September – October 2017

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…

Trump to Scrap Critical Health Care Subsidies, Hitting Obamacare Again

Robert Pear, Maggie Haberman and Reed Abelson, NY Times

WASHINGTON — President Trump will scrap subsidies to health insurance companies that help pay out-of-pocket costs of low-income people, the White House said late Thursday. His plans were disclosed hours after the president ordered potentially sweeping changes in the nation's insurance system. The twin hits to the Affordable Care Act could unravel President Barack Obama's signature domestic achievement, sending insurance premiums soaring and insurance companies fleeing from the health law's online marketplaces.

Without the subsidies, insurance markets could quickly unravel. Insurers have said they will need much higher premiums and may pull out of the insurance exchanges created under the Affordable Care Act if the subsidies were cut off. Known as cost-sharing reduction payments, the subsidies were expected to total $9 billion in the coming year and nearly $100 billion in the coming decade.

"The government cannot lawfully make the cost-sharing reduction payments," the White House said in a statement. It concluded that "Congress needs to repeal and replace the disastrous Obamacare law and provide real relief to the American people."

Lawmakers from both parties have urged the president to continue the payments. Mr. Trump had raised the possibility of eliminating the subsidies at a White House meeting with Republican senators several months ago.

"Cutting health care subsidies will mean more uninsured in my district," Representative Ileana Ros-Lehtinen, Republican of Florida, wrote on Twitter late Thursday. She added that Mr. Trump "promised more access, affordable coverage. This does opposite."

But Speaker Paul D. Ryan, Republican of Wisconsin, praised Mr. Trump's decision and said the Obama administration had usurped the authority of Congress by paying the subsidies. "Under our Constitution," Mr. Ryan said, "the power of the purse belongs to Congress, not the executive branch."

The future of the payments has been in doubt because of a lawsuit filed in 2014 by House Republicans, who said the Obama administration was paying the subsidies illegally. Judge Rosemary M. Collyer of the United States District Court in Washington agreed, finding that Congress had never appropriated money for the cost-sharing subsidies.

The Obama administration appealed the ruling and the Trump administration has continued the payments from month to month. This summer, a group of states, including New York and California, was allowed to intervene in the court case over the subsidies. The New York attorney general, Eric T. Schneiderman, said on Thursday night that the coalition of states "stands ready to sue" if Mr. Trump cut off the subsidies.

https://www.nytimes.com/2017/10/12/us/politics/trump-obamacare-executive-order-health-insurance.html

MIPS Reporting – Avoid Penalties and Report Today!

It's confusing, we understand. But here is what you need to know:

If you are a Medicare provider you need to report quality measures now to avoid penalties in your 2019 Medicare reimbursements.

Now that you know this *does apply to you*, what do you do about it? You are probably telling yourself that you don't have time for this; your schedule is full seeing patients and this is one more headache caused by the insurance companies just to be able to keep your reimbursement for seeing their patients. And if you have made any of those statements when reading this, we agree with you and you are absolutely right. But, if you fail to report by the required deadline your reimbursement will be penalized and nobody wants that.

NCDS has partnered with Mingle Analytics to make this simple and easy for you to report your quality measures and prevent penalties in 2019. Below are some key dates for quality measure reporting, as well as a link to get started.

Key Dates:

- October 2, 2017: Deadline for practices to begin an Improvement Activity in order to fulfill 90-day requirement within December 1, 2017: Client are encouraged to register for MIPS Solutions and begin their submission to avoid late season rush.
- March 31, 2018: Deadline for MIPS Solutions Registry by Mingle Analytics to send MIPS Submission to Medicare.

https://mingleanalytics.com/ncds

By clicking the link you will get a convenient solution to simplify this process and check it off of your "to do" list. As an additional benefit, our partnership with Mingle provides you with a discounted solution to keep your costs down and revenue up.

MINGLE ANALYTICS

MIPS Solutions™ Edition	Coupon Code	Client Price
Essentials	NCDS17ESS	$237
Performance	NCDS17PER	$379
Enterprise	NCDS17ENT	$664

At this point all clients should be focused on avoiding the penalty (see the "Essentials" at left) based on now and the end of the year.

MIPS reporting can be as simple as reporting one measure on one patient. For a better understanding of MIPS please see:

http://www.ncdsinc.com/mips-understanding-the-basics/

Help For Hurricane Harvey Victims

The devastation experienced in Houston, TX and surrounding areas during Hurricane Harvey continues to affect Texans and family members. Here at NCDS our hearts go out to our Texas clients and all of their patients.

Relief efforts are sweeping the nation, and here in Cleveland we couldn't be more proud of the people of our city. Grass-roots campaigns to bring everyday necessities to all of those affected are sweeping the nation. Collecting clean clothing, baby formula, diapers, pet food, children's toys and household goods make us all proud to be Americans.

For our Texas providers: If you have patients who are Superior HealthPlan members that have been affected by the recent hurricane and resulting floods, Superior has services available to help them.

Members may call Member Services if they need to:

- Get an emergency prescription refill.
- Replace necessary medical equipment, services or supplies.
- Get a new copy of their Superior Member ID card.
- Speak with a registered nurse, 24 hours a day, 7 days a week.
- Find a doctor in their area.
- Get help dealing with stress or depression.

All Superior members who live within the official disaster designated counties and who may need to replace necessary medical equipment, services, or supplies should seek replacement through any available supplier. If they cannot find a supplier, they can call Member Services to help find one. Supplies will be replaced even if the member is temporarily outside of the county in which they live.

https://www.superiorhealthplan.com/newsroom/IMPORTANT-Support-for-Hurricane-Victims.html

Oct. 1 Deadline Looming for EHR Hardship Exemption

Susan Morse – HealthcareITNews.com

Providers taking part in the EHR incentive program face an Oct. 1 deadline to file a hardship exemption or pay a penalty. The Medicare EHR Incentive Program ended with the 2016 reporting period. Providers now report to the quality payment program.

Those transitioning to the merit-based incentive payment system, or MIPS, may file for a hardship exemption for not meeting the requirements of meaningful use in prior years to avoid penalties in 2018, according to the Centers for Medicare and Medicaid Services. The deadline is Oct. 1.

Also on Oct. 1, the Medicare hospital inpatient prospective payment system and long term acute care hospital prospective payment system final rule takes effect. The rule contains several changes that will directly affect the Medicare and Medicaid EHR incentive programs.

For the full article: http://www.healthcareitnews.com/news/oct-1-deadline-looming-ehr-hardship-exemption

CMS Proposes to Revise Evaluation & Management Guidelines

Billing-coding.com

According to the recently released 2018 Physician Fee Schedule Proposed Rule, published in the Federal Register, dated July 21, 2017, the Centers for Medicare & Medicaid Services (CMS) acknowledges that the current Evaluation and Management (E/M) documentation guidelines create an administrative burden and increased audit risk for providers. In response, CMS announced its intention to undertake a multi-year effort with the input of providers and other stakeholders to revise the current E/M documentation guidelines. This revision will likely include removal of the history and exam documentation requirements.

CMS states in the provision: "Stakeholders have long maintained that both the 1995 and 1997 guidelines are administratively burdensome and outdated with respect to the practice of medicine, stating that they are too complex, ambiguous, and that they fail to distinguish meaningful differences among code levels. In general, we agree that there may be unnecessary burdens with these guidelines and that they are potentially outdated, and we believe this is especially true for the requirements for the history and the physical exam. The guidelines have not been updated to account for significant changes in technology, especially electronic health record (EHR) use, which presents challenges for data and program integrity and potential upcoding given the frequently automated selection of code level."

While CMS conducts few audits on E/M visits relative to the volume of Medicare Physician Fee Schedule (PFS) services they comprise, they have repeatedly heard from practitioners about the administrative burden. CMS states in the proposed rule that their prior attempts to revise the guidelines met with a lack of stakeholder consensus and support, which contributed to the current policy that allows practitioners to use either the 1995 guidelines or 1997 guidelines, resulting in further complexity in determining or selecting the applicable requirements.

CMS.gov
Centers for Medicare & Medicaid Services

CMS stated in the proposed rule that they are specifically seeking comment on how they might focus on initial changes to the guidelines for the history and physical exam as they believe documentation for these elements may be more significantly outdated, and that differences in Medical Decision Making (MDM) are likely the most important factors in distinctions between visits of different levels. Public comment on possibly eliminating the current focus on details of history and physical exam, and allow MDM and/or time to serve as the key determinant of E/M visit level is part of the proposed rule.

"Changing the scope of these models allows CMS to test and evaluate improvements in care processes that will improve quality, reduce costs, and ease burdens on hospitals," said CMS Administrator Seema Verma. "Stakeholders have asked for more input on the design of these models. These changes make this possible and give CMS maximum flexibility to test other episode-based models that will bring about innovation and provide better care for Medicare beneficiaries."

Ashley Thompson, American Hospital Association senior vice president for public policy analysis and development, said the AHA is concerned cancellation of the bundled payment models could cause problems for provider organizations that have spent valuable resources to implement these programs.

CMS will accept comments on the proposed rule until Oct. 16.

For more information on this article please visit: http://www.billing-coding.com/detail_article.cfm?articleid=5865

Cost Sharing Reduction Payments Officially Stop on Friday

Susan Morse – HealthcareFinanceNews.com

Cost-sharing reduction payments stop as of Friday, America's Health Insurance Plans has confirmed. The CSR payments were due on Oct. 20, according to AHIP, which said it has learned they will not be paid.

President Donald Trump has followed through on his October 13 decision to end CSRs despite legal challenges from an estimated 20 state attorneys general and the bipartisan Alexander-Murray bill being released today that restores the CSR payments for two years.

Without CSRs, insurers have said premiums for silver-tiered plans would be expected to increase by at an estimated 20 percent. As insurers face open enrollment starting Nov. 1, some have been granted the flexibility to refile their rates, while others will have to absorb the cost. The government required insurers to finalize premium rates on Sept. 29. Many insurers filed two sets of rates to account for a potential end to CSR payments. In states where insurers filed one rate, in most cases it appears to be up to insurance commissioners to decide whether payers can refile.

Blue Cross Blue Shield of North Dakota said the decision means it will have to absorb the cost associated with the lack of CSR funding. This means paying out-of-pocket to help lower income consumers pay deductibles and their own out-of-pocket expenses. "We understand the insurance commissioner's decision to deny additional rate requests, as additional increases at this point would cause disruption for consumers in North Dakota," said BCBSND spokeswoman Andrea Dinneen. "We expect that premiums may increase in 2019 as a result of these activities, however the full impact will not be known until we understand our 2018 membership and their utilization of health care services." In 2016, BCBSND received $4 million in CSR funds from the federal government, Dinneen said. "In planning for 2018 rates, we expected an increase in CSR payments, however we are not able to share a specific figure," Dinneen said. Despite not being able to collect higher premiums to make-up for the lack of federal funding, BCBS North Dakota will remain on the federal exchange in 2018, she said.

The nation's largest insurer, UnitedHealthcare, which withdrew from many ACA markets, has now about 30,000 people in four states who would be eligible for CSR payments in 2018, CEO David Wichmann said during an earning's call this week. The insurer submitted two rates, one that reflected a continuation of the payments, and another without the CSRs. "Thus, we expect any impact to be extremely small," Wichmann said.

Trump originally indicated on Monday he supported the bill, saying it represented a short-term fix until Congress crafted healthcare legislation for a vote in early- to mid-2018.

On Wednesday, responding to a reporter's question, White House Press Secretary Sarah Huckabee Sanders said it was correct that the president did not support the bipartisan plan. The president wants a bill that gives relief for all Americans, she said.

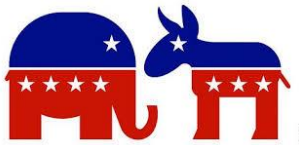
Trump tweeted Wednesday that he could never support bailing out insurance companies which "have made a fortune w/ Obamacare."

For the full article please visit:
http://www.healthcarefinancenews.com/news/cost-sharing-reduction-payments-officially-stop-friday

Bipartisan Plan to Curb Health Premiums Gets Strong Support

Erica Werener and Alan Fram – Associated Press

A bipartisan proposal to calm churning health insurance markets gained momentum Thursday when enough lawmakers rallied behind it to give it potentially unstoppable Senate support. But its fate remained unclear as some Republicans sought changes that could threaten Democratic backing.



Republican Sen. Lamar Alexander of Tennessee and Democratic Sen. Patty Murray of Washington said their plan had 24 sponsors, divided evenly between both parties, for resuming federal subsidies to insurers. Trump has blocked the money and without it, insurers are already raising premiums for many buying individual coverage and could flee unprofitable markets.

Senate Minority Leader Chuck Schumer said all 48 Democrats — including two independents who support them — would back the measure in a vote. That meant that combined with the dozen GOP sponsors there would be 60 votes for the plan, the number needed to overcome a filibuster, a delaying tactic meant to kill legislation.

"Every Democrat's voting for it. Do the math, baby," an exultant Schumer, D-N.Y., told reporters.

The politically compelling arithmetic raises pressure on Majority Leader Mitch McConnell, R-Ky., who's been noncommittal so far, to let the Senate consider the legislation. A McConnell spokesman offered no new statement from him.

The growing Senate support also improved the chances that the proposal would become law, perhaps later this year as part of a must-pass measure financing the entire government.

The measure would still have to clear the House, where Speaker Paul Ryan, R-Wis., and many conservatives have been cold to the idea, and win Trump's signature.

Two supporters of the bipartisan plan, GOP Sens. Lindsey Graham of South Carolina and Bill Cassidy of Louisiana, said in a statement that it "will not pass unless concerns of the House are addressed." They said they were seeking agreement on provisions adding flexibility for states to ease some requirements of President Barack Obama's health care law.

In an interview, Graham suggested making tax-favored health savings accounts more generous and giving consumers more information about medical prices. But he also mentioned letting insurers sell a wider range of lower-cost policies, which Democrats have resisted as a weakening of Obama's law.

The law also obliges the government to repay carriers for those costs, around $7 billion this year. A federal judge concluded that Congress never properly approved the money, but Obama and Trump continued the payments until Trump halted them last week.

The Alexander-Murray agreement extends the payments for two years. It gives states additional flexibility under Obama's law and allows consumers of any age to buy low-cost catastrophic coverage plans.

Questioned in the Oval Office on Thursday, the president again sounded lukewarm. "It'll be absolutely short term," Trump said of the bipartisan plan, "because, ultimately, we will be, it's going to be repeal and replace." Trump added, "I don't want the insurance companies making any more money ... than they have to."

For the complete article please visit:
https://apnews.com/c8291bc4501f473ca48f2c53915563ca/Bipartisan-plan-to-curb-health-premiums-gets-strong-support

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