Enhancing the Patient Experience – Be the PAtient

Day Egusquiza, President & Founder

AR Systems, Inc & The Patient Financial Navigator Foundation,, Inc.

“Hi everybody. Love being with you in our new virtual world. Mask on, smiling underneath, staying safe while we all stay connected. Perfect!”

Make up on, hair done, business.

Vs.

no make up, workout sweats…LOL

New definition of ‘business casual’

Most common phrases from 2020:

“Can you hear me?”

and the favorite, as we talk up a storm:

“You are still on mute.”

David Johnson: Cracks in the Foundation (Part 6) — Overcoming inadequate leadership. (hfm/9-22)

The American Hospital Association's (AHA) April 2022 *Cost of Caring* report pleads for more funding to offset double-digit increases in labor, supply and drug costs. Meanwhile, the latest West Health-Gallup Healthcare Value Index found that 95% of American adults find the perceived value of the healthcare they receive is "inconsistent" or "poor." Healthcare's leaders, including board leadership, should sit up and take notice.

A failure of healthcare leadership

- The economic principle is not complicated and applies to all industries. Demanding more money for overpriced services is no way to win consumers' hearts, minds and wallets. Warren Buffett famously observed, "Price is what you pay. Value is what you get."

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Hospital Purgatory’: Confidence in healthcare plunges as criticism grows louder and larger.”

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“We are going into hospital purgatory. It’s a period in which old rules may not work in the future. The only thing we know for sure is that it isn’t going to get easier. “ Dr Paul Keckley

Confidence in Medical System fell from 51% in 2020 to 38% in 2022.

What will make the change? How do we talk to our public? Like family or thru language they don’t understand . No one likes to feel stupid..

75th HFMA Anniversary- Day Egusquiza

- Day's article in the 75th HFMA anniversary "***HFM: How to engage with patients where they are by balancing automation with the human touch." 9-21***
  - ***The ability to maintain strong personal relationships with patients is a defining characteristic of successful provider organizations. In addition to having highly developed automated systems, a dedicated staff whose role is to personally engage with the patients is important for providers. (Think Pt Financial Navigator)***

  - The need for empathy
  - Case example of meeting pts where they are – Sr Centers
  - Engaging the pt means recognizing Social Determinants of Health
  - The Central Role of the Patient Financial Navigator
  - Get the Word out
  - Changes are coming – like physicians paid according to pt experience and quality score matrix, providers paid on quality scores including patients scoring. Complex system but may move the needle

Joe Fifer, FHFMA, CPA- President of HFMA

- "Why finance leaders should be consumer-obsessed?" Oct 2022
- There are disrupters –especially in the retail sphere- Amazon stands out. For several yrs, making forays into healthcare. Customer obsession is widely considered to be the fundamental pillar of its business philosophy. Buying One Medical/primary care doctors.
- Google, Apple, JPMorgan Chase's Morgan Health and CVS Health are also digging deeper into healthcare. They know the consumer experience is the Achilles heel of many legacy healthcare stakeholders.
- Consumer perceptions of the revenue cycle? Clearly, we have a lot of catching up to do as we become CONSUMER – OBSESSED? Been stressing since 2011.
- What has your organization done….lately?

AGENDA – Our patients

- Patients are scared and ill
- Healthcare focuses on the ‘business and language of healthcare” not thru the lens of the patient.
- All patients ‘assume’ they will be healed, their insurance will pay their bill/most of it, and even if their life is disrupted, it will be short term.
- Healthcare is the only industry that ‘provides Cadillac care ‘ and patient leaves without paying. ‘UNSECURED LOAN!”
- Patients are all ages, all level of digit understanding, some want a person to talk and explain, others can use webpage.
- Turnover is an issue when it comes to keeping everyone educated about all the issues impacting the pt thru the Revenue Cycle.

Meet the pt where they are – means?

- Connecting to purpose
- Who is the audience you are ‘speaking to? Baby boomers, Gen X, Millennials, Gen Z, Gen Y.
- Conversation/media or internal includes phrases that likely no one understands.
  - EX) Value over Volume
  - EX) Accountable Care
  - EX) Inpt rehab at the rehab cer which is really Skilled nursing care Skilled Home…with limited covera
  - EX) Medically necessary care and double WOW!

Let's talk about the impact to the patient and provider community…

Decisions in healthcare – Whose lens are we looking thru?

- **Business decisions** = easier for the healthcare provider to roll out and measure/Track and trend. Must be part of all conversations.

- **Patient Focused decisions** = walk the talk, realize that patients don't understand healthcare 'words'. Confused and scared can equate to angry.

"***My patient didn't ask to be sick; my patient didn't ask to have their life disrupted; my patient didn't ask to have their insurance pay so little or no insurance. My patient is scared and doesn't know where to turn. Be the Patient! Be the Patient Financial Navigator…they are your neighbors. This is what community-based looks like."***

Meet the patient where they are. Day E.

Relevant RCM Legislative Policies (Western Symposium. 1-23)

PRIORITY	TRACTION	PATIENT	PROVIDER	PAYER
COVID-19 Response	High	+	+	+/-
Premium Tax Credits HBE	High	+	+	+
ACA / Medicaid	High	+	+	+/-
Price Transparency	High	+	-	+/-
Surprise Billing	High	+	-	+
Telehealth	High	+	+/-	+
Limit M&A Activity	Moderate	+	-	+
Drug imports / Pricing reform	Moderate	+	+/-	+/-
Medicare Drug Pricing	Moderate	+	-	-
Lower Medicare to 60y	Low	+	+	+/-
Public Option	Low	+/-	+/-	-

https://revcycleintelligence.com/features/what-healthcare-cfos-can-expect-under-a-biden-presidency

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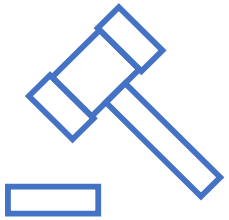
No Surprises Act



12/2/22:

Enforcement of co-providers co-facilities has "extend[ed] enforcement discretion" into 2023

FAQS ABOUT CONSOLIDATED APPROPRIATIONS ACT, 2021 IMPLEMENTATION - GOOD FAITH ESTIMATES (GFES) FOR UNINSURED (OR SELF-PAY) INDIVIDUALS – PART 3

December 2, 2022

Set out below are Frequently Asked Questions (FAQs) regarding implementation of Section 112 of Title I (the No Surprises Act (NSA)) of Division BB of the Consolidated Appropriations Act, 2021, and implementing regulations published in the Federal Register on October 7, 2021 as part of interim final rules with comment period, titled *Requirements Related to Surprise Billing; Part II*. These FAQs have been prepared by the Department of Health and Human Services (HHS) to address the provision of GFEs for uninsured (or self-pay) individuals, as described in Public Health Service Act (PHS Act) section 2799B-6 and implementing regulations at 45 CFR 149.610.

Additional FAQs related to GFEs for uninsured (or self-pay) individuals are available at https://www.cms.gov/cciio/resources/regulations-and-guidance#Good_Faith_Estimates.

Q1: Will CMS enforce the requirement that GFEs for uninsured (or self-pay) individuals include cost estimates from co-providers and co-facilities beginning on January 1, 2023?

A1: No. HHS is extending enforcement discretion, pending future rulemaking, for situations where GFEs for uninsured (or self-pay) individuals do not include expected charges from co-providers or co-facilities.

PHS Act section 2799B–6 and implementing regulations at 45 CFR 149.610(b)(1)(v) and (2)(i) require a GFE to include expected charges for any item or service that is reasonably expected to be provided in conjunction with the scheduled or requested item or service, including those provided by co-providers or co-facilities. In the *Requirements Related to Surprise Billing; Part II* interim final rules (IFR),[1] HHS indicated that it will exercise its enforcement discretion in situations where a GFE provided to an uninsured (or self-pay) individual from January 1, 2022 through December 31, 2022 does not include expected charges from co-providers or co-facilities. We explained that this exercise of enforcement discretion was necessary to allow time for providers and facilities to develop mechanisms for convening providers and facilities to request, and co-providers and co-facilities to provide, complete and accurate pricing information for the convening provider or facility to incorporate into the GFE for uninsured (or self-pay) individuals.

https://www.cms.gov/files/document/good-faith-estimate-uninsured-self-pay-part-3.pdf

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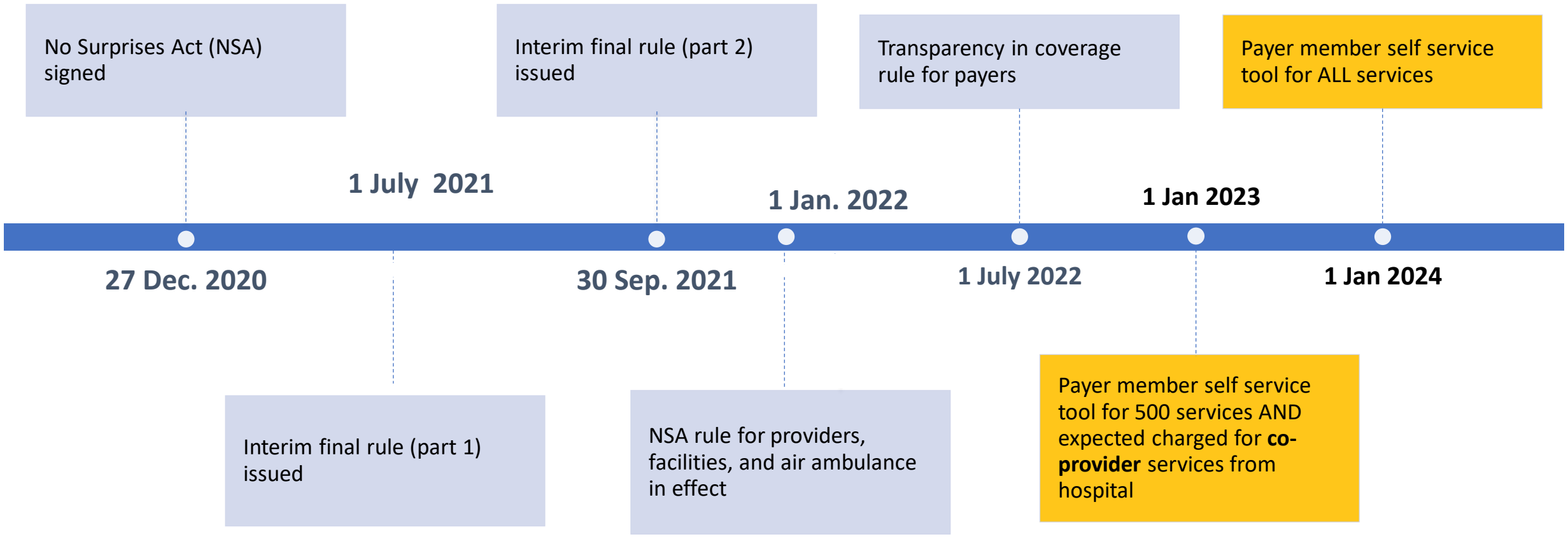
GFE GRID/TIMING – 10:3:1 rule

Date of scheduling / request	GFE should be sent within:
10+ business days in advance	Three (3) business days
Non-Scheduled	Three (3) business days from request
3-9 business days in advance	One (1) business day
<3 Days	Not required

No Surprises Act (NSA) Timeline



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Where did the No Surprises Act come from?

- Why did the public want something to protect them from out of network surprise bills? Did they know they were out of network? Start here.
- The most current reports/prior to the passage of the NSA legislation:

2018: 39% of patients reported Surprise Bills

- 1 in 6 ER visits
- Surprise: Cardiology consult, Anesthesiologists, Pathologists – while in hospital or having outpatient procedures.
- Patients were forced to a) pay all charges as out of network/no contract for reduced pricing and/or b) try to negotiate a reduced amount from the provider… the payer??

Which patient stops at the ER door? – “Wait, is the ER doctor in my insurance network?” Or during a cardiac observation stay – “Wait, is the consulting cardiologist in my network?” Really??

Now let's hear from a real patient experience with out-of-network/OON surprises

1. Patient had a dermatology visit.
2. Ended up removing a mole for further evaluation.
3. Unknown to the patient (what pt would ask – hey, where are you sending this to be evaluated and is this provider in my network)- the sample was sent out-of-state/OOS to a pathology company the provider had a business relationship.
4. When the statements were received, one came from the OOS provider with an additional $7.90 for OON penalties.
5. When called by the patient (which patient would know to challenge this?), the provider said that was how the insurance paid. And so on…with the pt finally stating, not paying.

And another patient trying to find a new provider – are they in her network? No Surprises is meant to help patients prevent going out of network – right?

1. Pt was referred to a regional hospital for testing/workup. First time going there – checking to ensure this hospital was in her network.
2. Checked webpage. Asked for provider list, with her insurance, for the region. Could not find the list this way.
3. Went to the insurance name.org, then prompted to find care, then find a doctor, and input employer name, Still nothing.
4. Called HR, said to call the insurance plan. They didn't know.
5. Called Ins. 2 different calls: 1st, after 4 transfers, yes in network but had to look under a new, enhanced benefit plan name:___. Asked how would an employee know this was how to look up when it is not the general insurance name but the benefit plan name. Unknown.

The struggles continue trying to get in-network confirmation

5. Called insurance /2nd person. Now was told, under the new benefit plan name (ex: Brighthealth within Blue Cross) that the regional hospital WAS NOT in-network. Also asked employer VP who negotiated the contracts – nope, not in-network.
6. Finally called the regional hospital and asked for the PFS Manager. She readily stated: Yes, all commercial plans sold in the area are in-network.
7. WHO TO BELIEVE? When we say – the PATIENT needs to be more accountable to stay in-network – how will the patient or their family understand the 'business of healthcare' when they are scared and sick?

Every PFS dept should have all plans/contracted. Every employer/HR should know. But the pt? They are 100% impacted and how very difficult it is to get this basic information. Carefully watch the EOB….

WHAT ARE THE BIGGEST PAIN POINTS FOR OUR PATIENTS *AND US WHO HAS THE SCRIPT TO REPLY?

PRIOR AUTHORIZATION UGLIES

- Pt does not understand outpt obs vs inpt. “They are in a bed on the floor.’
- Why does my insurance get to ‘deny prior auth’ when the physician says she needs it for my care? Now what?

DENIALS/PAYER FOR UNKNOWN REASON

- If a doctor orders the test or procedure, why does the payer get to deny saying it is ‘not medically necessary?”
- I just get a statement that says : insurance denial and all is for me to pay. I have insurance. What is this?

CHARGES THAT MAKE NO SENSE AND LARGE $

- Why aren’t these charges written so I can understand them?
- Why are they so high especially when my insurance doesn’t pay that amt any way?
- Hospitals make too much $

DIFFERENT +++=CRAZY

ELECTRONIC MEDICAL RECORDS

- Interoperability means?
- Hospital gives all community providers the ability to 'see history' but they can't update. What? Then no one can see the most current tx. (Pt could take it to the provider/great option…not!)
- Some hospitals have online access to see the results. But they are written 'for doctors by doctors.' How can I understand?
- I would love to be able to get an estimate but I have to get onto their webpage, have an account/MR with them, know the CPT code and match it correctly. WOW –what pt knows all that?

SAME HEALTH SYSTEM – DIFFERENT MONTHLY STATEMENTS

- I get so many statements from the multiple healthcare providers. Many do not make sense as there are charges, non-allowed, allowed amount, due from pt. But each statement is different and very hard to tie to the insurance statements.
- I get multiple statements from the same health system. REALLY? The clinics are on a different EMR than the hospital and they both send out their own statements. Can't they consolidate? Also, all my children get a statement, my wife and I. Can't they go under one general statement with itemized for them?
- This is hugely complex. Why?

ENGAGE CARE TEAMS, STAFF, COMMUNITY FOR FEEDBACK

ASK AND LISTEN

- Volunteers – usually have contact that others don't. Since COVID this has changed so who is now the 'non – clinician who listens and hears the pts?

- Nursing - when implementing:
- Preadmission financial program tie to the pre-op clinical visit.
- Prenatal classes – outline the average vaginal and C/S charges along with help thru Medicaid with resources.
- ER point of discharge collection – work with nursing and ER providers to have a financial d/c encounter

ASK AND LISTEN

- Senior Citizens Centers
- Office on Aging – they 'hear' from many senior activities and have ideas for improvement with the customer
- Staff – implemented a 2nd screen for registration so the pt can 'see' the questions and help with accuracy.
- Create a Pt Financial Navigator Booth at health fairs and other hospital-sponsored events. Bring your bills, we can help!
- Sponsor community outreach – ex) Medicare 101 each Oct-Dec.

Common Questions - part of any event

HEALTHCARE NEWS IN THE PRESS – REACTIONARY? POLITICAL?

WHO TRANSLATES TO THE PT AND THE STAFF AND COMMUNITY?

MEDICAID RE-ENROLLMENT/RE-DETERMINATION 4-23 THRU 4-24

ENDING OF THE PUBLIC HEALTH EMERGENCY 5-11-23

PAYER UGLIES IMPACTING PATIENTS AND PROVIDERS

AND START WITH A LITTLE "PAYER FUN"

THANKS, WARREN K/REGION 8 HFMA MEETING, 2022

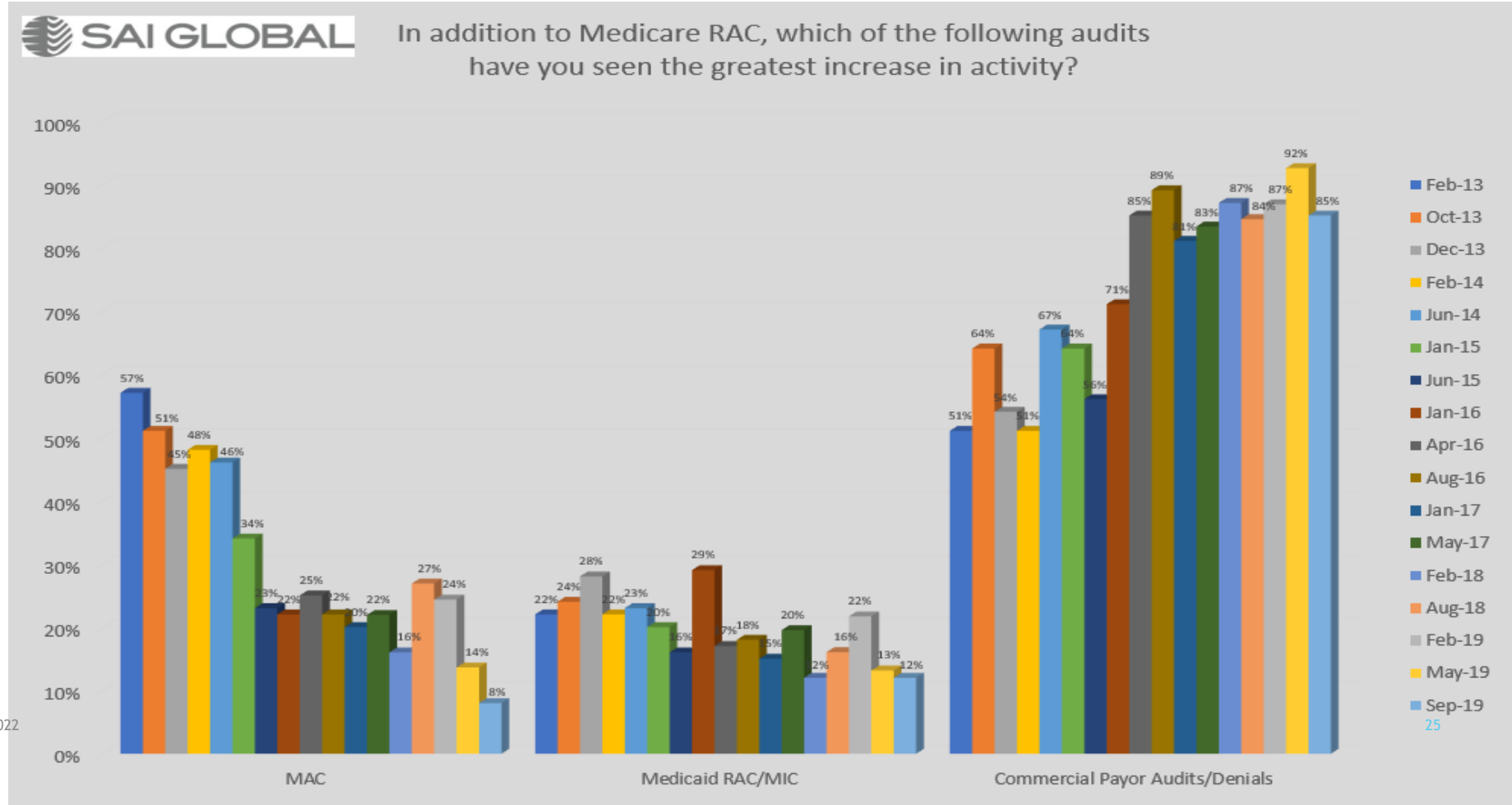
U	usually
N	nine
I	in
T	ten
E	experience
D	denials…..

C	called
I	in
G	got
N	no
A	answer

++All time favorite: Singing the"Blues "

8 year history with Compliance 360/SAI

AHA survey: 78% of hospitals =payer relationships are getting worse. 84% said the cost of complying with payer policies is increasing; 95% saw increase in staff time spent trying to get prior authorization. 11-22 Win/Lose!



And the continuing challenges with the payers…

- **Cost of Contracting**; Cost of prior authorization and repeat; Cost of trying to get Medicare Advantage coverage; Cost of records requests; labor and dollar delay costs. Huge!
- **AHA Nov 2022 survey:** "78% of hospitals = payer relationships are getting worse. 84% said the cost of complying with the payer policies is increasing. 95% saw an increase in staff time spent trying to get prior authorization".
- **Challenge – Win/Lose.** Who has the money has the power. Need to trigger to rebuild trust as each payer has their own operational rules – some super secret.
- **"The House Always Wins!"** Insurers' record profits clash with hospitals' hardships. Healthcare economists have classified 2022 as the worst financial year for hospitals in decades. (Becker report)
- **3rd Q payer profits:** United $5.3 B, up over 28% (traded on the stock market) Cigna $2.8B, up over 70%. Elevance Health $1.6B, up over 7%. Humana $1.2B down 20%. Centene $738M, up over 26%. Molina $230M up

Mgd Care Anguish-
A Brave New World Required-

Payer Policy Changes/Outside the Contract

Significant Growth of Medicare Advantage Plans

= Financial Impact to Providers

MA Plans can offer more than Traditional Medicare, not less!

- 42 CFR 422.101 states:
- "…each MA organization must meet the following requirements:
- (a) Provide coverage of, by finishing, arranging for, or making payment for, all services that are covered by Part A and Part B of Medicare…that are available to beneficiaries residing in the plan's service area…
- (b) Comply with-
- (1) CMS's national coverage determinations
- (2) General coverage guidelines included in original Medicare manuals and instructions unless superseded by regulations…"

- This regulation essentially states that MAO's may not be more restrictive than Medicare FFS/Traditional Medicare.

- Questions: Inpt only list? 2 MN rule? Prior auth? CHECK THE CONTRACT!

Timing of Determination Letters Contract language on timelines (ex)

- UHC: Faxed

DOS: 2-26	Received letter	3-1	
DOS: 4-17	Received letter	4-21	
DOS: 1-22	Received letter	1-25	
DOS: 5-12	Received letter	5-16	
DOS: 4-3	Letter dated:	4-6	Fax received: 4-8
DOS: 3-24	Received letter	3-28	**AVE: 4 days**

What if the pt has been discharged? Has the UB/claim already been sent as inpt? Was the PFS team told to hold these in a 'disputed status?" What is the timeline for the UR/Case Mgt team to submit original determination request?

- Humana: Faxed

DOS: 4-3	Received letter	4-6	
DOS: 5-8	Received letter	5-12	
DOS: 1-9	Received letter	1-13	**AVE: 4 days**

Payer Uglies – In Contract. Watch and ensure there is an understanding prior to signing. HUGE!

- Humana – Claims Payment Policy
- Subject: Inpt to outpt Rebilling
- Published: 9-2016 Policy # CP2015018
- Claim for inpt services when an inpt admission was not medically necessary. ***(PS Based on their decision and guidelines. Do you know it?)***
- ***Humana's Medicare Advantage plans follow the CMS guidelines for inpatient Part B rebilling. (PS- they do not use the 2MN rule, they require records sent for prior auth, delays in replying)***
- When an acute care hospital determines **BEFORE discharge t**hat the pt should not have been admitted as an inpt, Humana will ONLY accept services submitted on an appropriate outpt bill type (131) or 85X and will allow the provider to submit all codes for a normal outpt situation and required Condition code 44. (Again, not following TM rules but applying CC here. Even with this ruling, delays in ruling and time to get CC 44 done, which means pt notified, UR committee done, attending doc/notified and order changed – then can bill obs. UG!)
- When an acute care hospital or Humana determines **AFTER discharge** that the pt should not have been an inpt, Humana will only accept inpt bill type 121. This billing should reflect the reasonable and necessary Part B services and provide CPT codes where appropriate. Report condition code W2 to indicate this is a Part B claim and include "A/B Rebilling" in the treatment authorization field.
- For pre-admission services in the 3-day payment window, the hospital may separately bill for services prior to an inpt admission and should report "A/B Rebilling" in the treatment authorization field of the appropriate outpt TOB 131 or 851.

WOW and DOUBLE WOW! Additional Thoughts:

Did contracting know of this clause? Why allowed?

How long is it taking to get initial decision? 3-5 days? What are the chances of getting the P2P scheduled, done and decided PRIOR to the pt leaving?

Order says inpt? How did the provider bill?

Proactive Ideas for all non-Traditional Medicare/TM Contracting
Usually in Operational Addendum & Appeals

Outline key elements prior to signing the contract. Re-visit throughout the contract year if concerns arise. Rates are not included in this list.

1. **Timeline for submission of clinicals**. Week days, weekends, obs conversion request to inpt.
2. **Clinical guidelines the payer is using making the inpt decision** along with required REASON for not approving inpt with decision.
3. **Timelines for reply of request**. Weekends same as weekdays. 4-8 hrs maximum
4. **Once inpt has been approved, no additional record requests** unless pt is a candidate to move to a post-acute level of care. Contract language must be known – i.e. qualifying stay. (DRG)
5. **If granting access to the provider's electronic medical record**, critical to have a very limited review (ER if from the ER/labs/imaging/notes) with a firm timeline for decision. 4- 8 hrs maximum. Continued delay yields risk of the pt 'recovering in a lower level of care/obs." If in obs, grant access when the pt's condition needs reassessed. 8 hrs maximum.
6. **DRG hot spots**: Sepsis, ensure there is adherence to the HIPAA Standard Transactions- all covered entities.
7. **MA plans**: Ensure there is understanding that a disputed status may not resolved while the pt is in-house. TM rules do not apply. Status can be changed post discharge will full billing as inpt or outpt/131 bill type.
8. **P2P:** Any provider may discuss the account on the patient's behalf. All contracts allow both concurrent and post-discharge P2P. Once the request is made, a time is agreed to /recommended. Identify timeline with penalties if not adhered to. Agree to the qualifications of the payer MD. Outline the scope of the Payer MD can use –beyond meeting the clinical guidelines. No minimum LOS to be an inpt. (EX: all accts under 48 hrs are obs.)
9. **Re-admission deni**als. Outline exactly what is a 'related' case within 30 days. "Same as Medicare' = same day, same facility, same dx. Chronic dx are excluded. Identify which dx must be the same and in which 'spot' of the up to 10 dx.

Readmission Denials- CMS Policy (MA plans are wrong)

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 t**o, 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. Chpt 3 Sec 40 2.5

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. 1 Single payment with same day readmission.

Prior Authorization/PA = Pending Legislation- focusing on MA ‘delays & denials” of care

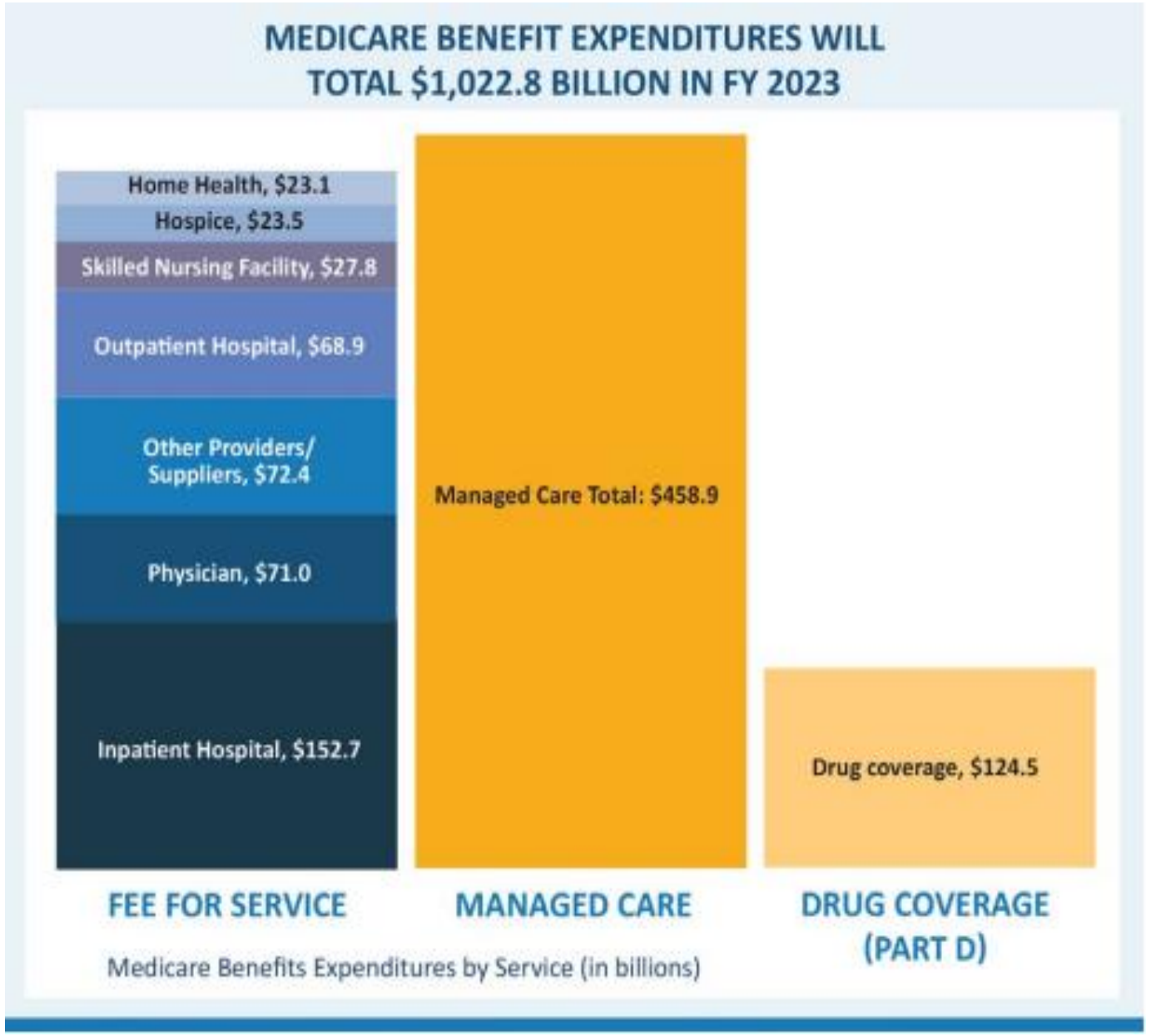
- The Improving Seniors' Timely Access to Care Act would require CMS to report how often they use PA as well as the rate of approvals and denials, and would require HHS to set up a real time decision process for all services that are typically approved. The bill would also include an electronic PA processing system that health care organizations have wanted for years.

- In their Viewpoint, researchers from the University of Colorado and John Hopkins University called for 3 other ideas:

  - The relative benefits and costs of PA should be reviewed by CMS at a procedure level. For instance, insisting on PA for high-cost chemotherapy when no other options exist will not reduce waste, but it will create additional administrative cost.
  - MA payers should report approval and denial rates to the CMS based on sociodemographic characteristics and by procedure type in order to evaluate whether PA is increasing health care disparities.
  - Based on what payers report to CMS about their denial rates, CMS should audit the PA denials of plans with high-denial rates and compare plans with high denials to other MA plans.

- In a statement, lead author Kelly E. Anderson, PhD, MPP, assistant professor at the University of Colorado Skaggs School of Pharmacy and Pharmaceutical Sciences, addressed the need for improvements when utilizing PA.

Traditional Medicare spend $439.4 Billion



Source: HHS FY2023 Budget in Brief-HHS.gov

Background Story 2019 – 2022

Humana MA enrollment increased from 400 to 2200 attributed to Stillwater Medical providers

Zero premium PPO MA Plans increase in popularity with new retirees

Local Insurance Brokers increase MA Sales

Traditional Medicare Supplements enforce medical screening during open enrollment

- *Stillwater Medical Reimbursement drops to 95% of Medicare*
- *MA Denials = 22% of total MA claims for this period*
- *Traditional Medicare denials < 1% for the same period*
- *Cost to provide care increases 26%*

Oklahoma hospital terminates Medicare Advantage contracts amid financial challenges

Stillwater Medical Center in Oklahoma has ended all in-network contracts with Medicare Advantage plans amid financial challenges at the 117-bed hospital, the *Stillwater News Press* reported Oct. 14.

Humana and BCBS of Oklahoma were notified that their members will no longer receive in-network coverage after Jan. 1, 2023.

"BCBSOK is willing to work with Stillwater Medical Center in finding solutions that will allow Payne County residents continued local access to Medicare Advantage providers," a BCBS spokesperson told the newspaper.

The hospital said it made the decision after facing rising operating costs and a high prior authorization burden for the MA plans.

"This was a very tough financial decision for the Stillwater Medical leadership team. Our cost to operate has increased 26 percent over the past 2 years," Tamie Young, vice president of revenue cycle at SMC, told the *News Press*. "Financial challenges are increased by a 22 percent denial of service rate from Medicare Advantage plans. This is in comparison to a less than 1 percent denial rate from traditional Medicare."

- **Physician support and approval is key before providing notice to a payer**
- **Respond to the Press before they create their own story**
- **Provide reference points and key words to employees and providers**
- **Explain the “why” in easy-to-understand language**
- **Communicate Empathy, not Sympathy**
- **Reassure that physicians and hospitals are still here to provide care**
- **Teach about options and how out-of-network benefits work**
- **Use Videos and Q&A format for social media**
- **Publish contact information for State Medicare Assistance Programs**
- **(PAINFUL to make the decision; PAINFUL for the pt to hear: When enough is enough. Horrible outcome for the pt. Day)**

The Anguish continues – Medicare Advantage is NOT Traditional Medicare

To Contract or not to Contract. What is the "win' for the provider to contract? To not contract? Out of network penalties to the beneficiary…but what if you didn't contract – where would the patient get their provider network?

The MA plan cannot sell without a provider network in your community.

Regulations 42 C.F.R. § 422.214
If non-contracting with a Medicare Advantage/MA plan….

§ 422.214 Special rules for services furnished by noncontract providers.

a) Services furnished by non-section 1861(u) providers.

1) Any provider (other than a provider of services as defined in section 1861(u) of the Act) that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA coordinated care plan, an MSA plan, or an MA private fee-for-service plan must accept, as payment in full, the amounts that the provider could collect if the beneficiary were enrolled in original Medicare.

2) Any statutory provisions (including penalty provisions) that apply to payment for services furnished to a beneficiary not enrolled in an MA plan also apply to the payment described in paragraph (a)(1) of this section.

b) Services furnished by section 1861(u) providers of service. Any provider of services as defined in section 1861(u) of the Act that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA coordinated care plan, an MSA plan, or an MA private fee-for-service plan must accept, as payment in full, the amounts (less any payments under §§ 412.105(g) and 413.76 of this chapter) that it could collect if the beneficiary were enrolled in original Medicare. (Section 412.105(g) concerns indirect medical education payment to hospitals for managed care enrollees. Section 413.76 concerns calculating payment for direct medical education costs.)

Anguish with MA plans –Not Contracted- sent CMS traditional Medicare rates to MA plans.

- Not being paid correctly according to the CMS/Traditional Medicare/TM rate.
- EX) Each claim, the hospital is sending the letter to actual payment rate issued by CMS/TM.
- EX) Each claim is not being paid correctly EVEN with the additional cost of manual intervention.
- EX) Southwestern states- MA plan said they 'did not like the new format of the CMS/TM rate letter.' Wanted it in a different format before they accepted it. WHAT?
- Each example – the hospital had submitted the CMS letter to the appropriate person/per the MA plan. Still required the per-claim proof.
- File complaint; in violation of previous slide 42 CFR 422.214 .
- Noteworthy:
  Many examples were Critical Access hospitals – who have daily rates with CMS TM. MA plans must follow all CMS TM for all services as there is no contract.

More Denial Reasons & Action Items – Ex Humana

Normal course of Inpt Request with payer. (Let's use Humana for teaching ex)

- Inpt denied as 'not medically necessary' for inpt level of care. SURPRISE
- UR and internal PA review the case. Decide to go to P2P to fight for inpt.
- Inpt continued to be denied. SURPRISE
- Now the hospital decided on one of the accounts to accept obs.
- They tell the payer they are going to downgrade to obs and bill
- Payer says: "You can't as you don't have an obs order" and the pt has gone home. (See previous note about no CC 44 with MA plans. Don't get it both ways)
- IDEA: Begin using a template for the medical record. It is telling the payer:

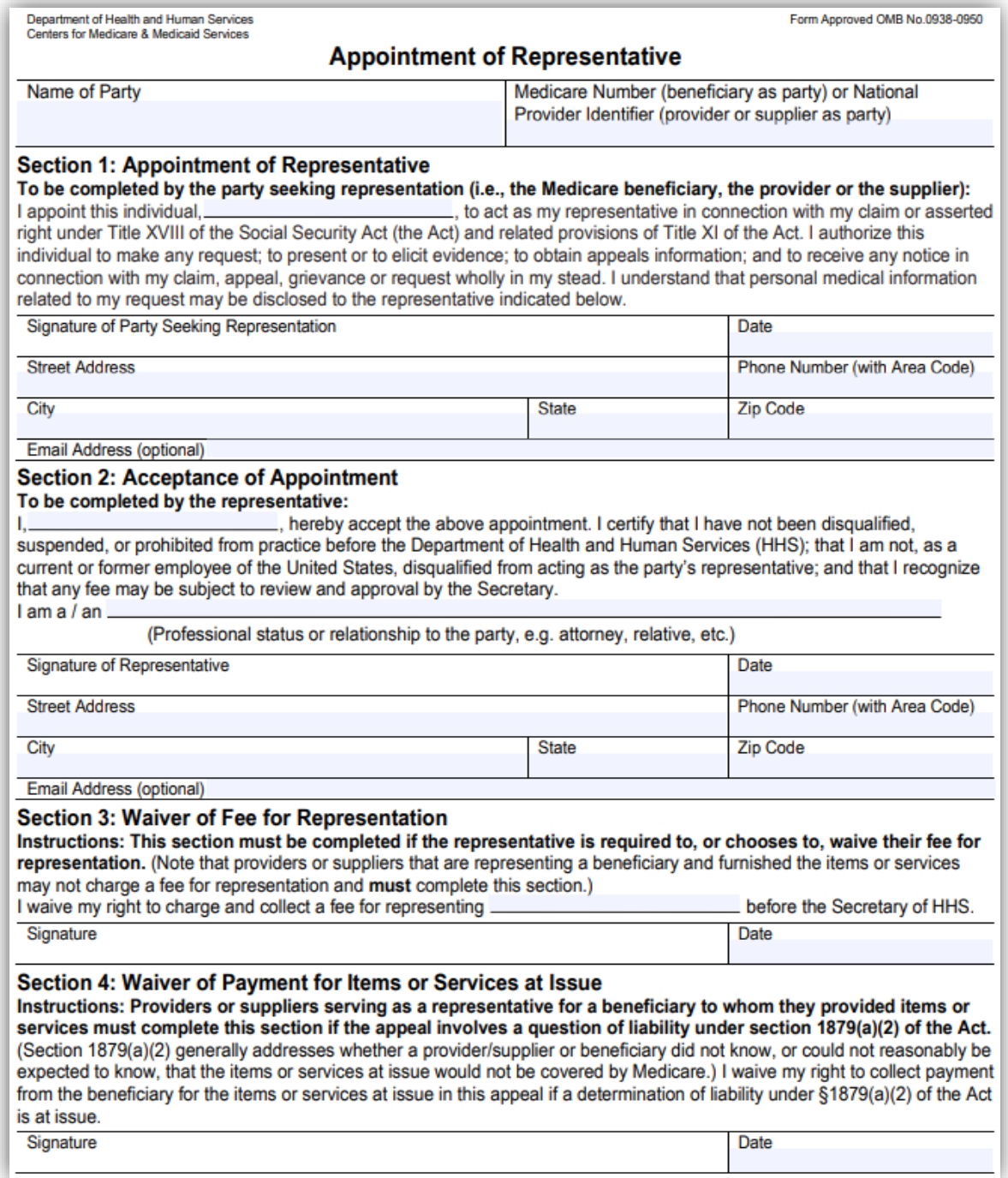
■ **" Thru communication with *payer's name*, the inpt order is being changed to observation as the payer will not authorize inpt and the facility agrees not to appeal or challenge the change in status. The account will be changed to OBS for billing purposes." Signed by MD or Internal Physician Advisor. Order is now in the chart for obs.**

Inspector General Office: Addressing concerns about improper denials in Medicare Advantage/MA. 5-11-22 (Did focused audit)

- **"A MA plan denied coverage for a walker a physician ordered for a 76-yr-old patient at risk of falling. The insurance company reported denying the walker because the pt received a cane in the past 5 years. A cane no longer provided the support the pt required to walk safely, and NO MEDICARE COVERAGE REQUIREMENT IMPOSES SUCH A FIVE-YEAR LIMIT.**
- **Another plan denied the MRI a physician ordered to assess why a 69-yr-old's pain and weakness continued five months after a fall. The insurance company's stated reason was that the patient did not first receive an X-ray. An X-ray could not detect the damage the physician suspected, and NO MEDICARE RULE MANDATES such an x-ray prior to MRI.**
- Recently, OIG reported that some MA organization denials of prior authorization requests raise concerns about beneficiary access to medically necessary care. ***We found that 13% of denied prior authorization requests and 18% of denied payment requests were for care that ACTUALLY MET Medicare coverage rules.***
- Sometimes insurers said the request lacked necessary information, but all necessary documentation was present. Some give up. Some seek alternative care or pay out of pocket. Some resubmitted repeatedly. Obtaining medically appropriate are should not require such resolve.
- Our recent study builds on prior OIG work. In 2018, we reported that MA appeal outcomes and audit findings raise concerns about service and payment denials. The insurance companies running MA plans overturned 75% of their own prior authorization and payment denials upon appeal. Essentially, beneficiaries or providers who persist were mostly successful. BUT THESE INDIVIDUALS ONLY APPEALED ABOUT 1% OF DENIALS.
- Providers can advise pts that they shouldn't necessarily take an 'initial no' for a final answer and that they can consult appeal rights of MA beneficiaries on CMS' webpage." (Patients do this? Scary to them)

CMS FORM 1696
Appointment of Representative (AOR)

- Must be accepted by all Medicare Advantage plans – cannot require a different form
- Sections 4 not applicable to Medicare Advantage because the Plan's Evidence of Coverage dictates any cost-sharing responsibility, unchanged by this form
- Providers cannot charge a fee for representing enrollee
- Valid for 1 year, and for life of an appeal
- **Use when a payer says – we will only speak to the ATTENDING! NOPE!**
- **USE THE FORM TO BE PRO-ACTIVE**



Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved OMB No.0938-0950

Appointment of Representative

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier (provider or supplier as party)

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint this individual, _____, to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the Act) and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance or request wholly in my stead. I understand that personal medical information related to my request may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 2: Acceptance of Appointment

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____

(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to, waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of HHS.

Signature	Date

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.) I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date

Medicare Advantage – Provider WINS – no post d/c

Use Regulations. Have legal letter ready to send to the payer if post-request for records/MA

If the plan approved the furnishing

of a service thru an advance

determination of coverage,

it MAY NOT deny

coverage later on the basis of a lack

of medical necessity." Medicare

Mgd Care Manual/Medical

Necessity, Chpt 4. Section 10.16.

- Approved for inpt. 10-18-18. Resulted in 1 day stay. Hired company to audit – denied and told to downgrade to obs. Not medically necessary for inpt. 9-19. Nope.
- Approved for obs 8-8-19. Did P2Pcall. Overturned and approved for inpt. 8-12-19. Indept firm (paid to deny) audited and stated downgrade to obs –could be treated in a lower level of care. 2-1-20. Nope.
- Of course, payer says you understood that this prior authorization was not a 'guarantee of payment' thru the contract language. Same language with commercial prior authorizations. But Medicare Mgd Care Manual adds more strength to the provider.

Medicare Advantage – Provider WINS –

Use Regulations. Have legal letter ready to send to the payer if post-request for records/MA

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Mgd Care Manual/Medical

Necessity, Chpt 4. Section 10.16.

- **New process: With each request for records from the MA plans, leadership reviews: was this already prior approved? Yes. Send attorney letter telling the MA plan/or their representative they are in violation of the above section. Discontinue requesting and any subsequent denials or recoupments or a formal complaint will be filed with CMS. Track and trend by payer. DO NOT SEND RECORDS - send letter instead.**

- Idea: Create attorney template letter to send with each MA request when a prior authorization was received..and due to the delay, payment made.
- Upon receipt of record request, do not send. Instead send the template letter/attorney signature.
- Track to ensure no recoupment occurs. Send formal compliant if needed.

Creating a Payer-Specific Matrix
Great tool in the toolbox

<u>Key elements in having the inpatient vs outpt observation discussion with non-Traditional Medicare payers</u>. (HINT: Better practice ideas)

- Each payer has their definition of 'what is an inpt.' ***Traditional Medicare is the only one using 2 Midnight rule; not IQ or MCG.***
- Each payer should have published what they are using in making that determination. (EX: Humana/MCG; United/MCG sort of/moving to IQ in May 2021; Indept BX plans/IQ-some moved to MCG)
- Each payer should have a way to request and complete a P2P challenge of patient status. (Contracted or within polices on webpage)
- Once this information is created as an internal matrix, now both the UR and the PA team know – what is this payer's unique definition of an inpt.
- **Oh, not so simple –you say**. YEP – as there is unlikely anything tied directly to a contact payment or penalty if they don't follow their own guidelines. BUT –it is the beginning step of a) requesting an inpt based on their own published clinical guidelines, b) UR's efforts to confirm the inpt and c) talking points if a P2P call must occur.

PAYOR	HEALTH PLAN	PLAN TYPE	CONTRACT IN PLACE	UM CRITERIA	DRG	SURGICAL LIST REFERENCE	IP NOTIFICATION/ AUTHORIZATION	INTAKE-IP NOTIFICATION CONTACT
Who is the primary Insurance Payor?	**What is the name of the Health Plan? UM should look at & start to think about what Payer and Plan Type does this patient have?**	**What type of plan is this? Knowing the type of plan can assist UM to think - Medicare regulation vs State Regulation vs Commercial contractual obligations vs. Corpoarte policy adherance in the absence of a contract**	**Is there a Contract with this payer/plan? A Yes vs No can prompt UM to think Contract specific rules at play vs. having to adhere to Plan's Corporate Policies**	**What UM Screening Tool does the Payer/Plan Use? Interqual, Millimen, CMS 2 MN Rule? Any other guidelines - IE: Medicare C list, Plan Specific Surgical Lists? Etc.**	**What DRG System is used - APR, MS, AP, Per Diem?**	**For Surgical Preadmissions - what does the plan reference for surgical bookings. EI: Medicare C-List, Medicaid IP Only list, Interqual, etc.**	**Who is responsible for the initial Notification of an IP Admission & Authorization Set-up? Financial Counseling, Patient Accounts, Business Office, Social Work, UM? *This information is important when retrospective denials occur for the technicality of "No Authorization Secured"; helps to get the visit back to the responsible party to attempt to rectify/update**	**If UM is responsible for any Inpatient Admission Notifications & Initial Auth Requests then who is the contact & how do they reach them?**
MVP	MVP Gold MVP Medicare	Medicare	YES	Interqual	MS-DRG	Medicare C-List	**Financial Counseling** - responsible for Notification of all ED Inpatient Amissions. **UM** - responsible for Notification of all Obs to IP upgrades occuring on Floor Units	For Obs to IP upgrade occuring on a floor - UM to contact Lisa at MVP. Phone 518-234-5678 Fax 518-234-5679

CMS Contacts for Regions 1-10 (7-21)

File complaints – squeak – with excellent examples of abuse

Will require the provider try to work it out with the payer first. Then file.. *Cannot be regarding rates*

Region 1	Robosora@cms.hhs.gov	CT, ME, MA, NH, RI, VT
Region 2	Ronycora@cms.hhs.gov	NJ, NY, Puerto Rico, Vir Islands
Region 3	Rophiora@cms.hhs.gov	DE, Dis of CO, MD, PA, VA, WV
Region 4	Roatlora@cms.hhs.gov	AL, FL, GA, KY, MS, NC, SC, TN
Region 5	Rochiora@cms.hhs.gov	Ill, IN, MI, MN, OH, WI
Region 6	Rodalora@cms.hhs.gov	Ark, LA, NM, OK, TX
Region 7	Rokcmora@cms.hhs.gov	IA, KS, MO, NE
Region 8	Roreaora@cms.hhs.gov	CO, MT, ND, SD, UT, WY
Region 9	Rosfoora@cms.hhs.gov	AZ, CA, HI, NV, Pacific Territories
Region 10	Rosea_ora2@cms.hhs.gov	AK, ID, OR, WA

Denials and being the patient advocate. A Financial Navigator for the most vulnerable. Pt loyalty means? BE THE PATIENT – Changes perspective!

And when the payer decides to deny a claim, the patient is overwhelmed.

Who is the provider navigator to help defend the denial or dispute w/payer?

Ex #1 Pt had a burn on lower leg. Insurance paid for the dressing but then stopped paying. Denied as not medically necessary. Didn't know where to go or who to help. Ended up calling their insurance agent/who sold the MA plan. The agent called the insurance and told the pt – nothing they can do. **He paid out of pocket for multiple months.**

Ex #2 Pt's insurance changed after the pt had 3 corrective surgeries. Specialized surgeon and procedures. A 4th surgery was necessary, but out of network. Pt asked their human resource /broker –nothing to help. Then directed to call the insurance directly and ask for help. After another denial, a navigator – advocate stepped in. Outlined the surgery, involved the surgeon to discuss the case directly with the payer, and asked for exception to continue with the same pt care and surgeon. Insurance plan said – there are plenty of in-network ortho surgeons. Now the battle to prove – can't change and no surgeon would take over this level of complexity. After many calls, the pt and advocate did get limited approval. **Then after-care denied**. (Can't make this stuff up!)

Ex #3 Pt had muscle pain with inability to dx without a test. A Vit D test was ordered as this was the accepted course of dx work- up for uncontrolled muscle pain. Insurance denied as not medically necessary and they had their own indept company who confirmed same. When told that the doctor needed to determine the level of Vit D –as it is directly related to the reason for muscle pain – didn't matter. **Pt was told they had to pay it and other services related to the Vit D test**. Pt asked the provider –what can they do? They stepped in and did do an appeal. All for a simple Vit D test.. Otherwise, the pt is left paying.

The complexity of healthcare – the relationship between the payer and the patient –all difficult for the pt who only believes:
If the physician ordered it, why did the insurance declare it as not medically necessary?
Physician directed care vs payer directed care. So very hard on the patient. Who can help them? Who actually knows what to ask?
Payer's going wild directly impacts the most vulnerable – the patient.

SUMMARY – Be the PAtient

- **YAHOO! Here comes the Pt Financial Navigator to the rescue.**
- Identify the 'best of the best"
- Best communicator and trainer – internal staff on resources, how to get help to all registration staff , customer service and ER = all points of entry thru the back end and appeals, etc.
- Best communicator to the patients.
- Create handout/other digital tools to answer the Most Common Questions from patients – insurance payment, deductible, copayments, billed charges vs allowables, prior auth means, inpt vs obs, and so forth …with the contact person the Pt Fin Navigator or a super well trained Customer Service Rep working closely together.

Mission Statement for the Revenue Cycle Staff

Mission statement for the Revenue Cycle staff:

My patient did not ask to be sick…

My patient did not ask to have their life disrupted …

My patient did not ask to have their insurance pay so little or not at all or no insurance….

My patient is scared and doesn't know where to turn to navigate the business of healthcare……

Be the patient. And the answers are easy.

Revenue Cycle Leads the Community Education

Every action = How does this impact the pt?

How can the Revenue Cycle help?

AR Systems, Inc
Training Library

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Thank You for Joining Us in this Educational Journey

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