Bristol Health, Inc.

The Patient, Patient Care, Safety & Cost Drivers

Office of the Healthcare Advocate
State of Connecticut
December 1, 2022

Bristol Health

Without question, health systems like Bristol Health are helping to keep healthcare costs in Connecticut lower.

72%

Governmental Payor Mix is 72%.

$15,669

Inpatient Average Cost per discharge is $15,669, 6th from the bottom in and less than half that of the highest average cost hospital in CT.

We are a Magnet Designated Hospital and the only hospital to have been awarded the Baldrige Regional Silver designation twice for performance excellence. Our quality and safety outcomes are excellent.

ExcellenceNorth Alliance
Empowering Organizations to Sustainably Thrive

MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

60.3% Medicare Advantage in CT is 52% of all Medicare Eligible, at Bristol Health it's 60.3%.

- The distribution of of Medicare Advantage enrollees adversely impacts providers in specific geographic areas in CT, which means it's not an issue for many hospitals, yet a crisis for others like Bristol Health.

- Traditional Medicare reimburses approximately 88% of cost. MAOs cost tons more to administer, forces you to take observation rates for admission the Medicare would deem appropriate and pay for, and they don't pay you anything while in-patients are waiting for authorizations to post acute care. While it's hard to estimate the actual overall percentage of cost that's reimbursed due to all of the MAO practices, on the high side maybe 78% of cost, on the low side getting close to State Medicaid at 68% of cost.

The Challenge of Medicare Advantage Concentration & Behavior

Over 50 Formal MAO Complaints

In response to over 50 formal MAO complaints filed by Bristol Health with CMS, on November 26, 2019 we received a rule clarification by the CMS Central Office in Baltimore, Maryland, including the Office of the General Counsel. The letter was sent to both Bristol Health and an MAO regarding the applicability of 42 § C.F.R. 422.113(c)(2)(iii).

- Specifically the Letter states that "42 § C.F.R. 422.113(c)(2)(iii) applies to both contracted and non-contracted facilities. Consequently the MAO's response is not a correct interpretation of the regulation. Specifically, when the MAO states "In a situation where a contracted facility requests authorization for an inpatient stay after a stabilizing an emergency medical condition, MAO responsibility for 'Post-stabilization care' immediately ceases if the facility is contracted for inpatient care" is an improper interpretation. *A Medicare Advantage Organization is financially responsible for post-stabilization care when the organization does not respond to a request for pre-approval within 1 hour or cannot be contacted."*

Bristol Health's Subsequent Action/Data

While the CMS opinion letter specifically references authorization for an "inpatient" stay after a stabilizing an emergency medical condition, in accordance with 42 § C.F.R. 422.113, delays also occur when we seek emergency to skilled nursing facility ("SNF") authorizations following stabilization of an emergency medical condition, and in fact the same 1 hour rule applies to these authorizations.

We also experience significant 2-3 day delays (overall avg. is 1.6) in SNF authorizations following inpatient stays. The issue with acute to post-acute transitions is that the MAO paids us nothing for the days the patient is parked in our hospital waiting for the authorization. While the language in 422.113 clearly states that post-stabilization care includes ALL covered services necessary to maintain the stabilized condition and further to improve or resolve the enrollee's condition, MAO's are required to cover all services that traditional Medicare would cover 42 § C.F.R. 422.101 and in fact there is no delay in traditional Medicare when an acute care patient needs post acute SNF stabilizing care. The practice of parking patients and not paying while doing so is contrary to MAO rules and regulations.

Experiencing an overall average of 1.6 day delays.

Subsequent to receiving the CMS letter, Bristol Health implemented a formal process in December of 2019 whereby every MAO request for pre-authorization of post-stabilization services included a formal letter citing 42 § C.F.R. 422.113(c)(2)(iii) for each patient along with supporting documentation.

- A copy of the notice is retained and all pertinent information is logged in a MAO Master Log ("*Master Log*") including the date and time the pre-authorization request was sent.
- If no pre-authorization or denial is received within one "1" hour, a second notice "*Notice of Financial Responsibility for Post-Stabilization Services*" is sent to the MAO. A copy of the second notice is retained and the date and time of the second notice is logged in the Master Log.

Extracting just one element from the Master Log related to MAO practice in accordance with MAO rules "the number of days it took to get pre-authorization for post-stabilization care services, specifically pre-authorization for acute care to post-acute SNF care" is presented in Chart A (next slide).

CHART A: Bristol Hospital, Inc. – Fiscal Year Ending September 30, 2021

Medicare Advantage Organization Non-paid Inpatient Days - (waiting for prior authorization to SNF)						
	MEDICARE ADVANTAGE ORGANIZATION					
	MAO 1.	MAO 2.	MAO 3.	MAO 4.	MA5.	Totals
Total SNF discharges for FY 2021 (10-1-20 through 09-30-21)	47	241	93	14	70	465
# of Cases sent on Insurance waiver / No authorization requirement	17	22	36	0	8	83
# of Cases needing SNF level authorization	30	219	57	14	62	382
# of Cases delayed due to authorization process	22	136	28	13	56	255
# of days lost awaiting authorization (Avoidable NON-PAID Days)	**28**	**218**	**37**	**18**	**105**	**406**
Average Days Delay per case	1.3	1.6	1.3	1.4	1.9	1.6
Percent of total cases sent with no authorization requirement	36%	9%	39%	0%	11%	18%
Percent of total cases needing insurance authorization requirement	64%	91%	61%	100%	89%	82%
Percent of cases needing insurance authorization with delay	73%	62%	49%	93%	90%	67%

During FY 2021, some MAOs waived pre-authorization requirements for short durations.

406 Days

Per Chart A, the total number of days that Bristol Hospital, Inc. received no payment at all (with respect to just this one element of non-compliance) was 406 days of full inpatient care.

95.05%

One MAO implemented a "Floor to SNF Program" which resulted in 23 out of 33 waivers being unrelated to Covid waiver. This makes the adjusted for Covid waiver or true MAO prior-authorization requirement ((465-23)/465) or 95.05%.

100% OF ALL PRIOR AUTHORIZATION REQUESTS WERE APPROVED, except for the ones where a denial was needed for Commercial and/or Husky. There were 21 initial denials, 7 of those were overturned on a peer to peer review and the other 14 were transferred to a SNF either under a secondary payer (either Husky or private pay).

The cost for Bristol Hospital, a non profit charitable organization, to provide this free care to MAO organizations that are being paid to cover what traditional Medicare covers using our last filed Medicare Cost Report would be ($1,294.77 x 406) or $525,676.62, using our observation rate ($2,467.96 x 406) or $1,001,991. Neither of these approaches captures the true incremental cost of providing care to patients that didn't need to be in our hospital. For example, the fact that we were and are in a severe national staffing crisis paying upwards of $190 per hour for a traveler nurse.

This bad behavior shifts costs that are the responsibility of the MAO to a hospital negatively impacting the ability of a hospital to provide care to the community it serves.

Bristol Hospital reported Loss/Income from operations of:

$7,169,497 in 2020 and $2,298,850 in 2021

What about the Patient?

What about the Patient?

- Unnecessary inpatient days…
  - Present added risks to patients.
  - Lengthens the time that it takes to fully stabilize, improve and resolve the patient's condition.

- Insurer practices, as in this example, force patients to suffer through periods of ineffective treatment before permitting access to the most appropriate therapy. Factually, these patients did not receive the care they needed while they were parked unnecessarily in a hospital inpatient bed.

- Because we had to care for these parked patients, admissions were blocked for new arriving inpatients and for patients in our emergency departments who urgently required an acute care bed.

- In December/January of 2022 when we were being overrun by very sick Covid patients, there were days where we had as many as 10 patients in acute care beds waiting for authorizations, not receiving the care they required while there were an equal number of patients in our ER waiting for an acute care bed. The situation was exacerbated by the number of holidays and the fact that the MAOs provided no authorizations on nights, weekends and holidays and refused prior authorization waivers until late January and early February when it was to late.

The Why

The Why

1

Hospitals cannot discharge a patient without a safe discharge plan.

2

Post acute facilities will not take an MAO patient without a prior-authorization – they will not get paid if they do.

3

MAOs get paid PMPM and are 100% at risk for the care that a patient receives.

4

Hospitals cannot bill a patient who is parked by an MAO unnecessarily in an acute care bed.

5

MAOs refuse every single time we negotiate or renegotiate our contracts to agree to a reasonable per diem for patients that are parked in our hospital. We have zero leverage as a community provider, we cannot go non-par without causing access issues.

6

MAOs get free care (they don't pay the Hospital or Post Acute Facility anything while a patient is parked in a hospital). Free hospital care includes physical therapy services for example and the longer they delay, the greater the chance the limited services the patient receives will improve their condition and avoid the cost and admission to a post acute care facility.

Lastly,

Congress didn't give CMS/Medicare any authority to address or resolve payment disputes (it is the responsibility of states.) They reasoned that dealing with beneficiary issues was more than enough. This is evidenced by the Office of the Inspector General (OIG) Reports dated September 2018 and April 2022, both of which raise concerns about MAO beneficiary access to medically necessary care.

Selected findings:

- Thirteen percent of prior authorization denials were for service requests that met Medicare coverage rules, likely preventing or delaying medically necessary care for MAO beneficiaries.
- Eighteen percent of payment denials were for claims that met Medicare coverage rules and MAO billing rules, which delayed or prevented payments for services that providers had already delivered.
- Stays in post-acute facilities were among the three prominent service types among the denials that met Medicare rules.