It’s time to stop MOC

BUY. SELL. MERGE.
Make your best move

PLUS
The end of meaningful use
Why clinical integration is vital

Providers as payers
Is it a good idea?

Doctors vs. Coders
The level of care debate

Master technology overload

Medical care in America is fragmented. Independent private practice means that every physician does his or her part in the care of patients. Other healthcare providers, such as physical therapists, do their part. All have their own medical records. All charge their fees. Somehow patients navigate their care among various providers.

If a person fell and broke her hip, more than 30 separate businesses may end up billing for services by the time the rehabilitation is over. These include the primary care physician, emergency room, radiologist, surgeon, anesthesiologist, pathologist, etc. All will charge what the market currently bears. The story is similar for a stroke or major cardiac event.

Compare that with an integrated delivery system where all of these providers work for the same organization and have a common billing system and medical record. Imagine the advantages of such integration and even the ability of such a system to bundle the charges for such services. The entities that pay for healthcare, such as Medicare, Medicaid and private insurance companies are increasingly interested in having healthcare provided by integrated delivery systems for the control of costs and consistency of quality.

Since Medicare and private insurance are moving toward "value-based reimbursement" in the future, does that mean that every physician needs to work for a large integrated delivery system? Not necessarily. Private practice physicians can work together and compete in this new market.

While care is still provided to individuals, the organization of care will be designed to achieve better outcomes and affordable costs for the entire population being served.

The best known example of clinical integration among private physicians is the experience of Mesa County, Colorado. Grand Junction is the city at the heart of this large county in western Colorado. This county is home to private physicians and historically has the lowest per capita Medicare costs in the nation. It was featured in Atul Gawande, MD’s 2009 New Yorker article, "The Cost Conundrum" (Read that article at http://bit.ly/cost-conundrum)

In Mesa County the doctors in all specialties are dedicated to high-quality care provided to all patients at reasonable costs. In addition, all the doctors decided jointly that everyone would take care of the whole population regardless of their insurance or lack of it. Everyone shared the Medicaid patients so that no one was overloaded. No one was guilty of price gouging. The result was health care outcomes as good as any large integrated delivery system in America.

Clinical integration is an imperative that is here to stay. No longer will healthcare covered by insurance be just one patient at a time. With modern information systems, the population being served is now visible in ways never seen before in medicine.

While care is still provided to individuals, the organization of care will be designed to achieve better outcomes at affordable costs for everyone in a service area. This is the Triple Aim: better care, better health and lower costs for a population. Independent physicians should not despair. Join a network of your colleagues and make this work for your area.

Joseph E. Scherger, MD, MPH, is a family physician in La Quinta, California, and a member of the Medical Economics editorial advisory board. Do you agree with the importance of clinical integration? Tell us at medec@advanstar.com.
COVER STORY

Maximize your practice’s value  

PAGE 18

MONEY

Physicians vs. coders
Understanding medical necessity when coding for level of care

PAGE 26

Direct-to-consumer ads
What does the proliferation of consumer-targeted pharma ads mean for physicians?

PAGE 28

TECH

Avoid technology overload
Maintaining productivity after introducing new tools to the practice

PAGE 30

Online reputation protection
Why physicians must protect their online identities

PAGE 40

OPERATIONS

Clinically integrated networks
How these networks can provide a way to stay independent by joining forces with other doctors

PAGE 41

Telehealth
Legal considerations before jumping into remote medicine

PAGE 45

POLICY

When providers become payers
Some provider organizations are exploring a new twist on an old idea

PAGE 46

THE LAST WORD

MOC exam has ‘dubious value’
Abolishing the maintenance of certification exam should not wait until 2020. It should be done now, write James J. Marino, M.D.

PAGE 53

IN EVERY ISSUE

7 Interactive
8 Our advisers
9 Your voice
15 Vitals
52 Advertiser index

MedicalEconomics.com
“There are big opportunities in primary care now because it’s fragmented.”

JOSEPH DAVIS, PRIVATE EQUITY FIRM MANAGING PARTNER

READ MORE ON PAGE 18

500

The number of clinically integrated networks in the United States as of 2015.

READ MORE ABOUT THEM ON PAGE 41

“The [MOC] secure examination needs to be a thing of the past.”

JAMES J. MARINO, MD

READ ABOUT MOC ON PAGE 53
Indication
- Repatha™ is a PCSK9 (proprotein convertase subtilisin/kexin type 9) inhibitor antibody indicated as an adjunct to diet and maximally tolerated statin therapy for the treatment of adults with heterozygous familial hypercholesterolemia (HeFH) or clinical atherosclerotic cardiovascular disease, who require additional lowering of LDL cholesterol (LDL-C).

Limitations of Use: The effect of Repatha™ on cardiovascular morbidity and mortality has not been determined.

Important Safety Information
- Contraindications: Repatha™ is contraindicated in patients with a history of a serious hypersensitivity reaction to Repatha™.
- Allergic reactions: Hypersensitivity reactions (e.g., rash, urticaria) have been reported in patients treated with Repatha™, including some that led to discontinuation of therapy. If signs or symptoms of serious allergic reactions occur, discontinue treatment with Repatha™, treat according to the standard of care, and monitor until signs and symptoms resolve.
- Adverse Reactions: The most common adverse reactions (> 5% of Repatha™-treated patients and more common than placebo) were nasopharyngitis, upper respiratory tract infection, influenza, back pain, and injection site reactions.
- In a 52-week trial, adverse reactions led to discontinuation of treatment in 2.2% of Repatha™-treated patients and 1% of placebo-treated patients. The most common adverse reaction that led to Repatha™ treatment discontinuation and occurred at a rate greater than placebo was myalgia (0.3% versus 0% for Repatha™ and placebo, respectively).
- Adverse reactions from a pool of the 52-week trial and seven 12-week trials, included:
  - Local injection site reactions that occurred in 3.2% and 3.0% of Repatha™-treated and placebo-treated patients, respectively. The most common injection site reactions were erythema, pain, and bruising. The proportions of patients who discontinued treatment due to local injection site reactions in Repatha™-treated patients and placebo-treated patients were 0.1% and 0%, respectively.
  - Allergic reactions occurred in 5.1% and 4.7% of Repatha™-treated and placebo-treated patients, respectively.
  - The most common allergic reactions were rash (1.0% versus 0.5% for Repatha™ and placebo, respectively), eczema (0.4% versus 0.2%), urticaria (0.4% versus 0.2%), and anaphylaxis (0.1%).

Neurocognitive events were reported in less than or equal to 0.2% in Repatha™-treated and placebo-treated patients.

In a pool of placebo- and active-controlled trials, as well as open-label extension studies that followed them, a total of 1,388 patients treated with Repatha™ had at least one LDL-C value < 25 mg/dL. Changes to background lipid-altering therapy were not made in response to low LDL-C values, and Repatha™ dosing was not modified or interrupted on this basis.

Although adverse consequences of very low LDL-C were not identified in these trials, the long-term effects of very low levels of LDL-C induced by Repatha™ are unknown.

Musculoskeletal adverse reactions were reported in 14.3% of Repatha™-treated patients and 12.8% of placebo-treated patients. The most common adverse reactions that occurred at a rate greater than placebo were back pain (3.2% versus 2.9% for Repatha™ and placebo, respectively), arthralgia (2.3% versus 2.2%), and myalgia (2.0% versus 1.8%).
- Immunogenicity: Repatha™ is a human monoclonal antibody. As with all therapeutic proteins, there is a potential for immunogenicity with Repatha™.

Please see Brief Summary of full Prescribing Information on adjacent page.
REPATHA™ (evolocumab)

BRIEF SUMMARY OF PRESCRIBING INFORMATION

Please see package insert for full Prescribing Information.

1. INDICATIONS AND USAGE

1.1 Primary Hyperlipidemia

REPATHA is indicated as an adjunct to diet and maximally tolerated statin therapy for the treatment of adults with heterozygous familial hypercholesterolemia (HeFH) or clinical atherosclerotic cardiovascular disease (CVD), who require additional lowering of low density lipoprotein cholesterol (LDL-C).

1.2 Homozygous Familial Hypercholesterolemia

REPATHA is intended for use in adults and other LDL-lowering therapies (e.g., statins, ezetimibe, LDL apheresis) for the treatment of patients with homozygous familial hypercholesterolemia (HoFH) who require additional lowering of LDL-C.

1.3 Limitations of Use

The effect of REPATHA on cardiovascular morbidity and mortality has not been determined.

2. CONTRAINDICATIONS

REPATHA is contraindicated in patients with a history of a serious allergic reaction to REPATHA [see Warnings and Precautions (5.1)].

2.1 Allergic Reactions

REPATHA is contraindicated in patients with a history of a serious allergic reaction to REPATHA [see Warnings and Precautions (5.1)].

2.2 Pregnancy

There are no data available on use of REPATHA in pregnant women. It is not known whether REPATHA can cause fetal harm when administered to a pregnant woman. The potential benefits of REPATHA therapy should be weighed against the possible risks to the fetus before prescribing REPATHA to pregnant women.

In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2% - 4% and 15%, respectively.

2.3 Lactation

Animal Data

In cynomolgus monkeys, no effects on embryo-fetal or postnatal development were observed up to 6 months after the observation the exposure to REPATHA was dosed during organogenesis to parturition at 50 mg/kg once every 2 weeks (13.2 mg/kg once every 2 weeks in REPATHA high dose) and did not find the recommended human doses of 140 mg every 2 weeks and 420 mg once monthly, respectively, based on plasma AUC. No test of humoral immunity in infant monkeys was conducted with evolocumab.

2.4 Pediatric Use

Risk Summary

The safety and effectiveness of REPATHA has not been established in pediatric patients with primary hypercholesterolemia or HeFH.

Table 2. Adverse Reactions Occurring in Greater than 1% of REPATHA-Treated Patients and More Frequently than in Placebo in Pooled 12-Week Studies

<table>
<thead>
<tr>
<th>Placebo (N=232)</th>
<th>REPATHA™ (N=439)</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Nasopharyngitis</td>
<td>3.8</td>
</tr>
<tr>
<td>Upper respiratory tract infection</td>
<td>6.3</td>
</tr>
<tr>
<td>Influenza</td>
<td>6.3</td>
</tr>
<tr>
<td>Back pain</td>
<td>5.6</td>
</tr>
<tr>
<td>Injection site reactions</td>
<td>5.0</td>
</tr>
<tr>
<td>Cough</td>
<td>3.6</td>
</tr>
<tr>
<td>Upper respiratory tract infection</td>
<td>3.6</td>
</tr>
<tr>
<td>Sinusitis</td>
<td>3.0</td>
</tr>
<tr>
<td>Headache</td>
<td>3.6</td>
</tr>
<tr>
<td>Myalgia</td>
<td>3.0</td>
</tr>
<tr>
<td>Dizziness</td>
<td>2.6</td>
</tr>
<tr>
<td>Musculoskeletal pain</td>
<td>3.0</td>
</tr>
<tr>
<td>Hypertension</td>
<td>3.0</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>2.6</td>
</tr>
<tr>
<td>Gastroenteritis</td>
<td>2.0</td>
</tr>
</tbody>
</table>

Table 2 includes erythema, pain, bruising

Adverse Reactions in Seven Pooled 12-Week Controlled Trials

In seven pooled 12-week, double-blind, randomized, placebo-controlled trials, 993 patients received 140 mg of REPATHA subcutaneously every 2 weeks and 1059 patients received 420 mg of REPATHA subcutaneously monthly in the mean age of the population (range: 18 to 80 years), 29% were older than 65 years, 49% women, 85% White, 5% Black, 3% Asian, and 5% Hispanic. Adverse reactions reported in at least 1% of REPATHA-treated patients, and more frequently than in placebo-treated patients, are shown in Table 2.

8. USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Risk Summary

There are no data available on use of REPATHA in pregnant women to inform a drug-associated risk. In animal reproduction studies, there were no effects on fetal weight or fetal organ development in rats, mice, rabbits, or cynomolgus monkeys following exposure to REPATHA. In one study in cynomolgus monkeys, REPATHA was dosed during organogenesis to parturition at 50 mg/kg once every 2 weeks and did not find the recommended human doses of 140 mg every 2 weeks and 420 mg once monthly, respectively, based on plasma AUC. No test of humoral immunity in infant monkeys was conducted with evolocumab in infant monkeys. Measureable evolocumab serum concentrations were observed in the infant monkeys at birth and at 2 weeks of age suggesting that evolocumab, like other IgG antibodies, crosses the placental barrier. FDA’s experience with monoclonal antibodies in humans indicates that they are unlikely to cross the placenta in sufficient quantities to be biologically significant and they are likely to cross the placenta in increasing amounts in the second and third trimesters. Consider the potential for adverse events during pregnancy to the fetus before prescribing REPATHA to pregnant women.

In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2% - 4% and 15%, respectively.

Animal Data

In cynomolgus monkeys, no effects on embryo-fetal or postnatal development were observed up to 6 months after the observation the exposure to REPATHA was dosed during organogenesis to parturition at 50 mg/kg once every 2 weeks (13.2 mg/kg once every 2 weeks in REPATHA high dose) and did not find the recommended human doses of 140 mg every 2 weeks and 420 mg once monthly, respectively, based on plasma AUC. No test of humoral immunity in infant monkeys was conducted with evolocumab.

© 2015 Amgen Inc. All rights reserved. Not for reproduction. v2.09/15

REPATHA™ (evolocumab)

Manuscript: Data Review

One Amgen Center Drive

Thousand Oaks, California 91320-1799

Amgen

Population: 200

Patient: http://pat.amgen.com/repatha/
Navigate 2016’s reimbursement challenges

With so many changes taking place in healthcare reimbursement, including the transition to value-based payments, payer consolidation, the growing popularity of high-deductible insurance policies, and the expansion of telehealth, the start of the new year is a good time to evaluate what primary care physicians can expect financially in 2016.


COPD resource center
The latest updates on treating chronic obstructive pulmonary disorder.
MedicalEconomics.com/tag/chronic-obstructive-pulmonary-disorder

TOP HEADLINES NOW

Payer negotiation tips for small practices
Negotiating with payers is one of the necessary evils that independent physician practices must endure.

Medicaid expansion
How to make it work for physicians.

The last words you should say to any patient
Why a simple thank you can work wonders for patient satisfaction.

New career directions
Financial factors and payment models mid-career physicians can consider.

PAYER CONSOLIDATION
Wondering how mergers among payers might affect your practice? We have answers.
http://ow.ly/RLkUP

CODING AND BILLING
#coding can make or break your medical practice. Follow these steps to hire the right person.
http://ow.ly/NS1iQ

MEANINGFUL USE
Doctors in small practices account for nearly half of all those who have attested to #MU2, our survey finds.
http://ow.ly/TTS12

CONTINUITY OF CARE
Good continuity of care requires #PCPs to become quarterbacks of their patients’ care.
http://ow.ly/NMLAq

REMOTE MONITORING
Remote patient monitoring is starting to fulfill its promise of better patient care.
http://ow.ly/SbNB4

LEADERSHIP
How can doctors take on leadership positions in today’s challenging healthcare environment?
http://ow.ly/UbJE
The board members and consultants contribute expertise and analysis that help shape the content of Medical Economics.
Doctors aren’t meeting care responsibilities

Doctors are lazy. That’s a brazen, derogatory, declaration that contradicts the usual lofty public image of physicians. We are perceived to be hard-working, dedicated and long-suffering individuals who care only about improving and maintaining the health of our patients. But I contend because of anecdotes shared by my patients and from personal experience, doctors seemingly do everything we can to avoid close interaction with the people we are Hippocratically obligated to serve. We simply have gotten complacent about our role and the importance of meaningful interaction with patients and choose to keep people at arm’s length. Sometimes we don’t even see the patient.

During the nearly 40 years I practiced family medicine, not a week went by when a patient didn’t tell me about their experience with other physicians. “You know doc, he wasn’t in the room five minutes.” Or, “he never examined me” What? A physical exam is one of the basic components required for the determination of a diagnosis, and it was omitted?

I know the physical exam takes time; you might have to wait for the patient to get undressed, or you might have to put on exam gloves. But that exam often provides surprisingly important information you would have otherwise missed. Atrial fibrillation, hepatomegaly, melanoma, DVT, pleural effusion, and murmurs are just a few of the problems easily detected by taking the time to examine the patient. So come on docs, let’s do our job. Examine your patients. They depend on us to do right by them.

In today’s world, however, it is not at all uncommon during office hours for the staff to send a patient to the ED who could easily be added to the doctor’s schedule. But because his “schedule is full” or “the office is about to close” the patient is shunted to an unfamiliar facility to see a physician they don’t know and who doesn’t know them. I think this practice undermines the physician-patient relationship and sends a message about the doctor’s dedication to patient care. We need to remember we’re in a service business and take it seriously.

And then there’s the monstrosity called electronic health records. The EHR concept has a serious purpose and is good for continuity of care, but nothing has driven a wedge between the doctor and patient or reduced physician productivity more than the EHR, and especially the Meaningful Use program.

Because of the complexity of EHRs and the need for thorough documentation, the physician is required to focus more on the computer during the visit than on the patient. Eye contact with patients is like the physical exam; it takes time and gets ignored.

“Laying on hands.” This is pure insanity and is a perfect setup for a lawsuit. Have we gotten so busy we have to diagnose and treat over the phone? No, we’re just complacent and lazy.

And finally, we come to the concept of “physician extenders.” Well-trained nurse practitioners and physician assistants provide good, competent care for patients the doctor is unable to see. And they do add to the bottom line financially in this era of bare-bones reimbursement. BUT do they see patients who could be seen by the physician? Has he gotten to the point of complacency that patient care has become an intrusion into other activities?

Nor has the medical profession in general asserted its influence in the matter of policy making. We have allowed insurance company execu-
Family docs have MOC concerns

Regarding the letter “ABIM is striving for greater transparency” (December 10, 2015): I am not an internist, but until several years ago I was a board-certified family physician. I have joined the debate on MOC because the problems that internists have with the ABIM MOC are similar to those that most family doctors have with the family practice MOC and for that matter the same that pediatricians have with their MOC.

I suspect that the only reason that criticism has been rare among the family doctors and the pediatricians is because generally they are not as aggressive as their colleagues in internal medicine, particularly the specialists who seem to be leading the movement for change.

But the point is that the American Board of Medical Specialties should take a good look at the boards of family medicine and pediatrics as well.

Even more important, after initial certification the responsibility of all the boards should be to promote medical education not to maintain certification. And it should not be done in a punitive manner. The education should be mostly self-assessment.

Physicians are besieged and crushed by numerous regulations that have known no precedent in medical history. Burnout is common and those doctors who can afford to are retiring earlier than they had planned.

Some have left their practices to join hospital networks. Others have taken administrative roles in private healthcare organizations. Clearly, doctors are feeling the strain and the dogmatic approach of the boards exemplifies how disconnected they are from the realities of everyday practice.

Patients value good doctors who give them time, act in their best interests, and are competent. Board certification doesn’t guarantee any of that. In fact MOC encourages doctors to be “test-takers” and in this way disadvantages them. The entire recertification process is out of sync with doctors’ intellectual, psychological, and practical needs.

If the CEO of the ABIM wants greater transparency he must remove the ignored and unresolved intellectual, psychological and practical difficulties that cloud and distort the MOC process in the first place.

Edward Volpintesta, MD
BETHEL, CONNECTICUT

Insurance execs’ salaries inflate healthcare costs

I believe there are more than three reasons for the increased healthcare spending. (“3 ways insurance mergers will affect physician practices,” October 25, 2015). The excessive salaries and bonuses of health insurance CEOs must add greatly to the cost of healthcare insurance. Is any one’s work worth a million dollar salary? Maybe our military in combat.

Also, the insurance companies’ stocks have done well. Profit is good.

But when does that profit margin become burdensome to the people requiring it? Apparently the insurance industry does not feel that physicians who actively help mankind (at great liability), are worthy of a “salary” anywhere near an insurance CEO. Instead, we physicians see our pitiful reimbursements trend downward.

James M. Merrill, DO
HURST, TEXAS
New practice models

AMA study: Independent physician use of ACO, PCMH models lags behind

Use of new practice and payment models intended to improve outcomes and pay providers more for value rather than volume remain low overall among physicians, primarily because of low adoption among solo practices, according to a new study by the American Medical Association (AMA).

Only 7% of solo practices are part of a patient-centered medical home (PCMH) while 13% participate in a Medicare accountable care organization (ACO), "Not surprisingly, physicians in solo practice were less likely to be part of a medical home and less likely to be part of a Medicare ACO than physicians in other practice types," the report reads.

At the same time, physicians practicing in larger, single-specialty practices—especially those in primary care—have seen gains in use of ACOs and PCMHs.

Twenty-six percent of internists, 28% of pediatricians, and almost 37% of family practice physicians in single-specialty practices were part of a PCMH.

Participation in ACOs among internists and family practice physicians in single-specialty, multi-physician practices was also relatively high. Internists in those arranges were using the new practice models 33% of the time, while family practice physicians were at 38.5%.

The primary factor in these relatively high participation factor was practice ownership. According to the study, "for single specialty practices, whether the practice was physician-or hospital-owned appeared to be an important factor driving medical home and ACO participation."

The study says that passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is expected to increase physician participation in ACOs and PCMHs, since that legislation repealed the sustainable growth rate and called on policy makers to establish "a framework that will reward physicians for quality and value rather than volume."

The Vitals is continued on page 17
Don’t miss an issue—renew your subscription now!

✔ Coding tips for better reimbursements
✔ Malpractice advice from the experts
✔ Practice management Q&As
✔ Strategies for optimal patient flow
✔ Practice makeovers to improve operational efficiency

Renew today!
Online subscription renewal only takes a minute

Visit MedicalEconomics.com/subscribe

Enter priority code: MEHAW
CMS: The meaningful use program is ending

Meaningful Use, the much-reviled government program aimed at encouraging doctors to adopt electronic health records (EHRs), is coming to an end.

"The Meaningful Use program as it has existed will now be effectively over and replaced with something better," Andy Slavitt, MBA, acting administrator of the Centers for Medicare & Medicaid Services (CMS) said last month during a speech to an investor's conference sponsored by the investment bank JP Morgan.

"Since late last year we have been working side by side with physician organizations across many communities...and have listened to the needs and concerns of many," Slavitt said. Details regarding the program's replacement will be announced "over the next few months," he said. The new program's guiding themes will be:

- Moving away from "rewarding providers for the use of technology and towards the outcome they achieve with their patients,"
- Enabling provider to customize their goals so vendors can build their products around practice needs rather than the government's needs. "Technology must be user-centered and support physicians, not distract them," Slavitt said.
- "Leveling the technology playing field for start-ups and new entrants" by requiring open application program interface so that apps, analytic tools and other technologies can get data in and out of an EHR securely, and
- Getting "deadly serious" about interoperability. "We will begin initiatives in collaboration with physicians and consumers toward pointing technology to fill critical use cases like closing referral loops and engaging a patient in their care" Slavitt said. "And technology companies that look for ways to practice 'data blocking' in opposition to new regulations will find that it won't be tolerated."

In October, the U.S. Department of Health and Human Services issued a Final Rule for stage 3 of the program that, among other steps, extended the deadline for meeting stage 3 to the start of 2018 and shortened some of the required reporting periods for attestation.

The changes did not mollify MU’s critics, however. The American Medical Association, for example, said in a letter to Slavitt that "Stage 3...continues to restrict innovations in technology for patients and physicians" and will impede the transition to the new Merit Based Incentive Payment System slated for 2019.

Similarly, the American Hospital Association and College of Healthcare Information Management Executives have called for delaying the start of stage 3 until 2019, and then only if at least 75% of eligible professionals have successfully attested to stage 2.

Launched in 2011 under the auspices of the Health Information Technology for Economic and Clinical Health (HITECH) Act, the Meaningful Use program made funds available to medical practices and healthcare institutions to offset the costs of purchasing and implementing EHR systems. To obtain the funds, however, EHR users had to attest to meeting certain goals such as capturing and sharing patient data, exchanging patient data with other providers, and having patients use an EHR’s patient portal.

In addition, the program imposes penalties, in the form of reduced Medicare reimbursements, for practices that do not adopt EHRs. Penalties began taking effect at the start of the year for practices that had not adopted EHRs by the start of 2015. According to CMS, 209,000 eligible providers are subject to such “downward payment adjustments,” although most of those will be for $1,000 or less.

Almost from the outset, Meaningful Use encountered opposition from physicians organizations, hospitals and other providers who complained that the reimbursements did not compensate for the lost productivity, frustration and additional expenses that result from EHR adoption. Moreover, they say, EHRs can’t meet some of the program’s requirements, particularly in the realm of interoperability.

Physician reactions

Hooray! Rewarding the Meaningful Use of health information technology was a good concept but failed in its application. The requirements and regulations were too onerous. People in Washington far removed from the care of patients should learn from this failure.

—Joseph Scherger, MD

It was inevitable that the incentive program would end as EHR adoption became almost universal. As always, the devil is in the details so will need to wait until the new plan is announced to assess if we will gain or lose. Rewarding outcomes makes sense, but population health requires a team approach which is very expensive and difficult since we still live in a fee-for-service environment that pays on production. Hopefully, that is recognized and the new incentives will help us to afford the teams.

—Mary Ann Bauman, MD

Make your best move

by JANET KIDD STEWART  Contributing author

IN THE PROCESS of buying or selling a practice, emotional issues can sometimes overwhelm financial ones. Fear of losing autonomy or worry over inevitable culture clashes often crowd out basic financial considerations, but it’s crucial not to overlook them.

Leveraging the timing of a deal, negotiating smartly, and making sure the practice financials mesh well are all as important as strategic fit, experts say. Details that seem small during negotiations can magnify quickly when learning to live with a new arrangement. And then there are the surprises that somehow didn’t come up during the due diligence that can doom any merger’s success.

Despite all the unknowns, however, physicians weren’t going to be starting up practices anymore [because of healthcare reform requirements], but we haven’t felt it, and we also haven’t seen any increase in the last five years in defaults or late payments,” Curtis says. Low default rates and expectations of only a modest uptick in interest rates should keep borrowing costs low and deals flowing, he says.

Irving Levin Associates tracked 78 large acquisitions of physician medical groups in 2015, up from 60 in 2014, for a total value of $2.3 billion, says Lisa Phillips, editor of the Health Care M&A Report.

In a separate survey by Jackson Healthcare internal medicine, family medicine, and cardiology were the three most common acquisition targets by hospitals. Southern, warmer climates continue to attract deals, but other factors are important, one veteran business appraiser says.

“Most buyers are picking locations based on personal reasons rather than profitability,” says Keith Borglum, CHBC, CBB, a healthcare business broker and appraiser.
and Medical Economics editorial consultant.

However, discerning whether buying or selling a practice is right for a particular group takes more than just a good borrowing climate.

**TIMING IS (ALMOST) EVERYTHING**

“I sold one practice recently to a physician who was active in mountain biking and wanted to be near the mountains. Another one I sold to someone who was relocating to be closer to aging parents to help take care of them, which is a common one now,” Borglum says. “So when you have a personal reason to want to be in a particular area, you have to look at the market and decide if you really want to start a practice yourself. Many times, it’s a lot easier just to buy one.”

Finding a buyer with a stake or interest in the geographic area makes a world of difference in pricing power compared with buyers evaluating several different markets, so being able to wait for the right candidate can have a significant impact, Borglum says.

“If someone has a reason to be in your market, a strategic interest, then finding a way into that market can be worth more to the buyer than it would be” for someone looking at a variety of locations, he says.

Generally, he says, practices that are being purchased today are going for about 1.5 times dividends, where dividends are defined as practice income after salary and other overhead costs are removed.

When dermatologist Matthew Elias, MD, a client of Borglum’s, heard a Fort Lauderdale, Florida dermatologist was interested in selling his practice a few years ago, he and his brother and practice partner, Merrick Elias, MD, moved fast to lock in a deal.

“My brother saw an ad for the practice and knew it had an amazing reputation, so we called [the buyer’s agent] right away,” says Matthew Elias. “The physician wanted out quickly, but didn’t want to sell to a huge group and wanted the practice to operate largely like it had before, so he was happy to talk with us and was very reasonable. It all happened very fast.”

**NEGOTIATE, NEGOTIATE, NEGOTIATE**

Taking advantage of timing isn’t the only financial consideration, however.

When the brothers considered buying a second practice with a more complex payer

---

**Knocking on the door**

*Private equity firms still showing appetite for medical practices*  By Janet Kidd Stewart

Private equity deals for physician-led practices continued to grow in 2015, and experts say the trend should seep into more types of practices as buyers look to roll them up through economies of scale. So how do these deals compare with selling to a hospital or large group, and what are the financial mine fields to avoid?

Selling to and becoming an employed physician in a hospital system can be the cleaner route to go, particularly if looking for a quick exit strategy, experts say, but some of the private equity deals can be compelling for doctors who want to maintain some control over their former practices and some financial skin in the game.

“There are big opportunities in primary care right now because it’s very fragmented,” says Joseph Davis, managing partner with Triton Pacific Investment Corp. in Los Angeles, California, a private equity firm. “By aggregating and consolidating back-office operations you can really get a lot of scale” as well as greater profitability, he says.

With appetites for deals high, sale multiples are getting richer, experts say. Depending on the geographic market and type of practice, physicians are commanding multiples of more than six times practice earnings, far higher than typical sales to larger practices and hospitals, these sources say.

“There’s a finite number of deals and a lot of auctioning going on so multiples are getting more expensive. And there is a more limited supply because a lot has been sold in the last few years,” says Saul Rudo, JD, a Chicago partner specializing in private equity at KattenMuchinRosenman LLP. Venture capital buyers are collecting enough capabilities through acquisitions to compete with large medical groups and hospitals in terms of synergies and cost containment, he says.

“Every situation stands on its own and a physician has to weigh how it will play out and whether he is of a certain age and just wants an exit strategy, but clearly a lot of doctors are looking for bigger, better situations,” Rudo says.

Maximizing a practice’s appeal—and ultimately its financial success—to private equity partners involves getting rid of practice debt and embracing services that accountable care organizations will be paid for going forward, such as chronic care management, says Michael Presley, executive vice president of United MSO of America LLC in Wellington, Florida. The company is buying medical practices in several states, typically offering payments over five years to spread out tax liabilities, and introducing common back-office functions and new service lines that will garner better reimbursements as healthcare moves to outcomes-based payments.

“A lot of times these VCs [venture capitalists] come in and it’s a bunch of blue suits changing the front office and it just doesn’t work,” he says. “Practices that are debt-free, hiring good staff and following up on patient care get our attention.”
mix, they spent more time bargaining to get to a purchase price that better reflected the future value of the practice, Matthew Elias says.

“We looked at a lot of practices that we ended up determining with Keith were significantly overvalued,” he says. One mid-career physician was carrying about $900,000 in debt, mostly from big purchases of medical equipment, he recalls.

“It kind of looked like he was trying to get out from under all these purchases and start over. Keith told us this guy should be paying us to take the practice,” Elias says. Not surprisingly, the brothers passed on that deal.

The deal they ultimately consummated ended up providing smaller patient volumes than they initially anticipated because they had to streamline and eliminate some payers. But having negotiated heavily on the price initially, they still got value out of the deal, he says.

PREPARING YOUR PRACTICE

Physicians considering selling to a larger group should keep detailed financial metrics in mind, says Sheri Bodager, vice president and executive director for Asante Physician Partners in Medford, Oregon.

Because Asante has been on the acquisition trail more aggressively since 2013, Bodager says she’s been surprised at the number of physicians who don’t consider the cost of their medical malpractice tail insurance until the very last minute in negotiations, for example. “It’s a common ‘Oh-my-gosh, what about this?’ moment, when they realize they need another $25,000 to make the deal work,” she says.

Some physicians also figure out late in the game that their expensive electronic health records (EHR) system will likely be useless to an acquirer because they’ll be joining the larger organization’s system, she says. In some cases, buyers will pay for an extra year of the EHR while the practice transitions its patient records, but it’s a point to negotiate sooner rather than as an afterthought, she says.

Continuing medical education is another point to negotiate early, Bodager says. And don’t forget about continuing staff time. Typically, buyers don’t take over accounts receivable, so practices need to budget in six to eight months of staff time to handle the conclusion of the old billing cycle.

Looking forward, physicians must consider carefully the financial metrics they’ll be required to hit under a new employment contract. “We’ve listened to our physician partners and tried to create production measures that are flexible depending on someone’s practice,” Bodager says. Some newly acquired physicians are on an RVU system, but others are under contract based on hours worked or numbers of patients seen in a day. Also, physicians typically are signing four-year agreements, which provide more stability than hospital contracts, which tend to have shorter terms.

Many agreements have been restructured in recent years to allow physicians more autonomy in various practice management functions, from hiring medical assistants to making referrals, Bodager says. “We have a board of directors and a finance committee so they have direct input and a structure that keeps [physicians] in the loop” of operations, she says.

Last year, Bruce Yager, MD, agreed to sell San Benito Pediatrics, the practice he founded 27 years ago near Hollister, California, to West Coast Health Foundation Inc., a nonprofit that is building a network of primary care sites.

Yager and his practice manager and wife, Kathleen, say their emphasis on practice financials and staff qualifications over the years helped the practice appear desirable to buyers. “Then the second thing was an alignment of values” with the buyer, Bruce says, which included a similar emphasis on patient care and a shared desire to retain existing staff.

CONSIDER THE SELLER

Making sure a practice is appealing to the widest pool of buyers is critical to achieving a sale, experts say. Some buyers will want to see a host of ancillary providers and multiple revenue streams, while others might be interested in some of the practice’s equipment, and others are interested only in its individual human capital.

“In our case we have all the ancillaries we need, so that’s just a duplication of what we already have,” Bodager says. “Sometimes we look at buying a practice building if it’s in the right area and we do buy exam tables, EKG machines, and waiting room furniture.”

Doctors thinking of retiring, however, should think about
Advancing anticoagulation with the largest novel oral anticoagulant clinical development program in history

Our commitment to the science and management of heart and vascular disorders runs deep. With proven results...and more to come.
diversifying away from all that human capital, Borglum advises. In other words, maximize the revenues coming from ancillary staff. “If you’re wanting to sell for the best price and are looking to slow down and retire, you want to start maximizing the practice income while reducing your personal work hours,” he says.

If a provider’s appointment waiting list is more than two or three weeks, he says, there is room to hire non-physician providers. As these ancillary providers form relationships with patients, physicians can transition more and more patients to them, Borglum says.

“You want to transition as much patient load as possible so you can bring down that waiting list to under two weeks and now you have an income stream that’s not dependent on your personal work hours,” Borglum says. “Then you can add as many ancillary services that aren’t already contracted out.”

MAKING IT WORK

Financing. Take the time to solicit competing offers for financing, Borglum says. Check a local credit union or community bank, and compare rates and terms with major players in medical practice financing, such as Bank of America Practice Solutions and Wells Fargo Practice Finance, he says.

Some smaller lenders will push physicians into Small Business Administration loans, which can be cumbersome and time-consuming to deal with, he says, so pay attention as much to the terms as the interest rates charged. And don’t go in hat in hand, he says. “Practices are a desirable account because they churn a lot of cash,” so go in expecting a great deal, he advises.

Digging into the numbers. As for due diligence, appraiser Monica Kaden, MBA, ASA, a director at accounting firm Marks Paneth LLP in Parsippany, New Jersey, looks for at least five years worth of tax returns and supporting documents, making sure they match with original documents such as patient log sheets and accounts receivable records. “You want to look at actual reports from the billing company to get a sense of gross charges,” she says.

6 ways to boost your medical practice’s value

By Keith L. Martin

Whether you are looking to sell to a hospital, grow your provider base, or partner with other practices to take advantage of strength in numbers, knowing the true value of your medical practice has become much more important. But knowing the value is one thing; boosting that value may be the more important piece.

“Value is an important thing to keep in mind, even if you don’t have an immediate desire to sell your practice,” says Daniel M. Bernick, a principal at Plymouth Meeting, Pa.-based The Health Care Group and Health Care Law Associates.

For example, noted Bernick, if a practice is looking to bring on a new associate physician, it’s likely in the future that he will want to buy into the practice. You’ll want to know the value of your practice as the valuation will affect compensation during the buy-in period. Another consideration, added Bernick, is simply that “life is unpredictable and you never know when it might be to your advantage” to sell, perhaps to a hospital or other large entity.

“Because the market is changing and larger entities enjoy an advantage in terms of negotiating with payers, it may make sense for you to sell your practice to a larger entity,” he says. “If that happens, you are going to want to know what the value of your practice is.”

Bernick noted there are six areas where you can start boosting the value of your practice, starting today:

1. Keep working.
Bernick notes this pertains to an older physician, as any potential buyers will want to see the financials prior to a deal. “If those financials show a declining revenue stream in the past few years it is very discouraging,” he says. “So you want to keep working and keep your revenue up so your practice continues to show good profit and is attractive to potential buyers.”

2. Maintain your “curb appeal.”
Just as you would put a fresh coat of paint on your walls before selling your home, do the same at your practice to spruce things up prior to a possible sale. And it is not just
Maintain an exit strategy. Sellers should keep Medicare provider ID numbers and other pertinent credentials current if they’re joining a larger group, and be crystal-clear about the details of any subsequent non-compete agreements, she says.

Sellers shouldn’t expect a windfall, Borghum adds. “You'll always make more money by working a practice rather than selling it. A sale is really only an exit strategy” for retiring, relocating or divorcing physicians, he says. Selling a practice for $1 and the obligation for the buyer to assume and maintain patient records is not uncommon, he says.

Know your value. On the other hand, don’t discount a practice’s potential value to an acquirer if it has something that sets it apart from other providers, suggests Peter Valenzuela, MD, MBA, chief medical officer for Sutter Medical Group of the Redwoods in Santa Rosa, California. He practiced family medicine before earning a business degree and taking on administrative roles.

“You want to ask yourself if there’s a reason they might want you in particular,” he says. “You want to know your unique value to an acquirer.

“There are a lot of strategic decisions going into these acquisitions,” he adds. For example, a practice might serve a particular ethnic group in the community, or have an established relationship with a payer that the acquirer doesn’t, he says.

It also helps to come into the new practice in a position of responsibility, Valenzuela says. As his own group has acquired other practices, he says, physicians have joined the new organization as board members with a strong voice, which has helped smooth the transition and kept new physicians engaged.

THE REWARDS OF INDEPENDENCE

Keeping buy-in costs low and communication channels open proved the key to a relatively smooth merging of six practices in the Tampa-St. Petersburg, Florida area over the last two years, says Robert Swiggett, MD, president of OrthoCare Florida. The 55 orthopedic surgeons involved in the practices were also motivated by the idea that they could control their destiny more together.

aesthetic items, Bernick noted, it is your practice website — which shouldn’t look “unprofessional or clunky” — and your financial reports on everything from aging of receivables to CPT volume. “To the extent you have professional-looking financials that look as though you are on top of things and are tracking the important aspects of your practice, that plays very well with potential buyers,” he says.

Maintain relationships. Bernick says it is important to keep up relationships with referring sources to show patient base consistency and growth, with training program directors to ensure you have good access to qualified physician candidates, and with others, including your local hospital. “The hospital is an important player in your marketplace and may be a potential buyer for your practice,” he noted.

Utilize non-compete clauses. While unenforceable in some states, Bernick notes that most states will allow a “geographically reasonable, properly drafted” non-compete clause for an associate physician, physician assistant or nurse practitioner. Without such a clause, you are raising a red flag for potential buyers in terms of your patient base. “If the associate is not subject to a non-compete, the buyer will worry that your associate may, at the time of sale, go into practice on their own or right across the street,” he says. “If that’s a possibility, that will really depress the value of your practice.”

Hold off on major tech investments. If you are considering a sale in the short term, hold off on long-term tech purchases, such as a new practice management system or EHR, says Bernick. One, there’s a good chance you’ll lose productivity during the adoption and integration of new technology, resulting in “a pretty big hiccup in your revenue flow.” Two, it’s likely that the buyer of your practice will have their own systems to integrate, rendering your new purchase — and the time and training involved — virtually useless.

Add ancillary services. If it makes sense for your practice and you have the ability, ancillary services can be a boost to your practice’s value. “Some [services] are more expensive and some are within reason, so if you can add it reasonably and make use of the ancillary service, that’s going to help your profitability and help your curb appeal,” Bernick says.

Editor’s note: This article was first published in our partner publication, Physicians Practice.
Provider M&A To Stay Strong in 2016

In your opinion, which of the following industries will be the most active overall in mergers and acquisitions in 2016?

( % of industry respondents, asked to select up to six)

<table>
<thead>
<tr>
<th>Industry</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technology</td>
<td>70%</td>
</tr>
<tr>
<td>Pharm/Biotech</td>
<td>60%</td>
</tr>
<tr>
<td>Healthcare providers</td>
<td>47%</td>
</tr>
<tr>
<td>Media/telecom</td>
<td>42%</td>
</tr>
<tr>
<td>Consumer goods</td>
<td>27%</td>
</tr>
<tr>
<td>Medical devices</td>
<td>24%</td>
</tr>
<tr>
<td>Health plans/insurers</td>
<td>22%</td>
</tr>
<tr>
<td>Oil &amp; gas</td>
<td>21%</td>
</tr>
<tr>
<td>Banking</td>
<td>17%</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>17%</td>
</tr>
<tr>
<td>Alternative investments</td>
<td>14%</td>
</tr>
<tr>
<td>Retail consumer markets</td>
<td>12%</td>
</tr>
<tr>
<td>Power, utilities</td>
<td>10%</td>
</tr>
<tr>
<td>Others</td>
<td>23%</td>
</tr>
</tbody>
</table>

Source: KPMG survey of 550 merger & acquisition executives
Florajen unites high potency with affordability.

Florajen contains more live probiotic bile-tolerant cells per dollar spent than any competitor.

Florajen is formulated with proven safe and effective strains. Its higher cell count delivers a level of potency with real and significant health benefits. Unlike the leading competitors, Florajen is refrigerated for freshness and quality and it is affordable for all your patients.

For Free Sample Packs to get your patients started, call 1-800-257-5433 or visit florajensamples.com!

<table>
<thead>
<tr>
<th>Beneficial Bacteria</th>
<th>Cost Per Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live Cells per Bottle</td>
<td>at Recommended Dosage</td>
</tr>
<tr>
<td>Florajen 600 billion</td>
<td>$13.95</td>
</tr>
<tr>
<td>Florajen3 450 billion</td>
<td>$15.95</td>
</tr>
<tr>
<td>Culturelle 300 billion</td>
<td>$24.99</td>
</tr>
<tr>
<td>Align 28 billion</td>
<td>$33.20</td>
</tr>
<tr>
<td>Florastor None*</td>
<td>$60.00</td>
</tr>
</tbody>
</table>

*No beneficial bacteria—only Saccharomyces, a yeast

Florajen®

High Potency Probiotics

www.florajen.com

Statements have not been evaluated by the Food and Drug Administration. This product is not medicinal and is not intended to diagnose, treat, cure or prevent any disease.
Why medical necessity is key to correct level of care coding

by BILL DACEY, CPC, MBA, MHA Contributing author

We are having a disagreement in our office about how to code for a single, stable chronic problem. The doctors insist that it should be a 99213 at least, maybe even a 99214, while our coder says that the decision-making only gives a 99212. Who is right?

A: You have identified one of the major flaws in the medical decision-making (MDM) tables. Not that it helps – but the problem is larger than just your office.

The fact is that the coding tables and audit sheets do not always line up as one might think they should based on knowledge and experience. The root of the problem is that the Table of Risk (table three) lines up with generally recognized medical necessity and common sense (for the most part), and table one doesn’t always do that.

Your coder is absolutely correct that the decision-making tables give a read of Straightforward MDM on a single stable established chronic with a lab (or without) and a prescription medication. Table III describes this as low level decision-making, but Table I does not.

If you look at enough encounters you’ll see that most are coded as 99213s - because they are single-system, stable problems consistent with low risk. Very few payers push back on these, or even comment on them, although Medicare administrative contractor Trailblazer once estimated that 70% or more of all 99213 were over-coded for this reason - and did nothing about it.

If providers do get questioned on this, they usually point to the supporting history and exam and the established patient rule of ‘two out of three’ needed for the history, exam and medical decision-making. In that case, they are essentially relying on the history and exam to carry the code. Most decent neuro follow-up notes for a periodic assessment of seizure management, or Parkinson’s, or really any systemic problem with risk will have some interval history, large neuro exams, and the patients clearly have significant problems requiring medication management. These should not code out to 99212 or minimal MDM. These encounters are miles from what is meant by a 99212—an ear re-check, contusions etc., and quite inconsistent with the RVU, risk and liability that go with the problems associated with a 99212.

The clinical examples supplement to the CPT manual include examples of a well-controlled migraine maintained on the same medication as an example of a 99213. Although these examples also have some variance, like the federal guidelines, they contribute to the overall body of knowledge on necessity and standards of care.

This is why you need to apply some common sense on these, and not the fixed coding algorithms that the decision-making tables represent. If you think the medical necessity and risk are there, you should give credit for low MDM for one stable chronic with med management of this sort. Remember, Table I is not in the federal guidelines.

Table III is. Your state Medicare program administrators have varying guidelines, and many do use Tables I and II, but these entities come and go, while the Federal rules haven’t budged on these tables in 20 years.

Medicare has always preached that “Medical necessity is the overarching criteria for all payments made,” If that is the case – then regard the guidelines as just that; guidelines, and don’t get stuck in counting when it takes you to the wrong place.

Q: The rules for Chronic Care Management (CCM) code say that I
Medical Necessity is the overarching criteria for all payments made. If that is the case, then regard the guidelines as that: guidelines.

Q: Does the time to develop a care plan count towards fulfillment of the 20 minutes required for CCM services?

A: This answer also comes from Medicare, so if this is being billed to a commercial plan then you should ask that payer for their policy on this.

Per Medicare, CCM services can only be billed paid after a patient has been seen by the provider during an AWV, an IPPE, or a comprehensive evaluation and management (E/M) visit. This visit would involve identification of and arrangement for CCM in future months (with fulfillment of CCM requirements).

Q: Can I bill Chronic Care Management CPT 99490 if the beneficiary dies during the service period? How about the TCM codes 99495 and 99496?

A: Medicare gives clear guidance on the first part of your question and states that CPT 99490 can be billed if the beneficiary dies during the service period, so long as at least 20 minutes of qualifying services were furnished during that calendar month and all other billing requirements are met. Other payers may or may not recognize this.

TCM, on the other hand, represents 30 days worth of oversight in transitioning the patient back to the community from the inpatient setting. If the patient dies between the day of discharge and the 30th day, you cannot have provided 30 days of transitional care.

Remember, if the patient dies after you have performed the included EM visit following the hospitalization, which would normally be included in the 99495 or 99496 code – that visit is billable if you met all the performance and documentation criteria for the EM level you choose to bill.

Q: Can I bill CPT 99490 along with CPT codes 99495 or 99496 for Transitional Care Management (TCM)? If I do perform both services in the same month, and they do not overlap – can I bill 99490 and 99495 for example?

A: You are correct. Both Medicare and CPT state that CCM and TCM cannot be billed during the same month. However, if the 30-day TCM service period ends during a given calendar month and 20 minutes of qualifying CCM services are subsequently provided on the remaining days of that calendar month, CPT code 99490 could also be billed that month. At least one Medicare contractor says “we expect that the majority of the time, CCM and TCM will not be billed during the same month.”

Although you will likely be paid for this coding combination in these circumstances, at least one of the services will be denied when initially submitted and you will need to appeal this and provide clear documentation of the separateness of the services.

Q: More ahead

How to manage technology overload
Direct-to-consumer ads: Helpful or harmful?

by KEVIN GAULT Contributing author

The flow of direct-to-consumer (DTC) advertising for the latest wonder drugs is constant and seemingly endless. TV, Internet and print ads captivate consumers with tales of medicines that can solve their health issues and improve their lives. But opinions vary about whether DTC advertising is helpful or harmful, not only for patients but for physicians.

“PEOPLE WHO see ads aren’t more likely to get a prescription for the advertised drug,” says Michael Ybarra, MD, an emergency physician and senior director for alliance development at Pharmaceutical Research and Manufacturers of America (PhRMA). “In fact, most patients who go to a doctor’s office and request a prescription don’t walk away with one. Instead, DTC advertising can open up a dialogue between the doctor and the patient—patients ask questions about their health and their medicines, and they end up working more closely with their doctor on their care.”

Ybarra adds that a 2004 FDA study found 53% of physicians reported better discussions with patients exposed to DTC advertising. The American Medical Association (AMA) disagrees. In November 2015, the association adopted a resolution opposing DTC advertising, citing concerns that the surging tide of ads drives patient demand for expensive medicines despite the clinical effectiveness of less-costly alternatives.

AMA members voted to support a ban on DTC advertising for prescription drugs and implantable medical devices, maintaining that the negative effects of commercially driven ads outweigh the minimal educational information the ads may offer to patients.

“The vote in support of an advertising ban reflects concerns among physicians about the negative impact of commercially driven promotions, and the role that marketing costs play in fueling escalating drug prices,” says AMA board chair-elect Patrice A. Harris, MD, MA. “Direct-to-consumer advertising also inflates demand for new and more expensive drugs, even when these drugs may not be appropriate.”

Market research firm Kantar Media found that advertising dollars spent by drug manufacturers grew 30% in the last two years to $4.5 billion. In recent years prices for both generic and brand-name prescription drugs have risen as well, including a 4.7% spike in 2015, according to the Altarum Institute Center for Sustainable Health Spending.

“The U.S. Food and Drug Administration’s (FDA) Office of Prescription Drug Promotion is investigating DTC and professional drug promotion. “We recognize that drug promotion raises certain issues for health care professionals and different issues for consumers, in light of differences in medical and pharmaceutical expertise,” Sarah Peddicord, a spokesperson for the FDA told Medical Economics. “The FDA is monitoring DTC promotion very closely to help ensure that adequate information is included to help the consumer accurately assess promotional claims and presentations.”

Opponents of DTC advertising claim that increases in drug prices can make it difficult for doctors to offer their patients the best therapies. “Patient care can be compromised and delayed when prescription drugs are unaffordable and subject to coverage limitations by the patient’s health plan,” says Harris.

“In a worst-case scenario, patients forego necessary treatments when drugs are too expensive.”

Send your financial questions to: medec@advanstar.com.
ICD-10
Keep on Track with Official CMS Resources

Now that the October 1, 2015, compliance date has passed, CMS encourages providers to:

1. Assess ICD-10’s impact on coding, billing, and other processes
2. Refine processes as needed

Visit www.cms.gov/ICD10 for resources

Coding and clinical documentation
Billing
Monitoring key performance indicators

Remember You Must Use:

ICD-9 on claims for services provided before Oct 1, 2015
ICD-10 on claims for services provided on or after Oct 1, 2015
How to manage technology overload

Introducing new tools for the practice should also include addressing ways to maintain productivity

by SHELLY SCHWARTZ Contributing author

THE PRACTICE of medicine looks radically different than it did just a decade ago. As digital health records replace paper-based charts, and tablets and smartphones enter the exam room, doctors are equipped as never before to treat patients how, when, and where they want it, a quality improvement measure widely attributed to better outcomes.

But all that technology can also come with a psychological price. Physicians who have adopted electronic health records (EHRs) often complain that their workloads have grown as a result. Others say patient volume has suffered with the adoption of mobile health (mHealth) solutions.

“I don’t think there’s any question we have a serious issue,” says Mitchell Morris, MD, global leader of Deloitte’s life sciences and health care division in Austin, Texas. “There is clearly a lot of improvement to be made to EHRs and software capabilities, and more importantly to how we implement automation.”

Indeed, practices that report the biggest productivity losses in the age of digital healthcare often are those that fail to adapt. “Many of the physicians who struggle are the ones who are trying to deliver care the way they have for years and that’s not a good fit with new technology,” says Morris.

Still, most doctors generally support the use of health IT, according to a 2014 survey by Deloitte, with 70% indicating EHRs provide useful analytics and 60% saying they help to support value-based care. Another two-thirds (72%) cite “faster and more accurate billing for services” as the biggest benefit to EHR adoption, while 67% pointed to time saving through e-prescribing and improved care coordination.

To realize those benefits from their mobile apps, EHRs and decisions support tools, however, practices must embrace a culture of change, put new processes into place, and commit to IT training.

“We have found that in settings where training has sufficient support, they tend to do much better,” says Morris. “Even software that people think is the greatest in the world
won’t give you what you need if you don’t train people to use it.”

Before health IT can be used effectively, practices must analyze its impact on both clinical and administrative functions, and develop a plan for workflow redesign, Morris says. Each time a practice makes a change, especially when implementing health IT, the workflow associated with that process changes, too, according to the Agency for Healthcare Research and Quality (AHRQ).

Failure to account for workflow impact leads to delays in wait times, billing and communication. The AHRQ suggests practices map their workflow as early as possible, preferably before implementing a health IT system, and continue to assess processes post implementation to ensure ongoing improvement.

“Redesigning how we work is really key to this,” says Morris. “Workflow redesign should take you through all the different stations in your office, from when the patient walks through the door, to check-in, to scheduling appointment reminders. Have you thought through and figured out how automation can enhance each one?”

That doesn’t happen often enough, says Chad Anguiln, MBA, director of professional services for Medical Advantage Group, a practice consulting firm in Ann Arbor, Michigan. Many physicians, he says, are more concerned with collecting incentive program dollars to help defray the cost of health IT adoption than on redesigning processes to boost productivity. The focus on making sure all the correct boxes are checked often leads to wasteful duplication of effort.

“Doctors and staff put information into their EHR and then they have an employee who is earning $12 to $15 an hour going back in to reenter that information into the registry so they can record to the incentive program,” Anguiln says. “They’re willing to spend on that, but they won’t spend time to fix their workflows.”

TEST, THEN TRAIN
To accelerate quality improvement, practices might consider using the Plan-Do-Study-Act (PDSA) model, developed by the Institute for Healthcare Improvement, which allows organizations to test big changes in small steps, identify unintended consequences, tweak as needed, and expand when ready. PDSA is designed to reduce waste by determining early on whether workflow changes help productivity.

As new workflows are deployed, says Anguiln, practices should try to obtain staff buy-in by communicating the benefits: a lighter workload, fewer errors or opportunity for professional growth. For example, practices that implement pre-visit laboratory testing enable their physicians to discuss lab results with patients during their visit while eliminating the need to review the results later, call patients to discuss them, and coordinate follow-up care.

Training is the other major driver of productivity gains. With every purchase of new technology, providers should ensure that they and their staff take full advantage of training available through the vendor and complete online tutorials, says Wanda Filer, MD, FAAFP, a family physician and president of the American Academy of Family Physicians (AAFP). In addition, staff members should receive training on how to use health IT (both at the front desk and in the exam room) without compromising the patient experience.

The American Medical Association notes that increased eye contact and sharing the computer screen with a patient can improve engagement and adherence. Mobile or easily-shared technology, such as laptops, tablets, and large monitors, it adds, can help physicians involve patients in the discussion.

WHERE TO GO FOR HELP

To determine whether your practice is prepared to implement new health IT, or upgrade the technology you already have, the American Medical Association provides a free Health IT readiness survey online (bit.ly/AMA-HIT-readiness). Your responses help identify prerequisites for change, potential barriers, user needs, time sensitive factors and appropriate action steps.

Similarly, the AMA offers a series of modules, called STEPS Forward (bit.ly/AMA-steps-forward), to help providers optimize health IT and improve efficiency. Its telemedicine module, for example, describes how telemedicine visits are conducted, what upgrades may be needed, and what questions practices should ask their state licensing board, malpractice carriers, payers and legal experts. It also highlights various models for implementing telehealth technology successfully.
Managing technology

Without proper training, however, Filer says EHRs can become “a third entity” in the exam room.

“That’s when you should be spending quality minutes and face-to-face time with your patient, and sometimes the computer can feel like an interloper in that relationship,” she says.

For many practices, the most effective training strategy is to invest in a “super user”—providing one employee with the highest level of training so that he or she can train the rest of the staff, says Anguil. The super user should be comfortable with IT and be given adequate time and resources to stay current on the latest upgrades. He or she also should help to explain the benefits of health IT in the office.

Equally important to improving productivity is engaging patients as partners in their care, by encouraging them to use patient portals for tasks such as scheduling appointments and requesting prescription refills, as well as using time-saving technologies such as secure messaging and telehealth. Often, that means changing the dialogue at the front desk. Rather than blaming federal requirements for longer wait times, try explaining to patients how the new EHR is designed to benefit them, says Anguil.

THE RISE OF SCRIBES
To meet the challenges posed by IT integration and the demand for more detailed documentation, some providers are using scribes, who assist in the exam room by entering detailed notes into the EHR during patient encounters. To ensure compliance, the Joint Commission requires physicians to sign, date and time all entries made by unlicensed scribes.

While adding to staff increases payroll, scribes can more than pay for themselves by enhancing a doctor’s efficiency, says John Bender, MD, a family physician with Miramont Family Medicine in Loveland, Colorado and a Medical Economics editorial advisory board member. The providers in his office who use scribes, for example, typically see 10 to 15 more patients per week than those who do not.

Importantly, Bender notes, scribes can also help reduce physician workload, when used effectively. The scribes in his office complete extensive training and shadow team members for several weeks before they’re permitted to work solo with a physician.

“There is no national consensus for best practices on how to employ scribes in practices,” he says, adding that a program emphasizing continuous learning is ideal. “It hasn’t worked for everyone. I’ve known physicians who say it slowed them down.”

James Jerzak, MD, a family physician with Bellin Health in Green Bay, Wisconsin, says he, too, has seen impressive productivity gains since incorporating care coordinators, who double as medical scribes, into his team-based practice model.

“We anticipated we’d take a loss with the extra personnel and that it was just preparing us for value-based payments, but we were pleasantly surprised to find that the level of service coding went up quite a bit because they had time to deal with all the different problems patients have that physicians may gloss over when rushing from patient to patient,” he says.

The care coordinators, or scribes, in his office save significant time in the exam room by completing order entry in real time, including medication reconciliation, prescription refills, and appointment scheduling. They also make the documentation process far less onerous, says Jerzak.

“It definitely saves time because I can just walk out of the exam room and quickly review and edit what they wrote before I see the next patient, so it’s not like creating a document from scratch,” Jerzak says, noting that some physicians question the improved efficiency. “It’s hard to get it until you come observe how it works. It’s all very logical.”

Jerzak says that he now sees roughly 23 patients per day, up from 20 before the care coordinator program began.

“At the end of every half day, all the notes in the office are done,” he says, adding that he can direct his full attention to the patient at every visit. While EHR adoption initially slowed his practice, Jerzak says the team-based model of care, in which a physician, care coordinator (medical assistant or physician’s assistant), clinical nurse, and scheduler, work together to meet the needs of their patients, helped restore productivity.

“Patients really bond with our care coordinators and get to know very well so the barriers to contact-
Managing technology

UNHAPPY EHR CUSTOMERS
Some productivity challenges related to technology, of course, are beyond the physician’s control. Filer is on her fourth EHR and says the latest version is generally hiccup-free, but still falls short on interoperability, which detracts from care coordination.

One of the hospitals in her community, for example, uses an EHR that is incompatible with her own. Recently, she requested records for a follow-up with a patient who had been to the emergency department. Instead of sharing it electronically, the hospital faxed her 16 pages of useless background.

“There was so much fluff in it that I couldn’t get to the pertinent data,” says Filer. “I didn’t know what her chief complaint was, what was done for her, or her ultimate diagnosis. I had to start from square one.”

In light of complaints related to interoperability, she says, the AAFP is urging the Office of the National Coordinator for Health Information Technology to make EHR technology more seamless between providers. The academy, along with other professional organizations, also is pushing for greater EHR usability.

At present, says Flier, the design and functionality of many EHRs creates inefficiency for healthcare providers, an often overlooked barrier to their adoption. “What

Strategies to optimize your workflow

Beware the illusion of anonymity
We’ve all made the fatal error of sending a poorly-worded, emotionally-laced email. It’s a terrible feeling but the behavior is so quick and easy to replicate.

The EHR offers the same illusion of protected communication. But be cautious with how you word communications to your nursing staff or what you choose to immortalize forever in an electronic record.

While many of us are careful with the office visit notes we write or dictate, we may be less careful in how we word comments in the patient’s chart or in electronic communication with our staff members.

Educate your staff
One of the best things I ever did was take 10 minutes to educate my medical assistant about the new cervical cancer screening guidelines.

Armed with the information and my preferences, she is now able to determine if a patient needs a pap smear 90% percent of the time. This allows her to educate my patient before I enter the room and to enter the correct orders for me electronically.

The more you can share with your medical assistant or nursing staff about your preferences and processes, the more they can do to help you with the growing pile of electronic work.

Find opportunities to standardize
Do you tell your patients with bronchitis or low back pain or toenail fungus the same thing every time? If you have (as most of us do) patient information that you use routinely, standardize that by using the tools available in your EHR to build custom text.

Look for these opportunities wherever you can find them. It will improve your documentation because the information will be complete and well thought out.

It will also save time because you will be able to short-cut the typing. Any time you can do a better job in less time is a win.

One-piece flow
Our organization models lean manufacturing principles. Therefore, one piece flow figures high on our list of model behaviors.

Like many physicians, I tend to batch work. I look at all my results over lunch or finish up all my charts at the end of the day. This is a definite no-no in the manufacturing world and, for the sake of safety, quality, and sanity, should become a no-no in medicine as well. Think about how hard it is to remember which of your six patients with pharyngitis had tonsillar exudate at the end of the day or which of your patient’s ears was infected.

Attending a recent professional practice seminar, I vowed to incorporate one piece flow into my clinic day. This meant that the note and orders were completed by the time I left the exam room.

When I started this process, I had the strangest feeling as I stepped out of the exam room into the hall at the end of

continued on page 38
I’m hearing from members is that their EHR has really dropped their level of productivity and that they seem to be designed primarily for billing rather than as a tool for the clinical setting,” Filer says.

Part of why doctors are so disgruntled with health information technology is that vendors, especially those selling EHRs, overstate the potential of their products, says Anguilm. Physicians who think they are purchasing technology that will make their lives easier often are sorely disappointed.

"Every time we meet with a frustrated physician, they say [EHR adoption] should have been about productivity and that they were told they could let go of a full-time employee or two [as a result of efficiencies gained],” he says. "But the reality is that the way EHRs are built...their objective was really more about accurate information with the goal of reducing the risk of critical errors and being able to manage a population of patients better.”

THE EVOLUTION OF CHANGE
Along with health IT regulation, physicians are grappling with meaningful use, ICD-10, and the Medical Access and CHIP Reauthorization Act (MACRA), the new Medicare payment reform law, which puts solo and small practices at a distinct disadvantage, according to Morris.

"Because of a variety of factors, including automation, it’s become increasingly difficult to maintain a viable small practice,” says Morris. “Not only do you have to have an EHR, but you also have to do quality reporting. It’s very difficult for small practitioners to afford the infrastructure.”

Strategies to optimize your workflow continued from page 37

a visit. It was the feeling of a clear and unburdened mind. Instead of mentally filing away pieces of information for later about the patient I just saw, I reminded myself I was done and moved on to the next patient with improved focus.

Rule of 3s
Despite my admonition to avoid batching work, inevitably it will happen.

So when work does pile up, think of the rule of threes. It is daunting to sort through 50 results, but you could sort through three. Do the work in little chunks throughout your day and the job becomes more manageable.

Set small goals
Sometimes I run into the note that I really don’t want to finish. Usually it involves a complex patient with multiple social and medical issues that ran over by a good 20 minutes. Sometimes I haven’t been able to type anything in the exam room because my attention needed to be fully on the patient for the entire visit.

Trying to reconstruct a complicated 45-minute office visit in your notes can be painful. This might be a situation you need to break into chunks and tackle just one part of the note throughout the day. Avoid the temptation to put this off because the task will become more onerous as the day (or days) pass.

Touch it once
If you’re like me, you probably look at certain lab results and can instantly and easily address them with a couple of clicks. Other lab results require you to review the chart, calculate the 10 year cardiovascular risk score, or consult a reference.

While our natural inclination is to put aside the more complicated work, don’t do it. When you see the result, address it and finish it. Otherwise it will take up electronic space, space in your brain, and will probably be a result (or refill request or patient call) that you click on repeatedly, waiting hours or days to finally reach a conclusion.

Use your own templates
Previously I used the standard templates provided by our organization, especially for acute complaints. This gave the illusion of efficiency, except that I didn’t necessarily conduct my visit according to the template, nor did I ask all of the same questions.

This translated into formulaic notes that failed to convey the story of the patient and which required a lot of editing. So, I moved to my own templates and narrowed it down significantly. For certain conditions (like new-onset headache), I have a lengthy list of questions I want to remember to ask every time.

Editor’s note: This article was first published in our partner publication, Physicians Practice
Want more? We’ve got it. Just go mobile.

Our mobile app for iPad® brings you expanded content for a tablet-optimized reading experience. Enhanced video viewing, interactive data, easy navigation—this app is its own thing. And you’re going to love it.

get it at medicaleconomics.com/gomobile
Why physicians must protect their online reputation

**by MARK ROWH Contributing author**

It seems only yesterday that word of mouth was the primary means for the public to hear opinions about physicians. But today, patients and potential patients are more likely to obtain such information online. In the process, comments posted about any physician—good or bad—are available to be seen by anyone, anywhere.

*CERTAINLY THE inclination to rely on online searches for information on products or services, including healthcare, is a trend that can’t be ignored. It’s a way of life most notably with millennials, but is also becoming increasingly common with other generations.*

“Google has made it much easier for patients to research physicians online,” says Brandon Seymour, CEO of Beymour Consulting, a Boca Raton, Florida, consulting firm specializing in search engine optimization and online reputation management. “This level of transparency puts a lot of pressure on physicians and their staff to consistently provide top-quality service.”

Unfortunately, a pattern of excellence may not be enough. Thriving in the age of social media may also require careful management of your online reputation. In fact, paying attention to your online image is tremendously important, according to Kevin Pho, MD, a New Hampshire internist who writes and speaks on social media. “More patients than ever are going online,” he says. “If you’re not proactive about the information that can be found about you online, you might not like what you see.”

Pho suggests creating online content about yourself. One strategy is to develop a profile on a site such as LinkedIn or Doximity. Such sites offer the opportunity to present positive information about you and your practice. Pho also suggests encouraging more patients to rate you online at sites such as Yelp and Healthgrades. “The majority of online reviews are positive,” he says. “If you ask patients to express their satisfaction, their comments can drown out any negative reviews.”

Handing out cards to patients with selected rating sites is a simple approach for increasing the volume of reviews, he notes. It’s also important to avoid overlooking the inevitable negative reviews. “Listen to what’s being said,” he says. “There may be legitimate concerns. People could be upset about nurses or parking or magazines not being current.” Studying such details can lead to corrective actions.

Reviewing the online presence maintained by other physicians can also provide helpful insights. “One of the great things about online communication is that it is viewable by the masses,” says Linda Pophal, MA, a digital marketing consultant for Strategic Communications in Delafield, Wisconsin. “That means you can easily see what others are doing online. You can learn from what seems to be working for them, and what doesn’t.”

Along with monitoring and managing online reviews, it’s important for physicians to have an up-to-date website, Seymour says. “Patient testimonials, staff and office photos, and information about the physician can be a huge value-add when potential patients are researching medical professionals,” he says.

Finally, it’s wise to refrain from addressing comments that you consider inaccurate or unfair. “You’ll probably just get into an argument and when that happens, things rarely turn out well,” he says.

*Please send questions about technology to: medec@advanstar.com*
Understanding clinically integrated networks

Joining forces with other physicians to thrive is necessary, and a clinically integrated network may be a route to consider.

by ELAINE POFELDT Contributing author

WITH PHYSICIANS facing pressure from all sides to deliver better quality care at a lower cost, clinically integrated networks (CINs) offer new approaches with some unique features compared with other types of physicians groups.

Run by physicians, sometimes with sponsorship by a hospital, CINs are networks of providers who use shared electronic health record (EHR) systems to track which methods of clinical care deliver the best bang for the healthcare buck among the patient population—and share that information so all can benefit.

There are about 500 CINs in the U.S., according to a 2015 white paper by Caradigm, a healthcare analytics company based in Bellevue, Washington. Their numbers have grown since 1996, when the Federal Trade Commission provided guidance on its anti-trust policies regarding healthcare organizations, so affiliated healthcare organizations could avoid anti-trust violations.

When it comes to CINs, “the keywords are efficiency, and low-cost but high-quality care,” says Glenn P. Prives, JD, an attorney at McElroy, Deutsch, Mulvaney & Carpenter, LLP in Morristown, New Jersey who has worked with CINs.

The vast majority of CINs are negotiating alternative, value-based contracts with payers, says Tomas Mikuckis, a Boston, Massachusetts-based principal in the health sciences group of Oliver Wyman, an international management consultancy based in New York City.

“Generally what we see are things like shared savings—or shared risk, for the more sophisticated ones,” he says. “Additionally, we have seen CINs/accountable care organizations (ACOs) frequently be a chassis for narrow network partnerships and product partnerships with commercial payers, especially in Medicare Advantage and the individual exchange market.”

And though CINs bring the advantages of being part of a group of physicians, they don’t require doctors to give up their individual practices—though there are some CINs consisting of employed physicians.
"This is not a merger," says Prives. "This is not a hospital buying practices. You stay in your own practices, just like you did before, but you are going to share best practices with the group."

It is important, however, to realize that CINs are a legal structure, not a payment model, notes Neil Kirschner, PhD, senior associate, health policy and regulatory affairs with the American College of Physicians. Their structure enables physicians to team up in negotiations with payers without violating the Stark anti-trust laws. "The legal structure allows them to provide more integrated and coordinated care and do some more bargaining with payers, which would not be allowed from independent providers," he says.

**PHYSICIAN INCENTIVES**

Many independent physicians like CINs because, in addition to the shared learning, the organizations bring some financial advantages.

The CIN negotiates on physicians’ behalf with payers and often can get better reimbursement rates. "The joint contracting aspect is always going to be attractive," says Prives. That can often outweigh any financial commitment the physicians must make. Members often get bonuses for achieving a CIN’s goals as well.

"It's case by case, in terms of the bonuses they give," says Kirschner. "Often, these CINs contract with payers, and the way the CIN pays its providers or share the contractual payments varies."

Prives says bonuses may not be limited to a percentage of savings and may also include compensation for achieving certain quality metrics.

In most cases, physicians will learn of the bonus formula before signing a participating provider agreement with the CIN. For physicians who are also owners of the CIN entity and thus eligible to share in any distributions made by the CIN, the method of distribution will be set forth in the governing document for the entity. For instance, if the entity is a limited liability company, this will be the operating agreement, Prives says.

CINs must balance the need to incentivize physicians against the financial demands of maintaining the CIN. "One of the key balance points is the investment in common infrastructures to support more efficient, effective and reliable clinical/population health activities," says Joe Kimura, MD, deputy chief medical officer of Atrius Health, a nonprofit, community-based physician group in Newton, Massachusetts. Hence, the CIN must balance the future facing strategic investments with annual bonus payments.

**NETWORK CHALLENGES**

Of course, CINs are not a cure-all for the complex pressures facing physicians. Membership can require a significant commitment from doctors.

For one thing, they need to agree with the goals of the CIN, note experts and physicians. The CIN likely will be evaluating the performance of the entire group in achieving those goals—as well as individual doctors' performance metrics.

For some physicians accustomed to independence, having their performance monitored by the CIN isn't easy. "It makes independent doctors very nervous," says David Birdsall, MD, vice president of CEP America, a California-based consulting firm for hospitals.

"Independent physicians are people who are very confident in their abilities and have a vision of their practice. They feel if they are affiliated with or in a network that is constraining, people now will tell them what to do or have expectations of them, and try to force different practices on them."

Membership in a CIN also requires a genuine willingness to accept new technology, since physicians must be willing to use EHRs to share patient data. Doctors who have been putting off making the transition to EHRs will need to embrace them to participate in a CIN. "Some could get left out, although those who are less tech-savvy could use this as an opportunity to get up to speed," says Prives.

And even when members of a CIN are all rowing in the same direction, the group’s success in improving patient care sometimes depends on factors not entirely in the physicians’ control. For example, if the CIN is focused on lowering hospital readmission rates, the CIN and the admitting hospitals its members use need to be focused on that goal, notes Jay Zdunek, DO, senior medical director of primary care at Austin Regional Clinic in Austin, Texas.
"There's a whole lot of coordination of care that has to take place to safely discharge a patient home and make sure they are not readmitted in a 30-day period," says Zdunek.

CIN VS. ACO VS. PCMH
Despite the challenges of running CINs, the timing may be right for more physicians to join them, say experts. Healthcare reform and changes in Medicare have helped to spur the wave of CINs and other collaborations among physicians, hospital systems and other healthcare providers, says Mickucks.

With groups such as accountable care organizations (ACOs) and patient-centered medical homes (PCMHs) working toward similar goals but organized differently, CINs fulfill some physicians' wishes that the others don't, some say.

ACOs are payment models in which groups of medical providers band together to deliver coordinated care to Medicare patients—with the goal of eliminating unnecessary and duplicated services. While ACOs share CINs' emphasis on better care and more value, they're run differently.

Unlike many ACOs, which tend to be dominated by hospitals, CINs might have a hospital sponsor, but the governance is strongly physician-led, Prives says.

In some cases, though, CINs are actually part of ACOs. Joining the network can help providers who treat Medicare patients collect incentives for providers able to achieve measures such as improved quality of care, meaningful use of EHRs, and better use of resources.

A PCMH is a payment model where there are groups of physicians who aim to improve the coordination and patient communication in primary care practices have some key differences from CINs, too. Among them is the fact that they don't negotiate with insur-

---

This is not a merger. This is not a hospital buying practices. You stay in your own practices, just like you did before, but you are going to share best practices with the group.”

—GLENN P. PRIVES, JD, ATTORNEY, MCELROY, DEUTSCH, MULVANEY & CARPENTER, LLP, MORRISTOWN, NEW JERSEY

---

Private practice survival tips
Joining a clinically integrated network (CIN) is one way to help preserve your independence, but there are other options to consider as well.

1. **Join forces**
In addition to a CIN, physicians can consider joining an independent physician association (IPA) to align with other physicians. Some have found that membership helps them negotiate tricky situations with payers where they might not otherwise get reimbursed.

2. **Look for high-impact savings**
The major expense items that practices need to get right are occupancy and personnel costs. Find ways to save on property costs and how to get the most form your employees.

3. **Focus on billing practices**
Make sure that someone in the practice has clear accountability for checking that all services get billed. Physicians can eliminate work that isn’t reimbursed through better claims management.

4. **Ensure collections**
Check on referrals and insurance authorizations before providing services and ask patients for copays at the time of check-in.

5. **Review the fee schedule**
You may discover you’re losing money in ways you may not be aware of. Regular review and calibration of your fee schedule could help.
Most physicians are getting accustomed to looking at their quality data. What’s changed [with CINs] is in addition to working with the patients in front of you, you are reaching out to the entire population.”

— KAREN CABELL, DO, CHIEF QUALITY AND PATIENT SAFETY OFFICER, BILLINGS CLINIC, BILLINGS, MONTANA
Considerations before leaping into telehealth

by RACHEL V. ROSE, JD, MBA Contributing author

One of the hottest trends in healthcare for physicians is telehealth. Many providers are eager to find ways to become involved in this exciting area, which has tremendous growth and revenue opportunities. It is essential for providers to understand the legal and reimbursement limitations of telehealth. Here are a few considerations.

1. Physicians may only treat patients in states in which the physician is licensed, with certain exceptions. Multi-state licensing has not kept up with the growth in telemedicine and physicians must become licensed in multiple states (or affiliate with providers in other states) to use a national telehealth model. This limitation is expected to change in the coming years.

2. Medicare regulations do cover some telehealth services, but reimbursement is still limited largely to rural areas for a limited number of services. This is also likely to change in the near future. Congress created the Center for Medicare and Medicaid Innovation (CMMI) in order to test innovative payment and delivery models. Also, legislative proposals have been introduced that may expand coverage of medical telehealth services. Accountable care organizations, in particular, have been encouraged to experiment with telehealth as a means of reducing costs and increasing quality of care.

3. Medicaid is a bit more progressive and has better reimbursement methodologies for telemedicine than Medicare. However, there is still a lack of consistency among states in both coverage and reimbursement, which can make it difficult to operate in multiple states.

In addition, many commercial payers have started to embrace telemedicine, but again there is inconsistency among carriers and from state to state. Acceptance of telehealth is undoubtedly growing, with many states enacting laws requiring payers to cover and pay for telehealth services in the same way they cover traditional in-person patient care.

There are rules regarding the types of providers that can be reimbursed for telehealth as well as the services that are required to be covered. Physicians must review the laws in every state in which they intend to practice, as well as the policies of those payers which they intend to bill.

Telehealth can take many different forms, from live interaction using technology like Skype, to the use of remote patient monitoring that can track data on patients with chronic conditions (diabetes, asthma) or those who have been released after treatment (heart conditions, stroke recovery).

Mobile health (mHealth) apps are allowing patients to collect their own data which, as technology improves, will be increasingly integrated with healthcare provider systems. With any type of data collection and transmission, there are always privacy and HIPAA issues of which providers need to be aware.

Physicians participating in any paid testing of mHealth devices/technology, or who may receive free technology as a part of a telemedicine model, must also remain vigilant concerning state and federal anti-kickback laws and similar restrictions.

Rachel V. Rose, JD, MBA, is a healthcare attorney in Houston, Texas. This article first appeared in our partner publication, Physicians Practice. Send your legal questions to: medec@advanstar.com.
When providers become payers

In an effort to cut costs and improve care, some provider organizations are exploring a new twist on an old idea

by SUSAN KREIMER Contributing author

When providers become payers

SPURRED ON BY healthcare reform, provider organizations are taking more control over the entire spectrum of medical services and financing. Their business savvy has spawned a number of health plans that operate as all-in-one providers and payers.

A burgeoning number of health systems are assuming the risk of insurance plan ownership. A 2013 survey of more than 100 hospitals and health systems across the country revealed that 34% of respondents already owned health plans. Another 21% reported their intentions of ownership by 2018, according to The Advisory Board Co., a Washington, D.C.-based technology, research and consulting firm.

“We have reached a tipping point with affordability in the U.S. healthcare system. The shift to value-based care, and the incentives that go along with it, are driving health systems to take on more risk,” says James Porter, MD, executive vice president and chief physician executive of Deaconess Health System in Evansville, Indiana.

In 2012, Deaconess began its program of assuming risk for populations, with a focus on creating a clinically integrated network of providers called OneCare, which initially targeted its own employees. That year, Deaconess established an accountable care organization (ACO), called Deaconess Care Integration, entered the Medicare Shared Savings Program and partnered with commercial insurers. Since then, Deaconess also has formed a partnership with a provider-owned health plan to offer this care model to additional members of the community.

When a health system sponsors its own insurance or partners with an existing provider-owned plan, it helps “connect the dots along the entire continuum of care,” allowing for better insights into the right care pathways for individual patients, Porter says. This delivers better outcomes and clinical value. “All in all, we are seeing that patient health and quality of care goes up, while costs come down,” he says.

‘MORE COLLABORATIVE THAN ADVERSARIAL’

Integration between providers and insurers “is a huge advantage in the new world order,” adds Francis X. Solano, MD, FACP, president of UPMC Community Medicine Inc., a network of about 300 primary care and specialty physicians affiliated with University of...
Pittsburgh Medical Center.

"In the past, both physicians and hospitals were ‘widget’ providers who were not really lined up with the insurer as to providing high-quality, cost-effective care," Solano adds. "We got a piece of the premium but were at the mercy of insurers as to their utilization metrics, which could have an onerous impact on our survival from a reimbursement perspective."

Now, in the dual role of provider and payer, "we are more collaborative than adversarial with insurers we own and work with," he says. "We can also impact change quickly, whereas we have little say with other insurers who only look at the bottom line."

Changes in Medicare reimbursement, such as bundled payments, are compelling health systems to exercise greater leverage in insurance plan design. "Medicare is trying to put a lot more risk for entire populations on the backs of providers, and health systems recognize that," says Christopher Kerns, managing director of research and insights at The Advisory Board. "As a result, they’re looking to expand their risk management capabilities into the commercial population as well, and starting their own health plan is a vehicle for them to do that."

Based on a pre-negotiated formula, shared savings are disbursed in the form of a monthly, quarterly, or annual bonus to hospitals and physicians who work together to reduce costs and improve quality. However, "the lion’s share of the savings tends to go to physicians," Kerns says.

Physicians’ emphasis on delivering value has accelerated in recent years, says Francis Mercado, MD, an internist and primary care division chief of Franciscan Medical Group, a Catholic Health Initiatives affiliate with about 700 providers based in Tacoma, Washington.

Now that the medical group is part of an ACO—Rainier Health Network—it has started investing in care managers and clinical pharmacists with the goal of reducing hospital admissions and readmissions. In addition, it uses technology to track patients, helping ensure necessary tests and follow-up, says Mercado, who is also Rainier’s chief medical officer.

Management of chronic conditions also holds promise for reining in costs while enabling patients to benefit from follow-up and education about their diseases. In July 2014, Mercado began an ongoing pilot study involving 10 complex patients whose health improved with the guidance of the network’s clinical pharmacists and nurses. Meanwhile, those providers were able to bill for chronic care management under the CPT code designed for that purpose.

Persuading some providers to adopt a new mindset of tying payments to cost savings is no easy task, however. "We’ve had challenges with well-meaning physicians who do not readily see the value of this somewhat sudden change," Mercado admits. With change comes uncertainty in reimbursement. "But I think they will turn around, especially if we are able to demonstrate an improvement in the overall healthcare of our patients," he says.

**PLAN ADVANTAGES**

Like any business decision, however, starting a health plan involves calculated risks. Collecting enough dollars in premiums is essential, as is predicting use of the plan’s services, says Holly D. Meidl, MBA, managing director and national healthcare practice leader at Marsh, an insurance broker and risk management advisory firm based in Nashville, Tennessee.

Although hospital systems foresee value in forming health plans, it’s too early to determine whether their endeavors will pay off, she cautions. Meanwhile, many primary care physicians are aligning with health systems or joining them as employees. Physicians hope to benefit from shared savings while bearing more of the risks and costs of care as the concept of population health management gains traction.

“For population health to improve care and reduce costs,” Meidl notes, “health systems need both the tight alignment of primary care physicians coupled with their health plan to create the greatest impact.”

The advantages of owning an insurance plan include more flexibility in controlling costs and capitalizing on provider organizations’ local brand recognition, which makes it feasible to compete against national players. However, Meidl predicts that health systems will continue to accept private and government insurance in addition to their own plans.

“It’s not about excluding anybody,” she
Providers as payers explains. “It’s about trading on their own brand, as well as being able to attract a member and a patient who they’ll be able to work with on multiple parts of the equation around their health.”

Competition in the marketplace is beneficial, Meidl says, adding that insurers are “jockeying for position and looking to make acquisitions.” With consolidation beginning to limit competition, future rivalry will stem from individual systems offering health plans.

The concept of provider organizations establishing health plans for their employees and even certain populations isn’t new. But healthcare reform has been a catalyst for motivating hospital systems to expand their plans to include broader segments of their communities, Meidl says.

All parties are incentivized under healthcare reform to engage in value-based purchasing—to carefully consider the necessity of tests and procedures and to eliminate redundancies, Meidl says. Physicians are prompted to rethink healthcare delivery and ask whether they can arrive at the same diagnosis without ordering as many tests.

CONTROLLING COSTS
Whether health systems will succeed in insurance plan ownership remains an open debate. Some hospitals tried in the early years of health maintenance organizations (HMOs) but encountered obstacles. However, experts contend, those HMOs emerged before modern data analytics became available to guide providers in steering members toward preventive health measures and care trajectories with favorable outcomes.

“Moving toward health systems taking financial risk is promising for the long-term health of the nation,” says Seth Frazier, MBA, chief transformation officer at Evolent Health in Arlington, Virginia, a consulting firm that helps health systems manage clinical and economic risks in the value-based care market. “We really see these efforts on the part of health systems as pioneering, and we have been able to learn a lot from those plans that are long-term successes.”

From both market- and patient-centered perspectives, he says, integrating financing and healthcare services promotes more value-based care. As health systems become more focused on prevention and complex care management, they help patients develop healthier lifestyles that decrease the need for more intensive and expensive services. This strategy focuses on administering better all-around care, not just individual services.

“Provider-sponsored models really create the opportunity to bend the cost curve while delivering better quality,” Frazier says. “We now have strong documented evidence that providing more of the right care produces savings.”

For patients, provider-owned plans may represent a variety of approaches, but they typically operate under an HMO framework. The group forming the insurance plan becomes its exclusive providers, notes Tricia Marine Barrett, MHSA, vice president of product design and support at the National Committee for Quality Assurance (NCQA), a Washington, D.C.-based nonprofit that collaborates with policymakers, employers, works to build consensus among stakeholders and drive improvement in the healthcare system.

“The difference is just that they are coming at the business from a different angle,” she explains. “They are a provider group or network first and then formed an insurance company rather than being an insurance company that builds a network.”

GREATER RISK, BETTER CARE
Integrating health plans and systems can address challenges related to price and cost transparency, data sharing, economic alignment, and clinical resource allocation to patients who require more intensive support, says Juan Serrano, former senior vice president of payer strategy and operations at Catholic Health Initiatives’ national office in Englewood, Colorado. Serrano was recently named president and CEO of insurance/reinsurance firm Munich Health North America.

A wholly-owned subsidiary, Prominence Health, offers commercial and Medicare Advantage plans, care networks, and related options. “Insurers may favor health systems that have figured out how to perform well in an integrated fashion,” explains Serrano. “Over time, those who can’t or won’t play in the integrated space will likely fall behind.”

Porter, Deaconess’ chief physician executive, believes there will be greater incentives
for investing in the capabilities to produce better patient outcomes, and those efforts will benefit all involved parties. “This trend of providers taking on more risk will grow as health systems continue to see significant results towards achieving greater care value and better patient engagement,” he says.

Primary care physicians in particular are vital players in managing patients with complex diseases and directing them to specialists. "One of our core beliefs is that it's important to identify those individuals who are most in need of a care partnership and working with them before their health deteriorates even further," says James T. Parker, MBA, president of Indiana University Health Plans Inc. in Indianapolis. "We've been very happy with the success we've had in that regard."

Launched in 2009 as a Medicare Advantage option serving Greater Indianapolis, the straightforward Medicare model presented a less-risky option to venture into health plan ownership, with only a fixed amount of resources required to make capped payments to providers, Parker says. In 2012 the plan broadened its scope, embracing the management of health benefits for the system's employees. Three years later, it entered the federal healthcare exchange for individual consumers while simultaneously launching products for commercial employers.

Parker acknowledges that the plan's expansion should be tempered with a healthy dose of restraint. "We've only been in the commercial market for a short period of time. It's important that our growth be sustainable," he says.

Nonetheless, Indiana University Health Plan's reputation as a large system with good clinical quality has spawned interest from potential purchasers. While its competitors have broader networks, the plan "is consistently less expensive," according to Parker. He says it's able to save money by improving members’ health, reducing utilization, and receiving favorable pricing from its exclusive network of partners.

**TEAM-BASED INSURANCE**

University of Pittsburgh Medical Center (UPMC) is proof that health systems can succeed in insurance plan ownership over the long haul. Two decades ago, the medical center embarked on this journey toward "creating an integrated ecosystem of healthcare delivery," where excellent coordination between experts resides at the epicenter, explains Scott Lammie, chief financial officer of UPMC Health Plan and senior vice president of UPMC Insurance Services Division in Pittsburgh, Pennsylvania.

This has provided UPMC with more insight into its own spending. "We're moving away from individual practitioner medicine to more team-based," Lammie says. "Team-based insurance enables the plan to com-

---

**Rewarding physician performance**

As part of the efforts to align provider payments with the “Triple Aim” (enhancing the patient experience, improving the health of populations, and lowering the per-capita cost of healthcare), some insurers are rewarding physicians for following a value-based model. For example, a provider would receive payment for meeting certain patient population measures or helping patients with diabetes control their blood pressure and cholesterol. The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures in the managed care industry.

Among the insurers employing this model is SelectHealth, a not-for-profit, wholly-owned subsidiary of Intermountain Healthcare in Salt Lake City, Utah, with more than 830,000 members in Utah and Idaho. Since January 1, SelectHealth has been offering multi-year insurance contracts with 4% increases annually for large employers with 100 or more eligible employees. This strategy is designed for organizations that agree to join for three consecutive years, says Scott Schneider, vice president of commercial sales at SelectHealth.

In exchange, employers are required to meet specific goals, such as prompting employees to choose a primary care physician who will coordinate their care. In addition, employers must conduct two physical activity campaigns per year and motivate employees with chronic diseases to partner with a care manager.

During the first year of the contract, half of the covered employees need to demonstrate involvement in these initiatives. In the second year, that figure increases to 60%, and to 70% in the third year, boosting member engagement significantly, Schneider says.

—Susan Kreimer
For population health to improve care and reduce costs, health systems need both the tight alignment of primary care physicians coupled with their health plan to create the greatest impact.”

— HOLLY D. MEIDL, MBA, NATIONAL HEALTHCARE PRACTICE LEADER, MARSH, NASHVILLE, TENNESSEE

Policy

Providers as payers

bines claims data with clinical input from physicians to better understand its members and their health challenges.” UPMC Health Plan uses that information to offer in-house, targeted wellness and disease management programs as well as clinical support to its members.

UPMC Health Plan is now part of the UPMC Insurance Services Division, which offers a full range of group and individual health insurance, Medicare, special needs, Children’s Health Insurance Program of Pennsylvania, Medicaid, behavioral health, employee assistance and workers’ compensation products and services to more than 2.8 million members, making it the nation’s second-largest provider-owned health insurance company.

The ability to work closely with providers and hospitals is a natural by-product of a health system establishing an insurer, a process Lammie compares to flying a plane. “An individual pilot can guide a plane, but it’s a lot safer and more effective with a crew and an air traffic control system behind you,” he says.

CARRIER COLLABORATION

Health systems contemplating entering the insurance business may consider tapping into a large carrier’s expertise to stratify risk among populations, design and establish pricing of products, and perform administrative functions. Other systems may feel more secure in formalizing a 50/50 split ownership with an insurance company, says Daniel P. Finke, chief executive officer of accountable care solutions at Aetna’s national headquarters in Hartford, Connecticut.

Although not every joint venture is an equal split, Aetna co-owns Innovation Health, with Inova Health System in Falls Church, Virginia. Each organization is financially on the hook for all aspects of performance—from underwriting to care management, quality, marketing, accountability to customers, and governance of the plan’s success.

Owning a health plan is “the fullest expression of risk that a provider can take,” Finke says. Ultimately, regardless of whether a health system pursues complete or partial plan ownership, “providers are seeing it as another opportunity for [a] revenue stream, when they’re sharing in the premium dollars. And some are considering it a natural extension of the services they’re already providing.”

As more forces come into play to re-engineer healthcare, plans will have to gain and maintain the loyalty of consumers to stay in business. Long-term survival will depend on a mix of quality, affordability, sophisticated decision support, and high-quality customer service, says Lammie of UPMC Health Plan, which began in 1996. “Every market is going to evolve over time,” he adds. Since the passage of healthcare insurance reform, “we are still kind of in a nascent transformational period.”

However, the ability to mitigate clinical risk doesn’t necessarily translate into skillfully overseeing the insurance end of the equation. Health systems will need to acquire greater market share if they hope to remain viable as care continues to shift from the hospital environment to outpatient settings, says Barrett of NCQA.

“It’s a very challenging time certainly for hospital systems, because it’s really turning their business model on its head,” she says. “They have increasingly a need to keep patients out of their hospitals, but they’ve got all this stranded capital invested in the management of this facility.”

Regardless of whether combining clinical and financial risks pays off in the long run, health systems’ foray into insurance ownership will leave a mark on healthcare by creating more connected entities of care.

“They will be noticed in the market,” Barrett says. “There are absolutely a number of success stories, and the numbers will grow. Whether they will displace the big national insurers is the part that’s a little harder to quite envision, but they will definitely play a significant role.”

MORE ONLINE


How millennials will change medicine bit.ly/millennialmedicine

The secrets of financial flexibility bit.ly/MEflexibility
MARKETPLACE

LEGAL SERVICES

**Legal Problems with Medicare/Medicaid**

Licensing Boards, Data Bank, 3rd Party Payors’ HIPAA, Admit, Criminal, Civil?

Federal Litigation, Civil Rights, Fraud, Antitrust, Impaired Status?

Compliance, Business Structuring, Peer Review, Credentialing, and Professional Privileges.

Whistle Blower!

Call former Assistant United States Attorney, former Senior OIG Attorney, Kenneth Haber, over 30 years experience.

301-670-0016  No Obligation.

www.haberslaw.com

TRANSCRIPTION SERVICES

**FaceSheet App**

- Highly customized.
- Capture visit and send info to biller all in 5 seconds.
- Forward patients to another provider with signoff note, HIPAA compliant.
- Web interface access for provider & Biller to check reports. 14% increased revenue.
- No lost Facsheets. No more paper.
- Available as FaceSheet in App store.

www.Facesheet.md  Call 888-592-2268

**Scribe into EMR Transcription Service**

- Less than a Dollar per dictation.
- One week free trial. No obligation.
- No Start-up costs, no contracts.
- Transcribe in your EMR.
- Same day turn around guaranteed.
- Transcripts to referral doctors same day.
- AAMTDictate iPhone/Android App.
- Physicians can use from nursing homes will send transcript by fax same day.

Call: 888 50-AAMTD  Email: info@aamtd.com

Visit: AAMT.COM

**Medical Equipment**

**Medical Equipment DEALS**

**www.medicaldevicestore.com**

**Tools for Increased Reimbursement & Office Efficiency at Discount Prices**

**EKGs with Interpretation**

- Cardiacare 2000 $1,255
- AT-2 Light $2,266
- AT-2 Plus $2,677
- add Spirometry for $1,000

**Cardiology Products**

- Cardiac Resting EKG $1,895
- Cardiac Holter $2,995
- Cardiac Stress $2,995

**Screener Audiometer**

**GE MAC1200 EKG Machine**

- Includes fax, modem, new patient cable, new universal alligator clips, EKG paper, electrodes and all accessories

**New, with 3 yr warranty:** Only $2,995

**Welch Allyn Integrated Diagnostic System**

- Combine any wall aneroid, ophthalmoscope, otoscope, specula dispenser and thermometer for a convenient modular package that puts everything for fast diagnostics at arm’s length

**Lifeline AED**

- Gold Standard AED Only $1,245.00

**Family Practice Exam Table**

- A durable, reliable, patient-friendly exam table for any office. Many base & upholstery color combinations

- Only $792.00

**Boost Your Revenue!**

**Diatom Tonometer Glaucoma Test**

Diagnose glaucoma in the earliest stages through a simple, noninvasive procedure. This unique methodology of intraocular pressure measurement through the eyelid provides new resources in ophthalmometry simplicity and safety of tests. Medicare is asking doctors to screen more patients for glaucoma - once every 12 months.

**Allergy Testing and Treatment - for the Non Allergicist**

With 40-50% of patients showing sensitivity to at least 1 allergen, allergies are reaching epidemic proportions. Because of this, a comprehensive Allergy Testing and Treatment Program is essential in any medical office.

Any staff can perform the test (CLIA Free), which takes 2 minutes to perform and 15 minutes to show results. No High Risk Allergens. Stop patients from relying on Over-The-Counter Drugs to live.

**CALL TODAY to ORDER: 877-646-3300**

**SHOWCASE & MARKETPLACE ADVERTISING**

Contact: Tod McCloskey at 800.225.4569 x 2739 • tmccloskey@advanstarr.com

MedicalEconomics.com
CONNECT

with qualified leads and career professionals

Post a job today

Medical Economics Careers
www.modernmedicine.com/physician-careers

Joanna Shippoli
RECRUITMENT MARKETING ADVISOR
(800) 225-4569, ext. 2615
jshippoli@advanstar.com

American Lifeline .................................................................25
Amgen Inc.
Repatha .................................................................5 – 6
Center for Medicare & Medicaid Services .........................29
Janssen Pharmaceuticals, Inc.
Xarelto .................................................................21
Pfizer Inc.
Nexium OTC .................................................................Back cover

* Indicates a demographic advertisement.
The American Board of Internal Medicine (ABIM) is an organization tasked with protecting the public from dangerous internists. That is a noble goal, however, their methods are of dubious value. After spending countless hours completing most of the medical knowledge self-assessment program (MKSAP 16) and taking a two-day comprehensive board review course (from the ACP), I passed my recertification exam in May 2014...by a margin of one question. But 35% of the doctors taking that test did not pass—an important fact that should not be overlooked.

In October and November 2015 I corresponded directly with Richard Baron, MD, the president and CEO of the ABIM. In his response to me he focused on the first-time test taker pass rate and the ultimate pass rate as the most relevant data. In fact, those are the only statistics available on the ABIM's website regarding the MOC recertification exam.

I strongly disagree with his opinion. The bar for passing the secure exam is set so high that many "non-dangerous" internists will fail and become second- and third-time test takers, and these people are not counted in the statistics on their website. It is inconceivable that any more than 5% of internists practicing for 10 or 20 (or soon 30) years are "dangerous." Some of us don't go to hospitals anymore, and some of us focus our practice more in certain areas of medicine than in others, thus tailoring our practices to suit our interests. We may need to look up information for unusual cases more than we did 20 years ago, but that does not make us non-dangerous or deserving of being put through the rigors of preparing for an examination just because the ABIM has set the bar way too high.

It is my opinion that in May 2014 when the preliminary pass/fail statistics showed 35% failure rate the ABIM should have realized that their tool was invalid and changed the cutoff before the results were made final. I believe that at any given time at least 95% of experienced practicing internists are not dangerously incompetent and should not fail that test.

Preparing for the exam is laborious, incredibly time-consuming and ultimately useless. To the best of my knowledge there are no evidence-based trials demonstrating that passing the recertification examination translates to better outcomes.

In a letter from Dr. Baron to me dated November 24, 2015, he stated, "The Assessment 2020 Task Force agreed that it is important and necessary for ABIM to continue to assess physicians through a process that culminates in a high-stakes, pass/fail decision." However, on the ABIM’s website under "Assessment 2020" key recommendations from the report include "replacing the 10-year MOC exam with more meaningful, less burdensome assessments." I am very confused by this contradiction. It appears as if Dr. Baron is ignoring his own organization's recommendation.

There is no doubt I am a much better physician now than I was 20 years ago when I first passed the ABIM certification examination, but I fear that my test-taking skills will fail me 10 years from now and I will be out of work and potentially unemployable at the age of 63 because I can’t pass a ridiculous examination that has no real bearing on my abilities to practice medicine. The secure examination needs to be a thing of the past and I hope that others will continue to protest until our voices have been heard.

Policing ourselves and insuring the safety of the public is a noble goal, but a "high-stakes, pass/fail examination" should not be a part of that process. Abolishing this examination should not need to wait until the year 2020, it should be done now.

James J. Marino, MD, is an internal medicine physician who practices at Sebastian Family Walk-In Care in Sebastian, Florida. Do you agree that MOC has little value? Tell us at medec@advanstar.com

MedicalEconomics.com
Recommend Nexium® 24HR for stronger, longer acid control vs omeprazole 20 mg1*

Now you can print up to 30 coupons per day right from your office. Help your patients with frequent heartburn save on the most powerful OTC acid blocker available.1,2

To print coupons and order samples, sign in at StartNexium24HR.com

*Acid control (pH >4) does not imply symptom relief. The correlation of pH data to clinical outcome has not been directly established.