Top 10 challenges facing physicians in 2016

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“There is great disorder under the Heavens, the situation is excellent.”

That observation from Mao Zedong might well describe the situation physician’s face heading into 2016. Confusion abounds, driven by uncertainties about issues from shifting payment models to new government mandates to ongoing battles over maintaining certification.

At the same time, the uncertainty and challenges facing healthcare present opportunities in 2016 and beyond for doctors to improve patient care by harnessing technology, strengthening care delivery teams, and getting reimbursed for more of the time they spend counseling and treating patients.

For the third consecutive year, Medical Economics presents its list of top challenges physicians will face in the coming year. We developed this year’s list in consultation with members of our editorial board. Some of the challenges—the impact of the Affordable Care Act and the growing emphasis on outcomes over quantity in reimbursements, for example—will be familiar. Others, such as getting reimbursed for chronic care management, appear for the first time.

While these challenges may look daunting when gathered together, each challenge can be addressed and overcome individually by strong medical practices looking toward the future. Physicians can gain momentum and seek opportunities in the ongoing change if they know what to expect as 2016 arrives.

Challenge 1: Getting paid what you deserve

As payment models change, physicians must prepare to take on risk
Doctors breathed a collective sigh of relief in April when Congress and the president came together to pass the Medicare Access and CHIP Reauthorization Act (MACRA), which included a permanent solution for repeated temporary fixes to the Medicare Sustainable Growth Rate methodology used to pay doctors.

But that solution came with a price: incentives to move to quality-of-care models for Medicare payments from the old fee-for-service model. Physicians will need to start thinking about adapting to the new models from 2016 through 2019 when implementation of the Merit-Based Incentive Payment System (MIPS) called for in the new law begins.

“There’s certainly going to be a lot of activity,” in 2016, says Josh Seidman, Ph.D., senior vice president at Avalere Health’s Center for Payment and Delivery Innovation in Washington, D.C. Questions that still need to be answered, he says, include:

- How will the Centers for Medicare & Medicaid Services (CMS) determine physician scores under MIPS, which requires a zero to 100 composite score?
- At what level will scoring take place? By practice or by individual doctors?
- Will the new pay-for-performance focus drive more doctors into alternative payment models (APMs) such as accountable care organizations (ACOs) and patient-centered medical homes (PCMHs)?

Medicare physician payments are set to increase 0.5% per year from 2016 through the end of 2018 under MACRA. That changes in 2019. Starting that January, APMs are exempt from MIPS. Physicians then can enter either an APM track for payments or the MIPS track. So a major question doctors will be wrestling with in 2016 is what will qualify as acceptable alternative payment models, Seidman explains. “The threshold question is whether they [doctors] want to participate in APMs; that really changes the nature of how they will be evaluated,” he says.

Not yet known is whether APMs will be required to accept greater financial risks for doctor/members than do existing Medicare Accountable Care Organizations (ACOs). ACOs have taken a population health
approach to care whereby providers share in any cost savings realized compared with fee-for-service. APMs may also be required to share in losses, meaning doctors who choose that track will take on more financial risk, Seidman cautions.

If doctors decide not to adopt an APM, “then they’re going to have to be subject to whatever the scoring methodology is in MIPS,” Seidman says. Among unanswered questions about such scoring is how much CMS will rely on patient-reported outcomes in compiling MIPS scores.

Doctors Seidman has consulted regarding the new MIPS system are anticipating it with a combination of apprehension and hope that it will allow them more control over patient care, he says. “There are a number of providers that recognize with more risk comes more control. If they take on more risk for a population, they get to have more control over decision-making. Some of them see this as an opportunity.”

Challenge 2: Affordable Care Act

Presidential election looms, but ACA firmly entrenched

Republicans in the House of Representatives have tried to repeal the Affordable Care Act (ACA) more than 50 times since the law’s creation, so there’s little doubt the ACA will surface as an election issue in 2016. Republican presidential candidates have called for its repeal while Democratic front-runner Hillary Clinton is proposing tweaks such as a $250 cap on drug costs for patients with chronic or serious illnesses.

But after the country elects a new president next November, it’s doubtful ACA will go away anytime soon, says Chris Sloan, manager at Avalere Health.

“Significant aspects [of ACA] have been implemented and interpreted from a regulatory perspective,” Sloan says. Unraveling that, even if a Republican wins the White House, likely will be extremely difficult. Few politicians on either side of the aisle have the appetite to strip health insurance from the 23 million people who have gained it under the ACA and the expansion of Medicaid it has brought about, he notes.
And Democrats might be in a position to take back control of the Senate, further complicating any Republican plans, Sloan predicts. So if a Republican does win the White House, expect the new administration to take a regulatory approach to altering the ACA by, for example, changing definitions for what are the essential healthcare services covered, Sloan says. Republicans have railed against coverage for birth control measures, for example, and numerous lawsuits have attacked it.

For doctors, though, a major influx of new patients gaining coverage under the law in 2016 seems unlikely, Sloan says. At the end of October even the Obama administration was projecting only a slight increase for the coming year, to around 10 million, in the number of Americans covered by exchange plans.

Moreover, Medicaid expansion appears to have stalled. Major states that have not expanded coverage, such as Texas and Florida, are unlikely to do so. Some smaller holdouts like Montana continue to expand, but overall there won’t be a major increase in Medicaid recipients in 2016, Sloan projects. Roughly 13 million people have gained Medicaid coverage under ACA-prompted expansion of eligibility rules.

In the commercial healthcare insurance arena, 2016 is the year when the individual penalty for not having coverage increases dramatically, to the greater of $695 or 2.5% of modified adjusted gross income, compared with $325 or 2% of modified adjusted gross income in 2015. But Sloan isn’t expecting that to produce a major jump in the number of people opting to buy insurance.

That’s because those now uninsured are largely lower-income individuals who typically would get tax refunds. ACA penalties would be subtracted from those, so such individuals might still decide they would rather go without insurance than have the added expense of monthly premiums they see as unaffordable, he predicts.

When taxpayers were offered the chance to sign up for coverage before getting hit with their 2014 tax penalty, only 200,000 of a possible 6 million signed up. “That’s a pretty limited impact in the first year,” he says.
The employer mandate to provide coverage also expands to those with 50 or fewer employees in 2016, but again Sloan doesn’t see that producing a massive number of newly-insured.

So rather than scrambling to handle major ACA changes in 2016, doctors will have an opportunity to catch their breath as they await the next shoe to drop in a post-election Washington.

Challenge 3: Chronic care’s uncertain promise

Aggravations abound in setting up chronic care management

In 2015, CMS began reimbursing physicians for coordinating the care of Medicare patients with chronic diseases, including services provided outside the traditional face-to-face visit. The program covers the costs of previously unbillable services, such as medication management or coordination with other specialists.

But reaping the financial benefits isn’t as simple as it might sound, some experts’ caution. “A lot of physicians underestimate how complex it is to set this up from a billing standpoint,” says Cynthia Dunn, RN, FACMPE, a Cocoa Beach, Florida-based consultant for the Medical Group Management Association Health Care Consulting Group. “There are a lot of requirements and you have to be very clear in your documentation.”

Under the chronic care management (CCM) program, physicians can bill for non-face-to-face care of patients with at least two eligible chronic conditions using CPT code 99490. To qualify, services must take at least 20 minutes of clinical staff time per month and the practice must create and regularly update a comprehensive care plan detailing the patient’s health problems, prognosis, treatment goals, interventions, medications, and need for social services.

In addition, the practice must use electronic health records (EHRs) and obtain written consent from the patient to implement the plan. If all conditions are met, practices are eligible to receive reimbursement of about $40 per member per month. “The process is so complex that we are seeing a whole segment of companies popping up offering to handle chronic care documentation and billing for a fee,” Dunn says.
“To benefit from a revenue standpoint, you have to do much more than sign up patients and submit claims.”

The key is using your clinical support staff effectively, according to a recent study in *Annals of Internal Medicine*. Investigators estimate that providing chronic care services for all eligible Medicare patients in a typical primary care physician panel requires about 24 hours of staff time per week, making it impractical for physicians to manage alone. Net revenue would increase across the board, they say, if physicians effectively use RNs, LPNs, or MAs on their staff to provide monthly CCM services.

The same holds true for advance care planning reimbursements, which are set to take effect in January 2016. CMS will allow practices to bill for discussions with patients and families about long-term treatment options and advance directives. The agency will pay approximately $86 for the initial 30 minutes (CPT code 99497) and $75 for each additional session (99498).

“There are a lot of components that you will have to take care of upfront to benefit from CCM services,” says Dunn. “But it can be worthwhile if you use your support staff effectively.”

**Challenge 4: Payer merger mania**

**Why payer consolidation is bad for physician practices**

As four of the nation’s biggest health insurers propose merging, the fallout for medical practices and their patients could be tighter controls on practices and higher patient costs.

In a recent letter to the Justice Department, the American Medical Association opposed the Aetna-Humana and Anthem-Cigna mergers, saying the deals are anti-competitive and will lead to higher consumer costs. The group analyzed individual local healthcare markets, concluding that the mergers would result in exceeding federal antitrust guidelines in up to 97 metropolitan areas in 17 states.
Lower reimbursements to physicians by insurance firms as payers consolidate, the organization says, will lead to physicians spending less time with patients in order to make up for lower reimbursements per patient.

Already, there are just a few players serving most U.S. health insurance markets, so competition is already limited, says Robert Laszewski, president of Washington, D.C.-based Health Policy and Strategy Associates, LLC.

While consolidating into larger provider groups may help physicians command better contracts with payers than if they go it alone, skeptics including Laszewski doubt that the cost savings touted as justification in mergers by both providers and payers will materialize.

“I have zero optimism these mergers will create good economies of scale,” he says of both groups’ merger aspirations. “The new [provider] groups will be more muscle bound, but less creative and there isn’t a lot of evidence that consolidation is leading to lower consumer prices.”

Integrated systems of care could produce higher quality healthcare, but fail to lower costs, says Laszewski. “We’re on track for the system getting bigger for the sake of getting bigger.”

For practices, it means a continued arms race is ahead, he says. Physician groups will have to form larger, integrated systems in order to market themselves. They’ll have to prove they are delivering value and quality, which is not possible looking at data from one solo practitioner.

There is some evidence that the Federal Trade Commission and the Justice Department may be signaling a limit to provider consolidation, notes Mitchell Morris, MD, vice chair and global healthcare sector leader for consulting firm Deloitte.

That makes continued insurance consolidation an even bigger problem. Where physicians once were able to not belong to a health plan if they didn’t like the terms, he says, now each plan accounts for such a large block of patients that it’s nearly impossible to ignore one of them.
“Meaningful use and ICD-10 were nothing compared to negotiating with giant conglomerates,” he says. “If you’re a GP in rural Texas and the only doctor it’s hard for [health plans] to exclude you, but if you’re in an urban area by yourself, it’s going to be difficult to negotiate successfully and handle the complexity involved” in dealing with huge insurers.

Challenge 5: Independence vs employment

Finding the best career path in a rapidly changing practice environment

Resist the urge to merge or sell out simply because it’s in the headlines.

Instead, evaluate the financial metrics of your practice and let the trends tell you if it’s best to stay independent, says Debra Phairas, president of Practice & Liability Consultants, LLC in San Francisco. If your productivity numbers—as benchmarked by the Medical Group Management Association or other data provider—put you in the 90th percentile of compensation per work relative value unit (RVU), for instance, you may not need to make a move, Phairas says.

If your compensation per RVU falls below the 50th percentile, especially if you’re taking home less than $200,000 per year, you may be better off joining a larger system with group benefits, she says.

“You have to assess the competition and what’s going on in your marketplace,” Phairas says. “If you have plenty of patients and you’re in an underserved area, you’re probably going to be fine. If you’re in an area with too many doctors and you’re seeing some of the bigger insurance contracts going to bigger groups, you’re going to begin having difficulty recruiting new doctors into your group and it might be smart to sell sooner rather than later.”

Amber McGraw Walsh, JD, partner and chair of Chicago-based law firm McGuireWoods’ Healthcare Department in Chicago, asks clients a series of initial questions designed to get physicians thinking about whether they are ready to—or even need to—merge.

“Are you at a critical point where you have to invest in [an] EHR to meet meaningful use standards? While that’s a critical question, it’s not the sole driver to consolidate,” Walsh says. “If that were the only thing pushing a physician to merge, I’d advise him or her to find another way to do EHR. But if the issues
are larger, like needing a bigger bench for call coverage or if they are running into difficulty recruiting physicians and physician extenders, it can make sense.”

Some of the other questions that do indicate a merger may make sense center on evaluating the ability of a practice to negotiate buying power—though buying cooperatives can help address that need if it’s a single purchase—and the right mix of talent, Walsh says.

“As the consolidations we’ve seen be most successful are the result of months or years of getting to know each other within the market and having detailed conversations about fit,” she says. “You talk about what you each do every day and how is that consistent or not consistent with the other’s vision. You ask yourselves if you can get comfortable with the inconsistencies because ultimately the combination will make us all better, or whether there are things you can’t get past.”

Challenge 6: MOC battle rages on

Angry physicians wait for promised changes

Physicians certifying in their sub-specialties through the American Board of Internal Medicine (ABIM) will see changes in the maintenance of certification (MOC) landscape beginning next year.

After an outcry over new MOC requirements announced in 2014, the ABIM backtracked early in 2015. It apologized for the changes, rescinded several of them, and announced it would seek more public input regarding the future of MOC. In the meantime, a new organization, the National Board of Physicians and Surgeons (NBPAS) sprang up promising a simplified and less expensive procedure for certification maintenance.

According to Richard Baron, MD, ABIM’s president and chief executive officer, one of the biggest changes physicians will see in the MOC process starting in 2016 is a more streamlined process for counting continuing medical education (CME) activities towards MOC requirements. As a result of a partnership between the ABIM and the American Council on Continuing Medical Education, Baron says, more CME activities will be counted towards fulfilling MOC requirements, and the CME provider will be able to notify the ABIM directly when the physician has satisfactorily completed the course.
A second change is that physicians will no longer be required to maintain underlying certification in some tertiary specialties, such as interventional cardiology, transplant hepatology, and adolescent medicine. This was one of the recommendations coming out of the ABIM’s “Assessment 2020 Task Force” issued in July 2015.

Baron says the ABIM is also considering a second task force recommendation—replacing the current 10-year MOC examination with what the task force calls “more meaningful, less burdensome assessments”—although it is unlikely to act on it in the immediate future. “We have confidence that the exam assesses knowledge reliably and well to state-of-the-art testing,” he says. “But what we’re hearing people say is that once every 10 years is not the best way to do this.”

For 2016, Baron says, ABIM executives will be looking at two specific aspects of the exam: security requirements and the extent to which the tests should be “open book.” The latter becomes especially complicated with access to information on the web. “It seems really simple to say ‘open book’ and in the days of books that had a plain meaning, but today it doesn’t, so we need to work that through,” he says.

Heading into 2016, NBPAS has about 2,700 diplomats and 18 hospitals in 10 states accepting its certification to grant admitting privileges to physicians, according to Paul Teirstein, MD, its founder and president. “I think we’re having a big impact on shaking up the whole issue of how best to help doctors stay up-to-date with changes in medicine,” Teirstein says. “We’re very pleased with our progress to date.”

Teirstein says there are “hundreds” of hospitals still considering whether to accept NBPAS certification, including his own employer, Scripps Clinic, in La Jolla, California. “It is a very cumbersome process to change bylaws,” he says.

Teirstein acknowledges that the ABIM has made numerous changes to the ABIM process, but adds that “it remains to be seen how those will be executed.” Citing the change that will allow more CME to count towards MOC requirements, he says, “that's a positive thing, but how exactly you do that, what you have to pay, what kind of paperwork is involved, all that remains unclear.”

Baron says the ABIM welcomes competition from NBPAS because “competition drives positive change.”
“I have spoken with Dr. Teirstein and members of his organization and we very much want an open dialogue,” he adds.

Challenge 7: The end of Meaningful Use?

Is it time to get rid of Meaningful Use?

Meaningful Use is going through a midlife crisis. As the government’s EHR incentive program transitions from incentives to penalties, physician participation in Meaningful Use Stage 2 continues to lag participation in Stage 1 by a wide margin. Just 57,726 eligible professionals (EPs) had attested to Stage 2 through September, according to the CMS. That was less than the 19% of the EPs who had attested in Stage 1.

Meanwhile, the medical establishment has mounted a frontal assault on the recently-announced Stage 3 rules. In November, a coalition of 111 medical societies led by the American Medical Association asked Congress to direct CMS to “refocus” Stage 3. That move came just a month after CMS delivered its final rule on Stage 3 criteria, on changes to Stage 1 and 2 requirements, and on the latest EHR certification requirements.

The coalition requested that the program focus on promoting interoperability and letting EHR developers innovate. It said that the poor performance of Stage 2 showed that the “check box” approach to Meaningful Use is not working.

The medical societies were expressing a widely-held belief in the industry that CMS will have to listen to sooner or later, says Michelle Holmes, MBA, a Seattle-based principal with ECG Management Consulting. “There’s a consensus forming that CMS needs to change course. That will gain momentum if the Meaningful Use stage 2 numbers come in as low as expected.”

The deadline for attesting to Stage 2 is Feb. 29, 2016. CMS is hoping for a last-minute surge in attestations following the changes it recently enacted in the program, including a substantial easing of the patient engagement criteria. But Holmes says the changes were “too little, too late” and probably won’t affect most doctors’ willingness to participate in Stage 2.
The roadblocks to attestation remain the same, including the difficulty of enrolling patients in portals to view, download, and transmit their records, and the lack of interoperability between different EHRs, Holmes points out. Moreover, she says, many of the physicians who received most of their incentive payments earlier don’t see the point in struggling to overcome these obstacles.

“Some people are saying, ‘I can do without the next installment payment, because it’s only a few thousand dollars,’” Holmes says.

In addition, some practices are shrugging off the penalties for not attesting, especially if they don’t have a lot of Medicare business, Holmes says. The penalties for failing to attest to Meaningful Use amount to 2% of Medicare revenues this year, rising to 3% in 2017.

Another challenge for those who seek to move forward in Stage 2 is having to report for a full calendar year in 2016, unless they’re new to the program. If a practice has all of its ducks in a row, this is not a major hurdle, Holmes points out. But if physicians don’t start measuring their performance on Meaningful Use measures until later in the year, they’ll have to be “nearly perfect” to reach the thresholds, she says.

All EPs are supposed to attest to Stage 3 in 2018, but they have the option of attesting in 2017. As a result, Holmes observes, CMS has the next year to decide whether to eliminate Stage 3 altogether. She doubts that will happen, but suspects CMS will make some significant changes in Stage 3 before 2017.

Starting in 2019, Meaningful Use will be folded into the Merit-Based Incentive Payment System (MIPS), along with CMS’ Physician Quality Reporting System (PQRS), and value-based modifier program. At this point it’s unclear how long the Meaningful Use component will continue. A CMS tip sheet on “payment adjustments” says EPs must continue to show Meaningful Use every year to avoid penalties. It’s even possible that CMS could continue to expand Stage 3 criteria.

But Holmes doesn’t believe this is likely. “I think that’s going to change somehow,” she predicts. “Market forces have to take over at some point.”

Challenge 8: The remote medicine disruption
Embrace remote medicine before it’s too late

As technology improves for connecting physicians and patients, these innovations are also presenting new challenges.

There’s been a lot of controversy among physicians over the telemedicine services that offer virtual visits for minor acute problems to millions of patients across the country. Part of the issue is that telemedicine detracts from continuity of care and increases the fragmentation of care delivery, notes Steven Waldren, MD, director of the Alliance for eHealth Innovation at the American Academy of Family Physicians (AAFP).

Virtual visits also present a financial issue, he notes. In a fee-for-service world, telemedicine firms are providing some of the acute-care services that primary care doctors rely on for their bread and butter. But as the industry moves toward value-based reimbursement, he suggests, physicians will focus more on the use of telemedicine in chronic care, which outside services don’t provide.

Meanwhile, several healthcare organizations and even some private practices have begun offering virtual visits themselves. In the early going, they often subcontract with telemedicine firms like American Well and Teladoc to provide these services. But in some practices, physicians are beginning to do telemedicine consults with their own patient panel. (Specialists have long provided care remotely, especially in rural areas.)

Based on Waldren’s interactions with AAFP members, he believes that about 10% to 15% of family physicians have started conducting virtual visits with their patients. Another 25% to 40% are interested, he says, but don’t know how to do it or how to make the economics work. Even when health plans cover virtual visits, as they must in more than half of U.S. states, doctors usually are paid less than for face-to-face office visits.

The workflow piece is also difficult to figure out, Waldren says. Physicians have to decide whether they want to do virtual visits during the day or over the weekend; expand their work schedules; have a designated doctor do them on a rotating basis; and/or have nurse practitioners or physician assistants do some of them. They have to develop policies on what they’ll diagnose or treat remotely. And they have to find out if they can bill for an office visit soon after a virtual one.
Scheduling is another challenge if doctors are doing virtual visits at prearranged times, he notes. But it’s possible to use a “store and forward” service that allows the patient to explain the problem and possibly send images to the doctor, who can then respond when he or she is free. Alternatively, any doctor in the practice who has downtime can go into the queue and respond to requests for virtual visits.

Another conundrum for physicians is how to address the burgeoning trend of remote patient monitoring. At this point it’s being done mostly with high-risk patients with serious conditions, and often with the goal of preventing readmissions. But Waldren believes that, as the technology evolves, mobile and home monitoring might be used routinely to help patients manage common chronic conditions such as diabetes and hypertension.

Physicians need better mechanisms to screen monitoring data and figure out what it means before they’re going to adopt this technology, Waldren points out. A mass of raw data from blood glucose monitoring, for example, isn’t going to be much help in managing a patient with diabetes. It has to be analyzed, both in light of the patient’s daily and weekly trends and in the context of the patient’s other vital signs and health behavior. Moreover, the data from various monitoring devices and apps has to be integrated at the practice level, he adds.

While it may take up to five years to develop these tools, Waldren advises physicians to take telehealth seriously now. “From a doctor perspective, you have to figure out how to leverage telemedicine to provide more for your patients. Somebody else will do it if you don’t. How you do that and make sure that fits with your patients and your bottom line will be an important piece going forward.”

Challenge 9: Risks and rewards of team care

Overcoming barriers to team-based care

The days of “paternalistic” medicine are over: 2016 is the year for physicians to embrace team-based care. Medicare is set to supercharge its emphasis on quality payments in 2019, when physicians will have the option of getting paid through an alternative payment model, such as accountable care organizations, patient-centered medical homes, or other yet-to-be determined programs that likely will focus on team-centered care. To reap the benefits of this change, physicians must begin building
effective teams that can hit quality goals, keep patients healthy and satisfied, and sustain their practice’s financial success.

The challenge is two-fold: Buying into the concept, which requires building a solid care team of providers you trust, and executing this major change while struggling with the daily grind of running a practice.

“With physicians, change is hard,” says Robert Wergin, MD, FAAFP, a family physician practicing in Milford, Nebraska, and board chairman of the American Academy of Family Physicians (AAFP). “The first thing you have to do with your staff is address the vision and goals you want to accomplish. Most team-based care staffs, after they go through change management and the way you’re going to handle workflow and patient management, are usually happier. They are all operating with their full skill sets and to the best of their abilities.”

But not all physicians are sold on the concept. According to a survey of primary care providers conducted by the Kaiser Family Foundation and The Commonwealth Fund earlier this year, nurse practitioners (NPs) and physician assistants (PAs) are overwhelmingly positive about the emergence of models based on team care, but more than 4 in 10 primary care physicians said “this shift is negatively affecting providers’ ability to provide quality care.”

The real challenge for physicians is finding ways to integrate staff members with varying levels of training and unique strengths and weaknesses into a unified team with common goals, a detailed workflow, and clear treatment responsibilities that follow clinical guidelines for when and how providers must consult with physicians for patient care.

Wergin points to three characteristics a practice must have to succeed at team-based care: flexibility to change and adapt when necessary, a staff champion who can lead and motivate the effort, and a trusting and open environment where providers focus solely on the best interests of patients, and are comfortable with their role on the team.

“Team-based care is about designing roles, and identifying the strengths and weaknesses of your staff members,” Wergin says. “We are all responsible for the best care possible for the patient.”
The concept of responsibility gets at one of physicians’ main worries regarding team-based care: medical liability. Physicians can be held liable for the errors of non-physician providers under their supervision, says Julie Brightwell, BSN, JD, an expert on medical liability and patient safety with The Doctors Company. She says solid and consistent communication and documentation are vital to mitigating these risks.

“The bottom line for the physician is they really need to be completely familiar and compliant with the state laws or regulations,” Brightwell says. “They should know what the definition of supervision and collaboration are, and make sure they are following those definitions. States get very specific on what’s required, and often physicians are ignorant of what’s required when they take on practitioners.”

Physicians should have scope-of-practice policies on file that detail care responsibilities and limits for team members, Brightwell says. These documents should be reviewed and signed by staff members on a regular basis.

Beyond careful documentation and procedures, the main thing physicians can do to protect themselves is lead and inspire employees and focus on patient safety above all else.

“What the physician really needs to do is be a good team leader,” Brightwell says. “The physician needs to lead the team in a way so it’s everyone’s responsibility to speak up about patient safety.”

Challenge 10: Data vulnerability

Save your practice by preventing data negligence

A Connecticut hospital recently paid a $90,000 fine to state officials after a stolen laptop threatened the confidentiality of personal information of nearly 9,000 patients. The hospital did not have a proper business associate agreement with a technology vendor and did not encrypt the data as required under the Health Insurance Portability and Accountability Act (HIPAA).

Most physicians and practice administrators may treat HIPAA policies the same way they treat vendor flyers: It’s the paperwork that always seems to fall to the bottom of the desk pile. But the worst time to
begin thinking about data security and HIPAA compliance is after a breach, so physicians need to make data security a priority in 2016.

“Physicians are practicing in a very different world than they were just a few years ago,” says Derek Kosiorek, a principal consultant with the Medical Group Management Association. Think about how someone would steal all the medical information from a practice in 1985, Kosiorek says. First, the thief would need to physically be in the office. Second, the person would have to spend weeks photocopying every page from every chart in the chart room. Finally, he or she would need to get all those pages out of the building. In addition, the theft would be a one-time occurrence.

“In today’s connected world, a thief doesn’t need physical access to the building, copying the files can take minutes and storage of the files is on a device that can fit in your pocket,” Kosiorek says.

Because of these changes, there is a good chance a practice may not even know that a data breach is happening. Given this sobering reality, how can physicians minimize the risk of a data breach, and equally important, the appearance that not enough was done to prevent it in the first place?

In enforcing HIPAA regulations, the Office for Civil Rights recognizes the environment practices are in and puts strong emphasis on the steps a practice has taken to mitigate the risk of data breaches. “This means a little work up front can stop a lot of frustration when a practice’s number is up,” Kosiorek says.

Practices should focus on creating a detailed breach response process, Kosiorek says. This includes establishing lines of communication for who gets notified and when in the event of a breach. The authorities and patients need to be informed, but depending on the size of the organization, public relations and media may need to be contacted as well.

Next, determine which data in the practice are encrypted—and which are not, Kosiorek says. Having encrypted data is a sign to authorities that you take threats seriously and have taken steps to prevent unauthorized access to data. This goes a long way in helping ensure your data is not lost. Forensic experts and authorities will take note of that, he says.

“How been around a couple of breaches, the hardest thing to do seems to be determining what was breached and when,” says Steven McCallister, CPHIT, CPEHR, a Seattle-based IT security expert and
healthcare consultant. “There is a difference between when a breach is recognized and when it should have been recognized.”

Things happen fast, McCallister notes, so make sure to add a checklist with your response documentation that notes key information while it’s happening. When did you notice the breach? What steps were immediately taken?

Often your best resources for protecting data are your employees. “Empower people to report deficiencies when they see them. If someone points out an issue, don’t make your response punitive. Praise them instead of calling them stupid,” McCallister says.

Finally, it’s important to have a data forensic specialist in your list of contacts, Kosiorek says. These are the people who can come in and examine network and workstation logs to determine what data were lost and the frequency that the breach occurred.

HIPAA rules are in place to protect not only your patients, but also your reputation, notes Kosiorek. It is very likely that a story about a breach will forever come up in any Internet search by a patient or potential referral partner.

“The way you respond will affect your credibility in the future, so make sure you are prepared,” he says. “After all, credibility is one of those quirky things that is very difficult to gain, but very easy to lose.”

Seven Financial Challenges in 2016

Diminished negotiating power

“In the past if you had three [health] plans in your area and two of them were strong, you could afford to not participate in the third because it might only have a 20% market share,” says Deloitte’s Mitchell Morris. “When dealing with such dominant market share, you can’t shrug them off. Meaningful use and ICD-10 are nothing compared to negotiating with giant conglomerates.”

Patients voting with their feet
Except in the wealthiest areas, patients could buckle under the dramatic increases they’ve experienced in higher deductibles and co-pays, experts say. That will mean a scramble for revenues for some doctors as patients forego some care or seek lower-cost providers.

**Revenues walking away, too**

If you do join a larger group, be aware that some of the ancillary services that used to enhance your income may now be performed by others in the group. Phairas has cardiology clients, for example, who maintain a lot of in-office testing services. If they choose to merge with a hospital they would potentially lose those services to the hospital radiologists, affecting their own RVU output.

**Getting fired**

It’s a real risk if mergers happen without strong due diligence around market demand, Phairas says. “It’s going to happen more often as hospitals lose money on the practices they buy,” she says. “It’s a big shock for physicians who never really contemplated being without a job.”

**Neglecting retirement**

With all the other challenges facing physicians in 2016, it’s easy to put retirement on the back burner. That’s a mistake, says Mitchell Kauffman, CFP, a financial planner with Raymond James Financial Services in Pasadena, California. He suggests looking into whether a defined benefit pension plan might be right for your practice. If you have a couple of senior partners and a just a couple of early-career support staffers, you can use a concept called Social Security integration to lessen required retirement plan contributions for the junior staff. That’s because traditional pension plans call for substantial payments into the plan near the end of a worker’s career, and not so much in the early years.

**Tax bites**

Couples earning more than a combined $250,000 in annual income need to be aware of the 3.8% Net Investment Income Tax, in place since 2013, notes Robert Keebler, CPA, MST, tax adviser and partner with Keebler Associates in Green Bay, Wisconsin. This is particularly true now as many physicians consider selling practices and other assets as consolidation continues, he says. The tax applies to gains
on sales of real estate, securities, and certain types of passive income, among other investments. If you are selling a building, for example, and have an interest in charitable giving, you could drop the proceeds into a Charitable Remainder Trust, taking the proceeds as retirement income over a period of decades, Keebler said.

**IRA stalls**

Contribution limits for IRAs are holding steady in 2016, so you can’t sock away more money next year, according to the IRS. The top income cutoff for making Roth contributions, however, is being raised by $1,000 to $194,000 for couples filing jointly. And if you earn more than that, you can do a so-called “back-door” Roth conversion, contributing to a non-deductible IRA and then converting it to a Roth, Keebler says.

**Meaningful use 3 concessions**

Physicians taking part in the government’s meaningful use program will have more time and flexibility for meeting the requirements for the third state of the program under the Final Rule the government released in October.

Changes include:

- Delays the start of the third phase of meaningful use until January 1, 2018, with the option of starting in 2017 for providers who feel they are ready to do so

- Reduces the number of objectives providers must meet from 18 to 10 during the reporting years 2015

- Reduces the thresholds for stage 2’s requirement for viewing, downloading, and transmitting patient information from 5% of a provider’s patient panel to a single patient and reduces the secure messaging requirement from 5% to simply having the capability

- Allows physicians and other providers to attest to their EHR use for any continuous 90-day period in calendar year 2015 by February 29, 2016
- Allows new MU participants for both Medicare and Medicaid 90-day periods in 2016 and 2017 to report on their EHR use
- Gives EHR manufacturers until the start of 2018 to develop the products required to meet new certification expectations
- Supports exchange of patient health information among providers and a more useful interoperable infrastructure for information exchange between providers and their patients.

**MACRA: Two roads to quality**

Starting in 2019, and each year after that, physicians who receive Medicare reimbursements will have to choose one of two paths:

<table>
<thead>
<tr>
<th>Merit-based Incentive Payment System (MIPS)</th>
<th>Alternative Payment Model (APM)</th>
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<tr>
<td>1. Under this program, traditional fee-for-service payments will be adjusted, with either bonuses or penalties, depending on a physician’s score on a new reporting program.</td>
<td>1. Physicians who choose APM will receive a 5% annual bonus to fee-for-service payments if they can prove they receive “substantial revenue” through an APM.</td>
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<td>2. The new reporting program will replace and combine aspects of the Physician Quality Reporting System (PQRS), Meaningful Use, and the value-based modifier.</td>
<td>2. “Substantial revenue” can be defined in two ways. The first is, by 2019-2020, 25% of Medicare payments must be attributable to the APM, increasing to 50% in 2021. The second is, starting in 2021, 50% of combined payments from Medicare and other payers must be attributable to the APM.</td>
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3. Physicians will receive a score between 0 and 100 based on four areas: clinical quality, meaningful use, resource use and practice improvement. The details of each area are yet to be worked out during the rulemaking process.

3. APMs will have their own payment rules, depending on the particulars of the payment arrangement of the organization.

4. Scoring weights in these areas may be adjusted to account for a physician’s ability to successfully report on each area. Physicians will receive credit for improvement from year to year.

4. Options for APM include use of a shared savings/financial risk arrangement, such as accountable care organizations or use of bundled payments.

5. Use of the patient-centered medical home (PCMH) model can qualify if the PCMH is shown to improve quality without lowering costs, or lowers costs without harming care quality.

Common reasons for lawsuits involving team-based care

**Providers practicing outside of scope of practice**

Physicians need to know the scope of practice for each team member, and the specifics need to be in a document that is updated regularly and signed by both the physician and the other provider.

**Inadequate supervision**

Is the physician supervising the other practitioners and how they are treating patients and documenting encounters? If not, they are placing themselves in legal jeopardy.

**Providers delay in seeking physician assistance**
Physicians and providers must have open lines of communication so that complex or unclear cases can be referred to the physician. Some practices use the “three-time” rule: If a patient comes to the practice with the same issue, the third encounter automatically is referred to the physician.

HIPAA Rule Violations: Categories and penalty amounts

The Health Insurance Portability and Accountability Act Omnibus Rule establishes four “tiers” of violations, based on what it terms “increasing levels of culpability,” with a range of fines for each tier. Violations of the same requirement or prohibition for any of the categories are limited to $1.5 million per calendar year. The language of the rule states that actual dollar amounts will be based on “the nature and extent of the violation, the nature and extent of the resulting harm, and other factors...including both the financial condition and size of the covered entity or business associate.”

- Did not know of breach: $100 to $50,000
- Had reasonable cause to know: $1,000 to $50,000
- Willful neglect, corrected: $10,000 to $50,000
- Willful neglect, not corrected: $50,000

MOC: Physicians speak out

‘MOC’ has become a mockery that utilizes continuing medical education as a veil under which the ABIM extorts money from physicians.” -- Steven I. Marlowe MD, FACP, Atlanta, Georgia

I am no longer interested in the ABIM despite being triple boarded at one time. I am content with ‘previously certified’ because I think the ABIM is all about feathering their own nest and not doing the right thing.” -- Jeffrey Rose, MD, Enumclaw, Washington

The MOC program for internists...who were grandfathered for recertification appears to be nothing more than a confusing money grab. At a time where IM generalists are increasingly becoming
endangered as a profession, this process only discourages seasoned practitioners from continuing to practice.”  -- Scott Fenske, MD, New Berlin, Wisconsin

“Enough is enough. We do not need more board certifications that only add cost and bureaucracy to our busy lives.” -- Erik Folch MD, MSc, Boston, Massachusetts

The consolidations we’ve seen be most successful are the result of months or years of getting to know each other within the market.”—Amber McGraw Walsh, JD, partner and chair, McGuireWoods, Chicago, Illinois