Supreme Court Coverage

Ready for 32 million new patients?

ACA’s impact forever changes healthcare financing and access to care

Plus

The real costs of implementing an EHR

Legal ramifications of unnecessary tests

Examining in-house labs for primary care practice

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You’ve got technology questions. We’ve got answers.
Where are the uninsured?

They will be rewinding last month’s Supreme Court ruling on the constitutionality of the Affordable Care Act (ACA) for years. And although it’s clear the ruling will forever change the financing of healthcare, the medical profession needs to fast forward to 2014, when the law will be fully enacted.

Assume that this country can afford to subsidize the estimated $1.1 trillion expected to add up over the next decade to care for the current 32 million of 50 million medically uninsured Americans. Let’s say that health insurance exchanges succeed in opening access to more affordable insurance policies and the proposed Medicaid expansion becomes a reality. Healthcare is changing, and many forces outside of the medical profession are influencing its direction. There are just as many unknowns when you peel away the layers of ACA that might confound the delivery of medicine and the new models it will produce.

Thirty-two million people—nearly the populations of Texas, Louisiana, and New Mexico—could be added to the ranks of the insured. Thirty-two million new appointments. Thirty-two million new reimbursements to manage. And although millions of ailments and diseases will be caught earlier and treated successfully, who in this fragmented healthcare delivery system is going to triage the influx of new patients?

Although much attention has been paid to reinvigorating the role of primary care as gatekeeper through Patient-Centered Medical Homes, primary care suffers from a numbers problem. Practitioners’ incomes are the lowest of all the healthcare specialties, and their ranks are dwindling as result of being overworked and underpaid. Some solo physician practices are simply closing due to the economic realities of operating a business.

We know that this profession puts the health and well-being of patients first, but a very germane economic question is at play and needs to be addressed: What will ACA do to reimbursements overall?

Do you really think that access to cheaper insurance policies will result in more “generous” reimbursements? When you tell us that reimbursement rates from some private payers can end up less than Medicaid, how can that economic reality buoy the ranks of primary care physicians who still are the lowest paid in the profession—a trend that has been well-documented by decades’ worth of Medical Economics salary surveys.

Acquisitions and consolidation of the more than 121,000 solo primary care practices adds new pressures, too. Hospital groups are already making a run at acquiring the role of gatekeeper through acquisition of office-based physician practices. Will solo and group practices be able to compete? What is the optimum practice size in terms of profitability and efficiency? Will midlevel providers become even more important as the demand for primary care services increases while more pressures mount to keep healthcare affordable? Will the laws of supply and demand ultimately force this kind of role change on primary care as baby boomers and new policy holders funnel into this system?

It is truly a fascinating and challenging time in healthcare. Physicians are frustrated, and the economics of medical practice have never been more complicated.

This month, our coverage looks at the Supreme Court’s ruling on ACA and its effect on you. In the coming months, Medical Economics will arm you with practical, usable, and actionable insight to help you weather this economic storm. And although we can all talk about the historical implications of this landmark decision, remember that this debate is about your future, too.

Write us; tell us what you think. Let us help improve your economic well-being while delivering compassionate and quality care to your patients. Send your comments to me at dverdon@advanstar.com.

Policy

Ready for 32 million new patients?

The Affordable Care Act’s impact forever changes healthcare financing and access to care. By Beth Thomas Hertz

- Reimbursement realities. By Jeffrey Bendix, MA, Senior Editor
- 8 ways to see more patients. By Beth Thomas Hertz
- The Massachusetts model: A case study. By Beth Thomas Hertz
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Top headlines from the Medical Economics team at MedicalEconomics.com

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3. Take a summer vacation to America’s National Parks
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Protect your patients from errant programming at MedicalEconomics.com/CommoneRxMistakes

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**Insurance intermediaries are bad for business**

I agree with Craig M. Wax, DO’s column “Free-market, posted prices prevent sticker shock” ([From the Board], June 10 issue).

Unlike Dr. Wax, however, we do not offer a discount to uninsured patients who pay with cash in our office for our evaluation and management services. Many of these patients have elected not to purchase health insurance, while many other people (myself included) are responsible enough in their finances to budget and pay for health insurance, which typically costs several hundred dollars a month.

If a cash-paying patient sees me four times a year at $150 each time, he or she pays $600 in healthcare costs (not including medications) for the year. That is less than 1 month of my insurance premiums. Why should I reward his personal choice not to purchase health insurance, while many other people (myself included) are responsible enough in their finances to budget and pay for health insurance, which typically costs several hundred dollars a month.

If a patient is unable to get insurance or can’t afford to pay for services, he or she can take advantage of the various safety nets that are in place in our area. I certainly do not receive a discount for prompt, responsible payments to my vendors, utility companies, or landlord.

Our typical insurance write-off is 45% to 50%. As Dr. Wax pointed out in his opinion piece, insurance should be between the patient and his or her insurance company. Our payments should not depend on some nebulous, negotiated (for large groups...we, as a small group, are told to take it or leave it) corporate fee schedule. Imagine if a patient tried this line of reasoning with the body shop after wrecking a car.

We have really thrown the baby out with the bathwater by filing insurance claims for patients. I would love to return to the time when patients actually paid their doctor bills at the time of service, filed their own claims, and then waited on whatever reimbursement they were due from the insurance company.

Get rid of the insurance intermediary, and I believe you would see massive price reductions. I know I would lower my fees if we were always paid at the time of service.

**Michael S. Jackson, MD**
Rome, Georgia

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**Recertification nothing more than a money grab**

I would like to make a correction to the letter “Recertification adds little value to my work” written by Dennis R. Burke, MD ([Talk Back], May 25 issue). The American Board of Family Medicine (ABFM) was established in 1969-1970. I am a charter diplomat and charter fellow in the ABFM.

I am one of 66 physicians who have recertified six times with the ABFM. I am in total agreement with Dr. Burke as far as the point he makes that recertification is of no special value. Most of the specialists do not have to take a recertification test, and that does not necessarily mean that they are not as smart.

The cost of being recertified in 2012-2013 is $1,700, which was reported to me by the ABFM. This cost does not include transportation, lodging, meals, and time out of the office.

It appears that this recertification business is just a money-maker for the ABFM, and if someone could show me otherwise, I would welcome that information.

**Robert Schiavone, MD**
Louisville, Kentucky

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**The link to referral rates**

With many primary care offices and specialists using nurse practitioners and physician assistants, I wonder whether the Archives of Internal Medicine study you wrote about looked for links between the increase in referrals and increased use of these midlevel providers (“In ‘troubling’ study, patient referrals skyrocket,” by Morgan Lewis Jr., [Medical Economics eConsult], January 25 issue).

Surprisingly, there also is no mention of whether the fear of malpractice also has increased referral rates in an effort to “cover your butt.”

**Carolyn Tran, MD**
Jacksonville, Florida
Health savings accounts often can be the answer to the rising cost of health insurance.  

**David J. Schiller, JD**  
TAX ATTORNEY  

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Are safety considerations limiting your use of ibuprofen?

It’s time to set the story straight

Take a closer look before your next OTC analgesic recommendation

Data and messages around OTC analgesics continue to evolve, and, therefore, treatment paradigms must evolve as well. Take another look, and you may find that some communications are not telling the full story. When considering which OTC analgesic to recommend, it is important to periodically review all the evidence on risks and benefits as the data set continues to grow.

OTC ibuprofen may be right for more patients than you think*

- Clinical studies have shown when OTC ibuprofen is taken as directed by the label for no longer than 10 days, there is a very low increased risk of stomach complaints or bleeding
- In a study by Moore et al, GI tolerability of OTC ibuprofen was at least as favorable as acetaminophen during 7-day therapy
- Studies have demonstrated that higher doses of ibuprofen are associated with a greater risk of GI side effects (odds ratio 4.6) vs lower (OTC) doses (odds ratio 1.1)

- Naproxen and OTC ibuprofen have the most favorable cardiovascular risk profile among widely used Rx and OTC NSAIDs
- For patients already on, or for whom you are considering initiating a cardioprotective aspirin regimen:
  - Taking ibuprofen at least ½ hour after the dosing of immediate-release low-dose aspirin is a practical method to minimize potential impairment of the antiplatelet effect of aspirin
  - Because the effect of aspirin taken daily on platelets is long lasting, the occasional use of ibuprofen poses a minimal risk of attenuating the antiplatelet effect of low-dose aspirin

- Overall, OTC ibuprofen has a low risk factor for developing acute or chronic renal conditions
- NSAIDs, including ibuprofen, demonstrate an increased risk of causing renal impairment at high (Rx) doses, especially among elderly patients or patients with reduced renal function

- OTC ibuprofen has a very low risk factor for developing liver injury, especially compared to the severe liver damage observed with acetaminophen overdose and the occasional liver reaction from aspirin

- A large-scale review article concluded that, when compared with all analgesics, OTC ibuprofen is less toxic in serious overdose situations and is rarely associated with deaths from either accidental or intentional overdose (or with serious adverse events)

*Remind patients to use OTC analgesics as directed.

Nothing is more effective than Advil® for acute pain. Rethink Relief. Think Advil®.

To get a closer look at the clinical evidence and the Advil® label, please visit us at www.AdvilAide.com.

We invite you to explore the latest data on ibuprofen in regard to GI tolerability; cardiovascular, renal, and hepatic safety; as well as toxicity. What you find may surprise you.

HEALTH INSURANCE

Get aggressive when managing denials

<table>
<thead>
<tr>
<th>Denied?</th>
<th>Reported conditions in the United States (ages 19 to 64)</th>
<th>Average annual expenditure</th>
<th>Maximum expenditure related to condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>33.2 million</td>
<td>$650</td>
<td>$61,540</td>
</tr>
<tr>
<td>Mental health disorders (depression, etc.)</td>
<td>18.9 million</td>
<td>$1,757</td>
<td>$98,058</td>
</tr>
<tr>
<td>Diabetes</td>
<td>11.9 million</td>
<td>$1,782</td>
<td>$66,007</td>
</tr>
<tr>
<td>Asthma</td>
<td>10 million</td>
<td>$1,234</td>
<td>$63,003</td>
</tr>
<tr>
<td>Arthritis</td>
<td>9.5 million</td>
<td>$1,875</td>
<td>$78,617</td>
</tr>
<tr>
<td>COPD</td>
<td>9.1 million</td>
<td>$1,423</td>
<td>$172,583</td>
</tr>
</tbody>
</table>

Source: Government Accounting Office, 2012
Notes: Expenditures include all sources for hospital inpatient stays, emergency room visits, outpatient visits, office-based medical provider visits, and prescribed medicines.
Mental health disorders include depression, bipolar disorder, and schizophrenia.
Arthritis includes osteoarthritis, rheumatoid arthritis, and infective arthritis.

Hypertension, mental health disorders, and diabetes lead the list of pre-existing conditions, according to a new report from the Government Accounting Office (GAO).

Although the GAO says millions of Americans are at risk for restricted, denied, or more expensive medical insurance coverage, a management expert says decisions made at the payer level often affect providers, too. Consequently, denials, whether they are for pre-existing conditions or simply a coding error, should be aggressively managed.

Although the Affordable Care Act will make it illegal for insurance companies to deny coverage based on pre-existing conditions in 2014, it won’t address some of the other inherent management problems associated with denials, says Jeffrey B. Milburn, MBA, CMPE, of the MGMA Healthcare Consulting Group.

Denied claims can represent as much as 30% of a practice’s billing cycle. Although you have no way of predicting whether an insurance denial could occur, gather data to determine reasons for denials and create an action plan to correct errors, resubmit denied claims, or bill patients a fee for service. Try to keep insurance denials to a 5% to 10% level, Milburn advises.

When it comes to pre-existing conditions, many of the group insurance plans reimburse, but a subset of patients is at risk for denials or denied access to health insurance.

EHR implementations shatter CMS estimates

More than 110,000 medical providers have attested to meaningful use after implementing electronic health record (EHR) systems, according to the Centers for Medicare and Medicaid Services (CMS). Only 3 months ago, CMS estimated it would reach 100,000 by the end of this year. Although the agency has doled out $5.7 billion in incentive payments to healthcare providers so far, officials estimate that about 20% of the provider market has attested to meaningful use. About 48% of hospitals have achieved meaningful use, CMS adds.

The EHR incentive programs began in 2011 to incentivize eligible professionals, hospitals, and critical access hospitals as they adopt, implement, and upgrade certified EHR technology. The program was established by the Health Information for Clinical and Economic Health Act of 2009. A National Center for Health Statistics survey shows that only 14% of respondents do not plan to apply for meaningful use incentives.

130,000

The number of primary care providers partnering with regional extension centers to implement EHR systems as of May 2012.

Want to find a REC? Go to MedicalEconomics.com/recfinder
Coalition of physicians, organizations in California wage legal war with Aetna

California physicians and two prominent medical organizations filed suit against Aetna claiming that the company denies patients access to physicians outside of its network. The class action lawsuit includes thousands of physicians as well as the California Medical Association and the Los Angeles County Medical Association. Recently filed in the Los Angeles County Superior Court, the lawsuit alleges the company threatened doctors with terminating Aetna contracts if they refer outside of the network and allegedly threatened patients with denial of coverage if visiting doctors outside of its provider network.

Aetna counters the action was filed in retaliation to litigation brought against some of the same physicians spearheading the class action lawsuit for inflated billing practices.

The most recent lawsuit seeks an immediate injunction against Aetna, an end to the practice, compensatory damages to patients and physicians, and punitive damages. The lawsuit accuses Aetna of false advertising, breach of contract, unfair business practices, and both intentional and negligent interference with healthcare providers.

Train a health coach to call plays for your hypertensive patients

A new study at the University of California-San Francisco (UCSF) shows that a little health coaching can go a long way toward controlling hypertension. In fact, the study saw an average 22 mm Hg drop in systolic blood pressure among a low-income minority population. But the lessons learned from the study apply to all primary care physicians, reports co-author Thomas Bodenheimer, MD. UCSF coaches reached out to their hypertensive patients through weekly telephone calls and delivered a dose of education on diet, medication adherence, monitoring, and follow-up on behavioral modification. And it worked. The coaches (all with undergraduate degrees) received 16 to 20 hours of training on hypertension, adherence, and facilitating lifestyle behavior changes. The study, published in the Annals of Family Medicine, suggests that you can use existing staff, with little training, to help manage patient outreach and save time.

WEIGHING IN ON OBESITY

If your patient has a body mass index of 30 or higher, get him or her off the scale and into a multicomponent behavioral intervention program, according to an updated recommendation from the American Academy of Family Physicians and U.S. Preventive Services Task Force. Most family doctors are screening for obesity, but the new recommendations say that a moderately or highly intensive intervention results in weight loss and improved health. The task force recommends that healthcare professionals offer or refer obese patients to a comprehensive weight loss and behavior management program consisting of 12 to 26 sessions in the first year.

Health chatter gets louder on social media

One-third of consumers use social media for health-related matters, including tracking medical symptoms and sharing opinions about their treatment.

Another 40% said they have used social media to find reviews of treatments or physicians.

Source: Health Research Institute at PricewaterhouseCoopers

CMS calls for 7% hike in reimbursements to family physicians

A proposed rule from the Centers for Medicare and Medicaid Services (CMS) would increase payments to family physicians by 7%. Other practitioners providing primary care services could see increases between 3% to 5%, CMS reports.

For the first time, CMS is proposing to pay for the care required to help a patient transition back to the community following discharge from a hospital or nursing facility. The proposal would call for CMS to make a separate payment to a patient’s community physician or practitioner to coordinate the patient’s care.

The final rule will be issued by November 1.
Ready for 32 million new patients?
ACA's impact forever changes healthcare financing and access to care

By BETH THOMAS HERTZ

With the U.S. Supreme Court’s landmark decision to allow most of the Affordable Care Act (ACA) to stand, tens of millions of patients are about to acquire health insurance in 2014, some for the first time. This represents a monumental change in our nation’s approach to healthcare delivery, and it will forever change the financing of medical care. But with a shortage of primary care physicians (PCPs), many doctors are uncertain about its initial effect on primary care and the future of it.

Glen Stream, MD, MBI, FAAFP, president of the American Academy of Family Physicians (AAFP), agrees.

“We hope to see fewer patients in emergency rooms and inpatient settings as we start to do a better job at preventing problems,” he says.

This has been shown to be the case in Massachusetts, where a study by the Blue Cross Blue Shield of Massachusetts Foundation found that the use of emergency rooms for nonemergency reasons declined 4% from 2006 to 2010 (see Massachusetts case study, page 25).

Stream knows that primary care is already at capacity in many parts of the United States, especially family medicine. An AAFP study in 2000 found that a national shortfall of 3,900 family medicine practitioners will occur by 2020. The Association of American Medical Colleges (AAMC) estimates a national shortfall of more than 90,000 physicians across all specialties by 2020.

“By 2014 [when the new laws fully take effect], thousands of family practitioners aren’t going to
Bystolic
Helping patients get the blood pressure reductions they need.

Indication
- Bystolic is indicated for the treatment of hypertension, to lower blood pressure. Bystolic may be used alone or in combination with other antihypertensive agents. Lowering blood pressure reduces the risk of fatal and nonfatal cardiovascular events, primarily strokes and myocardial infarctions. There are no controlled trials demonstrating risk reduction with Bystolic, but at least one pharmacologically similar drug has demonstrated such benefits.
- Control of high blood pressure should be part of comprehensive cardiovascular risk management, including, as appropriate, lipid control, diabetes management, antithrombotic therapy, smoking cessation, exercise, and limited sodium intake. Many patients will require more than one drug to achieve blood pressure goals.

Important Safety Information

Contraindications
- Bystolic is contraindicated in patients with severe bradycardia, heart block greater than first degree, cardiogenic shock, decompressed cardiac failure, sick sinus syndrome unless a permanent pacemaker is in place), severe hepatic impairment (Child-Pugh >B), and in patients who are hypersensitive to any component of this product.

Please see additional Important Safety Information on the following pages and brief summary of full Prescribing Information on the last page of this advertisement.
Bystolic. Significant blood pressure reductions with a low incidence of side effects.

Important new information about the cardiovascular benefits of lowering blood pressure

- The Food and Drug Administration (FDA) issued a guidance to explicitly make the connection between lowering blood pressure and improved cardiovascular outcomes in antihypertensive class labeling to address the public health concern of inadequate treatment of hypertension.
- The Bystolic Prescribing Information has been updated based on this guidance:
  - Bystolic reduces blood pressure.
  - Lowering blood pressure reduces the risk of fatal and nonfatal cardiovascular events, primarily strokes and myocardial infarctions.
  - There are no controlled trials demonstrating risk reduction with Bystolic, but at least one pharmaco- logically similar drug has demonstrated such benefits.
  - Control of high blood pressure should be part of comprehensive cardiovascular risk management, including, as appropriate, lipid control, diabetes management, antithrombotic therapy, smoking cessation, exercise, and limited sodium intake.
  - Many patients will require more than one drug to achieve blood pressure goals.

Effective as monotherapy and as add-on therapy

- In registration studies, Bystolic 5-20 mg achieved significant SBP/DBP reductions of up to -12.4/-11.1 mm Hg vs -4.5/-5.1 mm Hg for placebo (P<0.001).
- In a study by Neutel et al, Bystolic 5-20 mg demonstrated SBP/DBP reductions of up to -8.6/-8.6 mm Hg when added to an ACEI, ARB, and/or diuretic vs -2.6/-3.9 mm Hg for placebo (P<0.001).

Overall low discontinuation rate

- Discontinuation rate due to adverse events was 2.8% for Bystolic vs 2.2% for placebo.

Important Safety Information (continued)

Adverse Reactions

- The most common adverse events with Bystolic versus placebo (approximately ≥1% and greater than placebo) were headache, fatigue, dizziness, diarrhea, nausea, insomnia, chest pain, bradycardia, dyspnea, rash, and peripheral edema. The most common adverse events that led to discontinuation of Bystolic were headache (0.4%), nausea (0.2%), and bradycardia (0.2%).

Warnings and Precautions

- Do not abruptly discontinue Bystolic therapy in patients with coronary artery disease. Severe exacerbation of angina, myocardial infarction, and ventricular arrhythmias have been reported following the abrupt discontinuation of therapy with beta blockers. Myocardial infarction and ventricular arrhythmias may occur with or without preceding exacerbation of the angina pectoris. Caution patients without overt coronary artery disease against interuption or abrupt discontinuation of therapy. As with other beta blockers, when discontinuation of Bystolic is planned, carefully observe and advise patients to minimize physical activity. Taper Bystolic over 1 to 2 weeks when possible. If the angina worsens or acute coronary insufficiency develops, ressistant Bystolic promptly, at least temporarily.
- Bystolic was not studied in patients with angioplasty or who had a recent MI.
- In general, patients with bronchospastic diseases should not receive beta blockers.
- Because beta blocker withdrawal has been associated with an increased risk of MI and chest pain, patients already on beta blockers should generally continue treatment throughout the pericoronary period. If Bystolic is to be continued perioperatively, monitor patients closely when anesthetic agents which depress myocardial function, such as ether, cyclopropane, and trichloroethylene are used. If beta-blocking therapy is withdrawn prior to major surgery, the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.
- The beta-blocking effects of Bystolic can be reversed by beta agonists, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Additionally, difficulty in restarting and maintaining the heartbeat has been reported in beta blockers.

Forest Pharmaceuticals, Inc.
Subsidiary of Forest Laboratories, Inc.
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Bystolic is widely available on commercial and Medicare Part D formularies.

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<thead>
<tr>
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<td>Aetna</td>
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Formulary status information is valid as of March 2011. Coverage is subject to change.

Important Safety Information (continued)

Warnings and Precautions:
- Beta blockers may mask some of the manifestations of hypoglycemia, particularly tachycardia. Advise patients subject to spontaneous hypoglycemia and diabetic patients receiving insulin or oral hypoglycemic agents about these possibilities.
- Beta blockers may mask clinical signs of hyperthyroidism, such as tachycardia. Abrupt withdrawal of beta blockers in these patients may be followed by an exacerbation of symptoms or may precipitate a thyroid storm.
- Beta blockers can precipitate or aggravate symptoms of arterial insufficiency in patients with peripheral vascular disease.
- Because of significant negative inotropic and chronotropic effects in patients treated with beta blockers and calcium channel blockers of the verapamil and diltiazem type, monitor the ECG and blood pressure of patients treated concomitantly with these agents.
- Use caution when Bystolic is co-administered with CYP2D6 inhibitors (quinidine, propafenone, fluoxetine, paroxetine, etc.). When Bystolic is co-administered with an inhibitor or an inducer of CYP2D6, monitor patients closely and adjust the nebivolol dose according to blood pressure response. The dose of Bystolic may need to be reduced. When Bystolic is administered with fluoxetine, significant increases in d-nebivolol may be observed (i.e., an 8-fold increase in AUC and a 3-fold increase in Cmax for d-nebivolol).
- Renal clearance of nebivolol is decreased in patients with severe renal impairment. In patients with severe renal impairment (CrCl less than 30 mL/min) the recommended initial dose is 2.5 mg once daily; titrate up slowly if needed. Bystolic has not been studied in patients receiving dialysis.
- Metabolism of nebivolol is decreased in patients with moderate hepatic impairment. In patients with moderate hepatic impairment, the recommended initial dose is 2.5 mg once daily; titrate up slowly if needed. Bystolic has not been studied in patients with severe hepatic impairment and therefore it is not recommended in that population.
- Patients with a history of severe anaphylactic reactions to a variety of allergens may be more reactive to repeated challenge and may be unresponsive to the usual doses of epinephrine while taking beta blockers.
- In patients with known or suspected pheochromocytoma, initiate an alpha blocker prior to the use of any beta blocker.

Drug Interactions:
- Do not use Bystolic with other beta blockers.
- Both digitalis glycosides and beta blockers slow atrioventricular conduction and decrease heart rate. Concomitant use can increase the risk of bradyarrhythmia.
- Bystolic can exacerbate the effects of myocardial depressants or inhibitors of AV conduction, such as certain calcium antagonists (particularly of the phenylalkylamine [verapamil] and benzothiazepine [diltiazem] classes), or antiarrhythmic agents, such as disopyramide.

Use in Specific Populations:
- Use Bystolic during pregnancy only if the potential benefit justifies the potential risk to the fetus. Bystolic is not recommended during nursing.
- The safety and effectiveness of Bystolic have not been established in pediatric patients.
- In a placebo-controlled trial of 2,128 patients (1,007 Bystolic, 1,011 placebo) over 70 years of age with chronic heart failure receiving a maximum dose of 10 mg per day for a median of 2 months, no worsening of heart failure was reported with nebivolol compared to placebo. However, if heart failure worsens, consider discontinuation of Bystolic.

Please see brief summary of full Prescribing Information on last page of this advertisement.

References:
**BYSTOLIC® (metolozan) tablets**

**Brief Summary of Full Prescribing Information**

**Indications:** Use for stable angina, systolic hypertenison, and heart failure.

**Contraindications:** Contraindicated in patients with aortic stenosis, sick sinus syndrome, and severe bradycardia.

**Warnings and Precautions:**
- **Arrhythmia:** Low blood pressure may increase the risk of developing arrhythmias, including atrial fibrillation.
- **Heart Failure:** Use cautiously in patients with a history of heart failure.
- **Liver Function:** Use cautiously in patients with liver disease.
- **Renal Function:** Use cautiously in patients with renal impairment.
- **Drug Interactions:** Use with caution in patients receiving drugs that affect serum potassium levels.

**Dosing and Administration:**
- **Angina:** 5 mg once daily.
- **Hypertension:** 10 mg once daily.
- **Heart Failure:** 20 mg once daily.

**Adverse Reactions:**
- **Cardiovascular:** Hypotension, palpitations, chest pain, and tachycardia.
- **Respiratory:** Coughing and pharyngitis.
- **Gastrointestinal:** Diarrhea.
- **Skin:** Rash and pruritus.
- **Other:** Headache and dizziness.

**Labs:** Monitor liver function tests, serum potassium, and creatinine.

**Patient Counseling:**
- Inform patients of the importance of adherence to their medication regimen.
- Advise patients to report any adverse reactions immediately.

**Notes:**
- BYSTOLIC is a trade name of the active ingredient metolazan.
- The full prescribing information is available from the manufacturer's website or by contacting the FDA.
The increased demand could bring new attention to solving the problem, Stream adds. The AAFP advocates for issues such as how to get more medical students interested in family practice and help them cope with the lower salaries while facing burdensome debt and achieve higher reimbursement, he says.

Richard M. Dupee, MD, chief of the geriatrics service at Tufts Medical Center in Boston and governor of the American College of Physicians’ Massachusetts chapter, sees the aging workforce as another major problem.

“Some older physicians are retiring rather than bothering with the requirements to adopt electronic medical records, and they are not being replaced by younger ones,” he says. “In rural areas, there are fewer of the academic hospital-owned clinics to take up the slack.”

Massachusetts is in the process of trying to fix another disincentive to primary care careers: low reimbursement. A bill is pending in the state legislature to raise payments. Nationally, the Centers for Medicare and Medicaid Services recently announced plans to give family physicians, internists, and others providing primary care a raise, too. But the trend for doctor reimbursements has been going down, and it may likely get worse for some.

“If reimbursement is fair, physicians with capacity will welcome [newly insured patients],” he says. “Most seasoned physicians in their 50s or 60s are already maxed out. They can’t absorb more volume without more money to cover the extra staff they will need.”

ADVOCACY

The AAMC notes that U.S. medical schools have complied with requests to boost class sizes by 30% time over the past 6 years, but the overall supply of U.S. physicians cannot expand unless Congress increases the number of federally funded residency training positions, a number that has been frozen since 1997.

“The AAMC is working hard to revisit this freeze,” says Christiane Mitchell, director of federal affairs. “Staying where we are will leave U.S. medical school graduates without a training position. This is an immediate issue.”

She notes that there is no real policy justification for the freeze; it was merely a victim of budget-cutting. The possibility of further federal cuts also has been raised.

“If reimbursement is fair, physicians with capacity will welcome [newly insured patients].”

—Richard M. Dupee, MD

“Medical school graduates need a place to train. Without one, it limits their options and may discourage the best and the brightest from choosing medicine as a career,” she says.

MEDICAL HOME CONCEPT

Through all the changes that are going on, Stream and others stress the importance of developing Patient-Centered Medical Homes (PCMHs) to deliver care.

“The physician doesn’t have to do everything,” he says. “Everyone on the team can and should work to the limit of their training and licensure.”

The AAMC encourages physicians to maximize midlevel providers. “In Massachusetts, this has helped improve access to primary care,” Mitchell says.

Nurse practitioners know they are about to be elevated in the national healthcare dialogue. In fact, two organizations that represent them—the American Academy of Nurse Practitioners (AANP) and the American College of Nurse Practitioners (ACNP)—decided in early July to explore consolidating their operations. This move would significantly enhance the breadth and depth of work the organizations conduct on behalf of the nation’s 155,000 nurse practitioners (NPs).

“There has never been a better time for the consolidation of our organizations. Healthcare is at the center of the national agenda, and NPs are a vital part of the solution to the healthcare crisis facing our country today,” says Angela Golden, DNP, AANP president.

“When all our due diligence has been completed, our combined strengths will result in an organization that is stronger and better able to empower the NPs, who are so important in today’s healthcare environment,” says Jill Olmstead, MSN, ACNP president.

Stream encourages physicians to think beyond just NPs in developing the medical home concept. His practice, Rockwood Clinic, a multispecialty
practice in Spokane, Washington, employs not just the usual lineup of midlevel providers, but also has health coaches who work to keep patients up to date. Even if a small practice cannot afford to have someone in such a role full time, he says they might be able to coordinate sharing one with a nearby practice.

“We all need to use creative efforts to deliver better care without raising costs,” he says.

Stream notes that the ACA has provisions to help pilot PCMHs. For example, the Comprehensive Primary Care initiative is designed to foster collaboration between public and private healthcare payers to strengthen primary care. Medicare will work with commercial and state health insurance plans and offer bonus payments to PCPs who better coordinate care for their patients.

Primary care practices that choose to participate will be given resources to better coordinate primary care for their Medicare patients. The average payment will be about $20 per patient. This amount is designed to cover the costs of things that improve care such as telephone and email management of conditions and oversight of hospital discharges, Stream says.

“It allows care management without requiring you to be in the same room, which lets you cover more patients,” he adds. “We really see this as a game-changer.”

So far, the pilot program is available to physicians in seven states, including Arkansas, Colorado,

8 WAYS TO SEE MORE PATIENTS

Although some physicians may decide to not accept new patients, finding ways to accommodate the newly insured can boost the narrow economic margins of many primary care practices, experts say.

*Medical Economics* asked several practice management experts for their advice on ways primary care physicians (PCPs) could add more patients to their practices. Here is what they said.

1. Use midlevel providers

Triage patients first and assign the appropriate physician, midlevel provider, or staff member to see the patient, says Judy Bee of Practice Performance Group in La Jolla, California.

“Not all patients need to see a doctor,” she says. “It may be hard for some die-hards, but physicians may need to let go of some things that someone else can do just as well or better, such as school physicals.”

Michael D. Brown, of Health Care Economics in Fishers, Indiana, calls the use of midlevel providers a necessity.

“One person can only see so many people in a day. You have to let physician assistants [PAs] and nurse practitioners [NPs] do what you can’t,” he says. “A doctor just can’t do A to Z anymore.”

For example, he recommends having the staff take as much history as possible so the physician can focus on diagnosis once he or she is in the exam room.

Michael J. Wiley of Healthcare Management & Consulting Services in Bay Shore, New York, says it is important to not just use NPs and PAs, but to use them well.

“Don’t just let them be a glorified, expensive medical assistant [MA],” he says. “Groom them to be an independent provider.”

Doing so likely will require spending several weeks teaching them your practice styles and standards so that they know when they need to ask for your help.

“It takes time to train them, but it frees you up so much,” Wiley says. “Assigning them just two or three specific presenting problems to handle can be a good start.”

2. Take a group approach

Although midlevel providers can help ease a physician’s workload, Bee fears that there just won’t be enough of them to go around, at least initially.

She encourages physicians to consider offering some treatment or management in group settings. For example, a practice that sees many diabetic patients may consider offering classes where patients can all get answers to their questions at once, without making the doctor repeat the same information multiple times a day.

One clinic she works with offers such an event in the evenings. Half of the patients see a midlevel provider for individual discussions of their blood glucose levels, medications, and other matters, and the other half attend a class with the physician. Then the two groups switch.

“This can be even more effective than individual sessions because the patients can offer each other advice such as recommending a helpful product that they have found,” she says. “It can be a very useful model for any chronic disease that involves behavior modification, such as weight loss.”

The practice can receive reimbursement for the one-on-one visits. The time spent on education is not directly reimbursable, but can save a practice so much time during the week that it is worth it, Bee says.

“Seeing two times as many people while achieving better outcomes is a win-win,” she says.

3. Reduce the socializing

Brown believes that physicians can easily move from seeing six patients per hour to 10 by socializing less. Many physicians spend the first 80% of a visit chatting, he says. Although he agrees that some friendly talk is necessary, it needs to be wrapped up quickly. Be warm and friendly,
New Jersey, New York, Ohio, and Kentucky (Cincinnati–Dayton Region), and Oklahoma (Greater Tulsa Region). (The deadline to sign up is July 20.)

But if you are looking to get a glimpse of ACA’s impact to primary care, look no further than Massachusetts. The state has adopted many healthcare reform measures.

According to Joseph W. Gravel Jr., MD, president of the Massachusetts Academy of Family Physicians, since adopting new healthcare legislation, only about half of the state’s primary care practices are accepting new patients. Although his practice, Greater Lawrence Family Health Center in Lawrence, still accepts them, it has experienced tremendous demand for access. So much so that the practice uses midlevel providers and has opened a second location to help meet demand. Another office will open in the fall.

Also, the practice hired more NPs. “People who think NPs can replace a physician are wrong, but they can be an important part of a physician-led team,” he says.

Dupree calls the team approach the key to bringing primary care back to the forefront.

“It lets internists make the diagnosis, not specialists,” he says.

He is the only physician in his practice but has used NPs and medical assistants for years, calling them an ask how people are doing, but keep the conversation moving along.

“You can do this easily without losing patients. We all want to talk about our golf game, but you can do it quickly,” he says.

“Patients don’t want to chat. They want to get well. You can’t spend 8 of the 10 minutes you have allotted for a patient on unrelated matters and stay on schedule.”

He acknowledges that many doctors do not want to practice this way but says it may be inevitable, regardless of healthcare reform.

“Expenses are rising so much that you are going to need to earn 20% more just to keep up,” he says. “Show up late for rounds, chit chat a bit, and by 11 a.m., your waiting room is full and no one is happy.”

Wiley suggests that physicians who can’t quite see themselves going to 10 patients per hour consider adding at least two more appointment slots a day. At $75 each, times 10 per week, doing so can increase earnings an additional $37,500 per year with no added overhead.

4. **Extend your hours**

Too many practices resist the idea of expanded hours, but if a facility is maxed out, it may be the only way to increase patient access. Bee recommends adding 2 hours in the morning and 2 in the evening.

“This can be a huge productivity opportunity, especially if you have staff members who want to work part time,” she says. “They can split up the day, maybe one shift of 7 a.m. to 1 p.m. and another of 1 to 7 p.m.”

Patients really want the early morning and late day appointments that such a schedule allows, Brown says, so you are making them happy as well.

5. **Expand your offerings**

Primary care practices can offer many services internally rather than letting that money go elsewhere, Wiley notes.

He encourages practices to identify clinically appropriate services they can offer for which they can be reimbursed. For example, many don’t offer relatively easy services such as electrocardiography and pulmonary function testing due to staffing issues.

“They are losing a revenue-generating opportunity,” he notes. “If you need to hire an extra MA to do these types of tests, it is worth it.”

6. **Show them the money**

It also may be smart to incentivize the staff to work more efficiently, Bee says. For example, if an NP is paid at least in part based on the productivity he or she contributes to a practice, that person is going to be more willing to work over when a patient who really needs to be seen calls late in the day.

“Be willing to share the wealth,” Bee says.

Having a staff that is incentivized to help patients whenever possible makes the receptionist’s job so much easier. “They are the lowest-paid person, and yet they are the ones who get grief from patients when they can’t get in. Offering receptionists more options to help patients makes their lives better,” she adds.

7. **Reorganize**

Using the entire staff well is key, she says. One practice with which she consults designates one MA at a time to be the “desk jockey” who answers calls and triages patients instead of just letting whomever is available at the moment handle patient calls. Put an experienced person in this role, she says.

“The more they do it, the better they get at helping patients. This is such an important job,” she says.

Another office function that Bee thinks may need to be reimagined is the scribe, especially in offices with electronic health records. A scribe can help a physician maximize his or her time with the patient and not have to work late doing documentation.

“It will also make your records more accurate since you aren’t relying on your memory from hours ago,” she says.

8. **Define your own success**

Some doctors don’t want to work harder to earn more money, Wiley says. One of the first questions he asks clients is where they fall on the seesaw of income versus lifestyle. Those with kids in college or a high mortgage may make very different decisions than those with fewer obligations.

“Decide what are your goals,” he says, “then decide how you are going to get there.”

—Beth Thomas Hertz
essential part of a PCMH. Tufts is opening a new training program for physician assistants in the fall, he adds. Dupee has been unable to attract another PCP to join his practice but does open his facility to Tufts specialists to rotate through during the week to see his patients, many of whom resist driving 20 minutes into Boston for care. It’s a win-win arrangement, he says, because it keeps patients in his Tufts network in a way that is convenient for them and it nets him some additional referrals.

Although such creative solutions are necessary as adjustments are made, Gravel emphasizes that the benefits of reform far outweigh the hassles. “It is far better than the alternative, which is rationing healthcare based on employment status or income,” he says.

Send your feedback to medec@advanstar.com. Also engage at www.twitter.com/MedEconomics and www.facebook.com/MedicalEconomics.

### REACTIONS FROM PHYSICIAN ORGANIZATIONS

| Group                                      | Key argument                                                                                                                                                                                                                                                                                                                                                     | Full statement                      |
|--------------------------------------------|                                                                                                                                                                                                                                                                                                                                                               |                                   |
| **American Academy of Family Physicians**  | “The Affordable Care Act reduces numerous financial barriers to care...[and] recognizes the value of primary care by bringing Medicaid payment for primary care services to Medicare levels.”                                                                                                                                                                                                 | http://bit.ly/Msr5qD                |
| **American College of Physicians**         | “With the constitutional questions resolved, there is no excuse now for states, including those that filed suit against the law, to decline to move forward on setting up state health exchanges and other provisions of the law that involve a partnership between the states and the federal government. ACP also strongly urges states to move forward on expanding Medicaid...”                                                                 | http://bit.ly/LG6AHX                |
| **American Medical Association**           | “The health reform law upheld by the Supreme Court simplifies administrative burdens, including streamlining insurance claims, so physicians and their staff can spend more time with patients and less time on paperwork.”                                                                                                                                                      | http://bit.ly/MYbN80                 |
| **American Osteopathic Association**       | “We remain committed to promoting the critically important role of primary care physicians and continuing efforts to develop and expand patient-centered models of care...[and] we remain hopeful that progress can now be made towards the full repeal of the systemically flawed sustainable growth rate formula and the enactment of comprehensive medical liability reforms.”                       | http://bit.ly/NS4nrp                 |
| **Association of American Medical Colleges** | “Addressing the nation’s physician shortage...is now more critical than ever. Medical schools have done their part, increasing enrollments...but the overall supply...cannot expand unless Congress increases the number of federally funded residency training positions...to ensure that Americans have access to care—not just an insurance card.”                                                                 | http://bit.ly/N7gThS                 |
| **Association of American Physicians and Surgeons** | “This is a bleak day for America...The federal government has no constitutional authority to dictate how Americans shall pay for their medical care. It has no right to force them to turn over their earnings for the profit of private insurers or for the ‘public use.’”                                                                                                                      | http://bit.ly/Lj7plt                 |
The Massachusetts model:
A CASE STUDY

The Massachusetts government passed sweeping reforms to its healthcare system in 2006, with open enrollment for insurance beginning in 2007. The state’s experience could be telling for the rest of the country now implementing a similar system.

The impact of the Massachusetts reforms, according to two primary care physicians (PCPs) in the state, has been a spike in patient volumes, but the changes have actually made their jobs easier.

“It is important to note that most physicians here favor this. It has made it better for us, because caring for uninsured people is hard. So even if we are a little busier, it is still better, because patients aren’t delaying coming in for preventive care as much as they used to,” says Joseph W. Gravel Jr., MD, president of the Massachusetts Academy of Family Physicians.

Trying to coordinate care with specialists has become easier as well, because insured patients do not resist going, he adds. “It is really a great practice environment for primary care,” Gravel says. “The benefits far outweigh the increase in demand, as we are no longer left holding the bag with an uninsured patient who needs care.”

Richard M. Dupee, MD, chief of the geriatrics service at Tufts Medical Center in Boston and governor of the American College of Physicians’ Massachusetts chapter, agrees. “Emergency room visits went up initially as patients got insurance but struggled to find a physician, but that is settling out now,” he says. “In the long run, total costs will go down. Not right away, but 10 years from now, as patients experience fewer complications from untreated conditions.”

Dupee notes that many of the state’s newly insured are not being seen in small private practices, but instead are seen at larger hospital-owned academic clinics or community health centers. “The private practice model is dying,” he says.

About 70% of all doctors in Massachusetts favor the reform, primary care and specialists equally so, Gravel says. Only about 2% of the state’s population is uninsured now, mostly young adults who are unemployed and have decided that paying the penalty is less expensive than buying a policy.

Gravel says it was interesting to read coverage of the Supreme Court decision and contemplate the effect it might have in Massachusetts. “People here were worried that our good thing might get derailed by politics,” he says.

As with elsewhere in the country, there are too few PCPs in Massachusetts, but Gravel attributes that situation to many factors that predate health reform, such as the aging population and the fact that not enough primary care residency positions exist to train all of the graduates of the state’s four medical schools. Once they leave the state for a residency, many physicians do not return.

Funding more training opportunities is an investment easily justified by getting 40 years of care for the state’s citizens, says Gravel, who is program director for the Lawrence Family Medicine Residency.

—Beth Thomas Hertz

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### REACTIONS FROM OUR EDITORIAL BOARD

We asked our editorial board members for their assessments of the recent ruling. Their edited responses appear below. For longer versions, please see [www.MedicalEconomics.com/ACA](http://www.MedicalEconomics.com/ACA).

<table>
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<th>Board member</th>
<th>Opinion</th>
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<tr>
<td>Mary Ann Bauman, MD</td>
<td>I am nervous of the unknown and worried about the inevitable bureaucracy, but I am glad we are doing something to address our healthcare issues. So, I am pleased with the decision. The challenge for our practice will be to make sure that, if and when single payment programs are implemented, primary care gets its fair share, as there will be multiple players (hospitals, specialists, hospitals, rehab, home health, etc.) vying for those dollars.</td>
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<td>Gregory Hood, MD</td>
<td>Whether the Affordable Care Act (ACA) is repealed or implemented, healthcare and other social contract expenditures are on pace to outstrip what funds could possibly be raised by the government to pay for them. The elements of the practice of medicine that do work currently must be sustained and supplemented through innovation. We can’t stay on the path we’ve been on, but neither can we rely solely on the pathway of the ACA as it currently exists.</td>
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<td>Jeffrey M. Kagan, MD</td>
<td>The new law clearly will have a positive impact on the lives of many individuals who are either uninsured or underinsured. I expect my practice to get busier. We have one part-time midlevel and an advanced practice registered nurse, and we might need increase her hours or add a second one. I also think hospitals will get busier, with more patients seeking elective procedures, and the numbers of uninsured patients looking for primary care in the emergency department will decrease.</td>
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<td>Jeffrey K. Pearson, DO</td>
<td>What my patients and I really need from the U.S. government is not the mishmash more commonly referred to as ACA. Patients and providers are at the mercy of the insurance companies, but the health and well-being of humans should not be treated as a commodity. If it is designed properly, however, I am entirely behind a national, government-sponsored, single-payer healthcare system, as it would greatly simplify the lives of both my patients and my staff.</td>
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<td>Patricia J. Roy, DO</td>
<td>I don’t support this plan as the “be all, end all” program, but the court’s decision will move universal coverage way forward. As the demand for care far exceeds the supply, the value of primary care services will finally be compensated in a more fair way compared with other specialties. And more medical school graduates will see primary care as a viable alternative to provide them with a comfortable lifestyle as well as with the ability to pay back student loans.</td>
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<td>Joseph E. Scherger, MD</td>
<td>The greatest change will be many more people having health insurance, especially Medicaid. All primary care providers will have greater demand on their services, and since we do not have enough primary care physicians (PCPs), more nurse practitioners (NPs) and physician assistants (PAs) will work in teams with physicians to extend primary care to more people. Community clinics and other practices that treat Medicaid patients will expand greatly.</td>
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<td>Richard E. Waltman, MD</td>
<td>I applaud the ruling. Since my specialty is geriatrics, my practice has been greater than 75% Medicare for a long time. Although I share the usual concerns about reimbursement, Medicare works well for most of my patients. Let’s offer Medicare to everyone. Those who want “better care” (concierge medicine) can pay additionally for it. Also, let’s encourage medical students to enter primary care; let’s train them well, and then let’s provide them fair reimbursement.</td>
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<td>Craig M. Wax, DO</td>
<td>If not repealed or defunded, the ACA will hasten Medicare’s demise or create medical rationing. It will further bankrupt the U.S. government, forcing our dependence on foreign loans. The ACA also will force other patients into the failing state Medicaid system. Most private offices will not be able to accommodate the millions of potential new Medicaid patients, who then will have to seek care from the already overburdened EDs, subsidized clinics, or by paying cash to private physicians.</td>
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For primary care physicians (PCPs), the Supreme Court’s decision mostly upholding the Affordable Care Act (ACA) has made their reimbursement picture clearer—but only slightly. Most PCPs will still find themselves juggling their patient mix to attain a balance between patients who are covered by Medicare and Medicaid and those covered by private insurers, who generally reimburse at higher rates.

What is certain is that the law makes many more Americans eligible for some kind of health insurance, either through expanded Medicaid coverage, health insurance exchanges and their accompanying tax credits, or the individual mandate. Using data from the Congressional Budget Office, the Commonwealth Fund, a think tank focused on healthcare delivery, estimates that by 2016 about 32 million additional nonelderly Americans will have healthcare coverage as a result of the ACA.

Probably the most significant part of the ACA where PCPs are concerned, experts say, is the millions of previously uninsured adults who will be eligible for Medicaid coverage. Recognizing the financial burden that increase could pose for many physicians, beginning in 2013 the law increases Medicaid reimbursement rates to make them equal with Medicare rates—but only for 2 years.

Complicating the Medicaid picture is the part of the Supreme Court’s ruling that effectively neutralizes the federal government’s authority to financially penalize states that choose not to expand Medicaid coverage to their residents. When and to what extent you feel the full effect of the ACA ruling, in other words, may depend on where you live.

CONTINUED ON PAGE 28
**MEDICARE REIMBURSEMENT BONUS**

When it comes to Medicare, the picture is a little brighter. The Commonwealth Fund estimates that ACA includes a 10% Medicare payment bonus for practices in which at least 60% of the charges are reimbursed under primary care codes recognized by the Medicare physician fee schedule. The bonus went into effect at the beginning of 2011 and is scheduled to expire at the end of 2015. But hanging like a sword over the heads of PCPs is the threat of a 32% reduction in Medicare reimbursements scheduled to go into effect January 1 under the sustainable growth rate (SGR) formula.

Robert Zirkelbach, vice president of strategic communications for America's Health Insurance Plans (AHIP), the trade association representing the health insurance industry, says implementation of the ACA will accelerate two trends already under way in healthcare delivery. The first is a push toward greater cooperation and coordination of care among providers.

The ACA contains several provisions encouraging the formation of accountable care organizations to provide care for Medicare patients. ACOs offer the potential of financial rewards to physicians who are able to hold costs down while meeting quality metrics.

**MOVING AWAY FROM FEE-FOR-SERVICE**

“What we’re seeing is an effort to move the healthcare system away from the fee-for-service model and toward one that pays for value, quality, and desired health outcomes,” Zirkelbach says. “The ACA does take some important steps to try and build on what’s been working in the private [payer] system, so that’s certainly a plus.”

The second trend AHIP sees is towards provider consolidation, including hospitals and integrated health systems purchasing primary care practices. By reducing competition in a market, consolidation could enable remaining independent physicians to raise their fees. That would benefit individual physicians but might negate some of the larger gains the ACA was designed to bring about.

“One of the concerns we’ve raised is that the ACO program could be an incentive for further provider consolidation,” he adds. “Were that to happen, it would cause price increases that would far exceed the potential cost savings of accountable care,” he adds.

The Medicare primary care payment bonus and the promise of Medicaid reimbursements that are on a par with those paid by Medicare—even if just for 2 years—are a welcome relief for practices with large numbers of Medicaid and Medicare patients, says Reid Blackwelder, MD, FAAFP, professor of family medicine at the James H. Quillen College of Medicine in Johnson City, Tennessee, and a board member of the American Academy of Family Physicians.

In addition to seeing his own patients, Blackwelder directs Quillen’s family residency clinics in Kingsport, Tennessee, one of three the college operates. About 72% of the patients treated in the residency clinics are covered either by Medicare or Medicaid.

“Our clinics have already benefitted from the Medicare primary care bonus, and we estimate additional revenue of about $400,000 when the Medicaid-Medicare parity takes effect,” he says. “For us, that’s substantial money.”

Nevertheless, he says, the clinic is always seeking other sources of income, for instance by trying to attract more patients covered by private insurance. It is a situation similar to that faced by many independent primary care practices.

**THE CHALLENGE FOR DOCTORS**

“For regular physicians, the challenge is they are getting paid less for Medicaid [than by Medicare or private payers]. Why should they continue to serve a patient base that doesn’t allow them to make ends meet financially? Many are wondering if they should continue taking Medicaid patients, and some are wondering about Medicare as well,” Blackwelder says.

“The physicians who are out there on the front lines, working hard to care for their patients, who don’t turn anyone away regardless of ability to pay, they still have to pay overhead and their staff. The person who gets paid last is the owner-physician,” he adds.

Although PCPs are justifiably concerned about an influx of Medicaid patients, Blackwelder says, the new subsidies and the individual mandate will mean that many patients who had been getting free care now will have some form of insurance coverage. “The additional coverage will allow us to do the things [PCPs] do best, which is work with patients before they get into trouble and keep them out of the hospital and away from expensive care.”

Blackwelder says the AAFP, along with other organizations representing PCPs, has been pushing for legislation and rule changes that would raise PCP income and eliminate or modify the SGR formula. “The challenge is that none of these are quick fixes,” he says. “You can’t call your congressman and suddenly get higher payment. It takes a long time for things to change.”

**Continued from Page 27**
With Advil® and Tylenol®, OA patients may have to re-dose every 6 hours*
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Because OA pain can last many hours and days, patients using Extra Strength Tylenol or Advil have to re-dose more often if pain persists.

Compare the convenient dosing of ALEVE with other OTC brands

<table>
<thead>
<tr>
<th>Extra Strength Tylenol (acetaminophen) 500 mg/tablet</th>
<th>Advil (ibuprofen) 200 mg/tablet</th>
<th>ALEVE (naproxen sodium) 220 mg/tablet</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hour 0</strong></td>
<td><strong>Hour 6</strong></td>
<td><strong>Hour 12</strong></td>
</tr>
<tr>
<td>1st dose</td>
<td>2nd dose</td>
<td>3rd dose</td>
</tr>
<tr>
<td><strong>Hour 18</strong></td>
<td><strong>Hour 24</strong></td>
<td><strong>X</strong></td>
</tr>
<tr>
<td>4th dose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st dose</td>
<td>2nd dose</td>
<td>3rd dose</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2nd dose</td>
</tr>
</tbody>
</table>

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RECOMMEND ALEVE

Strong on pain. Long on relief.
Could an in-house lab be right for your practice?

With proper planning, this ancillary service may boost practice income and save valuable time

By RICHARD A. JACKSON, MD, FACP

Yes, you can incorporate a laboratory in your office and make a profit in 5 years. I know, because I did it, and so have more than 30,000 American College of Physicians (ACP) members.

Seven years ago, at an annual ACP meeting, a vendor asked me who was performing my lab work. As an internist, I use lab data as an integral part of the information I gather to help me treat and advise patients.

I replied that a major lab company was doing my lab work and that I had little control over quality and the reports I received. He countered that I was throwing away $120,000 a year, especially on the Medicare lab draws. He also told me that lipid profiles and chemistries for office and independent labs were reimbursed at a good rate.

This information caught my attention because the seven primary internists in our office were reporting that our reimbursements were dropping.

Finally, I thought, here was a way to stem the flow of cash from our office and at the same time control quality and other factors important to having a good, reliable lab.

After approval by our group, we asked a vendor to develop the plans for a draw station and the conversion of our lunch room to a lab. We discussed the purchase of lab equipment with our banker, who agreed that it was a good move. We borrowed $250,000 over a 5-year period and hired a lab technician who had 25 years’ experience. The technician hired a former lab colleague. We also found a specialist who wrote our lab manual.

OVERCOMING A FEW HURDLES

Of course—as with everything—eventually some problems occurred. One employee’s behavior became problematic and he quit when confronted. We hired a replacement who has worked out well.

When seeking reliable lab personnel, ask your local hospital’s technicians for recommendations. Also, rely on your lab director’s expertise when staffing your lab.

We have two full-time lab personnel who work in shifts; one arrives early to start-up the equipment and the other stays late to close down the lab. A part-time staff member picks up specimens and helps out in the lab. We now have two phlebotomists, a lab director, and a lab technician.

We purchased a chemistry analyzer that the salesperson insisted would serve us well. It was designed to run panels in a moderately complex lab. Unfortunately, this analyzer took 2 hours to bring online,

To calculate the costs and revenues for an in-house lab, see the story on page 36.

For additional information about in-house labs, see MedicalEconomics.com/inhouselab
calibrate, and run standards. Results never were accurate. We asked the salesperson to take it back and get us another machine; he refused. Subsequent legal action led to a settlement. Our lab director guided us to a quality machine that fit our needs, and it has performed well since we installed it.

MEETING PATIENT, PRACTICE NEEDS
Even after all of these events, the lab began to give us a profit fairly quickly, and we were able to pay off our loan on time.

In the years that followed, we’ve added several lab panels and two additional doctors. Despite some decrease in reimbursements, our practice still receives about 16% of its income from the lab.

Although reimbursement rates for such tests will vary by payer and region, we are seeing Medicare reimbursements of $14.97 for complete metabolic profiles, $11.02 for complete blood counts, $11.98 for basic metabolic profiles, $10.96 for lipid profiles, and $4.48 for urinalyses. Most physicians use a chemistry analyzer, a hematology analyzer, and an immunoassay machine.

We have a partnership with a major lab to perform those complicated tests for which we do not have capacity, so we can do the “usual” tests in the office. This process allows the national lab to perform the test, charge for it, and maintain its business model.

Another benefit of partnering with a major lab is that it has many draw stations in town. If a patient has a need for a blood draw for chemistries or monthly prothrombin times, it can be done at the nearest site of our national lab, and we can retrieve results from our office computer. That process saves a patient a long drive for a simple lab test.

The institution of a lab in our office has been an excellent decision. If I had to do it over, I now know that it would be best to change the order of the process by hiring the lab person first, so we would have the expertise of that professional to help design the lab and assist in selecting lab equipment, machines, other personnel, and chemicals.

What started out to be a project to increase our income also became a way to provide better, quicker, better-controlled service to our patients. 

Pros, cons, and reimbursements
Aside from the possibility of increasing your practice’s income, offering lab services could make life easier for you and your patients. Here are some of the advantages and disadvantages to consider before adding an in-house laboratory to your practice.

**Patient care.** Commonly conducted tests include complete blood count; complete and basic metabolic profiles; hemoglobin A1C; pregnancy; T4, T3, and thyroid-stimulating hormone; influenza; group A streptococcus; urinalysis; and microalbumin.

**Patient convenience.** An in-office lab can eliminate the need for patients to drive to facilities located away from your office for commonly required tests. Plus, patients will receive their test results quickly, often in less than an hour.

**Time savings.** Giving your patients the results of their tests while they are still in your office will save you and your staff time in making treatment decisions or reduce follow-up telephone work to share results or schedule new appointments.

**Disadvantages.** Equipment can be costly to purchase and maintain. There are space requirements in the practice. Additional staff is needed to operate the equipment. Reimbursements vary by payer and region. And there are some regulatory hurdles that could include laboratory certification.

— Diane Sofranec

We’re looking for success stories
Are you a family medicine or internal medicine physician who has found success adding an ancillary service to your practice? Tell us about your experience by sending an email to Editor-in-Chief Lois A. Bowers, MA, at lbowers@advanstar.com.

The author practices internal medicine in Houston, Texas. Send your feedback to medec@advanstar.com. Also engage at www.twitter.com/MedEconomics and www.facebook.com/MedicalEconomics.
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www.MedicalEconomics.com/HIMSS2012

You've got technology questions. We've got answers.
Focus on the facts

When deciding whether an in-house lab is right for your practice, calculate the costs and revenues you may incur.

By TIM DUMAS, MLT, CLS

An in-house laboratory should be run like a business. To successfully evaluate the merits of adding a lab to your practice, first calculate your projected revenue. Then you will need to know:

- cost per reportable, or the cost per test plus any extra items not included with it;
- reimbursement, which varies from state to state and from one insurer to another. For guidance, see www.cms.hhs.gov/ClinicalLabFeeSched/02_clinlab.asp#TopOfPage; and
- number of tests performed. Consider counting per month and keep in mind that volume varies based on time of year.

The two tables shown here offer a good example of the costs and revenues for a non-waived lab that performs a complete blood count (CBC) test. Reimbursement is based on the Medicare minimum ($10.94 per test) and will not change much. The only real control you have to increase revenue is to decrease your cost per test. The cost here of $1.25 per test is an average for CBC testing and will decrease with a higher volume of testing.

From the gross revenue per year—$25,581.60—subtract your fixed costs (see table 2). These costs are fixed because no matter how many tests you run, they remain the same. The average fixed costs per year are:

- hematology analyzer: $3,000 (estimate: $15,000 leased over 5 years);
- service contract: $1,700;
- proficiency testing: $350; and
- Clinical Laboratory Improvement Amendments fee for non-waived testing: approximately $600 per year.

Deduct your fixed costs from your gross revenue to calculate your net revenue ($19,931.60 in this example).

Could your practice use an extra $20,000 per year in net revenue? Even more important from the standpoint of clinical quality, how valuable is a stat CBC? You could, for example, diagnose flu versus an infection without having to write a prescription or call the patient back with the test results. Here is where you can factor in the savings from not having to call the patient back or open that chart again to review and comment on the results. It is just better medicine.

Although this example is not the whole story, you can use it as a template to determine the feasibility of performing a given test in-house.

The author is president of TLD Consulting LLC, Raleigh, North Carolina. Send your feedback to medec@advanstar.com. Also engage at www.twitter.com/MedEconomics and www.facebook.com/MedicalEconomics.

### TABLE 1
Calculating gross annual revenue for a non-waived lab

<table>
<thead>
<tr>
<th>Test type</th>
<th>CBC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of tests per month</td>
<td>220</td>
</tr>
<tr>
<td>Reimbursement per test</td>
<td>$10.94</td>
</tr>
<tr>
<td>Total reimbursement per month</td>
<td>$2,406.80 ($10.94 x 220)</td>
</tr>
<tr>
<td>Cost per test</td>
<td>$1.25</td>
</tr>
<tr>
<td>Total test cost per month</td>
<td>$275 ($1.25 x 220)</td>
</tr>
<tr>
<td>Gross revenue per year</td>
<td>$25,581.60 ($2,131.80 x 12)</td>
</tr>
</tbody>
</table>

### TABLE 2
Calculating net annual revenue for a non-waived lab

| Gross revenue per year | $25,581.60 (see Chart 1) |
| Fixed costs to be deducted: | |
| Hematology analyzer | $3,000 |
| Service | $1,700 |
| Proficiency | $350 |
| CLIA fee | $600 |
| Total fixed costs | $5,650 |
| Net revenue | $19,931.60 ($25,581.60 - $5,650) |
A gift from the feds that will protect your assets

Act now to take advantage of tax exemptions that may save millions as you provide for your spouse and family

By ALAN S. GASSMAN, JD, LLM, KENNETH J. CROTTY, JD, LLM, CHRISTOPHER J. DENICICO, JD, LLM, and ERICA PLESS, JD

If you are part of an affluent married couple who has not used all of your $5.12 million gift and estate tax exemption, consider funding a spouse and family exempt (SAFE) trust to protect assets from federal estate tax, future creditors, and potential mismanagement or excess spending by family members. Tax lawyers may call this an irrevocable defective dynasty trust with provisions for the grantor’s spouse and descendants.

The federal gift tax exemption is set to return to $1 million on January 1, 2013, so affluent families need to move quickly to make best use of the $5.12 million opportunity.

If you are an affluent unmarried individual, make complete use of your 2012 $5.12 million gift tax exemption before year end by transferring assets to trusts that primarily or entirely benefit descendants, friends, and other family members. Married couples have a unique opportunity because the grantor spouse can transfer assets to a trust to provide for the beneficiary spouse’s health, education, maintenance, and support, and the grantor spouse can cohabit and enjoy the benefits received by the beneficiary spouse. Additionally, the grantor spouse may be able to borrow from the trust.

ESTATE AND GIFT TAXES
When a person dies, the federal estate and gift tax systems add up the value of the person’s assets, al-

Plan ahead
These additional planning considerations may apply whether or not the grantor’s spouse is a beneficiary.

1 Protect the trust
If the trust also provides for health, education, maintenance, support, or other payments to descendants, how will the trust be protected from a descendant’s support claims or other items for which state law permits penetration of a trust?

2 Appoint a trusted protector
A trust protector can be appointed with certain powers, including the ability to remove and replace the trustee, amend the trust, modify distributions, and/or add beneficiaries. Therefore, trust protectors provide an extra layer of protection over the trust. It may be a good idea to appoint an independent third party, but make sure you fully trust this person.

3 Use designated representatives
Appoint designated representatives, with the power to waive accountings and to receive information that might otherwise have to be given to a beneficiary who is better served by not having all information.

POWER POINTS

- Gift, estate, and generation-skipping transfer tax exemptions for 2012 are $5.12 million but are set to return to $1 million on January 1.
- Current estate and gift tax laws provide affluent married couples with an incentive to establish more than one type of trust.
allowing deductions for assets that pass to charity, a spouse, or special trusts for charities and spouses. The law sets an amount, called the estate tax exemption, which can pass estate tax free. Each person is entitled to his or her own estate tax exemption. If the value of an estate minus allowable deductions is less than the estate tax exemption, then no estate tax is due.

The law provides an unlimited marital deduction, so spouses can transfer assets to each other without incurring estate or gift tax. Therefore, if the first spouse to die gives all of his or her assets to his or her surviving spouse, his or her estate will not pay any estate or gift tax. Typically, these assets will be held in a “marital deduction trust.” Without proper planning, however, upon the death of the surviving spouse, there typically will be a large amount of estate tax owed if the assets of the surviving spouse and marital deduction trust assets exceed the estate tax exemption. Therefore, it is essential to correctly use the unlimited marital deduction and the estate tax exemption.

Gifts also may be subject to federal estate tax if they do not qualify for the annual exclusion (currently $13,000 per recipient per year), the tuition and medical direct payment exclusion, the marital exclusion, or the charitable exclusion. Lifetime gifts that do not qualify for any of these exclusions are “taxable gifts.” Taxable gifts that use some of a taxpayer’s gift tax exemption also reduce a taxpayer’s estate tax exemption by the same amount.

If a person makes cumulative taxable gifts in

**CONTINUED ON PAGE 41**

### KNOW YOUR TRUST TERMINOLOGY

| **Beneficiary** | A party who receives benefits from a trust. |
| **Bypass trust** | A trust that is funded to maximize the estate tax exclusion amount. It is also referred to as a family trust or credit shelter trust. |
| **Defective trust/defective grantor trust/intentionally defective grantor trust** | A trust that is treated as disregarded from the grantor for income tax purposes and allows for additional planning opportunities without incurring income tax. |
| **Donee** | The party who receives something from another party. |
| **Donor** | The party who gives or appoints something to another party. |
| **Dynasty trust** | A trust that is designed to be held for the benefit of multiple generations of descendants. |
| **Estate tax exemption amount** | The amount permitted to pass free of federal estate tax. It is currently set at $5.12 million for 2012. |
| **Generation-skipping trust** | A trust that is established to avoid estate tax on transfers to descendants who are more than one generation level from the grantor (such as a grandchild). |
| **Gift tax annual exclusion** | The annual amount an individual is permitted to give another person without incurring gift tax. It is set at $13,000 for 2012. |
| **Gift tax exemption amount** | The amount of taxable gifts an individual may make during his or her lifetime without having to pay federal gift tax. It is set at $5.12 million for 2012. |
| **Grantor/settlor** | The party who funds the trust. |
| **Marital deduction trust** | A trust that is funded to maximize the unlimited marital deduction. It is also referred to as a qualified terminable interest property, or QTIP, trust. |
| **Power of appointment** | The power to appoint who will receive property held for the donee’s benefit. |
| **General power of appointment** | The donee is permitted to appoint the property to anyone, including the donee, the donee’s estate, the donee’s creditors, and creditors of the donee’s estate. |
| **Special/limited power of appointment** | The donee is not permitted to appoint the property to the donee, the donee’s estate, the donee’s creditors, and creditors of the donee’s estate. |
| **Taxable gift** | A gift that does not qualify for any of the gift tax exclusions and therefore either reduces the donor’s gift tax exemption amount or causes the donor to pay federal gift tax if the donee has made cumulative taxable gifts that have used all of the donor’s gift tax exemption amount. |
| **Trust protector** | The party appointed in a trust who has the power to change how trust assets will pass when the surviving spouse dies. |
| **Trustee** | The individual or entity that oversees and manages the trust assets. |
TWO TRUST OPTIONS

<table>
<thead>
<tr>
<th>1 Trust established by husband for wife</th>
<th>2 Trust established by wife for husband</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Beneficiary</strong></td>
<td></td>
</tr>
<tr>
<td>Wife and descendants, with the right to receive amounts as needed for health, education, maintenance, and support.</td>
<td>Children may be health, education, maintenance, and support beneficiaries, with husband being a beneficiary only in the event of dire financial emergency.</td>
</tr>
<tr>
<td><strong>Power of appointment</strong></td>
<td></td>
</tr>
<tr>
<td>Wife may have a power of appointment exercisable in favor of all common descendants of the parties.</td>
<td>Husband may receive no power of appointment under the trust. Trust protectors may be appointed with the power to change how trust assets would pass on surviving spouse’s death.</td>
</tr>
<tr>
<td><strong>Timing</strong></td>
<td></td>
</tr>
<tr>
<td>Husband may establish the trust for wife in 2011.</td>
<td>Wife may give continued thought as to whether to use her new $4 million exclusion until finally starting on a new trust and completing it in 2012.</td>
</tr>
<tr>
<td><strong>Trustee</strong></td>
<td></td>
</tr>
<tr>
<td>Wife</td>
<td>Children</td>
</tr>
<tr>
<td><strong>Trust assets</strong></td>
<td></td>
</tr>
<tr>
<td>This trust might own life insurance on husband’s life (because husband will not be a beneficiary) and other investments.</td>
<td>This trust would not own life insurance on wife or any second-to-die policy.</td>
</tr>
</tbody>
</table>

CONTINUED FROM PAGE 38

excess of the lifetime gifting exemption, which stayed at $1 million from 2002 through 2010, then such gifts will be subject to federal gift tax. They would have triggered a gift tax at a rate of 45% for years 2007 through 2010. Before 2007, the gift tax rate had been as high as 55% for gifts made after 1984.

Here’s an example of how the system works: If a father gave his daughter gifts equal to the annual exclusion each year plus additional gifts of $900,000 through 2009, then the father has used $900,000 of his $1 million gift and estate tax exemption. If the father died in 2009, then upon his death he could have transferred $2.6 million ($3.5 million — $900,000) without payment of estate tax.

For 2011, the gift and estate tax exemption was $5 million. For 2012, this amount has been adjusted for inflation and is $5.12 million. But under the current law, the exemption for gift tax and estate tax will revert to $1 million on January 1, 2013.

As a result of this $5.12 million temporary opportunity, many financially successful individuals are funding trusts for spouses and family members, taking advantage of the chance to gift more than $1 million if it fits in with the family’s financial and retirement planning.

For example, the generous new exemption amount permits the father who had given his daughter gifts equal to the annual exclusion each year plus $900,000 the ability to gift an additional $4.22 million ($5.12 million — $900,000) without paying any gift tax. If the January 1, 2013, $1 million exclusion amounts rear their ugly heads, then this person will have successfully transferred $4.12 million out of his estate, plus the growth thereon, without paying any transfer taxes. If this person waits until 2013, he will be limited to gifting only $1 million without incurring transfer taxes.

**DYNASTY TRUSTS**

Most of the gifting previously discussed here will be to trusts that benefit family members without being subject to creditor claims or federal estate tax that otherwise would apply to each family member. These are often called generation-skipping trusts, because although they benefit the next generation, they are not subject to federal estate tax when that next generation dies, and can thereafter then benefit the next level of descendants.

For example, if a grandparent transfers assets to his children, who then transfer the assets to their children, then two taxable events and two levels of taxation would exist. Alternatively, if the grandparent simply transfers assets directly to the grandchildren, only one taxable event and one level of taxation would exist. The grandparent, therefore, has skipped a generation’s level of taxation; hence the term generation-skipping. Such a transfer is called a skip transfer.

Congress wanted to curb the use of dynasty trusts, so it implemented the generation-skipping transfer (GST) tax. The GST is imposed in addition to the
estate and gift taxes, but similar to the estate tax, there is a GST exemption that is currently $5.12 million. Each person can allocate his or her GST exemption to avoid GST on skip transfers. When gifts are made to trusts, the grantor’s GST exemption can be allocated to the gift so that the trust will be a generation-skipping trust. Similar to the estate tax exemption, in 2013 the GST exemption also is set to decrease to $1 million.

"The current estate and gift tax laws create an incentive to establish more than one type of trust for affluent married couples."

Another advantage of this type of dynasty trust is that it can be structured so that the grantor can pay the income tax attributable to the dynasty trust assets to allow it to grow income tax free. This is known as a defective trust or a defective grantor trust. The payment of the income tax on the trust assets is not considered to be an additional gift by the grantor to the trust under the current estate and gift tax system.

EVERYONE BENEFITS
These types of trusts also can provide financial benefits for the grantor, which can include loaning money to the grantor or buying assets from the grantor on long-term low interest notes. If the grantor sells assets to such a trust, the grantor does not recognize any gain on the sale. The trusts also can co-own assets with the grantor under entities, such as limited liability companies and limited partnerships, where the grantor can maintain managerial control of the entity while knowing that the portion of the entity owned by the trust will not be subject to federal estate tax, creditor claims, or unwise spending by the beneficiaries.

If the dynasty trust is formed in a creditor protection trust jurisdiction, such as Nevada, Alaska, or Nevis, then it also may be possible for the grantor to be a discretionary beneficiary of the trust, and the trust still may remain outside of the grantor’s estate. If the trust is not formed in a creditor protection jurisdiction and any creditors of the grantor are able to reach the assets, then the value of the assets may be included in the grantor’s estate and be subject to estate tax.

In addition, many taxpayers and advisers are not aware that the grantor’s spouse can be a beneficiary of the trust, so monies that would be needed to support the grantor’s spouse can be distributed from the trust if and when financial circumstances would be appropriate for this to occur.

TWO ARE BETTER THAN ONE
As a result, many financially successful individuals are making large gifts equal to their remaining gift tax exclusion amount to irrevocable trusts that benefit the spouse and descendants. This type of trust is referred to as a bypass trust, because the assets placed in the trust will not become subject to federal estate tax at the level of the spouse or the donor. The assets are not taxed at the donor’s level because of his or her gift tax exclusion amount. The assets also escape taxation at the beneficiary spouse’s level if the trust has been properly structured so that the beneficiary spouse has limited use of the trust assets (for health, education, support, and maintenance, for example).

The current estate and gift tax laws create an incentive to establish more than one type of trust for affluent married couples. Although the donor or the first to die can use his or her remaining federal estate tax exclusion by funding a bypass trust, he or she also should consider funding a marital deduction trust for the surviving spouse and use the unlimited marital deduction to prevent assets from the first dying spouse’s estate that are larger than his or her estate tax exclusion amount from being subject to estate tax on his or her death.

Keep in mind, however, that although the assets in the marital deduction trust will escape taxation on the death of the first spouse, they will be included in the estate of the surviving spouse. Therefore, these assets could cause an estate tax liability when the surviving spouse dies, unless additional planning has been implemented.

MAXIMIZE EXCLUSIONS, DEDUCTIONS
The combination of a bypass trust and a marital deduction trust maximizes the use of the $5.12 million gift and estate tax exclusion and the unlimited marital deduction. For example, assume John and Mary, both U.S. citizens and husband and wife, have assets totaling $10.12 million. Further assume that all of these assets are in John’s name.

John establishes a bypass trust, funding it with the applicable gift tax exclusion amount of $5.12 million. On John’s death, the remaining $5 million will be transferred into a marital trust for Mary, and no estate tax will be due on John’s death.

The amount of estate tax due when Mary dies will be determined by the applicable estate tax exclusion available on the date of her death. If John and Mary died in 2012 under this structure, the full $10.12 million would pass estate tax free. However, if John died in 2012 but Mary dies in 2013, when the estate tax exclusion amount is $1 million, then Mary’s estate
will be subject to estate tax on $4 million unless additional planning is implemented.

**IT PAY TO ACT FAST**

The January 1, 2013, deadline is fast approaching and brings with it the possibility that the gift tax exemption and the estate tax exemption will be reduced to only $1 million. These potential dramatically reduced exemption amounts, coupled with currently low valuations and the ability to use discount planning in conjunction with gifting, make it very clear that affluent families will benefit greatly from establishing and funding a SAFE trust before the end of 2012.

Ready to sign up? Make sure you seek competent legal advice, because many state and tax laws must be navigated properly to make appropriate use of these opportunities.

Unfortunately, not all tax lawyers, certified public accountants, and other advisers understand how these rules all come together, and they may cause families to fall into traps that allow the Internal Revenue Service, creditors, divorcing spouses, and state taxing authorities to step into a trust if it is not properly designed, funded, and managed according to the fairly basic ground rules described here.

Send your feedback to medec@advanstar.com. Also engage at www.twitter.com/MedEconomics and www.facebook.com/MedicalEconomics.

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Do the Math
Survey identifies keys to EHR implementation success

Hiring outside help, purchasing quality hardware, and getting staff buy-in all important in this phase of adding technology

By DANIEL R. VERDON, Group Editor, Primary Care

**POWER POINTS**

- Plan for a drop in patient flow during an EHR implementation. Experts say it can be as high as 30%.
- Consider contracting with IT professionals during your implementation. According to survey data, about 60% of the study’s physicians paid for this kind of support.

Buying quality hardware, hiring outside help, and getting buy-in from the practice staff members were three of six key ingredients that helped ease challenges associated with an electronic health record (EHR) system implementation, according to primary care physicians participating in the Medical Economics EHR Best Practices study.

In a recent Medical Economics survey, 30 of the physicians participating in the study were asked to identify key factors that helped them prepare for this implementation. Although the responses varied, the study participants offered this advice:

- Hire a scribe to help with data-gathering and the creation of templates.
- Identify one main resource person at your vendor to help guide you through the implementation process.
- Research and buy quality hardware that supports the EHR.

“Cutting corners on hardware is penny wise and pound foolish. The stress, service calls, and cost of upgrades more than offsets the extra cost of buying good hardware,” says Dana Simpson, MD, of Life Center Family Medicine in Summerville, South Carolina.

- Get buy-in from your staff before implementing.
- Establish a timeline to complete online training each week before implementation.
- Set up weekly telephone conference calls with the vendor’s implementation manager to discuss progress, troubleshoot problems, and answer questions.

During the implementation phase, a majority of the study participants contracted with professionals outside of the practice to help during the implementation.

According to the survey, 44% of the 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.

More than 60% of the survey respondents report that the implementation negatively affected patient flow. And although the unanticipated costs now average $3,094 among study participants, 85% of the respondents say no out-of-pocket charges were billed by vendors.

Training was cited by many of the study participants as being a crucial to implementation success, but survey respondents were split about whether...
### Making progress toward stage 1 meaningful use

**Q:** For which of the following activities has your practice made reasonable progress toward stage 1 meaningful use requirements: Core level 1 objectives?

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Computerized provider order entry</td>
<td>11</td>
<td>38</td>
<td>41</td>
</tr>
<tr>
<td>Drug-drug and drug-allergy interaction checks</td>
<td>26</td>
<td>38</td>
<td>63</td>
</tr>
<tr>
<td>Maintain an up-to-date problem list of current and active diagnoses</td>
<td>33</td>
<td>54</td>
<td>74</td>
</tr>
<tr>
<td>E-prescribing</td>
<td>52</td>
<td>63</td>
<td>82</td>
</tr>
<tr>
<td>Maintain active medication list</td>
<td>52</td>
<td>63</td>
<td>74</td>
</tr>
<tr>
<td>Maintain active medication allergy list</td>
<td>48</td>
<td>63</td>
<td>78</td>
</tr>
<tr>
<td>Record demographics</td>
<td>44</td>
<td>67</td>
<td>78</td>
</tr>
<tr>
<td>Record and chart changes in vital signs</td>
<td>52</td>
<td>58</td>
<td>70</td>
</tr>
<tr>
<td>Record smoking status for patients 13 years or older</td>
<td>48</td>
<td>58</td>
<td>78</td>
</tr>
<tr>
<td>Report ambulatory clinical quality measures to CMS/states</td>
<td>15</td>
<td>13</td>
<td>30</td>
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<tr>
<td>Implement one clinical decision support rule</td>
<td>15</td>
<td>13</td>
<td>19</td>
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<tr>
<td>Provide patients with an electronic copy of their health information on request</td>
<td>11</td>
<td>21</td>
<td>48</td>
</tr>
<tr>
<td>Provide clinical summaries for patients for each office visit</td>
<td>7</td>
<td>21</td>
<td>41</td>
</tr>
<tr>
<td>Capability to exchange key clinical information among providers of care and patient-authorized entities electronically</td>
<td>4</td>
<td>8</td>
<td>7</td>
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<tr>
<td>Protect electronic health information</td>
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<td>Drug formulary checks</td>
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<tr>
<td>Incorporate clinic lab test results as structured data</td>
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<td>42</td>
<td>41</td>
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<tr>
<td>Generate lists of patients by specific conditions</td>
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<tr>
<td>Send reminders to patients per patient preference for preventive/follow-up care</td>
<td>11</td>
<td>17</td>
<td>26</td>
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<tr>
<td>Provide patients with timely electronic access to their health information</td>
<td>4</td>
<td>33</td>
<td>26</td>
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<tr>
<td>Use certified EHR technology to identify patient-specific education resources and provide to patient, if appropriate</td>
<td>7</td>
<td>29</td>
<td>41</td>
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<tr>
<td>Medication reconciliation</td>
<td>30</td>
<td>42</td>
<td>41</td>
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<tr>
<td>Summary of care record for each transition of care/referrals</td>
<td>4</td>
<td>21</td>
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<tr>
<td>Capability to submit electronic data to immunization registries/systems</td>
<td>0</td>
<td>0</td>
<td>18</td>
</tr>
<tr>
<td>Capability to provide electronic syndromic surveillance data to public health</td>
<td>0</td>
<td>8</td>
<td>7</td>
</tr>
</tbody>
</table>

*Note: N refers to the number of respondents.*
their staffs were adequately trained for the EHR implementation. In contrast, nearly 63% of respondents said the doctor was adequately trained. Only 54% of the respondents identified the practice as having a “super-user.” About 46% of the study’s respondents report that the system’s training modules did meet their expectations. (The other 54% of respondents said they did not.) Study participants where asked whether they have been able to integrate some of the interfacing features of their systems. The results include:

Images (scanned documents)
- Yes: 52%
- No: 48%

Laboratory findings
- Yes: 35%
- No: 65%

Billing
- Yes: 40%
- No: 60%

Scheduling
- Yes: 68%
- No: 32%

Hospital interface
- Yes: 0%
- No: 32%

E-prescribing
- Yes: 73%
- No: 27%

Health information exchange
- Yes: 8%
- No: 92%

Compliance with the Health Insurance Portability and Accountability Act
- Yes: 68%
- No: 32%

Medical equipment
- Yes: 8%
- No: 92%

When asked whether software vendors met their expectations, 42% of respondents said yes, but 39% remained undecided. Another 19% said vendors did not meet expectations. Despite some of the negative views about implementation, the majority of the survey participants report making progress in the EHR implementation, according to the Medical Economics survey.

In the most recent survey, 82% were e-prescribing and 74% were able to maintain an active medication list. Just 19% were able to implement one clinical decision support rule, and 7% were able to exchange key clinical information among providers of care and patient-authorized entities electronically (see table on page 45).
Reaching the Finish Line

Physician ranks as one of the first in EHR study to attest for meaningful use, and she's still smiling

By Jeffrey Bendix, MA, Senior Editor, and Diane Sofranec, Contributing Editor

Ask doctors why they are implementing an electronic health record (EHR) system and the majority will say their primary goal is to achieve meaningful use and collect on the government's incentive program to go digital.

Margaret Coughlan, MD, a family physician in Millbrook, New York, is no different, except that she is closer to reaching this goal than most.

With plans to attest for meaningful use this month, Coughlan ranks as one of the first study participants to reach stage 1 of meaningful use after just 6 months.

“I spent lots of time every evening gathering up that information and getting it in [the EHR] for every patient,” she recalls. “But then as soon as my 90 days were up, I was done.”

Coughlan uses an EHR system from athenahealth, and she says the upfront investment in time paid dividends as she neared full implementation.

“I'm a solo independent [physician]. I don't have a lot of staff. You've just got to put in a lot of effort upfront to do it quickly. It's up to you how quickly you want to [achieve meaningful use].”

Because she runs a low overhead practice that includes just two front-office staff members, the training and time commitment required to implement the EHR were overwhelming at first, Coughlan admits.

To save time, she adds information to the system as patients come in for their appointments. “I try to book longer slots and keep more openings so I can get all the data in [the system],” she says. “Why waste your time putting in something for someone who is not going to come back?”

Much of the training was of the on-the-job variety. “You learn more by doing,” she says, although training videos allowed her staff members to learn the system when it was most convenient for them, such as on weekends or during slow work periods.

For peers who have not yet chosen an EHR system, much less qualified for meaningful use, she recommends taking advantage of the demonstrations many companies offer. “It's so hard to figure out which one is good and which one is bad,” Coughlan says. “It's very overwhelming.” But in the long run, it's worth every penny of meaningful use incentive payments.

Margaret M. Coughlan, MD, will be among the first participants in the Medical Economics EHR Best Practices Study to achieve meaningful use.

**BIG CHALLENGE FOR A SMALL OFFICE**

Implementing an electronic health record (EHR) system has been a challenge for Mark Shiu, MD, a family physician in Rancho Cucamonga, California, but not because he prefers using paper charts.

The tech-savvy doctor, who has been practicing for about 6 years, says he has been using EHR systems for the past 4 years. “There's a greater learning curve if the office is paper-based than if you're switching from one [EHR] system to another,” he says. “Implementing the new system hasn’t been that bad because I have prior experience.”

What Shiu says he does find tricky is putting a new EHR in place while conducting business as usual.

“A lot of practices slow down, but because I am a solo practitioner, I don't have that luxury,” he says. “If I had to cut our [patient] load in half, I would really take a hit on my bottom line.”

Although maintaining his usual work pace during the implementation process has been a challenge.
Shiu devised a way to continue to see patients at the same rate. “Allow for a lot of preparation time before the actual launch of the software,” he advises. “You can train the staff and get comfortable with your templates before the actual full-on launch.”

Shiu is using ABEL Medical Software Inc.’s ABELMed, a software-as-a-service system. “The big cost factor is whether to have a system in-house or hosted,” he says. “I think an in-house system takes a lot of extra equipment, extra maintenance, extra people, and extra money.”

CONQUERING COMPUTER PHOBLIA

Don’t be afraid of computers, and enlist other people to assist you. That’s the advice Kevin Olson, DO, a self-proclaimed dinosaur has for his fellow physicians when it comes to using technology in the practice of medicine.

A solo family practitioner in Columbus, Ohio, since 1984, Olson had never used a computer before installing his electronic health record (EHR) system in January.

“I barely know how to use my cell phone. My kids make fun of me continuously,” he laughs.

Olson’s lack of computer experience has not hindered his practice’s productivity thus far. He continues to see 30 to 40 patients daily. He credits his nine staff members for the relatively easy transition.

“They’re all significantly younger than me, so they can do all this stuff on their telephones, never mind a computer,” he says.

Conversely, he admits, his own computer illiteracy has been the biggest challenge to implementing the system. Practice Fusion, the EHR vendor associated with the system he uses, has helped by loading the programs he needs onto his office computer.

“I practice a few times, and usually I can figure it out sooner or later,” he says.

Putting the EHR into service has not yet required Olson to spend any money. That may change in the coming months, however.

“I will probably buy an iPad that I can take from room to room so I can enter the patients’ information when I’m with them,” he says. For now, he writes notes by hand and enters the information later in the practice’s front-office computer.

“You just have to become computer literate. It’s honestly not that difficult once you sit down with it and understand what’s going on,” Olson says. “I’ve had colleagues tell me it’s been a nightmare to go to electronic records, but so far, knock on wood, we seem to be doing OK.”
Understanding the true costs of an EHR implementation

Plan for unanticipated expenses so they don’t slow your progress or delay a ‘return to normalcy’

By Michael McBride, Technology Editor

**POWER POINTS**

- Some costs can remain “hidden” until after an electronic health record (EHR) system installation begins.
- A 50% reduction in the number of patients a practice can see during an EHR installation is not unusual.
- Quality reporting and meaningful use criteria hinder a physician’s ability to complete patient encounter notes.
- Regional extension centers are mandated to assist primary care physicians implement EHRs—any EHR.

Electronic health record (EHR) systems are expensive. Just ask any physician who has implemented one. The up-front costs can be enormous, depending on the type of EHR. And other commonly unanticipated costs exist that every physician should account for, including information technology (IT) support, additional hardware, training, and over-time pay, just to name a few.

When creating a project budget, start with costs outlined in your vendor’s request-for-proposal response and the system/support agreement (that is, the end-user license agreement [EULA] you signed with your vendor). System costs encompass your capital expenditure for hardware, software, installation, training, and ongoing maintenance.

Generally, these costs are anticipated and scheduled before you even sign the EULA. Physicians’ practices vary so greatly, however, that additional equipment and IT support are common when implementing an EHR system.

Consider these additional costs and factor them into your budget. Also plan for a loss in productivity and efficiency resulting from the installation process itself. Remember that underestimating the true costs of an EHR implementation can get you into trouble.

It’s next to impossible to estimate what all the induced costs will be, even for vendors, because they don’t know how your practice actually operates and you’ve never installed one of their EHRs before. So it’s not uncommon for practices to find themselves in over their heads pretty quickly, requiring them to invest more capital and hire more staff than they originally planned.

**COST UP, REVENUE DOWN**

Thirty primary care physicians (PCPs) are participating in the Medical Economics EHR Best Practices Study, which began in January and will continue for 2 years.

Recent Medical Economics surveys have been tracking unanticipated (out-of-pocket) costs by the study’s physicians. Some of the findings:

- Study participants on average spent $5,900 on purchases related to hardware, software, peripherals, and network connections.
- About half of the practices averaged $3,094 for “IT and other outside support” costs.
- These costs do not factor in overtime pay or other workflow inefficiencies.

Averaged across all 30 practices, out-of-pocket expenses in the first 6 months of an implementation reached $6,516.

In a similar study published in the March 2011 issue of Health Affairs, 26 primary care practices in North Texas implemented an EHR across their medical network. The researchers considered the 

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Medical economics
July 25, 2012
MedicalEconomics.com

“Physicians are used to making decisions with imperfect information in a short time.”
—John Haughton, MD, chief medical informatics officer, Covisint, and founder of DocSite

CONTINUED FROM PAGE 52

hardware/software costs, as well as the staff members’ time and effort to complete the implementation.

They determined that a typical multiphysician practice would spend about $162,000 to implement an EHR, with $85,500 for first-year maintenance costs. They also estimated that the implementation teams spent approximately 611 hours “preparing for and implementing” the EHR system. The end-users (defined as the physicians, clinical staff members, and nonclinical staff members) required 134 hours per physician to become familiar enough with the EHR that they could comfortably use it with patients. (For more information about this study, see www.MedicalEconomics.com/Texasstudy.)

As a general rule, during the EHR implementation period (which can last more than a year depending on the hardware/software installation, staff training, and data integration), you can expect to see up to 50% fewer patients in the same period of time.

Simultaneously, you may have to increase your staff, or approve significant overtime for your existing staff members, just to get everyone home for dinner. That’s not even considering the extra time you need to invest to learn the new systems.

“If you’re putting in a new [EHR] system and it takes you 1 minute more per patient, that half hour [per day] is two billing slots,” says John Haughton, MD, chief medical informatics officer for Covisint and founder of DocSite. “If you’re getting $74 for a patient visit, then it’s $150/day times, maybe, 200 days, your office is open. That’s $30,000 per year.”

And that’s just from the cumulative effect of a 1-minute slow down per patient per day. That doesn’t take into account all the other ongoing reductions in workflow efficiencies, such as severe increases in the time it takes for your staff members to register patients, update their records, and process the billing. And that’s assuming the EHR functions correctly even at a slow pace.

Do you have a contingency plan if the billing module malfunctions? It has happened. It all adds up to reduced dollars flowing into the practice and increased dollars flowing out for an extended period of time.

The revenue decline poses financial trouble for many practices. As part of the budgeting process, consider taking out a small business loan in anticipation of covering the gap in lost productivity inherent with most EHR implementations.

GET PROACTIVE

The best course of action is to educate yourself on the true costs before you begin the EHR installation via sources such as Medical Economics and its ongoing 2-year EHR Best Practices Study. In addition, your local regional extension center’s (REC’s) mission is to help you implement an EHR—any EHR. RECs hold live events at which you can hear other PCPs discuss their experiences implementing EHRs in their practices and where you can meet one-on-one with their experts. Also:

- Develop a financial strategy that will carry you through the implementation period.
- Anticipate needing 50% more capital than you originally thought, and secure it in advance.
- Train your staff before you install the EHR. If you don’t train the entire staff, train one or two super-users who will then train the rest of the staff. Doing so will make the transition go considerably more smoothly.

DECREASING OVERTIME

It’s very important to fully understand the computer capabilities of your staff before you begin an EHR installation, says Elizabeth J. Neary, MD, who practices in a multispecialty private practice. “Analyze how comfortable they are [with health IT] before you jump into the EHR,” she says. “Even if it takes you a year to get your staff ready. Preparing them in advance will help decrease overtime [pay].”

Unexpected overtime cost is regularly named as a prime culprit when practices find themselves failing during an EHR implementation. It’s one of the “difference in time constants” that Haughton says can catch practices off guard.

“Business process and change—and health reform—is measured in months and years,” he says. “A
small practice may not have the capital reserves to
invest that would buffer it from a revenue slowdown,
especially in a time when you’ve got a bigger admin-
istrative burden. A lowering of dollars per unit of care
delivered puts primary care in a pretty tight vise from
a revenue perspective.”

**EHR SLOWDOWN**

To make matters tougher on physicians, today’s
EHRs are not really designed to “optimize speed of
throughput for the clinician,” Haughton says. In many
instances, a quick handwritten note in a patient’s
chart is all that’s needed to record the encounter.
Today’s EHRs, however, with their quality report-
ing and meaningful use integrations, make it chal-
lenging for doctors to complete their notes swiftly.
They must enter, and often re-enter again and again,
patient data that are not immediately germane to the
medical issue at hand. Thus, it can take physicians a
significantly longer time to input their notes into an
electronic record than it took with their old paper
processes—thereby increasing practice costs after
EHR implementation.

“That’s the giant ‘gotcha,’” Haughton says. “That
fast, brief note in primary care works like lightning
from a speed perspective. And that’s where the colli-
sion occurs.”

In addition, Haughton says that PCPs probably
aren’t making the kind of long-term decisions on
capital and time outlay that a chief executive offi-
cer of a Fortune 500 company would be making. They’re
thinking in terms of “Do we have enough money to
pay the bills at the end of the month?” And thus, they
don’t instinctively consider the long-term effects in-
stalling an EHR will have on their practices, he says.
Worst of all, Haughton adds, they may not even be
aware of the situation until it’s too late.

“Physicians are used to making decisions with
imperfect information in a short time,” he says. This
short-term problem-solving, however, can irreparably
damage a practice’s ability to survive an EHR imple-
mentation—especially when the time to recoup the
original financial outlay, in addition to the induced
costs, can take years.

**VALUE YOUR TIME**

When Neary implemented an EHR in her own prac-
tice, her staff members were surprised at the time
it took for them to become familiar with the new
systems. In fact, so much extra time was required that
they had to hire an additional receptionist, a move
they had not anticipated. They eventually determined
that had the staff members been better trained, hir-
ing a third receptionist probably wouldn’t have been
necessary.

These are the types of unanticipated costs that
over time can put enormous financial burdens on
practices. So much so that Neary recommends that
practices implement EHRs in stages.

all at once. First do e-prescribing, then take it step by
step.”

Whether it’s a client/server, software-as-a-service,
or cloud-based system, implementing any EHR will
send shockwaves through your practice, reducing staff
efficiency, decreasing practice revenue, and dramati-
cally affecting your bottom line. Count on it.

To survive the process, be constantly aware that
when you’re calculating the time and dollars it takes to
implement the EHR, the true costs can remain hidden
until you’re well under way. Plan for this contingency
and you dramatically improve your chance of success.

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Update vaccine code before flu season arrives

Q: We are updating our vaccine sheet for the upcoming season and had heard that a new vaccine code is coming out this year. Can you tell me what the code is and what the vaccine is for?

A: The flu season is almost upon us, and now is a great time for offices to update their vaccine billing sheets. For claims with dates of service after July 1, a new influenza virus vaccine code is effective. It is Q2034 for the influenza virus vaccine, split virus, for intramuscular use (Agriflu).

The Centers for Medicare and Medicaid Services will give you until October 1 to update your systems and include this new influenza virus vaccine code. Until systems are implemented, hold institutional claims containing code Q2034 with dates of service on or after July 1 and received before October 1.

As with other vaccines, co-insurance and deductibles are waived for Q2034.

Medicare provides coverage for one influenza virus vaccine per flu season for all beneficiaries. This may mean that a patient will receive more than one influenza vaccination in a 12-month period. Medicare may provide coverage for more than one influenza vaccination per flu season if it is reasonable and medically necessary.

For a listing of the vaccine, administration, and diagnosis codes that are payable this year, refer to the four charts located on this page and on page 57.

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Current Procedural Terminology vaccine codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>90654</td>
<td>Influenza virus vaccine, split virus, preservative-free, for intradermal use, for adults aged 18 to 64 years</td>
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<tr>
<td>90655</td>
<td>Influenza virus vaccine, split virus, preservative-free, for children aged 6 to 35 months, for intramuscular use</td>
</tr>
<tr>
<td>90656</td>
<td>Influenza virus vaccine, split virus, preservative-free, for use in individuals aged 3 or more years, for intramuscular use</td>
</tr>
<tr>
<td>90657</td>
<td>Influenza virus vaccine, split virus, for children aged 6 to 35 months, for intramuscular use</td>
</tr>
<tr>
<td>90658</td>
<td>Influenza virus vaccine, split virus, for use in individuals aged 3 or more years, for intramuscular use (not payable by Medicare as of January 1, 2011; use Q2034-Q2039)</td>
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<tr>
<td>90660</td>
<td>Influenza virus vaccine, live, for intranasal use</td>
</tr>
<tr>
<td>90662</td>
<td>Influenza virus vaccine, split virus, preservative-free, enhanced immunogenicity via increased antigen content, for intramuscular use</td>
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<tr>
<td>Q2034</td>
<td>Influenza virus vaccine, split virus, for intramuscular use (Agriflu)</td>
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<tr>
<td>Q2035</td>
<td>Influenza virus vaccine, split virus, when administered to individuals aged 3 or more years, for intramuscular use (Afluria)</td>
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<tr>
<td>Q2036</td>
<td>Influenza virus vaccine, split virus, when administered to individuals aged 3 or more years, for intramuscular use (Flulaval)</td>
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<tr>
<td>Q2037</td>
<td>Influenza virus vaccine, split virus when administered to individuals aged 3 or more years, for intramuscular use (Fluvirin)</td>
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<td>Q2038</td>
<td>Influenza virus vaccine, split virus, when administered to individuals aged 3 or more years, for intramuscular use (Fluzone)</td>
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<tr>
<td>Q2039</td>
<td>Influenza virus vaccine, split virus, when administered to individuals aged 3 or more years, for intramuscular use (not otherwise specified)</td>
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<td>90669</td>
<td>Pneumococcal conjugate vaccine, polyvalent, for children aged less than 5 years, for intramuscular use</td>
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<tr>
<td>90670</td>
<td>Pneumococcal conjugate vaccine, 13-valent, for intramuscular use</td>
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<tr>
<td>90732</td>
<td>Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals aged 2 or more years, for subcutaneous or intramuscular use</td>
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<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>90740</td>
<td>Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (three-dose schedule), for intramuscular use</td>
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<tr>
<td>90743</td>
<td>Hepatitis B vaccine, adolescent (two-dose schedule), for intramuscular use</td>
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<tr>
<td>90744</td>
<td>Hepatitis B vaccine, pediatric/adolescent dosage (three-dose schedule), for intramuscular use</td>
</tr>
<tr>
<td>90746</td>
<td>Hepatitis B vaccine, adult dosage, for intramuscular use</td>
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<tr>
<td>90747</td>
<td>Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (four-dose schedule), for intramuscular use</td>
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</table>
CONTINUED FROM PAGE 56

Commercial insurance vaccine administration codes

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<tbody>
<tr>
<td>90471</td>
<td>Immunization administration (for outpatient prospective payment system hospitals billing for the hepatitis B vaccine administration)</td>
</tr>
<tr>
<td>90472</td>
<td>Each additional vaccine (for outpatient prospective payment system hospitals billing for the hepatitis B vaccine administration)</td>
</tr>
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Medicare vaccine administration codes

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<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>G0008</td>
<td>Influenza virus vaccine administration</td>
</tr>
<tr>
<td>G0009</td>
<td>Pneumococcal vaccine administration</td>
</tr>
<tr>
<td>G0010</td>
<td>Hepatitis B vaccine administration</td>
</tr>
</tbody>
</table>

Diagnosis codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V04.81</td>
<td>Influenza</td>
</tr>
<tr>
<td>V03.82</td>
<td>Pneumococcus</td>
</tr>
<tr>
<td>V06.6</td>
<td>Pneumococcus and influenza</td>
</tr>
<tr>
<td>V05.3</td>
<td>Hepatitis B</td>
</tr>
</tbody>
</table>

The author is a medical consultant based in Indianapolis, Indiana. Do you have a primary care-related coding question you would like to have our experts answer in this column? Send it to medec@advanstar.com. Send your feedback to medec@advanstar.com. Also engage at www.twitter.com/MedEconomics and www.facebook.com/MedicalEconomics.

Beware legal ramifications of unnecessary tests

Earlier this year, nine medical specialty groups each released lists of the top five medical tests and procedures that are overused and often unnecessary in their areas of medicine. They did so as part of an initiative by the American Board of Internal Medicine (ABIM) Foundation to reduce healthcare spending and improve care. Each list also included information about when a test or treatment may be appropriate based on clinical evidence and guidelines.

The lists cover a wide range of tests, procedures, and treatments, including stress tests, nonsteroidal anti-inflammatory drugs, electrocardiograms, and immunoglobulin G testing. Some of the services routinely are used, whereas others are appropriate only for some patients, such as those with certain cancers. Many of the tests listed by these specialty boards can lead to unneeded invasive procedures, overtreatment, unnecessary radiation exposure, and misdiagnosis.

The American Academy of Family Physicians and the American College of Physicians were among the medical specialty associations that released lists. Eight more specialty associations also will release lists of tests and procedures later this year.

POWER POINTS

Nine medical societies released lists of the top medical tests and procedures that patients and physicians should question.

Additional litigation may be brought against physicians, healthcare clinics, and hospitals that provide the “unnecessary” tests and procedures.

LISTS FOSTER DISCUSSION

The medical specialty groups decided to create these lists as part of the ABIM Foundation’s Choosing Wisely campaign, an effort aimed at promoting an educational dialogue between physicians and patients. Patients are being urged by these medical specialty associations to actively question their doctors when any of the listed tests or procedures are recommended.

In many cases, doctors may be reluctant to tell patients when a test or procedure is unnecessary, due to their fear of malpractice lawsuits. Now that a list of tests that may not be necessary exists, patients will have access to some of the same information as their doctors, and they can ask whether a test or procedure is warranted. This ability allows shared decision-making between patients and physicians and can result in less uncertainty by patients about the medical care they are receiving.

Another motive behind the creation of the lists is reducing the occurrence of unnecessary healthcare. The Congressional Budget Office estimates that unnecessary medical treatment accounts for one-third of medical spending in the United States. Because approximately $2.6 trillion is spent on healthcare each year, a reduction in unnecessary procedures would help decrease medical spending and medical costs.

Continued on page 58
Continued from page 57

DOCTORS NOT PLEASED
This action taken by the medical specialty groups has brought complaints from some doctors. Because of the recommendations, physicians may find it more difficult to address the needs of individual patients.

Additionally, when physicians perform fewer diagnostic tests and procedures, their income can be reduced, especially under fee-for-service payment schedules that pay for each patient encounter separately.

LAWS PROTECT PATIENTS
This situation also may have the side effect of promoting additional litigation against doctors, healthcare clinics, and hospitals that provide the “unnecessary” tests and procedures. Many states have laws that have been around for decades that prohibit unnecessary tests and procedures and sanction those who provide them. For instance, Section 766.111, Florida Statutes, which was enacted in 1985, states:

Engaging in unnecessary diagnostic testing; penalties:
(1) No healthcare provider licensed pursuant to chapter 458 [medical doctors], chapter 459 [osteopathic physicians], chapter 460 [chiropractic physician], chapter 461 [podiatrist], or chapter 466 [dentist], shall order, procure, provide, or administer unnecessary diagnostic tests, which are not reasonably calculated to assist the healthcare provider in arriving at a diagnosis and treatment of a patient’s condition.
(2) A violation of this section shall be grounds for disciplinary action...
(3) Any person who prevails in a suit brought against a healthcare provider predicated upon a violation of this section shall recover reasonable attorney’s fees and costs.

This Florida law not only provides a private cause of action by a patient against a health provider who orders or furnishes such “unnecessary” diagnostic tests, but unlike other tort and medical malpractice statutes, it allows the prevailing party in such a case to recover attorneys’ fees and costs. This law may by itself promote litigation in the face of the lists of tests from the specialty groups.

FALSE CLAIMS CASES
Further, the law also may give rise to additional qui tam, “whistle-blower,” and false claims cases, especially those brought by individuals.

Qui tam cases have been brought under the federal False Claims Act for the recovery of Medicare payments from hospitals, physicians, medical groups, nursing homes, insurance companies, diagnostic testing facilities, clinical laboratories, radiology facilities, and many other types of healthcare providers. These cases allege that a false claim was submitted to the government. If the test or procedure was unnecessary, then it seems almost axiomatic that a claim for it is false. The plaintiff (or relator) bringing such cases receives a percentage of the recovery, which often amounts to millions of dollars in successful cases.

Most states now have similar false claims act or qui tam laws providing similar causes of action and recoveries to individual plaintiffs (or relators) in the case of state Medicaid payments as well.

Because medical necessity is a requirement for practically every Medicare and Medicaid service, as well as most services paid by private health insurers, the lists provided by the specialty may very well be exhibit one in future lawsuits.

LISTS BENEFIT DOCTORS AND THEIR PATIENTS
I do not disagree with, and am not critical of, the specialties providing this valuable information to the public. If anything, such information makes for a more educated patient populace and provider group and serves to eliminate tests and procedures that have no proven medical efficacy.

A doctor should have the knowledge, skill, training, and confidence to know when such tests and procedures are not warranted. If a physician persists in ordering these tests solely for the means of increasing profits, he or she should be penalized. If not, the physician should be able to justify them.
Performance benchmarks reveal practice efficiency

Q: I keep hearing about key performance indicators (KPIs) as an effective tool for evaluating how my practice is doing. What exactly are they, and how can I use them in my practice?

A: KPIs are profitability and productivity benchmarks that enable medical practices to monitor their overall performance efficiently from a financial standpoint and otherwise. Using KPIs as performance benchmarks truly can help boost your practice’s operational performance and increase its efficiency.

No two practices will have the same set of KPIs. Determining which factors to track is based on the aspects of your practice you want to improve. Examine your practice’s strengths and weaknesses, then decide which are your most critical challenges and what your goals and desired outcomes are. Such numbers as accounts receivables, net collection ratios, revenue, and operating costs tend to be the most frequently monitored KPIs in many practices. Review KPIs twice a year to make sure you are tracking all of the data necessary for obtaining useful management information.

When it comes to tracking these indicators, consider using a KPI dashboard, which can consolidate key metrics clearly and concisely in one place. Using a dashboard will ensure you can track this vital information on a year-to-date, rolling, or trailing 12-month basis, or if you prefer, more frequently—all from a single, easily accessible tool.

From this dashboard, you can view all of your crucial benchmarking data at a glance, receive alerts if something appears to be awry, and even generate detailed reports, all from a single interface. This simple consolidation of information will help you determine your practice’s strengths and weaknesses and help move you further along the road to quality improvement.

BUILD PRACTICE PROFITS BY TEACHING STAFF MEMBERS TO THINK LIKE OWNERS

Q: As a practice owner, I know I should focus on the financial aspects of the practice more than I do. But after I am done with providing medical care to my patients, usually I’m too tired to deal with the business side of the practice. How can I make this easier for myself and delegate more responsibility for the business aspect of the practice to members of my staff?

A: The first step you must take is to teach your staff to think like owners—not like receptionists, nurses, radiology technicians, or billing clerks. Everyone in the practice—not just the owners—must understand money and its relationship to the practice’s own health and well-being. All employees need to understand how the money flows and how it is being used.

A private practice’s finances has three key aspects: income, profit, and cash flow. Income is the money doctors pay themselves for being an employee of the practice. It is not related to ownership.

Profit is the second key aspect. It is what is left over after all expenses of running the business, including income, have been subtracted. Obviously, if profit numbers are negative, it means the practice is doing something wrong.

You might be surprised to learn, however, that a posted profit doesn’t always mean that your practice is doing everything right, either. Profits cannot be left to chance. They must be earned intentionally. If you cannot explain why a profit exists, if it’s a pleasant surprise rather than something expected, then the practice’s future might not be very profitable in the long run.

Cash flow is the third aspect to keep in mind. A practice needs cash flow to survive. Because the unpredictability of claims payments and other factors can affect incoming cash flow, cash often moves through a practice erratically. This uncertainty causes issues for outflow—which is dictated by supplies and equipment purchases, staff salaries, and the direct costs of performing clinical service.

Because of this unpredictability, even practices that are profitable overall can be cash-poor. And without cash in your bank account when you need it, your business is threatened, no matter how profitable the practice might appear to be on paper. Although you, as the physician/owner, must have ultimate control of the money that goes in and out of a practice, also teach key stakeholders in the practice to assist you in managing cash flow.

Answers to our readers’ questions were provided by Thomas J. Ferkoivc, RPh, MS, managing director, SS&G Healthcare Services LLC, Akron, Ohio. Send your practice management questions to medec@advanstar.com. Also engage at www.twitter.com/MedEconomics and www.facebook.com/MedicalEconomics.
Healthcare reform law includes surtax on income

Q: Now that the Affordable Care Act (ACA) has been upheld, I’ve been hearing that it includes a new tax on income that goes into effect next year. Is that true?

A: Yes, but only for taxpayers who are single and who have annual incomes of more than $200,000 and for joint filers with income of more than $250,000. For people in these categories, the law includes a special surtax of 3.8% that applies to investment income such as interest, capital gains, dividends, rental income, and earnings distributed from annuities.

Although we don’t yet know what the capital gains tax rates will be for next year, this additional tax probably will motivate high earners to accelerate income into 2012 when possible. Although you have limited control over interest and dividends, you can sell appreciated securities during 2012 so that you incur capital gains in 2012 and avoid the additional tax that will apply in 2013.

Generally, it does not make sense to sell an investment simply to avoid paying future taxes. But the additional 3.8% tax may substantially reduce your return on your past appreciation. In addition, the ACA contains a 0.9% tax on the Medicare portion of the payroll tax on income that exceeds the thresholds listed above.

Health Savings Accounts Often Can Make Sense Financially

Q: Like many of my patients, I am struggling with the increasing cost of health insurance. I’m thinking of using a high-deductible insurance plan in conjunction with a health savings account (HSA) for myself and my family. Do HSAs make sense for physicians?

A: HSAs allow individuals and families with high-deductible health insurance plans to contribute up to $6,450 annually (before taxes) for family coverage and $3,250 for individual coverage. Depending on your health status and that of other members of your family, the amount you save on premiums usually will be larger than your out-of-pocket costs, especially when you factor in the tax savings. Moreover, unused HSA funds ultimately can be used for other purposes, although any nonmedical withdrawals you make before age 65 are subject to a 20% tax.

Tax Rate on Dividends May Be Raised Next Year

Q: I’ve heard that the tax rate on income from dividends will be going up next year. True?

A: The government is expected to reinstate retroactively the 2011 provision permitting individuals aged 70 1/2 and older to make direct transfers of up to $100,000. Keep in mind that even if the provision is not reinstated, you still can deduct the contribution as a charitable gift if you itemize your deductions.
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The 7 steps to retirement savings catch-up

You know who they are: The physicians with the nicest office and the latest gadgets, the expensive second homes, the fast cars, kids in private schools. On the outside, they are shining examples of success. But too often, those same doctors are financial train wrecks waiting to happen—too little savings, too much debt, and too little time to change course.

Such a doctor might be in his or her 50s, so busy leading the good life that he or she has given little thought to retirement. Worse is the doctor past 60 who finally realizes that he or she can’t keep up this pace forever. Whether a person’s financial situation is a result of past mistakes, lack of planning, poor advice, or random misfortune, when crisis has been building for years, it can’t be fixed overnight.

But if any part of the above description applies to you, don’t despair. A common-sense dose of reality can bring new hope to a seemingly impossible situation. So here’s some advice in the form of seven things to take if you are in financial catch-up mode:

- **Face your situation honestly.** After decades of poor planning, risky investments, or lavish living, it’s time to take a full and complete inventory of where you are, without making excuses for those lousy partnership investments and time-shares. It’s time to be honest. Your loved ones are depending on you.

- **Start saving now, and continue to do so.** No magical investment will resolve the crisis. Savings come only from reducing spending or increasing income.

  Here’s an example: For the past decade, Bill and his family have taken an annual, $25,000 European vacation. Doing so required $42,000 pre-tax from his practice, or a gross income (before overhead) of about $100,000.

  One year instead, Bill and his family vacationed locally for $5,000. He took the remaining pre-tax income of $33,000, and contributed it to a retirement plan. In addition, Bill took one less week of vacation and worked instead, netting an additional $10,000 of pre-tax income. In all, Bill “found” $43,000 to fund his retirement.

- **Use the power of tax-deferred savings.** Most of us know the effect of compound interest. The bigger story is compound interest in a tax-deferred environment. For example, $150,000 of annual pre-tax retirement savings earning 6% interest for 10 years grows to nearly $2 million, generating more than $85,000 annually in after-tax income.

  If you had to pay taxes on the money first, and then pay taxes along the way, you would likely have only about $1.1 million, generating only $45,000 in after-tax income.

  Fortunately, retirement plans such as cash balance and defined benefit plans allow for accelerated, pre-tax funding in the later years of your practice.

- **Be flexible about the timing of your retirement.** Many doctors think they should sell their practices at their peak production to obtain the best value. It’s better to think of your practice as an income-generator, not a growth asset. A phased buy-out may make sense. Or just keep working as always, even if your income drops a bit.

- **Get rid of debt.** Cut up the credit cards. Pay down or pay off your home equity line of credit and your house mortgage. The less debt you have, the less income you will need in retirement.

- **Eliminate the luxuries.** Whether it’s a vacation house in the mountains or a vintage automobile in the garage, if it’s an affordable luxury, it’s time to let it go. Find less expensive hobbies and ways to relax.

- **Seek help.** Top athletes, famous actors, and star executives have personal coaches to help them face their challenges. Establish a relationship with an adviser whose only compensation comes from you, with no commissions. Fees should be transparent, and your adviser must adhere to the highest fiduciary standard, which means he or she must place your best interests first.

If you have been consistently saving for many years, congratulations! If not, don’t give up hope. Get your expert team on board and make a workable, practical plan. Then enjoy the ride. The view from the other side is worth the sacrifice.

The author is a principal and managing partner at Thomas Wrig Doll, a tax, retirement, accounting, and wealth management firm in the San Francisco Bay area. The ideas expressed in this column are his alone and do not represent the views of Medical Economics. If you have a comment or a topic you would like to see covered here, please e-mail medec@advanstar.com. Also engage at www.twitter.com/MedEconomics and www.facebook.com/MedicalEconomics.
Latest Research

A summary of current clinical articles from that pile on your desk

■ Effectiveness of bisphosphonates beyond 3 years is unproven


A systematic review by the U.S. Food and Drug Administration (FDA) finds questionable benefit to using bisphosphonates for more than 3 years for fracture prevention. The FDA examined fracture data from three clinical trials in which bisphosphonates were administered for at least 3 years in a randomized design, and for an additional 3 to 6 years during which patients underwent repeated randomization, for a total duration of 6 to 10 years’ use. Continuing bisphosphonate treatment yielded inconsistent fracture protection; the effect on vertebral and nonvertebral fractures differed. In the trial of the longest duration, only those women without vertebral fractures at baseline who also had a femoral-neck T score of less than −2.5 continued to show a reduction in the rate of nonvertebral fractures compared with those taking a placebo.

■ Azithromycin increases risk of cardiovascular death


A course of azithromycin is associated with an increased risk for cardiovascular death, according to a retrospective cohort study conducted in a Medicaid population. The cohort included patients who took 347,795 azithromycin prescriptions and matched controls who took no antibiotics (1.39 million control periods) and patients with 1.8 million prescriptions for amoxicillin, ciprofloxacin, or levofoxacin. Over 5 days of therapy, azithromycin use was associated with 2.49 times the risk for cardiovascular death and a doubling in the risk of death from any cause compared with no treatment, and with 47 excess cardiovascular deaths per 1 million courses compared with amoxicillin. Azithromycin also increased the risk for cardiovascular mortality when compared with ciprofloxacin, but not when compared with levofoxacin.

■ Electronic reminders help patient adherence to medications for chronic conditions

*J Am Med Inform Assoc. doi:10.1136/amiajnl-2011-000748. [April 25, 2012]*

Electronically reminding patients to take their medication, even without personal contact between the healthcare provider and patient, may improve adherence to medications for chronic conditions, at least in the short term. Researchers from the Netherlands identified 13 studies from a comprehensive literature search that evaluated the effect of either short message service (SMS) reminders, audiovisual reminders from electronic reminder devices (ERD), and pager messages on adherence in various patient populations (patients on antiretroviral therapy, patients with hypertension, patients with asthma, patients with glaucoma, and women using oral contraceptives). Eight of the studies demonstrated significant effects on patients’ adherence, and seven of them measured short-term effects (follow-up period <6 months). Improved adherence was found in all but one study using SMS reminders, four studies using ERD, and one pager intervention. The long-term effects of electronic reminders remain unclear, however.

■ Sweet news: Dark chocolate lowers risk of cardiac events

*BMJ online. 2012;344:e3657. [Published 31 May 2012]*

Daily dark chocolate consumption can prevent cardiovascular events in persons at particularly high risk for them, Australian researchers have found. According to their model, patients with metabolic syndrome who eat dark chocolate daily would have 85 fewer cardiovascular events per 10,000 population over 10 years. Patients from the Australian diabetes, obesity, and lifestyle study were entered into a Markov model to assess the effects of daily dark chocolate consumption in 2,103 patients with metabolic syndrome but without diabetes or cardiovascular disease. The effects of dark chocolate on blood pressure and lipids were gleaned from clinical trial results. The researchers estimated that, with 100% adherence, daily dark chocolate consumption would prevent 70 nonfatal and 15 fatal cardiovascular events per 10,000 persons over 10 years. To be effective, dark chocolate needs to contain at least 60% to 70% cocoa.
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“I put a little ball at the end, so it looks like it will bounce back.”

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WHAT WE CAN LEARN FROM THE FRENCH

EXAMINING ANOTHER SYSTEM CAN HELP DIAGNOSE PROBLEMS WITH U.S. HEALTHCARE

There is no provision for opting out. Numerous nonprofit health insurance companies exist and are regulated by the government to function solely as conduits for premiums collected and benefits paid to healthcare providers and enrollees.

French health insurance companies have no investors and no stocks traded on the market. You would no more invest in a French health insurance company than you would in the Red Cross. No chief executive officers (CEOs) are collecting multimillion dollar salaries. These health insurance companies don't have vast rooms with hundreds of employees who spend their days withholding payments to providers or denying benefits to enrollees for so-called pre-existing conditions.

In France, the incessant and mind-numbing bickering between insurer, enrollee, and provider is nonexistent, resulting in a steep reduction in size of administrative staff. And the financial savings are impressive: in the United States, health insurance companies keep 20% of premium dollars for administrative costs. In France, it's 5%.

Insurance. The French have different health insurance companies for different needs. Most people are employed and, as do many employed Americans, purchase insurance through their employers. Rates are quite low, mainly because healthcare costs are low. A person earning $40,000 a year pays roughly $22 a month for his or her insurance, and the employer contributes $200 a month for that worker's insurance.

Self-employed individuals purchase their insurance through a separate company, with the rate determined by income. Unemployed people have their entire premiums paid by the government. If you lose your job, you simply switch to the government plan until you find another job. So in France:

- You can never lose your insurance.
- It is not possible to be uninsured.
- You can never be denied benefits for any reason.
- The concept of a “pre-existing condition” is unknown.
- You can always see any doctor you like, primary care physician (PCP) or specialist.
- There are no networks to contend with.
- Doctors are not gatekeepers.
- The waiting time to see a physician or undergo a surgical procedure is the same as in the United States.

Costs. Costs are lower in France because the fee for every possible service—from a doctor's office visit or injection to a lab test, surgical procedure, prescription drug, or hospital stay—is tightly regulated by the government. Certain elective procedures, such as cosmetic surgery, aren't covered, but for these procedures one can purchase a supplemental policy similar to Medicare supplement insurance.

Surprising to visitors, every physician's office has the government fee schedule for his or her specialty posted prominently at check-in. French fees are lower than those in the United States. A typical office visit to a PCP costs about $23. Keep in mind, however, that in France, medical school is free, malpractice insurance rates are a fraction (1% to 2%) of what doctors pay in the United States, and French doctors don't need any extra...
Medical staff members to argue with insurance companies.

The medical offices themselves, whether housing PCPs or specialists, are surprisingly simple—almost austere by U.S. standards—small in size and minimally staffed, yet perfectly suited to a doctor’s needs. Pretentious office décor is a nonissue for French patients and physicians alike. And so:

- The French visit their doctors more times per year than Americans (eight visits versus five), yet the French system spends less than half what’s spent in the United States.
- France spends $3,200 per person per year for a system that covers everybody.
- The United States spends $2.24 trillion a year, or $7,500 per person, for a system that positions us 37th in world health evaluations and leaves 50 million people without access to healthcare.
- Overall, France spends about 11% of its total national wealth (measured as gross national product) on healthcare. The United States spends about 16% of ours.

**Technology.** A central component of the French system is the carte vitale, a plastic “vital card” containing a computer chip that holds a patient’s entire health history. When a patient visits any physician, the doctor places the card into a card reader to review the complete medical history. After providing treatment, the physician enters updated notes onto the card, including the price of the office visit and tests, then presses the send button. Immediately, the patient learns the co-pay for that visit (the maximum is $100), and within 3 days, both patient and doctor receive benefit checks from the insurance company.

There are no deductibles, but on principle, there is always a co-pay unless the patient is at poverty level, in which case there is no charge for the visit. Whether a patient is at poverty level or is the CEO of a major company, the doctor is paid the same amount of money for his or her services. No squabbling occurs with an insurer about whether a Pap smear is covered. No stigma surrounds being poor or unemployed.

The same card system pays the hospital, pharmacist, and physical therapist. And clearly, having the patient carry a detailed health history saves a fortune on unnecessary duplication of tests.

“Having the patient carry a detailed health history saves a fortune on unnecessary duplication of tests.”

The card completely eliminates paper. In my basement at home, I store roughly 100 cases filled with the charts of inactive patients from my medical group who have moved away or changed insurance companies and as a result were forced into a different physician network. If a patient returns to our practice, I go on a chart hunt. I must by law store these charts for 10 years. I often refer to inactive patients’ charts when considering new patients to our practice, I go on a chart hunt. I must by law store these charts for 10 years. I often refer to inactive patients’ charts when considering new patients for a new physician. This chart system saves a fortune on unnecessary duplication of tests.

**Life expectancy.** In a key measurement called Mortality Amenable to Health Care, which simply means “ability to cure people who have curable conditions,” the French rank near the top—well above the United States.

Our infant mortality rate is much higher than France’s, and the French have a higher life expectancy than Americans. A healthy 60-year-old French woman can expect to live to 81 years old. An American woman of the same age averages 77 years.

**Career satisfaction.** Surveys show that French physicians are happy with all of this, despite (like ourselves) complaining about their insurance reimbursements. Unlike U.S. doctors, French physicians are tightly unionized and when demanding a rate increase simply go on strike. Across the board, U.S. physicians earn twice, if not more, the salary of French physicians.

In France, one obtains entrance into medical school on brains alone, and the government picks up the tab. In the United States, one can lose medical school strapped with more than $150,000 in debt. Add in the huge dollars needed for malpractice insurance—plus the high costs of running an office filled with employees who spend the day arguing with insurance companies—and you can easily grasp why an American physician’s practice is money-oriented.

In some surveys, French doctors report their lives as “very satisfying.” On the other hand, and for all the reasons you’d surmise—insurance bickering, endless paperwork, malpractice threats, and millions of uninsured citizens—comparable surveys of U.S. physicians show that 75% discourage their children from careers in medicine.

Sadly, the one word that rarely surfaces to describe medical careers in these surveys of U.S. physicians is “satisfying.”

Maybe the Affordable Care Act will affect some positive change.
High Triglycerides (TG) should be considered along with LDL-C as part of a comprehensive approach to lipid management

Reduction of low-density lipoprotein cholesterol (LDL-C) is now well established as the primary treatment target in lipid management. However, recently published guidelines by the American Heart Association and the American College of Cardiology Foundation recommend a more comprehensive approach to lipid management that also considers the significance of biomarkers other than LDL-C, such as total cholesterol, non-high density lipoprotein cholesterol (non-HDL-C), very-low density lipoprotein-cholesterol (VLDL-C), high sensitivity C reactive protein (hs-CRP), apolipoprotein B (apo B), and triglycerides (TG).

**TG reduction with concurrent increases in LDL-C or adverse events may compromise lipid treatment goals**

Several therapies are used in the clinical setting for lowering TGs, such as fenofibrates, niacin, and prescription omega-3 fatty acids. Although these therapies effectively lower TGs, some have the potential to significantly increase LDL-C levels, while others have tolerability issues. Niacin, while effective at lowering TGs and boosting HDL-C, does have adverse events such as truncal and facial flushing, and can negatively impact levels of glycosylated hemoglobin (HbA1c). In patients with very high TGs, studies have shown that fenofibrates and omega-3 acid ethyl esters (principally made up of eicosapentaenoic acid [EPA] and docosahexaenoic acid [DHA]) may increase LDL-C up to 45%. Recent studies suggest that DHA may be responsible for a rise in LDL-C levels.

Visit [www.LipidU.com](http://www.LipidU.com) to find out more about the complex issues impacting lipid management today.