HEALTHEDGE

Medicaid MCOs: It is time for a new claims management strategy

The complexity and variability in state-by-state regulations have health plan executives scrambling to keep up with each state's latest Medicaid payment policies and fee schedules.

Medicaid managed health plans typically address this challenge by continuously expanding internal teams dedicated to loading fee schedules and configuring payment policies within their core claims systems. When you add in the complexity of multiple solutions and methods that may include proprietary third-party content, IT leaders end up diverting considerable time and money to IT development and maintenance.

However, with the increasingly complex and dynamic state-by-state regulatory and payment environment, it has become nearly impossible to keep up to date with and adapt to the constant and nuanced changes in Medicaid payment policies and fee schedules. Despite their best efforts, health plans find that their traditional approach is increasingly difficult to manage and continues to fall short, resulting in a less than ideal update frequency and gaps in policy applications.

The unfortunate consequences for health plans that cannot manage this complexity include missed reimbursements, incorrect payments, and subsequent time spent resolving payment disputes — all of which results in inefficiencies and unnecessary cost for the health plan.

> *"Variability in Medicaid is the rule rather than the exception"*
> – MACPAC

INCREASING MEDICAID COMPLEXITY

According to the Kaiser Family Foundation, there are over 280 Medicaid Managed Care Organizations (MCOs) that provide comprehensive managed care for over 55 million US adults, which is over 70% of all Medicaid enrollees. The diversity and economic status of the Medicaid population mean it can also be a more medically complex population than other payer sectors.

For health plan leaders that want to reduce these inefficiencies and drive down claims processing costs, they need to think differently and invest in solutions that lighten the load on internal teams while providing frequent and accurate data updates health plans need to succeed in managed care.

Further adding to the complexity of operating an MCO is the localization of each program. The Medicaid and CHIP Payment and Access Commission (MACPAC) explains it best: "Variability in Medicaid is the rule rather than the exception. States establish their own eligibility standards, benefit packages, provider payment policies, and administrative structures under broad federal guidelines, effectively creating 56 different Medicaid programs—one for each state, territory, and the District of Columbia."

Within each state Medicaid program, there are numerous pricing models that may be based on patient population or geography. For the same procedure on a similar patient, a hospital in Stockton, California may have a different pricing model than a hospital in Sacramento.

The typical release cycle for state Medicaid data varies from state to state, and updates can happen at any time. During natural disasters or events like the COVID pandemic, the number of updates to payment policies and fee schedules related to durable medical equipment and vaccine testing, for example, can increase dramatically. Unfortunately, since health plans typically only update Medicaid content on a quarterly basis, improper payments are compounded during times of crisis, increasing the likelihood of rework.

COVID and Hurricanes

In times of a pandemic or a natural disaster, waiting for quarterly updates is particularly detrimental to a health plan. On March 17, 2020, CMS announced expanded telehealth coverage and released a new COVID-19 diagnosis code. In a hurricane, new edits like allowing out-of-state professional claims may be implemented and lifted in a matter of one month's time. Even when CMS publishes updates on an ad hoc basis in times of crisis, many health plans lack the ability to quickly adjust and put the edits into production until the following quarter, resulting in unnecessary denials and rework.

A FAILING LEGACY APPROACH

Many health plans rely on a legacy approach to solve an evolving, increasingly complex problem. The legacy approach generally involves increasing headcount to keep up with pricing changes and edits, developing unique content and/or piecing together content from multiple sources.

A major problem that health plans face is keeping up with all the updates. While edits may change quarterly, they may also be deleted mid-quarter and adjusted retroactively. Codes may be revised or deleted at any time. However, due to the way National Correct Coding Initiative (NCCI) edits are released, retroactive deletions of edits and other changes that occur mid-quarter do not show until the next quarter is released. For a health plan, relying on quarterly updates increases the likelihood of a provider overpayment that must be clawed back.

In some cases, edits and pricing libraries may be incomplete. In other cases, professional edits and PPS pricers may be used for facility claims, editors may have limited state-specific content, and only focus on national rules. Using the wrong edits and price increases the risk of overpayments and downstream recovery.

The stakes are greater and the chances for problems are multiplied when a health plan operates in several states given each state's unique program regulations and policy changes.

There are three primary negative outcomes that can result from the legacy approach:

HEALTH PLAN WASTE

The internal claims processing team is either falling behind on updates, or they are working too hard to barely keep up. In either case, overhead is high because of the heavy internal lift required to deal with constant changes. And there is maintenance of a significant IT support infrastructure. If the team is not keeping up with changes, then there are more incorrect payments for them to chase down later.

PROVIDER ABRASION

Slow and inconsistent payments and repeated overpayment recovery strain payer-provider relationships and contribute to provider abrasion. Providers are already balancing increasing costs with the reduction in reimbursement rates, and the additional administrative burden from dealing with disputes can result in a lack of cooperation on other payer needs such as medical records, or worse, severing ties with the payer.

COMPETITIVE DISADVANTAGE

Effectively contracting with providers of all types in all locales is critical for winning and maintaining state procurement contracts as competition for members continues to increase each year. However, a reputation within the provider community for slow payment and regular overpayment recovery can impair the health plan's chances of renewing these important provider contracts and gaining new ones.

RESOURCES WASTED ON NON-PROPRIETARY ACTIVITY

Health plans are already operating on slim overhead budgets as it is. Unfortunately, because of legacy processes internal teams are managing software updates, maintaining IT hardware and infrastructure, and constantly managing complex codes to maintain customized edits. While the outcome may be proprietary, none of the activities performed are proprietary to that health plan. Other MCOs in each state work with the same pricers, regulatory changes, and updates.

THERE IS A BETTER WAY

Health plan leaders need to transform their thinking and find new ways to reduce claims processing costs. There are innovative solutions in the market now that dramatically improve Medicaid claims processing by automating pricing and edits content for health plans. These solutions can lighten the lift for claims operations and IT teams and allow these resources to be redeployed to more value-added roles and responsibilities.

While some point solutions address certain pain points, there are full platform solutions that can enable sophisticated claims processing while minimizing the lift for claims ops and IT teams. Here are six ways that technology can lighten your team's workload and streamline the claims process.

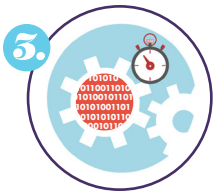
Six ways technology can lighten your team's workload:

Process claims correctly the first time.

Avoid errors with up-to-date pricing and important edits in each state.

Include all provider types and settings.

Data that cover all providers in every care setting eliminate the need to piece together multiple data sources.



Automate updates and data loads.

Reduce the need to manually update data sets, which can result in delays and human error.

Update more frequently.

Quarterly updates can be too slow for an organization that wants to react quickly and remain agile.

Keep an audit trail.

Automate the audit trail so teams do not need to rely on incomplete archives that place the burden on the user to prove and support claims pricing results.

Eliminate costly infrastructure.

Moving to a cloud-based solution can reduce demands on internal IT and business teams as well as eliminate maintenance of costly legacy software.

In a typical large health plan, there may be 20-30 people managing the legacy process. By implementing a cloud-based claims processing solution that automatically updates the latest regulatory and pricing content, eliminates the need for infrastructure support, and maintains audit data, many of these talented individuals previously used to support the legacy system can be redeployed to more value-added responsibilities.

ONE SOLUTION TO ELIMINATE IT BURDEN

Source, the Payment Integrity solution from HealthEdge, eliminates IT burden as a secure, cloud-based solution that provides updates automatically through our Software-as-a-Service (SaaS) delivery system. Source is delivered as a full-service model, which includes development and maintenance of all infrastructure and software code, and deployment of software updates for production use without requiring any intervention from your IT department.

We manage all your critical network configuration, pricing, and editing workflows by combining our powerful core functionality with the most comprehensive and up-to-date pricing data in the industry—all customizable to your specific payment terms—and with complete audit trails. While other vendors focus solely on hospital PPS reimbursement, we cover all of the critical provider types. And our team of SMEs are constantly updating our content offering to ensure you have the latest. Here are a few ways we support our customers:

Payment Integrity

- Management of all Medicaid and CMS regulatory updates with a once every two-week update cycle.
- Depth of content includes reimbursement rates and payment policy for all care settings in each state, including facility and professional claims down to the provider level.
- Cloud-based service with automatic updates to virtually eliminate IT lift.
- A unification of all claims payment processes that are updated in sync to return all applicable edits on a single pass.
- Complete audit trail of all claims processing to provide the transparency that supports CMS audits and improves provider relations.

Our elegant user interface allows easy management of editing rules. The logical separation of customer rules and data enables Source to update all edits without any maintenance required.

THE VALUE OF A GREAT VENDOR PARTNER

The ROI can be tremendous for health plans that find the right vendor. In one case a Source customer that processed 12+ million claims annually was able to reduce claim reworking by 40%, save approximately $6-12 per claim, and reduce IT overhead by $350-500K annually. The health plan improved CMS multi-state Medicaid program regulatory compliance, increased transparency on payment results, and spent less time preparing for audits, the latter of which increased staff satisfaction and retention.

To learn more about how Source can help your organization lighten the lift on your claims ops and IT teams, while improving claims processing, visit us at www.healthedge.com or request a demo.

40%
Reduction in rework

$6-12
per claim savings

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