Managed Care Transition

5 Questions Your Agency Should Be Asking

Do you have contracts with all Managed Care Organizations (MCOs)?

MCOs want to create networks of care providers. If you are not yet in-network, reach out! You can find contacts for each MCO on the MCTAC Matrix and also use the MCTAC "PEN" guide as a tool for negotiation.

TIP: Make sure that your agency identifies a contracting lead.

Are all of your sites credentialed with all MCOs?

While your organization may have state certification to provide services, you must submit credentialing documentation to each MCO for each service location. Be aware that each MCO has a different form for your provider locations. If you are not properly credentialed, you may not get paid for services.

Submitting credentialing documentation does not guarantee that your organization has been entered into all of the MCO's systems.

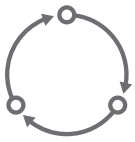
TIP: Check each MCO website for their provider network to see that you are listed there for the correct services. Make sure the listed addresses correspond to where you actually deliver those services.

Have you claims tested with any MCOs?

Claims testing is an opportunity for your EHR and billing departments to get on the same page. It will allow them to set up an efficient internal claims process that works for both multiple payers and multiple programs.

Testing claims with MCOs prior to the managed care roll-out allows your agency to build a relationship with MCO claims departments, giving you better access to MCOs so that when problems arise, you know where to turn.

TIP: Remember, most claims testing is basic and may not be done at the granular level necessary to guarantee your claims are clean and without error. Ask MCOs for further testing opportunities even after managed care has gone live.



Are you familiar with the authorization process for each MCO?

Depending on the programs you offer, services may require prior authorization and/or concurrent review. Please consult MCTAC Utilization Management (UM) slides for a program-by-program breakdown.

MCOs will monitor utilization patterns, including frequency and duration of visits. Tracking these patterns internally can help. Each MCO will request slightly different documentation to complete the process. You should reach out to each MCO's UM department to understand the requirements. Find out if authorizations can be completed via phone, fax, or web portal.

TIP: Most MCOs have different UM staff for HARP clients, so you may have to track your clients by MCO and by HARP vs. Mainstream. When calling MCOs, plan on developing relationships with HARP UM staff and "Mainstream" UM staff For more information see MCTAC's UM webinar series and Matrix.

Does your staff document for medical necessity?

In order to continue serving your clients, staff must be able to link the client's treatment plan and goals and also document that treatment is occurring with the right frequency, scope, and duration.

MCOs are required to ensure that services are necessary and appropriate. A good progress note connects an intervention to the goals of the client and back to the treatment plan, therefore clearly demonstrating the necessity of the service.

TIP: Train or review documentation best practices with your clinical staff. Make sure they know what evidence MCOs are looking for.