September – October 2013

NCDS update

A Billing Industry Newsletter for Clients

Keeping your office up-to-date on industry and insurance changes, late-breaking billing & reimbursement news, and general inter-office communication...

53% of Doctors Still Self-Employed

By: John Commins, HealthLeaders Media

While data shows there's been an uptick in hospital employment for physicians, more than half still work for themselves, an AMA survey finds. The number of physicians in solo practice, however, has dropped.

Conventional wisdom says physicians in private practice are a dying breed. The narrative says physicians are flocking to employed arrangements with hospitals and larger physician practices as health reform and compensation models push the healthcare industry away from fee-for-service and toward economies of scale, quality outcomes and population health.

An American Medical Association report released this week, however, suggests that the demise of private practice physicians may be overstated. "To paraphrase Mark Twain, the reports of the death of private practice medicine have been greatly exaggerated," AMA President Ardis Dee Hoven, MD, said in prepared remarks.

"This new data shows that while there has been an increase in hospital employment, more than half of physicians (53.2%) were self-employed in 2012, and 60% worked in practices wholly owned by physicians. Needed innovation in payment and delivery reform must recognize the wide range of practice types and sizes that exist today so all physicians can participate in the move to a more patient-centered system that rewards high-quality care and reduces costs."

Of course, the report also shows that conventional wisdom is not completely wrong. There has been a trend toward hospital employment over the past five years. In 2012, 29% of physicians worked either directly for a hospital (5.6%) or for a practice that was at least partially owned by a hospital (23.4%). The last AMA survey taken in 2007–2008 did not distinguish between direct hospital employment and employment in a hospital-owned practice, but found that 16.3% of physicians worked in one of the two settings.

Phil Miller, vice president of communications at Merritt Hawkins, says the AMA findings are consistent with what the Irving, TX-based physician recruiting specialists find in their annual recruiting assignments.

"I was a little surprised to see they indicated that a little over 50% of physicians are still self-employed. That contradicts a little some of the other things I have seen out there," he said. "In the great majority of settings that we are recruiting into it's an employed setting, mostly hospital employed. But it could be a community health center or a larger medical group, with the doctor coming in as an employee and not a practice owner." Miller says that in 2004 only 11% of the physician search assignments Merritt Hawkins conducted were hospital employed physicians. This year, that figure went up to 64%.

http://www.healthleadersmedia.com/content/PHY-296428/53-of-Doctors-Still-SelfEmployed

Docs Skeptical of Value-Based Care

By: Stephanie Bouchard, Healthcare Finance News

Doctors are told that the value-based care model will allow them to foster closer relationships with their patients, have greater access to clinical and pricing data and let them see fewer patients but earn more money. Value-based care sounds like a physician's dream come true, but many are not enthusiastic about it.

"I think many physicians – probably most – are pretty hesitant about it – not because, in the theoretical world, they want to stay fee-for-service and they want to continue with the way things have always been," said John Studebaker, a pediatrician who is also the chief medical information officer at population health management company Forward Health Group. "It's that the potential for misuse – for being beaten up with data that doesn't agree with what physicians know to be reality seems to be a high risk."

Many physicians have had the experience, he said, of receiving production reports from insurance companies or their employers and finding that the reports are inaccurate. He's received reports from his insurance company connecting him to his wife's patients, for example. "'I think the data you're giving me is wrong,'" he told his insurance company, and the response was, "'No, it's not wrong.' Well, you know I'm a pediatrician and you're giving me information on patients that are over 65. I think it's pretty clear to me that these aren't my patients that you're sending me information on.' The response was 'Well, we still think you're wrong.' And that's the environment that physicians have been in for 15 to 20 years," Studebaker said.

"I don't think there's a whole lot of trust that this is going to be done well."

Trust is really at the heart of the matter. It goes back to the 1990s, when managed care was touted as the model that would change healthcare for the better.

Physicians took personal financial risks for the managed care model and many got burned when the model collapsed, said Tom Doerr, a primary care physician practicing geriatric medicine in St. Louis who co-founded Lumeris, an accountable care solutions company.

Now, with the Affordable Care Act pushing the healthcare industry from volume-based care to value-based care, physicians who lived through the managed care era, in particular, are skeptical.

"I think older doctors have that taste in their mouths of 'OK. We're going to be put at risk. It's going to be underfunded. We don't really trust payers,'" Doerr said. "It's got to be a different model. It's got to be one where there is appropriate funding and where the payer is a genuine partner."

To view the complete article please visit: http://www.healthcarefinancenews.com/news/value-based-care-skepticism?page=1

6 Expectations for Physicians After Health Insurance Exchanges

By: Laura Miller, Beckersspine.com

Alex Tolbert, founder of Bernard Health, discusses six expectations for physician offices after health insurance exchanges are implemented.

1. Influx of patients. Without insurance as a barrier for seeking treatment, more patients will visit specialists. "Historically, there were instances where very realistically someone could have severe health issues and not qualify for health insurance," says Mr. Tolbert. "But starting January 1, that goes away. The other major inhibitor — high costs — goes away for people who are the most vulnerable because of subsidies that are part of healthcare reform."

2. Enrollment issues. Physician practices across the country are preparing for the increased volume, but they may also need to help current and potential patients enroll in the right government-subsidized programs to receive payment. "The biggest challenge is awareness of the steps that need to be taken to get coverage and enrolled," says Mr. Tolbert.

3. Patient collections are higher. Patients who don't qualify for high subsidies will likely choose a high-deductible plan because their monthly contributions are lower.

4. Out-of-network concerns. Consider who will be in-network with the exchanges and work with patients who have coverage. "You don't want your patients to sign up for a plan when you are out-of-network," says Mr. Tolbert. "Many exchange options have linear or smaller networks than the broad networks people are familiar with. You need to pick a plan and help people sign up for that if they don't already have insurance."

5. Help ongoing patients. There may be patients your practice sees on an ongoing basis, especially if you include pain management and conservative care. Choose a specific day this fall to help these patients sign up for the right plans. "If you have any patients who are uninsured, bring them in and help them sign up for free because this doesn't have to be charity work anymore," says Mr. Tolbert. "If uninsured patients are a big problem in your practice, figure out whether they want to be in-network and make signing them up a priority."

6. Help employees transition into the exchange. Most independent physician offices are small enough to drop their insurance coverage and allow employees to purchase coverage on the exchange without penalty. "When you have office staff members who are lower wage employees, they will be able to do better on the exchange than what the employer can offer," says Mr. Tolbert. "Help your employees transition into the exchange from the business-owner side of things."

For the complete article please visit the following: http://beckersspine.com/spine/item/16983-6-expectations-for-spine-surgeons-after-health-insurance-exchanges

How Does This Affect My Practice?

Regardless of your practice specialty you will be affected by the implementation of health insurance exchanges. It is a massive industry overhaul and it's imperative you educate yourself and your staff regarding the positive and negative impacts the exchange can have on your business. Patient liability has always been an important factor and will become even more imperative in the new exchange. Please recognize the significant impact your staff can make on your bottom line by collecting payments from patients when they are there and present in office. Also be sure to watch for more updates from NCDS via our newsletter as well as up-to-date Client Advisories dispatched on a frequent and ongoing basis!

Changes to Tricare Plans

Effective October 1, 2013 Tricare is changing the benefits of nearly 200,000 military retirees. Please be advised these patients will now have an increased out-of-pocket expense, making patients responsible for 25% of their healthcare costs under these changes.

Additionally, many of these military retirees are being switched from Tricare Prime to Tricare Standard, as a result of the Tricare Prime Service Area (PSA) reduction. Please be sure to ask patients for an updated ID card copy where applicable.

Medical Groups Fear ACA Grace Period Will Lead to Unpaid Claims

By: Jennifer Lubell, AmedNews.com

Washington Physicians are calling for real-time patient information regarding insurance coverage eligibility status from health plans purchased on new exchange marketplaces, citing a potential loophole that could leave doctors holding the bill. Doctors, practice administrators and hospitals have continued to express concerns to the Centers for Medicare & Medicaid Services about claims for services going unpaid when patients stop paying premiums but still retain insurance coverage. Beneficiaries delinquent on their premiums are given a 90-day grace period before their coverage is dropped. During the final two months of that grace period, health plans are instructed to designate claims submitted for physician services as pending, but the services ultimately could go unpaid.

"Physicians, hospitals and other health care providers cannot reasonably be expected to know or predict if an enrollee's premiums are paid or will be paid before the end of the grace period," officials from the Missouri State Medical Assn. and the Missouri Hospital Assn. stated in an Aug. 12 letter to CMS. "And they cannot reasonably be expected to bear the concomitant burden of uncertainty and a potentially significant financial loss."

The Missouri physicians' and hospitals' letter was one of the latest on the subject. CMS rules require health plans on exchanges to notify all affected providers "as soon as practicable" once a beneficiary falls behind on payments and enters the grace period. CMS, which will oversee the exchanges, has acknowledged the risk and burden to physicians and hospitals, but it gives health plans leeway to determine when and how to inform the professionals treating the patients.

"Permitting this latitude is unacceptable, especially considering that the insurers have ready access to the information that an enrollee has not paid his or her premium," MGMA-ACMPE President and CEO Susan Turney, MD, wrote in a July 3 letter. "We are very concerned that issuers' interpretation of 'as soon as practicable' will be too late for physicians to engage patients and make informed decisions prior to furnishing potentially uncovered services."

The health plan would be responsible for paying claims during the first 30 days after a patient enters the nonpayment grace period. If the enrollee continues to be delinquent in paying premiums, practices and hospitals would be left to collect payment directly from the patient when claims during the final 60 days of the grace period are rejected.

To view the article in its entirety please visit: http://www.amednews.com/article/20130902/government/130909984/4/

Doctors Make Capitol Hill House Calls, Give Prescription to Fix Medicare Now

Teams of physicians were on Capitol Hill Thursday and Friday, prescribing a cure for the ailing Medicare system. Coming from 24 key states, these doctors met with more than 100 lawmakers from their states to deliver a single message: Fix Medicare now.

The Hill visits were a targeted effort of the AMA's Fix Medicare Now campaign, which launched earlier this month when Congress returned from its summer recess. The grassroots campaign aims to put concerted pressure on members of Congress to reform the Medicare physician payment system by year's end.

"There's never been a better time to reform the Medicare physician payment system—or to urge Congress to take action," AMA President Ardis Dee Hoven, MD, wrote in a recent blog post.

"Each day 10,000 new Medicare patients enter the system," Dr. Hoven wrote. "These patients—and the millions more who already rely on Medicare—deserve a sustainable system that is focused on high-quality, cost-effective care. That can't happen without reform."

In August the U.S. House Energy and Commerce Committee unanimously approved a bill to repeal Medicare's failed SGR formula, enhance health care quality and make available new models of care delivery and payment. The U.S. House Ways and Means Committee and the U.S. Senate Finance Committee also are expected to issue their own versions of the legislation this fall.

The Fix Medicare Now campaign's new website lets both physicians and patients lend their voices to the growing chorus calling for an end to Medicare's failed funding formula and the establishment of a new system that fosters high-quality care. Physicians also can download a patient flier to remind them to contact Congress to protect Medicare and access to care.

http://www.ama-assn.org/ams/pub/amawire/2013-september-25/2013-september-25-general_news1.shtml

Want To Get Involved?

Simply visit the link above for the full article and several point-and-click resources that allow physicians to join the Fix Medicare Now Campaign and/or email your Congressional representative(s). There is also a patient flyer you can download to distribute to patients or post in your office to keep patients aware of the need for reform. Or you can also visit the link below to go directly to the Fix Medicare Now Campaign website, a grassroots initiative started by the American Medical Association.

http://fixmedicarenow.org/physicians/

Catholic Health Partners Entering Insurance Biz

Catholic Health Partners, Ohio's largest hospital operator and the owner of Mercy Health locally in the Toledo area, has launched its own insurance plans to be sold on Ohio's health care exchange next year. NCDS will keep you posted on the growing trend of hospital operators jumping into the pool of health insurer, uniquely positioning them as both the provider and insurer.

To prepare for the ICD-10 Implementation deadline of October 1, 2014, the NCDS Newsletter will feature an ICD-10 countdown in each issue! Watch for the logo above for ongoing updates, website links, news/information and webinar opportunities to communicate directly with NCDS for ICD-10 preparation. As always, any critical updates will be dispatched from NCDS via Client Advisory so watch your email and faxes regularly!

Doctors Shortchanged by Insurers' Shift to Credit Card Payments

By: Charles Fiegl, AMEDNEWS.COM

Washington Physician practices that have been receiving consumer credit cards as payment for their services also have been receiving lower pay than the contracted amounts agreed to in fee schedules, and the American Medical Association wants that to stop.

The AMA commented on the growing trend of plastic and virtual credit cards being issued by payers, including the Dept. of Veterans Affairs, in an Aug. 14 letter to the Centers for Medicare & Medicaid Services. The use of the cards has increased as health plans abandon sending paper checks in favor of cards that offer payers cash-back incentives.

A chief complaint is that fees are associated with the cards. Physicians may pay as much as 5% per transaction when office staff enters a card number in a credit card reader machine. The fees are not always transparent, and they result in physicians getting less than the negotiated prices for services.

"Physicians cannot afford any further cuts to their reimbursement, particularly with the current budget crisis and sequestration cuts," Dr. Madara wrote. "These fees take away valuable health care dollars that physicians can use toward other critical efforts like health [information technology], quality improvement, and payment and delivery reform initiatives."

To read the complete article please visit the following link:
http://www.amednews.com/article/20130826/government/130829997/1/?utm_source=nwltr&utm_medium=heds-htm&utm_campaign=20130826

NCDS Action:

NCDS has been aware of this tactic for some time. When these credit card payments are received our representatives contact the carrier to "opt out" based on the high fees incurred. We urge all of our clients not to process these cards! If you are currently processing these payments please forward to NCDS so we may opt out on your behalf. It typically takes 4-6 weeks for the first check to show up but subsequent claims are then paid via paper check, causing less of a delay. For more information on these types of payments from insurance carriers please contact Jessica Meyers in our payments department at 800-556-6236 option 26 or email jessicap@ncdsinc.com.

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