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Advomas Quarterly Newsletter | 2nd Quarter | Volume 77

NO-FAULT INSURANCE CHANGES

How You and Your Patients Will Be Impacted

MEDICAID WORK REQUIREMENTS

How You and Your Patients May Be Affected

TIMELY FILING LIMIT CHANGES

How to do All You Can to Ensure Your Claim Gets Paid

advomas®
Healthcare Eligibility Advocates

Dear Clients,

Our fourth issue of AdvoLife® highlights the most critical updates on payer reimbursement to date and discusses what to look out for as we enter the end of a wildly turbulent year.

Some of our biggest challenges faced over the last quarter have had to do with the perplexing issue of increasing self-pay for our clients. Advomas continues to increase your self-pay conversions for uninsured patients – but what about those with insurance with an outstanding balance? We have conducted a significant amount of research around this rising bucket and have found it is due to a web of factors. Most significantly, this number seems to be the aftermath of the rise in high-deductible health plan consumers unable to or simply refusing to make payments after services are rendered. We hope that the powers out of our control will pay close attention to insured consumer behaviors, and in the meantime, Advomas will continue our diligent pursuit of the highest payer source for your patients.

Possibly more notable than rising self-pay was the HB 4397 and SB 1 bill on auto No-Fault reform that was signed into law by Governor Whitmer this past June. We will continue to see this legislation change over the next several months and will be informing you through our law firm, Knight & Firth, P.C., of suggested process improvements.

After decades of business, Advomas is no stranger to adapting and navigating policy fluctuations. We are bolstering our experts and adding more resources to our complex payer resolution departments. We announced our legal department is growing, and we welcomed Michael Condit, J.D. to the Knight & Firth law firm. Mr. Condit will be conducting a series of onsite education sessions on No-Fault reform as it evolves and other best practices for securing the most appropriate payer for your uninsured and underinsured claims.

Advomas continues 2019 as a leader in complex payer resolution, dedicated to supporting your patients through the difficulties of insurance eligibility and maintaining coverage.

We thank you for your support of our mission and look forward to assisting you in improving your bottom line.

Jennifer Knight

Jennifer Knight
President

NEW NO-FAULT LAW

On May 30th, at the Detroit Regional Chamber's Mackinac Policy Conference, Governor Gretchen Whitmer signed into law Senate Bill (SB) 1, making many changes to Michigan's Auto No-Fault insurance law. The changes to the law will be rolling out in phases, with the first being effective July 1, 2020, when Michigan drivers will be provided with several personal injury protection (PIP) coverage options that could potentially lead to inadequate coverage, especially for those who are catastrophically injured in an auto accident.

The options available starting July 1, 2020 include:

- **Individuals on Medicare may be able to opt out of PIP entirely.**
- **Individuals with private health insurance that covers their entire household, covers treatments for injuries caused by auto accidents, and has a deductible less than $6,000 per person (i.e. not a "high deductible" plan) may opt out of PIP entirely.**
- **Medicaid beneficiaries may purchase as little as $50,000 in PIP.**
- **All other drivers must choose among PIP options of $250,000, $500,000, or lifetime benefit levels of coverage.**

Effective July 1, 2021, a new fee schedule for providers will be phased in over a two-year period, resulting in the following payment levels:

- **190% of Medicare for medical and rehabilitation treatment not covered in any of the categories below.**
- **220% of Medicare for providers who treat a high volume of Medicaid patients (only for care before initial discharge). A listing of the hospitals that meet this criterion is available through the Michigan Health & Hospital Association (MHA).**
- **230% for Level I and Level II trauma centers (only for care before initial discharge).**
- **250% for outlier providers treating a high volume of indigent patients.**
- **Attendant care will be reimbursed according to the workers' compensation fee schedule.**

In addition to the above, the new law also addresses some of the problems that resulted from the Covenant v. State Farm case which will prove advantageous to healthcare providers, and there were also changes made to how rates are set, to allow for premium savings to consumers. For example, the bill forbids insurers from using specific nondriving factors in setting auto insurance rates including marital status, credit score, gender, occupation, home ownership, ZIP code, and education level. Insurers may, however, still use territories when setting rates. In addition, the bill also requires insurers to give certain savings to drivers as noted below:

- **A 100% reduction in the PIP portion of insurance premiums for those who opt out entirely.**
- **A 45% reduction in the PIP portion of insurance premiums for Medicaid beneficiaries who purchase $50,000 in PIP.**
- **A 35% reduction in the PIP portion of insurance premiums for those who purchase $250,000 in PIP.**
- **A 20% reduction in the PIP portion of insurance premiums for those who purchase $500,000 in PIP.**
- **A 10% reduction in the PIP portion of insurance premiums for those who purchase an unlimited medical benefit option similar to what is offered now under the No-Fault system.**

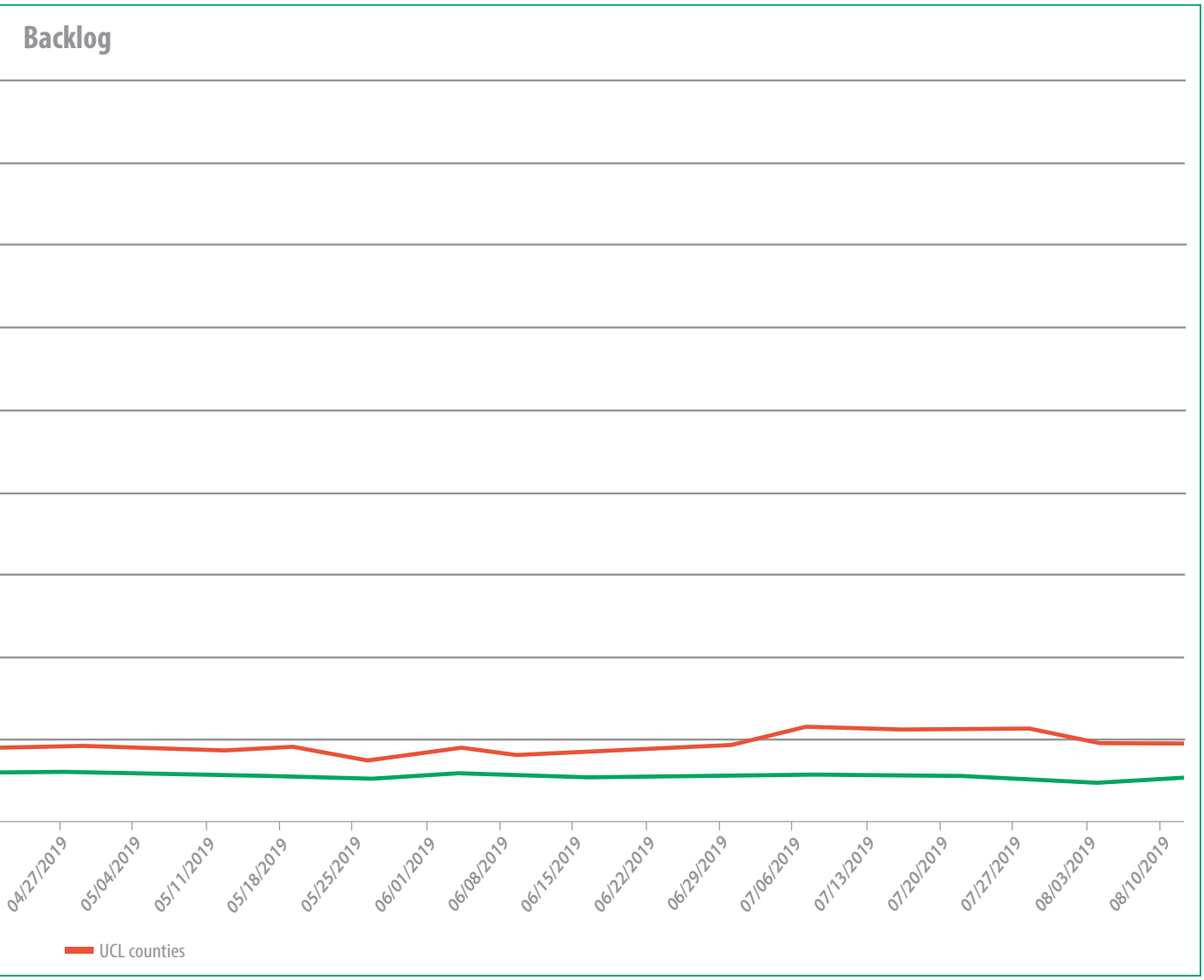
Our legal team is currently engaged in an in-depth review of SB 1 and we will be sharing further details and the potential impact to the provider community soon. (There is a link to the bill on our website.)

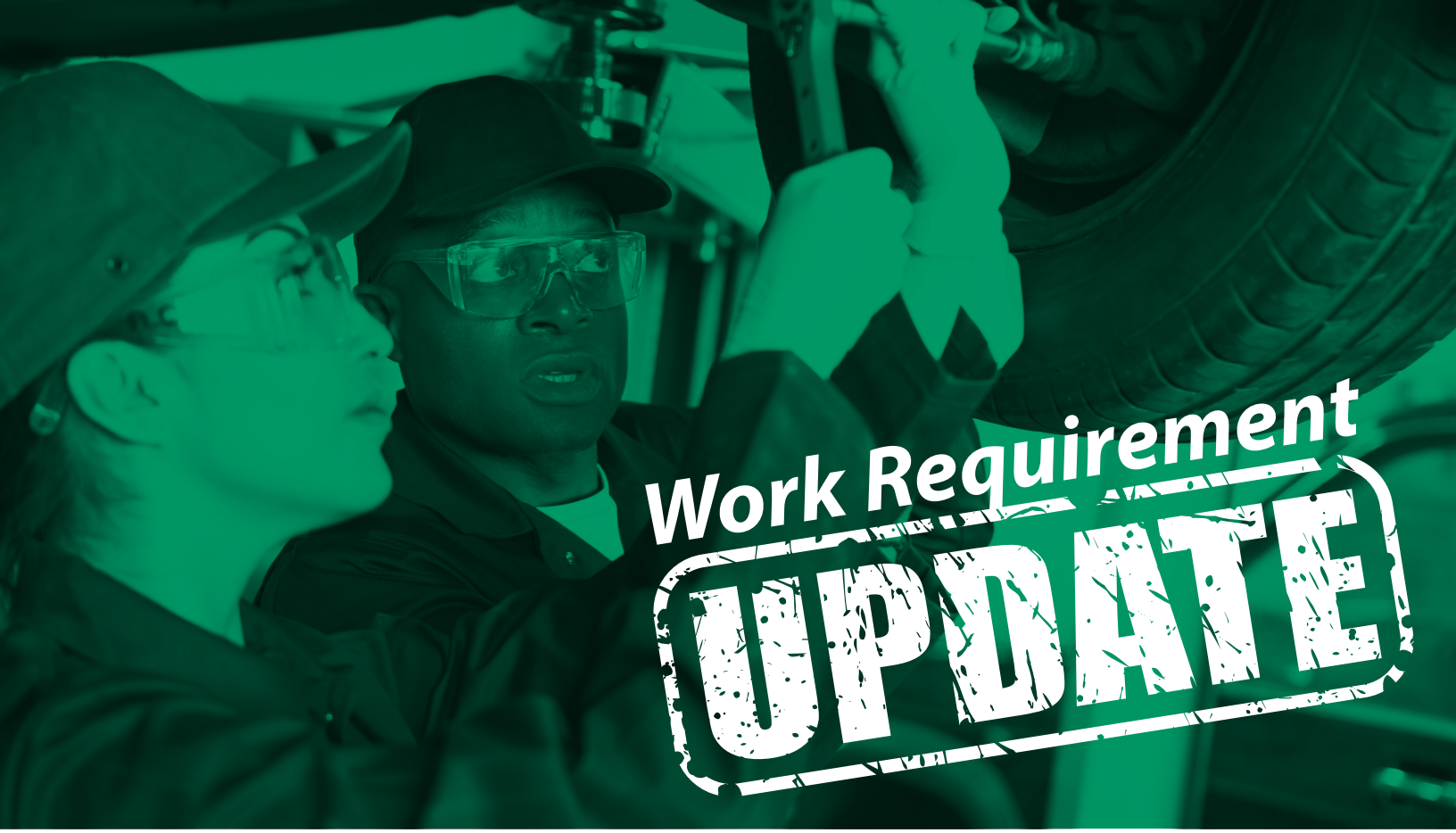
DHS UCL Update

Michigan Department of Health and Human Services (MDHHS) initiated a rollout of Universal Caseload (UCL) in February 2018. From February to October 2018, the program was rolled out to 50 counties across the state. Switching to a UCL has many potential benefits according to MDHHS, such as, "Faster and more reliable service: Clients don't need to leave voicemails, which may be dropped if a caseworker is sick. The aim is to handle most calls in one interaction; Greater efficiency: When work is shared across counties, capacity can swing based on level of need; More visibility: The shared system allows supervisors to observe client experience and caseworker interactions more easily."

The implementation of UCL in those eight months was not the smoothest and the new Director, Robert Gordon, finds the implementation results "unacceptable." The graph below makes it easy to see that the initial spike in the application backlog was significant. However, the improvements that they've made have been extraordinarily beneficial in bringing the backlog back down to being comparable with the counties who do not have a UCL.

Director Gordon visited/video conferenced with six counties, and while there, he spoke with managers, caseworkers, and clients. He has also spoken with the "Department's senior management, legislators, union representatives, and national experts on benefits delivery." Based off of meeting/speaking with everyone, he still thinks that this would be beneficial moving forward to provide better service to Michiganders. "Clients deserve better. Our caseworkers deserve better." Director Gordon says that we need to work and try to make UCL work – "simply going backward should be a last resort." When properly executed, UCL will still allow caseworkers to provide personalized service to individual clients, and at the same time, efficiently, effectively, and quickly help other clients. Director Gordon and department leadership have been working hard to do everything possible to help with the case backlogs. Whatever changes have been implemented have helped as the UCL backlog is close to the backlog in counties that do not have UCL yet. The rollout of the rest of the counties has been on hold since October 2018, and there is currently no date on when they will start again. (The link to the State's site with the updated graph below is on our website.)





Effective 1/1/2020, Public Act 208 of 2018 will impact Healthy Michigan Plan (HMP) recipients with the following changes:

I. Work Requirement

a. HMP recipients must now meet new Work Requirements of 80 hours per month, or be excluded from the requirement with an allowed exemption

i. The change applies to 19-62 year-olds

1. Required to be employed as follows:

a. Employment or self-employment

b. Education, job training, or vocation training directly related to employment

c. Unpaid work directly related to employment (such as an internship)

2. Or, required to be involved in qualifying activities such as:

a. Tribal employment programs

b. Medically or court ordered substance abuse disorder treatment

c. Community service with a 501(c)(3) organization (only allowed for three months in a 12-month period)

d. Job search related to job training

3. Or, meet the following exemptions:

a. Caretaker of a child under the age of six

b. Receiving temporary or permanent long-term disability benefits

c. Full-time student

d. Pregnant

e. Caretaker of a person with a disability (regardless of them being the caretaker's dependent or not)

f. Incarcerated with the last six months

g. Receiving unemployment benefits

h. Under 21 years of age who was previously in foster care

i. Receiving Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) benefits

4. Self-Attestation of qualifying activities will be allowed
5. Must report their compliance on a monthly basis (allowed three months of non-compliance within the 12-month calendar year)
6. Loss of coverage will occur after three months of non-compliance, with reinstatement once compliant again
    a. Will serve as a penalty month unless demonstrates exemption

There is currently a bill being considered by the Michigan legislature that will allow Michigan Department of Health and Human Services (MDHHS) to use "administrative data" to verify beneficiaries' activities without them self-reporting. There is also a bill being considered that will allow beneficiaries to report activities at the beginning of each month through the end of the month, this bill would also allow retroactive reporting of activities. (The identification process for who would qualify as a "medically frail" beneficiary is still being decided upon but may be self-attestation.)

II. Cost Sharing

a. In addition to the above, recipients of the Healthy Michigan Plan, enrolled in a Medicaid Health Plan for 48 cumulative months, will have new requirements as well:
    i. If income is over 100% of the Federal Poverty Level (FPL),
        1. Must complete a healthy behavior annually
        2. Must begin paying premiums for their coverage – 5% of income (an estimated $50-65 a month)
    ii. Loss of coverage for non-payment of premiums – loss will last until all due premiums are paid
    iii. Exemptions are allowed:
        1. Medically frail, pregnant women, Flint waiver, Native Americans, those under 21 and not enrolled in a managed care plan
        2. Certain hardship exemptions are allowed
    iv. 80% of HMP recipients are enrolled in a managed care plan
        1. 18% of them have been on HMO for 48 months or longer
b. Department of Health and Human Services (DHHS) sent notice in February 2019 of this change
    i. Exemptions will be decided starting in September 2019 and notice will be sent to the recipients
    ii. Recipients will be notified by DHHS at the point they meet 46 months to prepare for the changes

Health care providers can help beneficiaries in several ways: provide key preventive services to individuals that qualify as healthy behaviors, primary care providers can collaborate with an individual to complete an Health Risk Assessment (HRA), and MHPs can collaborate with individuals to complete an HRA and encourage beneficiaries to participate in wellness programs that qualify as healthy behaviors.

There is a tentative timeline that MDHHS presented for the work requirements and the 48-month changes implementation process:

- July will be the start of webinars and continued outreach to stakeholders;
- August will be the start of public comment on policy bulletins;
- September will be when the distribution of notices and transition letters will be sent out;
- October and November will be the start of exemption reporting, the publication of the final policy bulletin, and initiating the special processing unit; and
- December and January will have the release of the revised applications, the launch of the new technology systems, and critical communication with the beneficiary letter.

Both of these initiatives are all still a work in progress and as we learn more details, we will share them with you. Please visit our website for a link to a webinar that MDHHS provided on 30 July 2019. The state is hoping to hear any questions, comments, or suggestions for their consideration as they continue to design the process. Please forward them directly to the state as noted in the webinar or you can send them to Advomas at **ckorpela@advomas.com**, as we also intend to submit questions and suggestions to the state on behalf of providers and will share further details as we get them.

Timely Filing Reminders

At a recent Michigan Revenue Cycle Association (MRCA) meeting, the Michigan Department of Health & Human Services (MDHHS) provided a review and clarification of the changes made to the Medicaid Timely Filing policy effective 1/1/17 (section 12.3 of the Medicaid Provider Manual) to ensure that all providers are clear on the new requirements. While the main change to the policy requires that Medicaid claims must be filed and resolved within 12 months from the date of service, concerns have been raised that providers may be forgetting that there are exceptions to the 12-month filing limit, especially as it relates to patients who were approved retroactively for Medicaid to cover their service date(s).

MDHHS reminded providers that if Medicaid is approved after 12 months, an exception to the timely filing limit (TFL) is required to be authorized by the local MDHHS office, and the claim note "MSA-1038 on file" must appear in the remarks section of the claim. More importantly, providers were reminded that when patients are approved for retroactive Medicaid coverage prior to a year from date of service, the billing timeframe is extended to allow six months from the Medicaid coverage activation date to file the claim. In this instance, the note "timely filing" must appear in the remarks section of the claim. We are seeing some providers forgetting this part of the policy, especially when correcting a previously submitted claim and are writing off the claims for TFL rather than acknowledge the six-month extension. We highly recommend you revisit this with your billing teams to ensure claims are not being written off to TFL erroneously. We have noted below a reminder from MDHHS that includes the official policy releases and a Timely Filing Provider Tip sheet includes details of all exception scenarios. Along with that is a copy of the MDHHS MRCA presentation on our website for your reference.

Timely Filing:

Any claim with dates of service over a year old must have a claim note/remark to prevent denial

- **July 18, 2018: Attention All Providers: This serves as a reminder of MDHHS timely filing policy effective January 1, 2017. All claims must be submitted within a year of the date of service. For institutional invoices, this would be the header "To/Through" date of service; for professional invoices, this would be the claim line "From" date of service. Any claims with dates of service greater than a year old are REQUIRED to have a claim note to be considered for reimbursement, claims that do not have a claim note will be suspended/denied with CARC 16 and RARC N307. Reporting of a claim note does not guarantee reimbursement; the claim will be manually reviewed to determine if it meets one of the exceptions to the timely filing policy.**
- **MSA 16-37 Timely Filing Billing Limitations**
- **MSA 17-44 Clarification to MSA 16-37**
- **Timely Filing Provider Tip**

Securing Retroactive Authorizations

As of mid-2018, the Michigan Department of Health & Human Services (MDHHS) no longer activates patients into Fee For Service (FFS) Medicaid if they had been enrolled in a Medicaid Managed Care Plan within 2 months of the new coverage activation. Instead of the FFS coverage, the patients are now retroactively re-enrolled in the plan they had prior to losing their Medicaid coverage. This new process has caused a huge increase in the need for securing of retroactive authorizations from the plan because an authorization would not have been obtained from the plan at the time services were rendered. The Medicaid health plans have all acknowledged this problem and have requested that the provider include in the remarks section of the claim "retroactive enrollment" so the plan knows to process the claim. Molina Healthcare of Michigan has specifically requested that the provider include just "extenuating circumstances" in the remarks section, and the claim should pay. Without that exact verbiage noted, the claim will deny. If you are experiencing claim rejections when billing as noted above for cases such as this, please advise **Cheryl Korpela** at **ckorpela@advomas.com**, so we can assist with resolving this matter.

Inspire them and they in turn will work harder and be happy to be a part of your team!

Pomp and Circumstance

Based on research of 2,800 professionals conducted by Linkedin, the number one thing new hires want in a position is to know that the work itself is meaningful.

Celebrating the arrival of a young workforce hungry to change the world must be considered when onboarding new hires. Cultural identification is no longer the attracting factor. Candidates today are seeking the experience of the job itself. Today's prospective hires want to be wowed by what their new role entails. When integrating a new employee into your organization, take the necessary time to allow them to embrace what their new role is going to be and how it effects the overall company goals. Explain the expectations, but don't overload them with too much too soon. Forcing them to do too much too soon might invite failure. Identify each process in their position along with being candid to any related challenges. Make the basics of the job simple and easy to execute. Be welcoming to any ideas they have on how to redesign each segment while keeping the same principles. People learn better by doing; let them do the job. Lend support in doing the tasks, and then help them become successful by giving them the sense of feeling needed. Allowing employees to work hours that work best for them develops a sense of trust, and if orchestrated properly, you will build a loyal base of employees. It responds to their need for purpose and meaning.

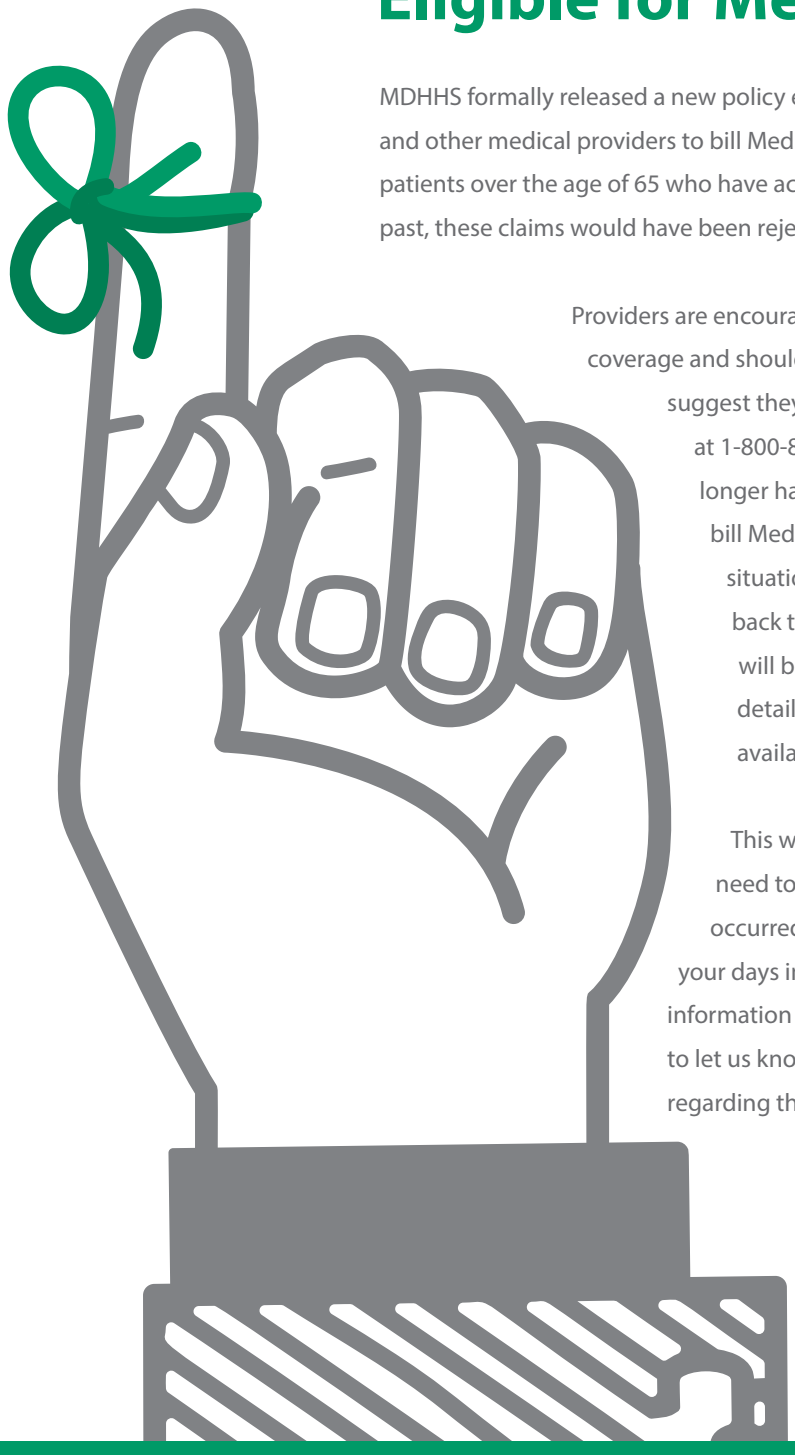
Today's young employees who completely understand their role within the organization and how it impacts the "world" begin to see their job as having a purpose. This, along with the transactional tasks of their position being easy, will allow the employee's focus to be on how to bring forth the greatest impact to make the company and their role within the company more meaningful. Inspire them, and they in turn will work harder and be happy to be a part of your team!

Penni Roberts, Advomas
VP of Human Resources

advomas® in the Community

REMINDER!

Claims for Medicaid Beneficiaries Eligible for Medicare



MDHHS formally released a new policy effective with dates of service January 1, 2019 that now allows hospitals and other medical providers to bill Medicaid fee for service and managed care plans for services rendered to patients over the age of 65 who have active Medicaid but do not have one or both parts of Medicare. In the past, these claims would have been rejected due to being "eligible for, but not enrolled" in Medicare.

Providers are encouraged by MDHHS to still advise their patients to apply for Medicare coverage and should refer them to their nearest Social Security office for assistance or suggest they contact the Michigan Medicare/Medicaid Assistance Program (MMAP) at 1-800-803-7174 for health benefit information and counseling. Providers no longer have to wait for the outcome of the patient's Medicare application to bill Medicaid for services rendered. As with other Third-Party Liability situations, should the patient secure Medicare that results in coverage back to their dates of service, a Medicaid takeback will occur and the provider will be able to bill Medicare for the services rendered at that time. For further details of this policy change, we have the reference link on our website available to you for MSA 18-50.

This was great news for all of the provider community as it removes the need to pursue Medicare coverage, reduces the many write offs that have occurred over the years with cases such as this, and at the same time, reduces your days in AR, and improves revenue to your hospital system! Please share this information with your front and back end teams as soon as possible, and be sure to let us know if you should have any questions or need anything further regarding this policy change.

Medicare Savings Programs 2018 vs. 2019

The Michigan Department of Health & Human Services (MDHHS) Medicare Savings Programs (MSP) offer assistance to patients with meeting the costs of Medicare premiums and other Medicare related expenses. The MSPs include the Qualified Medicare Beneficiary program (QMB), Specified Low-Income Medicare Beneficiary program (SLMB), and Qualified Individual program (QI). All of these programs help Medicare beneficiaries of modest means by having the state pay all or some of their Medicare costs (i.e. premiums, deductibles, and copayments).

To qualify, an individual must be eligible for Medicare and must meet certain income guidelines, which change annually. The federal requirement is for an additional $20.00 above the Federal Poverty Level for the programs, while individual states may be more generous with the income and resource amounts. Michigan has increased the individual monthly income by $29 - $40 per program and the married couple monthly income by $38 - $51 per program.

We have included the current income chart below as a reference in case your team encounters a patient who needs help with paying their Medicare premiums.

	Individual Monthly Income Limit			Married Couple Income Limit				
Medicare Savings Program	2018	2019	Difference	2018	2019	Difference	Program Pays For	Eligibility Effective Dates
Qualified Medicare Beneficiary (QMB)	$1,032	$1,061	+$29	$1,392	$1,430	+$38	Part A and B premiums AND deductibles, coinsurance and copays	Effective the month AFTER application processing (Unless patient is an SSI recipient)
Specified Low-Income Medicare Beneficiary (SLMB)	$1,234	$1,269	+$35	$1,666	$1,711	+$45	Part B premiums only	Retro is possible to the previous year
Qualifying Individual (QI)	$1,386	$1,426	+$40	$1,872	$1,923	+$51	Part B premiums only	Retro is possible within the current year

New Hire Employee Spotlights

"I was born and raised in St. Clair County. I have a Bachelor's degree in Criminal Justice. I have a husband, two children, and a dog. We raise pigs and now are raising cows. We spend our time outdoors (camping, mud bogs, fishing, cookouts). Family is everything. I was looking for a career that helps people and I found that with Advomas."

– Kim Hamilton

"I was born and still live in Lansing, MI. I am a graduate from Central Michigan University. Fire up, Chips! I have two boys, ages 9 and 6. They are wild and keep me busy. When not at work, I enjoy naps, food, playing bingo, and golf. I joined Advomas because I believe in helping others and enjoy being an advocate for people who need assistance. I believe everyone wants the same things in life: to be happy, healthy, and safe. Since we all live on this planet together, I believe we can do a better job taking care of each other. I love to learn and enjoy new challenges."

– Tabetha Harris

"I was born in Flint and raised in Clio, MI. I graduated from Clio High school in 2010. When I'm not spending my days in the good ol' Hurley Medical Center I'm spending my time with my 5-year-old son Zaydrian, who was diagnosed with Autism at the age of two. Every day is an adventure and always he teaches me something new. I started at Advomas in January of this year, and so far, I have learned that mostly people just want to feel recognized. Every day, I see people in my community just longing for someone to be there for them. I'm grateful to be that person. I love helping people, whether it be a friend, family member, or even a stranger. I'm very grateful to be able to be a part of a company who is so dedicated to the community."

– Lindsay Abbott

Presumptive Eligibility Check-In

with Darnell Thompson

Advomas is quickly closing in on completing its third year in assisting hospitals and health systems with applying their patients for the Presumptive Eligibility. Presumptive Eligibility (PE) is a state-run program that allows for temporary Medicaid coverage based on a patient's attestation that they are under the income threshold required for the Healthy Michigan Program (HMP).

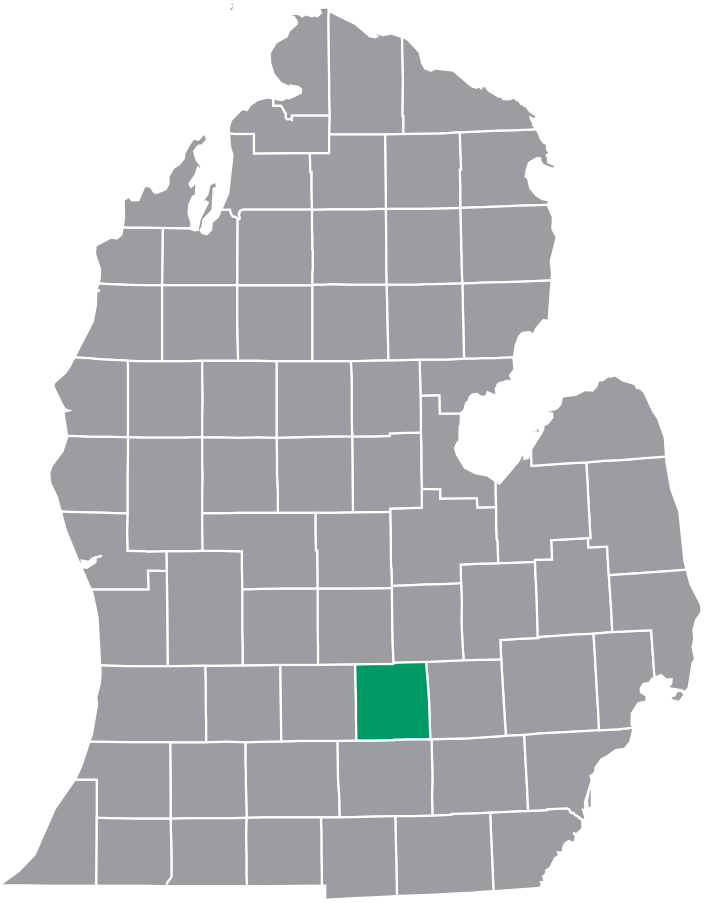
These applications are done in an Emergency Room setting, as PE coverage begins on the date of application and cannot be back-dated. Upon getting the necessary information for the PE application, Advomas provides the hospital with the information to complete the application. Once the patient is approved, they have coverage until the end of the following month of the stay. During this time, Advomas follows up by submitting a full Medicaid application and works with the patient to secure ongoing coverage.

With a program allowing for coverage based on one's word, there are standards that must be consistently met. If a hospital/health system decides to use PE, they must maintain a 75% rate of full Medicaid app submission on PE approvals, and 60% of the PE approved patients must be approved for full Medicaid. This seems to be the biggest deterrent from hospitals making use of the program, but this is also where Advomas' partnership with clients has made it work.

Once the hospital secures PE coverage based on an Advomas Eligibility Specialists' assessment, Advomas goes to work in assisting the patient in submitting the full application and working with them to secure necessary documentation and verifications to secure the ongoing coverage. For 2018, Advomas secured an 85% full application submission rate, 64% approval rate and is on pace for meeting these numbers in the current year.

With a solid combination of processes, communication between the patients, the facilities, and Advomas, the PE program has shown to be beneficial for the hospitals by securing payment in a more timely fashion when they may not have gotten it at all, as well as the patient by giving them coverage that shows active with 24 hours, so they can get prescriptions, follow-up care, and the peace of mind that they don't have to worry about taking care of a hospital bill.

For more questions on applying your patients for presumptive eligibility please contact **Darnell Thompson** at **248.989.4200 ext. 313** or email Darnell at **dthompson@advomas.com**.



Ingham Health Plan

Ingham County hospitals and healthcare providers: The Ingham County Health Plan (IHP) is a plan that the county started which is a "coordinated set of coverage options and health care delivery network from sustainable funding mechanisms with administrative oversight and broad community support." It is not Medicaid (MA) or insurance and does not satisfy the Affordable Care Act (ACA) individual insurance mandate. IHP will serve as a "safety net plan" for low-income Ingham County residents that do not qualify for other plans or dental coverage.

IHP members must meet several qualifiers: must live in Ingham County (but not necessarily planning on staying indefinitely); must have incomes at or below $28,000 per year (for one person) or 224% of the Federal Poverty Level (FPL) for a family; do not qualify for comprehensive insurance including Medicare (MCR), MA, for Healthy Michigan Plan (HMP); and must pay a $20.00 annual administration fee for full IHP coverage.

Common IHP members fall into several categories: non-citizens (non-legal or legal with less than five years residency); have limited Medicaid coverage (Spenddown or ESO); have Marketplace exemptions (must have exemption approval letter); have "pending" MA/HMP coverage (90 day coverage only); are over 138% FPL who did not enroll in a Marketplace Plan (due to either unaffordable coverage or the Marketplace was closed); or are seasonal workers (who are denied for specific months sure to a higher income but have a yearly income under 224% FPL.

With our clients in Ingham County, if we are unable to get them coverage from other sources, when applicable, we will refer them over to IHP so they can get some form of coverage. IHP members receive a lot of benefits. They are assigned to a participating doctor's office at enrollment to be assigned to a Primary Care Physician (PCP) and receive many benefits that are covered for free or are very affordable – office visits; specialist visits; outpatient lab tests; outpatient x-rays; outpatient tests, procedures, and surgery; prescription medications ($5 or $10 if on the approved list – if not on the list the IHP card serves as a Discount Card and savings range from 5-70% with an average of 20% discount); physical/occupational therapy (limited benefit); walk-in/urgent care; dental care (Delta Dental EPO plan) are all covered with a co-pay of $0, $5, or $10 (with the dental coverage varying).

For more information and questions please contact **Darnell Thompson** at **dthompson@advomas.com**

Introducing Mike Condit to Knight & Firth, P.C.

Mike has been litigating insurance related matters for over 33 years. He started his career at Plunkett & Cooney, P.C., working a host of insurance related matters including No-Fault litigation. More recently, he has been devoting a substantial part of his practice to representing healthcare institutions and healthcare providers. Mike has litigated cases throughout the State of Michigan in Federal and State Courts. He has been admitted to the U.S. District Court before both he Eastern and Western Districts of Michigan and has handled appeals before the U.S. Court of Appeals for the Sixth Circuit.

MARK YOUR CALENDAR!

MRCA 2019 and 2020

Fall Conference: Thursday, September 19 – Friday, September 20, 2019

Member Meetings: November 22, 2019; January 24, 2020; March 20, 2020; May 8, 2020

HFMA/MCACHE

Fall Conference: Monday, October 28 – Tuesday, October 29, 2019

Western Michigan HFMA 2019 and 2020

Member Meetings: September 13, 2019; December 12, 2019; January 16, 2020

MHA

2019 MHA Women in Healthcare Data: September 27, 2019

NOTES

From the Desk of Bruce Knight

I was charged with the task of writing a comment for our newsletter, and the most likely topic for me today should be the new no-fault law. So, I read it. Here's my comment:

It's a complete mess, and thankfully, it's still being rewritten and patched so much so that outside experts have been hired to try to make it workable. The take away from this is the insurance companies have much more political clout than either the medical providers or the injured. I can't remember any bigger disregard for the latter two groups.

I have spent my entire life with Advomas, helping and assisting the downtrodden. For some reason, I was laboring under the misconception that that was government's job, too. So, when something like this comes along, it just makes me sick.

I see hospitals hemorrhaging money in their emergency rooms, trauma centers closing or downgrading, and people dying. The upside is that death is less expensive than caring for a traumatic injury care, and the auto insurance companies will have some very good profitable years.

I will admit that the old no-fault law had some gaping holes which lead to abuse, fraud, and some unfairness. These relatively minor problems should have been fixed and could have with a couple of band aids, rather than the total amputation.

I don't know how our compassionate governor and caring legislators and senators can live with themselves with this debacle. Hopefully, the economic devastation they have just reigned on the injured and their caregivers will be corrected, even though it would be better to start over.

So, for now, we will wait and see if anyone comes out of the ether or where the ball lands.

On a happy note, I'd like to add that Mike Condit has joined us. Mike is a seasoned attorney with over 33 years of experience in litigating cases throughout Michigan. We will be working together even though his father crushed me in some litigation several decades ago. Mike inherited that killer gene, so this should work out.

W. Bruce Knight

W. Bruce Knight
Founder & CEO

Advomas is a proud member of

MHA Michigan Health & Hospital Association

hfma

MRCA Michigan Revenue Cycle Association

1607 East Big Beaver
Suite 350
Troy, MI 48083

p: 248.989.4200
f: 248.989.4201

advomas.com