STATLAW® New York

Volume XXIII Number X1 –November 15, 2015
Single Issue Price: $5.00

Late breaking news on medical-legal developments affecting physicians and health care professionals

CMS admits to underpaying dual-eligible health plans; issues with star ratings: The CMS recently released a highly technical document that, among other things, reveals it underpays health plans which enroll large numbers of people who are dually eligible for Medicare and Medicaid. To remedy that, the agency announced that it plans to modify its risk-adjustment model to make up for the underpayment. Compounding the underpayment issue is the fact that health plans which primarily serve low-income members who are dually eligible for Medicare and Medicaid have complained they unfairly get lower star ratings which make them ineligible for bonuses, and put them in danger of losing their Medicare contracts. The CMS has the statutory authority to boot a plan if it has fewer than three stars for three straight years. Although the CMS has historically dismissed industry complaints that Medicare's quality ratings and risk adjustments are unfair to plans that enroll low-income Americans with more complex health needs, the agency recently had a change of heart. The CMS' recently announced proposed changes to the quality ratings and the risk adjustments are, according to one CMS official, the agency's way of showing the healthcare industry that it is acknowledging its complaints. The CMS document outlines some tweaks to its risk model that officials believe will lead to more accurate payments to plans. The CMS is seeking comments on the proposed alterations by November 25, 2015, and will publish final changes in a notice for the following payment year in February 2016.

CMS to require prior authorizations for non-emergent ambulance services: The CMS will soon require prior authorization for regular non-emergency ambulance transportation in order for it to be covered under Medicare. The prior authorization program will begin in six (6) states that have been identified as the highest users of ambulance services for seniors who often need transportation three or more times a week to get to dialysis, cancer or wound treatment appointments. According to a 2013 OIG report, the number of ambulance transports reimbursed by Medicare Part B increased 69% between 2002 and 2011. In 2012 alone, Medicare Part B paid $5.8 billion for ambulance transports. A June 2013 Medicare Payment Advisory Commission report found that the volume of ambulance transports to and from a dialysis facility increased 20% between 2007 and 2011, more than twice the rate of all other ambulance transports combined. The initiative is the expansion of an effort that began last year in New Jersey, Pennsylvania and South Carolina. While opponents of this pre-authorization cite potential for patient harm, the CMS said few issues have been reported to the agency from stakeholders in New Jersey, Pennsylvania and South Carolina and the agency believes the program has, in those states, been a success to date.

Health Republic closing: As a result of the large volume of questions from consumers and physicians regarding the impending closing of Health Republic, the New York State Department of Financial Services (DFS) has published a Fact Sheet of actions being undertaken regarding Health Republic: http://ow.ly/UCwgl Among the significant statements made by DFS in the Fact Sheet:

> Prohibition Against Balance Billing and Surprise Billing of Consumers. NYS DFS is taking actions that will apply a New York State law that prohibits providers from collecting or attempting to collect from Health Republic consumers amounts that are owed by Health Republic. Additionally, New York Law requires insurers to permit an insured to obtain the services of an out-of-network provider if the insurer does not have an in-network provider with the appropriate training and experience to meet the particular healthcare needs of the insured.
>
> Helping to Ensure Continuity of Care. Under New York law, Health Republic members who are: a) in an ongoing course of treatment with a provider for a life-threatening or a degenerative and disabling condition or disease, or b) in the second or third trimester of a pregnancy when their new coverage becomes effective, may continue to receive care from their provider for up to 60 days (or through the pregnancy) under their new health insurance policy, even if their provider does not participate in their new health insurer's network.

The State is also in discussions with Memorial Sloan Kettering, and other health plans, to ensure access to care for Health Republic consumers for up to a year – subject to reasonable terms – with other health plans.

For more information on the above items, contact Kern Augustine Conroy & Schoppmann, P.C. at 1-800-445-0954 or via email at info@DrLaw.com.