



SUNFLOWER STATE  
HEALTH PLAN

# Claims

*Presented by: Teresa Dodd*



## Configuration

### Goals of the Payment Excellence Team

- Ensure claims are received and processed per the guidelines set forth for timeliness and accuracy
- Perform thorough research of benefits, reimbursement methodologies and billing requirements
- Create work processes for claims department and act as a resource for claims-related questions post go-live
- Create the health plan provider billing manual
- Partner with IT to test all aspects of claims receipt, instituting full end-to-end testing at least 45 days prior to go-live.
- Monitor pend volume and aging reports to mitigate risk on a go-forward basis and institute best practices to further reduce pends and increase auto-adjudication
- Partner with Provider Relations to resolve key provider issues and provide claims related education to providers and Provider Relations staff.
- Partner with Health Plan and Internal Audit to review check run and increase payment accuracy
- Manage all claims related issues for a period of 3-6 months post go-live

## Claims Operations

## Network Development

## Provider Data Management



## How Providers Can Avoid Common Issues:

- Read MCO billing manual
- Proactively communicate with MCO about past issues
- Partner with MCO for claims testing prior to go-live
  - Challenge MCO with difficult claim scenarios
- Register for secure portal immediately after provider loaded in MCO MIS system
  - Validate providers are all set up correctly
  - Get familiar with tools and resources available
- Proactively set up for electronic claim submission and EFT
- Familiarize billing staff with HIPAA compliance edits
- Ensure all EDI transaction/confirmation reports are received and reconciled after claims are submitted

## What Payment Excellence Team Will Do:

Partner with willing/select providers...:

- ...to discuss historic issues
- ...to verify we have providers set up correctly
- ...to test claims prior to go-live
- ...to share pre-payable results after go-live to ensure payments/denials are accurate before the final payables are run (for short period of time post go-live)

Review/Audit incoming claims in order to...

- ...track all claims related issues through to resolution and ensure all effected claims are proactively reprocessed without provider intervention
- ...proactively monitor rejects and denials to identify trends, system issues, edit issues or provider education opportunities
- ...complete 100% pre-payable check run review to ensure claims are paid/denied based on defined business/payment rules

Partner with claims operations to ensure any manual processing of claims are handled accurately and timely; including claims related appeals

## Proven Results:

- The most recent implementation produced a claims accuracy rate of 100% for the first month of claims processing
- In 2010 Centene paid clean claims (paper and electronic) in less than 7.5 days on average
- Centene maintains an average auto-adjudication rate of higher than 85% for all claims processed
- Our MIS and supporting IT organization have been recognized with several significant awards: most recently we ranked 22<sup>nd</sup> in Information Week's 2011 500 Most Innovative Business Technology Organizations – and we were the *top* Managed Care company on the list



## Providers Can Submit Claims in Multiple Ways:

- Electronically Via Clearinghouse
  - Emdeon, SSI, Gateway EDI, Availity, Smart Data Solutions
  - One Payer ID – 68069
- Electronically via Secure Provider Web Portal
  - Individual claims via Direct Data Entry
  - Batch claim submission
- Paper Claims
  - Mailed to our centralized mail center

### EFT/ERA through PaySpan Health

- ✓ Free Service and fast online enrollment
- ✓ Register for Webinars



## Farmington, Missouri Claims Center

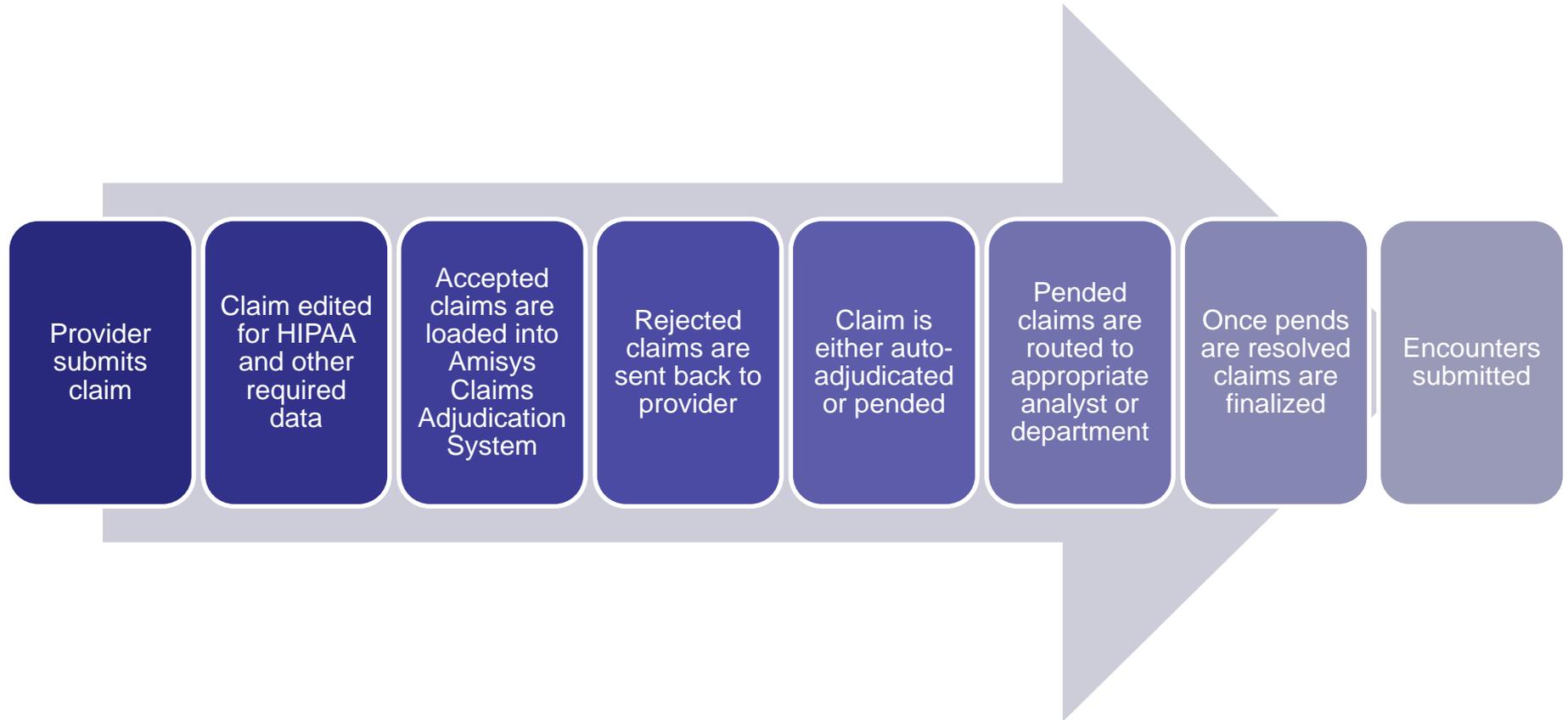
- Centralized mail room
- Vertexing, OCR validation and data entry
- High Dollar Review
- Quality Review Team
- Claims Processing Center
- Provider Claims Call Center



## Great Falls, Montana Claims Center

- Claims Processing Center
  - Kansas claims to be processed here
- Provider Claims Call Center
  - Kansas claims calls to be answered here

# Claims Process



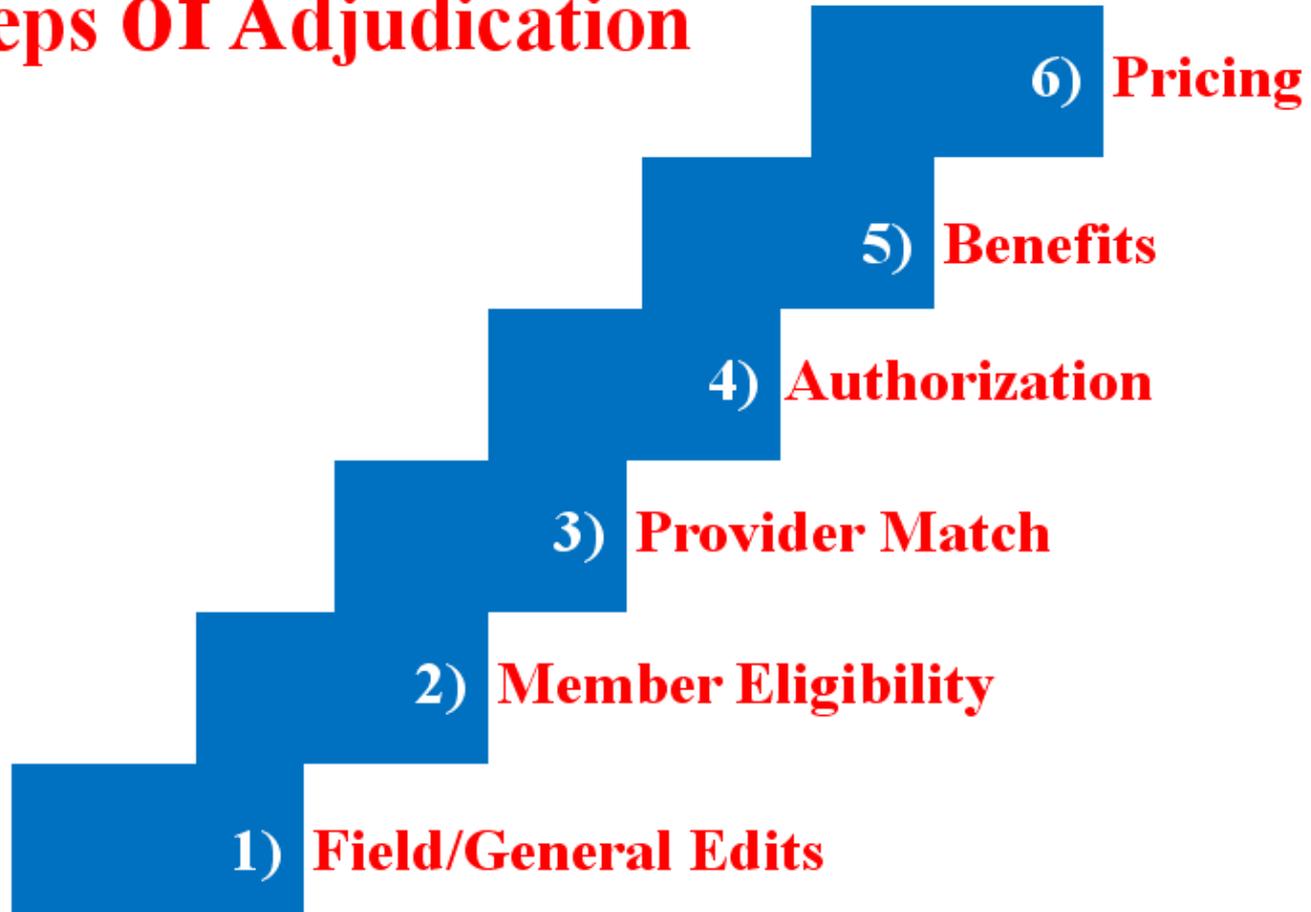


## Pre-Adjudication is Where the Following Happens:

1. HIPAA Compliance Checking
2. NDC Validation
3. Member/Provider Selection
4. Newborn Logic
5. Service Date Validation
6. Determination of Claim Type/Location
7. Code Set Validation
8. Procedure Code Placement
9. Consent Form Requirements
10. Modifier Placement
11. Anesthesia Minutes/Units



## Six Steps Of Adjudication





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# Prior Authorization

*Presented by: Monica Arter*

## Utilization Management

### Goals:

- Ensure services are appropriate for the symptoms provided in appropriate care setting and
- Meeting or exceed professionally recognized standards of care

Program is overseen by Medical Director. Only the MD can make an adverse determination based on medical necessity

### Processes include:

- Prior Authorization of Services
- Concurrent Review of Inpatient Hospitalizations
- Discharge Planning

## Prior Authorization

- Review to determine medical necessity before service is rendered
- Use InterQual, nationally recognized criteria, to authorize most services
- Limited prior authorization requirements with online code look-up service available
- Non-par services require prior authorization  
(exclusions – ER, family planning, routine lab and radiology)
- Requests may be submitted by fax, phone, or website. After normal business hours and on holidays, calls are directed to NurseWise, our 24-hour nurse advice line.

## Decision making and Notification

- Ask to submit request for standard prior authorization at least 7 days prior to date of service  
(no penalty if submitted up to and including date of service)
- Authorization requests processed in accordance with State and Code of Federal Regulations:
  - Standard requests are processed within 14 days of receipt with internal goal to process within 2 business days
  - Lack of necessary clinical information may result in delayed decision making
  - Peer to Peer consultants available for all adverse determinations
  - Expedited/Urgent requests are required to be processed within 72 hrs, our internal goal is 24 hrs
- Notification of authorization decision will be returned by phone, fax or web



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# Customer Service Center

*Presented by: Karen Bedell*



## Our Health Plan Customer Experience:

- **Dedicated Teams specialized in servicing our Customers.**
- **Single Dedicated Toll-Free Hotline for all Customer Inquires**
- **Integration of Nurse Triage and After-Hours Services**
- **Member Relationship Management Application**
- **First Call Resolution & Team Member Empowerment**
- **Quality Monitoring and Service Level Management**

Sunflower's promise:

***"One Call That's All"***

Members need to call only *one* phone number and place only *one* call.

# Call Management System (CMS)



Our Managers can:

- Drill down to performance by agent and/or group of agents
- Monitor service levels by specific caller type real time and historically
- Set alerts for specific thresholds

Queue/Agent Status - SSHP Eng Ref Member

Report Edit Format Tools Options Help

Split/Skill: Eng Ref Member  
Skill State: NORMAL

Calls Waiting: 1  
Oldest Call Waiting: :02  
Direct Agent Calls Waiting: 0  
% Within Service Level: 100  
Service Level: 30  
ACD Calls: 2  
Aban Calls: 0

Agents Staffed: 23  
Agents Avail: 0  
Agents Ringing: 0  
Agents in ACW: 0  
Agents on ACD Calls: 8  
Agents in AUX: 5  
Agents in Other: 10

Agent Name	Login ID	Extn	Role	Percent	AUX Reason	State	Direction	Split/Skill
Trousdale, Peggy	31359	41359	BCKP	0	Research	AUX		
Thomas M., Carolyn	51611	41611	BCKP	0	Break	AUX		
Munoz, Christopher	51630	41630	TOP	0	Aux Default	AUX	IN	1050
Bernardez, Marta	51723	41723	BCKP	0	Break	AUX		
Pierre, Daniel	51650	41650	TOP	0	Aux Default	AUX	OUT	1050
Sherman, Sheena	31386	41386	BCKP	0	ACD	IN		1050
Shaw Shatwan	51740	41740	TOP	0	ACD	IN		1050
Halpern, Elliot	51667	41667	BCKP	0	ACD	IN		1050
Charles, Betty	51614	41614	TOP	0	ACD	IN		1050

Agent Group Summary Daily - FLL/ELP CSRS

Report Edit Format Tools Options Help

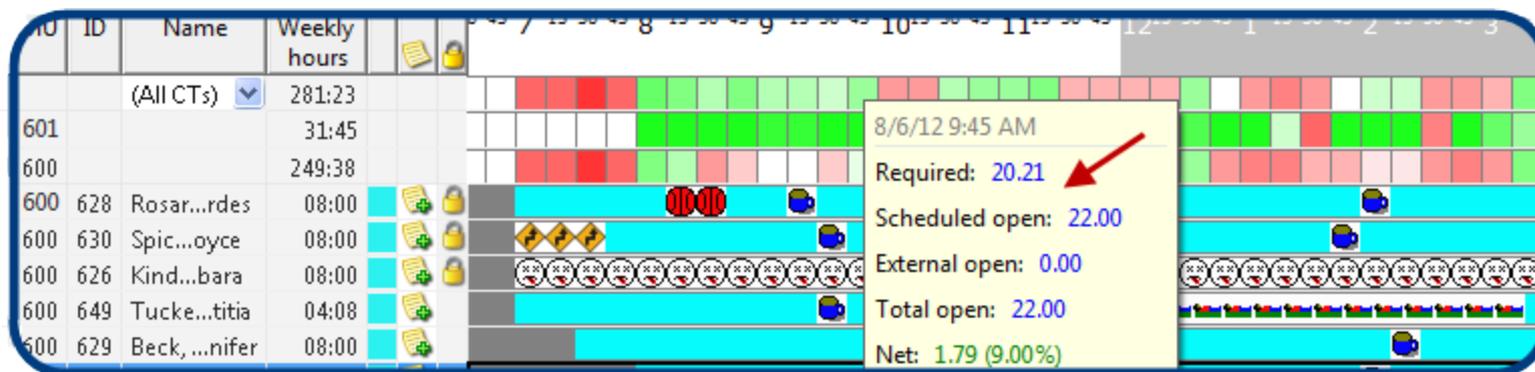
Date: 1/22/2009  
Agent Group: FLL/ELP CSRS

Agent Name	ACD Calls	Avg ACD Time	Avg ACW Time	% Agent Occupancy w/ ACW	% Agent Occupancy w/o ACW	Extn In Calls	Avg Extn In Time	Extn Out Calls	Avg Extn Out Time	ACD Time	ACW Time	Agent Ring Time	Other Time	AUX Time	Avail Time	Staffed Time
<b>Totals</b>	<b>1373</b>	<b>2:06</b>	<b>:17</b>	<b>46</b>	<b>39</b>	<b>4</b>	<b>5:08</b>	<b>596</b>	<b>:46</b>	<b>48:20:46</b>	<b>10:36:08</b>	<b>1:10:36</b>	<b>7:43:55</b>	<b>42:30:24</b>	<b>85:05:13</b>	<b>195:27:02</b>
Herrera, D	65	2:16	:45	51	36	0		18	:23	2:29:36	1:10:38	:01:31	:01:52	1:09:58	3:37:46	8:31:21
Reyes, O	64	2:27	:07	49	36	0		28	:28	2:36:18	1:07:19	:01:32	:32:17	1:27:37	4:43:36	10:28:39
Hernandez, Marissa	50	2:34	1:07	62	45	0		26	2:51	2:08:17	:55:40	:01:30	:03:24	3:17:58	2:03:55	8:30:44
Juarez, P	111	1:09	:18	53	41	0		38	:28	2:07:17	:52:43	:04:29	:30:02	1:25:06	3:24:27	8:24:04
Tealyvasquez, M	89	1:19	:25	50	38	1	:22	31	:40	1:57:11	:50:22	:03:02	:32:23	1:22:43	3:32:34	8:18:11

## Workforce Management Software that enables:

- In depth call volume forecasting
- Agent Scheduling
- Detailed staffing analysis
- Monitoring of agent activity

Agent ID	Name	Scheduled Activity	▼ O...	ACD	Login	Actual State
637	King, Maonica	Open	06:26	1	56375	Special Project
644	Rembert, Nathaniel	Open	00:23	1	56244	Break
643	Hill, Damiko	Break	00:23	1	56286	ACD In
652	Hill, Michele	Break	00:23	1	56417	Available
625	Haynes, Andrea	Open		1	56216	ACD In
645	Bender, Lisa	Open		1	56393	Default A...t On Hc
640	Burgos, Reinaldo	Open		1	56397	ACD In
641	Miller, Renalda	Open		1	56347	ACD In
642	Julaj, Guadalupe	Open		1	56260	Available
653	Alexander, Jamal	Open		1	56243	ACD In



# Quality Monitoring



Records agent interactions with callers:

- Calls can be reviewed with audio and visual content
- Built in forms for easy monitoring
- Enables improved service quality, agent performance, and member/provider satisfaction

The screenshot shows a software interface for monitoring call quality. At the top, there are tabs for 'Contacts (1878)', 'Properties', and 'Security'. Below the tabs is a pagination control with 'Page #: 1', a 'Go' button, 'Paging', and 'Total Pages: 2'. The main area is a table with columns for 'Content', 'First Agent...', 'Reviewed', 'First Agent', and 'Start Time'. Each row represents a call record, with a speaker icon indicating audio content and a computer icon indicating video content.

Content	First Agent'...	Reviewed	First Agent	Start Time
🔊	30075	No	Morris, Gina	September 12, 2011 4:29:09 PM
🔊 🖥️	30296	No	Miller, Tashianna	September 12, 2011 4:04:15 PM
🔊 🖥️	30128	No	Bragg, Frances	September 12, 2011 3:54:50 PM
🔊	30075	No	Morris, Gina	September 12, 2011 3:41:43 PM
🔊	30075	No	Morris, Gina	September 12, 2011 3:35:07 PM
🔊	30239	No	Thomas, Anita	September 12, 2011 3:20:55 PM
🔊	30296	No	Miller, Tashianna	September 12, 2011 3:15:36 PM
🔊	30281	No	Foster, Pamoja	September 12, 2011 3:08:04 PM
🔊	30167	No	Apollos, Daisy	September 12, 2011 2:50:30 PM
🔊	30281	No	Foster, Pamoja	September 12, 2011 2:43:35 PM
🔊	30281	No	Foster, Pamoja	September 12, 2011 2:36:33 PM



- **Features & Functionality:**
  - Customer Demographic Information
  - Special Requests & Customer Alerts
  - Customer Activities
  - Work Flow and Management of Turn-around-Times
- **Integration of Member Care Gaps**
  - Member Specific Preventive Service Reminders
  - Case Management Alerts
- **Campaign Management**
  - Integration of member correspondence, return mail, audio post cards
  - Retain Mail Alerts, success rates and inbound/outbound inquires
- **Integration of Field Based Activities**
  - Provider Relations Visits
  - Community Events

# Sample Work Flow Reminders



Microsoft Dynamics CRM

Create Phone Call Letter Task Fax Email Open Provider Groups Members Providers Alt Contacts New Alt Contact

AARON A

Phone 5552225555  
Medicaid# 0000000000  
Mailing Address 1234 Main Rd, St. Louis, MO-63123

Alerts  
No HRS or HRS is older than 1 year  
No PCP\_PMP assigned

Validate Member  
Instructions  
Please Validate the caller

### HIPAA Validation

Medicaid #: 0000000000  
 Name: Aaron A  
 SSN: 9990009999  
 Date of Birth: 1/1/1990  
 Mailing Address: 1234 Main Rd, St. Louis, MO 63123

Contact Name  
Phone Number  
Ext

Validation Not Required

Proceed Re-search Unable To Validate

### Common

- Other Insurance
- Phone Numbers
- Documents
- Authorized Callers
- Member Languages
- Email Addresses
- Care Gap**

Member  
**AARON A BRADLEY**

Member has one or more alert(s)

### Alerts

<input type="checkbox"/>	Alert Text
<input type="checkbox"/>	Member has either no HRS Form or the form is older than 1 year
<input type="checkbox"/>	Member has not completed the Preventive Care.

1 - 2 of 2 (0 selected)



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# Transition of Care

- Sunflower State Health Plan will honor existing treatment authorizations for all medical, behavioral health, and substance abuse treatments for an initial period of 30 calendar days, regardless of the provider's network status.
- Medically Necessary services will continued to be honored, with a non-participating provider for up to 90 days, or until the Member's care is transferred to a participating provider and a Care Coordinator can complete a comprehensive assessment and develop a new service plan.
  - Sunflower recognizes transition is not always possible or is not in the Member's best interest. For these Members, Sunflower will work with their existing providers to ensure that care can continue without disruption.
- For any additional behavioral health or substance abuse services that did not require prior authorization previously, Sunflower will implement a transition period in which the provider has an opportunity to assess the member, identified needed services, and request authorization, without disruption of services.

# Transition of Care



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- Identification of members in the process of receiving care is critical to ensuring continuity and seamless transition of care.
- Our internal processes will focus on quickly identifying new Members with existing services and providing individualized attention to the Member's health care needs.
- The Plan may become aware of need for continuity in any of the following ways:
  - State claims/auth data (if available)
  - Enrollment data and information from another MCO (if available)
  - Provider requests for authorizations and referrals
  - New Member Outreach