



Financial Management Professional Interest Section

August 8, 2024

Tips & Tricks for Revenue Cycle Success in Indiana Managed Care



What We'll Cover In Today's Session

- ▶ Managed Care in Indiana – New and Old
- ▶ New Pathways Program – 3 Newly Contracted Managed Care Entities (MCEs)
- ▶ MCE's Serving Other Programs
- ▶ How will the latest changes impact your business?
- ▶ EVV 101
- ▶ Billing complexities and disciplines for success



What Is The MCE Transition?

Indiana Medicaid transitioning to a Managed Care program called Pathways for Aging

Individuals who qualify for the program:

- ▶ 60 years of age and older
- ▶ Are eligible for a full-coverage aged, blind or disabled category (with or without Medicare)
- ▶ Can be receiving long-term support services including:
 - ▶ Resides in a nursing or long-term care facility
 - ▶ Are approved for an Aged and Disabled waiver
- ▶ Can be on the Behavioral and Primary Health Coordination program



NOT Eligible for the Pathways Program

- ▶ < 60 years of age
- ▶ Healthy Indiana, Hoosier Healthwise, Hoosier Care Connect Plan members
- ▶ Division of Disability Services Waiver members including
 - ▶ Family Support Waiver
 - ▶ Community Integration and Habilitation Waiver
- ▶ TBI Waiver
- ▶ Room and Board Members
- ▶ IDD Residents in Intermediate Care Facilities



MCE's Serving Pathways Program

You'll need individual contracts with each MCE and you can reach them using the information below.



INMLTSSProviderRelations@anthem.com

833-310-3775



in_providerservices@uhc.com



LTSSContracting@humana.com

866-274-5888

Pathways - How This Will Impact You

- ▶ Getting contracted with each MCE
- ▶ MCE's must contract with any willing provider for 3 years
- ▶ Performing billing across multiple MCEs
- ▶ Staying informed on the transition



MCE's Serving Other Programs

Hoosier Healthwise

- Anthem
- CareSource
- Managed Health Services (MHS)
- MDwise

Healthy Indiana Plan

- Anthem
- CareSource
- MHS
- MDwise

Hoosier Care Connect

- Anthem
- MHS
- UnitedHealthcare

EVV Complexity Increasing

- ▶ With the MCE Transition, EVV is not new.
- ▶ However, the state is more heavily enforcing EVV regulations for all programs.

That includes automatic claim denial for:

- EVV with data that doesn't match
- Visits that require more than what's approved

How Billing Is Changing

You might be familiar with only having to bill the state for Medicaid Waiver clients. Here's a before and after of the billing process.

BEFORE

You manually billed the state for Medicaid Waiver shifts with your clients.

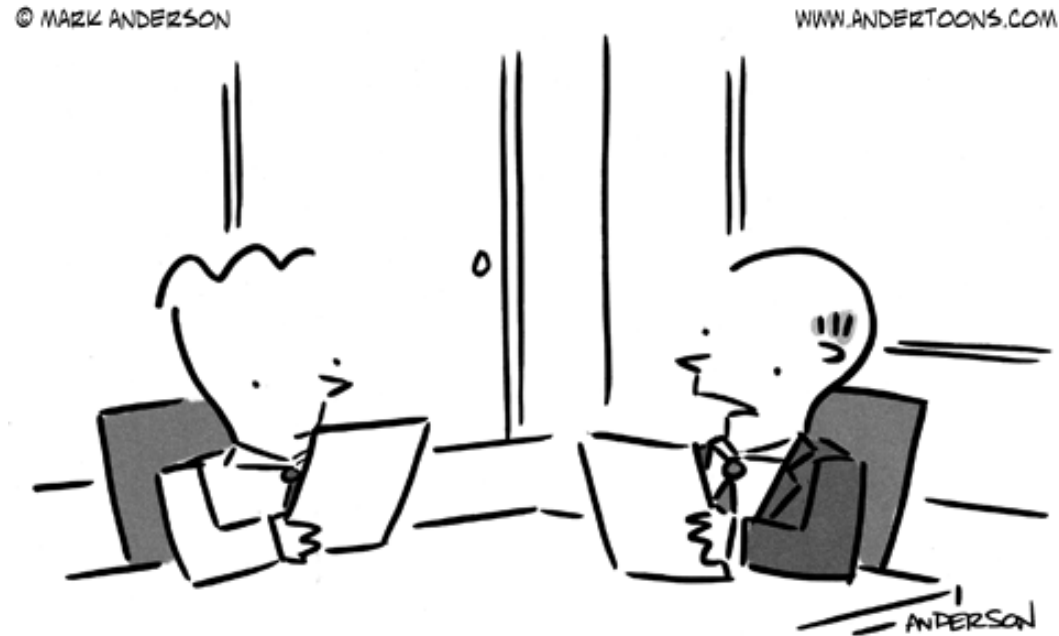
NOW

3 NEW payers are being added into the mix, and you need to be able to bill each one for the right services.

Revenue Cycle Management Processes

- ▶ Payer Contracts Administration
- ▶ Eligibility Tracking
- ▶ Authorization Compliance & Maintenance
- ▶ Billing Correctly – rates, codes, modifiers
- ▶ Claims submission – EDI tracking, resubmissions
- ▶ Payment reconciliation and posting
- ▶ Unpaid claims follow-up – denials, EVV discrepancies, unprocessed claims
- ▶ Reporting, tracking, metrics, KPI's

Payer Contracts Administration



"I understand what it means, I'm just saying
'LOL' isn't really appropriate in a contract."

Contracts Summary (Chargemaster)

<u>Payer</u>	<u>Dates</u>				<u>Terms</u>			<u>Contract Rates</u>			
	<u>Executed Copy</u>	<u>Inception</u>	<u>Expiration</u>	<u>Ever-</u>	<u>Timely</u>	<u>Timely</u>	<u>Timely</u>	<u>Code ==></u>	<u>T1019 - HHA Hourly</u>		
	<u>Received</u>			<u>Green</u>	<u>Filing</u>	<u>Appeal</u>	<u>Payment</u>	<u>Desc ==></u>	<u>Contract</u>	<u>Billed</u>	<u>Paid</u>
Payer 1											
Payer 2											
Payer 3											
Payer 4											
Payer 5											

Eligibility

iNSURED



Eligibility Tips

- ▶ Large dollar risk for billing incorrect payer or ineligible client
 - ▶ Up to 6 weeks billing at risk
- ▶ Obtain Medicaid ID# prior to admission
- ▶ Check Medicaid and Payer Eligibility 1st and 15th of each month – not earlier
- ▶ Payer switches – need auth from new payer (may be retro)
- ▶ An auth is not a guarantee of payment – eligibility is critical

Eligibility Complexities

Know the rules for Indiana:

- ▶ Auto-enrollment if consumer doesn't select a payer
 - ▶ Applies prospectively to new enrollees
- ▶ After 90 days – may switch at next Medicaid recertification date
- ▶ Consumers may change plans after going through a “Just Cause” grievance process
- ▶ Consumers in Traditional Medicaid may be switched to Pathways (or other managed care programs) as they age or qualify for applicable waivers
- ▶ Payer switches – need auth from new payer (may be retro)

Authorizations

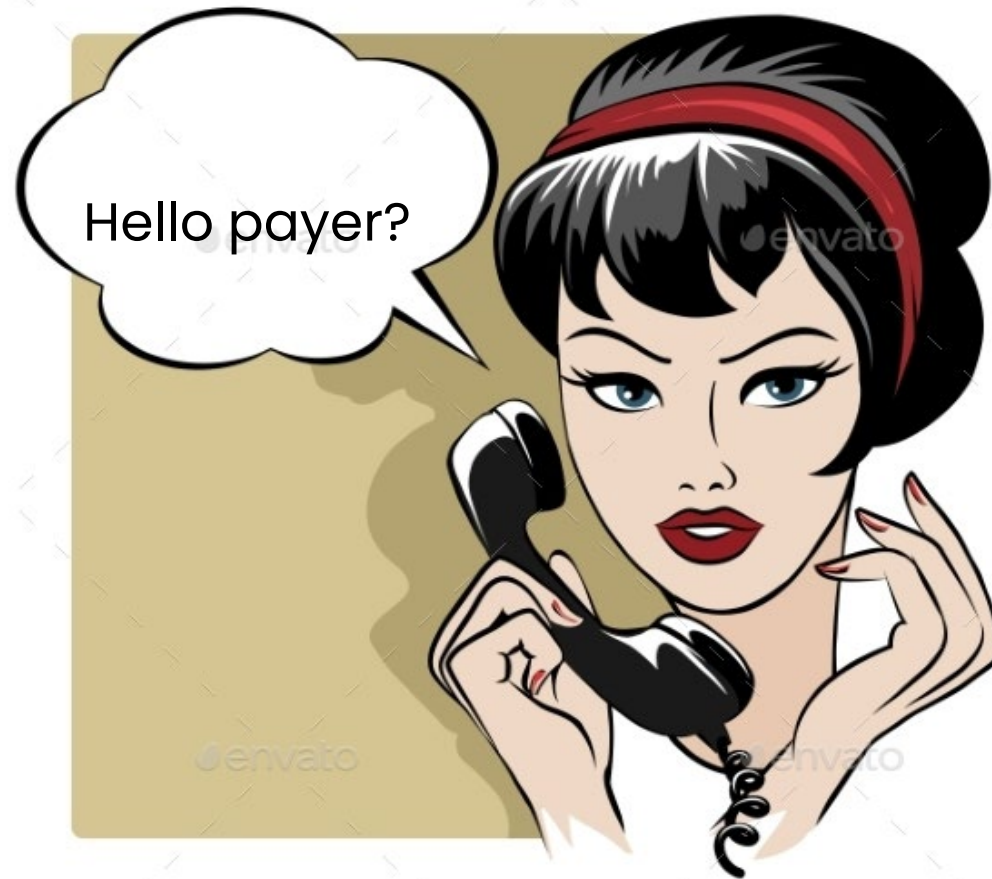


"The doctor will be with you in a few minutes. He's trying to figure out what disease goes with your insurance."

Authorizations and Case Set Up

- ▶ Second largest denial category (after Eligibility)
- ▶ Procedure codes, Modifiers, Member ID #, Units – count/type
- ▶ Watch for incorrect or missing info
- ▶ Units type and total units calculations
- ▶ Discrepancies vs contract
- ▶ Set up case correctly – eg procedure code/modifier and unit type per auth/contract/reality
- ▶ Monitor reauths – expiring, hospitalization returns
- ▶ Monitor system reports – expiring, expired auths
- ▶ Gaps from old expiration
- ▶ Service level changes – appropriate?
- ▶ Correct procedure codes, missing modifiers
- ▶ Make sure Dx code on bill matches auth

When In Doubt?



Billing Codes and Modifiers



Codes and Modifiers

- ▶ Contract, auth, service, and claim must match
- ▶ Auth shows non-contracted code? You're out of network or worse
- ▶ What's a modifier?
 - ▶ Defined by the payer eg:
 - ▶ Weekend services
 - ▶ Multiple beneficiaries on service in household

Claims Filing



Claims Submission

- ▶ Refer to payer's billing manual
- ▶ Put correct data in correct format in correct fields
- ▶ Bill electronically when possible
- ▶ Get paid electronically when possible
 - ▶ EFT, ERA
- ▶ Know timely filing rules – per payer contract or provider manual

Claims Not Billed



Unconfirmed Time In Your System

EVV discrepancies and paper timesheets

Monitor and resolve unverified time

- Report by coordinator



Held Billing – caused by system edits – your system and aggregator

Split shifts

Authorizations – end date

Procedure code/auth match

Monitor held billing edit reports

Release prior to timely filing deadline

EDI Tips



Verify claims counts / total dollars after every file



Check your rejections after every file



Check all payer portals for your files every week



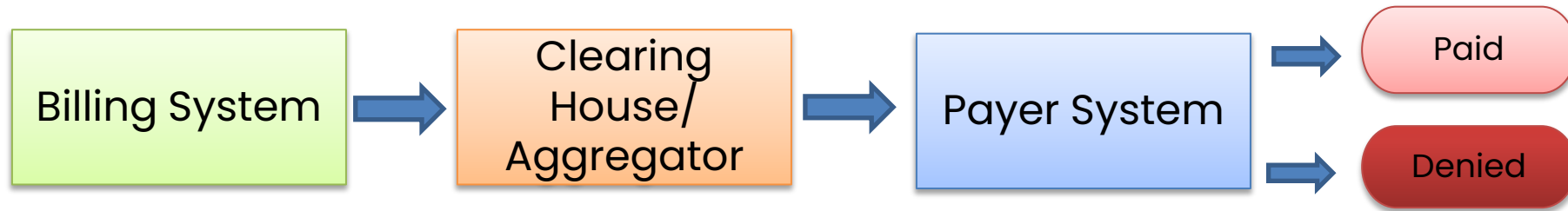
Check for, and post your payments every week

Set up auto-posting (ERA)



Identify, record and WORK denials every week

Payer System Denied Claims



▶ Denied Claims

- ▶ *Work your denials on a regular basis - start on receipt of eob*
- ▶ *Analyze your denials by payer and denial reason and look for trends*
- ▶ *Make process changes to avoid future denials*

▶ Examples of denials:

- ▶ Authorization not on File
- ▶ Number of Units Exceeds Limit
- ▶ Procedure/Service Not Authorized
- ▶ Client's authorization was terminated
- ▶ Client's authorization date range changed
- ▶ Duplicate Claim
- ▶ No EVV or EVV mi-match

Billing and Resubmission Tips

Resubmissions

- ▶ Resubmit entire claim, not just corrected DOS: Otherwise payer may recoup entire claim and only pay the corrected line
- ▶ MCE payers typically require a "6" or "7" in the bill-type field or claim will be denied as duplicate
- ▶ Above is typical, but always refer to provider/aggregator manuals

Metrics and Performance Tracking

AR Aging Reports

- ▶ The Aging Report will help you see which claims remain outstanding.
- ▶ If you missed working rejections or denials, these claims will be caught on your Aging Report. However, if applicable, your pre-billing held claims may not appear on the Aging Report since they have not yet been submitted for billing.
- ▶ This report is a tool for you to use to follow-up on all open balanced claims.

What Do I Need To Know? - Performance

Example Agency						
Billed vs Applied Dollars By Month						
Month	Billed	Adjustments	Net Billed	Deposits	Difference	<u>Deposits % Net Billed</u>
22-Jan	\$194,239	(\$508)	\$193,731	\$75,041	\$118,690	38.7%
22-Feb	\$189,312	(\$12,419)	\$176,893	\$150,063	\$26,830	84.8%
22-Mar	\$208,453	(\$5,094)	\$203,359	\$112,363	\$90,996	55.3%
22-Apr	\$199,312	(\$10,319)	\$188,993	\$211,363	(\$22,370)	111.8%
22-May	\$201,326	(\$440)	\$200,886	\$200,295	\$591	99.7%
22-Jun	\$209,127	(\$1,384)	\$207,743	\$56,286	\$151,457	27.1%
22-Jul	\$179,279	(\$15,332)	\$163,947	\$69,892	\$94,055	42.6%
22-Aug	\$182,872	(\$27,808)	\$155,064	\$285,566	(\$130,502)	184.2%
22-Sep	\$222,602	(\$12,030)	\$210,572	\$151,727	\$58,845	72.1%
22-Oct	\$210,041	(\$21,049)	\$188,992	\$209,972	(\$20,980)	111.1%
22-Nov	\$199,613	(\$2,427)	\$197,186	\$184,092	\$13,094	93.4%
22-Dec	\$224,520	(\$12,782)	\$211,738	\$295,643	(\$83,905)	139.6%
23-Jan	\$216,926	(\$2,207)	\$214,719	\$152,369	\$62,350	71.0%
Totals	\$2,637,622	(\$123,799)	\$2,513,823	\$2,154,672	\$359,151	85.7%
		-4.70%				

Agency Input: Biggest Issues

- ▶ Identification of Primary Payer (eligibility)
- ▶ Authed units – not enough to cover services ordered
- ▶ Payer switches – obtaining back-dated auths
- ▶ Auth changes not communicated by payer
- ▶ Auth disagrees with payer system
- ▶ Medicaid Eligibility – gap periods
- ▶ Reauths – gap periods
- ▶ Procedure code discrepancies – auth vs contract
- ▶ Billing rules – modifiers, individual/group hours on same claim
- ▶ Hospitalizations – need a new auth?
- ▶ Resubmission rules –
 - ▶ Paper? electronic?
 - ▶ 3rd position in bill type field – “6” or “7”?

Payer Input

- ▶ Top denials:
 - ▶ No authorizations/Units used on authorizations
 - ▶ Needing primary insurance
 - ▶ Not a valid member (eligibility)
- ▶ Top billing issues:
 - ▶ Not billing corrected claims correctly (not billing with indicator "6" or "7")
 - ▶ Overlapping dates of service on multiple claims
- ▶ Stale eligibility information
- ▶ Be sure you track pre-certification and bill the code on the auth or, if the auth has the wrong code, request an update

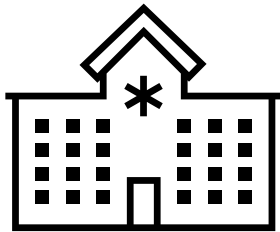
Who is Sandata?

Leading the IDD Provider Technology Industry

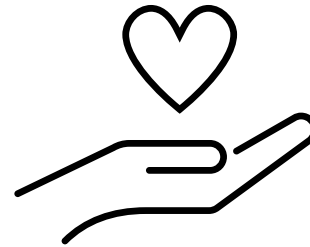
- ▶ Sandata has been a leading provider of software and technology solutions since 1978. We help payers and providers work together to more efficiently manage their businesses so individuals can get higher quality care.
- ▶ Our software and solutions are designed for:



Homecare



I/DD



Managed Care
Organizations
(MCO)

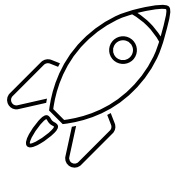


State Payer

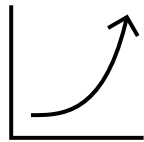
Strategic Advantage To Partnerships

Sandata Revenue Cycle Management

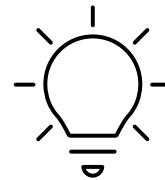
- ▶ Integrating RCM provides a modern approach to managing these financial operations through advanced automation and data management capabilities.
- ▶ Streamline Financial Operations
- ▶ Compliance and Security
- ▶ Scalability with Reduced Costs



Agency
Performance



Scalable
Growth



Proactive
Insights



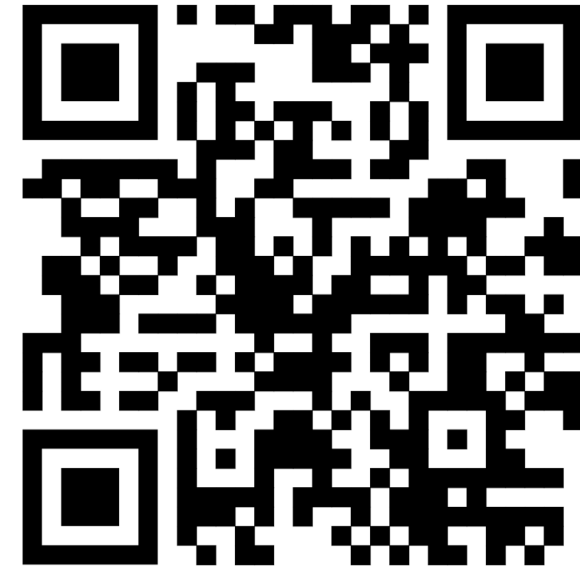
Agency
Partnership

Ready to learn more?

Book a demo for agency management



Book a demo for RCM



Thank You!

Phil Feldman
National Director of Revenue Cycle
Management
phil.feldman@sandata.com



Sponsorship Recognition

Alicia M. Boyd, CPA
Professional Corporation



CPAs / ADVISORS



INARF Strategic Priority: Data Collection, Advocacy

- Launching August 9, due August 30
- **New this Year: Free to Participating Members!**
 - Goal: increase engagement in the survey
 - Charging \$75 to Members that did not respond to the survey, but would like the results
- Results will be available at the end of November
- Thanks to Mindy Duddy for leading this project!



Contribute to the PAC

Your contributions to the INARF PAC are a critical part of INARF's legislative advocacy efforts. They are used to support elected officials who serve as champions of the provider community. Please consider supporting the INARF PAC today.

For more information and to contribute, visit:

www.INARF.org/INARF-PAC





Survey

Please use the QR code to take our
brief 3 question survey to let us know
how we did today!





Thank you!