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LEGISLATIVE NEWS

Experts: Unraveling Obamacare will be long, contentious process

You won't see any immediate or definite decisions on the fate of the Affordable Care Act (ACA), which is destined for major changes after the election of Donald J. Trump and the preservation of Republican majorities in both houses of Congress. Instead, any repeal legislation is likely to include a delayed implementation date while Republicans rush to assemble an alternative law that would stabilize the insurance market while mitigating the potential loss of coverage for millions of newly insured patients.

This potential delay already has major insurance companies worried, and many are likely to pull out of the subsidized insurance marketplaces established by the ACA unless Republicans guarantee that federal dollars will keep flowing for subsidies. Already, UnitedHealth and Aetna have terminated some of the less profitable plans they offered through the subsidized marketplaces, while other insurers have sharply increased premiums to keep their plans afloat.

"The best approach to keep insurance affordable and markets stable would be to fund temporary, transitional programs," writes Marilyn Tavenner, president and CEO of America's Health Insurance Plans (AHIP), in an op-ed in *The Washington Post*. "These would include maintaining subsidies for low and moderate-income individuals to purchase insurance and financial help for plans that enroll high-cost individuals, through at least Jan. 1, 2019."

Market stability is key

If the Republican Congress forces an immediately effective repeal bill into law using the reconciliation process, which would prevent a Democratic filibuster, the impact would be wide-ranging. "In the midst of an already established plan year, significant market disruption would occur," analysts at the non-partisan Urban Institute wrote in a study released Dec. 6. "Some people would stop paying premiums, and insurers would suffer substantial financial

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losses (about $3 billion); the number of uninsured would increase right away (by 4.3 million people); at least some insurers would leave the non-group market mid-year; and consumers would be harmed financially."

The question of how to keep the insurance markets stable during the transition to an ACA replacement will be difficult for Republicans to answer, even with the GOP in control of the White House and Congress, says Jack Hoadley, research professor at the Georgetown Health Policy Institute in Washington and a former HHS official during the transition to George W. Bush's administration. "The working assumption seems to be that we'll continue to operate [ACA] marketplaces for two or three more years, and to do that means continuing to spend federal dollars on Obamacare."

Essentially, Republicans must find a way to keep the ACA's components funded during the next few years, until the effective date of the repeal legislation and their replacement. This presents immediate problems for Republicans, such as an ongoing lawsuit filed by House Republicans that claimed the Obama administration illegally issued payments to insurance companies to subsidize costs for low-income enrollees because the money wasn't appropriated via Congress. A U.S. District Court judge had recently ruled in favor of House Republicans, but if the payments are stopped during the ACA's repeal process, the individual insurance market would likely capsize overnight. Now, Republicans are in the "awkward position" of asking the courts to delay further action on their own lawsuit, Hoadley says.

Dissension in the ranks

Such details – of which there will be many when overturning a law the size of the ACA – could cause splits within the Republican camp, Hoadley says. Some Republicans may refuse to put more dollars into fixing what they see as a failed system, while others may insist on propping up the ACA until their alternative program is signed into law. "You could envision more conservative members going one way and more moderate members going the other," Hoadley says.

There could also be divisions between President-elect Trump and Congressional Republicans. In a post-election interview, Trump indicated a preference for preserving the most popular provisions of the ACA, such as its requirement that insurers cover patients with pre-existing conditions and children ages 26 and under who live at home. These provisions are funded in part by the ACA's individual mandate, which is often seen as the law's most controversial component. Without it, and the influx of dollars from younger and healthier Americans, the popular features Trump wants to keep will swell the federal deficit, which Republican lawmakers have repeatedly pledged to reduce.

"There is no question that this funding is contentious," acknowledges Tavenner, who also served as CMS administrator from 2011 to 2015, in her op-ed. "But it is essential to deliver stable plan options and predictable premiums until a replacement plan can be designed, developed and deployed."

'See-saw' changes possible

At this point, it's too early to make any definitive predictions about the fate of the ACA, but Hoadley expects the picture to clear up significantly over the next two months. There could be "big, see-saw changes between now and Jan. 20, and then next year when the next round of proposed rules go out," Hoadley says.

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BREAKING NEWS

Overtime rule is postponed indefinitely

You don't have to implement any changes to your staff salaries or overtime hour tracking because the overtime final rule itself has been postponed, *The Business of Medicine* has learned. A federal judge from Texas granted an emergency motion for an injunction to block the U.S. Department of Labor from implementing the rule, which was scheduled to take effect Dec. 1.

This means the overtime rule won't be in effect until after a hearing, which could take more than a month, making it extremely unlikely for the overtime rule's future to be decided until after Jan. 20, when President-elect Donald J. Trump is sworn in. President Obama's labor secretary, Thomas Perez, has already moved to request an expedited hearing before Trump's inauguration, but the courts have no particular incentive to move quickly on a law with national consequences that would most likely be opposed by the incoming administration. Trump has stated in the past that he opposes the overtime rule, which more than doubles the salary threshold above which employees would be exempt from getting overtime pay.

The current threshold is $23,660, which means anyone making more than that amount annually may not have to be paid for overtime (defined as the number of hours in excess 40 per week). The final overtime rule sets the threshold to $47,476, and many medical practices have had to decide whether to give employees close to that salary a raise, or to start tracking their hours so overtime can be paid.

Practices react

Some practices have already implemented small raises of a few thousand dollars or less that put affected employees over that threshold. Most believe it would be bad for morale to reverse the raises just because the rule is now in legal purgatory.

At a 30-physician group practice in Rockford, Ill., a total of four employees were affected by the overtime rule, according to the group's human resources director. One, a salaried surgical technician, was given a raise that put her over the new overtime threshold, but she was also given new job responsibilities to justify the raise. Two billing and coding staffers were in line to receive a raise that would get them over the threshold, but news of the injunction came before they were informed about the raise, so the practice decided to leave their salaries unchanged.

In only one case, a staffer was informed about her raise – approximately $2,900 – before the rule was put on hold, and she will retain the raise because reversing it wouldn't be good for her morale.

For now, these individual decisions will be up to practices, and often they will need to make them on a case-by-case basis, but many other business are taking a wait-and-see approach with the Trump presidency fast approaching.

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HUMAN RESOURCES

New I-9 form required for employees in 2017

On Nov. 14, 2016, U.S. Citizenship and Immigration Services (USCIS), part of the U.S. Department of Homeland Security, issued an updated version of Form I-9: Employment Eligibility Verification. Under federal law, every employer that hires an individual for employment in the United States must complete Form I-9.

The updated form replaces a form that was issued in 2013 and expired on March 31, 2016. The updated form includes changes that should make using both the paper and electronic versions more intuitive and easier to use. Employers will be allowed to continue using the 2013 form until Jan. 21, 2017. Exclusive use of the updated form is expected by Jan. 22, 2017. The new form expires on Aug. 31, 2019.

The employer is obligated to provide the Form I-9, which consists of three sections, to any new hire and ensure that the employee correctly fills out and signs Section 1. Then, after inspecting the employee's documents, the employer must complete and sign Section 2. The employer is obligated to finish this process by no later than the third business day of employment. Section 3 is completed later, if the employee is rehired or must be re-verified because his or her work authorization is set to expire.

Ever since the first version of the Form I-9 was published in 1987, employers have struggled to complete the form correctly. Even though the form is relatively short — currently two pages — the Form I-9 process can be confusing, and employers frequently make mistakes. Unfortunately, those mistakes often lead to costly fines.

Form's field changes and updates

According to USCIS, the field updates and changes to the Form I-9 will make it easier for individuals to complete either a printed or an electronic copy of this form. The most significant change is the creation of a smart Form I-9 that users will be able to access and fill out on USCIS's website. This smart form includes a number of new features, which are all designed to guide the user through the process and reduce errors.

The new form:

- Asks for an individual's "other last names used" instead of "other names used"
- Streamlines certification for certain foreign nationals
- Prompts the person completing the form to include correct information
- Includes fields to enter multiple preparers and translators
- Dedicates a field to include additional information (this information will not need to be added on the margins anymore)
- Provides a supplemental page for preparers and translators

The electronic version of the form includes the following:

- Drop-down menus
- Calendars for filling in dates
- On-screen instructions for each field
- Easy access to the full set of instructions
- An option to clear the entire form and start over

This form is not a true "electronic" Form I-9 within the meaning of the USCIS regulations, but instead a "functionality tool" to ensure that the form is completed correctly.

Using the new smart Form I-9 is not required. Employers will still have the option to simply print out the form and complete it entirely by hand. In fact, USCIS has indicated that users will be allowed to complete all sections of the Form I-9 on paper or computer(s). Even if the employer chooses to use the smart version of the form, the form must still be printed out and signed by the employee and the employer representative. Employers utilizing E-Verify will still need to separately create "cases" and submit for confirmation. In addition, when employers choose to print the electronic version, a quick print response is now expected.

Steps practice should take

Employers should become familiar with the new Form I-9 and transition to exclusive use of the updated form by Jan. 22, 2017.

Employers should also determine whether they will use the manual or electronic versions of Form I-9. The electronic version may help employers avoid some common mistakes, but using it may require additional training.

USCIS has separated the instructions from the actual form allowing USCIS to include more detailed information on how to complete each field in the form. Please visit the USCIS website for more information regarding the new "Smart" Form I-9.

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MEDICARE RULES

Analysis: Don't expect Trump to save physicians from MIPS

The Affordable Care Act (ACA) has gotten most of the attention after the election of Donald J. Trump made it a near-certainty that the law won't survive in its current form – but your practice and daily workflow is more heavily impacted by a much lower-profile law, the Medicare and CHIP Reauthorization Act (MACRA).

MACRA, which includes the Merit-based Incentive Payment System (MIPS) is wholly separate from the ACA and is unlikely to see major changes, experts tell *The Business of Medicine*. "MACRA as a whole is just less of a partisan issue," says Jack Hoadley, research professor at the Georgetown Health Policy Institute in Washington. "The interest in value-based approaches is not particularly Republican or Democratic. People from both sides of the aisle have been interested in moving

away from the pure fee-for-service model."

That's actually good news for many practices that have invested time and resources into preparing for MIPS, says Joel James, director of public and government affairs at Signature Medical Group, a large, independent multispecialty group based in St. Louis, Mo. "There could be some tweaks to MIPS, coming from within CMS, and we're hopeful to see things like a better definition of what an advanced alternative payment model is, so more physicians can participate in APMs."

Trump's HHS pick 'very positive' for physicians

With Congress unlikely to touch the MACRA legislation, the incoming HHS secretary will have considerable leeway to make changes to MIPS. The president-elect has nominated Rep. Tom Price (R-Ga.), a former orthopaedic surgeon who has previously introduced legislation to replace the ACA, to be HHS secretary.

"My personal feeling is that he will be very positive for physicians, he's going to be very physician-focused, especially for practice-based physicians, because he knows what that's like," says James, who has worked with Price on a variety of physician advocacy issues in the past. "I know folks are concerned that Dr. Price is opposed to bundled payments and value-based care, but that's not really accurate. He's opposed to CMS acting on its own authority to make some of these programs mandatory."

For example, in his capacity as a member of Congress, Price has railed against the Comprehensive Care for Joint Replacement Model (CJR), saying that the program came with "tremendous risk and complexity for patients and healthcare providers," while decrying the fact that CMS made it mandatory. The agency had overstepped its bounds in pushing such a model so quickly on orthopaedic providers, Price argued in a letter to Andy Slavitt, the acting CMS administrator.

Much more will be known after Price is confirmed as HHS secretary, if his nomination can pass the Senate. What seems certain, however, is that your plans to prepare for the first MIPS performance year will need to continue as scheduled. For detailed guidance on your options to tackle the 2017 performance period, refer to the November issue of *The Business of Medicine.*

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EDITORIAL

What's all this nonsense about 'transparency'?

A few years ago, CMS, in a stated effort to be more transparent, released a database that contained most all of the procedures billed to Medicare by physicians for calendar year 2012. The next year, they released the same database for 2013 and earlier this year, they released the database for 2014. In each case, the data were two years old when released and with the exception of data analysts, policymakers and wannabe whistle-blowers, the data were not of much value.

Oh, I know, CMS touted how these data sets would allow the general public to evaluate and assess the quality of individual physicians, given them a more educated consumer decision, but that's not true. These data sets don't contain quality measures and, contrary to what CMS said, anything else that could be used to measure quality. The idea was that you could identify how many time a given provider performed a given procedure but this was wholly dependent upon their Medicare payer mix (not given) as well as the number of times that same procedure was performed on non-Medicare patients (also not given). For this purpose, the data were completely useless.

There was also this idea that consumers would download the data and be able to import it into Excel or SQL or some other database management program but with files as large as these, I don't see that happening to any degree. *The Wall Street Journal* compiled the data into a search engine that could be accessed from their web site and *ProPublica* put together an excellent search utility on their website that provided not only the data but some guidance on how to read it. But that still didn't change the issue of usability; the typical consumer would not be able to get much value from the data.

To keep the push for transparency going, in 2014, CMS released the Open Payments database. The database tracks pharmaceutical company contributions to doctors

and teaching hospitals and was touted as a great way to be able to investigate potential influence that these companies might have on the folks doing the research. Sounds good, except that the data were so messed up that at least one third of the entries were not published, again, rendering it almost useless. Furthermore, the first run only contained limited data for five months; August through December, 2013. Subsequent releases have not been a whole lot more accurate or useful than the original posting. But hey, it gives the illusion of transparency, doesn't it?

Just recently, CMS released a database that reported all kinds of data and statistics for hospice organizations around the country. The CMS website for the database states in part: "As part of the Obama Administration's efforts to make our healthcare system more transparent, affordable, and accountable, the Centers for Medicare & Medicaid Services (CMS) has prepared a public data set, the Hospice Utilization and Payment Public Use File (herein referred to as "Hospice PUF"), with information on services provided to Medicare beneficiaries by hospice providers."

And then, it ends with this: "Although the Hospice PUF has a wealth of payment and utilization information about hospice services, the data set also has a number of limitations. The information presented in this file does not indicate the quality of care provided by individual hospice providers. The file only contains cost and utilization information. Additionally, the data are not risk adjusted and thus do not account for differences in patient populations."

Now remember, these data are being made available to allow consumers, I guess, to make a more informed decision about selecting a hospital provider. But look again at the last paragraph where is states that there isn't any way to assess quality of care and that the data are not risk-adjusted so let's look at some other information that the typical consumer can use to their benefit. It contains the costs and payments, but those are pretty much fixed nationwide. It gives the number of physician services, which, as far as I can tell, without knowing anything about those services, is nothing more than an empty number. It talks about the average hours per day for home health visits, skilled nursing home visits and social services visits, whatever they mean. I couldn't assign any value to them. It reports total live discharges, which really tested my understanding of what hospice is all about. It even gave demographics, like average age, gender distribution and a breakdown by race and ethnicity. Again, I just don't see any benefit of these data for the typical consumer. And not to beat a dead horse, but this "new" release is also pretty close to two years old before it hits the street.

Lest you think I am complaining just for the sake of complaining, I wanted to talk about one more database, called the Integrated Data Repository. Here is CMS's stated IDR objective:

"An integral part of the CMS data warehouse strategy, the IDR ensures a consistent, reliable, secure, enterprise-wide view of data supporting CMS and its partners in more effective delivery of quality health care at lower cost to CMS' beneficiaries through state-of-the-art health informatics."

What's more, in the agency's annual report to Congress for fiscal years 2013 and 2014, CMS claims to have prevented and/or recouped $42 billion dollars, largely as a result of the IDR. The IDR is described in the report as a "key resource … an existing and continuously expanding repository of nationwide Medicare claims data. To develop and test more comprehensive models more quickly, analysts use historical claims from the national IDR to analyze patterns and develop models for the FPS. In turn, FPS models screen the IDR's aggregate, nationwide, historical information about billing behavior, creating more effective analytics using historical national data in both the development and implementation of the models."

This data would be very interesting and it's pretty current; in fact, it is frequently only a few months old. So if CMS is big on transparency, why can't I get access to this database? What might I use it for? I would use it in the same way the government and their lucky partners use it; to help providers identify, in advance, potential billing and coding issues that could result in costly audits and appeals. So why in the world would CMS want to give me access to something that might help providers identify potential problems *a priori*? Well, first would be this amazing dedication to more transparency and second, in CMS's own words:

"CMS's program integrity strategy is moving beyond the reactive 'pay and chase' method toward a more effective, proactive strategy that identifies potential improper

payments before they are made, keeps unscrupulous providers and suppliers out of Medicare and Medicaid at the outset, quickly removes wrongdoers from the programs once they are detected, and corrects improper payments as quickly as possible."

So not only is transparency apparently important to CMS, but they want to get beyond "pay and chase" methods, which prove to be more expensive than prevention. The way I see it, CMS has this database that analysts like me could use to help providers identify potential improper payments before they are made, but they don't want to give me access because I am not the kind of partner they want.

In the end, I am convinced that this move towards more transparency is a smoke screen to keep people busy while the valuable information is restricted to those who provide benefits only to CMS. It is illusory; and it's a shame because in light of the complete suspension of due process with regard to appeals and ALJ hearings, if providers had data on how to prevent improper billing and coding events, we could reduce the need for audits and hearings and bring some equanimity to an otherwise unfair and unreasonable process. And that's the world according to Frank.

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