Explaining the State Health Insurance Exchanges in Seven Minutes: A Video for Your Medical Practice Website

I came across this video from the Henry J. Kaiser Family Foundation and thought ***"This is exactly the kind of content medical practices can use for their website and social media content."*** In this seven-minute video, the "YouToons" learn how the coming healthcare reform will affect them by placing consumers into one of four insurance categories: employer covered, government covered, privately insured, and privately uninsured.

The video is a straightforward, approachable overview of a complicated subject, and would make a fantastic post on the website of a physician or medical office. Even providers without a website could educate patients by posting this link to Facebook or Twitter, or by including it in an email newsletter. My partner Abraham **wrote a primer** on talking to patients and staff about reform last July, but this video is even simpler, and is everyone's favorite – an entertaining movie! It even has clickable icons inside the video for calculating premiums and finding out the status of state health insurance exchanges by state.

Why is a video like this a great piece of content to share with your patients and readers? Here are three reasons:

Reason #1 – This is high-quality content, from a high-quality source.

The **Kaiser Family Foundation** is a non-profit, non-partisan healthcare research organization **"dedicated to filling the need for trusted, independent information on the major health issues facing our nation and its people."**

This is not from a political advocacy group or a campaign committee. It's critical that the quality of the information you share with consumers has the ability to positively impact their healthcare experience – whether it is satisfaction, financial or outcome-based. Regardless of whether you are for or against Obamacare, you need to stay focused on presenting factual information from strong reputable sources. You wouldn't take professional or medical advice from just anyone, so don't share just anything.

Reason #2 – This is actionable, in-demand information.

There is no shortage of noise on the internet about any given subject, let alone healthcare reform. Your patients (and staff) have questions! They are looking now for answers, and if you step up, **you have a serious opportunity to expand and strengthen your relationship with them**. Guiding patients through difficult subjects is what providers have always done, and using the internet to do this more efficiently at scale is a natural extension of the doctor-patient relationship.

If they don't get the information from you passively with a website or social media connection, there's a good chance they might call the office, or ask about it at your next appointment. I am sure you are happy to help with that, but it is not your core business, is it? Getting the word out preemptively can cut your costs as well as improving your brand.

Reason #3 – This is a low-impact way to reach healthcare consumers.

Blogging and creating social media content does not have to mean going outside of your comfort zone or hiring new people. It is as simple as finding great stuff, sharing great stuff, and using great stuff as a jumping off point for critical conversations with your stakeholders. You don't have to animate or record anything, but your authority as a practice (and the Kaiser Foundation's) means your panel can trust your info. Posts from providers or executives are great – but also time consuming, and not everyone is comfortable or in the habit of putting a few hundred words on a page for public consumption.

With a great, informative video like this you don't have to reinvent the wheel to reach your patients.

So keep your eyes open, and look for high-quality, actionable content that you can share!

(Photo Credit: ✿ SUMAYAH © ²º¹³ via Compfight cc)

A Guide to Healthcare Buzzwords and What They Mean: Part Two (M through Z)

Meaningful Use (MU)

Meaningful Use is the phrase used in the 2009 HITECH Act to describe the standard providers must achieve to receive incentive payments for purchasing and implementing an EHR system. The term meaningful use combines clinical use of the EHR (i.e. ePrescribing), health information exchange, and reporting of clinical quality measures. Achieving meaningful use also requires the use of an EHR that has been certified by a body such as CCHIT, Drummond Group, ICSA Laboratories, Inc. or InfoGuard Laboratories, Inc. The term can also apply informally to the process of achieving the standard, for example “How is our practice doing with meaningful use?”

mHealth

An abbreviation for Mobile Health, mHealth is a blanket label for transmitting health services, and indeed practicing medicine, using mobile devices such as cell phones and tablets. mHealth has large implications not only for newer devices like smartphones and high-end tablets, but also for feature phones and low-cost tablets in developing nations. Many different software and hardware applications fit under the umbrella of mHealth so the term is used conceptually to talk about future innovations and delivery systems.

NLP

An acronym for Natural Language Processing, NLP is a field of study and technology that seeks to develop software that can “understand” human speech – not just what words are being said, but what is meant by those words. By “processing” text input into an NLP program, large strings of text can be parsed into more traditionally meaningful data. For example, narrative from a doctor in a medical record could be transferred into data for research and statistical analysis. If we had every medical record and narrative in history, we

could search it and look for trends – and possible new cures and symptoms. IBM's famous Watson machine that could "listen" to Jeopardy! clues and answer is an advanced example of NLP.

ONCHIT

An acronym for "Office of the National Coordinator for Healthcare Information Technology," the ONCHIT is a division of the Federal Government's Department of Health and Human Services. The Office oversees the nation's efforts to advance health information technology and build a secure, private, nationwide health network to exchange information. Although the National Coordinator position was created by executive order in 2004, the Office and its mission were officially mandated in the 2009 HITECH Act as a part of the stimulus package.

Patient Engagement

Patient Engagement is a broad term that describes the process of changing patient behaviors to promote wellness and a focus on preventative care. "Engagement" can roughly be read to describe the patient's willingness to be an active participant in their own care and to take responsibility for their lifestyle choices. Patient Engagement efforts can be as simple as marketing campaigns for public heath and appointment reminders, and as advanced as wearable monitors that can transmit activity and exercise information so patients can track their fitness. Improving the health system's ability to engage patients is considered key to lowering healthcare spending and attacking epidemics like obesity and heart disease.

Patient Portal

A patient portal is software that allows patients to interact, generally through an internet application, with their healthcare providers. Portals enable communication between

providers and patients in a secure environment with no fear of inappropriate disclosure of the patient's private healthcare information. Patients can get lab results, request appointments and review their own records without calling the provider. Patient portals can be sold as a standalone software module or as part of a comprehensive Practice Management/EHR package.

Patient-centered Care

Patient-centered care is a healthcare delivery concept that seeks to use the values and choices of the patient to drive all the care the patient receives. As elementary as it sounds, developing a culture that places the needs and concerns of the patient – the whole patient – at the center of the decision-making process is a new development in the healthcare system. Patient engagement is at the core of patient-centered care, because the patient is the central driver of the decisions – as is only right!

PCMH

An acronym for Patient Centered Medical Home, a PCMH is a model for healthcare delivery where most or all of a patient's services for preventative, acute and chronic primary care are delivered in a single place by a single team to improve patient outcomes and satisfaction as well as lower costs. PCMHs may also operate under a different reimbursement structure, as they can be paid on an outcome basis or on a capitation model as opposed to fee-for-service.

PHR

An acronym for a "Personal Health Record," a PHR is a collection of health data that is personally maintained by the patient for access by caregivers, relatives, and other

stakeholders. As opposed to the EHR model, in which a single hospital or system collects all the health information generated in the facility for storage and exchange with other providers, the PHR is maintained, actively or passively with mobile data capture or sensor devices, by the patient. The PHR can supplement or supplant other health records depending on the way it is used.

PPACA

An acronym for the "Patient Protection and Affordable Care Act," the PPACA was a federal law passed in 2010 to reform the United States healthcare system by lowering costs and improving access to heath insurance and healthcare. The PPACA uses a variety of methods – market reforms to outlaw discrimination based on gender or pre-existing condition, subsidies and tax credits for individuals, families and employers, and an individual mandate forcing the uninsured to pay penalties – to increase access to insurance and lower healthcare costs.

PQRS

An acronym for the "Patient Quality Reporting System," PQRS is a mechanism by which Medicare providers submit clinical quality and safety information in exchange for incentive payments. Physicians who elect not to participate or are found unsuccessful during the 2013 program year, will receive a 1.5 percent Medicare payment penalty in 2015, and 2 percent Medicare payment penalty every year thereafter.

RAC

An acronym for "Recovery Audit Contractor," a RAC is a private company that has been contracted by the Centers for Medicare and Medicaid Services to identify and recover fraudulent or mistaken reimbursements to providers. There are four regions

of the United States, each with its own RAC which is authorized to recover money on behalf of the Federal Government. A pilot program between 2005 to 2007 netted nearly $700 million dollars in repayments and the program was made permanent nationwide in 2010.

REC

An acronym for “Regional Extension Center,” a REC is a organization or facility funded by a federal grant from the Office of the National Coordinator for Health Information Technology to provide assistance and resources to providers who want to adopt an EHR and achieve meaningful use but need technical or deployment support to get their system up and running. There are currently 62 RECs in the United States who focus primarily on small and individual practices, practices without sufficient resources, or critical access and public hospitals that serve those without coverage.

Registry

A Registry is a database of clinical data about medical conditions and outcomes that is organized to track a specific subset of the population. Registries are important to track the efficacy of drugs and treatment, as well as to analyze and identify possible treatment and policy opportunities to improve care. A registry can also be used to report PQRS.

Telehealth

Telehealth is a broad term that describes delivering healthcare and healthcare services through telecommunication technology. Although the terms telehealth and mhealth can be used somewhat interchangeably, “telehealth” tends to focus more on leveraging existing technologies – phone, fax and video conferencing to deliver services over a long distance, or to facilitate communication between providers. Remote

evaluation and management and robotics are both examples of care innovations that would fall under the telehealth umbrella.

Value-based Purchasing

Value-based purchasing is a reimbursement model for health care providers that rewards outcomes for patients as opposed to the volume of services provided. Both through increased payments for positive outcomes, and decreased payments for negative ones, value-based purchasing seeks to lower costs by focusing on increasing quality and patient-focus. Accountable Care Organizations and Patient Centered Medical Homes are both examples of delivery systems that rely on value-based purchasing.

Healthcare Reform: Talking to Patients and Staff

> *At Manage My Practice we like to keep our posts informative and actionable – and not political. I've tried to provide the facts about the reforms, and how they could affect your patients and staff in an unbiased and professional manner – exactly how you would present them as an administrator. I hope you find it useful. – Abe*

The process of passing and implementing a law is a long and winding road, but President Obama's Healthcare Reforms cleared a significant hurdle on Thursday when the Supreme Court upheld

most of the law as constitutional against challenges from many of the states as well as business organizations. You have probably been getting a lot of questions from employees, patients, friends and relatives, and even your providers and colleagues, and they all basically boil down to this: **How does the law affect me?**

As Managers and Administrators, one of the most basic ways you influence outcomes for your employees, your patients, and ultimately, your organization is **to be informed, and to inform others**. Can you give a basic overview of the law that was passed to a worried patient? Have your staff gotten any information about handling patient questions? Do your providers have a basic idea of how the practice will respond to the changes? Many states and organizations have been delaying plans for the changes in the PPACA because of the court challenges to the law (many were plaintiffs in the suit) or for this November's elections, which could put a President in the White House who has promised to repeal the law. On top of that, even if President Obama wins another term, a Republican-controlled Congress could choose not to fund certain programs so that the law could not be put into place. For the moment however, **the Affordable Care Act is the law of the land for the immediate future, and something all managers need to have a basic grasp on**.

What's changing for individuals?

The goal of the legislation is to decrease the number of uninsured people in the country by tweaking existing federal programs like Medicaid and Medicare, and issuing new regulations on the health insurance industry as well as on private businesses and individual citizens.

By the year 2014 everyone will have a responsibility to carry some kind of health insurance. If you don't get healthcare coverage through your work or your family, or through an

existing program like Medicare, Medicaid, or Tricare, you will have to purchase a minimum level of private insurance or face a penalty. Subsidies to help pay for the required insurance will be available to individuals and families who make up to 400% of the poverty level on a sliding scale.

One example from Wikipedia, of how that would work in real life: A family of four whose income is at 150% of the Federal Poverty Level (~$34,000 a year) would be subsidized so that their monthly premiums would be about 2% of income, or $50.

To further help individuals comply with the mandate to have insurance coverage, by 2014 each state will set up a Health Insurance "Exchange" a marketplace where individuals can compare benefits and premiums for health insurance, and find out if they qualify for federal subsidies.

Are My Taxes Going Up?

In addition to the individual mandate, in 2013 **people with income $200,000 a year or more ($250,000 a year for couples) will have their Medicare Tax increased** from 1.45% to 2.35% on the income above the limit. The Medicare Tax on Net Investment Income over the $200,000 limit will be raised from 2.9% to 3.8%. These increased Medicare taxes on high income individuals account for roughly half of the new income to pay for the bill. Other new taxes on individuals include a **40% excise tax on "Cadillac Plans"** or insurance plans that cost more than $10,200 a year for an individual ($27,500 for a family) starting in 2018, and a **10% sales tax on tanning services** that began in 2010. New restrictions will also be placed on Healthcare Savings Accounts and Medical Expenses taken as tax deductions.

How will Insurance Change?

Although people will be required to carry some form of policy,

new regulations on insurance companies should increase the overall benefit to the private citizen for purchasing coverage. For example, **insurance companies can no longer deny (or overcharge for) coverage to people with pre-existing medical conditions, cannot drop someone's coverage who becomes ill, and cannot impose either lifetime or annual caps on how much a policy will pay out in benefits**. Insurance now also has to pay for **basic preventative care like wellness visits without co-pays or deductibles**, and children can stay on their parents' insurance until their 26th birthday- *even if the child is not a financial dependent, or is married*. Insurance companies also have to adhere to a "Medical Loss Ratio", which means that they have to spend a certain amount of the money they collect from your premiums on either medical services or quality improvement. Every year the insurance companies must report how much of the premiums they collect are spent on these medical losses, and if they spend less than the ratio (80% for individual and small group plans, 85% for large group plans), **the difference is refunded to the policyholder**.

What about Medicare and Medicaid?

Federal Health Plans Medicare and Medicaid will also be changed. Medicare enrollees who hit the "donut hole" in the prescription drug benefit receive a 50% discount on covered name-brand drugs, and the benefit will continue to increase **until the "donut hole" is completely closed in 2020**. Also, federal money will be made available to the states to expand Medicaid coverage to anyone who makes up to 133% of the Federal Poverty Line. At the time of this writing, the governors of two states, Florida and Louisiana, have already indicated that they will not take the additional Medicaid funding from the federal government.

As Managers, Providers and Employees, what are some of the questions you've been getting about the ACA, and how have you been answering them?

Supreme Court Upholds Majority of Obama's Healthcare Reforms by 5-4 Margin

Per the excellent live coverage at SCOTUSBlog of the Supreme Court's decision in the constitutional challenge to the Affordable Care Act,

> ***The bottom line: the entire ACA is upheld, with the exception that the federal government's power to terminate states' Medicaid funds is narrowly read.***

The reporters had quick access to physical copies of the opinion, and found the explanation of the Mandate Status in the majority opinion.

> ***"Our precedent demonstrates that Congress had the power to***

> ***impose the exaction in Section 5000A under the taxing power, and that Section 5000A need not be read to do more than impose a tax. This is sufficient to sustain it. "***

Updates, with links to the full opinions, to follow.

UPDATE: SCOTUSBlog's Amy Howe has a great bird's eye view:

> *In Plain English: The Affordable Care Act, including its individual mandate that virtually all Americans buy health insurance, is constitutional. There were not five votes to uphold it on the ground that Congress could use its power to regulate commerce between the states to require everyone to buy health insurance. However, five Justices agreed that the penalty that someone must pay if he refuses to buy insurance is a kind of tax that Congress can impose using its taxing power. That is all that matters. Because the mandate survives, the Court did not need to decide what other parts of the statute were constitutional, except for a provision that required states to comply with new eligibility requirements for Medicaid or risk losing their funding. On that question, the Court held that the provision is constitutional as long as states would only lose new funds if they didn't comply with the new requirements, rather than all of their funding.*

UPDATE: Supreme Court Opinion now posted online.

UPDATE: Lyle Dennison of SCOTUSBlog also has a great primer for reading the opinion here.

UPDATE: Lyle Dennison's First Blog Post on the Decision is up. Really can't give enough credit to SCOTUSBlog for how well they've covered it.

UPDATE: Also at SCOTUSBlog, Kevin Russell explains that States now have a choice as to whether they will join the Medicaid

Expansion in the ACA.

Readers, as providers, managers, employees what are your reactions?

The PPACA Supreme Court Challenge: What Every Practice Manager Should Know

The **PPACA (Patient Protection and Affordable Care Act)** reforms that were passed almost two years ago have been contested in court almost from the moment President Obama finished signing the bill.

Several constitutional challenges to the law have rather quickly (in terms of the Supreme Court anyway) made it to the very top of the legal chain. Supporters and those opposed to

the new law both want to see a quick decision by the Court on the most controversial components of the law – specifically, the **"individual Mandate"** that requires people not receiving health insurance benefit opportunities from their workplace, or through government programs like Medicare, Medicaid, or Tricare, to purchase health insurance through an exchange with help from government subsidies. Those who do not purchase insurance that meets a minimum standard of coverage would pay a penalty to the Federal Government.

The individual mandate is by far the least popular of the of the pieces of the reform law's so-called **"Three-Legged Stool"** of policies. By regulating insurers so that they cannot:

- deny people coverage based on pre-existing conditions,
- drop them arbitrarily because of new ones,
- or impose lifetime spending caps,

the private market is opened up to people with chronic and congenital conditions that otherwise would be denied, while the mandate ensures that younger and healthier people also participate in the market so that risk is spread, and premiums can be kept low. The Federal Tax Subsidies to new purchasers help to offset the costs to individuals and families that are new to the market.

The twenty six states bringing suit believe that the federal government can not force an individual to buy insurance through the threat of a fine.

The Federal Government believes that it does have this power based on Article 1, Section 8, Clause 3, better known as the "commerce clause", which enumerates the power to

> ***To regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes.***

This section of the Constitution is the basis for many of the powers granted to the federal government over the states, and the limits of the commerce clause are the foundation of powers declared by, or given back to the states from the Federal Government. Many of the most important questions put before the Supreme Court are cases of the nature of Federal versus State power, so the Commerce Clause is one of the most hotly debated parts of the American Constitution.

The Obama Administration argues that the Individual Mandate is part of the broad powers given to the Federal Government to "tax" individuals in order to regulate interstate commerce.

The states involved in the suit, and conservatives opposed to the Reforms argue that this amounts to the Federal Government requiring individuals, under penalty of law, to purchase a product whether they want to or not – an intrusion on both individual and State freedom.

This week, the Court heard six hours of oral arguments from lawyers representing both the states suing, the federal government, and unbiased outside council brought in to argue positions held by neither side. **Four different challenges** are being considered, including:

- Can the Supreme Court rule on the law before the fine has ever been imposed?
- Is the Individual Mandate constitutional?
- If the Individual Mandate is not upheld, does it invalidate the rest of the law?
- Can the federal government force the states to expand their Medicaid programs, even if the federal government pays for the state program expansion?

Of the nine Justices on the Supreme Court, five were appointed

by Republican Presidents and four were appointed by Democrats, including two appointed by Obama. The four democratic appointees – Ginsburg, Breyer, Sotomayor and Kagan- are presumed to vote to uphold the bill, while Clarence Thomas, one of the five Republican appointed justices is presumed to vote to repeal. The other four justices: Scalia, Thomas, Roberts, and Alito are considered to be "swing votes". With mixed or limited records on Commerce Clause cases and Federal Power, many Court observers widely believe that their votes will be the deciding factors.

A decision will be handed down by the Supreme Court in late June.

What does this mean for medical practices as small businesses with more than 50 employees?

If the PPACA is upheld, and the practice does not offer medical insurance benefits to its employees and your employees receive income tax credits for purchasing health insurance through a state exchange, you will be required to pay a fee of up to $2,000 per FTE for every employee after the first 30.

Currently, practices with 25 or less employees with an average wage of up to $50K annual wages can get a tax credit of up to 35% of the cost of health insurance premiums.

What does this mean to medical practices of all sizes?

If the PPACA is upheld, in 2014 our world will change.

In 2014, we would expect to see patients moving away from the ER as a source of primary care and into practices, and there would literally be no more "Self-Pay" patients in traditional private practices! This will expand the complexity of pre-

visit eligibility and claims filing and patients will continue to be confused over benefits, but that is what insurance is all about.

What are your concerns for your practice or business if the PPACA is or is not upheld?

CMS Announces Medicare Providers Must Begin to Revalidate Enrollment By March 2013

Announcement from CMS:

All providers and suppliers who enrolled in the Medicare program **prior to Friday, March 25, 2011**, will be required to revalidate their enrollment under new risk screening criteria required by the *Affordable Care Act* (section 6401a). Providers/suppliers who enrolled on or after Friday, March 25, 2011 have already been subject to this screening, and need not revalidate at this time.

New Screening Criteria

In the continued effort to reduce fraud, waste, and abuse, CMS implemented new screening criteria to the Medicare provider/supplier enrollment process beginning in March 2011. Newly-enrolling and revalidating providers and suppliers are

placed in one of three screening categories – limited, moderate, or high – each representing the level of risk to the Medicare program for the particular category of provider/supplier, and determining the degree of screening to be performed by the Medicare Administrative Contractor (MAC) processing the enrollment application. More information on the screening categories is **here**.

Notices Will Be Sent to Providers/Suppliers

Between now and March 2013, MACs will be sending notices to individual providers/suppliers; **please begin the revalidation process as soon as you hear from your MAC**. Upon receipt of the revalidation request, providers and suppliers have 60 days from the date of the letter to submit complete enrollment forms. Failure to submit the enrollment forms as requested may result in the deactivation of your Medicare billing privileges. The easiest and quickest way to revalidate your enrollment information is by using Internet-based PECOS (Provider Enrollment, Chain, and Ownership System), at https://pecos.CMS.hhs.gov.

Fees Levied

Section 6401a of the *Affordable Care Act* requires institutional providers and suppliers to pay an application fee when enrolling or revalidating ("institutional provider" includes any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A; CMS-855B, **not including physician and non-physician practitioner organizations**; CMS-855S; or associated Internet-based PECOS enrollment applications); these fees may be paid via www.Pay.gov.

In order to reduce the burden on the provider, CMS is working to develop innovative technologies and streamlined enrollment

processes – including Internet-based PECOS. Updates will continue to be shared with the provider community as these efforts progress.

For more information about provider revalidation, review the Medicare Learning Network's Special Edition Article #SE1126, titled "Further Details on the Revalidation of Provider Enrollment Information."

Physicians Have Something to Celebrate as the Medicare Cut is Delayed One Year and Physicians Are Exempt From the Red Flags Rules

Two milestone Acts were approved by Congress this week and both will be presented to President Obama for his signature shortly.

Image via Wikipedia

What he will be signing:

1. The **"Medicare and Medicaid Extenders Act of 2010"** This legislation freezes Medicare physician payments at current rates through the end of 2011. The Act also includes funds for Medicare contractors to pay claims

for physician services affected by provisions of the Patient Protection and Affordable Care Act passed last spring. The bill, estimated to cost $19.3 billion over 10 years, will be paid for by changing a provision of the health reform act that provides tax credits for people who buy coverage. President Obama released a statement saying: “It’s time for a permanent solution that seniors and their doctors can depend on and I look forward to working with Congress to address this matter once and for all in the coming year.

2. “**Red Flag Program Clarification Act of 2010**” changes the Red Flags Rule’s definition of “creditor” and relieves doctors from complying with the Federal Trade Commission’s identity theft prevention law.

Very Cool Health Reform Timeline and Animated Video About September 23, 2010

The Center for Healthcare Transformation may not be my organization of choice, but they’ve put together an **excellent timeline of the PPAC** (Patient Protection and Affordable Care Act), also called the ACA or Affordable Care Act.

The timeline shows what’s happening in regards to Medicare, Medicaid, public health, insurance, Indian health, taxes and government programs. You can slide the timeline forward or backward and jump around in hourly, daily, weekly, monthly, quarterly, yearly, etc. increments. It gives you a wonderful sense of the Big Picture. It is also being constantly updated.

And, for a quick look at the ACA changes happening as of September 23, 2010, you can watch a short video that I made for the "? of the Day" tab above. I thought this tab was getting just a bit boring, so I thought I would post short animations there that readers could share with staff or whomever for infotainment. I posted the first video under the "? of the Day" tab and also here for your convenience.

GoAnimate.com: Jack Asks About Healthcare Reform by Mary Pat Whaley

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Forget January 3, 2011! PECOS Date Moved 6 Months Closer for Referring & Supplying Providers New Date is July 6, 2010

NOTE: The date has been ~~changed to July 5, 2011.~~ delayed indefinitely.

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Physicians and "eligible" providers received a jolt today in the May 5, 2010 Federal Register as the date for enrollment in PECOS was moved up (pending the comment period and any changes resulting from the comment period) six months for providers that order or supply durable medical equipment (DME) for Medicare patients. Instead of the January 3, 2011 date previously announced by CMS, the Patient Protection and

Affordable Care Act (Affordable Care Act or PPACA) has provisions to move the go-date to July 6, 2010, just 60 days away.

What does this mean to you? Unless something changes based on public comments, beginning July 6, 2010:

1. Providers with a National Provider Identifier (NPI) must include it on their Medicare and Medicaid enrollment applications and claims.
2. Providers of medical items/other items/services and suppliers that qualify for a National Provider Identifier (NPI) must include their NPI on all applications to enroll in the Medicare and Medicaid programs AND on all claims for payment submitted under the Medicare and Medicaid programs.
3. **The ordering/referring supplier must be a physician or an eligible professional with an approved enrollment record in the Provider Enrollment Chain and Ownership System (PECOS) thus changing the previously reported January 3, 2011 date given by CMS.**
4. Claims that do not meet these requirements will be rejected by Medicare contractors.

You can read the rule in its entirety **here.**

Want to read the comments on this interim final rule when they are published? Go **here.**

Historic Votes on H.R. 3590

and H.R. 4872 Usher In Healthcare Reform

As I write this Sunday night I am listening to the US House of Representatives' discussion/posturing prior to a 'yes" or "no" vote for the Senate's healthcare reform bill H. R. 3590. I don't usually listen to CNN Live, but I want to remember this moment as I think it is the beginning of significant change in healthcare.

I'm not sure what this change will be, but many things that have been status quo for healthcare during my career might change almost beyond recognition by the time I retire. This, I think, is a good thing. I don't think the current system is bad, but I sure think it could be better. As with any change, there will be good things, bad things, and unintended good and bad things. It should be fascinating.

Discussion has now timed out and the representatives are voting; 216 votes are needed to pass. The vote has just been announced (10:45 p.m.) and it is 219 Yeas to 210 Nays and the bill is passed! The next step is for it to be signed into law by President Obama, which might happen tonight or tomorrow.

Now the representatives are voting on H.R. 4872 – "The Health Care and Education Affordability Reconciliation Act of 2010" which contains fixes to H.R. 3590 that have been negotiated between the two chambers. The bill has just passed (11:37 p.m.) with 220 Yeas and 211 Nays! 4872 will now go to the Senate for a vote which some are predicting will pass as early as Tuesday.

President Obama spoke from the White House after the votes and said "Tonight we answered the call of history." The passage of these bills has been compared to the passage of Medicare in 1965 and the passage of Social Security in 1935.

Here are details of both bills.

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Details on H.R. 3590 ”˜”˜Patient Protection and Affordable Care Act’’

Cost: $940 billion over ten years.

Deficit: Would reduce the deficit by $143 billion over the first ten years. Would reduce the deficit by $1.2 trillion dollars in the second ten years.

Coverage: Would expand coverage to 32 million Americans who are currently uninsured.

Health Insurance Exchanges:

- The uninsured and self-employed would be able to purchase insurance through state-based exchanges with subsidies available to individuals and families with income between the 133 percent and 400 percent of poverty level.
- Separate exchanges would be created for small businesses to purchase coverage – effective 2014.
- Funding available to states to establish exchanges within one year of enactment and until January 1, 2015.

Subsidies: Individuals and families who make between 100 percent – 400 percent of the Federal Poverty Level (FPL) and want to purchase their own health insurance on an exchange are eligible for subsidies. They cannot be eligible for Medicare, Medicaid and cannot be covered by an employer. Eligible buyers receive premium credits and there is a cap for how much they have to contribute to their premiums on a sliding scale. *Federal Poverty Level for family of four is $22,050.*

Paying for the Plan:

- Medicare Payroll tax on investment income – Starting in

2012, the Medicare Payroll Tax will be expanded to include unearned income. That will be a 3.8 percent tax on investment income for families making more than $250,000 per year ($200,000 for individuals).

- Excise Tax – Beginning in 2018, insurance companies will pay a 40 percent excise tax on so-called “Cadillac” high-end insurance plans worth over $27,500 for families ($10,200 for individuals). Dental and vision plans are exempt and will not be counted in the total cost of a family’s plan.
- Tanning Tax – 10 percent excise tax on indoor tanning services.

Medicare:

- Closes the Medicare prescription drug “donut hole” by 2020. Seniors who hit the donut hole by 2010 will receive a $250 rebate.
- Beginning in 2011, seniors in the gap will receive a 50 percent discount on brand name drugs. The bill also includes $500 billion in Medicare cuts over the next decade.

Medicaid: Expands Medicaid to include 133 percent of federal poverty level which is $29,327 for a family of four.

- Requires states to expand Medicaid to include childless adults starting in 2014.
- Federal Government pays 100 percent of costs for covering newly eligible individuals through 2016.
- Illegal immigrants are not eligible for Medicaid.

Insurance Reforms:

- Six months after enactment, insurance companies can no longer deny children coverage based on a preexisting condition.
- Starting in 2014, insurance companies cannot deny coverage to anyone with preexisting conditions.

- Insurance companies must allow children to stay on their parent's insurance plans through age 26.

Abortion:

- The bill segregates private insurance premium funds from taxpayer funds. Individuals would have to pay for abortion coverage by making two separate payments, private funds would have to be kept in a separate account from federal and taxpayer funds.
- No health care plan would be required to offer abortion coverage. States could pass legislation choosing to opt out of offering abortion coverage through the exchange.

***Separately, anti-abortion Democrats worked out language with the White House on an executive order that would state that no federal funds can be used to pay for abortions except in the case of rape, incest or health of the mother. (Read more here)*

Individual Mandate: In 2014, everyone must purchase health insurance or face a $695 annual fine. There are some exceptions for low-income people.

Employer Mandate: Technically, there is no employer mandate. Employers with more than 50 employees must provide health insurance or pay a fine of $2000 per worker each year if any worker receives federal subsidies to purchase health insurance. Fines applied to entire number of employees minus some allowances.

Immigration: Illegal immigrants will not be allowed to buy health insurance in the exchanges – even if they pay completely with their own money.

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Details on H.R. 4872 – "The Health Care and Education Affordability Reconciliation Act of 2010" (fixes to 3590)

COST: $940 billion over 10 years, according to the

Congressional Budget Office.

HOW MANY COVERED: 32 million uninsured. Major coverage expansion begins in 2014. When fully phased in, 95 percent of eligible Americans would have coverage, compared with 83 percent today.

INSURANCE MANDATE: Almost everyone is required to be insured or else pay a fine. There is an exemption for low-income people. Mandate takes effect in 2014.

INSURANCE MARKET REFORMS: Major consumer safeguards take effect in 2014. Insurers prohibited from denying coverage to people with medical problems or charging them more. Higher premiums for women would be banned. Starting this year, insurers would be forbidden from placing lifetime dollar limits on policies, and from denying coverage to children because of pre-existing medical problems. Parents would be able to keep older kids on their policies up to age 26. A new high-risk pool would offer coverage to uninsured people with medical problems until 2014, when the coverage expansion goes into high gear.

MEDICAID: Expands the federal-state Medicaid insurance program for the poor to cover people with incomes up to 133 percent of the federal poverty level, $29,327 a year for a family of four. Childless adults would be covered for the first time, starting in 2014. The federal government would pay 100 percent of the tab for covering newly eligible individuals through 2016. A special deal that would have given Nebraska 100 percent federal financing for newly eligible Medicaid recipients in perpetuity is eliminated. A different, one-time deal negotiated by Democratic Sen. Mary Landrieu for her state, Louisiana, worth as much as $300 million, remains.

TAXES: Dramatically scales back a Senate-passed tax on high-cost insurance plans that was opposed by House Democrats and labor unions. The tax would be delayed until 2018, and the

thresholds at which it is imposed would be $10,200 for individuals and $27,500 for families. To make up for the lost revenue, the bill applies an increased Medicare payroll tax to investment income as well as wages for individuals making more than $200,000, or married couples above $250,000. The tax on investment income would be 3.8 percent.

PRESCRIPTION DRUGS: Gradually closes the "doughnut hole" coverage gap in the Medicare prescription drug benefit that seniors fall into once they have spent $2,830. Seniors who hit the gap this year will receive a $250 rebate. Beginning in 2011, seniors in the gap receive a discount on brand name drugs, initially 50 percent off. When the gap is completely eliminated in 2020, seniors will still be responsible for 25 percent of the cost of their medications until Medicare's catastrophic coverage kicks in.

EMPLOYER RESPONSIBILITY: As in the Senate bill, businesses are not required to offer coverage. Instead, employers are hit with a fee if the government subsidizes their workers' coverage. The $2,000-per-employee fee would be assessed on the company's entire workforce, minus an allowance. Companies with 50 or fewer workers are exempt from the requirement. Part-time workers are included in the calculations, counting two part-timers as one full-time worker.

SUBSIDIES: The proposal provides more generous tax credits for purchasing insurance than the original Senate bill did. The aid is available on a sliding scale for households making up to four times the federal poverty level, $88,200 for a family of four. Premiums for a family of four making $44,000 would be capped at around 6 percent of income.

HOW YOU CHOOSE YOUR HEALTH INSURANCE: Small businesses, the self-employed and the uninsured could pick a plan offered through new state-based purchasing pools called exchanges, opening for business in 2014. The exchanges would offer the same kind of purchasing power that employees of big companies

benefit from. People working for medium-to-large firms would not see major changes. But if they lose their jobs or strike out on their own, they may be eligible for subsidized coverage through the exchange.

GOVERNMENT-RUN PLAN: No government-run insurance plan. People purchasing coverage through the new insurance exchanges would have the option of signing up for national plans overseen by the federal office that manages the health plans available to members of Congress. Those plans would be private, but one would have to be nonprofit.

ABORTION: The proposal keeps the abortion provision in the Senate bill. Abortion opponents disagree on whether restrictions on taxpayer funding go far enough. The bill tries to maintain a strict separation between taxpayer dollars and private premiums that would pay for abortion coverage. No health plan would be required to cover abortion. In plans that do cover abortion, policyholders would have to pay for it separately, and that money would have to be kept in a separate account from taxpayer money. States could ban abortion coverage in plans offered through the exchange. Exceptions would be made for cases of rape, incest and danger to the life of the mother.

STUDENT LOAN OVERHAUL: Requires the government to originate student loans, closing out a role for banks and other private lenders who charge a fee. The savings ”“ projected to be more than $60 billion over a decade ”“ are plowed into higher Pell Grants for needy college students and increased support for historically black colleges.

MEDICARE: Extends Medicare’s solvency by at least nine years and reduces the rate of its growth by 1.4 percent, while closing the doughnut hole for seniors, meaning there will no longer be a gap in coverage of medication.