March – April 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...

Medical Mutual to Acquire Healthspan Insurance Customers

Casey Ross – The Plain Dealer via Cleveland.com

Medical Mutual of Ohio said Tuesday it will acquire the 105,000 members in the group and individual health insurance units of HealthSpan Partners. The deal will further consolidate the health insurance industry in Northeast Ohio, where Medical Mutual is already the biggest player. Financial terms of the deal were not disclosed. Medical Mutual executives said HealthSpan will continue to insure members enrolled in employer-sponsored plans through their renewal date or August 31, whichever comes first. Individual members will be insured by HealthSpan through the end of the year.

Will Medical Mutual's acquistion of HealthSpan's customers impact insurance prices?

Meantime, the companies will be working to transition HealthSpan's customers to Medical Mutual plans. Medical Mutual's chief executive, Rick Chiricosta, said the transaction is a positive development for HealthSpan members who have gone through considerable turmoil in recent months.

"Hopefully this means an element of stability for them," Chiricosta said during an interview with the Plain Dealer. "They are going to be in good hands with us. Our goal, as is HealthSpan's goal, is to transition as many members as possible over to our coverage."

In late 2015, HealthSpan announced plans to shutter its physician's group effective March 31. That left many members scrambling to preserve access to their doctors or find new ones.

Cleveland's largest hospitals have been aggressively recruiting HealthSpan's doctors in recent weeks. MetroHealth said it has acquired many of its primary care doctors, and both University Hospitals and Cleveland Clinic have been adding HealthSpan doctors to their systems.

Medical Mutual has contracts with all of the region's major health care providers. And as part of Tuesday's agreement, HealthSpan is endorsing the company as its replacement carrier.

"Medical Mutual has plans with comparable coverage based on rates, benefits and provider network, which, depending on the plan, is likely to include the same physicians offered by the HealthSpan network," said Jared Chaney, Medical Mutual's chief communications officer. "We are going to work hard to transition as much of the HealthSpan membership to us as we can. We think we will be a great fit for them."

Medical Mutual said it will contact HealthSpan's individual and group customers in coming months with information about replacing their current coverage.

NCDS Perspective: Medical Mutual has a strong reputation for quality service to providers and timely claim responses. Conversely, Healthspan's reputation is exceedingly poor, taking as much as three months longer to pay claims than other major carriers, requiring hold times of nearly an hour to status a claim as well as their notorious high deductibles for subscribers. We see this transition to be a very positive change for both members that carry Healthspan as well as the providers that treat them.

http://www.cleveland.com/healthfit/index.ssf/2016/03/medical_mutual_to_acquire.html

Ohio Readies Waiver to Require Cost-Sharing in Medicaid

WLWT.com

COLUMBUS —Republican Gov. John Kasich's administration said Wednesday it's moving forward with plans to require more than 1 million Ohioans on Medicaid to pay a new monthly cost for their health coverage or potentially lose it.

House Republicans added the provision to the state budget last year. The new charge would require federal approval. If successful, officials plan to begin requiring Medicaid recipients to pay into a health-savings account to support the cost of their coverage beginning in 2018.

More than 2.9 million Ohio residents are served by Medicaid, a $23 billion federal-state health program for low-income and disabled people.

Under the House Republicans' plan, the administration must seek a waiver of federal Medicaid rules so that Ohio can require certain Medicaid recipients to pay into a health-savings account regardless of their income.

Beneficiaries, except pregnant women, could be cut from the safety net program if they don't annually contribute 2 percent of their family income or $99, whichever is less.

The draft proposes a January 2018 start date for the health-savings account program. That's slated to be the final year of Kasich's term, though the two-term governor currently is running for president.

McCarthy said the start date could shift, depending on federal approval and how quickly new Healthy Ohio program could be implemented. Washington handles each waiver request uniquely, he said, and it's unclear how federal officials could rule.

"This waiver, like any waiver, you're uncertain of where you stand when you're submitting it," he said.

Still, no state has been given approval to drop Medicaid enrollees with incomes below federal poverty for not having paid monthly fees or contributions to a health savings account, according to a policy brief from the Kasich administration.

The plan also would require the Medicaid program to deposit $1,000 annually into each person's health savings account. Healthy Ohio enrollees would be subject to copayments, but only if there's a balance in their accounts. Health plans couldn't pay for any service until the person's health savings account is depleted.

House GOP's program replaced a plan from Kasich to charge a monthly premium of about $20 to roughly 120,000 people on Medicaid. The Republican state lawmakers had argued that cost-sharing policies like the savings accounts would encourage "personal responsibility" in the program.

Health care advocates and Democrats have said the policies create barriers to health care for those with little money.

For the complete article please visit: http://www.wlwt.com/news/Ohio-readies-waiver-to-require-cost-sharing-in-Medicaid/38779180

How Obama's 2017 Budget Takes on Surprise Medical Billing

Brooke Murphy – BeckersHospitalReview.com

President Barack Obama's budget proposal for 2017 includes a provision aimed at protecting consumers from financial hardship if they are hit with unanticipated medical bills, reports *Health Affairs*.

The practice of balance billing refers to a physician's right to bill the patient for an outstanding balance after the insurance company submits its portion of the bill.

Although details are minimal, the president's 2017 budget proposal includes a provision to eliminate the balance billing of privately insured patients. The administration would address the issue by requiring physicians who regularly provide services in hospitals to accept in-network rates for reimbursement, even if they aren't in the insurer's network.

However, federal and state regulators looking to protect consumers from surprise out-of-network medical bills must walk a thin line between two powerful interest groups: physicians and insurers.

Many providers argue the terms balance billing or 'surprise medical bills' largely place unfair blame on providers by construing them as predatory billers. American College of Emergency Physicians President Jay Kaplan, MD, said, "Many times what patients perceive as surprise bills are simply the high deductibles that come with low-priced premiums."

Although the president's proposal is unlikely to become law this year, it is a productive springboard for conversations around adequate network coverage and consumer financial protection.

For more information please see the link below:
http://www.beckershospitalreview.com/finance/how-obama-s-2017-budget-takes-on-surprise-medical-billing.html

CMS Hits Humana with $3.1 Million Penalty for Medicare Advantage, Drug Plan Violations

Susan Morse – HealthCareFinanceNews.com

Penalty is single largest imposed against 129 organizations found in violation of Medicare Advantage, prescription drug plans.

The Centers for Medicare and Medicaid Services has levied a $3.1 million penalty against Humana, the single largest imposed against 129 organizations found in violation of Medicare Advantage and prescription drug plans in an audit. Humana's civil penalty was based on an audit of its Medicare operations from April 20, 2015 through May 7, 2015, CMS said. Humana's systemic failure in complying with requirements related to Parts C and D resulted in enrollees experiencing inappropriate delays or denials in receiving covered benefits or increased out-of-pocket costs, CMS said.

Other organizations with fines at a million or above in actions taken in 2015 or 2016 include: Medical Card System, $1.29 million; Envision Pharmaceutical Services, $2.59 million; and Aetna, $ 1 million.

The March 3 release of the civil penalties, along with a list of organizations receiving suspension of enrollment and marketing activities, furthers CMS's goal of improving industry standards and providing continued transparency, according to Jerry Mulcahy, director Medicare Parts C and D Oversight and Enforcement Group, who sent out the notice to all Medicare Advantage organizations.

http://www.healthcarefinancenews.com/news/cms-hits-humana-31-million-penalty-medicare-advantage-drug-plan-violations

Aetna and Humana Merger

The Aetna and Humana merger will combine two of the largest Medicare Advantage insurers under one name. To help troubleshoot questions by providers as well as members, a new webpage has been launched by the company to answer frequently asked questions as well as inform all parties involved. The website offers some interesting information regarding their merger.

http://www.aetnaandhumana.com/

Medical Errors Don't Necessarily Mean Lawsuits: Patients Want Apologies, Explanations

David Ferguson – FierceHealthcare.com

'Deny and defend' gives way to 'acknowledge and apologize'

As healthcare turns toward a more patient-centered, value-based model, providers' approach to medical errors—the third leading cause of death in the U.S.--is also changing. Increasingly, the culture of secrecy that led to providers taking a "deny and defend" approach to medical errors is giving way to an "acknowledge and apologize" culture in which clinicians fully explain the mistake to the patient and then apologize for it, according to a *CNN* report.

Unfortunately, Deborah Craven never received that apology after surgeons at Yale New Haven Hospital mistakenly removed the wrong rib during a 2015 surgery to remove a mass from her rib. In fact, her lawyer told *CNN,* they never explained how the mistake happened. Worse, Craven claims one of the doctors lied to her to cover up the error. Had they simply explained what happened and said "I'm sorry," she would never have sued, according to her lawyer. Meanwhile, she is still waiting for an explanation of why the surgeons operated on the wrong rib.

Patient advocates say that when patients feel listened to and understood, they are more likely to negotiate a settlement than launch a lawsuit that could end up costing their provider millions of dollars.

Leilani Schweitzer, who lost her toddler son due to a simple error by a nurse at Lucile Packard Children's Hospital in California, told *CNN* that most victims of medical errors do not want to sue because it is painful and costly.

In her situation, the hospital immediately gave her a full apology, explained exactly how the mistake occurred, made financial restitution and then went the extra step of involving Schweitzer in its effort to ensure that the same mistake didn't happen to other patients. Within six years, the hospital hired her as a consultant for a program for patients on how to reach a resolution in the wake of an error. It's a mistake to think that all patients who've been harmed by medical error are only interested in money, Schweitzer said.

Smart institutions will take pains to establish communication and institute programs of restitution toward victims rather than assuming their relationship will be one of enmity from the outset, according to the article.

Earlier this year, *The Wall Street Journal* reported that more hospitals around the country are adopting this new approach to coping with medical mistakes. One California hospital not only provides an apology and a full explanation of how the error occurred, it will also give patients a waiver so they don't have to pay their medical bills, and financial settlements as an alternative to costly lawsuits.

http://www.fiercehealthcare.com/story/medical-errors-dont-necessarily-mean-lawsuits-patients-want-apologies-expla/2016-03-29

NCDS Client Advisories

Are you and your staff watching your fax and email for important updates from NCDS? NCDS circulates a client advisory whenever an important industry change occurs. Be sure to contact our office if you have any questions or concerns regarding an advisory or how it may impact your practice. Increased knowledge and communication is critical to keeping a strong relationship between our office and your staff.

Client Advisory

Tips for Improving Cyber Security and Protect Your Practice's Finances

JANET COLWELL – MODERN MEDICINE NETWORK

After more than $27,000 goes missing from his business account, a Texas physician learns that cyber criminals initiated a wire transfer using a fake domain name and an email almost identical to his own. Another physician returns from an international trip to find that criminals hacked his email and used it to transfer more than $30,000 from his medical group's account to an unknown bank in Hong Kong. In both cases—taken from the files of a cyber liability insurance underwriter associated with Austin, Texas-based Medical Liability Trust (TMLT)—the victims' banks were not liable for the losses because an authorized account holder approved the transfers, says John Southrey, CIC, CRM, manager of consulting services at TMLT, which provides medical professional liability insurance to Texas Medical Association members.

"Cyber fraud is the most underestimated and underappreciated risk faced by small businesses, particularly in healthcare," says Southrey. "Most physicians are not budgeting enough for computer data security because they think their practices are too small to attract the attention of cyber criminals. However, losses incurred as a result of a data breach can be worse than a direct tangible property loss such as from a fire or tornado … Many cyber-criminals consider physician practices to be low-hanging fruit because they have not kept up with technology."

Sara Hempfling, vice president of treasury management at St. Peters, Missouri-based Enterprise Bank and Trust, recommends that all of her clients purchase cyber liability insurance. Large companies may pay about $2,500 per month for $1 million in coverage, but smaller business often pay much less and some coverage is often included in standard professional liability policies, says Hempfling, who works with the bank's medical clients.

TMLT added cyber liability coverage in 2011. Since then it has handled more than 250 incidents, with more coming in nearly every week, Southrey says. The majority of cases involve data breaches of personal health information (PHI), which can take a financial toll on a practice, exceeding the base cyber liability coverage limit.

Please visit the link below for the complete article:
http://medicaleconomics.modernmedicine.com/medical-economics/news/improve-cyber-security-and-protect-practice-finances

Study: Satisfied Patients More Likely to Pay Medical Bills in Full

KELLY GOOCH – BECKER'S HOSPTIAL REVIEW

Recent evidence shows a strong correlation between patient satisfaction and paying medical bills. A study by Connance found 74 percent of satisfied patients paid their medical bills in full, compared to 33 percent of their lesser satisfied counterparts.

The survey was conducted via an internet survey in August 2014 with 500 adults from 46 states, 6 percent of whom were uninsured and 94 percent of whom were insured. All respondents had recently received hospital services.

Here are four findings from the survey.

1. Among respondents, 35 percent gave billing processes a top score of five on a scale of one to five, and 51 percent rated the billing processes a three or less. The percentage of respondents giving billing process a top score has gradually increased each year since 2010.
2. Among respondents giving billing processes a top score:
   - 82 percent would recommend the hospital
   - 95 percent would return to the same hospital for a future elective service
   - 74 percent paid their bills in full
3. Among respondents who were less than satisfied with the billing processes:
   - 15 percent would recommend the hospital
   - 58 percent would return to the same hospital for a future elective service
   - 33 percent paid their bills in full
4. Among the insured population, the study revealed satisfaction with billing processes differs by type of insurance plan. While 37 percent of insured respondents gave billing processes a top score, only 28 percent of those with a high deductible plan raked it similarly.

For the complete article please see the following link:
http://www.beckershospitalreview.com/finance/study-satisfied-patients-more-likely-to-pay-medical-bills-in-full.html

Anthem Member Incentive Reminder

Last month we sent you an advisory regarding the member incentive and wellness campaign from Anthem. This campaign urged patients to see their physician for a wellness/routine exam before the April, 30th deadline, and in exchange for meeting that requirement Anthem will provide your patient with a $50 gift card. Just as a reminder, please be sure to follow the important guidelines set forth for these incentives in order for your patient to get their reward. You can find more information on the link to Anthem's web page:

Anthem

https://www.anthem.com/wps/portal/ahpmedprovider?content_path=shared/noapplication/f2/s2/t4/pw_ad090993.htm&rootLevel=0&label=Medicare%20Advantage%20Providers

Or, please feel free to contact NCDS if you need another copy of the advisory for reference or if you have any questions when patients present their vouchers.

Maximize Your Revenue

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NCDS Medical Billing

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