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New MACRA Patient Codes Confusing, Providers Say

Providers are pushing back against proposed codes required by MACRA to identify which clinicians provide services. The codes are an integral part of the payment reform, as they are an effort to compare resources across practices. Industry leaders stated that the proposed version of the patient relationship codes, which were mandated by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, would be a burden and wouldn't accomplish the goal of effectively measuring resource use, a major performance category under the Merit-based Incentive Payment System (MIPS). The claims codes, which would be required if physicians choose to participate in a MIPS, would determine each provider's level of responsibility and the costs associated with providing care.

"Patient relationship categories must be mutually exclusive in a given situation, so a physician does not have to choose among two or more equally applicable categories for a patient in a particular circumstance. When applying patient relationship codes to encounters, there could be confusion if the clinician has different relationships based on the patient's different diagnoses" Dr. Robert Wergin, chair of American Academy of Family Physicians' board, said in a letter. The law requires providers to begin to include the patient relationship codes on their claims starting Jan. 1, 2018. CMS is expected to unveil a modified proposed set of codes by the end of November of this year.

Changes to ACA Exchanges May Be Enough To Keep Them Afloat

Proposed changes to help stabilize the Affordable Care Act health insurance exchange markets should be enough to stop the losses, but further changes will likely be needed next year. The rule, which was released a couple of months earlier than expected, includes changes in 2018 to the ACA risk-adjustment program as well as changes to plan requirements.

The rule changes are a response to tumult in the exchanges as Aetna, Humana and UnitedHealth Group have all said they will be significantly scaling back their plan offerings in 2017. That and overall low enrollment from consumers has led some to question whether the exchanges can remain viable.

The risk-adjustment changes are particularly key, as insurers have been saying consumers enrolling in the plans are sicker and have higher costs than expected. Risk adjustment will now factor in prescription drug data for disease such as hepatitis C, HIV/AIDS, end-stage renal disease and diabetes. Risk adjustment will also begin accounting for people who enroll outside of the open enrollment period. The next administration and Congress will likely have to make additional changes by the middle of next year to keep the exchanges afloat, such as network adequacy provisions, said Elizabeth Carpenter, senior vice president at the consulting firm Avalere Health.

CMS is proposing a standardized option, or Simple Choice plan, at the bronze level of coverage that qualifies as a high-deductible health plan that can be used with a health savings account. The rule states that high deductible plans are “an option valued by many consumers.”

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