THE BLIND MEN AND THE ELEPHANT

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How PPACA and changes in the health care environment are affecting commercial claims, contracts, Medicaid and Medicare, especially managed care.
Learning Objectives You Will:

- How is/will PPACA affecting claims, denials, and contracts
- How is/will the current environment affecting claims denials and contracts
- What changes/concerns should you make/have to be prepared for and better meet these changes
The Blind Men and the Elephant

- [http://en.wikipedia.org/wiki/Blind_men_and_an_elephant](http://en.wikipedia.org/wiki/Blind_men_and_an_elephant)
- The story of the **blind men and an elephant** originated in **India** from where it is widely diffused. It has been used to illustrate a range of truths and **fallacies**. At various times it has provided insight into the relativity, opaqueness or inexpressible nature of truth, the behaviour of experts in fields where there is a deficit or inaccessibility of information, the need for communication, and respect for different perspectives.

- It is a parable that has crossed between many religious traditions and is part of **Jain**, **Buddhist**, **Sufi** and **Hindu** lore. The tale is also well known in Europe. In the 19th century the poet **John Godfrey Saxe** created his own version as a poem. Since then, the story has been published in many books for adults and children, and interpreted in an ever-increasing variety of ways.

- **Interesting that the discussion of the parable is much like the parable itself.**
Unintended Effects

“Health-insurance companies are raising rates in Colorado, ending sales of child-only policies and blaming their actions in part on the federal health reform law, moves that regulators call "bizarre" and consumer advocates are vowing to watch” (same in Charleston Paper)

Health insurers seek rate hikes, citing new reform law

By Michael Booth The Denver Post 9/20/2010
Medical Loss Ratio

- CMS Regulation Health Insurance Issuers Implement Medical Loss Ratio Requirements under the Patient Protection and Affordable Care Act; Interim Final Rule
- Includes “incurred claims”
Medical Loss Ration “MLR”

- **In incurred claims Definition**
- An estimate of the amount of outstanding liabilities for a policy over a given valuation period. It includes all paid claims during the period plus a reasonable estimate of unpaid liabilities. It is calculated by adding paid claims and unpaid claims minus the estimate of unpaid claims at the end of the prior valuation period.

http://www.investorwords.com/19097/incurred_claims.html
MLR

- 21 references to “incurred claims”
- Fraud Recovery expenses may be included
EBSA Website

- U.S. Dept of Labor Employee Benefits Security Administration:
  - Also see:
  - http://www.dol.gov/ebsa/FAQs/faq_claims_proc_reg.html
The Department of Labor's Employee Benefits Security Administration has updated its website with the following:

- Summary of Benefits Coverage
2/9/12 update continued

- Automatic Enrollment, Employer Shared Responsibility and Waiting Periods
Just two examples: Time Period

- For purposes of calculating the time period within which a claim must be decided, a plan cannot extend the time period by treating as “filed” only those claims with respect to which all the information necessary to make a decision has been submitted (often referred to as “clean” claims). See § 2560.503-1(f)(4).
Time Period

When does the time period for making an initial decision on a claim begin to run? A: The time for making an initial claims decision begins to run when the claim is filed in accordance with a plan's reasonable filing procedures, regardless of whether the plan has all of the information necessary to decide the claim at the time of the filing.
ACA changes

- Notices to claimants must provide additional content. Specifically:
  - Any notice of adverse benefit determination or final internal adverse benefit determination must include information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.
ACA changes

- The plan or issuer must ensure that the reason or reasons for an adverse benefit determination or final internal adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the plan's or issuer's standard, if any, that was used in denying the claim. **In the case of a final internal adverse benefit determination, this description must also include a discussion of the decision.**
ACA changes

- The plan or issuer must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.
- The plan or issuer must disclose the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.
Interplay between Contracts and Health Plans

- Still no clear direction from Courts on when contract applies and when plan applies.
- Federal District Court Cases hold differently for different reasons; no clear direction at the Circuit Level.
- Best seems to be “amount” vs “benefits”
Explantion

- ERISA is a federal preemption suit
- (as time passes, you will see more similarities between this problem and medicaid/medicare managed care.
- Tremendous inconsistencies between contracts and plans. Payers control, why is that? Ex. Penalty for no authorization.
Examples

- **Preauthorization** –
  - **Contracts:**
    - Some are silent as to penalty
    - Some say won’t pay
    - Some say will provide retro review
  - **Plans**
    - Few say won’t pay
    - Penalties range from 50% to $300 penalty
Examples

- Some are completely inconsistent where contract says won’t pay, plan doesn’t require authorization
- Hold Harmless
- Whether you proceed contract vs plan: whether broad and continuing conduct over range of files, or case by case basis.
Medicare Managed Care

- Likewise, still not clear when “Medicare” applies, and when the contract applies.
  - And what if you’re not contracted?

“MEDICARE ADVANTAGE PREEMPTION GOES UNDER THE MICROSCOPE: HOW BROAD IS IT?” 2008 AHLA Peter J. Leininger, Esquire Cooper & Scully PCDallas, TX
“In order to obtain a “final decision,” a beneficiary must seek reconsideration of the adverse decision, take their claim to an administrative law judge (ALJ) if the denial is affirmed on reconsideration, and then, if the denial is reaffirmed by the ALJ, take their claim to the Medicare Appeals Council.”
Medicare Managed Care

“The Supreme Court has concluded that § 405(g) and § 405(h), when read together, require Medicare beneficiaries to channel any claim “arising under” the Medicare Act into Medicare’s exclusive administrative review process. “
Medicare Managed Care

- *Ardary v. Aetna Health Plans of California, the Ninth Circuit concluded that wrongful death claims brought against a fiscal intermediary for refusing to authorize a medical airlift did not “arise under” the Medicare Act.*

- *Kaiser v. Blue Cross of California, the Ninth Circuit acknowledged the breadth of § 405(h) preemption in a reimbursement dispute between Blue Cross of California and a healthcare provider.*
Medicare Managed Care

- Debates over the scope and applicability of § 405(h) were further complicated by the introduction of the Medicare+Choice program in 1997. In the Balanced Budget Act of 1997, Congress established Medicare Part C (referred to as Medicare+Choice), a managed care component of Medicare designed to "utilize innovations that have helped the private market contain costs and expand healthcare delivery options."
Essentially your sole remedy

“CMS also emphasized that various state law remedies would remain available to Medicare+Choice beneficiaries even if their dispute implicated areas of Medicare administration:

- [T]he specific preemption does not preempt State remedies for issues other than coverage under the Medicare contract (i.e. tort claims or contract claims under State law are not preempted). “ Page 6
“The updated statistics indicate that providers are winning a higher percentage of appeals than had been suggested by previous reports (all RACs had a 64.4% favorable result for providers in the new report compared to 34% in the prior) according to Michael Taylor, MD, senior medical director, government appeals and regulatory affairs at Executive Health Resources in Newtown Square, PA. 

http://www.healthleadersmedia.com/content/FIN-253037/CMS-Update-Indicates-High-Provider-Success-Rate-for-Appealing-Denials
Cost Benefit of Appeal

- Administrative Law Judge with jurisdiction over SC in Miami.
- Appeal hearings held by telephone
- May frequently need a physician present but not necessarily treating physician
Medicaid Managed Care

- Again, how much pure "Medicaid" how much by contract
- Preauthorization a good example in this context as well
Medicaid Appeals

- At SCDHHS, per federal reg, called a “Fair Hearing”.
- Right belongs to patient, must be assigned or authorized to Hospital.
- Again, must evaluate benefit of arbitrating under contract, vs requesting “fair hearing”.

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Pursuant to the CFR, the provider is not entitled to a state fair hearing. The member has that right and the provider may only represent the member if the member has requested a state fair hearing and has given the provider written consent to represent the member. The member drives the process because this grievance process is for the benefit of the member.
1. Appeal – meaningful resolution of disputed claims will not exist if no appeals are taken from clearly erroneous denials.
2. Since other than contract, all rights arise from patient, must have clear and well written Authorization provisions for commercial, Medicaid, Medicare and managed care added to your assignment provisions
7/6. Assignment & Auth Rep

- HANDOUT # 1.
QUESTIONS