Preparing for Managed Medicaid

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Agenda

- Define Managed Care
- How Does It Work?
- Fundamentals of Managed Medicaid
- Define Utilization Management
- Benefits of Managed Care
- Challenges of Managed Care
- How Managed Care Lowers Costs
- Succeed in a Managed Medicaid Environment
- Thrive in a Managed Medicaid Environment
Definition of Managed Care

Merriam-Webster Defines Managed Care as:
- a system of health care (as by an HMO or PPO) that controls costs by placing limits on physicians' fees and by restricting the patient's choice of physicians

Wikipedia Defines Managed Care as:
- a variety of techniques intended to reduce the cost of providing health benefits and improve the quality of care ("managed care techniques"), for organizations that use those techniques or provide them as services to other organizations ("managed care organization" or "MCO"), or to describe systems of financing and delivering health care to enrollees organized around managed care techniques and concepts ("managed care delivery systems").

Medicaid.gov Defines Managed Care as:
- a health care delivery system organized to manage cost, utilization, and quality.

Managed Care

Managed Care Companies are usually hired by one of these:

- Federal Government
- State Government
- Employers
- Individuals
How Does It Work

How does Managed Medicaid Work?
Once a member becomes Medicaid Eligible, they are enrolled with an MCO (except for some excluded populations). The State pays the MCO a PMPM fee to cover the cost of that Medicaid Member. The MCO is then responsible for managing and paying for the healthcare needs of that member.

Managed Care Networks

To be “in network” you must have a contract with the insurance company AND your entity must be credentialed.
Managed Care Networks

Contract — Payer Relations
Negotiates Rates/Executes Payer Contract

Credentialing
Credentialing Coordinator
MCOs must credential all providers before enrolling them into the network

In Network
MCO provides effective date of contract
Upon successful completion of contract and credentialing (approx. 30 days)

Fundamentals of Managed Care

Utilization Management

Utilization Management (UM) is the evaluation of the appropriateness, medical need and efficiency of health care services according to established criteria or guidelines and under the provisions of a managed care plan.

The purpose of UM is to make sure that providers are delivering the right care in the right place at the right time, in order to provide the most cost effective services.
Utilization Management

Utilization Management involves:

• Authorization Requirements
• Medical Necessity Criteria
• Case and Disease Management
• Concurrent Review
• Discharge Planning

Utilization Management

Authorization Requirements

When authorization is required, it MUST be obtained BEFORE services are rendered. Many insurance companies will not allow you to obtain retro authorizations. Services that require authorization may not be paid if they are provided without first obtaining authorization from the insurance company. In order to obtain authorization, you must prove that services are medically necessary.
Utilization Management

Medical Necessity

This term relates to services or supplies that are needed for the diagnosis or treatment of a medical condition and meet accepted standards of medical practice. MCOs will not pay for services or supplies that do not meet medical necessity criteria. You can still perform the services or provide the supplies, but you will not get paid.

*Clinical documentation must be sent to the insurance company to support Medical Necessity in order to obtain authorization for services.*

Benefits of Managed Care

To the Community:

- Improves overall Health Outcomes
- Lowers the cost of Health Care
- Increases access to Health Care
- Value added benefits for patients
- Improves the patient’s overall experience
- Grows community services through support and donations
- Creates jobs
Benefits of Managed Care

To the Provider:

- Education and Training – for you and your patients
- Tools and resources to help manage your patient’s care
  - Care Gaps for your patients
  - Clinical Practice Guidelines
- Additional Reimbursement Opportunities
- Partners in the community
- Lots of data!

Challenges of Managed Care

To the Provider:

- Multiple Payers take the place of one
- Requires the knowledge of multiple web portals, UM Requirements, etc.
- Will require changes to some internal administrative processes
- Regulatory, Compliance, and Quality Audits
- Members will change plans

CHANGE IS GOOD.
You go first!
Decreasing Health Care Costs

Every dollar saved used to be someone's revenue!

Managed Care Organizations

THE EVIL EMPIRE... (HEADQUARTERS)
How Does Managed Care Lower Costs?

- Utilization Management
- Re-direction of care to appropriate, lower level sites of service
- Focus on Preventive Services
- Care Integration
- Patient and Provider Education
- National Correct Coding Initiatives
- Fraud, Waste, and Abuse

Fraud Waste and Abuse

The U.S. Office of Management and Budget (OMB) estimates that improper payments made under the Medicaid program, including fraud, waste, and abuse, amounted to $17 billion [in FY 2014]. This figure is a little over 5 percent of the total cost of the program. By becoming aware of the extent and nature of the problem, health care professionals may put themselves in a better position to help prevent and detect Medicaid fraud and thereby protect their practices while also protecting the Medicaid program.²

Fraud Waste and Abuse

Waste encompasses over-utilization, underutilization or misuse of resources, and typically is not a criminal or intentional act.
- Ordering excessive laboratory tests
- Ordering an MRI instead of a mammogram for preventive care

Abuse is defined as ...provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.
- A provider can abuse the Medicaid program even if there is no intent to deceive

Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.


Types of Fraud and Abuse

Fraud and Abuse in the Medicaid Program may occur in many different forms, including, but not limited to:
- Medical identity theft
- Billing for unnecessary services or items
- Billing for services or items not rendered
- Upcoding
- Unbundling
- Billing for non-covered services or items
- Kickbacks
- Beneficiary fraud

I encounter two types of people during Managed Care implementations:

1) Those who look for reasons why it will fail

2) Those who look for ways to make it succeed

Which one are you?

Succeeding in Managed Care

- Use the Web Portals! (including the State portal)
  - READ the Provider Manuals
  - READ the Provider Communications from the MCOs and State
  - Use online services
- Familiarize yourself with your Provider Agreement/Contract
- Submit timely updates for any change of information
- Use the data that is available to you
- Get to know your Provider Relations Representative!
- Schedule regular meetings
- Utilize Electronic Health Records and Electronic Billing
Go Electronic!

Estimated Per-Transaction Costs and Savings Opportunity by Transaction Type

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<tr>
<th>Transaction Type</th>
<th>Estimated Health Plan Cost</th>
<th>Estimated Provider-Facility Cost</th>
<th>Estimated Total Industry Cost</th>
<th>Potential Savings Opportunity</th>
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Sources: CAQH, Index, Milliman Inc.

2013 U.S. Healthcare Efficiency Index; Electronic Administrative Transaction Adoption and Savings; Revised May 5, 2014

Thriving in Managed Care

- Know the populations you serve, and manage them accordingly
  - Refer patients to case and disease management
- Use MCO data to your advantage!
- Review the Clinical Practice Guidelines (CPGs)
- Partner with the MCOs
  - Provider Committees
  - Community Events (health fairs/charities)
  - Pilot Programs
- Work your claim denials timely
- Take advantage of creative reimbursement options
  - Pay for Performance
  - Value Based Purchasing
    - Quality vs. Quantity
The National Institutes of Health describe Pay for Performance as a health care model which provides financial incentives to clinicians for achieving better health outcomes. In the traditional “fee for service” model, doctors are paid a set amount regardless of patient outcomes.1

VBP rewards providers who deliver better outcomes in health and health care for the beneficiaries and communities they serve at lower cost.2

1. Value vs. Volume
2. Measures
   1. Patient Experience
   2. Health Outcomes
   3. Process of Care
   4. Efficiency

1. How to monitor multiple measures throughout the year
2. Employ rapid interventions
3. Payment Reconciliation


Get Prepared!

- Take advantage of the training opportunities
- Read your managed care contracts
- Read the manuals and Quick Reference Guides
- Familiarize yourself with all the web portals
- Review coding guidelines and documentation requirements
- Measure and review patient satisfaction in your organization
- Look for Fraud, Waste, and Abuse in your organization. Eliminate it!
- Engage your EDI and/or Clearinghouse partner
- Review and update internal processes
   - Prior Authorization Requests
   - Claim Denials Coordination
   - Claims Payment Reconciliation
- Go Electronic – Electronic Claims, EFT, ERAs, Web Transactions
- Expect errors – mistakes, not malice!
- If something doesn’t work, talk to the MCOs
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