July – August 2017

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...

Cleveland Clinic and CareSource Sever Ties; Many Medicaid Patients Will No Longer Have Access to Clinic

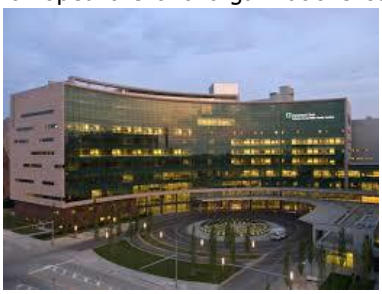
Ginger Christ, The Plain Dealer

CLEVELAND, Ohio - People on the state's largest Medicaid managed care plan no longer will be able to access care from the Cleveland Clinic.

Dayton-based CareSource, which serves roughly 1.3 million Medicaid members in Ohio, reportedly terminated its contract with the Cleveland-based health system, according to the Clinic. "The Cleveland Clinic is no longer a provider for CareSource," the Clinic said in a statement. "CareSource is informing its members this week of the transition to MetroHealth and other health systems with CareSource contracts, like Neighborhood Family, Care Alliance, NEON and University Hospitals."

CareSource could not immediately be reached for comment.

On June 28, when The Plain Dealer first reported on CareSource's potential break from the Clinic, the provider said it hoped the two organizations could still reach a resolution. At the time, CareSource said, "We value our long-term relationship with the Cleveland Clinic. Our hope is that contract negotiations have not ended and we're open to continued dialogue."



The Clinic has worked with CareSource since 2001, according to the Clinic. Details on how many people access the Clinic using CareSource were not available. However, Medicaid patients represent 14 percent of the Clinic's revenues, according to recent annual financial reports.

Those affected who still want to use the Clinic can switch to one of the other plans accepted by the system: Buckeye Community Healthplan, Paramount Advantage and United Healthcare Medicaid managed care plans.

NCDS Perspective: We see this as a positive for The Cleveland Clinic to hold Caresource accountable and simply say, *we won't take it anymore.* For years CareSource has been unaccountable for their bad claims processing, low reimbursement, authorization issues and poor or unavailable customer service. As an advocate for providers we are encouraged to see an entity as large as The Cleveland Clinic hold their ground and hedge their bets that CareSource subscribers will drop the insurer for another MCO before they will seek care elsewhere. While some opponents feel hospital system is leveraging public health for their own benefit, industry experts hope this will spark a trend which can facilitate better reimbursement and an improved patient/provider/insurance experience.

http://www.cleveland.com/healthfit/index.ssf/2017/07/cleveland_clinic_and_caresourc.html

Governors Preparing Bipartisan Healthcare Plan for Congress to Consider

Rachel Estabrook, NPR.org

In the wake of congressional Republicans' failure to pass a health care bill, two governors from different parties are going to bring their own ideas to Washington.

Staff for Colorado Gov. John Hickenlooper, a Democrat, and Ohio Gov. John Kasich, a Republican, are working on a joint plan to stabilize the country's health insurance markets. Kasich told Colorado Public Radio's *Colorado Matters* that they expect to release it ahead of September hearings in the U.S. Senate. They also intend to get other governors from both parties to sign onto the plan, to show support at the state level.

"We're getting very close. I just talked to my guys today, men and women who are working on this with [Hickenlooper's] people, and we think we'll have some specifics here, I actually think we could have it within a week," Kasich said in a joint interview with Hickenlooper that aired Tuesday.

The plan will flesh out a set of principles the two men wrote about in an op-ed in *The Washington Post*, in which they said another one-party health care plan is "doomed to fail," just like the Republican plans considered this year. In the op-ed, they asserted that the best place to start reform efforts is "to restore stability to our nation's health insurance system."

Bipartisan health care hearings, including the one the governors will appear at, are set to begin just after Labor Day when Congress returns from its August recess. Lawmakers will be consumed with a number of deadlines involving government funding, though — sending health care to the back burner.

"I'm not going to get into specifics with you until we have it all ironed out, but it's not going to be some pie-in-the-sky, way-up-there kind of stuff. There will be things that we will address that will have specific solutions. And one of the things we're finding out is the states do have some power to do some things unique to them, as long as these insurance markets are going to be stabilized," Kasich said.

One specific they agree on and would discuss: changing the Affordable Care Act mandate that employers with 50 or more employees provide insurance coverage. The governors say that number is too low, which deters hiring at small companies.

They also agree that the possibility of national single-payer coverage is not on the table in their discussions. In recent months, Hickenlooper and Kasich have appeared on national television shows to advocate for bipartisan health care reform that includes keeping the Medicaid expansion intact, with both took advantage of in their states.

For more information or to view the complete article please visit:
http://www.npr.org/2017/08/22/545307530/governors-preparing-bipartisan-health-care-plan-for-congress-to-consider

CMS Cancels Cardiac Bundles, Scales Back CJR Model: 8 Things to Know

Ayla Ellison – BeckersHospitalReview.com

CMS issued a proposed rule Tuesday that would cancel or scale back major bundled payment initiatives.
Here are eight things to know about the proposed rule.
1. CMS sent a proposed rule to the Office of Management and Budget last week. The title of the rule indicated CMS would cancel mandatory bundled payment initiatives for heart attacks, bypass surgery and hip and femur fractures. Details on the changes were revealed Tuesday when the proposed rule was made public.

2. The proposed rule would cancel the mandatory bundled payment program for heart attacks and bypass surgeries and the cardiac rehabilitation payment model, which is intended to test whether a payment incentive can increase the utilization of cardiac rehabilitative services.
3. The proposed rule would eliminate mandatory bundling for hip and femur fracture treatment under the Comprehensive Care for Joint Replacement program.
4. The cardiac bundled payment models and expansion of the CJR program are slated to begin Jan. 1, 2018.
5. The proposed rule would scale back the existing CJR model. Under the proposed rule, the CJR program would be mandatory for hospitals in 34 of the 67 geographic areas chosen for the program. The CJR model would continue on a voluntarily basis in the other 33 geographic areas. The proposed rule would also make participating in the CJR model voluntary for all low volume and rural hospitals in the 67 areas.
6. "Changing the scope of these models allows CMS to test and evaluate improvements in care processes that will improve quality, reduce costs, and ease burdens on hospitals," said CMS Administrator Seema Verma. "Stakeholders have asked for more input on the design of these models. These changes make this possible and give CMS maximum flexibility to test other episode-based models that will bring about innovation and provide better care for Medicare beneficiaries."
7. Ashley Thompson, American Hospital Association senior vice president for public policy analysis and development, said the AHA is concerned cancellation of the bundled payment models could cause problems for provider organizations that have spent valuable resources to implement these programs.
8. CMS will accept comments on the proposed rule until Oct. 16.

For more information on this artilce please see: http://www.beckershospitalreview.com/finance/cms-cancels-cardiac-bundles-scales-back-cjr-model-8-things-to-know.html

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Effective **September, 2017**, Molina Healthcare will only accept standard authorization forms which can be found on their website under the following link:
http://www.molinahealthcare.com/providers/oh/medicaid/forms/Pages/fuf.aspx
Please be certain to utilize this website tool for prior authorizations on your Molina patients to prevent denials for your services.

Interested in Eligibility for your practice?

Contact NCDS today to set up a quick and easy web demonstration of eligibility services you could be using to prevent denials! Many providers are already utilizing this service and seeing the numerous benefits. You are just a few clicks away from bad coverage denials and the path to faster reimbursement. Contact Jessica Meyers at 440-234-8833 ext. 26 or email jessicap@ncdsinc.com for more information!

Top 10 Healthcare Technology Advances for 2017, According to ECRI

Jessica Davis – HealthcareITNews.com

As the industry continues to shift into the value-based care model, healthcare organizations are looking for the right tools to support the move. This tech will support the improvement of patient care and, in some instances, cut operations' costs. "Navigating new technologies is one of the biggest challenges we hear about from hospital leaders," Robert Maliff, director of Applied Solutions for ECRI Institute, said in a statement. "They simply can't afford to miss the mark on which clinical advancements to bring in to improve patient care."

The topics and tech ECRI found will be most influential this year:
1. Liquid biopsies. Liquid biopsies are a genetic testing mechanism that uses a patient's blood, plasma, serum or urine, instead of biopsied tissue.
2. Genetic testing and biosensors for opioid addiction.
3. Abdominal surgery initiative.
4. Horizon scanners.
5. Ultraviolet-C LEDs for disinfection. This latest LED option comes in strips and emits UV-C light with the greatest germicidal effect. It reduces power usage, stabilizes power output, extends lifespan and can disinfect hard to reach areas. Developers are also working on sanitizing wands and UV disinfecting cabinets for mobile devices.
6. AI. The humanoid robot Pepper can interpret human body language and read emotion to respond accordingly to the user.
7. Robotic surgery. The latest surgical robot model is designed for complex surgeries.
8. Florescent endoscopic imaging.
9. Immunotherapy and stem cell therapy for Crohn's disease.
10. Type 1 diabetes vaccines. There are two types of these vaccines: a therapeutic vaccine and a preventative vaccine.

For the complete article please see the following link: http://www.healthcareitnews.com/news/top-10-healthcare-technology-advances-2017-according-ecri

American College of Surgeons Appeal to Health and Human Services Secretary Tom Price

On July 20, 2017 the American College of Surgeons (ACS) sent a letter to HHS Secretary Tom Price MD asking for his assistance in easing the regulatory and administrative burdens that have been placed on surgeons. The letter seeks to bring attention to the "substantial and unnecessary burdens imposed on physicians and their practices by certain existing regulations that negatively affect the delivery of care to patients covered under federal health insurance plans."

The letter elaborates on points such as global codes data collection, MIPS benchmarking, interoperability, prior authorizations, skilled stay requirements, program integrity, the two midnight rule for inpatient status, evaluation/management documentation and EHR, CMS requirements to prove medical necessity, medical translator services, lack of support for clinical care models and transplant center certification requirements.

The letter very thoroughly documents why these issues place a strain on providers and recommendations on how HHS can reduce or eliminate these burdens to relieve these pressures and improve patient care.

To read the complete letter and documents from the ACA please see:
https://www.facs.org/~/media/files/advocacy/regulatory/secretary%20price%20letter%20july%202017.ashx

BCBS Michigan Faces More Than 30 Lawsuits Alleging Hidden Health Plan Fees

Morgan Haefner – BeckersHospitalReview.com

More than 30 lawsuits filed against Detroit-based Blue Cross Blue Shield of Michigan in the past week claim the insurer charged employers unauthorized and hidden fees for their health plans, *Bloomberg BNA* reports.

Filed between Aug. 9 and Aug. 11 in Michigan's federal court, the lawsuits allege BCBSM issued hidden markups to employers' health plan assets to shore up its finances, the report states. The allegations stem from a 2014 appeals court decision finding the payer responsible for the unauthorized fees under the Employee Retirement Income Security Act. The decision also upheld a $6 million judgment against BCBSM.

More than 200 ERISA lawsuits alleging hidden health plan fees were filed against the payer since the 2014 decision, the report states. A college, an auto parts maker, a plastics manufacturer and a car dealer are among the employers suing BCBSM. BCBSM did not respond to *Bloomberg BNA*'s request for comment.

For the full story please see:
http://www.beckershospitalreview.com/legal-regulatory-issues/bcbs-of-michigan-faces-more-than-30-lawsuits-alleging-hidden-health-plan-fees.html

21st Century Cures is a Step in the Right Direction for Behavioral Health

Charlie Hutchinson – MedicalEconomics.ModernMedicine.com

Often considered the social outcast of healthcare, behavioral health has long struggled to obtain legitimacy in the eyes of the general medical community. But with more than 60 million Americans affected every year from mental illness, something has to change.

The 21st Century Cures Act is widely touted as a major win for behavioral health advocacy and better clinical outcomes. Given the overwhelming acceptance in Congress (94 in favor to 5 opposed in the Senate and 392 in favor to 26 opposed in the House of Representatives), it's evident that even the staunchest of political opponents sees the

The law is far from perfect, with only a fraction of the funds going to behavioral health, but the Cures Act is a significant step in the right direction for the mental health community to be more accepted as a part of whole patient healthcare.

In the past, government has rarely taken a definitive stand for the mental health community. One of the most prominent actions taken came in the form of The Mental Health Parity and Addiction Equality Act of 2008 (MHPAEA)—a federal law that ensured group health plans would offer similar benefits compared to those of medical or surgical benefits.

While this was the first step to bringing mental health to the same kind of level as the rest of the medical world, the Cures Act represents an important building block upon MHPAEA as it establishes the addition of a leader in government focused solely on behavioral health issues—an assistant secretary for mental health and substance abuse. This person will head the Substance Abuse and Mental Health Services Administration (SAMHSA), which will "lead public health efforts to advance the behavioral health of the nation."[1]Additionally, there will be the creation of a chief medical officer within SAMHSA to assist with program creation and development.

The creation of these new positions will provide fresh opportunities for the mental health community to move to the forefront of medical legislation and receive the significant attention it so desperately needs.

These appointments will be responsible for disseminating the most successful approaches to treating mental illness and how the government can best fill its role to ease access to proper mental health care. Most importantly, they will also be a central advocate for the field and for behavior health patients themselves.

Governmental representation is a significant benefit of the Cures Act, but the much-needed law also addresses high-level issues such as the lack of interoperability that is so common throughout healthcare technology.

Achieving interoperability, which has been the ultimate aim of any health care program introduced in recent years, seems to be easier said than done. Regardless, the Cures Act is one of the latest attempts to encourage greater interoperability between health technology and to discourage information blocking so that patient care can be more effectively coordinated.

Vendors found to be information blocking could be fined as much as $1 million per violation. In other words, interoperability no longer seems voluntary.

The act does not specifically call out behavioral health practices in this provision, but the emphasis on industry-wide interoperability will no doubt help these practices integrate into the broader medical community and ensure an easier transition.

For the full article please see the following link:
http://medicaleconomics.modernmedicine.com/node/440278

Maximize Your Revenue

Maximize Your Revenue

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