

The Health Care Bubble, Part 1I

By Nicholas F. Vasquez, MD, FACEP

As you may recall, in the last EPIC I talked about what I believe is the coming deflation of the health care bubble. I tried to lay the reasons why I believe this will happen including the deficit, the new Super Committee on the Debt and Deficit, as well jobs loss, and the spiraling cost of health care. I suppose its easy to be pessimistic but I feel that opportunities come disguised as problems. There are things we can do and must do to counteract the above mentioned trends. Personally I don't believe that either informed consumers or enlightened bureaucracies alone are going to crack the cost problem. I believe that motivated, dedicated physicians who pay attention to the costs and benefits of treatments will be the way we "save" health care. What we're trying to do is buy better outcomes for less money.

EM is leading the way in this department so far. We have seen a larger share of the patients every year, most recently topping 136 million visits in 2009. A recent study from MIT published in the journal Applied Economic Journal: Applied Economics showed there is direct correlation between lives saved and spending on emergency medicine. All this for just 2% of the overall health care budget.

Even with this, there will be pressure brought to reduce our spending. I think we in EM can continue to lead the way. The single greatest cost driver I can think of is a treatment that we think makes a difference but doesn't. Think about dialysis for a septic 92 year old. Or the Rotoprone beds that improve oxygenation in ARDS but not mortality. Or antibiotics for that case of sinusitis or bronchitis. Or Xigris in sepsis (otherwise known as activated protein C) which was recently pulled from the market for lack of efficacy. I presume you get my point; there's been a lot of good ideas in medicine that haven't really panned out. We have indulged some potentially bad habits for a long time, for some ostensibly good reasons.

Many physicians point to liability as a source of defensive medicine. A report by Price Waterhouse Coopers agreed, putting the cost of defensive medicine around \$210 billion annually (The Price of Excess, Price Waterhouse Coopers LLP, 2008). Additionally they point to patient satisfaction surveys which can allow disgruntled patients to vent their frustrations with a doctor even if the care was top notch. The new health care law puts patient satisfaction survey results into the calculation of reimbursement starting in 2012. We're all going to have to learn customer service it seems. How that will affect defensive medicine remains to be seen but I suspect that number will go up. One study recently in the Annals of Emergency Medicine showed patients trusted the CT scan over the physician's exam. You tell me, will a satisfied patient be the one who didn't get the CT scan?

Lastly, some people have alleged that we do more because we get paid more. I'm not so sure this applies to EM since I

have no idea what I get paid for. I can bill until the cows come home, but what gets paid I have no idea. I've documented beyond the point of tendonitis in my mouse hand and still get many charts downgraded. It's byzantine to me and as a result it's not really a motivator to add an additional treatment so I can get paid more.

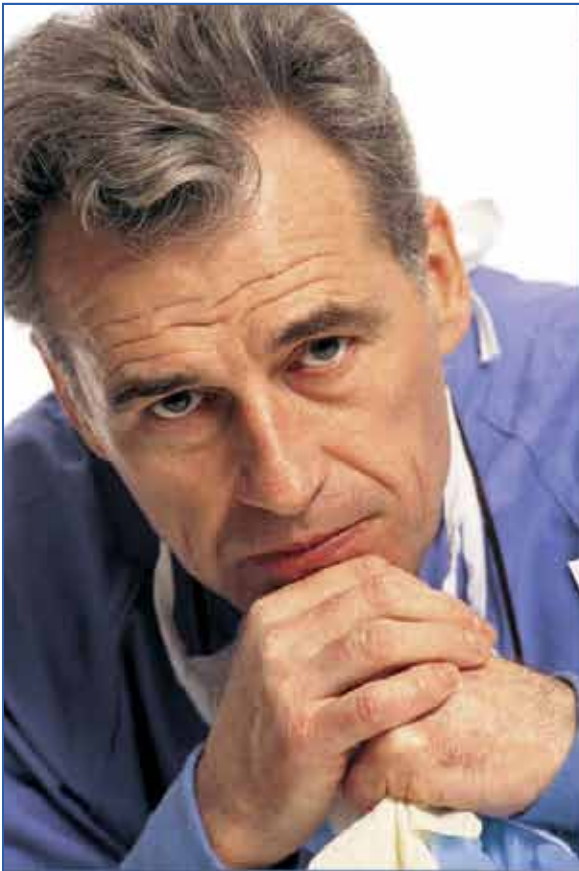
We need a better system... heck we first need a system! All systems require feedback. The only feedback we get is from patient complaints, M&M cases, and our own memory. As ED physicians we have only the encounter to make our intervention and after that we have no idea what happens. Wouldn't you want to know if your treatment made a difference over 2 weeks? Over 2 months? How about 2 years? Right now we just have to assume we're doing the right things.

First things first, we have to redesign our liability system. It serves no one well right now. The liability or tort system does not serve to remove bad doctors from practice. Right now, I bet you can name at least one physician you think should not be practicing. Why haven't they been sued out of existence? Moreover, basing the malpractice system on the courts means an injured patient must go through a competitive, lengthy process to get restitution. The only people who benefit are the ones who get to bill for their services in this system. Tort reform should continue to be our priority, replaced potentially by a no-fault system with public reporting of events. That could identify harmful physicians and reward the better physicians with a higher rating.

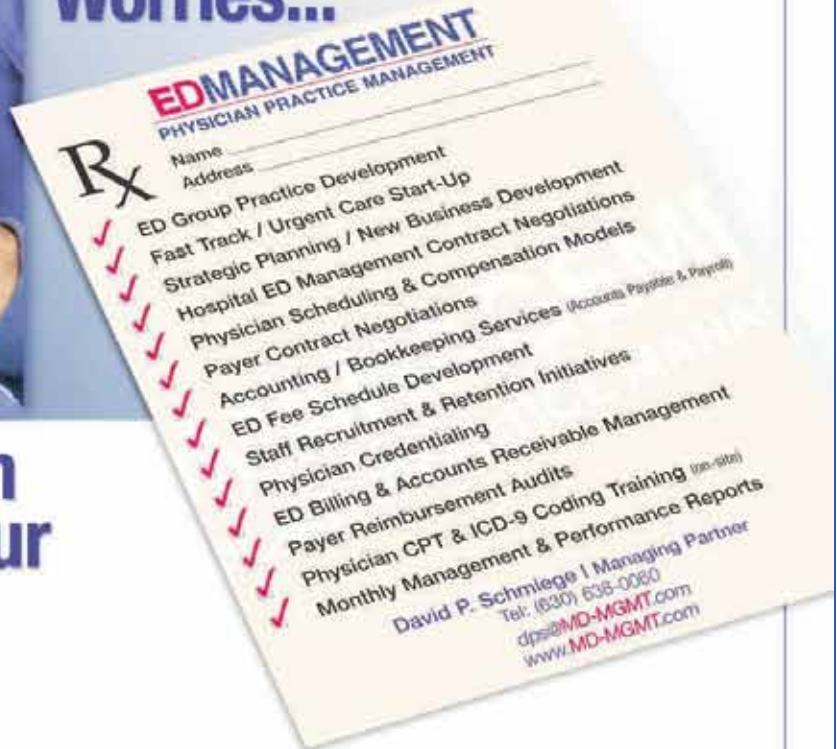
Next, we have to change our frame of reference. We focus on the short term, the single transaction or the single visit in EM. What we can do is to begin to focus on the medium term, not only the visit itself but also the immediate aftermath. I think it's time we begin to fill in that gap between ED and home. Transitioning from ED to home with the expectation of an outpatient follow up is sometimes treacherous. There are companies right now that will offer a service (much like Orbitz or Kayak) which allows you to make an online appointment with a specialist or a PCP. Wouldn't a verified follow up made for your patient lower our liability?

Furthermore, in-hospital transitions are also dangerous at times. Many ED's are the front door into the hospital and provide significant volume to many hospitalist groups. However, the time from "admission" to when they're actually seen by a doctor can be long. Sometimes this delay leads to complications and bad outcomes. What if the ED group actually employed a hospitalist group? Would the service provided by that group improve? Would the time between admission and admission orders improve? Also, wouldn't this allow you to better coordinate care between ED and the floor? I'm not suggesting we should all do this, but I am asking that we think outside the box. Why shouldn't we begin to move into this territory? We're already at risk for the patient's health. If we're already at risk, couldn't we do more to improve

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News and Notes

CMS Finalizes the ACO Rule

One of the centerpieces of the Affordable Care Act's delivery system reform was "shared savings" via Accountable Care Organizations. The focus of the Shared Savings Program is to provide coordinated care to Medicare FFS beneficiaries. Each ACO must serve a minimum of 5,000 Medicare beneficiaries who, unlike Medicare managed care, are free to seek medical services outside the ACO.

When CMS released its draft rule in May, the provider community -- physicians, hospitals and integrated systems -- were extremely critical of the onerous and rigid requirements. Many large systems such as Mayo, Geisinger, and Cleveland Clinic publicly stated that they would not apply for ACO status. All but the largest, integrated, risk-bearing physician groups were disheartened by the huge start-up costs for organization, legal, and HIT infrastructure.

Before the final rule came out Oct. 20, the Administration scrambled to roll out alternative ACO models to reignite provider interest -- the Pioneer model, which allowed greater risks and rewards for experienced delivery systems, and the Advance Payment model, which will provide start-up costs to physician and rural groups.

A few provisions that have changed respond to some of ACEP's comments:

- ◆ Risk assumption for shared savings has been modified so that some ACOs will share savings only.
- ◆ CMS has provided an "Advance Payment" model that is geared to physicians and small rural providers and provides some start-up funding (that is to be recouped from subsequent savings).
- ◆ Reduced the measures to be reported from 65 to 33.
- ◆ Allowed federally qualified health centers and rural health centers to participate.

ACEP is pleased with many provisions in the final rule, but there is little that applies directly to relationships and payment issues between ACOs and participating physician groups. However, ACOs must provide criteria to CMS on how savings will be distributed among its providers.

The final rule provides more flexible participation for physicians and directs ACOs to provide both tax ID numbers for groups and provider numbers for individual physicians who are part of a group. Emergency physicians and other specialty groups may participate in more than one ACO. Keep in mind that activity on ACOs will be generated at the local level, so ACEP is urging our members to be aware of your hospitals' plans to get involved. Contact btomar@acep.org for more info

Kaiser Family Foundation; Medicaid & Uninsured

From the Kaiser Family Foundation's Commission Medicaid and the Uninsured: Most Medicaid beneficiaries nationally are enrolled in some form of managed care, and, with current budget pressure and health reform on the horizon, states are expected to increase their reliance on managed care to deliver services in their Medicaid programs. This 50-state survey, conducted by the Kaiser Commission on Medicaid and the

Uninsured and Health Management Associates, provides a comprehensive look at state Medicaid managed care programs, documenting their diversity, examining how states monitor access and quality, and exploring emerging efforts to improve care, including managed long-term care and initiatives targeted toward dual eligibles. Executive summary and full report available at: <http://www.kff.org/medicaid/8220.cfm>

NEJM Study of Medical Liability Patterns

A study in the August 18 issue of The New England Journal of Medicine provides an updated comprehensive analysis of the risk of liability claims by medical specialty. The study reports that in any given year, an average of 7.4 percent of doctors are faced with medical liability lawsuits, but nearly 80 percent of those claims result in no payment at all by the defendant. The likelihood of being faced with a medical liability lawsuit did not necessarily correlate to payment by a physician; however, the study discussion points out that indirect costs, such as time, stress, added work, and reputational damage, cannot be accurately measured and therefore insured against. The specialty most likely to be targeted with medical liability lawsuits was neurosurgery, with over 19 percent of neurosurgeons dealing with lawsuits annually. Over the course of a career, doctors practicing in high-risk specialties such as neurosurgery, thoracic-cardiovascular surgery, and orthopedic surgery were nearly guaranteed to face a medical liability lawsuit, with 99% these physicians expected to be sued at least once in their career. Even physicians in low-risk specialties, including pediatricians and family practitioners, faced a 75% chance of being sued over the course of their career. The complete report is available at <http://www.nejm.org/doi/full/10.1056/NEJMsa1012370>.

ITLS

ITLS (International Trauma Life Support) had another great conference in Laughlin, NV, this past October. It was our third annual conference with our new "dual-track" format that includes a lecture track in addition to our provider course. We had over 100 students, faculty, sponsors, and volunteers! The reviews were fabulous and we look forward to the next one.

A special thanks to AzCEP members Dr. John Gallagher from Phoenix Fire Dept, who was one of our guest lecturers as well as the interim Medical Director of the course while I am deployed to Afghanistan. Thanks also to the Level I trauma centers who participated. We hope to get all the Level I's there next year! Without all our volunteers and sponsors, we would never be able to provide such a great conference.

Although initially designed as a pre-hospital course, more and more ED nurses and techs are taking the class. They have found it extremely useful for triage nurses and techs for "walk-in" traumas that present frequently to the ED. Please encourage your nurses and techs to attend (some ED groups sponsor a nurse or two). Also, we encourage EMS leaders to attend the lecture course, especially those from the rural areas. For more information on attending or becoming a sponsor or for a downloadable registration form, go to our website at: www.itlsaz.org or email us at itlsaz@gmail.com

Brad Butler, MD, FACEP
LCDR MC, USN
Medical Director, Arizona ITLS

UPH - Resident's Corner

By Lara Bickford, MD

RIP Kino ED

As you probably already know, two events have recently happened that have dramatically changed the Emergency Department at our hospital. The first is the opening of the new ED. The second is the renaming of the hospital to UAMC-South Campus. We are of the opinion that the old ED at UPH-Kino was unceremoniously dumped and wasn't given a proper send-off, so we've decided to take this opportunity to pay our respects. Kino ED, we'll miss you. Specifically, here's a quick list:

- ◆ NBH / SBH
- ◆ Doing a pelvic exam in "rooms" 10-13
- ◆ Room 9: a continuing prospective study on the comparative tensile strength of metacarpals vs plexiglass
- ◆ The seamless integration of PACS and other medical record systems
- ◆ Bernie's corner (mostly the lighting adjustments and the fan)
- ◆ Paper (charts, bed slips, etc.)
- ◆ Everyone else's paper from 3-9 days ago in the doc box
- ◆ Dictating
- ◆ The sound of the plastic clipboard hitting the pine box (still triggers PTSD)

Please join us in a moment of silence.

(single tear rolls down cheek)

With that out of the way, here is the update as to what's happening with the movers and shakers here in our program. First, a big shout out to our interns who seem to have survived being thrown to the wolves (with adult supervision of course) in their first couple months and are settling in nicely. Scholar Quest research is going well, Juniors are working on finishing our IRBs and collecting data, and the Interns are sharing a dartboard to determine their area of research interest. Finally, with the changing of the leaves (on Mt Lemmon at least) comes interview season. We just had our first interview dinner (including delicious Persian food imported all the way from Phoenix!) at ED Director Dr. Shirazi's house (another event that we may soon have to mourn – the gossip around the watercooler is that starting next year, applicant dinners will likely be held at residents' houses). I would like to send out a heartfelt thank you to the wonderful job the faculty has done on this, opening their homes to prospective residents and letting the rest of us make fun of their hairstyles in old photos. Until next quarter...

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the reward?

Currently many of us leave these transitions to a hospitalist or a primary care physician but have little choice as to which one. What if we had a choice? What if we had some information to be able to make that choice? Wouldn't we want to be able to send our patients, even the ones we don't like, to a competent provider who might actually take the time to sort out all those medications? Bundle payments and accountable care organizations offer that possibility. For example, let's say you, an orthopedist, a hospitalist, and a rehab facility form a partnership and bid for a bundled payment for all hip fractures that come your way. Is that really any different that what we do now? In this scenario you're selecting a pre-formed care pathway with a "known" cost. The way we've traditionally done it has been hit or miss. We just hope that the doctor is good, or assume that they're doing what they're supposed to. In the future, we might use our authority to make more informed decisions.

Value based and bundled payments are coming. If we're all going to be paid less for our efforts, we may have to compete for a bigger slice of the pie. The good news is we in EM have the opportunity to do something about the situation. I think the best we can do for our patients and the health of our specialty is begin to improve our cooperation with our patients and other providers. The goal is to buy better outcomes for less money than we're spending. We in the ED have shown an ability to do this in the past. I have tried to illuminate some future options for ED's. Leadership can take many forms. I strongly believe that we in the ED are leading the way and should continue to do so. The world around us is changing, we should prepare for it.

*Maricopa Medical Center
Resident's Column
By Beth Ranney, MD*

Halloween has come and gone and it is always a good time at the 'Copa. I am not sure which is spookier: running traumas with patient's "blood" being questionably real or their costume, or trying to figure out what is floating in the punch at Dr. Patti Eckholdt's annual Halloween party (pics). One thing is for sure as the weather cools off and fall approaches, interview season is soon upon us. We wish all the programs in Arizona the best of luck to find residents that are not only hard workers but are wonderful people as well. It is a time when we all get to celebrate the residency we belong to and realize why we love the people we work with. Cheers to the upcoming months!



The cooler weather also reminds us to be grateful we live in Arizona. Our department's fall volleyball team composed of both residents and attendings continues to be a force on the sand and we hope to continue in that spirit as we hit the asphalt for our annual Ragnar team. We are amazed at all the talent and spunk our interns have brought to the group whether it is on the court or in the department. The interns had a strong showing as residents came in on their much earned days off and helped over 200 students receive free sports physicals under the direction of our fearless leader, Dr Patty Bayless, during the month of August. We have also been very busy nurturing our newly official relationship with the Phoenix U of A College of Medicine. In the spirit of Halloween, our residents helped with a moulage event "Zombie Tri-age" (pics). We also teamed up with the medical student's EM interest group and gave wilderness medicine lectures at a Fossil Creek camping trip.



We again say bon voyage to our attending Dr. Patrick Connell, who is leaving on his annual trip to La Clinica Esperanza in Roatán, Honduras. He will graciously allow our residents to join him for a month of sunshine and learn about international medicine. We also welcome a new addition to our residency family; baby Eamon, who was born to Monique Bushman and her family this last month. We thank our third year residents who have done a great job in their leadership roles and helping maintain the flow in the department as our volume has increased 20% over the last few months. Congratulations to our chiefs Daniel Haase & Rachel Levitan who matched into fellowships in critical care and toxicology, respectively! We await more great news when the pediatric fellowship match is announced in the future.



Last but not least, to our attending, LCDR Brad Butler, we thank you for your service. We miss your "double shift Wednesdays" and your gallon size bladder buster jugs. Be safe as you serve our country in Kandahar, Afghanistan...you make us proud!



Congratulations to these new fellows in Arizona!

- * Blake Bulloch, MD, FACEP * Jason R Johnson, MD, FACEP * Michael Jonas, MD, FACEP *
- * J. Scott Lowry, MD, FACEP * Geoffrey J McKinzie, MD, FACEP * Andrew E Morrison, DO, FACEP *
- * Drew J Paulson, MD, FACEP * Anne Jennifer Richter, MD, FACEP * Ross B Rodgers, MD, FACEP *
- * Lisa R Stoneking, MD, FACEP * Eric D Van Moorlehem, MD, FACEP * Anna L Waterbrook, MD, FACEP *
- * Alice P Wright, MD, FACEP * Giselle Zagari, MD, FACEP*

**Kingman Regional Medical Center/
Midwestern University
Emergency Medicine Residency
Update**

By Tom Sichi, DO

A few issues ago we reported on Physicians for Humanity (PFH), a non-profit group working in Ecuador co-founded by Dr. Nicholas Bower and Patrick Cain, DO one of our second year residents. I decided it would be a great experience to do an international rotation and see first hand what PFH was doing in Ecuador. The month was split between three main separate clinical settings.

I worked in an emergency department which specialized in infectious disease on a number of occasions. Like many of our EDs here in the states the facility was run down and overburdened but impressively efficient despite these structural obstacles. The infectious pathology had some similarities to the states with a much higher rate of HIV, a large number of cases of disseminated and extrapulmonary TB as well as Histoplasmosis, Dengue fever and Malaria. I was able to speak with some of the regional authorities in infectious disease/public health about the vector-host control programs. They are currently studying a previously unexplained decrease in Dengue which may possibly be due to a recent Yellow Fever vaccination program inadvertently conferring a significant amount of Dengue prophylaxis. This research may have the potential to lead to a vaccine for Dengue! The ED physicians working here have a year of residency dedicated to ID and are able to see large volumes with very little burden of documentation.

The second part of the clinical experience was a home stay and working in a local clinic named Dispensario San Francisco in Duran run by support from Physicians for Humanity. Duran is an outlying region of Guayaquil which houses many families who have moved from the more rural areas of Ecuador



as part of the greater global rush towards urbanization. Like the Favelas of Brazil, much of the housing is thrown together on land with no official ownership, there are no addresses and no sewage or running water exists. Water is delivered by tanker truck that simply siphon from the nearest polluted bayou into open barrels for domestic use and unfortunately breeding mosquitoes. Living in the same neighborhood as the clinic allowed me to get to know many of the residents, diagnose disease and create treatment regimens which were realistic given the local conditions. Had I stayed in a sterile hotel I might not have had the same knowledge, empathy or rapport. In this population nearly all belly pain and diarrhea was empirically treated with anti-parasitic agents before any other work up was initiated.

The third part of the clinical experience was working with the local Hansen's disease providers in various clinical set-

tings. As with many parts of the world, most local physicians are not skilled in the diagnosis and treatment of Hansen's. Echoes of Molokai still ring as stigma surrounding the disease lurks as a significant barrier to care. I had worked with Hansen's in Tanzania in 2006 and the care in Ecuador greatly surpassed the care provided in rural Africa. The care was separated into a three tiered system mostly managed by Catholic Nuns. The first tier afforded perhaps my favorite clinical experience of the trip as I spent the day driving to remote cane homes of Hansen's patients to aid Sister Lus handing out medication, giving dosing advice and preventing and tending to wound/skin care issues. It was heart wrenching to see young women who had stopped taking the Rifampin due to side effects because the dosing had not been adjusted by weight. My pediatric Tarascons never felt so valuable. The second tier of care located in Guayaquil was an outpatient dispensary for medications and again basic wound care. The third tier was a long term care facility named The Damien House after the esteemed Father Damien who tended to the quarantined Hansen's community on the island of Molokai before succumbing to the disease himself. The facility cared for many patients who had been cured but suffered various sequelae or could not return to their home communities due being ostracized. One patient recently celebrated a happy centennial birthday after having been cured in the 1960s. The Damien House has recently had great success with reintegration of some of the long term patients into their home communities, this program both shines a visible light of hope on the patients and makes room for some of new patients identified by Sister Lus's outreach programs. The care in this facility was multi-faceted and far exceeded many so called skilled nursing facilities here in the states while running on a very limited budget. I would greatly encourage anyone with the means to donate to this facility. To donate to PFH: <http://physiciansforhumanity.org/donate.asp> For Damien House, send your contributions to: Damien House, Inc., 4407 N. Elston, Chicago, IL 60630 or for more info, please contact: Suzanne Belz, President, Damien House, Inc., (773) 282-9129. Damien House, Inc. is a 501(c)3 organization; gifts are tax-deductible.



Kingman Regional Medical Center has a great policy allowing residents to do international rotations which simultaneously adds great diversity to the possible learning experiences and allows residents to help more than just the people of Arizona. I looked at many residency programs that tout international emergency medicine curricula but require residents to use limited vacation time to actually travel. The ability to simultaneously obtain academic credit and draw a salary while being involved in philanthropy is a rare opportunity and real asset to the KRMC residency. The trip provided profound inspiration and clinical experiences invaluable to any developing physician. I would especially like to thank the program director Dr. Michael Sheehy, director of medical education Dr. Kelli Ward, Doreen Williams and Sheri Glass for their tremendously tenacious administrative support in making this trip a reality.

UNIVERSITY OF ARIZONA RESIDENT'S COLUMN

By Jen Luman, MD

Fall is a welcome reprieve in Tucson. The temperature has cooled and you can almost imagine the impending holidays and transitions that the change of season and advancement of the academic year brings. There is a lot of excitement in the air as the new season approaches and we plan for new change in the department and our professional lives. At the University of Arizona emergency department, these changes reflect the seniors searching for new jobs or fellowships, new hires joining the department, previous residents coming home to the department, and celebrations at home and abroad.

The senior class met with former alumni colleagues at ACEP in San Francisco. A grand party was held at Henry's Starlight Lounge in the heart of the Union street district. This was a fabulous event full of reunions, dancing, planning for the future, and a celebration of moving forward with life, and connecting with old friends.

We have new faculty joining the department as well. These folks reflect new faces to Tucson and the return of some favorites. The new faculty include; Dr. Jarrod Mosier who will join the department after completing his fellowship in critical care, Dr. Jeremy Racey who has determined that he missed academic medicine (and his home at the University of Arizona ED) too much to stay away and will begin as full time faculty January 2012, Dr. Michelle Rhodes who will join as a fellow in the clinician scientist program, Dr. Lori Stolz who will join as full time faculty after completing her ultrasound fellowship, and Dr. Brian Drummond.

Our department has also played a major role in disaster response planning both locally and across the state with two mass casualty incident drills (MCI) over the past month. We partnered with the military for 'Operation Angel Thunder', that tested the interface between military operations and public hospitals (UMC), the transport of large numbers of patients from alternative landing zones and the UMC helipad, and implementation of the hospital's 'Incident Command System' (ICS). The residents were heavily engaged and were able to volunteer as responders and involved in small group activities learning about the broader scope of MCI management. The drill was conducted under the close supervision of Dr. Josh Gaither. UMC ED also participated in the statewide MCI drill on November 4th, 2011. This drill investigates the possibility of a nuclear explosion and the management of a large number of patients with radiation exposures.

Research updates include progression of the Arizona Emergency Medicine Research Center's 'Arizona Neurological Emergencies Treatment Trials' (AzNETT), which includes a network of hospitals across Arizona, participating in the NIH Neurological Emergencies Treatment Trials (NETT) Network. AzNETT is one of 11 Regional Hubs that participates in large, simple trials to reduce the burden of acute injuries and illnesses affecting the brain, spinal cord, and peripheral nervous system. The project studies the use of rapid interventions implemented by paramedics in the field or by physicians in the Emergency Department.

The hospitals included in AzNETT are:

University Medical Center, Tucson
 University Physicians Hospital at Kino, Tucson
 Southeast Arizona Medical Center, Douglas
 Maryvale Hospital, Phoenix
 John C. Lincoln North Mountain Hospital, Phoenix
 Holy Cross Carondelet Hospital, Nogales
 Copper Queen Community Hospital, Bisbee
 Banner Thunderbird Medical Center, Glendale
 Banner Health Center-Payson, Payson
 Banner Good Samaritan Hospital, Phoenix
 Barrow Neurological Institute of St. Joseph's Hospital and Medical Center, Phoenix
 Arrowhead Community Hospital, Glendale



Updates to current projects include:

Patient enrollment and partnership with Maricopa Medical Center and Scottsdale Health Center in the POINT (Plavix and aspirin in TIA) and the ProTECT trials (progesterone for TBI). Locally, Tucson Medical Center is partnering in the POINT trial.

CAPITOL HAPPENINGS

By Richard E. Bitner, AzCEP Legislative Counsel

Gearing Up for 2012 Regular Session

With less than two months remaining before the 2012 Regular Session fires up on January 9th, the Legislature has begun the year end task of committee hearings on agency sunset audits and sunrise reports, and getting ready for bill introductions to start in a couple weeks. It has been an interim unmarked by any special sessions that produced legislation, but uniquely featured special elections, special judicial actions, an on-going ethics inquiry in the Senate, and a first ever Senate session to remove Colleen Mathis, the Independent Member and Chairwoman of the Independent Redistricting Commission. Most notably, the tumultuous recall election of Senator Russell Pearce, Senate President, has now run its course, resulting in the election of Jerry Lewis as the new Senator from Mesa's District 18. In a race that showcased Senator Pearce's leadership on anti-immigration issues, including SB 1070, and his relationships with the Fiesta Bowl scandal that is on-going, the recall results have again made Arizona national news.

As is their tradition the Senate Republican Caucus met two days after the recall election was decided and selected a new Senate President, Steve Pierce (R-District 1/Prescott). Senator Pierce previously served as GOP whip, and that assignment will now fall to Senator Frank Antenori (R-District 30/Tucson). Senator Andy Biggs (R-District 22/Gilbert) who contended unsuccessfully for the Presidency will retain his current title as Senate Majority Leader.

Other unfinished business at the Capitol includes:

- ◆ Senate Ethics proceedings against former Senate Majority Leader Senator Scott Bundgaard for a domestic dispute involving his former girlfriend in the right-of-way on SR 51 last February 25. Ethics proceedings were held in abeyance pending action by the county prosecutor. Senator Bundgaard pled no-contest in a plea deal earlier in the summer and received probation, and the Ethics Committee voted only just last week to hire a special independent counsel to prosecute the case. So, it appears the process will continue at a slow pace until counsel is retained, completes their preparation and are ready to present their case.
- ◆ The Fiesta Bowl scandal continues to linger, with the possibility remaining of not only of civil or criminal charges being brought against Fiesta Bowl officials, and staff, but also potentially involving some legislators, depending on whether authorities conclude they took tickets to football events in a manner prohibited by law or otherwise improperly failed to disclose gifts. Senate Ethics Chairman Ron Gould has already opined there may be legislative ethics violations to be pursued, but has indicated he will take no official action on any legislative ethics complaint that could be filed until the conclusion of the county prosecutor's criminal investigation. It is unclear when any conclusion will be reached in this matter.
- ◆ The Governor's decision to remove Colleen Mathis from her position as Chairman of the Independent Redistricting Committee was ratified by the Senate and is now to be the subject of arguments in a special action before the State Supreme Court on November 17th. The Court declined an initial request to stay her removal made the next day by the Commission's attorneys. Meanwhile, the Commission on Appellate Court Appointments has now begun the task of considering appointment of a replacement for Mathis, who was the only Independent on the Commission. The Redistricting Commission continues to hold public meetings around the state on the proposed redistricting plan, but without a fifth member to break a tie it seems unlikely they will be able to conclude adoption of a redistricting plan anytime soon. Once that is done, of course, the plan will almost certainly be challenged in court.

Future of AHCCCS Funding Remains in Doubt

The key features of the current AHCCCS budget are an enrollment freeze on "childless adults" which commenced July 1st, coupled with new 5% provider reimbursement cuts effective October 1 and a number of new co-pays and individual accountability measures for enrollees. The overall impact of the total package is expected to reduce AHCCCS expenditures by more than \$500 million this fiscal year, but much of the plan is subject to federal approval by the Center for Medicare and Medicaid Services (CMS). Some elements have been accepted, some rejected, and several are still under CMS review. The current status of key elements of the budget cuts enacted for the AHCCS program are summarized below, and can also be reviewed at the AHCCCS website "updates" page: <http://www.azahcccs.gov/shared/news.aspx>

- ◆ Eliminate new enrollment of childless adults and "freeze" those already enrolled as long as they continue to qualify for an estimated savings of \$190 million. An estimated 150,000 enrollees could lose coverage in the first year. It appears from latest enrollment figures that more than 26,000 have already lost coverage. ***This element has been approved by CMS but remains subject to a state constitutional challenge brought by the Arizona Center for Law in the Public Interest, which argues that freezing coverage for this population is an unconstitutional violation of the "Medicaid expansion" provisions of Prop 204, which guarantees AHCCCS coverage for all individuals at or below 100% the federal poverty level. The Arizona Supreme Court heard oral arguments in the case on October 19th and has yet to announce a decision. Should the petitioners prevail in this action, it would appear the Legislature would need to take speedy action to either enact additional revenue sources to support AHCCCS eligibility for this population, or enact further draconian cuts to other state supported institutions to shift appropriations over to AHCCCS.***
- ◆ Eliminate "spend down" program. Effective May 1, this program is frozen and beginning October 1 all those already eligi-

(Continued on page 11)

Arizona College of Emergency Physicians

SAVE THE DATE



Emergency Doc Day at the Legislature

Wednesday, February 1, 2012

8:00 a.m. – 2 p.m.

Arizona State Capitol

1700 W. Washington Street, Phoenix, AZ

We had a very successful first year and plan to build upon the event for 2012.
Join us for meetings and a luncheon with your State Legislators.
Please join us for the whole day or as long as you can.

Contact Stephanie in the AzCEP Office for details
602-336-4599 or www.azacep@gmail.com

Yes, I am planning to attend ED Doc Day at the Legislature.

I plan to attend: ALL DAY _____ ; or AM _____ LUNCH _____ PM _____
(8 am – 2 pm) (8 – 12 noon) (12 noon – 1 pm) (1 pm – 2 pm)

Name: _____

Home Address: _____
(We must have the HOME address to determine legislative district for meetings)

Phone: _____ Email: _____

Who Is Managing The ED Billing Company That You Have Outsourced Your Billing / Collection Activities To?



Talk About A Fox Guarding The Hen House!

Have you ever heard of a billing company telling a physician that they should be replaced because they have failed to pursue the ED's denied claims and patient receivables because it was not profitable for the billing company?

When It Comes to Your Financial Success, You Need a Strong Partner. Today, the changing landscape of emergency medicine poses more challenges for your practice than ever before. From falling reimbursement levels to tougher regulations, your emergency medicine practice faces a host of complex issues that threaten your fiscal health and your ability to deliver high quality medical services.

EDMANAGEMENT provides specialized revenue cycle solutions geared towards emergency medicine groups and hospitals that employ emergency physicians. With 20+ years of dedicated experience in the field of emergency medicine, our partnership has distinguished itself as an industry leader, committed to helping busy emergency medicine practices thrive in a demanding business environment.

From payment denials resulting from improperly coded claims to the justification of ancillary tests and procedures, the ED reimbursement process has become an administrative nightmare. Successfully

navigating it requires an intimate knowledge of bundling and unbundling procedure changes, current coding and compliance initiatives, payer-specific requirements and more. Each day, ED revenues fall through gaping holes in the system as a result of unskilled coding professionals, lack of coding education for physicians, and efforts to avoid fraud charges by down-coding.

Denial management is a growing concern. Practice expenses are increasing at an alarming rate while reimbursement is flat or declining. Today's challenging healthcare environment requires a level of expertise that few can provide. **EDMANAGEMENT** can help you meet these challenges.

We educate physicians on the importance of documentation and revenue optimization in the medical billing and collections cycle. We provide our clients with documentation feedback and analysis on every deficient chart. As your business partner, we'll increase cash-flow and help you strategize for future growth opportunities. With extensive expertise reimbursement, our professionals work with you to identify sources of revenue leakage and stop further loss before it starts. This means more health care dollars in your pocket, where they belong!

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PHYSICIAN PRACTICE MANAGEMENT

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(Continued from page 8)

ble will be phased out. This program currently covering some 5000 individuals exists to allow individuals who would not ordinarily qualify for AHCCCS but who have sustained extensive medical expenses to qualify for AHCCCS after “spending down” their assets to below 40% of the federal poverty level. **This is a state program not required by Medicaid and CMS approved its elimination last spring.**

- ◆ Eliminate enrollment of parents earning 75-100% of FPL for estimated general fund savings of \$17M. This contemplates no new enrollment for parents earning between 75-100% FPL. Coverage would continue for those already enrolled as of September 30, 2011, but only so long as they retain continuous eligibility. ***This element has been rejected by CMS.***
- ◆ Eliminate Federal Emergency Services Program participation. This would end Medicaid reimbursement for emergency care given to non-qualified aliens for an estimated savings of state general funds of \$20M. ***This element has been rejected by CMS.***
- ◆ Require 6-month redetermination of eligibility for potential savings of \$15M. ***This element has been rejected.***
- ◆ Expand mandatory co-payments for the “childless adult” population, including a new co-pay for “non-emergency use of an emergency department”. ***This element has been approved by CMS as essentially a pilot project, subject to various requirements for record-keeping, review and analysis, leading to a final evaluation whether such co-pays are good public policy that can be continued into the future.***
- ◆ Institute a no-show penalty for missed appointments, to be paid to provider. *SB 1357: AHCCCS; Missed appointments; Provider Remedy* implementing this with a \$25 missed appointment fee was signed by the Governor, but remains subject to federal approval. ***This element has been approved by CMS limited to charging a \$3 fee for parents and childless adults outside of Maricopa and Pima Counties who miss scheduled appointments without providing 24 hour notice of any cancellation.***
- ◆ Limit in-patient hospital days covered for adults over 21 years of age to 25 days per member per contract year, with certain exclusions (including burn units). ***CMS continues to review this proposal.***
- ◆ Provider reimbursement reduction of 5% effective October 1st. The budget authorizes the AHCCCS Administration to make further provider payments as it may deem necessary to balance the budget. This move comes on top of the five percent cut that already took effect April 1. ***CMS continues to review this proposal, but AHCCCS continues to assert that any reductions that are approved will be retroactive to October 1st.***

As an alternative to these cuts to healthcare coverage and provider payments, AzHHA and other healthcare organizations have proposed reforming AHCCCS and provide funding through a special healthcare assessment. This plan would save the state several hundred million dollars and leverage billions of federal dollars Arizona taxpayers are already paying that will otherwise be used to support healthcare in other

states. This plan remains on the table and AzCEP will continue to encourage Governor Brewer and lawmakers to support this viable alternative to eliminating healthcare coverage and instituting these provider payment cuts. Should CMS invalidate provider rate reductions, or more dramatically should the Arizona Supreme Court rule for plaintiffs and order 100% FPL eligibility is required by the Arizona Constitution, the Legislature will have the opportunity to reconsider a special healthcare assessment as an alternative to further cuts to K-12 education or state agencies to bridge the gap in funding.

Aggressive reductions in provider reimbursement only serve to further restrict healthcare access as fewer physicians elect to serve AHCCCS patients, leaving many of the newly uninsured the only viable option of seeking care in the emergency department. Further information and updates on the AHCCCS funding crisis and alternatives are available on the Arizona Hospital & Healthcare Associations website: http://www.azhha.org/member_and_media_resources/reports_data_and_tools.aspx

Many thanks to all of you who participated in the first ever ED DOC Day at the Legislature. We hope you will continue to build on the relationships you formed with your legislators that day, and will encourage other AzCEP members you know to join in for the next Day at the Legislature on February 1, 2012. Those desiring more information about legislative developments or AzCEP Public Affairs involvement than provided here may wish to check the AzCEP website for updates, consult the Arizona Legislative Information System (ALIS) at “www.azleg.gov”, or contact me or members of the Public Affairs Committee or Executive Team for assistance.

Calendar of Events

Mark your Calendar and Get Active in AzCEP!

Dec. 7	Board of Directors, Chapter Office
Jan. 4	Exec. Committee, Chapter Office
Feb. 1	Board of Directors, Chapter Office & <i>Emergency Doc Day at the Capitol</i>
March 7	Exec. Committee, Chapter Office
April 4	<i>Annual Membership Meeting</i>

***All AzCEP members are welcome and encouraged to attend the Board Meetings. Contact the Chapter office at 602-336-4599 for additional information. Board Meetings, unless otherwise noted, are held at 12:00 noon at our Chapter office in the Arizona Medical Association building, 810 W. Bethany Home Road, #110, Phoenix, AZ 85013.**

Changed Your Address?

If you change your business or home address please notify the National ACEP Office or AzCEP & the correction will be forwarded.

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AzCEP Mission Statement

The Arizona College of Emergency Physicians (AzCEP) exists to support the highest quality emergency medical care and to serve as advocates for our patients, our members and our specialty. {adopted by the AzCEP board, 10/2001}

Winter Issue of the Arizona EPIC

Submittal Deadline: February 1, 2012

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