RAM

RICHMOND ACADEMY OF MEDICINE

Patient's Advocate • Physician's Ally • Community's Partner

The Leg.Up

Local, state and national news of interest to the physician community

January 9, 2019

Email the Editor

Dr. Monahan Explains the Physician's Side of Surprise Billing

RAM President **Dr. Mark Monahan** bravely tackled the prickly subject of **surprise billing** in an op-ed that ran yesterday in the Richmond Times-Dispatch.

He writes, "Physicians want to focus on caring for our patients. We want to be reimbursed fairly at market rates. We want there to be enough doctors in-network to care for patients and an easy way for insurers to pay out-of-network providers.

"Doctors will fight to ensure that patients are not subjected to outrageous charges. We support meaningful legislation that works for physicians, patients and health plans."

The General Assembly opened today, and surprise billing is sure to be a hot topic. Join RAM at one of our White Coats on Call days (Jan. 30 or Feb. 6) to see how you can make a difference. Sign up here.

Free Clinics Transition With Medicaid Expansion

Virginia's free clinics are adapting to meet patient needs in the changing landscape of Medicaid expansion, reports the RTD.

"Medicaid expansion is an amazingly wonderful tool," RAM's Executive Director **Jim Beckner** says in the article. "But it is not a magic bullet."

That's why programs such as **Access Now** will continue to remain vital. Some patients will lose insurance or Medicaid coverage throughout the year for a variety of reasons. Access Now ensures they won't have to forego care.

Jan. 15: Learn about Co-Pay Accumulators, PBMs and More

Do you know what "**Co-Pay Accumulator**" or "Accumulator Adjustment" programs are and how they affect you and your patients? Do you know how PBMs (**Pharmacy Benefit Managers**) affect your prescribing habits? How financially successful have the PBMs become at your expense? Learn about these issues and what you can do about improving your practice and the lives of your patients at RAM's next dinner program.

Join us next **Tuesday, Jan. 15,** at the **Westin Richmond** to hear from **Dr. Madelaine Feldman**, who will discuss how an entity that a few years ago we knew little about — those PBMs — now affects drug pricing, patient cost sharing and the doctor-patient relationship.

Cocktails at 5:30 p.m., dinner at 6:15 p.m. and the presentation at 7 p.m. Guest are welcome ($40 guest fee).

Register here

Join Us for White Coat Days

The Virginia General Assembly kicked off its 2019 session today.

Now it's up to you to tell lawmakers how legislation they're considering will affect the practice of medicine. Join your colleagues and make your voice heard at one of **RAM's White Coat Days**:

- **Wednesday, Jan. 30**
- **Wednesday, Feb. 6**

RAM helps you prepare: We'll meet at 8:30 a.m., have breakfast and receive a quick briefing before meeting with lawmakers to share our input and perspective with them. It'll wrap up by 11:30 a.m.

CLICK HERE to sign up or call Lara at **804-622-8137** or email her at lknowles@ramdocs.org

COPN: 'Everybody's favorite topic'

This week, The Virginia Mercury offered up a look at the story behind the **certificate of need**: What it is, why it exists and why it has been a thorn in Virginia's side for decades.

The certificate is a regulation meant to control the number of medical facilities and services available in designated regions, notes the article. Providers must receive approval from the state certifying that there is a need before they can do things like open a freestanding emergency room or add new hospital beds.

The process is cumbersome and it can take years — and thousands of dollars — to complete.

And **it's been haunting Virginia's legislature for decades**. It started in 1973, and just a little over a decade later the first attempt at reform began. The effort has gone through some stops and starts since then, but like clockwork it presents itself as a puzzle that the General Assembly attempts to solve every few years.

The GA will be trying again this year. We'll keep you posted.

Consider These Anomalies About Physician Compensation

The term "physician compensation" could be among the top phrases in health care this year, says this blog on KevinMD.

The perennially hot topic got hotter when the Trump administration announced a proposal that would affect nearly 40 percent of Medicare payments, replacing a fee scale that compensated doctors more for seeing sicker patients with a flat-fee model that reimburses them at the same or similar rates regardless of the condition being treated or complexity of the visit.

To better understand the compensation landscape, the authors scoured **MGMA's 2018 Physician Compensation and Production Report** for anomalies that might be instructive.

Here's some of what they found:

1. **Non-metro areas rule**. Salaries are higher in big cities, so the thinking goes, than they are outside of them. That's not always the case in health care.
2. **Quality is still ignored**. Value-based care and quality incentives are supposed to be the future of physician compensation. While that may eventually be the case, at least 80 percent of compensation plans in 2017 did not include quality incentives.
3. **Compensation flattens over time.** In most industries, workers earn more as their careers progress. Physicians can throw that notion out the window. For primary care physicians, the upward trend holds true for the first few years. But under current compensation models, most max out sometime around year eight.
4. **The gender gap remains**. There's a massive difference in physician compensation between men and women. But it's complicated.
5. **Productivity and RVUs don't always make sense**. You probably know this already. Medicare pays physicians for their work based on relative value units (RVUs), determined by how much work a physician puts into delivering the service, the expenses of the physician's practice, and professional liability insurance. Medicare then calculates a fee by multiplying the RVU for a service by a dollar conversion factor. On average, physicians are typically paid $42 per RVU performed. A physician who performs 3,000 RVUs in a year should make about $126,000. But it's not simple; as a physician is more productive later in career, say completing 10,000 RVUs per year ends up earning more like $37 per RVU, less than the average.

Speaking of Pay, Poverty Affects Much of Health Care Workforce

A new study finds that **low wages and poor benefits leave many female health care workers living below the poverty line,** says Science Daily. The report that will appear in the January issue of the *American Journal of Public Health* has been published online.

The authors note that more Americans are employed in health care than in any other industry, and three quarters of them are women.

Although the average hourly wage for female health care workers of more than $19/hour was higher than the average of around $16/hour for all other industries, it was **almost 25 percent lower than the average for men working in health care**. The data suggested that 34 percent of female health care workers, and nearly half of the Black and Latina women working in the health sector, earned less than $15/hour. While the largest number of health care workers making less than $15/hour were employed by hospitals, such workers made up a larger share of the total workforce in home health care and at nursing homes and other residential care facilities.

Hospitals Post Prices Online, But Patients Remain Confused

On Jan. 1, hospitals across the country (including those at Richmond's three health systems) began complying with a **new federal law** that requires them to **publish online price lists** for the medical services they provide.

But, notes Kaiser Health News, what is popping up on medical center websites is a **dog's breakfast of medical codes**, abbreviations and dollar signs — in little discernible order — that may initially serve to confuse more than illuminate.

While more information is always welcome, the new data will fall short of providing most consumers with usable insight, says Kaiser. That's because the price lists displayed this week, called chargemasters, are massive compendiums of the prices set by each hospital for every service or drug a patient might encounter. To figure out what, for example, a trip to the emergency room might cost, a patient would have to locate and piece together the price for each component of their visit — the particular blood tests, the particular medicines dispensed, the facility fee and the physician's charge, and more.

Virginia Boards Look to End Conversion Therapy for Minors

Experts say there's **no evidence conversion therapy works** – but plenty that it causes harm, says WUSA –TV9.

As early as this month, Virginia's professional licensing boards could take the first steps toward ending the practice of conversion therapy for minors in the state.

A workgroup of representatives from five professional boards – psychology, counseling, social work, nursing and medicine – convened in October to hash out regulations that would prohibit state-licensed members of their professions from providing therapy intended to change a person's sexual orientation.

At its **recent annual meeting**, the MSV House of Delegates adopted a resolution recommending prohibition of conversion therapy in those under age 18. And the film "Boy, Erased" increased public awareness of the issue.

Medicare at 55 Could Gain Momentum in 2019

After two years of defending the Affordable Care Act from Republican appeal attempts, Democrats could go on the offensive with popular ideas they've had to keep on the shelf while out of power like lowering the eligibility age for Medicare, says Forbes.

One of those ideas is the so-called "**Medicare at 55 Act**," which gives Americans between the ages of 55 and 64 an option to buy into Medicare. It's one of the healthcare issues Democrats have talked about in recent years, but it hasn't gotten nearly the attention as their recent 2018 mid-term election campaign to save the ACA and its protections for patients with pre-existing medical conditions.

But now with Dems controlling the House, the concept may come up again. Stay tuned.

Rising Rx Prices: Older Drugs Share Responsbility

It's no secret that **drug prices are increasing**, but to what extent are rising costs explained by the advent of newer, better drugs? Science Daily reports that a recent study found that new drugs entering the market do drive up prices, but **drug companies are also hiking prices on older drugs**.

The paper, published in the January issue of Health Affairs, shows that for specialty and generic drugs, new product entry accounted for most of the rising costs, whereas for brand-name drugs, existing products explained most of the cost increases.

The researchers examined the list price of tens of thousands of drug codes from a national database between 2005 and 2016 and UPMC Health Plan pharmacy claims over the same time period. Drugs were considered "new" for the first three years they were available, or in the case of generics, the first three years after patent expiration.

What they saw was that each year the price of brand-name oral medications increased by about 9 percent -- nearly five times the rate of general inflation over the same time period -- and the price of brand-name injectables increased by 15 percent. In both cases, soaring prices were overwhelmingly attributable to existing drugs.

Medical Marketing Hits $30 Billion

The **health care industry spends roughly $30 billion per year on**

marketing, according to a new study published in the Journal of the American Medical Association. That's about a 70 percent increase over the past 20 years.

You might not be surprised to hear that marketing to doctors (drug companies spent $20 billion on marketing to health care professionals in 2016, mostly to provide free samples of their products) makes up the biggest share of promotional spending. Direct-to-consumer advertising (another $6 billion) is growing the fastest. Pharmaceutical companies are by far the biggest spenders.

The number of ads has also skyrocketed. Drug companies paid for 4.6 million total ads, including 663,000 TV commercials, in 2016, up from just 79,000 total ads in 1997.

Hospitals, clinics and other health providers spent a total of roughly $3 billion on direct-to-consumer advertising.

Did you know? The U.S. and New Zealand are the only countries that allow direct-to-consumer drug advertising, says Axios.

A Second Opinion Becomes a Guilty Verdict

Honest medical disagreements can get physicians convicted of insurance fraud, says The Wall Street Journal.

The article examines a disturbing trend in the enforcement of health-care fraud. Ten years ago, fraud usually meant billing for something you didn't do—a patient you didn't see, a procedure more expensive than the one you did. Those cases didn't ask judges and juries to play doctor.

But then prosecutors became concerned with unnecessary and expensive tests or procedures and started pursuing what are known as "medical necessity" cases. It's now a federal felony to do a test or procedure if a doctor hired by the government later decides it was unnecessary.

The Hidden System of Physician Referrals

Here's a topic that's been a source of friction for many physicians for years (and please note that The Leg.Up isn't taking a side on this).

Patients are often in the dark about why their doctors referred them to a particular physician or facility, says The Wall Street Journal. Increasingly, those calls are being driven by pressure to keep business within a hospital system, even if an outside referral might benefit the patient, according to documents and interviews with doctors, current and former hospital executives and lawyers.

Losing patients to competitors is known as "leakage." Hospitals, in response, use an array of strategies to encourage "keepage" within their systems, which in recent years have expanded their array of services.

The article says, "Hospitals have gained more power over doctors with a wave of acquisitions of practices and hirings in recent years, and hospitals are getting more aggressive in directing how physicians refer for things such as surgeries, specialty care and magnetic resonance imaging scans, or MRIs."

The WSJ has gotten a lot of letters about this. What's your take on this? Leg.Up wants to hear from you.

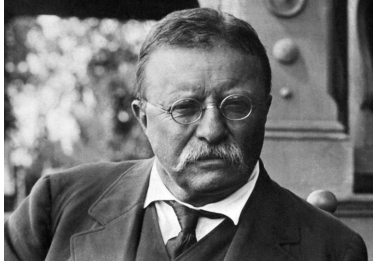
A Look Back: Theodore Roosevelt, Health Care Progressive

Here's an interesting read if you like history:

"His definition of national greatness included a commitment to helping the sick and the poor. A century after his death, we should follow his lead," says this op-ed in The New York Times.

Theodore Roosevelt died 100 years ago on Jan. 6, 1919,

at his home in Oyster Bay, N.Y. A pulmonary embolism, the doctors said. Americans found it hard to believe that Roosevelt was dead, much less that he had died in bed. For as long as they could remember, he had lived at full tilt. He was the frontiersman who faced down a grizzly, the Rough Rider who fought in the Spanish-American War, the presidential candidate who made a speech with a fresh bullet wound in his chest.



If Roosevelt's presidency had to be summed up in a word, "**strength**" would serve. Given the vast attention paid to the causes of Roosevelt's love of strength, there is a surprising lack of discussion about one of its most attractive effects: **an exceptional sensitivity to the needs of the sick and others in the grip of circumstances beyond their control**. Roosevelt's efforts on behalf of workers exploited by employers have been well chronicled, but from his earliest days in politics until the last months of his life, he worked equally hard to improve the health of his fellow citizens.

See You Next Week at RAM's General Membership Meeting

It's a busy time at RAM. Next week, we've got a very interesting General Membership meeting discussing PBMs; the General Assembly session started today and we'll be working hard to advocate for physicians; Access Now, Honoring Choices Virginia are running full speed; and in the RAM offices, we're finalizing a lot of informative and fun activities for 2019.

As always, please feel free to contact me with your ideas, suggestions and concerns (or complaints). You can reach me by email or at (804) 622-8136.

Thank you for being part of the Academy and its continuing conversation about the best practice of medicine.

Click here for past editions of The Leg.Up!

Lisa Crutchfield Barth
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