Modern Healthcare

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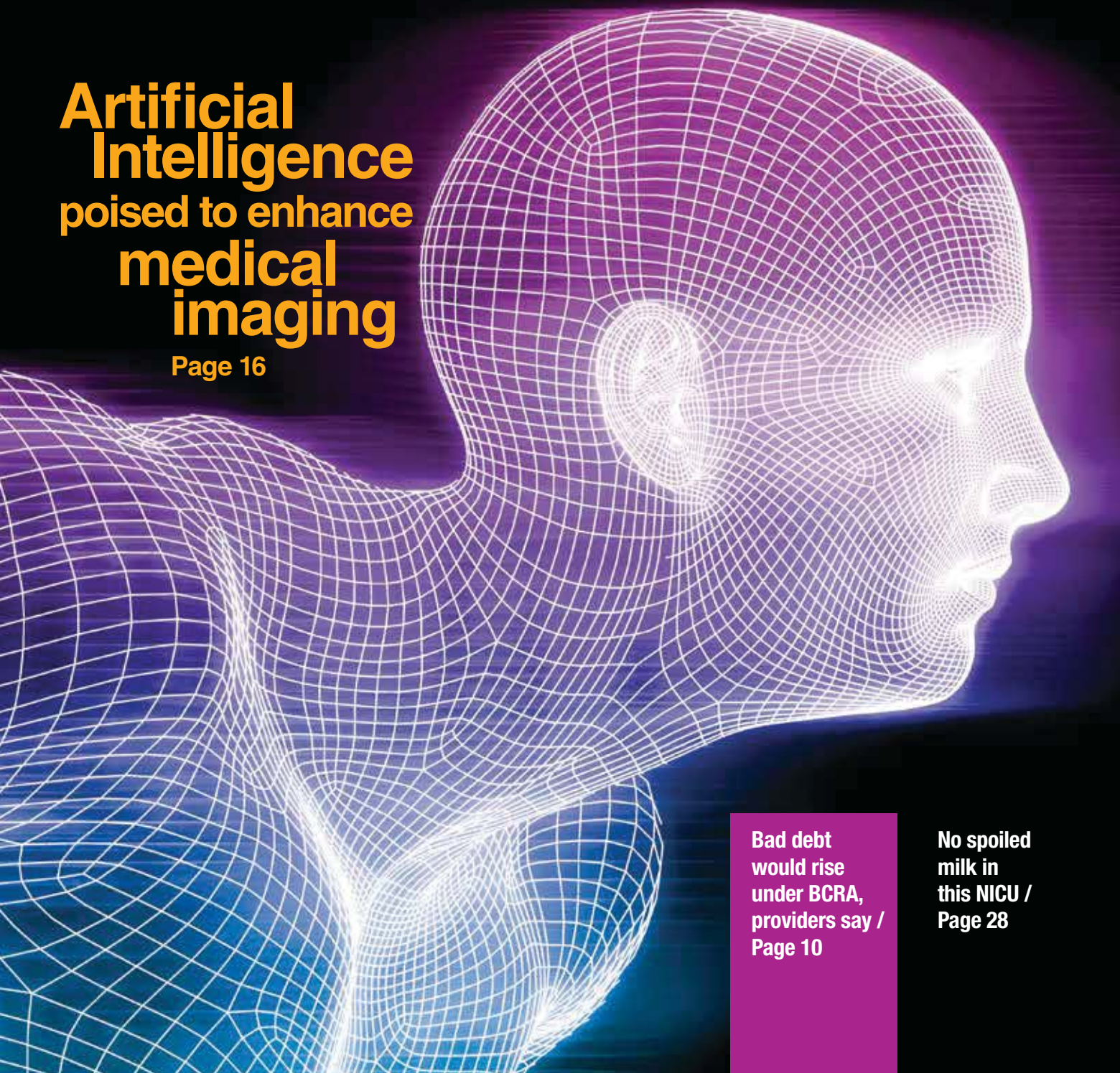

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Modern Healthcare

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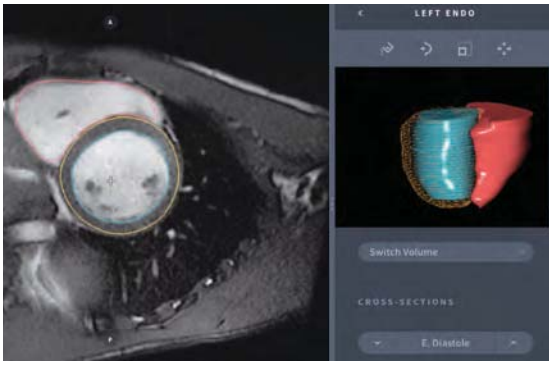

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Education and Events

Women Leaders in Healthcare conference

Chat with Aurora Aguilar, editor of Modern Healthcare, during lunch on July 19 at Modern Healthcare's annual Women Leaders in Healthcare event in Nashville. **/WomenLeaders**

Awards and Recognition

Send nominations for Up & Comers

Know some young healthcare leaders already making a difference in the industry? We're accepting nominations through Aug. 4 for this year's class of Up & Comers. **/UpandComers**

"It's going to be very hard to move the ball on population health if you take tens of millions of people and just cut them out of the system."

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late news

Georgia health commissioner picked as new CDC chief

HHS Secretary Dr. Tom Price late last week tapped Dr. Brenda Fitzgerald to be the next director of the Centers for Disease Control and Prevention. She will also serve as administrator of the Agency for Toxic Substances and Disease Registry, Price said in the announcement.

Fitzgerald

Fitzgerald has served as Georgia's public health commissioner since 2011. She is a board-certified OB-GYN.

Fitzgerald has handled a number of public health crises with national implications. In 2014, she led a task force to prepare Georgia's response for a potential Ebola outbreak. More recently, she was tasked to lead the state's effort to combat the Zika virus. Georgia had 118 cases reported from January 2016 to May 2017.

"The academic public health community looks forward to working constructively with Dr. Fitzgerald to advance our shared agenda of improving health locally, nationally and globally through the creation, transmission and application of public health knowledge and a well-prepared and resourced public health workforce," Donna Petersen, chair of the Association of Schools and Programs of Public Health, said in a statement.

Previously, Fitzgerald worked as a healthcare policy adviser for then-House Speaker Newt Gingrich and Sen. Paul Coverdell (R-Ga.) and served as a major in the U.S. Air Force.

"She has a real passion for improving people's health," said American Public Health Association Executive Director Dr. Georges Benjamin. Benjamin said he hoped Fitzgerald's familiarity with Price, a former Georgia congressman, would provide her with access to make a strong case for strengthening funding support for the CDC.

"I know that she has a deep appreciation and understanding of medicine, public health, policy and leadership—all qualities that will prove vital as she leads the CDC in its work to protect America's health 24/7," Price said in a statement.

The CDC stands to lose as much as 12% of its overall budget if the Senate's Better Care Reconciliation Act becomes law. The bill calls for eliminating the Prevention and Public Health Fund, which was created under the Affordable Care Act and provides more than $600 million annually to state and municipal health departments to fund infectious and chronic disease programs, as well as support emergency preparedness efforts.

"She understands what the prevention fund does and how other CDC funding support the states," Benjamin said.

Fitzgerald replaces Dr. Anne Schuchat, who has been interim CDC director since Dr. Tom Frieden resigned in January. Schuchat is expected to return to her former role as CDC principal deputy director, according to an HHS statement. **—Steven Ross Johnson**

Briefs

■ **Charles Stokes was officially named president and CEO of Memorial Hermann Health System. He had been filling the roles on an interim basis since Dr. Benjamin Chu abruptly resigned in June** to pursue a role crafting health and public policy. Along with serving as interim president and CEO, Stokes, who began his career as a registered nurse, was executive vice president and chief operating officer. As COO, he oversaw operations for 17 hospitals, more than 200 outpatient clinics, 25,000 employees and 5,500 affiliated physicians. Stokes joined Houston-based Memorial Hermann in 2008. The system late last month announced that it will cut 350 jobs due to escalating costs, declining reimbursements and a softened local economy.

■ **Despite the political uncertainty swirling around the future of the Affordable Care Act, healthcare had its strongest month so far in 2017 when it comes to creating jobs.** The industry added more than 36,500 jobs in June, far outpacing the 20,600 jobs added in May, according to the most recent jobs report by the Bureau of Labor Statistics. Overall employment in the sector is now 15.74 million. The bulk of the new hires were concentrated in ambulatory-care services, which added 26,000 jobs. Hospitals added 11,700 jobs. Even with these gains, jobs in the healthcare sector are growing at a slower pace compared to last year. Healthcare has added an average of 24,000 jobs per month in the first half of 2017, compared to an average monthly gain of 32,000 jobs in 2016.

■ **The maker of opioid painkiller Opana ER is pulling the drug off the market at federal regulator's request because it's being abused.** Endo International said it will voluntarily stop selling the pills, approved for use in patients with severe, constant pain, after consulting with the U.S. Food and Drug Administration. It's the first opioid drug that the FDA has sought to remove from the market due to abuse. The drugmaker said in a statement that the extended-release opioid is safe and effective when used as intended, and that Endo still believes Opana ER's benefits outweigh its risks.

Modern Healthcare

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the week ahead

With BCRA vote looming, HHS seeks comments on market stabilization

HHS is seeking information on how to make the healthcare system more patient-centric by, among other things, encouraging consumer choice in selecting insurance plans.

HHS is seeking input on Trump's executive order impacting ACA regulations.

The comment period opened in June in response to President Donald Trump's executive order aimed at easing any economic or regulatory burdens caused by the Affordable Care Act.

The comment period, which closes July 12, coincidentally comes as Senate GOP leaders continue to fine-tune their version of an ACA repeal-and-replace bill, the Better Care Reconciliation Act of 2017.

Many of the topics HHS is seeking comment on mirror those raised by Republicans as they aim to do away with portions of Obamacare. HHS asked about how it could improve the individual and small-group insurance markets.

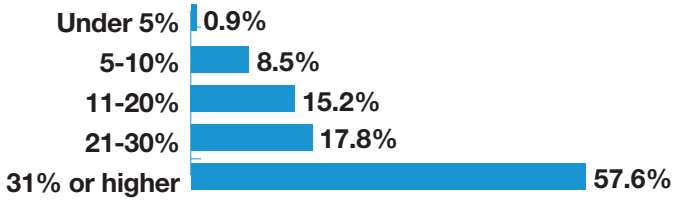
Specifically, it seeks recommendations on actions that could help consumers pick the right plans; how to stabilize the individual, small-group and nontraditional health insurance markets; how to make health insurance more affordable for consumers and small businesses; and which HHS policies may have hindered states' regulation of their insurance markets.

—Rachel Z. Arndt

The Meter

A bi-weekly poll taking the pulse of the Modern Healthcare audience

Over the next decade, what percentage of provider payments do you think will be tied to risk-based contracts?



To participate and see other poll results, go to ModernHealthcare.com/TheMeter

SOUTH

S.C. hospital to pay $1.3 million in EMTALA settlement

A South Carolina hospital last month agreed to pay nearly $1.3 million in the largest-ever settlement for alleged violations of the Emergency Medical Treatment and Labor Act.

AnMed Health, based in Anderson, S.C., and serving upstate South Carolina and northeast Georgia, reached a settlement with HHS' Office of Inspector General over allegations that in 2012 and 2013 it held patients with unstable psychiatric conditions in its emergency department without providing appropriate psychiatric treatment in 36 incidents.

"Instead of being examined and treated by on-call psychiatrists, patients were involuntarily committed, treated by ED physicians and kept in AnMed's ED for days or weeks instead of being admitted to AnMed's psychiatric unit for stabilizing treatment," according to the settlement agreement.

The patients—most of whom were suicidal and/or homicidal and suffered from serious mental illness—were held in the ED from six to 38 days. In each of these incidents, AnMed had on-call psychiatrists and beds available in its psychiatric unit to evaluate and stabilize the patients.

But it did not provide examination or treatment by a psychiatrist, according to the settlement agreement.

AnMed did not admit to liability under the settlement deal. In a written statement, AnMed said it had been a longstanding policy for its behavioral health unit to accept only voluntarily admitted patients, while patients who were to be involuntarily admitted were held in the ED until they could be transported to the state mental hospital.

The shortage of space in that facility often prolonged psychiatric patients' stays in the AnMed ED, the statement said.

AnMed has engaged in significant corrective action, including adding more training for staff and security to protect other patients and plans to expand its psychiatric inpatient unit from 15 to 34 beds by yearend.

"That's one of the reasons why the penalty was not even higher," said Sandra Sands, a senior attorney with the OIG who has been handling EMTALA cases since 1989. "They were very cooperative with the OIG during the investigation, and it appears they did things that went beyond what was required." **—Harris Meyer**

SOUTH

Kentucky seeks stricter Medicaid work requirements

After nearly a year of negotiations, Kentucky Gov. Matt Bevin has submitted an amended Medicaid waiver request to the CMS that proposes a stricter work requirement than the state originally requested.

The original 1115 waiver, submitted last August and dubbed Kentucky Health, would require able-bodied adults without dependents to work or participate in job training or community engagement such as volunteering for at least five hours a week, gradually increasing to 20 hours a week after a year.

Amendments submitted to the CMS last week would, among other things, eliminate the proposed ramp-up period for the work requirement.

This change mirrors Kentucky's current policy for residents receiving food stamps.

Bevin also suggested locking beneficiaries out of coverage for up to six months if they obtain a new job or salary and don't alert the state so that it can confirm the person is still eligible for Medicaid.

Dustin Pugel, a research and policy associate for the Kentucky Center for Economic Policy, told reporters that the change will cause more beneficiaries to lose their Medicaid coverage because many have jobs with variable income, including retail, restaurant and construction jobs. If those people fail to notify the state of their frequent changes, they could lose coverage.

Bevin estimates that these and other administrative changes will result in Kentucky Health saving $2.4 billion in federal and state dollars over the five-year waiver period, more than the $2.2 billion in savings stemming from the original waiver. **—Virgil Dickson**

CHS continues to restructure as it struggles with debt

Franklin, Tenn.-based Community Health Systems recently completed the sale of nine hospitals, part of the troubled hospital chain's plan to divest

30 facilities and offload debt.

In this latest round, CHS sold hospitals in Louisiana, Pennsylvania, Texas and Washington. CHS announced the divestiture plans in its first-quarter earnings report, posting a $177 million net loss, down from a $36 million profit over the same period last year. The system had $14.69 billion in debt in the first quarter, down slightly from $14.79 billion the quarter prior.

The system is still reeling from its $7.6 billion acquisition of Health Management Associates and its 70-plus hospitals. It spun off 38 of its hospitals into a separate, independent company called Quorum Health Corp. last year and used some of the $1.2 billion of net proceeds to pay off debt and improve its debt-EBITDA ratio, CHS CEO Wayne Smith said.

"Our current divestiture plan will also allow us to move to a portfolio of hospitals that are better-positioned in our markets with better volume growth, higher EBITDA margin, improved cash flow," Smith said in the first-quarter earnings call. "This will also allow us to direct future investments in our most attractive markets and regional networks, which provide a higher return on capital."
—Alex Kacik

NORTHEAST

Health system restores IT system after cyberattack

A health network that fell victim to a worldwide cyberattack on June 27 said that all acute, ambulatory and ancillary care services have been restored at its locations.

Heritage Valley Health System, Beaver, Pa., said there was a lack of access to computer systems following the cyberattack. But it said Heritage Valley Sewickley and Beaver hospitals, Heritage Valley Medical Group, Heritage Valley Pediatrics and Tri-State Obstetrics & Gynecology physician practices, ConvenientCare walk-in clinics and all other community locations had stayed open and operational.

Heritage Valley Health System CEO Norm Mitry said providing care without computer access is difficult, but physicians and employees "continued to deliver safe patient care throughout this adverse situation."

Heritage said the cyberattack was identified as the same ransomware attack that affected organizations worldwide. The system said there was no indication it was targeted specifically.
—Associated Press

MIDWEST

Centene ready to fill insurance gap in abandoned Missouri markets

Centene Corp. will sell individual health insurance exchange plans in 40 Missouri counties next year, including dozens of counties that were at risk of having no marketplace options in 2018.

The St. Louis-based insurer is one of a few health plans moving into markets that other insurers ditched because of financial losses and ongoing regulatory uncertainty over healthcare reform.

The CMS under the Trump administration has held up recent marketplace retreats by insurers Anthem and Aetna as a sign that Affordable Care Act marketplaces have failed. The agency last month projected 49 counties will have no exchange options next year.

If no marketplace health plan is available, consumers wouldn't have access to the federal financial subsidies that reduce premiums and lower out-of-pocket costs.

But those gaps in coverage are starting to be filled. Now 38 U.S. counties in Indiana, Ohio and Nevada are at risk of having no marketplace insurers, according to the Kaiser Family Foundation, which tracks insurer participation. In those "bare" counties, 25,133 people are enrolled in exchange coverage.

Centene, which serves 1.2 million marketplace members, previously announced it would start offering coverage on exchanges in Kansas, Missouri and Nevada, while expanding its footprint in the six states where it currently sells plans. It's still unclear which Nevada and Kansas counties Centene will enter.

Centene is one of a few insurers that have managed to turn a profit on the exchanges, thanks to its experience managing the care of low-income Medicaid members and its narrow-network, low-premium plans.
—Shelby Livingston

WEST

Cardiac arrest rates drop in Oregon after Medicaid expansion

After Oregon expanded its Medicaid program in 2014, the number of out-of-hospital cardiac arrests among people ages 45-64 in Multnomah County dropped by 17%, according to a study in the Journal of the American Heart Association.

The county, which includes Portland, Oregon's largest city, has about 290,800 residents.

People with insurance are more likely to receive routine, preventive care that can mitigate their risks for heart disease as well as cardiac arrest, said Dr. Sumeet Chugh, an author of the study and associate director of the Cedars-Sinai Heart Institute in Los Angeles.

"There is no question that having health insurance leads to a better quality of life and lower mortality, overall," Chugh said. "If you take a severe condition like cardiac arrest, that is mostly lethal, health insurance makes a difference."

Cardiac arrest is the leading cause of unexpected death in the U.S. and affects about 320,000 people per year, according to the American Heart Association. The fatality rate of an out-of-hospital cardiac arrest is also incredibly high, at about 70% to 90%.

The authors chose to focus on Oregon because the state was an early adopter of Medicaid expansion, and a state study on sudden unexpected deaths offered comprehensive details on cardiac arrest incidents in the Portland area.

More middle-aged Multnomah County residents acquired health insurance through Medicaid than other means, with an approximate 6.5 percentage-point increase after Medicaid expansion, from 7% to 13.5%. Insurance through direct-purchasing rose from 8.2% to 10% in the same period.
—Maria Castellucci

Small insurers take big hits under ACA's risk-adjustment program

By Shelby Livingston

Small health insurers and the few remaining co-op plans were again socked with large charges under the Affordable Care Act's risk-adjustment program.

The CMS in late June released data for the third year of the ACA's controversial risk-adjustment program, which shuffles money from plans with healthier enrollees to those with sicker ones. The agency also released the 2016 payments under the temporary reinsurance program, which protects health insurers against costly claims.

For ACA plans sold last year, 445 insurers split a total of $4 billion in reinsurance payments.

The permanent risk-adjustment program is meant to keep ACA insurers from cherry-picking healthier plan members over sicker, costlier ones. It collects payments from plans with healthier than average members and distributes that money to plans saddled with high-cost members. The zero-sum program is based on patients' risk scores, which factor in demographic information and health conditions. The CMS said 709 insurers participated in the risk-adjustment program.

The formula used to calculate payments in the risk-adjustment program has been criticized for unfairly favoring larger plans with more claims experience. Smaller companies that sell on the ACA's exchanges have said they don't have as much claims data, and therefore their membership base looks healthier than it is. Several, including Evergreen Health co-op in Maryland, New Mexico Health Connections and Minuteman Health of Massachusetts filed suits last year to halt the program.

GETTY IMAGES

The biggest winners were Blue Cross and Blue Shield-affiliated plans. Under the ACA, sicker patients flocked to the Blues' well-known brand, hence the companies' higher risk-adjustment payments.

Nevertheless, for 2016 the CMS said Evergreen must pay $9.4 million in risk-adjustment payments, though it will receive $2.5 million from the reinsurance program. Minuteman will have to pay $25.4 million in risk-adjustment payments, and New Mexico Health Connections will pay $8.9 million.

Several large health plans also lost big money under the programs. Kaiser Foundation Health Plan must pay $437.8 million in risk-adjustment payments for its ACA individual and small-group plans in California. It's set to receive $99.5 million in reinsurance payments.

The biggest winners were Blue Cross and Blue Shield-affiliated plans. Under the ACA, sicker patients flocked to the Blues' well-known brand, hence the companies' higher risk-adjustment payments.

Blue Cross and Blue Shield of Florida will rake in $615.7 million in risk-adjustment and reinsurance payments combined—the largest amount among participating insurers. Blue Shield of California will receive $572 million.

Responding to insurers' demands, the CMS changed the risk-adjustment formula for 2017, including accounting for people who enroll for only a portion of the year because of major life changes. In 2018, the formula will factor in prescription drug data for the costs of covering enrollees.

Still, the CMS said the risk-adjustment and reinsurance programs are working as they're supposed to. Insurers with high paid claims were more likely to receive risk-adjustment payments, while those with relatively low paid claims were more likely to pay in. The CMS noted that insurers in the lowest quartile of claims costs on average were assessed a risk-adjustment charge of 18% of total collected premiums, while those in the highest quartile of claims costs received a risk-adjustment payment of about 27% of their total premiums. Insurers with higher claims costs also received larger reinsurance payments. ●

THE TAKEAWAY

Small health insurers and the remaining co-op plans were again hit with large charges under the ACA's controversial risk-adjustment program. Blues plans received the largest payouts.

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Pharmaceuticals

Opioid prescribing varies widely among U.S. counties, report finds

By Steven Ross Johnson

Inconsistencies in prescribing practices are leading to significant variation across the country in opioid usage, according to a new government report.

Overall, annual opioid prescribing rates fell 13% between 2012 and 2015 to 70.6 prescriptions for every 100 people, according to a Centers for Disease Control and Prevention analysis.

But the decline was not seen across the board, with only half of U.S. counties experiencing reductions in that period. The amount of opioids per resident in the highest-prescribing counties was six times more than the amount found in the lowest-prescribing counties, the CDC found.

THE TAKEAWAY

The amount of opioids per resident in the highest-prescribing counties was six times more than the amount found in the lowest-prescribing counties.

Higher-prescribing counties shared a number of characteristics: higher rates of uninsured and Medicaid enrollment; higher rates of unemployment; a high prevalence of such chronic conditions as arthritis and diabetes, or people suffering from a disability; higher suicide rates; a larger percentage of non-Hispanic whites. These counties also had larger concentrations of dentists and primary-care physicians, the medical specialties that do most of the prescribing of opioids.

The CDC's Dr. Anne Schuchat said such factors explained only about one-third of the variations in opioid prescribing. It was not entirely clear what was driving the other two-thirds. "Clinical practice is really all over the place, which is usually a sign that you need better standards," Schuchat said during a call with reporters.

The report's findings offer a baseline measure of the scope of the opioid epidemic prior to the CDC's release of its opioids prescribing guidelines for chronic pain in March 2016.

Schuchat said the report's findings offer a baseline measure of the scope of the opioid epidemic prior to the CDC's release of its opioids prescribing guidelines for chronic pain in March 2016, and that plans were underway to examine in the next year or so how the numbers may have changed since the recommendations were issued. ●

Medicaid

Texas submits controversial abortion Medicaid waiver

By Virgil Dickson

Texas health officials last week asked the CMS to approve a family planning program that would explicitly exclude Planned Parenthood and providers that support or perform abortions. If approved, the waiver would set a precedent for Medicaid-funded family planning programs, according to Stacey Pogue, a public policy analyst for the Austin, Texas-based Center for Public Policy Priorities.

When the waiver was initially released in May, it was criticized for potentially violating federal law and jeopardizing patients' access to their doctors if they are affiliated with any provider that supports or performs abortions.

Texas lost federal funding for its family planning program, known as Healthy Texas Women, in 2013 after it stopped reimbursing for services performed at Planned Parenthood. Since then, the program has been totally state-funded.

Now facing a $2 billion budget shortfall, Texas is looking for ways to reduce spending and is seeking up to $300 million in federal funds to continue Healthy Texas Women for another five years.

THE TAKEAWAY

Texas has formally submitted a first-of-its-kind waiver that proposes a federally funded family planning program that does not include Planned Parenthood or providers that support or perform abortions.

Few, if any, women are getting abortions paid for by Medicaid, as that's prohibited by federal law with the exception of cases when the mother's life is in danger or if the pregnancy is the result of rape or incest.

Instead, a Planned Parenthood clinic is often where they see their primary-care doctors or get screenings for ailments such as breast cancer.

The CMS is taking comments on the waiver through Aug. 4. ●

LEADERSHIP... BY THE NUMBERS

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**Home Health Compare Star Ratings released by the Centers for Medicare & Medicaid Services for the reporting period of April 2017.*

BCRA spells trouble for providers as they weigh bill's Medicaid rollbacks

By Alex Kacik

Lawmakers return to Washington, D.C., this week following their July 4 holiday break. At the top of the agenda for Senate Majority Leader Mitch McConnell is tweaking the Better Care Reconciliation Act in hopes of shoring up "yes" votes from a handful of holdout Republicans.

Several senators balked at moving forward with a vote in late June, arguing that they hadn't been given enough time to study what was in the bill and how repealing parts of the Affordable Care Act would impact their states. As negotiations ramp up this week, providers remain concerned that, as originally crafted, the legislation would be bad not just for patients but for business, especially if projections that tens of millions of people would lose health coverage come to fruition.

"If Medicaid gets rolled back, there is no question there is going to be more uncompensated care," Cleveland Clinic outgoing CEO Dr. Toby Cosgrove said. "When up to 22 million people lose coverage, that becomes a substantial risk, particularly for safety-net and rural hospitals that are already losing money on patient care. But the implications go beyond patients and hospitals, they go to the communities, especially when their biggest employers are hospitals."

The bill would slash the ACA's financial assistance to families and individuals who couldn't otherwise afford healthcare, cap Medicaid spending and roll back the Medicaid expansion afforded to states' most vulnerable populations. The Congressional Budget Office projected that the Medicaid provisions would cause 22 million Americans to lose coverage, while a separate analysis suggested the bill would send insurance premiums surging.

Dr. Leonid Basovich examines Medi-Cal patient Michael Epps at the WellSpace Clinic in Sacramento, Calif.

AP PHOTO

THE TAKEAWAY

If the Senate's Better Care Reconciliation Act becomes law, providers could be faced with ballooning uncompensated-care costs that lead to service cutbacks, staffing reductions or hospital closures.

States such as California could be hit particularly hard. California has been approaching universal healthcare coverage largely thanks to the Medicaid expansion under the Affordable Care Act. Only 3.5% of California's population is uninsured and 1 out of every 2 children are covered by Medi-Cal, according to Marin General Hospital CEO Lee Domanico.

"If that were to reverse itself, it would really be devastating for those people and tough for us because that reimbursement could go to zero," he said. "Bad debt would go up, which had gone down through the Obamacare plan with more people insured through the exchanges and expansion of the Medi-Cal program."

Only 3.5% of California's population is uninsured and 1 out of every 2 children are covered by Medi-Cal, according to Marin General Hospital CEO Lee Domanico.

The Senate bill would leave states to fill the Medicaid funding gap or end coverage as the enhanced federal payments for expansion would be phased out over three years, starting in 2021. It would also cap the growth of federal Medicaid payments at the medical inflation rate, which is estimated to be 5.6% annually, beginning in 2020. Come 2025, the growth of those payments would be limited to the Consumer Price Index rate, which has

averaged around 1.4% since the Great Recession.

The CBO found that Medicaid spending would be 26% lower in 2026 than it would be compared to current spending trends, and the gap would widen to about 35% in 2036.

The bill permits states to opt out of the ACA's mandated essential benefits, which would allow insurers to turn away patients who need maternity care, mental health treatment, chemotherapy and emergency care, among others.

"We will go back to the days where the uninsured showed up in the ER," said Michael Rodgers, senior vice president of advocacy and public policy at the Catholic Health Association. "Catholic hospitals would be in a tough position because of our commitment to the poor and vulnerable."

As uncompensated care rises, operating margins would shrink, especially among hospitals in expansion states. Hospitals in D.C. and the 31 states that expanded Medicaid are projected to see a 78% increase in uncompensated care from 2017 to 2026, an analysis from the Commonwealth Fund found. Eleven of those states would see costs at least double, including Kentucky and West Virginia, which would have 165% and 122% increases, respectively. Providers would also face credit downgrades if the bill becomes law, Moody's Investors Service and Fitch Ratings said.

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Michael Rodgers
Senior vice president of advocacy and public policy
Catholic Health Association

Even though the proposed bill would bolster Medicaid disproportionate-share hospital payments, that will not offset the Medicaid cuts, researchers said. Hospitals in Medicaid expansion states could experience an average 14% decline in Medicaid revenue from 2017 to 2026, the Commonwealth Fund estimated.

The bill could also bring some unintended consequences as providers and physicians adapt and invest in infrastructure that supports new payment models. The majority of medical practice leaders are still not ready to comply with the Medicare Access and CHIP Reauthorization Act, and sweeping changes in healthcare policy may further slow that process, said Rebecca Altman of the Berkeley Research Group.

"I wonder if there isn't a tertiary effect on MACRA adoption when all of a sudden the volume of patients isn't there to make the return on managed-care teams efficient," she said.

For now, providers will have to wait.

"I haven't talked to any provider that supports the Senate bill," Cosgrove said. "The ACA has never been more popular." ●

CMS pushing forward with Medicaid managed-care rule

By Virgil Dickson

Despite promises to shift more regulatory autonomy to the states, the Trump administration is letting some controversial Obama-era Medicaid managed-care rules stand.

The CMS in late June opted to move forward with a mega-rule on managed care that expands federal oversight of Medicaid programs after refusing several states' requests to delay implementation.

Managed-care contracts that start on or after July 1, 2017, will have to comply with the new requirements, which the CMS says will improve the rate-setting process and make plans' spending more transparent. The rule was finalized last year.

The new requirements include stricter standards to ensure that managed-care rates are actuarially sound and cover all medical and administrative costs, taxes and fees for which the health plan is responsible.

Managed-care plans also must calculate and report their current medical loss ratio, which is a breakdown of what the plans spend on medical care versus other activities, including employee salaries, marketing, profits and administrative tasks.

GETTY IMAGES

The new requirements include stricter standards to ensure that managed-care rates are actuarially sound and cover all medical and administrative costs, taxes and fees for which the health plan is responsible.

By July 1, 2019, managed-care plans will be required to have a medical loss ratio of at least 85%.

The agency's refusal to delay enforcement may surprise some states, as the Trump administration hinted on several occasions that it may roll back the Obama-era rulemaking. Several states asked the CMS to delay compliance with parts of the rule that kicked in this month, citing the administrative burden associated with the rollout.

"These provisions in the final rule have significant federal fiscal implications for the Medicaid program and CMS will require compliance by the specified date in the final rule," CMS Medicaid Director Brian Neale said in a June 30 notice to states.

If states don't comply with the rulemaking, the CMS may not approve their managed-care contracts or proposed rates, according to regulatory attorneys. The agency could also reduce federal funding to the state Medicaid program until it complies with the requirements.

The CMS also said it will enforce a provision to eliminate so-called pass-through payments, which Medicaid managed-care plans receive on top of the base capitation rate. Those payments are used as incentives to attract providers to treat Medicaid enrollees if their base rates aren't enough to ensure access in an area.

At least 16 states have paid out $3.3 billion in pass-through payments on average every year. Three others have distributed about $50 million a year for nursing facilities, according to the agency, which opposes pass-through payments because they are not actuarially sound and are not directly related to contracted services. ●

THE TAKEAWAY

The CMS is moving forward with a controversial rate-setting rule for Medicaid managed-care plans in hopes of improving transparency.

Hospice

Study: Blacks and Hispanics report low-quality hospice care

By Maria Castellucci

Black and Hispanic patients are more likely to receive low-quality care from hospices compared with whites, according to a new study from RAND Corp.

Family caregivers for black and Hispanic patients reported lower quality scores compared with white patients. The patients had less access to timely care and were less likely to report that family members were treated with respect.

The findings are consistent with other studies that compare the quality of treatment between minority patients and whites, the study authors note. Other studies have found that black and Hispanic patients are more prone to poor quality care across most healthcare settings.

THE TAKEAWAY

Researchers found racial disparities in the quality of hospice care as well as emotional and religious support services for black and Hispanic patients.

It's difficult to know why this disparity exists, but it could be because blacks and Hispanics are more likely to live in urban and rural areas where healthcare quality is usually poorer, said Rebecca Price, lead author of the study and a senior policy researcher at RAND Corp.

Price and her co-authors analyzed survey responses from nearly 300,000 family members who were hospice caregivers and completed the CMS' Consumer Assessment of Healthcare Providers and Systems Hospice Survey from April 2015 to March 2016. The caregivers were from almost 2,500 hospices in all 50 states.

Family caregivers of black and Hispanic patients said the emotional and religious support provided by hospice teams didn't meet their needs compared with caregivers of white patients. This was particularly true for caregivers of Hispanic patients, who were significantly more likely to say that they received "too much" emotional support.

The findings are consistent with other studies that compare the quality of treatment between minority patients and whites.

Price said it's important for hospices to work to understand their patient populations and their unique cultural needs by offering language translators or working with faith-based organizations to accommodate a chaplain or pastor on-site. ●

Medicare

Spouses, kids are caring for older patients, but they get little support

By Steven Ross Johnson

Nearly 9 out of 10 caregivers for older Americans are unpaid, and those individuals work longer hours and receive less government support than their paid counterparts, according to a new study.

Approximately 900,000 Medicare beneficiaries received support from 2.3 million caregivers in 2011, according to the study published in Health Affairs. Researchers analyzed data from Medicare beneficiaries who lived in community settings and died within one year of study enrollment.

That's just the tip of the iceberg. In 2015, roughly 34 million Americans had provided unpaid care to an adult age 50 or older in the previous 12 months, according to figures from the National Alliance for Caregiving and AARP.

Unpaid end-of-life caregivers provide nearly double the hours of support per week compared to other caregivers, but they did not receive additional pay from government or private insurance, according to the Health Affairs study.

THE TAKEAWAY

Unpaid caregivers work longer hours and receive less government support than their paid counterparts.

The study illustrated the heavy economic burden family caregivers can face when they provide end-of-life support and how the healthcare system relies on family members to take on that care, according to Katherine Ornstein, assistant professor of geriatrics and palliative medicine at the Icahn School of Medicine at Mount Sinai in New York City and lead author of the study.

"We need to do more to make sure that our infrastructure is supporting (family caregiving) so that it can be done well and that the consequences for family members are not negative," Ornstein said.

The National Alliance for Caregiving and AARP calculated that unpaid care provided by friends or family members was valued at roughly $470 billion in 2013. ●

Hospitals struggle with the dilemma of patients hit by high deductibles

By Dave Barkholz

ORLANDO, Fla.—The rise of high-deductible health plans is driving one Missouri hospital to completely revamp patient registration, billing and collection.

Mosaic Life Care, a 297-bed hospital in the town of St. Joseph north of Kansas City, is a perennial on Truven Health Analytics' annual 100 Top Hospitals list, which recognizes facilities for patient care, operational efficiency and financial stability.

Yet last year, $23 million worth of self-pay patient care exposed deep flaws in the processes and technology the hospital used to log patient information, make insurance claims and approach patients for out-of-pocket costs, said Deborah Vancleave, Mosaic's vice president of revenue cycle.

"We win all kinds of awards for patient quality, but our revenue cycle didn't match that performance," said Vancleave, who spoke on the sidelines of the annual national conference held last month by the Healthcare Financial Management Association.

In the past five years, health insurers went from paying 90% of patient-care costs to only about 70%, and that's causing massive headaches for providers.

Vancleave said the stark reality of high-deductible healthcare—though on the radar of Mosaic executives last year—really hit home during the first four months of this year.

The hospital, she said, stayed nearly full during that time, posting record census and gross revenue. But net revenue didn't budge an inch from the prior year period because patients weren't paying their growing share of the cost of care.

Patients' self-pay total—the amount not covered by insurance—was up 9% over the four months, she said.

That's put Vancleave on a quest for improvement.

Just a month ago, Mosaic brought in ClearBalance to offer patients financing options for their out-of-pocket costs.

ClearBalance and other healthcare financing companies such as HealthFirst Financial arrange loans with patients that hospitals typically customize. Often they include a no-interest option for 12 to 24 months but as long as 72 months depending on what hospitals require.

ClearBalance, which has been making patient loans since 1992, has 150,000 patients on credit at any one time at scores of hospitals, CEO Bruce Haupt said.

HealthFirst, whose customers include Trinity Health, has $71 million in patient loans at any one time at about 220 hospitals, physician offices and ambulatory surgery centers, said KaLynn Gates, the company's president.

Vancleave said Mosaic enlisted ClearBalance to recover more of the out-of-pocket costs owed by patients and offer them a financing option.

Vancleave, who joined Mosaic a year ago after years at revenue-cycle giant Conifer Health Solutions, said the small-town hospital had tried a previous payment plan for patients. But it could only collect 20% to 30% of what patients owed. That was because of the hassle of sending out monthly bills and the difficulty of employees trying to collect from their neighbors.

"We win all kinds of awards for patient quality, but our revenue cycle didn't match that performance."

Deborah Vancleave
Vice president of revenue cycle
Mosaic Life Care

Since outsourcing the job to ClearBalance, the hospital has already received a seven-figure check from ClearBalance for outstanding out-of-pocket bills, Vancleave said.

Both ClearBalance and HealthFirst are "recourse" lenders, which means they pay the hospital upfront for the outstanding bills of patients who sign up for a loan.

But the hospital guarantees the money and repays the lender if patients default on their credit lines. The finance companies make their profit by getting a 10% to 15% fee for the outstanding amount of the loan.

Vancleave said the fee is worth the much higher rate of recovery that the hospital has gotten on out-of-pocket receivables.

Hospital and vendor executives at the HFMA conference said the strains from high-deductible plans are ballooning.

In 2016, for the first time, more than half of all workers (51%) with single coverage faced a deductible of at least $1,000, according to a study released last September by the Kaiser Family Foundation/Health Research & Educational Trust.

The study showed that 29% of workers were in high-deductible plans compared with 20% two years earlier.

Hospitals are struggling to collect the increased patient share of the cost, according to Crowe Revenue Cycle An-

THE TAKEAWAY

Losses from self-pay patients have hospitals scrambling to better manage patient registration and bill collections.

alytics, a unit of accounting and consulting giant Crowe Horwath.

Data derived from about 660 hospitals show overall managed-care net revenue has declined 2.5% for outpatients and 1.4% for inpatients based on unchanged contract rates over the past year. The cause was lower collection rates for "patient responsibility" dollars than for payer responsibility dollars.

About five years ago, insurers paid about 90% of hospital claims, with patients responsible for about 10%, said Jase DuRard, chief revenue officer for revenue-cycle vendor AccuReg. Today, the mix is 70% by insurers and 30% patient out-of-pocket, he said.

It's crucial in that environment to provide patients with as much information as possible upfront, before their procedures, said David Muhs, chief financial officer at Henry County Health Center in Mount Pleasant, Iowa.

The 25-bed critical-access hospital

In the past five years, health insurers went from paying 90% of patient-care costs to only about 70%, and that's causing massive headaches for providers.

uses RelayHealth revenue-cycle software from Change Healthcare to give patients a solid cost estimate of their out-of-pocket costs, often in a phone call before their care is even delivered, Muhs said.

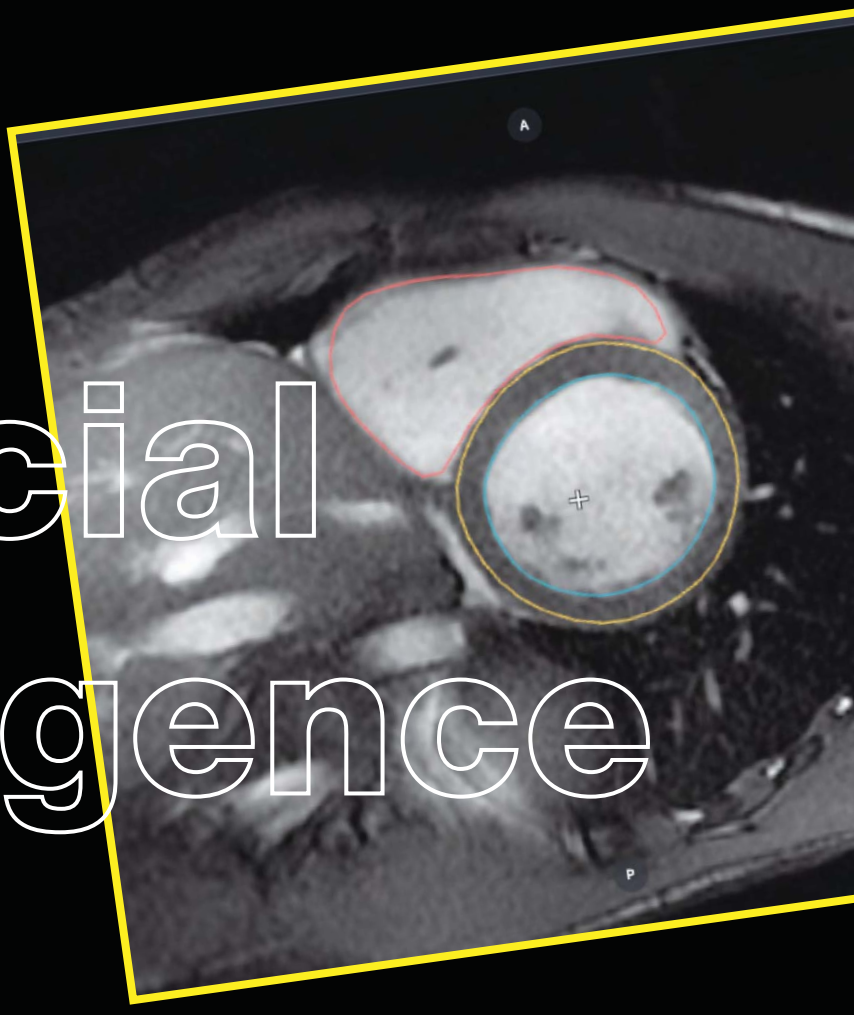
That transparency allows them to concentrate on their care or that of a loved one when it's time for treatment rather than hitting them with a big bill afterward, he said.

Vancleave said Mosaic recently turned to AccuReg tools to button down the accuracy of information the hospital gets at registration and help the hospital determine whether individual patients can afford to pay for care, should be signed up for Medicaid, or should go straight to a charity write-off.

She said pursuing collection from people who can't pay just causes them unnecessary angst and hurts the hospital's public perception and patient-satisfaction scores.

Revenue cycle staff "are the first point of contact with a patient and the last point of contact," Vancleave said. "That's important to keep in mind." ●

Artificial intelligence



By Rachel Z. Arndt

Radiologists look at a new image every three to four seconds during an eight-hour workday. That's hardly enough time to find the patterns, abnormalities and other markers essential in making a diagnosis. Hospitals are hoping to lessen that load by outsourcing some of that work—not to people across the ocean, but rather to machines.

These computers, running artificial intelligence and machine-learning algorithms, are trained to find patterns in images and identify specific anatomical markers. But they also go deeper and spot details the human eye can't catch. Early versions of these algorithms, currently in trials, are both accurate and fast.

Though hospitals are welcoming robotic overlords, radiologists need not worry about their jobs—at least not yet. After all, people are still necessary to read the information the machines produce and make sense of the data.

What's more, it's still the early days for artificial intelligence in imaging, and though the technology is promising—potentially lowering costs, improving quality and making providers more efficient and effective—there are significant hurdles to overcome.

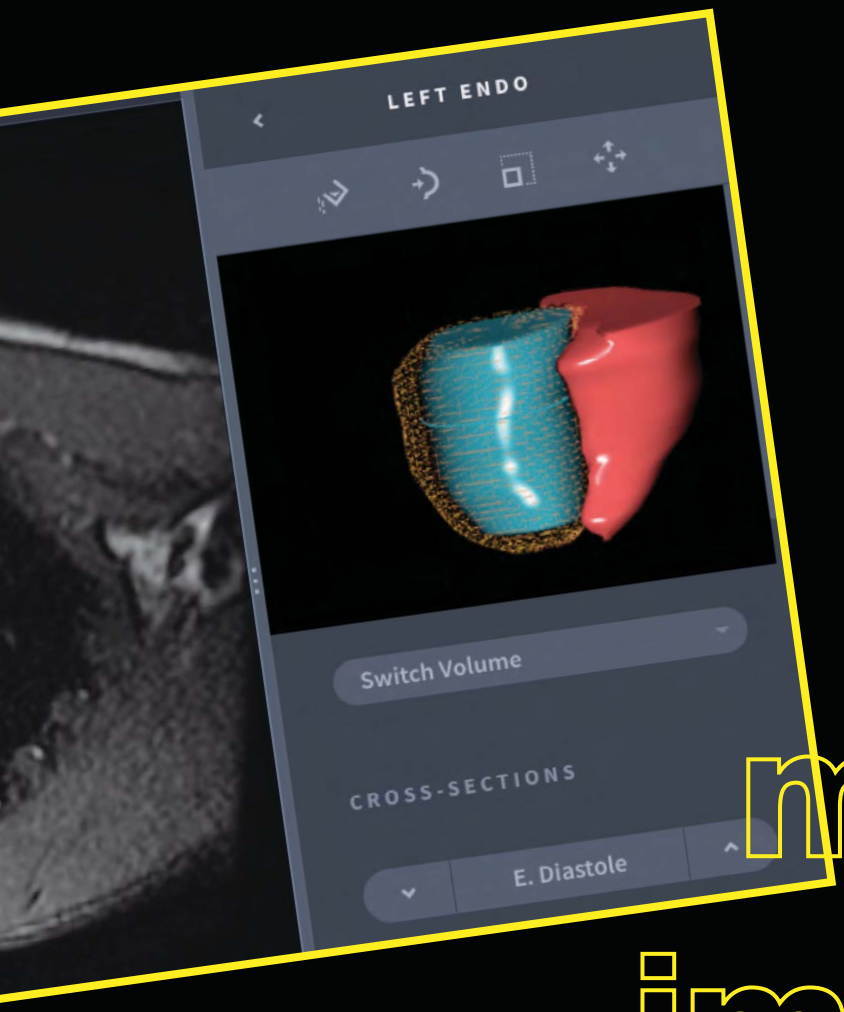
"We'll see our jobs changing slowly," said Dr. Keith Dryer, vice chairman of radiology at Massachusetts General Hospital, Boston. "If you look 10 or 25 years from now at what a radiologist is doing, it'll probably be dramatically different."

Indeed, just as the advent of digital imaging and communications in medicine—DICOM—drove transformation in the field decades ago, so could algorithms driven by big data once the kinks are worked out.

THE TAKEAWAY

Big data analytics in imaging could lower costs and improve efficiency, but first it must get past some roadblocks.

As radiologists do, artificial intelligence learns as it goes. In fact, learning is how it gets started in the first place. To "train" an algorithm to recognize, for instance, a stroke, developers feed it imaging studies of a brain suffering from an attack, teaching the machine the nuances



takes on medical imaging

that make pattern recognition possible. Then, as the algorithm goes into action in the real world, acting on what it has already been trained to do, it can gain new information from new images, learning even more in a perpetual feedback loop.

For instance, Arterys' cardiac MRI automates the most tedious steps in cardiac analysis, drawing on what it has learned from thousands of examples and applying deep learning algorithms. This kind of automation "frees up a lot of physician time and brings a huge amount of consistency to imaging and tracking changes over time in a patient," said Carla Leibowitz, Arterys' head of strategy and marketing. The browser-based software is in use at 40 sites around the world, including the University of California at San Diego and Fairfax (Va.) Radiological Consultants.

Like Arterys, Zebra Medical Vision relies on a vast supply of medical case data to train its algorithms so radiologists can find what they're looking for—and what they don't yet know they're looking for—more accurately, more quickly and more consistently. "That's a win for everyone," said Elad Benjamin, co-founder and CEO of Zebra Medical. "Radiologists are able to deliver better care at lower costs, and patients get the benefit of improved diagnoses."

Above: Usually images of the heart's ventricle surfaces, shown at right, are generated manually. Arterys can generate them automatically with a deep learning algorithm that identifies the contours of the ventricle surfaces on each slice of the study, seen on the left.

Zebra Medical's algorithms draw on one of the largest databases of anonymized medical imaging data—millions of patient records and their associated radiology reports. Each of Zebra Medical's algorithms is dedicated to a particular finding, such as emphysema in the lungs. The company has partnered with Intermountain Healthcare, which will use these algorithms for population health. The Salt Lake City-based health system has conducted a preliminary validation of the algorithm and is currently running more assessments. Once the technology is further devel-

oped, Intermountain hopes to use it to prevent excess hospitalizations by giving special treatment to those patients most at risk of a health problem.

Using AI for clinical decisionmaking depends in part on how the information is presented. "AI provides information in discrete answers to questions," said Dr. Keith White, medical director of imaging services at Intermountain. "It's interesting that AI and this kind of output corresponds to a change that radiologist leaders are already trying to work toward—which is to transform radiology away from being a narrative, prose-based dictation system into being discrete data and answers."

Getting the technology into hospitals isn't just a matter of having mature, capable technology. There are regulatory roadblocks, clinicians must be trained how to use AI, and it has to be integrated into the workflow.

Getting AI through the Food and Drug Administration's regulatory process is the first order of business. According to some, the FDA hasn't caught up with how AI works. The agency's draft guidance on software changes, released in 2016, calls for re-approval of some medical devices—including those running algorithms—every time they change significantly. That's particularly burdensome for AI, since changing quickly is at the very heart of what learning algorithms are supposed to do.

FDA regulation "is quite burdensome today," Leibowitz said, "and sometimes it's confusing and adds huge chunks of time to our development timeline." But she and others recognize that regulation is necessary if anyone's going to trust these algorithms in the first place.

Getting an algorithm certified is just the first step. It then has to be integrated into existing systems. Because AI usually produces discrete data elements, as Intermountain's White said, it's theoretically possible to bring those data elements smoothly into workflows. Ideally, AI will run on a case automatically, producing discrete assessments that the radiologist can validate and add to, which are then pulled into the electronic health record, where downstream providers can act accordingly.

"If we put more structured information into the EHR, it can follow the patient more consistently, as opposed to how we do it today, where we create a report," Dryer said.

But theory is often neater than practice, and some worry about how the output from AI will actually fit into the workflow, not to mention the EHRs themselves. "We need to ensure that there's interoperability," said Dr. Bibb Allen, chief medical officer of the American College of Radiology's Data Science Institute. Much as the industry created the DICOM standard to ensure that medical images were interoperable, it'll need to create standardized use cases with common data elements for AI.

One potential problem is how the algorithms are initially trained. Sometimes, the data they're fed in the learning process come from just one specific model of imaging machine. Because different models have different radiation doses and slightly different technologies, "you've got an inherent bias that's built in," said Steve Tolle, vice president and chief strategist of IBM's Watson Health Imaging.

To help avoid that bias, IBM is using a collaborative approach, working with 20 health systems to use images from many different sources to develop its Watson cognitive platforms, which one day, Tolle said, will be able to perform image analytics.

> **"It's an opportunity for radiologists to expand their role. There could be a way to push patients with emergent disease to the forefront of our work list. Radiologists have an opportunity to become managers of information that might go beyond just what we see in the images."**
>
> Carla Leibowitz
> Head of strategy and marketing
> Arterys

Even when the technology is strong, doctors may still be reticent to use it. "A real challenge is physician acceptance," Tolle said. "We believe you must have transparency so a doctor knows how a machine is driving toward a conclusion or recommendation. Doctors need to understand the science."

Once they do, they'll be more likely to accept the technology as a tool they can use with confidence, and not fear it as something that may replace them.

"We don't think this is going to replace the physician at all," said Arterys' Leibowitz. "The physician does a lot more than look for patterns and connect the dots."

Allen sees the technology as a way to allow radiologists to do more.

"It's an opportunity for radiologists to expand their role," he said. "There could be a way to push patients with emergent disease to the forefront of our work list. Radiologists have an opportunity to become managers of information that might go beyond just what we see in the images."

To facilitate that, the American College of Radiology established the Data Science Institute to work on the snags that could halt AI in its tracks: verification of algorithms, integration into workflows, FDA regulations and use cases.

It'll be awhile before all those areas are figured out, Allen admitted. But the potential—for population health, for precision medicine, for quality in general—points to the even broader potential to use AI not just for imaging but across the industry, making clinicians more effective and efficient, thereby lowering costs and improving quality for patients. ●

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Please join us as we celebrate Mr. Lipstein's outstanding leadership and lifetime commitment to improving healthcare at the annual **Gail L. Warden Leadership Excellence Award** dinner on November 14, 2017.

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Scrambling for innovative ways to stop opioid overdose deaths

By Steven Ross Johnson

AP PHOTO

A Manchester fire station helped place Madisen Peterson, left, a heroin user who has been clean for over four months, in recovery at Serenity Place, where he also volunteers.

June was another rough month in Manchester, N.H. Over the course of 30 days, there were 99 suspected opioid overdoses, six of which were fatal. That's the most overdoses in a month so far in 2017, according to Christopher Stawasz, regional director of emergency medical services provider American Medical Response.

It's the continuation of a dangerous trend for any city, let alone one with a total population of 110,000. From January to July 4, there were 419 suspected opioid overdoses, compared with roughly 400 for the same period last year. And for all of 2016, there were 787 suspected overdoses, 90 of which were deadly, according a report issued by Mayor Theodore Gatsas.

Similar to their counterparts in Colorado, Ohio and Washington—or anywhere in the nation, for that matter—public health leaders in Manchester are searching for any innovative intervention that can help turn the tide. They may have found one.

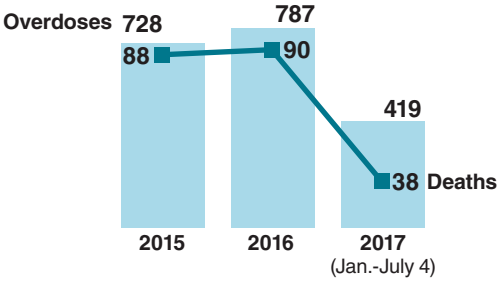
Last April, after a paramedic helped a colleague's relative get treatment for his addiction, the city launched the Safe Station program. Now, all 10 of Manchester's firehouses are a safe haven where people struggling with addiction can seek assistance. Paramedics are available 24 hours a day, 7 days a week, to conduct a full medical evaluation before transporting the patient to a local hospital's emergency department or a treatment facility.

The process takes less than 15 minutes, Stawasz said. That's compared to the weeks or even months it sometimes takes to get treatment. A recent New England Journal of Medicine study showed that only 21% of people addicted to opioids in the U.S. received any treatment between 2009 and 2013.

"You've got a very small window of time when people are willing to go for that help," Stawasz said. "The beauty of this program is that it captures them when they are most willing to get the help, and it gives it to them very quickly."

From May 2016 to June 2017, more than 1,800 people sought help through Safe Station. All of them went to either an emergency room or treatment facility. There is no threat of arrest or judgment, according to those running the program. The program has been credited with reducing the number of emergency calls due to overdose by 30%, according to Stawasz.

Suspected opioid overdoses
Manchester, N.H.



Source: American Medical Response

It's been so successful that the seven fire stations in Nashua, N.H., adopted the program last November. Nashua has its fair share of problems, too: 31 opioid overdoses resulting in four deaths in June and a 28% jump in suspected opioid overdose deaths from January to June. From November through June, 576 people used the Nashua Safe Station program.

Both cities have partnered with Harbor Homes, a not-for-profit provider of primary and behavioral healthcare and supportive services, to expedite moving Safe Station patients into rehab.

On the other side of the country in northwest Washington state, public health officials are taking an equally unorthodox approach to combating an opioid crisis.

"In this epidemic that's spiraling out of control, we should take advantage of every tool that we possibly can," said Dr. Jeff Duchin, public health officer for King County, Wash.

Last year, Duchin co-chaired a task force created by Seattle Mayor Ed Murray to address the opioid epidemic. One controversial recommendation was to set up sites where drug users, under supervision of a health professional, could inject illegal drugs. The idea is to not only monitor the addict, thus lowering the risk of an overdose, but also connect them with

Continued on page 23 >

THE TAKEAWAY

Public health leaders are searching for any—and every—innovative intervention in hopes of making a dent in the opioid epidemic.

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An old treatment becomes new again. But does it really work?

By Steven Ross Johnson

High Sobriety, a recovery treatment center in Los Angeles, offers patients daily doses of medicinal cannabis as a means of weaning them off opioids.

Joe Schrank, the facility's founder and program director, said the harsh effects of withdrawal often cause addicts to avoid going clean. That's where the often controversial use of cannabis can help, he added.

"Using medical cannabis can be really helpful for all the things that people experience when they go through detox, whether it's insomnia, bone pain or flu-type symptoms," he said.

But opponents say the practice switches out one addiction for another and that the efficacy of using cannabis to treat opioid addiction hasn't been thoroughly researched.

"To me, it's a massive improvement if they're switching from a drug that could kill them to a drug that cannot kill them," Schrank countered.

Currently, 29 states have passed laws allowing the use of cannabis to treat a host of medical conditions despite its designation as an illegal drug by the federal government and the fact that the Food and Drug Administration hasn't approved it for medical use. Mostly, cannabis is used to treat nausea in cancer patients undergoing chemotherapy. States have also approved it to induce appetite in HIV/AIDS patients, as well as to alleviate the effects caused by multiple sclerosis, Parkinson's disease, Crohn's disease, glaucoma and epilepsy.

No state has approved cannabis for the treatment of opioid addiction, and recent proposals in Maryland and New Mexico were ultimately rejected due to a lack of evidence that it works. Marijuana, however, has a relatively long history in being used to treat opioid addiction.

When it first entered the official drug compound and use directory of the U.S. in 1850, cannabis was listed as a treatment for opiate addiction. Back then, marijuana could be purchased as an over-the-counter remedy.

Ironically, it was the increased popularity of opiate-based medicines in the early 1900s that caused a decline of cannabis for medical use until the drug was eventually removed from the U.S. Pharmacopoeia in 1941.

Since then, a tight regulatory framework has made it harder to prescribe cannabis for medical purposes or to conduct research on the plant.

When cannabis was classified as a Schedule 1 drug under the Controlled Substance Act of 1970, the plant was flagged for its high potential for abuse and was listed as having no medical purpose.

"To me, it's a massive improvement if they're switching from a drug that could kill them to a drug that cannot kill them."

Joe Schrank
Founder and program director
High Sobriety

"This is the catch-22," said Yasmin Hurd, professor of neuroscience, psychiatry and pharmacological sciences at the Icahn School of Medicine at Mount Sinai Health System in New York City. "The reason why we have all of these people thinking that marijuana may be beneficial for this or that is because there is not enough science out there to help guide us."

Hurd examines the effects of cannabidiol, a compound found in cannabis that could help relieve symptoms of heroin withdrawal while working to impede the desire to get high.

But she admits there are a lot of open questions on how to use the treatment.

"The clinicians who are prescribing medical marijuana for their patients don't actually know which formulations or which dosing or so on to give for specific symptoms and disorders," Hurd said. "We are relying on anecdotal information from people using the drug to give us scientists and clinicians insights about it."

Dr. Matthew Roman, founder of Nature's Way Medicine, a primary-care clinic in Delaware, began using cannabis as a treatment in 2015.

"I've found in my experience now that patients really get a lot of benefit from this new alternative," he said.

Admittedly, there are variances in how practitioners use it.

Schrank encourages clients to take cannabis in edible or vapor forms over smoking in order to better control dosage. Roman said half of his patients choose to smoke it and half opt to vape through electronic cigarettes.

"A lot of it is based on lifestyle with this treatment when it comes to form of use rather than what works better," Roman said. "I think a lot of the people who are most affected by the opioid epidemic are becoming more open to marijuana because they see it as a gateway out of the opioid epidemic." ●

More than **52,000** **people died** from a drug overdose in 2015.

Since 2000, more than **300,000** **Americans have died** from an opioid overdose.

16 **states had increases** in synthetic opioid death rates from 2014 to 2015.

Source: Centers for Disease Control and Prevention

< *Continued from page 20*

treatment when they are ready. The site would also provide sterile needles to reduce the spread of infectious diseases such as HIV or hepatitis through shared needles. About 100 such sites currently operate in more than 60 cities worldwide.

Federal and state laws prohibit safe injections sites in the U.S., but some cities are considering them and the American Medical Association's House of Delegates in June voted to endorse some safe site pilot programs.

The Massachusetts Medical Society is also supportive. MMS President Dr. Henry Dorkin said safe injection sites have worked in other countries. The organization began examining applying the same approach in the U.S. after other more widely accepted actions such as needle exchanges and naloxone failed to reverse the rising number of overdose deaths. City leaders in Philadelphia, San Francisco and Ithaca, N.Y., have all proposed them—while raising concerns over the perceived acceptance of illegal behavior.

Studies of sites in Australia, Germany and the Netherlands show reductions in overdoses, crime and risky behaviors.

"There is still this fundamental, ingrained thought that it's just something about the person and it's not an illness," said Dr. Michal Frost, director of internal medicine at the Horsham Clinic, a behavioral health facility in Ambler, Pa. He believes that's stifled innovation.

Indeed, the last new opioid addiction treatment approved by the Food and Drug Administration was buprenorphine in 2002. The drug had been on market since 1981 when it was first used as a pain-relieving replacement for morphine. Naltrexone has been approved as a treatment for heroin since 1984, and methadone has been in use since the late 1940s.

Most new medications are simply a variation in the way buprenorphine, naltrexone, naloxone or some combination of those compounds are delivered.

Patient advocates hope that President Donald Trump's policies will cut regulations that tie doctors' hands in treating addiction and support new ways to make maintenance treatment more accessible. Thus far, the administration's most visible step has been creating a panel tasked with evaluating new and proven options. The commission missed its deadline to submit an initial report recommending federal approaches that can be taken to combat the opioid epidemic. ●

How to keep payment reform moving ahead

MERRILL GOOZNER *Editor Emeritus*

The only silver lining in the massive storm cloud hovering over the Affordable Care Act is the persistence of bipartisan support for payment reforms aimed at improving healthcare quality and lowering its cost.

While HHS Secretary Dr. Tom Price has temporarily postponed expanding the bundled-payment program, the House-passed American Health Care Act left intact all the delivery system reforms contained in the 2010 landmark ACA legislation, including funding for the Center for Medicare and Medicaid Innovation. The first version of the Senate bill did the same.

But that doesn't mean the CMS is proceeding smoothly toward value-based reimbursement. A new Government Accountability Office report found serious problems with Medicare's value-based purchasing program, which rewards or penalizes hospitals based on a suite of quality and efficiency measures.

Moreover, the constant attacks on the ACA may be slowing forward momentum. It's easier for career officials at the CMS to hunker down than to proceed aggressively toward achieving the Obama administration's goal of having 50% of Medicare payments in alternative payment models—either accountable care organizations or some form of bundled payments—by the end of 2018.

The evidence that is occurring on CMS Administrator Seema Verma's watch can be found in the latest draft rule governing implementation of the physician payment reforms in the bipartisan Medicare Access and CHIP Reauthorization Act. Fewer small practices will be subject to reporting the quality measures

The CMS may be right that the 37% of physicians who account for 65% of all Medicare payments will be governed by MACRA's new Merit-based Incentive Payment System rules. But that still leaves nearly two-thirds of the nation's physicians outside its core quality reporting system.

Until doctors take that first baby step, there's no way they will ever be ready to graduate into the risk-based contracting contained in alternative payment models such as ACOs.

Smaller practices and hospitals obviously have fewer resources to keep track of an ever-changing array of quality measures. That's why the CMS must limit its data reporting to measures that clearly help organizations and physicians improve quality and lower costs.

The GAO report on the hospital value-based purchasing program, which tracked performance by about 3,000 hospitals over the five years the program has been in effect, reveals what can happen when there are too many quality measures.

The report documents how the CMS heard the criticism that too many of its early measures focused on clinical processes, not on patient outcomes. For 2017, hospitals were scored on just three process measures, down from a dozen in 2013. On the other hand, the CMS added 10 outcomes measures, leaving the total about the same.

But hospitals don't have to report on all the measures. Moreover, they get to choose which measures they will report once they've hit the threshold for participation, and their scores in the missing categories are determined by their average score. No wonder smaller rural and urban hospitals, which report less data, do better under the program than safety net or large hospitals.

In 2015, the CMS added a single efficiency measure based on hospital's overall cost per beneficiary, and gave it a 25% weight for the final score. It's important to reward low-cost providers.

But that single factor enabled about 20% of lower-cost hospitals whose quality scores were below the median to jump into the group receiving rewards from the program, which redistributes up to 2% of Medicare reimbursement from poor performers to better ones.

Provider groups continue to pound on the CMS for requiring too many quality indicators. If it's going to maintain political and provider support for the evolution toward value-based reimbursement, the agency in its final rules published later this year must streamline quality reporting requirements and offer a clear rationale for every measure used in its payment reform programs. ●

Instead of improving healthcare coverage, Senate bill would take us back to square one

By Dr. Rod Hochman

I always considered the Affordable Care Act to be more about health insurance reform than healthcare delivery reform. While far from perfect, it has expanded coverage to millions of Americans who were previously unable to afford health insurance.

It also protects individuals with pre-existing conditions and ensures that every health plan offers consistent essential benefits.

Seven years later, I thought the national debate would finally shift from how we pay for healthcare to how we deliver it. By now, I thought the conversation would be about making Americans the healthiest people in the world and developing a healthcare system that's affordable, high quality and convenient for everyone.

Instead, we're back to square one. Rather than talking about how to advance the U.S. healthcare system, our nation's political leaders are talking about taking it backwards. The Senate Republicans' Better Care and Reconciliation Act is essentially a tax plan, not a healthcare plan. It proposes cutting taxes for the wealthiest Americans by taking $772 billion out of Medicaid over 10 years. This means 22 million individuals would lose health coverage, according to an analysis by the Congressional Budget Office.

The proposal does not just roll back the ACA, it takes us all the way back to pre-1965 when Medicaid first began. In other words, the bill would eviscerate Medicaid.

As a nation, demographics indicate our population is getting older and poorer. We need to protect the health of these individuals, and Medicaid is a vital safety net that plays that role. Nearly all of us have loved ones or know someone who depends on Medicaid for their healthcare.

Dr. Rod Hochman is president and CEO of Providence St. Joseph Health.

Medicaid supports 65% of all seniors in nursing homes. These are our parents and grandparents. The proposed "caps" don't adjust for aging populations, which means the oldest, most-vulnerable members of society would be hardest hit.

In addition, 50% of all births are covered by Medicaid. Imagine if these newborns didn't have access to care. That would have a profound effect on their long-term health. If children don't have good care from the get-go, their cost of care becomes more expensive over time, and their ability to function fully in society could be compromised.

Medicaid is also a lifeline for other vulnerable populations, including working people who don't have the option of employer-sponsored health benefits and don't make enough money to afford private insurance. Pulling the rug out from under millions of individuals—many who now have coverage and care for the first time—is not the answer.

Rolling back Medicaid also means a significant loss of coverage for mental health and substance abuse treatment. The opioid crisis alone is sweeping the nation, warranting a state of emergency. We are at a point where 23 veterans a day are committing suicide, and 39% of all disease burden is related to some form of mental illness. Medicaid is our nation's largest payer of mental health services. It's a travesty to consider cutting back coverage for mental health at a time when it is more urgent than ever.

Medicaid certainly has its flaws, and there is more that we can do on the provider side to improve the way we care for this population. For example, expanding access to primary care for Medicaid enrollees is one way we can identify health issues early and avoid more serious, costly care down the road. Likewise, offering better, more-coordinated mental health resources is also critical to creating healthier communities while lowering overall costs in the long run.

I would much rather be talking about innovative solutions for improving Medicaid instead of dismantling it. If the leaders of our Congress would work together on a bill that aimed to make our health system better, I believe many Americans would welcome the collaboration and find it refreshing. It's time to change the conversation and work toward real solutions, together. ●

Interested in submitting a Guest Expert op-ed?
View guidelines at **modernhealthcare.com/op-ed.**
Send drafts to Assistant Managing Editor David May at dmay@modernhealthcare.com.

Returning autonomy to states can fix what ails the ACA

Regarding the recent article "Cruz insurance proposal underscores trouble with protecting pre-existing conditions" (ModernHealthcare.com, June 30), Cruz is attempting to give autonomy back to the states. As a licensed insurance agent who has helped people for 14 years in nearly half the states, I salute him for striving to fulfill the promise made to repeal the Affordable Care Act and restore the marketplace that people once enjoyed.

States had full autonomy over their private markets before the ACA decimated it. If the ACA is repealed, it merely removes the layer of federal regulation that caused rates to skyrocket and carriers to leave the market. The state regulations remain.

The majority of states could repair their markets by inviting the carriers back. They would be free to offer lots of plan designs with low-priced options that folks could afford. In those states, anyone who delayed purchasing a plan in the private market until they developed an expensive condition would likely pay more for a plan, but the premium would be capped. No mandates, fines nor open enrollment period would be necessary.

In a few states whose laws mirror the ACA, they will continue to have high premiums, but they could adopt state regulations that offer more affordable choices.

Americans don't want the federal government dictating the type of plan they must have that doubles and even triples their premiums for features they don't want while eliminating their healthy discount in the name of "protection." The ACA is a failure and state autonomy can fix it.

Beverly Gossage
President
HSA Benefits Consulting
Eudora, Kan.

Meet the editor at our Women Leaders conference

Chat with Aurora Aguilar, editor of Modern Healthcare, during lunch on July 19 at Modern Healthcare's Women Leaders in Healthcare Conference in Nashville. Register at **ModernHealthcare.com/WomenLeaders.**

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best practices

No spoiled milk in this NICU

By Maria Castellucci

In neonatal intensive-care units, one of the most risky and detail-oriented tasks for nurses is feeding vulnerable babies. Nurses must be meticulous to ensure the babies don't receive the wrong mother's milk or expired formula.

A mistake can be life-threatening for babies who are already are already fragile, especially if the milk contains infectious agents or is spoiled. There is also an emotional toll on families if their infant receives another mother's milk. That kind of error can break down the trust between distressed families and the NICU care team.

"Parents don't need an added worry," said Dr. Christine Bixby, medical director of lactation services at Children's Hospital of Orange County in California.

So when the hospital experienced 45 breast milk handling mistakes from 2010 to 2012, Bixby said the staff was motivated to overhaul the process.

The hospital began making changes in January 2013 when it repurposed a nutrition lab to be used solely for the preparation of breast milk and formula.

Six dietetic technicians were deployed to work in the lab. With access to electronic health records, the technicians mixed all the milk a patient needed in a 12-hour period, following doctors' orders. While one technician prepared the milk, another observed to double-check their work. Labels were then printed with the patient's name and the milk order so nurses could verify the bottle is going to the right baby. On average, the technicians prepared 400 feedings per day.

The use of the dietetic technicians was highly successful, with the hospital reporting a 74% decrease in potential errors for breast milk handling.

Things didn't stop there. A bar code system was implemented in November 2013.

STRATEGIES

Deploy dietetic technicians to mix formula and breast milk in a designated area.

Use a bar code scanning system to streamline the milk administration process.

Ensure nurses and technicians have access to the physician's milk order within the electronic health record.

All babies in the NICU receive a wristband with a bar code that is scanned by nurses to generate a label. The label includes the baby's name as well as the physician's milk order. Physicians' orders from the EHR interface with the bar code scanning system to make the connection. That label is printed and placed on a feeding bottle, which is given to the mother. The mother handwrites the date and time the milk was pumped. The bottle is then given to the nurse, who double-checks that the label was filled out correctly by the right mother and places it in a refrigerator in the NICU.

Dietetic technicians come to the unit roughly four times a day to pick up the milk and bring it back to the nutrition lab for mixing. In the lab, the technicians scan the bar code on the bottle where the physician's order is displayed on a computer screen. About two to four technicians are preparing feedings at a given time, but they no longer have to double-check each other's work. The scanning system verifies that every bottle scanned belongs to the correct infant and the fortifiers added match the doctor's order in the EHR, Bixby said.

After the milk is mixed, the technician delivers the labeled bottle back to the NICU.

Once the nurses or the mothers are ready to feed a baby, they scan both the bar codes on the bottle and on the baby's wrist. The scanner analyzes both bar codes to ensure they match. If they do, a green pop-up box on the scanner screen informs the nurse that the right bottle is going to the right baby. If it doesn't match, a red light pops up on the scanner warning that there is an error.

The initiative continues to drive improvements. The 45 breast milk handling mistakes the hospital experienced in a two-year period has now declined to almost zero. The scanning system has saved the hospital an average of $30,000 a year because additional technicians are no longer needed to verify each other's work.

NICU nurses have also benefited by having more time to spend with infants and mothers. The unit administers more than 10,000 breast milk feedings per month and one nurse handles breast milk at least 12 times per shift. Before the technicians were deployed, NICU nurses could easily get overwhelmed as they tried to both properly mix and administer feedings to the babies while caring for their other health needs, Bixby said.

Now nurses have an additional hour of time to spend with the babies and their parents because they no longer have to mix milk and formula. "It freed the nurses up to talk to mothers about the importance of breast milk, regular pumping and skin-to-skin contact with their baby," Bixby said.

data points

Growth in generics doing little to curb drug prices

The exorbitant cost of prescription drugs continues to be one of the biggest drains on the healthcare system. The Food and Drug Administration in June took steps to increase competition by posting a list of branded drugs that are not protected by a patent and are not facing looming generic drug rivals. The agency will fast-track its review of generic drug applications.

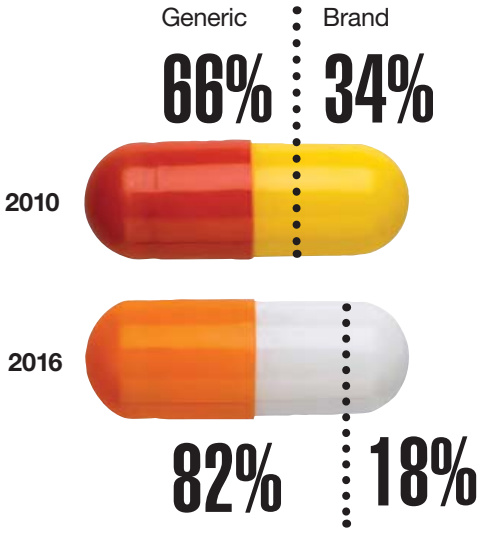
10%

Prescription drugs' share of U.S. healthcare spending

—CMS

While generics account for the vast majority of prescriptions, brand-name drugs eat up the lion's share of the cost.

Share of utilization



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Specialty drugs with long waits for generic competition

Harvoni	(hepatits C)	15 years
Sovaldi	(hepatits C)	> 10 years
Tecfidera	(multiple sclerosis)	6-9 years
Stelara	(plaque psoriasis)	6-9 years

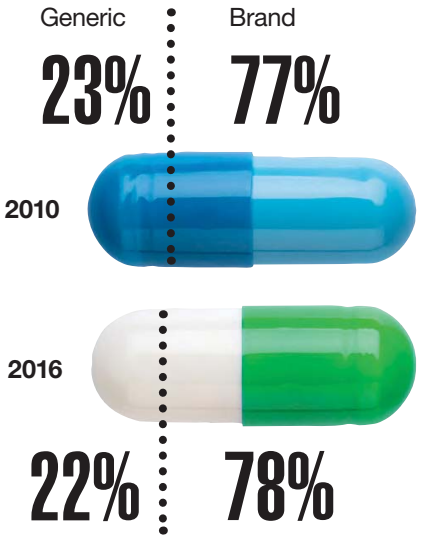
—The Health America Report, Blue Cross and Blue Shield Association, May 2017

59%

Drop in generic drug prices from 2010 to 2015 in Medicare Part D

—Government Accountability Office

Share of total spending



—The Health America Report, Blue Cross and Blue Shield, May 2017

Q&A

"First, the resources need to be there, and the coverage needs to be there."

'We are going to work hard to educate senators about exactly what is at stake here'

Dr. Bruce Siegel worries that efforts to repeal and replace the Affordable Care Act will not only leave millions of Americans uninsured, but also severely hamper efforts to advance population health. The president of America's Essential Hospitals, a trade group representing nearly 300 safety-net providers, is also concerned about what kind of trades Senate leaders may have to make to get a bill passed. Siegel visited with Modern Healthcare's editorial team in late June, a week before an initial vote on the Senate bill was delayed. The following is an edited transcript.

Modern Healthcare: You've expressed major concerns with the approach House and Senate leaders are taking with their healthcare bills. Are they listening? Do you get the sense that provider groups are being heard?

Dr. Bruce Siegel: There are hints of traction and we are hearing some senators raise concerns. Frankly, we are surprised we aren't hearing more. Senate Majority Leader Mitch McConnell is a very smart strategist. I don't agree with the policy, but I understand the politics of what he's trying to do.

We are concerned that there will be tradeoffs to try to get votes, like, "We'll put money into opioid prevention, just let us roll back Medicaid expansion."

That is a deal that could get offered, and we are concerned that we'll lose sight of the big picture.

A question for me would be: Is Sen. Jeff Flake going to vote to have 400,000 Arizonians lose health coverage? I hope not. I hope he won't vote to take $2.5 billion a year out of the Arizona economy.

These are significant impacts, and we are going to work hard to educate senators about exactly what is at stake here.

MH: What would a trade-off for the opioid crisis look like?

Siegel: I'm speculating, but there's a lot of talk about that now. I am all for putting resources into opioid prevention. Let's be clear about that, but taking 22 million people who are at higher risk of addiction, mental health, all those things, and removing them from the insurance system is not a recipe for combating opioids. That coverage needs to be a basic threshold, otherwise those people can't be assured that they'll have some access to the mental health or addiction services they need. I'm concerned that we'll be penny-wise and pound-foolish to think we're going to solve the opioid crisis with some targeted funding, but really have kicked the foundation of coverage out from under these people.

MH: Even some kind of funding package might not go toward such things as medication-assisted treatment. Do you have a long-term strategy to try and combat the opioid epidemic?

Siegel: First, the resources need to be there, and the coverage needs to be there.

From our point of view, our job is to figure out models out there that really work and spread them in our membership. We're going to spend time over the next six to nine months both in terms

of educational sessions and meetings to get that information out there because there are a lot of bright spots around opioid treatment and prevention. That technology transfer isn't happening as fast as it should happen nationally, and I think we're not alone as an association that is worried about that.

MH: What efforts are the association and its members making in terms of population health?

Siegel: There's a lot of confusion in the area of population health and a lot of different language being used loosely, and that's to be expected. We are focusing on the social determinants of health. Many times, talk around population health is about better care management, ACO models and the like; we're all for that, but our focus is going to be very much on social determinants because that's a space where we can make a difference.

When we surveyed our members, we have found strong interest in a couple of areas very specifically. Housing is one of them, food deserts, and then—this is a little harder to define—changing behaviors. Housing and food insecurity come up again and again. And when I talk about housing, some people look at it as supportive housing for those at risk, but a lot of people are just looking at it for housing, period. We cannot have a healthy community if people don't have safe, secure housing.

We have places like Bon Secours in Baltimore using tax credits to build low-income housing. They have done things like the Gibbons Commons development, which brings together housing, retail, job training and outpatient care. It's really quite impressive.

That is a wonderful thing, but a lot of our hospitals are also asking us, "Where do I just start? That's a great vision, but I am just beginning." Some of the things we're going to try to do over the coming months is help our hospitals identify where can they begin. How do they begin to set some priorities out of their community health needs assessment or somewhere else? They need to have some sort of way forward.

MH: What's it like in the boardrooms for your hospitals? Have they started to come along with that way of thinking?

Siegel: Some have. Many have not. I see some boards that are quite motivated to do this and often because there's board leadership, and they are invested in this. Sometimes it is driven by a conversation that goes like this from a hospital in Massachusetts: "We care for a large, low-income community in this population who are on Medicaid who have many social and economic challenges. Massachusetts is moving to a Medicaid ACO model. We are going to be increasingly at risk for the care of these patients, and we want to do a good job. If we can't begin to impact the social determinants, we will fail. We will fail clinically. We will fail financially. If this community continues to use the emergency room at the rates it uses it, if it has readmissions at the rate it has, then under what Massachusetts is now rolling out, we will fail."

MH: How are population efforts and community benefit affected by a healthcare financing policy change that retrenches funding. Does that change your members' trajectory in moving forward with those kinds of initiatives, or do they find a way to do it anyway?

Siegel: I think that they will find a way to do it, but it will be a lot harder. The Congressional Budget Office says 22 million people lose coverage, at least from the House bill. We know millions more people didn't get coverage who should have because not every state expanded Medicaid. So 10% of Americans won't have insurance who could have had insurance otherwise. All the work we're doing around either identifying their opiate problem in a primary-care visit or getting them a prescription or food from the food pantry, all those things that depend on them being in some sort of organized system of care goes away and they're back dependent on an emergency department or just out of luck.

It's going to be very hard to move the ball on population health if you take tens of millions of people and just cut them out of the system. The impacts on equity, the impacts on value will be significant. You start rolling back the expansion funding to these states, you've begun a terrible, distracting debate for years to come over how each state finances healthcare. You begin a debate over whether it even does finance care for these people or it just pulls back.

When all the bandwidth of your state Medicaid director and your state health commissioner and your governor and your legislature is trying to figure out if and how to replace billions in lost federal funding, there is going to be a lot less energy that goes into really moving on population health.

We'll work on it. It's essential to our mission, and I think hospital leaders realize that they can't change the trajectory of health in their community without working on this, but let's be real, there's going to be a battle royal over Medicaid—we're already in one—and that's going to suck a lot of energy out of the room. ●

"It's going to be very hard to move the ball on population health if you take tens of millions of people and just cut them out of the system."

news makers

Murphy to lead Geisinger's new innovation institute

Who: Karen Murphy

New role: Executive vice president, chief innovation officer and founding director of Geisinger Health System's new Steele Institute for Healthcare Innovation. She'll begin in September.

Background: Most recently, Murphy, a registered nurse, was health secretary for the state of Pennsylvania. In that role, she launched the Prescription Drug Monitoring Program to battle the opioid epidemic and put in place the state's medical marijuana program. Earlier, she was director of the CMS' $900 million State Innovation Models Initiative.

Transformation: "Throughout my entire career, I have always focused on transforming healthcare delivery and innovation, and I believe this is a continuation of that work," Murphy said. In her new role, she will lead the Steele Institute's team, working to transform healthcare delivery by improving patient experience, quality, efficiency and outcomes.

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FINDING BALANCE IN THE NEW NORMAL: BRIDGING THE GAP BETWEEN TRADITIONAL AND VALUE-BASED CARE STRATEGIES

1

The regulatory environment for providers is tremendously uncertain and rapidly changing. If providers want to thrive in this new world of value-based care, they need to better understand how clinical and financial data intersect.

Anita Mahon, chief strategy officer for the Value-Based Care Business of IBM Watson Health, and David Jackson, vice president of professional services for Truven Health Analytics, a part of IBM Watson Health, offered data-driven strategies for success during a webinar on June 15. The entire webinar can be accessed at *ModernHealthcare.com/FindingBalance.*

2

Approach your business challenges with a four-step plan

Whether devising a new approach for fee-for-service payments or implementing new programs for value-based care, it's important to conduct a data-rich readiness assessment that identifies your organization's risks and opportunities. Use those insights to create an action plan that prioritizes tasks based upon impact and ease of implementation, and make sure to establish a governance structure to implement that plan. Don't forget to think about how your approach will affect your post-acute network, and make sure to create a strategy for engaging physicians and staff. Finally, it's crucial that you use objective data to continually monitor the program's progress, and benchmark your hospital against peer institutions.

3

A balanced scorecard can help predict the future

This tool can help offer insight into future opportunities by tracking performance in clinical metrics like length of stay and mortality, as well as financial metrics like Medicare spending per beneficiary (MSPB). This can help you benchmark against your competitors and decide where to invest resources. Doing this at the service-line level can help determine whether certain service lines are driving exceptional results and could be identified as centers of excellence.

4

Pending legislation would change the healthcare landscape

The healthcare bill passed by the House and the bill under consideration in the Senate would make significant changes to the U.S. healthcare environment by rolling back Medicaid, changing the way pre-existing conditions are covered and making significant changes to taxes and individual plan subsidies. There will be a massive increase in the nation's uninsured population, even though the expected magnitude of that change is disputed. Providers need to look at their payer mix, state and local laws and other financial data to understand how the bill will affect reimbursement.

The industry is trending toward value-based care, but fee-for-service isn't going away

Experts at IBM Watson Health expect that value-based payment will represent 41% of revenue in 2020, up from 25% in 2016, a projection that is supported by multiple sources. But fee-for-service is still expected to represent 48% of payments. Hospitals can prepare for having their feet in both boats by focusing on performance in repeatable episodes of care while continuing to stick to the basics of cost reduction and quality improvement.

5

Medicare offers a substantial amount of actionable data

Providers looking to impact or understand their MSPB performance should make use of significant data on their facility available from the CMS. Apply groupings to that data: drilling it down to specific diagnostic categories or service lines and applying clinical classifications can help identify variation. Honing in on a specific disease or episode of care can make it easier to identify where variation may lie in the continuum.

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VANDERBILT UNIVERSITY

Grad student Patrick Wellborn with the granular-jamming cap that he helped develop.

Consider this research grounds for improving delicate surgeries

When a team of Vanderbilt University engineers sought a way to improve the reliability of positioning systems used in delicate nose and throat surgeries, coffee was the solution. Coffee grounds, that is.

The engineers designed a "granular jamming cap" filled with coffee grounds. The grounds form a thin layer inside a stretchy silicone cap adorned with reflective dots. Once on the patient's head, the cap is attached to a vacuum pump that sucks the air out, causing the grounds to conform closely to the contours of the patient's scalp.

Before the surgery begins, a scanner maps the precise location of each reflective dot relative to key features on the patient's head. During surgery, an overhead camera observes the position of the dots, allowing the navigation system to accurately track the position of the patient's head as the surgeon moves it. A monitor in the operating room displays the data in combination with a CT scan and the position of the surgeon's instruments for a 3-D view inside the patient's head.

This technology could replace one using markers that are taped to the head. That method is subject to slipping and jarring—movements that can cause large tracking errors during surgery. The coffee grounds approach has been found to reduce targeting errors by 83%.

"It's a very clever way to greatly improve the accuracy of the guidance system when we are operating in the middle of a person's skull: a zone where the accuracy of the current system is inadequate," said Dr. Paul Russell, associate professor of otolaryngology at Vanderbilt.

The cap's key ingredient was thanks to Robert Webster, an associate professor of mechanical engineering and otolaryngology. He remembered reading of experiments that used coffee grounds to help robots grip objects.

The team presented their research at the recent International Conference on Information Processing in Computer-Assisted Interventions. ●

Houston to Goop: We've got a problem

Claiming a product delivers health benefits can be a tricky business. Just ask Gwyneth Paltrow, whose Goop website has a blog post rhapsodizing about a line of "wearable stickers that promote healing."

The stickers, which cost $60 for a 10-pack, are made by Body Vibes, which claims the "smart stickers (are) programmed to deliver natural bio-frequencies to optimize brain and body functions, restore missing cell communication, and accelerate the body's natural ability to heal itself."

Goop gushed: "Body Vibes stickers (made with the same conductive carbon material NASA uses to line space suits so they can monitor an astronaut's vitals during wear) come pre-programmed to an ideal frequency, allowing them to target imbalances."

NASA's response: Huh?

AP PHOTO

Paltrow's Goop site made some spacy claims for a line of wearable stickers.

A NASA representative told Gizmodo that they "do not have any conductive carbon material lining the spacesuits."

And Mark Shelhamer, former chief scientist at NASA's human research division and now an associate professor at Johns Hopkins Medicine, was a bit blunter: "Wow, what a load of B.S. this is. Not only is the whole premise like snake oil, the logic doesn't even hold up. If they promote healing, why do they leave marks on the skin when they are removed?"

He added that NASA "does not line its spacesuits with conductive carbon material" and that its current spacesuit model has no carbon fibers at all.

In response, a Goop representative said, "Based on the statement from NASA, we've gone back to the company to inquire about the claim" and it was removed from Goop's site (although the healing claims remain).

Outliers will let late night host Stephen Colbert have the last word: "Previously if you wanted wearable stickers that promote healing, you had to buy a box of Band-Aids." ●

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