Protecting Access to Medicare Act of 2014

On March 31, the Senate followed the lead of the House of Representatives and passed the Protecting Access to Medicare Act of 2014, which was signed into law by President Obama on April 1. This represents the seventeenth time a bill has been passed to ‘patch’ the Sustainable Growth Rate for Medicare (SGR), which was originally passed in 1997. Under the SGR, Medicare payments to providers would have been reduced by roughly 24%. This ‘patch’ to the SGR has prevented the cuts to Medicare payments. While the American Medical Association and the American College of Physicians are both opposed to the SGR, they have also opposed this legislation as they have been lobbying for a permanent fix to the SGR. In an effort to gain support from these groups, the House of Representatives added some additional provisions, some key provisions include:

- Delaying the enforcement of the two-midnight rule until June of 2015;
- Delaying implementation of ICD-10 until at least October 2015;
- Amending PPACA to repeal the limitation on deductibles for employer-sponsored health plans¹.

These changes will impact your revenue cycle in several ways. The delay of the two-midnight rule change until 2015, for example, will have a large impact on Recovery Audit Contractor (RAC) review of medical necessity. While the enforcement of two-midnight rule has been delayed several times, providers should take steps now to ensure they are ready for the change and avoid an increase in denials around medical necessity.

Much has been made of the delay of ICD-10, and this may prove to be an opportunity for providers who are not currently on track for the implementation; providing additional time to prepare for the transition. A survey published in December 2013 by a workgroup for Electronic Data Interchange found that roughly 80% of survey participants had not begun testing, and only about half had conducted an impact assessment². Further, the 2013 National Physician Practice ICD-10 Readiness Survey Part Two found that 74% of medical practices had not yet begun implementation, and 22% of respondents had not yet begun to prepare for the change. Only 4% of practices surveyed indicated they had begun end-to-end testing related to ICD-10 implementation³. The majority of healthcare organizations have been focusing on the technology side of the ICD-10 transition, concentrating on planning and implementing all of the required system changes. For those providers, this delay provides an opportunity to give extended training to coding staff and improve clinical documentation processes.

Providers who are on track for the implementation of ICD-10 will be able to get to a much more granular level of detailed documentation around patient care. By keeping in place ICD-10 plans, a provider can

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¹ https://www.govtrack.us/congress/bills/113/hr4302
greatly improve clinical documentation efforts, thereby improving clinical data and information integrity, improving the reliability of quality measures, and being better able to demonstrate meaningful use. Improving the level of detail can also help reduce denials and increase timeliness of claims payments. As reimbursement models begin to move away from fee-for-service payments and towards risk-based reimbursement models, the detail that providers will capture from the ICD-10 transition will become vital. This level of detail will allow a provider to better understand the patient population they encounter and the costs associated with treating that population.

In light of the increased level of detail that will come with ICD-10 transition, providers should use the delay to put in place strategies for mitigating the expected productivity decrease associated with the transition. Some of the key items providers should undertake include enhanced education, a full review of revenue cycle processes, and any possible gaps that exist with existing technology and third-party vendors.

Clinical staff, including physicians, will need to have a clear understanding of the documentation required for the new codes. Coding staff will need to have a more in-depth understanding of anatomy and physiology to ensure that clinical documentation can be coded correctly. In addition, it will be important for administrative staff to understand the codes that will be required for precertification and referrals. Providers should also consider identifying the most-used ICD-9 codes by their organization and train clinical, coding, and administrative staff on how those codes will map to the extended set of codes available in ICD-10.

Providers can also take this time to thoroughly review their denials management processes. By identifying trends in denials prior to the transition, the provider can then work to decrease the number of accounts that require follow up or appeal. Proper denials management prior to the ICD-10 implementation can accelerate cash to the organization and help to offset the expected costs of decreased productivity.

One item that has not been widely discussed is the repeal of out-of-pocket deductible limits for employer-sponsored health plans put in place by the Patient Protection and Affordable Care Act (ACA). Under the ACA, nongrandfathered individual and group plans are prohibited from imposing out-of-pocket cost sharing (including copays, coinsurance, and deductibles, but not plan premiums) for Essential Health Benefits (EHBs) in excess of the threshold that applies to Health Savings Account (HSA) compatible high-deductible health plans. For 2013, these limits were $6,250 for an individual and $12,500 for self plus qualified dependents. Further, plans are prohibited from imposing deductibles in excess of $2,000 for an individual and $4,000 for self plus qualified dependents. Due to the complexity involved in designing plans that fit these criteria and could achieve the mandated actuarial value, the Department of Health and Human Services (HHS) had effectively delayed implementation of this provision by granting waivers. However, under the ACA, those waivers could not be extended beyond 2016.

The repeal of the out-of-pocket cost sharing cap is likely to impact providers’ revenue cycle processes, especially around patient liability estimation and financial counseling. We have seen a rapid shift by employers to greater cost sharing for traditional medical coverage, and a greater number of employers offering ‘consumer-directed’ and defined-contribution plans. A recent survey conducted by the National

Business Group on Health highlighted this shift. Based on the responses of the country’s largest employers, over one-third of employers surveyed (36%) are considering implementing a consumer-directed health plan with either an employee-owned HSA or an employer-owned Health Reimbursement Account (HRA). While the percentage of employers offering these plans has stayed relatively stable, the percentage of employers offering only these plans has been rising. The National Business Group on Health survey found that 22% of respondents would be implementing a consumer-directed plan as the only option for the 2014 plan year, up from 19% the previous year.5

This shift towards greater cost sharing by the employee has resulted in dramatic increases in out-of-pocket costs for patients. As an example, in 2006, only three percent of patients with employer-sponsored health plans faced an annual deductible greater than, or equal to $2,000 (for individual coverage). By 2012, this had grown to fourteen percent. In 2012, the average premium for an employee was just under $16,000, and the employee’s average cost sharing was thirty percent. Therefore, for individual coverage, an average employee will pay around $4,700 for insurance premiums, with an average deductible near $1,500. There is reason to believe that this trend towards rising patient out-of-pocket costs may now accelerate with the repeal of the out-of-pocket caps.

Due to the increasing patient share, it is essential that providers are able to provide estimates as far in advance of a scheduled service as possible, allowing the patient to make payment arrangements, and/or allowing the provider to direct the patient to the appropriate resources.

McKinnis Consulting Services (MCS) recommends providers perform a thorough assessment of their revenue cycle processes to ensure they are ready for these changes. MCS offers providers both operational and technical EHR performance assessments, which can outline gaps in existing processes and technology. MCS’ performance assessment solutions will provide a roadmap for providers to close these gaps and sustainably enhance yield and reduce costs.

For more information about McKinnis’s revenue cycle solutions, please contact info@mckinniscs.com or visit www.mckinniscs.com.

5 https://www.businessgrouphealth.org/pressroom/pressRelease.cfm?ID=214