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PAYMENT REFORM
Washington pitches new rules to reimburse doctors

THE FATE OF
INTERNATIONAL
MEDICAL GRADUATES
By its own account, the federal government has spent more than $35 billion to get the nation’s physicians to use and share data via EHRs. Yet, it continues to be thwarted by technology that retails for less than $100: the fax machine.

CMS Administrator Seema Verma said recently that EHR technology is making physicians’ work harder, causing more burnout. As a result, physicians are turning to fax machines as the next best thing to share data.

Yes, that staple of the 1980s remains more technologically consistent for some physicians than the sleek, drop-down menu-driven software CMS and other agencies have banked on to revolutionize healthcare. And it’s this subset of medical Luddites that’s causing a thorn in the side of regulators.

So much so that Verma gave health IT developers a mission: “Help us make every doctor’s office in America a fax-free zone by 2020,” she said, speaking at a recent ONC Interoperability Forum in Washington, D.C.

Now here’s what Verma means: It’s 2018. We do everything on smartphones from detailed records of every morsel of what we’ve eaten this week to how many steps we’ve taken. But in healthcare, our healers would rather figure out whether you transmit a paper record face up or face down in a fax machine than utilize our $35 billion investment. Let’s get to interoperability.

Verma touted a future featuring a truly interoperable healthcare system where patients can access records at any time and physicians can communicate effectively and efficiently.

“The reality is that once information is freely flowing from the patient to the provider, the advances in coordinated, value-based and patient-centric care will be even greater than anything we can imagine today,” she said.

Who can blame physicians for using tried-and-true communication that has served them well for years? It doesn’t make them “old school” or non-believers in technology, it makes them smart doctors. They don’t spend time on the phone with customer support, develop work-arounds to make the tool work for them, and they don’t spend thousands a year to maintain their fax machines.

Physicians are intelligent group. Until interoperability becomes a reality, they will use all tools at their disposal to effectively treat their patients. If the end of the fax machine means the dawn of true EHR interoperability, they’ll be the first one to turn in their ink cartridges.

But until the government can stop talking about interoperable systems and make them a reality, a “send” button may be the least stressful option for many of the nation’s physicians.

Keith L. Martin is editorial director of Medical Economics. Do you think true interoperability is possible by 2020? Tell us at medec@ubm.com.
EHR Report

Despite EHR frustration, physicians still not switching systems

Overall, how satisfied are you with your current EHR system?
- Very satisfied: 6%
- Satisfied: 24%
- Mixed: 32%
- Not satisfied: 20%
- Not at all satisfied: 18%

Is your practice considering switching to a different EHR system in the next year?
- Yes: 13%
- Not sure: 18%
- No: 69%

The 2018 Medical Economics EHR Report will provide exclusive physician survey data on the performance of their EHR systems. Full results in our October 25 issue.

Bloggers

"Without an added investment in primary care, innovation will be stifled, and we will not see substantial reductions in overall cost of care. Only a strong collaboration between payers and health systems, between self-insured employers and primary care groups, can achieve this outcome."

Glen R. Stream, MD, and Michael Tuggy, MD, on the true way to deliver value in healthcare

"Most clinicians are able to buy the groceries they want and need, and drive or take public transportation easily to work, appointments, and the grocery store. The majority of primary care providers live in safe neighborhoods. Many of our patients are not so fortunate."

Lori Rousche, MD, on implementing a team approach to address social determinants of health

Slideshow spotlight

10 internists to follow on Twitter

Check out 10 internists who offer unique and engaging content to their followers on Twitter.

For more, visit bit.ly/IMs-on-Twitter.

Topic Resource Center

HEPATOLOGY
- Direct-acting antiviral combo effective in hard-to-treat Hep C genotype 3
- DAA combo retreats chronic Hep C failures
- More than one-third of Hep C patients denied insurance coverage

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The nation’s largest physician-owned insurer is now expanding in New York.
Portal problems not extensively outlined

With regard to the articles in the July 10 Medical Economics ("Patient portals showing mixed results" by Jeffrey Bendix, and “What’s the future of patient portals?” by Mary K. Pratt), four important points were not sufficiently emphasized in the articles.

The first involves the degree of liability on the part of the physician for maintaining and responding to up-to-the-moment data on the portal. This first point could just as easily be made for earlier types of electronic correspondence, such as email, where Mr. Smith sends an email to the doctor at 3:30 a.m. complaining of chest pain, and for whatever reason (system or network failure, etc.) the message is not received by the doctor in a timely manner (or at all).

The second involves the possibility of the patient acting on her/his own in response to the portal data (the Dr. Google scenario), where the patient could search for OTC “treatment” for a perceived abnormal lab result in a manner that could potentially be harmful. This could also put the physician in a compromised position, legally, despite the fact that the physician made no specific recommendations.

Third, there is the general notion that the patient can simply set an appointment without follow-up from staff, that Mrs. Jones will be an adequate judge of the severity of her perceived illness, and that she will also be able to determine how long a visit she’ll need with the doctor.

This ignores the fact that often staff will be familiar with a patient’s history, whether that patient is prone to anxiety or exaggeration, or whether, conversely, the patient may be downplaying a potentially serious illness, and will schedule what perhaps should be an acute visit in two weeks. This carries possible liability problems for the physician that no “portal-use agreement” will handle in a serious legal situation.

Finally, there is mention of a need for a centralized patient portal. This would be effective only if we have a national database set up with adequate security, to which both patients and physicians have access. The current splintered system of non-interoperable databases, run by competing private for-profit enterprises, benefits no one except the shareholders and the MBAs whose job it apparently is to promote such systems.

Kurt Kaufman
PUTNAM, CONN.

Prior auth moratorium the ‘real solution’

Writing in “Your Voice” (“Place a moratorium on prior authorizations now,” June 10), Michael Berard, MD, is right.

Prior authorizations are a source of confusion and inconvenience to patients, and a time-consuming distraction for doctors and their staff.

A moratorium is a good idea.

The pharmacy benefit managers are just one more example of insurers’ disregard for how they restrict doctors’ freedoms to act in the best interests of their patients.

The real solution is for lawmakers to eliminate prior authorizations altogether.

Edward Volpintesta, MD
BETHEL, CONN.
Many physicians overwhelmed by burnout

Physician burnout—the feeling of being overwhelmed, stressed, and anxious about the daily grind of practicing medicine—is regularly discussed. But one aspect perhaps less discussed is its prevalence. A new physician survey from The Medicus Firm, a physician recruiting company, found that roughly 90 percent of physicians surveyed said they had experienced at least one symptom of burnout in the last year. The symptoms were described as mental or physical exhaustion, compassion fatigue and patient depersonalization, and lack of efficacy (in other words, a physician’s doubt as to the meaning and quality of his or her work).

**FINDING:**
Few physicians escape feelings of burnout

Q: Physician burnout is reportedly a growing trend among the physician workforce. Which of the following symptoms of burnout have you experienced, if any, in the past year?

- Exhaustion — physical or mental
  - Never in the past year: 11.33%
  - Some/occasionally experience: 43.71%
  - Frequently: 34.93%
  - Overwhelmingly: 9.42%
  - Not sure/neutral: 1.15%

- Compassion fatigue / depersonalization
  - Never in the past year: 18.66%
  - Some/occasionally experience: 47.33%
  - Frequently: 25.3%
  - Overwhelmingly: 7.32%
  - Not sure/neutral: 1.56%

- Lacking efficacy (Doubting the meaning or quality of your work)
  - Never in the past year: 26.83%
  - Some/occasionally experience: 44.68%
  - Frequently: 19.31%
  - Overwhelmingly: 7.32%
  - Not sure/neutral: 1.86%

**FINDING:**
Many physicians regret their career choice

One of the consequences of this burnout is that more than one-third of survey respondents said they regretted or had doubts about their choice of career.

Q: Would you choose medical practice as a career if given a chance to re-start your career?

1. Never in the past year
2. Some/occasionally experience
3. Frequently
4. Overwhelmingly
5. Not sure/neutral

1 in 5 physicians said they either probably definitely not choose medicine again

17% said they were unsure

As a result of these stressors, the report also found that as many as 1 in 5 physicians said they would have chosen a different career if they could go back and do it again.

35% of physicians surveyed said they frequently experienced physical or mental exhaustion during the past year.
How blockchain could make waves in healthcare

by CHERYL ALKON Contributing author

Blockchain technology enables multiple users to upload information into a single database that can be shared among all the users.

The technology has the potential to streamline healthcare delivery by, among other benefits, reducing the number of claim denials by improving the accuracy of data.

HIGHLIGHTS

- Blockchain technology promises to disrupt the healthcare industry and how many physicians practice medicine.
- Blockchain technology, in many ways, is like Google Docs, the online platform where a group of users can contribute to and edit a shared document to create a record of information—but perhaps a bit more sophisticated.
- Blockchain, often associated with cryptocurrency and digital trading, is a cooperatively maintained repository for information. The technology enables multiple users to upload and share information to provide a single accurate collection of details using a blockchain database, according to Mike Jacobs, senior engineer of Optum, a business unit of UnitedHealth Group.
- Physicians should be aware of the technology, because it could potentially improve healthcare delivery through sharing information. For example, blockchain can aggregate health records from other providers for more effective healthcare delivery that isn’t tripped up by, for example, health insurance claims getting denied due to inaccurate patient data.
- Looking at it more closely, the blockchain users could be multiple companies, such as medical provider groups and health insurance companies, who want to access the same information so insurance claims can be processed and paid efficiently the first time. Some small bits of information can be stored on the blockchain itself, but the rest of the data is kept in existing user’s computer systems or “off-chain”—in other storage locations.

In this case, the blockchain stores information about transactions, such as the time stamp and where the data lives. To gain access to data, users must have a special password. “You want to have the two ends of the transaction have the same information for it to happen in a frictionless way,” says Jacobs.

A ‘SINGLE SOURCE’

So what’s the use of this new concept in medicine? Take the example of insurance claims. Currently, numerous problems often come up when processing claims, because details about provider contacts, provider information such as an in-network designation, and/or insurance rules regarding coverage can all result in data that don’t match up among companies’ databases.

“It results in islands of data that are intended to cover the same information but can fall out of sync,” Jacobs says. “It causes problems, phone calls and faxes ensue, and there are many questions about, ‘Why was this claim rejected?’’ Blockchain can provide a single source of accurate information, thereby avoiding such problems, he says.

Blockchain is also known as distributed ledger technology. Just as a person keeps a ledger when paying bills, blockchain is the same—only in an electronic format, says...
Technology

Debbie Bucci, IT Architect with the Office of the National Coordinator for Health IT, a part of HHS.

“Multiple workers or participants are writing to it at one time, and they can craft different transactions one at a time and can’t erase it.” Writing to the blockchain means users can contribute to it at the same time while having access to the same accurate data at the same time.

While different parties add to the blockchain, the information itself remains in its original location whether that data is in an EHR or some other storage mechanism, notes Corinne Proctor Boudreau, senior solutions manager of physician experience of MEDITECH, an EHR vendor based in Westwood, Mass.

“Neither the blockchain or any particular entity takes a copy of and owns the data,” she says. “The distributive nature helps ensure data is stored where it originated from and in an unaltered state, thus providing a true historical record.”

**BLOCKCHAIN IN HEALTHCARE**

Blockchain’s healthcare applications are still emerging. In April 2018, five large healthcare organizations—Humana, the MultiPlan PPO network, Quest Diagnostics, UnitedHealth Group, and Optum—announced a blockchain project to incorporate provider data, such as name, address, specialty, and phone numbers, into one comprehensive database.

The goal is to run a pilot among the five companies through October, with results released in November and December, says Lidia Fonseca, MBA, MBI, chief information officer of Quest Diagnostics. Fonseca sees the alliance as a model of collaboration for quality improvement.

“It’s exciting and a great example of where companies are willing to cross company boundaries to bring benefits to the industry,” she says. The alliance hopes to help reduce some of the administrative burden for providers so that they can spend more time with patients and less on administrative tasks, Fonseca says, while also decreasing payment times.

Those tasks, which include time spent on phone calls and faxes to find out why claims are denied, added an estimated $2.1 billion across the healthcare system, according to statistics compiled in 2016 by the nonprofit Council for Affordable Quality Healthcare, which studies how to streamline the business of healthcare.

**WHAT’S NEXT?**

Opinions differ on whether blockchain can help healthcare. Some feel strongly that the concept can bring many benefits. Others think it’s too early to say whether blockchain can have an impact.

On the “benefits” side is Robert Chu, MEng, MCS, founder and CEO of Embleema, a Metuchen, N.J.-based healthcare blockchain network that launched a public beta release in mid-July. It allows patients to share their medical histories with providers, and in future versions, with pharmaceutical companies seeking subjects for clinical trials and, potentially, with health insurers.

Embleema secures data so providers can see a complete medical history without the need for patients to fill out forms at every visit. Pharmaceutical companies seeking patients for new clinical trials will also be able to search Embleema’s database in the future to find candidates.

“All data on the blockchain is fully controlled by the patient and will show a complete trail of who accesses that data,” says Chu.

Others are more skeptical.

“At this point, nobody has actually proven that blockchain will work in healthcare,” Bucci says. “I don’t think anyone has clearly demonstrated what patients will see or get out of it, nor has the industry been successful, beyond proof of concepts.”

Though blockchain may be difficult to understand, it is gaining momentum in healthcare and other industries such as finance. It’s a way to improve the accuracy of information shared among different users that can ultimately lead to better patient care and less time following up on inaccurate insurance claims, allowing physicians to spend more time with patients and less time on administrative tasks.

“Ultimately, it’s another tool in the box,” says Boudreau. “As with any tool, it is better suited to some uses than others.”

“At this point, nobody has actually proven that blockchain will work in healthcare. I don’t think anyone has clearly demonstrated what patients will see or get out of it, nor has the industry been successful, beyond proof of concepts.”

—DEBBIE BUCCI, IT ARCHITECT, ONC
HOW YELP MADE ME A BETTER DOCTOR

By Gloria Kim, MD

The Yelp review was searing. “Dr. Kim was a horrible doctor to work with,” she wrote, “everything from the wait times to the receptionist, to the nurses, to the bedside manner of the doctors has been appalling.” The writer minced no words. In paragraph after paragraph, she skewered everything about me and my office with vehement gusto. Reading this review, I was horrified and shocked. I couldn’t recall any patient interaction that went so horribly wrong or any patient who seemed to hate me so much.

I found her record. I had seen her multiple times and in fact had prescribed her Clomid, which successfully resulted in her current pregnancy. She was an anxious person and often had questions every visit. She had even gone to the ED for some concern, where they had found nothing wrong and discharged her. On her follow-up visit, I briefly reviewed her symptoms and also found nothing concerning. I reassured her and concluded the visit. Apparently, she was irate and soon after, transferred out of our office and wrote her scathing online review. There had been no missed medical diagnosis or poor outcome, she was just furious with my interactions.

For days and even months, her words rang in my mind. I was tempted to disregard her review as just an isolated histrionic person who hated me. Maybe she didn’t like me because she was “….” (and filled in the blank with all sorts of “-ist” views). Many times, I suspect doctors blow off these negative reviews as being by one of those impossible-to-please patients. We probably even try to cheer up our colleagues or ourselves by suggesting the reviewer was emotionally unstable. The truth was, her review really hurt. I care about what my patients think and wanted them to like me.

Once my initial anger and defensiveness calmed down, instead of discrediting her review, I objectively considered all the negative things she had said. I had spent a lot of time during her gynecologic visits and her new OB visit, but her subsequent OB visits were 10-minute slots. I was more focused during these times and shifted into a more routine checklist visit. Frankly, knowing she took more time than the typical OB patient, I avoided asking open-ended questions and tried to run through her list of questions as quickly as possible.

At that time, we had also switched to an EHR and for efficiency and accurate documentation, I was typing and talking to patients at the same time. The desk was placed such that if I wanted to use it, my back was to the patient. I realized that some patients took this turning away as an outright lack of interest and empathy.

After reading her comment where she said I never looked at her, I began swiveling around to face each patient and placed the laptop on my lap. I made sure to provide regular eye contact when patients were talking, to make sure they felt heard.
As for her anger about the long wait times, I realized that too often, I was running behind a lot—spending sometimes over an hour with a distressed patient, while letting my other, on-time patients wait. When a woman scheduled for a 20-minute annual began telling me of her disintegrating marriage, I handed her Kleenex and talked without looking at the clock. When another patient told me of her teenage son’s horrific and tragic death, I just couldn’t wrap it up. How can you neatly wrap up a child’s death in 30 minutes? I hadn’t become an OB/GYN just to brush cells off someone’s cervix.

But I ran behind without regard for my other waiting patients and that too, I realized, was unfair and something I needed to change. I made up for these unscheduled extra-long visits by trying to be ultra-efficient with my other patients and especially my routine OB visits. But I realized that this could leave my other patients feeling short-changed. For me, a 30-minute annual exam is one of many that day. But for that one patient, it is often their one time a year visit with me—a precious 30 minutes carved out of 365 days. I needed to remember that.

Also through this 1-star review, I understood the power words have over people and even reputations. After reading my own review, I wouldn’t have wanted to see me either! The verbal vitriol someone spews online in a moment of anger can have lasting effects on their target. While I rarely write online reviews, it made me think twice when tempted to vent online. Was I writing to vent or help other readers with a fair review? A fair review is measured and objective even if it isn’t positive. A vent is palpable with passion—bursting with words banged out in hell-bent fury.

Fortunately, most Yelp readers know that even 4½-star restaurants get their share of 1- or 2-star ratings. It’s probably true that no one doctor can make 100 percent of their patients satisfied and happy. I also needed to accept that. On the other hand, I shouldn’t blow off every negative review as thinking the patient was crazy or had an undiagnosed personality disorder. Online reviews are an increasingly important factor in medicine. Seventy-two percent of patients use online reviews as their initial step in finding a doctor, according to Software Advice, and 80 percent of consumers trust online reviews as much as personal recommendations according to a report by BrightLocal and the National Research Corporation.

With increasing focus on productivity, EHRs and documentation, ultimately we have less time to spend with patients. But with patient reviews being factored into provider’s evaluations, physicians are in a no-win situation.

Somehow in a shortened time slot, we need to make our patients feel listened to and their concerns adequately addressed. I once even read an article by a physician who raised his lagging ratings just by thanking each patient at every visit. Part of residency training should include a patient psychology class in how to make patients feel satisfied while actually spending less time with them.

Ralph Waldo Emerson wrote something I never forgot: “Every man I meet is my master in some point, in that I learn of him.” That quote has served me well over my career.

In every challenging interaction, in every unanticipated outcome, once my initial gut reaction subsides, I ask myself, “What, if anything, could I have done better? Is there something I need to change or improve?”

While the 1-star review hurt my feelings and my pride, it didn’t kill me or my practice, I learned from it and I grew. I still run behind often, but not to the degree I used to. I’ve learned to slow down once I step inside a room, face the patient, make eye contact and let them feel heard.

In the same way, I’m acutely aware of the other patients whose time is just as valuable, each patiently waiting for their allotted time with me. And I make sure to thank each one for waiting.

Gloria Kim, MD, is an OB/GYN in the Chicago suburb of Downers Grove, Ill., where she has practiced for eight years. She finds caring for patients the most rewarding aspect of her work. “I love encouraging them to live healthier and happier lives,” she says.

Kim believes many members of the public mistakenly believe that doctors are all rich and live extravagant lives.

“Most doctors I know work really hard and have made a lot of sacrifices to achieve and maintain their careers,” she notes.

When not at work, Kim enjoys playing the piano and the cello and cooking vegan dishes. When she retires from medicine she hopes to use her OB/GYN skills overseas, performing mission work.

To read all of this year’s Physician Writing Contest winners, visit: bit.ly/2018-PWC-winners
How can we get paid for addressing our patients’ mental health issues?

While any visit offers an opportunity to discuss the potential for mental health issues, one of the best opportunities to learn about a patient’s mental health is during the annual preventive visit, commonly known as a physical. This visit focuses on the patient individually and is a good time to ask questions regarding mental health, stress, activities of daily living, and sleeping, eating, and work habits.

At right are the codes that should be billed for these visits. They are based on the patient’s age and whether he/she is a new or established patient.

Also, keep in mind: If an illness or abnormality is encountered or a preexisting problem is addressed in the process of performing the preventive medicine service, and if the illness, abnormality, or problem is significant enough to require additional work to perform the key components of a problem-oriented evaluation and management (E/M) service (history, physical examination, medical decision-making), the appropriate office or other outpatient service code (99212–99215) should be reported in addition to the preventive medicine service code. Modifier -25 should be appended to the E/M code to indicate that a significant, separately identifiable E/M service was provided by the same provider on the same day as the preventive medicine service.

Renee Dowling is a billing and coding consultant with VEI Consulting in Indianapolis, Ind. Send your coding and billing questions to medec@ubm.com.
Opening an urgent care facility may just be the perfect business opportunity. It fits doctors’ skill sets and can supplement income or provide more independence while tapping into a physician’s entrepreneurial nature. But, according to those who have made the leap, the hours are long, the profits margins are thin, and the financial risks are high.

“I wish I knew before I opened my urgent care how many hours I would have to put in,” says George G. Ellis, Jr., MD, FACP, chief medical adviser to Medical Economics. Ellis owns the 910 Rapid Care clinic adjacent to his private practice in Youngstown, Ohio. “The private practice and urgent care consume about 90 hours a week for me.”

For a new urgent care to succeed, physician-owners must carefully research all the details about the location under consideration, the services and staffing requirements, and accept the fact that urgent care medicine demands a different mindset than private practice.

But when done right, urgent care can be an opportunity to help meet the medical needs of the community while providing financial rewards for the long hours and risks a physician must take to open the doors.

WHERE TO START

“There are a lot of people that think of opening an urgent care as a construction project, but that’s just 20 percent of what needs to be done and what they need to be thinking about,” says Laurel Stoimenoff, PT, CEO of the Urgent Care Association, which provides accreditation and resources to urgent care facilities. “Like studying for an exam, a lot of work needs to go in upfront before you start.”

The first thing to understand is the financial commitment. Stoimenoff says it will most likely take between $800,000 and $1.2 million to build and open an urgent care, depending on facility size and location.

And experts say location is extremely important. “This is retail medicine,” says Thomas Brown, MD, an internist and founder of Kathy’s Urgent Care, which operates three urgent care centers in the greater Hartford, Conn., area and has leases signed to open two more in the next several months. “The first consideration is what’s a viable location that will be profitable, and that entails a detailed demographic analysis.”

This analysis should include population density in a one-, three-, and five-mile radius around the proposed clinic. To be successful,
an urgent care needs at least 30,000 people within five miles, says Stoimenoff. The analysis also should include daily traffic counts on the street where it will be located, ease of getting in and out, number of parking spaces, and nearby competition.

“Find a visible location that is easy to get to,” says John Kulin, DO, an emergency medicine physician who is the founder and CEO of six Urgent Care Now clinics in the Philadelphia area. “Sometimes the most visible spot is not the easiest to get to.” For example, a potential location may be easily seen from a busy road, but doesn’t have direct access, making it inconvenient for the patient.

An average urgent care requires about 3,000 square feet, which usually translates to six exam rooms plus space for a lab and X-ray equipment, says Stoimenoff. But the total square footage will depend on the amount of competition and how many patients are expected to be seen each day. For example, Kulin says that in 2005 when his urgent care was the only one in the area, he built a 5,000-square-foot facility. As competition increased and patient counts decreased, the space requirements shrank. The facility he opened in 2017 required only 2,500 square feet.

GET CONTRACTS AND CREDENTIALS
With a possible location identified, the next step is to obtain payer contracts. “A lot of insurers are closing or limiting panels,” says Kulin. “I’ve seen urgent cares open up that did not even have the major insurers in the area and suffered the consequences. Even if it takes another three to nine months to get the contracts set up, if you are paying $70,000 a month in payroll, it’s worth it to wait.”

Brown says not getting credentialed early enough with insurance companies can cripple an urgent care’s cash flow in those crucial first few months and create difficult choices. “Should you turn away patients because you aren’t credentialed with the insurance company yet or see them for free and hope that four months from now when you get credentialed that they will retroactively pay for folks?” says Brown.

And while insurance companies understand the value of urgent cares as a means to keep patients out of more costly emer-
More people are getting into urgent care, thinking it’s easy or a great place to make money, but that’s not really true. It’s a good place to earn a living, but not a great place to get rich.”

—JOHN KULIN, DO, EMERGENCY MEDICINE PHYSICIAN, FOUNDER AND CEO, URGENT CARE NOW, PHILADELPHIA

Emergency departments, the increasing number of facilities can make it more difficult to contract with payers. This is why physicians must understand the details of each contract to find out who is going to pay for what before investing money in a new urgent care, says Stoimenoff.

“Knowing and understanding reimbursement is key,” says Ellis. “If you don’t know what you are being paid for, then you are in trouble.”

**DESIGNING AND STAFFING THE FACILITY**

Doctors need to invest time considering the design of the facility, and understand that urgent care clinics require a more practical and utilitarian space than a private practice to keep building costs down.

“Watch your overhead as a new urgent care provider,” says Kulin. “We function on margins that are not huge, so you don’t want to build the Taj Mahal. The office should be neat and easy to keep up with infection control. You don’t need marble counter tops and other things that don’t make sense in an urgent care setting.”

The design of the space will also depend on what services will be offered. For example, 99 percent of urgent cares have X-ray capabilities, says Stoimenoff, and most provide some level of lab services.

“Before you put any services in place, find out if it will be reimbursed,” says Kulin. “Make sure that any service you are considering offering you have done a [return on investment] study for. Run it like a business and not just on the idea that, ‘It would be nice to have this.’”

Before starting his urgent care, Ellis made a list of equipment he needed and then prioritized it, getting the high-priority items first and adding the lower-ranked items later, he says. A physician must also strike a balance between having the required equipment and materials in every exam room versus wasting time looking for them, which can hurt the efficiency of the operation.

Experts advise carefully considering staffing levels based on the projected number of patients and the services offered.

“Once you are up and running, the biggest expense won’t be overhead, it will be payroll,” says Brown. Start adding up the salaries of any doctors beyond the founder, a mid-level, an X-ray technician, a medical assistant, a biller, and any other personnel needed to provide the services and the financial demands become apparent. “Payroll is the beast you have to pay attention to,” says Brown.

Some payer contracts require a physician to be on-site at all times while others do not, so that’s another reason to have contracts settled before any construction starts. But regardless of the mix of physicians, mid-levels, and technicians, Kulin says everyone has to work to the top of their license and be cross-trained to do anything that is needed, such as turning exam rooms around and helping with splinting or casting. “You have to run as lean as you can without affecting the patient experience,” he says.

And if business declines or falls short of projections, doctors must be willing to...
make staffing reductions. “When you come into the market, you are the disruptor and the new guy offering something new and different,” says Kulin. “Then others come in and disrupt you. How will you respond? You have to be prepared if patient volume drops down.”

ESTABLISHING THE BUSINESS
Running an urgent care requires a different mindset than a private practice, experts say. It’s not just about the building and the equipment. Urgent care patients are fickle and have more options. If they don’t have a good experience, they will try a different clinic the next time.

“Customer expectations are different,” says Stoimenoff. “Throughput time is something doctors need to be watching in an urgent care. In many cases, the wait time is under 15 minutes and almost always well under 30, and if the doctor doesn’t understand how to get them through triage and use standing orders, they will struggle.”

The provider should be able to walk into the room and get the patients treated and on their way as quickly as possible, she adds. This allows the physician to see as many patients as possible while also creating a positive patient experience.

“Urgent care is a different kind of care,” says Ellis. “You have to cater to the patient. If you don’t, you won’t see them come back.”

Kulin says that urgent care patients expect a better customer service experience, starting with registration and running through the nurses and physician. This means that to grow the business, physicians have to have methods in place to get feedback from patients.

“We have a mechanism through our EHR where we get reviews back from people and adjust to that, making sure all our staff is informed about anything said, both positive and negative, and looks for opportunities to make a better overall patient experience,” says Kulin.

“The customer is never wrong,” says Brown. “It kills me when a patient comes back and thinks we misdiagnosed something. I can try to explain, but it’s too complicated, so I just say sorry and write off the bill. I can’t imagine that happening in a primary care practice.”

A commitment not just to customer service, but strong operational principles is the only way to succeed. “Running [profit and loss] statements and proformas have to become part of what they understand,” says Kulin. “If it’s not in their wheelhouse, they need to make sure they have someone at the beginning who can help. Realistically, an urgent care is a medical retail business.”

Consumers shopping retail stores expect convenient hours, and the same goes for an urgent care. To be accredited by UCA, a site must be open seven days a week for a minimum of four hours a day, for at least 3,000 hours total. “But we see most open 12-14 hours a day during the week and eight to 10 hours a day on weekends,” says Stoimenoff.

Physicians should create consistent hours matched to the patient population and where the facility is located to reduce confusion and increase visits. “If you run different hours on different weekdays, that tends to be problematic,” says Kulin. “If you have a bedroom community where patients are coming in...”
“Once you are up and running, the biggest expense won’t be overhead, it will be payroll.”

—THOMAS BROWN, MD, INTERNIST, FOUNDER, KATHY’S URGENT CARE, HARTFORD, CONN.

MARKETING
Marketing tactics for a new urgent care depend on how much money can be allotted, but it starts with something simple.

“The best marketing you can do besides a good website is a good sign,” says Stoimenoff. “So many people will discover the urgent care because they drove by the sign five days a week. Don’t scrimp on your sign.”

Beyond a good sign, doctors have found success with different strategies.

Kulin relies primarily on community involvement for marketing, including sponsoring civic and school groups. “I’d rather help put up a scoreboard at a school and get a lot more goodwill than a billboard that I’m paying $30,000 a year for,” says Kulin.

Ellis also relies on word-of-mouth and school sponsorships plus a Facebook presence. “Early on I did some traditional advertising, but the problem was only one in 100 said they heard about us through an ad; everyone else was word-of-mouth,” he says.

Brown focuses on marketing his urgent care facilities before they open. “We do a lot of local ads roughly two to three months before opening, and you want to do a big grand opening with the mayor to help get the word out,” he says.

Another key to marketing is building relationships within the medical community to attract referrals, experts say. Stoimenoff says this could start with the local hospital system, where maybe the urgent care could operate under the hospital’s brand in exchange for financial support and referrals for more complex cases.

“A BIG CHALLENGE
Even when everything is done right, experts say running an urgent care is a big challenge.

“The operating margins are thin, the upfront expenses are huge, and the payroll expenses are enormous compared to a private practice,” says Brown. But there is a sense of satisfaction that comes from creating and growing a business, and while he says six months into his first clinic he couldn’t imagine opening a second, he’s now looking at opening a fourth and fifth.

Likewise, Ellis is looking to expand. “For me, it’s the satisfaction of seeing the facility grow,” he says. “There are days where we’ve outgrown the building, and those are becoming more frequent.” He’s contemplated opening a second facility, but the problem is finding qualified staff.

“More people are getting into urgent care, thinking it’s easy or a great place to make money, but that’s not really true,” says Kulin. “It’s a good place to earn a living, but not a great place to get rich.”
What’s behind the growth of urgent care clinics?

by CHERYL ALKON Contributing author

For Sean McNeeley, MD, patient care was what drew him to medicine. But the challenges of running his own private practice, with its growing administrative burden, made it hard to stay there. So he decided to limit his work to urgent care.

“I loved being in private practice, but it was a challenge in family medicine to be able to do it all well and balance time with my family,” says McNeeley, the medical director of University Hospitals Urgent Care Network based in Cleveland.

Board certified in both family and urgent care medicine, McNeeley ran his private practice from 1999-2004 while also working at an urgent care clinic for extra income. Ultimately, he closed his practice to work solely as an urgent care physician. Today he oversees healthcare providers at ten University Hospitals Urgent Care Network facilities, while still seeing patients every week.

“Working in urgent care gives physicians the ability to balance work and life, which has no on-call schedule, no nights, and limited weekends,” says McNeeley, who is also the president of the board of directors of the Urgent Care Association.

While urgent cares typically are open longer hours than practices, he notes that patients don’t expect to see a particular provider when they seek care at an urgent care clinic, so when a physician is off work, they are truly off. “I can feel good about what I’ve done during the day and I can go home and have some personal time,” McNeeley says.

Interest in, and demand for, urgent care clinics is growing rapidly. The number of clinics has ballooned from 6,946 in 2015 to 8,285 as of June 2018, according to Laurel Stoimenoff, CEO of the Urgent Care Association (UCA) and co-author of “The Essential Role of the Urgent Care Center in Population Health,” a 2018 association report. Behind those figures lies an $18 billion industry experts predict will grow 5.8 percent this year.

Urgent care clinics handle about 89 million patient visits each year, or more than 29 percent of all primary care visits in the country, and nearly 15 percent of all outpatient physician visits, says Stoimenoff.

Urgent care isn’t booming only because of physicians seeking a better work-life balance. Other factors driving the industry’s growth include patient demand, convenience, and costs.

MEETING PUBLIC DEMAND

Patients seeking medical care don’t want to wait. Urgent care clinics, with their longer hours and walk-in appointments, fulfill that need in a way traditional physicians’ offices can’t always accomplish.

“This is the age of the patient as a consumer, where fast and convenient is never fast and convenient enough,” says Richard Park, MD, CEO and co-founder of CityMD, a group of urgent care clinics in New Jersey, New York, and Washington state, and president-elect of the UCA.

Urgent care clinics blend retail elements such as ground-floor locations that provide...
Trends
The growth of urgent care

easier access, and the ability to schedule same-day appointments using an online calendar program. A customer-first approach, oriented to service and technology, is fueling growth, says Stoimenoff.

However, urgent care clinics could become victims of their own success, writes Len Schlesinger, DBA, Baker Foundation Professor at Harvard Business School, in a column for athenaiInsight: “The tension that I see now is that as these urgent care clinics compete for patients, they might lose the focus that made them successful in the first place.”

REDDUCING HEALTHCARE COSTS
Urgent care centers save money compared to emergency departments, where many patients go, even though they are not experiencing a true emergency.

A 2017 Annals of Emergency Medicine study compared the average price-per-visit for Texas-based urgent care clinics, free-standing emergency departments, and hospital-based emergency departments in 2012 and 2015. Researchers found that urgent care clinics charged $1,168 in 2015.

At hospital-based emergency department visits, the average price per visit in 2015 was $2,259 and $2,199 at a freestanding emergency care clinic. Most of the visits, regardless of facility, were for 20 of the most common diagnoses, and prices for patients with the same diagnosis were, on average, almost 10 times higher at freestanding and hospital-based EDs when compared to similar services received at urgent care centers, the study said.

McNeeley says the cost of an urgent care visit is typically similar to a primary care physician visit, and much less than an ED visit. In addition, urgent care clinics offer more services than most primary care offices. “We can do more, such as run IVs, splint a fracture, or sew wounds,” he says.

FASTER, EASIER, CHEAPER
Millennials are considered relatively healthy and have only one or two episodic health emergencies a year, says Stoimenoff. This demographic makes up a quarter of all visits to urgent care clinics, according to a 2015 PNC Healthcare consumer survey. “I think it’s very appealing to that generation,” she says.

Other patient groups also report not always turning to a primary care physician for care. A UCA study of patients over age 65 found that 11 percent said they had no primary care physician. A Kaiser study from 2014-2016 reported that, on average, 17 percent of women in the United States didn’t use a primary care provider. For men it was 28 percent.

The growing number of older patients is also a factor, says Park, who oversees more than 100 CityMD clinics. An aging population is taking up the resources of primary care and emergency care departments, according to the same 2015 PNC Healthcare consumer survey. It found that 85 percent of seniors choose to see primary care physicians first. Only 11 percent of that population goes first to an urgent care center. This trend “is making other patients choose to go to urgent care clinics for faster, easier and cheaper service,” Park says.

Rural areas in particular are benefiting from the rise in urgent care clinics. A report by FAIR Health, a nonprofit that studies insurance claims, found that from 2007 to 2017 there was a 2,308 percent increase in insurance claims for procedures done in rural urgent care facilities compared to a 1,675 percent increase in urban areas.

And with more patients paying out of-pocket for healthcare services, more are turning to urgent care because costs are lower, says Park.

“About 35 percent of employees are on high-deductible health insurance plans, and that number is growing,” he says. Many of those patients pay from $6,000 to $8,000 out-of-pocket before insurance pays anything. About 80 percent of them never meet their deductible, so they are essentially self-paying and want to pay the lowest fees.

“Urgent care is one service that checks both boxes,” says Park. “It is faster, better, and less expensive, and relative to primary care physicians, urgent care centers provide better access and an extended scope of practice.”

Urgent care
By the numbers

$18 BILLION
annual revenues of U.S. urgent care clinics, with a projected 5.8 percent growth this year

89 MILLION
Number of patient visits handled by urgent care clinics each year

29 PERCENT
Share of primary care visits conducted annually in U.S. urgent care clinics

Source: The Urgent Care Association
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At a time when primary health care in the United States is more dependent than ever on foreign-trained doctors, the programs that permit those doctors to practice in this country face an uncertain future under the Trump administration.

Uncertainty, red tape, and anti-immigration policies have some primary care physicians contemplating leaving the U.S. for more welcoming countries, while some international medical graduates are reconsidering whether they want to practice here. A decline in the number of international medical graduates would worsen the already serious shortage of primary care doctors, particularly because they tend to choose primary care specialties and many of them work in medically underserved areas.

“We are making healthcare more accessible, but we are subject to such uncertainty that some of us are rethinking whether we have a future here,” says Ram Sanjeev Alur, MD, an Indian-born internist in Marion, Ill., who’s thinking of leaving the country.

**THE IMPACT OF INTERNATIONAL MEDICAL GRADUATES**

According to the American Immigration Council (AIC), just over one-quarter of doctors (247,449) in the U.S. were foreign-trained as of 2017, meaning they received their medical degrees from schools outside the country. A small percentage are U.S. citizens who went abroad to medical school, but most are not.

The percentage of these doctors in primary care is even higher. The same study found that nearly a third (31.8 percent) of physicians specializing in family medicine, internal medicine, or pediatrics are foreign-trained.

International medical graduates are more likely to serve in low-income areas, as well. More than half (53.4 percent) of all such doctors work in areas where the population has a per-capita income of $30,000 or less, according to the AIC. In areas where per-capita income is below $15,000 a year, these graduates account for 42.5 percent of all doctors.

In areas where 75 percent or more of the population is non-white, 36 percent of the doctors are trained outside the U.S. They also make up greater shares of all doctors serving populations with lower educational attainment.

With the Association of American Medical Colleges (AAMC) predicting a shortage of primary care physicians of up to 49,300 by 2030, the AIC and other organizations are

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**HIGHLIGHTS**

- Restrictions and backlogs on work visas have existed for a long time, but critics say it’s gotten worse under President Trump, who has made reducing immigration a centerpiece of his administration.

- Some states have started their own programs to make it easier for internationally trained doctors to practice within their borders.
raising concerns about the future of primary care.

“International medical graduates serve a very important purpose in providing primary healthcare in this country, particularly in light of the physician shortage,” said Ana Maria Lopez, MD, MPH, FACP, president of the American College of Physicians (ACP). The ACP and other healthcare organizations have lobbied Congress and regulators to ease some policies that made it more difficult for internationally trained physicians to practice here.

**ONE COUPLE’S STORY**
The difficulties of those policies are well known to Narayanan Krishnamoorthy, MD, and Chitra Mony, MD, a husband and wife practicing in Tallahassee, Fla. They went to medical school in India, then trained in Scotland.

In 2006, Mony matched with Tallahassee Memorial HealthCare’s residency program. A year later, Krishnamoorthy matched with the same hospital and joined his wife in Florida. Mony, who entered on a national interest visa, was required to work for

**How international doctors are licensed to practice in the U.S.**

For international medical graduates, getting approval to practice in the U.S. is a long and complicated procedure:

1. They must complete an accredited residency program in the United States or Canada. But first, the Educational Commission on Foreign Medical Graduates must certify the foreign national is academically prepared and has passed the first three components of the U.S. Medical Licensing Examination. Then, the physician must match into a residency program.

2. Once matched, the physician must obtain a visa to participate in medical training. This is usually the J-1 visa, which is limited to seven years, long enough for a residency and a fellowship for a sub-specialty training.

3. After completing residency, J-1 visa holders usually must return to their home countries for two years before they can re-enter the United States, often on an H-1B visa. International residency or fellowship graduates willing to work in medically underserved areas or with underserved patients for three years can apply for a federal waiver of the two-year residency requirement. The biggest sponsor of these waivers is the Conrad 30 program, which allows states to sponsor up to 30 waivers annually. Physicians who obtain clinical J-1 waivers can apply for a temporary H-1B visa in order to work in the United States but must work for the employer sponsoring them for three years. After three years, the physician can apply for permanent resident status (lawful permanent resident, or LPR, status).

4. Doctors may qualify for a temporary H-1B visa to complete U.S. residency training but need a residency program to sponsor them, which many programs won’t do. In addition, to qualify for the H-1B, the physician must generally have passed all three steps of the U.S. medical licensing exam, something that many physicians just beginning residency have not done. The maximum six-year duration of the H-1B can be a problem for physicians who wish to complete both residency and fellowship training in the United States, since that training can take six years, leaving the physician with no time left to practice medicine following training.

5. Whether the physician trains in J-1 status and then obtains a waiver of the two-year home residency requirement, or trains in H-1B status, LPR status following training is not guaranteed. Doctors may qualify for LPR, but an eligible family member or employer must sponsor them. This can take years to complete, especially if the physician is from a country with substantial backlogs like India.
“International medical graduates serve a very important purpose in providing primary healthcare in this country, particularly in light of the physician shortage.”

ANA MARIA LOPEZ, MD, MPH, FACP, PRESIDENT, ACP

Targeted by Trump

Fourteen million doctors’ appointments are provided annually by physicians from Iran, Libya, Somalia, Sudan, Syria, and Yemen—countries targeted by the Trump administration’s travel ban. These doctors provide:

- **1.2 million** appointments per year in Michigan
- **880,000** appointments per year in Ohio
- **700,000** appointments per year in Pennsylvania
- **210,000** appointments per year in West Virginia

The five cities with the highest share of doctors from targeted countries are:

2. **Toledo**, Ohio
3. **Los Angeles**, Calif.
4. **Cleveland**, Ohio
5. **Dayton**, Ohio

Source: Immigrant Doctors Project

International trained physicians

three years in an underserved area. Krishnamoorthy switched from an H-1B visa, which binds him to one employer, to an H4 visa Employment Authorization Document (EAD) work permit, which allows him more flexibility in working as the spouse of an H-1B visa recipient. They have both applied for green cards to become permanent residents but are in a quota-restricted waiting line that could take decades.

In the meantime, the couple fills multiple gaps in primary care in their community. She is a family practitioner at Tallahassee Memorial. He works four-and-a-half days a week as an internist at a large medical practice while also treating his patients who are admitted to the local hospital and rehabilitation center. He also works half a day a week at a wound treatment center and volunteers to train physician assistants and nurse practitioners, as well as medical students.

The couple have a 13-year-old daughter, who was born in Scotland, and an 8-year-old son, who was born in the United States. They say they want to stay in Tallahassee, but, after 12 years here, their future is still unsettled.

As part of its overhaul of immigration, the Trump administration has announced it intends to end the H4 visa EAD program, which allows H-1B visa spouses, like Krishnamoorthy, to work. He had his H4 visa renewed for three years in April and hopes he will be grandfathered in until 2021 if the program is ended. If not, he would have to apply again for an H-1B visa and return to work for the hospital system or another sponsoring employer.

That could put an end to his practice with the medical group, a practice he says he has built up to 2,000 patients, many of them Medicare recipients who turned to him after two other primary care doctors retired. If that happens, the couple is thinking of relocating to another country with a more welcoming immigration policy for doctors, such as Canada, Australia, or the United Kingdom.

“We are deeply rooted in this community, but what do I say to my 2,000 patients [if I leave]? I want people to know these things are happening,” Krishnamoorthy says. “We have always played by the rules and done everything right, but we might still have to leave.”

AN IMMIGRATION DEBATE

Most Americans agree that the country needs more international medical graduates, but their fate is tangled up in the larger debate over immigration. Many enter the country on H-1B visas, the same as other highly skilled foreign professionals, particularly IT workers who have drawn the fire of immigration critics.

Bureaucratic restrictions and backlogs have existed for a long time, but critics say it’s gotten worse under President Trump, who has made reducing immigration—legal and illegal—a centerpiece of his administration. Under the Trump administration, H-1B visa approval rates declined from more than 90 percent in fiscal 2017 to less than 85 percent in the first two months of fiscal 2018.

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become more demanding and less responsive to non-native doctors who want to practice in this country, say Jennifer Minear, JD, and Greg Siskind, JD, immigration attorneys who represent such doctors and the U.S. healthcare organizations that want to hire them.

“This is an administration that has a general hostility to immigration, no matter the occupation,” says Siskind. “The overall goal of the administration, I think, is to make the system as unpleasant as possible and try to reduce the number of applicants. I think that is their tactic.”

Minear says USCIS is making it more difficult and time-consuming to renew work visas through “requests for evidence,” demanding proof of everything from doctors’ salaries to their work schedules. From January to November of 2017, USCIS issued around 40 percent more requests than in all of 2016. Minear says USCIS has even challenged whether physicians meet the H-1B requirement that they be “highly skilled.”

“How anyone can assert that a job as a physician doesn’t require a college degree, I don’t know,” she says. “It’s almost like there’s been some sort of internal decision to deny those claims.”

The delays and increased scrutiny are difficult and expensive for the healthcare systems and practices that want to hire the doctors, Siskind says. Uncertainty over when a visa will be approved makes it hard for employers to know when an international medical graduate can be added to a rotation, he says. While visas are eventually renewed, it’s taking its toll. “There are doctors...
asking themselves whether the U.S. is a good long-term bet," he says.

In June, the U.S. Supreme Court upheld the administration’s travel ban, which severely restricts immigration from Iran, Libya, North Korea, Somalia, Syria, Venezuela, and Yemen. This policy could worsen the shortage of doctors.

According to the Immigrant Doctors Project, which opposes the travel ban, there are more than 7,000 doctors from the targeted countries practicing in the U.S. The travel restrictions will make it harder for physicians from those countries to work here and could impose hardships on those already here who will not risk traveling home for fear of not being able to return.

**STATE PROGRAMS**

Some states have stopped waiting for the government to act and started their own programs to make it easier to practice within their borders.

The Minnesota Department of Health’s Office of Rural Health and Primary Care in 2015 began its own program to help offset a projected shortage of 2,000 primary care physicians by 2025. So far, the initiative has funded six residency programs for non-native doctors with the requirement that they practice in underserved areas for five years after graduation.

“We really need (international medical graduates) to provide primary care and we need primary care,” says Yende Anderson, JD, head of the program.

Funding two residencies a year isn’t making a dent in the need, Anderson says, so she is trying to raise $3 million to $4 million a year from foundations and corporations to pay for 10 residencies annually.

UCLA has a program specifically for graduates of medical schools in Latin America. It allows qualified graduates who legally reside in the United States to get the same hands-on training with California physicians as UCLA medical school students.

More programs like that are needed to bring in Hispanic physicians, says Elena Rios, MD, MSPH, FACP, president of the National Hispanic Medical Association. Immigrant Hispanic communities are more likely to trust and seek treatment from doctors of similar backgrounds, she says.

“When people get sick, they want to be treated by someone they’re comfortable with, someone who speaks Spanish,” she says.

**PUSHING BACK**

As the primary care shortage worsens, healthcare organizations are calling for reform, but so far, progress has largely been limited to fighting to keep a faulty system from getting worse. For example, the AAMC, ACP, and other groups in June persuaded USCIS to reverse its decision to no longer accept AAMC resident stipend data for prevailing wage information on H1-B visas. That had resulted in the denials of visa requests from IMGs scheduled to begin work in residency programs July 1.

Some Indian-born physicians have formed Physicians for American Health Care Access to advocate that Congress create a separate path for doctors to obtain green cards. They also want reform of the rule that says no more than 7 percent of H-1B visas may be issued to natives of any one country in a year. That quota is largely responsible for the backlog of physicians from India, which accounts for more applicants than any other country.

One of the group’s founders is Alur, an internist at Marion Veterans Affairs Medical Center in southern Illinois. He has to renew his H-1B visa every three years and faces a decades-long wait for a green card. “I’m 42,” he says. “I can’t be doing this in my fifties and sixties. If things don’t go right then my job is in peril and my life here is in peril.”

“How anyone can assert that a job as a physician doesn’t require a college degree, I don’t know. It’s almost like there’s been some sort of internal decision to deny those claims.”

JENNIFER MINEAR, JD, IMMIGRATION ATTORNEY
The interview lies at the heart of the hiring process. This face-to-face encounter enables physicians and other staff to get to know a candidate in ways that go beyond a resume on a desk and letters of recommendation.

“A critical step when hiring a physician is to do your homework to understand what’s important to your own practice and what is the culture of the medical group,” says Jack Chou, MD, physician-in-charge at Kaiser Permanente Baldwin Park, part of the Southern California Permanente Medical Group in Baldwin Park, Calif.

Once clarified, bring those criteria into the interview, he adds. Here are five questions that can help a practice ascertain if a physician candidate will indeed meet those criteria.

“Tell me about your background.”

This open-ended question is an important starting point, although the practice already has information about background, credentials, and experience from the candidate’s resume.

“I like to hear individuals describe their own background to hear how they communicate, since communication skills are a critical part of being a good physician,” says Rick Kellerman, MD, professor and chair for family and community medicine at the Kansas University School of Medicine—Wichita.

Don’t be too specific at the beginning, he advises. A practice will want to know if the person’s self-report matches their resume and how he or she accounts for gaps in employment or other issues that might stand out. Then ask clarifying questions, he says.

“Why did you choose this profession?”

Chou notes that healthcare is a “service industry” and providing service goes beyond “talent and quality.”

Since the reasons for choosing a medical career reflect the candidate’s values and goals, they will highlight the candidate’s ability to provide service that transcends clinical skills. “So you want to find out why your candidate chose this particular profession,” Kellerman advises.

“Why are you interested in our practice?”

Understanding the motivations of a candidate is crucial in determining if he or she is a good fit.

Ask, for example, “Are there geographical motivations, perhaps nearby family?”

Interviewers should inquire how much a prospective candidate knows about the practice, which gives a sense of how much due diligence they have done and how thorough they are.

“Can you recall a disruptive patient?”

One way to ascertain whether a candidate is a good fit is to see how he or she relates to the nonclinical challenges patients often pose.

Chou’s group engages prospective physician associates in behavior interviewing, but their questions do not entail creating hypothetical “what-if” scenarios.

Instead, Chou asks open-ended questions such as, “Can you recall a patient who was disruptive and how you handled it?”

“A red flag would go up in my mind when a candidate is having difficulty coming up with situations that he or she dealt with or is trying to make up hypothetical answers,” he says.

“Do you have any questions for me?”

An equally important component of the interview is hearing what questions the candidate asks.

“Candidates who have no questions show a lack of interest in your group,” Kellerman warns.

And the types of questions candidates ask can help ascertain what their real interests. If they ask primarily about the salary and other financial arrangements, he notes that their major interest is monetary.

Batya Swift Yasgur MA, LSW, is a contributing author. Send your human resources questions to medec@ubm.com.
These are tough times to be a physician. Medical practice is unrecognizable from what it was 20 years ago, as doctors have moved en masse from being small business owners to employees in a corporate environment. There are a number of reasons why this has happened, but chief among them is a regulatory environment that makes it very difficult to be in small practice.

Being an employee may have perceived benefits for “security,” but comes at an enormous cost in terms of autonomy and independence. It is no secret that there is currently an epidemic of job dissatisfaction and burnout in medicine.

It’s such a shame for a profession everyone initially went into with very noble and altruistic intentions (over three-quarters of medical students, when surveyed by the American Medical Association, say they chose medicine for the simple reason of wanting to help people). Most doctors still graduate with high aspirations, but after a few years in practice, that enthusiasm falls by the wayside.

So what happens? In a nutshell, the reality of overwhelming bureaucracy in today’s corporate environment happens. Are there ways to regain that passion for medicine again? Possibly. Here are three:

“Most doctors still graduate with very high aspirations, but after a few years in practice that enthusiasm falls by the wayside.”

Choose your job very carefully
Different jobs can vary enormously in terms of work environment and administrative support. Consider any possible red flags before signing on the dotted line. Carefully spend as much time as you can at the institution (come back for a second day if needed) and observe in detail your future workplace. Talk to as many people as possible about their experiences.

Keep reminding yourself why you went into medicine
It’s likely that every minute you spend with patients and are in that “zone” of patient care will dramatically increase your chances of job satisfaction. Conversely, every minute with computers and tick-boxes will dramatically decrease it. Have a constant awareness of the parts of your job that you enjoy, and do your best to foster them.

Work to regain autonomy
Being able to exert more control over your own schedule and income, and not having that feeling of being controlled, would be important to any professional. There is estimated to be a shortage of over 100,000 physicians by the end of the next decade, according to the Association of American Medical Colleges, and most specialties are in high demand with the aging population. How can you leverage the supply-demand mismatch to your advantage?

There are myriad ways of doing so, including avoiding working full-time at only one institution and doing a mixture of different types of work (inpatient, outpatient, procedures, etc.)

Some physicians are happier than others, and it’s worth considering why. Doctors have worked way too hard to be discontent in their work, and if they find themselves in a tough spot professionally, they owe it not only to themselves to seek alternative options but to patients as well, who need happy doctors.

Ben Levin, MD, is a board-certified internist practicing on Cape Cod, Mass. He is co-founder of DocsDox, an online service that connects physicians with moonlighting and per diem opportunities.
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Doctors listed the burden of paperwork / quality metrics as their top concern in the Medical Economics 89th Annual Physician Report.

Paperwork? I thought medicine was fully electronic? But there is now more administrative work rather than less as the shift to fully digital practices proceeds along the same lines as the shift to value-based care and its data requirements.

Physicians continue to struggle with all being asked of them. One driver of additional administrative work is the demand from the Merit-based Incentive Payment System (MIPS) to gather “essential” data. Another is to keep up with ever-changing demographic and insurance data for the practice.

None of this appears to have a direct benefit for the patient but it is necessary for the operation of the business. The first questions for physicians are:

- Do I need this information?
- Why do I need it?
- Does it benefit the patient or the business?
- What is the best way to retain and access it now and in the future?

Another key question is: What is necessary to improve patient care? That’s a decision both patient- and specialty-specific. It is also related to what is needed for the practice or system, since patient data is expected to be shared with referring physicians.

Further, the business focus must be considered. Is it worth continuing with the MIPS program? Are we gathering demographic and insurance information in a timely manner and reviewing it frequently enough? If staff is too busy doing unnecessary tasks, they are not supporting the patient process as effectively as they should.

Using the “5S” workplace organization methodology in all areas of “paperwork” can help tremendously. The idea is to reduce paperwork or clutter in the work area. Work areas include the exam rooms, nurses’ station, and the clinician office.

If you look around at any of these areas, there are items that distract your attention or get in the way of “finishing” your current task. Following the 5S will start and keep you on the path to an efficient work environment and facilitate the reduction of paperwork. The 5S model is:

- Sort: identify what is needed, eliminate everything else
- Set in order: determine where needed items go and when
- Shine: update the data, removing anything unnecessary

Operations

Getting a handle on healthcare paperwork

by OWEN J. DAHL, MBA Contributing author

HIGHLIGHT

Take a serious look at what is being done, when, and by whom, to answer the questions of what is necessary work for patients and for the business.
Standardize: approach each patient in the same fashion with the same data goals in the first three S’s.  
Sustain: make all of this a habit.

Given this, we get to time and shuffling or rearranging all of the above to the right person/source at the right time.

If you realistically look at your day, you could deduce that 80 percent of your patient visits, regardless of diagnosis, require the same amount of resources. The other 20 percent would require more or fewer resources. This of course does not consider any new patients or patients that would require an office procedure. This also does not consider the time allocation to hospital rounds made at some time during the day.

Now that it is known that it is difficult at best to accomplish a “complete” patient visit in the time available, what can be done? Consider the following options:

1. HAVE A GOAL FOR ADDRESSING PAPERWORK
The most efficient physicians are those that complete the process, including appropriate documentation, as the patient leaves the exam room. This may require some significant changes in approach to each day. But consider why you are spending time after the work day completing your patient records.

2. REVIEW WHAT WORK CAN BE DONE BY STAFF
The necessary data is added to the record by the clinical staff at the triage point. Does the clinician need to ask the same questions or is the data provided sufficient and clear and the only need is for clarification on one or two aspects of care?

Is the outside report—e.g., image study or consultant report—scanned into the system or is it necessary for someone to look for it?

3. DETERMINE THE RIGHT TIME TO ENTER OR FOLLOW-UP WITH THE DATA
There may be time outside of a patient visit that the team can do their work rather than during the patient encounter.

“Another key question is: What is necessary to improve patient care? That’s a decision both patient- and specialty-specific. It is also related to what is needed for the practice.”

4. DESIGN / ARRANGE THE EXAM ROOM
Adequate face-to-face time with the patient ensures attention is paid and given during the visit.

This also includes access to the keyboard and screen. Each room should be designed for the maximum convenience of data entry and face time.

5. ADD A SCRIBE TO THE PROCESS
If you consider that a Medicare patient visit is a level 3 visit and you can see two more patients per day, the amount generated will be around $40,000 per year, which in most cases is adequate to justify a scribe.

Aside from the financial side, improved work-life balance and overall reduced stress may justify the addition.

It is not easy to consider the above thoughts when the office is too busy in the first place. But eliminating unnecessary paper or data gathering, shifting work to the right team member, and reducing waste and stress are positive outcomes. The requirement is to stop and take a serious look at what is being done, when, and by whom to answer the questions of what is necessary for the patient and for the business.

Owen J. Dahl, MBA, LFACHE, LSSMBB, is a nationally recognized medical practice management consultant with over 43 years of experience in consulting and managing medical practices.
When physicians sell their medical practice to a local hospital, the focus is typically on getting the best price for their assets and negotiating a generous long-term compensation package. These are certainly important aspects to any practice sale. However, more and more often, I am working with physicians who desire to repurchase their medical practices after some period of time.

Unfortunately, provisions related to buying back a practice are rarely contemplated or included in sale documents, which can make it difficult—if not impossible—for physicians to easily reacquire their former practice.

If physicians are even remotely interested in one day reacquiring their practice, it is a good idea to think about including provisions that describe how that process would occur. Some concepts to consider include the following:

1. How long must the selling physicians work before they can seek to reacquire the practice? Typically, practice sales are accompanied by an employment commitment of up to three (3) years. I like to link the reacquisition right to the physicians meeting this obligation.

2. What happens if there are numerous physicians in the practice being sold? Who has the right to repurchase the practice? Typically, the selling physicians should agree in advance how this process will work (i.e., a majority must agree to the transaction). Without establishing this clearly upfront, a battle can occur among the physicians, which is not in anyone’s best interest.

3. The time frame for the reacquisition should be specified in the initial sale documents to ensure the selling entity assists in getting the deal done. Without a time frame, the transaction may linger indefinitely and frustrate physicians. I like to suggest that the physicians be required to provide written notice triggering the reacquisition, and the parties then must use their best efforts to complete the transaction within six (6) months or another agreed upon time frame. Because a valuation of practice assets and renegotiation of equipment and other leases may be required, it is important to provide adequate time to complete the particular deal. Additionally, creation of a new practice entity, credentialing new payer contracts, and other details may need to be put into place, which can take several months to complete.

4. In drafting the reacquisition language, remember that the physicians reacquiring their practice will need to take possession of medical records, equipment, employees, practice space, and other assets essential to practice operations. These assets will either need to be valued at the time of the transaction or the parties will need to agree in advance to another approach that will meet fair market value requirements. It’s important to think through exactly what the practice will need to “take back” in order to allow the reacquisition to occur. Forgetting an important element can prevent a successful transaction from occurring. For this reason, it is ideal to draft this language at the time of the initial sale, when the parties are aware of all the assets being sold and can clearly outline future reacquisition needs and challenges.

5. The original sale document / employment agreement(s) entered into by the selling physicians and the hospital usually contain restrictions on competition, solicitation, and other competitive activities. These will need to be waived in the event of a sale. Although this seems obvious, it is essential to clarify this point and link it to the reacquisition rights.

Ericka Adler, JD, has practiced regulatory and transactional healthcare law for more than 20 years. Send your financial questions to medec@ubm.com.
Getting paid has never been so complicated for primary care doctors. An uncertain policy landscape, ever-changing regulatory requirements, and evolving practice and reimbursement models mean that physicians must constantly stay on top of how they are being paid to ensure they receive what they are owed.

In recent weeks, CMS officials have released a bevy of proposals that will affect how Medicare will pay physicians in 2019. The regulations cover value-based payments, level of care changes that will impact reimbursement rates, and continued efforts to equalize payments between office- and hospital-based doctors.

Physicians should remember these proposals could change after federal officials consider comments from the public and stakeholders. Final determination on all these issues is expected in late 2018.

Here are the proposed changes physicians should monitor:

- streamlining the Quality Payment Program (QPP), Medicare’s value-based payment initiative;
- restructuring the evaluation and management (E/M) level-of-care coding system as part of...
Money

Reimbursement changes

“The bottom line is, patients should not pay more for a service or procedure based on the building it’s done in.”

—MARNI JAMESON CAREY, EXECUTIVE DIRECTOR, ASSOCIATION OF INDEPENDENT DOCTORS

the 2019 Medicare Physician Fee Schedule (PFS), which sets out reimbursement rates for fee-for-service payments;

■ making brief patient check-ins via phone, text message, or video a reimbursable service; and

■ taking additional steps towards site-neutral payments for outpatient visits.

NO. 1: THE QPP AND VALUE-BASED CARE ARE HERE TO STAY

While doctors will find some beneficial changes, physician groups say the QPP needs to become more physician-friendly.

CMS is proposing changes to eligibility requirements, coding, some documentation requirements, and how certain categories are weighted, among others, with goals of streamlining billing and expanding access to care.

“Internists are excited to see that CMS is proposing long overdue improvements in the physician fee schedule and the QPP that will help physicians provide the highest quality care to patients,” says Ana Maria Lopez, MD, MPH, president of the American College of Physicians, in a statement.

The proposed changes to the 2019 rule governing the QPP include:

■ Expanded exemptions. A third low-volume threshold has been proposed: providing 200 or fewer covered professional services under the PFS. Any doctor who meets this requirement, or one of the previous two—$90,000 or less in Part B charges or caring for 200 or fewer Medicare beneficiaries—would be exempt from program participation.

■ Ability to opt in to the Merit-based Incentive Payment System (MIPS). Any clinician or group that does not meet the low-volume exemptions could choose to opt in to MIPS.

However, the decision to do so is irrevocable.

■ Changes to general performance category weights used to calculate MIPS scores. Quality would decrease from 50 percent of the total to 45 percent, while cost increases from 10 percent to 15 percent. Promoting interoperability (formerly called advancing care information) and improvement activities remain at 25 percent and 15 percent of the total score, respectively.

■ Removal of 34 quality measures deemed by CMS to be of low value.

■ Requiring the use of 2015 Edition Certified EHR Technology in 2019. This was originally proposed for 2018, but CMS backtracked to allow 2014 Edition certification because EHR vendors were not ready.

One notable change from the 2018 QPP rule that physician advocates lobbied for but did not receive was 90-day reporting periods for all four performance categories. Instead, quality and cost will remain 12-month reporting periods, and improvement activities and promoting interoperability will remain 90-day reporting periods.

“Reducing the reporting burden would allow more physicians to participate in MIPS and focus the program on rewarding quality care rather than quality reporting,” Anders Gilberg, senior vice president, government affairs, for the Medical Group Management Association, said in a statement.

“Requiring medical groups to submit excessive amounts of data to the government has little impact on the quality of care delivered to Medicare beneficiaries.”

The ACP also continues to argue that a 12-month reporting period for the MIPS performance categories does not offer any more insight to a practice than a 90-day period. “We are advocating for shortening the
reporting period to reduce the burden and shorten the feedback loop,” says Suzanne Falk, MPP, senior associate of regulatory affairs for the ACP, adding that a quarterly report with real-time feedback would add more value to the program for physicians.

Complicating the MIPS cost category is that not only is its weight increasing in the overall score, but it will include eight new episode-based measures. For 2018, MIPS is using cost measures that cover the total cost of care during the year or during a hospital stay. Now, CMS is proposing to use new episode-based measures to calculate costs. “Increasing the weight of the category while adding eight new measures is not a smart move,” says Faulk.

Another possible area of concern is the proposal to mandate use of EHRs with 2015 certification. The required upgrade could put an undue burden on smaller practices, says Faulk. She says many vendors do not have a 2015-certified product to offer. Practices also need time to implement the new software, and the 12-month reporting requirement means they would need to be ready January 1. “Vendors need more time and practices need more time to work out the kinks in the systems,” says Faulk.

Small practices required to participate in the QPP are still at a performance disadvantage because of the financial and labor requirements to be successful. “The performance gap between small and large practices is not because small practices aren’t providing good care or thinking about value,” says Faulk. “It comes down to a matter of resources and having people on staff to navigate the program.”

Valinda Rutledge, vice president of federal affairs for America’s Physician Groups (APG), a group which represents physicians practicing capitated, coordinated care, says the changes to QPP look to include “real action to advance the value movement” and indicate that MIPS is “here to stay.”

**NO. 2: THE MEDICARE PFS MAY SIMPLIFY LEVELS OF CARE**

A major proposed change in the PFS is to restructure the E/M codes. Currently, office-based physicians code for five different levels of care, with different codes and reimbursement rates for new and established patients based on the complexity of the visit.

CMS Administrator Seema Verma pitches the proposal as a bid to simplify and offer more flexibility in documentation requirements, delivering on the agency’s pledge to “put patients over paperwork.”

Under the proposal, E/M levels 2 through 5 would be combined into one payment rate, with add-on codes included to address visits of greater complexity. The potential impact is that office-based physicians who see more patients with less complex health issues (levels 1 through 3) could see reimbursement rates rise, while physicians who deal largely in levels 4 and five, could see reimbursement rates fall.

It’s unclear if the proposal will be approved, as it has received mixed reviews from healthcare observers. Organizations representing primary care physicians have expressed support for the proposal’s simplification and additional flexibility. Organizations that advocate for specialty physicians oppose it.

Jennifer Breuer, JD, vice chair of healthcare group for the law firm Drinker Biddle, says the rules will reallocate money to better reflect how care is provided.

“They will pay more for the kind of visits people are having to better reflect the actual
resources involved,” she says. “There’s long been a concern that the reimbursement rates applied to services don’t necessarily reflect the true cost or value of services. This is meant to emphasize with respect to primary care, what a visit means.”

“The flattening of the E/M codes from five to two is a massive undertaking and will create winners and losers among physician specialties.”

— VALINDA RUTLEDGE, VICE PRESIDENT OF FEDERAL AFFAIRS, AMERICA’S PHYSICIAN GROUPS

The ACP supports CMS’s efforts, particularly documentation streamlining and the use of add-on codes, which the organization says can reimburse for services provided by internists that “are currently not adequately supported in the traditional E/M structure.”

“We strongly support the proposal to reduce the burden of current E/M documentation requirements, specifically by allowing E/M documentation to focus on medical decision making, as ACP has strongly advocated for in the past,” the ACP statement reads.

Brian Outland, director of regulatory affairs for ACP, told Medical Economics that while the organization appreciates that CMS took some of their suggestions on easing physician burden, the college remains concerned about certain proposals, including the reduction of five E/M codes to two in.

“We want to make sure there is no disadvantage to physicians taking care of complex and frail patients,” he says. “A doctor could have a patient come in that has a cold or some less-sensitive problem and get paid the same as a physician taking care of someone with four or five chronic conditions that require attention and care and much more time.”

Others are skeptical of making these sweeping changes in such a short timeframe. Rutledge, with APG, says the organization is concerned about implementing changes of this magnitude by Jan. 1, 2019, as proposed. “The flattening of the E/M codes from five to two is a massive undertaking and will create winners and losers among physician specialties,” she says.

Terry Fletcher BS, CPC, healthcare coding executive with Terry Fletcher Consulting, says CMS officials seem to have designed the proposal with only primary care physicians in mind. “Paying the same amount, regardless of the patient’s condition, presenting problems or the complexity of services provided, makes absolutely no sense to me.”

Fletcher also believes that if this proposal or any form of it goes through, it is setting up practices to see fewer Medicare patients, and more commercial plans that won’t follow the Medicare model. “I also see this giving a big boost to concierge medicine, as physicians will simply be frustrated that their most consistent payer has now abandoned them for a one-code price,” she says.

Jennifer McLaughlin, senior associate director of government affairs for MGMA, says these broad changes will have trickle-down consequences into almost every aspect of Medicare payment policy and would impact a lot of physician practice workflows.

“Some of our members are cautiously optimistic that it could reduce some of the documentation burden and increase a physician’s ability to spend more time with the patient,” she says. “On the flip side, what we’re hearing is documentation isn’t just driven by coding requirements; a lot of it is driven by clinical needs and external factors.”

NO. 3: NEW PAYMENT OPPORTUNITIES FOR ‘TECHNOLOGY-BASED SERVICES’

A third major proposed change in the PFS includes streamlining documentation requirements and modernizing payment poli-
cies to enable Medicare beneficiaries to take advantage of the latest technologies to provide care.

For the first time, physicians would get reimbursed for services provided with the use of technology, but outside of telemedicine services and in-patient visits. For example, a brief, non-face-to-face check-in with a patient via phone, text messages, e-mail, or video conferencing to evaluate whether the patient needs to be seen in the office could be reimbursed under this proposal.

Furthermore, Medicare is also proposing to pay even when patients initiate the virtual communication, another first, Rutledge says.

Rutledge says that the reimbursement is proposed at $14 per virtual visit as opposed to $90 for an office visit, but it allows for more convenient check-ins and will be more efficient for patients and doctors alike.

NO. 4: CHANGES TO SITE-NEUTRAL PAYMENT RULES

In late July, CMS proposed a rule under which it would pay for most clinic visits under the PFS, rather than the more costly Outpatient Prospective Payment System (OPPS). The change, if approved, would represent another step toward the achieving the agency’s long-sought goal of site-payment neutrality—paying the same amount for a patient visit, regardless of whether it occurs in an independent or hospital-owned practice.

“The bottom line is, patients should not pay more for a service or procedure based on the building it’s done in. That’s the underlying logic here,” says Marni Jameson Carey, executive director of the Association of Independent Doctors, which supports the proposed rule.

CMS estimates that the rule would save it $760 million annually in the form of reduced payments to hospitals and lower Medicare beneficiary copayments. The OPPS is higher because it includes facility fees, charges hospitals add to cover the range of other services they provide, ranging from 24/7 emergency departments to imaging equipment. CMS says clinic visits—which it defines as “check-ups with a clinician”—are the most common type of service billed under the OPPS.

“Part of the reasoning around charging facility fees is to have these services at the ready should they be needed,” says Shari Erickson, MPH, vice president for governmental affairs and medical practice with the American College of Physicians. "But in most cases they aren’t necessary for these types of visits. So having insurers and patients pay more for them really isn’t appropriate."

The rule would apply only to hospital-owned practices that are not part of a hospital’s main campus. Practices located on hospital campuses would be exempt.

Erickson adds that the proposed rule will likely encounter stiff opposition from hospitals. “The challenge is that many of them have become reliant on facility fees along with other types of funding to pay for many of the things that hospitals do,” she says. “So I recognize there are challenges, but at the same time there needs to be other options to fund the needs of inpatient facilities.”

—Editors Jeffrey Bendix, Chris Mazzolini, and Todd Shryock, and contributor Keith Loria contributed to this report.
The flattening of the E/M codes ... is a massive undertaking and will create winners and losers among physician specialties.”

—Valinda Rutledge, Vice President of Federal Affairs, America’s Physician Groups

“[Urgent care is] a good place to earn a living, but not a great place to get rich.”

—John Kulin, DO, Founder and CEO, Urgent Care Now, Philadelphia

31.8% of U.S. primary care physicians who are internationally trained

—Medical Economics

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**Maria Young Chandler, MD, MBA**  
**Business of Medicine / Pediatrics**  
Irvine, Calif.

“Health” app on my iPhone to track my steps (I get in over 10,000 per day), and sleep (which I wish I got more of). There is also nutrition and mindfulness which I haven’t tried yet!”

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**Internal Medicine**  
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“Epocrates”

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“Medical: Epocrates; personal: Amazon”

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**Family Medicine**  
La Quinta, Calif.

“Medical: Google; personal: AP News”

**Salvatore Volpe, MD**  
**Pediatrics/Internal Medicine / Pediatrics**  
Staten Island, N.Y.

“Snapseed photo [editing] app for mobile”
MS is proposing changing documentation and payment for evaluation and management (E/M) coding as part of its “Patients over Paperwork” initiative.

In brief, CMS proposes simplifying documentation guidelines and collapsing E/M codes higher than 99211 and 99201 into one code with a blended rate of reimbursement.

For a more complete, but brief, outline of this proposal go to the CMS website. The goal of allowing doctors to spend more time with patients and less with documentation is the purported outcome, but this proposal will result in anything but achieving that goal.

The documentation which has been chosen for elimination/simplification is the easiest and least time consuming for physicians to perform with the electronic measures we have been encouraged to adopt.

Having adjusted our EHRs to accomplish the E/M requirements in place for the past 20 years, we are copying information and opening fields of previous data with a few clicks. In other words, physicians have gotten good at this. Calculating about 15 seconds per patient, changing this documentation would save about 10 physician hours annually.

The ever-increasing stress of our electronic time comes from listening to webinars, spending time working with our EHR vendors to create new and recognizable fields, and performing other IT gymnastics to meet CMS’s Merit-based Incentive Payment System (MIPS) requirements. We have been called upon to learn, implement, and pay to do all of this with our own time and resources, and we are doing our best to comply.

Perhaps because of the extra time CMS says will be generated by this proposal, or because they will no longer be able to track how much work we are doing for our patients, CMS has proposed a blended rate of reimbursement for all but nurse visits. This will greatly disadvantage providers who spend time caring for patients requiring complex care. Our practice serves a large Medicare population with problems that are increasingly time-consuming and very often qualify for 99204 and 99214 levels of care. The proposed new blended payment would result in at least a 3 to 5 percent cut in reimbursement. CMS proposes an additional code that physicians can use to add to the blended rate that would result in $5 more for primary care providers and an additional $15 for specialty providers.

According to the government document explaining CMS’s reasoning for the additional primary care code, it was created to cover “additional resource costs and maintain the work as budget neutral” for “visit complexity inherent to the evaluation and management associated with primary medical care services that serve as the continuing focal point for all needed health care services.”

It is both frightening and demeaning to discover that CMS believes the aforementioned care to be worth less for primary care providers than for specialists, and less than the cost of a Starbucks coffee.

CMS’s goal is to promote better, less costly care for patients and to encourage providers to take on risk for that care. It must take place in some form of a primary care office setting rather than overused specialty.

“Office physicians who depend on reimbursement from E/M codes will be disproportionately affected in comparison to specialists who are paid higher rates to perform procedures.”

Help physicians by killing off the fax machine, once and for all
emergency department, and hospital care.

A 3 to 5 percent decrease in Medicare reimbursement will result in less time available for each patient because doctors will need to see more patients every day to offset the financial loss. Visits will need to be shorter and will cover fewer concerns with patients returning more frequently. More patients will end up in EDs and hospitals.

“It is both frightening and demeaning to discover that CMS believes the aforementioned care to be worth less for primary care providers than for specialists, and less than the cost of a Starbucks coffee.”

There will be less money available for support staff and for new staff such as chronic care managers and mental health providers whom we are being encouraged to hire to improve the quality and broaden the level of our care.

There will be an increase in referrals to specialists to handle more complicated problems. With this increase in the use of referrals and hospitals, providers who were working to decrease resource utilization will be reluctant to assume financial risk for their patients’ care.

Office physicians who depend on reimbursement from E/M codes will be disproportionately affected in comparison to specialists who are paid higher rates to perform procedures.

For all the above reasons, I do not favor the adoption of this policy. If it is adopted in some form, the blended reimbursement rates should be within $1 to $2 of the current rates for 99204 and 99214 without the add-on $5 and $15 codes. We will already be giving up the higher reimbursement rates for 99205 and 99215.

As discussed, expenses for physicians in terms of time and resources is increasing. If CMS is to be the agent for beneficial change for Medicare patients and desires respect and cooperation from the practicing physician community, its proposals must be at least cost-neutral.

Lorraine Nardi-Gross, MD, is an internal medicine specialist in the lower Hudson Valley, N.Y.

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