MEDICARE AT 50: IS IT WORKING?

The impact on:

YOUR PAY
YOUR CARE DELIVERY
YOUR PATIENTS

PAGE 30
MEDICARE AT 50: IS IT WORKING?

An examination of what Medicare has meant to you, and what it means for your future.

STARTS ON PAGE 30

The impact on:

- Your pay
- Your care delivery
- Your patients

COVER STORY | SPECIAL REPORT

SPECIAL REPORT

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MOC: PHYSICIANS STRIKE BACK

Underlying much of the controversy surrounding maintenance of certification (MOC) is the question of how much—or even whether—the process as currently structured actually improves physician performance and/or patient outcomes. While the controversy remains far from settled, MOC critics have scored some significant gains by forcing reviews of MOC elements, and by possibly opening new paths to maintaining certification. Read more at: http://bit.ly/1Fxk0BM

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THERE'S A REASON DR. STIEFEL IS SO SUCCESSFUL. HE’S GOT 3,500 PEOPLE WORKING FOR HIM.

When we work as one, staying independent is a healthy option. work as one
Make sure you analyze demographics and market conditions in the community where you plan to open.”

—Dan Greenfield

Have a question for our advisers?
E-mail your question to medec@advanstar.com.
Lay people who hear “quality” will naturally assume that it means all aspects of providing good medical care. They don’t understand that this term does not account for important aspects of medical care...Use of the term “quality” devalues anything that cannot be measured.

Amy Rosenthal, MD, ORANGE COUNTY, NORTH CAROLINA

‘QUALITY’ IS FLAWED TERM FOR EVALUATING MEDICINE

To all those who use the word “quality” in reference to medical care without thinking twice: STOP. Stop using this word as though it encompasses all aspects of good medical care, because it does not. It only refers to those aspects of medical care that can be measured—nothing more.

It does not include the ability to get a good history, to make an appropriate diagnosis, to provide evidence-based care, to appropriately order labs/x-rays/consultations, to prioritize multiple medical problems, to consider patient preferences, or to communicate well with staff/patients/healthcare agencies.

Lay people who hear “quality” will naturally assume that it means all aspects of providing good medical care. They don’t understand that this term does not account for important aspects of medical care like the ones listed above. Use of the word “quality” devalues anything that cannot be measured.

I think it’s important that we come up with an alternative to describe the data that is now called “quality.” Language is powerful—we need to be careful how we use it.

Amy Rosenthal, MD
ORANGE COUNTY, NORTH CAROLINA

PATIENTS SUE DOCTORS FOR MANY REASONS

The cover article from your April 25 issue, “Your Best Malpractice Defenses” was well intended to help physicians minimize their liability potential, yet every recommendation is predicated on what the defendant is doing wrong. The entire approach still amounts to devoting more of an ever-dwindling day to negative purposes (It was particularly sad that the article needed to quote an attorney on the importance of reading body language for non-verbal cues.)

The article noted that patients sue out of anger. While this is very true, other important contributors are greed, stupidity, and vengeance. The article quoted a past president of the AAFP [American Academy of Family Physicians] advising against viewing each patient as a potential lawsuit. Quoting an AAFP official says less about the actual malpractice environment than it does about the misleading psyche of that organization.

The simple, unbalanced equation is that any patient, or vengeful surviving family member, can take a shot at a physician at any time with no consequences, and often enough get a nice cash prize for a settlement. Every patient IS a potential lawsuit. Moonbeams pretending that the issue rests on good care and communication are both naive and irresponsible.

Later in the April 25 issue there is an article on “The ethics of researching patients on the web.” The author—also an attorney-notes
The simple, unbalanced equation is that any patient, or vengeful surviving family member, can take a shot at a physician at any time with no consequences, and often enough get a nice cash prize as a settlement. Every patient IS a lawsuit. Moonbeams pretending that the issue rests on good care and communication are naive.”

Patrick Conrad, MD, PORT ST. JOE, FLORIDA

SUPPLY OF PRIMARY CARE PROVIDERS WON’T MEET FUTURE DEMAND

The conclusion of The Commonwealth Fund study stating that the current supply of primary care providers is sufficient to handle the increased demand brought on by the Affordable Care Act (ACA) is misleading: “Report: ACA Will Boost Primary Care Visits by 3.8%” (March 25, 2015.)

Even without the ACA’s influx the supply of primary care providers is insufficient. Why? Because patients live longer, have more hospitalizations, have a greater number of chronic diseases, see more consultants, have more tests and take more medications than ever before—all of which makes taking care of them more complicated and time-consuming.

Physicians, especially those in small groups, are having a difficult time trying to keep up with these responsibilities. The result is dissatisfaction and burnout for many of them.

To make matters worse the administrative hassles that burden primary care doctors consume as much as 30% of their day, which has caused many to join hospital networks and let their business staff handle them.

There are not enough primary care doctors now and have not been for several years, and the 11 years that it takes to train them are too long to meet the shortage.

Advanced practiced nurses (APRNs) have been given rights to practice independently in more than 20 states and are supported by the Institute of Medicine. Although organized medicine frowns on giving APRNs this independence, it is clear that access to primary care is insufficient and the APRNs have great potential to increase primary care access.

Clearly, there are not enough primary care doctors and The Commonwealth Fund’s conclusion that the ACA will have “modest effects” on workforce is erroneous and misleading.

Edward Volpintesta, MD
BETHEL, CONNECTICUT
STAY ON THE ROAD TO
ICD-10
OCT 1, 2015

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The ICD-10 transition will affect every part of your practice, from software upgrades, to patient registration and referrals, to clinical documentation and billing.

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- Update Your Processes—Review your policies, procedures, forms, and templates
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- Test Your Systems and Processes—Test within your practice and with your vendors and payers

Now is the time to get ready.
www.cms.gov/ICD10
MEDICAID STUDY: 5% OF ENROLLEES ACCOUNT FOR HALF OF ALL SPENDING

Only 5% of Medicaid-enrolled Americans account for 50% of total Medicaid spending, and the top 1% account for almost 25% of spending, according to a new study from the Government Accountability Office (GAO).

This “disproportionately large share” of expenditures has remained consistent in fiscal years 2009 to 2011, the report notes, with the least expensive 50% of Medicaid-only enrollees making up less than 8% of total Medicaid spending. The data was from 2011, the most recent year in which data could be compiled.

The report only counts individuals that solely use Medicaid as opposed to those that use Medicaid and Medicare. The report also concludes that Medicaid costs will increase because of Medicaid expansion made possible through Affordable Care Act (ACA).

According to the report, certain categories of Medicaid-only recipients had more expenditures than others. Over 52% of high-expenditure enrollees had mental health conditions in 2011. That percentage stayed relatively constant from 2009, when 50.13% of enrollees were in the same category. In non-high expenditure categories, only 13% had mental health conditions. In fact, there was a surprising consistency for all categories, with none having variations of more than a three percentage points.

“Studies on healthcare spending generally find that a small percentage of individuals account for a large portion of expenditures, and Medicaid…is no exception,” the GAO concluded in an open letter.

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HIGH-EXPENDITURE MEDICAID PATIENTS

<table>
<thead>
<tr>
<th>States with the most</th>
<th>States with the fewest</th>
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<tr>
<td>North Dakota</td>
<td>Tennessee</td>
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<tr>
<td>Iowa</td>
<td>New Mexico</td>
</tr>
<tr>
<td>Oregon</td>
<td>Pennsylvania</td>
</tr>
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</table>

Source: GAO

Optum, the division of United Healthcare tasked with overhauling HealthCare.gov in 2013, has announced that it will not submit a rebid for the $40 million per year contract so that it can pursue other ventures.

The company reported that it had stabilized HealthCare.gov’s forward-facing infrastructure. Optum is “confident that HealthCare.gov will remain a stable and reliable platform” once the contract is over.

Optum was one of several dozen contractors that worked on HealthCare.gov before the site’s launch in October 2013. After the site suffered severe problems in the early days, Optum was appointed to spearhead the reconstruction process and have the site working by Thanksgiving, 2013.

Optum’s contract is scheduled to end in July 2015, but the company says it may assist in the transition for a few more months. Optum will continue to operate the website’s data services hub and data systems.
Cancer costs soar in hospital outpatient setting versus private practice

**The Good News** is that the five-year relative survival rates for major cancers are rising. The bad news is that patient out-of-pocket costs associated with IV cancer drugs have also increased as physician-owned practices have been purchased by hospitals, according to a recent report from IMS Institute for Healthcare Informatics.

Patient access to life-saving oncology medicines that are now infused or injected in hospital outpatient facilities may be threatened as the costs are nearly triple those of patients receiving the treatments in physician-owned offices.

“In the U.S., patient out-of-pocket costs associated with IV cancer drugs have risen steeply as consolidation of smaller group practices into larger hospital systems has triggered higher outpatient facility costs shared with patients.”

From the report: Hospital outpatient costs compared to physician office costs

1. Reimbursement levels for drug administration costs in hospital outpatient facilities are on average an incremental 189% of the level of physician office-reimbursed costs for commercially insured patients under the age of 65.

2. Higher costs in hospital outpatient facilities are incurred despite the increasing proportion of hospital systems that benefit from discounted drug pricing via 340B eligibility.

Source: IMS Institute for Healthcare Informatics

FDA approves patient pain control device

Patients who are recovering from surgery in the hospital now have the opportunity to control their analgesic dosing. Ionsys (fentanyl iontophoretic transdermal system) from The Medicines Company has just been approved by FDA for this use.

The pain drug device is the first needleless, patient-controlled, preprogrammed, opioid-based treatment available for the short-term management of acute postoperative pain in hospitalized adults needing opioid analgesia. Postsurgical patients recovering in the hospital can control their analgesic dosing by pushing a button as needed to deliver fentanyl transdermally via an imperceptible electrical current.

According to Eugene R. Viscusi, MD, professor of anesthesiology and director of acute pain management at Thomas Jefferson University, Philadelphia, the new pain drug device “may make patient mobility and physical therapy easier while reducing the potential burdens associated with a programmable pump.”

FDA based its approval on three placebo-controlled trials establishing the device’s efficacy and safety.

“In the U.S. patient out-of-pocket costs associated with IV cancer drugs have risen steeply as consolidation of smaller group practices into larger hospital systems has triggered higher outpatient facility costs shared with patients.”

1. Reimbursement levels for drug administration costs in hospital outpatient facilities are on average an incremental 189% of the level of physician office-reimbursed costs for commercially insured patients under the age of 65.

2. Higher costs in hospital outpatient facilities are incurred despite the increasing proportion of hospital systems that benefit from discounted drug pricing via 340B eligibility.

Source: IMS Institute for Healthcare Informatics

**The Vitals** is continued on page 17
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Study: EHRs reduce prescribing problems in patients with diabetes

PRIMARY CARE

Physicians often complain that the benefits of using electronic health record (EHR) systems are outweighed by the costs of implementing the technology and meeting government meaningful use (MU) standards. But a new study suggests that in at least one area—reducing adverse drug events—EHRs are having an impact.

The study examines whether physicians who meet the MU2 threshold for electronic prescribing—using the technology for at least 50% of the prescriptions they write—have lower rates of adverse drug events (ADEs) among their patients with diabetes. The results were published online May 6 by the Journal of the American Medical Informatics Association.

The authors looked at prescriptions from 129,000 providers written for Medicare beneficiaries with any type of diabetes and at least 90-days supplies of anti-diabetic medications, using claims from Medicare Parts A, B and D beneficiaries. ADEs are a particular concern among Medicare beneficiaries, the authors say, due to the greater prevalence of chronic disease—especially diabetes—and polypharmacy among that population. Moreover, they say, anti-diabetic drugs are the most common cause of hospitalized or have an ED visit for an ADE. The high e-prescribers had a 7.9% chance of at least one ADE occurring among their patient panel (when weighted for panel size) compared with a 9.4% chance among the low prescribers. Similarly, the high prescribers had rate of 3.45 ADEs per 1000 patients, versus 3.99 per 1000 for the low prescribers.

The authors ascribe the lower incidence of ADEs among the high prescribers to the facts that “e-prescribing helps providers to send error-free and legible prescriptions to pharmacies,” and that “e-prescribing capability is accompanied by varying degrees of decision support and drug interaction alerts.”

Hepatitis C infections are soaring in 4 states because of high rates of opioid abuse, according to a new report from the Centers for Disease Control and Prevention (CDC).

In Kentucky, Tennessee, Virginia and West Virginia, new hepatitis cases among people aged 30 years and younger rose from 1.25 per 100,000 in 2006 people to four per 100,000 in 2012, the CDC found in the May 8 issue of its Morbidity and Mortality Weekly Report (MMWR).

A majority (73%) of the hepatitis C patients said they injected drugs, which can spread the virus. “We’re in the midst of a national epidemic of hepatitis C,” John Ward, director of viral hepatitis prevention at the CDC, told USA Today. More than 20,000 Americans die from hepatitis C a year, which is more than the number who die from AIDS, according to Ward.

The rate of new hepatitis C infections rose from 0.3 cases per 100,000 people in 2010 to 0.7 cases in 2013. In 2013, Kentucky had the highest rate of infections, with 5.1 cases per 100,000, according to the CDC.

The authors ascribe the lower incidence of ADEs among the high prescribers to the facts that “e-prescribing helps providers to send error-free and legible prescriptions to pharmacies,” and that “e-prescribing capability is accompanied by varying degrees of decision support and drug interaction alerts.” They note that a meta-analysis of studies published before 2006 showed that “even with many e-prescribers not having any decision support, e-prescribing was associated with fewer prescription errors, and fewer potential and actual ADEs.”

The authors add, however, that aspects such as comorbidity and patient income also have an impact on ADE rates, and thus “e-prescribing will not address all the factors leading to ADEs.”
Depression is one of the most common mental health conditions in the United States, according to the National Institutes of Mental Health. It has been estimated that this disorder will affect approximately 18% of adults at some point in their lives.

Patients with depression incur heavy physical, financial, and emotional burdens. Depression is linked to higher rates of obesity, heart disease, stroke, sleep disorders, and other conditions, and it often co-occurs with other illnesses. Symptoms negatively affect energy, concentration, memory, and decision-making.

Depression accounts for more than $210 billion in annual medical expenditures in the United States. About 40% of this total is directly attributable to depression. The remainder is associated with treatment of related physical and mental illnesses, reduced productivity, and costs associated with suicide, with workplace costs accounting for about 50% of expenditures.

Despite significant improvements attainable through depression management, an estimated 75% to 80% of patients either do not seek or are not receiving proper treatment. Primary care physicians can address this gap by identifying patients at risk for depression and implementing a multidisciplinary plan of care for those patients requiring treatment and support.

“The earliest and best opportunities to identify depression are in the clinics of primary care providers,” noted the Prevention Practice Committee of the American College of Preventive Medicine.

Continued on page 19

**NUMBER OF PEOPLE WITH DEPRESSION**

1 in 10 American adults are affected

20% Approximate increase in the number of patients diagnosed with depression every year

**TOTAL ECONOMIC IMPACT**

Depression is associated with a two-fold increase in healthcare costs.

Accounts for more than $80 billion in annual U.S. medical expenditures

Although treatment is associated with high success rates, it is estimated that 75-80% of patients either do not seek or are not receiving proper treatment.

**PATIENT MANAGEMENT TIPS**

- Screen patients for symptoms
- Address treatment non-adherence
- Encourage patient self-care
- Collaborative care is critical
- Include continuity of care in your in-office systems

Source: Healthline, Depression and Bipolar Support Alliance
PATIENT MANAGEMENT TIPS

Screen patients for symptoms. While many patients are diagnosed with depression as adults, symptoms of depression can develop at any age. Up to 1 in 33 children and 1 in 8 adolescents have clinical depression.

Depression often co-occurs with other conditions, especially cancer, strokes, heart attacks, diabetes, HIV, Parkinson’s disease, eating disorders, and substance abuse. Extensive patient screening tools or questionnaires are not always necessary; focused patient communication can efficiently open the door to further discussion and confirmation of a diagnosis.

The use of the following screening questions showed a sensitivity and specificity of 97% and 67%, respectively, when used in a primary care setting with patients not receiving psychotropic drugs:

- During the past month, have you often been bothered by feeling down, depressed, or hopeless?
- During the past month, have you often been bothered by little interest or pleasure in doing things?

If either of these questions is answered in the affirmative, further investigation should be conducted using a validated screening tool.

Address treatment non-adherence. Up to 80% of patients with depression who receive treatment—including medication, referral to psychotherapy and support groups, or a combination of these methods—show improvement in their symptoms in four to six weeks.

However, medical non-compliance is the cause of approximately half of cases of unsuccessful depression treatment. About 25% of patients given an initial prescription for an antidepressant either do not get it filled or never take the first dose.

Patients often stop taking their medications too early due to adverse effects, financial concerns, fear of addiction, or short-term symptom improvement that leads them to believe it is unnecessary to continue treatment.

A phone call from a practice assistant to a patient can increase the initial uptake of treatment significantly by asking three questions:

- Did you get the prescription filled?
- Did you take the first dose?
- Do you have any questions or concerns you’d like to discuss?

Participation in patient-to-patient support groups has been reported to improve treatment compliance by nearly 86%, and can reduce in-patient hospitalization.

Additionally, support group participants are 86% more willing to take medications and cope with side effects than are patients who do not participate.

Encourage patient self-care. Effective patient-centered care includes education on self-management techniques to help reinforce treatment adherence. Incorporating activities such as journal-writing and self-monitoring into a treatment plan can inspire patients to take responsibility for their care.

When appropriate, suggest that a family member or loved one attend appointments to provide advocacy and support, and involve them in the development of patient treatment plans.

Collaborative care is critical. Collaborative care among primary care physicians and behavioral health specialists is critical for effective treatment of patients with depression. Studies have reported that collaborative care models increase effectiveness of treatment and reduce the cost of care overall.

Approaches that have been demonstrated to improve patient outcomes in large trials have four common features:

- Use of a validated screening tool such as the Patient Health Questionnaire-9 or the Quick Inventory of Depressive Symptomatology (16-item) Self-Report (QIDS-SR16),
- clinical use of an evidence-based treatment guideline,
- a care manager, and
- collaboration with a psychiatric specialist.

A sample collaborative care plan might include maintaining a list of patients receiving treatment for depression, establishing a plan for providing patient education, contacting the patient at established intervals to ensure compliance, and ensuring follow-up visits and outcomes measurements.

Include continuity of care in your in-office systems. In-office systems can help coordinate care, ensure continuity, and communicate patient status between all treating clinicians.

Frequent, structured monitoring and follow-up with patients, such as phone or email consultations conducted by a nurse or care manager, should be built into any such system.

Written by Nicole Klemas, ELS

Reviewed by Larry Culpepper, MD, MPH
Boston University School of Medicine
Boston Medical Center
Boston, Massachusetts

Continued on page 23
**Clinical Economics: Depression**

**Overview**

**Patient management tips**

**Key coding considerations**

Continued from page 19

**KEY CODING CONSIDERATIONS**

**TREATING DEPRESSION** requires understanding the possible diagnosis codes. Please see the table at right for a selection of available codes.

Note: Although you must report a diagnosis code on the claim, Medicare does not require a specific diagnosis code for screening for depression in adults. Use Healthcare Common Procedure Coding System code G0444 to report an annual, 15-minute depression screening for Medicare patients. ❑

--- Coding tables by Renee Dowling

**SOURCES**


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**Depression Diagnosis Codes**

<table>
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<th>Description</th>
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<td>R45.6</td>
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y patient’s mother answered the routine reminder phone call and could barely speak the words. “She died from meningitis.”

Then silence.
When had it happened? Why?
How did our clinic not know?

A WISE MENTOR
He was a retired military colonel, excellent pediatrician, and a dedicated clinician. He was well-respected by all the pediatric residents and the type of doctor you would want to look after your own child. He was usually at the hospital after the house staff had gone home for the day; and being on his team for the month meant outstanding teaching but longer hours and more detailed lists of things to accomplish.

Inpatient pediatric medicine during the winter months is a time of high turnover, when the volume of patients and paperwork can become overwhelming. Unlike other attendings, he insisted that residents personally call each primary care physician when their patient was discharged from the hospitalist service. It was not enough to speak to a nurse or fax the hospital summary.

I remember waiting on hold for long periods of time for a community doctor, only to relay the same information which had already been summarized in the discharge paperwork. And my gesture to communicate was occasionally met with annoyance from a busy pediatrician who was pulled away from their clinic schedule. As a resident, I silently questioned the usefulness of this time-consuming task.

My first job out of residency was at a general pediatric clinic attached to a community hospital. I often admitted clinic patients to this hospital, but children who required a higher level of care or specialist consultation were transferred to a tertiary center.

Not infrequently, a clinic patient would be admitted to the “downtown hospital” without any communication back to my office. It was only when the patient came to the clinic for a follow-up appointment that I learned of their recent hospitalization. I thought back to residency and became nostalgic for those discharge phone calls, wishing I was on the receiving end of the communication.

It was nothing out of the ordinary—a

“Never again did I want to be ignorant about a patient’s medical course during their time in the hospital.”
first appointment with a baby who had been discharged from the neonatal ICU a few days earlier. She had been born at 32 weeks gestation and was a classic “feeder and grower,” leaving the NICU without chronic issues. I knew the family from looking after the older sibling and was happy that this baby, although premature, was gaining weight and healthy. She had received her first palivizumab injection for RSV protection in the NICU and I arranged for two additional doses in our clinic in the subsequent months.

A couple weeks later, a clinic administrator called the family to remind them that the baby’s palivizumab injection was scheduled for the following day. Her mother picked up the phone and could barely speak the words: “She died.” We were stunned. When had it happened? Why? How did we not know?

I called the tertiary care hospital and asked to be connected to the pediatric ICU. Had they cared for this baby recently? Yes. What happened to her? She was admitted with late-onset GBS sepsis and meningitis. Things didn’t turn around. She died. Why wasn’t I called? Why didn’t I get any paperwork? I don’t know. My office just called this mother to remind her about her deceased baby’s appointment! Oh.

LESSONS LEARNED
The breakdown in communication frightened me. Due to my lack of awareness of what had happened to this infant, our clinic’s well-intentioned attempt to connect with the family had left an already grieving mother with fresh sorrow. And beyond that was our shared bewilderment—both the mother’s and mine—that her baby’s pediatrician would not know about her daughter’s passing.

I was reminded once more of that respected mentor in residency, the one who insisted on direct physician-to-physician communication for every discharged patient. At the time, those phone calls seemed inefficient and of questionable value. Now I was fully cognizant of the importance of the conversations, however brief, with the patient’s primary care physician.

Never again did I want to be ignorant about a patient’s medical course during their time in the hospital.

I have moved on from that clinic but frequently reflect on that baby and her mother and the circumstances of our patient-physician relationship. I am now working as a pediatric hospitalist and have many opportunities to share my knowledge and experiences with residents and students. Most physicians have stories which illuminate the enormous importance of effective transfer of information among members of a treatment team.

While the vast majority of physician-to-physician communications serve to improve care, the occasional failure highlights how critical these interactions are. Despite the ease of electronic messages, I find that they can be easily overlooked in a rush to see patients and complete charts. In my experience, a minute on the telephone or in the hallway can clarify a patient’s management more than ten pages of typed text.

Now that I am the attending conducting teaching rounds and overseeing the residents, I insist that every patient’s discharge plan include a call to the primary care physician.

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While the vast majority of physician-to-physician communications serve to improve care, the occasional failure highlights how critical these interactions are.”
“No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime.” With those words, President Lyndon B. Johnson signed Medicare legislation into law 50 years ago.

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**IT WAS** the culmination of a decades-long effort to make healthcare affordable to the nation’s elderly population, and represented the first large-scale government involvement in the nation’s healthcare system—a role that was highly controversial at the time and remains so today.

In the ensuing years Medicare has evolved into a financial and regulatory colossus covering more than 52 million Americans and accounting for 3% of the federal budget, and touching virtually every aspect of healthcare financing and delivery. (See accompanying table, “Medicare by the numbers.”) And while beneficiaries are shouldering more of the cost of their care now compared with the program’s early days, the fact remains that Medicare has significantly reduced the financial burden that healthcare used to impose on the elderly, and given them greater access to healthcare.

In addition to its original tar-
Medical Economics reports on the birth of Medicare

By Jeffrey Bendix, MA Senior Editor

Medicare was signed into law in the summer of 1965, and even though it did not go into effect until the following year, Medical Economics began analyzing the program and its impact on primary care physicians right away.

Much of our reporting looked at how the program might affect hospitals and physicians’ relationships with them. That was hardly surprising, given that Medicare’s original goal—and most of the focus among lawmakers and the general public at the time—was on protecting the elderly against financially ruinous hospital bills.

An article in the August 23, 1965 issue of Medical Economics predicted that doctors would come under greater pressure both to hospitalize elderly patients and to discharge them quickly once they had been admitted. Regarding the former, the article quotes a Pennsylvania surgeon, Charles Young: “Now that the over-65s who didn’t have private insurance have come under Medicare, some are bound to want to be hospitalized when they need any sort of treatment.”

The pressure to discharge would come from the utilization committees that hospitals were required to have to receive Medicare funds. The article calls these the “watchdog group of staff doctors appointed to certify that your patient is sick enough to be in the hospital, and to make sure he doesn’t stay any longer than necessary.”

“As a physician, you’ll have to work harder to keep ahead of your utilization review committee,” it warned. “In making hospital rounds, you’ll have fellow physicians checking your patients, your judgment, and in some cases, your work.”

The article predicted that Medicare would accelerate the trend of doctors’ practices becoming “hospital-oriented,” because, increasingly, that’s where elderly patients would be. It quotes an executive at a suburban Chicago hospital: “By and large, medicine today is not a home practice, it’s an office-hospital practice. And hospitals eventually will have to provide space and facilities for doctors to get a better job done.”

Some of our coverage also looked at Medicare’s possible impact on doctors’ practices. The August 23 article warned, for example, of more visits from elderly hypochondriacs and from “bargain hunters,” such as the hypothetical “Mr. D” who has “read through the Medicare act and noted all that it entitles him to—and he wants it all because it’s available and doesn’t cost him much.”

An article from earlier that summer addressed the question of whether doctors should participate in Medicare at all. The article reported that that summer’s American Medical Association meeting included—echoing today’s Tea Party movement—“emotion-charged speeches larded with references to the Boston Tea Party, Bunker Hill, the muskets of the American Revolution and other symbols of resistance and rebellion.”

Opponents of Medicare urged physicians not to sign any Medicare forms, including those required for admitting a Medicare patient to the hospital. But supporters countered that hospitals might then not admit the patient, because they would not get paid for doing so.

Moreover, supporters said, the only way nonparticipation could be effective would be if every doctor in a community participated—something that even die-hard Medicare opponents admitted was highly unlikely. And a medical society or other group trying to organize nonparticipation might find itself subjected to a federal anti-trust suit for restraint of trade.

“With very few exceptions, doctors want to be law-abiding citizens,” Irvin E. Hendryson, MD, an AMA trustee was quoted as saying. “If all else fails and conditions get to the point of being really destructive of good care, we’ll have to consider what to do about it.”

On the subject of payments to physicians, predictions regarding Medicare’s impact proved largely accurate. The legislation said that physician reimbursement would be set according to “reasonable” and “prevailing” fees at the time. But Charles Letourneau, MD, a hospital consultant and president of the American College of Legal Medicine foresaw that the ambiguities surrounding those terms would lead to government-set fees.

Going even further, an executive with a commercial insurance provider said, “The basis of paying physicians for the care of those 65 and over will undoubtedly exert a strong influence on charges for care of those under 65”—a prediction that has also proven on target.

Less accurate was the prediction that Medicare would lead to the revival of house calls, which even then were disappearing. The reasoning was that Medicare included coverage for home care, provided that the patient was under the care of a physician, and thus “more doctors will be looking after patients at home again. “ Clearly, that time has not yet arrived.
get population of those 65 and over, today Medicare covers the disabled, and, since 2006, has included a limited prescription drug benefit. The program introduced concepts such as diagnostic-related groups (DRGs), relative value units (RVUs) and sustainable growth rate (SGR) that have become part of the nation’s healthcare payment lexicon and was instrumental in desegregating the nation’s hospitals. Most of the nation’s commercial health insurers use Medicare’s reimbursements as a benchmark for setting their own.

“The preamble to the Medicare legislation says, ‘Nothing in this title shall be construed to authorize any Federal employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided,’” says Stuart Guterman, vice president, Medicare & cost control with The Commonwealth Fund. “And I’ve heard people say that still applies today, except that the word ‘nothing’ should be changed to ‘everything.’”

The signing ceremony on July 30, 1965 took place in Independence, Missouri, the birthplace of former president Harry S Truman. As president from 1945 to 1952 Truman had led the first concerted efforts to establish a national health program, initially one that would cover all Americans, and later a plan that would cover just the elderly. Both failed, due in large part to fierce opposition from the American Medical Association, a role it would reprise later with Medicare.

Medicare was just one element in a torrent of laws and initiatives passed in the mid-1960s that became known collectively as the Great Society legislation and included the Civil Rights Act of 1964, the Economic Opportunity Act, the Voting Rights Act of 1965, Medicaid (which Johnson signed at the same time as Medicare), the National Endowment for the Arts and Humanities, the Immigration and Nationality Services Act of 1965, the Higher Education Act of 1965 (which included the creation of what later came to be called Pell grants), and Head Start, among others.

Still, in terms of longevity and impact, Medicare ranks among the major accomplishments of the Great Society, Joseph Califano, an aide to President Johnson (and later secretary of the U.S. Department of Health, Education and Welfare) said in a telephone interview with Medical Economics.

“In terms of what people remember, and what affects millions of people, it’s right there at the top. It changed everything.”

THE ORIGINAL LEGISLATION
At the time, however, few foresaw the law’s wide-ranging impact. In fact, its initial scope was fairly modest. It consisted of two parts. Part A was for hospital insurance (90 days), as well as 100 days of post-discharge nursing home care, home visits from a nurse, and hospital diagnostic services.

There were no premiums, but all

MEDICARE BY THE NUMBERS

Number of Medicare enrollees in 2013

$582.9 BILLION

Total Medicare expenditures

14%

Medicare’s share of the total federal budget

2030

Estimated year in which Medicare hospital insurance trust fund will be depleted

12%

of Medicare benefit payments goes to physicians

25%

of Medicare benefit payments goes to Medicare Advantage plans

$220.4 BILLION

Amount held in Medicare hospital insurance trust fund

14%

of Medicare’s share of total national health expenditures

20%

Medicare’s share of total national health expenditures

*All data are as of 2013
Sources: 2014 Medicare Trustees Report, CMS, Kaiser Family Foundation
covered services included some modest copays and deductibles. It was financed through a payroll tax.

Part A’s design and method of financing was modeled on Social Security. “It was the idea that people would pay into the system during their working years so they would have the coverage they needed when they retired,” says Tricia Neuman, Ph.D., senior vice president and Medicare policy director at the Kaiser Family Foundation. “It was very important to the designers of the legislation that the program not be just for low-income people, so there was a sense that everyone contributes and everyone benefits.”

“We would laugh at the bills that scared people then, when they might have to pay several hundred dollars for a hospital stay,” says Guterman. “But that was a lot of money then, especially to elderly people without much income.”

Part B covered doctors’ services, diagnostic x-rays and laboratory tests, and various home health agency services. Enrollees paid a $3 monthly premium, with the remaining cost of covered services subsidized by the federal government. Although nominally optional, Part B was (and remains) such a bargain compared with commercial health-care insurance policies that the vast majority of eligible seniors use it.

The two-part design of the program was in deference to the political realities of the time, explains Edward Schumacher, Ph.D., chairman of the Department of Health Care Administration at Trinity University in San Antonio, Texas.

“Part A was basically hospital insurance that everyone would have to buy [through the payroll tax], and the Part B side would be funded differently so it wouldn’t look like a complete income transfer. The idea was to that people would have some skin in the game,” he says.

Califano says that including premiums in Part B was also intended to deflect criticism from the AMA, which was denouncing Medicare (as it had earlier proposals for government-financed healthcare programs) as “socialized medicine.”

“It gave the AMA the ability to say ‘we’re being paid by the patient. We’re not working for the government,’" he recalls.

**IMPACT ON THE ELDERLY**

Medicare’s popularity among the elderly was quickly apparent. A million people enrolled in the first week, and the percentage of Americans over 65 with hospital insurance grew from 50% in 1965 to 96% by 1970, according to the Kaiser Family Foundation.

According to The Commonwealth Fund, the hospital admission rate for older Americans rose from 18% to 21% between 1963 and 1970, and the percentage seeing a physician rose from 68% to 76%. Moreover, according to a 205 paper from the National Bureau of Economic Research, Medicare was associated with a 40% reduction in spending among those with the largest out-of-pocket expenditures.

An important side benefit was the rapid desegregation of the nation’s hospitals, which had to comply with recently-enacted civil rights legislation in order to receive Medicare dollars.

**MEDICARE AND PAYMENT**

Along with providing access to healthcare for greater numbers of Americans, Medicare’s most significant impacts have been in payment reform and quality improvement, both of which have been driven by the program’s ongoing struggle to control costs.

“The program is intended to help people. And finding the right balance between considerations of cost, and considerations of the missions of the program is really the core issue of the challenges it faces,” says Guterman.

The first step in that direction occurred in 1983 when Medicare instituted pre-determined payment amounts, known as diagnostic-related groups (DRGs) for hospital stays. Before the advent of DRGs, Medicare reimbursed hospitals for their costs, and physicians according to the “usual, customary and reasonable” (UCR) rates of the time. “That basically meant that physicians and hospitals got to decide what their Medicare reimbursements were going to be, and as a result, federal spending on Medicare blew through the budget projections,” says Chapin White PhD., senior researcher with the RAND Corp.

The use of DRGs had two consequences, experts say—one intended and one unintended. Their introduction “encouraged hospitals to change the way they thought about their product and broaden their perspective so that they looked at the whole patient for the hospital stay,” rather than individual procedures and services, says Guterman.

"Not only do we have to set the price, we have to set quality and patient satisfaction and all these other metrics. It’s like having to turn eight different dials.”
Primary care before Medicare

Ernie Chaney, MD, FAAFP, practiced family medicine in Belleville, Kansas from 1957 through the early 1980s. Now 87 and retired in Texas, Chaney spoke recently with Medical Economics about what it was like practicing medicine before Medicare, and how the arrival of Medicare affected his relations with his patients.

Q: How long were you in practice?
A: I started in 1957. I practiced in Belleville, Kansas, a town that was 3,000 in population. In the early 1980s I got seduced into academic medicine at the medical school in Wichita where I was director of the family practice residency training program. I did that for about 14 years then retired, but then the dean called me and said ‘I need someone to take care of the family practice department,’ so I went back for a couple of years. I’ve been retired since then.

Q: Before the start of Medicare, how did your elderly patients pay for their care?
A: Some of them had some retirement (insurance). Most of them were agricultural people. It was a wheat-farming community. And if they were unable to pay their bill, then my partner and I just sent them a Christmas card saying merry Christmas, I know you’re having a tough time and just forget about the bill.

Q: What did you think of Medicare when you first heard about it?
A: I had some concerns about the third party payer between me and the patient. And that did happen, in my observation. It was easy for us to say to the patient, you need to have something done, it will cost this much and we’ll have to see how we can pay for it. Later on, when a lot of people had the (Medicare) insurance, then the philosophy of the patient sometimes changed to, ‘I really want one of these tests. I think you owe it to me because I’m paying taxes and the government’s paying for it anyway.’ That certainly did happen to us, and I’m sure it happened to other physicians.

Q: How did Medicare change the day-to-day operations of your practice?
A: It sure interfered in the business end of the practice. You had to then make sure that the people working in your office knew about all the rules and regulations and things that had to be done to get paid. And if you wanted to get paid at all you had to follow them. In addition, you had to be sure your office personnel filled out everything properly. You were always concerned that even with an honest mistake they may turn around and say, ‘Oh you’ve done something here, we’re going to have to review all your charts.’

Q: Did you have to hire more staff?
A: Yes, and they had to be trained. You had to make sure they understood the government rules and regulations to make sure you got paid, and that you didn’t get accused of any kind of lack of knowledge of what you had to do.

Q: What do you think your patients thought about Medicare?
A: I think most of them didn’t understand how much it was going to affect their care. We had some patients who thought, well, the government’s paying for it so I can get everything I want. I’d like to have a chest x-ray. Well, you had one two years ago, you don’t have any problems that need to have a chest x-ray, so I don’t think you need one. Well the government’s paying for it so I want to have one. It’s my philosophy, that if you pay for something out of your own pocket, or at least a portion of it, then you have more appreciation of how money is spent in medicine.

Q: Looking back, do you think Medicare was beneficial to your practice? Your patients?
A: I don’t think that’s the answer to the problems we have in the practice of medicine. I think a better way is to have a good relationship between the patient and the physician not only in healthcare needs but in payment for the healthcare. And for those who really can’t pay, then I think it’s my responsibility as a physician to give that care for free, and not rely on some third party. I don’t think Medicare, to our situation, was a great benefit. I’m not sure it was worth anything at all.
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Medicare subsequently extended the fee schedule approach to payment to most of the other services and facilities the program covers, from dialysis centers to skilled nursing facilities, says White. "Across the board Medicare has moved from letting providers basically write their own check to setting the payment amounts in tighter and tighter ways."

Payment reform came to individual physicians in the early 1990s in the form of relative value units (RVUs) and the accompanying physician fee schedule. Instead of UCR rates, henceforth the government would reimburse doctors using a formula that incorporated the amount of time, skill, and training required to perform a service, practice expenses, and malpractice costs.

Here, too, there were unexpected consequences, notes Schumacher. "It (the RVU system) creates a huge incentive for doctors to do stuff. Because if I talk to you and tell you you’ve got diabetes and need to do this and this, I don't really get paid for that. But if I have to amputate your foot because of diabetes, I get reimbursed really well. So no one wants to be a primary care doctor because the reimbursements for specialists are so much higher."

QUALITY INITIATIVES
Medicare’s efforts to monitor and improve the quality of care it pays for has drawn the attention—and ire—of physicians in recent years due to its flurry of initiatives such as the Physician Quality Reporting System and Value-based Modifier. But Medicare’s concern with quality goes back decades.

"There is renewed, intensified interest in in quality improvements, which in many respects has been intensified by the Affordable Care Act, but Medicare has a long history of setting standards with a goal of improving quality of care provided to people covered by the program," Neuman says. For example, when concerns about the quality of nursing homes arose in the 1980’s, Congress passed a law saying that any nursing facility accepting Medicare (or Medicaid) funds would have to comply with federal quality requirements.

Payment reform and quality improvement have come together in the effort to nudge the nation’s healthcare system away from fee-for-service reimbursement, which virtually everyone agrees is both costly and counterproductive to good outcomes. The Centers for Medicare & Medicaid Services (CMS), which administers the program, has been attempting to jumpstart alternative models such as the accountable care organization and the patient-centered medical home.

Earlier this year Sylvia Burwell, secretary of the U.S. Department of Health and Human Services (the parent organization of CMS), announced twin goals of having 50% of Medicare provider payments to be in alternative payment models, and 90% of Medicare fee-for-service payments tied to qual-

HISTORY OF MEDICARE

1949 President Harry Truman proposes national health insurance plan

1951 Truman administration proposes plan for 60 days of hospital insurance covering Medicare beneficiaries receiving Old Age and Survivors Insurance

January, 1965 President Lyndon B. Johnson uses State of the Union address to call for a bill providing hospital insurance to the elderly

1962 President John F. Kennedy asks Congress to pass legislation providing hospital insurance to the elderly

July, 1965 Johnson signs Medicare legislation into law

July, 1966 Medicare goes into effect

1972 Medicare benefits extended to individuals under 65 receiving Social Security disability cash payments for at least 24 months, and to people with end-stage renal disease who require maintenance dialysis or a kidney transplant.
Weaning Medicare and other payers from fee-for-service “makes a lot of sense” but will be a significant challenge, says Trinity University’s Schumacher. “It’s been hard enough setting prices on a fee-for-service scale, but now not only do we have to set the price, we have to set quality and patient satisfaction and all these other metrics. It’s like having to turn eight different dials,” he says.

WHITHER MEDICARE?
Almost from its launch, Medicare’s long-term financial outlook has been a topic of concern, and debate, among program administrators, members of Congress, and presidents. Those concerns have grown more acute in the last few years as the first wave of baby boomers—the huge cohort born between the late 1940s and mid-1960s—has begun enrolling in the program. The Medicare trustees 2014 report puts the estimated “depletion date” of the hospital insurance trust fund—the part that finances Part A—at 2030, and says the trust fund for Part B is “adequately financed” for the next 10 years.

While 2030 may seem fairly close for a program of Medicare’s size and importance, it is four years further out than was projected only a year earlier. That difference highlights a phenomenon that has become apparent in the last few years: the rate of increase in Medicare spending has been slowing, averaging just over 3% since 2009, according to a 2014 Kaiser Family Foundation study co-authored by White and Neuman. “Both the magnitude and duration of the slowdown in Medicare spending growth have no precedent in Medicare’s nearly 50-year history,” the authors write.

Among the reasons for the slowdown cited in the study are provisions in the Affordable Care Act, such as the so-called “productivity adjustments” and reductions in payments to Medicare Advantage plans, cuts in payments to physicians resulting from sequestration at the start of 2013, and heightened efforts to combat fraud.

Because of the spending slowdown, “the sense of urgency (about Medicare’s finances) has been diminished,” Neuman says. “But there is a long-term challenge ahead with the number of people aging onto Medicare.”

Neuman and other experts say Medicare is unlikely to undergo any major expansions either in benefits or covered populations for the foreseeable future. Some of the changes policymakers have discussed include caps on out-of-pocket spending for beneficiaries, offering greater premium and out-of-pocket payment support to low-income individuals, and using Medicare and adding some form of long-term care benefit.

“But the big question remains, how could benefit improvements be paid for, and who will pay?” Neuman says. “There really are no easy answers.”
Accounts receivable
Strategies for better management

From eligibility verification to patient engagement, managing accounts receivable is a vital process to maintaining financial health.

by DEBRA BEAULIEU-VOLK Contributing author

Maintaining healthy accounts receivable (AR) is essential to strong financial performance, but it’s easy for practices to feel overwhelmed or become complacent when it comes to keeping this piece of the revenue cycle on track. Here’s some strategies to keep your AR on target.

The aging of your AR is crucial to watch because the older bills get, the harder and more costly they become to collect, says Laurie Morgan, MBA, a senior consultant with California-based Capko & Morgan. “When your AR slips and you have a very large backlog or balance, it can seem like you’ll never be able to tackle it,” she says.

What’s more, this challenge has been compounded in recent years by the rise in patient financial responsibility for medical care. While high-deductible plans have existed for some time, they’ve become even more widespread as more and more products available through new health insurance exchanges offer low premiums in exchange for high deductibles or coinsurance.

The multitude of new plans available to patients can in itself result in complexity and confusion for practices. Throw in the fact that many affected patients are unfamiliar with how health

HIGHLIGHTS

01 If your patient ARs are mounting quickly, it could suggest deficiencies in your front-desk processes or the way employees communicate to patients about your payment policy.

02 It’s crucial to engage patients early in setting expectations so that a bill or request for payment will not come as a surprise.
Managing accounts receivable

38 insurance works in the first place, and AR can suffer dearly.

ANALYZE YOUR AR IN DETAIL

The first step in improving your AR is to analyze your starting point. But just as the proportion of patient-paid AR has evolved, so too should the way you run reports. “It’s important to break down the patient AR from the insurance AR to be able to understand what’s driving each of them. You can’t just look at it as one massive AR,” says Morgan.

So if you note that your patient AR is mounting quickly, for example, that could suggest deficiencies in your front-desk processes or the way employees communicate to patients about your financial policy. Declining performance on the insurance side could also indicate front-desk errors, or point to a larger issue related to a third-party or centralized billing function.

PRIORITIZE INSURANCE VERIFICATION

A starting point for addressing many of these issues is your process for verifying patients’ insurance coverage and eligibility.

“Making sure we’re checking insurance eligibility well in advance of that patient presenting to the clinic is a strong indicator of AR,” says Stephanie Davis, director of revenue cycle management for Halley Consulting Group in Ohio.

Most systems that practices use to check eligibility—including payer websites, software built into practice management systems or third-party products—can now provide medical office employees with detailed information that can help with AR. This data includes, for example, not just whether the patient has coverage, but how much of the deductible has been used up and even if the policy is in danger of suspension due to nonpayment of premiums. Ideally, practice employees communicate (and potentially translate) this information to patients before they come to the office for an appointment.

“If patient insurance eligibility is not being verified or we’re not connecting with the patient prior to them presenting to the office, it creates a massive amount of work on the back end to try and resolve open AR or open claims,” Davis says.

Tina Smith, CPC, CPC-H, administrator

6 tips to manage patient collections accounts

By Rebecca Fox, MD

Every practice will have patients with unpaid balances. While it is unpleasant to ask people to pay what is owed, it is critical to collect this revenue.

Here are some of the strategies my practice has put in place to improve patient payment collections:

1 Retrain front-desk staff

The most important approach is to train (or retrain) the staff that serves as the first point of contact for patients: your front-desk staff. Make sure staff members are able to view patient accounts when checking in a patient. As they are confirming insurance and demographics, they can politely remind the patient about a past-due balance and ask how the patient would like to pay it. It’s crucial not to ask a yes or no question such as, “Do you want to pay your balance today?” The answer will usually be “no.” A more effective approach is to ask if the patient would prefer to pay with a check or credit card.

2 Look for other payment options

Because we are a pediatric practice, our front-desk staff also looks at siblings’ accounts to see if there are any credits that could be moved from one account to another. Parents are always thrilled when we can do that and reduce their bill somewhat (and it’s always better to apply the credit rather than for us to write a check back to the patient).

3 Ask a staff member to step up

We also have one front-desk person in each of our offices who, in addition to her regular duties, is assigned to work the list of past-due balances. She calls patients about their balances in between answering phones and checking patients in and out. Make sure that the person you choose has excellent phone etiquette, but also has the tenacity to not take “no” for an answer.
Managing accounts receivable

Don’t keep chasing patients

Then, of course, there is the persistent non-paying patient. Every phone call and letter sent to the patient costs your practice money and cuts into the revenue you could receive from that delinquent payment. Don’t keep chasing a non-payer. Set very clear rules on just how many calls or letters you will send. We call three times and send two “dear patient” letters.

COLLABORATE WITH OUTSIDE BILLERS

Of course, the revenue cycle extends far beyond the front desk—even if a practice uses a third-party billing company. “Practice managers are often really busy and anxious to offload some things to not worry about,” Morgan says. “So the temptation is there to start thinking as though billing is someone else’s job.”

But even when most of the billing legwork is outsourced, practice managers have to work in concert with billers to make sure all parties are getting the information they need and performance is meeting expectations. Success in this area depends on maintaining a strong relationship with your billing company, according to Smith. Because her office is in a rural area, she enjoys the benefit of using a local billing company whose employees pick up the practice’s charge slips and drop off reports in person.

When face-to-face interaction with billers isn’t an option, it becomes even more important for an individual in the practice who understands billing rules to communicate with the company routinely. When possible, the same billing company employees should work with a given practice consistently, she adds, so the company becomes familiar with your office’s charges and contracts.

FOCUS ON CODING

In almost any primary care practice, there is opportunity for physicians to improve documentation and coding. When physicians see patients in multiple settings, such as nursing homes or hospitals, it’s especially important for practices to have systems in place to capture all of the services physicians are providing across these settings, says Davis.

“You would be amazed at the amount of billable services that are not captured by physician practices just because we don’t

If patient insurance eligibility is not being verified or we’re not connecting with the patient prior to them presenting to the office, it creates a massive amount of work on the backend.”

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Don’t keep chasing patients

Then, of course, there is the persistent non-paying patient. Every phone call and letter sent to the patient costs your practice money and cuts into the revenue you could receive from that delinquent payment. Don’t keep chasing a non-payer. Set very clear rules on just how many calls or letters you will send. We call three times and send two “dear patient” letters.

Make the consequences clear, and stick to them

In the letters we make it very clear that failure to contact us about payment will result in dismissal from the practice and having the account turned over to collections. Remember if you must turn the account over to a collection agency, you will receive pennies on the dollar. However, many patients will pay the entire balance when they have been sent to collections to have their name removed from these services.

Dismiss when necessary

When a patient does pay his or her overdue balance, you must decide whether you want to continue seeing that patient. If you think that the patient will continue to be a problem paying bills in a timely manner, you may need to terminate the doctor-patient relationship. In that case. Remember that you must give the patient a 30-day grace period in which you will see him or her for urgent matters. Otherwise you risk being charged with patient abandonment.

However, remember that you have an ethical responsibility to care for patients even if they have a balance. Should the patient be very ill when coming to your office, you cannot turn him or her away that day because of an unpaid balance. For non-urgent services such as consults or physical exams, you can postpone the appointment until the balance is paid.

We all work very hard each day and our practice also has bills to pay in a timely manner. Make sure you work those patient accounts receivable regularly, and collect the money owed to your practice.
Managing accounts receivable

Have processes implemented that will allow physicians to enter that charge capture," she adds.

Even if physicians are using a superbill, they need to make sure not only that they are capturing all charges, but also know which of them they can and can’t charge separately, Smith says.

"It’s a challenge because it’s not physicians’ area of expertise. They want to be seeing patients, not learning all the coding rules and regulations. But at the end of the day it’s the physician who is responsible. If there’s evidence of fraudulent billing, it’s not going to come back to the billing company. It’s going to come back to the physician," she says.

Accurate coding also speeds up the billing cycle, which increases the likelihood of patients paying their balances, Morgan points out. Any delay in the time it takes a bill to get through the clearinghouse and then to the health plan for payment also stalls the practice’s bill to the patient.

The more time that elapses between when the patient is seen and when he or she receives a bill, the greater the chances the patient will have forgotten about the bill, will consume staff time questioning the bill, or simply not pay it. "So you lose money not just on the operating expense of dealing with the problem, but you may not get paid at all," Morgan says. "Even in the best case it creates a negative experience for the patient, which is a result you don’t want."

ENGAGE PATIENTS

Instead, it’s crucial to engage patients early in setting expectations so that a bill or request for payment will not come as a surprise.

This step doesn’t stop with providing patients with your payment policy or reminding them of their balances. It also means giving patients easy ways to connect with the practice and pay their bills, says Davis.

"Patients are very technologically savvy, and the more you can give them access to communication tools, such as an online portal, and convenient methods of payment, it makes it easier for the patient to be engaged in that process," Davis says.

BEWARE OF CONSOLIDATION CAVEATS

Patient engagement and accessibility are particularly important when a practice is going through a transition such as a merger or hospital buyout, notes Morgan.

Of particular concern, switching to a hospital billing system often results in billing delays, leading to the problems mentioned previously that can sour a patient’s relationship with the practice. "So anything you can do in the clinic to communicate what’s going on, such as changes happening, updates to infrastructure, potential billing delays, or a new person to talk to with questions can head off problems," Morgan says.

Also, while being owned by a hospital or health system can be a plus when it comes to negotiating contracts, adopting hospital-centric policies is not always advantageous from a billing perspective, according to Davis. "We recommend you try to get the best of both worlds, whereby you allow the practice to continue to do their charge capture and other revenue cycle functions that are going to drive that performance," Davis says.

FOLLOW THE GOLDEN RULE

Regardless of your practice structure, Davis recommends following a credo of, “Whoever enters the data owns the data.”

An example of this philosophy at work would be when a claim comes back denied because of an incorrect subscriber ID. Rather than taking the seemingly quickest route of fixing the error at the back-office level and resubmitting, Davis suggests routing the claim back to the employee who made the mistake so he or she can see what happened and not perpetuate the cycle.

“Our front-desk personnel are typically people who strive to do their best. And where we see the breakdown is when we don’t provide that feedback loop and we don’t allow them to understand the results of their actions,” Davis says. "Engaging employees in the solution is the ultimate training."
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Practical Matters

STARTING AN URGENT CARE CENTER
5 ESSENTIALS FOR SUCCESS

by VALORA GURGANIOUS, MBA, and DAN GREENFIELD Contributing authors

Is 2015 the year you decide to open an urgent care practice? If you are interested in urgent care medicine, you are not alone. Growth is expected to continue as patients seek immediate access to medical care and lower-cost alternatives to emergency department visits. Despite the rewards, urgent care medicine comes with risks—especially for physicians unprepared for the business demands of operating an urgent care center.

According to the American Academy of Urgent Care Medicine (AACUM), the number of urgent care facilities has increased 14% to 9,300 centers since 2008.

The economics support this trend. The Urgent Care Association of America (UCAA, 2013 benchmark survey) showed that 83% of urgent care centers experienced growth, and approximately 88% of practices expanded an existing location or added a new location in 2014.

Any exploration of starting an urgent care center should begin with these considerations:

Consider an urgent care specialty
Although most urgent care providers have trained in internal, family or emergency medicine, consider offering some form of specialized care at your urgent care clinic.

Consultants at DoctorsManagement are seeing the emergence of walk-in orthopedic/sports medicine clinics or even after-hours pediatric urgent care clinics. These facilities can triage and attend to injuries and illnesses without the need to schedule appointments with physician offices hours or days in advance.

Other urgent care clinics offer cash-based services and market medical weight loss, substance abuse treatment, or aesthetic services to complement their walk-in primary care.

Determine what lines of service your urgent care will provide, then equip and select experienced staff to deliver that care.

Just be careful not to extend beyond the scope of your own practice experience or professional capacity.

Choose your location carefully
Location has always been a factor for physicians opening a practice, but going where patients live and work is particularly relevant when selecting a site for an urgent care center.

Make sure to analyze demographics and market conditions in the community where you plan to open your urgent care. Select a location near your ideal target patient population, then design your clinic to best serve them.

For example, an industrial or corporate park may be an ideal location for those specializing in occupational medicine, while proximity to a community sports complex or schools is a natural fit for those focusing on sports-related injuries, physicals and vaccinations.

Commercial town centers, where consumers shop or do errands, are optimal, high-visibility locations for an urgent care center, but bear in mind that you may find competition from other urgent care providers.

The UCAA estimates that you may find an average of four urgent care centers for the average target market population of 114,000.

Select design and layout based on patient and staff needs
While it may be tempting to select a large space in an ideal location, choosing a space that exceeds your clinic’s space requirements will result in start-up cost.
Practical Matters

overruns, underutilized exam rooms and lost profits.

A good rule of thumb: Health Space Design advises its clients to plan for 1,500 square feet per physician, which allows for three exam rooms per provider.

Allocate an additional 1,000 square feet for a reception/waiting area, a lab, and radiology room. Look for designs that reduce clutter, maximize patient flow and minimize the distance staff and physicians must travel between exam rooms.

Remember: an urgent care center is as much a retail space as a medical space.

Patient comfort, peace of mind and convenience are top priorities, so opt for an environment that is more warm, welcoming and less clinical.

Include amenities for enhancing the patient experience such as flat-screen TVs, coffee stations, free Wi-Fi, accessible electrical outlets and even fish tanks. Signage and the use of large windows will help attract street traffic to your clinic.

When hiring a designer, make sure their experience includes an understanding of clinical processes and regulations governing a medical space. Consider referrals from peers or contact trade associations such as the American Institute of Architects (AIA) and the International Interior Design Association (IIIDA.)

**Branding is Important**

In today’s retail medicine environment, gaining mind and market share are critical. Patients have choices on whether to use you, another urgent care center or to visit a hospital emergency department.

Your location, your design, your logo and your website are all part of the branding experience that is so crucial in a competitive marketplace. Your brand is a shorthand of your benefits and perceived value allowing customers to assess the quality of care even before they walk through the door.

Urgent care centers rely on walk-ins without appointments or physician referrals, so your brand is particularly important in turning first impressions into return trips and patient referrals.

Having a consistent look and feel in the market is also valuable for physicians who are considering opening multiple locations. It can save design and material costs and can even attract investors or franchisees looking for businesses that are scalable and well-known in the marketplace.

**Don’t equate your skill as a doctor with your skill as a business person**

You may have mastered clinical medicine, but it’s likely that you have little training in the business of medicine. From insurance contracting, accounting, payroll, hiring and firing employees to coding and marketing, your focus should be on delivering superior care to your patients, not on addressing these challenges each day.

Choose an experienced manager or management consultant to help you make the daily business decisions that will maintain the smooth operation, compliance and profitability of your urgent care clinic.

Of course these are only a few of the many considerations you need to make when launching an urgent care center. Urgent care centers are an appealing alternative or complement to a traditional medical practice, but understand the rules of engagement before taking the plunge.

**“Determine what lines of service your urgent care will provide, then equip and select experienced staff to deliver that care. Just be careful not to extend beyond the scope of your own practice experience.”**

Valora Gurganious, MBA, is a senior practice management consultant with DoctorsManagement, LLC, and Dan Greenfield is co-founder of Health Space Design. Send your practice management questions to medec@advanstar.com.
In Depth

How Congress Killed SGR
Many factors were at play to allow for the historic outcome [54]

Affordable Care Act
Majority of Americans support subsidies [61]

Policy

After SGR: Physician pay facing a value-driven future

While many details remain to be finalized, here’s what physicians need to know about the future of Medicare reimbursement

by Beth Thomas Hertz Contributing author

The annual battle over the Medicare Sustainable Growth Rate (SGR) formula has come to an end. But the program that replaces it will be Medicare’s leap into the world of value-based payment and risk sharing, and the resulting changes will have a massive impact on how physicians are reimbursed.

For Wanda Filer, MD, FAAFP, president-elect of the American Academy of Family Physicians (AAFP), the end of SGR means physicians no longer have to live under the constant threat of cuts in Medicare reimbursements.

“It was hard for practices because they didn’t know what the payment structure was going to be and that’s really scary, especially for many of the smaller practices.”

Robert Doherty, senior vice president of governmental affairs and public policy for the American College of Physicians (ACP), also considers this to be good news, saying he has “never seen medicine more unified on an issue than the end of SGR.”

However, while many physicians breathed a sigh of relief, they also have many questions about how these changes were going to be and that’s really scary, especially for many of the smaller practices.”
(Becoming a PCMH) is a bold step forward. It’s good for their practice, good for their patients, and now they will hopefully get payments for it so they can sustain those changes.”

—WANDA FILER, MD, PRESIDENT ELECT, AMERICAN ACADEMY OF FAMILY PHYSICIANS

will affect their practices. Small practices, in particular, are going to face challenges succeeding under these new payment models, and may be required to collaborate to make strides.

MACRA: SOME DETAILS
In a May 1 conference at ACP’s annual meeting in Boston, Doherty reviewed some of the details about the legislation replacing SGR, known as the Medicare Reauthorization and CHIP Renewal Act, or MACRA. He said it creates a four-and-a-half-year timetable during which physicians are guaranteed 0.5% increases in their fee-for-service payments.

However, in 2019, it creates a “fork in the road” at which physicians must choose a path that they think is best for their practice: either the Merit-based Incentive Payment System (MIPS) or some form of alternative payment model. Their decisions need not be permanent; they can change each year.

Doherty described MIPS as a fee-for-service plan that has an increasing financial risk for quality. Physicians will be measured based on clinical outcomes, meaningful use of electronic health records, resource use (efficiency) and practice improvement. Increased payments will go to the top scorers.

For physicians who want to move more into systems of care, the alternative payment models may be more appealing, he said. Physicians will be guaranteed 5% fee-for-service increases over six years, but they will be paid according to performance. There is risk—they can earn more but they can also be paid less if they don’t deliver savings, Doherty says.

One exception to this scenario is the patient-centered medical home (PCMH) model, in which a physician does not have to take on financial risk, but does have to show that he or she can improve quality without increasing costs, or can lower costs without losing quality.

Doherty dismissed rumors that this law penalizes doctors who don’t participate in Maintenance of Certification (MOC). The government can let physicians count their MOC work toward their MIPS practice improvement component, but it is only one option to meet that requirement.

“We supported that because it is a hassle reduction,” he says. “If you have to do MOC whether you like it or not and you are reporting it to your certifying board, we felt it should help count to qualify you for the MIPS program.”

REACTION TO THE NEW LAW
Filer says the .5% reimbursement increases in the first few years, while small, are preferable to the 21% cuts that were looming, especially since about one in four patients a typical family practitioner sees are Medicare beneficiaries. (In some practices it is as high as 60%.)

Now that the payment structure is stabilized, she says, AAFP looks forward to the chance to attain payment differentials through advance practice models. She is glad the law includes ways to help small practices transition to a PCMH and start earning value payments for care that doesn’t necessarily require face-to-face visits.

“There is an alignment of many projects that include support for small practices to do that hard work of transformation and allow them to get paid for the services they
are doing, and get some of our members off that proverbial hamster wheel of being paid for volume and let them instead coordinate care for their patients,” she says. Christian Shalgian, director of advocacy and public policy for the American College of Surgeons (ACS), notes that the initial legislation ending SGR included a 10-year payment freeze, so the .5% increases for the first few years is better. He is skeptical, however, that it will be enough to cover surgeons’ rising expenses. “As we move into new alternative payment models, doctors could do better,” he says.

For surgeons, those new models could include bundled payments. Shalgian notes that surgeons have worked with something similar for years, with global payments for surgery. “There is enough flexibility in the new law allowing various options to be created under this, and not restrict surgeons to one or two options,” he says.

WHAT LIES AHEAD
Expert agree that much work lies ahead,
SGR reform

however, as the details of MACRA are sorted out.

Shari Erickson, MPH, ACP’s vice president of governmental affairs and medical practice, praises MACRA but says the rulemaking that will take place over the next several years will be critical.

“I celebrated for about five minutes then I started thinking about all the work that is ahead of us,” she says.

For example, an area that will need to be addressed is the metrics that will be used to assess quality and resource use in the MIPS option.

“They likely will be building on the existing measures that are in the PQRS [Physician Quality Reporting System], value-based modifier, and meaningful use program, but they also need to take a closer look at ensuring that those measures are the right measures,” she says.

Other questions to be addressed: how will physician input be factored into resource use decision-making, as required by the law? How will feedback be used in the rule-making process? How will MIPS composite scores be calculated?

There are just as many questions about the criteria that will be required to be part of an advanced practice model, she says. There are parameters in the legislation covering these topics but the details need to be laid out. “We want to make sure it is done in a way that reduces the burden on all involved,” Erickson says.

ACP will establish a priority list and a timeline for how it can influence such decisions, she says. She adds that ACP has a lot of work ahead educating its members as they decide which path their practices will take.

Filer says that AAFP’s next goals include seeing the Children’s Health Insurance Program (CHIP) reauthorization extended beyond the two years included as part of MACRA. CHIP is important to family physicians because they care for about 70% of adolescents in the U.S., and CHIP offers coverage to age 18.

Filer says AAFP also would like to see the teaching health centers program be continued beyond the two years MACRA provides. She says this program has been an innovative and successful teaching model that benefited primary care in particular by creating new residency spots. About 100 trainees were expected to participate but more than 700 actually did.

Smaller practices are going to have to collaborate. They are going to have to get together with other practices in their community along with their local hospitals and create a network.”

—NITIN DAMLE, MD, FACP, PRESIDENT-ELECT, AMERICAN COLLEGE OF PHYSICIANS

MACRA: IS MOC REQUIRED?

The Merit-based Incentive Payment System (MIPS) will evaluate physicians on a variety of criteria, including clinical quality. One option for physicians to receive credit is through practice assessments related to maintenance of certification (MOC), according to the American College of Physicians (ACP).

Does that mean that MOC, a controversial program that many physicians oppose, is required while participating in MIPS if physicians do not want to have their reimbursement penalized?

Many details need to be worked out about the MIPS program during rulemaking, but MOC will not be required as part of MIPS, says Robert Doherty, senior vice president of governmental affairs and public policy for the ACP. Instead, it may become one of many possible methods physicians can use to complete this section of the MIPS process.

“ACP supported allowing physicians who are participating in MOC to have it count as an option for this subcategory,” Doherty said during a news conference at the ACP annual convention. “If physicians are already pursuing these activities for MOC purposes, then ACP believe they should receive credit for them for this purpose as well.”
“It has been a great workforce opportunity and there has been a huge interest in it,” she says.

Shalgian says ACS will continue to lobby as MACRA is implemented. “In a bill this size, there always needs to be improvements,” he says. “We are working closely with CMS [the Center for Medicare & Medicaid Services] as to how they implement various sections of the new law. We have some important hurdles to still go to make sure this is implemented correctly.”

WINNERS AND LOSERS
Did any part of healthcare “lose” in MACRA’s passage?

Filer says the only potential losers are physicians who want to hold tight to fee-for-service or who are having quality problems, because they will be at risk for reduced payment over the next few years. “But my hope is that this will lift all boats,” she says.

“There definitely are incentives to encourage physicians to make some decisions about whether pursuing advanced practice models will be beneficial to them,” she adds.

About one-third of AAFP’s members have transitioned to a PCMH. She says it is hard work, and some early adopters have not yet seen much return from their investments in time and money. However, she believes the new law should help.

“(Becoming a PCMH) is a bold step forward. It’s good for their practice, good for their patients, and now they will hopefully get payments for it so they can sustain those changes,” Filer says.

Nitin Damle, MD, FACP, ACP’s president-elect, thinks MACRA opens many new opportunities in a secure environment, and he hopes the result will be better quality and lower costs. However, he notes that small practices may have difficulty going down either path. The accountable care path is particularly hard for practices that have too few lives to cover losses and distribute risk.

“Smaller practices are going to have to collaborate. They are going to have to get together with other practices in their community along with their local hospitals and create a network. They do not all have to be under the same bricks-and-mortar structure but they do have to have some collateral relationship in order to be able to participate in ACOs,” he says.

Physician pay: The next 10 years

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*The threshold for exceptional performance is a composite score equal to the 25th percentile or higher than the performance threshold. The bonus cannot exceed 10% annually.

Alternative payment models (APMs)

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*The FFS bonus does not include any incentives/penalties resulting from the APM’s payment structure.

Source: American College of Physicians
How Congress finally killed SGR

Legislators and physician organizations took last year’s failed attempt and pushed it through in a different political climate

by STEVE BARLAS  Contributing author

WHAT MACRA DOES

The doc fix legislation eliminates the sustainable growth rate (SGR) formula that has dictated drastic reductions in the Medicare fee update for many of the past 15 years, after being established in 1997.

The underlying provisions in H.R. 2 are the very same ones that were in the legislation that ran aground in the last Congress. The new law eliminates the SGR, substitutes a .5% fee-for-service (FFS) update through 2019, eliminates any update for the five years thereafter.

Also starting in 2019, the bill offers physicians two options for increasing earnings beyond the 0 percent update. One is an FFS-grounded Merit-Based Incentive Payment System (MIPS). The other is Alternative Payment Model (APM) program.

Physician groups pushed hard for the bill. Says AMA President Robert M. Wah, MD, “Not only did MACRA stabilize the Medicare program, it put in place significant reforms that could reshape how we deliver health care in this country.”

But that popping of champagne corks is probably a bit premature. It is true that future SGR-mandated cuts in Medicare reimbursements are averted. In addition, some of the penalties currently assessed in three Medicare programs—Physician Quality Reporting, Meaningful Use and Value-Based Payment Modifier—will be reduced starting in 2019. Physician reporting, now required separately for all three, will be consolidated in one report for MIPS. Those are solid pluses.

However, inflation will almost certainly swallow the .5% update in each of the next five years. Rep. Michael Bur-
gess, MD, (R-TX), the prime sponsor of MACRA, says in an interview with *Medical Economics*, “Half a percent for five years was not high enough, and I walked out of the room on several occasions. But it wasn’t going to go any higher and it was important for me to leave a fee for service option and eliminate the doc fix drama.”

**WHAT CHANGED FROM LAST YEAR?**

The AMA’s Wah praised House Speaker Rep. John Boehner (R-OH) and Majority Leader Rep. Nancy Pelosi (D-CA) for getting MACRA through a contentious Congress, especially since its predecessor, H.R. 4015, failed last year. A variety of factors accounted for this year’s success, the most important of which was the financing package.

In 2014, the GOP “paid for” elimination of the SGR, and the associated $141 billion hit to the budget over the next 10 years, by introducing legislation that would have effectively killed the Affordable Care Act. That source of financing was anathema to Democrats. The bill passed the House of Representatives by a vote of 238-181, with near-exclusive Republican support. But Sen. Harry Reid (D-Nev.), then the Senate majority leader, refused to bring the bill up for a vote.

But the November 2014 election changed the political calculus. Republicans won control of the Senate. Reid was no longer at the wheel, replaced by Sen. Mitch McConnell (R-KY). Democrats in the Senate still could filibuster the bill, and perhaps block its passage in 2015. But that became less of an issue as Boehner began negotiating the financial terms with Pelosi. Eliminating the ACA was no longer considered as an option to pay for SGR repeal.

Instead, Boehner and Pelosi came up with a financing package built on compromise and concessions from a number of parties, both inside and outside Congress. According to one source, the scuttlebutt is that Boehner and Pelosi both plan to retire at the end of this Congress, and were motivated by the desire to erect a legislative edifice to their tenure. The House passed the bill by a vote of 392 - 37 on March 26.

The major Republican concession was to finance the bill in part by adding $141 billion to the federal deficit over the next 10 years. But Burgess explains that the deficit-busting nature of H.R. 2 did not incite more of a Republican House revolt because the 10-year cost of repealing the SGR was $1 billion less than keeping the SGR and continuing to pass one-year “patches” to the fee schedule over the next 10 years.

Burgess points out that the remaining cost of the $214-billion SGR repeal package was paid for by making structural changes to Medicare.

Here is where the Democrats compromised, as did some of their constituencies, primarily seniors. The legislation includes $34 billion of Medicare beneficiary reforms, in the form of higher premiums for wealthier seniors in Parts B and D in 2018, and increasing the number of beneficiaries paying those higher premiums in following years.

In addition, Medicare recipients will have to pay higher out-of-pocket costs for Part B supplemental insurance, which will save the federal government another $1 billion or so.

Hospitals contributed $34 billion to the funding of the bill in the form of reduced payments. Testifying before a House committee in January, Richard Umbdenstock,
“NOT ONLY DID MACRA STABILIZE THE MEDICARE PROGRAM, IT PUT IN PLACE SIGNIFICANT REFORMS THAT COULD RESHAPE HOW WE DELIVER HEALTH CARE IN THIS COUNTRY.”

—ROBERT M. WAH, MD, AMA PRESIDENT

president and chief executive officer of the American Hospital Association (AHA), said “Offsets should not come from other health care providers, including hospitals, who are themselves working to provide high-quality, innovative and efficient care to beneficiaries in their communities and are being paid less than the cost of providing services to Medicare beneficiaries.” In the end, hospitals swallowed a bitter pill.

After the House passed the legislative package, its fate still hung in the balance during an early April congressional recess. But upon its return, on April 14, the Senate passed the bill by a vote of 92-8. President Obama signed it into law soon thereafter.

WHAT IT MEANS FOR DOCS Despite the accolades from physicians groups, it is unclear just how good a deal MACRA will turn out to be for doctors. Again, inflation is expected to consume the .5% update in each of the next five years.

After that, FFS transitions to the Merit-based Incentive Payment System (MIPS). Whether a physician receives a negative or positive update between 2019 and 2024 will depend on his or her score above or below some pre-established threshold. The score will depend on how well that physician does with reporting under PQRS, meaningful use, and value-based modifier programs, which will be consolidated into a single program that will be—at least theoretically—easier to comply with.

Scores falling below the threshold will result in penalties. Doctors who don’t report at all—and Burgess acknowledges that some physicians won’t—will receive the maximum penalty, which will be 4% in 2019 and up to 9% after 2022. Even physicians who do report will face penalties if their score is below the established threshold, with the exact amount dependent on how far below the threshold they score.

Physicians who score above the threshold will receive incentive payments of up to 4% in 2019 and up to 9% in 2024, depending on how far above the threshold they score. Exceptional performers will also qualify for an additional bonus pool.

Physicians who choose to participate in an APM program will receive a 5% bonus. However, they will be participating in risk-based, value-payment programs such as accountable care organizations (ACOs). Consequently, they face the possibility of the 5% bonus eroding in part or in full if their costs exceed their revenue. Several of the Pioneer ACOs participating in Medicare’s first-generation program have left the program exactly because the penalty was more than the incentive.

The elimination of the SGR allows physicians to breathe somewhat easier until 2019, although current penalty/incentive programs remain in place until then.

Steve Barlas is a Washington, D.C.-based writer who analyzes policy issues for Medical Economics.
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POLLS

MAJORITY OF AMERICANS SUPPORT ACA SUBSIDIES

by LISA SMITH  Contributing editor

Two polls released in May show majority support for the Affordable Care Act (ACA) including the health insurance tax subsidies now under review by the Supreme Court. If the Court eliminates the subsidies, it could have serious ramifications for physicians and the patients they treat.

AN ASSOCIATED PRESS (AP) poll of 1,077 respondents taken April 23-27 showed that, while 60% of Americans are not closely following the tax subsidy challenge, 56% said that the Supreme Court’s ruling should allow subsidies to continue in states that are running their own health insurance exchanges. In the event of an adverse ruling, 51% said the law should be updated to allow states to offer subsidies.

Respondents were about evenly split in their confidence that justices would rule based on objective interpretations of this provision of the law rather than personal opinions. The poll also showed that healthcare remains an extremely important/very important point for 78% of Americans, up from 76% in March 2014.

In addition:

- 44% of respondents said they approve of the way President Barrack Obama is handling healthcare versus 38% last March;
- 61% of Americans either support or neither support nor oppose the healthcare law, compared to 56% last March, and
- Opposition to the law fell to 38% from 48% last March.

A new Reuters poll also shows majority support for the ACA: 60% of respondents who obtained insurance under Obamacare are generally satisfied with it, 73% of them Democrats and 53% Republicans.

As with the AP poll, most Americans were unaware of the upcoming King v. Burwell subsidy challenge. Results show 23% of respondents support a ruling abolishing the subsidies for state exchanges, while 43% oppose that move.

There was also widespread bipartisan support for keeping certain tenets of the law untouched, including the dependent-care component that allows children to stay on their parents policy until the age of 27.

Source: AP poll