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UnitedHealthcare's Medicare Advantage cuts and the Connecticut counties' injunction

[Note: The original version of this article was sent to RIMS members by broadcast email on December 16. RIMS members also received several earlier bulletins on United's network terminations by means of the same technology. To receive these and other timely advisories, please be sure RIMS has your current email address. A quick email to Sarah Stevens at sstevens@rimed.org is all that is required.]

UnitedHealthcare's surprise contraction of its Medicare Advantage physician network continues to generate waves. However, as of this writing, nothing has materially changed in the overall outlook for thousands of doctors and hundreds of thousands of elderly in a dozen states as a result of the cuts, though United's timetable for downsizing may have hit a speed bump in the form of a preliminary injunction affecting two counties in Connecticut (see below).

The frustration felt by physicians and patients is compounded by United's continued reticence about its actions and intentions. It is further compounded by the apparent impotence of state and federal authorities to hold United accountable and to protect elderly patients from disruption of their care. In Rhode Island, as in the other states, the state medical society, the state attorney general, public health officials, insurance regulators and members of Congress have all expressed concern and disapproval to United. The Rhode Island Medical Society, the AMA and members of Congress have urged federal authorities at CMS to require United to keep faith with physicians and patients. However, CMS has been slow to take substantive action.

Hartford and Fairfield County medical societies file suit

In the wake of the United terminations, every affected state medical society, including RIMS, investigated legal options to halt and reverse the disruption, but no state society found a promising legal theory. However, two county medical societies in Connecticut filed for a temporary restraining order against United on November 15 in the U.S. District Court in Bridgeport, and to the surprise of many, Judge Stefan R. Underhill granted the medical societies a preliminary injunction against United on December 5. To no one's surprise, United immediately appealed to the Second Circuit, which is expected to rule on the matter in a few weeks.

In granting the injunction, Judge Underhill indicated some wonderment at the mechanism United employed to terminate the physicians. He found that United is fully within its contractual rights to terminate physicians "without cause" by serving notice at least ninety days prior to the *anniversary date* of their participation contracts. But United apparently ignored anniversary dates and chose instead to terminate physicians by "amending" their contracts unilaterally. In finding that United erred, Judge Underhill explicitly left open the option for United to terminate the physicians on their anniversary dates. Thus, even if the Second Circuit upholds the District Court's injunction, the county societies at best will have bought a stay of execution for a number of their members. (United disputes Underhill's interpretation of the participation agreement and insists its terminations are contractually sound and will be effective for all the terminated physicians on February 1, 2014.)

Exactly how many of the two county societies' members may have gotten a reprieve through this action? United's appeal to the Second Circuit includes numbers that United has otherwise refused to disclose. According to United, 240 physicians in the two Connecticut counties (Hartford and Fairfield) received termination notices, a number that

continued page 3

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The Rhode Island Medical Society was founded in 1812 to promote the art and science of medicine. RIMS is the eighth oldest state medical association in the country.

The Medical Society also publishes a monthly magazine, *Rhode Island Medical Journal.* Current and archived issues are available at www.rimed.org.

ELAINE C. JONES, MD
PRESIDENT

Connecting the Dots on United's October Surprise

It has been widely assumed that UnitedHealthcare's calculated implosion of its Medicare Advantage physician network in a dozen or more states has been motivated less by a desire on United's part to rid itself of particular physicians than by a desire to shed certain panels of costly patients from its subscriber base. This theory would appear to be supported by the fact that so many dropped doctors enjoy outstanding reputations in our own community, both among their peers and with their patients. The seeming predominance of subspecialists among the ranks of the de-selected also supports this analysis.

Building on the theory that United is dumping expensive patients, some observers see a Machiavellian market strategy in the move: given that these elderly patients are more attached to their doctors than to their health plan (a safe assumption, no doubt), they will elect to migrate to United's competitors in order to stay with their doctors. As they do so, this theory goes, they will drive up competitors' costs. Well, maybe. Or maybe not. (See below.)

As for the predicted migration of subscribers, we can already see that a good deal of movement has in fact taken place in Rhode Island away from United's Medicare Advantage plan and into Blue Cross'. We heard an estimate that a third of United's 36,000 Medicare Advantage customers have used the Open Enrollment period as an opportunity to switch. For its part, Blue Cross noticeably stepped up its advertising to encourage the switch, and by all accounts it has welcomed former United subscribers with open arms. Yet some speculate that these patients are sleeper cells who will eventually generate a cost explosion for Blue Cross. Thus, according to these theories, United stands to gain competitive advantages in two ways by trimming its physician network: shedding costly patients from its own rolls and sticking competitors with them.

A different view

But not everyone sees it that way. One experienced medical practice manager asserts that United's network cuts are an admission of failure, while its main competitor in Rhode Island, Blue Cross, is doing well to capitalize on a valuable opportunity to expand its market share. This manager told RIMS recently that he "saw it coming," that there have been many signs that United's Medicare Advantage product was performing poorly, not only in Rhode Island. Rhode Island Blue Cross, in contrast, according to this observer, has a successful formula for managing its Medicare Advantage plan and is justifiably confident that it can absorb United's thousands of Medicare Advantage refugees into its own Medicare Advantage plan and not be victimized by higher costs. According to this theory, United has done what it had to do: faced with an unwieldy tangle of poorly controlled networks, United elected to blow them up and start over with a smaller subscriber base and tighter networks.

This latter theory actually dovetails with what United is saying about itself – in what little the company has been willing to share with RIMS, state and federal authorities, and the media about its motivations and plans. (As we have observed before, United's reticence gives us license to speculate, so here we go!)

Starting with the cryptic full-page advertisement United ran in the *Providence Journal* on October 19, United has implicitly cited Washington's "severe funding reductions for Medicare Advantage plans" as the prime motivating factor for making deep network cuts. Moreover, when United sent its top brass from Minnesota and from its local New England franchise to our offices to meet with RIMS' leadership on November 14, they brought with them a four-page, full-color brochure with graphs showing that "the net impact of cuts to the Medicare Advantage Program in 2014 total (sic) –6.7%," and will run to "more than $200 billion over ten years (2010–2019)." These cuts, the brochure warns, "will result in disruption for seniors, as plans are forced to exit certain market areas, reduce the number of plan offerings, reduce benefits, increase out-of-pocket costs, and tighten provider networks."

Yet these warnings appear to be undercut by another graphic in the same brochure showing how the Medicare Advantage program has substantially reduced inpatient admissions and readmissions, as well as inpatient days and ED visits, compared with traditional Medicare. Indeed, it is this success in controlling utilization that enables Medicare Advantage plans to provide attractive, richer benefits to subscribers while still maintaining healthy profit margins.

However, Medicare Advantage plans also cost the government substantially more per Medicare beneficiary than traditional Medicare. That fact, combined with the knowledge that the Medicare Advantage program has proven to be very lucrative for companies like United, gave rise to provisions in the Affordable Care Act that are designed to gradually reduce the government's per capita outlay for Medicare Advantage and bring those costs into closer parity with traditional Medicare. Seen in this light, United's alarm seems overwrought and its response (gutting its networks) extreme.

There is another potentially big unanswered question in all this, and that is: What role does CMS' "5-Star" rating system for Medicare Advantage plans play in United's calculations? CMS annually provides hefty monetary incentives to plans for good performance and awards them up to five stars in half-star increments, with substantial bonus dollars attached to each half star. No 5-Star plans are available in the Rhode Island market currently, but BCBSRI's MA plan was awarded four this year, while United's got 3.5. CMS's ratings are based on a number of measures, most of which seem to be related to subscriber and provider satisfaction, including the frequency of member complaints and responsiveness of "customer service."

One wonders what impact United expects its network downsizing will have on its prospects for winning stars next year. When we met with them, United's executives denied that the company is planning to exit the Medicare Advantage market here or elsewhere anytime soon. Instead, they said, they plan to do a more attentive and effective job of working with and supporting their reduced network. It sounds like those physicians who survived the cut can look forward to a new level of intensity in their continuing relationship with United. ❖

allegedly amounts to 8% of the physician population in those counties. Of these 240 physicians, United says that 115 exercised their contractual right to appeal, and, having appealed, "some of those have already had their removal rescinded" according to United.

The question of standing

United cites these numbers in support of its main argument to the Second Circuit, which is that the county societies lack standing to sue. United argues that 92% of the counties' physician members are either totally unaffected by United's terminations or, if they are affected at all, they theoretically stand to benefit from increased patient traffic. RIMS' legal advisors suggest that such an argument alone might well carry the day in the First Circuit and thus result in a reversal of the injunction (Rhode Island, Massachusetts, Maine and New Hampshire make up the First Circuit); however, case law may be different in the Second Circuit. (United argues further that even if the physicians who had their appeals denied were subsequently to sue on their own behalf, they too would lack standing to the extent they had failed to exhaust the administrative remedies provided in their contracts, which include arbitration.) The Second Circuit has agreed to expedite the case, so we should have some answers in a few weeks.

Below the radar

Meanwhile, members of AARP were surprised to learn that in mid-October, even as United's network cuts were causing distress to thousands of AARP members, the giant Association reached a new agreement with United under which it will further expand its program of co-branding certain United products.

At about the same time, some Rhode Islanders were surprised to learn that the State of Rhode Island renewed its contract with United for another three years to administer health coverage for state employees and retirees through the end of 2016. ❖

Regional variations in Medicare payments to physicians

Is Rhode Island really at the bottom, as "everyone" believes? (Short answer: Not by a long shot)

CMS published its annual "Final Rule" on 2014 Medicare payments to physicians in the *Federal Register* on November 27, 2013. If we bracket out the absurd turbulence that is periodically injected into Medicare's physician payment system by the SGR formula, this annual release of new data by CMS provides a useful opportunity to review how Medicare's payment system works and to take stock of its impact on Rhode Island physicians in particular. (*Rhode Island Medical News* last examined this topic in February 2010.)

First, a review of the basics. Medicare payments to doctors everywhere in the U.S. are products of essentially three factors:

- A nationally uniform Resource-Based Relative Value Scale (RBRVS)
- A nationally uniform Conversion Factor (CF), which converts the total Relative Value Units (RVUs) assigned to each CPT code into dollars
- A set of Geographic Practice Cost Indices, or GPCIs (charmingly pronounced "gypsies"). The GPCIs are intended to modulate Medicare payments in order to fairly reflect regional variations in the actual cost of practicing medicine and to correct for the fact that physicians' overhead is higher in Manhattan, say, than it is in Little Rock.

There are three GPCIs, one to modulate the value of each of the three "Resources" that go into the RBRVS. Those three Resources are physician "Work," "Practice Expense" and what Medicare calls "Malpractice," which means the cost of medical professional liability insurance. Of course, the latter is simply another component of practice overhead, but RBRVS measures it separately, perhaps because geographic variations in the cost of liability insurance do not always vary in relation to the other elements of Practice Expense.

In assigning Relative Value Units to physician Work, the RBRVS considers the time, skill, intensity, training and experience required to provide a particular medical service. Similarly, Practice Expense is considered to have three main components: support personnel expenses, medical office rental expense, and equipment/supplies. The RBRVS system attempts to allocate an appropriate proportion of these resources in the form of RVUs to each of the thousands of services defined by CPT.

Implicit in the allocation of RVUs is an overwhelming emphasis on the physician Work and Practice Expense components and a lesser emphasis on the "Malpractice" component. Work and Practice Expense have long been weighted about equally and together account for almost 96 percent of the Relative Value Units in the Medicare RBRVS. That leaves liability weighing in with a little more than 4 percent of the total RVUs. This reflects a long-standing determination by CMS that, overall, the direct costs of professional liability insurance account for less than 5 percent of the total cost of running a medical practice.

Interestingly, for 2014 CMS is shifting more weight to Work and assigning less to Practice Expense, while leaving the Malpractice weighting unchanged. The shift from Practice Expense to Work appears to be attributable in part to a diminution in the amount of Practice Expense attributable to employee compensation. Specifically, the 2013 and 2014 weightings are:

	2013	2014
Physician Work	48.266%	50.866%
Practice Expense	47.439%	44.839%
Malpractice	4.295%	4.295%
	100.000%	100.000%

The fact that Medicare will pay a physician in Woonsocket, Rhode Island, 6.9 percent more than a physician in Wonooski, Vermont, for the same CPT code is a function of the GPCIs. The difference in payment reflects the fact that, by Medicare's measurements (which are hardly perfect but are also not static and are annually reviewed, refined and updated), the overall cost of the resources that go into providing the service associated with a given CPT code is 6.9 percent higher in Woonsocket than it is in Wonooski.

Here is how the GPCIs work their magic. Medicare divides the U.S. into 89 geographic "localities" and assigns to each locality its own set of three GPCIs to adjust for the local value of Work, Practice Expense and Medical Professional Liability. Rhode Island is its own single locality. Vermont is another. Connecticut is another. In all, 34 states are single "localities" in the Medicare payment system. Massachusetts is two localities: "Metropolitan Boston" and "The Rest of Massachusetts." Maine is also two: "Southern Maine" and "The Rest of Maine." California has nine localities. New York State has five.

The GPCIs are numeric multipliers that are applied to modify each of the three RVUs for Work, Practice Expense and Malpractice for a particular CPT-coded service before they are totaled and then converted to dollars. A GPCI value of 1.0 indicates that local practice costs, and therefore payment, coincide with the national average. Medicare assigns a GPCI greater than 1.0 where it determines that the value of professional work, practice overhead or liability expense within a

given locality is above the national average, and therefore payment will also be above the average.

Medicare pays physicians in many localities, especially in predominantly rural areas, at GPCI-adjusted rates that are below the national average. This has been true despite the fact that Congress for several years required CMS to fudge on the Work GPCI: in a variation on the Wobegon Effect, no locality could be below average with respect to the value of physician work. Accordingly, every locality's Work GPCI was 1.0 or greater in 2013, but this floor for the Work GPCI has expired and no longer exists as of 2014.

In a similar kind of fudging, the Affordable Care Act has mandated since 2011 that the Practice Expense GPCI for five sparsely populated "frontier states" may not fall below 1.0. The five "frontier states" are Montana, Wyoming, Nevada and the Dakotas. With these exceptions, GPCIs can and do dip below 1.0 in many localities.

The bottom line

So what were Rhode Island's GPCIs for 2013, and what will they be for 2014? In 2013, all of Rhode Island's three GPCIs were above 1.0, which means that Medicare reimbursed Rhode Island physicians at rates that were above the national average. Indeed, Medicare has always paid Rhode Island physicians at rates above the national average, at least since the advent of RBRVS over twenty years ago. Rhode Island's 2014 GPCIs ensure that this pattern will continue.

Specifically, Rhode Island's 2013 and 2014 GPCIs are as follows:

	2013	2014
Physician Work	1.017	1.020
Practice Expense	1.052	1.052
Malpractice	1.187	0.971

Among other things, these 2014 GPCIs suggest that Medicare thinks Rhode Island's medical professional liability rates have improved substantially relative to the rest of the country, going from well above the national average to somewhat below. Unfortunately, this supposed improvement does not pass the sniff test and casts doubt on Medicare's data and methodology. Liability rates everywhere are overwhelmingly stable, not only in Rhode Island but all across the country. Rhode Island rates for physicians and surgeons have certainly not decreased recently, nor have rates in the rest of the country increased. Whether Rhode Island's 2014 liability GPCI represents a mistake, a correction or a recalibration, its impact on Medicare payment is in any case greatly muted by the fact that RBRVS gives this element of practice overhead expense a weighting of only 4.295 percent.

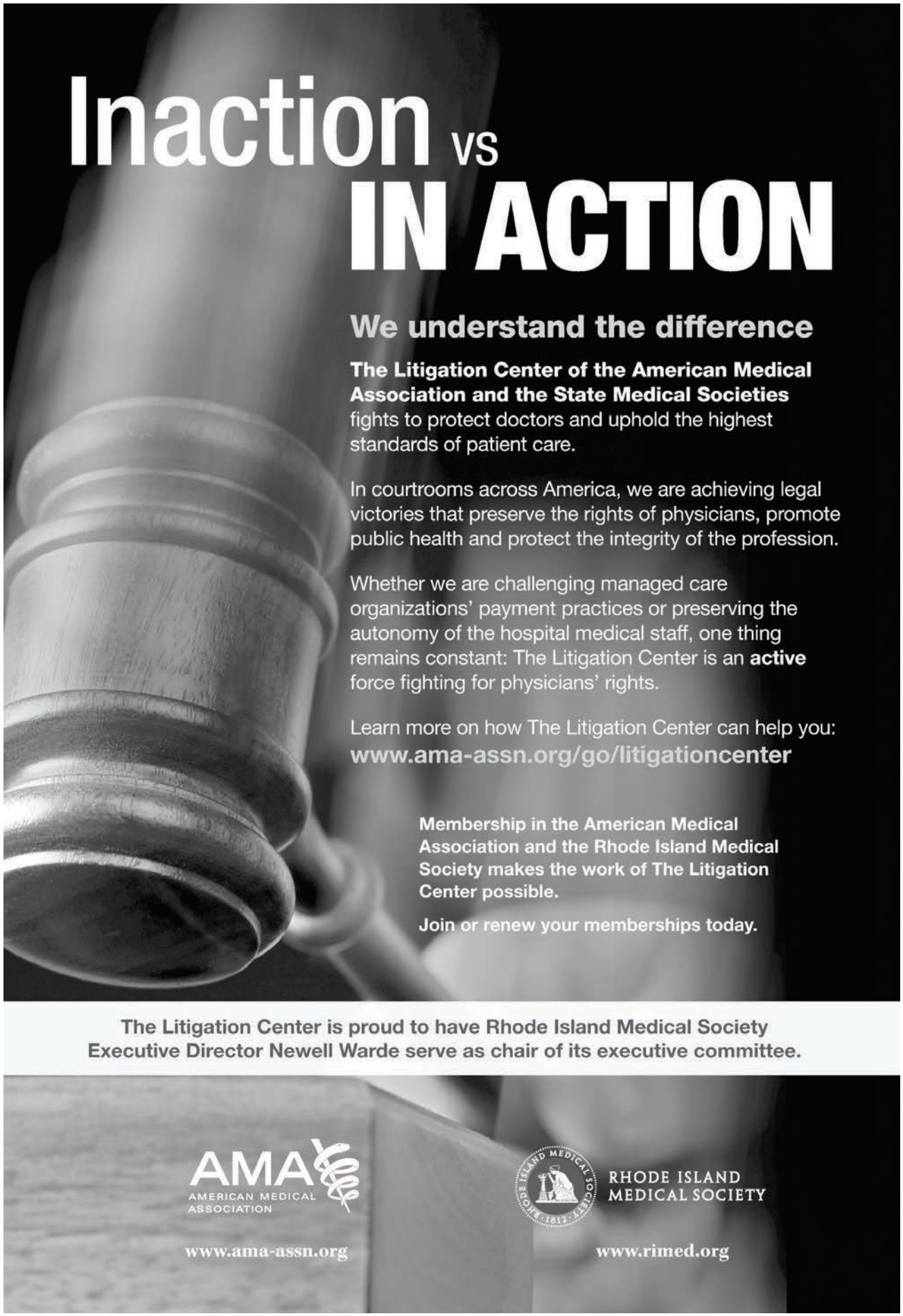
Also puzzling but much more positive is the 0.3 percent increase in the value assigned by Medicare to Rhode Island physicians' work in 2014 compared with 2013. The Rhode Island Work GPCI rises from 1.017 to 1.020 in 2014, which is higher even than Metro Boston's 2014 Work GPCI (1.016). In combination with the overall higher weighting being given to physician Work by RBRVS in 2014, this increase in Rhode Island's Work GPCI offsets the decline in the liability GPCI.

Comparisons of overall Medicare payment levels among states and localities can be facilitated by calculating a weighted average of their three GPCIs to arrive at a composite Geographic Adjustment Factor (GAF). The 2014 formula for calculating any locality's GAF would be as follows:

(Work GPCI x .50866) + (PE GPCI x .44839) + (MP GPCI x .4295) = GAF

Thus, Rhode Island's 2014 GAF works out to 1.0322439, suggesting that Rhode Island physicians on average receive 3.2 percent higher payments from Medicare than the national average and are the third highest paid in New England after Connecticut (7.3 percent above average) and Metro Boston (6.4 percent above the national average; note that while Boston's Work GPCI is lower than Rhode Island's in both 2013 and 2014, the Hub's Practice Expense GPCI is much higher, and therefore Metro Boston doctors continue to be paid at an overall higher rate). The "Rest of Massachusetts" is 2 percent above average and New Hampshire is 1 percent above. Southern Maine is 2 percent below the national average, and the Rest of Maine is 8 percent below, while Vermont is 4 percent below. Mississippi is lowest in the nation at almost 9.5 percent below the national average.

Where, then, does the persistent notion come from that Rhode Island physicians are at the bottom of Medicare's reimbursement barrel? It may have its origins in a misunderstanding of a study conducted by the Rhode Island Public Expenditures Council (RIPEC) of fee-for-service Medi*caid* programs across the U.S. more than twenty years ago. Published in 1993, just before the advent of RIteCare, that study found that Rhode Island fee-for-service Medicaid was 49th in the nation in the rate at which it was paying physicians. 50th was Arizona, which essentially did not have a Medicaid program at that time. ❖



The Litigation Center is proud to have Rhode Island Medical Society Executive Director Newell Warde serve as chair of its executive committee.

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Diary of a Delegate - AMA Interim 2013

National Harbor, Maryland

PETER A. HOLLMANN, MD
RHODE ISLAND DELEGATE TO AMA

The AMA House of Delegates (HOD), the policy setting body of the AMA, met November 16–19, 2013, in National Harbor, Maryland. Representing RIMS were Elaine Jones, MD, President, and Peter Hollmann MD, Delegate. This was the first meeting since 1999 that Michael Migliori, MD, was not in attendance. (Alyn Adrain, MD, will be succeeding Mike as a Delegate effective January 1, 2014.) Also from Rhode Island were Barry Wall, MD (American Academy of Psychiatry and the Law) and Yul Ejnes, MD (American College of Physicians). The Warren Alpert Medical School of Brown University was well represented in the Medical Student Section (MSS) meeting that preceded the HOD; Grayson Armstrong was voted Chair-Elect of the MSS. Newell Warde, PhD, and Steve DeToy attended as well. They also conducted visits with our Congressional delegation regarding SGR and United Healthcare's network terminations.

Repeal of SGR

There was one big issue at this meeting with all others being less significant: SGR and the looming 24% Medicare fee cut. It is a unique time in the many years that we have endured SGR threatened or actual cuts. There is presently a framework supported by both parties and both the House Ways and Means and the Senate Finance Committees. Bipartisan and bicameral??? No you are not suffering hallucinations.

So, what's the story?

- SGR is not fair.
- SGR is ineffective.
- SGR cuts recoup money already spent and is an accounting issue over minor variances from budget that have been compounded over many years.
- SGR threatens Medicare and access.
- SGR can be fixed for the lowest amount (in budget dollars) in many years $140–150 billion. It will probably cost less to fix it now than to have more patches.

The framework does have some bitter pills. There is no actual bill, and the chances of passage are far from certain. The HOD recognized that many of the items the profession opposes may need to be accepted and improved after SGR is gone. It wisely gave the AMA the authority, with wide latitude, to work with House Ways and Means and Senate Finance Committees. The HOD itself was surprisingly unified on this matter.

Here is the skinny on the SGR repeal framework and process:

- A 10-year conversion factor freeze – This is necessary to keep the price tag low enough to pass Congress. Other solutions proposed in the past had annual cuts. This freeze is potentially offset by positive updates for those who participate in Alternative Payment Models (APMs) such as an ACO. Quality bonuses can also lead to increases. It is hoped that with a stable budget process after SGR repeal that more reasonable updates can be approved in future legislation.
- Bonus/Penalties in Pay for Performance (Value Based Modifier) – While far from perfect, EXISTING Law has this already. The framework proposes consolidation of programs and substantial administrative simplification (though it is still hardly simple). It returns money compared to the budgeted/expected penalties. It funds measure development, small practice support and looks to the profession to lead measure development.
- Redistribution of RVUs for "overvalued" services – CMS, with RBRVS Update Committee (RUC) recommendations, has improved the accuracy of the valuation of many services and re-distributed $2.5B over the last 5 years. The framework expects this to continue to the tune of 1% of all Physician Fee Schedule payments per year. Failure to do so would lead to anything under 1% being removed from the pie rather that redistributed within the pie. Since this is theoretically budget neutral and therefore not a savings program, it is hoped that this will not go forward as the dollar redistribution is simply not realistic when one considers the total amount of the pie that is E/M. There is concern that it is intentionally unrealistic so that cuts will be implemented.

Payment for Chronic Complex Care Management – this has been long supported by the AMA and is included.

"Pay-go" – The framework does not indicate where the money will be found. It does not need to, but a final bill will require this. It appears the House will look for cuts only, and that the cuts will need to be in the Medicare Program. This pits physicians against other providers and Medicare Advantage Plans who are arming themselves for battle. If the cuts are not there, then they may be against our patients in terms of reductions in benefits, increased age for benefits or means-testing. This would probably doom the legislation. The House wants "structural reform" of Medicare to pay for this, whereas the Senate may have greater flexibility. These differences are why SGR repeal may not happen. Congress will be under severe pressure whatever path is taken and this is why physicians need to be strongly supportive of change and accept some less desirable provisions. We will need to show gratitude publicly, even if we are less than fully satisfied.

What can you do about this?

- Write your U.S. congressman and senators and tell them how a 24% cut on January 1 or cash flow disruptions due to delayed decisions will affect your employees, your patients and your practice.
- Recognize the need to address the cost off-sets and express appreciation for making this a priority before the end of the year.
- Prepare for APMs and performance measurement. Even if SGR repeal fails, penalties related to PQRS and other pay-for-performance programs are fast upon all of us. Turn penalties into bonuses by getting onto an electronic record, getting Meaningful Use money. Evaluate your opportunities related to APMs. An educational forum at the HOD included information about how small practices and large integrated systems are preparing and succeeding. The common theme is coordination and information systems.
- Contribute to AMPAC and RIMPAC; join the AMA if not a member.

More than SGR

Other important issues were the subject of new policy or were informational. The AMA will not be able to make all of them items of priority, of course, but many agenda items stake out new positions and stimulate positive change. Others are aspirational, with little likelihood of success.

- Code of Ethics: The Code of Ethics is undergoing revision in organization and language, but not in the principles. It is being done to make information more accessible and in a more contemporary presentation.
- RAC Audits: Success on Appeal should result in the physician receiving interest and payments to offset appeal costs.
- Electronic Record Support: Records have ongoing costs and these should be built into payments.
- ICD 10: A New England Delegation resolution was passed that seeks regulations for payers to provide financial assistance for ICD 10 implementation. Other resolutions reaffirmed opposition to ICD 10 and asked for timely filing and appeal time provisions to be relaxed, especially with concerns over CMS's Information Technology capacity and the potential for the CMS claims system to fail with ICD 10 implementation.
- FDA Regulation of Tobacco and Nicotine: The FDA should have authority.
- Admission/Observation/Two Midnight Rule: There were several resolutions that supported reduction of inappropriate actions requiring physician determination of status upon hospital entry. Regulations are fresh and confusing to many, so AMA Council or Board Reports with policy recommendations/actions are to follow.
- DEA registration fees: They should not be increased.
- Self-administered drugs: The classification of drugs as self-administered (Part D) or physician administered (Part B) is being done in some contractor regions with inadequate practicing physician input. The AMA seeks a requirement for Contractor/Carrier Advisor input.
- Team Based Care: An excellent report on evolving models of practice with policy on the subject. Teams are physician led and payment should go to the treating physician who oversees the team.
- Aging Criminals being admitted to Long-Term Care Facilities: Support convening long-term care, prison health, mental health and substance abuse professionals to create guidance and model policy.
- Grace Period Coverage for Exchange Products: Current rules require insurers to extend grace periods, but allow retroactive cancellation if premiums are not paid. This is an issue for current employer-based coverage also, but may grow in an individual market. The AMA will seek payment based upon insurer statements of coverage when checked at the time of service.
- Non-conforming (in ACA) policy coverage cancellation: There was a lot of discussion about cancellations of policies, just like on the news. Most of the comments seemed to be non-factual, but all agreed the AMA should work to promote smooth transitions so that the net effect is not a decrease in insureds.
- Cost of/Changes in Clinical Skills Exams for students: This is a costly step students must take towards licensure. Some changes have been made that would seem to be designed to modestly raise the failure rate. The AMA goal is to help evaluate the cost effectiveness of this exam and to promote an educational system where all students are competent and advance.
- Pain as a Vital Sign: The AMA has Commissioners on the Joint Commission. The AMA will ask the Joint Commission to review its accreditation standards around pain assessment, especially as to whether it improves prescribing or actually leads to excessive narcotic use.
- And more...There were other ideas that will result in AMA Council or Board Reports and policy recommendations in the coming year.

Physician Satisfaction

The AMA rolled out the results of a RAND study it funded. This research confirmed several factors for physician satisfaction, which were consistent across practice models and medical specialties:

- Being able to provide high-quality care to patients, including sufficient time and practice organization
- Having some autonomy and control over the day-to-day work situation
- Identifying with practice leadership
- Sharing a sense of community with other physicians

The Litigation Center

The Litigation Center reported on many actions related to liability matters, medical staff autonomy and fair payment. Our Newell Warde chairs the Litigation Center board. The Center contributed mightily to our, albeit failed, attempt to get the Rhode Island courts to overturn the imaging and surgi-center income taxes.

Read More about the Interim Meeting from the AMA.

Go to http://www.ama-assn.org/ams/pub/meeting/index.shtml

The Rhode Island Delegation thanks all RIMS members for their interest and support.

PUBLIC HEALTH

HIV infections: "Getting to zero"

The Rhode Island Health Department has asked RIMS' help in informing physicians about the Department's campaign to make Rhode Island the first state to reduce to zero the number of new HIV infections in a year.

Rhode Island saw 125 new cases in 2009, and just 78 in 2012. The Department's goal is to reduce the number of new cases by 20 a year for the next four years, so that Rhode Island will be free of new cases by 2016 – and be the first state to "Get to Zero."

The Department is using social media, billboards, and radio ads to remind everyone ages 13 to 64 to be tested, and those most at risk – those with multiple sexual partners – to be tested every six months, or every time they have a new partner. In this way the Department hopes to reach the estimated 400 Rhode Islanders who are infected and don't know it.

The Department is asking all health professionals licensed to order testing – physicians, dentists, physician assistants, podiatrists, and advanced practice nurses – to help by ordering an HIV test for every patient they see in the recommended age group or risk category. ❖

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The goal of this new electronic payment standard is to reduce healthcare costs and improve your operating efficiency by helping your practice:

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- Minimize fraud due to lost or stolen checks
- Enhance reporting functions with financial software

Medicare deadline is January 1, 2014

By this date, health care providers must be able to accept ACH payments for Medicare claims. And you can depend on Webster to provide the payment information and support you need to make a successful transition to an electronic payment system.

Webster's cash management solutions can help

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Working for you

Below are some of the advocacy activities in which the Rhode Island Medical Society engaged during the month of November 2013 on behalf of Rhode Island physicians and patients.

November 1, Friday
Coalition of Mental Health Professionals of RI, 8:30–10:30 am, 49 Pavilion Avenue, Providence

Worker's Compensation Advisory Board, regarding rehabilitation services, 1–2:30 pm, at Worker's Compensation Court

Kids Count: annual update on children's health in Rhode Island, 12–1:30 pm, Providence Marriott

Health Care Planning and Accountability Advisory Council, 2:30–4 pm, Dept. of Administration

November 4, Monday
Meeting with Dr. James McDonald, CAO of the Board of Medical Licensure and Discipline, regarding fees for providing medical records, 9–10:30 am, at Health Department

RIMS Executive Committee, 6–8:30 pm, Sheraton Hotel, Warwick

November 5, Tuesday
RIMS Physician Health Committee (Herbert Rakatansky, MD, chair), 7:30–8:30 am at RIMS

Purdue Pharmaceuticals regarding opioid epidemic in Rhode Island, 2:30–3:30 pm at RIMS

Public hearing on Pentec Health matter, House Committee on Health, Education and Welfare, 4–5 pm, State House

November 6, Wednesday
Joint Legislative study commission on the integration of behavioral health and primary care, 9–11 am, State House

AMA conference calls on SGR matter before Congress, 12–1 pm and 7:30–8:30 pm

November 7, Thursday
Joint legislative study commission on behavioral health and firearm safety, 3–5 pm, State House

Medical Review Advisory Committee (Peter A. Hollmann, MD, chair), 6 pm at RIMS

November 8, Friday
Office of the Health Insurance Commissioner, conference regarding administrative simplification, 12–1:30 pm at OHIC

AMA Advocacy Resource Center conference call (Steven DeToy, chair), 2-2:30 pm

RIMS President Elaine Jones, MD, and staff meet with Governor Chafee's chief of staff, 3:30–4:30 pm, State House

November 12, Tuesday
Health Benefits Exchange Expert Advisory Committee, re: 90-day "grace period" issue, 8–9:30 am, at RIMS

Medical Student Health Council (Dr. Rakatansky, Ms. Boyd), 6–7 p., at RIMS

November 13, Wednesday
Health Care Planning and Accountability Advisory Council, 2–3:30 pm, Dept. of Administration

Department of Environmental Management, re: medical waste, 3–4 pm, at DEM

RIMS educational program on ICD-10 (in collaboration with the Medical Group Management Association), Nancy Enos presenting, 6–8 pm

November 14, Thursday
Meeting with CMO, provider relations and network staff of BCBSRI (Dr. Elaine Jones, Dr. Peter Karczmar, RIMS staff), 8–9 am at BCBSRI

Meeting with CMO of UnitedHealthcare Group and CMO, CEO and network manager of UnitedHealthcare of New England, re: UHC terminations of physicians in Medicare Advantage network (Dr. Elaine Jones, Dr. Peter Karczmar, RIMS staff), 4–5 pm, at RIMS

November 15, Friday
RIMS' executive director and government affairs director visit the Washington offices of Senator Reed, Senator Whitehouse and Representative Langevin regarding SGR matter, UnitedHealthcare terminations, 9:30 am–12:30 pm.

AMA House of Delegates: Newell Warde addresses the Organization of State Medical Society Presidents (OSMAP) regarding the work of the Litigation Center, 2 pm, National Harbor, MD

November 16, Saturday
AMA House of Delegates: New England Delegation Caucus 6:30 am–2 pm; House of Delegates 2–5 pm (Dr. Elaine Jones; Dr. Peter Hollmann), National Harbor, MD

November 17, Sunday
AMA House of Delegates; Reference Committees; New England Delegation Caucus

Litigation Center of the AMA and State Medical Societies: open meeting for all House of Delegates attendees 3–5 pm; Executive Committee meeting 5–6:30 pm (RIMS' Newell Warde, chair), National Harbor, Maryland

November 18–19, Monday–Tuesday
AMA House of Delegates, National Harbor, MD: Dr. Peter Hollmann, Dr. Elaine Jones, RIMS staff

November 19, Tuesday
OHIC: Health Insurance Advisory Committee, 4:30–6 pm, Department of Labor & Training

November 20, Wednesday
Primary Care Physician Advisory Committee, 7:30–9 am, Department of Health

OHIC: Administrative Simplification Task Force (Dr. Alyn Adrain, RIMS staff), 9–11 am at RIMS

Meeting with the Director of the Division of Elderly Affairs regarding UnitedHealthcare terminations of physicians in Medicare Advantage network, 10:30–11:30 am at DEA

Conference call: Legislative Study Commission on the Integration of Behavioral Health and Primary Care, 10:30–11:30 am

November 21, Thursday

Rural Health Day, Scituate Community Center: Dr. Louise Kiessling honored by the Dept. of Health as a Rural Health Champion: 8:30–10 am

Health Centers Association, RI Academy of Physician Assistants, RI State Nurses Association at RIMS, 1–2 pm

Meeting with Director of Health and CAO of Board of Medical Licensure and Discipline (Dr. Elaine Jones, Dr. Peter Karczmar, RIMS staff), 4–5 pm at the Department of Health

RIMS Committee on Continuing Medical Education (Patrick J. Sweeney, MD, PhD, chair), 5:30–7 pm at RIMS

November 22, Friday

Health Professional Loan Repayment Program, 12:45 – 1:30, Dept. of Health, Director's Office

RIMS submits nomination of Lt. Governor Elizabeth Roberts to the AMA for a Dr. Nathan Davis Award

November 25, Monday

OHIC: helping physicians collect copayments and deductibles, 10–11 am, Dept. of Labor and Training

November 26, Tuesday

Meeting with director of the RI Health Centers Association, 9:30–10 am

Meeting with government affairs director of the Hospital Association of RI regarding state regulatory matters, 2:30 –3:30 pm, at HARI

Senator Jack Reed fundraiser (AMPAC: Dr. Michael Migliori, Dr. Michael Silver, Mr. Warde), 5–7 pm, Hope Club, Providence

ELAINE C. JONES, MD, was inaugurated as the 155th President of the Rhode Island Medical Society on Saturday, September 27, 2013. An alumna of Smith College, Dr. Jones earned her medical degree at the Medical University of South Carolina and did a residency in internal medicine at Baystate Medical Center, and residency and a fellowship in neurology at Rhode Island Hospital. She is in solo private practice in Bristol and Greenville. She is a past president of the medical staff of Roger Williams Medical Center.

PETER KARCZMAR, MD, was inaugurated President-Elect of the Rhode Island Medical Society on Saturday, September 27, 2013. Dr. Karczmar is a pulmonologist associated with Coastal Medical, Inc., practicing in East Providence. He is a past president of the medical staff of The Miriam Hospital.

RUSSELL A. SETTIPANE, MD, was inaugurated Vice President of the Rhode Island Medical Society on September 27, 2013. Dr. Settipane specializes in allergy and immunology with practices in Providence, Wakefield and Middletown.

JOSE POLANCO, MD, continues as Treasurer of the Society, having succeeded Dr. Jerry Fingerut in 2013. **ELIZABETH LANGE, MD**, continues as Secretary of the Society. New to the Executive Committee as Councilors-at-Large are **BRADLEY J. COLLINS, MD**; **DIETER POHL, MD**; **PATRICK J. SWEENEY, MD, PHD**; and **IRA J. SINGER, MD**.

GRAYSON W. ARMSTRONG, MD '15 at the Warren Alpert Medical School of Brown University, is Chair-Elect of the American Medical Association's Medical Student Section (AMA-MSS). Hailing from Weddington, North Carolina, Mr. Armstrong is currently on a leave of absence from Brown working toward a master's degree in public health at Harvard University. The AMA-MSS elected him on November 15 in National Harbor, Maryland; he will become chair in June 2014. The AMA-MSS represents more than 48,000 AMA member medical students nationwide.

JERRY FINGERUT, MD, has received the Dr. John J. Cunningham Citizen's Award from the Rhode Island Health Centers Association. Dr. Fingerut recently retired as Medical Director of the Blackstone Valley Community Health Center and as Treasurer of RIMS.

LOUISE S. KIESSLING, MD, FAAP, received the 2013 Rural Health Award of the Rhode Island Health Department in recognition of her selfless devotion and "countless volunteer hours working to improve children's behavioral health services in southern Rhode Island." Dr. Kiessling, allegedly retired since 2003, is the former Pediatrician-in-Chief at Memorial Hospital of Rhode Island, as well as the founder and director of the Neurodevelopmental Center there. She is a former member of the RIMS Council.

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RIMS Insurance Brokerage Corporation's new partner, Coverys, named again to Ward's prestigious top 50

For the fourth consecutive year, Ward Group has recognized Massachusetts-based Coverys as one of the 50 top-performing property and casualty companies in America. Ward's annual analysis measures financial strength, operations, service, safety, consistency and performance over the most recently completed five-year period.

Coverys is a leading provider of medical professional liability insurance in the northeastern U.S. and one of the largest 10 such insurers in the country.

Coverys is also the latest addition to the RIMS-IBC's expanding palette of high-quality offerings. These include NORCAL Mutual Insurance of San Francisco and a full array of personal and business products through a new co-brokerage agreement with Butler & Messier of Pawtucket, in addition to the long-standing relationship with service-oriented Good Neighbor Alliance for life, health and disability coverage.

Now a full-service agency, the RIMS-IBC nevertheless remains primarily focused on medical professional liability insurance, where the IBC's exceptional level of expertise and professional service offers unique value to doctors. Medical liability coverage is of paramount importance to the financial security and professional reputation of every physician, but the market for such coverage is notoriously treacherous and confusing. The staff of the RIMS-IBC know how to help practices understand their options and make wise choices tailored to their personal needs and timetables.

The RIMS-IBC is proud to place business with two of the strongest and most respected insurers in the nation. NORCAL and Coverys are both rated "A" by A.M. Best, and both have the DNA of physician-owned and physician-directed mutual insurance companies in their family trees.

More information is available through the RIMS website (www.rimed.org, click on RIMS-IBC). The staff of the RIMS-IBC can be reached at 401-272-1050. ❖

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RIMS NEWS

RIMS founder's portrait featured at RISD

Perhaps for the very first time in its nearly 220 year history, James Earl's portrait of Dr. Amos Throop (1736–1814), founder and first president of the Rhode Island Medical Society, is now on public display. The painting is part of a major exhibition entitled "Making it in America" at the Rhode Island School of Design Museum. The show runs through February 9 and includes more than 100 artworks, mostly drawn from the Museum's own collection of Americana.

The portraitist James Earl (1761–1796) was born in Massachusetts and trained in England. He visited Providence in 1794 or 1795 and painted several of the city's leading citizens. His portrait of Dr. Throop remained in the hands of Throop's descendants until his grandnephew made a gift of it to the Medical Society in 1890. From 1912 to 2012, the painting graced the walls of RIMS' headquarters. In January 2012, as part of the bicentennial observances of the Society's founding in 1812, RIMS sent the painting to the Williamstown Art Conservation Center in Williamstown, Massachusetts, to be conserved in preparation for its transfer to the RISD Museum on long-term loan. The exhibition represents not only the painting's first known public showing ever, but also its post-conservation debut.

The RISD exhibition provides a sweeping survey of American art from colonial times to the early 20th century and includes some of RISD's best-known treasures, including paintings by Winslow Homer and John Singer Sargent, glassware by Louis Comfort Tiffany, a monumental Prairie Style desk designed by Frank Lloyd Wright, and spectacular silverwork by Providence's own Gorham Manufacturing Company. Besides the Throop portrait, painted at the apex of James Earl's career, the show also includes at least one of the Museum's own four works by Earl.

The title of the exhibition, "Making it in America," applies in a double sense to most of the works, including both Earl and his subject. Amos Throop was born in Woodstock, Connecticut, the son of a Harvard-educated Congregationalist minister from Bristol who died almost nine months before Amos was born. Young Amos was sent to live with relatives for his schooling in Bristol, then came to Providence as an apprentice and house guest of the town's leading physician, Jabez Bowen. The Bowen house still stands on Bowen Street. Dr. Throop and his wife lived the last years of their lives in the once elegant Georgian mansion that is now situated across from Mill's Tavern on North Main Street, next to Throop Alley; at the time of his death, Throop was both president of RIMS and chief executive of a bank.

RIMS' 18th-century portrait of Dr. Throop is on exhibit at the RISD Museum through February 9, 2014.

The RISD Museum is located at
20 North Main Street in Providence.
Hours are Tuesday–Sunday
10 am to 5 pm.