The new Pure Mammography center at the mall in Lake Grove is part of a trend to make health care more convenient.

Medical Arts Radiology with 10 locations on Long Island and a proud member of the Independent Physician Association of Nassau / Suffolk Counties has opened a mammography screening center at the Smith Haven Mall. Mammography, ultrasound and Dexa Scans are performed at this location.

It's the "first" screening site the diagnostic imaging group has opened inside a mall. The center, called Pure Mammography, will operate during regular mall hours, accepts insurances and for those uninsured a screening cost is only $45.00.

"Everyone knows how common breast cancer can be," Barry Morgenstern, Director of Breast Imaging at Medical Arts Radiology. "Breast screening is one of the major medical advances of the last 50 years. Unfortunately, only about 50% of women do this. It's a potentially lifesaving exam."

For more information, contact the IPA at ipasuffolkcounty@gmail.com or call 631-698-1900.
**IPA News...**

**Elite Pilot 9 Kicks Off**

IPA News along with Anthem BCBS has identified its "Elite Pilot 9" to begin its Enablement Program that will provide a robust clinical service that will include patient care managers, patient navigators and coding specialists. This program is crucial to securing the status of our clinical integration for the IPA. Population Health is the cornerstone of value-based contracting as fee-for-service is phased out.

The following physicians have been identified at the "Elite Pilot 9":
- Dr. Christine Doucet
- Dr. Tanya Adams
- Dr. John Muratori
- Dr. Christopher Ng
- Dr. Anthony Tomasso
- Dr. Dominick Basile
- Dr. Richard Sabinsky
- Dr. Marc Lewandowski
- Dr. Mohammed Azaz

**Enhanced Agreements – are you participating?**

Have you reviewed your contracts to make sure you are receiving the benefits of our IPA and the many contracts that we have available to our members? Reach out to Frank DiMotta, COO IPANS for additional information.

**Local, State and National News...**

**Most patients don’t understand healthcare pricing**

With wages stagnating and health care costs rising, there’s a push for more consumerism in the health care market—price transparency and informed choice will help protect the financial interests of patients. People want high-value, effective health care. But making that happen faces many challenges.

According to a recent report in Health Affairs, American adults largely do not associate the price of health care with quality—they don’t think the price reflects anything rational. In addition, the amount of time and effort patients are able to invest in seeking information about health care billing, or finding the best prices, is limited. While some pricing information can be found online, patients most often ask family and friends or the receptionist at the doctor’s office.

For more information, and to read the article, please see [insight.athenahealth.com/most-patients-don't-understand-healthcare-pricing](http://insight.athenahealth.com/most-patients-don't-understand-healthcare-pricing).

**NY health systems need standardized quality metrics to advance value-based payments, exec say**

As Medicare, Medicaid, and commercial payers impose ever more quality measures and reporting requirements, New York health systems need to use consistent quality reporting metrics, or face further draining of resources and frustration among doctors. A March 2016 study published in Health Affairs showed U.S. physician practices are spending $15.4 billion a year to report quality measures.

According to a 2015 analysis by Catalyst for Payment Reform, 34% of commercial, in-network payments, and 33% of Medicaid payments in New York were tied to performance. The state plans to have 80 to 90% of Medicaid managed care payments in value-based arrangements by April 2020.

Going forward, New York would do well to look at efforts in other states, such as California and Vermont, that are reforming and standardizing the reporting of quality measures across payer types, and begin its own harmonization process.

**Out-of-network claims being billed correctly?**

An Annual Wellness Visit (AWV) is a face-to-face personalized prevention plan of services and not a comprehensive physical exam. It therefore, does not involve any management of disease or require an examination except for measurement of height, weight, BMI, blood pressure, and possibly waist circumference.

**Did You Know that an Annual Wellness Visit IS NOT an Annual Routine Physical?**

An Annual Wellness Visit (AWV) ICD-10 Code G0438 (Initial) and G0439 (Subsequent) is preceded by a Health Risk Assessment Form (HRA) completed by the patient before the visit. An AWV is a face-to-face personalized prevention plan of services and not a comprehensive physical exam. It therefore, does not involve any management of disease or require an examination except for measurement of height, weight, BMI, blood pressure, and possibly waist circumference.

An Annual Routine Physical (ARP) ICD-10 Code Z99.979 (65 y/o or older) is a face-to-face comprehensive, multi-system exam and history based on the patient’s age, gender, and identified risk factors. It does not involve a chief complaint or a present illness. It does include a comprehensive systems review, family and social history, as well as a comprehensive assessment/history of pertinent risk factors. It can include weight, anthropometric data, and simple laboratory tests.

For Medicare Advantage patients both benefits are on per calendar year and there is a $0 co-pay. Both visits are reimbursed at a substantially higher fee than 99213 or 99214 visit. Straight Medicare does not reimburse for an ARP but does reimburse for an AWV with a $0 co-pay. For more information, go to www.cms.gov and search “AWV”.

**IPA NEWS**

Connecticare of NY
Emblem PPO-EPO (out-of-network PT/1BH)
First Health/CNN HealthFirst
HIP - Medicaid (PT/1BH)
MultiPlan/PHCS
National Health Administrators, Inc.
Savility (MultiPlan)
Today's Options
Tricare/Sierra Military VillageCareMax

**QUALITY ASSURANCE**

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**Out-of-network claims being billed correctly?**

Northwell Health representatives said they believe the company is one of Health Republic's largest creditors, with $21.7 million in outstanding claims, including $17.2 million in out-of-network claims, according to court filings. Typically Northwell receives an assignment of benefits form before providing treatment to a patient whose health plan's network does not include Northwell, and it receives payment directly from the insurer.

In the case of Health Republic, Northwell's leadership was concerned that out-of-network claims processed by DFS might be paid to the patient with the expectation the patient would pay the funds on to Northwell.

**New York is among five states with highest surprise billing rates**

New York state has one of the nation’s highest rates of medical episodes that are likely to lead to surprise medical bills, or unexpected bills from out-of-network providers, according to a study of claims data published in Health Affairs Wednesday.

Examining medical claims, researchers identified treatment episodes in which one or more providers were out of network and the patient was likely to be unaware of that fact, or unable to choose an in-network provider. Such a case might arise if a hospital is in-network but the doctor who treats the patient is not, or if a provider is taken to an out-of-network hospital by an ambulance. Based on the researchers’ analysis, some 35% of hospital inpatient admissions from the emergency department likely resulted in surprise bills for New York patients in 2014, compared with just 20% nationwide. New York was among the five states with the highest rates of visits that likely produced surprise bills, alongside Texas, New Jersey, Florida and Alaska.

New York enacted a law in 2015 targeting surprise bills, which requires hospitals to disclose which health plans they accept and the standard charges for their services. It also requires them to alert patients that their doctors may not be in their insurance network, even if the hospital is. The law has helped to resolve billing disputes between providers and insurers, C ran’s reported in April.

**Mount Sinai Hospital sees 168% jump in operating profits**

Mount Sinai Hospital earned $108.4 million in operating income for the Mount Sinai Health System in the nine months ended September 30, 2016, a 168% increase over the same period last year, when the hospital brought in $40.5 million. Revenue from serving patients rose to almost $171 million, an 11.5% increase over the same period a year ago.

The hospital’s revenue has helped buoy other facilities in the health system. In total, Mount Sinai Hospital transferred $33.4 million to affiliates, including Beth Israel, in the first nine months of the year, up from $28.5 million during the same period the previous year. In May, Mount Sinai Hospital also agreed to guarantee Beth Israel’s mortgage and term loans, which had an outstanding balance of about $125 million as of June 30, 2016.

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**Hospital CEO Pay per Patient Day**

Does the health care industry operate in an alternate universe, when compared with the rest of the American economy? One indicator might be hospital CEO salaries. Lawyer and journalist Steven Brill represented the salaries of the CEOs of the largest hospital systems according to how much they were paid for each night patients stayed at the hospital. In this breakdown, in 2015 the CEO of nonprofit Greenwich Hospital was paid $56.40 per patient per night. The CEO of Cleveland Clinic Health System earned $22.96 per patient, of Trinity Health, $0.75.

It’s not a perfect metric, but it’s still revealing—a good way to compare the relative scope of responsibilities of CEOs.

For more information, and to read the article, see [https://www.axios.com/stay-in-a-hospital-pay-the-ceo-56-a-night-2242870721.html](https://www.axios.com/stay-in-a-hospital-pay-the-ceo-56-a-night-2242870721.html).