THE LEADING EDGE

FALL 2015 ISSUE

THE LEADING EDGE

Welcome!

This edition of the Leading Edge starts with a focus on ICD-10. As our ICD-10 Feature describes, October 1 is only the beginning and we won't really know the impacts until later this month and perhaps longer. Plus we continue our series of ICD-9 to ICD-10 comparisons.

There is now an ICD-10 Hotline and ICD-10 Survival Kit on our website. We encourage and invite ICD-10 questions and issues.

In our lead article, we highlight some "Fun Facts" about the ASC industry even though the title may be a misnomer since they highlight the continuing disparity in rates between ASCs and HOPDs.

We also have reminders about proper documentation for anesthesia line placements and procedures.

Our features concentrate on forces changing the insurance and reimbursement landscape, starting with Private Healthcare Exchanges. Employers are increasingly adopting them as a way to offer more choices to employees and retirees while better managing health insurance costs.

High deductible health insurance plans are growing rapidly, both in exchange and employer plans. We explain why even more seem inevitable. Unfortunately, evidence shows that some consumers don't understand these plans. This leads to unpaid deductibles and to patients skipping important needed care because of the cost.

Our last feature describes where ACO's are today. Recent CMS data shows savings, but only for some ACO's. But CMS priority to expand "alternative payment models" has led to more flexible Medicare ACO rules. And private ACO's continue to expand.

You can print any article in this newsletter as a PDF and there is a PDF "button" to download the entire newsletter for email or printing.

We appreciate your feedback and suggestions. Please call or email me with comments and topics: bgilbert@ahsrcm.com and (908) 279-8120.

Bill Gilbert

ASC Industry "Fun Facts"

Adapted from: Rechtoris, Mary, "50 Things to Know about the Ambulatory Surgery Center Industry," *Becker's Hospital Review*, July 22, 2015

1. Each year, physicians perform more than 23 million procedures in ASCs.

2. The 10 most common services ASCs provide are:
   - Cataract surgery w/ IOL insert: 17%
   - Upper GI endoscopy: 7.8%
   - Colonoscopy and biopsy: 6%
   - Diagnostic colonoscopy: 2.6%
   - After cataract laser surgery: 4%
   - Lesion removal colonoscopy: 4.6%
   - Injection spine: lumbar, sacral: 3.2%
   - Infection foramen epidural lumbar, sacral: 3.9%
   - Injection paravertebral: lumbar, sacral, add on: 3.4%
   - Injection paravertebral: lumbar, sacral: 2.4%

3. Of all the ASCs operating in the United States, 20 to 25 % have some ownership by a hospital partner.

4. The number of Medicare-certified ASCs increased at an average annual rate of 1.1 % from 2012 to 2013, with the majority of the new ASCs being for-profit facilities. The growth rate is minimal partly due to higher Medicare payment rates for ambulatory procedures in hospital outpatient departments than in ASCs. From 2012 to 2013, 51 ASC facilities either closed or merged with other centers.

5. The Medicare rates are 82 % higher in hospital outpatient departments than ASCs for 2015. CMS proposes to update OPPS rates by -0.1 %, based on a hospital market basket increase of 2.7 % with a -0.6 % adjustment for multi-factor productivity and a -0.2 % point adjustment requirement by law for the CY 2016 Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System.

6. As a way to enhance patient care provided in ASCs, the Medicare Payment Advisory Commission proposed that CMS implement a value-based purchasing program, rewarding high-performing providers while penalizing low-performing providers no later than 2016. ASCs began submitting data in 2012 under the Quality Reporting Program on four patient safety indicators and one process measure.

7. CMS added nine spine codes to the ASC-payable list effective Jan. 1, 2015. The codes include:
   - 22551 Neck spine fuse & remove bel c2
   - 22554 Neck spine fusion
   - 22612 Lumbar spine fusion
   - 63020 Neck spine disc surgery
   - 63030 Low back disc surgery
   - 63042 Laminotomy single lumbar

- 63045 Removal of spinal lamina
- 63047 Removal of spinal lamina
- 63056 Decompress spinal cord

CPT codes 22551, 22554, 22612 were moved to codes APC 0425, resulting in a higher reimbursement.

8. Bundled payments are an increasing trend for payment in ASCs. Bundled payments are most common among orthopedic procedures and colonoscopy. They aid in cost management while providing more pricing predictability, said Hoag Orthopedic Institute Administrator Gabrielle White.

9. If only half of the eligible surgical procedures moved to ASCs from hospital outpatient departments, Medicare would save $2.5 billion a year.

10. The Centers for Medicare & Medicaid Services released the 2016 proposed payment rule for ASCs and HOPDs on July 1, 2015. ASCs could see an effective update of 1.1 % and HOPDs would see an effective update of 1.9 %. The inflation update factor is substantially different for ASCs and hospitals. While ASCs could have an inflation update factor of 1.7 %, HOPDs could have an inflation update factor of 2.7 % if the proposed rule is finalized as drafted.

11. ASCs must have an inspection conducted by a state official or a representative of an organization authorized by the government to ensure ASCs are meeting regulations. Accreditation bodies for ASCs include the American Association for Accreditation of Ambulatory Surgery Facilities, the Accreditation Association for Ambulatory Health Care, Healthcare Facilities Accreditation Program and the Joint Commission.

Documenting Line Placements and Procedures

Procedural Documentation

- Line placements and other ancillary services may be furnished in conjunction with anesthesia provided to the patient or may be furnished as an independent service.
    - These are professional "surgical" procedures;
    - "Flat Fee" reimbursement;
- Only clinicians employed by your group can bill for these services.
- The 2015 RVG book specifies:
    - "the interpretation of the data obtained from these "invasive" monitoring devices is accounted for in the usual anesthesia fee, their placement is not"

Documentation Criteria

Proper documentation for any procedure performed (e.g., a-lines; CVP; TEE probes, etc.) is crucial for substantiating procedures performed. When documenting ancillary procedures, include the following information:

1. The site of insertion and/or the procedure performed;
2. The technique employed and the equipment utilized (e.g., size, type);
3. The reason the procedure was necessary (symptoms are acceptable);
4. Initials or signature of the person who performed the service; and
5. The time the procedure was performed to distinguish the procedure from pre and post-induction times.

FAQ's

Q: I placed two lines – can I bill them?

A: Yes as long as each placement has a supporting note within the medical record and there are two insertion sites

Q: I placed the CVP and used it to thread the PA catheter, can I bill both?

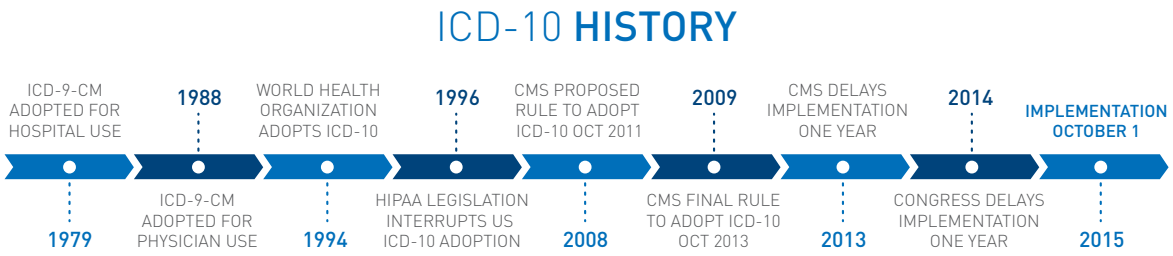
A: No, only the PA catheter is billed as the more inclusive service

Q: I have a patient who needs to be put to sleep because they are too young to hold still, can I still bill the line placement?

A: Yes; Pre-induction and post-induction insertions are both billable.

- Post-induction placements should be supported through medical necessity, age, agitation, trauma etc.

ICD-10 is Here!



Now that October 1 has arrived, we know that ICD-10, after years of delay, is real. But the impacts are only starting. Of course, physicians have updated their documentation, EMRs, superbills, etc. And AdvantEdge, like the rest of the industry, has updated its systems to handle the larger code set.

At this point, we don't really know how prepared payers are to accept the new codes. Testing and payers' statements suggest that most claims should be processed without being rejected. But that doesn't tell us how long it might take. Nor does it tell us whether we might see some new denials or other issues (the good news is that there are no new denial codes, existing CARC and RARC codes will continue be used). The bottom line: the cash flow risk to practices, hospitals and others isn't known yet. We should begin to understand the risk, or lack thereof, later this month.

A GAO report about CMS readiness for ICD-10 also concludes that we won't really know until claims are being processed [1].

It's worth noting that Medicare's decision to not require full ICD-10 specificity is a good transition step (for 12 months) but still requires a valid ICD-10 code (see the explanation at the end of this article). At the same time, Medicare just announced that the Guidance ("flexibilities") applies only to Part B Medicare fee-for-service claims, not to Medicare Advantage claims. **"Medicare Advantage risk adjustment payment and audit criteria remain unchanged."** And the HFMA is reporting that "The CMS clarification came amid indications that few private insurers outside of Medicare Advantage would provide the same post-payment flexibility."

We do know that there are many resources to help with getting the right ICD-10 code onto a claim form. As an example, AdvantEdge has the ICD-10 Hotline and Survival Kit available. CMS and many companies have spent the past months (and years) providing detailed suggestions and assistance.

A big issue for most hospital-based physicians and many other specialists is their dependence on the referring/ordering physician to provide enough detail to choose the ICD-10 code. Hopefully, the planning and communication that has been underway will prevent this from becoming a big issue. But many specialists are cautious until the new information flows are sorted.

The issue, of course, is that it hasn't been practical for physicians and other providers to adopt these changes until quite recently. As a result, most are expecting a drop in productivity. How much of a drop is a big unknown. The same applies to coding work.

The good news is that there are indications that the transition won't be as hard as many feared—as long as preparations have been made. For example, as coders have begun to get familiar with using ICD-10, their productivity has picked up rapidly. This is because no coder or physician has to deal with all 69,000 ICD-10 codes, just like they don't deal with all 14,000 ICD-9 codes. Most deal with a relatively small subset.

Of course, at this point in the first week of October, no one really knows whether the transition will be rocky or smooth. We are about to find out!

ICD-10 Reminders

ICD-10 was effective October 1 for everyone:

- **The good news:** any issues will be identified quickly and many people and organizations will be responding.
- **The bad news:** the cutover may slow payer response times and affect provider or coder productivity during the transition.

CMS and the AMA recently announced a "grace period" of one year – what does that mean?

Basically that claims will not be denied if they are not as specific as ICD-10 codes allow, as long as a valid ICD-10 code is used. Here is some of the CMS and AMA language:

- For 12 months, Medicare **will not deny** physician or other practitioner claims based solely on the specificity of the ICD-10 diagnosis code—as long as the physician / practitioner used a "valid code" from the right "family" of codes."
- Medicare claims with a date of service on or after October 1, 2015, **will be rejected** if they do not contain a valid ICD-10 code.
- "Family of codes" is the same as the ICD-10 three-character category. Codes within a category are clinically related and provide differences in capturing specific information on the type of condition. For instance, category H25 (Age-related cataract) contains a number of specific codes that capture information on the type of cataract as well as information on the eye involved. Examples include: H25.031 (Anterior subcapsular polar age-related cataract, right eye), which has six characters; H25.22 (Age-related cataract, morgagnian type, left eye), which has five characters; and H25.9 (Unspecified age-related cataract), which has four characters. **One must report a valid code and not a category number. In many instances, the code will require more than 3 characters in order to be valid.**

Source: Clarifying Questions and Answers Related to the July 6, 2015 CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities

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[1] "While CMS' actions to update, test and validate its systems, and plan for contingencies can help mitigate risks and minimize impacts of system errors, the extent to which any such errors will affect the agency's ability to properly process claims cannot be determined until CMS's systems begin processing ICD-10 codes" (GAO report, September 2015).

High-Deductible Plans Grow Despite Issues

As more consumers opt for lower annual premiums in exchange for larger out-of-pocket expenses, the popularity of High-Deductible Health Plans (HDHP) is increasing. Many are concerned that consumers don't realize the implications of the tradeoff which means providers often need to remind or educate their patients about their new financial obligation. Nonetheless, the trend toward more HDHP's continues.

Employers and healthcare policy makers hope that consumers using HDHPs will help put market forces back into medicine. Part of the logic is that consumers will shop around for lower prices when they have to write the check. To date, there is some, but limited, evidence of this behavior. At the same time, however, there is also evidence that some consumers put off needed care due to the out-of-pocket costs. Also working against price shopping, some HDHPs have "narrow" provider networks.

But the steady upward creep in health insurance deductibles has easily outpaced the average increase in a worker's wages over the last five years, according to a new analysis released on Sept 22 by the Kaiser Family Foundation. Also, there is evidence that deductibles are now causing consumers to forgo needed care, including for chronic conditions.

In response to HDHPs, more and more providers are posting prices on their websites, in addition to publishing quality-performance and customer-satisfaction survey results to allow consumers to make informed choices about their healthcare.

Consumer Impact

According to the Kaiser Study, 81% of workers who receive their insurance through an employer now pay a deductible. And those deductibles have climbed from a yearly average of $900 in 2010 for an individual plan to above $1,300 this year (8% more than last year), while employees working for small businesses have an even higher average of $1,800 a year. One in five workers has a deductible of $2,000 or more. Of course, many of the policies being sold to individuals on the state exchanges also rely on high deductibles to keep premiums low.

At the same time, and partly (some would argue mainly) because of this trend, total premiums are increasing modestly. The cost of a plan for both a single person and a family rose an average of 4 percent this year, according to Kaiser, well below the double-digit increases that were the norm a decade ago. The average cost of a family plan rose to $17,545, with employees paying an average of $5,000 toward their premiums.

But as wages have stagnated, the steady increase in deductibles is squeezing many on HDHPs, with workers feeling increasingly vulnerable to high medical bills. The National Center for Health Statistics reports that, in 2014, 36.9 percent of people under age 65 with private health insurance were enrolled in an HDHP. And the percentage is higher in 2015.

What concerns policy experts and employers is evidence that higher deductibles are making people forgo care, even when they have serious conditions. "It may be tamping down on unnecessary care, but we're seeing a lot of evidence of skimping on necessary care," said Sara

R. Collins, vice president for health care coverage and access at the Commonwealth Fund, a nonprofit group that conducted a survey last fall about the effect of out-of-pocket health care costs on consumers.

Forty percent of people with private health insurance whose deductible equaled 5 percent or more of their income said they had decided not to go to the doctor when they were sick or had chosen not to get a test or go to a specialist, according to the survey.

A recent analysis by Truven Health Analytics of employers' insurance claims showed that companies saw lower utilization, with fewer of their workers going to the doctor or getting lab tests, when workers had a high-deductible plan. But they also saw a decline in care for people with chronic conditions. In some cases, even when preventive care was covered under a high-deductible plan, workers were getting fewer mammograms and cervical cancer screenings. [1]

Employer Incentive

High-deductible plans are on the rise as the option of choice for both employees and employers. In its 2015 Health and Well-being Touchstone Survey, PricewaterhouseCoopers reported that 83% of employers offered a high deductible plan in 2014, rising from 67% in 2014. One-third of employers reported that the high-deductible plan was their most popular.

"There's clearly an incentive on the part of employers to offer these," stated Maribeth Shannon, Program Director at the California Healthcare Foundation in a Dallas Morning News article. "Some of it's financial. Some of it's philosophical. There are a lot of employers who feel employees should have a little skin in the game, a little more responsibility for the healthcare costs they consume."

In addition, the ACA's so-called "Cadillac Tax" on high-value health plans could further fuel the growth of high-deductible plans. But the tax and its implications have been met with decidedly mixed reviews, including proposed legislation to eliminate or reduce the tax. Beginning in 2018, current ACA provisions require employers offering benefit-rich health plans that exceed annual limits to pay a 40% excise tax (over $10,200 for individual coverage and $27,500 for family coverage). The goal of this tax is to help fund the ACA and slow the growth of healthcare costs. However, many employers have begun looking into ways to avoid the tax by scaling back their offerings or increasing deductibles and co-pays.[2]

Over the past two years, several large companies, including J.P. Morgan, Wells Fargo, General Electric and Honeywell, began offering consumer-driven HDHP plans as the only option. Bank of America employees earning more than $100,000 have no choice but to select a consumer-directed high-deductible plan, according to a recent *New York Times* article.

Mercer's 2014 national survey of employer-sponsored health plans, found employers' average cost for a high-deductible plan paired with a tax-advantaged health savings account to be 18% less than a Preferred Provider Organization (PPO). On average, HDHPs cost employers 20% less than a Health Maintenance Organization (HMO). The average cost of HDHPs was $8,789 per employee, compared to $10,664 for PPOs and $11,052 for HMOs.

"While new plan implementations are driving up consumer-directed high-deductible plan

enrollment, we are also seeing growth in enrollment in existing plans as employees become more comfortable with consumerism and employers provide them with tools to help manage the higher deductible," stated Beth Umland, Mercer's Director of Research for Health and Benefits, in a statement that accompanied the announcement of the survey results.

Health Plan Consumerism

Supporters of the shift away from traditional insurance plans acknowledge that "consumerism" in healthcare faces challenges, ranging from decreasing competition in medicine as hospitals and insurers merge, to the potential that high-deductible health plan consumers will forgo needed care due to their out-of-pocket costs.

Currently, patients directly pay 11% of the $3 trillion spent annually on healthcare. As reported in the Wall Street Journal, that is equal to $330 billion, which is more than Americans spend annually on anything other than shelter, food or transportation.

Consumers with high-deductible plans typically pay most of their healthcare costs out-of-pocket until annual deductibles are met. The assumption is that they are more likely to "shop around" and compare prices for office visits, procedures, lab testing and other healthcare services. It comes as no surprise that "When you talk to consumers, they tend to gravitate to the plan with the lowest premium," as stated in a USA Today article by Douglas Ghertner, President of Change Healthcare, a company focused on helping consumers shop for healthcare services. Where consumers have a choice, it is clear that lower monthly premium cost is the main appeal for high-deductible consumer-directed health plans.

It is common to find high-deductible health plans paired with health-savings accounts (HSAs) which allow employees to use pre-tax dollars to pay for medical expenses. (An individual is only eligible for an HSA if their HDHP has single deductibles over $1300 or family deductible over $2600). Of course, annual deductibles of $2,500 or more for an individual employee and $5,000 or more are now common for a plan with in-network doctors and hospitals. Tracy Watts, Mercer's National Leader for Health Care Reform has stated "It's a major shift from the old 'first-dollar coverage' mentality. These tools put the consumers in the driver's seat, giving them the ability to make smart financial decisions about their healthcare spending."

To help employees cope with HDHPs, employers should ensure families with the plans contribute to health-savings accounts. They should also encourage employees to be receptive to trends that increase competition, such as telemedicine, expert second opinions and medical tourism, suggests David Goldhill, President and CEO of Game Show Network, and Paul Howard, Ph.D., Manhattan Institute Senior Fellow and Director of the Manhattan Institute's Center for Medical Progress. "The rise of high-deductible plans also requires a shift in states' priorities. Liberating information on the cost and outcomes of various medical services becomes key. So does reforming laws that restrict nurses' scope of practice, limit corporate practice of medicine, or require certificates of need. Paring back these anticompetitive regulations would encourage capital to flow toward nimble startups challenging overpriced, entrenched providers."

Hospital Impact

Financial risk for hospitals has also begun to shift as patients assume more out-of-pocket responsibility, according to a new report from Crowe Horwath LLP.[3]

For the report, 444 hospitals' transactions were analyzed through June of this year. Since ACA health insurance exchanges opened to extend coverage to millions of previously uninsured Americans in 2013, provider revenue sources have transitioned to more dependable payer reimbursements as the number of uninsured self-pay patients' falls.

According to the analysis, accounts receivable (AR) from insured self-pay patients rose 13% in the last year. They saw a 22% decrease in uninsured self-pay patients over the same period, largely due to the previously uninsured enrolling in Medicaid in states that expanded their programs under ACA. Insured self-pay dollars overshadowed uninsured self-pay dollars 22 to 1 in the first quarter of 2015. But according to the analysis, the fact that average collection amounts for insured self-pay patients are also up slightly between the first quarter of last year and the first quarter of 2015 is even better news. This is because payments from insured self-payers have a much bigger impact on providers' bottom lines than uninsured payments (the 22 to 1 factor).

The Crowe Horwath report warns, "While the uninsured self-pay patient population appears to be performing better from an AR perspective, the expanding insured self-pay patient volume and AR highlights the need for providers to focus on this area of growing financial risk." Providers are encouraged to develop plans aimed at improving the process for collections from patients with more financial responsibility. As an example, for payment plan options for patients who cannot pay the entirety of their initial balances, providers can track self-pay patient collections and use other approaches such as using plan-specific charity care data when negotiating payer contracts and developing policies that provide payment options for patients who cannot pay the entirety of their initial balances.[4]

As powerful economic forces continue to lead more consumers into high-deductible plans and patients seek how to best spend their healthcare dollars; practices, providers, agencies, and hospitals continue to improve their patient (self-pay) collection processes.

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[1] Abelson, Reed, "Health Insurance Deductibles Outpacing Wage Increases, Study Finds," *New York Times*, September 22, 2015
[2] Downing-Peck, Andrea, "Clinical Pathology Laboratories Stand to Benefit as Patients Gain Control Over Their Healthcare Spending Through High-Deductible Health Plans," *Dark Daily*, August 21 2015
[3] Budryk, Zack, "Increased Coverage Significantly Shifts Hospitals' Financial Risk," *FierceHealthPayer*, September 11, 2015
[4] Budryk, Zack, "Increased coverage significantly shifts hospitals' financial risk," FierceHealthPayer, September 11, 2015

More Employers Choose Private Insurance Exchanges

Building on policy and economic imperatives to contain the growth of healthcare costs, employers and health insurance companies are expanding their use of private health exchanges.

The Affordable Care Act created the concept of a public "insurance exchange" as a new way for individuals and small businesses to buy health insurance. The primary objective is to keep premiums reasonable through competition among insurers and to allow consumers the opportunity to find a health plan that fits their individual needs.

Private exchanges take this idea and extend it to employers. So a private exchange is an online health insurance marketplace for a company's employee base. The difference between an exchange and traditional health insurance is that employees choose from a variety of insurers and plans; unlike traditional plans from one insurer. The mechanics are that employers provide their workers a defined contribution toward the premiums. Employee choices are broader and often include vision and dental options from several participating insurance companies.

Aon PLC (traditionally a provider of insurance and reinsurance brokerage, human resources solutions and HR outsourcing services) now runs private exchanges for corporations. Aon has noted a significant increase in employer interest saying that more employers have approached them about private exchange quotes to see how much money they can save, and more insurance carriers want to be on Aon's private platform. (The impending "Cadillac Tax" is an additional incentive for employers; see our Second Quarter issue for more details). Other HR consulting companies, including Mercer, Towers Watson and Buck Consultants, operate private exchanges, as do some insurers.

The consulting firm Accenture reports that nearly 6 million workers selected health plans through private exchanges for 2015, doubling the number from 2014. Though this is a small portion of the employed market, Accenture predicts 40 million of the approximately 150 million people with employer health insurance will be choosing their plans through private exchanges by 2018. In 2015, Hallmark Cards sought predictability in its healthcare costs and a less complex role in offering health benefits and moved 6,100 full-time, active employees to Aon's fully insured private exchange.[1]

One of the biggest employers to jump into a private exchange, drugstore operator Walgreens Boots Alliance, has used Aon's private exchange for two years now. Of the 200,000 eligible Walgreens employees, nearly three-quarters have chosen a bronze or silver plan, with United-Healthcare enrolling the most members this year. 39% of Walgreens employees making less than $25,000 per year chose a bronze plan, while only 21% of workers with annual salaries above $100,000 picked a bronze plan. Not surprisingly, the price of health plans is a dominant consideration for lower-wage workers.[1]

The growth in private exchanges is not limited to active employees: companies are looking at private exchanges for their retirees, in addition to current staff. The BCBS Association is building an exchange for all of its affiliate plans with the goal of enrolling retired workers in Medicare Advantage, supplemental Medigap policies or Part D prescription drug plans. In 2014, AT&T moved its Medicare-eligible retirees to a private exchange run by Aon.

At the same time, private exchanges remain far from common. Numerous studies and surveys have shown that consumers and employees place more value in their doctors and provider networks than the actual number of coverage choices they have. Companies worry that private exchanges indirectly encourage plans where employees shoulder more out-of-pocket costs and some employers are reluctant to shift their workers into fixed-dollar benefit structures.

Despite this apprehension, those employers who have adopted private exchange plans are noticing a change in engagement amongst employees. In the past, employees would often spend a couple of minutes browsing over their health plan options, or in some cases, ignore the process entirely. The private exchanges have spurred employees to take the annual enrollment period more seriously and to be much more aware of their care options.

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[1] Herman, Bob, "Employers Warming Up To Private Insurance Exchanges," *Modern Healthcare*, July 24, 2015

ACO Quality & Financial Results Emerge

Accountable care organizations now cover approximately 23 million lives, according to Leavitt Partners. As ACOs expand there have been growing pains: Recent CMS data shows just one in four ACOs qualified for shared savings in 2014, 27 Medicare Shared Savings Program ACOs discreetly left the program and Pioneer ACOs have dwindled to 19.

Yet interest in ACOs and value-based care persists. In January, an additional 89 MSSP ACOs joined the ranks and 20 major health systems, payers and other stakeholders pledged to convert 75 percent of their business to value-based arrangements by 2020. In March, CMS launched its newest pilot, the Next Generation ACO. The estimated number of ACOs in public and private programs tops 740, according to Leavitt Partners, and if trends continue, ACOs have the potential to cover at least 75 million lives. [1]

In June, CMS released a final rule modifying the Medicare Shared Savings Program (MSSP), impacting the 330 ACOS in 47 states which currently serve 4.9 million Medicare beneficiaries.

Then in August, CMS released the 2014 results for 353 ACOs showing they generated net savings of $411 million in 2014 and improved in most quality measures, although many of ACOs did not generate enough savings to receive bonuses. Kaiser reported that 196 ACOs saved money last year, while 157 cost more than expected. But Kaiser believes the CMS results show the ACO program performing better than it actually is, calculating that the program showed a net loss of $3 million in 2014, vs. the $411 million in savings reported by CMS.

A recent study in the JAMA Internal Medicine by Harvard researchers found that CMS' Pioneer accountable care organizations are reducing the number of services they provide to patients that have minimal clinical benefit, suggesting that the program is having its intended impact.

The Final Rule

The final rule seeks to resolve several issues identified in the proposed rule and it updates payment policies, payment rates, and quality provisions for services furnished on or after January 1, 2016. HHS Secretary Sylvia Mathews Burwell's longer-term vision to move away from FFS put CMS in a position where it needed to retain most of the current MSSP participants and attract new providers. This meant it had no choice but to agree to the most substantive changes requested by provider organizations.

On December 1, 2014, CMS issued a proposed rule that was met with many critical responses on key provisions. Most notably the National Association of ACOs (NAACOS) and the American Hospital Association (AHA) said ACO participation should be more financially rewarding and flexible. The rule allowed MSSP ACOs operating under the lowest-risk Track 1, which involves a one-sided (upside-only) participation agreement, to enter into a similar three-year agreement in the same track if they satisfied the quality criteria and did not generate losses greater than the negative minimum savings rate in at least one of their first two performance years. Although the final rule removed the requirement that ACOs entering the program under Track 1 transition to Track 2 after one agreement period, it did specify that ACOs may operate under the one-sided model for no more than two agreement periods-clearly emphasizing that the

two-sided model is the future of the program.

Almost immediately after the proposed rule was published, NAACOS contended that prospective assignment of beneficiaries should be used in Track 1 instead of only in the two-sided higher-risk, higher-reward Track 3 (also created within the proposed rule).

Opponents of the proposed rule warned that the proposed sharing of cost savings could adversely affect program participation by creating a disincentive for ACOs to continue in the program and discouraging other providers from forming ACOs. CMS responded in the final rule by increasing the upper limit of the sharing rate during the second one-sided agreement to 50%, consequently maintaining the limit of the first performance period. In addition CMS asserted again that the established methodology (preliminary prospective assignment with retrospective reconciliation) works effectively, and thus declined to implement prospective assignment in Track 1.

CMS has complied with most of the major changes requested by provider organizations and conveyed a message of flexibility. In doing so, it has avoided a departure of current ACOs with CMS estimating that at least 90% of eligible MSSP ACOs will renew their participation and that new providers will join the program so that the longer-term vision of "accountable care" can be realized. In support of the ACO concept, on January 26, U.S. Department of Health and Human Services (HHS) Secretary Sylvia Mathews Burwell announced plans to aggressively increase the share of Medicare spending under accountable care and other alternative payment models through 2018.[2]

2014 ACO Results

CMS released the 2014 results for 353 ACOs on August 25th showing that 20 Pioneer and 333 Medicare Shared Savings Program ACO's generated net savings of $411 million in 2014 and improved in most quality measures. Some of the more intriguing points of the results:

- 97 ACOs earned bonuses totaling $422 million out of $833 million in savings they produced. For ACOs in their first year, organizations must report quality scores but do not have to meet performance targets. Savings are awarded under formulas that account for performance on quality targets after the first year in the program.[3]
- 15 of the 20 participating Pioneer ACOs generated a total of $120 million in savings in 2014, their third performance year. This is up 24% from the second performance year when they generated $96 million in savings. Of those that generated savings, 11 earned shared savings payments of $82 million. A particularly strong improvement was seen in medication reconciliation (70% to 84%), screening for clinical depression and follow-up plan (50% to 60%) and qualification for an electronic health record incentive payment (77% to 86%).
- Five Pioneer ACOs generated losses and three owed CMS shared losses of $9 million.
- The mean quality score among Pioneer ACOs increased to 87.2% in performance year three from 85.2% in performance year two, which was itself an improvement from 71.8% in performance year one. They improved an average of 3.6% compared to performance in year two over 28 of the 33 quality measures and showed significant improvement in medication reconciliation, clinical depression screening and follow-ups, and EHR incentive payment qualification.[4]
- The average performance score for patient and caregiver experience increased in five of seven measures compared to the prior year.
- The pool of beneficiaries attributed to a Pioneer ACO grew 2% over 2013 to 622,265.

- Of 333 MSSP ACOs, 97 saved a total of $806 million and earned $347 million in shared savings for 2014, up from $315 million in shared savings in 2013. 89 other MSSP ACOs reduced costs, but did not meet the minimum threshold to share in savings.
- The results indicate ACOs improve over time: among ACOs that entered the program in 2012, 37% generated shared savings, compared to 27% of those that entered in 2013, and 19% of those that entered in 2014.
- 92 ACOs in the Medicare Shared Savings Program earned bonuses, but six did not receive payouts because they did not meet the quality requirements. Quality improved on 27 of 33 quality measures for those ACOs with more than one year of performance results.
- Total savings per ACO increased from $2.7 million per ACO in performance year one to $4.2 million per ACO in performance year two to $6.0 million per ACO in performance year three.
- No Track 2 MSSP ACOs owed CMS losses. Total net savings to the Medicare Trust Funds was $465 million, an increase from 2013.

Acting CMS Administrator Andy Slavitt said in a news release, "These results show that accountable care organizations as a group are on the path towards transforming how care is provided. Many of these ACOs are demonstrating that they can deliver a higher level of coordinated care that leads to healthier people and smarter spending."

Another reason is the limited financial incentives of Medicare ACOs, she said. Few stand to lose money if they fail to achieve savings, known as "downside risk". Pioneer ACOs are at risk for losses, but Medicare's Shared Savings Program made the potential for losses voluntary. Those that agreed also receive larger potential payouts.

Some states have also embraced the ACO approach for Medicaid. According to a blog post in the journal *Health Affairs*, New Jersey has certified three of six applicants for its Medicaid ACO Demonstration Project and insurers may well benefit by following the three community coalitions during the three-year demonstration project. The community-based ACO approach offers an "exciting new model for providing care to Medicaid recipients," Joan Randall, chief operating officer of The Nicholson Foundation, wrote in the blog. This is due to the requirement for ACOs to serve a specific geographical region that they define that includes at least 5,000 Medicaid members. The ACOs also must include all hospitals within the specified area in addition to 75% of Medicaid primary care providers and four or more qualified behavioral health providers.[5]

In a statement, Charlotte based Premier Inc. vice president of population health management Joe Damore said, "We believe ACOs hold great promise and are particularly pleased that more than 45% of the MSSP and Pioneer ACOs participating in Premier's population health management collaborative, one of the largest ACO collaboratives in the country, qualified for shared savings payments. Critical to their success, collaborative members focus on 10 key strategies to operate a highly-successful population health management entity, including benchmarking performance with peers, population health data management, leveraging a gap assessment tool and sharing best practices."[6]

CMS expects the number of beneficiaries served by ACOs to continue to grow. Since its introduction, the number of Medicare beneficiaries served by ACOs has consistently grown from year to year, and early indications suggest the number will continue to increase throughout next year.

Kaiser Report

Almost half of all Medicare accountable care organizations are costing the government more than originally estimated, according to a new report from *Kaiser Health News*.

The report says CMS believes the ACO program is performing better than it actually is due to using historical benchmarks and an alternative method for calculating savings.

After paying bonuses to 97 ACOs that reported savings last year, the Medicare ACO program recorded a net loss of $3 million, *Kaiser* reported.

That loss could be attributed to the low number of ACOs accepting financial risk. *Kaiser* found only 7% of ACOs last year accepted a financial risk deal, where they would be eligible to earn larger bonuses but would also have to pay CMS if their patients cost more than estimated.

Reluctance by ACOs to accept financial risk has been so prevalent that CMS has allowed the groups six years to participate without penalties, instead of phasing out the no-risk option. CMS has also introduced incentives over the past year for ACOs members to assume greater risk, and potentially reap greater awards. [7]

JAMA Internal Medicine

Researchers at Harvard Medical School looked at 31 healthcare services that were deemed of little clinical benefit, such as certain cancer screenings and certain preoperative, imaging and cardiovascular tests.

They measured service count and spending per 100 Medicare beneficiaries before the Pioneer program began, from 2009 to 2011, and in the first year of the program, which started in 2012. Pioneer ACOs in their first year performed 1.9% fewer low-value services, or 0.8 fewer services per 100 beneficiaries. They also reduced spending on those services by 4.5%.

Those organizations that had been performing the largest number of low-value services prior to 2012 saw the largest reduction, or a decline of 1.2 services per 100 beneficiaries.

"Despite the limitations of the study, our findings … are consistent with the conclusion that the overall value of healthcare provided by Pioneer ACOs improved after their participation in an alternative payment model," the authors wrote. [8]

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[1] "100 Accountable Care Organizations to Know: 2015," *Beckers Hospital Review*, September 23, 2015
[2] Perez, Ken, "New MSSP ACO rule: Practicing the Art of the Possible," *HFMA, August* 01, 2015
[3] Evans, Melanie, "Few Medicare ACOs earned bonuses in 2014," Modern Healthcare, August 25, 2015
[4] Rappleye, Emily, "CMS releases 2014 Medicare ACO quality, financial results: 10 things to know," *Becker's Hospital Review*, August 25, 2015
[5] Overland, Dina, "Why insurers should be watching New Jersey ACOs," *FierceHealthPayer*, August 25, 2015
[6] Leventhal, Rajiv, "Medicare ACOs Produce $411M in Savings in 2014, Many Fall Short of Bonuses," *Healthcare-Informatics*, August 26, 2015
[7] Mongan, Emily, "45% of ACO's Cost More than Estimated," *McKnights*, Sept 16, 2015
[8] Kutscher, Beth, "Pioneer ACOs perform fewer low-benefit services," *Modern Healthcare*, Sept 21, 2015

Locum Tenens: Rules and FAQs

The AdvantEdge Compliance Office would like to remind everyone of the Medicare guidelines when contracting with a temporary substitute physician, commonly known as a 'locum tenens'. The FAQ's below are from several CMS MAC's and answer questions commonly posed by physicians and administrators.

The Basics:

A physician may hire a substitute physician to take over his/her practice when they are absent for reasons such as illness, pregnancy, vacation or continuing medical education. The substitute physician, known as a 'locum tenens', generally does not have their own practice and many move from area to area as needed.

- The regular physician generally pays the substitute physician a fixed per diem amount.
- The substitute physician's status is that of independent contractor, rather than employee, and his/her services are not restricted to the contracting physician's office.
- Services of non-physician practitioners (e.g., CRNAs, NPs and PAs) may not be billed under the Locum Tenens or Reciprocal Billing reassignment exceptions. Locum provisions apply only to physicians.
- The 'regular' physician cannot be submitting claims (providing services in another facility) while a locum tenens is 'standing in' for the regular physician. The regular physician is presumed (required) to be 'unavailable'. The regular physician, who is away, cannot be practicing somewhere else while having a locum covering for him/her at their primary location.

FAQ's

1. The Medical Group has a signed contract and has HIRED a new physician to replace one who has left. Can the newly HIRED physician act as a locum for a physician who recently left, while the group awaits enrollment for the new hire?
    - No, a locum tenens is NOT an employee; rather, their status must be that of an independent contractor.

2. Our practice is in the process of enrolling Dr. X. While awaiting the credentialing process, can we use Dr. X as a locum tenens for a physician who is on vacation?
    - No, in such a case, the locum tenens concept is not applicable. Locum tenens is only appropriate for absent physicians who retain a substitute physician for no longer than 60 continuous calendar days.

3. How can a group that loses a physician use locum tenens while recruiting a new physician?
    - The group can contract with a locum tenens physician and pay him/her a fixed amount per diem. The payment to the contracted physician is considered to be paid by the regular physician (the group pays the locum tenens physician on behalf of the regular physician.) [1] The group may bill for the contracted physician for up to 60 continuous days. The claim contains a modifier Q6. The claim must contain both the group NPI and the regular physician NPI. The group must keep on file a record of each service provided by the substitute physician and make this record available to any MAC upon request.

4. If a physician terminates and leaves our group and we contract with a locum tenens physician, what are the guidelines for this situation? When do we have to notify Medicare of the change?
    - If a physician terminates and leaves your group, a contracted locum tenens physician can see the exited physician's patients for up to a 60-day continuous period, beginning with the first day the locum physician sees one of the exited physician's patients.
        - **IMPORTANT NOTE:** CMS requires that providers report certain "reportable events" within specific timeframes. You must report a change of ownership or control, including any revocation or suspension of a Federal or State license within 30 days of a reportable event. Also, the group has up to 90 days to notify Provider Enrollment that the physician left the group. To learn more, refer to the CMS Provider Enrollment Fact Sheet titled "The Basics of Medicare Enrollment for Physicians and Other Part B Suppliers."

5. In replacing a physician who has left the practice, is there a requirement that the locum start within a certain time period from the departure date of the regular physician?
    - No, but the eligibility period for the locum tenens physician substitution may be affected because the practice is required to notify Provider Enrollment of the change in practice status (physician left practice) within 90 days.

6. Our regular physician has been terminated from the group due to suspected illegal activities which will most likely affect his medical license in the near future. Should I contract with a locum tenens to provide services while we search for a new provider?
    - If the groups 'regular' physician is not in good standing, it is not advisable to use the exited NPI's number to continue to bill for services provided by a locum. These services will most likely come into question, with possible future retraction of payment.

7. Our regular physician will need to be absent for an extended period of time. Can we arrange for the same locum tenens physician to see the regular physician's patients during the extended absence?
    - The period for which a single locum tenens physician may substitute cannot be more than 60 continuous days. The 60-day period begins the first day the locum tenens physician provides services for Medicare patients of the regular physician. An exception to this 60-day rule is for regular physicians who are called to active duty in the armed forces. In that case, the time is unlimited.

8. Our organization operates multiple sites throughout the state and often employs locum tenens to fill in for regular physicians. Can we bill for the locum tenens under another provider's NPI number if that provider is not located (regularly scheduled) at the site where the locum tenens is practicing?
    - No, the regular physician must be temporarily unavailable. Because there is no "regular physician" who is temporarily unavailable, the situation would not permit billing under the locum tenens rule. Moreover, a physician who does not work at the site in question could not be considered the regular physician in the context of the locums rule because that physician is not "unavailable" for one of the permissible reasons.

9. Can a locum tenens physician see new patients?
    - Yes, as long as the patient requested or was seeking services from the regular physician.

10. Does locum tenens apply to a deceased provider?
    - No, Medicare only permits payment for services furnished prior to a physician's death. When a physician becomes deceased, his/her billing number, NPI and enrollment are deactivated and cannot be used after the date the physician passes away. Therefore, a locum tenens arrangement would not be permitted.

11. Is the 60-day period cumulative or consecutive?
    - The 60-day continuous day period begins the first day the locum tenens physician provides services for Medicare patients of the regular physician. This period continues for up to 60 calendar days, with no breaks, even if the locum tenens does not see patients on some of those days. In situations where the regular physician is going to be absent for more than 60 days, an alternative plan for physician coverage and patient care should be created. An exception to the 60-day continuous rule is for regular physicians who are called to active duty in the armed forces. This time is unlimited.

12. Our physician will be out for 60 continuous calendar days, beginning June 1st. Will Medicare allow two different locum tenens physicians to substitute for the same regular physician?
    - A regular physician may use more than one locum tenens to substitute for his/her absence during the same 60-day period; however, the substitutes cannot act on the same day. Assuming that each locum tenens physician is providing services within his/her respective 60-day continuous period, locum tenens physician Dr. A can provide services, for example, on Monday, Wednesday, and Fridays, and locum tenens Dr. B can provide services on Tuesday, and Thursday, but Dr. A and Dr. B cannot be scheduled as the substitute for the regular physician on the same day.

13. Does the locum physician have to be of the same specialty as the physician who is absent?
    - No.

14. Our practice has a high volume and our physicians are unable to see all of the patients. Can we use a locum physician and bill under the provider who is out for the day if it is their regular day off?
    - No, in such a case, the physician is a regularly scheduled physician and the locum tenens concept is not applicable.

15. We had two providers leave our specialty group. We are using two locums to cover as we recruit replacements. Can we assign a locum to an absent provider and always bill their services under this provider, or do we have to bill the provider that was 'requested'? In some cases, they are new patients.
    - A locum tenens physician is the substitute for a physician who is absent. Once entered into, the locum tenens physician should not substitute for a different absent physician. It is the expectation that the locum tenens will see only those patients that requested the regular physician for which the locum is substituting. This would include a new patient.

16. If a practice wants to "try out" a doctor they are considering hiring, can the practice bill under locum tenens?
    - No, this does not meet the CMS definition for locum tenens.

17. If a practice just "needs help" to get through a busy period, i.e. a doctor is ill and working part time, can the practice hire a locum to bill under the part time doctor's name/number?
    - No, locum tenens is only applicable when the locum physician is substituting for the regular physician for those periods defined in the Internet Only Manual (IOM). It does not apply when the regular physician is working part time due to an illness.

Remember, to the extent that services billed were discovered to have been submitted incorrectly, the entity should do a voluntary disclosure and refund monies improperly paid and received, in compliance with the reverse false claims provision of the False Claims Act. Failure to do so would result in those claims being deemed false claims, and FCA damages and penalties would apply.

CMS guidelines are found in the CMS Medicare Claims Processing Manual, Publication 100-04, Chapter 1, Section 30.2.11.

[1] This works until the physician who left the group is linked to a new group, but in no case longer than 60 continuous days.

Compliance Week: Nov 1-7

Starting November 1st through the 7th, AdvantEdge employees can access the Compliance Corner page for helpful tips and resources for Compliance Week.

ICD-9 to ICD-10: GERD & Diseases of the Esophagus

Diagnosis: Gastro-Esophageal Reflux Disease

ICD-9 Code(s): 530.81
Listed Under: Diseases of The Digestive System 520-579 → Diseases of Esophagus, Stomach, And Duodenum 530-539 → Diseases of esophagus 530

ICD-10 Code(s): K21.0, K21.9
Listed Under: Diseases of the digestive system K00-K95 → Diseases of esophagus, stomach and duodenum K20-K31 → Gastro-esophageal reflux disease K21

Note: ICD-10 code K21.0 Type 1 excludes newborn esophageal reflux (P78.83)

Diagnoses in shaded areas are titles only and are not billable

DIAGNOSIS	ICD-9	ICD-10	ICD-10 Description
Gastro-Esophageal Reflux Disease	**530.81**	**K21**	**Reflux Disease**
Gastro-Esophageal Reflux Disease	530.81	K21.0	Reflux Disease With Esophagitis
		K21.9	GE Reflux Disease Without Esophagitis

DIAGNOSIS	ICD-9	ICD-10	ICD-10 Description (if different)
Diseases of the Esophogus	**530**	**K20**	**Esophagitis**
Esophagitis, Unspecified	530.10	K20.9	Esophagitis, Unspecified
Reflux Esophagitis	530.11	K21.0	Gastro-Esophageal Reflux Disease With Esophagitis
Acute Esophagitis	530.12	K20.9	Esophagitis, Unspecified
Eosinophilic Esophagitis	530.13	K20.0	Eosinophilic Esophagitis
Other Esophagitis	530.19	K20.8	Other Esophagitis