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GROUP

When the earth moves under your feet: Medicaid and the Shift to Managed Care

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EXECUTIVE SUMMARY

Nationally, the shift from traditional Medicaid and traditional Medicare to Managed Medicaid and Managed Medicare is both one of the hottest trends and one of the most difficult for hospital back offices to adapt to.

The traditional pain points in Revenue Cycle Management are amplified with these plans: eligibility and authorizations requirements, variation from standard CMS claims editing, working with third party administrators (TPAs), and new reimbursement methodologies.

Many of the tried and true techniques to fine tune AR management remain the best approach, but the current environment requires a disciplined approach to seismic safety for the reimbursement infrastructure.

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INTRODUCTION

During an earthquake, the stress applied to the ground can cause a phenomenon known as soil liquefaction. Uncompacted, moist soil tends to compress under stress, leaving these particles "floating" between the remaining water particles which do not compress as easily. Structures tend to become highly unstable on the solid ground where they were built – and often topple as a result.

The changes going on in the Medicaid and Medicare markets across the US are causing a similar shifting of the ground beneath the feet of many providers. Managed Medicare and Medicaid are proliferating across the United States in the hope of bringing efficiencies to our healthcare delivery system.

The challenges posed by the increase in Managed Medicaid and Managed Medicare plans, while not outside of the usual set of problems, have a dramatically increased impact on the stability of the revenue cycle, and therefore are extremely daunting. Instead of dealing with a single Medicaid payer, providers now need to deal with upwards of eight to ten, all with varying degrees of adopting Medicaid regulations and levels of technology. If not responded to in an effective manner, they will likely have very significant Net Revenue and Cost-To-Collect impact. Organizations who had not adopted best practice processes before the payer mix shift need to act now, before they are toppled by the shift happening beneath their feet.

THE ISSUES

Shifting Payer Mix

Nationally, there is a trending payer mix shift. Traditional Medicare patients are electing enrollment in Managed Medicare Plans, and many states are electing to outsource management of their Medicaid populations to commercial Managed Medicaid Plans. In theory, the financial motivation behind these changes is that these commercial health plans can more efficiently manage the business, thus drive reduced administrative costs and achieve better health outcomes. In practice, health systems experience higher administrative burdens, increased revenue leakage from denials and underpayments, and lower net reimbursement.

New Reimbursement Methodologies

Another national trend is experimentation with new reimbursement methodologies. In aggregate, there is population health risk sharing and incentive programs based on various quality measures.

The most difficult reimbursement methodology to understand is the adoption of Enhanced Ambulatory Patient Groups (EAPGs), a model similar to – but distinctly not identical to – the Medicare APC (Ambulatory Payment Classification) method. Outpatient services are grouped into logically associated groups which carry specific reimbursement values that are multiplied by provider-specific weights to calculate reimbursement. On top of this, there are various rules for combinations of EAPGs and specific diagnoses that affect which EAPG some CPT Codes map to.

In an already complicated world, EAPGs inject an entirely new level of complications. Monitoring payer compliance administering contractual rates requires implementing expensive proprietary technology – on top of any contract management software already implemented – at significant cost and complexity.

Almost all managed Medicare and Managed Medicaid plans generally say that they follow CMS processing rules, but in the details, they tend to pick and choose which rules they adopt. Each payer publishes (annually, quarterly, and even monthly) updated guidance on non-covered services and changes to bundling rules.

Eligibility and Authorizations

Managed Medicare and Managed Medicaid plans put additional burdens on the Patient Access functions, particularly the insurance verification and authorization processes. First, many of the patients who have elected (or been assigned to) a Managed plan continue to tell schedulers and registrars that they have "Medicaid" or "Medicare". When the staff performing those functions are pressed for time, they often just pull forward whatever insurance was on the last registration.

In this new world of managed care, detailed insurance verification is critical. Verifying Medicare or Medicaid often returns a "positive" check – because the patient does have those benefits – however, the staff needs to read all of the details of the verification, particularly the Coordination of Benefits section that would indicate if the patient has elected (or been assigned to) a managed plan. Further, additional audit steps need to be implemented to ensure the correct Plan Code configured in the registration system is selected. Many providers bill traditional BCBS to one electronic payer ID and Managed Medicaid BCBS to a different electronic payer ID. Just picking the most common BCBS Plan Code on the system can often result in downstream eligibility denials. Alternatively, picking a generic Medicare and Medicaid HMO plan code may cause delays in processing and timely filing issues.

Authorizations are even more complicated. Managed Medicaid and Managed Medicare payers have the most restrictive authorizations rules of any payers. They also make more frequent changes to policy than commercial plans and are the least forgiving (in terms of retro-

authorization) on appeal. In the old world, Patient Access could rely on Medicare's National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) and a relatively small list of procedures requiring authorization for traditional Medicaid.

Today, that single Medicaid list is split into as many as eight to ten separate Managed Medicaid Plans, each with their own nuances. Now, the team needs to balance a very significant and volatile matrix of plans and procedures requiring various forms of notification, authorization, and precertification.

Use of TPAs

Over the past ten years, outsourcing has been a common way for insurance companies to reduce their administrative costs. With the complex nature of Managed Medicare and Managed Medicaid plans and the significant differences between these plans and their core commercial products, even the largest payers have begun to rely on third party administrators (TPAs).

Unfortunately for many providers, these TPAs do not provide the service level normally associated with large commercial insurance companies. This causes a variety of difficult problems. Many do not provide standard Electronic Data Interchange transactions for claim status or remittance processing. Some do not even provide online portals for basic services, and their call centers performance levels are notoriously poor.

HOW PROVIDERS CAN RESPOND

The problems associated with Managed Medicaid and Managed Medicare plans are daunting. But the good news is that none of these problems are new. Providers have always faced insurance verification, authorization, payment compliance, and poor claims processing problems.

The solution is simply to do everything you've always done . . . just do it better, more comprehensively, and more precisely.

Failing to adapt to the new challenges puts revenue in peril. Organizations who had not adopted best practice processes before the payer mix shift need to act now. The following are some practical actions providers can take to raise their performance level.

Financial Clearance Processes

- Coordinate with Managed Care Contracting and put together a detailed list of the Managed Medicaid Plans that are contracted with your health system and the associated plan codes to select during registration. Build a training package that outlines which payers are contracted, what their insurance cards look like, and what services require special attention. This list needs to be maintained quarterly at a minimum.

- Review with all staff that perform insurance verification the particular screens/sections to review the Coordination of Benefits section of the eligibility check result (271 transaction). Run a check of a patient that has Managed Medicaid on your insurance verification platform and take a screenshot of the section showing the plan the patient has been assigned to.

- Implement a 1st of the month process to re-verify all in house patients with Managed Medicaid plans to catch any cases that have eligibility cut over between plans between months.

- Build an authorization matrix that the staff can use as a job aid to quickly refer to, instead of going from memory. The monthly process of updating the job aid serves as a training aid itself. Managers who walk the floor and check all the workstations for an updated authorization matrix will quickly know if the staff are up to date on authorization requirements.

- Implement a specific process for how to handle newborn Medicaid cases. Each Managed Care payer likely handles adding a baby to the plan differently. Having a process in place to systematically ensure every newborn is covered either through traditional Medicaid or Managed Care Medicaid is crucial, especially given that these cases are often higher dollar.

Claims Processing

- Nationally there are very few billing editors and regionally there are even less. Ensure your claims editor is configured to handle Managed Medicare and Managed Medicaid claims as their own claims class. Simply following the commercial claims edits or even just the Medicare or Medicaid edits is not sufficient. Often edits need to be run in a specific sequence to ensure the right outcome is achieved on the final bill.

- In addition, many Medicaid HMO payers have implemented strict front-end edits to ensure specific encounter data is present and accurate so that they can in turn have all encounter reporting requirements to submit to the state. Examples of these include taxonomy codes, National Provider Identifier (NPI) validation, and National Drug Code (NDC) requirements. Look at billing throughput

by payer is key to ensuring edits are being worked and all claims are reaching the payer timely. *(See Appendix)*

- Many of the payers who use TPAs to process their claims will accept claims through the editor, but then have a separate set of edits to accept those claims into their adjudication system. Claims may pass through the clearinghouse edits and be marked as received (and even assigned a trace number – DCN), but then never get processed for payment. When you call the payer call center, the representative may say something like "we never received that claim." Instruct your team to refer to have the trace number handy and do not allow them to simply state that the claim is past the filing limit. *(See Appendix A for an example payer scorecard tracking claims processing performance)*

Underpayments and Denials Management

- The reimbursement rules are so complicated and volatile that it is almost certain payers are making underpayments errors. If contract management software is over-budget, or IT cannot handle another project, find a vendor who can do these recoveries for you on a contingency basis. Manage them actively and be sure to capture the themes, so you can work with the payers to systematically stop the underpayments and avoid excess vendor fees.

- Managed Medicare and Managed Medicaid tend to have significantly higher rates of initial denials (remittances denying line items or entire claims) than commercial or government payers. Tracking these denials in details is critical. Build a denials management scorecard and a cross-functional team to implement process changes to prevent denials in the future. *(See Appendix B for an example Denials Scorecard)*

- Hold payers accountable for non-descript denials such as non-covered, lacks information, or payment included as a part of another service. As an example, “lacks information” can be used as a general catch all for more specific information the payer is looking for on the claim including NDC codes, NDC units, and missing procedure codes to name a few.

CONCLUSION

As the potential impacts of soil liquefaction have become better understood, building techniques have been adjusted to minimize damage. Active efforts to compact soil and the injection of stabilizing materials can greatly reduce the impacts. But these efforts all come with additional costs.

The problems posed by the increase in Managed Medicare and Managed Medicaid plans are not new, but they can have very significant Net Revenue and Cost-To-Collect impact if not aggressively managed. The techniques we recommend are tried and true, but they need to be executed to a whole new level of performance. Facilities need dedicated resources who specialize in this payer mix to help manage the new complexities introduced. The need for denials analysis and payer management starts to increase exponentially; business offices are no longer working with a single payer - Medicaid (or Medicare) - as now there are upwards of 10 payers for each, all holding significant volume, with varying processing issues. This trend ensures additional administrative cost – revenue cycle executives need to decide whether those costs are in the form of increased performance level of the revenue cycle operation or in the form of revenue leakage from failing to adapt.

Providers that plan ahead and improve their operations before the impacts of managed care hit – before the earthquake compacts the soil – will be best positioned to prevent their revenue cycles from toppling.

FOR MORE INFORMATION

Please contact us with questions, comments, or for additional information.

The Colburn Hill Group and authors of this paper can be reached through our website:

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We look forward to hearing from you!

APPENDIX A

Most Managed Medicaid Payers are contractually required to process 90% of claims within 30 days, and 99% of claims within 90 days of submission. Measuring this performance is very difficult, but provides visibility to a part of the process the billing staff cannot control or influence.

Formula -- # of claims adjudicated (paid or denied)/# of claims submitted

% of Claims Adjudicated Within 30 Days	Claim Date								
Payer Name	2016-05	2016-06	2016-07	2016-08	2016-09	2016-10	2016-11	2016-12	2017-01
Payer #1	68%	77%	75%	74%	76%	72%	75%	76%	74%
Payer #2	66%	75%	74%	73%	75%	71%	76%	77%	75%
Payer #3	69%	78%	77%	76%	78%	74%	79%	80%	78%
Payer #4	72%	77%	76%	75%	77%	73%	78%	79%	77%
Payer #5	67%	72%	71%	70%	72%	68%	73%	74%	72%
Payer #6	70%	75%	74%	73%	76%	72%	77%	78%	76%

% of Claims Adjudicated Within 90 Days	Claim Date								
Payer Name	2016-05	2016-06	2016-07	2016-08	2016-09	2016-10	2016-11	2016-12	2017-01
Payer #1	76%	85%	83%	82%	84%	80%	83%	84%	82%
Payer #2	74%	83%	82%	81%	83%	79%	84%	85%	83%
Payer #3	77%	86%	85%	84%	86%	82%	87%	88%	86%
Payer #4	80%	85%	84%	83%	85%	81%	86%	87%	85%
Payer #5	75%	80%	79%	78%	80%	76%	81%	82%	80%
Payer #6	78%	83%	82%	81%	84%	80%	85%	86%	84%

APPENDIX B

Understanding the complete impact of denials can be difficult, and tracing denials back to their root causes takes time, diligence, and skill. However, measuring the complete process – including claim errors detected by the claims scrubber and all line item and claim level denials on payer remittances – is the best way to identify controllable sources of revenue leakage.

Formula 1 -- # of claims that have errors, rejections, or transmission failures in claims editor/# of claims that pass through editor

Clean Claim Rate	Claim Date				
Payer Name	2016-09	2016-10	2016-11	2016-12	2017-01
Payer #1	65%	68%	71%	74%	77%
Payer #2	67%	70%	73%	76%	79%
Payer #3	55%	58%	61%	64%	67%
Payer #4	78%	81%	84%	87%	90%
Payer #5	81%	84%	87%	90%	93%
Payer #6	33%	36%	39%	42%	45%

Formula 2 -- # of claims with a denial/# of claims remitted

Denial Rate						
Payer Name	2016-08	2016-09	2016-10	2016-11	2016-12	2017-01
Payer #1	11%	12%	12%	11%	13%	11%
Payer #2	13%	14%	11%	12%	14%	12%
Payer #3	14%	15%	12%	13%	15%	14%
Payer #4	16%	17%	11%	14%	16%	15%
Payer #5	17%	18%	12%	15%	17%	17%
Payer #6	11%	12%	12%	11%	13%	11%