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Obamacare hasn’t solved the challenge of uninsured patients

It will cost a lot to solve the challenge of covering the 30 million Americans who are still uninsured despite the Affordable Care Act.

First, I would hope that we all agree that no one in the United States should be uninsured and that the cost of covering the uninsured is our biggest challenge. There are arguments about the astronomical cost of expanding government programs like Medicaid and Medicare and offering government subsidies of premiums but I haven’t heard a more convincing argument than doing just that.

Many of us are convinced we’re paying higher premiums to cover the cost of those without insurance, but I don’t mind it in order to help those in need.

Some of those who are fortunate or self-made say, “If I did it, why can’t everyone else?” As much as the “haves” want to believe it wasn’t circumstance or luck that got them where they are, it was. It was also genes and chance that kept them from being a “have-not.”

Maybe our country is suffering from “compassion fatigue.” Or perhaps we have what Ronald Reagan referred to as a “selfish populous.”

I’ve heard many proposed solutions to support universal coverage but I’m not convinced any are sufficient to address the problem. Creating jobs is one solution that we all probably agree would eventually lead to more health coverage. This is likely the best solution; it helps people help themselves. It may help the unemployed portion of the 30 million people find work and another portion may already be working yet not insured.

“I suffer a bit every day knowing there are millions of children and families who need care and aren’t getting it, in the country we consider the greatest in the world.”

Legislation has been proposed that would allow the undocumented to purchase healthcare insurance without subsidies, but I’m not sure how many could afford it. Even under low-cost, less comprehensive plans not allowed under the ACA, families would still likely be left with large uncovered costs. There are tax credits, refunds and tax-deductible health savings plans but many people can’t afford to save because they’re living paycheck to paycheck or won’t save unless they’re forced to.

Some companies are allowing employees to cover children over age 26 and other family members such as parents. This seems reasonable but I’d imagine it raises costs for the employer.

It has been proposed as part of the new Republican anti-poverty plan that current welfare to work requirements should be expanded. Many of those receiving government assistance would like to work but have other challenges such as childcare, transportation and even stable housing.

As a pediatrician, my heart smiles now that California has decided to cover all children under Medicaid who are in need and passed legislation to investigate allowing anyone who lives here to purchase healthcare insurance regardless of legal status. But I suffer a bit every day knowing there are millions of children and families who need care and aren’t getting it, in the country we consider the greatest in the world.

I challenge all healthcare professionals to do your part. Speak up, get into the discussion and help solve this challenge. All of us deserve to be cared for, and who is better than healers, to find the most humanitarian solution possible?

Maria Chandler, MD, MBA, is a pediatrician, clinical professor at the University of California, Irvine, president of the Association of MD/MBA Programs, and member of the Medical Economics Editorial Advisory Board.

How should doctors respond to the problem of uninsured patients? Tell us at medec@advanstar.com.
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Eliza...
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Should Congress create a national solution to physician liability issues or is it better handled by the states?

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8 ways practices are shaking up their operations to build a winning culture

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“One of the major make-or-break moments for physician-run businesses is their choice of professionals.”

JAMES ALLEN, MBA, BAIN & CO.

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“With ACOs stressing value-based care, people are going to realize that they have to think outside the visit.”

DANNY SANDS, MD

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Grade F

How physicians rated dealing with patients covered by the health insurance exchanges

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Disappointed in Gruber comments on Obamacare

After reading “Leveraging Your Value: how to negotiate narrow networks (June 10, 2016),” I have yet to wrap my head around the fact that you quoted Jonathan Gruber from MIT. As it appears, the author of the article and the Medical Economics editorial team have short-term memory issues and have forgotten who Jonathan Gruber is and what he has said about the passing of the ACA*. Let me refresh your memories.

Jonathan Gruber was one of the architects of Obamacare. In 2013, he discussed how the ACA came to pass by stating (and I am quoting from “The Hill”): “Lack of transparency is a huge political advantage. And basically, call it the stupidity of the American voter or whatever, but basically that was really, really critical for the thing to pass.” He suggested voters would have rejected Obamacare if the penalties for going without health insurance were interpreted as taxes, either by budget analysts or the public. He went on to say: “If you had a law that made it explicit that healthy people are going to pay in and sick people are going to get subsidies, it would not have passed.”

The irony here is not that you quoted an “expert” who publicly referred to the American people as stupid, it’s that the very deceptive law he helped craft is now in many respects responsible for the narrow networks that your article discusses! Amazing.

I’ve been reading Medical Economics for many years and I find it a helpful, informative publication. This article lost all credibility with the Gruber quote and I ask that in future issues, please carefully screen your subject matter experts rather than banking on the short term memory of your customers.

Joseph Badolato, DO
CAMAS, WASHINGTON

*Editor’s note: Jonathan Gruber apologized for his November 2014 comments.

Disturbing technology advances are turning doctors into robots

I am a 65-year-old family physician working with 2 internists in a small independent adult medicine practice serving a relatively sophisticated population. I see medical care becoming more impersonal and relying on “clinical guidelines” instead of looking at the individual patient.

The use of extenders by specialists who directly see patients independently clearly demonstrates a decrease in care. Many of my patients complain that the specialist stares at the computer and has to click boxes instead of looking at them and listening.

The hospital systems are buying practices and controlling more and more physicians, and destroying their autonomy. Guidelines are being produced whose results are intended to serve the population as a whole to reduce costs but I fear the individual can fall through the cracks. I see more and more insurance companies dictating what I can order and what treatment it will pay for patients.

Newer technologies and medications are unaffordable to most patients. I can’t order a nuclear stress test unless certain criteria are met. Our practice spends time fighting insurance companies to get medications and tests approved for our patients and don’t get paid for our efforts. The Medicare advantage programs are a good example of what I perceive is our future, and that is healthcare rationing.

As a patient seeing physicians that don’t know me, I find these big offices to be impersonal and the physician rushed. I have observed poor care at large institutions when the main physician relies too heavily on his supportive team.

When a patient calls, a real human being answers the phone. When a patient comes into the office, they are treated in a more personal and caring manner. It’s too bad that this so called “progress” is resulting in impersonal care regulated by the government, institutions like hospitals and insurance companies.

I see a disturbing trend of stricter control of physicians, loss of autonomy, and gradual increased care rationing, all designed to cut costs.

Robert Sacks, DO
MARLTON, NEW JERSEY
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House Republicans recently announced their plan to replace President Obama’s healthcare reform law—the first proposal in the six years since the Affordable Care Act’s (ACA) passage to carry the endorsement of House GOP leadership.

The plan discards the mandates and penalties that have made the ACA a target for GOP lawmakers. However it comes with uncertain costs and an unknown effect on the number of insured Americans.

It is the most anticipated piece of the six-part policy agenda being rolled out by House Speaker Paul Ryan (R-Wis.), as GOP lawmakers move to establish a platform separate from presumptive Republican presidential nominee Donald Trump, writes the Washington Post.

**Highlights of the plan include:**

- **A refundable tax credit for Americans who don’t have employer-provided insurance**
  While somewhat similar to the ACA subsidies, individuals would not be subject to income limits, would not be required to purchase insurance through an exchange and could purchase a wider variety of plans.

- **Expanding the use of private health savings accounts, or HSAs**
  The GOP says this will help patients understand the true cost of their care and allow them to decide how much to spend, and provide them with the freedom to seek treatment at a place of their choosing.

- **Allow insurance companies to charge young people less and older people more**
  The ACA allows insurers to charge older subscribers no more than three times what they charge younger ones for the same plan in the same state. The GOP has called this 3-to-1 ratio “unrealistic” and proposes allowing a 5-to-1 ratio to better align premiums with costs.

- **Funnel the costliest patients to subsidized “high-risk pools”**
  The GOP plan would establish state-based “high-risk pools” for the sickest patients and direct $25 billion in federal support to them over 10 years.

- **Restructuring Medicaid and Medicare**
  Medicaid funds would be handed to the states either as block grants or as per-capita allotments. Medicare would move towards a “premium support” model where seniors would choose a private health plan and Medicare would pay at least a portion of the premium.
Reboot your practice

In uncertain times, adopt a startup mentality and use these 8 traits of your successful peers

by JANET KIDD STEWART Contributing author

WITH ALL THE PRESSURES facing independent practices—from adjusting to value-based payments to meeting the growing demands of patients—business innovators may provide some key practice management lessons.

Lance M. Black, MD, is a former family practitioner who now develops medical devices. He is medical affairs manager for the Global Center for Medical Innovation in Atlanta and is a chapter coordinator for the Society of Physician Entrepreneurs.

“It starts with our training. Physicians are trained to be very conservative,” Black explains. That can conflict with a business mentality, he says, even though private practice owners are, by definition, entrepreneurs. “They’re not going to jump into an unproven treatment, while entrepreneurs are more willing to move fast and take chances.”

But can physicians learn some skills from the business world when it comes to running their practices? Can enthusiasm and an outsider’s view spark healthy innovation?

Business experts and physicians who have run their own practices identify eight core traits that are common to practices that excel:

1/ Retain passion

Physician-run practices reflect their founder’s mentality and typically are passionate about their patients, but physicians aren’t always natural business people.

As a result, many of them are caught between doing what is in the best interest of patients and financial necessity, says James Allen, MBA, a senior partner with Bain & Co. in London and author of “The Founder’s Mentality: How to Overcome the Predictable Crises of Growth.”

“All great companies start with a founder...
mentality and then over time, many lose that and die in complexity," he says. They often struggle with how to professionalize their practice while still keeping their focus and sense of urgency.

2/ **Adopt the sales gene**
That struggle may be easing, some physician entrepreneurs say, as economic realities adjust attitudes about new revenue sources.

Amy Baxter, MD, chief executive of MMJ Labs, LLC, and a former pediatric emergency medicine physician, says she sees more physicians getting comfortable with selling products in their offices, for example. Baxter invented pain-relieving devices for pediatric and adult patients undergoing injections.

“One trend I’m seeing is physicians who didn’t want to be a part of anything to do with business, starting to realize there are value-adds for their patients by providing some things in the office that are useful,” Baxter says. “It’s been very common for endocrinologists to have glucometers and other things that help with diabetes management, but pediatricians? Almost never.”

Now, she says, that’s changing. “As other sources of revenue dried up, more doctors are feeling less uncomfortable about having products patients can buy.”

3/ **They hire ‘owners’**
Another key factor in making a practice more entrepreneurial is smart hiring decisions, Allen says.

“One of the major make-or-break moments for physician-run businesses is their choice of professionals,” he says. Managers who put profits ahead of patient care is a prescription for disaster, he says. In a turbulent industry such as healthcare, professionals have to respond quickly to change. If physicians have staffers who react with a bureaucratic attitude rather than with the mission of the practice in mind, it will result in bad decisions, he says.

“Founders don’t focus enough time on cultural fit and whether a person they are bringing in buys into the mission,” he says. Physicians need to hone job descriptions and then hire staff members who fit the description, rather than hire ‘owners’ who would be more interested in profits than patient care.”

**Making the leap**

**What about adopting some entrepreneurial skills to launch a side business or potential new career?**
Experts say it pays to learn before you leap there, too.

Trying to develop a product while running a practice is time consuming and exhausting, says former pediatric emergency medicine physician Amy Baxter, MD, who now serves as chief executive of MMJ Labs LLC. Launching a product takes much longer than most physicians expect, she says. For those who have a product in development, she recommends applying for a patent and licensing the product to developers rather than attempting to control the entire manufacturing process.

“I talk to physicians all the time who have ideas and think [product development] is going to be a two- or three-year process and then they’ll be sitting on a beach with a drink,” she says. And if their idea is for just one product, licensing is much more cost-effective, she says.

Of course, it helps to have that entrepreneurial drive from a young age. Baxter sold hand-painted rocks at age four and got involved in Junior Achievement as a student. But it was paying attention to her own life that ultimately led her to start her pain-relief company.

“At four, my son went in for immunizations and had a brutal experience. A while later I was driving for a long time and noticed my hand getting numb from the steering wheel vibration,” she recalls. After experimenting with vibrations and frozen vegetables, she invented a vibrating cold pack to reduce needle pain that she sells to consumers and doctor’s offices. She holds six patents on related products.

The hardest part about making the entrepreneurial leap, Baxter says, is learning to live with ambiguity.

“The safety of medicine, particularly academic medicine, is powerful because you are never in jeopardy like you are in a business venture,” she says. “What’s hardest is the not knowing. You have to be willing to fail and act without sufficient data to be an entrepreneur.”

To get started, Baxter recommends experimenting with business ideas while still running a practice. “It’s safe to start getting familiar with medical entrepreneur communities and learning about licensing,” she says.

Also, don’t surround yourself with family and friends as you test-drive your business plan, she says. “Try your idea out on people who don’t love you and don’t quit your day job” until well down the entrepreneurial road, she suggests.
than being dazzled by a well-known employer name on a resume. Smaller, physician-driven practices, for example, need to look for candidates who have excelled in that environment. And be prepared to pay for the right expertise, he says.

4/ Check egos
A little humility goes a long way in keeping physicians open to new ideas and potential sources of revenue, Allen says. “Many physicians were trained in hierarchical structures and are used to privilege and recognition,” none of which fosters the kind of collaborative culture that leads to really great entrepreneurial practice ideas, he says. Physicians who are labeled by colleagues, hospitals or payers as hard to work with tend to also be those who find it most difficult to adapt and thrive, he says.

5/ Balance stars and systems
Growing practices typically face the need to do more compliance, and can often be caught flat-footed when they neglect it, Allen says. He recalls the case of a physician who failed a payer’s audit because the practice wasn’t increasing its security measures as more staff members were given access to medications.

How to keep new controls from sucking the urgency and passion out of a practice?

One way is to make employee motivation a key goal. “Compliance systems can end up taking over the original culture and you lose the original, insurgent mission,” he says. “Everybody becomes a slave to the system and you start to de-motivate the best doctors.”

Try promoting an outstanding young partner or staff member to a level that is two pay or performance grades higher, he suggests, rather than adhering strictly to performance plans. And ask yourself whether you’ve become a slave to the status quo. Are you clinging to a relative-value unit (RVU) model instead of performance pay, for example, when you initially disliked the RVU model?

The attitude that change must be resisted is an innovation killer, Allen says. “Becoming the enemy of change and trying to fight all of it is never good. New regulations can be bureaucratic and stupid, but some of them are actually good for patients and if you don’t change, you’ll be disrupted,” he says.

6/ Build a learning environment
Creating a practice culture where learning from mistakes is valued is another crucial step in energizing a practice.

Nodding to Syed’s work on industries that learn from failure, Allen encourages practitioners to develop cultures where employees communicate more regularly and effectively about what isn’t working in patient management, documentation and practice financials.

7/ Do more with less
Another skill physicians can learn from their entrepreneurial counterparts is doing more with fewer resources.

Felmont (Monte) Eaves, MD, FACS, a plastic surgeon and medical director at Emory Aesthetic Center in Atlanta, Georgia, has developed several devices in entrepreneurial ventures over the course of his career, a passion that came from growing up watching his father, an engineer, build products. “There are lots of lessons you carry back and forth” between the practice and the startup venture, he says. “A big one is resource management. There’s only so much money, people and time, so startups are always trying to be as cost effective as they can.” Even in well-established practices, it’s irresponsible to overspend, so forcing critical thinking about priorities is essential, he says.

8/ Join in
Participating in and leading industry associations helped to inject life into both sides of Eaves’ career. “I think far and away the thing I did that meant more to me in terms of managing a practice and a startup was being involved” in those organizations, he says. “I had to build consensus among volunteer groups of people, articulate vision and get other people’s buy-in.

“You build relationships that are long-lasting and lead to all kinds of new ventures,” he adds. “Today I’m working on new device ventures with people I worked with 20 years ago in those associations. It’s a community.”
Analysts and the nation’s physicians weigh in on how the Affordable Care Act has affected the daily practice of medicine

by JOANNA HAUGEN and JORDAN ROSENFELD contributing authors

The Affordable Care Act (ACA) has been a lightning rod for criticism from various healthcare stakeholders, including physicians, since the law’s passage six years ago.

With the upcoming presidential election likely to alter the landscape of “Obamacare”—from simple tweaks by Democrats to outright attempted repeal by Republicans—Medical Economics asked healthcare policy experts and our readers to debate the law’s effect on U.S. physicians.

Our editorial staff, with the assistance of our physician advisers, selected eight provisions and consequences (both intentional and unintentional) stemming from the law. Policy analysts provided their thoughts on how Obamacare has shaped the last six years. Then we asked physicians from our editorial advisory board, our 200-member Reader Reactor Panel (comprised of physician readers nationwide who help direct our content), and our e-newsletter subscribers to grade the various elements based on their own experiences. Each physician ranked each element in terms of how it assisted their day-to-day work as physicians on a score from 0 (not at all) to 10 (extremely helpful). The average of all respondents was used to derive the letter grade. Physicians also offered short justifications for their ranking.

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Medicare bonus for primary care services

In July 2011, the Centers for Medicare & Medicaid Services (CMS) implemented the Primary Care Incentive Program (PCIP), a provision of the ACA designed to address disparities in Medicare reimbursements between primary care providers and specialists. This was driven by concerns from a Medicare Payment Advisory Commission’s (MPAC) annual report that primary care physicians’ fees were being undervalued compared to specialists who provide discrete procedurally-based services.

Enrolled physicians could claim a 10% bonus fee for services paid for under the Physician Fee Schedule (PFS) for any Medicare patient in their care, new or existing.

The program paid out $664 million in 2012 to approximately 170,000 primary care physicians, an average of $3,938 per provider, according to the MPAC report.

ANALYSIS

This program was necessitated by the growing numbers of primary care physicians who were closing their practices to Medicare patients, due to the many challenges of meeting Medicare rules and regulations, according to Mark Rust, JD, managing partner of Barnes & Thornburg LLP, and past chair of his firm’s National Healthcare Department in Chicago, Illinois.

Physicians were “dropping the program if they could get away with it, and if they couldn’t, [making] shorter visits to try and keep their heads above water with the level of payments they were getting and concomitant administrative demands made by Medicare,” he says.

There’s also a subtle professional rivalry between specialists and primary care physicians, says Anthony Lo Sasso, PhD, professor of health policy and administration at the University of Illinois, Chicago. “Specialists doing the invasive, more costly, higher-reimbursement treatments would say these are very skill-based [services], but primary care says, ‘well, we’re trying to change their behavior, prevent them from having angioplasty or what have you, so maybe that’s more valuable.’”

Primary care is underfunded, agrees Tim Hoff, PhD, professor of health management and health policy at Northeastern University’s McKim School of Business in Boston, Massachusetts. However, he feels that giving money for just two years and then taking it away is not a long-term solution.

“The reimbursement [for physicians] is not where it needs to be, and very often the solutions are these very temporary quick fixes. Let’s give everybody more money but then when the money gets taken away, it puts the primary care physicians right back in the same position they were in before.”

Physicians were not convinced that the temporary increase in reimbursements helped PCPs sufficiently to call the provision a success. “You can certainly appreciate the extra 10% that you get for those services,” Lo Sasso says, “but I think if it was a permanent change, then that would change the calculus.”

Rust is more conclusive. “It failed to create a sustained atmosphere for raising the level and quality of service in the action of providers,” he says.

Whether physicians really benefitted from the bonus also depended on the size of the practice. Hoff says one quarter of primary care physicians didn’t earn any incentives because their practices were simply too full to take on new Medicare patients.

Practices that did benefit from funds to expand services or administrative staff were then left in a financial lurch.

GRADE: 33 = F

PHYSICIAN FEEDBACK

“One time is not enough. It’s like saying your veteran’s medical benefits for the leg you lost should only be for one or two years when it affects you and negatively impacts the rest of your life.”

“The ACA has slowed down my work flow far more than what provided me to compensate.”

“It was a silly Band-Aid.”

“This is such a miniscule amount of money compared to what it takes to run a medical practice. It is totally meaningless.”

“The extra money was helpful, but it still did not bring us into parity with specialists.”
once the program concluded in 2015. This is likely to have trickled down to patient care, says Hoff, "if you are a patient that benefitted from some of these investments that some practices made with this Medicare money, and then those go away."

Ultimately, unless Congress passes legislation to refresh or revise the incentive program, Rust feels that it can be best considered "a one-time drop in the bucket. This is the typical approach of the federal government: throw a little bit of money at something and say we solved the problem," he says.

MPAC recommends replacing the incentive model with a per-beneficiary payment model, which would encourage high-quality care through the use of care coordination teams, rather than the fee-for-service approach, which rewards high volume of services over quality of care.

Medicaid-Medicare parity

The ACA required individual states in 2013 and 2014 to reimburse qualified providers—family physicians, internists, and pediatricians—under Medicaid at the same rate they were paid for services under Medicare. The federal government paid 100% of the difference, which amounted to approximately $5.8 billion in 2013 and $6.1 billion in 2014.

This provision, often referred to as "Medicaid primary care parity," was designed to encourage PCPs to participate in Medicaid. It was included in the ACA because physicians have been less willing to treat Medicaid patients than those covered by Medicare, most often due to lower reimbursement rates.

In a study by the Center for Healthcare Strategies, just 66% of physicians accepted Medicaid patients versus 82% that accepted Medicare patients. Also, given that the ACA was designed to significantly increase enrollment in Medicaid, the incentive program hoped to close this gap.

Despite hopes that federal lawmakers would reauthorize the reimbursement increase in 2013, they did not, so the program ended in December 2014. States were left with the option of deciding whether to revert to the previous payment levels or continuing at the higher levels without the matching federal funds. As of March, 31 states and the District of Columbia had decided to continue paying the enhanced rates, while 19 states had declined.

ANALYSIS

Determining whether it worked is tricky. Analysts feel that its short duration and lack of effective data on what motivates practitioners to accept Medicaid patients poses challenges to measuring the program’s efficacy.

"The federal government oftentimes acts like they can wave their magic wand, and create great social policy with an idea they unilaterally came up with," Rust says. "If the states are rejecting it, there's a reason why: it’s not working." This could simply mean that states don’t want to spend the money.

The difference in rates between Medicare and Medicaid payments also varies from state to state, says Lo Sasso. However, he cites a 2012 University of Pennsylvania study that showed "the magnitude of the fee increase was associated with an average greater appointment availability. "So that would suggest that physicians’ practices did respond to some degree," Lo Sasso says.

It’s difficult to determine if already over-burdened primary care physicians are motivated by higher reimbursements to take on more Medicaid patients. "I don’t think that most physicians consider the compensation pay for Medicaid patients to be worth the effort of putting the claims in. So the willingness to treat Medicaid patients, in my experience, has usually been out of a sense of charity," says Lo Sasso.

Though physicians’ motivation for taking on Medicaid patients vary, many are facing increased patient loads and administrative burdens that affect their ability to take on new patients. "You can provide these bumps in funding and reimbursement but it’s a capacity issue at this point," Hoff says. "Is it significant enough to really enable these practices, particularly smaller ones, to increase their capacity? Not really."

Although the program was not as effective as some would have hoped, the healthcare com-
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munity shouldn’t be so quick to write off the program as a failure, says Carrie Nixon, JD, co-founder and CEO of Healthcare Solutions Connection and managing member of the Nixon Law Group in Fairfax, Virginia. She feels that healthcare reform has and continues to be “a grand experiment” at innovation and reform. “Generally we don’t get things right the first time around,” she says.

However, Nixon is concerned about the implications for Medicaid patients, who are low-income, and include a large number of elderly and patients with mental illnesses. If PCPs aren’t incentivized to take more Medicaid patients, she says, “We’ll have more people visiting emergency rooms and driving up costs. That’s not a sustainable solution.”

The solution to the problem ultimately lies in further legislation, but any real progress is unlikely before this year’s presidential election.

**PHYSICIAN FEEDBACK**

“I’m grateful for the parity, but it was too short-lived.”

“Once again a short-term fix for long-term problems which mandates one and then walks away to leave someone else holding the bag.”

“Temporary increases do little to change the trajectory of the demise of primary care.”

“My work load has gone up tenfold with all the forms and paper work. I can’t keep up any longer with regular patient care.”

“I wasn’t fooled into taking short-term money for long-term pain.”

“It hasn’t improved my daily work. But it has improved access for patients which I really do appreciate. It has allowed us to offer our services to a group that otherwise we would not be able to afford to do so.”

**Increased coverage through healthcare insurance exchanges**

One of the key goals of the ACA was to increase access to affordable health insurance by providing options for uninsured Americans with pre-existing conditions, extending coverage for young adults and expanding coverage for early retirees. For people ineligible for Medicare and Medicaid, this coverage was made available through online marketplaces, or exchanges.

Initial estimates from the Congressional Budget Office in 2012 were that between 23 million and 25 million people would receive coverage through the exchanges from 2016 on, but actual enrollment has been lower.

During the open enrollment period for 2016, about 12.7 million consumers signed up for coverage through the exchanges—9.6 million through the federally-run HealthCare.gov website and 3.1 million through state-based marketplaces, according to CMS. Though current enrollment numbers have not met the estimate noted in 2012, this is a significant number and should be considered a success, says Hector De La Torre, executive director for the Transamerica Center for Health Studies in Los Angeles, California.

**ANALYSIS**

The ability of consumers to clearly see and compare insurance policies when purchasing has been lauded as a success of the exchanges. “Greater choice and greater transparency has allowed some individuals to make more informed buying decisions,” Hoff says, noting there are more product varieties tailored to different needs and abilities to pay and access particular types of providers.

Despite the apparent success of the exchanges, however, they have experienced problems. The launch of the
federal exchange was marred by computer problems that undermined early enrollment, and some states completely botched the rollout of their exchanges. Oregon, for example, failed to launch an online enrollment portal for its Cover Oregon exchange in a timely manner.

Though coverage is now more available because of the exchanges, affordability remains a problem for some. Premiums on the exchanges increased more in 2016 than in 2015, with policies for the lowest and second-lowest cost silver plans running on average 4.4% higher, according to the Kaiser Family Foundation. Due to these higher rates, many people are opting for plans with high deductibles and high copays in order to avoid paying higher monthly premiums.

“There is a tradeoff,” De La Torre says. “People are looking for the cheapest plans and prices, and they’re limited in what they get for that, and it means more out-of-pocket expenses.” Additionally, many of those who have bought coverage through the exchanges had a greater need for medical care, but this hasn’t been counterbalanced with healthy enrollees, some of whom have chosen instead to pay a penalty for going without healthcare insurance.

“Basically what the exchanges attracted was 100% of the sick people and a smaller percent of the healthy people,“ Rust says. To address this imbalance, the ACA authorized risk corridors to help stabilize costs for insurers by offsetting high losses and sharing in large profits, but these will end at the end of 2016.

This preference for lower premiums, the disproportionate percentage of unhealthy participants and the looming end of the risk corridor program have had a cumulative effect, and insurance companies have felt the pinch. For companies like UnitedHealth, Aetna and Humana, participating in the state exchanges provided an opportunity to remain competitive with rival companies, but it’s come at a cost. “They’re trying to balance the need to compete effectively with other insurers by price or premium while at the same time comply with the mandate of the law that covers a pretty robust basket of services,” Lo Sasso says.

In April, UnitedHealth, the largest health insurer in the country, announced that it plans to drop coverage in most state exchanges by 2017, citing small markets and substantial risks that resulted in a $475 million loss on ACA exchange policies in 2015 and a projected $500 million loss this year. While 145,000 people currently enrolled with UnitedHealth will need to change insurance providers, they represent a small percentage of Americans insured through the exchanges.

For its part, the government appears unconcerned: “As with any new market, we expect changes and adjustments in the early years with issuers both entering and exiting states,” said Benjamin Wakana, a spokesperson for the U.S. Department of Health and Human Services (HHS) in an emailed response to the announcement.

**PHYSICIAN FEEDBACK**

“High deductibles and copays essentially render patients with these insurances ‘insuranceless,’ except for prevention visits. If anything is found the patient is unable to afford subsequent care and so does not seek it. No real gain.”

“Coverage is shockingly bad, and at a high price.”

“Getting people on insurance has been helpful but clumsy. High deductibles appears to me to be a by-product of insurance companies protecting their assets.”

“Why would selling an insurance policy with a large deductible help someone who can’t even afford the premiums? They can’t pay the deductible, so they still can’t afford care. Who made out? Insurance companies. Who lost? Private practice doctors who had to deal with patients who stiffed them for the deductibles on policies. Thanks Obama!”

“Many patients have been able to access health care that they were not able to access previously.”

“[Physicians] have been the ones who have to explain that the patient does have to pay their exorbitant copays—usually we end up with zero and an angry patient.”

“We are getting patients in with many problems and don’t always have the resources to address them.”

“Things are worse trying to determine benefits and coverage.”

“More coverage is good, but more coverage does not equal more access.”

→27
Narrow networks

GRADE: 29 = F

To keep premiums down and have their plans be competitive on the exchanges, many insurance companies have opted to narrow their provider networks, meaning that they have placed limits on the doctors and hospitals available to subscribers. Narrow networks tend to work in two ways: First, insurance companies simply do not pay for appointments with healthcare providers who are not designated as part of the network. Second, participants may visit physicians who are considered out-of-network, or not in the top tier of chosen doctors, but they must pay more of the cost to do so.

To some extent, narrow networks have been around since the 1990s, but perhaps their impact is being felt more acutely under the auspices of the ACA as an unintended consequence of the law’s passage. Ensuring that adequate care is available under these increasingly narrow networks remains a concern for those seeking coverage, despite consumer protections built into the ACA.

“\textit{It is possible that you could get a narrow network...with very poor quality physicians and hospitals},” Rust says. “\textit{It’s not, in my experience, extremely likely, but it is possible}.”

Limited consumer choice may only become apparent once specialty care is needed or provider options are severely limited. “\textit{It’s already creating bigger access problems across the country},” Hoff says, noting that it may take several months to see a specialist if only a few are available through an insurance plan.

De La Torre agrees: “\textit{Certainly in rural areas, people may be forced to travel long distances to see a physician or go to a facility that is in-network},” he says. Or someone who develops a condition that requires specialists may find minimal options to meet those needs within the network. Additionally, lists of providers included in a network are often outdated, making it difficult for patients to determine whether their preferred physicians are included.

The ACA requires that all “qualified health plans” include an “adequate” selection of primary care providers, specialists and other ancillary healthcare providers, but a recent study published in the \textit{Journal of the American Medical Association} found as many as 14% of plans sold on the federal government’s health exchange were “specialist-deficient” (with endocrinology, rheumatology and psychiatry being the most commonly excluded specialties). Ultimately, this can result in a hefty out-of-network financial burden.

These networks have benefitted some physicians because they have received enhanced reimbursements and a guaranteed flow of patients from being in-network. However, “\textit{some of them are going to be overwhelmed},” Hoff says. If there is a high demand for specific providers within a plan, those physicians are under pressure to meet the demands of their patients even if they cannot serve them in a timely manner, he says.

\textbf{ANALYSIS}

When employers are deciding what insurance plans to offer their employees, Rust says, they often choose plans with larger networks because they have to please a large number of employees. However, when individuals are choosing their own plans, they’re more likely to consider the balance between coverage options and cost, and “\textit{it becomes much easier to offer a narrow network at a less expensive price and let the consumer decide},” he says.

According to the consulting firm PricewaterhouseCoopers, many exchange plans have narrower provider networks with more limited options for healthcare providers and facilities than employer-provided plans, but employer interest in narrow networks is increasing as well. Limited networks include PPOs (preferred provider organizations) and health maintenance organizations (HMOs), both of which can be effective in reducing premium costs. PPOs limit networks to providers willing to accept reduced rates set by the plan, while HMOs use a dedicated provider network to manage care and reduce costs.

In fact, consulting firm McKinsey & Co. found that about 70% of plans sold on exchanges had limited networks. Additionally, a University of Pennsylvania study found that in 16 states, 50% or more of the health plans sold on ACA exchanges had narrow physician networks. “\textit{It’s allowed, it’s what their competitors are doing and it’s what consumers are asking for in terms of price},” De La Torre says.

Price is a huge determinant when consumers choose a healthcare plan on an exchange, and some analysts have questioned whether they give up quality in the process. A report by AcademyHealth notes that, in general, quality is not a criterion for exclusion or inclusion in a network, and participants struggle with measuring the relative cost, efficiency and quality of healthcare providers.
As narrow networks have blossomed under the ACA, questions are being raised as to who, if anyone, should oversee this trend, since few regulations exist. “There are regulations out there on network formation that address narrow networks from the federal government, but it is really much more something that state regulators know and understand,” Rust says. In addition, he notes, there is tension between regulations that kill narrow networks and healthy competition that drives down prices.

PHYSICIAN FEEDBACK

“Patients often do not understand the implications of a narrow network. I end up having to take time to explain the plan—something the insurance company should do or reimburse me for my time doing their job.”

“There are far too many restrictions placed on physicians in allowing them to participate in plans. Unnecessary!”

“Insurance companies are prohibited from cherry picking healthy patients, so they cherry pick physicians who treat healthy patients.”

“Patients are squeezed by ever pared down numbers of physicians on these lists. If I can’t send my patients to specialists within a reasonable travel time, the patient simply can’t go. This is particularly true in rural areas.”

“It is unfair and profits a few. If a physician has a license in good standing they should not be eliminated from an insurance plan.”

“[Obama said] ‘If you like your plan, you can keep your plan.’ The result? Reduced choice.”

“The network delineations in our area are so arbitrary and inappropriate that all they do is impede care.”

In October 2011, CMS established the rules for accountable care organizations (ACOs) to take part in the Medicare Shared Savings Program (MSSP) to provide Medicare patients with high-quality, coordinated care. Made up of primary care physicians, specialty care providers and hospitals who agree to work together in this effort, ACOs were intended to ensure that patients receive the appropriate care at the right time and avoid unnecessary duplication of services.

In theory, by meeting quality measures and spending wisely through coordinated care, parties working within the framework of ACOs would share in the savings achieved for the Medicare program. In 2012, ACOs were evaluated in 33 areas based on four key domains (patient/caregiver experience, care coordination/patient safety, preventative health and at-risk populations.) Seven additional benchmarks within those domains will be released prior to the 2017 reporting year.

ANALYSIS

Participation in an ACO is voluntary, but some physicians have felt pressured to join one so as not to miss out on potential referrals, especially if nearby hospitals or other providers have joined one, says Gary Young, JD, PhD, director of the Northeastern University Center for Health Policy and Healthcare Research in Boston, Massachusetts. Despite the lure of ACOs’ intended benefits, many participants have felt the initiative’s growing pains.

When it launched, 27 ACOs were selected to participate in the MSSP, and by January 1, 2016, there were 434 participating ACOs across the country serving more than 7.7 million beneficiaries. The Pioneer ACO Model, an initiative by CMS to test alternative ACO program designs to inform the evolution of the MSSP, launched in January 2012 to support organizations that already had experience operating an ACO.

“They were selected because they’d already made progress in building the fundamental infrastructure and capabilities that were required to coordinate care, reduce costs and manage risks,” says Rita Numerof, PhD, a healthcare business strategist and president of Numerof & Associates in St. Louis, Missouri. “If anyone could be successful in providing accountable care, these would be the ones that would be able to do it.”

However, only nine Pioneer participants remain after others dropped out of the program. According to an August
Historically, payers have used a fee-for-service (FFS) model that paid physicians for every service and test they provided based on customary charges of similar physicians in a geographic area. As a result, many physicians felt a sense of urgency to see as many patients as possible as quickly as possible—a potential detriment to patient care and source of physician burnout.

The ACA implemented several new programs intended to improve the quality of care, but the Medicare Access and CHIP Reauthorization Act (MACRA) significantly modifies the FFS model. This shift in physician reimbursement is designed to promote value over volume, because physicians are rewarded when they report data and outcomes that show they have achieved appropriate value-based outcomes.

Outcomes-based reimbursement

GRADE: 28 = F

**Analyst**

After spending years focused on how many patient appointments they could squeeze into the day, physicians are having to adjust how they practice medicine. “This is really important in changing the mindset we’ve had in this country around healthcare, which is to stop focusing so much on treatment after people get sick and focusing instead on health promotion and prevention,” Young says.

While a healthier population sounds like a laudable goal, the emphasis on value is placing new burdens on the

PHYSICIAN FEEDBACK

“ACOs are a lot of work; some of it beneficial across all products, and other parts are so much busywork.”

“So far this creates the best opportunity for better care and lower cost.”

“ACOs add layers of work for physicians, reducing our ability to spend time with our patients and adding unnecessary burdens to our already busy schedules. And all of this with marginal if not negligible benefit.”

“As a primary-care provider I’m totally neutral. It rewards us for doing the right things (coordinating care, for example), though it does not give us the resources up front to do so.”

“This is managed care reintroduced under another name. There will be temporary savings then rapidly increasing costs again as the market becomes controlled.”

“Patients fear the ACO practices are withholding care due to costs. There has also been animosity among ‘team members’ over who should get how much money if there’s savings.”
“I take care of patients other doctors refuse to see. Many of them are noncompliant. The noncompliance of the patients adversely affects my ratings and may lead to me having to turn away some of these patients.”

healthcare system. One of the questions, of course, is how to measure value. Metrics outlined in the creation of ACOs are meant to address this in part, but reporting infrastructure and requirements continue to be problematic.

“There’s so much reporting, data collection, number crunching, documentation, interaction with patients designed to capture numeric information and metric information, and the typical independent physician who might be in a private practice increasingly doesn’t have the scale, infrastructure or capacity to be able to meet those requirements,” Northeastern’s Hoff says.

Additionally, how can value be measured when patients become healthy and no longer require medical services? “This creates a lot of challenges for hospital executives who still need to fill their beds to some degree and have substantial numbers of employees,” Young says.

ACOs are a value-based model, consolidating care and reducing duplicate services by sharing risks and savings. But working under a model that rewards results has its own stresses. In fact, a 2013 survey by Wolters Kluwer Health found that managing shifting payer reimbursement models is the most pressing business challenge among physicians.

Moreover, a 2015 study by Rand Corporation sponsored by the American Medical Association found that “financial incentives applied to physician practices via alternative payment models were not simply ‘passed through’ to individual physicians.”

Independent practitioners are also increasingly partnering with other caregivers under a bundled payment system. With bundled payments, healthcare providers share a single payment for a range of services instead of each provider billing separately. This benefits the patient, because she can see what, exactly, she is paying for among a comprehensive set of services—and payers and providers share risk.

“If we look at it as a product and figure out a way to reduce all the different cost components and we have motivation to make money by getting the patient out quicker and healthier, and if we all come together as a team, won’t it be better for the consumer to look at a single price for the whole thing?” attorney Rust asks.

Under this system, however, there is a concern that physicians may lose some clinical autonomy when hospitals are in charge of bundling. Someone has to make decisions when it comes to determining how cases are managed and who is paid what, Rust says, and that’s often the person at the top—the hospital CEO. “That’s the vertical line, the consolidation of the industry,” he says.

PHYSICIAN FEEDBACK

“Unintended consequence of this in a long run will be that no one will be willing to take care of sick patients, because they will cost the doctor money in reimbursement. Quality measurement should be whether or not the appropriate patient is advised to have a colonoscopy and whether or not the diabetic is told to take his medicine and lose weight. This is a very dangerous game that the government is playing with physician reimbursement and it will be the death of the small practice.”

“Costs associated with building the infrastructure to report measures (some of which are dubious at best) are not offset by gains in reimbursement. In the ideal situation of every provider meeting standards, there will be no extra money. Ultimately could just be a complicated way to cut reimbursement.”

“A difficult chaff but coupled with ACOs adds opportunity to increase safety, quality and save cost.”

“Let’s start paying lawyers and politicians using a similar grading system.”

“The emphasis has moved from the patient to the process.”

“The problem is that this law does not reward good medicine, it only rewards good recordkeeping.”
Physician ratings via the Physician Compare website

The ACA required CMS to establish the Physician Compare website, modeled somewhat after the existing Hospital Compare website. The goal of the website is to provide information about providers that will help consumers make better-informed healthcare decisions, and to create clear incentives to encourage high-quality physician performance. In its first iteration in 2010, Physician Compare took advantage of Medicare’s existing Healthcare Provider Directory, but CMS has been working since to enhance the site and improve its usability for consumers. It now includes about 40,000 of the approximately 800,000 practicing physicians in the U.S.

ANALYSIS

One reason the data is slow to be added may be the way that physicians are sending their information to CMS. Some medical groups are using a clearinghouse or intermediary, third party to get it to the government, according to Joel Shalowitz, MD, MBA, FACP, professor of preventive medicine at Northwestern University’s Feinberg School of Medicine in Chicago, Illinois. “Sometimes those companies aren’t doing their jobs, so it’s delayed.”

Many physicians feel that CMS should have waited to launch the site until after all the data is added and has been vetted for accuracy. “Physicians think CMS did not do enough to highlight the disclaimer that this is not comprehensive yet,” De La Torre says.

In addition, many physicians are discouraged by high error rates in accuracy of their members’ information. “The College of American Pathologists had like a 50% error rate for their members,” Shalowitz says. “It might be indicative that the system isn’t what it should be.”

While inaccuracy alone is troubling, it’s made more complex by the fact that physicians will receive a 2% penalty on Medicare/Medicaid payments for not reporting their most up-to-date information to CMS, regardless of whether physicians themselves or a third party sent it. The data submission period closed in November 2015, but penalties are assessed retroactively in two-year increments, so 2016 penalties are based off of 2014 reporting, and so on until and unless new rules are announced.

The American Medical Association and other physicians groups are especially unhappy with the forthcoming fines, De La Torre says. “If the data is incomplete or wrong, they feel it’s unfair.” He predicts that many physicians will challenge those fines in the coming year.

CMS faces a challenge in creating performance standards for the website that are fair and accurate to all physicians.

PHYSICIAN FEEDBACK

“We need a site for insurance companies and congressmen as well.”

“This website constitutes CMS’s engagement in cyberbullying practicing physicians.”

“... My incentive is the patients under my care. My patients refer their friends and family to me—that referral matters more to them than some kind of grade on a website.”

“Penalizing physicians is not a way to encourage better healthcare. Incentives are great for doctors and patients alike, but punitive measures are for the court system, not the legislative body.”

“The site is not accurate and getting information corrected is next to impossible even when multiple documents are submitted. It appears to be at random and not vetted at all.”

“Not all that is important can be measured, and not all that is measurable is important.”

 “[The site is] horribly inaccurate.”

“Garbage in equals garbage out.”

“Physician Compare does not adequately measure true ‘quality’ in taking care of patients.”
cians across different specialties and sizes of practice. “The data could be timely and accurate, but not meaningful,” Shalowitz says.

He posits a hypothetical situation in which two doctors perform the same procedure, but in different size practices, with different degrees of challenge. The numbers might show a higher morbidity rate for one doctor because he has a smaller practice, or a larger number of sicker patients. “That data is worse than nothing because it would steer people to the wrong place,” Shalowitz says.

Others wonder how likely consumers are even to use the website once it is completed. Shalowitz feels it hasn’t been up long enough, or with sufficiently complete information, for accurate analysis. “In my 15 years of experience, most people don’t make use of objective information in making their healthcare decisions. It’s more often word of mouth,” he says.

While there is some evidence that people pay attention to report cards, De La Torre says, “in general people say healthcare is too complicated, or the quality is not great, but they give their own physicians higher ratings.”

Practices and physicians had a 30-day window to approve their data before it went live on the Physician Compare website, but that review process ended in November, 2015. Physicians who didn’t review their information will see it go live anyway, without an appeals process, according to the CMS website.

For physicians hoping CMS might take down the website due to widespread provider dissatisfaction, De La Torre says that’s unlikely. “CMS is not going to back down,” he says. “This is the path we’re heading down.”

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Expansion of health IT

The HITECH Act set the electronic ball rolling in 2009 and CMS introduced its electronic health record (EHR) meaningful use program in 2010. Still, the question remains whether health IT has improved patient care through a secure, interoperable nationwide health information network enough to offset the added burden to physicians’ practices, as the government promised at the time.

The Affordable Care Act further encouraged physicians to make the transition from paper to digital records to improve patient care and physician communication.

ANALYSIS

Though a Merritt Hawkins study of 650,000 American physicians found that 85% of physicians have adopted EHRs since 2012, 46% felt that EHRs detract from their patient care. The reporting requirements have proven to be a barrier for many physicians even to obtain the incentives in the first place. Carrie Nixon, JD, says that the most up-to-date numbers, from 2013, show that out of 1.25 million eligible providers, 450,000 did not submit the data to qualify for incentives. That resulted in a loss of 1.5% of the total reimbursement, which she calls “a pretty significant amount.”

“I think most physicians would say that [EHR incentive programs] have had a negative impact because they are having a difficult time getting their arms around the reporting requirements,” she says. “They’ll tell you it’s taking away from time to care for their patients.”

Even for physicians who have been able to use their EHRs without many problems, and successfully attest to Meaningful Use, the software has a ways to go before it becomes intuitive. “The ACA encouraged coordinated care but the tools we have don’t do a very good job of that because they are dealing with layers of segregated data,” says Robert Rowley, MD, a family physician and health IT consultant in Hayward, California.

The move to coordinated care is a positive development that might not have happened without the legislative push of the ACA, Rowley says, but the EHR vendors haven’t caught up. The tool he uses to chart and bill patients in his own practice, has taken him nine months to master.

Others believe expansions in health IT have been more positive than negative and just need time. “It’s allowed information transfer to occur more quickly across the system,” Hoff says. He also sees health IT as especially useful for population-based healthcare and spotting patients who need extra attention more quickly. “It allows much better documentation in some ways...so it provides greater transparency as a whole,” he says.

The transition to electronic data also has helped physicians save money by getting rid of paper charts and their concomitant need for storage and retrieval. “One nice thing...
is you don’t have to look for a chart, which is a big savings on time and hence money,” Feinberg School of Medicine’s Joel Shalowitz says.

However, he also thinks that the shift away from written notes has negatively impacted patient care. Now, providers spend more time checking off boxes than writing an effective narrative. “You don’t get the feel of what happened with the patient, and that’s a big problem,” Shalowitz says. Still, given that physicians report spending 20% of their time on non-clinical paperwork, it’s unlikely that they will be inclined to return to paper-based charting.

Hoff says that many physicians see technology “as this evil device that’s enabling them to be watched over and have their work controlled.” He points to the Merritt Hawkins’ physician satisfaction survey, saying, “At the heart of a lot of discontent right now is all the metrics that are placed on them. Medicine is becoming one big cookbook of measurements.”

Nixon suggests that all of these early frustrations are just “growing pains” and that once physicians are used to and have incorporated them into their daily practice, “work flow will become easier, second nature.”

Other changes in technology that hold promise for the future include telemedicine, in which patients can meet virtually with doctors, thereby providing access for patients who can’t easily get to their doctors. “It’s good for the patient because they can maybe get contact with their regular physician, and it’s good for the doctor to have continuity with an established patient relationship,” Hoff says.

Of course, physicians are concerned about how they will be paid for such visits. “I hear doctors ask all the time, what’s the business model for that going to be, what’s reimbursement going to be like, because traditionally those kind of visits have been undercompensated,” Hoff says.

Ultimately, it’s impossible to tease apart how much new health IT has been the result of the ACA and how much would have taken place anyway. “All of these things are very much tied together,” Shalowitz says, “You can’t just say the ACA flipped a switch.”

**PHYSICIAN FEEDBACK**

“It is not ready for prime time. This is the single most detrimental hurdle to practicing.”

“Nothing ruins a patient’s experience faster than a computer in the exam room.”

“The idea was good but the incentives were never meant to offset the ongoing cost increase to implement EHR use and maintenance, I think that just opened doors to lots of IT vendors who are overcharging because they can!”

“EHRs are clearly beneficial for patients—things are more organized. EHRs are still in an early stage and hopefully will get better for docs, especially in connectivity between systems.....”

“E-prescription efficiency and accuracy is wonderful. Printing a legible plan for the patient is wonderful. Legible consults and records are wonderful. But...everything involved in patient care takes longer.”

“I use an EHR and like it. I have to be careful not to get stuck looking at my screen and not the patient. I think it is a useful way to organize my patient’s records without clutter. Is the quality of care better? I am not sure.”

“The EHR is the single worst thing among many to happen to medical practice in the past 15 years.”

“My EHR cost over $75,000, not counting the hundreds of hours invested by my staff and I to make it work. I will never recover that investment.”

“There needs to be seamless, user-friendly interoperability, but the costs associated need to be very low so those of us in small private practices can afford it.”

“Some EHR functionality is very helpful, but I spend a large amount of time as a clerk. Thank you 9th grade typing teacher!”
Improve your coding, increase your revenue

Five areas physicians should keep an eye on to optimize reimbursement for the remainder of 2016

by NANCY M. ENOS, FACMPE, CPC Contributing author

HIGHLIGHTS

Medicare established two codes for billing and reimbursement of an Annual Wellness Visit in 2011. This service continues to be underused and under documented.

Time-based codes require careful documentation of time spent and a summary of the discussion.

REIMBURSEMENT FOR evaluation and management (EM) services is often the most challenging for primary care physicians and their billing staff. The most common EM codes are based on location, patient status, and level of service.

A good understanding of the opportunities, and a review of common errors found in audits, will help your practice obtain payment and peace of mind.

PROLONGED SERVICES

The 2016 Office of the Inspector General Work Plan includes a warning that the government plans to audit claims for CPT 99354-99356 for prolonged services with or without direct patient contact.

A good understanding of the opportunities, and a review of common errors found in audits, will help your practice obtain payment and peace of mind.

Prolonged services are for additional care provided to a beneficiary after an EM service has been performed. Physicians submit claims for prolonged services when they spend time in addition to the time spent with a beneficiary for a usual companion EM service. The necessity of prolonged services is considered to be unusual.

Apply the codes if: the time is documented; it is medically necessary; and the provider was attending the patient the entire time (e.g. for chest pain or respiratory distress.) The codes should not be used if the provider was in and out seeing other patients during the time interval. Direct (face-to-face) patient contact is required. Only count the time spent face-to-face, even if the time is not continuous.

Prolonged service CPT codes 99354 and 99355 were revised in 2016 to report EM or psychotherapy services and can now be reported with 90837 (psychotherapy) as well as 99201-99215 (office visits), 99241-99245 (outpatient consultations), 99324-99337 (residential/assisted living) and 99341-99350 (home services)

The 2016 CPT included the new code 99415. It covers prolonged clinical staff service (service beyond the typical service time) during an EM visit in the office or outpatient setting, direct patient contact with physician supervision; first hour (list separately in addition to code for outpatient EM service). Use code 99416 for reporting each additional 30 minutes. The prolonged services codes cannot be reported for more than two patients at the same time.

COMMON ERRORS: Audits of claims for prolonged services frequently show that this...
“time-based” code is not supported by documentation of time. Prolonged service code(s) may be added to a base EM code only by the rendering provider.

Prolonged service codes cannot be used to represent cumulative episodes of care by multiple, same-specialty providers within a group. While there is no required time format, many carriers recommend clock time (for example, 11 a.m. to 11:45 a.m.) but will also accept time documented as “45 minutes was spent.” The note should support how the time was spent.

**ADVANCED CARE PLANNING**

Many physicians spend time with patients and their families discussing end-of-life issues. The Annual Wellness Visit (AWV) is one opportunity to have this discussion.

Effective January 1, 2016, the Centers for Medicare & Medicaid Services (CMS) has said that it would allow payment when furnished as an optional element of the AWV and waive the deductible and coinsurance. However, these codes are not limited to primary care providers, and can be furnished in settings beyond the AWV. Neurologists and oncologists, for example, also have these discussions and can bill for advance care planning (ACP).

ACP can occur at any time. When ACP occurs during another visit, such as EM, Chronic Care Management (CCM) or Transitional Care Management (TCM), there will be cost sharing, in the form of copays and deductibles, similar to other physicians’ services.

CPT 99497 for ACP includes the explanation and discussion of advance directives such as standard forms, with completion of such forms when performed by the physician or other qualified healthcare professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate. CPT 99498 can be used to report each additional 30 minutes.

These codes are not bundled with Medicare’s covered preventive services such as Initial Preventive Physical Exam G0402 or AWV G0438 (initial) or G0439 (subsequent). The CPT code(s) for ACP should be billed using modifier -33, and no Part B coinsurance or deductible (consistent with the AWV) will apply.

**COMMON ERRORS:** Missing the opportunity to report this service is the biggest mistake at this early stage. Start using the code, but don’t forget to document each element of the service.

The ACP codes (99497 and 99498) cannot be reported with critical care codes in any category and they exclude treatment and management plans for an active problem.

**TRANSITIONAL CARE MANAGEMENT**

The billing date requirement for use of the TCM codes has created workflow problems for providers and their billing staff.

Since January, CMS has offered new date of service options for TCM reporting. CMS now allows submission of the claim on the date of the face-to-face visit, consistent with the current policy governing the reporting of global surgery and other bundles of services under the Medicare Physician Fee Schedule.

**COMMON ERRORS:** Practices must document the contact with the patient within two business days. Electronic health record (EHR) systems that have a telephone log make it easy to comply with this requirement.

Develop a workflow that can track your patients in the hospital, their dates of discharge and the dates of contact with them. Calls to initiate or restart community services, medication reconciliation, and instructions also should be documented.

**ANNUAL WELLNESS VISIT**

Medicare established two codes (G0438 and G0439) for billing and reimbursement of an AWV in 2011. This service continues to be underused and underdocumented.

A common mistake is to use the EHR template for an “annual physical.” The components are quite different. Using a checklist, ask your EHR clinical documentation support specialist to create a template that will capture all the required elements. Also, be sure to scan or include a copy of the patient’s Health Risk Assessment form.

Depression screening can be performed in writing by the patient or verbally by the provider. The responses should be docu-
COUNSELING, RISK FACTOR REDUCTION AND BEHAVIOR CHANGE INTERVENTION

CPT codes 99401-99429 provide an opportunity to bill for preventive medicine (outside of an annual physical) behavior change intervention in an individual or a group setting.

There are four codes in the range of 99401 to 99404 based on 15-minute intervals for preventive medicine counseling and/or risk factor reduction interventions. Issues such as a healthy diet, exercise and drug abuse or contraception and healthy lifestyle may be reported.

Counseling focused on smoking can be reported in addition to EM services on the same date:

- 99406: Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
- 99407: Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

Counseling for alcohol and/or substance abuse (other than tobacco) are reported with:

- 99408: Alcohol- and/or substance- (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
- 99409: Alcohol- and/or substance- (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes

Code 99078 should be reported for patients who have existing symptoms or illness: physician or other qualified healthcare professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (e.g., prenatal, obesity or diabetic instructions).

Codes 99411 and 99412 can be used to report preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); based on time: 30 minutes and 60 minutes, respectively.

COMMON ERRORS: Check insurance carriers for their reimbursement policies based on coverage guidelines, and be sure to document the time spent, as well as the discussion.

Time-based codes require careful documentation of time spent, with clock time (e.g. 11 a.m. to 11:30 a.m.) and a summary of the discussion. Medicare does not cover this range of codes, but does accept alternative “G” codes for smoking cessation (G0436-G0437).

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RESOURCES

To learn more about the documentation of Advanced Care Planning services, check online for resources and forms or visit your State Medical Society or [http://www.polst.org/](http://www.polst.org/). Medicare has published a MLN Matters article that can be found at bit.ly/MLM9271.

Sample Health Risk Assessment
bit.ly/HRA-framework

SLUMS Dementia exam
bit.ly/SLUMS-exam
Legally Speaking

Understanding liability as an attending physician

by FRANK J. WENICK, JD Contributing author

Who is in charge? In healthcare, the answer is clearer than ever before in regard to treating the patient of a private attending physician who has been admitted to a hospital: the private attending physician is the one in charge.

IN A NEW YORK CITY case (MacDonald vs. Beth Israel Medical Center) with far-reaching implications, a New York State appellate court ruled that hospital staff, even including the hospital’s attending physician, is shielded from liability if the staff defers to the private attending for all medical decisions—and exercises no independent medical judgment.

While there is longstanding precedent in such cases involving nurses, residents or other hospital staff, the MacDonald decision was the first ruling to establish a broader standard extending immunity from liability to in-house attending physicians.

With more and more hospitals in recent years evolving their own employees into attending physician roles, this appellate decision clarifies the parameters of everyone’s responsibilities—and the need for specificity in determining duties and protocols when a private attending physician is in charge.

Price of leadership

Why did the court rule so broadly? I believe it was because the court wanted to establish beyond all reasonable doubt the relationship between private and hospital attending physicians. The ruling seemed to indicate that when a clear chain of command exists, a plaintiff unhappy with a medical outcome cannot hold liable those who were responsible for carrying out the private attending’s plan.

From the perspective of a hospital administrator, this ruling confirms that all hospital physicians and staffers playing a supporting role to a private attending physician—and following his or her direction—cannot be held liable if the treatment plan is challenged. A physician with a different specialty would have a coordinate responsibility and therefore potentially have independent liability.

Conversely, from the perspective of private attending physicians, the ruling confirms the great burden on them, as they are expected to set a clear course of treatment with the understanding and expectation that hospital employees will not interfere.

Of course, there is one key caveat, as expressed in previous court decisions: The immunity from liability is lost if the private attending physician’s orders (and/or the patient’s situation) are so clearly contraindicated by normal practice that the hospital must intervene.

Protection for all

To ensure that all parties are protected from liability to the greatest extent possible, hospitals and private attending physicians should consider the following suggestions:

- When the roles and responsibilities of the attending private physician and the hospital are clearly delineated, there will be less chance for confusion regarding decision-making.
- Yes, the private attending physician is in charge. But if his or her treatment is clearly contraindicated and intervention is warranted, the hospital and its staff must take immediate and appropriate action.
- In the course of monitoring and performing routine tasks in caring for the patient, the hospital staff should stay in regular contact with the private attending physician. This is especially important during complicated cases that may require frequent course changes.

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Harness the power of patient-generated data

Practices have been collecting this data for decades—and now is the time to start using it

by KEN TERRY Contributing author

HIGHLIGHTS

The best-known pre-visit questionnaire is Instant Medical History, a 20-year-old survey that has been integrated with many EHRs.

Most physicians already use some form of patient-generated data in their practices. But workload, liability and financial issues need to be resolved before the use of this kind of data is widely expanded.

MOST DOCTORS, if asked to define the term “patient-generated data,” probably would associate it with answers given in patient interviews or the clipboard forms new patients fill out in the waiting room. But in the computer age, patient-generated data includes far more than that. The sources of this information now range from pre-visit questionnaires and health risk assessments to functional status surveys and remote monitoring devices.

The government wants physicians and hospitals to start using this kind of information more broadly. For example, the Centers for Medicare & Medicaid Services (CMS) recommends that physicians administer health risk assessments (HRAs) to gather information for annual Medicare wellness visits.

The Stage 3 rules of Meaningful Use, still in effect for participants in the Medicaid electronic health record (EHR) incentive program, require that 5% of patients seen contribute data to their EHR. The successor to the Medicare EHR incentive program—Advancing Care Information, part of the Merit-based Incentive Payment System that is scheduled to take effect next year—has a similar though less challenging mandate.

The Office of the National Coordinator for Health IT (ONC) has also been promoting patient-generated data, especially functional status information. In the interoperability road map that ONC released last year, the agency stated that patient-generated data should be incorporated into longitudinal health records to help individuals improve their health.

Patient-generated data is also essential to the value-based care delivery model that the healthcare industry is pivoting toward. In the future, physicians will have to monitor and keep in touch with patients between visits to manage population health, and they will have to be aware of every patient’s health risk factors.

“There’s no way you can move toward value-based care without incorporating patient-generated health data,” says Danny Sands, MD, an internist affiliated with Beth Israel Deaconess Medical Center (BIDMC) in Boston, Massachusetts, and an assistant professor of medicine at Harvard Medical School.

Here are some of the different kinds of patient-generated data and what some physicians are doing with it.

PATIENT-GENERATED DATA, EXPLAINED

A report from a technical expert panel for ONC defines patient-generated health in-
formation as “health-related data created, recorded, gathered or inferred by or from patients, family, personal caregivers or designees to help address a health concern. This data could be an observation, a result, a device finding, a confirmation or a change/correction/addition of data in the patient’s existing health record.”

This definition covers health-related information that a patient brings to visits, such as copies of his or her medical and family health history, notes the report. Sometimes doctors may request that a patient or a caregiver keep track of certain information and report on it at the next appointment.

For example, Jeffrey Pearson, DO, a San Marcos, California-based family physician, asks some patients to track their blood pressure or their blood sugar. Pearson may have a hypertensive patient use a blood pressure cuff to take random readings during the week after a visit to see whether his high reading during that encounter was the result of “white-coat” syndrome. The patient is asked to send a secure email message to Pearson’s patient portal, which automatically documents it in his EHR.

PRE-VISIT QUESTIONNAIRES

Among the more formal methods of tracking patient health between visits is with a pre-visit questionnaire. A growing number of practices are adopting these instruments, often to improve billing, says John Mafi, MD, MPH, an assistant professor of medicine at the UCLA David Geffen School of Medicine in Los Angeles, California.

The best-known pre-visit questionnaire is Instant Medical History, a 20-year-old survey that has been integrated with EHRs such as Cerner, Allscripts, NextGen and Greenway. Allen Wenner, MD, a family physician in Columbia, South Carolina, and the founder of Primetime Medical Software, which markets Instant Medical History, says that his system has grown to encompass more than 100,000 variables related to patients’ medical complaints.

Instant Medical History is an interactive program that uses branching logic to ask patients questions about their illness. Patients can fill out the surveys online or on tablets in the office. The results are summarized in bullet points, with only positive answers highlighted.

Wenner says doctors can scan the summaries in under 10 seconds, absorbing information that can help them diagnose problems more quickly. Having to ask patients fewer questions, he says, can save doctors an average of four minutes, or more than 25% of a 15-minute visit.

In addition, he says, the data can help physicians refer patients more appropriately and sometimes faster. For example, he has sent patients with early signs of appendicitis to surgeons without seeing them after reviewing their survey results.

Sands, cochair of the panel that authored the ONC report, agrees that pre-visit questionnaires such as Instant Medical History can be useful. But patients must be willing to take the time to complete these surveys, he notes, and doctors must suggest it to them.

Other observers are skeptical. Lisa Iezzoni, MD, director of the Mongan Institute for Health Policy at Massachusetts General Hospital in Boston, thinks some patients lie on questionnaires and that visual cues can help doctors get at the truth. Jeffrey Kagan, MD, an internist in Newington, Connecticut, and member of the Medical Economics editorial advisory board, says he believes patients might misunderstand some questions in pre-visit surveys. He is more comfortable with information gathered during face-to-face interviews, he says.

HEALTH RISK ASSESSMENTS

As mentioned earlier, CMS urges physicians to use HRAs in conjunction with the Medicare Annual Wellness Visit. The purpose of this visit is “to encourage individuals to take an active role in accurately assessing and managing their health, and consequently improve their well-being and quality of life,” according to a report on HRAs sponsored by the Centers for Disease Control and Prevention (CDC).

Administering an HRA and using it as the basis for feedback and advice to patients can help accomplish this goal, the report says.

HRAs include questions about many kinds of health risk factors, including health behaviors, notes the report’s lead author Ron Z. Goetzel, PhD, a senior scientist at the Johns Hopkins Bloomberg School of Public Health and vice president at Truven Health Analytics. For example, an HRA might ask patients how physically active they are, what

What is patient-generated data?

Patient-generated health data (PGHD) are health-related data created, recorded or gathered by or from patients (or family members or other caregivers) to help address a health concern.

PGHD include, but are not limited to:

- health history
- treatment history
- biometric data
- symptoms
- lifestyle choices

PGHD are distinct from data generated in clinical settings and through encounters with providers in two important ways:

- Patients, not providers, are primarily responsible for capturing or recording these data.
- Patients decide how to share or distribute these data to health care providers and others.

Examples include blood glucose monitoring or blood pressure readings using home health equipment, or exercise and diet tracking using a mobile app.

Source: U.S. Department of Health and Human Services
“Even if a physician disagrees with a patient’s assessment from a patient-reported survey, it’s important for the physician to understand what the patient’s perceptions are.”

— Lisa Iezzoni, MD, Director, The Mongan Institute for Health Policy, Massachusetts General Hospital, Boston, Massachusetts

kind of food they eat, how much stress they feel, and whether they smoke, he says.

HRAs, which usually take 15 to 30 minutes to fill out, typically are completed online. Goetzel says. Most of the surveys are general, covering 10 to 15 health categories. But some are specific to a particular condition. For example, the HRA of the American Heart Association focuses on seven risk factors relevant to coronary artery disease.

How can HRAs help doctors care for individual patients? “A patient who walks in may be smoking and drinking, may be overweight, having problems at work, feeling lousy and not physically active,” Goetzel says. That information, which the patient might not feel comfortable sharing with the doctor face to face, is now available in their HRA. “So the physician can say, ‘Here are some of the risk factors we saw in your report, let’s talk about them.’”

Jeffrey Lederman, MD, an internist in Long Branch, New Jersey, and his partner regularly use HRAs. Part of the national MDVIP network, which encourages its concierge practices to use these surveys, Lederman’s practice asks patients to fill out the HRA two weeks before their annual physical exam. They can complete the survey either online, using the MDVIP portal, or in the office. Although that portal is not yet integrated with Lederman’s EHR, he says his staff can upload the PDF of the results so he can see it when he opens a patient’s chart.

“An HRA gives a great summary of the patient’s own self-awareness about their health care, and it can be very helpful to physicians,” he says. If a patient is in a medium risk category because of hypertension, diabetes and being overweight, he says, he can look up their physical exercise score and see that they’re not exercising enough. Then he can discuss an action plan with the patient.

In some cases, HRAs have alerted Lederman to issues he wouldn’t have thought of asking about. For example, responses on an HRA prompted him to order a sleep study for one patient, who turned out to have sleep apnea.

Kagan has begun using a home-grown HRA in conjunction with Medicare wellness visits, he says. His partner built an EHR template for an annual wellness visit that includes the HRA and questions about activities of daily living and the patient’s physical environment.

FUNCTIONAL STATUS SURVEYS

Functional status surveys, which measure how patients feel about their health and their ability to cope with activities of daily living, have been around for decades. They can be used to measure outcomes and to manage the care of patients who are recovering from procedures. But they are still little-used outside of academic medical centers.

One reason is that many doctors don’t believe that the data from these surveys are as valid as objective clinical measures. Iezzoni rejects that view.

“I think there’s always an inherent validity to what the patient says,” he says. “They’re the ones who are living in their body, they’re the ones who have to perform activities of daily living or get someone to help them with it. So even if a physician disagrees with a patient’s assessment from a patient-reported survey, it’s important for the physician to understand what the patient’s perceptions are.”

Kagan, who cares for a lot of Medicare patients and does work in nursing homes, uses a functional status survey with his hospice patients. The survey includes basic questions about their ability to talk, walk, hold their head up and so forth, he says. This kind of instrument could also be valuable to doctors in measuring the functional status of other elderly people, he adds.

At Dartmouth Hitchcock, a New Hampshire health system that includes an academic medical center, functional status surveys have been used in the spine center for 20 years and, more recently, in the orthopedic surgery department. The spine center uses a 36-question general survey, plus shorter questionnaires on conditions such as back pain.
When Sohail Mirza, MD, was recruited to chair the orthopedics department in 2008, he implemented a series of short functional status surveys as part of a streamlining of the department’s overall workflow. These surveys—distributed online or in the waiting room—were integrated into the group’s EHR. For the past five years, they have been used routinely in knee replacement surgery and in hip operations. About half of the patients complete them online, and the rest do it on tablets in the waiting room.

Now medical director of Dartmouth-Hitchcock’s Center for Surgical Innovation, Mirza says that the orthopedics department has each new patient fill out a generic survey, which takes about 10 minutes. When patients undergo an elective procedure, they’re asked to complete a shorter survey with more detailed questions. The results are available in the EHR for physicians to see when they’re interviewing patients.

One purpose of the baseline functional status surveys is to help surgeons discuss the appropriateness of surgery with patients. “After five years, we have found that

PATIENT-GENERATED HEALTH DATA: What are the concerns?

Provider Concerns
Providers may be hesitant to accept PGHD because they fear an influx of information that might interfere with their ability to deliver quality care. Such providers may be concerned that they will have the burden of reviewing large amounts of data, leading to increased liability and unrealistic patient expectations.

Specifically, there are concerns about providers being held accountable for information that was not received or reviewed in a timely manner and information that may require an urgent response. Additionally, some providers have expressed concern about the financial impact of PGHD including the use of staff and physician time for reviewing, processing and analyzing the data and potentially integrating it into the EHR.

Patient Concerns
Patients may be concerned about their providers failing to use PGHD to meet their health care expectations.

Concerns may include whether their doctor or her staff has received or seen the data the patient sent and if they will confirm receipt; whether the information sent was saved in the patient’s chart; whether the information was shared with his or her provider or family members as appropriate; whether the information was securely received and stored; and whether the patient generated data is valued and well-received by their doctor.

Technical Issues
Technical and data standards are vital to the effective use of PGHD.

The information must be collected and submitted in standardized ways that ensure that the information cannot only be received but also understood and integrated into the EHR if desired. Consumer-friendly vocabularies will need to be identified and integrated into patient portals and eHealth tools to help patients submit useful information. In a dynamic consumer eHealth environment, it will be critical to balance the need for initial standards to jump start PGHD activity and the need to enable innovation, which requires allowing standards to evolve.

Also, given the importance of provenance in PGHD, the technical shortcomings identified in the environmental scan mentioned above will need to be addressed.

Privacy and Security Issues
All stakeholders need to be assured that PGHD is private and secure. Authentication of the patient (or caregiver if that person is submitting information) is critical to ensure that information can be attributed to him or her with confidence. A method of linking specific information to its source will be important in tracking data as it moves from system to system, particularly from patient-controlled sources to provider EHRs, so that the integrity of the data can be ensured. There could be a need to address patient authorization for secondary sharing of PGHD, if the patient prefers that the data not be shared with other providers or for other purposes. The identity of and authorization for providers and staff receiving or accessing the information needs to be established. Transmission must be secure; encryption may be desired.
these baseline scores are very predictive of where patients end up three months, six months and a year after surgery," Mirza says. "Take knee surgery. Some patients are doing so well that they’re not going to gain a whole lot more in terms of function by having a knee replacement." If a patient’s score indicates that the patient is unlikely to benefit from a knee operation, the surgeon advises him or her of that.

The physical function scores on surveys taken after surgery help doctors gauge the speed of a patient’s recovery and decide what kind of therapy they may need, Mirza says. The score at 30 days after discharge indicates whether the patient is on track with other people like them, and how much more rehab they are likely to need.

### SHARING VISIT NOTES

In recent years, the idea of sharing visit notes with patients has gained traction among physicians, partly because of the Open Notes studies done by Harvard Medical School researchers. These studies indicated that visit note sharing increases patient engagement and medication adherence.

Now some of the same researchers are working on a pilot to find out what happens when patients are encouraged to comment on and add to their doctors’ notes. In addition, an offshoot of the Open Notes project called Our Notes is investigating the concept of having patients contribute to their notes before, during and after visits.

UCLA’s Mafi leads the Our Notes project. The aim of his research, he says, is to find out how to get patients more engaged in their own care. Pre-visit data entry is already occurring in some practices, and doctors who share their notes with patients may receive comments from them, he points out.

But experts have told Mafi’s team that having patients co-document encounters with physicians is a challenge because of workflow issues. “This is rare and I don’t think we’re ready for it yet, but it could be part of the future,” he says.

Sands of BIDMC is among the rare doctors who does this in his practice. He and the patient both look at the EHR during a visit, and he shows the note to the patient as he writes it. But for this arrangement to work, he says, the computer must be properly positioned and the doctor must know when to interact with it and when to talk with the patient while not typing in the computer.

In addition, Sands has started copying his notes for patients. He hasn’t had any problems with this, although it has altered how he documents visits in some ways. When a patient wants to add to or correct something in the note, he says, he inserts an addendum. (Legal considerations prevent changes to a note after it’s been signed, he says.) So far, few patients have asked to change anything.

Pearson has been sharing notes with his patients for 30 years. “I tell them to read the note, and if they see anything that I misheard or that they disagree with, to tell me so I can fix it or make an addendum,” he says.

Whenever possible, he tries to finish the note in the exam room with the patient present so he can confirm the facts. Otherwise, patients can look at the note later and correct it if necessary, he says. While he’s usually accurate, sometimes patients will pick up errors.

Kagan also shares notes with patients, and sometimes they ask for corrections. In his experience, “most of the corrections have to do with social kinds of things.” For instance, patients might not want to be characterized as smokers or drinkers, or they’ll insist they don’t have hypertension, because they take antihypertensive drugs that keep their blood pressure down.

Most physicians already use some form of patient-generated data in their practices. But workload, liability and financial issues must be resolved before its use is widely expanded.

In addition, the lack of integration between EHRs and applications used to collect patient-generated data must be addressed before doctors can use more of this type of information in their everyday work. Particularly with functional status surveys, some doctors must be convinced that patients’ contributions to the record are as valid and as useful as clinical data.

Despite these obstacles, it’s likely that there will be an increased focus on patient-generated data as the industry moves to population health management, which requires continuous communication with patients. Notes Danny Sands, “With ACOs stressing value-based care, people are going to realize that they have to think outside the visit.”
Doctors, don’t fear the death talk with patients

by LISA PRICE, MD Contributing author

The advance directive: The words instill a sense of foreboding, a finality few are prepared to face. I have discussed advance directives countless times during my career with older adults and their families. This conversation can be challenging because people often don’t want to think or talk about their death or the death of a loved one. Physicians also can feel trepidation anticipating this conversation.

A RECENT SURVEY of 735 physicians by the John A. Hartford Foundation, the California Health Care Foundation and the Cambia Health Foundation reported that 46% felt unsure of what to say.

In addition to the challenge all of us face in discussing death, there are other barriers to overcome. In this same study, 29% of physicians reported having received no formal training in discussing end-of-life issues, 29% reported their practice had no formal system for assessing a patient’s end-of-life wishes, and 24% reported that their electronic health record did not have a place to indicate a patient had an advanced care plan.

As recently as 2009, the discussion of end-of-life care was linked to the politically-charged term “death panels,” and providers were not reimbursed for having these often complex and difficult discussions.

Having the talk

Despite the barriers, physicians overwhelmingly (99%) recognized the importance of having these conversations with their patients. As more and more Americans become older—10,000 of us turn 65 each day—improving comfort with and skill at having discussions of end-of-life care will become increasingly important.

In January, the Centers for Medicare and Medicaid Services (CMS) began reimbursing health providers $80 for having at least a 30-minute conversation with their patients regarding advanced directives. Hopefully, the fact that CMS recognizes the importance of this service will lead more people to have these conversations with their doctors.

CMS isn’t the only one who finds these conversations important: patients value them as well. The Centers for Disease Control and Prevention found that 60% of Americans said it was important for their families not to be burdened at the end of their lives.

The presence of advanced directives has been associated with bereaved families reporting greater use of hospice care by their loved ones and fewer problems with communication with providers. There are resources available to help providers start the conversation and improve their skills. One is The Conversation Project (http://theconversationproject.org), which contains tool kits for starting the discussion. These are general or disease-specific, and intended for both providers and the public.

Another is the Physicians Order for Life Sustaining Treatment Paradigm (POLST). It has a website containing information, tools and training resources for providers, patients and families.

Providers must overcome the challenges inherent in having this uncomfortable conversation for the good of older patients. Physicians agree nearly universally (99%) about the importance of having advance directive conversations as a way to honor older patients’ end-of-life wishes. Providers must start the conversation with families, caregivers and older adults. By opening the dialogue everyone involved will benefit from “the talk.”

Lisa Price, MD, is chief medical officer at InnovAge, in California, Colorado and New Mexico. She is board certified in internal medicine and geriatrics. Send questions to: medec@advanstar.com.
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Malpractice reform efforts pit uniformity vs state autonomy

A malpractice reform bill introduced earlier this year in the U.S. House of Representatives, the latest attempt to rein in medical malpractice awards on a national level, already has run into some conservative opposition on Capitol Hill.

The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2016 is supported by several medical groups, such as the American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP), as well as by insurers, while the American Bar Association (ABA) opposes it.

Key provisions of the measure include a $250,000 limit on non-economic damages in medical malpractice cases, a “fair share rule” that allocates damages in proportion to fault, a time limit of three years after manifestation of injury for filing suits or one year after the claimant discovers the injury, whichever occurs first.

The bill also places limits on the fees attorneys can collect from claimants in malpractice cases, setting a sliding scale from 40% of the first $50,000 awarded to 15% of any amount over $600,000.

Neither backers nor opponents think Congress will act on the measure in presidential election-dominated 2016. Rather, they expect the issue to surface in the next Congress.

“We think we need uniformity whereby doctors will be playing by the same rules and patients will have the same rule all across the country,” says Mike Stinson, vice president of government relations and public policy with the Physician Insurers Association of America (PIAA) regarding the group’s support for the measure.

The ABA, in a letter to the House Judiciary Committee, argues that medical liability is an issue for states, not the federal government, to regulate. “For over 200 years, the authority to determine medical liability law has rested in the states. This system, which grants each state the autonomy to regulate the resolution of medical liability actions within its own borders, is a hallmark of our American justice system,” the association says.

Some conservative members of the House Judiciary Committee have raised the same issue about the proposal. The Judiciary Committee has postponed marking up the bill because of the conservatives’ objections over the states’ rights issue.

In a rare display of bipartisanship, several committee Democrats also voiced opposition to the bill, agreeing with conservative Republicans that medical malpractice should be left to states to address.

Similar measures have been introduced in Congress in the past but failed to pass. “We’ve supported an iteration of this bill for years now,” notes Ryan Crowley, ACP senior associate for health policy.

In its letter of support for the measure, the AAFP wrote that it “supports the HEALTH Act’s significant reforms that will help repair the flawed medical liability system, reduce the growth of health care costs and preserve everyone’s access to medical care.”

Proponents argue that limiting malpractice claims on a national level will mean doctors will have less reason to practice defensive medicine, ordering numerous tests to cover themselves against potential lawsuits, and that in turn will reduce costs. Lower premiums and less fear of malpractice lawsuits would encourage more doctors to continue practicing, backers have said.

But UCLA law professor Allison Hoffman, JD, contends that while various state efforts to rein in med mal claims may have cut insurance premiums for doctors, problems remain. “The evidence on where that improves the quality of care or physician supply is still really inconclusive,” she says. “These laws have definitely cut claims. But that’s not the end goal.”

John Frank is a contributing author. How should Congress reform medical malpractice? Tell us at: medec@advanstar.com

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