September – October 2016

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…

WHAT IS MACRA?

If all of the talk about PQRS, MIPS, APMs QRURs and MACRA have you feeling dazed and confused, you are not alone! The healthcare market is abuzz with lots of initials and abbreviations lately and understanding all of these is key to comprehending the physician payment models of the future. This issue NCDS is breaking down MACRA and why it's important. Watch coming issues for more details on MIPS and PQRS to stay informed on these important, industry-changing issues. NCDS is actively working on implementing solutions that can help your practice make a smooth transition. Be sure to contact Mick Polo at mickp@ncdsinc.com today for more information on how NCDS can help your practice with these models!

MACRA 101

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is bipartisan federal legislation signed into law on April 16, 2015. The law does many things, but **most importantly it establishes new ways to pay physicians for caring for Medicare beneficiaries.** The law also includes new funding for technical assistance to providers, funding for measure development and testing, it enables new programs and requirements for data sharing, and establishes new federal advisory groups. It is comprehensive legislation that has the potential to significantly restructure US healthcare.

The Federal Department of Health and Human Services (HHS) and CMS have been engaged in the process of drafting rules based on the legislation since the law passed.

What Does MACRA Do?

In the simplest possible terms, MACRA repeals the Sustainable Growth Rate (SGR) Formula that has determined Medicare Part B reimbursement rates for physicians and replaces it with new ways of paying for care.

If you recall past NCDS Newsletters this was always a big topic in the spring, as every year the SGR threatened to suspend or slash provider Medicare reimbursement by anywhere from 18-25%. MACRA is the solution developed to prevent that from looming over provider reimbursement every spring. MACRA is essentially the solution to SGR cuts to reimbursement.

Under MACRA, participating providers will be paid based on the quality and effectiveness of the care they provide. A growing percentage of physician payment will be based on value – not on volume – like the current fee-for-service system. High value care will be defined by measures of quality and efficiency and providers will earn more or less depending on their performance against those measures.

MACRA's value-based payment programs will be based on two new reimbursement structures; MIPS and APMs. Be sure to watch our next edition for a breakdown on these payment programs!

Article credits: www.NHRI.ORG . For more information please visit: http://www.nrhi.org/work/what-is-macra/what-is-macra/

ANTHEM JUDGE CONSIDERS SPLITTING MERGER TRIAL INTO TWO SECTIONS

DIANE BARTZ – REUTERS.COM

The judge who will rule on whether the government may stop health insurer Anthem from buying competitor Cigna said on Friday that she was considering splitting the trial into phases.

Judge Amy Berman Jackson of the U.S. District Court for the District of Columbia said that she was mulling hearing separately about the effect of the merger on the national market in one phase and on local markets in a second phase with a potential decision after the first set of arguments.

The Justice Department argues that the deal would reduce competition and raise prices for consumers.

"My initial reaction is that it's better," said Christopher Curran, who is arguing the case for Anthem. "If we're going to lose and we lose quickly, that's better for everyone." The trial in the case is to begin on Nov. 21, with a conclusion by Dec. 30.

The government also alleged that the merger would give the new, combined company too much power to set the rates of health care providers, essentially a monopoly case. That could be argued with either phase, said Jon Jacobs, who argued for the Justice Department.

"I'm going to think about this. I think it's more complicated than I had thought," the judge said, adding that she still believed it would be beneficial to hear arguments in phases.

Cigna's lawyer, Charles Rule, asked if he would be allowed to object to questions from Anthem, referring to the contentious relationship between the two companies.

"I'm not sure exactly what will come up," said Rule. "(But) there may need to be an objection."

The judge responded with surprise. "I'm not going to tell you that it's prohibited but I find it highly extraordinary," she said.

Anthem had sought a ruling by the end of the year on whether the government could stop the deal because the insurer said it needed time to wrap up merger reviews by state insurance commissioners by April 30, a deadline the companies set to complete the deal.

The Justice Department filed lawsuits on July 21 asking a federal court to stop two huge healthcare mergers: Anthem's planned $45 billion purchase of Cigna, as well as Aetna Inc's $33 billion planned acquisition of Humana. The trial on the Aetna deal is set for Dec. 5.

If both mergers go through, No. 1 U.S. insurer UnitedHealth Group Inc. would rank second after Anthem. Aetna would be No. 3.

Please visit: http://www.reuters.com/article/us-cigna-m-a-anthem-hearing-idUSKCN1202AD

NCDS Perspective: This article is a follow up to our last issue's cover article. The Anthem/Cigna merger is on the forefront of healthcare news because of the magnitude of the companies, combined with the amount of leverage they would have to drive prices up (not to mention the potential to make coverage out of reach for millions of currently insured Americans). NCDS is closely following the story and will continue to present updates as they become available.

Integrated Behavioral Health With Primary Care: A Key Focus of our Physician Group Incentive Program

www.BCBSM.com

At Blue Cross Blue Shield of Michigan, we recognize the important role that behavioral health practitioners can play in improving patient care. In addition to treating patients with psychiatric disorders, they can help patients cope with chronic medical problems, comply with medication regimens and adjust to life changes, stress, anxiety and pain.

Patients who have chronic medical conditions in conjunction with behavioral health disorders also experience higher health care costs — with much of the difference attributable to higher medical, not mental, health expenditures. One analysis found that although the presence of comorbid depression or anxiety boosts medical and mental health care costs, more than 80 percent of the increase stems from medical spending.

In fact, the monthly cost for a patient with a chronic disease and depression is $560 more than for a person with a chronic disease without depression, according to a study by S. Melek and D. Norris titled *Chronic Condition and Comorbid Psychological Disorders*.

That's one reason we've been working with physician organizations to improve communication between primary care physicians and behavioral health specialists and ensure coordination of care between providers and various health care settings. We call this initiative Integrating Behavioral Health into General Medical Care, and it's part of our Physician Group Incentive Program.

The initiative rewards 11 select POs based on participation in collaborative activities and completion of specific quality improvement activities. These POs have made significant progress in improving behavioral health-primary care integration in such areas as the following:

- Meeting Healthcare Effectiveness Data and Information Set performance goals
- Integrating depression screening into practices
- Implementing referral processes to behavioral therapists and community resources
- Embedding behavioral health specialists into primary care offices

In addition, some physician organizations have held expos to highlight the work of primary care practices, behavioral health practices and other resources within the community. "These expos have been enormously successful in making sure that participants were aware of the work that was taking place within the community and the services that were available," said Kathleen Kobernik, a senior health care analyst with Value Partnerships. "These events help health care providers determine the best approaches to take for patients who may benefit from behavioral health services."

NCDS Perspective: This integrated approach to behavioral health in conjunction with primary care is an interesting initiative that should help improve the quality of life for patients with chronic illnesses and the mental toll those illnesses take on their quality of life. We will be monitoring this initiative to see if BC/BS expands this beyond the Michigan region as well as any reports released on the effectiveness of the initiative.

http://www.bcbsm.com/newsletter/hospital_physician_update/2016/HPU_1016/HPU_1016c.html

Did You Know?

Reviewing consumer surveys can be a great way to get in touch with the needs of your patients, as well as understand what they want in order to attract new patients. Below are a few beneficial findings from recent patient surveys that show trends when it comes to expectations when making appointments and billing. A growing percentage of patients want assistance from the provider office staff to help understand their responsibility prior to being seen. With rising healthcare costs, premiums and deductibles to pay, patients are trying to navigate the complicated healthcare world by first evaluating cost. Knowing what patients are looking for can help position your practice for patient retention and growth. Additionally, this can help your staff be better prepared to field patient questions. Posting signage in the office as well as having pamphlets available to patients regarding payment methods, payment plans, additional charges, etc., are other helpful, passive ways to communicate important information to patients once present in the office. The more information you can provide the better equipped your patients will be!

47% of consumers will switch providers for the ability to understand cost upon scheduling and to easily understand and pay a bill using a preferred method

– Accenture 2014 Global Consumer Pulse Survey

What it means: The impacts of consumers no longer putting up with the mysteries of healthcare costs are real. Consumers are more sensitive than ever to how much they are spending on healthcare. Consumers also bring experiences from innovators in other industries, like Uber and Amazon, where costs are clearly communicated and payments are convenient. These experiences have set their expectations for the healthcare payments experience.

What healthcare organizations can do: As the new stakeholder in the healthcare payments industry, consumers want convenient, digital experiences to pay and manage their healthcare expenses. Healthcare organizations can deliver by offering digital experiences through online and mobile payment channels, eliminating paper from the process and being transparent about costs.

NCDS Perspective: Being open to utilizing new payment methods is an important component to helping your practice change with trends. Offices that do not have a credit card machine could consider a Square card reader for credit card payments, as an increasing number of patients are interested in transactions that are easy, paper free, with emailed receipts. It is always the best practice to capture the payment when the patient is present.

91% of consumers say it's important to know their payment responsibility prior to a provider visit

– Consumer Healthcare Payments Survey 2015

What it means: Rising consumer payment responsibility has changed how consumers approach visits to providers. Consumers want to know upfront how much they will owe and then understand how to make payments. Questions like "how much is this going to cost?" and "what are my payment options?" have become common in the provider-consumer relationship.

What healthcare organizations can do: This consumer demand goes beyond providers making their retail pricing available. The need is for consumers to understand an estimate of what they will actually pay based on their benefit information which can include variables like their deductible, co-payments and coinsurance. Healthcare organizations can deliver accurate estimates and a positive consumer experience by following some best practices.

Medicare Provider Revalidations

WWW.CMS.GOV

CMS has completed its initial round of revalidations and will be resuming regular revalidation cycles. In an effort to streamline the revalidation process and reduce provider/supplier burden, CMS has implemented several revalidation processing improvements. Revalidations are required due to Section 6401(a) of the Affordable care act to:

- Established new screening requirements for new and existing providers/suppliers
- Required all existing providers/suppliers to be revalidated under new screening requirements
- Reinforces the revalidation requirements at 42 CFR §424.515

If your organization is due for revalidation Your Medicare Administrative Contractor (MAC) will send a revalidation notice within 2-3 months prior to your revalidation due date. If you do not know how to complete your revalidation and would like NCDS to handle this for you please contact Susan Mobley at 800-556-6236 option 25 or email susank@ncdsinc.com . Medicare revalidations are required once you are selected and if you do not complete the revalidation as specified within the required timeframe Medicare suspends paying all of your claims. To view a sample revalidation letter on Medicare's website please visit https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/SampleRevalidationLetter.pdf . Additionally, if you would like to review more information on Medicare revalidations please see the following website: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html .

Aetna to Pull Out of Most Obamacare Exchanges

TAMI LUHBY – MONEY.CNN.COM

The insurer will stop offering policies on the exchanges in 11 of the 15 states where it currently operates, according to a press release it issued Monday evening. Aetna will only sell Obamacare products in Delaware, Iowa, Nebraska and Virginia.

Aetna said earlier this month that it was halting its exchange expansion plans for 2017 and reviewing its participation in President Obama's signature health reform program. The company noted Monday that it has lost $430 million in its individual policies unit since the exchanges opened in January 2014.

Aetna, which had 838,000 exchange customers at the end of June, said its policyholders are turning out to be sicker and costlier than expected. The company, along with its peers, has criticized the federal program designed to mitigate those risks.

"Providing affordable, high-quality health care options to consumers is not possible without a balanced risk pool," said Aetna CEO Mark Bertolini. The company will continue to offer individual policies outside of the Obamacare exchanges in the vast majority of markets where it now does business. Off-exchange products are not eligible for federal subsidies.

The Obama administration said Monday the exchanges are serving 11 million people and have brought down the uninsured rate to the lowest on record.

For more on this change to Aetna's Obamacare programs please visit: http://money.cnn.com/2016/08/15/news/economy/aetna-obamacare/

Expert Panel Recommends Expansion of Services With No Cost Sharing for Women

MICHELLE ANDREWS – WWW.KHN.ORG

The list of preventive services that women can receive without paying anything out of pocket under the health law could grow if proposed recommendations by a group of mostly medical providers are adopted by federal officials later this year.

The draft recommendations, which are subject to public comment until Sept. 30, build upon and add to the eight recommended preventive services for women now covered by insurers for no out-of-pocket cost. As a result of the health law, the initial list was developed in 2012 by the Institute of Medicine — now called the National Academies of Sciences, Engineering, and Medicine. It requires most health plans to cover well-woman visits, screening and/or counseling for sexually transmitted infections, domestic violence and gestational diabetes as well as breastfeeding support and supplies.

In addition, most health plans must cover, without cost sharing, all methods of contraception that have been approved by the Food and Drug Administration. The proposed new recommendation would allow women at average risk for breast cancer to begin screening as early as age 40 and receive a mammogram every one or two years. That's consistent with current rules established by Congress, but it's a more liberal standard than the guidelines from the U.S. Preventive Services Task Force, which recommends women generally be screened every other year starting at age 50.

For the complete article please visit: http://khn.org/news/expert-panel-recommends-expansion-of-services-with-no-cost-sharing-for-women/

Paramount – No Retro Authorizations

In a written notice dated October 5, 2016 Paramount states "effective immediately Paramount will no longer retro-actively authorize claims for services that were provided without obtaining the appropriate pre-authorization/notification. Paramount will deny claims with **no member liability** for services that require prior authorization and will **no longer review retro-active appeals** for such claims.

For a complete list of procedures that require a pre-authorization/notification, as well as Paramount's medical policies and appeal exceptions can be found on their website at: www.paramounthealthcare.com/priorauth you can also utilize: http://www.paramounthealthcare.com/documents/provider/Prior-Authorization-List.pdf

NCDS Perspective: Many providers may not be aware that Paramount is a carrier that requires an adjustment form to be completed for every claim resubmission/denial, even if the denial was the result of their internal error. They are currently 5 months behind in working the adjustment forms and appeals. NCDS sees this change as an opportunity for Paramount to refuse payment on these types of cases and not have to review the adjustment form. Though it is disappointing any time an insurance company makes a change like this they have the option to do so imbedded in their provider contracts. Please make sure office staff in charge of prior authorizations are aware of this change as failure to complete this before rendering the service will mean no payment.

Maximize Your Revenue

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Medical Billing

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