2013: ACA IMPLEMENTATION DOMINATED HEALTH CARE NEWS

This was a landmark year in health care, as providers, brokers, regulators and policymakers worked to implement the Affordable Care Act (ACA). Here is a recap of 2013’s top stories:

- The employer mandate (for companies with 50 or more full-time employees) was delayed until Jan. 1, 2015.
- HealthCare.gov transitioned from a highly functioning informational website to a non-functioning transaction portal. Enrollment figures are woefully behind the original target of 7 million by March 1, forcing the Obama administration to delay the start date for imposing penalties on the uninsured by six weeks.
- Gov. Jan Brewer signed legislation in June to expand Medicaid. The law includes a $250 million hospital assessment and is expected to add 300,000 lives to AHCCCS.
- Price transparency and cost-shifting received national exposure in a Time magazine article, "The Bitter Pill," published in February.
- Consolidation ramped up in for-profit and not-for-profit markets. In October, Dallas-based Tenet Healthcare Corp. acquired Vanguard Health Systems (Abrazo in Arizona) in a deal valued at $4.3 billion. Tenet now operates 77 acute care hospitals, ranking in the top three for both revenue and facilities owned. Also, at press time, Franklin, Tenn.-based Community Health Systems (CHS) was in the process of buying Naples, Fla.-based Health Management Associates for $7.6 billion. If approved, the deal would make CHS the largest for-profit hospital operator, with 206 acute-care hospitals across 29 states.
- In terms of compliance, providers were focused on HIPAA, ICD-10 transition and meaningful use of electronic medical records.
- The Centers for Medicare & Medicaid Services cut Medicare payments by up to 1 percent for 2,213 hospitals with high readmission rates for heart attack, heart failure and pneumonia.
- CMS revealed how its original 32 Pioneer ACOs performed in 2012. Results were mixed: While all 32 Pioneer ACOs improved quality and patient satisfaction scores in 2012, just 13 achieved enough savings to share them with Medicare. Overall, those 13 ACOs achieved $76 million in shared savings. Banner Health’s Pioneer ACO saved CMS more than $13 million. Two Pioneer ACOs left the program completely, and seven moved to the Medicare Shared Savings Program. As of Jan. 10, 2013, doctors and health care providers had formed 106 new ACOs in Medicare.

SAVE THE DATE
State-of-the-State
Tucson – Wednesday, Jan. 22
The Arizona Inn
Phoenix – Friday, Jan. 24
Pointe Hilton at Squaw Peak
Join your colleagues for a conversation about key issues in health care, presented by Jim Hammond, Steve Rees and Beth Lazare, deputy director of AHCCCS.

2014: FOCUS ON ENROLLMENT AND ADEQUATE PROVIDER NETWORKS

Open enrollment runs through March 31, and many eyes will be on HealthCare.gov to see if it reaches enrollment goals. In October and November, 3,601 Arizona residents signed up for a plan sold over the federal marketplace, according to estimates released in early December. Nationwide, nearly 365,000 people picked a health insurance plan through state and federal exchanges through the end of November. That is far short of the 1.2 million target the Obama administration had set for the first two months.

The Obama administration said late on Dec. 19 that people who have had their insurance plans canceled because of new requirements under health reform may be able to claim a “hardship exemption” to the requirement that Americans have coverage by March 31, or face a penalty. Sen. John McCain blasted the move as “another sign of the disintegration of Obamacare.” It is unknown how many Americans will take advantage of the exemption and delay purchasing coverage in 2014.

Another question: Will Arizona providers, including dentists, be able to handle the influx of newly insured residents, as well as those who are now eligible for Medicaid? The state expects to absorb nearly 800,000 newly insured people in the coming years. Arizona ranks 43rd in the nation for its share of primary care doctors, according to the Association of American Medical Colleges.

MEDICARE CHANGES PAYMENTS, INCREASES PROVIDER SCRUTINY

Change for hospital outpatient clinics
The Center for Medicare Services (CMS) last month released a final 2014 hospital outpatient and ambulatory surgical center payment rule, which includes a flat rate for outpatient clinic visits instead of varying payments based on the severity of the patients’ conditions. According to CMS, “a single code and payment for clinic visits is more administratively simple for hospitals and better reflects hospital resources involved in supporting an outpatient visit.” The rule means that the 10 procedure codes for outpatient clinic visits will all fall under a single code, and the new payment rates will be calculated based on statistical averages in 2012 claims data for the five levels of severity. CMS decided not to enact a similar policy for emergency room visits, at least not yet.
Name-brand drugs cost Medicare
A study by ProPublica, which analyzed the prescribing habits of 1.6 million Medicare medical practitioners nationwide, found that 913 of those practitioners cost the program an extra $300 million by disproportionately choosing name-brand drugs. A main reason for this over-spending: Extra Help, a Medicare program that helps people with limited resources pay for prescription drug costs. In the Extra Help program, low-income participants pay less than $7 per prescription, regardless of its cost. In 2012, $62 billion was spent on Part D, with more than one-third of that expenditure on Extra Help. Over-prescribing brand-name drugs in Medicare comes at a time when other government programs and private health plans are imposing stricter controls and incentives for the use of generic drugs in place of brand-name drugs.

Ruling impacts Medicare networks
A judge in Connecticut issued a preliminary injunction prohibiting UnitedHealthcare from dropping doctors from its provider networks for Medicare Advantage plans. While this ruling applies only to Connecticut, it could have far-reaching implications for network management across the country, as UnitedHealthcare and other carriers face the possibility of additional litigation.

Medicare Recovery Audits increase
Medicare Recovery Audits are up, producing a 28 percent increase in complex denials in the third quarter of 2013, compared to the first quarter. Recovery audits are HHS’s efforts to check billed claims for overpayments, underpayments and inappropriately coded claims. About $2.5 billion of more than $10 billion in Medicare payments, from 2010 through September 2013, was denied. Of those investigations that resulted in denial of payment, hospitals appealed 47 percent, with a 67 percent success rate in getting the decision overturned. More than three-fourths of all hospitals were audited during the survey period, beginning in 2010.

LAGNIAPPE
::: CORAM, a unit of Apria Healthcare Group, has signed a letter of intent to be acquired for 2.1 billion by the second-largest U.S. drugstore chain, CVS Caremark Corp.
::: Late last week, an attorney representing Gov. Jan Brewer asked the court to dismiss a lawsuit brought by 36 state legislators challenging the vote to expand Medicaid in Arizona. The lawsuit alleges that key provisions of the law are unconstitutional.
::: The Wall Street Journal reported the average deductible in a bronze (least-expensive) plan on the federal exchange is $5,081 per year. That is 42 percent higher than the average deductible of $3,589 for individually purchased plans in 2013.
::: Former Microsoft executive Kurt DelBene will be the permanent, top official responsible for the rescue efforts of the online insurance marketplace, HealthCare.gov. Jeff Zients, who was brought in to troubleshoot after the disappointing launch in October, will postpone his start as White House chief economic adviser until February to continue assisting with the HealthCare.gov site reconstruction.
::: According to a new report by Families USA, 71 percent of customers who purchase plans through the individual marketplaces will be eligible for federal premium subsidies.
::: Arizona Foundation for Medical Care announced that it has added Mayo Clinic to its network effective December 1, 2013.
::: The Department of Health and Human Services announced that the 2014-2015 open enrollment period under the Affordable Care Act will be delayed and lengthened by one week. The dates for open enrollment are now set for Nov. 15, 2014, through Jan. 15, 2015.
::: Arizona’s 2012 Medicaid budget ranked 33rd nationwide, at almost $8.6 billion, a 10.1 percent increase over 2011. The average spending per enrollee for 2012 was $7,087.
::: A federal judge in New York ruled several Catholic organizations are not required to provide insurance coverage for employee’s contraception, a current requirement of the ACA.

COMINGS & GOINGS
2013 HIGHLIGHTS
John Amos was promoted to president & CEO of Yavapai Regional Medical Center in Prescott, with the retirement of Tim Barnett. Eddy Broadway became the new CEO at Mercy Maricopa Integrated Care. Dawn Ciri was named AVP, regional operations / managed care for Tenet Healthcare Corp. Tom Dameron returned to Arizona to become president of the mountain states, western region for Aetna, Inc. Barbara Dember was named president and CEO Verde Valley Medical Center. F. Dana Ellerbe was named CEO of Havasu Regional Medical Center, a LifePoint hospital. Brian Erstad was promoted to head of the Department of Pharmacy Practice at the UA College of Pharmacy. Michael Franks was promoted to divisional strategic development leader for Humana – Desert Pacific Region. Dr. Dean French was named the new CEO at Sierra Vista Regional Health Center. Dr. Michele Halyard was named vice dean of the Mayo Medical School – Arizona campus. Jeri Jones was promoted to UnitedHealthcare’s west region president for community plans (United’s Medicaid programs). The west region encompasses an 11-state area, including Arizona. Cigna promoted Edward Kim to president & general manager for the company’s Arizona market. Rose Megian became regional health plan officer & president of Health Net of Arizona. Banner Good Samaritan Medical Center promoted Dr. Steve Narang to CEO of the hospital. The Arizona Department of Health Services appointed Cory Nelson as deputy director of behavioral health. Bruce Pearson, CEO of John C. Lincoln North Mountain Hospital, will also oversee Scottsdale Healthcare Osborn Medical Center as its CEO. Richard Polheber was appointed CEO at Benson Hospital. Beth Soberg added Arizona to her area of responsibility as CEO of UnitedHealthcare for CO, NM, MT, WY and now AZ. Greg Polk was named president and CEO of the Arizona Hospital & Healthcare Association. David Wanger was named CEO at Green Valley Hospital. White Mountain Regional Medical Center appointed Greg Was CEO.

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