Managed Care Lessons Learned

THE PROVIDER'S PERSPECTIVE
Presenters

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Introduction and Housekeeping

‣ Housekeeping
  • WebEx Chat Functionality for Q&A
  • Slides are posted at MCTAC.org and a recording will be available soon (usually less than one week)
  • 1 pager: *5 Questions Your Agency Should Be Asking* also available within a week

‣ Reminder: Information and timelines are current as of the date of the presentation
Agenda

- MCTAC Overview
- Lessons Learned
- Q & A
What is MCTAC?

‣ MCTAC is a training, consultation, and educational resource center that offers resources to all mental health and substance use disorder providers in New York State.

‣ MCTAC’s Goal
Provide training and intensive support on quality improvement strategies, including business, organizational and clinical practices to achieve the overall goal of preparing and assisting providers with the transition to Medicaid Managed Care.
CTAC & MCTAC Partners
Lessons Learned

Managed Care Readiness Team
Staff Education
Contracting and Credentialing
Authorizations
Billing
EHR and Claims Testing
Collaborating with MCOs
Cash Flow
Managed Care Readiness Team
Managed Care Readiness Team

Purpose of the team

- Coordinate across all of the different aspects of the agency or organization
  - Everyone must understand ‘bigger picture’, their role, and how they will be impacted
  - Everyone will be impacted, but cannot predict how
    - These meetings serve as an opportunity to work through that
Managed Care Readiness Team

Who is on the team

- Multiple departments/functions of the organization
  - Finance
  - Operations
  - Programmatic staff
  - Legal
  - HR
  - Compliance
  - Outcomes
  - Training
Managed Care Readiness Team

Team meetings

- Track progress and identify gaps
- Anticipate concerns, report issues, brainstorm solutions
  - Workflow
  - Training
  - Billing
Managed Care Readiness Team

Key lessons

♦ Team must:
  • Have a leader to hold everyone accountable
  • Must be fluid/adaptable and collaborative
  • Meet on a regular basis
  • Maintain greater vision *and* focus on shifting details (almost daily!)
  • Establish trust to problem-solve across the departments
Staff Education
Managed care 101 for all staff – the basic changes

- Frontline staff:
  - May be limits on service duration
  - Be able to explain changes to clients
- Back office: billing will be different

Many ways to educate staff – use all of them!

- MCTAC’s resource library
  - Eg., Top Acronyms guide (Tools on MCTAC.org)
- Staff meetings
- Newsletter to inform staff of upcoming and on-going changes
- Formal trainings (in-house and external)
MCOs use data to determine whether specific services or level of care is necessary, appropriate, and cost-effective.

MCOs know more about clients’ service use than you (tracking claims data).

This is a more complex way of tracking client progress:
- Number of visits
- Type of visits (medication v. group v. individual)
- Diagnosis
- Progress
Staff Education

Documentation

› Ensure that documentation provides the information needed to communicate effectively with MCOs
  • Diagnosis
  • Treatment plan
  • Goals
  • Progress notes

› Documenting for medical necessity means focusing on need more than strengths
  • Walk tightrope of recovery orientation vs. deficits/symptoms
Whether you are delivering HCBS services or referring out such services, everyone needs to understand:

- Definition of HARP and HCBS
- What HCBS offers
  - HCBS providers need to know details about designated services
- Plan of Care and connection to services
- Relationship between Health Home, MCO and HCBS provider
Contracting and Credentialing
Contracting

Work with all MCOs possible

- To maximize possible client base, try to contract with all MCOs, not just some
- Proactively reach out to each MCO
  - Look at the MCTAC Matrix to find contracting contacts for each MCO
- Be aware of “All Products” clause
- Use **P.E.N. guide** for best results
  - Prepare, Evaluate, Negotiate
Remember: government rates are only operational for two years. After that, negotiate rate with MCO directly
  - Have to prove value to get best rate

Having a contract doesn’t mean you will get referrals
  - Why would an MCO choose you? (better outcomes!)
Credentialing

“Credentialing” is a catch-all phrase

- Approval process conducted by each MCO
- Ensures your agency site and staff are all appropriately registered with MCOs
- Required for reimbursement

- Not the same as contracting
- Having credentialed staff doesn’t make you credentialed
- Submitting documentation doesn’t guarantee your organization is entered into all the MCO’s systems
Must submit credentialing documentation to each MCO

- Different forms for each MCO
- Each location separately credentialed (can include multiple programs in single location)
- Information typically requested includes:
  - Address
  - Tax ID
  - NPI number
  - Services provided
  - ADA compliance
Authorizations
Authorizations

Start early

- Authorizations start October 1, but you need to start working on them now
  - Sort clients by MCO, by program
  - This is a learning process for MCOs as well
    - ICL experience: We had to let MCOs know who was in our ACT and PROS programs (in a secure manner); they didn’t have this information
Authorizations

Who to contact

› Understand how each MCO wants to be contacted
  • Fax vs. phone call vs. web portal for submitting authorizations

› Most MCOs have different UM staff for HARP vs. Mainstream clients
  • Need to develop relationships with both departments (twice as many relationships)

› Use the **MCTAC Matrix** to look up who to speak with at each MCO about Authorizations
Both existing and new clients will eventually require authorizations or tracking

- **Clinics:**
  - No initial authorizations
  - 30 visits or more (depends on MCO), with possible request for more treatment
    - Need to track these visits to know when to request further care
    - Visits include assessment, groups, individual

- **PROS and ACT:** initial authorizations required
(Re) Authorizations  *(concurrent review)*

**Understanding requirements**

› Make sure Program Directors or leader understand each MCO’s re-authorization process and requirements
  
  • Document for medical necessity
  
  • Some MCOs prefer clinicians to request re-authorizations, others do not - check
  
  • Most MCOs want to see in documentation
    
    o Diagnosis
    
    o Treatment plan
    
    o Medications
    
    o Progress notes
    
    o Functional deficits
(Re) Authorizations

Timing

- First round of authorizations will take the longest
- Subsequent reauthorizations/concurrent review will occur on schedule which varies by MCO and type of program, for example:
  - Every 3 months, or 6 months
  - Every Treatment Plan Review
  - After X number of visits
- Document conversations with MCOs (in your EHR or otherwise) for reference if there are disputes
Tracking outliers

- Understand service use patterns
  - How long clients stay in service
    - Discharge planning from Day 1
    - At least one MCO says expected outpatient clinic visit frequency is 2 times a month – what does this mean for services?

- Emphasis on outcomes and data
  - More than just “services delivered”
  - What is proof services are effective?
    - Decrease hospitalizations
    - Medication Adherence
Billing
Billing

The Process

90 days to send in clean claim

Create claims

Send to 3rd Party Biller (if you use one)

3rd Party Biller sends claims to MCO

MCO receives claims

MCO adjudicates claims

You are responsible for making sure claims made it through each step (just because you have a clearinghouse don’t assume you are in the clear)

Even if claim is clean/adjudicated, MCO can still deny for clinical reasons
Billing

- Be clear who is carved in to managed care and who is still excluded
  - “Dual Eligibles”
  - OPWDD
  - Under 21

- Always verify insurance
  - Epaces
  - Insurance cards
  - Navinet
Billing

Getting paid

› Need a well-organized workflow to get clean claims out the door
  • Need to coordinate program, EHR, and finance staff

› Most claims denied because of the nuts and bolts of the claims process, not clinical reasons

› Pay attention to when you bill (no payment after 90 days)
  • Complicated with multiple programs because not all billed on date of service (PROS/ACT bill at end of month)
EHR and Claims Testing
EHR

- Make sure EHR can bill multiple MCOs (not just a single Medicaid payer)
- If applicable, make sure EHR has capacity to bill for all relevant programs (not just some)
- Are other organizations in your region using the same EHR system?
  - Collaborate/troubleshoot with each other
EHR

Modifications to system

- Assessment tools to measure outcomes need to be coded into EHR
- Ability to input authorizations into EHR
- Train on EHR system modifications and additions
  - System is constantly adapting based on new MCO information: need training to keep pace with changes
Claims Testing

‣ Who
  • Finance Team/Biller
  • MCO
  • Clearinghouse/ 3rd Party Biller
    • Make sure in advance they have capacity to accept claims for clinics, PROS, ACT etc.

‣ Set up an internal process that links:
  • Frontline staff entering authorization requests
  • EHR system with proper billable service options
  • Finance department preparing claims

‣ Test multiple program types, not just one model
Claims Testing

Limitations

› Claims testing merely tests the mechanical process of receiving the claim, not if there are any problems with the claims themselves.

› If the MCO isn’t offering to do claims testing, push them
  • Also can ask MCO do “real time” claims testing and work with them to fix problems live over the phone.
Collaborating with MCOs
Collaborating with MCOs

- Interactions with MCOs will involve many of your agency’s departments
  - Can designate a single staff person as primary point person or gatekeeper with MCOs (if there is capacity)
  - If no single designated person, keep information flowing through regular team meetings

- Contacting MCOs
  - Provider Relations are the MCO gatekeepers
  - Reach out to them if you don’t have a more specific contact (see MCTAC Matrix for contact info)
Building on MCO experience

- MCOs active in NYC now have knowledge of the process
  - Use their knowledge, forms, claims testing offers
  - NYC MCOS who are also contracting in ROS have already worked through some problems
Do MCOs have the right info?

› Check each MCO’s website for their list of providers
  • Is your agency listed
  • Does it list correct services
  • Is address and other contact info for services correct

› If important details are missing, contact Provider Relations

› Don’t assume MCOs are going to get everything right
Remember

 › You may get conflicting guidance from MCOs
   • While you may have to comply with MCO’s guidance, your senior leadership can also advocate if there is a more efficient or logical way to do something

 › You may need to explain program models to MCO representatives

 › MCOs are partners– collaborate!
Cash Flow
Lines of credit

- Prepare to do this at least 3 months before the transition
- Given the complicated transition process, it is likely you will see an interruption of revenue
Tools and Resources
Tools

**MCTAC Managed Care Matrix**
- Includes MCO contact info for:
  - Contracting
  - Credentialing
  - Billing
  - UM

**MCTAC Interactive FAQ**
- Find the answers to your questions

**MCTAC Billing Tool**
- Interactive UB-04 Form

**Get the Right Tools**
- Further Resources
Plan Matrix (con’t)
Billing Tool

The Managed Care Technical Assistance Center

Efficient Practices. Efficient Care.

Billing Overview

FORM UB-04

The MCTAC Billing tool is an interactive UB-04 form that walks through the components required to submit a clean claim. Whether you are new to the process or just want to quickly check one field, the billing tool is the ideal reference.

This tool will tell you what information is required for each field and will note specific plans’ requirements.

Please note this guidance applies to outpatient/ambulatory services only.

Hover over or click each numbered field for more information.

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6. Statement covers period - from/through

Enter billing period. When billing for monthly cases, only the

date of service is listed per claim form. Enter the
date in the FROM box. The THROUGH box may contain
the same date or may be left blank.

CPT/HCPCS

Please refer to updated Billing manual for

further guidance.


Dates must be entered in the format MM/DD/YYYY

Required

Note for outpatient. THROUGH box cannot be left
blank. If service was performed on one date the

Thru/Date box should contain the same date as the

FROM box.
The MCTAC FAQ tool is a collection of some of the most frequently asked questions surrounding areas of Managed Care Implementation in New York State.

Select a category (General, Billing, Contracting, Utilization Management, Revenue Cycle Management, HCBS, or Outcomes) to see common questions on that particular topic. Then narrow down the results by subcategory using the sidebar. You can also sort results by top questions or NYS policy and use the view all function to easily print or save all questions for future reference.

This list will continue to be updated to incorporate new information as it becomes available and additional questions we receive at our trainings and via email. Have a question that’s not answered here? Contact us at MCTAC.info@nyu.edu and we’ll do our best to help.

Pick a category that best suits your question:

- General Managed Care
- Billing
- Contracting
- Utilization Management
- Revenue Cycle Management
- Home and Community Based Services
- Outcomes
Resources

- Know where your voice can be heard
  - MCO/Provider/ State DOH Meetings

- NYS OMH Managed Care Mailbox
  OMH-Managed-Care@omh.ny.gov

- NYS OASAS Mailbox
  PICM@oasas.ny.gov
Questions