Compliance News

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Getting Ready for the MCO's in Iowa

By Jeff Steggerda

The transformation of the Iowa Medicaid program to a 100% Managed Care Health Plan is underway. The bids are in and in just a short time Medicaid providers across the State will know who their future business partners will be. On August 17th DHS will announce the selection of 2-4 (most likely 4) companies whose bids were selected. I have participated in numerous meetings with these companies and have drawn several conclusions regarding how this transformation is going to impact our clients and the approximately 475,000 Medicaid beneficiaries.

The implementation timeline is going to put pressure on everyone. Once the selection is announced, each provider's management team should be prepared to act quickly to any communications from DHS or the MCO's. Some of the items outlined here can be obtained or organized now to be better prepared.

Here are the key areas that Iowa Medicaid providers will need to address in the coming weeks:

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PEPPER Reports, What Should You Know

By Jim Wilkes

PEPPER is the Program for Evaluating Payment Patterns Electronic reports. PEPPER reports show an individual provider's statistical data in six target data sets and compares this data to National, Regional, and State average data. This is one tool CMS utilizes when prioritizing a provider's risk level for improper billing. In addition, based on this analysis, how CMS should utilize their resources in reviewing and pursuing those providers for improper billing.

The advantage providers have, is the availability of this data to review, make appropriate changes in their programs, or be prepared to explain why they are "outliers" in any particular data set. PEPPER reports are updated every year between April 18th and May 9th. The data covers the CMS fiscal year of Oct 1st – Sept 30th of the year prior to posting. For example, the data set posted around April 2015 will include provider statistics which fall within Oct 1st, 2013 through September 30th, 2014. Episodes of care refer to a residents stay from admission through discharge date and remain discharged for 30 consecutive days. For example: A patient admitted April 20th, discharged on May 1st, re-admitted May 20th, discharged again June 30th,and remains discharged through July

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What you do today can improve all your tomorrows.
Ralph Marston

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1) Credentialing – this refers to general operating and ownership information that each provider will be required to submit to each managed care company. There may be a standard credentialing form to be used by all the MCO's but it hasn't been approved yet. This information will be similar to Medicaid renewals or the Medicare Form 855-a

2) Contracting – each MCO will require each provider to enter into a formal contract. You will be responsible for understanding the terms of this agreement and because of the rapid turnaround it is not likely that these will be negotiable. The contracts will be much alike for various provider groups. Owners, Boards of Directors, Management and Administrators may find it necessary to engage legal counsel to review these agreements prior to signing.

3) Billing/Claims Processing – Each provider will likely contract will all 4 MCO's. Nursing facility claims will be submitted using standard claim format UB-04. Each MCO will have their own claim submission portal and you will need to get enrolled at each site. Testing is scheduled to start in October. Providers should also assess their current technology – if upgrades are necessary you should address these as soon as possible.

4) Education and Dissemination of Information – There will be many opportunities for various education programs during this transition. Providers should invest time and resources for their management team(s) to bring this information to the appropriate staff. The MCO's and your trade association are going to be the source for most of this education. I suggest a distribution checklist to make sure that the necessary management and staff gets copied on incoming messages. This includes Owners and Boards of Directors.

5) Network Adequacy (Services and Location) – This is a term used by the MCO and DHS to make sure that All Required Services are available to all Medicaid beneficiaries. Some services even require 2 provider options for every service in every area. The common requirement is that every service is available to every beneficiary within 60 miles or 60 minutes. Some services or locations may have a 30 minute/30 mile requirement. I believe each of the MCO's will be developing their own networks and will not use outside companies to put networks together. I believe you should only communicate with representatives of the MCO.

6) Member Enrollment – All Medicaid beneficiaries will be enrolled with one of the MCO's. There is not an "opt-out" for Medicaid beneficiaries. Many Medicaid beneficiaries will be seeking advice from you. You should initially help to make sure the beneficiaries are getting their letters and post cards from DHS. These letters will have instructions and explanations – these could start as early as August 15. The new program is labeled "Iowa Health Link" https://dhs.iowa.gov/ime/members/medicaid-a-to-z/iahealthlink - NOTE that this site has not been updated yet.

7) Managed Care Protection – Providers and beneficiaries have built-in protections to ensure service delivery and provider payment. There are appeal rights and specific grievance procedures. The State's contracts will have specific performance requirements for the MCO's including language to guarantee minimum provider payment levels. The MCO's cannot exclude "any willing provider" for at least 2 years. This type of contracting is complex and comprehensive – The risks for each provider is dependent upon your volume of Medicaid.

8) Antitrust – More information later.

9) Value Based Purchasing – MCO's must develop VBP for various provider types. For Long-Term Care this is likely to include Patient Experience, ReHospitalization, Quality Measures, ETC. We plan to participate with any MCO planning in this area to create equitable and attainable measures.

10) Impact Analysis – Has Managed Care improved Access, Quality and Efficiency? Do the benefits outweigh the burdens? Beneficiaries, Providers and the State will implement and analyze a variety of metrics to determine the answers to these questions.

Your management team is going to have these pressures added to their current challenges. Are you prepared? BCG is organizing to help you meet these issues and get your systems ready. I am scheduling meetings with BCG staff, Clients and other ownership groups to better prepare for these changes. We look forward to working with you.

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20th. This counts as one episode of care. This is particularly important on the data set analyzing 90+ day episodes of care. It doesn't look at just admit through discharge, but the entire spell of illness treated at a provider. If a provider has a " * " instead of numeric data in their target area, it means the provider's volume is below 11 denominator counts and not a significant enough statistic to provide useful comparison. This would indicate lower risk due to very low volume.
The six target data sets are the following:

1. Therapy RUGS with High ADLs. The numerator is count of days billed within episodes of care ending in the report period with RUG equal to RUX, RVX, RHX, RMX, RUC, RVC, RHC, RMC, and RLB. The denominator is total days billed within episodes of care ending in the report period for all RUGS billed. Facility "outliers" fall above the 80th percentile or below the 20th percentile.
2. Non-therapy RUGS with High ADLs. The numerator is count of days billed within episodes of care ending in the report period with RUGS equal to HE2, HE1, LE2, CE2, CE1, BB2, BB1, PE2, and PE1. The denominator is total days billed within episodes of care ending in the report period for all RUGS billed. Facility "outliers" fall above the 80th percentile or below the 20th percentile.
3. Change of Therapy Assessment. The numerator is count of assessments with AI second digit equal to "D" which indicates change of therapy assessment. The denominator is total number of assessments within episodes of care ending in the report period. Facility "outliers" fall above the 80th percentile only.
4. Ultrahigh Therapy RUGS. The numerator is count of days billed within episodes of care ending in the report period with RUG categories equal to RUX, RUL, RUC, RUB, and RUA. The denominator is total days billed within episodes of care ending in the report period for all Therapy RUGS. Facility "outliers" fall above the 80th percentile only.
5. Therapy RUGS. The numerator is count of days billed within episodes of care ending in the report period for therapy RUGS. The denominator is total days billed within episodes of care ending in the report period for all RUGS billed, therapy and non-therapy. Facility "outliers" fall above the 80th percentile only.
6. 90 + Day Episodes of Care. The numerator is count of episodes of care ending in the report period with a length of stay of 90 + days. The denominator is count of all episodes of care ending in the report period. Facility "outliers" fall above the 80th percentile only.

Recommended action would be for a provider to attain their PEPPER report. Review for outliers, analyze the factors that contributed to any outliers, make policy changes to bring the provider into industry ranges, or prepare an analysis summary regarding the unique services the provider supplies patients which create the outlier. All three comparative data sets are used to analyze risk. However, priority is set to National Data, then Regional Data, and last but not least – State Data.

To obtain your PEPPER report, you must be the CEO, President, or Administrator of a provider. If so, then follow these steps:

1. Go to http://PEPPERresources.org home page, in your provider type box, choose "PEPPER Distribution – Get Your PEPPER". On the following page, next to your provider type, choose "PEPPER resources Portal". This should take you to the secure PEPPER portal.
2. In the PEPPER portal, complete the required information boxes. Then, certify that you are the CEO, President, or Administrator of this health care provider.
3. Next screen is where you complete the provider's information. You will also need a Validation Code. This codes helps validate the person requesting the PEPPER report is associated with the provider. The Validation Code is any patient control or medical record number of a claim processed with dates of service between Sept 1 and Sept 30th of the year prior to the request date.
4. Choose "submit" at the bottom of the page
5. A file download screen will appear which will have at least 1 file for downloading.

The PEPPER report is just one tool you can use to analyze your provider's program and risk of being an outlier. It is a snapshot that can be used with very little resources and time commitment in evaluating these program outliers.

What's New at BCG Research

We are happy to announce a new automated website to run your OIG and EPLS Exclusion List Reports! All you will have to do is upload your employee list and vendor list into our system once, and then each month update your employee list with new hires. Once a year, go through and delete employees that have been terminated longer than 6 months. Every 22nd day of the month, you will receive an automated report with your records. I don't think it gets easier than this! We are very excited about our new system!

No more contracts! Our system is automated and will charge your account monthly through our Paypal system:
***If you signed a contract with BCG Research between January through May 2015, then you are good to go and you will just need to contact me to set up two employees from your organization to use the new system. You will not be charged to use the system until 2016.
***If you have not signed a contract in 2015, then you will need to contact me to get log on information. You will need to have a Paypal account, so if you want to get that set up before September 10th , that's a great idea! If we have not heard from you by September 10th , your accounts will be locked out of the new system, so don't wait to contact us and get everything set up.
***Hotline's will be available to renew also when you first activate your account. Make sure to click that box if you are using or want to use our hotline system.

As the system develops, we hope to add other verification systems to the website to make this a complete tool. We understand that facilities have enough to do, we hope you find this new system simple, friendly and easy to use!

Contact me at karen@bcgdata.net to get registered to use the new system.

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Social Media & Blogging Guidelines

These guidelines are suggestions of dos and don'ts of social media and blogs. This list is not inclusive.

*Get approval: Do not announce organization news on a social media site or blog. Do not reference clients, clients, or partners without their approval.

*Don't betray our client's trust: Disclosing confidential client Protected Health Information (PHI) in an inappropriate manner is a federal offense. Even acknowledging the care of a client is an unacceptable disclosure of PHI.

*Don't cheat your employer: Social media sites may be addictive in nature. Employees should not be checking their Facebook updates or other sites when they are supposed to be doing their job.

*Use a disclaimer: If you publish a blog, post a comment, or share an image and it has something to do with the work you do, make it clear that what you say is your view and opinions and not necessarily the views and opinions of the organization.

*Respect copyright laws.

*Don't jeopardize your reputation and/or future employment opportunities: You should consider everything you post online begins to build a lifetime record of you.

*Be accurate: Respect the facts and link to the trusted sources that validate your opinions.

*Be professional: Employees are reminded that statements made in the confines of private blogs and chat rooms must treat the organization and its employees, clients, and competitors with respect.