Managed Care for New York Skilled Nursing

PART 1 – What do the changes mean to you?

Presented by:

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Today’s Agenda...

- Introduction
- Medicaid Managed Care
- Key elements of NH Inpatient transition
- Impact on SNF operations
- Challenges and Opportunities
Introduction
Medicaid Redesign Goals

• Achieve the federal “triple aim”
  – Population health
  – Improved care
  – Lower cost

• Create budget certainty for the state
  – Redirect Medicaid spending from *fee-for-service* to *capitation*

• Contract with and pay fewer entities

• Integrate Medicaid with Medicare

• Access federal funding
Why Managed Care

Health Reform Infrastructure

- Care coordination and management
- Preventative health benefits
- Capitation and risk
- Single point of contact
- Provider network
- Added benefits or lower cost-sharing
Global impact of Medicaid Redesign and Medicaid Managed Care on skilled nursing facilities.

- Consolidation and contraction
- Lower occupancy
- Lost revenue
- Increased competition
SNF transition experience determined by

- Upstate vs. Downstate
- Urban vs. Rural
- Local economics
- Number of plans
- Size
- Organizational complexity
**Medicare PPS vs. Medicaid Managed Care**

<table>
<thead>
<tr>
<th>Medicare PPS</th>
<th>Medicaid Managed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>All inclusive PPS Rate based on clinical assessment</td>
<td>Bench Mark rate or Levels based on custodial or skilled care</td>
</tr>
<tr>
<td>MDS</td>
<td>UAS-NY</td>
</tr>
<tr>
<td>MDS Coordinator</td>
<td>Case Manager</td>
</tr>
<tr>
<td>Medicare B of A benefit</td>
<td>MMC / MLTC / FIDA</td>
</tr>
<tr>
<td>Med A included/excluded services</td>
<td>SNF Rate included/excluded services</td>
</tr>
<tr>
<td>Technical Component (TC) vs. Professional Component (PC) vs. Global Charge</td>
<td>Operating component vs. Capital component</td>
</tr>
<tr>
<td>Negotiating rates with Part B vendors</td>
<td>Negotiating rates with Plans</td>
</tr>
<tr>
<td>Payment delays due to lack of knowledge and new work flows</td>
<td>Payment delays due to lack of knowledge and new work flows</td>
</tr>
</tbody>
</table>
What’s Next

Transition to risk based reimbursement

• Value-based Purchasing (VBP)
Farewell Medicaid FFS

When one door closes…
Farewell Medicaid FFS

…and another door opens!
Medicaid Managed Care (MMC)
Medicaid Population

MLTC

- High Needs/High Cost Duals/Non-Duals
  - Non Long Term Care
  - Long Term Care
    - Mainstream HMO
      - BH SNP
      - AIDS SNP
    - Mainstream HMO
      - LTC SNP (former MLTCP)
      - CCM

- Children/Families
  - Mainstream HMO

- Partial Benefit
  - Possible FFS or other TPA

- Childless Adults
  - Mainstream HMO

Hospitals, Nursing Homes, Physicians, Nurses, etc.
Serving as part of plan networks, health homes, ACOs, etc.

Source:
Medicaid Managed Care (MMC)

- Populations and services not previously covered by commercial (LTHHC, SNF, BH, OPWDD)

- **Social Responsibility**
  - Incentives and controls to USE resources to improve population health, not DENY services for profit
MMC vs. Commercial

MMC Incentives and Controls

• Transparency
• Cap on profits
• Quality Measures/Quality Pool
  • Number of claims paid and days claims outstanding
  • Dis-enrollments – reasons why
  • Utilization statistics
  • Cost per unit statistics
  • Patient Satisfaction
• Advocacy Groups
Key Elements of Nursing Home Transition to Medicaid Managed Care
Nursing Home Transition

Office of Health Insurance Programs

Transition of Nursing Home Benefit and Population into Managed Care

February 2015 Implementation

Source:

Transition of Nursing Home Populations and Benefits to Medicaid Managed Care

January 2015

Source:

TRANITION OF NURSING HOME POPULATIONS AND BENEFITS TO MEDICAID MANAGED CARE
Frequently Asked Questions
January 2015

Source:
### 2014 Availability of Managed Long-Term Care Plans in the NYC Region

<table>
<thead>
<tr>
<th>MLTC Health Plan</th>
<th>Member Services Phone Number</th>
<th>Bronx</th>
<th>Kings</th>
<th>New York</th>
<th>Queens</th>
<th>Richmond</th>
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<tr>
<td>Aetna Better Health</td>
<td>1-888-456-9126</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
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<tr>
<td>AgeWell New York</td>
<td>1-866-586-8044</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
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<tr>
<td>AlphaCare of New York</td>
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<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
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<tr>
<td>Amerigroup Community Connections</td>
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<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
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<tr>
<td>ArchCare Community Life</td>
<td>1-855-380-2589</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
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<tr>
<td>CenterLight Select</td>
<td>1-877-225-8500</td>
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<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
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<tr>
<td>CenterPlan for Healthy Living</td>
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<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
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<tr>
<td>Elderplan dba Homefirst</td>
<td>1-866-396-4177</td>
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<td>YES</td>
<td>YES</td>
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<td>YES</td>
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<tr>
<td>ElderServe</td>
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<td>YES</td>
<td>YES</td>
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<td>YES</td>
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<tr>
<td>Extended MLTC</td>
<td>1-855-299-8492</td>
<td>YES</td>
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<td>YES</td>
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<td>YES</td>
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<tr>
<td>Fidelis Care at Home</td>
<td>1-888-343-3547</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
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<tr>
<td>GuidNet</td>
<td>1-866-722-4049</td>
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<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
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<tr>
<td>HIP MLTC</td>
<td>1-877-411-3523</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
</tbody>
</table>

Source:
Managed Medicaid Plans

• Do you qualify for Medicaid?
• What level/type of health care service do you need?
  – Routine (CHP, FHP)
  – Episodic (Maternity, joint replacement)
  – Chronic (Community based LTSS, Nursing Home)
• Are you eligible for Medicare (Dual Eligible)?
• Are you in a FIDA County (NYC, Nassau, Suffolk, Westchester)?

MMC
Medicaid Managed Care
(aka Mainstream)

or

MLTC
Managed Long Term Care
NH Benefit Transition Timeline

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 1, 2015</td>
<td>NYC – Bronx, Kings, New York</td>
</tr>
<tr>
<td></td>
<td>Queens, Richmond</td>
</tr>
<tr>
<td>April 1, 2015</td>
<td>Nassau, Suffolk, Westchester</td>
</tr>
<tr>
<td>July 1, 2015</td>
<td>All remaining counties</td>
</tr>
</tbody>
</table>

Highlights

- Current residents stay Medicaid FFS (not required to enroll in a plan)
- Individuals already covered by MLTC or MMC can not be dis-enrolled if long term placement required
- No one will be required to change NH due to transition
- Individuals new to Medicaid after effective date required to enroll in MLTC or MMC
- Individuals can change plans at any time to access desired NH (no lock-in)

Who Qualifies for NH Benefit:

- Eligible adults age 21+ who need long term custodial placement in a NH
## Two scenarios for new long term placement

<table>
<thead>
<tr>
<th>No Medicaid</th>
<th>Has Community Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medicare Advantage or Medicare FFS and no Medicaid on admission</td>
<td>• Dually eligible - Medicare Advantage or Medicare FFS and MLTCP</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Has Medicaid</th>
<th>Has Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Dually eligible – FIDA, PACE, MAP</td>
<td>• Medicaid only – Medicaid Managed Care</td>
</tr>
<tr>
<td>Steps for long term placement</td>
<td>No Medicaid</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Clinical determination for long term placement</td>
<td>No change.</td>
</tr>
<tr>
<td>Need for conversion to “institutional” Medicaid</td>
<td>No change. NH coordinates application.</td>
</tr>
<tr>
<td>If eligibility is confirmed by LDSS</td>
<td>NH bills Medicaid FFS until Plan enrollment, then Plan pays.</td>
</tr>
<tr>
<td>Once eligibility is determined by LDSS, plan enrollment or change completed by NY Medicaid Choice (aka Maximus)</td>
<td>60 Days to choose a plan. If no plan chosen, then auto assigned to plan that has contract with NH.</td>
</tr>
<tr>
<td>NAMI</td>
<td>No change.</td>
</tr>
<tr>
<td>If eligibility denied by LDSS</td>
<td>No change. NH collects privately.</td>
</tr>
</tbody>
</table>
Restriction/Exemption Codes.

- If approved, LDSS will enter specific Restriction/Exception (R/E) codes into WMS to identify the type of long term placement for managed care enrollees.
- These R/E codes will appear on plan rosters.
- ePACES will also reflect this information.
- R/E codes will also drive a Plan’s premium rate payment.
Eligibility

Restriction/Exemption Codes.

• MMC (Mainstream) R/E codes:
  o N1 - 1821 - Regular SNF Rate – MC Enrollee
  o N2 - 1822 - SNF AIDS – MC Enrollee
  o N3 - 1823 - SNF Neuro-Behavioral - MC Enrollee
  o N4 - 1825 - SNF TBI - MC Enrollee
  o N5 - 1826 - SNF Ventilator Dependent - MC Enrollee
  o N6 – 3479 – Partial Cap 21+ NH Certifiable (ends 3/31/15)
  o N6 – 3478 – MLTC Age 18+ (begins 4/1/15)
  o N6 – 3489 – Primary FIDA 21+ Dial Eligible
  o N7 - N/A – NH Budgeting approved. Awaiting M/C Enrollment

• MLTC R/E code:
  o N7 MLTC enrollee placed in SNF
Network Requirements

• If plans do not have a nursing home to meet the needs of its members, it must authorize out of network.

• Members will be allowed to change plans to access the desired nursing homes (no lock-in).
  • NH can direct patients to plans it contracts with

• If beds are not available at the time of placement, the plan must authorize out of network.
  • Member must have choice of two participating NH’s with available beds
Discharge Planning

- Plan must work with NH to ensure members are receiving care in the least restrictive setting. The decision should not be based on finance.

- Plan should be notified of all discharges.

- The NH, Plan, and member or representative must all be involved in discharge planning.

- The NH is responsible for creating and executing the care plan while in the facility.

- Plan may authorize and review care plans.

- Plan must authorize all community supports needed to retain the member in the community, if appropriate.
During Transition

• Benchmark rate guaranteed for 3 years after a county is deemed mandatory
  • Includes all aspects of NH FFS rate (Operating, Capital, Per Diems, Cash Assessment, Case Mix and Quality)
  • Universal Settlement outside of NH rate
• Can negotiate a rate acceptable to all parties and approved by DOH (risk sharing arrangement)
• Contracted rate must be increased by the Plan if it falls below the current market Benchmark rate at any time.
  • Benchmark rate will be updated on the DOH website at least twice a year
  • Plan must process retro active rate changes to NH’s
During Transition (continued)

• Bedhold
  • Policy remains the same, although prior authorization may be required

• Pharmacy
  • Current NH pharmacy arrangements must be honored during 3 year transition period unless another arrangement is negotiated
  • Residents receiving drugs not on the Plan’s formulary will continue receiving such drug for a 60-day period. After that, the Plan and provider must transition the member to a drug on the Plan’s formulary, where appropriate.
During Transition (continued)

- Medical (Medicare Part B)
  - Dual eligible members – services are still covered by Medicare FFS, Medicare Advantage, FIDA, PACE or MAP (i.e., physician services, lab, x-ray, PT, OT, Speech)
  - Medicaid only members - providers bill
    - Service included in benefit package bill to Plan
    - Service not included in benefit package bill to Medicaid FFS

- Pharmacy (Medicare Part D)
  - Dual eligible members - covered by Part D provider
  - Medicaid only members - bill to Medicaid FFS
# Benchmark Rate Billing Matrix

<table>
<thead>
<tr>
<th></th>
<th>Mainstream Managed Care</th>
<th>Managed Long Term Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ancillary is included in the benchmark rate &amp; is part of MC benefit package</td>
<td>Plan pays NH as part of benchmark rate</td>
<td>Plan pays NH as part of the benchmark Rate</td>
</tr>
<tr>
<td>Ancillary is <strong>not</strong> included in the benchmark rate &amp; is part of benefit Package</td>
<td>Plan pays administering provider</td>
<td>Plan pays administering provider</td>
</tr>
<tr>
<td>Ancillary is <strong>not</strong> included in the benchmark rate &amp; is <strong>not</strong> part of benefit Package</td>
<td>N/A</td>
<td>Administering provider bills Medicaid FFS</td>
</tr>
</tbody>
</table>

*Ancillary services can include: Lab Services, Electro-cardiology, Electro-encephalogy, Radiology, Inhalation Therapy, Podiatry, Dental, Physician, Psychiatric, Hearing Only, Medical Directors, Medical Staff Services, and Utilization Review.*
## Summary of Covered Services

<table>
<thead>
<tr>
<th>Service</th>
<th>MLTC-P</th>
<th>MAP</th>
<th>PACE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care management</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Home nursing</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Home health aides</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Personal care</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Nutrition services</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Adult day health care</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Medical social services</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Non-emergency transportation</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Personal emergency response system</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Physical, occupational, respiratory, and speech therapy</td>
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<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Nursing home care</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Physician care</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Inpatient hospital care</td>
<td>X</td>
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</tr>
<tr>
<td>Outpatient hospital care</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Laboratory/Radiology services</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Dialysis</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Mental health, substance abuse, and OPWDD services</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Emergency transportation</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

*Source: “Managing Long Term Care Services for Dual Eligibles”, Patrick J Roohan, New York State Department of Health, September 27, 2010*
Capital

- Calculated by DOH
- Passed through from Plans to Providers
- “Guaranteed” after 3 year transition
- NH Capital Workgroup will identify changes needed
- Capital Pool
Primary Care Provider

- All Plan members must have a PCP
- Members can retain their community PCP when they transition to NH
- Plan may use NH physician as a PCP if he/she maintains responsibilities similar to other network PCP’s
  - i.e., Disease management, referrals, and hours of availability
Impact on SNF Operations
Impact on Providers

Innovation

or

Devastation

YOU decide!
SNF Transition Issues

- Protect cashflow – Soft census, billing changes
- Contracts – Getting them, terms
- Partnering with plans and hospitals
- Understand SNF vs. Plan role in managing “transitions in care”
- Educate staff
  - Admissions, Social Work, Case Management, Billing
- Educate Families
  - NY Medicaid Choice
    (http://www.nymedicaidchoice.com/)
Impact on SNF Operations

- Contract Negotiation
- Admission and Discharge practices
- Case Management – skilled staff required!
- Revenue Cycle Management
- Internal Communications
Contract Negotiation

- Will be evolutionary and vary greatly by Plan
- Need to know if rate covers cost of service
- Know your strengths and be able to demonstrate (QUANITFY) them:
  - 5 Star rating (what it is and why, back story)
  - NHQP Score
  - Average LOS
  - Hospital readmission statistics
  - Staffing (NP or PA, Wound care nurse, etc.)
  - Special services (i.e., Diabetes management training for patient and family, bariatric, memory impaired)
# Sample Master Insurance Schedule

### ABC Nursing and Rehab Facility

**Revised: 11/27/14**

<table>
<thead>
<tr>
<th>Manage Care Plans:</th>
<th>Products:</th>
<th>Revenue Codes</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
<th>Notes</th>
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<tr>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>HIP &amp; Magnacare</td>
<td>121, 128, 110</td>
<td>148</td>
<td>158</td>
<td>138</td>
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</table>

<table>
<thead>
<tr>
<th>ALL INSURANCE PLANS</th>
<th>Out of Network-All-Mcr/Mcd/HMO/PPO etc</th>
<th>$325</th>
<th>$425</th>
<th>$525</th>
<th>$625</th>
<th>$725</th>
<th>Or at Medicare Rate - MDS Rate</th>
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<tbody>
<tr>
<td>Aetna</td>
<td>All-MCR/MCD/HMO/PPO/EPO etc</td>
<td>$240</td>
<td>$240</td>
<td>$340</td>
<td>$340</td>
<td>N/A</td>
<td>Rate increase requested.....Currently being reviewed</td>
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<td>Affinity Health Plan</td>
<td>Medicaid</td>
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<td>$330</td>
<td>$360</td>
<td>$650</td>
<td>N/A</td>
<td>Rate increase received...Effective date 04/01/2013</td>
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<tr>
<td>Affinity Health Plan</td>
<td>Medicaid</td>
<td>$255</td>
<td>$330</td>
<td>$360</td>
<td>$650</td>
<td>N/A</td>
<td>Rate increase received...Effective date 04/01/2013</td>
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<td>Amerigroup/Healthplus</td>
<td>Medicaid</td>
<td>400</td>
<td>400</td>
<td>400</td>
<td>400</td>
<td>N/A</td>
<td>One Flat Rate......Effective date 11/12/2012</td>
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<td>Medicaid</td>
<td>250</td>
<td>$250</td>
<td>$250</td>
<td>$250</td>
<td>N/A</td>
<td>One Flat Rate......Effective date 11/12/2012</td>
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<td>Cigna</td>
<td>All-MCR/MCD/HMO/PPO/EPO etc</td>
<td>$375</td>
<td>$475</td>
<td>$575</td>
<td>$650</td>
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<td>$430</td>
<td>$530</td>
<td>$600</td>
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<td>Elderplan</td>
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<td>$430</td>
<td>$530</td>
<td>$600</td>
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<tr>
<td>Empire BC/BS/Wellpoint</td>
<td>All-MCR/MCD/HMO/PPO/EPO etc</td>
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<td>475</td>
<td>575</td>
<td>575</td>
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<tr>
<td>Fidelis Care of NY</td>
<td>Medicare/Medicaid</td>
<td>225</td>
<td>$275</td>
<td>$325</td>
<td>$400</td>
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<tr>
<td>GHI</td>
<td>Commercial/HMO/PPO/EPO/POS</td>
<td>325</td>
<td>425</td>
<td>550</td>
<td>N/A</td>
<td>N/A</td>
<td>No Level 4, reserve for Vent patients..New Rates effective date 10/01/2012</td>
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<td>GHI</td>
<td>Medicare/No Medicaid Program</td>
<td>310</td>
<td>$375</td>
<td>425</td>
<td>N/A</td>
<td>N/A</td>
<td>No Level 4, reserve for Vent patients..New Rates effective date 10/01/2012</td>
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<tr>
<td>Guildnet</td>
<td>Medicaid</td>
<td>$240 + qpd</td>
<td>$315 + qpd</td>
<td>$400 + qpd</td>
<td>$510 + qpd</td>
<td>Quality Product Distribution</td>
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</tr>
<tr>
<td>Healthcare Partners</td>
<td>Medicare</td>
<td>$240 + qpd</td>
<td>$315 + qpd</td>
<td>$400 + qpd</td>
<td>$510 + qpd</td>
<td>Quality Product Distribution</td>
<td></td>
</tr>
</tbody>
</table>

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**Contract Negotiation**

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**Notes:**
- **Not Contracted:**
  - Guildnet
  - Healthcare Partners

**Quality Product Distribution:**
- HealthNet

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**Out of Network-All-Mcr/Mcd/HMO/PPO etc**: $325 $425 $525 $625 $725 Or at Medicare Rate - MDS Rate

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**HIP & Magnacare**: 121, 128, 110 148 158 138

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**Revenue Codes**: 190, 191, 199 192 193 194 195

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**HIP & Magnacare**: 121, 128, 110 148 158 138
Admission and Discharge

Admissions Practices

- Benefit verification (on-line and by phone)
- Authorizations (level, timeframe)
- Family education (benefits counseling)

Discharge Practices

- Change perception of who is dischargeable
- Discharge begins on admission
- Work with Plan on target discharge date
  - Not under your control anymore
- Discharge planning more involved
  - Coordinating with multiple Plans to identify approved providers
Case Management

- Dedicated resources
- Experienced
- Proactive
- Excellent communication skills (documentation comes from your EMR)
- Work with all departments to identify issues timely
Revenue Cycle Management

Billing Frequency
- Bill on day of, or day after, discharge
- Weekly billing ALL payers excluding Medicare A

Billing Tools
- Claims Management Software
- Clearing house (Emdeon, Capario, RelayHealth)
- Outsource billing

Collections
- Will spend more time to collect same or less money for short term patients

Cashflow

Clean claims are critical
Communication

• Staff
  • Interdisciplinary
  • Real-time (EMR, e-mail, secure texting)

• Families
  • Educate about plans, benefits (or lack of), and who is paying when
  • Difference between your decisions and the insurers (discharge date, services authorized)

• Vendors
  • Patient’s primary payers/plans, who to bill
Managed Care for New York Skilled Nursing

PART 2 – Important Changes to Admissions, Billing and Collections

Presented by:

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Leveraging Technology to Strengthen Cashflow
Leveraging Technology

- Eligibility Verification
  - Who, when, how
- Claims Management
  - Built in or external
  - Claim scrubbing
  - Claim status
  - Working by exception
- Automated secondary claims
Eligibility Verification

• Who - Admissions AND Business Office
• When - On admission, prior to every billing
• How – Both phone and on-line
  • On-line - Through your billing software or third party i.e. Ability, eMedNY, Plan websites
  • Manual vs. Automated
Leveraging Technology

Claims Management

- Built in or external
  - Clearing House
- Claim scrubbing
  - Understanding edits
- Claim status
  - Track adjudication through claim history
- Working by exception
- Automated secondary claims – **YES YOU CAN!**
Questions?
Resources:

- **OHIP Transition Document February 2015 - UPDATED:**
  

- **MLTC Plan Directory:**
  

- **MLTC Regional Consumer Guide:**
  

- **Managed Care Program Comparison**
  
  https://www.health.ny.gov/professionals/patients/discharge_planning/docs/managed_care_program_comparison.pdf