





2010 Legislative Updates

ICE Service Denial Standardization Team – Main




Presenters

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Objectives


- Identify key aspects of Health Care Reform (HCR) by year
- Compare timeliness standards affected by HCR
- Address changes to content related to HCR
- Discuss updates to CMS regulations and templates
- Review upcoming changes to NCQA
- Update citations and required elements on the DMHC Technical Assistance Guide (TAG)

Health Care Reform - 2010 

Effective on/after September 23, 2010:


- **Appealing Insurance Company Decisions**
 - Grandfathered (GF) or Non-Grandfathered (NGF)
 - Plans subject to ERISA
 - Self-funded or financed by purchase of policy
 - State internal claim and appeal laws
 - State external review laws



Health Care Reform - 2010 


Effective September 23, 2010:

- **Children with pre-existing conditions**
 - Prohibits denial of coverage to children based on a pre-existing condition
 - Includes both benefit limitations and outright coverage denials
- **Rescissions**
 - Prohibits rescinding of coverage
 - Must provide at least 30 days advance notice to allow appeals

Health Care Reform - 2010 


Effective September 23, 2010

- **Eliminates lifetime limits on coverage**
- **Free preventive care**
 - Includes mammograms, colonoscopies without deductible, co-pay or share of cost
- **Phases out annual dollar limits over three years**
 - Eliminates by 2014
- **Choice of PCP within participating panel**
 - Parents may choose PCP of minor
 - OB/GYN without referral

Health Care Reform - 2010 


Effective July 1, 2011

- **Uniform claims and appeals process**
 - GOAL: to reduce delays, therefore averting lapses and resultant injuries
 - GOAL: to enhance enrollee satisfaction and to improve plan quality
- **Decrease complexity → increase efficiency for claims, appeals**
- **Enhance transparency → improved efficiency, confidence**
- **Improve denial and appeal documentation to improve understanding**
- **Timeliness and standardization → fewer delays and errors**

Health Care Reform - 2010 


Commercial Urgent Turn Around Time Standard
Effective July 1, 2011

- **Urgent Pre-Service Request**
 - Defined as a delay of care could jeopardize the life or health of member or subject member to unmanageable pain.
- **Decision Timeframe and/or Delay Notification Requirements**
 - Decision must be made in a timely fashion appropriate to the members condition not to exceed 24 hours after receipt of the request.

Health Care Reform - 2010 


Commercial Urgent Turn Around Time Standard (cont'd)


- **Initial Notification of Approval and/or Denial:**
 - No later than 24 hours after receipt of request. May be Oral, Electronic, or Written .
 - Must document date and time of all notification methods.
- **Written/Electronic Notification of Denial to Practitioner & Member:**
 - Initial oral notification must be followed by written or electronic notification no later than 3 calendar days after the initial oral notice.
 - If requested by the practitioner, initial notification may only be to the practitioner.

Health Care Reform - 2010 

Enhancements to the Commercial Service Denial Notice (CSDN)


- **Adding:**
 - CPT Codes and Description
 - ICD-9/10 Codes and Description
 - Claim Amounts (as applicable)



Health Care Reform - 2010 

Dear *[Member Name]*:

[Insert requesting provider/physician name] has asked for *[Insert (1) name(s) of requested service/treatment and the (2) ICD-9/10 and/or CPT code(s)]* for *(3) [Insert Diagnosis and Diagnosis Code(s)]*. The service/treatment requested is being *[insert one: modified, or delayed in delivery, or denied]* by *[insert Provider Organization or Plan Name]* because there is *[insert only one: lack of medical necessity or no covered benefit or lack of eligibility.]* This decision was based on your *[insert description of the review process (only one): medical information or evidence of coverage or plan eligibility]*.

Health Care Reform - 2010 

Adopt no later than July 1, 2011:

- **National Associations of Insurance Commissioners (NAIC) Standards**
 - External review of plan decisions
 - Clear information
 - Expedited access
 - Health plans must pay the cost of external appeal
 - Review by an independent body
 - Emergency process for urgent claims
 - Final decisions must be binding

Health Care Reform - 2011 

Effective January 1, 2011:


- **Rx discounts for seniors (brand name)**
 - Expands over 10 years
- **Free preventive care for seniors**
- **Improving health care quality and efficiency**
 - Test markets: new ways of delivering care
 - GOAL: reduce costs, slow increases while improving care
 - HHS will submit a national strategy by 1/1/11



Health Care Reform - 2011 


Effective January 1, 2011:

- **Community Care Transitions Program**
 - Goal to reduce readmits
 - Coordination with and connection to local resources
- **Premium limits to be spent on health care services or quality improvement**
 - Large group/employer plans – 85%
 - Small group/employer/individual – 80%

Health Care Reform - 2011 


Effective January 1, 2011

- **Gradual reduction of overpayment to insurance companies for MA plans**
 - MA plans remain in effect
 - Bonus payments for high quality care (not defined)

Health Care Reform - 2011 

Effective October 1, 2011:


- **Innovation to reduce costs**
 - Independent Payment Advisory Board to develop proposals
 - GOALS: target waste, reduce costs, improve outcomes, expand access
- **Community First Choice Options**
 - Allows states to offer home/community based services vs. SNF

Health Care Reform - 2012 

Effective January 1, 2012


- **Integrated health systems**
 - Incentives to physicians to join "Accountable Care Organizations (ACO)"
 - Better coordination of patient care
 - Improve quality outcomes
 - Help prevent disease and illness
 - Reduce unnecessary hospital admissions


If the ACO can provide high quality care while reducing costs, the ACO will share in the cost savings!

Health Care Reform - 2012 

Effective March 2012:

- **Health Disparities**
 - New/ongoing federal program required to collect:
 - × Race
 - × Ethnicity
 - × Language
 - GOAL: Data to help HHS identify and reduce disparities



Health Care Reform - 2012 

Effective October 1, 2012:


- **Voluntary options for long term care insurance**
 - CLASS program
 - Cash benefits for adults who become disabled
- **Paperwork and Administrative Cost Reductions**
 - Standardized billing
 - Standards for secure, confidential electronic exchange
 - GOAL: reduce paperwork and admin burden
 - GOAL: reduce medical errors, cut costs, improve quality

Health Care Reform - 2012 

Effective for discharges on or after October 1, 2012:


- **Linking payment to quality outcomes**
 - Establishes a hospital Value-Based Purchasing program (VBP) in original Medicare
 - × Hospital financial incentives to improve the quality of care
 - Public reports of performance beginning with measures:

× heart attacks	× surgical care
× heart failure	× health care associated infections
× pneumonia	× patient perception of care

Health Care Reform - 2013 

Effective January 1, 2013:

- **Improving Preventive Health Coverage**
 - Applies to Medicaid programs
 - Preventive care services at little or no cost
- **Expanding authority to bundle payments**
 - Payment per episode of care rather than fragmented
 - Team payment (facility, providers, etc.) rather than separate payments to each


Health Care Reform - 2013 

Effective January 1, 2013:

- **Increasing Medicaid payments to PCPs**
 - No less than 100% Medicare by 2013
 - Fully funded by federal government


Effective October 1, 2013:

- **Providing additional funding for Children’s Health Insurance Program (CHIP)**
 - Two additional years funded

Health Care Reform - 2014 


Effective January 1, 2014:

- **Establishing Health Insurance Exchanges**
 - No employer offered plan, buy insurance directly via Exchange
 - Transparent and competitive insurance marketplace
 - Individuals and small businesses can purchase
 - Plans will meet certain benefits and cost standards
 - Members of Congress will be purchasing via Exchange

Health Care Reform - 2014 


Effective January 1, 2014:

- **Promoting Individual Responsibility**
 - Ability to pay will determine
 - Fees to offset the costs of uninsured
 - Exemptions for those unable to afford
- **Ensuring Free Choice**
 - For employees unable to afford employer offered coverage
 - Use employer health care funds to purchase via Exchange

Health Care Reform - 2014 


Effective January 1, 2014:

- **Increasing Access to Medicaid**
 - \$14,000 for an individual
 - \$29,000 for a family of four (poverty level)
 - 100% federal funding for the first (3) years, decreasing to 90% in subsequent years
- **Makes Care More Affordable**
 - Tax credits to middle class with incomes above 100% and below 400%
 - \$43,000 for an individual
 - \$88,000 for a family of four
 - Reduced cost-sharing (co-payments, coinsurance and deductibles)

Health Care Reform - 2014 


Effective January 1, 2014:

- **Ensuring Coverage for Individuals Participating in Clinical Trials**
 - Prohibited from dropping or limiting coverage if person chooses to participate in a clinical trial
 - Applies to all clinic trails managing cancer or other life threatening diseases
- **Eliminating Annual Limits on Insurance Coverage**
 - Prohibits imposed annual dollar limits on amount of coverage

Health Care Reform - 2014 


Effective January 1, 2014:

- **No Discrimination Due to Pre-Existing Conditions of Gender**
 - Prohibits refusal to sell coverage or renew related to pre-existing conditions
 - Eliminates higher rates based on gender or health status
- **Increasing Small Business Health Insurance Tax Credit**
 - Implements second phase for small business tax credit who are non-profit organizations
 - Allows 50% credit of employer's contribution to provide health insurance for employees
 - Allows up to 35% credit for small non-profit organizations


Health Care Reform - 2015 


Effective January 1, 2015:

- **Paying Physicians Based on Value Not Volume**
 - Ties physician payments to quality of care provided
 - Payments modified
 - ✦ Higher value of care receives higher payments
 - ✦ Lower quality of care receives lower payments


CMS Marketing Material Guidelines (MMG) 2011 CY Revisions 

- **OMB**
- **Disclaimer Statement**
- **Envelope Statements**




OMB Model Notices 

- **NOMNC, NDMC, DENC**
 - All have expiration dates 8/31/10
- **Directed to use until new notices are published**
- **No need to update with latest MMG changes**
 - New templates will have placeholders for disclaimers

Disclaimer Statements 

- **Insertion into current versions**
 - Not required in current versions
 - CMS approved templates are compliant
 - × Provider Organizations comply with Health Plans
- **Alternate language disclaimer**
 - ICE to work with CMS re: standardization


Envelope Statements 

- **12 point Times New Roman font (or equivalent)**
- **Does not need to be bold and all CAPS**
- **Plan/Group logo allowed**
- **Must be prominently displayed**
- **Must be submitted to CMS for approval**
 - Do not need MM# or approval date


**NCQA UM Standards
2011 Additions and Changes** 

- **Communication Services**
- **Handling of Appeals**




NCQA 2011 Additions 

- **UM3 Communication Services**
 - The organization provides access to staff for members and practitioners seeking information about the UM process and the authorization of care
 - Element A: Access to Staff
 - ✦ Factor 7. The organization offers TDD/TTY services for deaf, hard of hearing or speech-impaired members
 - ✦ Factor 8. Language assistance for members to discuss UM issues


NCQA 2011 Amendments 

- **UM9 Appropriate Handling of Appeals**
 - The organization adjudicates member appeals in a thorough, appropriate and timely manner
 - Element F: Final Internal and External Appeal Files
 - ✦ Scoring changed:
 - 100% The organization meets all factors
 - 80% No scoring option
 - 50% The organization meets only 1 factor
 - 20% No scoring option
 - 0% The organization meets factor 1, inconsistent or meets no factors

DMHC: Technical Assistance Guide 


Released August 2010

- **UM 001 - Policy and Procedures**
- **UM 002 - Decision Making & Timeframes**
- **UM 003 - Criteria Development**
- **UM 004 - Communication Requirements for Decisions**
- **UM 005 - Disclosure of Process to Authorize or Deny**
- **UM 006 - Process as part of QA Program**

DMHC: Technical Assistance Guide 

Released August 2010

- **UM 007 - Terminal Illness Requirement & Compliance**
- **UM 008 - Delegation Oversight**
- **UM 009 - Mental Health Parity Coverage & Claims Administration**
- **UM 010 - Mental Health Triage & Referral**
- **UM 011 - Standing Referrals**

Summary 

- ✓ **Summarized key elements within the HCR**
- ✓ **Reviewed the impacted TAT Standards**
- ✓ **Discussed Commercial and Medicare Model Notice and Template content enhancements**
- ✓ **Addressed accreditation agency changes**
- ✓ **Reviewed TAG updates**

Questions? 