THE NEW ART OF WAR
MEDICARE ADVANTAGE PLANS

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Self Regional Healthcare

DISCLAIMERS

- I have no conflicts to report but am willing to entertain any ideas that you may have!

OBJECTIVES

1. Discuss local, regional and national efforts to deal with MAP's
2. Outline how to report complaints to CMS
3. Discuss our success with Humana

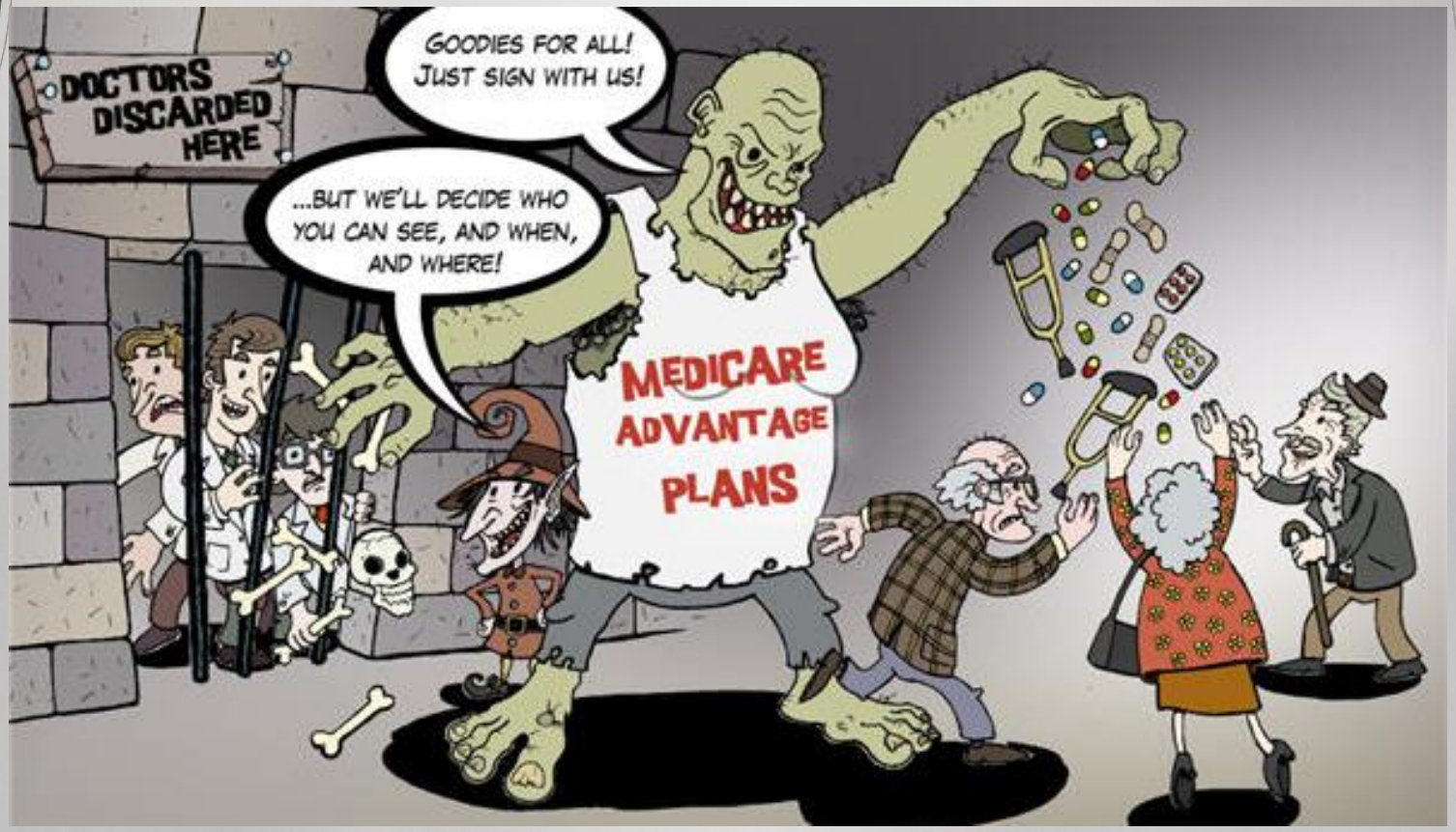
Self Memorial Hospital 1951

Self Regional Healthcare 2016

MY BACKGROUND

- Founding and Managing partner Piedmont Physicians for Women an OB/GYN private practice 1982-2014
- President, United Physicians Care, a six county IPA 1995-present
- Chairman of the Board, Upper Savannah Health Services, A PHO with our IPA and four hospitals. 1997-present
- Co-Chair Finance Committee, Vice Chair Local Steering Committee and serve on the Compliance Committee for My Health First an upstate clinically integrated network 2015-present
- Physician Advisor Self Regional Healthcare 2014-present

THE ENEMY


DOCTORS DISCARDED HERE
GOODIES FOR ALL! JUST SIGN WITH US!
...BUT WE'LL DECIDE WHO YOU CAN SEE, AND WHEN, AND WHERE!
MEDICARE ADVANTAGE PLANS

GOVERNING REGULATION

- "An MA plan must provide an enrollee with coverage for all items and services covered by Medicare Part A (except hospice services) and Part B that are available to beneficiaries in the plan's service area. See 42 C.F.R. § 422.101(a). Medicare coverage of various medical items and services under original (fee-for-service) Medicare is governed by the Medicare statute (title XVIII of the Social Security Act (Act)) and implementing regulations (title 42 of the Code of Federal Regulations). Coverage is also governed on a national basis by manuals issued by CMS, as well as by National Coverage Determinations (NCDs). Medicare Administrative Contractors for Medicare Parts A and B may issue local coverage determinations (LCDs) and other guidelines, which further define and explain local coverage policies for the particular geographical area which that contractor oversees. An MA plan must comply with NCDs, LCDs, and general coverage guidelines included in original Medicare manuals and instructions. 42 C.F.R. § 422."

MAP'S USE THE RULE THAT BENEFITS THEM

- Not required to exactly follow Medicare rules but will quote them if it is to their advantage
- Seeing denials more commonly than before
- Significant increase in audits
- Most do concurrent review either approve inpatient or more frequently offer observation
- Retroactive Denials
- DRG Validation Audits

HOW DID WE ADDRESS HUMANA?

- 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 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 and are getting help from Mr. Ray Farmer
- 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 my 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
- It is Important to be sure you file the First Level Appeal before going to CMS to demonstrate that the plan is not working with you
- American College of Physician Advisors has a Governmental Task Force bringing to bear on CMS issues around the same plans.
- All others welcome to join in the fight

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

FUTURE IMPLICATIONS FOR THE MAPS

- Significant decrease in denials from Humana at our 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 now subject to RAC audits

NEXT ON THE AGENDA

- 30 Day Readmission Policies
- Plan Specific Language- United home visit
- Zero Dollar Remit without notification of Denial- WellCare
- Plans Quote CMS Policy including the Readmission Reduction Program – same day, QIO requires action or inaction
- Potentially financially devastating
- Denials Team should have input into negotiation of contract language

BREAKING NEWS

- Recent Meetings with Humana

QUESTIONS?