MONOPOLIZING MEDICINE

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Why hospitals’ quest to control healthcare may be a losing game.

STARTS ON PAGE 20

- How to preserve physician independence
- Facility fees explained
- Why physicians sell their practices
EHRs DISTRACT DOCTORS FROM PATIENTS: STUDY

A new study further validates one of the major complaints physicians and patients have regarding electronic health records (EHRs): That because doctors now spend so much time looking at computer screens they often miss important nonverbal cues from patients. The study also finds that many doctors don’t let patients view the EHR, thus missing a chance for patient engagement.

Find more details at MedicalEconomics.com/EHRfocus
Your goal in preparing for a financial audit should be to achieve a quick result at low cost.”

—Ellen Bartholemy, CPA

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from the Trenches

My feeling is that the American Board of Internal Medicine is using maintenance of certification as a money-making proposition and have lost touch with all the demands of private practice. They may be doing this in the name of improving quality, but in reality they are going to drive some very experienced older physicians out of practice.

Benjamin Levinson, MD, WEST COLUMBIA, SOUTH CAROLINA

MOC REQUIREMENTS WILL DRIVE OUT EXPERIENCED PROVIDERS

I have been in private practice for over 27 years. I was board certified in internal medicine after I finished my residency with the promise it was the only time this would be required of me. I have kept up the best I could with the demands of my practice with continuing medical education and constant reading. From the feedback from my thousands of patients I must have done a pretty good job.

Now the demands of my practice require me to keep up with the latest electronic health record technology, meaningful use requirements, medical home requirements, and the upcoming transition to the International Classification of Diseases-10th revision. I am being asked to see more and more patients with the Affordable Care Act as well.

I am in the twilight of my career and although I still love the practice of medicine, I would also like to spend some time with my wife, children, and grandchildren. The thought of having to study for another board exam is almost overwhelming. The time and expense cannot be worth the effort, especially with the other demands on me at this time.

My underlying feeling is the American Board of Internal Medicine is using maintenance of certification (MOC) as a money-making proposition and have lost touch with all the demands of private practice. They may be doing this in the name of improving quality, but in reality they are going to further drive some very experienced older physicians out of practice leaving healthcare more and more in the hands of younger extenders. I firmly feel the quality of medicine will be far from improved when that happens.

Benjamin Levinson, MD
WEST COLUMBIA, SOUTH CAROLINA

LINKING MOC TO REIMBURSEMENTS IS POWER GRAB

I am a young physician who has recently started my career. I am double boarded in pediatrics and pediatric cardiology. The MOC in pediatric/peds cardiology is a joke. The educational requirements are virtually no different from any other CME that can be found elsewhere. The practice improvement requirements are completely out of touch with a private practice physician.

It is painfully clear that the academics that run the MOC show (in pediatrics) are out of touch with physicians practicing outside of an academic environment. Other projects are very invasive, asking for detailed information about the patients and population that I see. I do not feel like I should reveal that data to anyone.

The link to reimbursement is a clear
power grab by an already overpriced, money-hungry organization. The presidents of these organizations are paid far more than most physicians can ever hope to make and want to keep an already glutinous revenue stream flowing. Does it really cost more than $2,500 to give a computerized test? More proof that they are reaching for additional power is their attempts to have state boards link licensure to board certification and MOC.

The final problem is that we are not on a level playing field. The older, grandfathered physicians get a free pass, with the newer docs having to do all these expensive, time-consuming, and worthless exercises.

James A. Bishara, MD
LAFAYETTE, LOUISIANA

PAYMENT OUTLOOK FOR DOCS WORSE THAN CLOUDY
Assuming the reimbursement numbers you listed in your article, “The payment outlook for 2014” (January 10, 2014) are correct (I suspect these are RVU rates paid to employed physicians) it is not hard to see why the future of the independent primary care physician is at best cloudy.

When I was economically forced to leave my solo practice my overhead was about $150/hour. If one does the math using your reimbursement figures, in order for a doc to earn $150,000 a year, he would have to see a 99213 patient in less than 10 minutes. Those figures are generated with some unlikely assumptions; that the doctor has 40 hours per week of patient-booked hours, that he works 48 weeks per year, and that every appointment is filled.

When I left solo practice I was being paid $52 for an office visit while the large, multi-specialty group down the street was being paid $95 for the same visit. The insurance company had no interest in improving my position and organized medicine threw up their hands and said there was nothing they could do.

If our government and the public believe that the best and brightest will go to school until after their 30th birthday and incur hundreds of thousands of dollars of debt in order to make less than most public safety officers, they will be sadly mistaken. I’m afraid that cloudy is being optimistic.

Steve Howard, MD
BELMONT, CALIFORNIA

MOC WASTES TIME, MONEY
I am a board-certified family practice physician. I do not see any reason to continue to study for MOC re-certification. It is a waste of my time and money. I do my CME participation with CME meetings, journal articles, and online programs.

Kamrudin Mithani, MD
HAVRE DE GRACE, MARYLAND
SURVEY SHOWS PATIENTS IN MANY CITIES WAIT WEEKS FOR APPOINTMENTS

How long do patients wait to see their physician?
That depends on where they live and what kind of doctor they want to see. Merritt Hawkins’ 2014 survey of physician appointment wait times breaks down wait times for five specialties in 15 metropolitan markets. The shortest wait? 1 day to see a family physician in Dallas. The longest? 256 days to see a dermatologist in Minneapolis.

For primary care physicians, the average appointment wait time was 19.5 days across the metropolitan areas. That’s less than the 20.3 days in 2009, the last time the survey was completed.

The longest average wait was in Boston, at 66 days, and the shortest was in Dallas, at five days.

Merritt Hawkins, a healthcare consulting firm, said in its report that while more patients have access to insurance now because of the Affordable Care Act (ACA), that is not the same thing as having access to a physician.

“As millions of the previously uninsured obtain healthcare coverage through the ACA, ways will need to be found to ensure access to physicians, through increases in the number of medical residency positions available nationwide, through the use of innovative staffing models that redistribute some of the work previously handled by physicians to other clinicians, through equitable payments to physicians, through the use of online and mobile technology, and through other methods,” the report reads.

The report also explores access to Medicare and Medicaid. While Medicare access was good across most markets, with 77% of physicians accepting Medicare patients, only 50.6% of physicians surveyed said they accept Medicaid. That’s down from 65% in 2009.

“Medicaid does not guarantee access to physicians in many cases,” the report says.

HHS EXPANDS LAB REPORT ACCESS

While patients can still obtain laboratory test reports from their physicians, a new rule from the U.S. Department of Health and Human Services (HHS) will give patients or their caregivers a new option to obtain their test reports directly from the laboratory while maintaining strong protections for patients’ privacy. “Information like lab results can empower patients to track their health progress, make decisions with their health care professionals, and adhere to important treatment plans,” said HHS Secretary Kathleen Sebelius.
FDA Investigates Testosterone Product Safety

The Food and Drug Administration (FDA) said it is investigating the risk of stroke, heart attack, and death in men taking FDA-approved testosterone products.

In a Jan. 31 safety announcement, the agency said: “Healthcare professionals should consider whether the benefits of FDA-approved testosterone treatment is likely to exceed the potential risks of treatment... We urge healthcare professionals and patients to report side effects involving prescription testosterone products to the FDA MedWatch program.”

The investigation was prompted by the publication of two recent studies, published online in PLOS ONE and in the Journal of the American Medical Association (JAMA), that found increased risk of heart attack and stroke in men who take testosterone products.

“These findings raise concerns about the potential safety of testosterone therapy,” wrote the authors of the JAMA study.

The agency said it “has not concluded that FDA-approved testosterone treatment increases the risk of stroke, heart attack, or death” and that patients should speak with their physicians before discontinuing any treatment programs.

SGR deal revamps reimbursements, incentive programs to focus on quality

Congress has agreed on legislation to repeal the Sustainable Growth Rate (SGR) formula used to set Medicare reimbursements for healthcare providers. Over the next five years, as new payments models are phased in, Medicare providers would be guaranteed annual .5% reimbursement increases.

Changes to the SGR formula would not only affect physician reimbursement. The proposed legislation also overhauls current incentive programs, establishing the Merit-Based Incentive Payment System. The new incentive program combines Meaningful Use, the Physician Quality Reporting System, and the Value-Based Modifier programs. A new assessment of physicians using quality, resource use, EHR Meaningful Use, and clinical practice improvement will reward value over volume, according to a press release from the U.S. House Ways and Means Committee.

Other incentives include a 5% bonus for practices that move toward alternative payment models (APMs), including Patient-Centered Medical Homes, and a requirement that practices receive 25% of their Medicare income via APMs in 2018-2019.

Also, the proposed law will establish a Physician Compare website for patients to research data on quality and care, and will allow qualified clinical data registries to purchase claim data to analyze patient safety and quality metrics.

Doctor’s groups, including the American Medical Association, the Medical Group Management Association, the American College of Physicians, and the American Academy of Family Physicians are expressing optimism that the new legislation will be a step in payment reform that pays physicians for quality instead of quantity.

The legislation must still be passed by both houses of Congress and signed by President Barack Obama before it becomes law.

Congress established the SGR in 1997 as a way to limit healthcare spending by linking Medicare payments to the overall inflation rate. But Congress has avoided declines annual fixes. Since 2003, Congress has spent $150 billion in short-term patches to avoid extreme cuts to physician pay; the most recent will expire on March 31.

The legislation, as currently worded, would repeal the SGR and begin a transition away from a volume-based reimbursement system and towards one based on value and quality outcomes.

Notable elements of the proposal include:

1. Consolidates three existing quality programs into one that rewards providers for meeting performance thresholds.
2. Implements a process for improving payment accuracy.
3. Provides incentives for improved chronic care coordination.
4. Introduces physician-developed clinical care guidelines.
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ICD-10 preparation lagging behind: MGMA survey

The nation’s medical practices are lagging badly in their preparations for converting to the International Classification of Diseases-10th Revision (ICD-10) coding system on October 1, 2014, a recent survey from the Medical Group Management Association (MGMA) finds.

When asked to rate their practice’s “overall readiness level for ICD-10 implementation,” only 9.4% of respondents said they have made “significant process,” whereas 79% said either they had not yet started implementation or were only “somewhat ready.” None said they had completed implementation.

“The critical coordination that must take place between practices and their software vendor, clearinghouse, and health plan partners is simply not happening at the pace required for a seamless implementation,” says Susan L. Turney, MD, MS, the president and chief executive officer of MGMA. “Very simply, ICD-10 is behind schedule.”

Nearly 87% of respondents said their electronic health record (EHR) system need to be upgraded or replaced to accommodate ICD-10 diagnosis codes. Of that group, slightly more than half (50.7%) said the replacement cost was, or will be, covered by their vendor.

About 55% of respondents plan to begin ICD-10 testing with their EHR system between June 1 and October 1. Slightly more (57%) say they will begin testing with their PMS in the same timeframe.

About 67% of respondents said that choosing the appropriate diagnosis code would be “much more difficult” under ICD-10. Other anticipated difficulties include “ability to include most-frequently used diagnosis codes on a superbill” (60.3%), and “ability to document the patient encounter” (42.4%).

Responses came from more than 570 physician group practices that included more than 21,400 doctors.
**Doctor’s Bag**

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**First Treatment for Peyronie’s Disease Approved by FDA**

The U.S. Food Administration (FDA) has approved the use of Xiaflex (collagenase clostridium histolyticum) to treat men with Peyronie’s disease, or a bothersome curvature of the penis. It is the first FDA-approved non-surgical treatment option for men with the condition: a collagen build-up in the penis resulting in an abnormal curvature deformity of at least 30 degrees upon erection.

Peyronie’s disease can cause bothersome symptoms during intercourse. Xiaflex was first approved by the FDA in 2010 for the treatment of Dupuytren’s contracture, a progressive hand disease that affects a person’s ability to straighten and properly use their fingers. Xiaflex works for Peyronie’s disease by breaking down the buildup of collagen. Treatment consists of a maximum of four cycles, each consisting of two Xiaflex injection procedures and one penile modeling procedure. For the treatment of Peyronie’s disease, Xiaflex is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) due to the risks of serious adverse reactions, including penile fracture and other serious penile injury. REMS requires healthcare professionals and facilities be certified to ensure Xiaflex is dispensed properly.

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**Generic Zemplar Tablets Released in United States**

Teva Pharmaceutical Industries Ltd. has launched a generic equivalent to Zemplar (paricalcitol) tablets in the United States. As the first to file, the product is eligible for 180 days of marketing exclusivity.

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**Patient Engagement Systems**

www.patientengagementsystems.com
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**Patient Engagement Systems (PES) has added a Virtual Lifestyle Management (VLM) service from DPS Health to its suite of patient engagement and clinical decision support tools for patients with diabetes and chronic kidney disease (CKD). The enhancement aims to help providers improve outcomes and lower costs associated with treating patients with chronic conditions.**

With the VLM service, PES customers will have access to lifestyle coaching and behavior change services integrated with population monitoring, analytics, and communication. Based on the National Institute of Health’s landmark Diabetes Prevention Program, DPS Health’s VLM service is an evidence-based, year-long, online weight management program that engages individuals to improve their physical activity and nutrition habits to achieve lasting weight loss.
Hospitals across the United States are merging and purchasing physician practices at a faster clip than they have in decades. While some experts believe the pace of acquisition is not sustainable, the economic forces driving hospital consolidation is also driving up the cost. For employed physicians, that could mean employment trouble. For independent groups, it could signal opportunity.

The consolidation trend has been promoted by reform efforts seeking to reduce waste and reward value instead of volume, but these monopolizing forces are contributing to a rise in cost, according to recent studies. While independent practices struggle with payer pressures and management challenges, they are delivering a greater quality/value proposition overall.

Some experts say it could be enough to tip the market.

Independent physicians have a strong move yet to play. Put simply, fighting to preserve physician autonomy may be one key to help rein in America’s enormous medical bills.

And patients, adds H. Christopher Zaenger, CHBC, chief executive officer of Z Management Group in Barrington, Illinois, and a Medical Economics editorial consultant, but it won’t be a factor until that information can become more publicly known.

“Healthcare is less affordable than ever for the average American family,” according to the Association of Independent Doctors. “Independent doctors have a critical role in our nation’s ability to sustain affordable and high quality care.”

Hospital acquisitions lead to higher prices

Through mergers and acquisitions, hospitals have grown larger and gathered more physicians under their control in the last decade or so. More than 105 hospital mergers
occurred in 2012, up from about 50 to 60 annually from 2005 through 2007, according to a January report in the *New England Journal of Medicine*.

As for physician employment, a 2012 survey by American Hospital Association showed that between 2000 and 2010, hospital employment of physicians increased by 32%. As of 2012, the majority of physicians were employees instead of owners, according to a survey conducted by the American Medical Association. Nearly 58% of family physicians and 50% of internists identified themselves as employees.

One reason hospitals are buying physician practices is a strategy by administrators to find new revenue streams by shifting more healthcare services out of hospitals and into outpatient centers, says Paul Keckley, PhD, a Nashville-based healthcare industry analyst and blogger.

But has the consolidation and acquisition reduced healthcare costs? The answer is no, experts say.

“Hospital acquisition of physician practices leads to higher prices,” adds Paul Ginsburg, PhD, president of the Center for Studying Health System Change, a non-partisan think tank that studies the healthcare industry.

In May 2013, the *Denver Post* reported on a patient who received the same cardiac stress test twice from the same cardiologist. The first test, when the physician was independent, cost about $2,100. The second test, performed a year later after the practice was purchased by a local hospital, cost more than $8,000, mostly because of an added facility fee by the hospital, the newspaper reported.

A March 2013 report by the Medicare Payment Advisory Commission, an independent Congressional panel that oversees Medicare, acknowledged that an office visit with a physician in a hospital outpatient depart-

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**Office vs. hospital payments**

Medicare fee-for-service payments for non-emergency evaluation and management (E&M) patient visits differ between office-based physicians and hospitals. In its 2013 report, MedPAC called for “site neutral” payments for E&M visits between physician offices and hospital outpatient departments.

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SOURCE: Centers for Medicare and Medicaid Services, 2011

*Hospital payments include payment to physician and payment to hospital.
Indication
BELVIQ is indicated as an adjunct to a reduced-calorie diet and increased physical activity for chronic weight management in adults with an initial body mass index (BMI) of:
• 30 kg/m² or greater (obese), or
• 27 kg/m² or greater (overweight) in the presence of at least one weight-related comorbid condition (eg, hypertension, dyslipidemia, type 2 diabetes).

Limitations of Use
• The safety and efficacy of coadministration of BELVIQ with other products intended for weight loss, including prescription drugs (eg, phentermine), over-the-counter drugs, and herbal preparations, have not been established.
• The effect of BELVIQ on cardiovascular morbidity and mortality has not been established.

Important Safety Information
Contraindication
• BELVIQ should not be taken during pregnancy or by women who are planning to become pregnant.

Warnings and Precautions
• BELVIQ is a serotonergic drug. The development of potentially life-threatening serotonin syndrome or Neuroleptic Malignant Syndrome (NMS)-like reactions have been reported during use of serotonergic drugs, including, but not limited to, selective serotonin-norepinephrine reuptake inhibitors, and selective serotonin reuptake inhibitors, tricyclic antidepressants, bupropion, triptans, dietary supplements such as St. John’s Wort and tryptophan, drugs that impair metabolism of serotonin (including monoamine oxidase inhibitors), dextromethorphan, lithium, tramadol, antipsychotics or other dopamine antagonists,
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BRIEF SUMMARY:
For prescribing information, see package insert.

INDICATIONS AND USAGE
BELVIQ is indicated as an adjunct to a reduced-calorie diet and increased physical activity for chronic weight management in adult patients with an initial body mass index (BMI) of:
- 33 kg/m² or greater (obese), or
- 27 kg/m² or greater (overweight) in the presence of at least one weight related comorbid condition (e.g., hypertension, dyslipidemia, type 2 diabetes)

Limitations of Use:
- The safety and efficacy of coadministration of BELVIQ with other products intended for weight loss including prescription drugs (e.g., phentermine), over-the-counter drugs, and diet supplements has not been evaluated.
- The effect of BELVIQ on cardiovascular morbidity and mortality has not been established.

DOSAGE AND ADMINISTRATION
The recommended dose of BELVIQ is 10 mg orally twice daily. Do not exceed recommended dose. BELVIQ can be taken with or without food. Response to therapy should be evaluated by week 12. If a patient has not lost at least 5% of baseline body weight, discontinue BELVIQ, as it is unlikely that the patient will achieve and sustain clinically meaningful weight loss with continued treatment.

CONTRAINDICATIONS
- Pregnancy

WARNINGS AND PRECAUTIONS
Serotonin Syndrome or Neuroleptic Malignant Syndrome (NMS)-like Reactions. BELVIQ is a serotoninergic drug. The development of a potentially life-threatening serotonin syndrome or Neuroleptic Malignant Syndrome (NMS)-like reactions has not been reported during use of serotoninergic drugs, including, but not limited to, selective serotonin-norepinephrine reuptake inhibitors (SSRIs), tricyclic antidepressants (TCA), monoamine oxidase inhibitors (MAOIs), and direct serotonin receptor agonists. These drugs have the potential to impair metabolism of serotonin (including monoamine oxidase inhibitors [MAOIs], direct serotonin receptor agonists) and are known to increase the risk for cardiac valvulopathy due to priapism (e.g., sickle cell anemia, multiple myeloma, or leukemia), or in men with anatomical deformations of the penis (e.g., angulation, cavernosal fibrosis, or Peyronie’s disease). There is limited experience with the combination of BELVIQ and medications indicated for the treatment of bradycardia or a history of heart block greater than first degree. Neuroleptic Malignant Syndrome (NMS)-like reactions have been observed in clinical trials with BELVIQ. BELVIQ has not been studied in combination with tricyclic antidepressants (TCA) or selective serotonin reuptake inhibitors (SSRI) or atypical neuroleptic agents. In clinical trials with other antipsychotic medications, including, but not limited to, typical antipsychotics, atypical antipsychotics, and direct serotonin receptor agonists, the risk of neuroleptic malignant syndrome may be increased.

Valvular Heart Disease. Regurgitant cardiac valvular disease, primarily affecting the mitral and/or aortic valves, has been reported in patients who took serotoninergic drugs with 5-HT2A receptors on cardiac interstitial cells. At therapeutic concentrations, BELVIQ is selective for 5-HT2A receptors as compared to 5-HT2C receptors. In clinical trials of 1 year duration, 2.4% of patients receiving BELVIQ and 2.0% of patients receiving placebo developed echocardiographic criteria for valvular regurgitation at one year (mild or greater aortic regurgitation and/or moderate or greater mitral regurgitation): none of these patients was symptomatic. BELVIQ has not been studied in patients with congestive heart failure or hemodynamically-significant valvular heart disease. Preliminary data suggest that 5-HT2C receptors may be overexpressed in congestive heart failure. Therefore, BELVIQ should be used with caution in patients with congestive heart failure.

Diabetes Mellitus. In the combined population, adverse reactions associated with 5-HT2A receptor agonists and antipsychotics, including, but not limited to, typical antipsychotics, atypical antipsychotics, antipsychotics, and direct serotonin receptor agonists, should be discontinued immediately if the above events occur and supportive symptomatic treatment provided.

Psychiatric Disorders. Events of euphoria, hallucination, and dissociation were seen with BELVIQ at supratherapeutic doses in short-term studies. In clinical trials of at least 1 year in duration, 6 patients (0.2%) treated with BELVIQ developed euphoria, as compared with 1 patient (0.1%) in placebo-treated patients. Doses of BELVIQ in these patients did not exceed 15 mg twice a day.

Some drugs that target the central nervous system have been associated with depression or suicidal ideation. Patients treated with BELVIQ should be monitored for the emergence of worsening of depression, suicidal thoughts or behavior, and/or any unusual changes in mood or behavior (e.g., agitation, depression, anxiety, agitation, irritability, or agitation). Potential Risk of Hypoglycemia in Patients with Type 2 Diabetes Mellitus on Anti-diabetic Therapy. Weight loss may increase the risk of hypoglycemia in patients with type 2 diabetes mellitus treated with and/or insulin secretagogues (e.g., sulfonylureas); hypoglycemia was observed in clinical trials with BELVIQ. BELVIQ has not been studied in combination with insulin. Measurement of blood glucose levels prior to starting BELVIQ and during BELVIQ treatment is recommended in patients with type 2 diabetes. Decreases in medication doses for anti-diabetic medications which are non-glucose-dependent should be considered to mitigate the risk of hypoglycemia. In patients who develop hypoglycemia after starting BELVIQ, these changes should be made to the anti-diabetic drug regimen.

Priapism (painful erections greater than 6 hours in duration) is a potential effect of 5-HT2A receptor agonism.

If not treated promptly, priapism can result in irreversible damage to the erectile tissue. Men who experience an erection lasting greater than 4 hours without pain or not should seek medical attention and discontinue the drug and seek emergency medical attention.

BELVIQ should be used with caution in men who have conditions that might predispose them to priapism (e.g., sickle cell anemia, multiple myeloma, or leukemia), or in men with anatomical deformations of the penis (e.g., angulation, cavernosal fibrosis, or Peyronie’s disease). There is limited experience with the combination of BELVIQ and medications indicated for the treatment of bradycardia or a history of heart block greater than first degree.

Table 1. Adverse Reactions Reported by Greater Than or Equal to 2% of BELVIQ Patients and More Commonly Than with Placebo in Patients in Clinical Trials

<table>
<thead>
<tr>
<th>Adverse Reaction</th>
<th>Number of Patients (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BELVIQ 10 mg BID N=3196</td>
<td>Placebo N=3185</td>
</tr>
<tr>
<td>Gastrointestinal Disorders</td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td>264 (8.3)</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>207 (6.5)</td>
</tr>
<tr>
<td>Constipation</td>
<td>186 (5.9)</td>
</tr>
<tr>
<td>Dry mouth</td>
<td>169 (5.3)</td>
</tr>
<tr>
<td>Vomiting</td>
<td>122 (3.8)</td>
</tr>
<tr>
<td>General Disorders And Administration Site Conditions</td>
<td></td>
</tr>
<tr>
<td>Edema</td>
<td>439 (13.7)</td>
</tr>
<tr>
<td>Infections And Infestations</td>
<td></td>
</tr>
<tr>
<td>Upper respiratory tract infection</td>
<td>439 (13.7)</td>
</tr>
<tr>
<td>Nasopharyngitis</td>
<td>414 (13.0)</td>
</tr>
<tr>
<td>Urinary tract infection</td>
<td>207 (6.5)</td>
</tr>
<tr>
<td>Musculoskeletal And Connective Tissue Disorders</td>
<td></td>
</tr>
<tr>
<td>Back pain</td>
<td>201 (6.3)</td>
</tr>
<tr>
<td>Musculoskeletal pain</td>
<td>65 (2.0)</td>
</tr>
<tr>
<td>Nervous System Disorders</td>
<td></td>
</tr>
<tr>
<td>Headache</td>
<td>537 (16.8)</td>
</tr>
<tr>
<td>Dizziness</td>
<td>270 (8.5)</td>
</tr>
<tr>
<td>Respiratory, Thoracic And Mediastinal Disorders</td>
<td></td>
</tr>
<tr>
<td>Cough</td>
<td>138 (4.3)</td>
</tr>
<tr>
<td>Gastrointestinal pain</td>
<td>111 (3.5)</td>
</tr>
<tr>
<td>Sinus congestion</td>
<td>92 (2.9)</td>
</tr>
<tr>
<td>Skin And Subcutaneous Tissue Disorders</td>
<td></td>
</tr>
<tr>
<td>Rash</td>
<td>67 (2.1)</td>
</tr>
</tbody>
</table>

Table 2. Adverse Reactions Reported by Greater Than or Equal to 2% of BELVIQ Patients and More Commonly Than with Placebo in Patients in Clinical Trials

<table>
<thead>
<tr>
<th>Adverse Reaction</th>
<th>Number of Patients (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BELVIQ 10 mg BID N=325</td>
<td>Placebo N=252</td>
</tr>
<tr>
<td>Gastrointestinal Disorders</td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td>24 (9.4)</td>
</tr>
<tr>
<td>Toothache</td>
<td>7 (2.7)</td>
</tr>
</tbody>
</table>

(Table continues)
patients who developed echocardiographic criteria of mild or greater aortic insufficiency and/or the possible occurrence of regurgitant cardiac valve disease was prospectively evaluated in 28 of patients with congestive heart failure or hemodynamically-significant valvular heart disease. The relative risk for valvulopathy with BELVIQ is summarized in Table 3. BELVIQ was not studied in patients with severe valvular heart disease or in patients with severe renal impairment or end stage renal disease. Treatment of overdose. In clinical studies that used doses that were more than 100 mg daily, the rates of adverse responses at supratherapeutic doses suggests that lorcaserin may produce psychomotor dependence.”

Other Adverse Reactions
- Serotonin-associated Adverse Reactions, SSRIs, SNRIs, bupropion, tricyclic antidepressants, and SNRIs: Allergic reactions, rash, urticaria, angioedema, and Stevens-Johnson syndrome occurred in 1% or less of patients treated with BELVIQ and placebo. In one patient, 0.1% of BELVIQ-treated patients and 4.8%, 0.8%, and 0.0% of placebo-treated patients, respectively, had anorexia nervosa, depression, and tremor, respectively.
- Metabolism And Nutrition Disorders
  - Hyperlipidemia: 75 (20.8) 94 (24.0)
  - Worsening of diabetes mellitus: 7 (2.7) 8 (2.2)
  - Decreased appetite: 6 (2.1) 3 (0.8)
- Musculoskeletal And Connective Tissue Disorders
  - Back pain: 30 (11.7) 20 (5.9)
  - Muscle spasm: 12 (4.7) 9 (3.6)
- Nervous System Disorders
  - Anxiety: 37 (14.9) 23 (6.3)
  - Insomnia: 18 (7.0) 12 (3.2)
  - Somnolence: 15 (5.8) 10 (2.6)
- Psychiatric Disorders
  - Psychiatric disorders leading to hospitalization or drug withdrawal occurred in 4.3% of patients treated with BELVIQ and placebo (1.2% vs. 0.4%, respectively), followed by tremor (2.3% vs. 0.2%, respectively), confusional state (0.2% vs. 0.1%, respectively), disorientation (0.1% vs. 0.1%, respectively), and gastrointestinal disorders (0.1% vs. 0.1%, respectively). In non-diabetic patients without diabetes and 1% and 0.9%, respectively, with symptoms occurred in 2.2% and 1.1%, respectively, for patients treated with BELVIQ and placebo, respectively.

Drug Interactions
- Use BELVIQ with caution in patients taking drugs that are CYP 2D6 substrates, as BELVIQ can increase exposure of these drugs. BELVIQ is listed in Schedule IV of the Controlled Substances Act. Use BELVIQ in patients with severe renal impairment or end stage renal disease. Treatment of overdose. In clinical studies that used doses that were more than 100 mg daily, the rates of adverse responses at supratherapeutic doses suggests that lorcaserin may produce psychomotor dependence.”

Pregnancy
- Teratogenic Effects: Use BELVIQ in patients with severe renal impairment or end stage renal disease. Treatment of overdose. In clinical studies that used doses that were more than 100 mg daily, the rates of adverse responses at supratherapeutic doses suggests that lorcaserin may produce psychomotor dependence.”

PREGNANCY
- Pregnancy Category X: There are no data from well-conducted animal or human studies that evaluate the effects of lorcaserin on fetal development. Use BELVIQ in pregnant women, including those who are already overweight or obese, due to the potential benefit to a pregnant woman and may result in fetal harm. Maternal exposure to lorcaserin during pregnancy may impact fetal outcome. Use BELVIQ in patients with severe renal impairment or end stage renal disease. Treatment of overdose. In clinical studies that used doses that were more than 100 mg daily, the rates of adverse responses at supratherapeutic doses suggests that lorcaserin may produce psychomotor dependence.”

Pediatric Use
- There are no data from well-conducted animal or human studies that evaluate the effects of lorcaserin on fetal development. Use BELVIQ in patients with severe renal impairment or end stage renal disease. Treatment of overdose. In clinical studies that used doses that were more than 100 mg daily, the rates of adverse responses at supratherapeutic doses suggests that lorcaserin may produce psychomotor dependence.”

Table 3. Incidence of FDA-Defined Valvulopathy at Week 52 by Treatment Group

<table>
<thead>
<tr>
<th>FDA-defined Valvulopathy, n (%)</th>
<th>Study 1</th>
<th>Study 2</th>
<th>Study 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relative Risk (95% CI)</td>
<td>1.13</td>
<td>1.02</td>
<td>1.16</td>
</tr>
<tr>
<td>Pooled RR (95% CI)</td>
<td>1.16</td>
<td>0.81</td>
<td>1.07</td>
</tr>
</tbody>
</table>

- *Patients without valvulopathy at baseline who received study medication and had a post-baseline echocardiogram; ITT-intention-to-treat; LOCF-last-observation-carried forward.

Drug Interactions
- Use BELVIQ with caution in patients taking drugs that are CYP 2D6 substrates, as BELVIQ can increase exposure of these drugs.

**USE IN SPECIFIC POPULATIONS**

PREGNANCY
- Pregnancy Category X
  - Risk Summary: BELVIQ is contraindicated during pregnancy, because weight loss offers no apparent benefit to a pregnant woman and may result in fetal harm. Maternal exposure to lorcaserin in late pregnancy in rats resulted in lower body weight in offspring which persisted to adulthood. If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential risk to the fetus. See Clinical Considerations. A minimum weight gain, and no weight loss, is recommended for pregnant women, including those who are already overweight or obese, due to the obligatory weight gain that occurs in maternal tissues during pregnancy.

- Animal Data: Reproduction studies were performed in pregnant rats and rabbits that were BELVIQ treated during the period of organogenesis. In the rat, embryotoxicity occurred at oral doses of up to 44 and 19 times human exposure in rats and rabbits, respectively, did not reveal evidence of teratogenicity or embryotoxicity with lorcaserin hydrochloride.

- In a pre- and postnatal development study, maternal rats were dosed from gestation through postnatal day 21 at 5, 15, and 50mg/kg belviq; pups were indirectly exposed in utero through milk and via placental transfer. The highest dose of belviq times human exposure resulted in maternal weight loss and lower pup viability. All doses lowered pup body weight similarly at birth which persisted to adulthood; however, no developmental abnormalities were observed and reproductive performance was not affected at any dose.

- Nursing Mothers: It is not known whether BELVIQ is excreted in human milk. Because many drugs are excreted in human milk, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

A PHYSICIAN IN A HOSPITAL OUTPATIENT DEPARTMENT IS REIMBURSED AT A RATE 80% HIGHER THAN THE SAME PROCEDURE PERFORMED IN A PHYSICIAN’S OFFICE.

MEDICARE PAYMENT ADVISORY COMMISSION, MARCH 2013

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The stunning result: On only two services—evaluation and management visits and echocardiograms—Medicare paid hospitals $1.3 billion more in 2010 than they would have paid if the services had been performed in a physician’s office rather than an outpatient department, MedPAC reports. In 2011, that number rose to $1.5 billion.

ECONOMIES OF SCALE?
Advocates of healthcare consolidation argue that economies of scale will, in time, reduce waste in the system and ultimately push prices down. Hospital consolidation can promote competition to the extent that it can reduce costs through less duplication of equipment and better internal oversight, says Matthew Cantor, a partner with the law firm Constantine Cannon in New York.

Not far from the Long Island office of Michael J. Wiley, CHBC, AVA, of Healthcare Management and Consulting Services Inc., and a Medical Economics editorial consultant are two 400-bed hospitals just four miles apart. Both have cardiology and orthopedics units, which are particularly important for filling beds. Were the hospitals to merge, Wiley says, it would be easy to remove those duplicate services, and the “center of excellence” concept could facilitate that process.

Besides, Wiley notes, insurers find it more expensive to manage multiple providers and hospitals, so there’s a potential benefit for them when health systems consolidate.

But despite these promises, economies
of scale from hospital mergers and practice acquisitions are difficult to find, says David Dranove, PhD, professor of health industry management at Northwestern University’s Kellogg School of Management in Evanston, Illinois. Dranove, who points to a June 2012 report by the Robert Wood Johnson Foundation.

The foundation’s Synthesis Project released a report summarizing three dozen published studies on the effects of hospital mergers and hospital acquisition of physician practices on prices, costs, and quality of care. The report, written by Martin Gaynor, PhD, of Carnegie Mellon University, and Robert Town, PhD, of The Wharton School at the University of Pennsylvania, presents some key findings:

- Hospital consolidation generally results in higher prices across geographic markets.
- When hospitals merge in already concentrated markets, the price increase can be dramatic, often exceeding 20 percent.
- Physician-hospital consolidation has not led to either improved quality or reduced costs.

Such consolidation was found to have been undertaken “primarily for the purpose of enhanced bargaining power with payers” and therefore did not lead to true integration nor to enhanced performance.

One possible reason for the lackluster results is lack of clinical integration following mergers or acquisition of practices.

“Most hospitals that have hired all these doctors have done nothing with them but cut them a W-2,” says Alice G. Gosfield, JD, of Alice G. Gosfield and Associates, Philadelphia, a healthcare attorney and Medical Economics editorial consultant.

Hospitals sometimes passively hire physicians who admit lots of patients, high-priced specialists and “random physicians to garner their referrals,” Gosfield says, but this works against creating a culture that can sustain a high-value, high-quality health system. Some hospitals have been able to boost collaboration with doctors, but others tend to think that they own doctors, agrees William J. De-

### Consolidation trend leads to rise in facility fees

One of the effects of the healthcare industry’s consolidation has been the rise of the facility fee. When hospitals acquire independent medical practices, they will now often reclassify the practice as an outpatient facility. Doing so allows them, under Medicare rules, to add a separate facility charge to a patient’s bill, sometimes increasing the cost for relatively simple medical procedures by hundreds of dollars.

While the practice has helped hospitals’ bottom lines, it has generated protests from patients and their insurance companies, who say that the practice is driving up healthcare spending. “Facility fees are a way to allow hospitals to earn more for a simple office visit,” is how a spokesman for the Medical Group Management Association put it to Medical Economics in 2013.

Hospitals say the fees are necessary to cover the costs of the services provided (or available) to patients after the medical practice becomes part of a hospital system.

National data on the extent of facility fees does not exist, but the Medicare Payment Advisory Commission (MedPAC) estimated in 2012 that facility fees for office visits would add $2 billion annually to Medicare spending by 2020. MedPAC also found that the percentage of doctor visits classified as “outpatient”—meaning it took place in a hospital-owned facility—grew from 5% in 2004 to about 7.5% in 2010.

Although comprehensive data on the size of facility fees is also not available, plenty of anecdotal evidence exists. For example:

- The same report includes an anecdote of a woman in Iowa City, Iowa, who had nasal polyps removed at an ambulatory surgery center, a 45-minute procedure. The center billed her for almost $26,000 in facility fees, for which her portion was $1,086. The center said its rates were in accordance with national standards, the Center says.

The spread of facility fees represents both a threat and opportunity for independent practices, say management consultants. The threat is the appeal of “one-stop shopping” offered by practices that become part of a hospital system—even if it is accompanied by a facility fee. On the other hand, if you can show patients that your practice provides high-quality care at a lower price than does a hospital-affiliated practice, it could prove to be a competitive advantage in the local marketplace.
Monopolizing medicine

DOCTORS REALLY DON’T WANT TO SELL THEIR PRACTICES. THEY DO IT KICKING AND SCREAMING.”

— H. CHRISTOPHER ZAENGER, CHBC, CHIEF EXECUTIVE OFFICER, Z MANAGEMENT GROUP, BARRINGTON, ILLINOIS

Marco, MA, CMC, president and chief executive officer of Pendulum HealthCare Development Corp. in Rockford, Illinois.

FALLOUT FOR PHYSICIANS

The big question is why hospitals are working so hard to expand, both horizontally through mergers and vertically through acquisitions of practices, and what the fallout will be for physicians.

Hospitals are facing growing financial uncertainty due to the tension between quantity and quality, between a known reimbursement scheme based on volume and a newer one based on value.

“We’re at a point of infection,” says Caroline Steinberg, vice president/trends analysis at the American Hospital Association.

“Hospitals feel like they have one foot on the boat and one foot on the dock” as the health-care sector transitions from a primarily fee-for-service model to a new world of accountable care organizations and bundled payments.

A “crossfire” between a system based on volume and another based on value is how Keckley describes it. “Hospitals have to live in both worlds simultaneously.”

Hospitals are facing lower reimbursements from Medicare and other payers and—in an environment where performance is measured and quality increasingly drives reimbursements—they can expect to see fewer admissions than they currently do, says Gosfield.

“The problem of managing dollars and quality of care ... has been the main struggle in healthcare for decades,” says Michael D. Brown, CHBC, president of Health Care Economics in Indianapolis, Indiana and a Medical Economics editorial consultant. “We all want quality, but finding a way to pay for it is the problem.”

“One of the big uncertainties” for hospitals now, says Ginsburg, is which trend will dominate: lower admission rates or an ACA-expanded patient pool, with a high proportion of older patients. For hospitals, he says: “The future is what’s done in offices, or in the home, or in retail,” not on an inpatient basis.

THE EMPLOYMENT LURE

This is the third cycle of hospitals buying up physician practices in recent decades, says Zaenger, who has observed the healthcare industry for about 30 years. He says this buying trend is different.

“We have legislation that gives legs to the model,” Zaenger says, because the Affordable Care Act sets a framework for community-level integration among hospitals, ambulatory facilities, and physicians.

Zaenger says the primary reason physicians sell their practices and join a hospital system as an employee is that they think they’re eliminating administrative chores and stress. They also hope to make as much money with less work, or more money for the same amount of work—which often turns out to be an illusion.

A boom in practice acquisitions in the early 1990s managed-care era was driven by hospitals’ desire to have primary-care physicians as referral sources, says Ginsburg. The current question, he adds, is: “How much better are they at it now? Can those practices be profitable for a hospital?”

The offer of working for a hospital can certainly be compelling for physicians, says Wiley. “There’s a wave toward being employed by hospitals,” he says, and it appears strongest among primary care physicians (PCPs).

Take an independent PCP earning $150,000 annually, under more stress every year, and facing the need to spend $25,000 on an electronic health record (EHR) system. Wiley suggests...
A new class action settlement with Baxter will provide payments to distributors and healthcare providers who purchased IG or albumin directly from Baxter or CSL.

A $64 million settlement has been reached with Baxter International Inc. and Baxter Healthcare Corporation (collectively, “Baxter”) in a lawsuit about whether manufacturers of IG and albumin unlawfully agreed to restrict output and to fix, raise, maintain, or stabilize prices. Baxter denies all of these claims and says that it did nothing wrong.

IG (or “immunoglobulin”) and albumin are plasma-derivative protein therapies used by hospitals and other healthcare providers in the treatment of certain illnesses.

TWO SEPARATE SETTLEMENTS.

This Baxter settlement is separate from a prior settlement with CSL Limited, CSL Behring LLC, and CSL Plasma Inc. (collectively, “CSL”) along with a trade association called Plasma Protein Therapeutics Association (“PPTA”). Even if you previously participated in the settlement with CSL and PPTA, you have separate legal rights and options in this new settlement with Baxter.

WHO IS INCLUDED?

The Court decided that the Settlement Class includes all distributors, hospitals and other healthcare providers in the United States, who purchased IG and/or albumin directly from Baxter or CSL, at any time from January 1, 2005 through December 31, 2009.

WHAT DOES THE SETTLEMENT PROVIDE?

Each Settlement Class Member who submits a valid Claim Form will receive a payment based on the total dollar amount of its purchases of IG and/or albumin in the United States, including its territories, directly from Baxter and CSL between January 1, 2005 and December 31, 2009.

HOW DO YOU ASK FOR A PAYMENT?

To receive a payment you must submit a Claim Form by April 7, 2014. Claim Forms have been mailed to Settlement Class Members who are known to Baxter and CSL. The Claim Form is also available at the website or by calling 1-866-287-0504.

Even if you submitted a claim in the settlement with CSL and PPTA, you will not receive a payment from the Baxter settlement unless you submit a Baxter claim. If you want to receive payments from both settlements, two separate claims must be submitted.

YOUR OTHER OPTIONS.

If you do not want to be legally bound by the settlement, you must exclude yourself from the Settlement Class by March 3, 2014, or you will not be able to sue, or continue to sue, Baxter about the legal claims this settlement resolves, ever again. If you exclude yourself, you cannot get a payment from the settlement. Also, if you previously requested exclusion from the settlement with CSL and PPTA, you must submit a separate exclusion request to be excluded from the Baxter settlement. If you stay in the settlement, you may object to it by March 31, 2014. A Detailed Notice available at the website or by calling 1-866-287-0504 explains how to exclude yourself or object and has more information about the settlement.

The United States District Court for the Northern District of Illinois will hold a hearing in the case, known as In re: Plasma-Derivative Protein Therapies Antitrust Litigation, Case No. 09-CV-7666, on April 16, 2014, to consider whether to approve the settlement, and a request by Plaintiffs’ Counsel for attorney fees of $21.33 million and payments of $50,000 to the Class Representatives. You or your own lawyer, if you have one, may ask to appear and speak at the hearing at your own cost, but you do not have to.
that if a hospital were to offer that physician $175,000 annually, and “All you have to do is be a doctor,” that could be a difficult proposition to turn down.

And hospitals are casting a wider net this time, Ginsburg says, targeting specialists as well as PCPs.

Research by the Deloitte Center for Health Solutions, where Keckley was executive director from 2006 until 2013, found that 60% of primary care practices are now exclusively aligned with a single hospital, though not necessarily employed by it, Keckley says.

But as hospitals absorb ever more physicians and practices, experts suggest that the choice for the remaining private practices may not be so cut and dried between independence and employment.

Many physicians are weighing the growing burdens of private practice against the ability to focus on patient care and clinical efforts as an employee. Many doctors are selling because they feel they have no better choice.

“Doctors really don’t want to sell their practices,” says Zaenger. “They do it kicking and screaming.”

DEGREES OF INDEPENDENCE

Practice management consultants say a vast and potentially rewarding middle ground exists between slugging it out as an independent and giving it all up for a hospital’s paycheck.

The first strategy for preserving independence, says Gosfield, is to clinically integrate with other physicians. Clinical integration, she says, is a process of physicians working together systematically to improve their collective ability to deliver high-quality, safe patient care.

The crucial element in integration is standardization, Gosfield adds. This includes not only the expectation that all participants will use and adhere to clinical practice guidelines and protocols, but also that standards for referrals (based on clinical performance of those providers) and standardized documentation.

Physicians like independence but also want access to greater resources that only affiliation with a hospital can typically bring, says Pendulum Healthcare’s DeMarco. While hospitals might sometimes seem to be saying to doctors, “Work for us—or else,” he says, the doctor’s question for the hospital should be “What can I do to connect with you?”

And the ways to connect are plentiful. In addition to simply forming larger group practices, one option that has seen renewed interest is the independent practice association (IPA), Ginsburg says.

IPAs, which are particularly active in areas with substantial health maintenance organization (HMO) enrollment such as California and Massachusetts, contract with HMOs for professional services and can accept some risk, such as through capitated payments.

“There are more opportunities for risk-based contracting in general,” and IPAs can play into those, Ginsburg says.

IPAs, which are particularly active in areas with substantial health maintenance organization (HMO) enrollment such as California and Massachusetts, contract with HMOs for professional services and can accept some risk, such as through capitated payments.

“With more opportunities for risk-based contracting in general,” and IPAs can play into those, Ginsburg says.

Although the individual practices remain separately owned, the IPA supports them with health information technology and EHR, and can handle functions such as utilization management. Ginsburg also notes that doctors don’t have to be exclusive to an IPA.

“Small independent practices have been small independent practices have been subjected to a lot of pressures,” from the financial side and from meaningful use. An IPA could make it possible for a small practice to thrive.

PAUL GINSBURG, PHD, PRESIDENT OF THE CENTER FOR STUDYING HEALTH SYSTEM CHANGE
subjected to a lot of pressures” from the financial side and from meaningful use, Ginsburg says, so an IPA could make it possible for a small practice to thrive.

Ginsburg does sound one note of caution: “There are more paths to remain independent these days, but only if there are enough partners left to do these things with,” he says. “If too many independent practices are bought up,” it limits the opportunities to form IPAs.

There are other approaches, which Gосfіeld calls “alignment strategies,” that fall short of hospital employment. These include co-management, a contract under which a hospital leases nurse practitioners to a practice (the doctor bills retail, but pays wholesale), or leasing an entire practice to a hospital through a professional services agreement.

“Grouping is becoming a model,” Zaenger says, but adds, “The downside to grouping for physicians is the loss of control.” Physicians, especially those in the 45 to 55 age range tend to be independent, he says, but they still want leverage with insurers.

Still, the benefits are there. Zaenger knows of a gastroenterology group in the Chicago area that has grown from seven doctors to more than 35 over a period of about four years and is now the largest such group in suburban Chicago. The group’s “strategic business unit” model lets each individual practice maintain some independence and divide revenue internally however they wish.

These days, some type of collaboration or alignment is needed, but the form can be flexible, such as through an accountable care organization, says DeMarco. An affiliation agreement between a practice and a hospital, short of selling the practice, might involve services often otherwise provided by a management service organization, such as help with billing, EHRs, office staff and coding, and continuing medical education, he says.

In addition to the physicians it employs outright, says DeMarco, the Cleveland Clinic offers an affiliate program and an associate program, and the Mayo Clinic provides similar options. An ob/gyn group in Cedar Rapids, Iowa, affiliated with Mayo and was so successful that it eventually drove the only other local ob/gyn practice out of business, he says.

Just remember that the ultimate goal of any affiliation won’t necessarily be to achieve an ideal compromise, but simply to find a solution that can work over the long term.

**SHIFTING EMPLOYMENT ENVIRONMENT**

If, as Dranove predicts, practices will continue to increase in size. It could be driven by the attitudes of younger physicians. They don’t mind being employees, says Ginsburg.

Physicians who are in training now expect to work within healthcare systems, Keckley agrees, while Baby Boomer physicians have a stronger entrepreneurial, go-it-alone streak. “Boomer doctors don’t make good employees,” he says.

The physicians who are most willing to sell their practices, says Zaenger, are predominantly “the green and the gray docs,” that is, those freshly out of school and those nearing retirement.

Still, several factors point toward a more challenging job setting in the future. Cantor says greater hospital control might lead to reduced employment opportunities for certain physicians. Steinberg foresees layoffs and reductions in services, citing a hospital that closed its obstetric unit and one in New Hampshire that recently closed its skilled nursing facility.

Hospitals are going to have to do more with less, Wiley predicts, adding that it’s more cost-effective to get a given amount of work done with two $500,000-a-year doctors than three $400,000 doctors, especially once you consider the savings in benefit packages and malpractice insurance.

Another piece of the new environment, Wiley says, is productivity measures using Relative Value Units, versus the previous model of a flat salary with no corresponding productivity requirements.

“If you came from a private practice, you know the need to be productive,” but productivity requirements, which have long been used by hospitals, can still be a shock for physicians who aren’t used to them. “To be profitable, hospitals have to change that mind set,” Wiley says.

One bright spot is that although hospitals traditionally relied on specialists, reform efforts require strength in primary care, says Keckley. “As you transition from volume to value, primary care physicians become more important.”

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**THE FIRST STRATEGY FOR PRESERVING INDEPENDENCE IS TO CLINICALLY INTEGRATE WITH OTHER PHYSICIANS.**

—ALICE GOSFIED, JD, OF ALICE G. GOSFIED AND ASSOCIATES
Obesity’s growing threat

While the adult obesity rate went up again in 2013, associated health problems could explode in the next 10 years unless patients and physicians take action

by LISA ZAMOSKY Contributing author

Few health problems pose a greater threat to patients than obesity and its related ailments. Primary care and family physicians are on the front lines of the battle against obesity. That’s why, experts say, it’s critical for doctors to find ways of instituting health and behavioral modification programs into their practices to help patients make meaningful lifestyle changes.

In 2010, more than 78 million U.S. adults and roughly 12.5 million children and adolescents were obese, according to the Centers for Disease Control and Prevention. And the rate is rising.

According to a recent analysis by Gallup Healthways, the adult obesity rate in 2013 was 27.2%, up from 26.2% in 2012, and it is on pace to surpass all annual average obesity rates since Gallup-Healthways began tracking it in 2008.

As our waistlines expand, so too do the number of medical problems caused by excess body weight. A 2012 report by the Robert Wood Johnson Foundation, “F as in Fat, How Obesity Threatens America’s Future,” found that if obesity rates continue on their current trajectories, the number of new cases of type 2 diabetes, coronary heart disease and stroke, hypertension, and arthritis could increase 10-fold between 2010 and 2020—and double again by 2030. All this comes with a current annual price tag of $190 billion.

“As evidence unfolds, everyone is beginning to appreciate that obesity and excess body weight are driving medical conditions and costs. You cannot get medical costs under control as long as we have these rising rates of obesity,” says Donna Ryan, MD, professor emeritus at Pennington Biomedical Research Center at Louisiana State University Health System, and previous past president of The Obesity Society.

New obesity guidelines

New obesity treatment guidelines will give doctors a helping hand.

The American Heart Association, American College of Cardiology and Obesity Society recently developed a set of guidelines to help healthcare providers tailor weight loss treatments to adult patients affected by overweight or obesity.

The guidelines are the result of a systematic review of the latest scientific evidence from 133 research studies on the risks of obesity and the benefits of weight loss.
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The goal of the guidelines was to provide recommendations as to who needs to lose weight and give physicians the weight loss techniques that have been proven to work to help patients lose weight, Ryan says.

The guidelines recommend screening for body mass index at each annual visit, or more often if appropriate, and using the screening results to engage patients in a discussion about their weight and its impact on their overall health.

Many doctors find that having the conversation with patients about their need to drop pounds can be difficult. But with the right approach most people are willing to listen, says Adam Tsai, MD, MSCE, a practicing physician with Kaiser Permanente Colorado and chair of The Obesity Society’s public affairs committee.

“One thing doctors can do is mention the topic in a way that doesn’t offend the patient. That’s a really important thing. Some patients don’t want to talk about it but most are interested in advice from their physician,” Tsai says.

Ryan agrees that talking with patients about their weight can be touchy. “The conversation is still not an easy one. If patients aren’t ready to hear what you have to say they’re going to turn you off.”

She suggests a three-step approach:

- **Ask:** Can I talk to you about your weight and what you do you think about losing weight?
- **Advise:** Let patients know they don’t need to lose 100 pounds to feel better. Even a modest drop in body weight will help.
- **Refer:** Have a list of commercial or hospital-based programs you can send patients to.

One of the most effective messages physicians can convey, obesity experts say, is the second item on Ryan’s list—that they don’t need to lose a significant amount of weight to make a substantial difference in their health. In fact, a sustained loss of just 3% to 5% of one’s body weight can “produce clinically meaningful health benefits,” reducing the risk of type 2 diabetes and limiting the need for medications to control high blood pressure and diabetes, the guidelines state.

**MAKING LIFESTYLE CHANGES**

The new obesity guidelines also recommend that doctors work with patients to develop a weight loss plan. According to Tsai, a good weight loss program has three components:

- Specific recommendations for limiting calorie intake
- A plan to increase physical activity
- A behavior modification plan that helps patients change their behavior around eating and exercise.

His recommendations are in line with the new obesity guidelines, and with a study just published in the journal *Obesity*. It found that diet and exercise alone enabled half of participants with type 2 diabetes to maintain a 5% loss of body weight over an eight-year period through intensive lifestyle intervention for weight management that included diet and exercise. Called the Look AHEAD trial, it is the largest and longest randomized controlled trial of behavioral intervention for weight loss.

There’s no shortage of diets to choose from, yet no one diet program is better than another when it comes to losing weight, Ryan says. “We looked at 17 different diets and in terms of weight loss, didn’t see superiority among any of them,” she says.

**FINDING THE RIGHT DIET**

Ultimately, a successful diet has to be consistent with the patient’s preferences. There is no magic formula, experts say. “We usually say the best diet is the diet you can stick to,” Tsai says.

Still, for people looking both to lose weight and manage particular health conditions, some diets may be better than others.

In fact, *U.S. News & World Report* recently named the DASH diet as the best overall diet, and the top choice for people with high blood pressure, an assessment both Tsai and Ryan agree with.

For heart health, the Ornish diet took the top spot. The Mediterranean diet was named the best plant-based diet. And Weight Watchers was named the best commercial diet plan.

“Of all the organized pay-for programs out there I think Weight Watchers has been the most effective for my patients,” says Rebecca Jaffe, MD, MPH, FAAFP, a director of the American Academy of Family Physicians.

Medications can also play a role in helping patients lose weight. “When we put peo-
ple on meds they may need it long-term to avoid weight gain," Tsai says.

The U.S. Food and Drug Administration has approved two drugs for long-term treatment of overweight and obesity. They are phentermine and topiramate extended-release (brand name Qsymia), and lorcaserin HCl, marketed under the brand name Belviq.

Some insurers have not covered these medications in the past, but recently Aetna, CVS Caremark, and a few other payers have placed included one or both among their formularies. Eisai, one of the manufacturers of Belviq, reports that 50% of insured commercial lives can now have access to its drug.

Making lasting change, as the Look AHEAD trial demonstrated, depends on patients engaging in a comprehensive lifestyle program that helps them both drop weight and maintain that weight loss.

The guidelines recommend in-person meetings—two to three per month for at least six months—as the most effective method of helping patients achieve their weight-loss goals.

“That can be done by going to Weight Watchers. You don’t have to be in a dietician-based program, though research shows dietician programs are more successful,” Tsai says.

In fact, the new obesity guidelines recommend patients work with trained healthcare professionals, such as a registered dietician, behavioral psychologist or other trained weight loss counselor.

**SHIFTING PRACTICE AND PAYMENT TO BETTER MANAGE OBESITY**

Effective treatment of obese patients means addressing a wide array of clinical, cultural, and psychological issues as well as lifestyle modifications such as diet and exercise.

Adding to the challenges associated with treating obesity is the environment in which most independent physicians practice today. A 15-minute office visit hardly leaves enough time for the range of medical issues with which patients present, and few physicians have the training to address the full spectrum of patient needs.

Although it has no obesity-specific pro-
gram, the National Commission on Quality Assurance (NCQA) offers guidelines for physicians practicing in the Patient-Centered Medical Home model that support the care the obesity guidelines indicate are required for patients who are overweight or obese.

NCQA’s PCMH standards include six areas of evaluation on the extent to which practices:

- enhance access and continuity by accommodating patients’ needs during and after hours, provide medical home information, and offer team-based care;
- identify and manage patient populations by collecting and using data for population management;
- plan and manage care with the use of evidence-based guidelines for preventive, acute, and chronic care management;
- provide self-care support and community resources by giving patients and families information, tools, and resources;
- track and coordinate care, such as tests, referrals, and care transitions; and
- use data to measure and improve performance for continuous improvement.

“The program is structured to focus on a few conditions so that the practice can give us concrete examples of how they manage care for patients. The majority of practices report obesity and a large number of pediatric obesity cases,” says Mina Hawkins, assistant vice president of NCQA’s physician recognition programs.

These standards help guide physicians in developing or enhancing a medical practice infrastructure that can help patients with chronic disease, including those who are obese. In many respects, they also complement the new obesity treatment guidelines.

For example, prioritizing the identification of patient populations, including those in need of weight counseling, is a goal of both the obesity guidelines and NCQA’s PCMH standards, and one that can be achieved in part with the effective use of electronic health records.

“We expect practices to show they are us-

THE COST OF OBESITY

According to the Centers for Disease Control and Prevention, the medical costs for people who are obese are at least $1,400 higher than those of people of normal weight. Today we spend about $190 billion each year in the United States on obesity and its related health problems.

Increased body weight contributes to a variety of chronic—and costly—diseases. Here are some of the more common health problems associated with being overweight and obese, and their annual costs to the U.S. healthcare system:

**Arthritis**

Arthritis and related conditions cost the U.S. economy nearly $128 billion per year in medical and indirect expenses, including lost wages and productivity.

**Cardiovascular diseases**

The total cost of cardiovascular diseases in the United States in 2010 was an estimated $444 billion. Treatment of these diseases accounts for about $1 of every $6 spent on health care in this country.

**Cancer**

The national cost for all types of cancer in 2010 was $124.57 billion.

**Diabetes**

The American Diabetes Association published new research in March 2013 estimating that the total cost of diagnosed diabetes was $245 billion in 2012, up 41% from the previous five years.
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† Based on minimum label dosing for 24 hours if pain persists.
‡ Reflects latest OTC label dosing for Extra Strength Tylenol for adults and children 12 years and older—maximum daily dose reduced from 8 pills (4 grams) to 6 pills (3 grams) with a dosing interval change from every 4-6 hours to every 6 hours unless directed by a doctor.

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ing the data they are collecting on patients,” Hawkins says.

Providing tools for lifestyle modification is also something NCQA evaluates in its reviews. Hawkins says the organization looks to see that doctors are providing patients with the tools they need, for example, to log how frequently they exercise and their daily calorie intake. Are physicians providing referrals to community resources and counseling to help them adopt healthy behaviors? All of this should be on-going and well documented in patients’ medical records.

With new guidelines in place to create more of a road map based on solid scientific evidence, the hope is that doctors will be better able to provide their patients with the help they need to make lasting change in their weight and their health.

Ryan says it’s ultimately about adjusting how we think about obesity. “The thing to understand is obesity is a lot like hypertension, it’s a chronic condition and patients will need ongoing help.”

### Prescription drug options

**Orlistat (Xenical):** Blocks fat to prevent its absorption. Sold over-the-counter as Alli.

**Lorcaserin (Belviq):** Affects serotonin receptors in the brain to help patient eat less and feel full after eating smaller amounts.

**Phentermin-topiramate (Qsymia):** A mix of two drugs to suppress appetite and cause patient to feel full and make foods less appealing.

**Other appetite suppressors (various brands):** A variety of drugs, including benzphetamine and diethylpropion, can suppress hunger and create a feeling of fullness.

**SOURCE:** National Institutes of Health

### 5 DIETS TO RECOMMEND TO YOUR PATIENTS

1. **DASH diet:**
The Dietary Approaches to Stop Hypertension diet, was created to fight high blood pressure. But experts recommend it because DASH is nutritionally complete, can prevent or control diabetes, and encourages heart health. The DASH diet emphasizes portion size, food variety, and nutrients.


2. **Mayo Clinic diet:**
This diet stresses lifestyle changes to help patients reach and maintain a healthy diet for life. It uses the Mayo Clinic Healthy Weight Pyramid as a guide to smart eating and daily exercise. The diet is broken into two parts, a two-week “Lose it!” phase devoted to jump starting weight loss and a “Live it!” phase based on steady weight loss and healthy living.

   Learn more at: [www.mayoclinic.org/mayo-clinic-diet/art-20045460](http://www.mayoclinic.org/mayo-clinic-diet/art-20045460)

3. **Mediterranean diet:**
This diet emphasizes fruits and vegetables, healthy oils, and fish. It limits intake of red meat and butter. Research shows the Mediterranean diet can reduce heart disease risk.

   Learn more at: [www.mayoclinic.org/mediterranean-diet/art-20047801](http://www.mayoclinic.org/mediterranean-diet/art-20047801)

4. **Weight Watchers:**
A well-known, subscription based diet plan, weight watchers uses a point system to tell participants what and how much they can eat each day. The plan emphasizes consumption of fruits and vegetables.

   Learn more at: [www.weightwatchers.com](http://www.weightwatchers.com)

5. **TLC diet:**
The Therapeutic Lifestyle Changes diet was created by the National Institutes of Health, and was designed to promote cardiovascular health. It limits calories to promote healthy weight and reduce cholesterol levels, and limits consumption of saturated fat, cholesterol, and sodium.

   Learn more at: [www.nhlbi.nih.gov/cgi-bin/chd/step2intro.cgi](http://www.nhlbi.nih.gov/cgi-bin/chd/step2intro.cgi)
Surviving the ‘go live’ stage

Flipping the switch on your EHR system tests your staff’s productivity, relationship with patients, and the reliability of your new system

by DONNA MARBURY, MS, and ALISON RITCHIE editors

After weeks, or even months, of preparation, the real test of your electronic health records (EHR) system is when you start using it in office with real patients on real time. Though you may have anticipated a few glitches, it is inevitable that productivity will suffer, your staff will be frustrated and you will have to explain the new digital system to your patients.

“The first couple of months were brutal, and much of that was just extra hours spent getting up to speed on the nuances of the system,” said Daniel S. Goodman, MD, an Atlanta, Georgia, internist, and one of the 29 participants in the 2-year Medical Economics EHR Best Practices Study. “But we’re used to it now, and things are running smoothly. The entire staff is onboard with the EHR, and productivity is high.”

“So why is go-live so frustrating?”

“Consider that physicians are faced with integrating records and trying to achieve a level of functionality with the system,” says the Medical Economics EHR Best Practices Study leader George G. Ellis, Jr, MD, FACP, in Boardman, Ohio. "At the same time, they are learning how to use it while examining patients, diagnosing conditions, and treating them. Workflow adjustments add new complications to an already complicated process.”

HIGHLIGHTS

01 Practices should concentrate on implementing the EHR system for the staff and office first, and the physicians second.

02 It’s critically important to evaluate your current workflow, including reviewing your process map and working with your EHR vendor to create a new map that describes how you want you practice to operate.
The reality is that doctors are populating medical records from scratch. And there are many steps in the process from verifying insurance eligibility, processing payments, to gathering family, social, medical, and surgical histories, to diagnosing and/or treating health conditions or diseases. The point? It takes time; a lot of it especially during the first days of go-live. Prepare to see fewer patients, because most physicians are spending the time “trying to smooth over the patient experience,” Ellis says.

Some of the key findings from the Medical Economics’ Best Practices Study were that 96% of the physicians participating cited excessive time to implement, and 89% noted a disruption to the practice. And when it came to that dreaded go-live date, 37% of the physicians in the study said they were truly ready.

According to the Center for Health IT of the American Academy of Family Physicians, practices should concentrate on implementing the system for the staff and office first, and physicians second.

Part two of this three-part series is designed to look at training, workflow design, patient engagement, go-live tips, obstacles, testing, and productivity, supplied by the 29 participating physicians, vendors, and other sources.

Below are real-world suggestions about how you can minimize the stress of implementing an EHR system in the first months.

**WORKFLOW**

**Review the workflow process map you created prior to implementation.**

It’s critically important to evaluate your current workflow, says Frank Cohen, a practice management consultant. He recommends reviewing your process map and working with your EHR vendor to create a new one that shows how you would like your practice to operate.

**Scanning in documents or starting fresh?**

Most practices have thousands of patient records, and if implementing a new EHR system, you will have to decide between scanning all the documents into the system, and entering information manually as patients make appointments. Experts say that you should set a goal of retiring the paper version of charts by the patient’s second visit. And it takes a lot of time.

There are pros and cons to scanning paper documents into your EHR system. On one hand, all of your data will be electronic and you can move paper charts off site to a secure place. However, the charts will be attached to the record, which makes them harder to search, and you will have to sort them into categories (X-rays, labs, administrative, etc.).

You will probably have to pay staff overtime, hire additional staff members, or contract scribes to manually enter, or preload, medical records from scratch. And there are many steps in the process from verifying insurance eligibility, processing payments, to gathering family, social, medical, and surgical histories, to diagnosing and/or treating health conditions or diseases. The point? It takes time; a lot of it especially during the first days of go-live. Prepare to see fewer patients, because most physicians are spending the time “trying to smooth over the patient experience,” Ellis says.

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Go live your charts. Nurses or physicians can update EHRs with the patient when they come in for a visit, or your staff can enter charts a little at a time. It will be important that immunization records, allergies, medications, recent imaging and other important consultations be entered or scanned into the EHR system as soon as possible.

**Conduct a practice run with team members before you go live.**

Before your go-live date, Dean Sorensen, MBA, CPHMS, principal consultant and chief executive officer of Sorensen Informatics, recommends establishing a test environment to make sure production is not impacted while training or testing new suggestions.

According to Health and Human Services (HealthIT.gov), “Make sure to cover all aspects of the EHR Implementation cycle and allocate enough time to become familiar with new tasks. Your organization should complete the following tasks before your EHR implementation go-live.”

HHS offers these suggestions:

- Test your EHR.
- Begin training your staff in the EHR application and on new policies and procedures.
- Ask your staff to create usernames and passwords.
- Complete a “patient walkthrough” to simulate an entire patient visit.
- Place signs in offices and hallways to notify patients the go-live is taking place and to request their patience through the process.

**Consider a scribe or temporary staff.**

Many practices find it beneficial to hire a scribe to enter information into the EHR system at the direction of the physician. EHR study participant Andrew Garner, MD, said he received complaints from patients about specialists who focused too much on their EHR, and he wanted to make sure that didn’t happen at his practice. “That’s why I’m choosing to do the scribe model,” he said. “When you use a scribe, you’re implementing two new things at once. That has its challenges, too. But when that patient said, ‘I feel like I lost you, Doc. It was a wake-up call. I thought I was doing a good job of not getting lost in the computer.’

But hiring a scribe means additional costs. Objective metric reports will help practice’s determine if a scribe is financially beneficial, says Maxine Lewis, CMM, CPP, CPC-I, CCS-P, president of Medical Coding and Reimbursement in Cincinnati, Ohio. She says to evaluate the “relative value units per hour or shift, number of patients seen per hour or shift, clinical versus administrative time, average charge per billable visit, number of incomplete and deficient charts, door-to-discharge time, and patient satisfaction survey results.”

Garner calculated that alone it takes him 8 minutes to finish a chart. However, with a scribe, it only takes 4 minutes.

**Go live on a Friday**

Some physicians suggest going live with your EHR system on a Friday.

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**MAIN FLOW: PATIENT SEEN IN OFFICE**

Patient calls to make appointment

Patient arrives, checks in for appointment

Nurse gets patient, puts in exam room

Clinician sees patient in exam room

Post-exam procedures (optional)

Patient check-out

Optional: appointment reminder

Phone appointment workflow

Patient check-in workflow

Nursing pre-visit workflow

Clinical exam workflow

Exit procedures workflow

For additional workflows, see the online version of this article at www.MedicalEconomics.com/EHRworkflows.

Source: Robert Rowley, MD
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*Source: Carbonview Research–Employee Morale Survey
Go live

Friday. Your practice will have a full week to prepare for any last minute issues, and you will have the weekend to assess and make adjustments. You can also frontload patient visits to make Friday a light day in anticipation of a drop in productivity.

PATIENT ENGAGEMENT

Start training your patients

One strategy Ellis offers was to have a staff member float in the practice’s waiting room to help patients during check-in.

If your practice has a patient check-in kiosk, it can save front-office staff a lot of time and reduce paperwork.

Either way, patients will likely be unfamiliar with the new process, Ellis says. So, you will need to factor in time to train your patients. To help facilitate this process, designate a staff member to help patients and be available to answer questions.

Educate patients about online portals

Your patients who aren’t as computer savvy might need help accessing online patient portals. They are actually very powerful tools to help engage patients in entirely new ways. Patient portals help patients access lab and test results, send refill requests and communicate with the physicians and practice. Provide postcards or brochures with step-by-step instructions on how to sign up for the portals online.

If you have an additional workstation, you can set it up in your waiting area and help patients log into the portals and access their information for the first time. (Remember to have safeguards in place to stay compliant with HIPAA standards.)

Should EHRs be in the exam room?

Some practices do not allow them in the examination rooms, while others find it useful to verify patient information and engage patients in their care.

Whatever strategy works best for your practice, test it and adapt it to see what is the least intrusive and most efficient way to use your system.

Here are some strategies to help:

- Some physicians have set up examination rooms with a work space so that the physician and patient can sit together to work within the EHR and verify its accuracy.
- If that is not possible, position computer screens so that you can see the patient. Try not to turn away from the patient when you have to input information.

Top 10 EHR implementation challenges

1. Excessive physician and staff time to implement

2. Disruption to practice

3. Concern with the time it will take to implement and be eligible for meaningful use

4. Concern with staff skills and ability to implement

5. Unexpected costs for associated hardware

6. Unexpected costs to implement the basic system

7. Concern over quality of the system

8. Concern with vendor quality and support

9. Unexpected costs to customize the system to my practice’s needs and requirements

10. Unexpected costs to maintain the system and keep functional

Source: Medical Economics EHR Best Practices Study
Make sure you listen to the patient’s concerns before using the EHR. One of the biggest complaints from physicians is that this computer system interferes with the physician and patient interaction.

The trick, physicians say, is to stay focused on the patient during the encounter and settle in on a workflow that serves the patient and accurately records patient health information.

TECHNOLOGY AND SYSTEM MAINTENANCE

Have on-site tech support the first few days of the launch

Many EHR vendors offer on-site tech support (sometimes fees apply). Practices could also choose to contract with an outside professional. In 2012, at the beginning of Medical Economics’ EHR study, 44% of the study participants contracted with an information technology (IT) professional or an IT firm, 12% hired other outside assistance, and 8% paid for assistance from a regional extension center, which offers local support for practices. Melissa Lucarelli, MD, one of the study’s participants, said her practice signed up with a regional extension center. They brought in vendors, and they also conducted HIPAA risk analysis assessments.

Customize templates for your practice

Practices often have their own way of documenting office encounters, and EHRs don’t have to be one-size-fits-all systems. Ask your vendor to help you create custom templates for clinical documentation.

You will need to use the system in ways to make the process faster. Templates can help.

Consider running your old and new billing system at the same time

Practices may have difficulties testing certain claims and payers with the EHR. But Lucarelli says running both the old and new billing systems could prevent a drop off in collections if those problems occur.

“It really worked well, because you have to transition your old medical management system over at least 90 days because there are collections in various states of payment,” she says. “So you can’t just shut off your old system and switch to the new anyway. We actually continued generating claims on the old system at the same time as we were generating 6, 8, or 10 new claims a day on the new system. I had my clinic manager pick which patients were going to be arrived in the EHR, so that we had a mix of payers as well. We would actually track the time to collections and see where the system was hanging up.”

The reality is most practices can’t afford claims hung up in the system. The idea is to test and devise ways so it lessens the impact on cash flow.

Take advantage of scheduling features

Use the appointment reminder feature in your EHR system to save your practice time and help decrease no-shows. Your system may be able to send me reminders via automated phone message, email, or text. This feature will also free up time for your staff who would normally have to call patients individually.

Other useful scheduling features can remind your staff and patients of billing issues, and automatically require follow up visits.

This helps everyone in the office know when changes in the schedule are made.

Create a spreadsheet to log any issues with the system

When problems occur with your EHR system, stay organized. Use a spreadsheet to track what the problem is, the date it occurred, who is responsible for fixing it and the status of the project. Lucarelli says at one point during implementation, she had more than 100 open issues. But her spreadsheet allowed her to easily communicate them with her vendor.

Communicate issues with your vendor

Expect errors to occur within the system when it’s first up and running, and communicate the problems with your vendor. “Heaven help the practice that gets an EHR and thinks it’s all going to work just because the vendor says so,” says Frank Cohen, practice management consultants. “They’re going to be in real trouble.”

MORE ON EHR BEST PRACTICES

This series continues

March 10, 2014:
Best Practices related to EHR use and proficiency
Understanding the basics of the RVU can assist physicians and practice managers in a wide variety of finance and management-related tasks.

When it comes to managing practice finances, physicians have few better tools at their disposal than the Relative Value Unit (RVU). RVUs can be used for everything from helping to determine compensation in a multi-physician practice to deciding whether to take a buyout offer from a hospital system.

WHAT ARE RVUs?
RVUs are part of the system Medicare uses to determine how much it will reimburse physicians for each of the 9,000-plus services and procedures covered under its Physician Fee Schedule, and which are assigned current procedural terminology (CPT) code numbers. The dollar amount for each service is determined by three components: physician’s work, practice expenses, and malpractice insurance. (Physician’s work, in turn, is divided into four subcomponents: the time it takes to perform the service, the technical skill and/or physical effort required to perform the service, the amount of mental effort and judgment required, and the stress arising from any potential risk to the patient from performing the service.)

Each of these three components is assigned an RVU. Then, to account for variations in living and business costs across the country, each of the three components is multiplied by a factor.
known as the Geographic Practice Cost Index, or GPCI. The three components are added together, and the resulting sum is then multiplied by a dollar amount known as the conversion factor to arrive at the reimbursement dollar figure:

\[
\text{Reimbursement amount} = (\text{Work RVU} \times \text{Work GPCI}) + (\text{Practice Expense RVU} \times \text{Practice Expense GPCI}) + (\text{Malpractice RVU} \times \text{Malpractice GPCI}) \times \text{Conversion factor}
\]

The dollar amount of the conversion factor is established each year by Congress. The RVUs themselves are determined as part of what's known as the Resource-based Relative Value Scale (RBRVS), a system for describing, quantifying, and reimbursing physician services relative to one another. The values in the RBRVS scale are reviewed periodically by a panel of physicians, known as the Relative Value Scale Update Committee (RUC), representing every sector of medicine.

**WHY THEY WERE CREATED**

The RVU/RBRVS system was created as a way of bringing more uniformity to Medicare's reimbursement systems while also trying to rein in spiraling medical spending, explains H. Christopher Zaenger, principal of Z Management Group in Barrington, Illinois, and a *Medical Economics* editorial consultant. Until then, Medicare based its reimbursements on what it determined were the "uniform, customary, and reasonable" fees for a service in a given market.

In 1988, the Centers for Medicare and Medicaid Services commissioned a study from the Harvard School of Public Health to look at the resources and costs associated with the services that doctors provide. That study led to the introduction of the RBRVS system in 1992. It has been in use ever since, although not without controversy. (See "Liked or loathed, RUC wields broad influence" at www.modernmedicine.com/news/liked-or-loathed-ruc-wields-broad-influence).

**USING RVUS FOR PRACTICE MANAGEMENT**

From a practice management perspective, understanding RVUs is important because "they are the language the payers speak when contracting with practices, and for reimbursing doctors for the work they do," explains Jeffrey Milburn MBA, CMPE, an independent national practice consultant with the Medical Group Management Association (MGMA.) "It's kind of a national standard, and like it or not, doctors need to be familiar with the system."

The reimbursement impact of the RVU system is not limited to Medicare. "If you look at most contracts today, you see that virtually every commercial carrier benchmarks its fee schedule to the Medicare fee schedule," says Zaenger. "Historically it's always been higher than what Medicare pays, but over the last three to five years that has changed, and now there are some plans that actually pay less than Medicare."

The percentage of the Medicare fee schedule a commercial insurer will pay often is a function of the supply of, and demand for, the type of service a practice provides. "I always refer to what I call the geographic and specialist monopoly," explains Milburn. "For example, if you're the only orthopedic group in town, you have not only a geographic monopoly but a specialty monopoly. That would give you a lot of leverage with the insurance company, which means it will pay much more than Medicare."

Conversely, if many practices are providing the same service in a community—or if only one commercial payer includes the community's physicians in its panel, the doctors will have to accept whatever rate the payer sets, even if it's less than Medicare, or risk losing patients.

Along the same lines, RVUs are a useful way of comparing how well payers reimburse for the same service or procedure, says Frank Cohen, principal of the Frank Cohen Group, a medical consulting firm in Clearwater, Florida and a *Medical Economics* editorial consultant. To do so, says Cohen, first divide the practice's total expenses for the year by the practice's RVUs, to produce a dollar cost per RVU.

Armed with that information, says Cohen, "you can go to a payer and say 'I do so much better with these other payers that it's not worth it for me to see your patients anymore.' You'll have a lighter patient load and you'll make more money." And while practices sometimes balk at the idea of giving up virtually every commercial carrier benchmarks its fee schedule to the Medicare fee schedule; historically it's always been higher than Medicare (but now there are some plans that actually pay less than Medicare.”

—H. CHRISTOPHER ZAENGER, PRINCIPAL, Z MANAGEMENT GROUP
any patients, "sometimes the best thing you can do for your business is to send the bad payers to your competitors."

Knowing the costs and revenues associated with specific procedures and payers can yield an additional benefit, Cohen notes. In most cases, costs and revenues tend to increase relative to each other. But occasionally a practice may encounter certain procedures where, for whatever reason, the cost-to-revenue ratio is much higher than in others. In those cases, he says, he advises practices to try to negotiate a "carve out," whereby the payer reimburses at a higher rate for those procedures.

Cohen also advises clients to measure their providers' productivity-per RVU relative to one another. That can be done by calculating each provider's revenue and RVUs as a percentage of the practice's total revenue and RVUs, and then dividing the results. (See table, "RVU-based productivity).

Cohen cautions, however, that there may be valid reasons for a provider's low ratio, such as his or her willingness to see more Medicaid patients than others in the practice. "Rather than looking at the ones that are doing poorly and ask what they're doing wrong, I prefer to look at why some are doing better, and see if there's something that can be applied to the ones not doing as well," he says.

**RVUs and Physician Compensation**

Another potential function for RVUs is as

### Using RVUs to calculate productivity bonus

<table>
<thead>
<tr>
<th>Income Calculations</th>
<th>Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>RVUs (Professional)</td>
<td>2800</td>
</tr>
<tr>
<td>RVU %</td>
<td>0.2000</td>
</tr>
<tr>
<td>Professional Income</td>
<td>176,998.85</td>
</tr>
<tr>
<td>Ancillary</td>
<td>34,998.85</td>
</tr>
<tr>
<td>Imaging Income Allocation</td>
<td>—</td>
</tr>
<tr>
<td>Lab Income Allocation</td>
<td>—</td>
</tr>
<tr>
<td><strong>Gross Income Distribution</strong></td>
<td>211,997.70</td>
</tr>
</tbody>
</table>

**LESS: Direct Expenses**

<table>
<thead>
<tr>
<th>Expense</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auto and Travel</td>
<td>(1,661.45)</td>
</tr>
<tr>
<td>Professional Dues</td>
<td>(2,700.82)</td>
</tr>
<tr>
<td>Health Insurance - Physician</td>
<td>—</td>
</tr>
<tr>
<td>Disability Insurance - Group Physician</td>
<td>—</td>
</tr>
<tr>
<td>Professional Liability Insurance - Physician</td>
<td>(31,272.82)</td>
</tr>
<tr>
<td>Journals and Publications</td>
<td>(393.27)</td>
</tr>
<tr>
<td><strong>Net Income Distributable</strong></td>
<td>175,969.34</td>
</tr>
</tbody>
</table>

**LESS: Distributions Made (salary)**

<table>
<thead>
<tr>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>120,000.00</td>
</tr>
</tbody>
</table>

**Net Bonus Payable**

<table>
<thead>
<tr>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>55,969.34</td>
</tr>
</tbody>
</table>

Source: Z Management Group Ltd

The dollar amount of the RVU conversion factor is established each year by Congress. The RVUs themselves are determined as part of the Resource-based Relative Value Scale, a system for describing, quantifying, and reimbursing physician services relative to one another."
a tool to help multi-physician practices determine how much to pay their physicians. Practices typically use them for this purpose in one of two ways, says Milburn. The first is straight productivity, whereby the practice multiplies the number of work RVUs the doctor generates by its own conversion factor to arrive at a compensation figure.

The conversion factor typically is determined by dividing the national median compensation for a specialty by the median number of work RVUs for that specialty, data for which can be obtained from the MGMA or American Medical Group Association. That conversion factor acts as a “market rate” for doctors in that specialty for each RVU they produce, says Milburn.

The second approach is to pay each physician a salary plus a bonus tied to the number of work RVUs generated over a base number, such as 2000 RVUs. “When a practice wants to put in a productivity incentive, that’s typically how they will do it,” says Milburn.

With hospital systems across the country looking to grow, RVUs can be among the tools a practice uses to decide whether to sell, says Zaenger. That’s because most large systems use RVUs to set physician compensation and productivity bonuses. “They really need to analyze their practice from an RVU standpoint, so if the hospital says they will be benchmarked at, say, 4600 RVUs per year for their evaluation and management services, they know if that’s a realistic number for them to attain.”

### Relative Value Unit-Based Productivity

The following table illustrates the calculation of RVU productivity ratios for physicians in a multi-specialty practice.

<table>
<thead>
<tr>
<th>Provider name</th>
<th>Specialty</th>
<th>Percent of practice revenue</th>
<th>Percent of practice RVUs</th>
<th>RVU productivity ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smith</td>
<td>Family medicine</td>
<td>13.47%</td>
<td>12.56%</td>
<td>1.07</td>
</tr>
<tr>
<td>Jones</td>
<td>Family medicine</td>
<td>13.93%</td>
<td>16.10%</td>
<td>0.87</td>
</tr>
<tr>
<td>Barnes</td>
<td>Family medicine</td>
<td>4.11%</td>
<td>5.77%</td>
<td>0.71</td>
</tr>
<tr>
<td>Adams</td>
<td>Pediatrics</td>
<td>13.14%</td>
<td>9.81%</td>
<td>1.34</td>
</tr>
<tr>
<td>Frey</td>
<td>Pediatrics</td>
<td>8.66%</td>
<td>8.74%</td>
<td>0.99</td>
</tr>
<tr>
<td>Leary</td>
<td>OB-GYN</td>
<td>12.25%</td>
<td>13.14%</td>
<td>0.93</td>
</tr>
<tr>
<td>Baron</td>
<td>OB-GYN</td>
<td>9.96%</td>
<td>14.86%</td>
<td>0.67</td>
</tr>
<tr>
<td>Singer</td>
<td>Orthopedics</td>
<td>6.81%</td>
<td>6.16%</td>
<td>1.11</td>
</tr>
<tr>
<td>Corsi</td>
<td>Orthopedics</td>
<td>17.66%</td>
<td>12.86%</td>
<td>1.37</td>
</tr>
</tbody>
</table>

*Calculate revenue per provider as a percent of total practice revenue
*Calculate total RVUs per provider as a percent of total practice RVUs
*Divide percent revenue by percent RVUs to calculate productivity ratio

Source: The Frank Cohen Group
Setting salaries, dealing with raise requests, and other personnel matters

Staff salaries are among a practice’s largest expenses. These tips will help practice managers fine-tune their pay scales and build merit into their compensation plans.

by KEITH BORGLUM, CHBC  Contributing author

Setting salaries

HIGHLIGHTS
01 Handle raise requests from staff makers by researching what pay levels the market supports. Use it to set pay accordingly and educate staff.
02 Merit pay increases can be a better way to handle raises than simply increasing pay because it will increase worker productivity.

I

t is often difficult to determine how much to pay a particular staff person, and how much to pay them in relation to other staff in the office. This difficulty can be compounded by many factors.

Both employers and employees sometimes confuse salary and wages. Salaries are fixed amounts of pay per month. A wage is an hourly dollar amount. Most full-time staff work 2,000-2,200 hours per year. When paying a salary, you would think that you have a dependable, fixed amount for your budget, but that’s often not the case depending on the job description and the laws of your state. And job descriptions and laws are commonly in flux.

Many states have laws about which staff can be on a fixed salary. Often, salaried staff have to be either licensed personnel using their licensed skills more than 50% of the time on their job, or managers supervising at least five persons whose jobs the manager does not perform.

It can be tricky. Is your RN actually doing tasks requiring an RN license, or is s/he acting primarily in the role of a unlicensed medical assistant more than half time? Or do they spend time as a manager? If your office manager is managing five other staff, and you do a “reduction in force” by one person, what do you do? In both of these cases, you might need to be paying overtime wages, whether or not these persons are salaried.

Salaried-staff are often due overtime wages by law if overtime is worked. Just putting them on a fixed salary does not circumvent the labor laws of your state. These are questions best answered by a labor attorney in your state, or more cost-effectively by just reading the employer guides provided free by your state Labor Board, Chamber of Commerce, or private vendors.

FACTORS AFFECTING PAY
Practices in high cost of living and urban locations often need to pay more to attract good staff than do practices in suburban locations.

Practices in rural locations may pay more or less depending on the availability of staff; since in some locations there is a commuting population that may accept less pay for a local job. In other rural locations a practice may need to pay more to attract staff from urban or suburban centers due to a lack of local qualified staff. Local or regional unemployment can be a big factor in any setting, as can the closure of a hospital.

The skills of individual team members can also affect compensation. Of course licensure has an effect but so does experience.
Setting salaries

$ Money

3 STEPS TO CONTROLLING STAFF COSTS

1. ESTABLISH A BUDGET

The first step is to look at benchmark data for practices that are similar to yours. According to the National Society of Certified Healthcare Business Consultants, median staffing for solo and small primary care practices is three to four full-time equivalent support staff per doctor, presuming no nonphysician providers or ancillary services and approximately 20 to 25 patient office visits per day. The budget for this level of staffing typically is about 20% to 24% of gross collections.

2. ADJUST FOR YOUR PRACTICE

Determine the proper staff size for your practice by adjusting the benchmarks you find for staff count and costs to account for any special circumstances related to your practice, such as staff productivity, payer mix, capitation payments, use of quality measures, and local wage levels. Once you have tailored the benchmarks to suit your circumstances, you will have a custom benchmark that you can use to evaluate staff costs and easily can update it annually to compare with the national surveys.

3. OBTAIN STAFF INPUT

Discuss your findings with your staff members and solicit their input for staying within budget, then review the data monthly. The benefit of investing in the effort of budgeting, just as it is in investing in other good practice-management behavior, is a flowing, more profitable, and less stressful practice.

The primary way workers express their unhappiness is through requests for raises. ... Happy staff members stay on the job, often at lower pay. If you have lots of turnovers or raise requests, try finding out what might be making your staff unhappy, and fix it.

and on-the-job skills. “Time-in-grade”—or how long the person has been employed in the practice—also has some impact, even though it often shouldn’t; since doing a job badly for a long time rarely results in decreasing pay.

DEALING WITH RAISE REQUESTS

Staff often have unrealistic expectations about earning capacity and wages.

A staff member might have heard others bragging about their wages. Your worker mentally converts that top decile into a belief that it represents the median. Then the person comes to you and says: “Dr. Newguy’s physician assistants are getting $18 per hour, and I’m only getting $12 per hour, so I deserve a raise or I quit.”

Do you give it? What if Newguy is a cosmetic dermatologist and you are a primary care practice? Budgets differ. What if Newguy is the biggest jerk in town, and the only way he can keep staff is to grossly overpay? Do you still try to compete on pay with Newguy?

Rather than just acquiescing to the raise, or denying it outright, the following response might be more fruitful: “I’m willing to consider a raise if I am underpaying. Let’s try to find some statistically relevant data on compensation and benefits over the next week or so, and meet again next Wednesday to discuss it.”

Then go find the data. This is highly educational for both staff and the boss. Maybe you are underpaying, and if you don’t come up to market rates, you’ll lose good team members.

There are a number of free resources online to help find the pay rates in your community, or you can refer to local studies or purchased reports. I prefer Salary.com because it graphically displays data by zip code, and as a curve, and is easily understood. Some of the medical-specialist accounting and consulting firms whose members belong to the National Society of Certified Healthcare Business Consultants (find them at NSCHBC.org) perform annual local studies in their communities that are available to clients or for a fee. Those studies also often provide detailed job descriptions to which you can compare. Don’t make the mistake, though, of misapplying the data. A registered nurse working as a physician assistant should be paid as an PA, not as an RN.

MERIT AND PRODUCTIVITY

If a raise is indicated, try to tie it to a merit or productivity bonus rather than a wage.

A merit bonus might be, “If you become a certified medical assistant, I’ll pay for half the schooling and give you a $5,000 per year raise when you graduate.” Note that $5,000 per year sounds like a lot more than the $2.50 per hour it represents.

A productivity bonus might be, if you are seeing 18-20 patients a day, and have capacity for 22 patients per day, tell your staff that every day the practice sees 22 patients, each staff person gets a $10 bonus. Like magic, you will be seeing 22 patients per day, paying some bonuses, but your productivity and profitability will increase.

STAFF HAPPINESS AND RAISES

The issue may not really be about dollars.

The primary way workers express their unhappiness is through requests for raises. Studies have found that employees who threaten quitting as a tactic to get a raise often end up quitting within 6 months anyway. Happy staff stay on the job, often even at lower pay. If you have lots of turnovers or raise requests, try finding out what might be making your staff unhappy, and fix it.

You might then save a few dollars, and end up with a happier place to work.
Financial Strategies

PREPARING FOR AN AUDIT: HOW TO REDUCE COSTS AND PRACTICE DISRUPTIONS

by ELLEN BARTHOLEMY, CPA, Contributing author

Many medical practice owners are required to undergo an annual audit of their financial statements when they’ve borrowed money from a bank or other financial institution, have outside investors, or are considering selling their practice. These steps will help you reduce the expense of an audit and prevent disruption to your operation.

YOUR GOAL in preparing for a financial audit should be to achieve a quick result at a low cost. You can achieve this goal by being prepared and by fostering an attitude of cooperation and communication. Unlike an IRS audit, the relationship with a financial auditor should not be an adversarial one. If you and your staff work together with the auditors, you can make the process more effective and efficient, thereby reducing fees and the time to complete the audit.

The tips below will help complete the audit efficiently.

Involves staff
Designate a point person who will be responsible for providing the auditors with access to records and files and for directing them to the appropriate individuals to answer questions or explain operations. Providing a main point of contact will also minimize duplications and omissions. Make sure you explain to your staff why the audit is happening and how important it is to cooperate. This will ensure the audit will proceed quickly and efficiently.

Prior to the auditors beginning their work, arrange a meeting so they can meet the office staff and develop a rapport. This planning meeting should include a discussion of the expected timelines, the information they will need, who will be responsible to provide the information, and by what date. If possible, provide an overview of your practice’s functions and a tour of the facility so that the auditors can get a perspective on your overall operations.

Gather documents
Request a list of schedules, working papers and documents the auditors will need from your records. Providing this information will make the audit more efficient, which will help to keep the cost down.

Ask the auditor in which format they would like the records. Many auditors today use paperless filing systems for their working papers. If so, you should provide the working papers in electronic format. They can be sent via email and password-protected or through a secured server. If you can have everything ready for the auditors when they start their work, it will maximize their efficiency.

Prepare a working paper for every balance sheet account. The working papers should reconcile the supporting documentation to the general ledger account.

Prepare a draft of the practice’s financial statements and complete the supporting schedules. Documenting your more complex processes, such as medical insurance filing, with a flowchart is a very effective way to communicate them to the auditor.

Meeting with the auditors periodically during the audit process will allow you to stay informed and resolve issues in a timely manner.

Ellen Bartholemy is the director of accounting services at Hall & Company, CPAs, in Irvine, California. Send your practice management questions to medec@advanstar.com.
HOW TO ADAPT YOUR PRACTICE TO THE DEMANDS OF HEALTHCARE REFORM

by MICHAEL CHADWICK, CFP  Contributing author

How the Affordable Care Act (ACA) will impact primary care physicians from a financial perspective has yet to be fully realized, but it probably won’t add to your practice’s bottom line if you continue to do what you’ve always done. Now is the time to adapt and move forward.

THE ACA CHANGES can be daunting for a solo practitioner or small independent group. Reimbursements will be lower for ACA plans, and will require doctors to do more paperwork. Doctors can expect reductions to the Medicare rate from commercial rates on standard procedures.

The ACA takes healthcare towards an outcome-based approach, where doctors can get paid for keeping people healthy and out of the hospital.

First, determine whether you’ll be part of the new ACA health plans and if so, gear your practice to serve those newly insured who can now see you rather than go to the emergency department for basic care when they were uninsured.

This will require physicians to revisit their billing processes, as these plans carry higher deductibles. Determine if you want to be in the collections business or try alternative billing strategies that are more efficient.

Many of these plans have small deductibles for routine procedures and that can help the office with cash flow if the patients previously were not seeing a doctor. These same plans have high deductibles for non-routine or non-well care procedures, and these deductibles are often $1,000 to $6,250 per person per year. Billing strategies that would help include requiring deductibles up front, offering finance plans for expensive procedures, similar to the way dentists do, and offering payment plans if patients can’t qualify for other alternatives.

Physicians now must be conscious of the costs of various procedures and have open dialogue with patients on affordability to ensure that they are not getting themselves into a financial position they cannot get out of. Until now, the cost of medical care wasn’t often an issue unless the patient was uninsured or out of work. Now it’s going to have to be part of the visit.

The offices ahead of this learning curve will be at a tremendous competitive advantage, compared with those who are not.

Michael Chadwick, CFP, is chief executive officer of Chadwick Financial Advisors in Unionville, Connecticut. Send your practice management questions to medec@advanstar.com.

4 ways to adapt

1. Work with employer groups and associations to help them implement programs to reduce the actual cost of care by keeping people healthy. Many such organizations now give people incentive to stay well by lowering their insurance rates.

2. Educate yourself on how the laws are playing out in your community. Position yourself as a subject matter expert, someone who can decode the ACA and alleviate the confusion patients face. This will help your practice grow organically.

3. Embrace technology and business solutions that will help you comply with the new rules and make your business more efficient.

4. Train your staff to adapt to the new workflow and focus on a niche market or geographical region where you can attract and retain patients you’re best suited to treat.
Legal Advice from the Experts

Legally Speaking

Protecting Controlled Substances at Your Practice

by Barbara D. Knothe, JD Contributing author

Many practitioners store, administer, or dispense controlled substances in the office, but they may not be aware of legal requirements concerning the safeguarding and record-keeping of these drugs.

The U.S. Drug Enforcement Administration (DEA) has stepped up enforcement efforts against distributors, prescribers, and pharmacies, bringing administrative, civil, and criminal actions to combat diversion of controlled substances. These actions can result in denial or revocation of a DEA registration, civil penalties, and criminal prosecution.

The DEA tracks the ordering and dispensing of controlled substances through its database, through onsite inspections of pharmacies and physicians’ offices, and through “suspicious order reports” from distributors. The administration is authorized to conduct unannounced onsite inspections of registered locations, including dispensing physicians’ offices.

Also, the DEA has the authority to inspect and evaluate the overall security systems of practitioners to determine if they meet the intent of the law, which is to prevent theft or diversion.

Federal regulations set forth specific physical security controls for practitioners:

- Controlled substances shall be stored in a “securely locked, substantially constructed cabinet.” The intent is that controlled substances must be adequately safeguarded for the area.
- Criminal background and DEA screening of all potential employees is critical.
- Practitioners are required to notify the DEA of the theft or significant loss of any controlled substances within one business day of discovery of the loss or theft. When determining whether a loss is significant, the practitioner is required to consider certain factors, including the quantity and type of controlled substances lost, and whether they are likely candidates for diversion, considering local trends and other indicators. We advise practitioners to report any loss to the DEA, in case the diverted drugs are traced back to the practitioner’s office.
- Practitioners must maintain inventories and readily retrievable records of controlled substances dispensed in their practices, and the records must be maintained and available for inspection for at least two years.

Many state laws are more stringent than federal law and must also be complied with. For example, New York state law and regulations require state registration, safeguarding, and record keeping for controlled substances in the office setting. New York practitioners must maintain meticulous records of all controlled substances received and administered or dispensed.

Federal and state laws carry significant administrative, civil, and criminal penalties for violations of controlled substance laws. Strict adherence to all physical safeguarding and recordkeeping rules is vital in the practice setting.

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- Practitioners are required to notify the DEA of the theft or significant loss of any controlled substances within one business day of discovery of the loss or theft. When determining whether a loss is significant, the practitioner is required to consider certain factors, including the quantity and type of controlled substances lost, and whether they are likely candidates for diversion, considering local trends and other indicators. We advise practitioners to report any loss to the DEA, in case the diverted drugs are traced back to the practitioner’s office.
- Practitioners must maintain inventories and readily retrievable records of controlled substances dispensed in their practices, and the records must be maintained and available for inspection for at least two years.

Many state laws are more stringent than federal law and must also be complied with. For example, New York state law and regulations require state registration, safeguarding, and record keeping for controlled substances in the office setting. New York practitioners must maintain meticulous records of all controlled substances received and administered or dispensed.

Federal and state laws carry significant administrative, civil, and criminal penalties for violations of controlled substance laws. Strict adherence to all physical safeguarding and recordkeeping rules is vital in the practice setting.
Coding Insights

MAKING SENSE OF MEDICARE DENIALS, ICD-10 CODES FOR COMMON CLAIMS

Q: We have learned to check our Medicare carrier’s local coverage determinations to see what diagnoses codes we can bill with procedures. How are we going to know what ICD-10 codes will work on our claims?

A: I’m so glad to hear you thinking ahead and following the Local Coverage Determinations (LCDs) for direction. In a MLN Matters® article (Number MM8348) effective October 7, 2013, the Centers for Medicare and Medicaid Services (CMS) announced that all Internal Classification of Diseases, Tenth Revision (ICD-10) LCDs and associated ICD-10 articles will be revised no later than April 10, 2014. This will give your office plenty of time to research and understand the revised articles that apply to the

- CO-183: The Referring Provider is not eligible to refer the service billed.
- N574: Our records indicate the ordering/referring provider is not of a type/specialty that cannot order or refer. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider.
- CD-16: Claim/service lacks information which is needed for adjudication.
- N264: Missing/incomplete/invalid ordering provider name.
- N265: Missing/incomplete/invalid ordering provider primary identifier.
- N575: Mismatch between the submitted ordering/referring provider name and records.

Make sure the qualifier in the electronic claim 2420E NM102 loop is a one (person). Organizations (qualifier two) cannot order/refer.

Can’t bill patient
In response to your second question, SE1305 reads, “Claims from billing providers and suppliers that are denied because they failed the ordering/referring edit will not expose a Medicare beneficiary to liability. Therefore, an Advance Beneficiary Notice (ABN) is not appropriate in this situation.”

Q: We have received a couple of denials from Medicare that we cannot figure out. They say that the referring provider cannot order or refer. Can you explain what this means? Can we bill the patient?

A: Our practice has received a couple of denials from Medicare that we cannot figure out. They say that the referring provider cannot order or refer. Can you explain what this means? Can we bill the patient?

ACCORDING TO MLN Matters SE1305, beginning January 6, 2014, the Centers for Medicare and Medicaid Services (CMS) turned on the Phase 2 ordering/referring denial edits. This means that Medicare will deny Durable Medical Equipment, Prosthetic, Orthotic, and Supplies (DMEPOS) claims if the ordering/referring physician is not identified, not enrolled in Provider Enrollment, Chain, and Ownership System (PECOS), or not of a specialty type that may order/refer the service/item being billed.

Below are the American National Standards Institute (ANSI) denials that will be listed on your Remittance Advice if the ordering/referring provider’s National Provider Identifier (NPI) reported on the claim does not pass the edits:
- CD-183: The Referring Provider is not eligible to refer the service billed.
- N574: Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider.
- CO-16: Claim/service lacks information which is needed for adjudication.
- N264: Missing/incomplete/invalid ordering provider name.
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Make sure the qualifier in the electronic claim 2420E NM102 loop is a one (person). Organizations (qualifier two) cannot order/refer.

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We want your questions on coding and ICD-10. Send them to medec@advanstar.com.
procedures your office performs.

These LCDs and articles will receive a new LCD or article ID number; however, they will not be considered new policies because only revisions were made, leaving the intent of the coverage/non-coverage unchanged.

The MLN Matters® article also states that those LCDs and articles that don't contain ICD-10 information, or articles not attached to an LCD, will be published on the Medicare Coverage Database (MCD) no later than September 4, 2014.

Keep an eye out for these LCDs and articles, so your office will be on top of the changes prior to the ICD-10 conversion on October 1, 2014.

To read the full MLN Article, go to MLN Matters® Article MM8348.

Q: WHEN WE TRANSITION TO ICD-10, HOW ARE WE GOING TO BILL THEM ON OUR CLAIMS SINCE THEY ONLY ALLOW FOR DIAGNOSIS CODES UP TO FIVE DIGITS?

A: The Centers for Medicare and Medicaid Services (CMS) and the Office of Management and Budget has approved an update to the CMS-1500 form, officially designated as "version 12/12," which can be used starting January 2014.

Physicians will see two significant changes on the new form. Version 02/12 will give physicians the ability to:

- Identify whether they are using ICD-9-CM or ICD-10-CM codes, which will be very important during the transition period, and
- Use up to twelve codes in the diagnosis field (the current limit is four).

According to MLN Matters® MM8509 released on December 27, 2013, the new form will be effective with claims received on or after April 1, 2014. However, there is a phase-in period. CMSs timeline for implementation is as follows:

- January 6, 2014: Medicare begins receiving and processing paper claims submitted on the revised CMS 1500 claim form (02/12)
- January 6—March 31, 2014: Dual use period when Medicare receives and processes paper claims submitted on the old (08/05) and new (02/12) CMS 1500 claim forms
- April 1, 2014: Medicare receives and processes paper claims submitted only on the revised CMS 1500 claim form (02/12).

It's important to note that if you are submitting your claims electronically, talk with your software vendors about their timelines for updating practice management systems and Electronic Health Records systems to accommodate use of the new form.

The answers to readers’ questions were provided by Renee Stantz, a billing and coding consultant with VEI Consulting Services in Indianapolis, Indiana. Send your practice management questions to medec@advanstar.com.
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The number of states choosing to expand Medicaid eligibility under the Affordable Care Act (ACA) will almost certainly increase in the coming years, and the growth will transcend partisan politics, U.S. Health and Human Services Secretary Kathleen Sebelius, told Medical Economics.

Speaking at a February news conference in Cleveland, Ohio, Sebelius noted that governors of 31 states, including 11 Republicans, have opted in to Medicaid expansion, and HHS is “in conversation” with others. The Medicaid program is jointly administered by the federal government and the individual states.

“We're encouraged by the number of governors who have stepped up,” she said, adding that more states are coming to see they can gain financially from expanding access to Medicaid. Earlier in the day she spoke in Kansas City, Missouri, which she says is losing $5 million per day by not broadening access to Medicaid for its residents.

Among the provisions of the ACA was a mandate for states to expand Medicaid eligibility for families with incomes up to 138% of the federal poverty level. The law included federal funding to pay the entire costs of the increased coverage for 6 years, and 90% in 2020. In 2012, the U.S. Supreme Court ruled that states could decide for themselves whether to expand Medicaid eligibility for their residents.

Sebelius’ news conference was part of an ongoing HHS campaign to promote enrollment through the health insurance exchanges created as part of the ACA. An HHS spokesman said Sebelius has visited more than 18 cities in recent months, focusing on those with large uninsured populations and where the federal government, rather than the state, has been operating the exchange. The open enrollment period for 2014 ends March 31. Medicaid enrollment continues year-round.

In response to a question regarding the demographics of people who have signed up for health insurance so far, Sebelius said that about 75% of the three million new enrollees are under the age of 35. She also noted that when Massachusetts passed its law expanding health insurance coverage for residents, young and healthy residents were among the last to enroll before its deadline.

During an appearance in New Jersey, Sebelius said that many uninsured patients are resigned to the fact that health insurance is not for them. This misconception needs to be changed, she said. “If they don’t have insurance, they figure it will never be affordable,” she said, according to the Newark Star-Ledger.

Sebelius’ tour comes at a time when many uninsured Americans have a negative view of the ACA. A Kaiser Family Foundation poll found many uninsured Americans say they are worse off under the law. Unfavorable views outnumber favorable views by a 2 to 1 margin.

Will further Medicaid expansion by states help improve healthcare delivery in the United States or cause greater problems? Tell us at medec@advanstar.com. Your comments could be included in the next issue of Medical Economics.
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