THE LEADING EDGE

Welcome!

Welcome to the Fall edition of the Leading Edge.

In our first article, we highlight the recommendation to remove total knee surgery from in-patient only. Next we highlight AAAHC recommendations on colonoscopy best practices.

Then we have a piece on the trend for more Ambulatory Surgery for Breast Cancer.

The next article summarizes what everyone in the ASC world knows: moving procedures to the ASC from a HOPD reduces costs without impacting quality or outcomes.

Our feature articles begin with a look at telemedicine: is it at a "tipping point?" Many think so despite the barriers that remain.

Next we look at Medicare Advantage. This below-the-radar version of Medicare insures nearly a third of Medicare patients in what otherwise look like commercial plans. But increasingly, we see MA adopting narrow networks.

Healthcare exchanges are highlighted in our next feature. Everyone has seen the news about insurers dropping out. But exchanges aren't going away so expect to see more narrow networks and expanded efforts to attract younger and healthier consumers.

In our final feature, we describe current industry efforts to improve population health. It is clear that managing a population's health is hard but we are beginning to see early success stories.

In the Compliance Corner, you will learn why OIG exclusion checking is so important and about a new AdvantEdge offer that can assist you with exclusion testing.

You can print any article in this newsletter as a PDF and there is a PDF "button" to download the entire newsletter for email or printing.

A last, personal, note. This is my last issue of the LeadingEdge. I am retiring in October. But rest assured that the LeadingEdge and the other AdvantEdge newsletters are in good hands. Hannah Paoletti does most of the heavy lifting and Mike Krivich is on board to take over my end of things. I'm sure the quality of articles will continue to improve, which has always been our objective.

We appreciate your feedback and suggestions. Please call or email Mike with comments and topics: mkrivich@ahsrcm.com and (630) 874-2545.

Bill Gilbert

Panel Endorses Removing Total Knees from Inpatient-Only List

The Advisory Panel recently recommended that CMS remove total knee arthroplasty (TKA) from its inpatient-only list. Following a presentation by Sohrab Gollogly, MD, an orthopedic surgeon affiliated with the Monterey Peninsula Surgery Center in California, on August 22nd, the Advisory Panel on Hospital Outpatient Payment (HOP) made the unanimous recommendation to CMS.

The purpose of the HOP is to advise the Secretary of the US Department of Health and Human Services (HHS) and the Administrator of CMS on optimal strategies related to the clinical integrity of procedures within the hospital outpatient prospective payment system (OPPS), including "removing procedures from the inpatient list for payment under the OPPS payment system."

Although the HOP's recommendations are not binding on CMS, ASCA says it is "pleased to see this body support the movement of this code to the outpatient setting."

"ASCA appreciates this panel's recognition that total knee replacements can be performed safely and effectively as outpatient procedures for many patients within the Medicare population, and we hope CMS will heed this recommendation," said William Prentice, ASCA chief executive officer. "ASCs have been performing these procedures safely on non-Medicare patients for years and are well-versed in the importance of patient selection based on a patient's entire health profile. Age alone should not be an exclusionary factor."

Source: Government Affairs Update, "HHS Advisory Panel Recommends Total Knees Be Removed from Inpatient-Only List," *ASCA News Digest Vol. VI, Issue 32*, August 25, 2016

AAAHC Colonoscopy Best Practices

A new report from the Accreditation Association for Ambulatory Health Care (AAAHC) Institute for Quality Improvement (IQI) shows compliance with national recommendations on colonoscopies can improve the safety of the procedure and increase patient satisfaction.

The report is the fifth in a series of best practices studies undertaken by the Performance Measurement Initiative of the IQI and was performed during July through December 2015. The authors explained that keeping the period to no more than 6 months helped avoid possible distorted results from new developments in the healthcare industry, such as changing technology. Researchers collected data from 54 ambulatory healthcare organizations, for a total of 1,419 routine colonoscopy cases. Using self-reported data from patients, ages 16-86, the authors identified the following as best practices for improvement in colonoscopy procedures at ambulatory care organizations:

- Follow Guidelines for Testing Fluids Used for Sterilization or High-Level Disinfection

- Existing national guidelines recommend sterilization (for critical use cases) or, if that is not possible, high-level disinfection (HLD) of GI endoscopes, and sterilization of cutting instruments that break the mucosal barrier before use. Of the organizations in the study, 2% reported using only sterilization, 79% said they used only HLD, and 19% reported using both.
- The authors also recommend providing steps for testing fluids used for scope sterilization or HLD, yet only 85% of the ambulatory organizations surveyed report indicated that they follow all of the steps.

- Follow Guidelines for Pre-sterilization Equipment Cleaning

- A 96% self-reported compliance rate was found among the participating organizations but feedback on specific reprocessing practices for fluid testing and equipment cleaning suggested that not all participating organizations were fully adhering to national guidelines.
- The study's authors insist focus on adequate, ongoing training and assessment of reprocessing colonoscopes and cleaning equipment is essential to ensuring optimal patient safety. They suggest organizations perform annual competency testing for all staff who reprocess endoscopes, as well as provide instructions when guidelines or manufacturers' instructions change.
- The authors also recommend opting for disposable rather than reusable cutting instruments. "For those few organizations still using reusable cutting instruments, compliance with manual precleaning recommendations shows opportunities for improvement," Kuznets said.

- Educate Patients on Proper Bowel Preparation

- Results showed that 25% of patients had more than "a little discomfort" during bowel preparation.
- "Poor patient compliance with directions for bowel preparation can mean cancellation and rescheduling of the procedure, because the endoscopist can't proceed or the endoscopist is not able to detect significant polyps — i.e., those greater than 5 millimeters in size," Kuznets notes. "In the latter case, poor bowel prep may lead to a

> less effective colonoscopy and the need for a shorter interval between colonoscopies. Rescheduling and shorter intervals between colonoscopies are expensive for everyone involved. This is not just taking additional patient and GI center time, but it also increases the potential for missing significant polyps."

One of the study's researchers and IQI vice president and senior director Dr. Naomi Kuznets commented, "It is very positive that almost all patients find the procedure itself to be comfortable and would recommend it to a friend. At the same time, we need this to be as safe a procedure as possible and this includes, but is not limited to, being vigilant with regard to compliance with national and manufacturers' recommendations on colonoscope and instrument reprocessing. We also need the procedure to be as effective as possible, and that means good bowel prep."

Source: Bachert, Alexandria, "AAAHC Report IDs Best Practices for Colonoscopy," *MedPage Today*, August 28, 2016

Ambulatory Surgery for Breast Cancer

More women with breast cancer are choosing to have mastectomies over breast-sparing procedures and almost half do not need to stay overnight at the hospital, according to a federal analysis.

The Agency for Healthcare Research and Quality (AHRQ) study shows that treatment trends for breast cancer are evolving with more women opting for outpatient mastectomies versus more conservative surgeries combined with radiation treatment.

Using data from 13 states that represent a quarter of the population, the federal Agency for Healthcare Research and Quality found that the rate of mastectomy increased by 36 percent from 2005 to 2013. During that same period, the overall incidence of breast cancer remained the same, the report says.

According to the study, 45% of mastectomies in 2013 were performed in hospital-affiliated outpatient surgery centers with no overnight stay – an increase of 22% from 10 years ago.

Ambulatory breast cancer surgery continues to steadily gain acceptance for a number of reasons:

- Early discharge has shown to have no adverse effects on patient outcomes and has been attributed to better psychological adjustment for the patient, economic savings, and a more efficient utilization of health care resources
- Minimal care is typically needed post-discharge
- Unplanned conversions to inpatient admission and readmission rates are low
- Wound complications are infrequent and no issues with drain care have been reported
- The period of postoperative observation is short and monitoring is not intensive
- Ambulatory surgery is only suitable for patients without serious comorbidities, where the likelihood of major perioperative events is low
- Optimal management of pain, nausea, and vomiting is essential to ensure a quick recovery and return to normal function
    - Regional anesthesia such as the thoracic paravertebral block has been employed to improve pain control during the surgery and in the immediate postoperative period
    - The block provides tremendous pain relief and reduces the need for opiates, which also consequently reduces the incidence of nausea and vomiting
    - Increasing popularity of total intravenous anesthesia with propofol has also helped reduce the incidence of nausea and vomiting in the postoperative period
- Ambulatory surgery can be safely performed in centers where there is a well-designed workflow to ensure proper patient selection, counseling, and education, and where patients and caregivers have easy access to medical services should problems arise after discharge.

The trend concerns some patient advocates, who say there are less invasive options such as lumpectomy that are just as effective. They also have concerns that other factors, such as financial issues, might be leading some patients to be sent home too soon.

"I'm alarmed and concerned," said Karuna Jaggar, executive director of the patient advocacy group Breast Cancer Action. "As a patient watchdog group, we would want to know that women are not facing undue pressure," including the pressure of cost, "to go home before they are ready."

Rep. Rosa DeLauro, D-Conn., said that she plans to reintroduce next month a version of the 2013 bill that would bar insurers from requiring less than a 48-hour hospital stay, commenting, "Mastectomies are a major operation, and after going through such a physically and emotionally traumatic experience, women should have the ability to continue to stay in the hospital and receive the care they need."

According to the report, the increasing rate of mastectomies was driven mainly by women having double mastectomies. The overall mastectomy rate rose from 66 per 100,000 to 90 per 100,000 between 2005 and 2013. At the same time, the rate of double mastectomies more than tripled, from 9 per 100,000 women to 30 per 100,000.

Source(s): Tan, Ern Yu; Pek, Chong Han; Lim, Boon; Tey, John, "Ambulatory surgery for the patient with breast cancer: current perspectives," *Dove Medical Press*, August 2016; Appleby, Julie, "More Women Are Having Mastectomies and Going Home the Same Day," *NPR*, February 22, 2016

ASCs Reduce Outpatient Procedure Costs

A new analysis shows that ASCs can reduce outpatient surgery costs by more than $38 billion dollars annually compared to hospital outpatient departments.

The analysis was conducted by *Healthcare Bluebook*, a national provider of quality and cost data for healthcare services, in partnership with *HealthSmart*, an independent administrator of health plans for self-funded employers. The Ambulatory Surgery Center Association (ASCA) provided technical assistance and expertise to the study. The companies conducted the analysis using a sample of de-identified commercial claims data for 2014.

Key points from the study include:

- For all payers throughout the U.S., ASC prices were found to be significantly lower than HOPD prices for the same procedures.
- ASCs reduced a patient's out-of-pocket costs by more than $5 billion annually through lower deductibles and coinsurance payments.
- Cataract patients in Charleston, WV with an ACA silver plan showed average savings of $566 in out-of-pocket costs by choosing an ASC.
- For commercially insured populations, ASCs were only able to perform 48% of the procedures that surgeons say they could safely perform in a surgery center. .
- If the remaining 52% of potential ASC cases were performed in an ASC setting, the U.S. healthcare cost savings would be $41 billion annually.

ASCA CEO William Prentice commented on the findings, stating, "The physicians and nurses providing care in ambulatory surgery centers, as well as the millions of patients they have treated, have long known that ASCs provide a high-quality, low-cost site for outpatient procedures."

Prentice continues, "This study is solid evidence that consumers, policymakers, insurers and employers need to take fuller advantage of the exceptional healthcare value offered by ASCs."

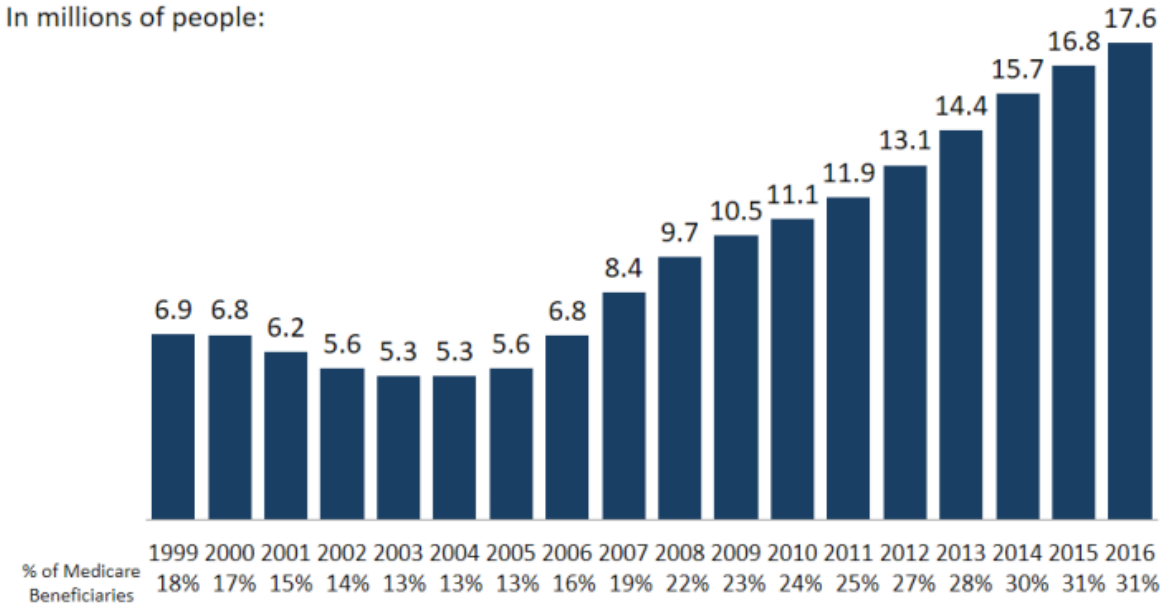
Source(s): Vaidya, Anuja, "ASCs Reduce Outpatient Procedure Costs by $38B per Year Compared To HOPDs: 5 Insights," *Becker's ASC Review*, June 14, 2016

Medicare Advantage: Positioned to Expand Rapidly?

Despite debates over Medicare Advantage (MA) costs and benefits vs. traditional Medicare, MA continues to expand. CMS just announced that the average MA plan premium will decrease in 2017 vs. 2016 (to $31.40 from $32.59) and current projections are for 18.5 million enrollees in 2017, nearly one-third of total Medicare.

Figure 1

Total Medicare Private Health Plan Enrollment, 1999-2016



NOTE: Includes MSAs, cost plans, demonstration plans, and Special Needs Plans as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses and beneficiaries in territories other than Puerto Rico.
SOURCE: Authors' analysis of CMS Medicare Advantage enrollment files, 2008-2016, and MPR, "Tracking Medicare Health and Prescription Drug Plans Monthly Report," 1999-2007; enrollment numbers from March of the respective year, with the exception of 2006, which is from April.

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In 2017, MA will cover 60 percent more beneficiaries than it did in 2010, with premiums that are 13 percent lower on average. Current projections are that MA will represent more than 40% of Medicare by 2026, and that could be conservative.

Medicare Advantage Attractive to Insurers

While insurers receive a capitated payment (per enrollee) for MA, they have traditionally found the business very attractive (i.e. profitable) even with ACA-imposed reductions. One of the reasons is the ability to attract healthier enrollees.

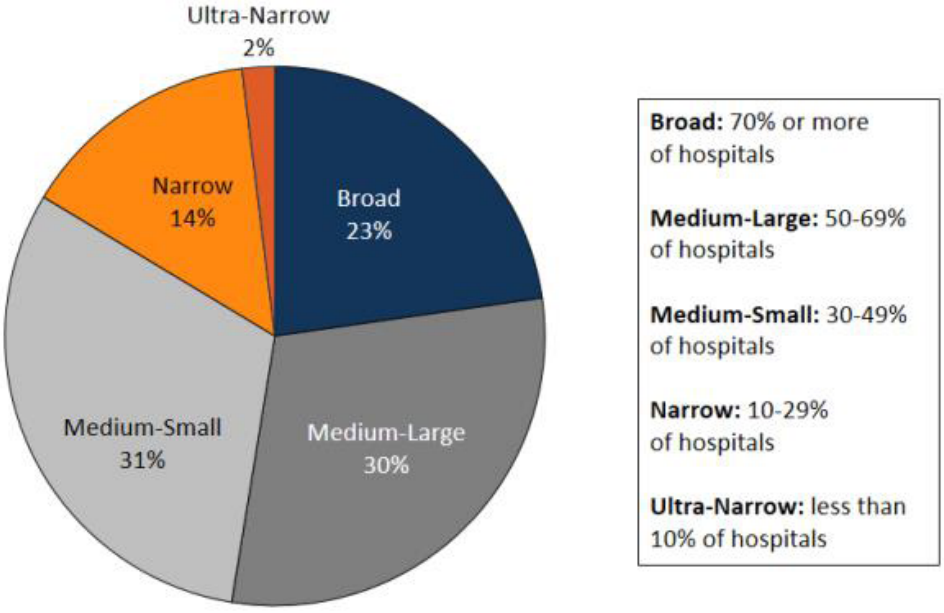
Going forward, with MA payments increasingly based on quality and adjusted for patient risk,

insurers see MA as a natural extension of their ACO efforts. After all, a MA plan promises comprehensive coverage and can evolve easily into primary care coordination and other aspects of an ACO framework. Even today, nearly two-thirds of MA plans are HMOs.

To keep MA premiums attractive (the primary reason that consumers sign up for MA), insurers increasingly rely on narrow networks. A recent Kaiser Foundation analysis found that 16% of MA plans had narrow networks in 2015 and 23% had broad networks (see graph). It is expected that MA networks will become increasingly narrow to support care coordination, ACO and efficiency objectives.

Figure ES.1

Hospital Networks Vary Across Medicare Advantage Plans:
16% Have Narrow Networks and 23% Have Broad Networks



Total = 409 Medicare Advantage Plans Available in 2015

SOURCE: Kaiser Family Foundation analysis of Medicare Advantage plans' hospital networks in 20 counties, 2016.

Other findings from the Kaiser study include:

- On average, Medicare Advantage plan networks included about half of all hospitals in their county.
- Most plans (80%) included an Academic Medical Center in their network, but one in five did not.
- Two in five plans in areas with an NCI-designated cancer center did not include the center in their networks.
- In 9 of the 20 counties studied, none of the plans offered in 2015 had a broad network of hospitals within that county.
- Among HMOs, which comprised the majority of the plans in the study (75%), broad and narrow network plans had similar average premiums ($37 vs. $36 per month) and similar quality ratings (3.8 vs. 4.1 stars).

Provider-Sponsored Medicare Advantage

A significant factor driving MA growth comes from provider-sponsored plans (e.g. Kaiser, Geisinger, SummaCare, etc.). Between 2012 and 2015, provider sponsored plans represented 54% of MA entrants. According to an Avalere Health analysis, 58 percent, or 11 out of 19, new MA parent organizations in 2016 are provider-sponsored. As shown in the figure, 70 provider parent organizations offer 403 MA plans in 41 states to 35 million Medicare beneficiaries in 2016. In total, 64 percent of Medicare beneficiaries have access to a provider-sponsored MA plan in 2016.

Provider-sponsored MA plans have been successful signing up consumers. In 2015, almost 6 percent of all Medicare beneficiaries were enrolled in a provider-sponsored MA plan. This means one in every five MA enrollees. The impact is even more striking when looking at specific geographies. Provider-based MA plans, almost by definition, have a limited geographic footprint. Within those footprints, the largest provider-based plans have MA penetration that ranges from 15 to 55% of MA enrollees. Some smaller plans have even higher penetration, but in a small footprint.

It seems highly likely that we will see more provider-based plans, both for MA and in other markets. In fact most existing provider-based MA plans are part of a broader set of plans that include commercial, Medicaid and, in some cases, exchange plans. Pressures to expand alternative payment models, such as ACOs and medical homes, will continue to position providers to become payers, despite the challenges involved. The natural result will be more provider-based MA plans and enrollees, especially in their targeted geographic area.

The Cost & Quality Debate

Presently, there is debate within the industry around whether or not MA effectively saves Medicare money and the overall quality of MA programs. A Kaiser study shows provider data often is very difficult to review, can be out of date and frequently contains inaccurate information about the quality of providers in some MA provider networks, making evaluation of MA programs more difficult.

In 2014, Medicare paid about $160 billion to MA organizations to provide health care services

for approximately 16 million beneficiaries. CMS, which administers Medicare, estimates that about 9.5 percent of its payments to MA organizations were improper, according to the most recent data—primarily stemming from unsupported diagnoses submitted by MA organizations. CMS currently uses RADV audits to recover improper payments in the MA program.

In terms of quality, healthcare consumers often link health care quality with their choice of doctor. MA plans with limited provider networks, or with inadequate information about which providers are in-network, cause consumers to feel they have limits on their options and therefore may not have access the best possible care.

However, significant changes in how all health insurance plans create and manage their provider networks are changing how health care consumers perceive a provider network. Advocates attest that well-managed health care provider networks are changing how customers are experiencing health care by enabling providers to connect with each other and help deliver better health outcomes and a more satisfying experience for patients.

For example, UnitedHealthcare provides financial incentives to health care providers who meet or exceed industry benchmarks for health care quality. Additionally, the federal government now rates and provides financial bonuses to MA plans that exceed health care quality and customer satisfaction benchmarks. Called the Star Ratings program, this pay-for-performance system means that the best-performing Medicare Advantage plans are able to offer more benefits even as they improve the overall quality of the health care their members receive.

Advocates claim that the higher efficiency of such private options should push the government towards expanding the role of managed care plans. But opponents say the sizeable positive selection faced by MA plans to support claims of over-reimbursement is costing the government money, instead of saving.

Insurers have also chimed in on the debate, claiming the MA star ratings are unfair and leave insurers with a high proportion of dual-eligible members at a disadvantage, in addition to unfairly penalizing plans focused on serving low-income, medically complex members.

A 2015 study from The National Bureau of Economic Research (NBER) which analyzed quality of care at the hospital level, found that private MA plans provide greater efficiency and lower costs by reducing unnecessary hospitalizations and elective care. In the report's conclusion, NBER says it found "no evidence that this is accompanied by reduced quality of care for Medicare patients when enrolled in MA; quality indicators, if anything, deteriorate when MA plans exit."

A report published by the Government Accountability Office (GAO) in April, titled *Fundamental Improvements Needed in CMS's Effort to Recover Substantial Amounts of Improper Payments*, concluded that CMS needs to improve its oversight of Advantage plans to assure that provider networks are robust. The report also criticized CMS for doing too little to assess the accuracy of Advantage plan provider lists.

Following the GAO's report, CMS has put the industry on notice that it will levy sanctions against MA carriers that do not meet its standards and has foreshadowed requiring machine readable directories in the future.
The agency has published its network adequacy review requirements for the first time and

established new requirements for consumer notices and surprise bills. Plans must now create "machine readable" provider directories which can be checked regularly by regulators and researchers, and facilitate inter-plan comparison. Additionally, CMS recently published other new requirements regarding provider network directories, consumer notices, and special enrollment periods for midyear network changes.

Looking Ahead

Currently in 2016, 31% of Medicare enrollees are in Advantage plans, up 11% since 2010. With conservative projections, that number is expected to hit 41% by 2026, according to Congressional Budget Office (CBO) predictions. Insurers have many incentives today to make MA more attractive and that trend is unlikely to change, despite recent debates about MA costs and quality. In addition, as providers gain experience bearing risk and develop better care delivery models, they will continue to expand their MA offers. The result is that we should expect to see an increasingly diverse set of MA plans over the next several years which will drive increased MA penetration.

Source(s): "Provider-Sponsored Health Plans: Enrollment, Quality, and Future Impact," *Avalere*, January 2016; "Does Medicare Advantage Cost Less Than Traditional Medicare?" *The Commonwealth Fund*, January 28, 2016; Moody, Katherine, "A Look at States' Efforts to Coordinate Care for Medicare, Medicaid Populations," *FierceHealthPayer*, March 21, 2016; "MEDICARE ADVANTAGE: Fundamental Improvements Needed in CMS's Effort to Recover Substantial Amounts of Improper Payments," *Government Accountability Office*, April 2016; Miller, Mark, "Medicare Advantage Grows, But Provider Choice Is Limited," *Reuters*, July 11, 2016; Herman, Bob, "More Tweaks Coming For Value-Based Medicare Advantage Project" *Modern Healthcare*, August 11, 2016 Herman, Bob, "Cigna's Medicare Problems Won't Be Fixed By Annual Enrollment," *Modern Healthcare*, September 6, 2016

Telemedicine: At a Tipping Point?

Telemedicine has been around in one form or another for many years. But the convergence of technology and need (care coordination, medical services in rural areas, etc.) is now driving rapid expansion. Whether this continues to the point where telemedicine is mainstream will be determined by regulatory action and provider inertia.

Increased Acceptance & Use of Telemedicine

The healthcare industry is constantly searching for new ways to enhance quality of care and serve more patients. With recent advancements in technology, more providers are relying finding that telemedicine can be an effective tool.

Specialty tools, such as teleradiology are steadily gaining acceptance as more providers discover the benefits in enhanced patient care The use of telemedicine tools and electronic communications (i.e. smartphones, email, webcam) has enabled providers to deliver patient consults, communication, physician consults, and chart transfers in convenient and innovative ways. These tools also offer useful and manageable ways to monitor, track, and share patient history and outcomes. Patient use of telemedicine tools is also on the rise, as new technology has offered simple ways to monitor and track personal health (i.e. blood pressure, heart rate, Rx, exercise, etc.).

Implementation Barriers

While technology advancements have driven the development of new telemedicine tools, as with any new mechanism, patient and provider utilization varies. Misconceptions around complexity and regulation as well as the common resistance to trying something new have limited physician and patient adoption. An additional barriers to broad acceptance and use of telemedicine and tools are licensing and reimbursement.

Currently physicians in the U.S. are required to have a valid license in the patient's state in order to provide medical care. Virtual-visit companies are limited to matching users only with locally licensed clinicians. These limitations have led 17 states to join a compact that allows doctors licensed in one member state to quickly obtain a license in another. When it comes to reimbursement, employer and insurer coverage varies depending on type of service and the state. Medicare, in particular, has been highlighted as a laggard in paying for telemedicine "visits."

Increasing Support

The good news, despite some resistance, is that telemedicine appears to be gaining steam in rural areas. From 2003 to 2013, the industry saw a 28% increase in telemedicine visits made by Medicare beneficiaries. And recently, HHS announced it plans to award $9 million

in grants to health care officials in three states to test telemedicine in an effort to reduce overdose-related deaths in rural areas.

The benefits from telemedicine use are also catching-on with other insurers. As more private and public plans provide reimbursement, partnerships between health insurers and telemedicine providers are increasing. The American Telemedicine Association (ATA) and other organizations have developed accreditation programs to identify top-quality telemedicine sites versus the sites that consumers should be cautious to use.

Additionally, the AMA has approved new ethical guidelines for telemedicine, calling for participating doctors to recognize the limitations of such services and ensure that they have sufficient information to make clinical recommendations.

On the state level, the USDA recently awarded MaineHealth approximately $400,000 toward the advancement of telemedicine efforts. Currently, 32 states have passed "parity" laws requiring private insurers to reimburse doctors for services delivered remotely if the same service would be covered in person, though not necessarily at the same rate or frequency.

Increasing Support = Increased Use

As technology advances and various applications become more mainstream, telemedicine expansion is expected to continue.

For physicians, telemedicine provides an efficient way for health systems to improve patient outcomes and save on costs. Web companies such as Teladoc, Doctor on Demand and American Well are expected to host around 1.2 million virtual doctor visits this year, up 20% from last year.

Healthcare organizations are increasingly embracing telehealth as a solution to many of the challenges facing health care, even in the highest acuity environment, the intensive care unit (ICU).

For example, in Arizona, one hospital pioneered a 24-hour, collaborative tele-ICU program and during its first year of implementation reduced ICU length of stay by 21%. The elevated care provided in the ICU and improved ICU length of stay further contributed to a 31% reduction in overall hospital length of stay. The total length of stay reduction resulted in $2.3 million in savings for the hospital.

For patients, the use of telemedicine is higher than ever with a reported 15 million plus U.S. citizens receiving remote medical care in 2015, according to the ATA, which predicts utilization to increase to 30% in 2016.

Roughly 97% of patients frustrated by hospital wait times, according to a 2015 survey. As a result, telemedicine and virtual appointments are a persuasive option for many people seeking medical care. It was also found that 75% of patients who have not used telemedicine previously are interested in using it instead of an in-person medical appointment. Further, 67% said that telemedicine somewhat or significantly increases the satisfaction they have with their medical care.

As the industry shifts from volume-based to value-based payment, interest grows in any solution that improves outcomes and reduces costs. More hospitals and health systems are embracing telemedicine as one means to utilize available resources efficiently while improving patient outcomes.

Source(s): Thielking, Megan, "Telemedicine Is Gaining Steam in Rural Areas," *STAT Morning Rounds*, May 11, 2016; Bird, Julie, "Medicaid, Private Insurers Embrace Pacts with Telemedicine Providers," *FierceHealthPayer*, June 27, 2016; Beck, Melinda, "How Telemedicine is Transforming Health Care," *The Wall Street Journal*, June 26, 2016; Schulze, Rachel, "Federal Grants Aim To Boost Telemedicine Services among Providers In Four States," *American Health Line*, July 20, 2016; Ripton, JT; Scott, Peter, "7 Telemedicine Myths Debunked," *Medical Economics*, May 30, 2016; Clegg, Andrea, "Telehealth: Bringing State-of-the-Art Technology to ICU Care," *hfma*, September 01, 2016; Abrams Kaplan, Deborah, "The Rising Acceptance of Teleradiology," *Diagnostic Imaging*, September 01, 2016

Healthcare Exchanges Evolve with More Narrow Networks

Narrow networks are steadily becoming the primary way for insurance companies to be profitable on the exchanges.

Health insurance plans with limited networks of providers are common on the Affordable Care Act's (ACA) health insurance Marketplaces (exchanges). Recent studies have found that these "narrow network" plans constitute nearly half of all Marketplace offerings in the first two years of coverage, with one analysis concluding that nearly 90% of all consumers had the option of buying such a plan if they chose.

Since exchange consumers clearly prioritize low premiums over a broad provider network (whether they fully understand the tradeoffs when purchasing exchange plans is an oft-debated topic), more carriers are looking to narrow networks as a way to lower costs and premiums. As a result, one estimate says 75% of ACA plans in 18 states are expected to have narrow networks next year.

Insurers have to balance their narrow network against the ACA federal network adequacy protections applicable to commercial health insurance markets. The provisions require all qualified health plans available on the Marketplaces to maintain a "sufficient choice of providers" and "provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers." The law also requires qualified health plans to include within their networks "essential community providers" (i.e. providers "that serve predominately low-income, medically-underserved individuals"), such as federally qualified health centers, family planning clinics, and certain specialty care providers.

Plans that provide limited or inadequate access to in-network providers make it more likely that enrollees will obtain care from out-of-network sources, exposing them to significant expenses and the possibility of surprise medical bills. Physicians and other providers hoping to provide care for patients with exchange coverage need to work to be part of these networks, despite insurance company pressure in the other direction. From the providers perspective, many narrow plans have limited or no out-of-network payment provisions.

Future of ACA Exchanges and Narrow Network Plans

Despite substantial premium increases forecast for 2017, a number of insurers are struggling to profit on the ACA exchanges. Many major insurers are choosing or contemplating an exit from the market. For 2017, Aetna is dropping 70% of its health plans in ACA markets, blaming a poor risk pool and "the current inadequate risk-adjustment mechanism." Yet, despite some who argue otherwise, these trends do not appear to signal the end of ACA exchanges. They do signal that narrow network plans will remain and become more common.

For insurers, limited networks not only offer the opportunity to reduce costs but also the flexibility to create these networks allows for a wider range of plan designs and a greater

variety of coverage options for consumers.

For providers, narrow networks may reduce negotiating leverage. Providers generally prefer few or no restrictions on a consumers' choice of providers vs. a narrow network where providers feel they are faced with 2 bad options: accept low reimbursement or be excluded from the network., Many providers are skeptical about the extent to While insurers claim to use networks to promote quality with a better ability to capture provider performance, many providers are skeptical.

For consumers, narrow network plans present a critical trade-off.Some may value the premium savings associated with limited networks more than they do a broad choice of providers, while others may be more willing to pay more in up-front premium costs for greater network flexibility or to secure access to a specific physician or care facility.

Analyses by McKinsey and Company concluded that within the first two years of Marketplace coverage, consumers on both ends of the spectrum had options from which to choose. Further, though the majority of Marketplace shoppers had access to both narrow and broad network plans, "no meaningful difference" was found regarding the quality of such networks.

Exchanges Not As Large As Originally Projected

Initial ACA enrollment projections predicted 24M people would enroll in ACA marketplace plans by 2016, vs. current enrollment of 11M. Also unexpected by many, the number of plans that offer a wide choice of doctors and hospitals is on a steady decline in 2016.Two-thirds of plans are health maintenance organization plans that offer care from only a limited choice of doctors and hospitals.

CMS has noted that although the uninsured rate for young adults has dropped by more than half since the implementation of the ACA, this group is still more likely than others to remain without coverage. Adults 25–34 years were twice as likely to lack health coverage when compared to 45–64 year old adult (15.9% vs. 8.1%) and adults in the 18–24 age bracket had higher rates of uninsurance than and 35–44 age group (13.7% and 14.3%).

Lower enrollment numbers have several explanations. One is that the Administration says employers have continued to provide health coverage themselves rather than send employees to the exchanges as originally predicted. A second is the weak signups from younger consumers noted above. A third is political resistance to the exchanges in many states, especially those which did not expand Medicaid.

Another reason is the early issues with exchange websites and the signup process. As a result, Insurers such as Blue Cross Blue Shield (BCBS) in Florida, Tennessee, and North Carolina have begun utilizing retail centers as a tool to boost enrollment and avoid website technology failures.

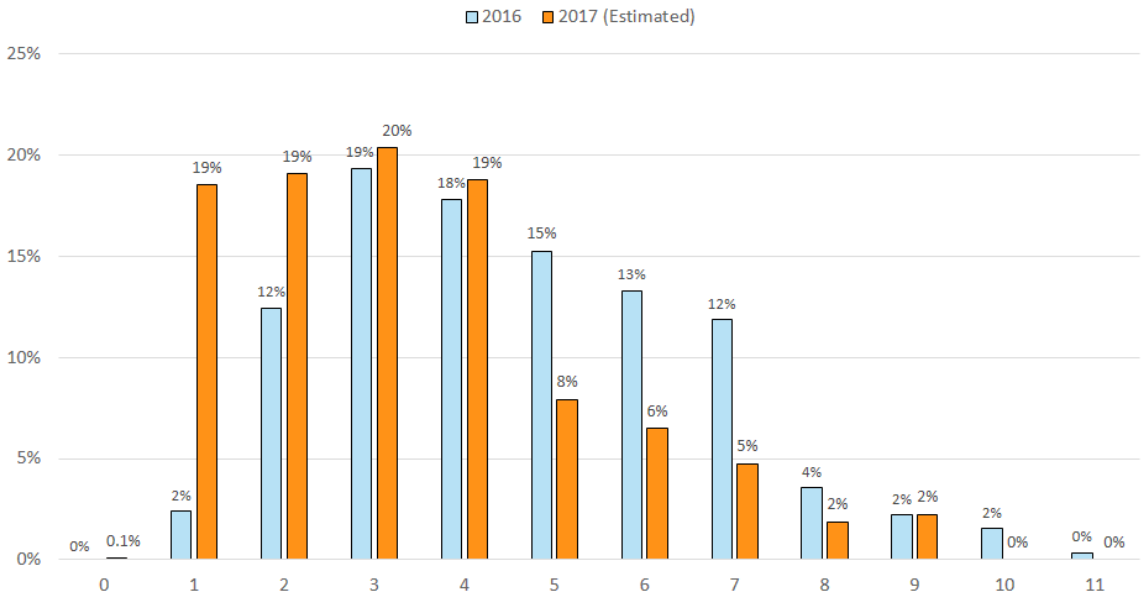
State Standings

A Kaiser Family Foundation report projected the number of counties with just one insurer selling exchange plans would rise from 225 counties in 2016 to 664 counties in 2017. A separate KFF analysis shows that after a brief spike in 2015, average exchange plan options per state have declined.

States in 2014 had an average of 5.9 insurers per state, and then in 2015 had an average of 6.9 insurer options, which fell to 6.5 in 2016 and is projected to drop to 5.8 insurers per state in 2017.

Figure 1

Distribution of Exchange Enrollment by Number of Insurers in 2016 and Potential Distribution in 2017



Source: Kaiser Family Foundation analysis of data gathered from insurer rate filings, exchange and state government reports, healthcare.gov and state exchange websites, insurer press releases, and media reports. Note: Enrollment is based on 2016 signups. See methods for details. Data as of August 26, 2016.

The future of narrow networks in the ACA exchanges will partially rest upon whether they can continue to draw more enrollees, as well as improve the risk pool to help to stabilize markets. CMS in June introduced their 'Strengthening the Marketplace by Covering Young Adults' plan which employs several strategies to reach out to young adults leading up to the 2017 Open Enrollment period.

Taking steps to increase enrollment and provide coverage to more young people, who are more often healthy than older individuals, is one way experts predict will help balance the ACA marketplace risk pool and reduce overall costs. A similar balance is needed between flexibility

for insurers in designing networks while ensuring consumer have access to high-quality care. Narrow networks will become increasingly effective, experts predict, by implementing oversight and better standards to measure network adequacy.

Experts agree that the long-term implications of narrow networks remain to be seen. Given that the narrow network strategy relies on consumer behavior, one recurring theme is the need to educate and assist consumers in making informed choices.

Source(s): Bernstein, Sam, "Starbucks Announces Launch of Private Insurance Exchange for Employees," *American Health Line*, July 22, 2016; Sweeney, Evan, "Study: Individual Market Premiums Far Lower With the ACA than Without," *FierceHealthPayer*, July 22, 2016; Blavin, Fredric; Shartzer, Adele; Long, Sharon; Holahan, John, "Employer-Sponsored Insurance Stays Strong, with No Signs of Decay under the ACA: Findings through March 2016," *The Urban Institute*, July 13, 2016; Small, Leslie, "3 Possibilities for the Future of the ACA Exchanges," *FierceHealthPayer*, August 5, 2016; Herman, Bob, "Should ACA risk adjustment be more like Medicare Advantage?" *Modern Healthcare*, August 20, 2016; Sanger-Katz, Margot, "Think Your Obamacare Plan Will Be Like Employer Coverage? Think Again," *NY Times*, August 19, 2016; Sweeney, Evan, "Retail Centers, Narrow Networks Contribute to Florida Blue's Exchange Success," *FierceHealthPayer*, August 24, 2016; Drost, Heather, "What the Latest Insurer Exits Mean For the ACA Exchanges," *American Health Line*, August 2016; Wilde Mathews, Anna, "Insurers Move to Limit Options in Health Care Exchange Plans," The Wall Street Journal, Aug. 31, 2016; Caspi, Heather, "Public Option Back On the Block?: What It Means For Private Payers," *Healthcare Dive*, September 1, 2016; Haefner, Morgan, "75% of ACA Plans In 18 States Will Have Narrow Networks Next Year," *Becker's CFO Report*, September 1, 2016; Caspi, Heather, "While Uninsured Rate Hits Historic Low, Young Adults Still Not Sold," *Healthcare Dive*, September 8, 2016

Population Health: Slow but Steady Progress

Managing the health of diverse populations with often complex and disparate needs is no easy task. And though Population Health Management (PHM) may be a difficult challenge, the healthcare industry is starting to see early success stories.

Definitions

There are a variety of definitions for population health management, which as a term, as supplanted "population health" within the healthcare community. The term population health is now used to describe the broader context of health including education, societal issues, etc. Here are a few example definitions: of Population Health Management:

"The iterative process of strategically and proactively managing clinical and financial opportunities to improve health outcomes and patient engagement, while also reducing costs."(Symphonycare)

Population Health Management is a collection of activities, not reimbursable in the fee-for-service model, but important in the care we deliver to our patients.(Partners Healthcare)

Population Health Management is the aggregation of patient data across multiple health information technology resources, the analysis of that data into a single, actionable patient record, and the actions through which care providers can improve both clinical and financial outcomes.(Wellcentive)

Early Success Stories

Northwell Health – created an Office of Population Health Management: a centralized department within the health system that coordinates all population health efforts. Within the office: *CareConnect*, the health insurance plan and a care management group called Northwell Solutions coordinate services provided to those with chronic illness.

St. Vincent Health System – saved $5.8M in 2015, giving credit to its participation in MissionPoint Health Partners ACO's care management model. This provided the opportunity for groups of doctors, hospitals and other healthcare providers to share the financial benefit that comes from improving patient health while reducing costs.

Plant City Family Medical Specialists – says new CMS rules have been a gain to patients and the practice by using *CareSync's* care coordination technology and 24/7 nursing services to help providers outsource their chronic care management initiatives.

PHM Implementation

To effectively implement population health, the initiatives must be central components of the organization's overall strategy. One-time projects or task forces may help get started but won't be effective by themselves. IT and data analytics are important so that clinicians have access to current information that enables them to identify and understand high-risk patients and share data about them with other clinicians. In some cases, telemedicine can help assure frequent contact: e.g. to verify compliance with prescription medication.

But many say that the biggest requirement for a successful implementation is a cultural or mindset change. For example, rather than measuring the outcome of a procedure, the metric should be "was the patient able to return to an active lifestyle?" This requires leadership and training, coupled with a long-term focus and commitment.

Learning from Experience

While we know a lot about PHM implementation, there are still lessons to be learned from experience.

To date, PHM may be central to an organizations' core strategies, yet many leaders and healthcare providers have only a vague understanding of how it will truly affect the way they deliver healthcare. For example, a patient's activation level, or ability to self-manage health and health care, is linked to the risk of developing a chronic disease and using expensive and avoidable health care services in the future. By stratifying populations by activation level, health care delivery systems are better able to identify and support patients with limited self-management skills, helping to improve outcomes and prevent unnecessary costs.

Successful population health initiatives not only seek to improve coordination among providers, address social determinants of health and forge innovative partnerships, they also emphasize the importance of staff education and cultural evolution. In the long run, investing time and resources in each of these components will yield the best results, both for the community as well as providers.

Evolution of PHM

The growing momentum behind population health management represents a marked departure from traditional healthcare. PHM metrics are focused on prevention and long-term health improvement, the patient's ability to return to an active lifestyle, rejoin the workforce, and maintain a high quality of life.

Most of a PHM strategy's success depends on clinicians and administrators who are on the front lines of delivering care. With support from leadership, if they have the tools to understand the population being served from the patient's perspective and turn that understanding into a customized action plan for each individual, real progress is highly likely.

Of course, more sophisticated technologies and tools are on the horizon. Bat the end of the day, PHM success happens one patient at a time.

Source(s): Dowling, Michael, "Michael Dowling: How to Make Population Health a Robust Strategy — Not a One-Off Project," *Becker's Hospital Review*, September 8, 2016; Monegain, Bernie, "St. Vincent's Saves $5.8 Million with ACO, Population Health Programs," *Medical Practice Insider*, July 18, 2016; Miliard, Mike, "Practice Puts Chronic Care Management Tools To Work In Population Health Strategy," *Medical Practice Insider*, July 18, 2016; Ananth, Sita, "Tackling Contradictions of Population Health, and Five Key Success Factors," *H&HN Magazine*, September 1, 2016; Jain, Anil, "The 5 Areas to Target in Improving Population Health Management," H&*HN Magazine*, September 1, 2016; Hibbard, Judith; Greene, Jessica; Sacks, Rebecca; Overton, Valerie; Parrotta, Carmen, "Improving Population Health Management Strategies: Identifying Patients Who Are More Likely to Be Users of Avoidable Costly Care and Those More Likely to Develop a New Chronic Disease," *The Commonwealth Fund*, August 23, 2016; "Q&A: New York-Presbyterian CEO On Population Health, Expanding His System," *Modern Healthcare*, August 13, 2016

$5.6M for Not Checking OIG Exclusion List

33 healthcare organizations have paid 5.6 million dollars in penalties for not checking the OIG exclusion list. These are only the organizations who have self-disclosed to date in 2016; it does not include other OIG investigations.

Specifically, these entities self-disclosed to the OIG that they allegedly violated the Civil Monetary Penalties Law (CMPL) by **"employing an individual that they knew or should have known was excluded from participation in Federal health care programs."** By self-disclosing to the OIG they also agree to pay any penalties assessed.

Under the CMPL, Civil Monetary Penalties (CMPs) apply for violations that can include:

- Presenting a claim that you know or should know is for an item or service not provided as claimed or that is false and fraudulent;
- Presenting a claim that you know or should know is for an item or service for which Medicare will not pay; and
- Violating the Anti-Kickback Statute

The CMPL authorizes penalties of up to $50,000 per violation, and assessments of up to three times the amount claimed for each item or service, or up to three times the amount of remuneration offered, paid, solicited, or received.

Liability under CMP often depends upon actions taken "knowingly" but can also be based upon a "should know" standard. "Should know," generally speaking, refers to deliberate ignorance. So, specific intent to commit fraud is not required to trigger CMP liability. The importance of the intent element is largely tied to the reality physician's and other providers face in the current healthcare world: pressure to produce can inspire cutting corners and up-coding or weak medical necessity standards. What seems "innocent" or unknown can, where CMP is concerned, have major financial consequences.

The OIG Background Check Requires OIG Exclusion Monthly Monitoring

For new employees, it is industry standard and best practice to conduct a pre-employment background check of the OIG exclusion list. This also meets certain state statutory requirements regulating healthcare. When an employer combines a background check of the exclusion list with state Medicaid exclusion lists as well as license verification, education verification, employment verification, a Social Security number validation, and appropriate criminal records history it can safely rely upon certain protections against *negligent hire*.

But after hire, there is a legal doctrine called negligent retention, which is applied if an employer fails to conduct regular checks of certain public records that may change (such as license verification, criminal record verifications and exclusion background checks). This doctrine also applies to third party contractors and even referring physicians.

The OIG maintains the List of Excluded Individuals and Entities (LEIE) and updates this list at

least monthly as found on the OIG website https://oig.hhs.gov/exclusions.

Under the Exclusion Statute[1]; the OIG must exclude from all Federal health care programs, providers and suppliers convicted of:

- Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare or Medicaid;
- Patient abuse or neglect;
- Felony convictions related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of a health care item or service; or
- Felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

The OIG also has the discretion to impose exclusions on a number of other grounds. E**xcluded providers cannot participate in Federal health care programs for a designated period. An excluded provider may not bill Medicare, Medicaid, and other Federal healthcare programs, such as TriCare and the Veterans Health Administration as well as State Children's Health Insurance Program (SCHIP) for services he or she orders or performs.** In addition, if services are furnished to a patient on a private-pay basis, no order or prescription given to that patient will be reimbursable by any Federal health care program. At the end of an exclusion period, an excluded provider must affirmatively seek reinstatement; reinstatement is not automatic.

Summary

In order to avoid what can be large penalties for unknowingly employing or being associated with an excluded provider, Physician groups, hospitals, ASCs, agencies and other providers must have a proactive program to check all exclusion lists (state as well as OIG) on a monthly basis.

If you are interested in outsourcing this important function for your organization, AdvantEdge has a practical solution to fit your needs. Please contact your Client Manager or AdvantEdge sales for more information.

[1] 42 U.S.C. § 1320a-7