THE LEADING EDGE

SUMMER 2015 ISSUE

THE LEADING EDGE

Welcome!

Welcome to the Summer 2015 edition of the Leading Edge. We have a reprise of the highly anticipated "King vs. Burwell" Supreme Court ruling. Like many, we anticipated that a different outcome would have wide repercussions. Fortunately for many consumers, providers and insurers, that isn't the case.

Our next feature highlights the ACA's "Cadillac Tax." Expect to hear a lot more before the tax goes into effect in 2018.

Since the 2014 adoption of Medicare's home and community based services (HCBS), states have expanded their HCBS programs, particularly for those with behavioral health problems within Medicaid. There are many implications for providers and patients, especially those with disabilities.

Bipartisan legislation recently introduced in the House proposes to eliminate certain federal barriers to care and clarify privacy standards for families and caregivers. It would allow caregivers to be personal representatives for mental health patients and meet HIPAA privacy regulations, especially for information available via electronic health records. It would also extend the EHR incentive program to mental health providers.

A recent HHS proposed rule would apply mental health (MH) and substance use disorder (SUD) parity to coverage offered by Medicaid managed care organizations, CHIP and Medicaid Alternative Benefit Plans. It gives states and plans 18 months to comply with the new standards. Commenters universally feel this timeframe is too short given the complexities associated with implementation.

Our Medicare feature shows how Medicare is, by historical standards, very recent. And issues such as concerns about costs and reimbursement are even more recent.

The next feature summarizes our annual client survey. The punchline: our clients expect results and service. That is really not a surprise. But it does reinforce the relevance of our client promises: More Money, Faster and ClientFirst Service.

With ICD-10 now only 4 months away, in AdvantEdge News we update our ICD-10 implementation plans. And we continue our ICD-9/10 comparisons with "Specific Delays in Development."

A reminder that you can print or email any article as a PDF. Plus the "Download Current Issue" choice at top right downloads the entire newsletter for email or printing.

Please call or email me with comments and suggested topics for the next issue: bgilbert@ahsrcm.com and (908) 279-8120.

Bill Gilbert

Home and Community Based Services – the Future of Healthcare?

In January 2014, the Centers for Medicare & Medicaid Services (CMS) announced the publication of an important final rule about home and community-based services (HCBS) provided through Medicaid's 1915(c) HCBS Waiver program, the 1915(i) HCBS State Plan Option, and 1915(k) Community First Choice. The rule enhances the quality of HCBS, provides additional protections to HCBS program participants, and ensures that individuals receiving services through HCBS programs have full access to the benefits of community living.

Home and community-based services (HCBS) is a specific term for Medicaid's waiver services intended to provide opportunities for beneficiaries to receive support within their home or in the community, allowing states to provide non-institutional and non-clinic-based services. The program will serve consumers who traditionally have received care in institutional settings. HCBS provides treatment for a variety of targeted populations groups, such as people with mental illnesses, behavioral, intellectual or developmental disabilities, and/or physical disabilities.

Medicaid's HCBS regulations seek to enhance the quality of HCBS by expanding personal care, home health, adult day care, respite care, and by providing additional protections to individuals that receive services under these Medicaid authorities. Mobility limitations, brain injury, intellectual disabilities, and developmental disabilities often limit the individual to their home. Through its client focused services, the location of the treatment is determined by looking at the needs of the individual and what best supports the client's treatment plan.

HCBS allows Medicaid to provide health care coverage to individuals with the greatest treatment and support needs as well as provides more tangible treatment options. As Medicaid costs continue to increase, due to expanded coverage and longer life spans, HCBS is quickly gaining favor as it reduces Medicaid costs by providing service to clients outside of the traditional treatment setting, reducing costs for traditional office and institutional needs. Of course, there are concerns that patient (client) needs may not be fully addressed in the HCBS setting.

In a study of 26 states over a period of 7 years (2005-2012), which reviewed the cost effectiveness of HCBS services, AARP Public Policy Institute notes "The studies consistently provide evidence of cost containment and a slower rate of spending growth as states have expanded HCBS." As more states become aware of the cost effectiveness of HCBS, the number of state Medicaid plans expanding HCBS waiver programs grow. Between 2009 and 2011, state and federal spending on Medicaid waiver HCBS for people with intellectual and developmental disabilities increased by 10.7%, from $25.1 billion in 2009 to $27.8 billion in 2011. Medicaid paid $134.1 billion for institutional care or HCBS in 2012. In 2014, CMS released their rule defining settings eligible for Medicaid reimbursement for HCBS. As a result, 41 states implemented HCBS waivers or SPA expansions, and 46 had adopted plans to do so in fiscal year 2015. States are focused on closing state hospitals and moving consumers to the community.

Along with the fiscal benefits, providers, payers and health plans are looking to HCBS as a means of providing accountable and quality care in hand with treatment based, client centered services. New remote monitoring tools (released by CMS this past March) enable those providers

offering transitional, supervisory, and rehabilitation services the ability to continue to support and work with clients following their discharge from a formal facility. These community supports help the client reacclimatize and the treatment progress to be monitored indefinitely, reducing readmissions by transitioning from facility to community and increasing overall success rates.

Currently, there are three different HCBS health home models:[1]

1. The most popular (chosen by 11 states) amongst state Medicaid programs are those which contract directly with providers. These programs certify, pay, and monitor providers of health home services directly.
2. Four states have opted to contract directly with health home providers in addition to contracting with a separate agency that only provides care coordination services, both receiving payment from the state. Care coordinators offer support to provider organizations, provide additional care coordination to enrollees, identify high-risk patients and are expected to support and strengthen the health home network.
3. The remaining health home model, utilized by four states, is a Medicaid program that contracts with lead entities responsible for paying providers and making sure the core health home competencies are achieved. These providers assume many of the state's duties related to health homes and manage the program, health plans, or behavioral health organizations that manage the network of health home providers.

For more information regarding Medicaid's HBCS rules click here.

[1] Mandros, Athena, "Who is Actually Managing Home Health Services?", OpenMinds, March 14, 2015.

Helping Families in Mental Health Crisis

H.R.2646 – Helping Families in Mental Health Crisis Act of 2015

On June 16, the House Energy and Commerce (E&C) Subcommittee on Health heard the mental health bill, H.R. 2646, the Helping Families in Mental Health Crisis Act. The bill aims to fix the nation's broken mental health system by refocusing programs, reforming grants, and removing barriers to care. [1]

The bipartisan legislation proposes the expansion of mental health services, adding a new Health and Human Services (HHS) leadership position to oversee substance use disorders and mental health. It also proposes to eliminate certain federal barriers to care and clarify privacy standards for families and caregivers by allowing caregivers to be personal representatives for mental health patients to meet HIPAA privacy regulations, especially for information available via electronic health records.

The bill would loosen HIPAA regulations if six conditions are met: [2]

- Such disclosure is for information limited to diagnoses, treatment plans, appointment scheduling, medications, and medication-related instructions, but not including any personal psychotherapy notes
- Such disclosure is necessary to protect the health, safety, or welfare of the individual or general public.
- The information to be disclosed will be beneficial to the treatment of the individual if that individual has a co-occurring acute or chronic medical illness.
- The information to be disclosed is necessary for the continuity of treatment of the medical condition or mental illness of the individual.
- The absence of such information or treatment will contribute to a worsening prognosis or an acute medical condition.
- The individual by nature of the severe mental illness has or has had a diminished capacity to fully understand or follow a treatment plan for their medical condition or may become gravely disabled in absence of treatment.

HR 2646 has several objectives, including:

- Improve integration of mental healthcare and physical healthcare in Medicaid,
- Spur early intervention in the treatment of psychosis,
- Improve the use of health information technology in mental health care,
- Provide resources for suicide prevention.
- Improve data collection and outcomes measurement
- Expand the availability of evidence-based services.
- Remove discriminatory barriers to acute inpatient treatment in Medicaid and Medicare
- Advance enforcement of the mental health insurance parity law. [3]

The bill would also extend the EHR incentive program to include mental health providers and would allow primary care and behavioral care programs to work together, benefiting both the provider and patient.

Though the revised version of the mental health bill seems to be gaining support, lawmakers and others still express some concerns with the measure. Funding for the bill must be budget neutral and suggestions have been made to obtain it from government prison funds as persons with behavioral health problems often end up in the criminal justice system. [4] There was also criticism that if the bill allows medical record access to a broad base of health professionals, privacy rights of family members could be violated if they are mentioned in the patient's record.

The next stage of the legislative process is a mark-up in committee where the bill will be further refined. It would then move to the floor of the House for a vote.

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[1] Energy & Commerce Committee, "Health Subcommittee to Examine Landmark Mental Health Legislation Next Week," Committee on Energy and Commerce, June 9, 2015
[2] Snell, Elizabeth, "Proposed Mental Health Bill Accounts for HIPAA Regulations," Health Security, June 08, 2015
[3] Giliberti, Mary, "An Opportunity for Comprehensive Mental Health Reform," NAMI, Jun. 17, 2015
[4] Robeznieks, Andis, "Push to change HIPAA provisions gains ground with dueling House bills," Modern Healthcare, June 17, 2015

Parity Proposal: States and Insurers Seek More Time

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is intended to ensure that patients with insurance benefits for mental health and addiction treatment received coverage on par with what they receive for medical and surgical care. On April 10, 2015, the Department of Health and Human Services published a proposed rule in the Federal Register that would apply mental health (MH) and substance use disorder (SUD) parity to coverage offered by Medicaid managed care organizations (MCOs), the Children's Health Insurance Program (CHIP), and Medicaid Alternative Benefit Plans (ABPs).

In response, during the week of June 8, CMS received 160 letters as the comment period ended. Once the rule is finalized, states and plans will have 18 months to comply with the new standards. Payers and states feel this is an unattainable timeline due to the "administratively complex changes". State officials agreed with this concern due to the amount of time needed to review services, pull patient and claims data, and develop compliance documentation on the individual state level, combined with the need for contract changes with the plans and an amendment process for the state's Medicaid plan as it's currently written on file at the CMS.[3]

MH and SUD services covered by Medicaid differ among state programs. A majority of MH/SUD services are not mandatory under federal Medicaid law. This allows each state flexibility on what MH/SUD services to cover and what treatment limits to place on coverage. States also have flexibility to design delivery mechanisms for MH/SUD services such as fee-for-service arrangements, managed care, or prepaid health plans. A number of states choose to deliver Medicaid services through a combination of structures: providing medical/surgical services through MCOs and delivery of MH/SUD services through a fee-for-service or prepaid health plan arrangement. Though parity does not apply to traditional fee-for-service Medicaid coverage, the proposed rule does clarify parity protections be applied to all beneficiaries enrolled in an MCO for delivery of any services.[1]

In the proposed rule, CMS would give carve-out states two options for bringing their Medicaid programs into compliance. The first would be for the state to amend its plan to ensure that MH/SUD services provided on a fee-for-service basis comply with parity when combined with the medical/surgical services provided by the MCO. The second option would be for the state to include relevant MH/SUD services in the MCO or prepaid health plan contract, in which case the MCO or prepaid health plan would be responsible for complying with parity. CMS explains its intent is to require states that use carve-outs to provide evidence of parity compliance when they submit their MCO contracts to CMS for approval. In managed care states without carve-outs, CMS proposes to require the MCO to undertake the parity analysis and inform the state of any changes needed in the MCO contract. In states with carve-out arrangements, the state would be responsible for conducting the parity analysis across delivery systems to bring MH/SUD coverage into compliance.

The proposed rule also addresses the responsible party for any increased costs associated with parity compliance, with the intention to require that any additional costs be incorporated into the rates paid to MCOs and prepaid health plans that provide MH/SUD services. Building these costs into the capitated rates paid by the state means the Medicaid program would be responsible for the costs of parity compliance, in place of the plan. By the same token, CMS

proposed not to include any increased cost exemption for managed care plans in the Medicaid regulations, noting that bringing Medicaid coverage into compliance with parity may save money, as beneficiaries will be better able to access services for MH/SUD conditions that, when untreated, often contribute to higher healthcare costs. Given the wide range of configurations across states and the potential disruptions such a requirements will have, CMS also proposed to require parity analyses across the overall delivery system and solicited comments on their intended approach.[2]

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[1] Moss, Monica E., "Another Round of Parity – This Time for Medicaid," *Open Minds Daily Executive Briefing*, April 25, 2015
[2] Moss, Monica E., "Will Medicaid Parity Solve Access Issues?" *Open Minds Daily Executive Briefing* , April 28, 2015
[3] Dickson, Virgil, "States and insurers need time, money to cement mental-health parity rules," *Modern Healthcare*, June 12, 2015

Supreme Court Denies Challenge to ACA in King v. Burwell

Insurance premium subsidies provided by the Affordable Care Act ("Obamacare") continue to be available to Americans in all states. The U.S. Supreme Court 6 to 3 ruling on June 25 in King v. Burwell means the premium subsidies remain accessible to healthcare exchange enrollees in all states.

Prior to the ruling, there was great concern about the impact had the ruling gone the other way. 6.4 million people were at risk of losing their subsidies, and many were concerned about the possibility of chaos in the private insurance market. Had the court ruled against the subsidies, many feared a significant impact on individual health insurance consumers, health insurers, health care providers and employers. Depending on transition assumptions, the timing could have been problematic. Key state and federal deadlines for establishing exchanges in 2016 have already passed, and others are quickly approaching. Without a clear pathway for states to quickly set up an exchange, states had few options for quickly establishing an exchange. Plus health insurers are already well down the road in deciding which products to offer and the accompanying fees for 2016.[1]

The ruling sided with the Obama administration and against the plaintiffs who argued that the literal ACA language limited subsidies to only those exchanges established by a state. ACA supporters were concerned that, had this ruling gone the other way, the most popular ACA provision, namely the prohibition against health insurers taking pre-existing conditions into account when setting premiums or scheduling benefits, would have been in jeopardy. ACA supporters insist the two features go hand in hand because the law forces health insurers to accept any applicants without taking pre-existing conditions into consideration and charge everyone the same age (except tobacco users) the same premium.[2]

Leading up to the Court's decision, King vs. Burwell caught the attention of a number of institutions who analyzed the possible impact of the imminent ruling. In a recent report released by the American Academy of Actuaries, it warned that an adverse decisions could lead to pressure on the individual mandate, with the risk of causing a great deal of damage. The report also cautioned that removing the individual mandate altogether could impact the viability of the entire market, resulting in significantly increased premiums for those remaining.

In anticipation of the Court's ruling, some states had already permitted exchange plans to file two sets of rates for 2016, while others had spent months strategizing how to respond to the disruption if the Court had opted to rule against the ACA. [3] Many worried a decision in the opposite direction would lead to a dramatic spike in the nation's uninsured and the disintegration of the healthcare law itself. Avalere's analysis estimated approximately 2.3 million exchange enrollees (37 percent of those enrolled) were uninsured before enrolling in exchange coverage and that these consumers would be unlikely to continue purchasing coverage without access to subsidies.

The three opposing Justices along with others not in favor of the ruling criticized the majority by stating that the law is ambiguous, pointing to a specific part of the law that says subsidies are only available to those who enroll through an "exchange established by the state." The Internal Revenue Service has interpreted this to allow subsidies in all states, but opposing parties in the case disagreed. They feel the court should have employed the Chevron doctrine,

a common policy that says federal agencies must follow the letter of the law where the law is clear and if a law is ambiguous, courts must defer to a government agency's reasonable interpretation of it. The Justices explained that the utilization of the Chevron doctrine would not be appropriate for this case, saying that it would be extremely unlikely that Congress would have delegated the interpretation of the law to the IRS. The federal government argued that the law's purpose is clear, and has been indicated to be so in other parts of the law maintaining that Americans in every state should be allowed the right to be eligible for subsidies. [4]

Leavitt Partners' state-specific fact sheets: 'King v. Burwell State Impact Fact Sheets' have further information about how a ruling in favor of the plaintiffs would have impacted each individual state.

[1] McDermott Will & Emery, "*King v. Burwell*: When Would a Supreme Court Ruling Restricting Affordable Care Act Premium Subsidies Go into Effect?", June 19, 2015
[2] Graham, John, "King v. Burwell: How Important Is Obamacare's Individual Mandate?", Forbes: Healthcare, Fiscal, and Tax, June 6, 2015
[3] June 8, 2015 – Radiology Business Management Association – RBMA Washington Insider – King v. Burwell Update http://www.rbma.org/RBMA_Washington_Insider_2015_06_08/#1
[4] Schencker, Lisa, "BREAKING: Supreme Court upholds subsidies in King v. Burwell", Modern Healthcare, June 25, 2015

The Cadillac Tax: Big Impacts Expected

The "Cadillac Tax" is an excise tax included in the Affordable Care Act (ACA) to slow healthcare spending growth and to help offset the ACA costs. It is scheduled to be in place for 2018 and will tax employers who offer their employees "Cadillac" health insurance plans ($10,200 for an individual and $27,500 for families).

Businesses, especially those with traditional or generous health plans, now have much to consider. The Spring Healthcare Trend Survey from Wells Fargo Insurance analyzed more than 65 insurers nationwide and found that 38 percent of large employers will likely hit the tax threshold in 2018 if they do not make changes to their plan.

Small and mid-size employers with traditional health plans may be less aware of the upcoming tax. This includes many healthcare companies, including physician groups and hospitals. As a result, the "Cadillac Tax" may come as a surprise to some, especially considering the magnitude of the 40 percent tax–which applies to every dollar above the threshold.

In preparation, some employers are opting for high-deductible coverage with an optional health savings account. The most recent survey from the International Foundation of Employee Benefit Plans (IFEBP) shows that due to the Affordable Care Act:

- Nearly 10 percent of the surveyed organizations are putting a full-replacement high-deductible health plan in place.
- 11 percent of those surveyed are considering high-deductible health plans with no savings accounts, while 13 percent plan to use high-deductible health plans with a health reimbursement arrangement (versus an HSA).
- A small percentage (6%) have implemented or expanded the use of low-cost "skinny plans", while 3 percent more plan to do so over the coming year.

Employers providing health insurance to their employees will still be able to write off the cost of offering coverage from their taxes, but under the Cadillac Tax, it is also possible that the open-ended tax breaks employers receive for providing coverage will ultimately inflate healthcare costs. [1]

As more employers opt for high-deductible health plans, there is growing concern about financial stress from patients' inability to afford the deductible costs. More than 1 in 5 organizations have been forced to either increase copayments or coinsurances for primary care, increase participants' share of prescription drug costs, or increase the employees' share of dependent coverage costs. Of the businesses surveyed, increasing the employee portion of dependent coverage cost (13 percent) and increasing copayments or coinsurances for primary care (11 percent) were found to be the most common cost-management plans over the next 12 months. Since many companies will want to avoid the steep excise tax, the financial pressures on patients seem likely to increase. [2]

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[1] Zweig, Dori, "'Cadillac tax' could be latest threat to Affordable Care Act", *Fierce Health Payer*, April 6, 2015
[2] Mrkvicka, Neil et al, "'2015 Employer-Sponsored Health Care: ACA's Impact' Survey Results", *International Foundation of Employee Benefit Plans*, 2015

Medicare Turns 50!

(Logo designed by the HBMA)

On July 30, 2015, Medicare will be 50 years old. And while many in the health care community like to complain about aspects of the program, it has certainly provided millions of seniors and disabled citizens with much needed healthcare.

Although it seems like Medicare has been around forever, its legislation was only introduced in 1965. At that time, only about half of Americans who were 65 years of age or older had any health insurance, and many of their policies did not offer meaningful health care coverage. To add to the problem, seniors were the sickest population making them unattractive to private insurers in the individual health insurance market. They faced medical bills roughly triple those for everyone else.[1]

However, during the 50's and early 60's, seniors were a strong political constituency and demographic trends showed that this population would grow tremendously over time. Their large voting block influenced proposed legislation to provide retired Americans with health insurance that began with President Truman and continued through the Kennedy years. Finally, in 1965, President Lyndon Johnson persuaded Congress to pass a final Medicare bill including hospital coverage (Part A), physician coverage (Part B) and Medicaid, an additional program designed to help the poor with health coverage.

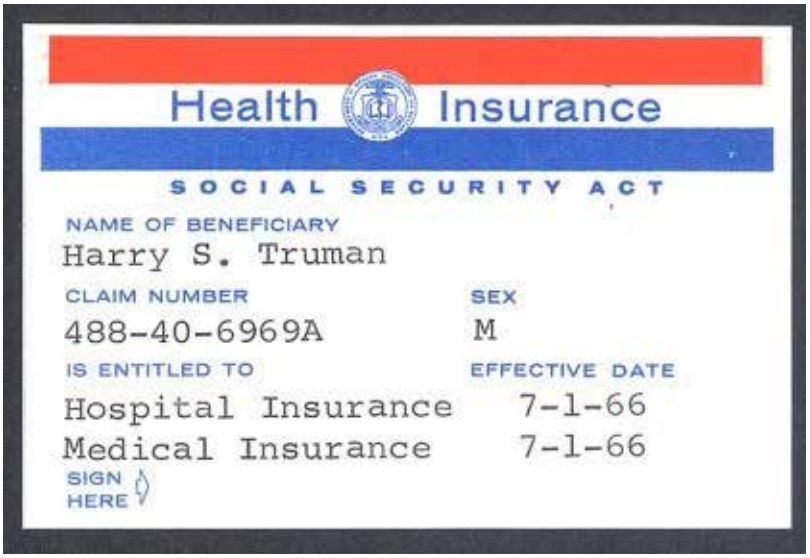
Medicare coverage encouraged the elderly to use medical services. Between 1963 and 1970, the rate of hospital admissions per 100 elderly Americans rose from 18 to 21 annually and the proportion of elderly persons who had contact with a physician each year increased from 68% to 76%.

Over the years, as medical costs grew, so did Medicare expenditures. Spending per Medicare beneficiary increased from $385 in 1970 to $12,210 in 2013. Aggregate spending has grown from 0.7% of the gross domestic product (GDP) in 1970 to 3.5% today.[2]

The following timeline highlights the important legislative steps in Medicare's journey from 1966 through today, all with the objective to improve care and coverage at an affordable cost to Seniors while containing the cost.

The Medicare Journey

The following Medicare Journey timeline draws from the Kaiser and MedPage articles shown in the Resource section below.



The First Medicare Card

July 30, 1965 – *Medicare Signed in to law* – President Lyndon Johnson signs H.R. 6675, establishing Medicare for the elderly and Medicaid for people with low income and limited resources.

July 1, 1966 – *Benefits begins* – More than 19 million Americans aged 65 or older enroll in the Medicare program. At the time, the cost for Medicare Part A deductible was $40 per year and Medicare Part B premium was $3 per month.

October 30, 1972 – *Disability Coverage* – President Richard Nixon signs the Social Security Amendments of 1972, the first major change to Medicare since its inception. Under the legislation, coverage is expanded to people younger than 65 with long-term disabilities and individuals with end-stage renal-disease.

1977 – *HCFA is born* – The Health Care Financing Administration (HCFA) is created to integrate and administer both Medicare and Medicaid and begins to oversee costs.

July 18, 1984 – *Deficit Reduction Act of 1984* – DEFRA froze physician fees, established the "participating physician or supplier" agreement, and established fee schedules for laboratory services

April 7, 1986 – *Review of Reimbursement Policies* –The Physician Payment Review Commission (PPRC) was created as part of the Omnibus Budget Reconciliation Act of 1986. The PPRC's mission was to slow down costs and recommend future reimbursement policies for physicians.

December 19, 1989 – *Omnibus Budget Reconciliation Act of 1989* – Congress replaces reimbursement of reasonable and customary charges with a physician fee schedule derived

from a resource-based relative-value scale (RBRVS). Limits are placed on physician balance billing and physicians are prohibited from referring Medicare patients to clinical laboratories in which they have a financial interest.

1997 – ***The Sustainable Growth Rate and Medicare Advantage*** –The Balanced Budget Act of 1997 created a host of changes to the program. Most notably, it implemented the sustainable growth rate (SGR) formula, which was set to begin in 2003. The SGR was to be a mechanism to reduce fees if Medicare spending on physicians' services exceeded an aggregate target. The Act also created the State Children's Health Insurance Program (SCHIP) and Medicare Part C, now called Medicare Advantage. That program formally gave beneficiaries the option of an HMO-style Medicare plan instead of the fee-for-service program.

1998 – ***Medicare.gov*** – The federal government designed its first website to provide updated information on the Medicare program.

2000 – ***SCHIP expanded*** – The Medicare, Medicaid and SCHIP Benefits Improvement Act of 2000 increased payments to providers and reduced some copayments for beneficiaries.

2001 – ***HCFA becomes CMS*** – The Health Care Financing Administration is renamed to The Center for Medicare and Medicaid Services (CMS).

December 8, 2003 – ***Modernization Act*** – The "Medicare Prescription Drug, Improvement, and Modernization Act" is signed in to law by President George W. Bush. Among the many changes, the MMA made a prescription-drug benefit available, on a voluntary basis and only from private plans, with a premium paid directly to the plan which would go in to effect in 2006.

January 1, 2006 – ***Part D begins*** – Medicare Part D, created as part of the 2003 MMA, goes into effect and Medicare beneficiaries begin receiving subsidized prescription drug coverage. In 2013, a total of 39.1 million Medicare beneficiaries were enrolled in a Medicare prescription-drug plan.

March 23, 2010 – ***the Patient Protection and Affordable Care Act (ACA)*** – President Obama signs the ACA which mandates that Medicare beneficiaries receive certain free preventive care services and health screenings, a free annual wellness exam and also reduces the out-of-pocket expenses of Part D enrollees. It also created the Center for Medicare and Medicaid Innovation, which received $10 billion to develop, assess, and disseminate new payment approaches and other strategies that are designed to improve quality and lower spending for health care services. These innovations include the introduction of their Accountable Care Organizations (ACOs), the Bundled Payments for Care Improvement Initiative, the Comprehensive ESRD Care Initiative, the Community-based Care Transitions Program, and the Comprehensive Primary Care Initiative.

The ACA also implemented a quality-rating system for Medicare Advantage plans to provide higher payments to plans earning higher ratings.

August 2, 2011 – ***Budget Control Act of 2011*** – The law includes provisions to reduce net federal spending by $2.1 trillion over ten years and raise the debt ceiling by up to $2.4 trillion. The law also specifies that if a proposal from the Joint Select Committee on Deficit Reduction is not enacted, a sequester of $1.2 trillion over 10 years would go into effect January 2, 2013, resulting in a

sequestration of up to two percent of Medicare payments to providers and plans.

April 1, 2013 – ***Medicare Sequestration of 2%*** goes into effect

April 1, 2014 – ***Protecting Access to Medicare Act of 2014*** prevents a 24 percent cut to payments for physician services due to SGR formula. Instead, it institutes a 12-month "doc fix" in traditional Medicare, which freezes payment rates through March 31, 2015. This is the 17th law instituting a doc fix since 2003. The Act also extends several otherwise expiring provisions, including the Medicare therapy cap exceptions process and the Qualifying Individual Program.

2015 ***Medicare Costs*** (See the above Qualifying Individual Program)

- ***Part A*** – Beneficiaries usually do not pay a monthly premium for Medicare Part A (Hospital Insurance) coverage if they or their spouse paid Medicare taxes while working. This is sometimes called "premium-free Part A." If a beneficiary must buy Part A, they can pay up to $407 each month.
- ***Part B*** premium is $104.90 per month with a $147 year deductible. For those beneficiaries who make over $85,000 a year, the premium is higher.

April 15, 2015 – ***SGR is repealed*** and replaced with a 0.5% update to the current conversion factor from July 1, 2015 thru December 31, 2015. Providers will then receive an annual 0.5% update through 2019. The 2019 rate will be maintained through 2025 while giving providers the opportunity to receive additional payment adjustments through the new Merit-Based Incentive Payment System (MIPS). In 2026 and beyond, providers participating in APMS (Alternative Payment Models) that meet certain criteria will receive annual updates of .75%, while all other professional will receive annual updates of .25%.

Resources

Kaiser Medicare Timeline

NE Journal of Medicine article part 1

MedPage – Medicare at 50

[1] Blumenthal, M.D., M.P.P., David, et al, "Medicare at 50 – Origins and Evolution," N*ew England Journal of Medicine*, January 29, 2015.
[2] Ibid

Customer Survey Insights

As most readers know, AdvantEdge conducts an annual survey of its clients in the first quarter of each year. Results help AdvantEdge Client Managers, operations and executives focus the company's energy on those items that have the highest value to clients.

In this article, we share insights from this year's survey. One of the first survey questions asks about the importance of different aspects of our service: e.g. meeting frequency, reports, problem resolution, etc. Like previous years but more so, this year's respondents (representing almost one third of AdvantEdge clients) say the top priority isn't one thing, but several. Namely, a combination of payments (meaning cash collected) plus accessibility and responsiveness. In other words: performance and service.

When asked how we are doing on these important factors, the vast majority of clients say "good" or "excellent." Of course, there is always room for improvement and open-ended questions invite suggestions and comments. Along those lines, we heard about ICD-10 (a lot), PQRS, meaningful use, specific ideas for new reports, etc. But mostly we heard nice things about Client Managers. Things like "Our client manager is outstanding", "Our client manager is attentive, thorough, and prompt", and "The best aspect of working with AdvantEdge is the personal contact; having the same people managing and working on our account; having people who are experienced and knowledgeable."

Consistent with those comments, when asked to rate AdvantEdge performance, customers give high marks for responsiveness, including reports and access to information. This matches with the AdvantEdge commitment of full transparency in billing.

While the positive results are gratifying, the AdvantEdge team isn't taking them for granted. We all know that positive ratings only happen when our work is done effectively, day in and day out. Customers make that clear in the survey and AdvantEdge workflows, training and leadership focus on top quality results with responsive service every day.

HIPAA Security Data Breaches – The News is NOT Getting Better!

On May 15th, news reports described a significant data breach by a Business Associate. The investigation focused on one rogue employee from the North Carolina based billing company Medical Management LLC (MML). The result, so far, is forty of the billing company's clients having to notify patients. The clients identified so far have facilities in NY, NJ, PA and IL.

The reports describe a call center employee (since terminated by MML and also arrested) who copied personal information items from the billing system over the past two years and then illegally disclosed that information to a third party. Federal Authorities are involved in the investigation and they notified MML of the activity. The personal information that was accessed and potentially compromised included names, dates of birth and social security numbers. There is no evidence, at this time, that information about medical history or treatment was disclosed.

HIPAA requires covered entities and business associates to "secure all electronic protected health information against accidental or intentional causes of: unauthorized access, theft, loss or destruction, from either internal or external sources." HIPAA security regulations govern electronic records, while HIPAA's privacy rules apply to paper records.

"Theft", "Unauthorized Access" and "Loss" dominate as reasons for breaches, and the latest breach statistics are staggering; from March 2009 through April 2015, **more than 133 million patient records have been affected by 1,199 HITECH Act breaches**, according to a report recently released by the HHS Office for Civil Rights (OCR) https://ocrportal.hhs.gov/ocr/breach/breach_report.jsf

And, according to a study by Kaiser Permanente, recently published in the *Journal of the American Medical Association*, of health record breaches reported between 2010 and 2013, the percentage of breaches attributed to hacking more than doubled during the three-year period, accounting for 12% of incidents in 2010 and 27% in 2013. However, such incidents comprised less than one-third of all large-scale reported breaches. Researchers noted that more than 50% of the breaches resulted from loss or theft of laptops, paper records, and thumb drives[1]

Please note that these statistics are HIPAA related breaches only, they do not include the hundreds of millions affected by online financial breaches at companies such as Target, TJ Maxx, Home Depot, etc.

In addition, many healthcare breaches still go unreported, and many breach offenders don't make the OCR's "wall of shame." Moreover, breaches involving the health records of fewer than 500 individuals do not have to be publicly reported, which also skews the reported numbers.

Why is Healthcare Data Theft Growing?

Security experts say health data is showing up in the black market more and more. Records that contain a social security number or mother's maiden name are used for identity theft. Healthcare companies saw a 72% increase in cyber-attacks from 2013 to 2014, according to

the security firm Symantec. Researchers have also noted that the number of electronic data breaches likely will continue to rise as the use of EHRs quickly expands, along with increased adoption of Cloud-based analytics services, gene sequencing, personal health records, and other health-related technology.

Credit card numbers aren't worth very much to hackers anymore since credit card companies can shut down cards quickly; fifty cents to a dollar may be what a hacker can fetch for one on the black market. Health-related records are currently estimated to be ten to twenty times more valuable because the information can be used, for example, to set up fraudulent Medicare/ Medicaid billing, and bill over and over.

Risk Analysis Inadequacies

Failure to perform and act upon a comprehensive risk analysis is often where companies lapse. Based on the complaints that OCR has received, risk analysis failures top the list for the biggest security issues. By understanding workflow, policies, and procedures, you get a more complete picture of what is actually happening in your environment, and from there you can implement a plan that significantly lowers your risk of breach.

Final Thoughts

Employees will make mistakes, and some may even steal. Hackers will never go away, and cyber criminals do not only target large companies. Here is a short list from Managed Solutions with tips to help you prevent a healthcare data breach.

1. Conduct a Risk Assessment

Stage One of the CMS EHR Meaningful Use incentive program requires that all providers conduct a risk assessment of their IT systems. This is in accordance with the HIPAA Privacy and Security Rules that govern the transmission of all electronic patient information. The risk assessment forces providers to review security policies, identify threats and uncover vulnerabilities within the system.

2. Provide Continued HIPAA Education to Employees

Educate and re-educate employees on current HIPAA rules and regulations. Furthermore, review and share state regulations involving privacy of patient information. If employees are in the know and reminded of the implications of data breaches, risk of violation can be drastically reduced.

3. Monitor Devices and Records

Remind employees to be watchful of electronic devices and/or paper records left unattended. More often than not, data breaches occur due to theft of these items from a home, office or vehicle. While it is "IT's" job to safeguard patient information, employees should be reminded to do their part in keeping data safe as well.

4. Encrypt Data and Hardware

Encryption technology is key when avoiding data breaches. While HIPAA doesn't require data to be encrypted, it also does not consider loss of encrypted data a breach. Therefore, be sure to encrypt patient information both at rest and in motion to avoid potential penalties. Furthermore, protect hardware such as servers, network end points, mobile and medical devices as these items are also vulnerable.

5. Subnet Wireless Networks

Ensure that networks made available for public use do not expose private patient information. One way of achieving this is to create sub-networks dedicated to guest activity and to separate more secure networks for medical devices and applications that transmit and carry sensitive patient information.

6. Manage Identity and Access Stringently

With so many members of the healthcare system frequently accessing patient information – for a multitude of different reasons – it is important to carefully manage the identity of users. For instance, make sure users are only granted access to information pertinent to their position and that log on/off procedures are easy and enforced on shared machines. Automation helps create a "paper trail" and ensures efficiency and safety for all involved.

7. Develop a Strict BYOD Policy

BYOD or Bring Your Own Device policies should be airtight and follow the same strict security guidelines outlined above.

8. Examine Service-Level Agreements Carefully

If you are considering moving patient information and data to the cloud, make sure you understand the Service-Level Agreement (SLA) with your potential Cloud Service Provider (CSP). Specifically, ensure that you, not the CSP own the data and that it can be accessed reliably, securely and, more importantly, timely (in the event of a crash). Also, verify that the SLA complies with HIPAA and state privacy laws.

9. Hold Business Associates Accountable for IT Security Policies

It is imperative to update business associate agreements to reflect evolving federal and state privacy regulations. Healthcare organizations often have hundreds or even thousands of vendors with access to patient data. In the event of a breach, the healthcare provider is ultimately responsible. Therefore, hold BAs accountable for providing security and risk assessments and develop processes for reporting breaches.

10. Establish Good Legal Counsel

In the event of a data breach, your organization will be investigated and most likely fined by the Office for Civil Rights. Lawsuits from patients will also ensue, so be sure to be prepared from a legal standpoint. Compliance is key, so don't be advised to withhold known information about the breach.

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[1] Doyle, Katherine, "Health Data Breaches on the Rise," *Reuters*, April 14, 2015.

AdvantEdge ICD-10 Readiness

With October 1 now only 4 months away, and counting, ICD-10 is looking very real!

AdvantEdge preparation efforts continue so that clients can be assured of a smooth transition. This includes systems, staff training, and much more. One key element directly impacts clients: physician training and preparation. For clients where AdvantEdge does diagnosis coding, provider documentation will need to become more specific. Clients who do their own diagnosis coding need to become familiar with the ICD-10 codes for their specialty.

System Readiness

Since 2011, the AdvantEdge development team has been managing a major project to change applications to process ICD-10 codes—in parallel with ICD-9 codes. We have been ready to initiate testing of ICD-10 codes with payers since 2013. In 2014, AdvantEdge was selected to partner with Emdeon to test ICD-10 processes since our systems were ready to test earlier than most others. Other tests were run in 2014 with payers prepared to do so. In 2015, end-to-end testing is underway with a number of Medicare MACs, commercial payers and clearinghouses.

Coding Readiness

The AdvantEdge coding team has been preparing for ICD-10 for the past two plus years, using the guidelines of the AAPC. Among other items, these guidelines strongly recommend expanded coder training in physiology and anatomy. AdvantEdge coders have completed the required anatomy and physiology education sessions through AHIMA that will be instrumental in the correct coding for ICD-1. In addition, our coders are gaining experience through dual coding of selected cases.

Two AdvantEdge coders are certified AHIMA ICD-10 trainers. They have established a comprehensive ICD-10 curriculum which all AdvantEdge coders are completing. Every AdvantEdge coder is currently certified for ICD-9 and is required to complete training and be recertified for ICD-10.

Client Readiness

The largest impact of ICD-10 may be on AdvantEdge clients and their physicians. This is because of the additional documentation required in order for AdvantEdge coders to assign the correct ICD-10 code. To assist that process, this newsletter has been publishing ICD-9 / ICD-10 comparisons for the past 3 years, including in this issue. Recently, those comparisons were compiled for Radiology, Pathology and Anesthesia. Those cross walk documents have gotten very positive feedback from clients and client managers. In addition, several AdvantEdge whitepapers are available that provide additional details to help with ICD-10 planning. As an example, most hospital-based physicians will need additional information from their referring / ordering physicians in order to have enough detail for an ICD-10 report.

Summary

AdvantEdge Healthcare Solutions is confident that the company and its clients will be ready for the ICD-10 transition on October 1, 2015.

If you have any questions, please contact your AdvantEdge Client Manager.

ICD-9 to ICD-10 Specific Delays in Development

Diagnosis: Specific Delays in Development

ICD-9 Code(s): 315.00 – 315.9

Listed Under: Mental Disorders 290-319 → Neurotic Disorders, Personality Disorders, And Other Nonpsychotic Mental Disorders 300-316

ICD-10 Code(s): F80 – F89

Listed Under: Mental, Behavioral and Neurodevelopmental disorders F01-F99

Diagnoses in shaded areas are titles only and are not billable

DIAGNOSIS	ICD-9	ICD-10	ICD-10 Description
Specific Delays in Development	**315**	**F80**	**Pervasive and specific developmental disorders**
Developmental Reading Disorder, unspecified	315.00	F81.0	Specific reading disorder
Alexia	315.01	R48.0	Dyslexia and alexia
Developmental dyslexia	315.02	F81.0	Specific reading disorder
Other specific developmental learning difficulties	315.09	F81.81	Disorder of written expression
Mathematics disorder	315.1	F81.2	Mathematics Disorder
Other specific developmental learning difficulties	315.2	F81.81	Disorder of written expression
		F81.89	Other developmental disorders of scholastic skills
Expressive language disorder	315.31	F80.1	Expressive language disorder
Mixed receptive-expressive language disorder	315.32	F80.2	Mixed receptive-expressive language disorder
		H93.25	Central auditory processing disorder
Speech & language developmental delay due to hearing loss	315.34	F80.4	Speech & language developmental delay due to hearing loss
Childhood onset fluency disorder	315.35	F80.81	Childhood onset fluency disorder
Other developmental speech or language disorder	315.39	F80.0	Phonological disorder
		F80.89	Other developmental disorder of speech and language
		F80.9	Developmental disorder of speech and language, unspecified
Developmental coordination disorder	315.4	F82	Specific developmental disorder of motor function
Mixed developmental disorder	315.5	F82	Specific developmental disorder of motor function
Other specified delays in development	315.8	F88	Other disorders of psychological development
Unspecified delay in development	315.9	F81.9	Developmental disorders of scholastic skills, unspecified
		F89	Unspecified disorder of psychological development