THE LEADING EDGE

SUMMER 2015 ISSUE

THE LEADING EDGE

Welcome!

Welcome to the Summer 2015 edition of the Leading Edge. We have a reprise of the highly anticipated "King vs. Burwell" Supreme Court ruling. Like many, we anticipated that a different outcome would have wide repercussions. Fortunately for many consumers, providers and insurers, that isn't the case.

Our next feature highlights the ACA's "Cadillac Tax." Many hospitals, physician groups and other employers are likely to be impacted directly by this 40% excise tax. Expect to hear a lot more before the tax goes into effect in 2018.

Our anesthesia topics start with results showing that so-called ERAS (Enhanced Recovery After Surgery) protocols require significant resources to implement but also result in cost savings.

Recent SGR repeal legislation introduced alternative payment models (APMs) as the new moniker for Medicare value-based payment models. The ASA is promoting the Perioperative Surgical Home (PSH) as an APM. We describe a number of factors to consider when evaluating a PSH, an ACO or other APM models.

We also update AQI/NACOR efforts as a Qualified Clinical Data Registry (QCDR) able to report PQRS measures. Specifically, more measures are available than via claims or registry reporting. But this entails planning and preparation, particularly around ways to capture data that don't unduly burden the anesthesiologist.

Our Medicare feature shows how Medicare is, by historical standards, very recent. And issues such as concerns about costs and reimbursement are even more recent.

The next feature summarizes our annual client survey. The punchline: our clients expect results and service. That is really not a surprise. But it does reinforce the relevance of our client promises: More Money, Faster and ClientFirst Service.

With ICD-10 now only 4 months away, in AdvantEdge News we update our ICD-10 implementation plans. And we continue our ICD-9/10 comparisons with "Other and Unspecified Malignant Neoplasm of Skin."

A reminder that you can print or email any article as a PDF. Plus the "Download Current Issue" choice at top right downloads the entire newsletter for email or printing.

Please call or email me with comments and suggested topics for the next issue: bgilbert@ahsrcm.com and (908) 279-8120.

Bill Gilbert

Enhanced Recovery After Surgery

Enhanced Recovery After Surgery (ERAS), also known as Enhanced Recovery Programs (ERPs) or "fast-track programs" have become an important focus of perioperative patient management.

Initiated by Professor Henrik Kehlet in 1997, ERAS' protocols are multimodal perioperative care pathways designed to achieve early recovery after surgical procedures by maintaining preoperative organ function and reducing the profound stress response following surgery. These protocols replace traditional perioperative care practices with evidence-based best practices when necessary, while also providing a comprehensive scope of the surgical process.

The ERAS Society notes, "The key factors that keep patients in the hospital after surgery include the need for parenteral analgesia, the need for intravenous fluids secondary to gut dysfunction, and bed rest caused by lack of mobility." The ERAS protocol considers these factors and how they may impact patient recovery, while allowing all involved in perioperative care to work as a well-coordinated team to provide the best care.

The key aspects of ERAS protocol include:

- Preadmission counseling
- Fluid and carbohydrate loading
- No prolonged fasting
- No/selective bowel preparation
- Antibiotic prophylaxis (curbing infection complications with antibiotics)
- Thromboprophylaxis (aiding the prevention of coronary thrombosis)
- No premedication

ERAS practices seek to alter the physiological and psychological responses to major surgery and have been shown to lead to a reduction in complications by up to 50%, reduced care time by more than 30%[1], and resulted in patients resuming normal activities at accelerated rates. In addition to the physical benefits experienced by the patient, there is also economic value in the implementation of ERAS protocols.

In a recent publication of a cost-analysis of ERAS in colorectal surgery, for example, Dr. Tarik Sammour and his colleagues evaluated whether costs saved by reduced postoperative resource utilization would impact the financial burden of introduction and implementation of an ERAS program. While looking at the ERAS group, their report shows a significant reduction in overall length of hospital stay, reduction of intravenous fluid use, shortened duration of epidural use and fewer general complications.

The data shows the cost of putting an ERAS program into practice was approximately $102,000, but was offset by costs saved by the reduction of postoperative resource utilization. The report also shows the direct medical and indirect non-medical costs were significantly lower in the ERAS group, resulting in an overall cost savings of roughly $6,900 per patient.

The application of ERAS protocols represents a significant change in all practices and a potential increase in the use of resources. Though the awareness of the benefits ERAS implementation continues to expand throughout the healthcare industry, some providers are slow to incorporate ERAS' evidence based guidelines into practice as it challenges traditional surgical doctrine and requires all involved providers and staff to be comfortable implementing and be proficient in the utilization of all ERAS principles.

[1] Varandhan, KK et al. The enhanced recover after surgery (ERAS) pathway for patients undergoing major elective open colorectal surgery: a meta-analysis of randomized trials. Clin. Nutr 2010

Alternative Payment Models are Coming

Most physicians were happy when Congress repealed the Sustainable Growth Rate (SGR) this April in the Medicare Access and CHIP Reauthorization Act – no more worrying every year about whether a huge reduction in Medicare reimbursement would take place. As a replacement for the SGR, the Act instituted so-called alternative payment models (APMs) for physicians, including anesthesiologists, as the future of Medicare reimbursement by shifting into value-based payment models, including accountable care organizations, bundled-payment arrangements and medical homes.

While CMS evolves their APM program, and private insurance carriers continue to expand their payment model alternatives, fee-for-service will continue as the primary payment system for the next few years. However, APMs will become an increasing part of a physician's income from all insurers. Now is a good time to evaluate your practice or department, if you have not already done so, to prepare for participating in these APMs.

There are essentially six different payment categories that are available today or will be available as payment methods for physicians.

- Fee-for-service without gain sharing
- Discounted fee-for-service with potential gain sharing
- Percentage of bundled payment
- Portion of shared savings
- Bonuses for quality and/or performance metrics, and
- Withholds and risk pool participation

Anesthesia practices are not alike so determining which type(s) of APMs to participate in will depend on the characteristics of the practice. At the American Society of Anesthesiologists' (ASA) Practice Management meeting this spring, Dr. Marc Leib, (an anesthesiologist and Chairman of the ASA's Committee on Economics) stated that key pieces of data must be obtained and understood to establish a basis on which to evaluate eventual proposals by APMs:

- What is the cost of providing specific services?
- What are the typical fee-for-service payments for similar services?
- What is your minimum (bottom-line) acceptable payment for each service?
- What is a comfortable profit margin based on risk-taking for each service and a potential upside gain based on the care team achieving a savings?

He further advises anesthesia practices to understand the details of any package being offered and to "consider how much of the share will go to the hospital, surgeons, hospitalists and postoperative care, such as that provided by physician therapists." He also suggests adjusting for the practice's patient pool and the risk of taking on severely ill patients.[1]

Currently, according to the Medscape Anesthesiologist Compensation Report 2015, Accountable

Care Organizations (ACOs) are the most popular alternative payment models for anesthesiologists.

- 29% – ACO participation (up from 23% last year)
- 7% – Not in an ACO, but plan to be this year
- 6% – Cash-only practice
- 4% – Concierge practice

Before joining an ACO, anesthesiologists need to know what an ACO is, how to recognize one with a likelihood of success, and the professional opportunities and risks involved in joining. ACO payments are usually bundled, with shares to be determined by the ACO. Anesthesiologists must promote their importance to the ACO in order to receive enough of the bundled payment to give the practice an acceptable profit margin. This can only be done with good financial information in place and with good statistics to demonstrate the following to an ACO[2]:

- ***Dedication to Quality and Outcomes*** by having the ability to track quality measures, including surgical care improvement project measures and operational measures plus the ability to show that the group uses these measures to improve performance.
- ***Deliver care at a lower cost*** by obtaining efficiencies in perioperative processes and working with cost-effective, high-quality instruments.
- ***Lead Others in Reaching Goals*** by taking charge of the entire perioperative set of functions, including pain management.
- ***Increase the efficiency of perioperative functions*** to enable more volume and prevent delays, which could extend to preventing bottlenecks in the emergency or radiology department.

Over the last year, the ASA has been promoting the idea of the **Perioperative Surgical Home** (PSH) model of care. The PSH is a patient-centered, anesthesiologist-led system of coordinated care striving for the ACA's triple goals of better health, better health care and reduced costs of care, similar to the **Patient-Centered Medical Home**.

The ASA is promoting the PSH as a payment model by announcing its intentions to petition CMS to recognize the PSH as an APM. This would validate the PSH as a payment mechanism and simplify quality reporting.[3]

There is opportunity for any of the six afore-mentioned payment models to be applied to a PSH organization plus entities that pay for PSH services could propose other methodologies.
The PSH would also apply the same steps, as mentioned earlier in the article, to evaluate any proposals it makes with either a hospital or insurers.

The PSH must also understand the difference between negotiating with a hospital and an insurer. For hospitals, the PSH should demonstrate how it can decrease the costs of providing services to surgical patients, such as fewer inpatient days for surgical patients, decreased utilization of blood products, only-necessary laboratory and imaging tests, fewer cancelled surgical cases and improved patient satisfaction scores.

For insurers, the advantages could include fewer inpatient days, fewer laboratory and imaging tests, more rapid patient recovery, decreased utilization of postoperative physical therapy, decreased use of narcotics, more rational use of post-discharge care and other cost-saving benefits.[4]

Added to those negotiations, a PSH can apply risk stratification and stop loss insurance to mitigate its financial risk.

Joining an ACO or taking the step to form or join a PSH is complicated and anesthesiologists need as much data as possible about the practice. Data can come from provider claims, hospital records, insurance company data, patient demographic mix, etc. The more financial data the practice has, the more it can evaluate its potential risks in joining an APM. And, the more operating and outcome data the practice has, the stronger position the practice will have in negotiating a sound and profitable contract.

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[1] Anesthesiology News, "Bundled Payment Plans Require Data and Negotiation," Policy & Management, April 2015, Volume 41:4
[2] Rodak, Sabrina, "4 Skills to Look for When Including Anesthesia Groups in an ACO,"Beckers Hospital Review, November 14, 2012.
[3] Leib,M.D., J.D., Marc L., and Dunbar M.B., ChB., M.B.A, "Payment Models for the Perioperative Surgical Home", ASA Newsletter, April 1, 2015.
[4] Ibid

A Guide to NACOR & PQRS

Maintained by the Anesthesia Quality Institute (AQI), The National Anesthesia Clinical Outcomes Registry (NACOR) has been designated by the Centers for Medicare & Medicaid Services (CMS) as a Qualified Clinical Data Registry (QCDR) reporting mechanism. The American Society of Anesthesiologists (ASA) has contracted with AQI to develop a meaningful way for all eligible professionals (EPs) to successfully participate in the Physician Quality Reporting System (PQRS). This approach offers a more robust, though potentially more complex, way to participate in PQRS, compared to traditional claims-based or registry reporting for PQRS.

A potential advantage of the AQI approach is the ability to report more PQRS measures, including 9 as mandated by CMS for 2015. In contrast, claims-based reporting has only a handful of measures available in 2015. By using AQI, individual EPs and group practices can also quantify their performance on a particular quality metric vs. other groups in the AQI database. As a reminder, those who report PQRS satisfactorily for the 2015 program year will avoid the 2017 PQRS negative payment adjustment. Until the option to participate in Alternative Payment Models (APM) becomes available, providers should prioritize fulfilling the current quality programs to ensure the avoidance of penalties.[1]

Eligible Professionals

Anesthesiologists, Certified Registered Nurse Anesthetists (CRNAs) and Anesthesiologist Assistants (AA) who are paid by the Medicare Physician Fee Schedule are eligible to participate in the PQRS program.

Reporting Requirements

The AQI repeats the CMS requirement for EPs to report at least nine measures covering at least three National Quality Strategy (NQS) domains, and report each measure for at least 50 percent of the EP's patients (Medicare and non-Medicare). Of these measures, 2 out of 9 must have results that meet the Reporting Requirements for QCDR for 2015.

The following requirements must be met in order to report through the ASA QCDR:

- Sign all ASA, QCDR and NACOR agreements.
- Submit monthly case data from billing software to AQI.
- Determine the 9 measures that are going to be reported (Check the denominator codes of each measure to determine if you are eligible to report the measure)
- Take the ASA QCDR Readiness Assessment to begin registration for the QCDR reporting service. (The AQI notes: To participate in the ASA QCDR, you must either be a member of ASA or pay the QCDR reporting fee. You must also participate in and submit data to NACOR.)
- Review your PQRS reports monthly by logging into AQI's member's only page.
- Attend regularly scheduled AQI conference calls to monitor compliance.
- Sign off on quarterly PQRS reports provided by AQI.
- Approve the final transmission of your PQRS data to CMS.

The Anesthesia Quality Institute provides more information on the ASA QCDR here.

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[1] Bolles, Andrew "PQRS reporting in 2015: Consider Qualified Clinical Data Registry (QCDR)," Becker's Hospital Review, April 27, 2015

Supreme Court Denies Challenge to ACA in King v. Burwell

Insurance premium subsidies provided by the Affordable Care Act ("Obamacare") continue to be available to Americans in all states. The U.S. Supreme Court 6 to 3 ruling on June 25 in King v. Burwell means the premium subsidies remain accessible to healthcare exchange enrollees in all states.

Prior to the ruling, there was great concern about the impact had the ruling gone the other way. 6.4 million people were at risk of losing their subsidies, and many were concerned about the possibility of chaos in the private insurance market. Had the court ruled against the subsidies, many feared a significant impact on individual health insurance consumers, health insurers, health care providers and employers. Depending on transition assumptions, the timing could have been problematic. Key state and federal deadlines for establishing exchanges in 2016 have already passed, and others are quickly approaching. Without a clear pathway for states to quickly set up an exchange, states had few options for quickly establishing an exchange. Plus health insurers are already well down the road in deciding which products to offer and the accompanying fees for 2016.[1]

The ruling sided with the Obama administration and against the plaintiffs who argued that the literal ACA language limited subsidies to only those exchanges established by a state. ACA supporters were concerned that, had this ruling gone the other way, the most popular ACA provision, namely the prohibition against health insurers taking pre-existing conditions into account when setting premiums or scheduling benefits, would have been in jeopardy. ACA supporters insist the two features go hand in hand because the law forces health insurers to accept any applicants without taking pre-existing conditions into consideration and charge everyone the same age (except tobacco users) the same premium.[2]

Leading up to the Court's decision, King vs. Burwell caught the attention of a number of institutions who analyzed the possible impact of the imminent ruling. In a recent report released by the American Academy of Actuaries, it warned that an adverse decisions could lead to pressure on the individual mandate, with the risk of causing a great deal of damage. The report also cautioned that removing the individual mandate altogether could impact the viability of the entire market, resulting in significantly increased premiums for those remaining.

In anticipation of the Court's ruling, some states had already permitted exchange plans to file two sets of rates for 2016, while others had spent months strategizing how to respond to the disruption if the Court had opted to rule against the ACA. [3] Many worried a decision in the opposite direction would lead to a dramatic spike in the nation's uninsured and the disintegration of the healthcare law itself. Avalere's analysis estimated approximately 2.3 million exchange enrollees (37 percent of those enrolled) were uninsured before enrolling in exchange coverage and that these consumers would be unlikely to continue purchasing coverage without access to subsidies.

The three opposing Justices along with others not in favor of the ruling criticized the majority by stating that the law is ambiguous, pointing to a specific part of the law that says subsidies are only available to those who enroll through an "exchange established by the state." The Internal Revenue Service has interpreted this to allow subsidies in all states, but opposing parties in the case disagreed. They feel the court should have employed the Chevron doctrine,

a common policy that says federal agencies must follow the letter of the law where the law is clear and if a law is ambiguous, courts must defer to a government agency's reasonable interpretation of it. The Justices explained that the utilization of the Chevron doctrine would not be appropriate for this case, saying that it would be extremely unlikely that Congress would have delegated the interpretation of the law to the IRS. The federal government argued that the law's purpose is clear, and has been indicated to be so in other parts of the law maintaining that Americans in every state should be allowed the right to be eligible for subsidies. [4]

Leavitt Partners' state-specific fact sheets: 'King v. Burwell State Impact Fact Sheets' have further information about how a ruling in favor of the plaintiffs would have impacted each individual state.

[1] McDermott Will & Emery, "*King v. Burwell*: When Would a Supreme Court Ruling Restricting Affordable Care Act Premium Subsidies Go into Effect?", June 19, 2015
[2] Graham, John, "King v. Burwell: How Important Is Obamacare's Individual Mandate?", Forbes: Healthcare, Fiscal, and Tax, June 6, 2015
[3] June 8, 2015 – Radiology Business Management Association – RBMA Washington Insider – King v. Burwell Update http://www.rbma.org/RBMA_Washington_Insider_2015_06_08/#1
[4] Schencker, Lisa, "BREAKING: Supreme Court upholds subsidies in King v. Burwell", Modern Healthcare, June 25, 2015

The Cadillac Tax: Big Impacts Expected

The "Cadillac Tax" is an excise tax included in the Affordable Care Act (ACA) to slow healthcare spending growth and to help offset the ACA costs. It is scheduled to be in place for 2018 and will tax employers who offer their employees "Cadillac" health insurance plans ($10,200 for an individual and $27,500 for families).

Businesses, especially those with traditional or generous health plans, now have much to consider. The Spring Healthcare Trend Survey from Wells Fargo Insurance analyzed more than 65 insurers nationwide and found that 38 percent of large employers will likely hit the tax threshold in 2018 if they do not make changes to their plan.

Small and mid-size employers with traditional health plans may be less aware of the upcoming tax. This includes many healthcare companies, including physician groups and hospitals. As a result, the "Cadillac Tax" may come as a surprise to some, especially considering the magnitude of the 40 percent tax–which applies to every dollar above the threshold.

In preparation, some employers are opting for high-deductible coverage with an optional health savings account. The most recent survey from the International Foundation of Employee Benefit Plans (IFEBP) shows that due to the Affordable Care Act:

- Nearly 10 percent of the surveyed organizations are putting a full-replacement high-deductible health plan in place.
- 11 percent of those surveyed are considering high-deductible health plans with no savings accounts, while 13 percent plan to use high-deductible health plans with a health reimbursement arrangement (versus an HSA).
- A small percentage (6%) have implemented or expanded the use of low-cost "skinny plans", while 3 percent more plan to do so over the coming year.

Employers providing health insurance to their employees will still be able to write off the cost of offering coverage from their taxes, but under the Cadillac Tax, it is also possible that the open-ended tax breaks employers receive for providing coverage will ultimately inflate healthcare costs. [1]

As more employers opt for high-deductible health plans, there is growing concern about financial stress from patients' inability to afford the deductible costs. More than 1 in 5 organizations have been forced to either increase copayments or coinsurances for primary care, increase participants' share of prescription drug costs, or increase the employees' share of dependent coverage costs. Of the businesses surveyed, increasing the employee portion of dependent coverage cost (13 percent) and increasing copayments or coinsurances for primary care (11 percent) were found to be the most common cost-management plans over the next 12 months. Since many companies will want to avoid the steep excise tax, the financial pressures on patients seem likely to increase. [2]

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[1] Zweig, Dori, "'Cadillac tax' could be latest threat to Affordable Care Act", *Fierce Health Payer*, April 6, 2015
[2] Mrkvicka, Neil et al, "'2015 Employer-Sponsored Health Care: ACA's Impact' Survey Results", *International Foundation of Employee Benefit Plans*, 2015

Medicare Turns 50!

(Logo designed by the HBMA)

On July 30, 2015, Medicare will be 50 years old. And while many in the health care community like to complain about aspects of the program, it has certainly provided millions of seniors and disabled citizens with much needed healthcare.

Although it seems like Medicare has been around forever, its legislation was only introduced in 1965. At that time, only about half of Americans who were 65 years of age or older had any health insurance, and many of their policies did not offer meaningful health care coverage. To add to the problem, seniors were the sickest population making them unattractive to private insurers in the individual health insurance market. They faced medical bills roughly triple those for everyone else.[1]

However, during the 50's and early 60's, seniors were a strong political constituency and demographic trends showed that this population would grow tremendously over time. Their large voting block influenced proposed legislation to provide retired Americans with health insurance that began with President Truman and continued through the Kennedy years. Finally, in 1965, President Lyndon Johnson persuaded Congress to pass a final Medicare bill including hospital coverage (Part A), physician coverage (Part B) and Medicaid, an additional program designed to help the poor with health coverage.

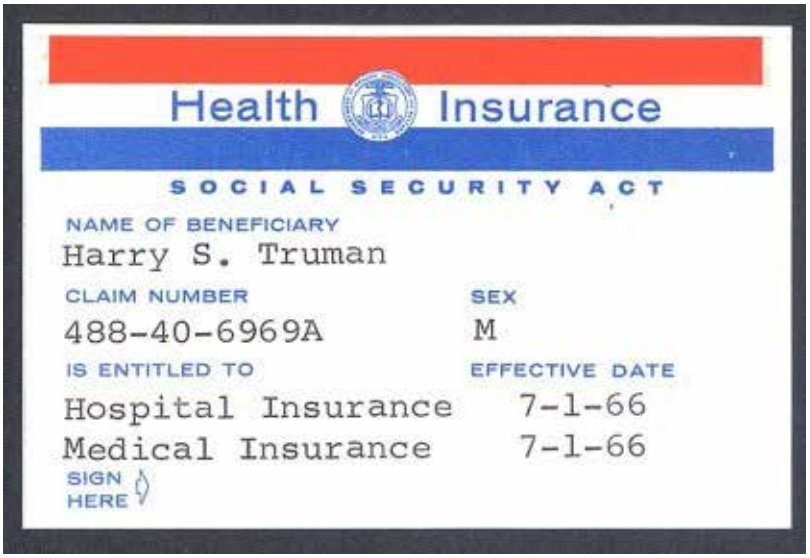
Medicare coverage encouraged the elderly to use medical services. Between 1963 and 1970, the rate of hospital admissions per 100 elderly Americans rose from 18 to 21 annually and the proportion of elderly persons who had contact with a physician each year increased from 68% to 76%.

Over the years, as medical costs grew, so did Medicare expenditures. Spending per Medicare beneficiary increased from $385 in 1970 to $12,210 in 2013. Aggregate spending has grown from 0.7% of the gross domestic product (GDP) in 1970 to 3.5% today.[2]

The following timeline highlights the important legislative steps in Medicare's journey from 1966 through today, all with the objective to improve care and coverage at an affordable cost to Seniors while containing the cost.

The Medicare Journey

The following Medicare Journey timeline draws from the Kaiser and MedPage articles shown in the Resource section below.



The First Medicare Card

July 30, 1965 – *Medicare Signed in to law* – President Lyndon Johnson signs H.R. 6675, establishing Medicare for the elderly and Medicaid for people with low income and limited resources.

July 1, 1966 – *Benefits begins* – More than 19 million Americans aged 65 or older enroll in the Medicare program. At the time, the cost for Medicare Part A deductible was $40 per year and Medicare Part B premium was $3 per month.

October 30, 1972 – *Disability Coverage* – President Richard Nixon signs the Social Security Amendments of 1972, the first major change to Medicare since its inception. Under the legislation, coverage is expanded to people younger than 65 with long-term disabilities and individuals with end-stage renal-disease.

1977 – *HCFA is born* – The Health Care Financing Administration (HCFA) is created to integrate and administer both Medicare and Medicaid and begins to oversee costs.

July 18, 1984 – *Deficit Reduction Act of 1984* – DEFRA froze physician fees, established the "participating physician or supplier" agreement, and established fee schedules for laboratory services

April 7, 1986 – *Review of Reimbursement Policies* –The Physician Payment Review Commission (PPRC) was created as part of the Omnibus Budget Reconciliation Act of 1986. The PPRC's mission was to slow down costs and recommend future reimbursement policies for physicians.

December 19, 1989 – *Omnibus Budget Reconciliation Act of 1989* – Congress replaces reimbursement of reasonable and customary charges with a physician fee schedule derived

from a resource-based relative-value scale (RBRVS). Limits are placed on physician balance billing and physicians are prohibited from referring Medicare patients to clinical laboratories in which they have a financial interest.

1997 – *The Sustainable Growth Rate and Medicare Advantage* –The Balanced Budget Act of 1997 created a host of changes to the program. Most notably, it implemented the sustainable growth rate (SGR) formula, which was set to begin in 2003. The SGR was to be a mechanism to reduce fees if Medicare spending on physicians' services exceeded an aggregate target. The Act also created the State Children's Health Insurance Program (SCHIP) and Medicare Part C, now called Medicare Advantage. That program formally gave beneficiaries the option of an HMO-style Medicare plan instead of the fee-for-service program.

1998 – *Medicare.gov* – The federal government designed its first website to provide updated information on the Medicare program.

2000 – *SCHIP expanded* – The Medicare, Medicaid and SCHIP Benefits Improvement Act of 2000 increased payments to providers and reduced some copayments for beneficiaries.

2001 – *HCFA becomes CMS* – The Health Care Financing Administration is renamed to The Center for Medicare and Medicaid Services (CMS).

December 8, 2003 – *Modernization Act* – The "Medicare Prescription Drug, Improvement, and Modernization Act" is signed in to law by President George W. Bush. Among the many changes, the MMA made a prescription-drug benefit available, on a voluntary basis and only from private plans, with a premium paid directly to the plan which would go in to effect in 2006.

January 1, 2006 – *Part D begins* – Medicare Part D, created as part of the 2003 MMA, goes into effect and Medicare beneficiaries begin receiving subsidized prescription drug coverage. In 2013, a total of 39.1 million Medicare beneficiaries were enrolled in a Medicare prescription-drug plan.

March 23, 2010 – *the Patient Protection and Affordable Care Act (ACA)* – President Obama signs the ACA which mandates that Medicare beneficiaries receive certain free preventive care services and health screenings, a free annual wellness exam and also reduces the out-of-pocket expenses of Part D enrollees. It also created the Center for Medicare and Medicaid Innovation, which received $10 billion to develop, assess, and disseminate new payment approaches and other strategies that are designed to improve quality and lower spending for health care services. These innovations include the introduction of their Accountable Care Organizations (ACOs), the Bundled Payments for Care Improvement Initiative, the Comprehensive ESRD Care Initiative, the Community-based Care Transitions Program, and the Comprehensive Primary Care Initiative.

The ACA also implemented a quality-rating system for Medicare Advantage plans to provide higher payments to plans earning higher ratings.

August 2, 2011 – *Budget Control Act of 2011* – The law includes provisions to reduce net federal spending by $2.1 trillion over ten years and raise the debt ceiling by up to $2.4 trillion. The law also specifies that if a proposal from the Joint Select Committee on Deficit Reduction is not enacted, a sequester of $1.2 trillion over 10 years would go into effect January 2, 2013, resulting in a

sequestration of up to two percent of Medicare payments to providers and plans.

April 1, 2013 – *Medicare Sequestration of 2%* goes into effect

April 1, 2014 – *Protecting Access to Medicare Act of 2014* prevents a 24 percent cut to payments for physician services due to SGR formula. Instead, it institutes a 12-month "doc fix" in traditional Medicare, which freezes payment rates through March 31, 2015. This is the 17th law instituting a doc fix since 2003. The Act also extends several otherwise expiring provisions, including the Medicare therapy cap exceptions process and the Qualifying Individual Program.

2015 *Medicare Costs* (See the above Qualifying Individual Program)

- ***Part A*** – Beneficiaries usually do not pay a monthly premium for Medicare Part A (Hospital Insurance) coverage if they or their spouse paid Medicare taxes while working. This is sometimes called "premium-free Part A." If a beneficiary must buy Part A, they can pay up to $407 each month.
- ***Part B*** premium is $104.90 per month with a $147 year deductible. For those beneficiaries who make over $85,000 a year, the premium is higher.

April 15, 2015 – *SGR is repealed* and replaced with a 0.5% update to the current conversion factor from July 1, 2015 thru December 31, 2015. Providers will then receive an annual 0.5% update through 2019. The 2019 rate will be maintained through 2025 while giving providers the opportunity to receive additional payment adjustments through the new Merit-Based Incentive Payment System (MIPS). In 2026 and beyond, providers participating in APMS (Alternative Payment Models) that meet certain criteria will receive annual updates of .75%, while all other professional will receive annual updates of .25%.

Resources

Kaiser Medicare Timeline

NE Journal of Medicine article part 1

MedPage – Medicare at 50

[1] Blumenthal, M.D., M.P.P., David, et al, "Medicare at 50 – Origins and Evolution," N*ew England Journal of Medicine*, January 29, 2015.
[2] Ibid

Customer Survey Insights

As most readers know, AdvantEdge conducts an annual survey of its clients in the first quarter of each year. Results help AdvantEdge Client Managers, operations and executives focus the company's energy on those items that have the highest value to clients.

In this article, we share insights from this year's survey. One of the first survey questions asks about the importance of different aspects of our service: e.g. meeting frequency, reports, problem resolution, etc. Like previous years but more so, this year's respondents (representing almost one third of AdvantEdge clients) say the top priority isn't one thing, but several. Namely, a combination of payments (meaning cash collected) plus accessibility and responsiveness. In other words: performance and service.

When asked how we are doing on these important factors, the vast majority of clients say "good" or "excellent." Of course, there is always room for improvement and open-ended questions invite suggestions and comments. Along those lines, we heard about ICD-10 (a lot), PQRS, meaningful use, specific ideas for new reports, etc. But mostly we heard nice things about Client Managers. Things like "Our client manager is outstanding", "Our client manager is attentive, thorough, and prompt", and "The best aspect of working with AdvantEdge is the personal contact; having the same people managing and working on our account; having people who are experienced and knowledgeable."

Consistent with those comments, when asked to rate AdvantEdge performance, customers give high marks for responsiveness, including reports and access to information. This matches with the AdvantEdge commitment of full transparency in billing.

While the positive results are gratifying, the AdvantEdge team isn't taking them for granted. We all know that positive ratings only happen when our work is done effectively, day in and day out. Customers make that clear in the survey and AdvantEdge workflows, training and leadership focus on top quality results with responsive service every day.

HIPAA Security Data Breaches – The News is NOT Getting Better!

On May 15th, news reports described a significant data breach by a Business Associate. The investigation focused on one rogue employee from the North Carolina based billing company Medical Management LLC (MML). The result, so far, is forty of the billing company's clients having to notify patients. The clients identified so far have facilities in NY, NJ, PA and IL.

The reports describe a call center employee (since terminated by MML and also arrested) who copied personal information items from the billing system over the past two years and then illegally disclosed that information to a third party. Federal Authorities are involved in the investigation and they notified MML of the activity. The personal information that was accessed and potentially compromised included names, dates of birth and social security numbers. There is no evidence, at this time, that information about medical history or treatment was disclosed.

HIPAA requires covered entities and business associates to "secure all electronic protected health information against accidental or intentional causes of: unauthorized access, theft, loss or destruction, from either internal or external sources." HIPAA security regulations govern electronic records, while HIPAA's privacy rules apply to paper records.

"Theft", "Unauthorized Access" and "Loss" dominate as reasons for breaches, and the latest breach statistics are staggering; from March 2009 through April 2015, **more than 133 million patient records have been affected by 1,199 HITECH Act breaches**, according to a report recently released by the HHS Office for Civil Rights (OCR) https://ocrportal.hhs.gov/ocr/breach/breach_report.jsf

And, according to a study by Kaiser Permanente, recently published in the *Journal of the American Medical Association*, of health record breaches reported between 2010 and 2013, the percentage of breaches attributed to hacking more than doubled during the three-year period, accounting for 12% of incidents in 2010 and 27% in 2013. However, such incidents comprised less than one-third of all large-scale reported breaches. Researchers noted that more than 50% of the breaches resulted from loss or theft of laptops, paper records, and thumb drives[1]

Please note that these statistics are HIPAA related breaches only, they do not include the hundreds of millions affected by online financial breaches at companies such as Target, TJ Maxx, Home Depot, etc.

In addition, many healthcare breaches still go unreported, and many breach offenders don't make the OCR's "wall of shame." Moreover, breaches involving the health records of fewer than 500 individuals do not have to be publicly reported, which also skews the reported numbers.

Why is Healthcare Data Theft Growing?

Security experts say health data is showing up in the black market more and more. Records that contain a social security number or mother's maiden name are used for identity theft. Healthcare companies saw a 72% increase in cyber-attacks from 2013 to 2014, according to

the security firm Symantec. Researchers have also noted that the number of electronic data breaches likely will continue to rise as the use of EHRs quickly expands, along with increased adoption of Cloud-based analytics services, gene sequencing, personal health records, and other health-related technology.

Credit card numbers aren't worth very much to hackers anymore since credit card companies can shut down cards quickly; fifty cents to a dollar may be what a hacker can fetch for one on the black market. Health-related records are currently estimated to be ten to twenty times more valuable because the information can be used, for example, to set up fraudulent Medicare/ Medicaid billing, and bill over and over.

Risk Analysis Inadequacies

Failure to perform and act upon a comprehensive risk analysis is often where companies lapse. Based on the complaints that OCR has received, risk analysis failures top the list for the biggest security issues. By understanding workflow, policies, and procedures, you get a more complete picture of what is actually happening in your environment, and from there you can implement a plan that significantly lowers your risk of breach.

Final Thoughts

Employees will make mistakes, and some may even steal. Hackers will never go away, and cyber criminals do not only target large companies. Here is a short list from Managed Solutions with tips to help you prevent a healthcare data breach.

1. Conduct a Risk Assessment

Stage One of the CMS EHR Meaningful Use incentive program requires that all providers conduct a risk assessment of their IT systems. This is in accordance with the HIPAA Privacy and Security Rules that govern the transmission of all electronic patient information. The risk assessment forces providers to review security policies, identify threats and uncover vulnerabilities within the system.

2. Provide Continued HIPAA Education to Employees

Educate and re-educate employees on current HIPAA rules and regulations. Furthermore, review and share state regulations involving privacy of patient information. If employees are in the know and reminded of the implications of data breaches, risk of violation can be drastically reduced.

3. Monitor Devices and Records

Remind employees to be watchful of electronic devices and/or paper records left unattended. More often than not, data breaches occur due to theft of these items from a home, office or vehicle. While it is "IT's" job to safeguard patient information, employees should be reminded to do their part in keeping data safe as well.

4. Encrypt Data and Hardware

Encryption technology is key when avoiding data breaches. While HIPAA doesn't require data to be encrypted, it also does not consider loss of encrypted data a breach. Therefore, be sure to encrypt patient information both at rest and in motion to avoid potential penalties. Furthermore, protect hardware such as servers, network end points, mobile and medical devices as these items are also vulnerable.

5. Subnet Wireless Networks

Ensure that networks made available for public use do not expose private patient information. One way of achieving this is to create sub-networks dedicated to guest activity and to separate more secure networks for medical devices and applications that transmit and carry sensitive patient information.

6. Manage Identity and Access Stringently

With so many members of the healthcare system frequently accessing patient information – for a multitude of different reasons – it is important to carefully manage the identity of users. For instance, make sure users are only granted access to information pertinent to their position and that log on/off procedures are easy and enforced on shared machines. Automation helps create a "paper trail" and ensures efficiency and safety for all involved.

7. Develop a Strict BYOD Policy

BYOD or Bring Your Own Device policies should be airtight and follow the same strict security guidelines outlined above.

8. Examine Service-Level Agreements Carefully

If you are considering moving patient information and data to the cloud, make sure you understand the Service-Level Agreement (SLA) with your potential Cloud Service Provider (CSP). Specifically, ensure that you, not the CSP own the data and that it can be accessed reliably, securely and, more importantly, timely (in the event of a crash). Also, verify that the SLA complies with HIPAA and state privacy laws.

9. Hold Business Associates Accountable for IT Security Policies

It is imperative to update business associate agreements to reflect evolving federal and state privacy regulations. Healthcare organizations often have hundreds or even thousands of vendors with access to patient data. In the event of a breach, the healthcare provider is ultimately responsible. Therefore, hold BAs accountable for providing security and risk assessments and develop processes for reporting breaches.

10. Establish Good Legal Counsel

In the event of a data breach, your organization will be investigated and most likely fined by the Office for Civil Rights. Lawsuits from patients will also ensue, so be sure to be prepared from a legal standpoint. Compliance is key, so don't be advised to withhold known information about the breach.

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[1] Doyle, Katherine, "Health Data Breaches on the Rise," *Reuters*, April 14, 2015.

AdvantEdge ICD-10 Readiness

With October 1 now only 4 months away, and counting, ICD-10 is looking very real!

AdvantEdge preparation efforts continue so that clients can be assured of a smooth transition. This includes systems, staff training, and much more. One key element directly impacts clients: physician training and preparation. For clients where AdvantEdge does diagnosis coding, provider documentation will need to become more specific. Clients who do their own diagnosis coding need to become familiar with the ICD-10 codes for their specialty.

System Readiness

Since 2011, the AdvantEdge development team has been managing a major project to change applications to process ICD-10 codes—in parallel with ICD-9 codes. We have been ready to initiate testing of ICD-10 codes with payers since 2013. In 2014, AdvantEdge was selected to partner with Emdeon to test ICD-10 processes since our systems were ready to test earlier than most others. Other tests were run in 2014 with payers prepared to do so. In 2015, end-to-end testing is underway with a number of Medicare MACs, commercial payers and clearinghouses.

Coding Readiness

The AdvantEdge coding team has been preparing for ICD-10 for the past two plus years, using the guidelines of the AAPC. Among other items, these guidelines strongly recommend expanded coder training in physiology and anatomy. AdvantEdge coders have completed the required anatomy and physiology education sessions through AHIMA that will be instrumental in the correct coding for ICD-1. In addition, our coders are gaining experience through dual coding of selected cases.

Two AdvantEdge coders are certified AHIMA ICD-10 trainers. They have established a comprehensive ICD-10 curriculum which all AdvantEdge coders are completing. Every AdvantEdge coder is currently certified for ICD-9 and is required to complete training and be recertified for ICD-10.

Client Readiness

The largest impact of ICD-10 may be on AdvantEdge clients and their physicians. This is because of the additional documentation required in order for AdvantEdge coders to assign the correct ICD-10 code. To assist that process, this newsletter has been publishing ICD-9 / ICD-10 comparisons for the past 3 years, including in this issue. Recently, those comparisons were compiled for Radiology, Pathology and Anesthesia. Those cross walk documents have gotten very positive feedback from clients and client managers. In addition, several AdvantEdge whitepapers are available that provide additional details to help with ICD-10 planning. As an example, most hospital-based physicians will need additional information from their referring / ordering physicians in order to have enough detail for an ICD-10 report.

Summary

AdvantEdge Healthcare Solutions is confident that the company and its clients will be ready for the ICD-10 transition on October 1, 2015.

If you have any questions, please contact your AdvantEdge Client Manager.

ICD-9 to ICD-10 Other and Unspecified Malignant Neoplasm of Skin

Diagnosis: Other and Unspecified Malignant Neoplasm of Skin (Lip, Eyelid, Ear, Face, Scalp & Neck)

ICD-9 Code(s): 173.00 – 173.49

Listed Under: Neoplasms 140-239 → Malignant Neoplasm Of Bone, Connective Tissue, Skin, And Breast 170-176 → Other and unspec malignant neoplasm of skin 173-

ICD-10 Code(s): C44.00 – C44.49

Listed Under: Neoplasms C00-D49 → Melanoma and other malignant neoplasms of skin C43-C44 → Other and unspecified malignant neoplasm of skin C44-

Diagnoses in shaded areas are titles only and are not billable

DIAGNOSIS	ICD-9	ICD-10	ICD-10 Description (if different)
Other & Unspecified Malignant Neoplasm of Skin	**173**	**C44**	**Other & Unspecified Malignant Neoplasm of Skin**
Skin of Lip	**173.0**	**C44.0**	
Unspec, malignant neoplasm of skin of lip	173.00	C44.00	
Basil cell carcinoma of skin of lip	173.01	C44.01	
Squamous cell carcinoma of skin of lip	173.02	C44.02	
Other specified malignant neoplasm of skin of lip	173.09	C44.03	
Skin of Eyelid, including canthus	**173.1**	**C44.1**	
Unspecified malignant neoplasm	173.10	C44.101	
Right eyelid		C44.102	
Left eyelid		C44.109	
Basil cell carcinoma	173.11	C44.111	
Right eyelid		C44.112	
Left eyelid		C44.119	
Squamous cell carcinoma	173.12	C44.121	
Right eyelid		C44.122	
Left eyelid		C44.129	
Other specified malignant neoplasm	173.19	C44.191	
Right eyelid		C44.192	
Left eyelid		C44.199	

DIAGNOSIS	ICD-9	ICD-10	ICD-10 Description (if different)
Skin of Ear and External Auditory Canal	**173.2**	**C44.2**	
Unspecified malignant neoplasm	173.20	C44.201	
Right ear		C44.202	
Left ear		C44.209	
Basil cell carcinoma	173.21	C44.211	
Right ear		C44.212	
Left ear		C44.219	
Squamous cell carcinoma	173.22	C44.221	
Right ear		C44.222	
Left ear		C44.229	
Other specified malignant neoplasm	173.29	C44.291	
Right ear		C44.292	
Left ear		C44.299	
Skin of Other & Unspecified Parts of Face	**173.3**	**C44.3**	
Unspecified malignant neoplasm, unspecified part of face	173.30	C44.300	
Nose		C44.301	
Other parts of face		C44.309	
Basil cell carcinoma , unspecified part of face	173.31	C44.310	
Nose		C44.311	
Other parts of face		C44.319	
Squamous cell carcinoma, unspecified part of face	173.32	C44.320	
Nose		C44.321	
Other parts of face		C44.329	
Other specified malignant neoplasm	173.39	C44.390	
Nose		C44.391	
Other parts of face		C44.399	
Scalp and Skin of Neck	**173.4**	**C44.4**	
Unspecified malignant neoplasm	173.40	C44.40	
Basil cell carcinoma	173.41	C44.41	
Squamous cell carcinoma	173.42	C44.42	
Other specified malignant neoplasm	173.49	C44.49	