ISOS Demonstration Teleconference 25 April 2013

Participants
Jim Houtsma – American Legion Post 123 Angeles
Ken Fournier – RAO Manila
Jim Boyd – RAO Angeles (Joined about 12 minutes into the call)
Mark Nelson – RAO Manila
Mick Frewen – ISOS
Mark Zimmerman – ISOS
LTC George Carter – C, Program Operations, TAO-P
Katherine – ISOS (Last name wasn't clear)

Of note most of the local participants, 8 out of 12, were not on the call.

Announcements by ISOS from Mr. Frewen

Introduced Katherine who is the new supervisor of Global 24 in Singapore and the Philippines, has a degree in nursing, some business experience and spent some time in the Navy.

Introduced LTC Carter who apparently is new at TAO-P

Said they continue to grow the network. Said Phase II development is underway.

Stated what he calls "Training consultants" are spending more time working with the providers on their claims. Believes this will significantly speed up claims processing.

He said beneficiaries can call or email them to assist other beneficiaries but they have to have a signed authorization on file first. He said he would email the blank form to us after the call but failed to do so.

Next LTC Carter addressed the need to keep your DEERS email and phone number current so they can contact you.

Mr. Frewen continued to expound on his decision not to discuss policy on the calls.

Discussions

Next he addressed a question from Mr. Boyd, although he wasn't on the call yet. Since Mr. Frewen ignored our suggestion to provide all call members with the questions we only have his brief explanation of the questions. Based on his abbreviated explanation apparently Jim Boyd wanted to know why all providers at an approved hospital couldn't be automatically approved. It was explained that certification and approval requirements had to be met which had to be applied individually and as is well know that a great many do not want to participate because of various reasons but primarily because they do not want to deal with a complex foreign claims process. There is also apparently an issue with numbers of physicians and hospitals in these areas that are thought to have been previously involved in fraud.

Ken Fournier asked about an excluded list of providers so beneficiaries would know not to see those providers that TMA feels are defrauders and will not allow them to be certified or approved. Because it appears Ken was dropped from the call the question was never answered even after he returned a few minutes later.

Next he addressed a question by Mr. Fournier but all we know was it had something to do with approved providers and revolved around the list and the webpage. Again because we are not provided with the questions we have no way of knowing the full extent of the question or if the actual question is being answered. It appeared, based on the answer that it had to do with the sudden loss of 30 approved providers between the 1 April 13 and 15 April 13 lists. Mr. Frewen explained that by mistake they added 30 providers that were not approved and apparently not even on the certified list as he said they were not yet certified. He went on to say they discovered their mistake and the list was revised and reposted the next day, 2 April 13. He further claimed that only 7 providers have left the network since the start and all in January and early February. Two because they were neurologists, he called them urologists to start, because their medical association does not allow members to join networks and 5 because they didn't want to be involved with a complex foreign claims process that requires they change their business practices.

Because so many providers come and go from list to list and their entered names change as well it can be difficult to know who is approved and who isn't and who left the network and who was simply lost by ISOS somewhere in cyber space. For example when the 15 Feb 13 list came out 18 physicians went missing due to unknown reasons. Most magically reappeared on the 1 Mar 13 list after we asked TMA why so many providers had dropped out of the network and we were even thanked for finding ISOS's error. Without our continuous monitoring of their database, if and when this error would have been caught by them is extremely questionable given their long history of poor data maintenance.

So we have to take their word that only 7 providers really dropped out since the published lists cannot confirm that due to so many errors in the data.

When we questioned the actual correction of the list because the "Update" date on the webpage remained as 1 April 13 until 15 April 13 he insisted that the date was changed to 2 April 13. But we know it was not as we check it almost daily for updates due to their long history of bad data and changes. Even when we checked it early on 15 April 13 to see if the standard update had been posted we also noted that the date remained 1 April 13. We know from past history where we discovered and reported errors in their data we also explicitly caught them trying to sneak in updated approved lists without making any reference to the update that they have done this in the past leaving the date on the spreadsheet as it was before as well as the date on the webpage in an apparent attempt to hide their poor performance. The point here is that the data is not trustworthy and has not been trustworthy from ISOS for years and nothing has changed. An error of 30 fraudulent and not even certified providers means almost 25% of the listed physicians were not approved or certified providers. If someone had used one and attempted to avoid the massive price increases approved by ISOS by paying cash their claim would have been denied out of hand.

The discussion moved to waivers and Mr. Frewen attempted to defend the change in policy that limits continuity of care and countered what we were previously told by Mr. Halliwell that TMA said waivers were good for only 90 days and that was the policy from day one; apparently there was no need to convey that to beneficiaries. Although, in the end, very little was cleared up apparently some individuals may be granted waivers for periods longer than 90 days on the basis of continuity of care. But he pointed out the it is TMA's mandate that everyone be required to see only those limited providers available in the network which is a back handed way of saying all waivers will sooner or later be withdrawn regardless of the merits for legitimate continuity of care. He also said most beneficiaries know this and are happy to comply. I pointed out it was more likely they simply gave up and went back to paying for their own care using their provider of choice as the majority have done for a long time and Ken relayed a similar opinion. The response was it is policy that we all WILL see those providers they dictate we see and there will be no discussion, quality of care issues notwithstanding.

I mentioned that Baypointe was not accepting patients and Mr. Frewen claimed they were and are accepting patients and he said he has an employee at Baypointe and they were seeing patients as he was speaking and absolutely denied anyone was having any problems. Apparently a lot of retirees were hallucinating.

At this point he said he had addressed all the questions submitted. I pointed out he had not addressed the issue I submitted. The question again was not addressed to the listeners. It dealt with the issue of claims being process for care where beneficiaries pay 100% of the cost of their care. The question was submitted in February and Mr. Frewen ignored the problem in favor of talking around the issue. See the complete issue and questions at, Deductible Claims Processing. The issue contained three specific questions but again he ignored the specific questions in favor of saying claims are being filed. When I asked him when he was going to answer my questions he claimed he had. So I pulled up the issue and read the questions to him.

The first question: Explain how you will know that a provider saw a patient and was paid 100% of the cost of care if they never file a claim. If there is no way for you to know this say so.
Answer: ISOS knows 100% of all visits that occur and monitor the claims with WPS to determine which claims are submitted. Note: However unless the information he claims is fed to him by the providers on each and every visit includes the cost of the encounter and the amount paid he still doesn't know which of these were paid 100% by the beneficiary.

The second question: Explain what provisions within the contracts or agreements with Demonstration providers will penalize them for failure to file these claims and what the penalty is. If there are none say so.
Answer: Long silence, then he avoided the question by claiming TRICARE policy dictates how long they have to submit claims. (He was again avoiding the question and referring to the timely filing rule which only says they understand after 3 years they cannot file a claim but the policy contains nothing about a requirement to file a claim.) He then went on to claim they would file these claims because they have a financial incentive to be paid; ignoring the obvious that they were already paid which is the very reason they no longer have any incentive which I pointed out to him. I then repeated the question. Another long silence and then he referred back to his answer to the first question apparently thinking he could avoid the second question. I told him he was

avoiding the question and he claimed he wasn't and then said the contractual agreements they have with providers are between them and the providers and essentially none of our business and that TMA policy dictates filing of claims by providers but as usual failed to be specific preferring to hide behind "TMA policy dictates" and leaving it at that.

The last question was not addressed at all. What is extremely clear and reinforced by his continued avoidance of the questions or talking around them is that there is absolutely no requirement in TMA policy or in the contracts that requires providers to ever file a claim. The assumption has always been that providers are incentivized because they will only be paid if they file a claim. When ISOS and TMA decided to meddle in the program because of significant issues with getting providers to sign up by offering to require we pay deductibles and copays up front and in their haste to force it on us they forgot they broke the system and as usual beneficiaries are the ones that will pay the price. While we recognize there maybe exceptions, many beneficiaries will never see credit for their deductibles and end up paying them two or three times and then start over again next year. In fact it is already happening.

Ken Fournier asked if we could be provided with statistics on the number of claims filed, time frames etc. Mr. Frewen said he would not provide any data to us and Ken remarked something to the effect, "So much for transparency". Later in the discussion he agreed to verbally address some of these at the next call. Ken reminded him he promised that two months ago but so far he had failed to come through.

Ken Fournier asked about an issue raised previously on CT scans and Frewen claimed it was with TMA and all we can do is wait although it has been six months. LTC Carter asked to be told what the issue was and Ken addressed it to him. Frewen claimed CMAC changes are complex and take a long time. LTC Carter added that a change can take years. However it was pointed out that TMA changes them when they want and ignores those they do not want to change. I pointed out that our CMAC was poorly designed, over pays outpatient visits which allows for the massive increases directed by ISOS, so far up to $50, for visits, but also underpays in many other areas and that we have addressed these issues for years and apparently TMA likes it that way. There was no response.

Ken Fournier reminded Mr. Frewen that Jim Boyd asked them to look into the possibility that hospitals might consider allowing outpatient prescriptions to be filled under the program where beneficiaries paid just deductibles and copays, which they agreed to do before, and asked the status. Mr. Zimmerman stepped in and said pharmacy was not part of the demonstration and therefore there would be no discussion on it and would speak no more of it; so much for their claim we are here to discuss improvements and issues with the demonstration.

Mark Nelson tried to address the issue of semi-private rooms that Mr. Frewen earlier refused to discuss claiming, wrongly, they had no responsibility for the kinds of rooms we get under the Demo because it reflects TMA policy and we are not allowed to discuss policy. As usual Mr. Frewen talked around the issue preferring to address policy and how his staff has made sure hospitals are aware of policy but ignoring the reality that a beneficiary was forced into a ward situation which even Mr. Frewen inadvertently admitted when he said that a ward is 6 beds or more. He then went on to state if a hospital tries to put someone in a ward they should contact

Global 24 and they will resolve the problem. I pointed out he did contract them and all they did was spout policy but offered no assistance at which point Mr. Frewen jumped back in claiming they did offer assistance by giving clear direction as to what the entitlement is but the beneficiary chose to ignore it. It's hard to understand how telling him what the hospital should have done is considered assistance in any way, shape or form. In the end he agreed to discuss the issue but only in private with the sponsor.

Jim Boyd brought up an issue with heart and eye doctors not being approved for Sacred Heart and that they claim they are not being paid for professional fees. They said they would follow up on these issues.

After one hour and five minutes the call was ended.