Hall, Kistler & Company LLP

# Doctor Perspectives

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Spring 2010

## Healthcare Reform: Summary and Timeline

The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010. One week later, on March 30, 2010, the Health Care and Education Reconciliation Act (HCERA) was signed into law. These two laws represent the culmination of the healthcare reform efforts that have been underway since President Obama took office.

Now comes the lengthy task of deciphering the thousands of pages that make up this legislation to determine who is impacted, how, and when. Generally speaking, the primary goals of this comprehensive legislation were to extend coverage to the approximately 32 million uninsured Americans, to improve the healthcare delivery system, and to curb the rising costs of healthcare.

The achievability of these goals will be dependent upon successfully meeting the timeline that has been established. The legislation also contains many provisions that deal with regulations that have yet to be developed. Development and implementation of these regulations will be the responsibility of the Secretary of the Department of Health and Human Services. Until all of these regulations are written and finalized, we will not know the full direct and indirect impact of this legislation. What we do know is that a number of significant changes will take effect immediately and over the next several years.

The following provides a summary of some of the key changes by year:

### 2010

**Small Businesses:** Businesses with 25 or fewer full time equivalent employees with average wages of less than $50,000 could qualify for a tax credit of up to 35% of the employer's contribution towards their employees' health insurance premiums. Employers must be contributing at least 50% of the cost of the premiums to qualify. This tax credit will be available through 2013.

**Insurance Practices:**

- Eliminates the use of lifetime limits on coverage for individual and group plans. Annual limits will have new restrictions until 2014, at which time they will be prohibited.
- Coverage cannot be rescinded, except in the case of fraud.
- Prohibits exclusions for pre-existing conditions for children.
- Increases the age for dependent coverage for children to 26 years. This includes children who are married, but will not cover their spouse or children.

**Medicare Claims:** Part B claims submission deadline is changed from 15 to 12 months from the date of service.

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# Healthcare Reform: Summary and Timeline (continued from pg 1)

## 2010 (continued from pg 1)

**Imaging:** The technical component discount on single session studies of consecutive body parts is increased from 25% to 50% beginning in July.

**Medicare Part D Drug Program:** Provides a one-time $250 rebate to enrollees who reach the coverage gap.

## 2011

**Medical Loss Ratio:** Health Plans must report the percentage of premium dollars that are spent on care. If this percentage is less than 85% for plans in the large group market and 80% for plans in the individual and small group market, rebates must be provided. This is effective for plan years in 2010, with the rebate provision effective January 1, 2011.

**W-2 Reporting:** Employers must report the value of employer provided health insurance on the 2011 Form W-2.

**Individuals:** The costs of over the counter drugs will no longer be reimbursable through flexible spending accounts, health savings accounts, or health reimbursement accounts. Additionally the penalty for non qualified distributions from HSAs increases from 10% to 20%.

**Medicare:** Offers a 10% bonus to primary care providers who meet certain requirements regarding the location of services. This is effective for 5 years.

**PQRI:** Incentive for 2011 is 1% of Part B allowed charges for professional services. An additional .5% is available for those who participate through a newly offered Continuous Assessment Program.

**Medicare Advantage:** Payment cuts begin.

**Medicare Beneficiaries:** Will receive a free annual wellness visit. Cost sharing on certain types of preventative care and screenings will be waived.

**Medicare Part D Drug Program:** Begins phase out of the coverage gap by implementing brand name discounts and generic coverage to enrollees in the gap. Gap will be fully closed by 2020.

## 2012

**PQRI:** Incentive for 2012 through 2014 is .5%. CMS is required to provide practices with timely feedback.

## 2013

**Medicaid:** Effective for 2013 and 2014, primary care services provided by primary care physicians are reimbursed at 100% of current Medicare rates. States will receive additional Federal funding to compensate for these increases.

**Employers:** Deduction for Medicare Part D drug subsidy is eliminated.

**Individuals:**

- .9% Hospital Insurance Tax on individual earnings over $200,000 ($250,000 joint)
- 3.8% Hospital Insurance Tax on net investment income if adjusted gross income exceeds $200,000 for an individual ($250,000 joint)
- FSA contributions are limited to $2,500 per year. This limit will be increased annually based on cost of living factor.
- The threshold for itemized deductions for unreimbursed medical expenses increases from 7.5% to 10%.

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# Healthcare Reform: Summary and Timeline (continued from pg 2)

## 2014

**Insurance Exchanges:** State insurance exchanges will be established for individual and small group (less than 100 employees) purchasers.

**Individuals:**

Penalty for failure to obtain coverage starts. It will be phased in over 3 years and then will be subject to a cost of living adjustment.

Individuals who make up to 400% of the Federal poverty level will receive tax credits to assist with the purchase of insurance on the exchange.

**Small Businesses:** Employers who purchase coverage through the Exchange will be eligible for a tax credit for a period of two years. Employers must be contributing at least 50% of the cost of the premiums to qualify.

**Large Employers:**

- Employers with 50 or more full time equivalent employees that do not offer coverage will be subject to a penalty of $2,000 per full time employee per year. The first 30 employees are not included in this calculation.
- Annual penalties will apply if the coverage that is offered does not meet certain minimum requirements. Employers must pay at least 60% of the benefit costs for each covered employee, and the costs paid by each employee cannot exceed 9.5% of his/her modified adjusted gross income.
- Vouchers will be offered to employees in lieu of coverage if the employees' cost is 8%-9.8% of their income. Employees can use these vouchers to purchase individual coverage from the exchange.
- Employers with 200 or more employees are required to automatically enroll new full-time employees in the company offered health insurance plan. Employees will have to formally opt out of such coverage, if requested.

**Medical Loss Ratio:** Medicare Advantage Plans must now have a medical loss ratio of 85% or provide a rebate to the Department of Health and Human Services. Additional penalties for non compliance could also apply.

**Insurance Practices:**

Adults can no longer be denied coverage for pre-existing conditions.

Annual limits on coverage are prohibited.

The issuance and renewal of insurance is guaranteed.

The maximum waiting period is 90 days.

Rate regulations take effect, limiting or eliminating rate differentials that can be charged.

**Medicaid:** Eligibility for enrollment is expanded to 133% of the Federal poverty level. Adults with no children will also be eligible.

## 2015

**PQRI:** A 1.5% penalty is assessed for non-satisfactory participation by a practice.

## 2016

**PQRI:** A 2% penalty is assessed for non-satisfactory participation by a practice.

## 2017

**Insurance Exchanges:** States will have the option to open their exchanges to large employers.

## 2018

**Tax on High Cost Health Plans:** Insurers providing employer sponsored health plans defined as high cost (or 'Cadillac Plans') will be assessed a 40% excise tax on amounts above the thresholds of $10,200 per year for individual coverage or $27,500 per year for family coverage. These thresholds are adjusted for retirees 55 years and older who are not eligible for Medicare and individuals in high risk professions. The thresholds will also be indexed for inflation each year starting in 2019.

# New HIPAA Security Requirements

The Health Information Technology for Economic and Clinical Health Act of 2009, perhaps better known as HITECH was part of the 2009 American Recovery and Reinvestment Act. Under HITECH, HIPAA privacy and security provisions have been significantly affected. Practices need to be sure that they have put in place requirements that went into effect February 2010, as well as be prepared for additional changes once clarification is given on some of the other provisions. It also needs to be noted that these changes and requirements not only affect providers, but their Business Associates as well, who now must meet many of these same requirements.

The law not only includes enhanced individual's rights concerning disclosure, but also indicates what is required in the case of a breach of security, how the law affects electronic health records, including requiring an entity to be able to account for **all** EHR disclosures. Finally, new penalties have also been instituted.

**Patient Rights Concerning PHI**

- If an individual pays out of pocket for any service, they have the right to exclude any information related to that service from being provided to a health plan.
- If an entity uses electronic health records, the individual has the right to request a copy of that record in an electronic format.
- Entities engaged in any form of written fundraising must clearly give any recipient of the correspondence an opportunity to "opt out" from receiving any further type of fundraising requests.
- Marketing activities will require a patient's authorization unless it is directly related to the care of the patient, part of a service being provided by the entity, or being used for the coordination of care or case management of the patient's condition.
- Entities will also be required to determine what "minimum necessary" information is needed when disclosing information, providing only the information needed to process a request from an entity. Guidelines are expected to clarify the "minimum necessary" in August 2010.
- On the horizon:
    1. By January 1, 2011, practices that utilize an EHR system will be required to provide patients, upon request, a listing of all disclosures of PHI, including any made for the treatment, payment, or health care operations related to the patient's care (if your EHR system was put in place prior to January 1, 2009, you will be required to implement this by January 1, 2014).
    2. Regulations are expected by August 2010 to prohibit the sale of any PHI without a release from the patient, of any PHI unless it relates to the treatment of the patient, is for research reasons, or in the interest of public health activities.

**Standards Required for Safeguarding PHI**

- Entities should update all policies and procedures, to reflect how they will protect PHI, including updating policies on:
    1. How they will prevent, identify, and limit incidents of disclosure and correct any disclosure of PHI.
    2. Minimizing access to electronic medical record systems to only those individuals who need direct access.
    3. Protecting and limiting access to where the systems are housed.
- Stay current on all technology and institute periodic checks on "encryption" methods being used to secure PHI.

**Breach of Privacy**

- If a breach has occurred, covered entities must notify the affected parties within 60 days of identifying the breach, including what happened and what information was released.
- This must be done in writing and sent to the patient's last known address. If this is unknown, the information needs to be posted, for example on the entity's web site.
- In cases where 500 or more individuals are affected, covered entities are required to notify both HHS and prominent media outlets.

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# New HIPAA Security Requirements (continued from pg 4)

**Penalties**

Previously, most cases were identified by patient complaints however under the new rules; the expectation is that the appropriate agencies will take a more active role in ensuring that the new regulations are enforced by executing audits of covered entities and their Business Associates. In addition to CMS, the new law allows for state Attorney Generals to pursue cases also.

Penalties have been increased. In the past, the maximum civil penalty allowed was $100 per incident capping out at $25K per year. Now, depending on the circumstances, one of three penalties could be assessed:

- $100 per incident with a $25,000 yearly maximum for innocent mistakes
- $1,000 per incident with a $100,000 yearly maximum for knowingly releasing PHI without "willful neglect"
- $50,000 per incident with a $1,500,000 yearly maximum for incidents involving "willful neglect"

What will define "willful neglect" is yet to be defined, however the consequences are now much greater and practices need to ensure that they are doing everything possible to minimize their risk.

# Government EHR Funding: Updates on Stimulus Funding and Meaningful Use

By now, most physicians are aware of the upcoming availability of stimulus funds that will assist in offsetting the costs associated with the purchase, implementation, and meaningful use of qualified EHR systems within their practices.

Two incentive opportunities exist for the funding. An eligible professional (EP) can receive up to $44,000 through Medicare participation and up to $63,750 through state Medicaid participation. A provider can only participate through one program; however, these amounts are per EP. That means that each EP within a practice can earn the incentive, provided each meets the meaningful use requirements that are currently being proposed.

Generally speaking, the American Recovery and Reinvestment Act (ARRA) defined four broad provisions regarding the use and requirements of EHR systems to qualify for the funding. "Certified" systems must be connected in such a way that health information can be electronically exchanged. Physicians must e-prescribe, and the systems must be able to submit clinical quality and measurement data (as defined by the Secretary).

Additionally, the proposed criteria, which defines meaningful use for EPs, consists of 25 objectives and measures centering around health IT functionality and clinical quality. They include the following:

- Computerized physician order entry (CPOE)
- E-prescribing, including the maintenance of active medication lists and checks for drug allergies, interactions, and formularies
- Recording of demographics, lab results, and smoking status
- Recording and charting changes in vital signs
- Reporting of ambulatory quality measures and specific conditions by patient
- Use of patient reminders
- Electronic eligibility checks
- Electronic claims submission
- Patient access to health information electronically (including medical record requests)

The proposed criteria relate to Stage One of meaningful use, which begins in 2011. There are a total of three stages, and each stage will expand on the previous one. Stage Two begins in 2013 and Stage Three in 2015.

While there are still many questions left to be answered and the proposed criteria are subject to change, it is important that practices start thinking about these requirements and how they will meet them.

**Note: Practices need only report 3 months of meaningful use in 2011 to qualify for the 1st year of funding.**

# National News

## CMS

### CHANGE IN TIMELY FILING REQUIREMENTS

The Patient Protection and Affordable Care Act (PPACA), signed by the President on March 23, 2010, has reduced the amount of time you have to file your Medicare claims from 15 months to 12 months. While providers will still have 15 months to file claims for dates of service from October 1, 2009 through December 31, 2009 (claims must be filed by December 31, 2010), the 12 month timely filing will apply to all dates of service furnished on or after January 1, 2010. From that point on all claims must be filed within one year of the date of service.

### PECOS SYSTEM UPDATES WILL BE REQUIRED AS OF JANUARY 2011

All eligible providers who order or refer services or items for Medicare beneficiaries are required to be currently enrolled in the Provider Enrollment, Chain and Ownership System (PECOS).

Effective October 5, 2009, if the referring/ordering eligible provider's name is not provided on the claim form, the claim is denied. If the provider is listed, but not current in the PECOS system, the claim is paid, however the provider receives a notice on their remittance that the ordering/referring provider edits are not being met.

*This will change starting January 3, 2011 when CMS will require that the ordering/referring physicians have a current enrollment record in PECOS, and if they do not, their claims will be rejected.*

Although a provider may be enrolled in Medicare, they may not have a current record in PECOS. If you have not submitted any enrollment information updates (i.e. change of address, etc.) since November 2003, chances are that you are not current in PECOS. Even if you have submitted enrollment information since then, there is still a possibility that you are not current. To see if you are currently enrolled, go to https://pecos.cms.hhs.gov. You will need your user name and password. If you do not have a user name and password, go to the NPI Enumerator home page at https://nppes.cms.hhs.gov/NPPES/Welcome.do to create one.

If your PECOS record does not exist or is not current, you will have to submit the appropriate CMS enrollment form to update your information. Remember, it may take up to 60 days or longer for your application to be processed—so don't wait - ACT NOW and call us if you need assistance with this process.

### CHANGE IN INTEREST RATES FOR MEDICARE OVERPAYMENTS AND UNDERPAYMENTS

A new interest rate for Medicare overpayments and underpayments went into effect January 25, 2010. The new rate is 11.25%. For details on the interest rate go to: ht**tp://www.cms.gov/transmittals/downloads/R165FM.pdf**

### EDI FORMAT CHANGES

On January 4, 2010, the Level I implementation of HIPAA versions 5010 (healthcare claims) and D.0 (pharmacy claims) for Electronic Data Interchange (EDI) Standards were implemented. Versions 5010/D.0 imparts significant changes in the content of the data that providers will submit with their claims, along with the data available in response to electronic eligibility or claims status inquiries. Level I testing incorporate internal testing activities for the new versions of the EDI Standards. You should be ready to meet Level I compliance by December 31, 2010, so that you can begin Level II testing activities, which will involve external testing with trading partners, by January 1, 2011. January 1, 2012 marks the date for full compliance with Versions 5010 and D.0. http://www.cms.gov/MLNMattersArticles/downloads/SE0904.pdf

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# National News (continued from pg 6)

## ASC FEE SCHEDULE AND PAYMENT POLICY CHANGES

Effective April 1, 2010, CMS has implemented changes and revisions in the payment of certain drugs and biologicals. Included in the changes are updated payment rates for certain HCPCS codes for 2009 dates of service, new drug codes that are separately payable and how to correctly report number of units for drugs. For complete details see the MLN Matters article at http://www.cms.gov/MLNMattersArticles/downloads/MM6866.pdf.

## NEW PLACE OF SERVICE CODE

CMS adds a New Place of Service (POS) code for Walk-in Retail Health Clinics effective March 11, 2010. Walk-in Retail Health Clinics are defined as " a walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventative and primary care services." For details go to: http://www.cms.gov/MLNMattersArticles/downloads/MM6752.pdf

## CCI UPDATES

Effective April 1, 2010, (CR6819), please take note that the quarterly update to the Correct Coding Initiative edits went into place. Information on current CCI and MED edits is available at http://www.cms.gov/MLNMattersArticles/downloads/MM6819.pdf

## Red Flags Rule Delayed Again

In response to the Federal Trade Commission where the FTC remains intent on applying the Red Flags Rule on identity theft to patients and physicians, the AMA and other professional organizations successfully delayed implementation of the Rule until at least December 31, 2010. The AMA is continuing its efforts to persuade the FTC that physicians are not "creditors" and should not be subject to the new identity theft rules. In the interim, the AMA provides guidance where physicians can incorporate identity theft protection and detection into your current practice's existing compliance with HIPPA and privacy policies.

The Red Flags Rule requires organizations have reasonable policies and procedures in place to identify, detect and respond to identity theft flags. Each medical practice's experience and circumstances as well as the degree of risk must be considered in the development of any specific plan.

Key procedures to consider including in your practice's plan are:

- Identify the red flags that occur in your practice, such as: patient complaints on billing or credit reports, records showing inconsistent medical treatment or an explanation of services rendered that were never received
- Detect red flags within a practice's processes through staff training on patient identity verification
- Establish a procedure to document an incident and, if necessary, a responding action plan
- Continue to review and update your program and incorporate oversight and re-training

Additional information can be found by visiting www.ama-assn.org/go/pmc.

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# KAREN M. BRENNEMAN, CPA, MT

## PARTNER

karenb@hallkistler.com

Karen came to Hall, Kistler with extensive experience in the area of Tax. She has 21 years of knowledge in the areas of compliance and consulting for tax; accounting; and management advice. She also has considerable knowledge dealing with C-Corporations, state and local corporate tax and retirement planning.

Karen's experience with physicians includes compensation planning, practice management, mergers and acquisitions and the complete set up of a Practice, from opening the door to retirement planning for physicians.

Karen's responsibilities also involve consulting on tax saving strategies including charitable giving, retirement planning, and estate and gift planning. In addition, she covers the areas of acquisitions, reorganizations, and succession planning for closely held companies. Although Karen specializes in Tax, C-Corporations and Physician organizations, her depth of knowledge of the accounting industry allows her to serve a wide range of clients.

Karen earned both her Bachelor of Science Degree in Accounting and her Master of Taxation from The University of Akron. She is a member of the American Institute of Certified Public Accountants and the Ohio Society of Certified Public Accountants.

Actively involved in the community, Karen is on the Finance Committee of the Stark Development Board, is a member of the 15th class of Leadership Stark County, Vice President of the Canton Rotary, is a board member of the Canton Regional Chamber of Commerce, past Treasurer of Community Services of Stark County, a church Junior Youth Sunday schoolteacher and a member of the Atwood Yacht Club.

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**Karen Brenneman, CPA, MT**
**Partner**
**Director of Healthcare Consulting**
**karenm@hallkistler.com**
**330-453-7633 ext.123**
**Visit us on the web at www.hallkistler.com**

HALL, KISTLER & COMPANY LLP
CONSULTANTS AND CERTIFIED PUBLIC ACCOUNTANTS

**220 Market Avenue, South - Suite 700**
**Canton, OH 44702**