January – February 2016

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...

15 From 2015: Stories that Defined the Year

STAFF – BECKER'S HOSPITAL REVIEW

What happened in 2015? Things spiked, like the price for a Daraprim pill, which grew 5,000 percent overnight.

Things stopped, like low-volume surgeries at three prestigious academic medical centers. Some things exceeded estimates, such as the price of EHR rollouts, while others fell short, such as the acuity of the physician shortage. 2015 was a year marked by supersized insurers, goals for interoperability and payment, cyberattacks and hacks, oral arguments, star ratings and 70,000 new diagnostic codes. Here's a look back at the year's most interesting and powerful events.

1. New goals and deadlines for value-based care *By Molly Gamble* When it comes to value-based healthcare, January 2015 was a month for the books. Late that month, HHS released a series of goals and deadlines in its plan to shift from volume- to value-based payments. By 2018, the government wants to make half of all Medicare payments under an alternative model, which includes accountable care organizations, patient-centered medical homes or bundled payments. By 2016, the benchmark is to have 30 percent fit that bill.

2. Hackers break into Anthem *By Akanksha Jayanthi* In late January, Indianapolis-based Anthem discovered its network had been compromised by hackers. The breach affected 78.8 million individuals, making it the biggest healthcare data breach disclosed to date.

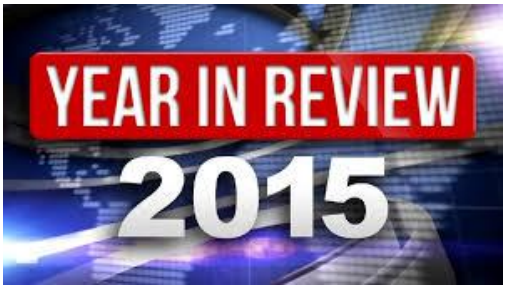
3. U.S. spends more on prescription drugs — and a 5,000% price hike heats up the debate *By Tamara Rosin* When 32-year-old Turing Pharmaceutical Founder and CEO Martin Shkreli raised the price of Daraprim, an antiparasite medication developed 62 years ago, jaws dropped when the price of Turing's recently acquired drug shot up by 5,000 percent overnight, from $13.50 per pill to $750.

4. Supreme Court upholds federal premium subsidies in *King v. Burwell* **5. EHR rollouts bleed over budgets** *By Carrie Pallardy* EHR implementations are invariably expensive, and often pricey enough to surprise healthcare organizations. A Capterra survey of 400 EHR users found providers spend an average of $117,672 per year on EHR software, or $31,710 more (37 percent higher) than their expected cost.

6. Stars, grades and Yelp reviews — for hospitals *By Emily Rappleye* The lights were flipped on in healthcare this year as a plethora of provider ratings, rankings and reviews hit the Web. CMS released a five-star rating system in April to its Hospital Compare website, with the number of stars determined by HCAHPS scores. More than 3,500 hospitals were given 12 star ratings — one summary star rating and 11 sub-ratings specific to HCAHPS measures.

7. Insurer mega-merger frenzy: The big 5 become the big 3 *By Erin Marshall* At the beginning of 2015, the traditional big five insurers included Aetna, Blue Cross Blue Shield — which includes 36 companies, the largest being Anthem — Cigna, Humana and UnitedHealthcare. But a fast twist of summer events turned the big five into the big three. Hints of mega-mergers began in late May when there was talk of Cigna or Aetna acquiring Humana.

8. How many physicians will the U.S. need? AAMC unveils new estimates *By Emily Rappleye* Ongoing coverage of the national physician shortage was punctuated by a report released in March by the American Association of Medical Colleges. This report garnered quite a bit of attention because it lessened the projected physician shortage from its 2010 estimate. The new forecast puts the U.S. need for physicians between 46,100 and 90,400 over the next decade, whereas the 2010 estimate projected a shortage of 130,600 physicians by 2025.



9. Congress passes permanent 'doc fix' legislation *By Ayla Ellison* One of the most closely watched stories in the early part of 2015 was passage of legislation that permanently eliminated the sustainable growth rate — a flawed physician payment formula that Congress had prevented from going into effect since 2002. Designed to restrict growth in Medicare Part B spending by establishing targets for expenditures, the SGR formula was enacted by Congress as part of the Balanced Budget Act of 1997. The formula's methodology, which the Medicare Payment Advisory Commission told Congress is "fundamentally flawed," limited spending for physicians' services by linking updates to target rates of spending growth.

10. ONC rolls out interoperability roadmap *By Max Green* Unveiled Oct. 6, the final version of the Office of the National Coordinator for Health Information Technology's interoperability roadmap outlines exactly how the federal government plans to achieve secure, nationwide healthcare information exchange by 2024.

11. Nearly 2,600 hospitals dinged in year 4 of CMS' Readmissions Reduction Program

12. ICD-10 finally rolls out *By Carrie Pallardy* Oct. 1 was viewed with much trepidation, but the ICD-10 go-live day came and went quietly compared to the events leading up to it. After delays in 2009, 2012 and 2014 it seemed possible the coding system's go-live date could be pushed back again, and there were legislative efforts geared toward just that.

13. Major health systems move to end surgery programs with low case volume

14. Patients die from superbug outbreaks

15. Adventist Health System's record-breaking $118.7M settlement for improper physician compensation

For more information or to read this article in its entirety please visit: HTTP://WWW.BECKERSHOSPITALREVIEW.COM/HOSPITAL-MANAGEMENT-ADMINISTRATION/15-FROM-2015-STORIES-THAT-DEFINED-THE-YEAR.HTML

Panel Calls for Depression Screenings During and After Pregnancy

Pam Belluck – NYTimes.com

Women should be screened for depression during pregnancy and after giving birth, an influential government-appointed health panel said Tuesday, the first time it has recommended screening for maternal mental illness.

The recommendation, expected to galvanize many more health providers to provide screening, comes in the wake of new evidence that maternal mental illness is more common than previously thought; that many cases of what has been called postpartum depression actually start during pregnancy; and that left untreated, these mood disorders can be detrimental to the well-being of children.

It also follows growing efforts by states, medical organizations and health advocates to help women having these symptoms — an estimated one in seven postpartum mothers, some experts say.

"There's better evidence for identifying and treating women with depression" during and after pregnancy, said Dr. Michael Pignone, a professor of medicine at the University of North Carolina at Chapel Hill and an author of the recommendation, which was issued by the United States Preventive Services Task Force. As a result, he said, "we specifically called out the need for screening during this period."

The recommendation was part of updated depression screening guidelines issued by the panel, an independent group of experts appointed by the Department of Health and Human Services. In 2009, the group said adults should be screened if clinicians had the staff to provide support and treatment; the new guidelines recommend adult screening even without such staff members, saying mental health support is now more widely available. The 2009 guidelines did not mention depression during or after pregnancy.

"It's very significant that the task force is now putting forth a recommendation that's specific to pregnant and postpartum women," said Katy Kozhimannil, an associate professor of public health at the University of Minnesota. "Policy makers will pay attention to it. Increased screening and detection of depression is an enormous public health need."

The panel gave its recommendation, which was published in the journal JAMA, a "B" rating, which means depression screening must be covered under the Affordable Care Act.

For years, obstetricians and other health care providers who saw women during and after pregnancy often felt ill equipped or reluctant to ask about problems like depression, anxiety and obsessive-compulsive disorder.

"OB-GYNs thought that if they identify something and don't have resources to support it, it puts them at significant legal risk," said Dr. Samantha Meltzer-Brody, the director of the perinatal psychiatry program at the University of North Carolina at Chapel Hill. If a mother is "feeling so anxious you're going to come out of your skin or feeling that you're going to harm your baby, you may think: 'Oh, my God, I'm having these crazy feelings and nobody's talking about it. I must be a terrible mother.' "

For the complete article please see the link below: http://www.nytimes.com/2016/01/27/health/post-partum-depression-test-epds-screening-guidelines.html?ref=health&_r=0

Patients Unhappy With Doctors' EHR Use

Rose Schneider Krivich – MedicalEconomics.ModernMedicine.com

No surprise here—patients say they are usually less satisfied with their doctor's care when computers were used during appointments, according to a recent *JAMA Internal Medicine* study.

"Many clinicians worry that electronic health records (EHRs) keep them from connecting with their patients," Neda Ratanawongsa, MD, MPH, associate professor at the University of California-San Francisco, who co-authored the research letter, told Reuters. "So it's not surprising that we found differences in the way clinicians and patients talk to each other."

For the study, researchers interviewed 47 patients diagnosed with at least one chronic condition who visited one of 39 doctors at a public hospital between 2011 and 2013. The interviews were conducted before and after the appointment, and in post-appointment interviews patients were asked to rate the quality of their care over the last six months.

Further, the researchers videotaped the appointments and reviewed the footage, rating the length of time the doctor spent using a computer to access EHRs. The EHRs could be used to review test results, prescribe medications, track healthcare maintenance and refer patients to specialists.

The results showed that patients rated their care as "excellent" in about 50% of the 25 encounters with high computer use, compared with more than 80% of the 19 encounters with low computer use.

Physicians who spent more time using a computer were found to have spent less time making eye contact with their patients and were more likely to do more "negative rapport building," such as correcting patients about their medical history or drugs taken in the past based on information stored in their EHR.

Nevertheless, Ratanawongsa emphasizes that these actions are not necessarily bad, noting, "(EHRs) give important health information to clinicians, which may help safety-net patients with communication barriers like limited health literacy and limited English proficiency." While EHRs may bring benefits, many physicians remain discouraged about them.

Brandon Peters, MD, expresses similar feelings. "Where I see the EHR interfering with my visits is trying to capture the entire visit, including complaint ROS exam and plan, in real time," says Peters, staff physician at Vidant Family Medicine in Edenton, North Carolina. "I find myself looking at a screen pushing buttons and not at the patient, (and) as we all know, many of the most important data points derive from a careful nuanced interview, not from making sure we asked about or examined enough body systems to justify an appropriate code." Using EHRs has transformed his patient visits from therapeutic care sessions to more like a data collection session, he said.

Medical Economics Advisory Board Member Melissa E. Lucarelli, MD, shared her tips for improving patient satisfaction when using EHRs, which she said, causes patients to witness "first-hand" frustrations of documentation and coordination of care from their doctors. "To counteract this effect, I try to make a conscious effort to look away from the screen and make eye contact with the patient as often as possible during an office visit, and it is even more important than ever to exchange personal greetings and to take time to listen to their concerns," says Lucarelli.

To view this article in its entirety please visit: http://medicaleconomics.modernmedicine.com/medical-economics/news/patients-unhappy-doctors-ehr-use?page=0,2

Cleveland Clinic Patient Wins Fight Over "Facility Fee"; Broader Problems Persist in Hospital Funding

Alya Ellison – Becker's Hospital Review

CLEVELAND, Ohio -- Hollis Smola said the bill from the Cleveland Clinic confirmed her lowest opinion of American health care.

The Dec. 5 statement indicated she had paid in full for the cost of a recent check-up at the Clinic's Marymount Hospital, but it stated that she still owed another $85 for a "facility fee."

"It's not right," said Smola, a 60-year-old Cleveland resident who is uninsured and paid $213 in cash for her visit. "I followed the rules. Everything was fine, and then they tell me, 'No, you owe more money.'"

The hospital's about-face represents a small victory in a long-running fight over facility fees -- charges that hospitals are permitted to tack on to patients' bills to cover the increased overhead of operating their buildings.

For the first time late last year, Congress and President Obama also took action on the issue, passing legislation in November that limits hospitals' ability to charge such fees.

However, the Bipartisan Budget Act of 2015 only prevents health systems from charging facility fees at clinics they acquire in the future. It does not apply to existing facilities where they have already been charging the fees for years.

Still, health care finance experts said the tweak could help spark broader change by removing one financial incentive for health systems to continue gobbling up local medical clinics, a trend that has led to rapid consolidation across Northeast Ohio in recent years.

"This will apply an appropriate brake on the huge movement to acquire physician practices," said Harold Miller, chief executive of the Center for Health Care Quality and Payment Reform. "But if we don't realize there is a bigger problem to solve here, then all it will be is a temporary fix." That bigger problem, according to Miller and other advocates of payment reform, is that the current system of funding hospital care fails to recognize a wide array of costs for which they do not get reimbursed.

The federal legislation approved in November seeks to eliminate that difference for any future facilities, but finance experts said the law is at best a temporary patch on a much deeper wound.

Meanwhile, some states are taking action on their own to address complaints from consumers, who are increasingly being forced to pay facility fees under high-deductible insurance plans.

For Smola, the additional charge was an unwelcome surprise that arose when her regular physician moved his office to Marymount Hospital from a different facility run by University Hospitals.

After inquiries from The Plain Dealer, Clinic spokeswoman Janice Guhl said in a statement that the charge for the facility fee was not handled properly and that it would be dropped from Smola's bill.

Please visit the link below for the complete article:
http://www.cleveland.com/healthfit/index.ssf/2016/01/cleveland_clinic_patient_battl.html

Few Consequences for Health Privacy Law's Repeat Offenders

Gregory Korte – USA Today

While working at CVS Health, helping to resolve customer complaints, Joseph Fenity had his own health information inappropriately shared by a colleague. Distressed by what happened, he went on leave and never returned.

When CVS Health customers complained to the company about privacy violations, some of the calls and letters made their way to Joseph Fenity. One patient's medication was delivered to his neighbor, revealing he had cancer. Another was upset because a pharmacist had yelled personal information across the counter.

Fenity worked on a small team that dealt with complaints directed to the company president's office, assuring customers their situations were rare. "I sincerely apologize on behalf of CVS Health," Fenity says he'd respond. "This is not how we handle things. The breach of your protected health information was an isolated incident and we'll do better." In fact, Fenity learned — partly from battling CVS over the privacy of his own medical information — that was "a lie."

CVS is among hundreds of health providers nationwide that repeatedly violated the federal patient privacy law known as HIPAA between 2011 and 2014, a ProPublica analysis of federal data shows. Other well-known repeat offenders include the U.S. Department of Veterans Affairs, Walgreens, Kaiser Permanente and Walmart.

And yet, the agency tasked with enforcing the Health Insurance Portability and Accountability Act took no punitive action against these providers, ProPublica found.

In more than 200 instances over those four years, that agency, the Office for Civil Rights within the U.S. Department of Health and Human Services, reminded CVS of its obligations under the law or accepted its pledges to improve privacy protections. (CVS did pay a $2.25 million penalty in 2009for dumping prescription bottles in unsecured dumpsters.)

Over the course of this year, ProPublica has reported on loopholes in HIPAA and the federal government's lax enforcement of the law. A story earlier in December detailed how the Office for Civil Rights only rarely imposed sanctions for small-scale privacy breaches that caused lasting harm.

For the full article please visit:
https://www.propublica.org/article/few-consequences-for-health-privacy-law-repeat-offenders

Do Physicians Drink Too Much Coffee? Study Breaks Down Consumption By Specialty

Max Greene – Becker's Hospital Review

Researchers attempted to answer this question by looking at one full year's worth of purchasing habits at a large teaching hospital in Switzerland.

Orthopedic surgeons drank the most coffee, followed by radiologists, general surgeons, neurosurgeons, neurologists, internists, gynecologists and anesthetists, according to the paper. Other findings included men drink more coffee than women and older clinicians were more likely to consume more than younger clinicians.

http://www.beckershospitalreview.com/hospital-physician-relationships/do-physicians-drink-too-much-coffee-study-breaks-down-consumption-by-specialty.html

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