WELCOME TO THE CLAIMS/PAYMENTS UNDER MEDICARE/MEDI-CAL MANAGED CARE SESSION

October 28, 2013
Cindy Cameron
Senior Director of Finance & Reimbursement
LightBridge Hospice, LLC

Kristina Runnels
Director Patient Financial Services
VITAS Healthcare Corp
OVERVIEW

- Medi-Cal Managed Care Program
- The 3 models of care
- Relationship between Medi-Cal and the Managed Care contracted entities.
OVERVIEW

Understanding the Division of Financial Responsibility (DOFR) between the Health Plans and its contracted affiliates who may hold risk for authorization or claims payment.
OVERVIEW

Understand how the Health Plans communicate/educate their affiliates (Medical Groups, IPA’s, Capitated Hospitals) in the hospice claims process under Managed Medi-Cal as it relates to:

- Authorizations
- Coding claims
- Hospice notification processes
- Determine Financial Risk for services
OVERVIEW

The Medi-Cal All Plan Letter and Room & Board payment requirements.
OVERVIEW

Recommendation to Providers on whom to contact in a shared risk situation, when both entities deny responsibility for claims payment, or deferring to each other.
OVERVIEW

Common Challenges and “Pitfalls” in the Claims process:

- From billing the claim
- To receiving the payment
Recommendations to reduce Challenges and “Pitfalls” in the claims process:
MEDI-CAL MANAGED CARE

Risk
Delivery system
Cost Certainty
Quality Outcomes
MEDI-CAL MANAGED CARE PROGRAM

- Transfer risk and responsibility from the state to the managed care plans
- Cost containment and cost certainty for all entities
- Cost effective healthcare provided through managed care delivery systems
- High quality measures/outcomes
Approximately 4.5 million Medi-Cal beneficiaries in 30 counties receive their health care through three models of managed care: 

- Two-Plan
- County Organized Health Systems (COHS) and
- Geographic Managed Care (GMC).

Medi-Cal providers who wish to provide services to managed care enrollees must participate in the managed care plan’s provider network.

Source: DHCS.CA.GOV WEBSITE/MEDI-CAL MANAGED CARE
Two Plan serves about 4.0M beneficiaries in 14 counties:

TWO PLAN MODEL
How It Works

In most Two-Plan model counties, there is:

1. “Local Initiative” (LI) and a
2. “Commercial plan” (CP)

The Department of Health Care Services (DHCS) contracts with both plans.

Source: DHCS.CA.GOV WEBSITE/MEDI-CAL MANAGED CARE
Local government, community groups and health care providers are able to give input when the LI is created.

The LI is designed to meet the needs and concerns of the community.
TWO PLAN MODEL
How It Works

The CP is a private insurance plan that also provides care for Medi-Cal beneficiaries.

Source: DHCS.CA.GOV WEBSITE/MEDI-CAL MANAGED CARE
EXAMPLES OF AN LI & CP

Local Initiative

SANTA CLARA FAMILY HEALTH PLAN

Commercial Plan

ANTHEM BLUE CROSS OF CALIFORNIA
TWO-PLAN

Source: CAPMAN Capitation Report 10/8/13
County Organized Health Systems (COHS)

COHS serve about 1.3M beneficiaries through six health plans in 14 counties:

- Marin, Mendocino, Merced, Monterey, Napa, Orange, San Mateo, San Luis Obispo, Santa Barbara, Santa Cruz, Solano, Sonoma, Ventura, and Yolo.

Source: DHCS.CA.GOV WEBSITE/MEDI-CAL MANAGED CARE
County Organized Health Systems (COHS)

How It Works

- In the COHS model counties, DHCS contracts with a health plan created by the County Board of Supervisors.

- Local government, health care providers, community groups, and Medi-Cal beneficiaries are able to give input as the plan is created. The health plan is run by the county.

- In a COHS county, most everyone is in the same managed care plan.

Source: DHCS.CA.GOV WEBSITE/MEDI-CAL MANAGED CARE
EXAMPLES OF COHS

CAL OPTIMA
COHS

Source: CAPMAN Capitation Report 10/8/13
GMC serves about 619K beneficiaries in two counties:

- Sacramento
- San Diego

Source: DHCS.CA.GOV WEBSITE/MEDI-CAL MANAGED CARE
Geographic Managed Care (GMC)

How It Works

In GMC counties, DHCS contracts with several commercial plans. This provides more choices for the beneficiaries, so the health plans may want to try new ways to enhance how they deliver care to members.

Source: DHCS.CA.GOV WEBSITE/MEDI-CAL MANAGED CARE
EXAMPLES OF GMC

COMMUNITY HEALTH GROUP

MOLINA
Source: CAPMAN Capitation Report 10/8/13
Nearly half of states have or are planning Medicaid Managed LTSS Programs

New Hampshire released a request for proposal (RFP) in October 2011, after the survey was completed. Although the state did not indicate plans to implement an MMLTSS program on the survey, the RFP includes the non-dual aged and disabled as a mandatory population in its managed care program, and dual eligibles as a voluntary population for July 1, 2012. The state is also seeking a waiver to include dual eligibles as a mandatory group in managed care.

Source: The Transformation of Long Term Services and Supports, AARP Public Policy Institute, February, 2012
FULL RISK/SHARED RISK AGREEMENTS
FULL RISK/SHARED RISK CONTRACTED PROVIDERS

Medi-Cal Agency and Contracted Managed Care entities enter into an arrangement by which the Contracted Managed Care entities accept risk for providing defined Medi-Cal services.

- Alternate types of capitation packages:
  - All Medi-Cal-covered LTC services only
  - All Medi-Cal-covered acute and LTC services
  - All Medicare and Medi-Cal-covered services (additional plan contract with CMS required for Medicare portion)

- Contracted Managed Care Entities then enter into agreements with providers through negotiated rates, per diems, capitated arrangements, etc. via a DOFR
Division of Financial Responsibility (DOFR)
Division of Financial Responsibility (DOFR)

Provides a framework for Contracted Managed Care Plans and Providers to use when allocating financial responsibilities for services.
Division of Financial Responsibility (DOFR)

- Useful tool for provider contracting, financial management, and claims administration of capitation/risk arrangements
- Reduces or potentially eliminates gray areas in defining which party has risk for a service
- Enables similar DOFR system configuration by contracted parties, thus making the contractual relationship more efficient
Division of Financial Responsibility (DOFR)

- Can be used to direct claims to the appropriate entity

- When claims payment is disputed, the DOFR can be used as a point of reference and can reduce Provider disputes

- Health plans’ ability to load a coded DOFR into their systems will reduce claims processing errors and reduce days in AR
ALL PLAN LETTER
ALL PLAN LETTER

WWW.DHCS.CA.GOV
Medi-Cal Managed Care Division
For Health Plans
All Plan, Policy & Duals Plan Letters
Medi-Cal Managed Care Letters
All Plan Letters
2007 - All Plan Letters
The Medi-Cal Managed Care Division (MMCD) communicates with Medi-Cal managed care contractors and Duals Plans participating in the Dual-Eligible Demonstration Project, by means of All Plan, Policy, and Duals Plan Letters.

All Plan Letters (APLs) are the means by which MMCD:

a) conveys information or interpretation of changes in policy or procedure at the Federal or State levels
b) provides instruction to contractors, if applicable on how to implement these changes on an operational basis.
c) Questions concerning a specific All Plan, Policy, or Duals Plan Letter, please call (916) 449-5000.
1) The purpose of this All-Plan Letter (APL) is to summarize contractual, regulatory and statutory requirements applicable to Medi-Cal managed care plans with respect to their responsibilities to provide hospice care services for its members. This APL updates and supersedes APL 05003.

2) The only requirement for initiation of outpatient hospice care services is a physician's certification that a member has a terminal illness and a Member's "election" of such services.

3) Of the four levels of hospice care as described in Title 22 CCR s51349, *only general inpatient care is subject to prior authorization*.

4) No prior authorization is necessary for the hospice to bill the plan for the room and board covered by Medi-Cal while the patient is receiving hospice care services under Medicare.

5) Prior authorization is not a Med-Cal requirement for routine home care, continuous home care or respite care.
Authorization for GIP

- Documents to be submitted for prior authorization include:
  - 1) Written prescription signed by the patient's attending physician;
  - 2) Patient's Hospice Election form
  - 3) Certification of terminal illness by a physician; and
  - 4) A Hospice General Inpatient Information Sheet (DHS 61 94).

- Prior authorization is not a Med–Cal requirement for routine home care, continuous home care or respite care.
COORDINATED CARE INITIATIVE

DHCS SLIDES
INSERTED HERE
CHALLENGES IN CLAIM/PAYMENT OPERATIONS
CHALLENGES IN CLAIMS/PAYMENT OPERATIONS

- Greater financial risk for missed authorizations/re-authorizations
- Operational efficiencies to manage the claims process for multiple plans
- Communication/relationships with each plan to resolve underpayments, denials, appeals, etc.
- Managing timing/delays in payments
CHALLENGES IN CLAIMS/PAYMENT OPERATIONS

- System and IT requirements
- Staff resources, communication and education
- Data analytics for financial performance
- Regulatory Compliance
COMMON “PITFALLS” IN THE CLAIMS PROCESS
COMMON “PITFALLS” IN THE CLAIMS PROCESS

- Financial responsibility is ill-defined creating an impact to both cash flow and accounts receivables
- Non-standard formats across multiple plans creates claims processing errors/confusion
- Insufficient/ill-defined service descriptions
- Coding errors/mismatches
- Unnecessary costs on behalf of billing departments in tracking lost claims or appealing erroneously denied claims
COMMON “PITFALLS” IN THE CLAIMS PROCESS

- Denials related to miscommunication or misinterpretation of the DOFR

- Physicians time on payer interaction, writing letters to justify medical necessity

- Claims “ping pong” and misdirection

- Balance billing issues

- Affordable Care Act’s Medical Loss Ratio (MLR) requirements — If they fail to meet these standards, the insurance companies will be required to provide a rebate to their customers starting in 2012.
REDUCING "PITFALLS" IN CLAIMS PAYMENTS
CLAIMS PAYMENTS

- Understand who has Financial responsibility
- Learn the contract terms, rates, timelines for claims submission, payments, appeals process
- Verify eligibility to determine which services are covered
- Define which services require prior authorization and which entity issues the authorization
CLAIMS PAYMENTS

- Clarify reimbursement rates for each service
- Utilize billing coding and descriptions approved by each plan (they may be different)
- Avoid unnecessary costs in appealing denied claims by contacting the payor prior to billing in order to clarify the process.
- Create a standard process for managing the differences between each plan contract and then educate your team
In each contract understand the definition of:

- “Clean Claim”
- Billing rates, format, billing codes
- Eligibility verification process
- Prior Authorization/Re-authorization requirements
- Covered services
- Medical necessity requirements
- Required claims attachments
- Required notifications
- Deadlines for claims submission and payments
- Compliance and audit requirements
MEDI-CAL ALL PLAN LETTER
WEBSITE

- http://www.dhcs.ca.gov/formsandpubs/Pages/MMCDPlanPolicyLtrs.aspx
CONTACT INFORMATION

- Medi-Cal Managed Care Division Contact Information

- **Phone:** (916) 449-5000

- **Mailing Address:**
  P.O. Box 997413, MS 4400
  Sacramento, CA 95899–7413
3841 North Freeway Blvd., #225
Sacramento, CA 95834
(916) 925–3770 tel
(888) 252–1010 toll free
(916) 925–3780 fax
Email: info@calhospice.org

http://www.calhospice.org/
OPEN DISCUSSION
QUESTION & ANSWER