

AR Systems, Inc Training Library Presents

What is going on with the Payers?

Managed Medicare /Part C & Commercial

Attacking Mgd Care Anguish.

Instructor:



Day Egusquiza, Pres
AR Systems, Inc

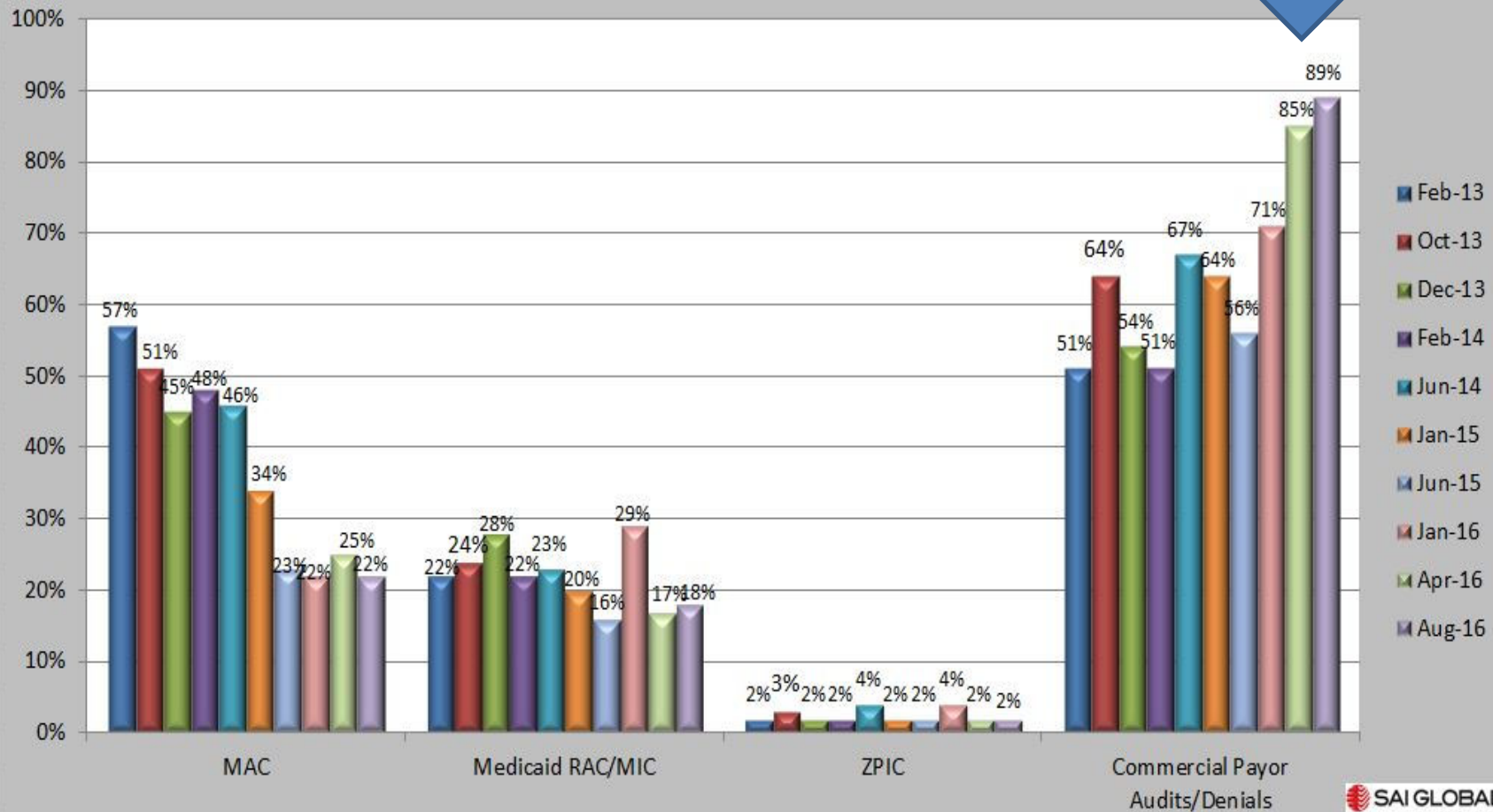
Learning objectives

- Attendees will learn the newest issues impacting Mgd Medicare /Part C while gaining clarity as to what is different from Part A
- Attendees will identify the key elements of contracting and learn how to minimize the impact of the new challenges.
- Attendees will gain an enhanced understanding of the 'brave new world' with Managed Medicare.
- Attendees will have action items for all contracting with all payers.

Mgd Care Anguish- A Brave New
World is Required-
Attacking DRG Downgrades, Pt
Status Disputes,
Re-Admission Denials...



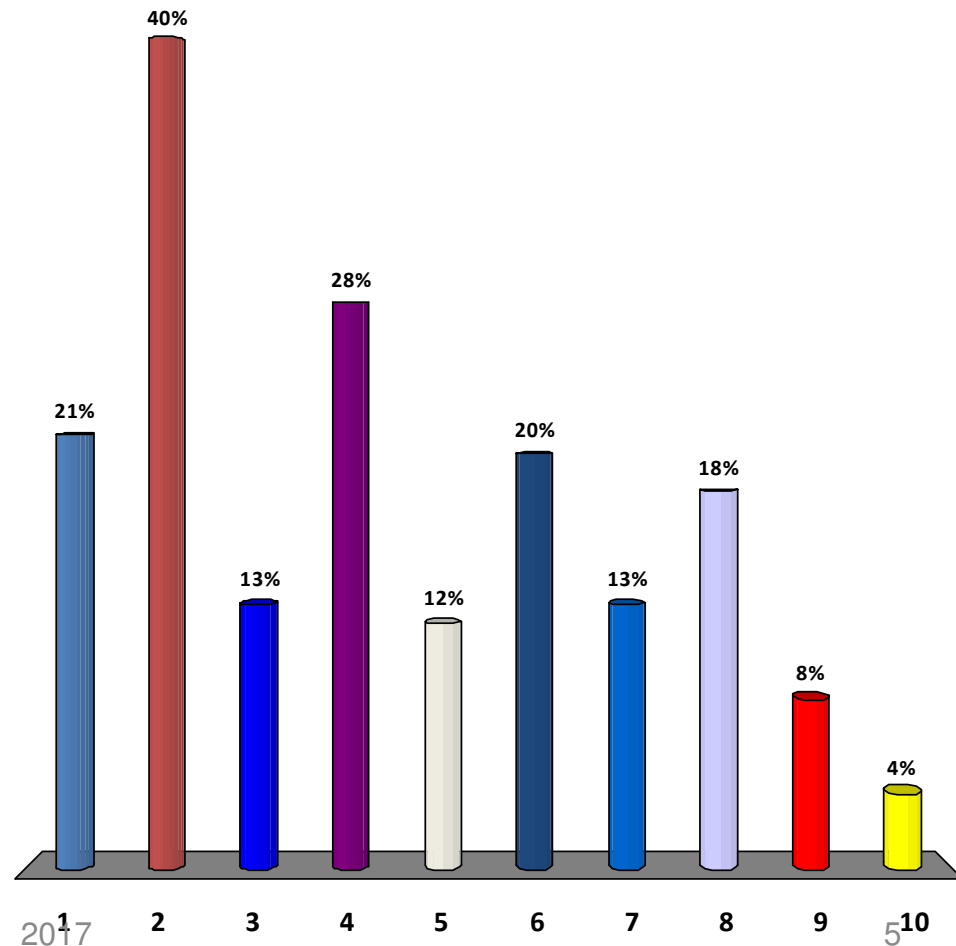
In addition to Medicare RAC audits, which are you seeing an increase of activity? 3 Year Trend



Which payers are causing you the most anguish? By volume of accounts (pick 2)

Results from 2016 PA & UR Boot camp

1. Medicare/MAC
2. Humana /Part C Medicare
3. Humana/commercial
4. United/part C Medicare
5. United/Commercial
6. Aetna/Part C Medicare
7. Aetna/Commercial
8. Managed Medicaid
9. Other – Part C Medicare
10. Other - Commercial

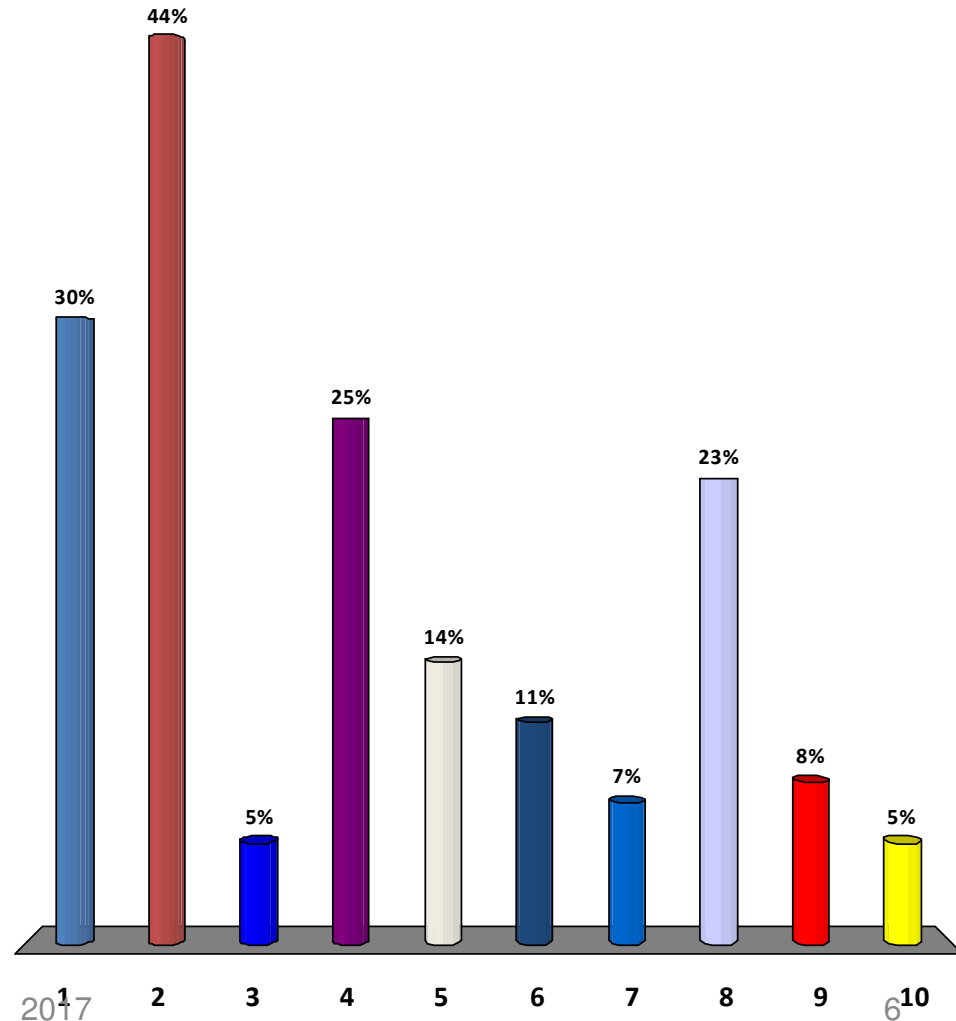


Which payers are causing you the most anguish?

By dollar amount (pick 2)

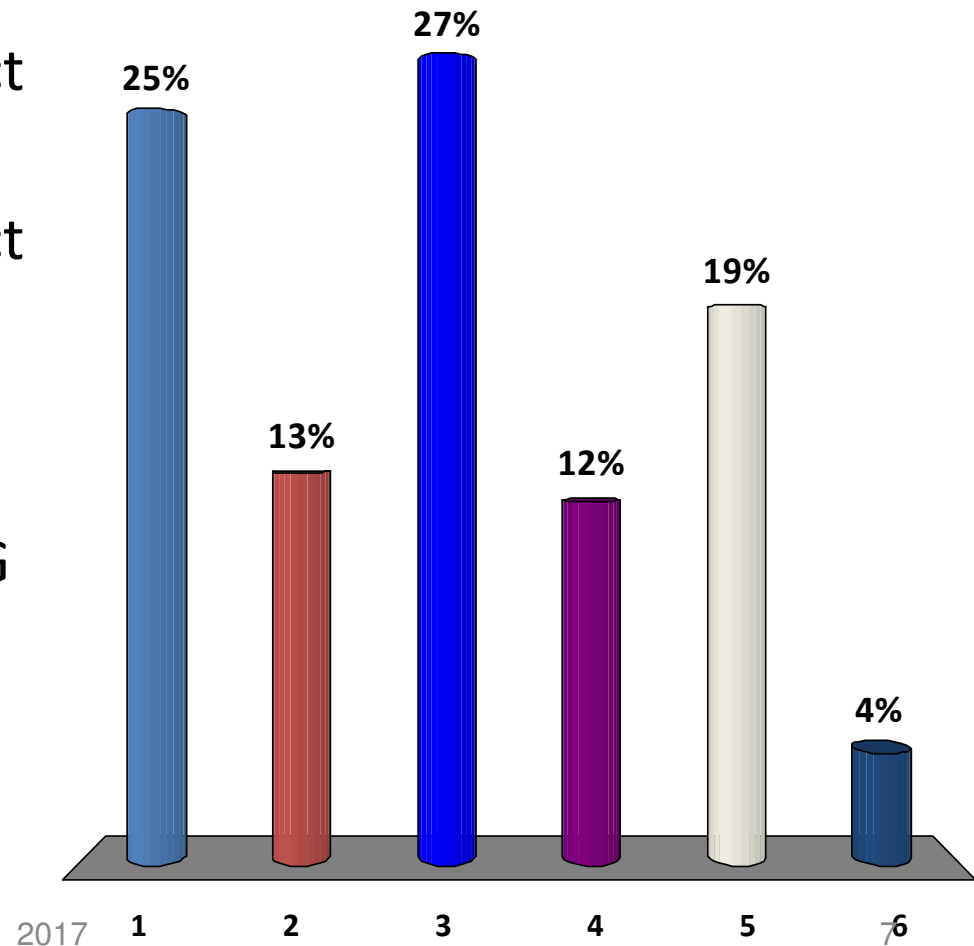
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2. Humana /Part C Medicare
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4. United/part C Medicare
5. United/Commercial
6. Aetna/Part C Medicare
7. Aetna/Commercial
8. Managed Medicaid
9. Other – Part C Medicare
10. Other - Commercial



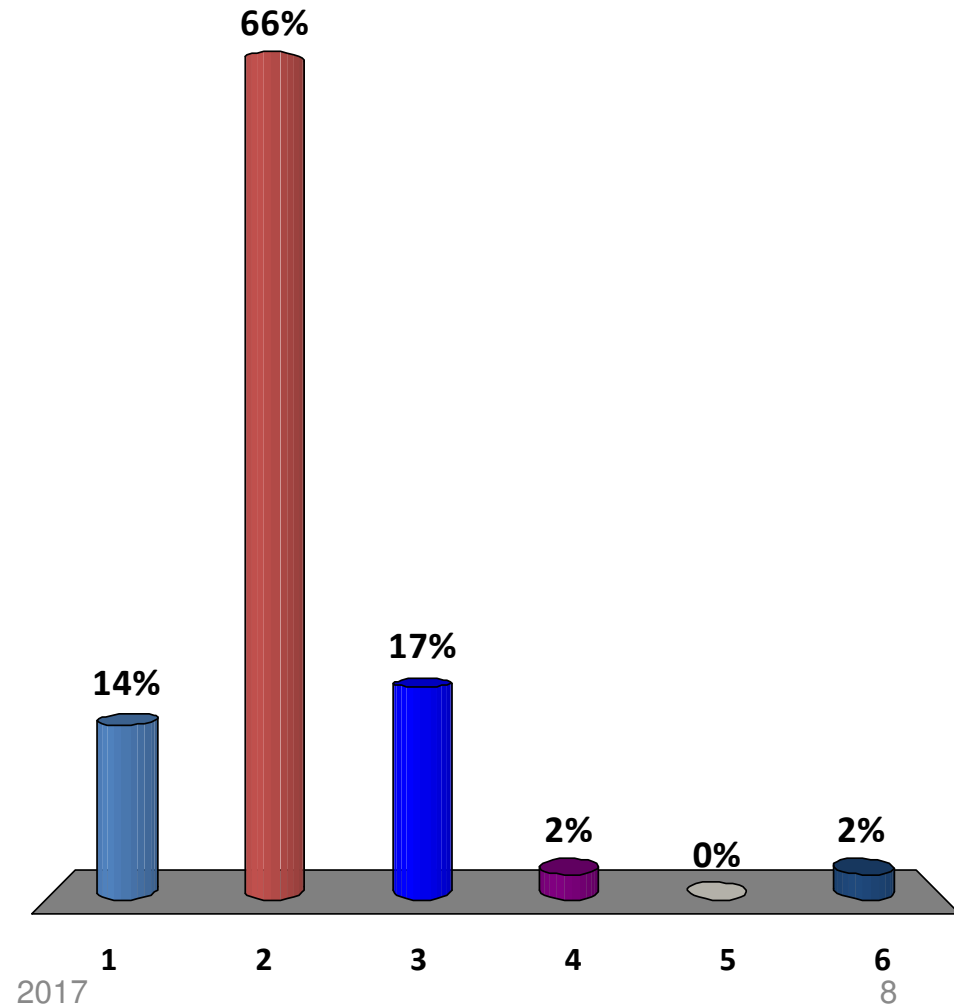
What strategy best describes your UR and PA's role with non-Traditional Medicare and Commercial disputes and denials: (2016)

1. Just fight them as they happen
2. Just fight them but give direct feedback to contracting
3. Just fight them but give direct feedback to the denial mgt team
4. Just fight them but give feedback to the CFO and BEG for help with contracting
5. Just fight them and have limited internal help
6. None of the above



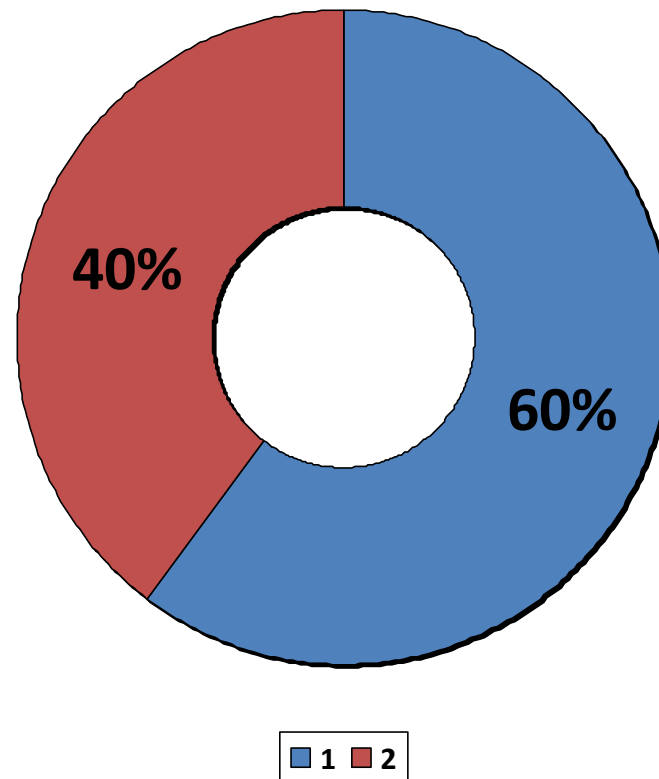
What is your current strategy for fighting denials? (2016)

1. Overwhelmed so only appeal the really strong ones
2. Appeal all
3. Only appeal based on dollars at risk
4. Appeal complex only
5. Don't appeal
6. Don't know



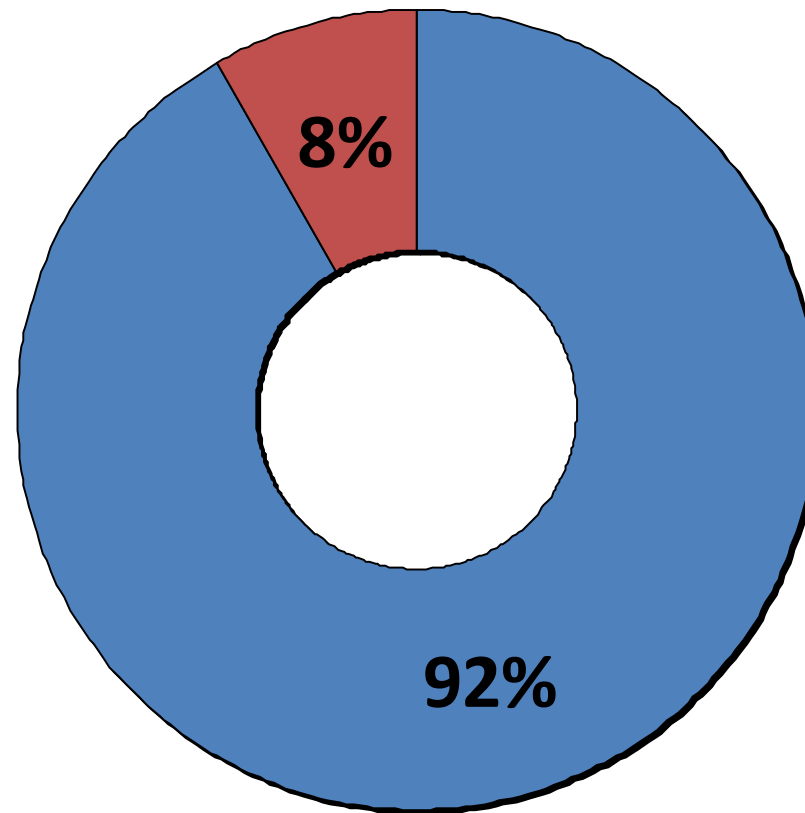
Do you have a physician advisor/PA designated to assist with your appeal strategy? (2016)

1. Yes
2. No



Do you use peer to peer with the payers/P2P (your MD/PA with the payer's MD) as part of your appeal strategy? (2016)

1. Yes
2. No



More ‘baby steps to improved accountability’

- “Humana stumbles on news of lower Medicare Rating.” 10-16 *Trying to merge with Aetna*
- Result: membership dropped, Humana, Inc fell the most in more than 3 months.

“ CMS’s star quality ratings are a critical measure of success in the Medicare program, with high ratings translated to bonuses for top-performing Medicare Advantage (MA) plans and member retention, enrollment and marketing advantages for both MA and Part D high achievers. But the ratings are a moving target, with CMS making modifications each year that make it more difficult for plan sponsors to focus on all needed areas of improvement. There are also continuing concerns that the measures do not adequately measure performance for plans serving low-income and disadvantaged members, resulting in inaccurate comparisons of plan performance. And given that there’s a two year lag in data for the performance measures, plans have a small window to make adjustments to their stars strategy for the 2018 measurement year.”
AISHealth.com”

Risk adjustment data validation

RADV

- The diagnoses that PacifiCare submitted to CMS for use in CMS's risk score calculations did not always comply with Federal requirements. For 55 of the 100 beneficiaries in our sample, the risk scores calculated using the diagnoses that PacifiCare submitted were valid. The risk scores for the remaining 45 beneficiaries were invalid because the diagnoses were not supported by the documentation that PacifiCare provided.
- As a result of these unsupported diagnoses, **PacifiCare received \$224,388 in overpayments from CMS. Based on our sample results, we estimated that PacifiCare was overpaid approximately \$423,709,068 in CY 2007. (Not recovered yet)**

GAO Slams CMS on MA Audits

- GAO found that CMS's methodology does not result in the selection of contracts for audit that have the greatest potential for recovery of improper payments.
- CMS's goal of eventually conducting annual RADV audits is in jeopardy because its two RADV audits to date have experienced substantial delays in identifying and recovering improper payments.
- CMS has not expanded the recovery audit program to MA by the end of 2010, as it was required to do by the Patient Protection and Affordable Care Act.

GAO-16-76 Published: Apr 8, 2016

UPDATE: Medicare Failed to Recover Up to \$125 M in Overpayments, records show. 1-6-17

“Under intense pressure from the health insurance industry, CMS quietly backed off their repayment demands and settled the audits in 2012 for just under \$3.4 M – short changing taxpayers by up to \$125M in possible overcharges just for 2007!” http://khn.org/news/Medicare-failed-to-recovery-up-to-125-million-in-13-overpayments-records-show/?utm_campaign

overpayments-records-show/?utm_campaign

What is the Regulation for Managed Medicare?

(Dr Ronald Hirsch/Accretive Health, 2016 PA & UR Boot camp**)

Medicare Advantage/Part C plans must provide their enrollees with all basic benefits covered under original Medicare. Consequently, plans may not impose limitations, waiting periods or exclusions from coverage due to pre-existing conditions that are not present in original Medicare.

MA plans need not follow original Medicare claims processing procedures. MA plans may create their own billing and payment procedures as long as providers – whether contracted or not – are paid accurately, timely and with an audit trail.

Medicare Managed Care Manual, Ch 4

1-17 Privately run health plans have enrolled more than 17 M elderly and disabled people – about 1/3 of those eligible for Medicare – at a cost to tax payers of more than \$150B a year. **Same article as slide 21 /added NOTE: Most hospitals have less than 1/3 of their business Managed Medicare – less in rural setting/shared risk too high.

Managed Care Process

- **Front end process:-**
The Managed Care Team is very influential
Notification/ Status and Criteria assignments
Clarify Policy and Process
- **Continued stay process:-**
Report accurate but complete information
- **Post acute care transitions:-**
Ensure correct placement for pt to promote safe healing and reduce readmissions

What's your Case Manager's Reality?

- Demand patients stay observation for days on end
- 48-72-96 hrs to get approval for post-acute care
- Contracted home care agency has bad reputation
- DME supplier will not deliver supplies in a timely manner
- Bundling all readmissions within 30 days
- Did I mention – DRG challenges? Inpt is finally approved only to see a reduction in the DRG payment.
- **TREAT MGD MEDICARE AS A COMMERCIAL PAYER**

And UR/UM has the first point of contact challenge...

- Who is the primary payer?
- What are their rules for inpt?
- Is this payer contracted? What are the pt status contract terms? If not contracted, then what?
- What guidelines is the payer using to support /determine inpt? Milliman? Interqual? Neither?
- Who is the provider who will write the inpt order?
- What if the payer disputes the inpt request?
- What are the payer's rules for resolving a pt status dispute?
- Does UR know ANY of the contract terms? Why not..
- AND if pt status changes are contractually limited for after discharge, then what??

One RAC Relief User Issue

- Sending appeals and then following up to check the status only to learn they don't have any record of us filing an appeal and we will need to resend it to them.
- Suggested Response: Would you like me to contact the Office of Civil Rights and file the HIPAA breach report for you since you lost PHI that I can prove was in your possession? **

3 Legs of Anguish – Pt Status, DRG Downgrades, Re-Admissions

- Pt Status – what is their definition of an inpt?
- DRG Downgrades – what documentation standards are required to allow all physician inclusion of ALL dx the pt has and are included in the thought process/not always the actual treatment?
- Readmissions - Related means? 30 days when CMS does not use this standard. Preventable means?

- Hint – all must be in the contract! Usually silent.

2017



Specifics – Disputes with payers

Internal MD to Payer's MD

- **Do more Peer to Peer** calls- preferred Internal Physician
 - Get involved
 - Educate front line attending
 - Let them know what works
 - Let them know what is in question
 - Reward for great documentation
 - Share with all



It's all in the Contract



- What criteria are used?
- United Health Care Policy Number: H-006
- **Coverage Statement:** Hospital services (inpatient and outpatient) are covered when Medicare criteria are met.
- For coverage to be appropriate under Medicare for an inpatient admission, the patient must demonstrate signs and/or symptoms severe enough to warrant then need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.

Update - United

- As of Aug 2015, UHC no longer uses the CMS two-midnight standard to make inpt admission determination.
- UHC believes the best way to help UHC's members get access to the care they need is to rely on evidence-based guidelines and treatments. Evidence-based guidelines allow UHC to review a member's health condition based on the clinical documentation and provide consistent, clinically validated decisions for hospital admissions.
- More specifically, United uses Milliman Care Guidelines (MCG) to determine medical necessity and the appropriate level of care.
- UHC will also provide a copy of MCG criteria upon request before, during, or after a reconsideration request.
- Sites should now consider: "If appeal results in an adverse decision, we request a copy of the individual criteria used to determine medical necessity be provided with the determination."
- Per UHC 2016 Provider Manual – pp 113-114 Criteria for Determining Medical Necessity.

UnitedHealth Adopts Bundle Payment Model for Orthopedic Care 12-16

- To reduce the high spend associated with hip, knee and spine surgeries, United Healthcare has adopted a bundled payment model.
- “Along with higher spends, members regularly show poorer health outcomes’, said Michelle Lobe, VP of Network Strategies & Innovations.
- “For the most part, about 17% of company spend is in the orthopedic arena. Hip, knee, spine procedures constitute about 33% of that.”
- “By partnering with **high quality providers**, payers may also find their members experience better outcomes and decreased cost.”

Cigna Obs Policy 0411

- In general, the duration of observation care services does not exceed 24 hours, although in some circumstances, individuals may require a second day. Observation care for greater than 48 hours without inpatient admission is generally considered not medically necessary and may be subject to medical review.

(Dr Ron Hirsch/Accretive – from PA & UR boot camp 2016.**)

Aetna Precertification List

- Observation stays greater than 24 hours will require precertification. Observation stays greater than 24 hours are considered an inpatient stay and are subject to all inpatient policies, including the timely notification requirement. **

- **Inpatient admission required rather than observation care because of 1 or more of the following:**
 - Significant finding or clinical condition judged too severe (eg, treatment intensity or expected duration requires inpatient admission) **or too persistent (eg, insufficient improvement or worsening despite initial intervention or treatment for up to 24 hours)** to be within scope of observation care, including 1 or more of the following:
 - Vomiting that is severe or persistent
 - Severe electrolyte abnormalities requiring inpatient care
 - Hemodynamic instability that is severe or persistent
 - Acute renal failure
 - Other significant finding or clinical condition judged not to be within scope of observation care
 - Treatment or monitoring requiring inpatient admission (eg, due to intensity or expected duration) as indicated by need for 1 or more of the following(6)(7)(8):
 - **Continued inpatient IV hydration due to failure of rehydration treatment (eg, for greater than 24 hours) and expected improvement with further inpatient evaluation and treatment**

Readmissions- CMS Policy

- When a patient is discharged/transferred from an acute care Prospective Payment System (PPS) hospital **and is readmitted to the same acute care PPS hospital on the same day for symptoms related to**, or for evaluation and management of, the prior stay's medical condition, hospitals will adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim. Please be aware that services rendered by other institutional providers during a combined stay must be paid by the acute care PPS hospital as per common Medicare practice.

Aetna Readmission Policy

- Effective July 1, 2015, we're changing our readmissions policy. To match our readmissions policy for Aetna Medicare members, we're also extending the review timeframe for readmissions from 2 days to 30 days for our Aetna commercial members. This policy will apply to agreements that include a diagnosis-related group (DRG) methodology for inpatient stays. **
- **ALERT:** All plans are using 'related' readmissions. Some are using 'preventable' readmissions. All denied for separate payment.

Regence Readmission

Hospital readmission review (group and Individual plans)

All hospital readmissions for the same, similar or related condition which occur within 48 hours of the original discharge from hospital/facility or as defined in the Hospital Provider Contract is considered a continuation of initial treatment.

The two hospital stays will be consolidated into one, combining all necessary codes, billed charges and the length of stay. The maximum allowable for Covered Services will be recalculated per the reimbursement terms of the hospital/facility contract so that reimbursement is for a single, per case reimbursement.

More readmission info- UNITED

- Per United Healthcare's "Hospital Readmissions", effective 10-1-16. Promoting Safe Hospital Discharges
- **Approx 19% of Medicare pts are readmitted within 30 days.**
- Only 37% are able to state the purpose of their meds
- Only 14% knew their medication's common side effects
- Only 42% are able to state their diagnosis
- 25% of discharged patients require additional outpt work-ups with greater than 1 of 3 work-ups not completed.
- As many as 41% of pts are discharged with test results still pending with 37% of the results actionable. Two of three docs are unaware of results.

Sources:* Mayo clinic proceedings: 2005 80 (8): 991-994 &
J Gen Internal Medicine: 2009 : 24(9): 1002-6

United Health Care Readmission

- A LVN, LPN or RN will review the medical records and supporting documentation provided by the facility to determine whether the two admissions are related.
- If the subsequent admission is related to the initial admission and appears to have been preventable, the LVN, LPN or RN will submit the case to a medical director, who is a physician, for further review.
- The medical director will review the medical records to determine if the subsequent admission was preventable and/or there is an indication that the facility was attempting to circumvent the PPS system. **

Anthem/Part C Medicare Readmission

- Anthem Medicare Advantage considers a readmission to the same hospital for the same, similar, or related condition on the same date of service to be a continuation of initial treatment. Anthem Medicare Advantage defines same day as services rendered within a 24-hour period (from time of discharge to time of readmission) for participating providers. **

- **Anthem Medicare Advantage will utilize clinical criteria and licensed clinical medical review for readmissions from day 2 to day 30 in order to determine if the second admission is for:**
 - The same or closely-related condition or procedure as the prior discharge
 - An infection or other complication of care
 - A condition or procedure indicative of a failed surgical intervention
 - An acute decompensation of a coexisting chronic disease
 - A need that could have reasonably been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge or during the post discharge follow up period
 - An issue caused by a premature discharge from the same facility **

How Did We Address Humana?- Dr Baker, 2016 PA & UR Boot Camp++

- Received two main areas of denials- prior authorization for inpatient only months later to deny and DRG validation audits going after cases with single CC or MCC
- Filed multiple appeals trying to address the issues directly with Humana
- Set up a meeting with Human Corporate Compliance Group to address the egregious nature of these denials.
- No progress when trying to deal directly



Humana Continued++

- Worked with SCHA /South Carolina to develop a complaint mechanism through the Atlanta Regional Office for CMS via email:
PartDComplaintsRO4@cms.hhs.gov
- First complaint on the prior authorization issue presenting to CMS that if concurrently reviewed and approved should not be able to change based on outcome “risk realized” and that since as a facility we had every right to expect payment then we should be able to hold the beneficiary financially liable
- Received call from Humana within twenty four hours to correct these denials and to assure that this practice was to stop immediately the problem had been they had not checked the box on their form allowing the financial recovery group to audit these accounts

Humana ongoing++

- Secondly addressed the DRG validation audits by raising the question with CMS that if Humana is paid on a “Risk Adjustment Data Validation” or a risk score on each beneficiary based off billing data but was not allowing diagnoses which had been billed for DRG assignment had they reported this to CMS and if not was this fraud?
- Again received almost immediate response that of course this was not an issue as all these claims were being paid.

Regional Implications++

- Continuing work with SCHA reaching out to SC Department of Insurance to try to address who has regulatory authority over the MAPs
- Reaching further to the NAIC to get their input as well since CMS has stated their only role is financial viability but these are federally mandated programs and as such not regulated by the states
- Continuing work with this task force
- Currently starting a letter writing campaign from hospital C Suite to state representatives to increase the postal poundage in their inbox
- Ongoing Discussions with anyone willing to listen

National Impact ++

- Published results on a list serv known as RAC-Relief@googlegroups.com
- **Dramatic increase in the filing of complaints about all of the Advantage Plans with CMS** to the point that most now have specific people assigned for complaints
- American College of Physician Advisors has a Governmental Task Force bringing to bear on CMS issues around the same plans.
- BUT NEW WORLD WITH SITE AND HUMANA/2017



National Contacts at CMS for Complaints: ++

- Humana

- Uvonda Meinholdt
Health Insurance Specialist
Kansas City Regional Office
Phone: 816-426-6544
FAX: 443-380-6020
Uvonda.Meinholdt@cms.hhs.gov

- United

- Nicole Edwards
- Phone: 415-744-3672
- Nicole.edwards@cms.hhs.gov

- Coventry Health / Aetna

- Don Marek
- Health Insurance Specialist
- Denver Regional Office
- Phone: 303-844-2646
- Don.Marek@cms.hhs.gov

- BCBS Anthem

- Anne McMillan
- Health Insurance Specialist
- Chicago Regional Office
- Phone: 312-353-1668

General CMS Contact

Melanie Xiao, Health Insurance Specialist
CSM San Francisco Regional Office
415 744 3613
Melanie.Xiao@cms.hhs.gov



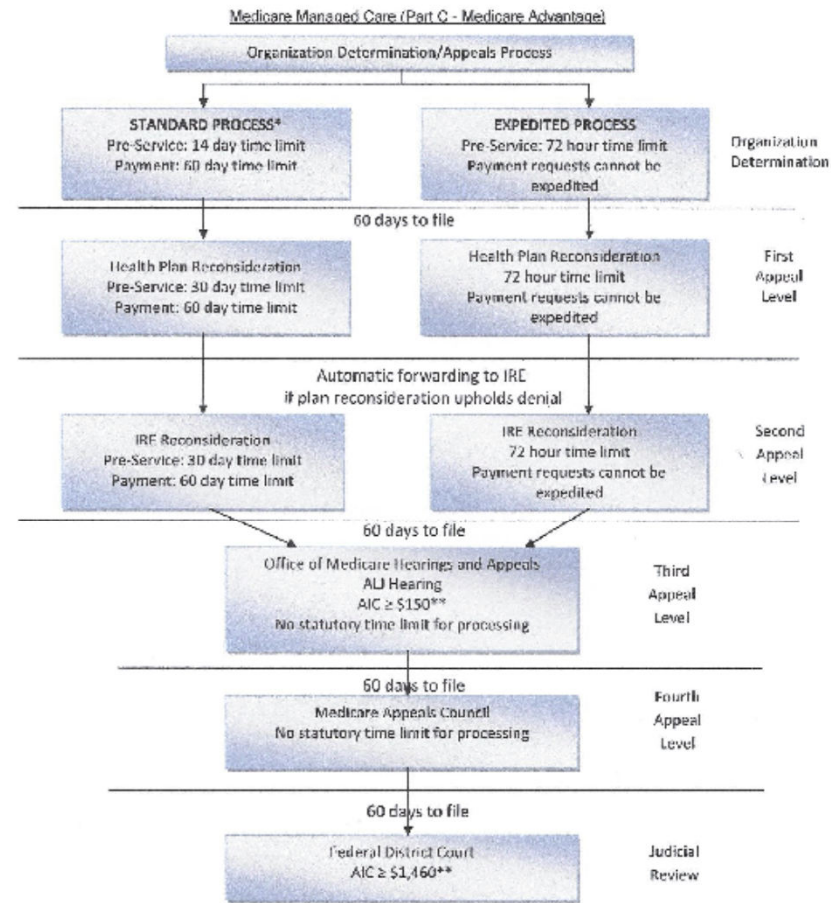
Future Implications for the Medicare Part C/Advantage++

- Significant decrease in denials from Humana at our/SC facility
- **CMS involvement in regulating the plans as evidenced by a ban on CIGNA for enrolling new beneficiaries and a fine on Humana for \$3.1 million for improper administration of Part D and some Part C benefits**
- Medicare Advantage Plans are subject to RAC audits..but??



Part C/Medicare Appeals

- Unless the contract speaks directly to the levels of appeal, all Medicare patients should receive all five (5) levels of appeal.
- ALERT: Closely monitor the language within the contract to ensure it is not limiting.
- ALERT: If there is no contract with the Mgd Care Medicare/Part C/Medicare Advantage, then the Part A/Traditional levels of appeal apply.
- <https://www.cms.gov/medicare/appeals-and-grievances/mmcag/downloads/managed-care-appeals-flow-chart-pdf>



AIC = Amount in Controversy / ALJ = Administrative Law Judge / IRE = Independent Review Entity
 *Plan must process 95% of all claim dollars from out-of-network providers within 30 days. All other claims must be processed within 60 days.
 **The AIC requirement for an ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the consumer price index. The chart reflects the amounts for calendar year (CY) 2015.

Proactive Strategies – Contracts

GOAL: It is a internal team sport

- Develop a template for terms for all payers – commercial and Medicare Part C/Advantage –beyond payment.
- Areas to include:
 - Timeline to submit clinicals – inpt vs obs
 - Timeline for determination from the payer- within 12 hrs
 - Immediate call/appeal including guarantee of a peer to peer call within 24 hrs with clear time assigned and kept.
 - Clearly outline criteria being used to determine inpt status. (Beyond ‘medically necessary ‘ care.)
 - DRG – Correct coding guidelines being used. (Disallowing dx that are not being treated...lower the DRG payment.)
 - Re-admission guidelines. (Related? Like CMS?)
 - Appeal rights – post discharge. Ensure all 5 levels with Traditional Medicare are included for all Part C plans.
 - “Using Traditional Medicare/CMS” rules – but what happens when they don’t?

And more updates- Part C

- Managed Medicare Plans/Part C = HUGE
- They do not have to adapt Traditional coverage rules.
- Treat them like a Commercial Payers – get pre-certs, determine if they are using ‘2 MN’ rule methodology and/or clinical guidelines.
- Update contracts to CLEARLY outline the tools used to determine: what is an inpt.
- Always use: Physician order with rationale for why? (Sound familiar??)
- If not contracted –TRADITIONAL MEDICARE APPLIES!
- Big increase in denials...& disputes of status
- **WHAT IS THE PAYER’S DEFINITON OF AN INPT!**



Proactive Strategies - Payers

- Schedule monthly meetings with the primary contracted payers.
- Have examples of 'abuse' with inpt status and DRG and readmission. (3 hot spots)
- Involve contracting with all payer operational meetings/calls.
- Involve UM with all payer operational calls.
- Involve Coding leadership and/or CDI with meetings.

Last tid bits



- Part A rules only apply if contracted.
 - “Can’t change status after discharge.” HUGE! Many disputed statuses are not resolved until after discharge. Ensure this is allowed in contract language.
 - Humana IS imposing no change of status after D/C. HUGE win for Humana as disputed status may involve P2P calls – which can take days to coordinate...pt is discharged with a disputed status... NO !
 - “Condition Code 44 has to be done” HUGE! Since Part C Medicare has to be contracted for status confirmation, it is not applicable unless contractually included.
 - Managed Part C plans ‘quote’ CC 44 for disputed status – inpt back to obs. Again, unless it clearly states that CC 44 is part of the contract – it is not used. HUGE win for the payer as disputes can take days to resolve – SO pt is an inpt until dispute is resolved. DO NOT Allow – ‘we follow CMS guidelines’ without additional clarity.

Complexity from all directions- Patients impacted

- Patients unaware they are ‘seamlessly converted ‘ to the Mgd Medicare Plan when they had the same carrier as a Commercial plan. HOLY MOLY!
- See www.washingtonpost.com/national/health-science/senior-surprise-getting-switched-with-little-warning-into-Medicare-advantage/2016/07/26.
- Patients received letter /one of many as they approach 65. They MUST opt OUT of the plan or they are **seamlessly** being enrolled. “With Medicare’s specific approval, a health insurance company can enroll a member of its marketplace or other commercial plan into its Medicare Advantage plan...which takes effect within 60 days unless the member opts out.”
- Many pts without their doctor and more money out of pocket as didn’t know they were part of a Mgd Plan!!!

BREAKING NEWS - HOLD

- Oct 24, 2016 CMS has temporarily stopped accepting new proposals from health insurance companies seeking to **automatically** enroll their commercial or Medicaid patients into their Medicare Advantage/Part C plans.
- CMS disclosed 29 Medicare Advantage companies – including Aetna, United, and several Blue Cross and Blue Shield insurers. Half of the companies received their approval this year.
- Members currently are AUTO enrolled unless they opt out.
- Dialogue want the pts to OPT IN..so they have choice. Doctor relationships are huge when the pt is AUTO enrolled.
- www.modernhealthcare.com/assets/pdf/CH1075661021.pdf
- www.modernhealthcare.com/article/20161004/news/161009981

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Thanks for joining us!
Free info line available.

NEW EXPANDED WEBPAGE: <http://arsystemsdayergusquiza.com>



2017 PA & UR Boot Camp – “**Attacking Payer Denial’s Boot Camp**- Creating a Collaborative Team. Turning Anguish and Aggravation into Action”
July 19-21, 2017 Bonita Springs, FL