August 2024 Third Party Changes of Significance

MISSISSIPPI MEDICAID

No news items for the month of August from Mississippi Medicaid. MOA is continuing to work with MS Medicaid to ensure an understanding of the coverage for the D-SNP Medicare Dual Eligible Advantage Plans and to ensure that the portal providers in information necessary for doctors to understand coverage and eligibility for each and every MS Medicaid patient.

CMS, NOVITAS, RAILROAD MEDICARE

Beneficiaries Dually Eligible for Medicare & Medicaid — Revised, CMS. August 1, 2024

"Learn what's changed (PDF). CMS added information on Qualified Medicare Beneficiary billing prohibitions."

QMB Billing Prohibitions

- All Original Medicare and MA providers and suppliers (not only those that accept Medicaid) can't charge QMBs Medicare Part A and Part B cost-sharing for covered services.
- Providers and suppliers may bill state Medicaid programs for these costs, but states can limit Medicare cost-sharing payments under certain circumstances. This applies even if the provider or supplier doesn't participate in Medicaid.

  Note: QMBs may have a small Medicaid copayment.
- Providers should use the Medicare 270/271 HIPAA Eligibility Transaction System (HETS) and the Medicare Remittance Advice and Medicare Summary Notice (MSN) messages to identify whether a beneficiary is a QMB and owes no Medicare cost-sharing.
- MA providers and suppliers should contact the MA Plan to learn the best way to identify the QMB status of plan members both before and after claims submission.
- Providers and suppliers may verify beneficiaries' QMB status through automated Medicaid eligibility-verification systems in the state where the person lives or by asking them for other proof, like their Medicaid identification card, MSN, or other QMB status documentation.
- Providers who inappropriately bill people enrolled in QMB are subject to sanctions.
- If you bill a QMB Medicare cost-sharing, or turn a bill over to collections, you must recall it. If you collect any QMB cost-sharing money, you must refund it.
- Providers and suppliers can't charge people enrolled in QMB even if their QMB benefit is from a different state than the state where they get care.
- Certain types of providers may seek payment for Medicare deductible and coinsurance amounts as a Medicare bad debt. The Provider Reimbursement Manual - Part 1 has more information about bad debts.

Many beneficiaries are unaware of the billing restrictions (or concerned about damaging relationships with providers) and sometimes pay the cost-sharing amounts. Others may experience undue distress when unpaid bills are referred to collection agencies. Access to Care Issues Among Qualified Medicare Beneficiaries (QMB) has more information."

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf

Now Available: 2023 MIPS Performance Feedback, 2023 MIPS Final Score, and 2025 MIPS Payment Adjustment Information. CMS QPP. August 12, 2024

"The Centers for Medicare & Medicare Services (CMS) has released Merit-based Incentive Payment System (MIPS) performance feedback and final scores for the 2023 performance year and associated MIPS payment adjustment information for the 2025 payment year.

Your 2023 final score determines the payment adjustment you'll receive in 2025; a positive, negative, or neutral payment adjustment will be applied to the Medicare paid amount for covered professional services furnished in 2025.

REMINDER: There's no exceptional performance adjustment for the 2023 performance year/2025 payment year. Congressional funding for the additional adjustment for exceptional performance expired after the 2022 performance year/2024 payment year.

How Do I Access Feedback?

Sign in to the Quality Payment Program (QPP) website using your Health Care Quality Information Systems (HCQIS) Access Roles and Profile (HARP) system credentials; these are the same credentials that allowed you to submit your 2023 MIPS data.

Click "View Feedback" on the home page and select your organization (Practice, Alternative Payment Model (APM) Entity, Virtual Group).

Practice representatives can access individual, subgroup, and group feedback.

Third party representatives can't access final feedback or payment adjustment information.

If you don't have a HARP account or QPP role, please refer to the Register for a HARP Account (re: HARP account) and Connect to an Organization (re: QPP role) documents in the QPP Access User Guide (ZIP, 4MB) and start the process now.

Now Available: 2023 MIPS Performance Feedback, 2023 MIPS Final Score, and 2025 MIPS Payment Adjustment Information

Now Available: 2023 Targeted Review

MIPS: Now Available: 2023 Targeted Review. CMS QPP. August 12, 2024

"Review your MIPS performance feedback, including your MIPS final score and payment adjustment factor(s), on the Quality Payment Program website.

Individual clinicians, groups, subgroups, virtual groups, APM Entities (including Shared Savings Program ACOs), designated support staff and authorized third party intermediaries may request that CMS review the calculation of their MIPS payment adjustment factor(s) through a process called targeted review.

When to Request a Targeted Review

If you believe there's an error in the calculation of your MIPS payment adjustment factor(s), you can request a targeted review now until October 11, 2024, at 8 p.m. ET.

For example:

- Data were submitted under the wrong TIN or National Provider Identifier (NPI).
- Performance categories weren't automatically reweighted even though you qualify for reweighting due to extreme and uncontrollable circumstances.

Note: This isn't a comprehensive list of circumstances. If you have questions about whether your circumstances warrant a targeted review, please contact the QPP Service Center by phone at 1-866-288-8292 (TRS: 711) or by email at QPP@cms.hhs.gov.

How to Request a Targeted Review

You can access your MIPS final score and performance feedback and request a targeted review:

Sign in using your HARP credentials (ACO-MS credentials for Shared Savings Program ACOs); these are the same credentials that allowed you to submit your 2023 MIPS data.

Click "Targeted Review" on the left-hand navigation.

CMS generally requires documentation to support a targeted review request, which varies by circumstance. A CMS representative will contact you about providing any specific documentation required. If the targeted review request is approved and results in a scoring change, we'll update your final score and/or associated payment adjustment (if applicable), as soon as technically feasible. Please note that targeted review decisions are final and not eligible for further review.

2023 Targeted Review User Guide (PDF, 15MB) – Reviews the process for requesting a targeted review and examples for when you would or wouldn't request a targeted review.

2025 MIPS Payment Year Payment Adjustment User Guide (PDF, 710KB) – Reviews information about the calculation and application of MIPS payment adjustments, and answers frequently asked questions.

Telehealth Services: Billing & Payment for Place of Service Code 10 . CMS MLN Matters. August 15, 2024

"Starting January 1, 2024, use place of service (POS) code 10 for telehealth services provided in a patient's home. Medicare pays for these services at the Medicare Physician Fee Schedule non-facility rate.
More Information:
Telehealth Services (PDF) fact sheet
Sections 20.4.2 and 190 Medicare Claims Processing Manual, Chapter 12 (PDF)
Section 10.5 Medicare Claims Processing Manual, Chapter 26 (PDF)
Instruction to your MAC (PDF)"

CMS Complaint Data and Enforcement Report on Health Insurance Market Reforms. CMS. August 2024 [as reported in the AOA First Look, August 22, 2024]

"Fierce Healthcare (8/21, Tong) says CMS "issued a new report Tuesday detailing total complaints related to the No Surprises Act and Affordable Care Act compliance." The report indicated that "providers and consumers earned $4.18 million in relief after the agency received more than 16,000 complaints, as of June 30. More than 12,000 complaints were tied to the No Surprises Act compliance, while 248 were about Affordable Care Act compliance." Approximately "3,000 cases are still open." About "35% of closed cases found no violation."
https://www.cms.gov/files/document/august-2024-complaint-data-and-enforcement-report.pdf

Quick Reference Guide. Palmetto GBA Railroad Medicare. August 16, 2024

"The Railroad Medicare Quick Reference Guide is a publication to assist providers with submitting claims to Railroad Medicare. In this guide you can find information about many Railroad Medicare topics including Provider Enrollment, submitting electronic and paper claims, using the eServices portal and the Interactive Voice Response (IVR) system, Appeals, Medical Review, Medicare Secondary Payer, Overpayments and Recoupments, and more. Please share with appropriate staff."
https://www.palmettogba.com/palmetto/rr.nsf/DID/7JYQ282514#ls

CMS Updates Health Equity Disparities Impact Statement. CMS. August 20. 2024

"CMS updated the Health Equity Disparities Impact Statement, which is posted online and was sent to partners via listserv. This tool can be used by all health care stakeholders to identify and address health disparities while improving the health of all people, including people with disabilities, sexual and gender minorities, racial and ethnic minorities, individuals with limited English proficiency, and those who live in underserved areas."
https://www.cms.gov/newsroom/cms-round-up/cms-roundup-august-23-2024

OTHER

AOA Reimbursement and Coverage Fairness Townhall
When: Oct 29, 2024
Time: 9:00pm EDT
RHW: This is the second in the series of AOA Events on reimbursement and coverage fairness.
https://eyelearn.aoa.org/learn/course/569/102924-aoa-reimbursement-and-coverage-fairness-townhall?generated_by=13037&hash=e16127a554224f8e73c8edee3dffc8b09566fbbc

Aetna Change in Coverage for 92060 Reversed. Aetna. August 5, 2024
RHW: Regarding Aetna coverage of 92060: In a discussion with Aetna regarding this policy, the correction was made for the broad denials of 92060 (see below). However, the Aetna Clinical

Policy Bulletin 0489 does deem that the RightEye technology CANNOT be billed using 92060. Per Aetna, RightEye (and some other technologies) is experimental, unproven or investigational.

From Aetna:

"Broad non-coverage of CPT 92060 was discontinued with the next claims payment system update on 8/10/24. Please advise your members to appeal any denied claims for CPT 92060 between 7/16/24 and 8/10/24 with records."

From the Aetna Clinical Policy:

1. Experimental, Investigational, or Unproven

Aetna considers the following procedures experimental, investigational, or unproven because the effectiveness of these approaches has not been established:

- Eye tracking digital system (e.g., CureSight System) for the treatment of amblyopia, and for all other indications;
- Online / digital therapeutic vision training software (e.g., RevitalVision) for the treatment of amblyopia, and for all other indications;
- Orthoptic vision therapy for all other indications (e.g., anisometropic amblyopia, concussion, diplopia following orbital fracture, intermittent exotropia, and traumatic brain injury, and vertical heterophoria);
- RightEye Sensorimotor for the treatment of amblyopia, and for all other indications;
- Visual information processing evaluations."

https://www.aetna.com/cpb/medical/data/400_499/0489.html

Aetna Change in Coverage for 92060 Reversed. Aetna. August 5, 2024

"From the Executive Medical Director of Aetna Medical Policy and Operations: "Aetna's change in reimbursement for 92060 relates to an updated version of Clinical Policy Bulletin 0498 Orthoptic Vision Therapy, published on 7/16/2024, and the designation of CPT 92060 as "not covered for indications listed in the CPB".
https://www.aetna.com/cpb/medical/data/400_499/0489.html
Broad non-coverage of CPT 92060 will be discontinued with the next claims payment system update on 8/10/24. Please advise your members to appeal any denied claims for CPT 92060 between 7/16/24 and 8/10/24 with records."

United Health Care Commercial + UMR Medical Drug Benefit Drug Policy: Intracanalicular and Intravitreal Corticosteroid Implants Policy Number: 2024D0107E. Effective Date: August 1, 2024.
United Health Care Individual Exchange Intracanalicular and Intravitreal Corticosteroid Implants Policy Number: IEXD0107.06 Effective Date: August 1, 2024

"This policy provides information about the use of certain specialty pharmacy medications administered by the intracanalicular and intravitreal route for certain ophthalmologic conditions.
This policy refers to the following intracanalicular and intravitreal corticosteroid implant products:

Dextenza® (dexamethasone ophthalmic insert)
Iluvien® (fluocinolone acetonide intravitreal implant)
Ozurdex® (dexamethasone intravitreal implant)
Retisert® (fluocinolone acetonide intravitreal implant)
Yutiq® (fluocinolone acetonide intravitreal implant)

Dextenza is proven and medically necessary when all of the following criteria are met:
One of the following diagnoses:

- Ocular inflammation and pain following ophthalmic surgery; or
- Ocular itching associated with allergic conjunctivitis

and

- Prescribed by or in consultation with an ophthalmologist; and
- Dose does not exceed one insert per eye; and

- Authorization is for no more than one month

Iluvien is proven and medically necessary when all of the following criteria are met:

- Diagnosis of diabetic macular edema (DME); and

Both of the following:

- Member has been previously treated with a course of corticosteroids; and
- Member did not have a clinically significant rise in intraocular pressure

and

- Prescribed by or in consultation with an ophthalmologist; and
- Dose does not exceed one implant per eye; and
- Authorization is for no more than one month

Ozurdex is proven and medically necessary when all of the following criteria are met:

Diagnosis of one of the following:

- Macular edema following branch retinal vein occlusion (BRVO); or
- Macular edema following central retinal vein occlusion (CRVO); or
- Non-infectious uveitis affecting the posterior segment of the eye; or
- Diabetic macular edema (DME)

and

- Prescribed by or in consultation with an ophthalmologist; and
- Dose does not exceed one implant per eye; and
- Authorization is for no more than one month

Retisert is proven and medically necessary when all of the following criteria are met:

- Diagnosis of chronic non-infectious uveitis affecting the posterior segment of the eye; and
- Prescribed by or in consultation with an ophthalmologist; and
- Dose does not exceed one implant per eye; and
- Authorization is for no more than one month

Yutiq is proven and medically necessary when all of the following criteria are met:

- Diagnosis of chronic non-infectious uveitis affecting the posterior segment of the eye; and
- Prescribed by or in consultation with an ophthalmologist; and
- Dose does not exceed one implant per eye; and
- Authorization is for no more than one month

Intracanalicular and intravitreal corticosteroid implant products are unproven and not medically necessary for the treatment any other indication due to insufficient evidence of efficacy including, but not limited to the following:

- Cystoid macular edema after cataract surgery
- Radiation retinopathy"

Commercial: https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-medical-drug/intravitreal-corticosteroid-implants.pdf

Individual Exchange: https://www.uhcprovider.com/content/dam/provider/docs/public/policies/exchange/intracanalicular-and-intravitreal-corticosteroid-implants-iex.pdf

United Health Care Commercial + Individual Exchange: Glaucoma Surgical Treatments Policy Number: 2024T0443HH Effective Date: August 1, 2024

United Health Care Community Plan: Glaucoma Surgical Treatments Policy Number: CS050.V Effective Date: October 1, 2024

"Policy Changes under Coverage Rationale:

• Replaced language indicating "goniotomy or gonioscopy-assisted transluminal trabeculotomy for pediatric glaucoma (age 18 years or less) is proven and medically necessary" with

"goniotomy or trabeculotomy for pediatric glaucoma (age 18 years or less) is proven and medically necessary"

- Revised list of unproven and not medically necessary indications; replaced:
  - o "Combined canaloplasty (ab interno) and gonioscopy-assisted transluminal trabeculotomy (e.g., OMNI® Surgical System)" with "combined; canaloplasty (ab interno) and trabeculotomy (e.g., OMNI® Surgical System, Streamline Surgical System)"
  - o "Goniotomy or gonioscopy-assisted transluminal trabeculotomy (for all other indications [not listed as proven and medically necessary in the policy])" with "goniotomy or trabeculotomy (for all other indications [not listed as proven and medically necessary in the policy])"

Commercial/Individual Exchange: https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-medical-drug/glaucoma-surgical-treatments.pdf
Community Plan: https://www.uhcprovider.com/content/dam/provider/docs/public/policies/index/comm-plan/glaucoma-surgical-treatments-cs-10012024.pdf

United Health Care Community Plan: Macular Degeneration Treatment Procedures Policy Number: CS072.Q Effective Date: August 1, 2024

"Coverage Rationale Replaced language indicating "implantable miniature telescope (IMT) is proven and medically necessary when used according to U.S. Food and Drug Administration (FDA) labeled indications, contraindications, warnings, and precautions for treating individuals with end-stage, age-related macular degeneration" with "IMT is proven and medically necessary when used according to FDA [guidance as outlined in the FDA section of the policy] for treating individuals with end-stage, age-related macular degeneration"

https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medicaid-comm-plan/macular-degeneration-treatment-procedures-cs.pdf

Second-Largest Medicare Advantage Insurer [Humana] Prepares to Lose Over 200K People. Newsweek. August 2, 2024

"Humana, the second-largest Medicare Advantage insurer nationally, expects to lose more than 200,000 beneficiaries next year as it reduces benefits and exits certain markets. "

"Louisville, Kentucky-based Humana said it expects to lose the patients as it limits the benefits available and leaves several markets in 2025. The insurance company is making the changes in hopes to increase its profits as the government increases costs. …"

https://www.newsweek.com/second-largest-medicare-advantage-insurer-prepares-lose-over-200k-people-1934046

Insurers Use Home Visits To Boost Medicare Payments. AOA First Look. August 5, 2024

"The Wall Street Journal (8/4, Wilde Mathews, Weaver, McGinty, Maremont, Subscription Publication) reports that a Wall Street Journal investigation has found that insurers use home visits to gather inaccurate diagnoses using devices not FDA-approved for the purpose. They then use this to increase Medicare payments. The investigation revealed that from 2019 to 2021, these visits generated $15 billion in extra payments. In response, CMS has increased audits and removed some diagnoses from payment eligibility."

Medicare Advantage Consensus Waning Ahead Of 2024 Election, Noah Tong. Fierce Health Care. August 19, 2024.

"Both political parties are more open to Medicare Advantage (MA) reform than in previous election cycles, a shift former federal officials warned should be a warning call for the health insurance industry to refocus its messaging and advocacy efforts surrounding the plans.

Scrutiny is ramping up among Democrats concerned MA is not a good deal for taxpayers and within a group of more populist Republicans, whereas there used to be more bipartisan agreement on the program's importance.

…

The Centers for Medicare & Medicaid Services (CMS) finalized its 0.16% cut of MA benchmark payments in March, causing an uproar of pushback from insurers saying the decision would result in layoffs, a retreat from service areas and fewer supplemental benefits for members.

Some lawmakers hoped CMS wouldn't go through with the plan, while others pointed to a MedPAC report that found Medicare is projected to overpay MA plans by $88 billion as compared to what traditional Medicare would've received. …"

https://www.fiercehealthcare.com/payers/medicare-advantage-consensus-waning-2024-election

Most State Medicaid Programs Cover Routine Eye Exams For Adults, But Coverage Of Other Routine Vision Services Varies. Lipton, et al. Health Affairs. August 2024

"More than twelve million US adults ages forty and older are affected by vision impairment, and projections suggest that this number will double by 2050. Although most vision impairment can be eliminated with corrective lenses, many adults lack access to routine eye care. In this study, we analyzed detailed state-by-state Medicaid policies for 2022 and documented variability in coverage for adult vision services. Most fee-for-service Medicaid programs covered routine eye exams, although many did not cover glasses (twenty states) or low vision aids (thirty-five states), and about two-thirds of states with routine coverage required enrollee cost sharing. Managed care plans generally provided consistent or enhanced coverage relative to fee-for-service programs, although coverage sometimes varied between plans within a state. We estimated that about 6.5 million and 14.6 million adult enrollees resided in states without comprehensive coverage for routine eye exams and glasses, respectively. These findings reveal important gaps and opportunities for states to increase access to routine vision care."

https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2023.00873?journalCode=hlthaff

Claim Denials Becoming Increasingly Frustrating For Healthcare Providers, Report Shows. AOA First Look. August 9, 2024

"Modern Healthcare (8/8, Hudson, Subscription Publication) reports, "Insurance claim denials continue to be a vexing problem for healthcare providers, forcing them to expend more resources to reverse payers' decisions in an already-inflated cost environment." Requests for additional information are becoming "a growing burden on providers, but some payer programs are worse than others, according to a report published Thursday by consulting firm Kodiak Solutions." Insurance payers "initially denied 3.8% of billed charges in the first five months of 2024 requesting more information." These requests have forced providers to shoulder "rising administrative costs for staffing and other resources needed...to follow up with patients when a claim or parts of it are denied." In the first five months of the year, Medicaid and commercial payers issued the highest number of denials at 9.2% and 8.1% respectively, potentially due to "constantly changing Medicaid rules and multistate providers dealing with different rules in different states.""

Report:https://static1.squarespace.com/static/65d790c56a64c0761fd9171e/t/66ad47fe0c92b05e206ef424/1722632192313/K1005+KPI+Benchmarking+Report+Aug+Q3+2024.pdf

Wellcare Claims Process Changes. Magnolia Health Weekly News. August 9, 2024

"Effective August 1st, 2024, the Wellcare Claims Department will no longer accept claim inquires submitted to a Provider Relations Representative that have not been previously disputed.

This change is necessary to ensure that all inquiries adhere to regulatory requirements, and proper channels and protocols established by our Provider Manual.

The claims payment dispute process addresses claim denials for issues related to untimely filing, incidental procedures, bundling, unlisted procedure codes, non-covered codes, etc. Claim payment disputes for par Providers must be submitted to Wellcare in writing within 90 calendar days of the date of denial set forth in the EOP.

Claim Dispute Forms: https://www.wellcare.com/mississippi/providers/medicare/forms.

Providers can also submit dispute requests through the secure Provider Portal at www.provider.wellcare.com

When submitting a Wellcare Claim inquiry to your Provider Relations Representative, include all relevant documentation of the dispute process. Examples include:

· Claim Payment Dispute Number
· Appeal Number
· Tracking Number
· Call Center Reference Number

FTC EyeGlass Rule AOA Compliance Toolkit

"This toolkit includes frequently asked questions, template authorizations and information regarding AOA's advocacy regarding the Eyeglass Rule."

"The new Eyeglass Rule of 2024 goes into effect on Sept. 24. The new rules require doctors to obtain confirmation from a patient that the prescription was provided to the patient. In cases where the prescription is provided electronically, doctors need to obtain consent to send the prescription electronically and retain that consent. The Eyeglass Rule of 2024 mirrors the requirements of the Contact Lens Rule of 2020. AOA has developed a toolkit to assist doctors with compliance."

Practice Success Resources | AOA
https://www.aoa.org/AOA/Documents/Practice%20Management/practice%20resources/Eyeglass%20Rule%20Frequently%20Asked%20Questions%207%2026%2024.pdf

Covering Telemedicine Routine Vision Exams. March Vision/UHC. August 15, 2024

"As a reminder, we cover telemedicine routine vision exams consistent with an in-person exam when those telemedicine exams meet our expectations and requirements as listed in the Clinical Practice guidelines section of the Provider Reference Guide.

You must use your professional judgment to determine whether telemedicine is appropriate for a member. To submit telemedicine claims, telemedicine exams must be allowed in your state, and you must complete a Telemedicine Attestation and have it approved by us. Please reach out to your Provider Relations Advocate for instructions.

Additional credentialing may be required, including verification of licensure in states where members are located. Once approved to submit claims, use Place of Service Code 02 with the codes below on your electronic (EDI) claim, paper claim or claims submitted via the portal. Claims for materials must be filed separately with the appropriate Place of Service Code. Members must be informed in advance when exams are performed via telemedicine.

Accepted codes for telemedicine claims are: 92002, 92004, 92012, 92014, 92015, or S6020, S6021 when applicable. Our HEDIS® requirements apply to all telemedicine exam claims.

Dilated Fundus Exam (DFE): If a telemedicine exam indicates the possibility of active ocular pathology, you must refer the member for local, in-person care. Additionally, if a DFE is warranted after a telemedicine exam, the DFE must be offered within 7 days and within a reasonable distance of the telemedicine site."

https://www.uhcprovider.com/vision/marchvision-news-covering-telemedicine-routine-exams.html?cid=em-providernews-PCA12402278-aug24

Review Your State's Benefit Summary. March Vision UHC. August 15, 2024

"To help ensure you are always aware of the covered benefits in your state, you should routinely view your state's benefit summary on our Provider Reference Guide page, under State Specific Plan Benefits and Requirements. Member benefits may change at any time and it's important to verify eligibility and benefits before rendering services to each patient."

Mississippi Guidance:
https://www.marchvisioncare.com/docs/MarchDocuments/Provider%20Reference%20Guides/MS_ProviderReferenceGuide.pdf?tm=2024-08-16%2007:55:26

Mississippi State Specific Plan Benefits and Requirements:

https://www.marchvisioncare.com/docs/MarchDocuments/StateSpecificPRG/Mississippi.pdf?tm=2024-08-16%2008:25:26
https://www.marchvisioncare.com/providerreferenceguides.aspx

New Provider Demographic Update Tool. Magnolia Health. August 16, 2024

> "Magnolia Health is committed to providing our providers with the best tools possible to support their administrative needs for MSCAN and Ambetter. Whether it's making an address change or terminating a provider, we have created an easy way for you to request updates to your information and ensure we receive what is needed to complete the request in a timely manner.
>
> Try the Provider Demographic Tool Today! https://www.magnoliahealthplan.com/providers/resources.html
>
> Please note, MSCAN and Ambetter Delegated Providers will continue to submit rosters to magnoliacredentialing@centene.com.
>
> Wellcare Providers will continue to submit rosters and demographic updates to msproviderupdates@centene.com.
>
> Need to review your existing information or have a question? If you are a contracted provider, you can visit our Provider Directory to review your information https://www.magnoliahealthplan.com/find-a-doctor/find-a-provider-guide.html."

Representatives Press Insurance Regulators To Detail Efforts Against "Troubling" Health Insurance Tactics. AOA First Look. August 22, 2024

> "The New York Times (8/21, Hamby) reports Reps. Bobby Scott (D-VA) and Mark DeSaulnier (D-CA) "on Tuesday called on health insurance regulators to detail their efforts against 'troubling practice[s]' that have raised costs for patients and employers." In their letter "to a top Labor Department official, [the] two congressmen cited a New York Times investigation of MultiPlan," which found that "the firm and the insurers can collect higher fees when payments to medical providers are lower, but patients can be stuck with large bills" while employers are charged high fees. Scott and DeSaulnier 'highlighted MultiPlan as an example of 'opaque fee structures and alleged self-dealing' that drive up health care costs.' They 'asked how the Labor Department was enforcing disclosure requirements and whether it would issue rules clarifying them.'"

https://www.nytimes.com/2024/08/21/us/congress-multiplan-health-insurance-medical-bills.html

A Win for Employers: Judge Blocks FTC's Non-Compete Ban Nationwide. Genesis E. Torres and Devon D. Williams. Ward and Smith, PA Attorneys at Law. August 20, 2024

> "On Tuesday, August 20, 2024, Judge Ada E. Brown, a United States District Judge for the Northern District of Texas, delivered a nationwide victory to businesses and employers across the country when she granted Ryan LLC (a tax service firm) and the U.S. Chamber of Commerce's (the country's largest business lobby) Motions for Summary Judgment against the Federal Trade Commission ("FTC"). Judge Brown's ruling blocked the FTC's Non-Compete Rule scheduled to take effect September 4, 2024. She ordered that the Non-Compete Rule "shall not be enforced or otherwise take effect," fully nullifying it and blocking the FTC's would-be enforcement. "

https://www.wardandsmith.com/articles/a-win-for-employers-judge-blocks-ftcs-non-compete-ban-nationwide

CMS Blocks Two Private Sector Enrollment Sites From Obamacare Marketplace, AOA First Look. August 23, 2024

> "KFF Health News (8/22, Appleby) reports the Centers for Medicare & Medicaid Services has "blocked two private sector enrollment websites from accessing consumer information through the federal Obamacare marketplace, citing 'anomalous activity.'" The agency "said in a written statement that it had suspended the two sites – Benefitalign and Inshura – 'while the anomalous activity is researched to ensure the [enhanced direct enrollment] EDE partners are in compliance with CMS data standards.'" In the meantime, "the websites, [a spokesperson] said, are cooperating with CMS, and they conducted an internal review that found no security

issues." The announcement comes as the CMS "is under the gun to curb unauthorized enrollment and switching of Affordable Care Act plans by rogue agents," receiving "more than 200,000 complaints in the first six months of the year about such actions."

https://kffhealthnews.org/news/article/aca-obamacare-plan-switching-fraud-lawsuit-benefitalign-inshura-blocked-access/

ACA Marketplace Enrollees Had Access To 40% Of Physicians Near Their Home Through Their Plan's Network, Analysis Shows. AOA First Look. August 30, 2024

"Healthcare Finance News (8/29, Lagasse) reports, "On average, Affordable Care Act marketplace enrollees had access to 40% of the doctors near their home through their plan's network, with considerable variation around the average, according to an" analysis. Additionally, 23% of "marketplace enrollees were in a plan with a network that included a quarter or fewer of the doctors in their area, while only 4% were in a plan that included more than three-quarters of the area doctors in their network." Several of the "narrowest network plans were found in large metro counties, where enrollees on average had access to 34% of doctors through their plan networks," while "plans in rural counties tended to include a larger share of the doctors in the area," though had fewer doctors overall. The findings were published by KFF."

https://www.kff.org/private-insurance/report/how-narrow-or-broad-are-aca-marketplace-physician-networks/

Feds Killed Plan To Curb Medicare Advantage Overbilling After Industry Opposition. Fred Schulte. Kaiser Family Foundation Health News. August 27, 2024

"A decade ago, federal officials drafted a plan to discourage Medicare Advantage health insurers from overcharging the government by billions of dollars — only to abruptly back off amid an "uproar" from the industry, newly released court filings show.

The Centers for Medicare & Medicaid Services published the draft regulation in January 2014. The rule would have required health plans, when examining patient's medical records, to identify overpayments by CMS and refund them to the government.

But in May 2014, CMS dropped the idea without any public explanation. Newly released court depositions show that agency officials repeatedly cited concern about pressure from the industry.

The 2014 decision by CMS, and events related to it, are at the center of a multibillion-dollar Justice Department civil fraud case against UnitedHealth Group pending in federal court in Los Angeles.

The Justice Department alleges the giant health insurer cheated Medicare out of more than $2 billion by reviewing patients' records to find additional diagnoses, adding revenue while ignoring overcharges that might reduce bills. The company "buried its head in the sand and did nothing but keep the money," DOJ said in a court filing. …"

https://kffhealthnews.org/news/article/medicare-advantage-overbilling-diagnostic-codes-cms-killed-rule/