September 2018 Infoline

HI  Darn, Summer is about to end. We are having a lovely fall in Idaho.  Our thoughts are with our friends and colleagues in the Carolinas and others impacted by the Florence fury.

So hard to watch the ongoing pain.  We care...

**\*\*\*IT IS CONFIRMED!  The 7th National Physician Advisor and Utilization Review Bootcamp is INKED in!  YAHOO!  \*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

**2019 Boot Camp:**

**Medicare Advantage:  Building Blocks of Contracting, Provider-Sponsored MA Plans and the Ongoing Denial Challenges.**

**Pre-Con:  "The Basics:  Medicare 101, CDI 101, P2P 101, and Denials/Appeals 101."**

**Yep, the title outlines the 3 major focus areas that will be taught in a 'how to' format= a BOOTCAMP.**

**When:   Mon-Weds, July 29-31st   (Mon/pre con; Tues and 1/2 day Weds/general sessions)**

**Where:  Washington, DC**

**Same price as in all previous years; same option of live webstreaming or in person/only conference offering both for all sessions- so it is like being with us.**

**We would love to have you join us as we continue our MA journey together.  \*By 2020, it is forecast that 50% of all Medicare pts will be in a MA plan. \* Time to get our A game on plus explore pro-active options... if you can't beat them, be one!  Love it!**

[**http://healthcareupdatenewsservice.com/blasts/RACSumit20180919.html**](http://healthcareupdatenewsservice.com/blasts/RACSumit20180919.html)-web link

**HEY IF ANY OF YOU ARE CURRENTLY IN A PROVIDER-SPONSORED MA PLAN/your facility is either doing it alone or with a partner/like a payer - I would love to hear from you.  Speak?**

We will continue to develop the dynamic specifics over the next few months but knew many of you are developing 2019 budgets now.

Can't wait!

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**DISRUPTIONS IN HEALTHCARE - so many cool, crazy, new culture, generational challenges, and payment rule changes are in play.**

**Below are some highlights and areas to watch. Impact to the providers = always!**

**Rise of Convergence in healthcare.**

Convergence means a company merges its capabilities with another organization in an adjacent industry.  Only works if the industry's solutions are not comprehensive, compelling or able to satisfy customer needs.

EX)   Cigna Corp was approved to buy Express Scripts.- the nation's largest pharmacy benefit manager.

EX)   CVS pharmacy is buying Aetna/pending

EX)   Walmart in serious conversation with purchasing Humana.

Google this activity and read some of the reasons why.

    a)  Pharmacy costs - trying to get a handle on it in multiple ways.  Growing their pharmacy business/Walmart

    b)  Diversify their traditional base - offer vision, hearing, lab tests, in-store clinics, one-healthcare-stop and capture pharmacy costs better. (CVS has 10,000 stores)

    c)  Grow their healthcare diversified presence. ("Consumers of Walmart(who already have stores in many rural neighborhoods/image of low cost) and other sophisticated retailers will begin to identify them as their trusted healthcare partner and use them for an increasing range of healthcare services.  " John Matthews, KPMG.

Potential hidden impact to patients/employees:  OUT OF NETWORK FOR SERVICES especially Pharmacy. Let's ponder:  CVS owns an insurance company/Aetna - and you have been historically getting your drugs as Costco. Your employer has Aetna; now you will very likely be out of network --as CVS pharmacy owns Aetna/directing of traffic.   You would expect this the employer who has Aetna is explaining that in-network = CVS.   But, contracting can still occur with other pharmacy groups - like Rite Aid, Costo, others.  But anticipate more of this type of 'in-network' restrictions as that is how you control costs.  You control leakage...

**Guest Contributor:  Dr Phil Baker, Medical Director for Case Mgt, Self Regional Healthcare, SC**

**"CMS answers questions for NON-participating Medicare Advantage Facilities   8-18**

As many of you are aware, I have been on the front lines of the battles with the MA plans for the last several years.  In my ongoing efforts, I have gotten responses frm the CMS Medicare Advantage Group relating to facilities that are  not contracted with these plans.  These are points that CMS has agreed to enforce with the Plans and there is a process to report violations to CMS for intervention.  We are having ongoing discussions about trying to get all the Plans to have to follow the same set of regulations in their contracts so that we can teach our medical staffs one set of rules instead of multiple.

CMS has stated in email communications that for NON-contracted facilities the MA Plans ARE REQUIRED to follow Traditional/Original Medicare regulations.  That means they MUST follow the "Two Midnight rule' for inpt determinations and NOT MCG or Interqual. The Plans are NOT allowed to do an (auto) 30 day readmission denial.   All (5) levels of appeal that are available under Traditional Medicare are to be followed including the same timeframes.  Clean claims must be paid within 30 days and all other claims have to be adjudicated within 60 days.  You can report violations of the NON-participating MA plan to Melanie Xiao at CMS  (*[melanie.xiao@cms.hhs.gov](mailto:melanie.xiao@cms.hhs.gov)*) and she will address this with the plan on your behalf.  (Thanks, Dr B for all your ongoing efforts on this very hot, problematic issue.)

Additional areas with the MA plans:

    We continue to hear of prior authorizations being done for inpt at the time of service and then much later, after another request for records, a separately contracted company is now denying as not medically necessary.  NOPE, can't do that.  There is a Medicare Managed Care Manual which is very helpful.  Dr Baker helped us again with the reference that we should all have readily available.

    Medicare Managed Care Manual   Chapter 4, Section 10.16 Medical Necessity.

**"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."   If this continues, there are individuals within CMS (who oversees the MA Plans) to file a complaint.  Go to our webpage under "Value Added Training" and see the list with their contact info.**  Squeek!

**WOW!  Short Term Health Insurance/STHP**.  These were originally allowed for 'gap-up to 3 months- but the Adminstration just allowed it for up to 3 years, which is essentially for all to buy.  Let's take a look at the elements of many of the STHPs that are available.  Buyer beware!

    1)  Affordable Care Act - has 10 essential benefits that have to be included.  Pre-existing protection.  No limit on coverage.  26 yr old coverage. No waiting periods. Insurance has to be offered -employers with 50 employees or more.

    2)  STHP - does not have to abide by any of the ACA.  No pre-existing protections.  Many do not have mental health, pregnancy, prenatal, prescription drug coverage. Others do not cover sports injuries, specific exclusions like cataract, pain manaement, and immunizations.   Others only cover inpts on weekdays.  Others have waiting periods.

NONE OF THIS IS CURRENTLY ALLOWED UNDER THE ACA.

    3)  92% of all employers have less than 50 employees.  So 92% of Americans working for less than 50 employees may not have insurance.  Small employer premiums are skyhigh.  Limited options but in today's full employment world, benefit packages matter.  USE THE STATE'S HEALTH EXCHANGE for small employers with each individual applying for themselves or their families.  Their income may allow for subsidies.  But regardless, they need to explore OPTIONS.

    4)  In walks the STHP option.  Can't afford premiums; may not truly understand the 10 essential benefit, protections that were not in place prior to 2010, and all the limits.  What the employer /especially small employer may see:  Massive reduction in premiums...not realizing that the BENEFITS they are paying for are also greatly reduced.  How many people understand all the WORDS in their coverages? Most don't ...until they need them...

    5)  The insurance group called the STHP '-junk insurance.

    6)  EX. of premium difference.   ACA Essential Benefit coverage for 40 yr old single male in Atlanta. Premium  $371  (without any subsidies )  vs   STHP premium of $47.  Wow - who wouldn't jump at those kind of premium diferences!  WOW!

HOSPITAL /ALL PROVIDER VERIFICATION PROCESS:

Get ready for this new, highly reduced plans to be sold in your community.  Contact your primary payers and ask them - what is being sold?  What is the name of their new product?

when will it be sold?  How can you 'see' when verifying online coverage that it is a STHP?    Remember - each plan can create their own list of coverage and limitations.  -There is no standardization.

Every healthcare provider needs to 'dig deeper' than simply:  BC HMO.  It may be their new BC HMO STHP.  Much different benefit package.

Our pts also need to be taught what they actually have as they may think:  "Thank goodness I have insurance and it is BC."  Little do they understand the limitation in coverage.

Much higher out of pocket and many non-covered services. Think back prior to 2010 ACA...  here we go again.

**\*\*\*\*Hey, come and say hi when I have the privilege to particpate in one of the below conferences...or shout out a HI when doing an audio.  It is a joy for me ...anytime!\*\*\***

    Sept 27th            Region 7, HFMA            Attacking Mgd Care - Chapter 1 and 2

    Oct 17th             Branson, MO, HFMA      Disruption, Attacking Mgd Care

    Oct 25th             U of Rochester               Compliance Conference - Inpt vs obs Plus Total Knee Anguish

    Nov 8-9th            AICPA                           Disruption in healthare

    Nov 12-13           Region 9, HFMA             Attacking, Disruption

Thanks to each of you for allowing us to continue to be a part of your professional life.  It does take a village and we are so grateful for your willingness to share...

    "The Shortest Distance Between Two People is LAUGHTER! -Victor Borge