DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Giese	2-22-12

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER :0::330	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Mr. Keck	'repare reply for appropriate signature DATE DUE_ _____ ___ [ ] FOIA DATE DUE_____ [X] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

YORK COUNTY MEDICAL SOCIETY

February 15, 2012

Mr. Anthony Keck
Director, Health and Human Services
State of South Carolina
P.O. Box 8206
Columbia SC 29202

Dear Mr. Keck,

The members of the York County Medical Society have been charged by Governor Haley to identify problems and provide solutions to the Medicaid crisis.

Medicaid patients rank among the most disadvantaged of our society. The care of these patients is difficult based on multitudinous medical problems, societal issues, time constraints, and a paucity of physicians willing to participate. The current situation has reached crisis stage because these patients ultimately get even routine medical care in the most expensive /least efficient venue: the Emergency department.

The problems can be divided into four categories; reimbursement, communication, accountability and managed care.

Reimbursement Problems
Reimbursement currently does not cover overhead and therefore it costs MDs to treat patients. Reimbursement delays cause financial strain on MDs. In some practices, over 50% of accounts receivable over 120 days are due to Medicaid. Twenty-five percent of accounts receivable over 120 days are over 360 days old. Outsourced Medicaid reimbursement to a 3rd party payors means no accountability. Intentional delay by payors results in denial of physician payment for late filing. Reimbursement is inconsistent. The same injection will be paid at different rates; sometimes covered and sometimes not. Injections that are compounded are filed with pharmacy NDC #, but denied for lack of NDC # when payors "misplace" the NDC form included with the original invoice.

Reimbursement Solutions

Increase reimbursement to a level that allows physicians to get paid for their work. No business can survive if costs exceed revenues. Previously, the state has depended upon physician dedication to compensate for financial suicide. This era has passed. Physicians will not participate in a system that ultimately will result in bankruptcy. Lack of physician participation results in patients going to ER and increases costs. When discharged from the Emergency Department, patients cannot get a physician for follow up and will more often than not return to the ED for maintenance treatment.

Outsourced Medicaid reimbursement to 3rd parties results in a lack of accountability because there are no penalties for fraudulent activity.

Reimbursement must be timely (<14 days) when filed electronically. Physicians are constantly threatened with reduced reimbursements, possible fines and/or criminal prosecution for lack of compliance. Payors must be held to the same standards and have financial penalties for delayed reimbursement and fraudulent activity (denials based on inaccurate criteria, internal delays, prolonged "on- hold" time, deliberate denials for legitimate service). Administrators of these organizations should face jail time for fraudulent activities. These administrators have no problem making medical decisions, let them face the same consequences as physicians.

Payors must be excluded from participation if they are repeat offenders (3 or more infractions during one calendar year). The appeals process re denials must be streamlined (<24 hrs). Physician reviewers must have expertise in the area reviewed. Payors must pay for a panel of independent physicians to review contested denials. Physician reviewers employed by the payors have a conflict of interest that precludes fair and objective review

Patient Problems

Patients are unaware they have been assigned to an HMO/ primary MD. These patients are also unaware they need prior authorization to see certain physicians. When the patient presents for service, this creates resentment because they are unable to be seen without prior authorization. Patients sometimes "forget" to bring copayment at the time of service

Patient Solutions

Patients debit cards should be restricted to transportation and co pays only. There should be financial penalties for no shows. Drug and alcohol testing should be instituted.

Managed Care Issues

There are too few participating MDs for referral of complex patients. This results in increased liability as physicians are forced to practice outside their area of

expertise. Physicians must waste time obtaining prior authorization for generic drugs. These "delay tactics" are twice as costly; we are underpaid, if paid at all, by Medicaid and also we are not seeing "paying" customers. Physicians have no ability to speak with an independent, board certified MD with expertise in the area under review regarding denials. HMO savings are a shell game. Payment denials for legitimate service is fraud and results in inability to find participating MDs. HMOs tout "cost savings" to the state that may or may not be true.
York County Board of Disability patients are exempt from assignment to Medicaid HMOs. When these patients are erroneously assigned, MDs cannot get reimbursed. Patients who require MRIs are told they must fail to respond to physical therapy before MRI approval, yet physical therapy referrals are denied. Blue Cross Choice Medicaid has no neurosurgeons in network, this results in increased liability for MDs caring for these patients. Absolute Total Care issues denials based on medical review. The procedure will pay, but the consult to determine the need for surgery is denied for lack of medical necessity. Bilateral procedures are authorized, but one side pays, the other is denied

Managed Care Solutions

Managed Care/ HMOs must abide by their contractual obligations re: prior authorization, timely reimbursement, and timely appeals by qualified MDs. Failure to meet contractual obligations should result in fines or exclusion from further participation.
Managed Care/ HMOs should disclose how much money is spent on claims review/denials, how much is saved and the turnaround time for payment of incorrect denials. Incorrect denials should be paid with interest; no more interest-free loans to insurance companies or the state. Absolute Total Care requires prior authorization for procedures that are automatically authorized once a phone call is made. MD staff must waste time on hold to get authorization number. This constitutes a de facto financial penalty (wasted staff time = wasted money). Other Medicaid HMOs don't require prior authorization for auto approve procedures. Absolute Total Care needs to be monitored by the state because they are not meeting the contractual obligations to patients or providers. This constitutes fraud and should be prosecuted by the state as such. The state should rescind the contract with ATC, and any other entities that fail to meet contractual obligations to patients and/or providers.

Medicaid Webtool Issues

Medicaid Webtool provides no clear indication if a child has coverage. If Medicaid Webtool misspells the patients' name, the patient is then unable to get a Medicaid ID, Without Medicaid ID, the MD can't get reimbursement for services rendered.

MDs cannot access info until mom presents the Medicaid ID. Webtool was updated as of 1/1/12. The EDI department was not aware that multiple log ins are now required. MDs were informed they must fax requests but told it will be 3 weeks until log ins available. There is no way to verify if the fax was received. MD will lose money for no coverage or be denied payment for late filing when the billing paperwork is lost by the state.

Medicaid Webtool Solutions

Medicaid Webtool must be accurate, functional and user friendly. The site must be completely overhauled, evaluated and updated regularly. Failure to do so is a waste of time and money.

Physicians have provided care for economically disadvantaged patients for many years. Medicaid's inadequate reimbursement, in conjunction with the needless delays, fraudulent activities by insurance companies without real consequences, and paucity of participating subspecialists have combined to make MD participation in Medicaid a "lose-lose" proposition. Unless significant changes are undertaken by the state, Medicaid patients will have no alternative but to seek care in the most expensive/ least efficient venues (Emergency Departments, Urgent Care centers). This will increase the cost of care to the state with less benefit to the patients. The current situation makes the MD providers losers; however the state and its citizens are the ultimate losers as fewer physicians participate now and in the future. The York County Medical Society is prepared to meet with you at your earliest convenience to resolve these critical issues before it is too late.

Respectfully Submitted,

Sushil K. Singhi, M.D.

Sushil Singhi, MD, FACC, FACP
President,
York County Medical Society

William F. Alleyne, II, MD FCCP
Chair, Task Force Member
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cc: Governor Nikki Haley
Senator Ralph Norman
York County Medical Society

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Department of Health & Human Services
OFFICE OF THE DIRECTOR

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