What Doctors Can Learn from Hip Hop Mogul Jay-Z

Do you know who Jay-Z is?

If not, chances are your kids do. Jay-Z is one of the most successful rap artists of all time, and has parlayed that success into a career in fashion, merchandising, his own line of vodka, as well as an ownership stake in the NBA's New Jersey Nets franchise that he recently sold to begin a new career as a sports agent. More than anything, Jay-Z has found a way to brand himself as someone who brings glamour, street credibility, and cool to any project he is involved with. His success, beyond the normal hard work and talent, is ultimately in **marketing himself.**

Where do Doctors come in?

The healthcare industry is focused on marketing more than ever. Declining reimbursement, increasing regulation, and the long-term shift from volume to value have turned the heat up on physicians, practices, hospitals and systems to change the way they do healthcare business to cut costs, improve outcomes for patients and deliver more value. Cost matters now more than ever for all the stakeholders in healthcare, and with more competition comes the need for ways to separate yourself in the market, and engage with **potential** and current patients.

This summer Jay-Z put out a new album and he did it in a very

unique way

To promote his album, Jay-Z ran a commercial during Game 5 of the 2013 NBA finals announcing that he had recorded a new album, and that it would be available to download, free of charge for the first million people to download it from a mobile app made especially for the release. The catch? The album would only be free to people who had a Samsung mobile device – a mobile phone or tablet. Jay-Z signed an exclusive deal with Samsung to promote the album (modestly titled Magna Carta Holy Grail), Samsung products and the free mobile app to get the album **before it was available via retail.** Because of the hype (and the price, of course) the million downloads happened almost as soon as the album was made available on July 4th.

- Samsung purchased the albums from Jay-Z, so RIAA certified the album Platinum immediately.
- Samsung was able to associate themselves with one of the biggest music releases of the year, and guarantee that only their current (and future) customers were first to hear it.
- More than that, using the permissions of the mobile app, both Jay-Z and Samsung were able to get tons of valuable market research about the internet and mobile habits of the downloaders.
- The fans (at least the first million of them with a Samsung) got a brand new album from Jay-Z for free.

This is a basic form of content marketing, but it was groundbreaking for an artist as big as Jay-Z and a company as big as Samsung.

What can doctors learn?

Market research is critical. *Jay-Z made a few million selling*

the digital copies of his album to Samsung, but the information he gained from the app downloads was priceless for future collaborations.

The more you know about your patient base and where they come from, the better. For niche specialists, your market might be global so you'll need to know more about them to reach them. Market research can take many forms, from hard data from census and surveys to anecdotal methods as simple as asking one of your patients "What could we be doing better?" In a future where providers are reimbursed based on value, leveraging the data in your EMR to understand your patient population as a whole will be critical to many of your most important business operations.

You gain by giving things away for free. *By buying and giving away a million Jay-Z albums, Samsung became aligned with a major force in global culture and music — and probably sold a few phones too.*

What about all of the questions you hear over and over again on the phone and in office visits? Seasonal stuff about allergies, sunburns, the flu and physicals for sports. What if you *gave this info away* to anyone who wanted it on your practice website? With the changes coming in the ACA, what if your practice manager wrote a post or white paper about how your patients can prepare for what will and won't change? If your practice offers a special service that is hard to find locally for many people, what if you prepared an ebook about how your particular therapy benefits patients, or how they can change other lifestyle habits to complement their current therapy? All of these things are ways to reach a wide variety of people, gain credibility, and give away high-quality free information that can be converted to marketing leads for your practice.

Separate yourself. *Jay-Z probably couldn't have released his* ***first*** *album in this manner. Jay-Z has been successfully*

building his brand for almost twenty years now though. ***The name Jay-Z has come to mean quality.***

To compete and thrive, healthcare providers must be able to offer a level of service and execute that service in a way that makes them stand out from the crowd. If someone moves to town and Googles the name of family practice doctors in your area, do you know whose practice comes up in the results, and how you can capitalize on that? If people ask their neighbors who is the best cardiologist in town, would they say your name? If you treat a more specialized population, where do they gather to compare caregivers, and what do they say about you? To brand yourself today as a quality care provider, you have to actively highlight and grow your footprint and reputation for outstanding value and patient satisfaction.

Physicians and other healthcare providers may never listen to Jay-Z, or any rap. But chances are, Jay-Z's marketing example could lead the way.

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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!

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The New Age of Managed Care Contracting: Talking with Maria Todd of The Healthcare Business Institute

Dr. Maria Todd has been in healthcare since 1979 and has been the nation's leading managed care trainer and consultant since 1989. She's trained more than 70,000 healthcare professionals via more than 2500 road show seminars presented through McGraw Hill Healthcare Education Group, HFMA, MGMA, Heritage Professional Education and Business Network. Her iconic ***Managed Care Contracting Handbook*** sold more copies than any other managed care professional handbook in history, and is now in 2nd edition. No other industry professional has

contributed more to the art of managed care contracting and managed care professional skills education than Dr. Todd. Manage My Practice recently sat down with her to learn more about “the new age of contracting.”

Mary Pat: Maria, you are teaching attendees at your contracting course what is new about payer contracting. What’s different in the current environment?

Maria: The managed care contracting scene is radically different under healthcare reform and the PPACA. Anyone who hasn’t revisited their contracts in the past few years because they conveniently “rolled over” year to year may find that they could be shut out of renegotiation, certain networks and other strategic updating that should have been done vigilantly since 2009.

Mary Pat: Do managers still need all the previous skills related to contracting with payers?

Maria: They need even more! For example, they will need to be able to safely configure bundled case rates without overlooking costly inclusions due to vague or ambiguous descriptions and accurately calculate the business opportunities and risks under capitated models.

Mary Pat: Contracting carries a lot of risk. How do you teach people about contract risk?

Maria: By showing them the ambiguities in every day contract language that doesn’t look like legalese but can create loopholes for payment bundling, denials, foreclose appeals, and force the physician to refrain from billing.

Mary Pat: Many physicians have told me that there is no real negotiability in payer contracts anymore. I don't believe that is true – what do you think?

Maria: I have always been able to negotiate some changes, perhaps not all that I'd like to. The fact of the matter is that if there is nothing to negotiate, the contract is considered "adhesive" and unfair and the courts can toss it out. Language can also be construed in interpretation against the drafter, if it is ambiguous. Also, the courts are not there to be paternalistic. If you negotiate some and leave others the courts put the onus on the physician or his/her manager for not finishing the job. You are not entitled to a fair contract unless you negotiate one. The class teaches participants how to spot problems and mitigate them, and provides more insight to defend a reason to say "no thanks, I've had enough!"

Mary Pat: You say "Price is not the driver anymore." What is?

Maria: New trends in contracting level the pricing field. That means that quality and service accountability, as well as adherence to evidence-based care protocols and guidelines will be measured, prescribing habits and patient engagement…only now, they will be contracted performance elements. The whole new ball game of pay for performance is now driven on different metrics. If one doesn't perform at a base level, one will have to find another ball field.

Mary Pat: Do managers and physicians need the help or review of a lawyer before

they sign a payer contract?

Maria: Yes.. but for the right reasons. Too many attorneys are asked to assist on operational reviews. For most attorneys, those without practical experience in health administration and operations, (late entrants into law school after a career in healthcare, for example) the doctors and managers you mention are asking the attorneys to work outside their scope. Attorneys should, for the most part, review for enforceability and compliance, not fee schedules, operational practicability, and procedural matters that are purely at the discretion of the contracting parties to agree.

Mary Pat: In your course you discuss contracting with ACOs. Can you talk about what practices will need to learn to be able to contract appropriately with ACOs?

Maria: Which ones to align with, first. Second, how to get out if they make a bad decision, and third, what to look for and watch out for along the way. No one wants to miss the ACO with the successful management and operations and shared savings outcomes, and be left with the ACO that doesn't function well, isn't aligned and doesn't make any shared savings bonus at the end of the year.

Mary Pat: Many managers do not know how to handle ERISA (self-funded insurance plans where the employer acts as its own payer) claims. Do you teach skills to deal with ERISA claims?

Maria: I teach 3 ways to deal effectively with this problem. We know practices hear "We're ERISA and we don't have to pay timely or accurately." We teach practices how to get paid

faster and more accurately from ERISA payers and teach them exactly what to say to the "ERISA Excuse."

Mary Pat: Do you talk about out-of-network strategies in your course?

Maria: Yes, because there will be times when the right strategy is to say no. Even them physicians and other healthcare providers may be able to attract market share in other ways, some that may even cost less in overhead and hassle factor – like, cash, for instance.

Mary Pat: What is the single most important thing (without giving away any trade secrets from your course!) that you wish managers and physicians would know about contracting?

Maria: How 150 words and phrases we use in everyday language like "shall" and other words like appropriate, adequate, reasonable, material, use best efforts, use reasonable commercial efforts, best, other, indemnify and hold harmless, can make life so miserable for physicians and their managers and collections staff because they didn't realize the implications.

Maria has very graciously agreed to give Manage My Practice readers a 20% discount **(code MMP2013)** on her 3-day managed care contracting workshop which will be offered on August 14, 15 & 16, in Denver, Colorado. The Healthcare Business Institute, a new non-profit training and professional skills development institute in Denver, Colorado will host this hands-on workshop at the Grand Hyatt Denver Downtown. For more information and registration, call 800-209-7263 or register

online here.

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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.

The Sunshine Act and Its Impact on Physicians and Patients

On Friday, February 1st, The Centers For Medicare and Medicaid Services (CMS) released their final regulations on the Physician Payment Sunshine Act that was passed as a part of Heathcare Reform in 2010. The PPSA or "Sunshine Act" mandates that any manufacturer of medical supplies, medical equipment or pharmaceuticals will disclose to the Department of Health and Human Services (DHHS) any payments, gifts, or "transfers of value" over $10. The resulting disclosures will be publicly available in a database of transactions so that there will be "sunshine" on any financial relationships, direct or indirect, between providers and manufacturers. **All of the disclosure requirements are the responsibility of the vendor**, but the public nature of the resulting data has implications for day to day operations in your practice, as well as any relationships you might have with prominent manufacturers.

What is the Purpose of the Sunshine Act?

Supreme Court Justice Louis Brandeis said "Sunlight is the Best Disinfectant", and that idea is central to this "Sunshine Act." The hope is that by ensuring that any transactions between manufacturers and providers are documented and made public, all other stakeholders in the healthcare system will be able to make decisions based on the best possible information – and "disinfect" any conflict of interest that

could impact patient care outcomes.

For example, if a physician prescribes a drug and the manufacturer of that drug makes (completely legal) payments to that physician, access to that information could inform decisions by patients, payers and affiliated providers of the physician. For better or worse, this information will be in play as a part of the public record – and like all parts of the public record, will be open to interpretation.

Whether or not any financial relationships physicians might have with manufacturers end up influencing individual patient treatment decisions, a record of the payments will be a part of a growing body of public information that will influence patients' perceptions of medical quality, and will ultimately be a part of determining how they engage with physicians. In other words, these financial relationships are now a part of your public image and brand. As such, we are advising our clients to be proactive about how they are presented in these disclosures.

When Does the Sunshine Act Start?

- Vendors will begin recording information on payments starting on August 1st, 2013.
- Q4 2013 data is due to CMS on March 31st, 2014.
- Data will be publicly released September 30th, 2014.
- Vendors, providers, and other covered entities will have 45 days to review or dispute data to be published.
- The final ruling exempts manufacturer sponsorship of speakers at a Continuing Medical Education (CME) event from the Sunshine Act.
- Food purchases by manufacturer reps will be divided by the total number of employees, not just the number of physicians, but only the physicians' portions will be reported.

What Should Medical Practices & Physicians Do?

CMS suggests that physicians and other care providers would do well to keep their own records of any value exchanges they receive and it makes sense. Even though physicians aren't responsible for reporting the data, they can be affected by it, and so they should monitor it for accuracy and completeness. Physicians should review any and all manufacturer relationships to get an overview of what the reporting will look like. Talk to vendors about reviewing data before it is reported so there are no surprises. Keep in mind, even if a relationship is completely ethical, legal and beneficial to your patients, if it can be portrayed as unethical, it can harm you.

Finally, you need to be sure to regularly review the information that is publicly available in September of 2014, even after checking with the manufacturers before they report, and reconciling this information with your own records. Mistakes get made, typos don't get fixed, and you are ultimately responsible for your own brand as a provider – so check it!

How is your practice preparing for the Physician Payment Sunshine Act? Let us know in the comments below!

HHS Releases a Proposed Rule

for ICD-10 Go-Live October 2014

Today HHS announced a proposed rule **(complete rule here – 175 page pdf)** that would delay the go live for ICD-10 from October 1, 2013 to October 1, 2014. What follows are excerpts from the proposed rule.

Why Has HHS Proposed a Change to the Live Date for ICD-10-CM and ICD-10-PCS?

The final rule adopting ICD-10-CM and ICD-10-PCS (collectively, "ICD-10") as HIPAA standard medical data code sets was published in the Federal Register on January 16, 2009. The ICD-10 final rule requires covered entities to use ICD-10 beginning October 1, 2013.

In late 2011 and early 2012, **three issues** emerged that led Secretary of HHS Kathleen Sebelius to reconsider the compliance date for ICD-10:

1. The industry transition to Version 5010 did not proceed as effectively as expected;
2. Providers expressed concern that other statutory initiatives are stretching their resources; and
3. Surveys and polls indicated a lack of readiness for the ICD-10 transition.

The Transition to Version 5010

As the industry approached the January 1, 2012 Version 5010 compliance date, a number of implementation problems emerged, some of which were unexpected. These included—

- Trading partners were **not ready** to test the Version 5010 standards due to vendor delays in delivering and installing Version 5010-compliant software to their provider clients;
- Version 5010 errata were issued to correct **typographical mistakes** and other maintenance issues that were discovered as the industry began its internal testing of the standards, which delayed vendor delivery of compliant products and external testing;
- Differences between address requirements in the "provider billing address" and "pay to" address fields adversely affected **crossover claims processing;**
- **Inconsistent payer interpretation** of standard requirements at the front ends of systems resulted in rejection of claims, as well as other technical and standard misinterpretation issues;
- Edits made in test mode that were later **changed** when claims went into production without adequate notice of the change to claim submitters; and
- **Insufficient end to end testing** with the full scope of edits and business rules in place to ensure a smooth transition to full production.

Given concerns that industry would not be compliant with the Version 5010 standards by the January 1, 2012 compliance date, the HHS announced on November 17, 2011 that they would not initiate any enforcement action against any covered entity that was not in compliance with Version 5010 until March 31, 2012, to enable industry adequate time to complete its testing and software installation activities. **On March 15, 2012, this date was extended an additional 3 months, until June 30, 2012.**

The ICD-10 final rule set October 1, 2013 as the compliance date, citing industry testimony presented to NCVHS (National Committee on Vital and Health Statistics) and many of the over 3,000 industry comments received on the ICD-10 proposed rule.

The analysis in the ICD-10 final rule with regard to setting a compliance date emphasized the interdependency between implementation of ICD-10 and Version 5010, and the need to balance the benefits of ICD-10 with the need to ensure adequate time for preparation and testing before implementation.

As noted in the ICD-10 final rule, "[w]e cannot consider a compliance date for ICD-10 without considering the dependencies between implementing Version 5010 and ICD-10. We recognize that any delay in attaining compliance with Version 5010 would negatively impact ICD-10 implementation and compliance." (74 FR 3334) Based on NCVHS recommendations and industry feedback received on the proposed rule, we determined that "24 months (2 years) is the minimum amount of time that the industry needs to achieve compliance with ICD-10 once Version 5010 has moved into external (Level 2) testing." (74 FR 3334) In the ICD-10 final rule, we concluded that the October 2013 date provided the industry adequate time to change and test systems given the 5010 compliance date of January 1, 2012.

As implementation of ICD-10 is predicated on the successful transition of industry to Version 5010, we are concerned that the delays encountered in Version 5010 have affected ICD-10 planning and transition timelines.

Providers have Expressed Concern that Other Statutory Initiatives are Stretching Their Resources

Since publication of the ICD-10 and Modifications final rules,

a number of other statutory initiatives were enacted, requiring health care provider compliance and reporting. Providers are concerned about their ability to expend limited resources to implement and participate in the following initiatives that all have similar compliance timeframes:

1. **The EHR Incentive Program** was established under the Health Information Technology for Economic and Clinical Health (HITECH) Act, a part of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5). Medicare and Medicaid incentive payments are available to eligible professionals and hospitals for adopting electronic health record (EHR) technology and demonstrating meaningful use of such technology. Eligible professionals and hospitals that fail to meaningfully use EHR technology could be subject to Medicare payment adjustments beginning in FY 2015.
2. **The Physician Quality Reporting System** is a voluntary reporting program that provides incentives payments to eligible professionals and group practices that satisfactorily report data on quality measures for covered Physician Fee Schedule services furnished to Medicare Part B Fee-for-Service beneficiaries.
3. **The eRx Incentive Program** is a reporting program that uses a combination of incentive payments and payment adjustments to encourage electronic prescribing by eligible professionals. Beginning in 2012 through 2014, eligible professionals who are not successful electronic prescribers are subject to a payment adjustment.
4. Finally, section 1104 of the Affordable Care Act imposes **additional HIPAA Administrative Simplification requirements** on covered entities.

<u>January 1, 2013</u>

• Operating rules for eligibility for a health plan and health care claim status transactions

<u>December 31, 2013</u>

- Health plan compliance certification requirements for health care electronic funds transfers (EFT) and remittance advice, eligibility for a health plan, and health care claim status transactions

January 1, 2014

- Standards and operating rules for health care electronic funds transfers (EFT) and remittance advice transactions

December 31, 2015

- Health plan compliance certification requirements for health care claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, health care claims attachments, and referral certification and authorization transactions

January 1, 2016

- Standard for health care claims attachments
- Operating rules for health care claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, referral certification and authorization transactions

Proposed October 1, 2014

- Unique health plan identifier

Current State of Industry Readiness for ICD-10

It is crucial that all segments of the health care industry transition to ICD-10 at the same time because the failure of any one industry segment to successfully implement ICD-10 has the potential to affect all other industry segments. Ultimately, such failure could result in returned claims and provider payment delays that disrupt provider operations and negatively impact patient access to care.

In early 2012, it became evident that sectors of the health

care industry would not be prepared for the October 1, 2013 ICD-10 compliance date. Providers in particular voiced concerns about their ability to meet the ICD-10 compliance date as a result of a number of factors, including obstacles they experienced in transitioning to Version 5010 HIPAA Requirements from the Affordable Care Act and the other initiatives that stretch their resources. A CMS survey conducted in November and December 2011 (hereinafter referred to as the CMS readiness survey) found that 26 percent of providers surveyed indicated that they are at risk for not meeting the October 1, 2013 compliance date.

Given the evidence that segments of the health care industry will likely not meet the October 1, 2013 compliance date, the reasons for that likelihood, and the likelihood that a compliance date delay would significantly improve the successful and concurrent implementation of ICD-10 across the health care industry, we are proposing to extend the compliance date for ICD-10.

One-Year Delay Justification

The HHS is proposing to extend the compliance date for ICD-10 for 1 year, from October 1, 2013 to October 1, 2014. This change would be reflected in the regulations at 45 CFR 162.1002. While a number of alternatives were considered for the delay, as discussed in the Impact Analysis of this proposed rule, it is believed a 1-year delay would provide sufficient time for small providers and small hospitals to become ICD-10 compliant and would be the least financially burdensome to those who had planned to be compliant on October 1, 2013.

To determine the new compliance date for ICD-10, the need for additional time for small providers and small hospitals to become compliant was balanced with the financial burden of a delay on entities that have developed budgets and planned process and system changes around the October 1, 2013

compliance date. Entities that have started planning and working toward an October 1, 2013 implementation would incur costs by having to reassess and adjust implementation plans and maintain contracts to manage the transition beyond October 1, 2013. We concluded that a 1-year delay would strike a reasonable balance by providing sufficient time for small providers and small hospitals to become compliant and would minimize the financial burden on those entities that have been actively planning and working toward being compliant on October 1, 2013.

Finally, in its March 2, 2012 letter to the Secretary on a possible delay of the ICD-10 compliance date, the NCVHS urged that any delay should be announced as soon as possible and should not be for more than 1 year. The NCVH made this recommendation in consideration of its belief that a delay would cause a significant financial burden "that accrues with each month of delay."

The HHS believes that a 1-year delay would benefit all covered entities, even those who had are actively planning and striving for a 2013 implementation. A 1-year delay would enable the industry as a whole to test more robustly and implement simultaneously, which would foster a smoother and more coordinated transition to ensure the continued and uninterrupted flow of health care claims and payment.

Therefore, the HHS is proposing that covered entities must comply with ICD-10 on October 1, 2014.

Bonus: Some Interesting Data I Found in the ICD-10 Proposed Rule:

- The total number of health care claims in 2013 is projected to be 5.8 billion.
- The cost to health plans for manually processing a pended claim is $2.30 per claim.
- According to the Medical Group Management Association

(MGMA), the staff time required to manually process a returned claim is 15 minutes, at a cost of approximately $4.14 for labor, a factor derived from the Bureau of Labor Statistics. This includes staff time spent to correct the error and resubmit claims that are returned.

- Using the experience of one university's bachelor's-level health information management program, students take the ICD coding course in the spring of their junior year. Students enrolling in Spring 2012 courses will graduate in May 2013. Anticipating the October 1, 2013 compliance date, the university started offering ICD-10 courses this spring in place of ICD-9 with the understanding that it will be preparing students for employment after graduating in 2013. If ICD-10 is delayed a year, as proposed in this rule, the 30 students in the program will have to take ICD-9 courses in addition to their ICD-10 courses in order to obtain the ICD-9 competencies to get jobs. The extra course will cost each of the 30 students approximately $2,000 (in-state tuition) or a total of $61,000.
- Total cost of a 1-year delay in the compliance date of ICD-10 = $3,808M (mean average)
- According to the U.S. Census Bureau, Detailed Statistics, 2007 Economic Census, there are approximately 220,100 physician practices.. The U.S. Census Bureau data indicates that two percent of physician practices have revenues of $10 million or more, therefore approximately 4,400 physician practices are not small entities.
- According to the Small Business Administration's size standards, a small entity is defined as follows according to health care categories: Offices of Physicians are defined as small entities if they have revenues of $10 million or less; most other health care providers (dentists, chiropractors, optometrists, mental health specialists) are small entities if they have revenues of $7 million or less; hospitals are small

entities if they have revenues of $34.5 million or less.

- The 2007 Census Bureau reports that there are approximately 6,500 hospitals. The data indicates that 85 percent of hospitals have sales/receipts/revenues of $10 million or more.
- Statistics cost of delaying ICD-10 to 2014 were based on:
    - Physician practices with less than 50 physicians = 233,239
    - Physician practices with 50 to 100 physicians = 590
    - Physician practices with more than 100 physicians = 393
    - Hospitals with less than 100 beds = 2757
    - Hospitals with 100 to 400 beds = 2486
    - Hospitals with more than 400 beds = 521

Haven't Started Your ICD-10 Preparations Yet?

Start your plan by reviewing the resources below:

- Centers for Medicare and Medicaid Services (CMS) ICD-10 overview
- American Health Information Management Association (AIHMA) ICD-10 implementation
- American Academy of Professional Coders (AAPC) ICD-10 implementation

Manage My Practice offers ICD-10 transition help to physician practices, focusing on documentation improvement to support ICD-10 coding. For more information, please complete the contact form ***here.***

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?

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.**