Patient Grandma Alice

Admit: 1/14/13
7 Day Auth

Diagnosis: Diabetes, S/P ORIF

Services Needed:
IV Zosyn x 7 days ($2800)
PT/OT 1hr
Stg III wound on heel
Lovenox x 10 days ($1800)

Day 3: IV Vanco ordered for 14 days ($480)

Day 7: IV Zosyn dc'd

Day 8: Therapy increased from 1 hr to 2 hrs per day

Discharged 1/28/13

FACILITY RCVD AUTH FROM HMO FOR LEVEL II FOR 7 DAYS

Maximum Use of Contract

"NO CLUE" SNF

Jan 14-28 Level II $345 x 14 days

Total Billed $4830

Total Paid $2415

Out of Pocket $5080

(Vanco $480)
(Zosyn $2800)
(Lovenox $1800)

LOSS $-7495

"ON THE BALL" SNF

Jan 14-16 Level III (IV ZOSYN) $440 x 3 days

Jan 17-19 Level IV (IV VANCO) $490 x 3 days

Jan 20 Level III (DC'D ZOSYN) $440 x 1 day

Jan 21- 28 Level IV (THERAPY) $490 x 7 days

Vanco $480
Zosyn $2800
Lovenox $1800

Total Billed $11,740

Total Paid $11,740

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Mastering Managed Care
Key Components to Success

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