CMS Proposes Allowing States To Define Essential Health Benefits

CMS proposed a 365-page rule recently aimed at giving states more flexibility in stabilizing the Affordable Care Act exchanges and in interpreting the law’s essential health benefits as a way to lower the cost of individual and small group health plans. The agency said the purpose is to give states more flexibility and reduce the burdens on stakeholders in order to stabilize individual and small-group insurance markets and improve healthcare affordability.

CMS also described the rule as giving more flexibility in defining the ACA’s minimum essential benefits to increase affordability of coverage. The states would play a larger role in the certification of qualified health plans offered on the federal insurance exchange. Additionally, they would also have more leeway in setting medical loss ratios for individual-market plans.

"Consumers who have specific health needs may be impacted by the proposed policy," the agency said. "In the individual and small group markets, depending on the selection made by the state in which the consumer lives, consumers with less comprehensive plans may no longer have coverage for certain services. In other states, again depending on state choices, consumers may gain coverage for some services."

CMS acknowledged it’s unclear how much money the new state flexibility will actually save, and states are not required to make any changes under the new policy. CMS urged states to consider the so-called spillover effects if they choose to pick their own benefits. These include increased use of other services such as increased use of emergency services or increased use of public services provided by the state or other government entities.

The proposed rule comes after months of calls from health insurers and provider groups for the federal administration to help stabilize the struggling individual insurance market. The rule also tweaks the requirement that enrollees need to have prior coverage before attempting to get coverage via special enrollment after moving to a new area.

Time To Get Ready For 2018
Coding and Compliance Tips by Lori Shore, CPC, RCC

It’s hard to believe that another year has flown by and it’s time to start talking about coding changes for 2018. The concepts haven’t really changed in radiology --- bundling and diagnostic x-rays organized by number of views. This year brings some heavy hitters on both fronts. Percutaneous AAA repairs are being bundled to include pre-procedure sizing, non-selective catheterizations, radiological supervision and interpretation, angioplasty and/or stenting. There are still add-on codes for temporary balloon occlusion and extension prostheses. Cut-downs are not included in the bundle and are separately reportable, if done by the radiologist.

Treatment of varicose veins is also being bundled to include non-compounded foam sclerosant and all imaging and guidance. Vein ablation using chemical adhesive (i.e. cyanoacrylate) is also being bundled to include imaging. Those are the main changes that will hit your pockets. Now for the changes that will hurt the coders’ brains. I have been coding for longer than most of our younger radiologists have been alive and the one constant was the code for chest x-ray, well no more. In keeping with renaming all diagnostic x-ray codes by number of views, the codes for both chest and abdominal x-rays will change effective 1-1-18. Start preparing now!
More and more, patients call to request price estimates. Referring providers question the cost of your facility’s imaging services. Payers steer patients to lower cost competitors.

The market may be demanding lower-priced imaging, but lower prices without increased volumes means less revenue. And the last thing imaging programs need is less revenue. So for many, imaging prices stay high.

But new payer dynamics, like Anthem’s site-of-service policy and Medicare’s site-neutral payments, are shaking up the outpatient imaging market and prompting leaders to reconsider their pricing strategies.

**Patient price-sensitivity is a familiar challenge for imaging**

Price is an important factor in imaging’s ability to capture patient market share. According to our Imaging Consumer Preferences Survey, 30% of respondents (n=2,000 imaging patients) reported that a low out-of-pocket cost was the most important factor when choosing an imaging provider. Across all demographic groups "having an out-of-pocket cost less than $30" ranked at the most important factor.

And this trend is expected to continue, as patients take on greater financial responsibility for their health care costs. According to a 2017 Kaiser Family Foundation survey, nearly half of patients reported difficulty covering their entire deductible. Patients are not just shopping, but putting off care altogether due to costs. The same survey found that nearly a quarter of insured patients and nearly half of uninsured patients postponed or skipped recommended medical tests or treatments.

Imaging is particularly vulnerable to price-based competition, as quality is difficult for patients to compare, low-cost alternatives exist in most markets, and non-urgent procedures allow patients time to shop. 43% of adults with health insurance report difficulty affording their deductible and 22% of Americans report that they or a family member skipped a recommended medical test or treatment in the past year.

**New payer policies increase urgency for imaging programs to address price**

On top of patient price-sensitivities, payers have taken aim at the high cost of outpatient imaging. In the private market, payers have been steering patients to lower cost sites for nearly a decade. But two new policies are changing the dynamics of outpatient imaging and prompting programs to reevaluate their pricing strategies:

- **Medicare’s site-neutral payment policy:** In the public space, Medicare is—albeit slowly—rolling out a site-neutral payment policy to reduce the payment discrepancy between hospital-based and freestanding imaging. Site-neutral payments requires off-campus facilities that open after November 1, 2015 to bill on a lower Medicare payment rate, currently set at just 50% of the hospital rate. This policy intensifies margin concerns of imaging programs moving into the ambulatory space.

- **Anthem’s site-of-service preauthorization policy:** In the private space, Anthem, the second largest insurance company in the United States, announced this summer that it will no longer pay for certain advanced imaging services performed at hospital-based sites. This increases the likelihood that hospital-based imaging programs will lose volumes to freestanding competitors.

**Develop a price competitive strategy for your market**

Whether in response to patient price-sensitivity or payer dynamics, imaging leaders are increasingly rethinking their pricing strategy. A successful pricing strategy is rooted in a comprehensive understanding of the role pricing pressures play in your market. There are three primary metrics that organizations should assess:

1. **Patient price sensitivity:** How likely is it that patients will forgo care at your facility due to price?

2. **Competitor cost advantage:** How susceptible are you to lower-priced competitors taking market share?

3. **Private payer steerage:** How significant is volume and revenue loss due to payers steering patients to lower cost sites?

Read the complete article [here](#).