May - June 2018

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…

Ohio Closer to Work Requirements for Medicaid

Kaitlin Schroeder – DaytonDailyNews.com

Ohio is a step closer to forcing some Medicaid recipients to get jobs if they receive the government assistance.

The Ohio Department of Medicaid on Monday said it had officially submitted its request to create the work requirements for those covered through the expansion of Medicaid, the state-federal health insurance program that covers residents with low incomes or disabilities.

Ohio Department of Medicaid

Medicaid was expanded in the state in 2014 under the Affordable Care Act, and the expansion in fiscal year 2018 will account for about 710,000 out of the 3 million Ohioans on Medicaid.

The new work requirements, if approved by the U.S. Centers for Medicare and Medicaid Services, would require those covered by Medicaid expansion to either have a job for at least 20 hours per week, be looking for work, or attending school or job training.

The state estimates that about 95 percent would already either meet the work requirement or be exempt. Some of the exemptions include being 50 years or older, participating in drug or alcohol treatment, pregnancy or complying with work requirements associated with other programs like SNAP, also known as food stamps.

Out of the 36,000 enrollees that will not meet the work requirements or have an exemption, the state estimates about 18,000 will ultimately lose their Medicaid eligibility.

Ohio Medicaid is requesting permission to add work requirements because the Republican-majority Ohio General Assembly put the language into the budget last summer that required the department to do so.

Ohio Senate President Larry Obhof, R-Medina, said Medicaid expansion and its costs have been a source of frustration for him and his Republican colleagues. He said the work requirements exempt the neediest while driving those with the ability to work toward self-sufficiency, which follows in the consistent theme of welfare reform since the early 1990s.

"I think we should measure our success on how many people we've been able to give a hand up to … helping people get back on their feet and get back into the workforce instead of keeping people dependent on government," Obhof said.

For more information on this article please visit the Dayton Daily News at the link below: https://www.daytondailynews.com/news/ohio-closer-work-requirements-for-medicaid-what-really-going/D4QEV2yOdUHhmWKAzRey6M/

NCDS Perspective: This and similar proposals are trending nationwide with other states. As these initiatives roll out providers and staff need to be diligent with checking eligibility for Medicaid coverage to avoid the pitfalls of nonpayment.

Tech Companies Could Soon Drive Down Healthcare Costs, Says Mary Meeker

Jillian D'Onfro, CNBC.com

As people in the U.S. increasingly struggle to make ends meet, the "consumerization" of healthcare and rising data availability could be on the cusp of reducing healthcare spending, Meeker predicted during her annual presentation on the future of the internet. People are spending more on healthcare than ever before, Meeker's data shows, and people are starting to view it with the same expectations that they would have for other consumer products, including desires for on-demand access and transparent pricing. Technology companies, from startups to top firms, have started to fill gaps and provide solutions.

Google

amazon

Major companies like Apple, Amazon, and Google all have big aspirations to move deeper into healthcare. Apple is testing a product that will let users keep their medical records on their iPhones, for example, and Amazon, Berkshire Hathaway, and J.P. Morgan Chase announced a partnership to cut healthcare costs and improve services for employees.

Meanwhile, start-ups like Oscar Health, an insurer building out a claims processing system, and Cedar, which provides simplified healthcare billing, are also working to address pain points across the healthcare space.

"Will market forces finally come to health care and drive prices lower for consumers?" Meeker asks. She hopes so.

Meeker's colleague John Doerr, the chair of Kleiner Perkins and long-time investor in the tech industry, has been talking up opportunities in the health sector for several years now, and is investing in health-related startups.

https://www.cnbc.com/2018/05/30/mary-meeker-on-healthcare-consumerization-driving-down-costs.html

NCDS Perspective: This article gives great insight as to the perspective of the tech-savvy patient. Statistics show 94% of the millennial demographic are smartphone users, greater than 80% in the 30-49 age bracket and greater than 70% of 50-64 age group are smartphone users. The American population has grown accustomed to instant access to what they want, when they want it and now it appears it's not just limited to reservations, shopping and social media. This opens new opportunities for providers to explore a better connection to patients and enhanced accessibility. NCDS has increased its efforts to connect to our providers and their patients, using social media, auto dial calling for payments/reminders, Papaya payments as well as enhancements to our credit card processing portal. In last month's newsletter we shared an article regarding Amazon's efforts to penetrate the healthcare market and each month there is more information revealing global giants trying to carve out their niche in healthcare. We will continue to watch for updates as these internet industry-leaders make their way into the healthcare market.

WellCare Health Plans to Acquire Meridian for $2.5 Billion

Susan Morse – HealthcareFinanceNews.com

WellCare Health Plans in Tampa, Florida, is acquiring Meridian health plans as well as pharmacy benefit manager MeridianRx for $2.5 billion, in a move that will strengthen its managed Medicaid and Medicare Advantage businesses.

The definitive agreement includes the acquisition of Meridian Health Plan of Michigan, Meridian Health Plan of Illinois, and PBM MeridianRx, in a transaction expected to close by the end of 2018.

Upon completion, WellCare will have the top Medicaid membership market share in Michigan and Illinois, increasing its leading market position from four to six states, the company said.

WellCare will also expand its MA business through the addition of Meridian's 27,000 MA members in Michigan, Illinois, Indiana and Ohio.

"Meridian is a well-performing health plan, and WellCare and Meridian share a similar commitment to serving our members through a comprehensive, integrated approach to healthcare," said WellCare CEO Ken Burdick. "This transaction aligns with our focus on government-sponsored health plans, will strengthen our capabilities and growing business, and will advance our growth agenda."

Meridian serves approximately 1.1 million Medicaid, Medicare Advantage, integrated dual-eligible and Affordable Care Act marketplace members in Michigan, Illinois, Indiana and Ohio.

One-time transaction-related expenses of $75 to $85 million and integration-related expenses of $50 to $60 million will be partially offset by $30 to $40 million in synergies that are expected to ramp up over the next few years, WellCare said.

Revenue of $4.3 billion is projected for the family-owned, for-profit Meridian in 2018.

Meridian has achieved high quality ratings from the National Committee for Quality Assurance for its health plans in Michigan and Illinois.

For the complete article please visit: http://www.healthcarefinancenews.com/news/wellcare-health-plans-acquire-meridan-25-billion

Update from HealthNet Federal Services

Dear Provider:

Thank you for providing high quality services to veterans through the U.S. Department of Veterans Affairs (VA) Patient-Centered Community Care (PCCC) and Veterans Choice Program (VCP). On March 27, 2018, VA announced it will allow the Health Net Federal Services, LLC (HNFS) PCCC/VCP contract to expire at the end its five-year term, effective Sept. 30, 2018. Over the next six months, our priority will be to work closely with VA and our community providers to ensure a smooth transition as we close out our PCCC/VCP contract.

Provider reimbursement

- We remain focused on program performance improvements and have initiated an aggressive claims inventory reduction plan to address aged claims.
- We've committed to you and the VA that by May 31, 2018, we will reach and maintain a standard of processing 95 percent of clean claims within 30 days of receipt.
- We will continue to work collaboratively with VA to ensure providers receive prompt and timely payments during this period of transition.

As we work through this transition, we will post additional FAQs and updates at www.hnfs.com/go/VA

NCDS Perspective: NCDS will continue to watch for updates. Veterans Affairs has always been a difficult payer for private practice. Allowing this contract to expire may invite increased delays and disorganization with claims processing.

Missing the Whole Story: Behavioral Health Slow to Adopt New Pay Models

Tara Bannow - ModernHealthcare.com

A few weeks ago, Dr. Kevin Bozic saw a 68-year-old patient who appeared to exemplify the "perfect bundle" under Medicare's test payment program for knee replacements. She was only in the hospital for one night. She wasn't readmitted and didn't report complications within 90 days.

But in their follow-up visit, she was miserable. That perplexed Bozic, an orthopedic surgeon and chair of the surgery and perioperative care department at the University of Texas at Austin's Dell Medical School. The surgery, performed by a different surgeon, was 18 months ago. The patient's X-rays looked fine, her range of motion was good and there wasn't any swelling or redness around her knee. Then Bozic checked out her preoperative X-ray, which showed very little arthritis to begin with.

"I suspect this was a patient who had significant anxiety that was manifesting itself as knee pain and perseverating on that, became fixated on that knee pain as the source of her problem and saw a well-meaning surgeon who said, 'I know how to fix that. I'll do surgery,' " he said.

Bozic's practice now screens all patients for behavioral health conditions like anxiety and depression that could be contributing to their pain prior to surgeries, a protocol that wasn't in place when the 68-year-old patient had her knee replaced. If providers detect such conditions, they advise patients to see their in-house therapists before agreeing to surgery. Since making the change in June 2016, the practice has reduced the number of orthopedic procedures it performs by nearly 50%, while increasing the number of patients treated using different modalities. "You need a multidisciplinary solution where you can step back and say, 'OK, what else is going on with this patient?' And then you need the ability to treat the other things that are going on with that patient," he said.

Value-based purchasing hasn't caught on in the behavioral health sector at nearly the same level as other medical specialties. That's partly due to the fact that most providers don't use standardized metrics to gauge outcomes and some small providers are reluctant to adopt expensive electronic health record platforms and other technology necessary to facilitate data collection and sharing. To be sure, a wealth of pilot programs are actively testing behavioral health value-based purchasing among commercial and government payers in several states. But so far, they're happening in silos.

The Scattergood Foundation, a Philadelphia-based not-for-profit that awards grants to improve the behavioral health sector, released a report in September that highlighted 11 such models, but none have been scaled, said Joe Pyle, the organization's director. "I think we're starting to see it, but not at the level that we need to," he said.

CMS last year rolled out new diagnostic codes that providers can use to bill for patients with psychiatric or behavioral health conditions, including substance abuse, who are treated by a primary-care team with physical and behavioral providers working in collaboration. Codes for the Psychiatric Collaborative Care Model were updated in January.

http://www.modernhealthcare.com/article/20180526/NEWS/180529966?#utm_medium=email&utm_source=ccl-healthcare&utm_campaign=ccl-healthcare-20180529&cci_test=healthcare

MIPS: Individual vs Group Reporting Explained

BLOG CONTRIBUTOR: MINGLE ANALYTICS

The Quality Payment Program (QPP) allows physicians to choose whether they will participate in the MIPS program as an individual or a group. This is one of the first decisions a practice will need to make when planning their MIPS reporting strategy.

The impact of this decision affects the performance of each Eligible Clinician (EC) reporting under a Tax Identification Number (TIN), and ultimately, the potential to earn an incentive.

When selecting a reporting option, individual or group, the choice is made for all three categories.

Here's a brief overview of each option.

Individual Reporting

According to CMS, an individual is defined as a single clinician, identified by a single National Provider Identifier (NPI) number tied to a single TIN. If you are an Eligible Clinician **(read Mingle's blog post about MIPS Eligibility if you aren't sure)** who chooses to report MIPS individually, your Final Score is based on your performance alone.

Reporting the three performance categories as individual means that you will need to find Quality measures and improvement activities for each provider in the practice. For "Promoting Interoperability" (the new name for Advancing Care Information) each provider must pass the base score measures on their own to qualify for points in this category.

While reporting as an individual allows complete control over the performance and payment adjustment, collecting the data individually for your ECs could also mean a large administrative workload.

If choosing to report as an individual, CMS allows you to choose one of the following methods to submit quality data:

- Qualified Clinical Data Registry (QCDR)
- Qualified registry
- Electronic Health Record (EHR)
- Claims

For quality, the eligible instances are determined by the patients seen by that provider in the practice. However, the quality action could be met by another provider they see.

For example: Measure 226, requires that you ask patients about smoking at least once within the two years prior to the eligible visit date in the performance year. If a patient sees provider A in the performance year, the patient is in the denominator for Provider A. If the patient was asked about smoking by Provider B in a visit during the previous year, Provider A gets "credit" for the quality action. However, if Provider B, does not see the patient in the performance year, the patient is not in the denominator for Provider B.

If provider B also saw the patient during the performance year, then both Provider A and Provider B would report (and receive credit for the quality action) for that patient and essentially, you would report on that patient twice within the practice.

Keep this example in mind as we think about how group reporting determines the denominator.

Group Reporting

CMS states that a group consists of a single TIN with two or more eligible clinicians (including at least one MIPS eligible clinician), as identified by their NPI, who have reassigned their Medicare billing rights to the TIN.

The process for group reporting allows a group of providers to submit their data and be scored collectively—meaning each physician in the group will earn the same MIPS Final Score—and receive the same payment adjustment (including EC's that weren't in the group during the performance year).

Fundamentally, group scoring treats all EC's in the group as if they were one individual.

In most cases, group reporting significantly reduces the level of effort. And for very large groups, it might be the only method that is technically feasible.

Here is how group reporting affects each category.

Quality

Instead of choosing measures for each provider in the group, you select measures based on the patients seen by the whole practice. The measures do not have to apply to everyone in the group.

In a multi-specialty group, this means that you can choose measures that the group performs well on, even if some providers do not perform as well, or do not have eligibility for the measures chosen. This makes a big difference when you have many specialists in the practice.

The eligible instances for the measures are determined based on the patients in the practice, regardless of which NPI or how many NPIs saw that patient.

For example: Measure 226, requires that you ask patients about smoking at least once within the two years prior to the eligible visit date in the performance year. If a patient sees provider A in the performance year, the patient is in the denominator for the whole group. If the patient was asked about smoking by Provider B in a visit during the previous year, the group gets "credit" for the quality action.

If provider B also saw the patient during the performance year, the patient is reported on just ONCE for the group and the group receives credit for the quality action for that patient.

And any group of 16 or more providers and greater than 200 eligible instances, CMS will automatically calculate the All Cause Hospital Readmission Measure and it will count toward their Quality score. Individual providers are not eligible for this measure.

Improvement Activities

For Improvement Activities, if just one provider is participating in an activity, the entire group gets credit.

Claims reporting is not an option as a reporting mechanism, but these other options are available:

- Qualified Clinical Data Registry (QCDR)
- Qualified Registry
- Electronic Health Record (EHR)
- CMS Web Interface (groups of 25 or more NPIs)

That summarizes how group reporting affects each of the MIPS performance categories, however, there are more rules and requirements that you need to be aware of when deciding your reporting option.

Please see the link below for the full article and more helpful information on MIPS Reporting: http://go.mingleanalytics.com/individual-vs-group-reporting

Maximize Your Revenue

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