Medicare Advantage and The 2-Midnight Rule: Level the Field with Medicare Advantage Payers

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Presented By

Jerilyn Morrissey, MD, serves as Versalus Health's senior vice president of clinical and regulatory affairs. Morrissey is responsible for consulting and strategic advisement for hospital leaders, case management staff, and physician advisors on regulatory, private payer, and utilization management issues. Morrissey leads Versalus Health's clinical and regulatory affairs teams, providing education for hospital executives, case management, physician advisors, and attending physicians. Morrissey is passionate about using data and technology to help hospitals navigate complex Medicare regulations and understand payer practices and their impact on the hospital revenue cycle. Morrissey's experience as a practicing physician, a physician advisor for a nationally recognized health system, and as a director of clinical information for a national payer, afford her a unique perspective to solve utilization management's evolving challenges.

Morrissey received a bachelor of arts in biology from the Illinois Wesleyan University and her medical degree from the University of Illinois. Morrissey is currently a licensed physician in California.

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Presented By

Joseph R. Zebrowitz, MD, is co-founder of Versalus Health, a company providing hospitals with next-generation analytic and operational solutions focused on the intersection of utilization management, revenue cycle, and compliance. Before Versalus, Zebrowitz served as executive vice president for Executive Health Resources (EHR) where he was a trusted advisor to thousands of hospitals and established the standard for medical necessity reviews. Zebrowitz's career focus has been on assisting hospitals in gaining an accurate picture of their compliance and revenue integrity.

Zebrowitz received a bachelor's degree in psychology from the University of Pennsylvania and his medical degree from Temple University School of Medicine.

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Learning Objectives

- At the completion of this educational activity, the learner will:
  - Describe the regulatory framework that applies to Medicare Advantage (MA)
  - Discuss what MA payers are and are not allowed to do
  - Identify recourses available to providers when payers do not abide by the rules

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Agenda

- Review the regulatory framework that applies to MA payers
- Review specific tactics that MA payers utilize to erode provider revenue
- Understand how analytics can be leveraged to uncover these tactics with precision
- Fighting back – what strategies providers can employ to level the playing field

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Medicare Advantage Organizational Tactics

- Medicare Advantage organizations (MAO) employ tactics that aggressively erode provider reimbursement
- Each payer uses a combination of different strategies to achieve its revenue goals
- Payer tactics target many points along the clinical revenue cycle – from utilization review (UR) to clinical documentation improvement (CDI)/coding to the business office

But can they? Do they have any responsibilities?

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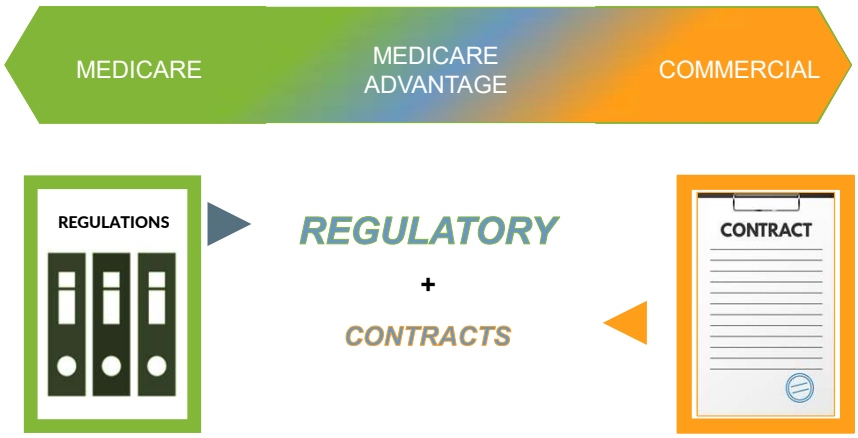
What Are The MA Rules Of Engagement?



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Sources of Information

What are the regulatory/legal standards we will review today?

- ✓ Social Security Act (SSA)
- ✓ *Code of Federal Regulations*
- ✓ CMS Internet-Only Manuals (IOMs):
  - *Medicare Managed Care Manual* (100-16)
    - Chapter 4: Benefits and Beneficiary Protections
    - Chapter 13: Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals Applicable to Medicare Advantage Plans, Cost Plans, and Health Care Prepayment Plans (HCPPs), (collectively referred to as Medicare Health Plans) – *New*
- ✓ HHS Office of the Inspector General (OIG) reports

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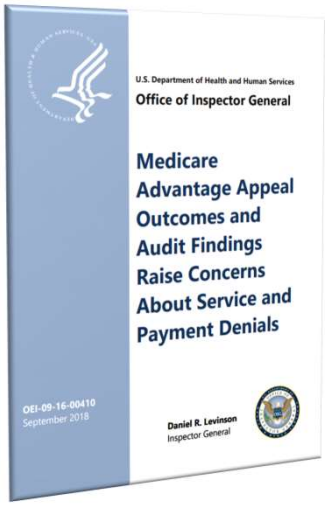
The OIG Provided The Following Overview



"…**Medicare pays the insurer** (called a Medicare Advantage Organization, or MAO) **a risk-adjusted payment each month for as long as the beneficiary is enrolled**. In exchange for the monthly payment, **the MAO agrees to authorize, and pay for, all medically necessary care for the beneficiary that falls within Medicare's benefits package**." [1] [Bold added by author]

Source: Office of Inspector General, Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials, OEI-09-16-00410. September 2018
Retrieved from: https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf Accessed 1 Feb 2022

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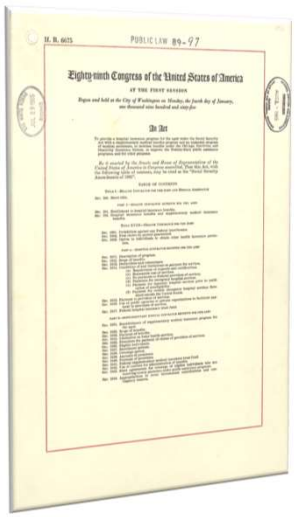
The SSA Focus On Medicare Member Benefits



MA plans must provide a "basic benefit" that is not less than the benefit(s) provided to Medicare Fee for Service (FFS) beneficiaries. Section 1852(a)(1)(A) of the Act states:

"*[E]ach Medicare + Choice plan* ***shall provide to members*** *enrolled under this part, through providers and other persons* that meet the applicable requirements of this title and part A of title XI, **benefits under the original Medicare fee-for-service program option**…" [Bold added by author]

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The Code Of Federal Regulations Focus On Medicare Member Benefits

33796 Federal Register / Vol. 85, No. 106 / Tuesday, June 2, 2020 / Rules and Regulations

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 417, 422, and 423

[CMS–4190–F]

RIN 0938–AT97

Medicare Program; Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Final rule.

SUMMARY: This final rule will revise regulations for the Medicare Advantage (MA or Part C) program, Medicare Prescription Drug Benefit (Part D) program, and Medicare Cost Plan program to implement certain sections of the Bipartisan Budget Act of 2018 and the 21st Century Cures Act. In addition, it will enhance the Part C and Part D programs, codify recent or existing CMS policies, and implement other technical changes.

DATES: Effective Date: These regulations are effective August 3, 2020.

Applicability Dates: Except for §§ 422.100(d)(2)(i), 423.100(d)(2)(i), and 423.134(d)(1) and (2), the provisions in this rule are applicable beginning January 1, 2021. The provisions of §§ 422.100(d)(2)(i) and 423.100(d)(2)(i) are applicable beginning January 1, 2022. The provisions of § 422.114(d)(1), (2), and (3) are applicable beginning January 1, 2022. The provisions of § 423.134(d)(1) and (2) are applicable beginning January 1, 2022.

FOR FURTHER INFORMATION CONTACT: Thomas Wardon, (410) 786–2387, or Carli Diehl, (410) 786–4063—General Questions.

Kimberlee Lewis, (410) 786–2549—Part C Issues.

Lucia Patterson, (410) 786–0621—Part D Issues.

Kristy Nishimoto, (206) 615–2367—Beneficiary Enrollment and Appeals Issues.

Stacy Davis, (410) 786–7413—Part C and D Payment Issues.

Melissa Bailey, (312) 938–2329—D-SNP Issues.

SUPPLEMENTARY INFORMATION: CMS intends to address all of the remaining comments from the February 2020 proposed rule in subsequent rulemaking. Therefore, CMS plans to make any provisions adopted in the subsequent rulemaking effective on or before January 1, 2022, applicable no earlier than January 1, 2022. Notwithstanding the foregoing, for proposals from the February 2020 proposed rule that would codify statutory requirements that are already in effect, CMS intends to propose to operators that the statutory provisions apply and will continue to be enforced. Similarly, for the proposals from the February 2020 proposed rule that would implement the statutory requirements in sections 2007 and 2008 of the Substance Use-Disease Prevention, Addiction, Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (hereinafter referred to as the SUPPORT Act), CMS intends to implement these statutes consistent with their effective provisions.

I. Executive Summary and Background

A. Executive Summary

1. Purpose

The primary purpose of this final rule is to implement certain sections of the following federal laws related to the Medicare Advantage (MA or Part C) and Prescription Drug Benefit (Part D) programs before the contract year 2021 MA plan bids (due by statute on the first Monday in June):

• The Bipartisan Budget Act of 2018 (hereinafter referred to as the BBA of 2018).

• The 21st Century Cures Act (hereinafter referred to as the Cures Act).

The rule also includes a number of other changes to strengthen and improve the Part C and D programs, codifies in regulation several CMS interpretive policies previously adopted through annual Call Letter and other guidance documents, and makes other technical changes. We took a measured approach to review each provision proposed and focused finalizing in this first final rule those most helpful for holding those that implement the Coronavirus Disease 2019 (COVID–19) pandemic, other public health emergencies, as well as those topics on which using a finalize now would advance the MA program.

While we intend to address the remaining proposals from the February 2020 proposed rule (84 FR 54602, 54, 2019), proposed in this final rule in subsequent rulemaking, we intend to issue a final rule on more technical regulatory actions, CMS plans to make any provisions adopted in the subsequent rule, although subsequent, no later than January 1, 2021, effective on or before January 1, applicable no earlier than January 1, 2022. Notwithstanding the foregoing, for proposals from the February 2020 proposed rule that would codify statutory requirements that are already in effect, CMS intends to propose to operators that the statutory provisions apply and will continue to be enforced. Similarly, for the proposals from the February 2020 proposed rule that would implement the statutory requirements in sections 2007 and 2008 of the SUPPORT Act, CMS intends to implement for statute consistent with its effective provisions.

2. Summary of the Main Provisions

a. Medicare Advantage (MA) Plan Options for End-Stage Renal Disease (ESRD) Beneficiaries (§§ 422.56, 422.52, and 422.110)

The Cures Act (Pub. L. 114–255) amended section 1851(a)(3)(B) of the Act to provide special enrollment options for MA plans to serve both end-stage renal disease (ESRD) and under non-called payment and coverage changes to the MA and original Medicare programs. Specifically, since the beginning of the MA program, beneficiaries with ESRD have not been able to enroll in MA plans subject to limited exceptions. Section 1.5 MMA of the Cures Act removed this prohibition. Section 1.5 of the Cures Act applies on or after January 1, 2021. We are codifying this change in regulations in §§ 422.100(d)(2), 422.52, and 422.110.

b. Medicare Fee-for-Service (FFS) Coverage of Costs for Kidney Acquisitions for Medicare Advantage (MA) Beneficiaries (§ 422.100)

With the new operational options, the Cures Act also made several payment changes to the MA and original Medicare FFS programs. Section 1.5(b)(1) of the Cures Act amended section 1862(a)(1)(B)(i) of the Act to include coverage of costs associated for kidney transplants from the MA and Medicare benefits, as MA plans is required to cover tax as MA enrollees including as covered under section 1862(a) of the Act effective January 1, 2021. These costs will be covered under Medicare Fee-for-Service (FFS) program. Section 1.5(b)(2)(A) of the Act amended section 1851(i) of the Act providing the MA organization that offer than the MA organization that offered the plan in which the individual is enrolled for expenses for organ

Medicare Managed Care Manual
Chapter 4 - Benefits and Beneficiary Protections

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(Rev. 121, Issued: 04-22-16)

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10.13 – Skilled Nursing Facility (SNF) Coverage

In the revisions to the ***Code of Federal Regulations, 42 CFR §417, 422,*** **and** ***423 (F.R. 2020-11342***), CMS revised regulations for the Medicare Advantage (MA or Part C) Program, Medicare Prescription Drug Benefit (Part D) Program, and the Medicare Cost Plan Program, and offered insight into CMS' intent as relates to the revision:

> "*We remind MA organizations of our long-standing guidance in Chapter 4 of the* Medicare Managed Care Manual *about medical necessity in the context of supplemental benefits and how MA plans may develop their own medical necessity policies and procedures,* ***so long as access to and coverage of Part A and Part B benefits is not more restrictive than Original Medicare****."* *(85 FR 33804)* [Bold added by author]

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At the Agency Level: Medicare Managed Care Manual, Chapter 4

> *"Every MA Plan:…*
>
> - ***Must make determinations based on****: (1)* ***the medical necessity of plan-covered services*** *- including emergency, urgent care and post-stabilization - based on internal policies (including coverage criteria* ***no more restrictive than original Medicare's national and local coverage policies****)… Furthermore,* ***if the plan approved the furnishing of a service through an advance determination of coverage, it may not deny coverage later on the basis of a lack of medical necessity*** *(*Program Integrity Manual, *Chapter 6, Section 6.1.3(A)); "*
> - *Must accept and process appeals consistent with the rules set forth at 42 CFR Part 422, Subpart M, and Chapter 13 of the MMCM." [*Bold added by author]

Source: CMS Medicare Managed Care (MMC) Internet Only Manual (IOM), Pub 100-16, Chapter 4: Benefits and Beneficiary Protections, Section 10.16 "Medical Necessity" Retrieved from: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf Accessed 1 Feb 2022.

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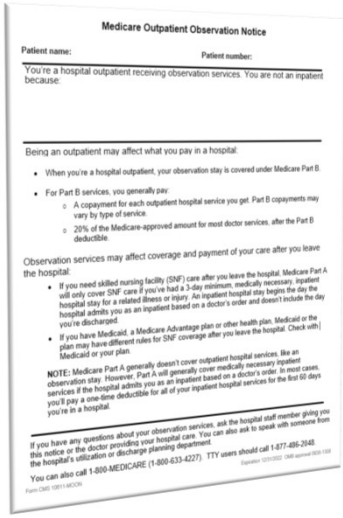
An Everyday Example That Regulatory Requirements Apply To Both Medicare FFS And MA



Medicare Outpatient Observation Notice

Patient name: Patient number:

You're a hospital outpatient receiving observation services. You are not an inpatient because:

Being an outpatient may affect what you pay in a hospital:

- When you're a hospital outpatient, your observation stay is covered under Medicare Part B.
- For Part B services, you generally pay:
  - A copayment for each outpatient hospital service you get. Part B copayments may vary by type of service.
  - 20% of the Medicare-approved amount for most doctor services, after the Part B deductible.

Observation services may affect coverage and payment of your care after you leave the hospital:

- If you need skilled nursing facility (SNF) care after you leave the hospital, Medicare Part A will only cover SNF care if you've had a 3-day minimum, medically necessary, inpatient hospital stay for a related illness or injury. An inpatient hospital stay begins the day the hospital admits you as an inpatient based on a doctor's order and doesn't include the day you're discharged.
- If you have Medicaid, a Medicare Advantage plan or other health plan, Medicaid or the plan may have different rules for SNF coverage after you leave the hospital. Check with Medicaid or your plan.

NOTE: Medicare Part A generally doesn't cover outpatient hospital services, like an observation stay. However, Part A will generally cover medically necessary inpatient services if the hospital admits you as an inpatient based on a doctor's order. In most cases, you'll pay a one-time deductible for all of your inpatient hospital services for the first 60 days you're in a hospital.

If you have any questions about your observation services, ask the hospital staff member giving you this notice or the doctor providing your hospital care. You can also ask to speak with someone from the hospital's utilization or discharge planning department.

You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Form CMS 10611-MOON

Expiration 12/31/2022 OMB approval 0938-1158

- Hospitals and critical access hospitals (CAH) are required to provide a Medicare Outpatient Observation Notice (MOON) to Medicare beneficiaries (*including MA plan members*)
- This informs the beneficiary that he/she is a hospital outpatient receiving observation services and is not inpatient of a hospital or CAH
- The MOON is required for MA and FFS beneficiaries

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Are Commercial UR Screening Criteria More Restrictive Than Medicare?

Medicare Managed Care Manual
Chapter 4 - Benefits and Beneficiary Protections

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"…the organization determination must be reviewed by a physician or other appropriate health care professional with sufficient medical and other expertise, ***including knowledge of Medicare coverage criteria***, before the *MAO* issues the organization determination decision." –*MMCM*, Chpt 4

COVERAGE determinations may be no more restrictive than Medicare's national and local coverage policies...

So, what are Medicare's coverage policies as it relates to status?

- The regulatory definitions of inpatient and observation? **YES**
- UR screening criteria? **NO**

Are commercial UR screening criteria more restrictive than Medicare?
YES!!!

Source: CMS Medicare Managed Care (MMC) Internet Only Manual (IOM), Pub 100-16, Chapter 4: Benefits and Beneficiary Protections, Section 10.16 "Medical Necessity"
Retrieved from: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf Accessed 1 Feb 2022

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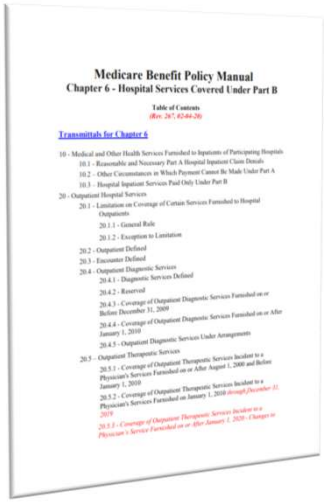
How Does Medicare Define Observation?


Medicare Benefit Policy Manual
Chapter 6 - Hospital Services Covered Under Part B

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20.5.3 - Coverage of Outpatient Therapeutic Services Incident to a Physician's Service Furnished on or After January 1, 2020 - Changes to

At the agency level, *Medicare Benefit Policy Manual* (IOM) 100-02 Chapter 6 §20.6

> "Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made ***in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours.*** [Bold added by author]

Source: CMS Medicare Benefit Policy Manual Internet Only Manual (IOM), Pub 100-02, Chapter 6: Hospital Services Covered Under Part B, Section 20.6 "Outpatient Observation Services" Retrieved from: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673 Accessed 1 Feb 2022

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Even Though The Payers Get Paid More You Will Get Paid Less

Each payer deploys its own unique methods to undermine hospital's revenue by taking advantage of the disconnects that occur in the *clinical revenue cycle*.

PAYER	REVENUE EROSION TACTICS
UnitedHealthcare	• Affiliated hospitalists control inpatient orders and documentation • Difficult inpatient authorization; inpatient to observation denials • DRG downgrades • ED-level downgrades
aetna	• Inpatient to observation denials • Observation definition for UM contradicts definition for claims payment • Use "notifications" to change policy • Line-item denials; proprietary bundling • Day-level downgrades • ED-level downgrades
Humana	• Inpatient to observation denials • DRG downgrades (most aggressive) • Difficult inpatient authorization; inpatient to observation denials • Blocked peer-to-peer appeals
BlueCross BlueShield	• BlueCross Blue Shield tactics and level of aggressiveness varies by state • Difficult inpatient authorization; inpatient to observation denials • DRG downgrades • Difficult or no peer-to-peer appeals • Complex written appeals process • Technical denials

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The Three Phases Of Payer Accountability

Get Your Own House in Order	*Exhaust Your Contractual Appeal Rights*	*Escalation, Arbitration, and Litigation*
Enhance	**Enforce**	**Escalate**
Enhance Internal Processes	*Enforce Appeal Rights*	*Escalate Payer Issues & Improve Contract Language*

THE 3Es OF PAYER ACCOUNTABILITY

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Use Actionable Analytics To Get Your House In Order!

VHI: Medicare Advantage Perf

Data for the period April 1, 2018 - March 31, 2019

Compare MA performance vs. MFFS

	--- Managed Care ---	--- UM Team ---	--- CDI/Coding ---	--- LOS/Throughput ---	--- Business Office---
	Contract & Rates	2+MN OBS Utilization	CMI	IP Cost & LOS [2]	Revenue Realization [3]

Payer	Contract Revenue	Contract Yield (Pymts/ Chrgs)	Performance Variance vs. FFS	% of Payer's Revenue	Contract & Rates: Reimb Variance	Contract & Rates: % Reimb Variance	2+MN OBS Utilization: Oppty (vs. MFFS)	2+MN OBS Utilization: 2+MN OBS Rate	2+MN OBS Utilization: OBS Rate Q1-2019	CMI: CMI Reimb Variance	CMI: % CMI Var	CMI: Med	CMI: Surg [4]	IP Cost & LOS [2]: Cost Variance	IP Cost & LOS [2]: % Cost Variance	IP Cost & LOS [2]: % LOS Var	Revenue Realization [3]: Variance $ (proj 350 days need)	Revenue Realization [3]: % Pymt Var
Medicare FFS	$50,088,491	8.6%							1.3%				17					
Payer 1	$14,302,519	6.9%	($2,096,971)	-14.7%	$625,432	103%	($2,641,668)	31.9%	34.4%	($212,987)	-1.7%	1.16	2.71	$206,040	-1.5%	12.3%	($73,788)	5.6%
Payer 2	$12,019,147	7.2%	($1,700,900)	-14.2%	$267,982	102%	($843,565)	18.2%	18.8%	($619,415)	-5.6%	1.12	2.57	($497,276)	2.15%	13.5%	($8,626)	4.2%
Payer 3	$12,803,050	8.1%	($719,061)	-5.6%	$550,257	100%	($4,528)	8.2%	21.7%	$305,976	2.1%	1.21	2.77	($255,020)	2.2%	10.6%	($1,315,746)	16.7%
Payer 4	$10,890,679	8.5%	($563,664)	-5.2%	($175,518)	99%	($447,657)	17.8%	17.4%	$291,062	2.1%	1.12	2.66	($212,043)	2.0%	27.1%	($19,508)	6.3%
Other	$3,176,376	7.8%	($201,864)	-6.4%	n/a	n/a	($118,055)	17.4%	17.8%	($50,439)	-4.2%	1.07	2.67	$49,239	0.0%	-0.4%	($82,609)	7.8%
Total	$53,191,771	8.1%	($5,282,460)	-10.8%	$1,268,153	101%	($4,055,473)	26.4%	29.9%	($285,803)	-0.9%	1.16	2.65	(709,060)	-1.7%	3.3%	($1,500,277)	5.7%

Managed Care | UM | CDI/Coding | LOS/Cost | Denials

Lower CMI could simply be lower acuity if cost/LOS is also lower

Start by comparing each MAO's performance to Medicare FFS

The true performance of an MAO can only be accurately and reliably understood when evaluated based on the cumulative impact of all the tactics that effect performance.

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Let's Review Some Misconceptions

EXAMPLE 1

If a payer agrees to *pay 103% of Medicare*, this contract will *definitely yield more revenue* than if those patients were Medicare FFS

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Payer 1 Agrees To Pay 103% Of Medicare

- Logically, higher contract rates relative to Medicare FFS should yield more revenue
- For this contract, 103% of Medicare rates should result in an additional $625K of incremental revenue
- But beware, this is not the whole story…

VHI: Medicare Advantage Performance Dashboard - *Recommendations* - **Hospital 1**

Data for the period April 1, 2018 - March 31, 2019

Compare MA performance vs. MFFS					--- Managed Care ---		--- UM Team ---			--- CDI/Coding ---				--- LOS/Throughput ---			--- Business Office---	
					Contract & Rates		2+MN OBS Utilization			CMI				IP Cost & LOS [2]			Revenue Realization [3]	
Payer	Contract Revenue	Contract Yield (Pymts/ Chrgs)	Performance Variance vs. FFS	% of Payer's Revenue	Reimb Variance	% Reimb Variance	Oppty (vs. MFFS)	2+MN OBS Rate	OBS Rate Q1-2019	CMI Reimb Variance	% CMI Var	Med	Surg [1]	Cost Variance	% Cost Variance	% LOS Var	Variance $ (proj 360 days aged)	% Pymt Var
Medicare FFS	$50,088,491	8.6%	n/a					4.0%	8.3%	7.3%	n/a	0%	1.18	2.77	FFS v. GM/LOS	$673K	17%	n/a	7.9%
Payer 1	$14,302,519																	
Payer 2	$12,019,147																	
Payer 3	$12,803,050				$550,257	101%												
Payer 4	$10,890,679				($175,518)	99%												
Other	$3,176,376				n/a	n/a												
Total	$53,191,771				$1,268,153	101%												

$625,432 103%

Lower CMI could simply be lower acuity if cost/LOS is also lower

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Does The 103% Materialize?

- Despite the higher contracted rates, Payer 1 has the *highest revenue shortfall* compared to Medicare FFS
- In fact, had Payer 1 patients walked in with Medicare FFS cards, Hospital 1 would have received $2.1M more!
- Payer 1 conditioned the hospital's UR department to self-downgrade long stay cases to observation to avoid denials. End result was a ~32% long observation rate costing $2.6M relative to Medicare FFS

VHI: Medicare Advantage Performance Dashboard - Recommendations - Hospital 1

Data for the period April 1

Compare MA performance

Payer	Contract Yield (Pymts/ Chrgs)	Performance Variance vs. FFS	% of Payer's Revenue	2+MN OBS Utilization: Oppty (vs. MFFS)	2+MN OBS Rate	OBS Rate Q1-2019	CDI/Coding: CMI Reimb Variance	% CMI Var	Med	Surg	LOS/Throughput: Cost Variance	% Cost Variance	% LOS Var	Business Office: Revenue Realization: Variance $ (proj 360 days aged)	% Pymt Var
Medicare FFS	$50,0	8.6%	n/a	Target: 4.0%	8.3%	7.3%	n/a	0%	1.18	2.77	FFS v. GMLOS	$673K	17%	n/a	7.9%
Payer 1	$14,3	6.9%	($2,096,971)	($2,641,668)	31.9%	34.4%	($212,987)	-1.7%	1.16	2.71	$206,040	-1.5%	12.3%	($73,788)	5.6%

Lower CMI could simply be lower acuity if cost/LOS is also lower

WARNING

Den... ...itioning: Focusing on individual KPIs such as denial rates without
und...
unn...

BEST PRACTICE

- Enhance internal UR processes to reverse the trend of overuse of observation
- Use CMS definitions of Inpatient and observation for MA payers

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Let's Review Some Misconceptions

EXAMPLE 2

The best payers for my hospital are the ones that issue the fewest denials

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Net Inpatient Realization™

Managed Care Net Inpatient Realization: 2+MN Patient Population

Rolling 12 months ending 10/31/2019. Key Stakeholders: UM, Billing, Appeals, Managed Care

	UM/Patient Status; Billing						Business Office / Appeals									Managed Care	
	2+MN OBS Rate			2+MN IP Billed			Denial Volume			Missed	Peer-to-Peer		Written Appeal			Net Inpatient Realization	
Payer	OBS Cases	2+MN OBS Rate	% of Total	IP Cases	2+MN IP Rate	% of Total	Denials	Denial Rate	% of Total	Not Appealed	P2Ps	% OT	Appeals	% OT		Net IP	Net IP / Total Vol
Aetna / Coventry	290	10%	*22%*	2,613	90%	*23%*	770	29%	*40%*	223	510	61%	238	17%		2,192	76%
United	343	18%	*26%*	1,563	82%	*13%*	120	8%	*6%*	102	6	67%	14	71%		1,457	76%
Humana	114	6%	*8%*	1,787	94%	*15%*	265	15%	*14%*	57	14	7%	207	37%		1,599	84%
Cigna	197	12%	*15%*	1,445	88%	*12%*	74	5%	*4%*	59	11	64%	8	38%		1,381	84%
Molina	119	7%	*9%*	1,582	93%	*14%*	255	16%	*13%*	92	33	45%	148	67%		1,441	85%
Wellcare	160	11%	*12%*	1,291	89%	*11%*	152	12%	*8%*	35	91	81%	43	35%		1,228	85%
OptumCare	74	8%	*6%*	849	92%	*7%*	188	22%	*10%*	90	85	52%	54	15%		713	77%
Other BCBS	27	9%	*2%*	269	91%	*2%*	45	17%	*2%*	23	15	53%	14	79%		243	82%
Other	20	10%	*1%*	179	90%	*2%*	49	27%	*3%*	35	8	88%	7	71%		142	71%
Total	**1,344**	**10.4%**	*100%*	**11,578**	**89.6%**	*100%*	**1,918**	**17%**	*100%*	**716**	**773**	**61%**	**733**	**37%**		**10,570**	**80%**
	UM/Bill Discrepancies:		*171 (1.5%)*					*% Not Appealed:*		*37%*							
Net Inpatient Realization:			***89.6%***					***74.8%***				***78.4%***		***80.4%***			***80%***

Managed Care Target: >92%

Medicare Actual: 96%

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Net Inpatient Realization™

Payer		Denial Volume			Net Inpatient Realization	
		Denials	Denial Rate	% of Total	Net IP	Net IP / Total Vol
Aetna / Coventry	2	770	29%	*40%*	2,192	76%
United	3	120	8%	*6%*	1,457	76%

BEST PRACTICE

- **Rethink your KPIs:**
  - **Denial rate and overturn rate in isolation are not good indicators of MA payer performance**
  - **"Overturn rate" may be impacted by low rates of appeal**

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Let's Review Some Misconceptions

EXAMPLE 3

Some physicians keep MA patients in observation status for over two midnights…

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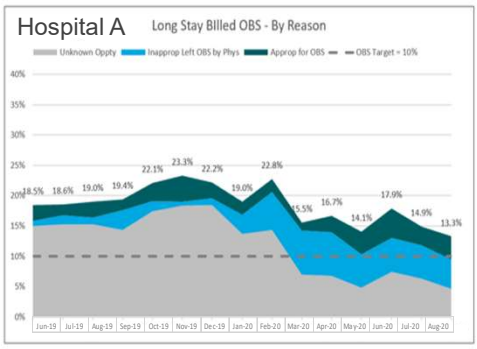
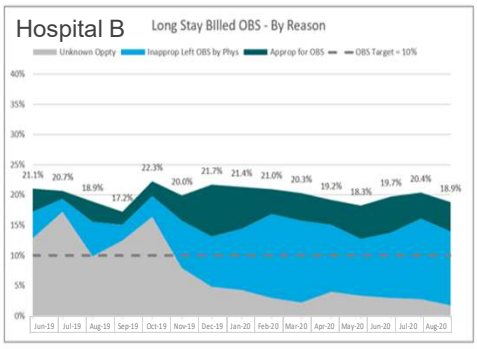
Uncovering The "Fox In The Hen House"

Two hospitals. In Hospital A, physician advisors work with attendings to change order for 2+ midnight cases appropriate for inpatient status. In Hospital B, attending physicians do not change orders despite meeting inpatient status. Why?"





WARNING

Investigation into Hospital B revealed that the physicians refusing to follow Medicare guidance were affiliated with a payer! The physicians were accountable to metrics developed to encourage leaving patients in observation despite meeting CMS inpatient guidance

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Uncovering The Fox In The Hen House: Physician Benchmarking

Compare 2+MN OBS Rates by Physician

Payer Affiliated Physician Group Treating Medicare Advantage vs Medicare FFS

	2+MN Patient Status:			---2+MN OBS Rates---		2+MN OBS	---2-3 MN Avg Charges---		---Medical CMI; IP Cases*---		FFS-Medicare
Cases by Physiciar	Inpt	OBS	Total	MA	FFS-Medicare	vs FFS-Medicare	MA	FFS-Medicare	MA	FFS-Medicare	2+MN Cases
BLACK WIDOW	588	286	874	33%	7%	4.7x	$28,502	$32,041	1.18	1.22	115
IRON MAN	576	268	844	32%	15%	2.2x	$29,934	$29,210	1.17	1.28	109
PEPPER POTS	527	313	840	37%	10%	3.8x	$29,188	$29,721	1.20	1.12	71
HULK	256	200	456	44%	15%	2.9x	$34,007	$36,116	1.31	1.27	233
THANOS	321	118	439	27%	3%	7.9x	$31,782	$31,651	1.14	1.13	440
WINTER SOLDIER	261	176	437	40%	13%	3x	$31,574	$31,321	1.29	1.28	204
JARVIS	311	88	399	22%	7%	3.3x	$34,144	$38,310	1.19	1.34	166
CAPTAIN AMERICA	78	26	104	25%	10%	2.6x	$37,088	$29,724	1.15	1.40	31
CLINT BARTON	75	19	94	20%	15%	1.3x	$40,323	$34,252	1.14	1.09	40
LOKI	59	20	79	25%	18%	1.4x	$34,428	$38,869	1.28	1.17	28
Total	3,052	1,514	4,566	33%	9%	3.6x	$31,027	$32,906	1.20	1.21	1,437
							5.7% lower		*1.5% lower*		

BEST PRACTICE

- **Use data to compare physician performance**
- **Understand which physicians are driving high long stay observation rates**
- **Determine if the physicians have payer business relationships undermining your hospital's performance & compliance**

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Get Your House In Order: ENHANCE Your Process

Remember: the MAO has designed its UR process to create a path of least resistance for the hospital to accept lower revenue. So, in summary…

- Use actionable analytics to compare performance of your MAOs against Medicare and identify payer dynamics and specific tactics that have the greatest net revenue impact
- Simply focusing on reducing denial rates or appeal overturn rates creates "observation conditioning" and gives a false sense of success
- Improve UR case review process
  - Use CMS definitions of inpatient and observation for MA payers
  - Develop KPIs that truly measure REVENUE success

A stepwise approach that starts with analytics and ends with intervention enables *providers to level the field*

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Escalate

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ESCALATE – The Joint Operating Committee

- Now that you are enforcing your contractual rights, you may continue to see several examples of bad payer behavior
  - *(e.g., a payer's hospitalist group that is non-cooperative with UR or a payer medical director who is an outlier compared to his/her peers)*
- Your agreement with payers likely includes requirements for a Joint Operating Committee (JOC) meeting to address contractual disputes
- Are you having these meetings? Who is attending? Who is determining the strategy?
- With preparation and planning, these meetings may help you *level the relationship* with your MAO payer

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How To Prepare For A Joint Operating Committee Meeting

- **Use actionable analytics (for each clinical revenue cycle areas)**
  - Areas to focus:
    - Inpatient vs observation definition
    - Administrative denials
    - Peer to peer performance
    - Overturned peer to peer appeal's payment: payment delays and payment amounts
    - Appeal opportunities
- **Outline issues to discuss in the meeting**
  - Some examples include:
    - Unclear definition of inpatient vs outpatient status that drives high volume of peer-to-peer discussions
    - Overturned denials via peer-to-peer denied again and require additional appeals
    - Payments of peer-to-peers determined to be inpatient appropriate delayed
- **Be prepared for MAO common rebuttals**
- **Bring case examples to support arguments**
- **Get definite next steps (with dates and accountable parties)**
- **Push for contract changes regardless of where you are in the contract life cycle**
  - Understand the contract value of each term you want to negotiate

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So, If The JOC Does Not Achieve Results

- Most payer contracts have an arbitration clause. If not, you still have rights to litigation
- Many facilities are concerned about escalation into arbitration, we hear this all the time: "We don't want to hurt our relationship with the payer"
  - If the relationship was "good," there would be no need to consider arbitration/litigation
- The payer is not worried about the relationship when it takes your money
- We have been involved in nearly 100 payer/provider Arbitrations and litigations and learned two things:
  - Almost all these cases settle in favor of the provider
  - The payer and provider continue to do business and actually have a better relationship

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The 3Es of Payer Accountability

Get Your Own House in Order	*Exhaust Your Contractually Allowed Rights to Appeal*	*Escalation, Arbitration, and Litigation*
Enhance	**Enforce**	**Escalate**
Enhance Internal Processes	Enforce Appeal Rights	Escalate Payer Issues & Improve Contract Language
✓ Don't let the payer use hospital's internal process as an excuse ✓ Improve UM case review processes ✓ Don't let denials create "observation conditioning" ✓ Bring 2+midnights observation rate in line with Medicare FFS and CMS definition of observation	✓ Ensure that every inappropriately denied case receives a peer-to-peer discussion and appeal ✓ Check that payers are following contractual terms ✓ Quantify the impact and keep track of the most egregious cases	✓ Gather data and examples regarding the payer's inappropriate behavior that can be used to improve contract language ✓ Use JOC or executive escalation ✓ Utilize arbitration to enforce contractual rights or fair treatment if contract allows egregious behavior

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Conclusion

- MAOs are required to provide benefits to members that are no more restrictive than traditional Medicare
- MAOs are required to reimburse providers at a level not below that of traditional Medicare
- However, whether through inappropriate use of commercial screening tools, UR denials, DRG downgrades, etc., few, if any, MAOs actually live up to these legal requirements
- To address inappropriate MAO behavior in all areas of the clinical revenue cycle:
  - Enhance internal processes
  - Exhaust your contractually allowed rights to appeal
  - Escalate payer issues & improve contract language

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Thank you!

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