Attacking Managed Care & Medicare Advantage Denials-

The New Battleground

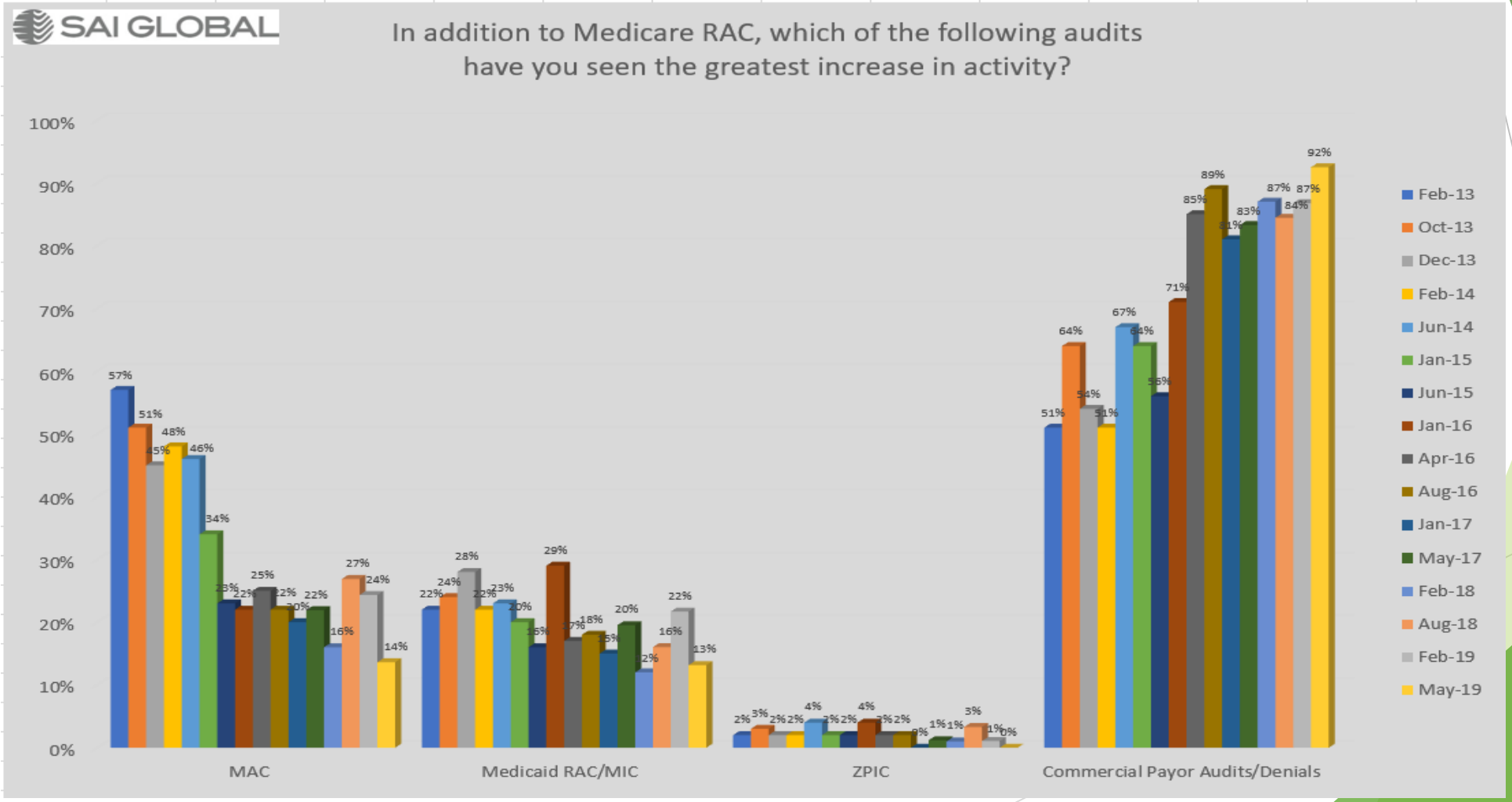
Mgd Care Anguish-
A Brave New World Required-

Payer Policy Changes/Outside the Contract

Significant Growth of Medicare Advantage Plans

= Financial Impact to Providers

6 year history from Free Webinars SAI GLOBAL 2013-current



Risk adjustment data validation
RADV-Medicare Advantage Plans

- The diagnoses that PacifiCare submitted to CMS for use in CMS's risk score calculations did not always comply with Federal requirements. For 55 of the 100 beneficiaries in our sample, the risk scores calculated using the diagnoses that PacifiCare submitted were valid. The risk scores for the remaining 45 beneficiaries were invalid because the diagnoses were not supported by the documentation that PacifiCare provided.
- As a result of these unsupported diagnoses, PacifiCare received $224,388 in overpayments from CMS. Based on our sample results, we estimated that PacifiCare was overpaid approximately $423,709,068 in CY 2007. (settled in 2017)

GAO Slams CMS on MA Audits

- GAO found that CMS's methodology does not result in the selection of contracts for audit that have the greatest potential for recovery of improper payments.
- CMS's goal of eventually conducting annual RADV audits is in jeopardy because its two RADV audits to date have experienced substantial delays in identifying and recovering improper payments.
- CMS has not expanded the recovery audit program to MA by the end of 2010, as it was required to do by the Patient Protection and Affordable Care Act. GAO-16-76 Published: Apr 8, 2016

UPDATE: Medicare Failed to Recover Up to $125 M in Overpayments, records show. 1-6-17

"Under intense pressure from the health insurance industry, CMS quietly backed off their repayment demands and settled the audits in 2012 for just under $3.4 M – short changing taxpayers by up to $125M in possible overcharges just for 2007!" http://khn.org/news/Medciare-failed-to-recovery-up-to-125-million-in-overpayments-records-show/?utm_campaign

Proposed Enhanced Risk Validation Audits with MA Plans 9-19

- Each yr CMS takes a random sampling and examines the medical records to determine whether the dx submitted by the plan match the actual disease the beneficiary has. If a plan exaggerates a dx, for ex., then it could be required by CMS to pay back some of the money.
- MA payments are adjusted via a 'risk score ' based on factors such as population health, age and dx. MA plans submit dx data to CMS which is used to calculate the risk score.
- Proposal to change how risk adjustment data validation/RADV auditing is done. Comments were due by the end of Aug, 2019.
- Only plans audited will face penalties. Proposal is to extrapolate the results from the audits to apply to an OVERALL error rate for ALL plans. This means that a plan's payment rate could be effected even if that MA plan wasn't audited by CMS.
- 2012- CMS created Fee-for-Service Adjuster to address any differences with MA's system and Traditional Medicare. But hasn't been finalized. CMS proposed to get rid of the FFSA when calculating adjustments. AHIP/ins plans lobby group- NO TO ALL
- PS Dx errors from Traditional can impact MA's Dx as using same coding/hospital same for all.

Medicare Advantage/Part C/MA – increase enrollments

- By 2020, it is forecast that Medicare Advantage/MA will constitute 50% of the Medicare market.
- Significant changes were made to allow revision/expansion supplemental benefits –like hearing aides, health club memberships, in home visits, home delivered meals, glasses, and others 'patient specific needs."
- 2019 – allow negotiation with pharmacy pricing
- Significant payments to plans for "Star Rating"(4&5) rated by pts.
- Limiting out of pocket yearly expense - $6,700 currently
- But not all plans are sold in all counties of the country.
- No ability to have a Medicare Supplemental – pt pays all out of pocket plus monthly premium.
- MA IS NOT TRADITIONAL MEDICARE. Medicare 's rules do not apply if the hospital signs a contract. IF NOT CONTRACT, Traditional Medicare rules apply.

Medicare Advantage is not Traditional Medicare – Key 'hot ' elements

- Keys to successful (quasi) interaction with a MA plan
- Create a spreadsheet: terminology impacting –what is the payer's definition of inpatient beyond 'medically necessary'. This may be in the policy section or as an addendum vs contract language.
- Language should address:
- Volume of medical record requests – primary payer only.
  - Rationale for request.
  - Peer to Peer allowance – any physician with knowledge of the patient.
  - Concurrent plus post discharge on an disputed inpt status or other medically necessary determination.
  - Patient status determinations can be made post discharge
  - Do not include 'same as Medicare " in the contract-unless all are used. (No prior auth, no sending records, no concurrent review, use the 2 MN rule.

Proactive Strategies –GOAL: It is a internal team sport

- Develop a template for terms for all payers – commercial and Medicare Part C/Advantage –beyond payment.
- Areas to include:
  - Timeline to submit clinicals – inpt vs obs
  - Timeline for determination from the payer- within 12 hrs
  - Immediate call/appeal including guarantee of a peer to peer call within 24 hrs with clear time assigned and kept.
  - Clearly outline criteria being used to determine inpt status. (Beyond 'medically necessary ' care.)
  - DRG – Correct coding guidelines being used. (Disallowing dx that are not being treated…lower the DRG payment.)
  - Re-admission guidelines. (Related? Like CMS?)
  - Appeal rights – post discharge. Ensure all 5 levels with Traditional Medicare are included for all Part C plans. UNLESS you signed a contract limiting it to the levels within the contract.
  - "Using Traditional Medicare/CMS" rules – but what happens when they don't?
  - Build Addendums to contracts – outlining the operational aspects of the contract

Other hot contracting or addendum issues.

- How are ‘ongoing updates ‘ being handled? The contact language will likely state agreement with policy updates. Who is watching the webpage?
- What information is being ‘tracked and trended’ and brought to the attention of the contracting /finance team? Is it quantifiable? Or just some pretty ugly stories? (All true, but hard to get around the magnitude of the problems.”
- Abuse –is legal involved with abusive patterns? EX) United uses MCG to determine inpatient. However, the patients continue to meet MCG definition of inpt yet the payer continues to deny. “Patient could be treated in a lower level of care.” “No, patient met **your definition of INPT..it is an inpatient.”**

It's all in the Contract or is it Policy-outside the contract?

- United Health Care **Policy Number: H-006**
- **Coverage Statement:** Hospital services (inpatient and outpatient) are covered when Medicare criteria are met. **DANGER ZONE***

- For coverage to be appropriate under Medicare for an inpatient admission, the patient must demonstrate signs and/or symptoms severe enough to warrant then need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.

Limited knowledge of lack of benefits - MA

- MA plans are ‘county’ specific within a state
- Only certain plans are sold in certain counties
- “Community coverage” with the MA plan
- Therefore, if the pt needs care that is not within their ‘community’ (Pt needs care outside their local community) - Out of network potential penalties. Exception – all Emergency care is covered. Just not after treatment care or ongoing care. (Snow birds-NO)
- Provider networks- MA plans cannot sell in your community unless they have a provider network.
- To contract or not to contract- what does the provider get for accepting less than billed charges? Win for payer, win /baby win for provider is??
- General enrollment – 1x yr; opt out thru March yearly.

Medicare Advantage – Provider WINS – use regulations

- "HUGE HUGE!! If the plan approved the furnishing of a service thru an advantage 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.
- **2 MN required for MA plans**. "Each MA organization must meet the following requirements: a) provide coverage by furnishing, 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 areas. Services may be provided outside of the service area of the plan if the services are accessible..2) General coverage guidelines included in original Medicare manuals and instruction, unless superseded by regulations .. 42 CFR, subpart C, 422.101." MA plans must comply with NCD and Guidelines.

Medicare Advantage/MA plans 'using Traditional Medicare' to their advantage..

- Part A rules only apply if contracted.
  - "Can't change status after discharge." HUGE! Many disputed statuses are not resolved until after discharge. Ensure this is allowed in contract language.
  - EX) Humana IS imposing no change of status after D/C. HUGE win for Humana as disputed status may involve P2P calls – which can take days to coordinate…pt is discharged with a disputed status… NO !
  - "Condition Code 44 has to be done" HUGE! Since Part C Medicare has to be contracted for status confirmation, it is not applicable unless contractually included.
  - Managed Part C plans 'quote' CC 44 for disputed status – inpt back to obs. Again, unless it clearly states that CC 44 is part of the contract – it is not used. HUGE win for the payer as disputes can take days to resolve – SO pt is an inpt until dispute is resolved. DO NOT Allow – 'we follow CMS guidelines' without additional clarity.

Payer‘mis-information’ for Medicare Advantage plans

- “Recently we received a denial for a status 3 years after the encounter. The pt was here for an OP Hemorrhoid procedure developing vomiting with distension of a colonic ileus. History of Olgilvie syndrome failed 48 hrs of outpt treatment. Inpt was approved thru payer contact prior to billing/3 years ago. Now the 3rd party vendor is stating he did not meet inpatient criteria.”
- Medicare Managed Care Manual, Cpt 4, Section 10.16. And Program Integrity, Cpt 6, Section 6.1.3 Medical necessity applies:
- **“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.” YAHOO!**
- Turn in abuse to CMS – as oversight for all MA Plans.

Difficult Case Studies – Medicare Advantage

- Pt has dementia with no acute condition upon arrival to the ER. Minor medical issues are addressed in observation. UR begins the process of trying to get placement for the pt as she is not safe to return to her home.
- 6 days in a bed. MA plan refuses inpt status.
- Care Mgt continues to try to get placement.

CHANGE THE CONVERSATION

- **MA plans are paid a per member, per month to manage their patient.**
- **When informing the MA plan about THEIR patient in your facility - "your patient is here and the patient needs to be placed for long term care. YOUR patient is having difficulty getting placed. We are into day 6 with no placement. We will need to be paid for 6 days at our per day rate of $3000. Additionally, YOU need to get placement for YOUR patient. Time to discharge…. "**

Regulations 42 C.F.R. § 422.214
If non-contracting with a 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.)

Why would a patient select MA over Traditional Medicare?

- Part B = monthly premium/out of SS monthly Check. $130 monthly
- Part D = monthly premium/sold by insurance/but required. $80 monthly
- To cover co-pays and deductibles = Medicare Supplemental insurance. $180 per person/insurance co
- No cap on out of pocket costs with Traditional
- **Traditional Medicare = Approx $390 per person**
- MA plans = collapse Part A,B, D into 1 monthly premium. Usually much less than Traditional fees.
- Some MA plans are not charging ANY Monthly premiums.(United/AARP) Each plan can develop their own package… ***EX* Chicago 70 yr thru United PPO. $38 monthly premiums******
- **MA plans are paid a per-member, per month for all signed up patients. No additional funds with inpts.**

Mgd Care Anguish-
A Brave New World Required-
Attacking DRG Downgrades, Pt Status Disputes,
Re-Admission Denials…

3 Legs of Anguish – Pt Status, DRG Downgrades, Re-Admissions

- Pt Status – what is their definition of an inpt?
- DRG Downgrades – what documentation standards are required to allow all physician inclusion of ALL dx the pt has and are included in the thought process/not always the actual treatment?
- Readmissions - Related means? 30 days when CMS does not use this standard. Preventable means?
- Hint – all must be in the contract! Usually silent.
- Look to operational addendums vs
- Payer –specific policies… UGLY

Concurrent Review & Days Denied of a Determined Length of Stay

- EX) The patient was approved inpt. The payer gave the facility 2 -day approval.
- The UM /Case Mgt sends another set of records on day 3 to ask for continued inpt coverage.
- The payer denies day 4 of the 4 day stay.
- The facility involves their internal physician advisor to schedule a P2P call to dispute the lost day.
- After the call, it is still not approved. Facility is deciding to file a formal appeal.
- Million dollar question: WHY DO ANY OF THE CONTINUED CONCURRENT REVIEWS ONCE THE INPT HAS BEEN APPROVED? The DRG payment is not impacted for a lost day. The payment is a single payment – regardless of # of days. Wasted resources…

DRG Downgrades

- Lots of discussion regarding tying in the diagnosis outlined to the treatment. Simply listing dx is not sufficient to ‘earn the higher DRG payment.”
- Differing interpretations of ‘co-morbid’ conditions.
- Differing interpretations of ‘primary and secondary ….reasons for admit.’ Different DRG assigned.
- Peer 2 Peer/P2P calls..always!

Challenges with DRG & Coding

- Payment is based on a dx based DRG payment.
- Challenges with the providers tying in all diagnoses as part of the clinical pathway
- Payers are requesting records for multiple co-morbid conditions that drive up the DRG payment.
- Track and trend requests, outcome, with action items attached.
- What does the contract state regarding record requests? Volume? Reason?

Massive Requests for Records

- First: If contracted, what does the contract state regarding request? Volume? Frequency? Reason? ALWAYS validate with each request. (EX: NY health system)
- Second: If no contract, why send the records? If MA plan with no contract, what would 'traditional Medicare do' with the same issue? Threats to not pay or recoupment payment. IMMEDIATELY report to CMS /abuse.
- Third: Track and trend all requests. Why? What is the finding? Report to contract management ASAP.
- Fourth: HIPAA Standard Transaction and Privacy (2003ish) – only send 'minimally necessary information.' Never the full record. If prior authorized (all are) – then why do they need the record POST care?

One RAC Relief User Issue- Lost Medical Records??

- Sending appeals and then following up to check the status only to learn they don't have any record of us filing an appeal and we will need to resend it to them.

- Suggested Response: Would you like me to contact the Office of Civil Rights and file the HIPAA breach report for you since you lost PHI that I can prove was in your possession? **

Specifics – Disputes with payers Internal MD to Payer's MD

- **Do** more **Peer to Peer** calls- preferred Internal Physician
  - Get involved
  - Educate front line attending- documentation enhancements
  - Let them know what is in question
  - Share with all
  - Think internal Physician Advisor to effect change internally
  - **BIG: Healthplans (Humana) are including language about 'providers treating pt'**
  - **BIG: No longer do post-denial calls. Only concurrent.** 9-18 (POLICIES)

Update - United =25% market share

- As of Aug 2015, UHC no longer uses the CMS two-midnight standard to make inpt admission determination.
- UHC believes the best way to help UHC's members get access to the care they need is to relay on evidence-based guidelines and treatments. Evidence-based guidelines allow UHC to review a member's health condition based on the clinical documentation and provide consistent, clinically validated decisions for hospital admissions.
- More specifically, **United uses Milliman Care Guidelines (MCG) to determine** medical necessity and the appropriate level of care.
- UHC will also provide a copy of MCG criteria upon request before, during, or after a reconsideration request.
- **Sites should now consider: "If appeal results in an adverse decision, we request a copy of the individual criteria used to determine medical necessity be provided with the determination."**
- Per UHC 2016 Provider Manual – pp 113-114 Criteria for Determining Medical Necessity.

Non-Participating update –United

Applies to Medicare Mgd/Advantage and Commercial

1. New Regional Director for SC- updated change in policy toward non-participating facilities and the loss of ability to interact with United.
2. **Non-Par will no longer have any cases concurrently reviewed.**
3. Peer to Peer discussions will no longer be available (no concurrent)
4. All cases will be retrospectively reviewed by Change Healthcare/EquiClaims and Cotiviti –who United contracts with to do their reviews.
5. Initial appeals will have to go to whichever contractor issued the denial and if the appeal is signed by a physician –then it will be reviewed by a Medical Director. Otherwise you will have to appeal up to 3 X to the contractor to eventually have it reviewed by the Medical Director after which you would have one chance to appeal to United but no guarantee of Medical Director involvement.
6. Non-par facilities still required to notify United of an admission but they will no longer be allowed to submit any clinical information since no concurrent review will be allowed.
7. Watch addresses on denial letters… could be wrong – miss deadline.

Thanks, Dr. Baker, Self Regional Healthcare 7-17

More payer anguish -Place of service Audits

- “One carrier has enlisted HDI to audit place of service. They sent us 10 cases, all Medicare Advantage, DOS vary from 2016-2018, only one case had a 1 day LOS and they all say the same thing: “The patient could have been safely and appropriately cared for in an outpt level of care.” Now that sounds like a medical necessity denial to me. The kicker? I have already been denied 4 of these cases (back in 2016 and 17) and one was overturned by peer to peer, the other three were overturned on written appeal. How can this be possible? “ Western Conn. 8-18
- SEE PG 18. It can’t! But think of the wasted administrative costs to continue to a) track, b) defend and c) repeat defend. Track and trend and turn all costs into Contracting.

More payer anguish - Outpt

- "For the last month or so, we have been getting letters from UHC wanting the medical records on all our outpt services and even if they are the 2nd payer and owe us under $100, they want the records. They are asking for records for a simple CBC, strep test, drug screening, mammo,and colonoscopies. In many cases, it is costing us more to send them the medical record than what our actual reimbursement would be. I filed a complaint with our UHC Advocate and we have a phone call set up. They are calling it "pre-payment letters.' In many cases we have a prior authorization and they are still wanting the complete medical records. Now other payers are starting to do the same thing." Ill small hospital
- Most are commercial UHC and we are contracted..
- No idea why we would agree to this but under PROTOCOL, we have to respond.

More Payer-Provider Challenges -Cigna
No longer paying drug administration

- Effective 5-19: Reimbursement policy for infusion and injection.
- "We routinely review our coverages, reimbursement and administrative policies… In that review, we take into consideration one or more of the following: evidence-based medicine, professional society recommendations, CMS guidance, industry standards and our other existing policies."
- 'As a result of this review, we want to make you aware that we will NO LONGER SEPARATELY REIMBURSE infusion and injection administration services billed by facilities because infusion and injections administration services are considered INCIDENTAL TO THE PRIMARY SERVICE and are not separately reimbursable."
- "The affected CPT codes: 96360-96379 and 96521 thru 96523. This aligns with our current reimbursement poslicies for facility routine supplies. (EXCLUDES: Chemo 96400-530 and sub-inj 96372)
- NOTE:" In Nov, 2018, we began applying this update to claims from the ER DEPARTMENTS. This updates expands to all areas within a facility." (No observation or ER. What if have chemo and non-chemo drugs at the same treatment time?)
- WOW! A) What is the primary service that is being paid? B) If it is drugs, are you getting full billed charges as it must now cover all visit and all infusion costs C) What about the ER visit or HBC visit?

Payers /Physicians- “Really really hate Prior Authorizations/PA” - AMA survey 3-18

- New survey of American Medical Association –examined the attitudes of 1,000 physicians regarding prior authorization.
- Insurance companies: As an effort to deliver the best possible therapy to the patient and to avoid unnecessary care.
- Physicians: Simply a tactic to make expensive care more onerous, driving down the costs to the insurance companies.
- Q **How would you describe the burden: 84% very high.**
- 86% report that the burden has increased over the past 5 yrs.
- 79% reported having to repeat prior auths even for pts previously approved.
- Ins requests prior auths 29.1 x per week.
- 78% reported that PA can at lead to treatment abandonment.
- **Dedicate an average of 14.6 hrs per week for Prescription and medical services per practice = 2 business day.**
- **UPDATE: CMS wants to eliminate faxes by 2020 and replace with digital. 90% of payer communications done by phone or fax. Could save $3.20 to $3.64/transaction if moved to fully electronic prior authorization. While prior auth applies to less than 15% of covered services, there is a need to simplify. (9-18 Himss/Susan Morse, Senior Editor)**

Readmissions- CMS Policy

- 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 to**, 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. 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.

30-Day Readmission CMS

CMS Hospital Readmissions Reduction Program (HRRP)

Section 3025 of the Affordable Care Act added section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reduction Program, which requires CMS to **reduce payments to IPPS hospitals with excess readmissions,** effective for discharges beginning on October 1, 2012. The regulations that implement this provision are in subpart I of 42 CFR part 412 (§412.150 through §412.154).

In the FY 2012 IPPS final rule, CMS finalized the following policies with regard to the readmission measures under the Hospital Readmissions Reduction Program:

- Defined readmission as an admission to a subsection (d) hospital **within 30 days of a discharge from the same or another subsection (d) hospital;**
- Adopted **readmission measures for the applicable conditions of acute myocardial infarction (AMI), heart failure (HF), and pneumonia (PN).**

In the FY 2014 IPPS final rule, CMS finalized the expansion of the applicable conditions beginning with the FY 2015 program to include:

(1) patients admitted for an acute exacerbation of chronic obstructive pulmonary disease **(COPD);** and

(2) patients admitted for elective **total hip arthroplasty (THA) and total knee arthroplasty (TKA).**

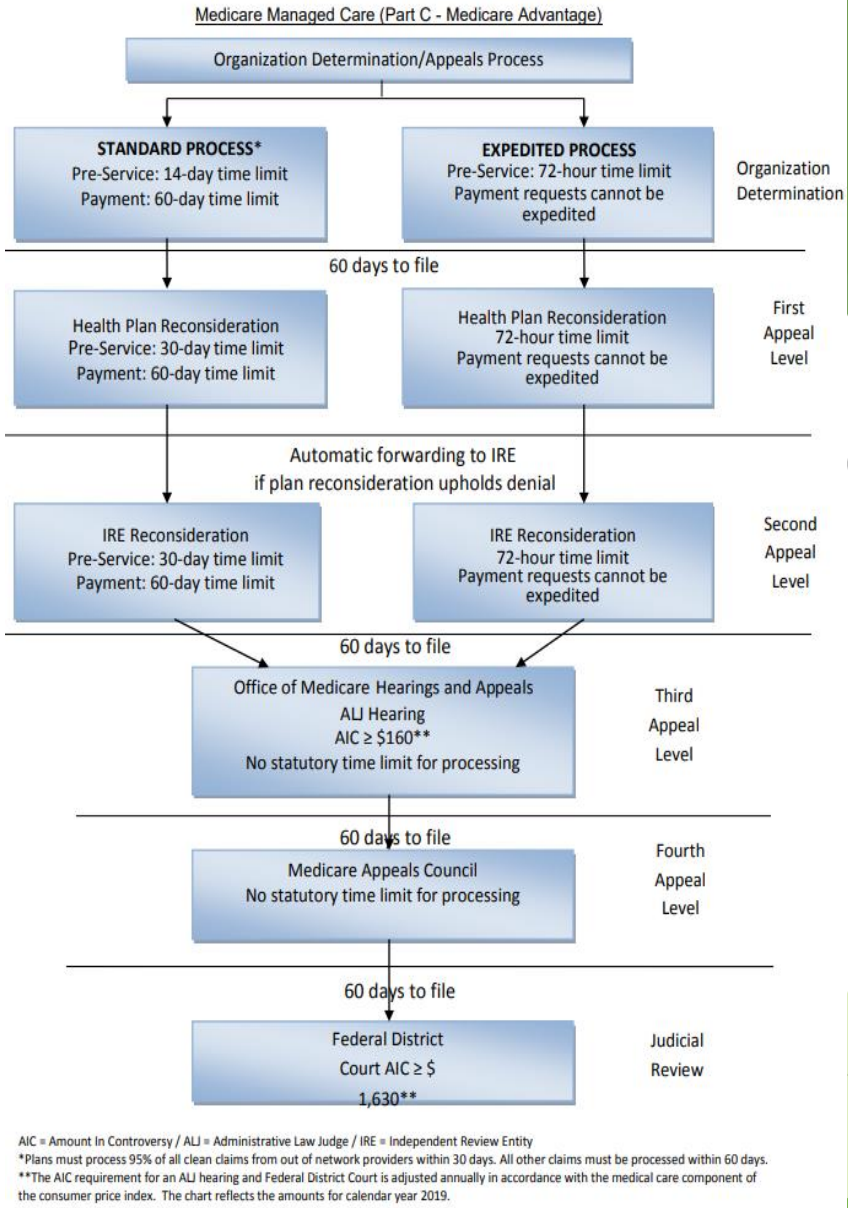
In the FY 2015 IPPS final rule, CMS finalized the expansion of the applicable conditions beginning with the FY 2017 program to include patients admitted for **coronary artery bypass graft (CABG) surgery.**

United Health Care Readmission

- A LVN, LPN or RN will review the medical records and supporting documentation provided by the facility to determine whether the two admissions are related.
- If the subsequent admission is related to the initial admission and appears to have been preventable, the LVN, LPN or RN will submit the case to a medical director, who is a physician, for further review.
- The medical director will review the medical records to determine if the subsequent admission was preventable and/or there is an indication that the facility was attempting to circumvent the PPS system. **
- Aetna MD/CA case in court: did not do review of case/just read recommendation by clinical team. AG's investigating
- FULL DENIALS of the 2nd admission by MA PLANS…and other COMMERCIAL PAYERS…

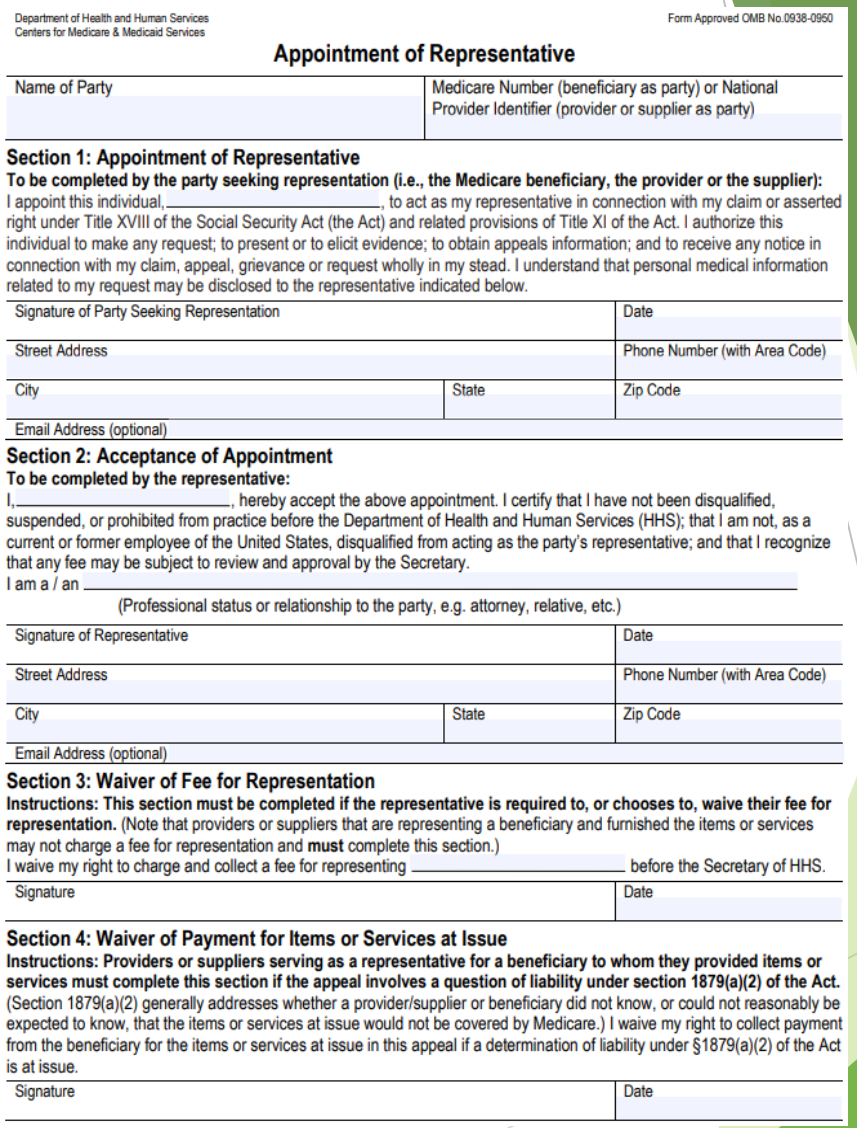
MA Appeals Process

- Enrollee (beneficiary) appeal rights shown
- Non-contract providers may access standard payment appeal pathway if waiver of liability completed
- Anyone with formal representative authority can access full enrollee appeal rights without waiver of liability
- Note automatic forwarding to IRE if first level reconsideration upheld



CMS Form 1696 – formal representative

- 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



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

CMS Contacts for Specific Plans and General Contact

- **Humana MED C Contact at Medicare:**
- Uvonda Meinholdt
  Health Insurance Specialist
  Kansas City Regional Office
  Phone: 816-426-6544
  FAX: 443-380-6020
  Uvonda.Meinholdt@cms.hhs.gov

- **UHC MED C Contact at Medicare:**
- Nicole Edwards
- Phone: 415-744-3672
- Nicole.edwards@cms.hhs.gov

- **Coventry Health Care Med C/Aetna Med C**
- Donald Marik
- Health Insurance Specialist
- Denver Regional Office
- Phone: 303-844-2646
- Donald.Marik@cms.hhs.gov

- Blue Cross Blue Shield Anthem Med C:
- Anne McMillan
- Health Insurance Specialist
- Chicago Regional Office
- Phone: 312-353-1668
- Anne.McMillan@cms.hhs.gov
-
- **General CMS Contact:**
- Melanie Xiao
- Health Insurance Specialist
- Medicare Advantage Branch
- Division of Medicare Health Plans Operations
- Centers for Medicare & Medicaid Services
- CMS San Francisco Regional Office
- 90 7th Street, 5-300 (5W)
- San Francisco, CA 94103-6708
- Phone: 415-744-3613
- FAX: 443-380-6371
- melanie.xiao@cms.hhs.gov

Success stories of filing a MA complaint. *80 bed Ill hospital* SQUEAK

- Last Nov, filed complaint with Medicare C Advocate.
- Two were against Aetna and two were against United Healthcare.
- Surprise – Aetna settled with us within 30 days after receiving the complaint. UHC –another matter.
- They were cooperating and then suddenly, would not return phone calls or send a letter stating why they had not paid.
- Both accts were behavioral health and over a year old.
- Told –don't reply, they will file another complaint- done in March.
- 15 days after the 2nd complaint, both accts were paid, not only that, they were paid with interest. NO MA CONTRACT so traditional Medicare rules apply. (i.e. 60 days = interest)
- AND the Part C Advocate told them they had to send a letter explaining what happened and why it took so long to remedy.

Complexity from all directions- Patients impacted

- Patients unaware they are ‘seamlessly converted ‘ to the Mgd Medicare Plan when they had the same carrier as a Commercial plan. HOLY MOLY!
- See www.washingtonpost.com/national/health-science/senior-surprise-getting-switched-with-little-warning-into-Medicare-advantage/2016/07/26.
- Patients received letter /one of many as they approach 65. They MUST opt OUT of the plan or they are seamlessly being enrolled. “With Medicare’s specific approval, a health insurance company can enroll a member of its marketplace or other commercial plan into its Medicare Advantage plan…which takes effect within 60 days unless the member opts out.”
- Many pts without their doctor and more money out of pocket as didn’t know they were part of a Mgd Plan!!!

BREAKING NEWS - HOLD

- Oct 24, 2016 CMS has temporarily stopped accepting new proposals from health insurance companies seeking to automatically enroll their commercial or Medicaid patients into their Medicare Advantage/Part C plans.
- CMS disclosed 29 Medicare Advantage companies – including Aetna, United, and several Blue Cross and Blue Shield insurers. Half of the companies received their approval this year.
- Members currently are AUTO enrolled unless they opt out.
- Dialogue want the pts to OPT IN..so they have choice. Doctor relationships are huge when the pt is AUTO enrolled.
- www.modernhealthcare.com/assets/pdf/CH1075661021.pdf
- www.modernhealthcare.com/article/20161004/news/161009981

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