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NCDS update

A Billing Industry Newsletter for Clients

Keeping your office up-to-date on industry and insurance changes, late-breaking billing & reimbursement news, and general inter-office communication…

Four Words That Imperil Health Care Law Were All A Mistake, Writers Now Say

Robert Pear – New York Times

WASHINGTON — They are only four words in a 900-page law: "established by the state." But it is in the ambiguity of those four words in the Affordable Care Act that opponents found a path to challenge the law, all the way to the Supreme Court.

How those words became the most contentious part of President Obama's signature domestic accomplishment has been a mystery. Who wrote them, and why? Were they really intended, as the plaintiffs in King v. Burwell claim, to make the tax subsidies in the law available only in states that established their own health insurance marketplaces, and not in the three dozen states with federal exchanges?

The answer, from interviews with more than two dozen Democrats and Republicans involved in writing the law, is that the words were a product of shifting politics and a sloppy merging of different versions. Some described the words as "inadvertent," "inartful" or "a drafting error." But none supported the contention of the plaintiffs, who are from Virginia.

"I don't ever recall any distinction between federal and state exchanges in terms of the availability of subsidies," said Olympia J. Snowe, a former Republican senator from Maine who helped write the Finance Committee version of the bill. "It was never part of our conversations at any point," said Ms. Snowe, who voted against the final version of the Senate bill. "Why would we have wanted to deny people subsidies? It was not their fault if their state did not set up an exchange." The four words, she said, were perhaps "inadvertent language," adding, "I don't know how else to explain it."

Former Senator Jeff Bingaman, Democrat of New Mexico, said there may have been "some sloppiness in the drafting" of the bill. Mr. Bingaman, who was a member of both committees that developed the measure, said he was surprised that the lawsuit had reached the Supreme Court because the words in dispute appeared to be a "drafting error." As far as I know, it escaped everyone's attention, or it would have been deleted, because it clearly contradicted the main purpose of the legislation," Mr. Bingaman said. When the Supreme Court offers its judgment, it could affect more than 7.5 million people now receiving subsidies through the federal exchange and a health care industry that accounts for 17 percent of the nation's gross domestic product. The plaintiffs say the law allows subsidies only where marketplaces have been "established by the state." It is a distinction that those who drafted the law say they did not intend to make.

For the complete article please visit: http://www.nytimes.com/2015/05/26/us/politics/contested-words-in-affordable-care-act-may-have-been-left-by-mistake.html?_r=1

What is King v. Burwell?

Jessica Meyers – NCDS

As monumental as it was to witness the overhaul of healthcare with the implementation of the Patient Protection and Affordable Care Act in 2010, the Supreme Court decision in this case has the potential to be just as monumental in potentially ruling Obamacare as unconstitutional. If you have not heard of the King v. Burwell case, in a nutshell it is important because the challengers argue that the federal government have implemented subsidies when the law is written stating that subsidies can be only be provided on state run exchanges.

To side in favor of the challengers would make the existing subsidies illegal, which in turn would revoke the subsidies issued to more than 7 million Americans who purchased plans through Obamacare, essentially crippling the premise of 'affordable care'. To side in favor of the law has strong ramifications for the Court's exercise of judicial review. The case is being so closely examined to see how heavily the political climate is capable of influencing a Supreme Court decision. In past Supreme Court precedents it has been ruled that it is the legislative department's job to enact the laws, the executive department's job to enforce the laws and the judicial department's job to interpret the laws. Established precedent states it is the Court's obligation to interpret the law as it is written, yet lawmakers now assert the verbiage finalized in the PPACA is merely a drafting error. Called into question here is whether the Court will strike down the federal subsidies, essentially crippling Obamacare, or if they will uphold the law on a premise of a drafting error in the verbiage used when the law was written.

There is no win/win situation in this case. If the Court determines the subsidies to be illegal, more than seven million Americans would not be able to afford their health insurance premiums. Conversely, if the Court does not interpret the law as written, it strongly calls into question the political biased of the Court and their ability to make sound decisions without the political climate affecting their opinion.

NCDS will continue to watch as this extremely important case plays out in the Supreme Court. Please watch for client advisories and/or upcoming newsletters for more information.

CareSource to Expand Market

As one of the largest companies in the Dayton region, CareSource is now looking at expanding its business into two new states. It will seek to offer its CareSource Just4Me health insurance product for West Virginia. CareSource will be the second plan on its marketplace. The company also hopes to be awarded a Medicaid contract there as well.

It also just submitted an RFP in Georgia, which is re-bidding its statewide Medicaid Managed Care program. There are 9 programs pre-qualified there. It also submitted an RFP for the state's home and community-based waiver program.

Humana Puts Itself Up for Sale, Reports Say

Anthony Brino – HealthCareFinanceNews.com

A takeover of the company would likely be the largest health insurance acquisition since the $20 billion merger of Anthem and WellPoint in 2003. Humana, the former nursing home operator turned Medicare insurance giant, is apparently up for sale in what could the biggest health insurance acquisition ever. Humana executives are putting the 54-year-old company on the market and have hired Goldman Sachs as an advisor, reported the Wall Street Journal. Humana's shares hit an all-time high of $219 when the news broke on Friday.

Humana is valued at more than $25 billion, with revenue last year of $48 billion. A takeover of the company would likely be the largest health insurance acquisition since the $20 billion merger of Anthem and WellPoint in 2003.

The Wall Street Journal reported that Humana's possible buyers are Aetna and, in what would be more of a merger, Cigna, which had 2014 revenue of $34 billion.

Louisville-based Humana has the second largest membership in Medicare Advantage, one of the fastest growing insurance segments thanks to the Baby Boomer retirement wave. Humana's 3 million Medicare Advantage customers and 7 million Part D members added to another national insurer's membership would rival UnitedHealth Group's 3.2 million Medicare Advantage population.

Brian Kane, Humana's CFO since 2014, is also a 17-year Goldman Sachs M&A veteran. Kane worked on deals such as Aetna's $7.3 billion acquisition of Coventry and Amerigroup's $4.9 billion sale to WellPoint.

There is a piece of uncertainty with Humana, though. The Justice Department is investigating the company's risk adjustment practices in Medicare Advantage plans. With the Affordable Care Act's medical cost ratio effectively capping insurer's profit margins, publicly traded insurers are going to have to increase membership to grow earnings in the long-term. "We view this step as a trigger event in a managed-care industry overdue for consolidation," as Leerink Partners analysts wrote recently. "We expect the next year will see multiple strategic actions among the major players."

http://www.healthcarefinancenews.com/news/humana-puts-itself-sale-reports-say?mkt_tok=3RkMMJWWfF9wsRogvqTIZKXonjHpfsX56O0qUKO3lMI%2F0ER3fOvrPUfGjI4HRcBhI%2BSLDwEYGJlv6SgFQ7LHMbpszbgPUhM%3D

NCDS Annual 5K for The Gathering Place

NCDS' first team 5k was a great success, benefiting The Gathering Place, a foundation that provides programs and services to those touched by cancer free of charge. NCDS staff enjoy participating in community events, especially those that benefit such a worthy cause!

In Other Humana News: Digital Member ID Cards Available Soon

Humana has advised that their members will soon have the convenience of a digital member ID card. This means that your patients with Humana coverage may present a digital member ID card on their smartphone, instead of a physical member ID card. Patients can print a paper version from their MyHumana ID Card Center or fax a copy of the card to your office from their smartphone. Please be aware of this new form of technology and how the patients can get their information to you. Correct insurance information is a constant challenge and we will watch to see if embracing new forms of technology can help overcome that hurdle!

AMA President Dr. Robert Wah: MU is a 'Prison for Innovation'

Akanksha Jayanthi – BeckersHospitalReview.com

At the 2015 AMA Annual Meeting, Robert Wah, MD, president of the American Medical Association, outlined key challenges facing healthcare, including a special emphasis on health IT.

"I'm honored to speak to you as I complete my term as your president about what we've achieved, where we've progressed and where there's yet work to be done," Dr. Wah said.

While Dr. Wah voiced his optimism for the future, through the metaphor of the movie series "Back to the Future," he also indicated frustrations with current federal regulations, specifically those centered on health IT.

Dr. Wah alluded to a scene in "Back to the Future" where Marty McFly and Doc Brown walk by a storefront window with a sign saying "Fax here."

"That gives a pretty big laugh unless you're in a practice that's still faxing paper records back and forth because electronic records can't interact, can't interoperate without side systems," Dr. Wah said. "While the AMA and the broader physician community strongly supports the use of tech to improve the health of our patients, the meaningful use requirements for EHRs are a heavy burden and a prison for innovation."

He suggests instead that EHR need to be interoperable, and physician-patient interactions need to be encouraged. Team care and coordination, and streamlined workload and payment can help to create a better healthcare future.

However, Dr. Wah also mentioned another challenge, which he equates to Biff the Bully: ICD-10.

"We believe ICD-10 will further disrupt physician practices when they're already facing headaches like meaningful use. Nonetheless, Congress and the [Obama] administration seems intent on implementing them on Oct. 1," Dr. Wah said. "End-to-end testing showed clams acceptance rates would drop from 97 percent to 81 percent if ICD-10 were implemented today. That's a 20 percent failure. And that's among the doctors who volunteered, the ones who sit in the front of the class waving their hands."

Dr. Wah said the AMA will continue to urge more testing, a grace period, hardship exemptions and advanced payment authorities to reduce the potential for cash flow issues. "The challenge of changes swirls all around us," Dr. Wah said. "We need to see it as an opportunity to maximize those opportunities. IT will take hard work, imagination and creativity."

To read more about this and related articles please visit: http://www.beckershospitalreview.com/healthcare-information-technology/ama-president-dr-robert-wah-mu-is-a-prison-for-innovation.html

House Bill Plans 2-Year ICD-10 'Grace Period' Without Denials

Jacqueline DiChiara – RevCycleIntelligence.com

The House of Representatives proposes the implementation of a two-year ICD-10 "grace period" to help physicians and healthcare providers more effortlessly transition from ICD-9 into ICD-10. Introduced by Representative Gary Palmer (R-AL-6) on June 4, this new bill – Protecting Patients and Physicians Against Coding Act of 2015, H.R. 2652 – intends to smooth out the code submission process for ICD-10-CM/PCS.

Within the proposed two-year window under H.R. 2652, healthcare providers' coding errors would not mean a denial of ICD-10 based claims submitted to Medicare and Medicaid. Physicians would hopefully be better alleviated from negative ICD-10 aftermath. Payments would not be withheld and penalizations would not go into effect within the "grace period."

Under H.R. 2652, there would be no further ICD-10 delay following October 1, 2015. Incorrectly coded claims would be paid for by the Centers for Medicare & Medicaid Services (CMS).

This is the third ICD-10 related bill introduced into the House within the past five weeks. H.R. 2652 shadows the House's push to freeze ICD-10 implementation, backed by the American Medical Association (AMA). It also follows the House's proposal of the ICD-TEN bill intended to mandate Sylvia M. Burwell, Secretary of the Department of Health and Human Services, to implement additional transparent testing opportunities.

The pair of earlier introduced bills has yet to gain momentum. They require many more sponsors and cosponsors to have formal legislative legs, reports the *Journal of AHIMA.* This bill is vital, says Representative Palmer, because rural and smaller physician practices are not yet prepared for the ICD-10 transition. "Although another delay would assist many in the medical community, if ICD-10 is to be implemented on October 1, patient care should not suffer," states Palmer, in a letter to Congressmen requesting their advocacy.

The American Health Information Management Association (AHIMA) has voiced a lack of support for this newly proposed House legislation. In an interview earlier this year with *RevCycleIntelligence.com,* AHIMA confirmed a lack of support for further ICD-10 delay. "From our perspective, a delay is not only unnecessary, it's not a solution to any of the problems that have been raised, such as financial disruptions immediately following the transition," stated Sue Bowman, MJ, RHIA, CCS, FAHIMA, Senior Director, Coding Policy and Compliance of AHIMA. "I find the whole concept of a delay somewhat interesting because it's not clear what problem a delay would solve," she maintained.

For the complete article please visit:
http://revcycleintelligence.com/news/house-bill-plans-2-year-icd-10-grace-period-without-denials

NCDS Perspective: Regardless of the implementation date NCDS has completed ICD-10 testing at every stage and is fully prepared for this conversion, if/when it does happen. NCDS is concerned about the readiness of insurance carriers throughout this conversion but that is a variable we cannot control. NCDS certified coders have been preparing and taking extra courses to be ahead of the change and we are ready to help our clients review any changes they would like to implement to make this a smooth transition.

ProMedica System Must Sell Off St. Luke's Hospital

Marlene Harris – Toledo Blade

ProMedica's nearly five-year battle to keep St. Luke's Hospital under its umbrella ended on Monday when the U.S. Supreme Court denied the hospital system's request to review its appeal of a Federal Trade Commission ruling against its merger with St. Luke's Hospital.

In a unanimous opinion issued in April, 2014, a three-judge panel of the 6th U.S. Circuit Court of Appeals in Cincinnati denied ProMedica's petition to overturn the FTC ruling issued in 2011 that said it would be illegal and anti-competitive for ProMedica to merge with St. Luke's in Maumee.

ProMedica then asked that the full court of 12 justices review the case. The Circuit Court denied ProMedica's request, so the company filed a petition in December with the U.S. Supreme Court, which announced its decision Monday.

"We are pleased that the Supreme Court has allowed the 6th Circuit's decision to stand," FTC spokesman Betsy Lordan said in a written statement. According to documents supplied by the FTC, in addition to agreeing with the commission that the merger was anti-competitive, the courts also upheld the commission's order requiring ProMedica to divest itself and sell St. Luke's to an FTC-approved buyer within 180 days after the order becomes final and effective.

ProMedica officials said this means there will be no immediate changes at St. Luke's for employees or consumers. "What that means is yet to be determined. There will be a negotiation process between ProMedica and St. Luke's, and the FTC will ultimately approve it, and so what exactly divestiture means we'll find out," said Tim Langhorst, ProMedica spokesman. The FTC could leave some room for the two entities to partner together in some capacity, he said. According to information provided by the FTC, once St. Luke's is turned over to an approved buyer, ProMedica must restore to St. Luke's any assets that were removed from it.

The hospital system must place no restrictions on the acquirer's use of the St. Luke's assets and contracts and allow the acquirer to recruit and employ any St. Luke's employee so it can establish an independent, complete, full-service medical and hospital staff.

ProMedica, the area's largest health system, has battled with the FTC since July, 2010, less than two months after the merger agreement with St. Luke's was signed. The federal agency immediately questioned whether this pairing of ProMedica with St. Luke's, reducing the number of hospital systems in Lucas County from four to three, would result in higher prices for consumers.

Circuit Judge Raymond Kethledge — who wrote the 2014 ruling for the Court of Appeals against the merger — asserted that "ProMedica's rates before the merger were among the highest in the state, while St. Luke's rates did not even cover its cost of patient care. That was true even though St. Luke's quality ratings on the whole were better than ProMedica's."

The judge went on to state that if St. Luke's is allowed to remain part of the ProMedica system, all ProMedica hospitals would be in an even more dominant position in the Toledo-area market because "the merger would allow ProMedica to unilaterally increase its prices above competitive levels."

It was well known that St. Luke's was struggling to remain the only independent hospital in the Toledo area before it merged with ProMedica.

For the complete article and related updates please visit:
http://www.toledoblade.com/business/2015/05/05/ProMedica-must-sell-off-St-Luke-s-nbsp.html

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