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Obamacare Co-ops Have Flown the Coop

By Richard J. Gimpelson, MD

One half of the Obamacare “Consumer Operated and Oriented Plans” (Co-ops) have gone broke, leaving nearly three quarters of a million Americans looking for new health coverage. These co-ops have received more than $1.1 billion in loans, which will probably never be fully repaid. (Report by Greg Corombos, WND Radio). These co-ops were set up to provide low-cost medical coverage for those unable to afford higher-priced plans or for those not receiving employer-provided insurance. Besides not having medical coverage, another concerning issue is that those who lost coverage could face fines from the IRS for not having coverage as mandated by federal law.

I searched the Internet and found hundreds of reports on the co-op failures:

- “Collapsing Obamacare Co-ops Signal Big Trouble to Come,” thefiscaltimes.com
- “Financial Health Shaky at Many Obamacare Insurance Co-ops,” washingtontimes.com
- “Most Health Insurance Co-ops are Losing Money, Federal Audit Finds,” nytimes.com
- “Busted: Obamacare Co-ops Are Underwater and Sinking Fast,” forbes.com
- “Obamacare ‘Co-ops’ Failing, Falling Behind on Loans,” washingtonpost.com
- “New York Health Co-op Ordered to Close Down,” washingtonpost.com
- “More Than Half of ACA Co-ops Now Out of Insurance Marketplaces,” washingtonpost.com
- “One-Third of Obamacare Co-ops Are Now Officially Dead,” dailycaller.com

This last report refers to the Obamacare Co-op, Republic Health, which was the only co-op that includes the renowned cancer center, Memorial Sloan-Kettering. The Inspector General of the U.S. Department of Health & Human Services reported that 21 of 23 operating co-ops faced staggering losses, some greater than the original loans that were supposed to last 15 years. These non-profit co-ops were unsustainable without government subsidies.

The co-ops were supposed to eliminate for-profit insurance companies and lead to socialized medicine; however, as noted in the prior paragraph, the government subsidies could not keep up with the co-op expenses. At this time 22 of the 23 co-ops have lost money or have gone broke.

In summary, the government should not be in the insurance business unless you are happy watching your tax dollars go up in smoke.

Don’t forget to vote November 2016!

Dr. Gimpelson, a past SLMMS president, is co-director of Mercy Clinic Minimally Invasive Gynecology. He shares his opinions here to stimulate thought and discussion, but his comments do not necessarily represent the opinions of the Medical Society or of Mercy Hospital. Any member wishing to offer an alternative view is welcome to respond. SLMM is open to all opinions and positions. Emails may be sent to editor@slmms.org.

Dr. Richard J. Gimpelson

HARRY’S HOMILIES ©

Harry L.S. Knopf, MD

ON STRESS

Let us go singing as far as we go:
The road will be less tedious.
- Publius Vergilius Maro (Virgil)

We physicians seem to be more stressed, especially lately. We have new codes, new forms to complete, and generally more everything—except income. There is no doubt that stress can and will take its toll on us. But how to cope with it? Our friend, Virgil, whom I quoted, has a suggestion: SING! Remember how you used to sing “100 Bottles of Beer” on long car trips? It was fun, and it did make the “road … less tedious.” As a singer, I know that the act of singing is as satisfying as a good run or a long walk. And if you are any good, then your audience will be happier as well. So next time your assistant asks you about what code you need for this patient—try singing it. I bet you that it will bring on a smile.

Dr. Knopf is editor of Harry’s Homilies.© He is an ophthalmologist retired from private practice and a part-time clinical professor at Washington University School of Medicine.
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Reservation Deadline – December 18, 2015

SLMMS 2016 Installation Banquet and Annual Meeting

Join in celebrating the installation of Samer Cabbabe, MD, as 2016 SLMMS President and the 2016 SLMMS Council, and the presentation of SLMMS Awards.

Saturday, January 9, 2016 | 6 p.m. Reception | 7 p.m. Dinner

Windows on Washington | 1601 Washington Ave. | St. Louis, Missouri, 63103
Complimentary valet parking provided

INFORMATION
Liz Webb | 314-989-1014, ext. 108 | lizw@slmms.org

Who would you be without your reputation?
Make sure your reputation is protected with medical malpractice insurance coverage from PSIC.

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The year 2015 has brought changes in the field of medicine. We have traveled further down the path of Obamacare. We have been introduced to the new SGR "doc fix," and finally have seen the implementation of ICD-10. More U.S. physicians are leaving private practice for hospital employment. More than 50 percent of physicians are now employed by organizations associated with health-care systems or hospitals themselves.

Hospital Employment Pros and Cons
There are both pros and cons associated with hospital employment. As a hospital employee it is almost certain that the paycheck will clear and arrive in a timely fashion. Incomes are generally higher in employment than private practice, most significantly due to the loss of overhead/rent. The hospital administration takes over the worries of billing, collections, human resources and other daily functions. However, compensation can be changed. Most hospitals pay physicians by a production RVU-based formula. That formula can and does change. Demands may increase. Metrics may also change. Quality and patient satisfaction measures are now part of the overall compensation package.

The physician is no longer in charge. Staff knows who writes their checks. The hospital sets the policies of the practice. Autonomy is greatly diminished. Your EHR, if you have one, may not be compatible with the hospital’s.

So how do you decide if it is the right decision? Make sure that your future goals correlate with the hospital’s long-term plans. If they don’t align, consider the impact on your practice style. Make sure to talk with other physicians who have made the switch to become an employee. Make sure you understand the compensation package in depth. How secure is the guaranteed salary? What happens if you want to leave? What are the penalties for exiting the existing contract? What is the non-compete? There are a multitude of factors to consider when making the decision to become a hospital employee, and this is just a brief overview of the topic. If you are in the middle of this process, good luck to you.

Obamacare Promotes Consolidation Into Employment
Does Obamacare pose a threat to private practice? A recent commentary in The Wall Street Journal by Scott Gottlieb reveals the dirty little secret about recent attempts to fix Obamacare. Both parties want to consolidate previously independent physicians into hospital employment. Obamacare activists view this as necessary to enable payment provisions that move the financial risk onto the providers and less risk to government programs like Medicare. Doctors need to be part of a larger, more financially secure institution to absorb the added risk.

Once independent physicians become the exception rather than the rule, the continued Obamacare agenda will become a reality. As consolidation between health-care systems continues, competition among providers diminishes. Lack of competition will make it harder to continue market-based alternatives to Obamacare. Resulting medical monopolies will make more regulation the solution to the cost and quality problems. So what is the answer? An alternative to Obamacare would give support to independent physicians, preserve local competition between physicians, and protect choice for their patients.

MACRA and the Trojan Horse
Last but not least, in 2015 Congress passed the SGR "doc fix" through the Medicare Access and CHIP Reauthorization Act (MACRA). Many support the new law due to its repeal of the SGR formula. But with over 250 pages, all written in legalese, it has become known as the Trojan Horse Law. Its eventual impact on health care is vexing.
One of the hidden aspects of the law is to eventually move away from the traditional fee-for-service payments to providers to an outcome-based model. The patient has no responsibility for compliance. The physician bears the burden for poor outcomes even if the patient makes unhealthy lifestyle decisions.

Advocates of the policy claim that this will lead to better clinical outcomes. However, physicians cannot afford to treat patients without compensation. Physicians will eventually stop seeing non-compliant and complex patients. Many doctors will stop seeing Medicare patients altogether.

In my opinion, the worst part of this law is the extension of the Meaningful Use Program. Physicians for years have decried this program. Technology necessary for the implementation of the program does not even exist. Reporting the metrics necessary is also pulling doctors away from face-to-face time with their patients. The doctor-patient relationship is now on life support. Meaningful Use should not be used to diminish physician reimbursement, at least until the technology has been made functional. There also are questions about how the law might utilize Maintenance of Certification as part of meeting MACRA’s optional Merit-Based Incentive Payment System (MIPS) requirements. Apparently the rules are still being written on this.

P.S. On behalf of our SLMMS leadership, we extend our thoughts and prayers to the people of France in the wake of the recent terrorist attacks.
I recently read that change in health care occurs faster than in any other industry. One significant change we have seen in recent years is the growing number of physicians choosing employment over independence in private practice. With increasing frequency, both practicing physicians and those completing training are seeking employment. Regulatory changes, economic forces and lifestyle preferences are all reasons cited for this trend.

Articles can be found in abundance about how this phenomenon is impacting the practice of medicine, as well as physician and patient satisfaction, and employment threats to doctor autonomy. The fact is the number of our country’s employed physicians is growing, and is expected to continue to grow over the next five years. So, in this issue with the theme “Independence vs. Employment,” let’s examine how this trend is changing your medical society.

It’s no secret that medical society membership across the country is in decline. Fewer new practitioners are embracing organized medicine, and many longtime members are abandoning it. One of the most common reasons we hear for dropping membership is the doctor has become employed, so they see less value in continuing, or they assume many of the benefits of society membership will now be provided by the employer.

As much as I hate to admit it, I do understand why many physicians come to this conclusion. But it’s not the complete picture, and it’s also an inaccurate assumption. The benefit of organized medicine that physicians value most is advocacy. Your medical society, whether local or national, is here to represent your interests and protect the physician-patient relationship. That process of influencing positive change is unlikely to be found through an employment contract.

So as the future of physician practice continues to change, organized medicine must change with it. SLMMS strives to be a beneficial membership for both the independent and employed physician. Our leadership is reflective of this, and our educational offerings, programs and benefits must continue to do so as well. Keep in mind that we are an organization that protects and serves the interests of all physicians—across all specialties, allopathic or osteopathic, active or retired, or still in training. The same is true of employed or independent. Your medical society always welcomes your ideas to continue to move our organization forward.

Your medical society, whether local or national, is here to represent your interests and protect the physician-patient relationship.

Moving forward requires strong physician leadership, so allow me to take this opportunity to invite you to participate in the upcoming Physician Leadership Institute. This ambitious program, launched last year, is a most visible benefit of society membership, with tuition significantly discounted. Following a successful first effort, SLMMS is partnering with Anders Health Care Services and Healthcare Management Alternatives to again produce the five-part series, beginning February 13. See the story on the next page for more information, or visit our website at slmms.org.

I thank you for your generous support of our Society this past year, and look forward to 2016 with great excitement. I hope to see all of you at our annual meeting and installation dinner on Saturday, January 9, at Windows on Washington. Remember that your reservations are due to the SLMMS office by Friday, December 18.

Keep in mind that we are an organization that protects and serves the interests of all physicians—across all specialties, allopathic or osteopathic, active or retired, or still in training. The same is true of employed or independent.
Following a very successful inaugural course this past year, SLMMS is partnering with Anders Health Care Services and Healthcare Management Alternatives, Inc. (HMAI) to present the 2016 Physician Leadership Institute. This five-week, high-intensity program, open to physicians only, puts emphasis on the business side of medical practice, with the objective of developing leadership and management skills, and begins its 2016 sessions on February 13.

The curriculum was developed based on the Medical Group Management Association (MGMA) Body of Knowledge, but with significant physician input. “We’ve retained about two-thirds of last year’s curriculum, but made some revisions based on participant evaluations and a PLI alumni physician focus group,” explained Jerrie Weith, president and lead consultant with HMAI. The five sessions are as follows:

- Session 1 – Foundations of Health Care
- Session 2 – Finance and Revenue
- Session 3 – Practice Management
- Session 4 – Risk and Compliance
- Session 5 – Leadership Skills

The coursework is designed to be relevant to all practitioners, whether they are independent, hospital-based, or part of a large group. “The classes are discussion-based and highly interactive, and will be led by a diverse group of knowledgeable experts, including alumni from the 2015 program,” said Kathleen McCarry of Anders. Sessions will be held on Saturdays from 8:30 a.m. to 2:00 p.m. at Anders’ educational facility in its office at 800 Market St., Suite 500, in downtown St. Louis.

This year, 23 Continuing Medical Education hours will be awarded for completion of the entire curriculum. Tuition for the five-session program, including lunch and all materials, is $750, discounted to $500 for SLMMS members. Group discounts will also be available.

For more information or to register, visit http://anderscpa.com/physician-leadership-institute/ or use the link in the story on the SLMMS website. Enrollment is for all five sessions; the deadline for enrolling is Jan. 31. Early enrollment is encouraged as last year’s program was at capacity.

Testimonials from 2015 Participants

“Excellent overview for physicians looking at administrative or leadership positions within their respective organizations.” – Alan Sandidge, MD

“Very thought provoking. It helps to take the time to develop leadership and management skills.” – Jack Galbraith, MD

“The PLI is a great program. It provides a lot of insight into leadership and practice.” – Raghav Govindarajan, MD

“The PLI provides well-organized presentations and discussion material not easily accessed in other ways.” – Steven Shields, MD

“Great overview of relevant practice topics in our current changing environment.” – Michael Beat, MD

“This opened my mind to different issues, ideas and horizons.” – Helen Nguyen, MD

SLMMS, ANDERS HEALTH CARE SERVICES AND HEALTHCARE MANAGEMENT ALTERNATIVES PRESENT

The 2016 Physician Leadership Institute

February 13 | February 27 | March 12 | April 2 | April 23
Anders Headquarters, 800 Market St., St. Louis
Up to 23 CME hours will be awarded
Tuition: $750 ($500 for SLMMS members)
Visit http://anderscpa.com/physician-leadership-institute/to register
Maintenance of Certification has become a moneymaking system for certifying boards, while delivering questionable evidence that it improves patient care, said Paul Kempen, MD, PhD, at the 13th annual SLMMS Hippocrates Lecture on Sept. 30.

An anesthesiologist from Weirton, W.Va., Dr. Kempen has been a strong national advocate against the American Board of Medical Specialties (ABMS) Maintenance of Certification (MOC) and the Federation of State Medical Boards (FSMB) Maintenance of Licensure (MOL) programs in their current form.

He applies the economic term “regulatory capture” to refer to the use of laws and policies to induce compliance with corporate self-serving programs. He noted how regulatory capture is occurring with the practice of medicine, as “special interests co-opt policymakers or political bodies, regulatory agencies in particular, to further their own needs.”

Dr. Kempen described how the certifying boards and specialty societies make money selling products to help physicians prepare for board exams. In another conflict of interest, journal articles in support of certification programs are typically written by physicians who serve on the boards, he added.

The majority of available data indicates MOC has no impact on patient outcomes, he said. ABMS itself admits “there is no certification that guarantees performance or positive outcomes.”

MOC is costly for physicians—one study found the average cost of MOC to a physician over a 10-year period is $23,607 but could run as high as $66,000. ABMS medical recertification programs have significant prevalence only in the United States and not in other countries; plus, the 33% failure rate is way too high, Dr. Kempen noted.

Several groups, particularly the American College of Cardiology, the American Gastroenterology Association and the American Medical Association, have been at the forefront of working for change. He supports the recommendation of the American Board of Internal Medicine Assessment 2020 Task Force that the closed-book test be replaced with a combination open-book and closed-book.

“Open-book is how we practice. Google is the greatest tool we have every day,” Dr. Kempen said. With so much medical literature, it is impossible for the practitioner to keep up with all the relevant journal reading, he added.

Changes in Maintenance of Certification Urged

Maintenance of Certification has become a moneymaking system for certifying boards, while delivering questionable evidence that it improves patient care, said Paul Kempen, MD, PhD, at the 13th annual SLMMS Hippocrates Lecture on Sept. 30.
Coping with ICD-10 Challenges? Medi Globe America’s Resources Can Help

October 1 brought the long-delayed transfer to ICD-10 codes into reality for medical practitioners. The good news is the sky did not fall down and we did not face the end of modern medicine as we know it. Seriously, though, is your practice struggling with the challenges of reimbursement, compliance, ICD-10 and regulatory changes? Are you doing so in a cost-efficient manner? Don’t forget about the benefits available to SLMMS members through Medi Globe America.

For the past year, Medi Globe America, has partnered with SLMMS to provide discounted scribe and coding and review services to our membership. They have recently launched an all-new website at www.mediglobeamerica.com.

Given the recent regulatory changes, Medi Globe has put emphasis on enhancing ICD-10 ready coding services, according to Prahaan Cumarasamy, founder and CEO. “Our coding audit services include documentation completeness for coding and billing compliance, medical necessity and recommendations on the correct level of service,” he said. “All suggested ICD and CPT codes are based on the clinical documentation provided.”

Medi Globe America’s extensive resources support 180 medical groups and eight hospitals, handling more than 500,000 patient encounters per month. Their staff includes 65 ICD-10 certified and trained coders.

SLMMS members may obtain coding and coding review services through the utilization of Medi Globe’s virtual scribe service, or they be purchased independently at a discounted rate. To learn more, call 800-289-9752, ext. 104 or email ICD-10@mediglobeamerica.com.
For the third consecutive year, volunteers from the St. Louis Metropolitan Medical Society staffed four-plus tables at the Oct. 16 World Food Day event at John Burroughs School. They were among more than 1,650 volunteer packagers assembling 362,556 meals throughout the day. Macaroni and cheese meals will be distributed by the St. Louis Area Foodbank to needy families, and international rice and bean meals will be delivered through a school-based feeding program in Tanzania.

World Food Day is a worldwide day of action against hunger. An estimated one in nine individuals lives with chronic hunger every day throughout the world, according to World Food Day USA. SLMMS was a Silver Sponsor for the St. Louis event.

SLMMS Volunteers Pack Meals for the Needy

Ali Ahmad, MD; Armaan Ahmad (front), Kamran Ahmad and Saima Ahmad, MD.

Front from left, SLMMS Executive Assistant Liz Webb, Jill Nowak, Anne Webb, Mary Beth Webb, Back row, SLMMS Executive Vice President David Nowak, SLMMS Vice President j. Collins Corder, MD, Katie Corder, Jillian Cole.

SLMMS Past President Joseph Craft, MD, back row right, and family members.

Saint Louis University medical students, front row from left, Mackenzie Giumo-Zorkin, Victoria Hayes, Alexis Webber, Niveditha Manivannan, Corinne Casino, Alvin To; back row from left, Geoff Beck, Natalie Gaio, Andy Hayden, Mia Harton, Amanda Grynewicz, Bethany Carey, Lewis Tian.

Washington University medical students, women front row from left, Radhika Jain, Rababin Tooba, Rina Amatya; back row from left, Zhuchen Xu, John Steven Ekman, Derek Schloemann, Kavon Javaherian, Thomas Hong, Craig Yugawa.
Resolution Timeline Shifts Forward for 2016

Due to the earlier date of the 2016 MSMA Annual Convention, to be held March 18-20 at the St. Louis Renaissance Airport Hotel, the SLMMS timetable for submitting resolutions has moved forward. Our resolutions represent the voice of organized medicine in the state. If you’re considering an idea for a resolution, we encourage you to bring it forward with the following schedule in mind.

Per our bylaws, for a resolution to be introduced and sponsored by SLMMS, it must be presented twice to our delegation. We encourage you to introduce it first at the SLMMS Delegates’ Briefing Session, scheduled for Tuesday, Dec. 15, 2015, at 7:00 p.m. in the dePazzi Bentley Room in the von Gontard Conference Center at Mercy Hospital St. Louis.

Resolutions accepted by the SLMMS delegates at the Briefing Session go forward to a second meeting held in conjunction with the monthly SLMMS Council meeting on Jan. 12. All resolutions receiving final approval at the second meeting are then submitted as sponsored by the Society. The deadline for submission to MSMA is Feb. 1, 2016, for publication in convention materials.

Please notify the SLMMS office as soon as possible to have your issue added to the agenda. It is preferable for the author to be present at the Briefing Session and at the joint meeting with the Council to defend and explain the rationale for the resolution(s).

Visit the SLMMS website for a link to MSMA’s Guidelines on Resolution Writing. Resolutions may be introduced individually at the convention, but different guidelines must be followed. For more information on this process, call the SLMMS office at (314) 989-1014.

I have very exciting news! I am starting a new wealth advisory partnership called Clarity Financial Planners. My new partner is Shannon Moenkhaus who is a Certified Financial Planner. Shannon has been a wealth advisor for nearly two decades – specializing in income and estate tax planning. I look forward to her being my partner in the wealth management business. My entire team is moving over to Clarity. I appreciate your trust and confidence in me and my team over the years and look forward to working with you in our new partnership.

-Bill Bender
The Legacy of the Manhattan Project in St. Louis: Cancer Concern?

Residents, government face effects of contamination along Coldwater Creek

By Faisal Khan, MBBS, MPH, Director, St. Louis County Department of Public Health

Brief History

The St. Louis region played a significant role in the development of America’s atomic weapons program in the 1940s. From 1942 to 1957, the Mallinckrodt Chemical Plant extracted uranium and radium from ore at the St. Louis Downtown Site (SLDS) in north St. Louis. During this time and until 1967, radioactive process byproducts were stored at a 21.7-acre site adjacent to Lambert-St. Louis Airport, which is now referred to as the St. Louis Airport Site (SLAPS). In 1966, certain SLAPS wastes were purchased, moved to and stored at 9170 Latty Ave. in Hazelwood. Part of this property later became known as the Hazelwood Interim Storage Site (HISS). During this move, improper handling and transportation of the contamination caused the spread of materials along haul routes and adjacent vicinity properties.

Environmental Contamination

SLAPS is located at the headwaters of Coldwater Creek, which travels through the middle of north St. Louis County before draining into the Missouri River near its confluence with the Mississippi River. The Latty Avenue site also is located along Coldwater Creek about a mile downstream from SLAPS. This was an open-air storage site and was intended to be so, in order to dry the radioactive material prior to shipping. The original downtown site, HISS and SLAPS were turned over to the U.S. Army Corps of Engineers for cleanup activities, under the government’s Formerly Utilized Sites Remedial Action Program (FUSRAP).

The sites contain soils contaminated with radium, thorium, and uranium as a result of federal defense activities performed under contracts with the Manhattan Engineer District and the Atomic Energy Commission (MED/AEC) in the 1940s and 1950s.

The rapid development of residential subdivisions in the North County area during the 1960s and 1970s completely changed the creek’s downstream landscape from sparsely populated farmland to thriving suburban communities. The construction booms in the 1950s and 1960s led to soil re-grading and the process redistributed the contaminant materials (that had been sent downstream by runoff), possibly creating potential modes of human exposure through inhalation and ingestion.

Community Concerns

A cohort of residents who grew up in the Coldwater Creek area in the 1960s and 1970s noticed that a lot of their high school classmates and neighbors were dying of various types of cancer. They created a Facebook page to bring together residents with similar concerns. That page grew to more than 20,000 participants in a year. Admittedly, these are all self-reported conditions. Nonetheless, there are some huge red flags to consider. For example, 30 cases of appendix cancer were identified in a relatively small geographic area when there are less than 1,000 cases nationwide per year. The community is also concerned about many other conditions that may or may not be associated with exposure to contaminants from Coldwater Creek such as leukemia, brain tumors, breast cancer and colon cancer.

Cleanup of Coldwater Creek

The U.S. Army Corps of Engineers, St. Louis District, is conducting a radiological cleanup program for the St. Louis sites under FUSRAP. This program involves extensive and meticulous testing along the banks of the creek as well as its bed and adjoining properties (parks, back yards). Any traces of contamination found are carefully removed with clean margins around the soil. The contaminated material is then removed and shipped for disposal elsewhere. Cleanup in St. Cin Park in Hazelwood, located just north of I-270 along the creek, was conducted this summer. The FUSRAP project website address is shown in “For More Information.”
West Lake Landfill

Between 1970 and 1973, most of the material from the Latty Avenue site was transported to Canon City, Co. The remaining 8,700 tons of leached barium sulfate was mixed with 39,000 tons of clean fill and deposited at the West Lake Landfill in Bridgeton as cover. This project remains under the supervision of the U.S. Environmental Protection Agency. The Agency for Toxic Substances and Disease Registry of the U.S. Dept. of Health & Human Services recently released a Health Consultation on the West Lake Landfill describing risk to public health. The report’s website address is shown in “For More Information.”

What Can Physicians in the St. Louis Region Do?

I would urge all physician colleagues in clinical practice in the St. Louis region to consider the following actions:

1. **Educate.** Please raise awareness of this issue (for yourself and your colleagues). A good start would be the U.S. Army Corps of Engineers FUSRAP project website. Its address is shown in “For More Information.”

2. **Listen.** Please listen to the concerns of any patients who grew up in the area around Coldwater Creek and take the time to reassure them based on your own clinical judgement.

3. **Participate.** Please consider attending a community meeting on this issue to listen first hand to concerns your fellow residents have about their health as it relates to this issue.

For More Information


5. West Lake Landfill project site. www.westlakelandfill.com

COLDWATER CREEK KEY SITES

Cleanup in St. Cin Park, summer 2015.

Area of high resident reported cancer incidence

St. Cin Park Cleanup Site

St. Louis Metropolitan Medicine 13
From the upcoming value-based Medicare, to IT Meaningful Use, to higher patient co-pays and narrow provider networks, the challenges facing physicians continue to grow. In this fast-changing health-care environment, many physicians are considering the choice between employment, independence and other options in between.

New data released by the American Medical Association in July 2015 shows the number of physicians employed by hospital systems continues to increase. According to the data, the share of physicians who worked directly for a hospital, or in practices that were at least partially owned by a hospital, increased from 29.0 percent in 2012 to 32.8 percent in 2014. This compares to an estimated 16 percent in 2007-2008, meaning that the share of physicians working in hospital-owned practices has doubled in the past eight years.

Conversely, the number of physicians who were owners of their practices dropped from 53.2 percent in 2012 to 50.8 percent in 2014. In 1983, 76.1 percent of physicians owned their practices. When employed physicians in physician-owned practices are included, 56.8 percent of physicians worked in practices that were wholly owned by physicians in 2014, down from 60.1 percent.

Remaining physicians who do not work in physician-owned or hospital-owned practices serve in universities, nonprofit organizations or other settings.

Younger physicians are more likely to be employed by their practice than older physicians. In 2014, employment ranged from 59.0 percent among physicians under the age of 40 down to 33.3 percent among physicians over the age of 54. Women physicians are more likely to be employed than men (51.8 percent for women vs. 38.8 percent for men), because women physicians tend to be younger due to their more recent entry into the field, and because women are more represented in specialties such as pediatrics.

The share of physicians in solo practice declined to 17.1 percent in 2014, down from 18.4 percent in 2012 and 43.8 percent in 1983. The share working in multi-specialty practices grew to 24.7 percent in 2014 from 22.1 percent in 2012, and the share of direct hospital employees increased to 7.2 percent from 5.6 percent. The 42.2 percent working in single-specialty groups represented a drop from 45.5 percent.

What advantages do the different settings offer?

**Hospital Systems**

Working for a hospital system affords access to its electronic health records system which contains data on a patient’s encounters with various physicians, hospitals and other providers across the health system. Both Mercy Clinic and SSM Health have Epic systems; BJC is in the process of converting to Epic.

“With specialist and primary care data on one platform, it is a luxury to have this information at our fingertips,” said James Bleicher, MD, SSM Health president of physician and ambulatory services for the St. Louis region.

Both SSM and Mercy report their EHRs provide the basis of robust quality programs. Mercy’s quality program prepares it to support Accountable Care Organizations and the new value-based program being launched for Boeing St. Louis employees, said John Hubert, MD, (SLMMS), president of Mercy Clinic East Communities, the physician unit of Mercy in the St. Louis area.
Mercy has care management and population management systems in place for diabetes, hypertension and congestive heart failure, Dr. Hubert said. “In hypertension, we have 92,000 patients cared for by Mercy physicians. Utilizing an initiative of the American Medical Group Foundation, we have achieved 80 percent patient compliance with control of blood pressure levels, compared to 65 percent a few years ago. Mercy has done well compared to others in the American Medical Group Association database.”

At SSM, the EHR and quality programs are useful for patient-centered medical homes in place at several practices.

Both Mercy Clinic and SSM Health emphasize their groups are governed by physicians and are separate from the hospitals. Dr. Bleicher said, “This is a physician-led organization. Decisions are made by physicians.”

When formerly independent practices join SSM Health, “The most important thing is to be aligned from a cultural standpoint, in how we provide quality and deliver the patient experience,” Dr. Bleicher said. In addition, SSM Health professionals work with the practice to integrate financials and systems.

Dr. Hubert said, “It’s always about communication and accessibility. We make sure there is communication with the practice staff. We bring them into the family and let them know they will be treated fairly. It can be a big change going from a small organization to a large one.”

SSM Health has 442 physicians in its clinic, with about 40 percent being primary care. Mercy Clinic has about 650 physicians. Both continue to look at selective growth.

“We think we have a terrific model,” Dr. Hubert said.

**Independence**

In the face of the changing landscape, many physicians are determined to remain independent. One is gastroenterologist Robert McMahon, MD, a past president of SLMMS.

“Independence is another word for freedom. You can make choices, adapt and innovate quickly. Why add more bureaucracy and waste to a practice that should be run by physicians?” he said.

Independence has its price, he added. “It is a lot of work to manage a practice. You do have control of the costs, but are totally responsible for them and remain dependent on commercial and government insurance for revenue. Competition is relentless. Growth is limited by one’s available time.”

Another problem is narrow health insurance networks that exclude solo or small-group physicians.

Various national sources offer strategies for independent practices to remain strong in today’s environment. *Medical Economics* shares this advice:

- Accept that EHRs are necessary and use them to improve patient care.
- Look for ways to differentiate your practice in services, efficiency and outcomes.
- Make population health management part of your care.
- Find ways to reduce costs.
- Consider collaborations through such vehicles as independent physician alliances.

Dr. McMahon collaborates with other physicians in an ambulatory surgery center. Physician-run centers typically have lower costs than hospitals, according to many published reports.

“The majority of my referrals are either direct from patients or from other independent physicians,” Dr. McMahon said. “I enjoy the collaboration and communication with referring physicians, and the rewards of a job well done. I believe there is a continuing role for independent physicians.”

**Multi-Specialty Options**

Two multi-specialty options in the St. Louis area afford physicians benefits of a large group while also enabling them to remain independent.

The St. Louis Physician Alliance now has more than 460 physicians in 145 practices at 250 locations in Missouri and Illinois. The SLPA formed an Accountable Care Organization in 2014 which was awarded a three-year Medicare Shared Savings Program agreement with CMS effective Jan. 1, 2015.

“As a clinically integrated network, we share extracted data from the practices’ systems and paper charts,” said Scott Hardeman, MD, (SLMMS), SLPA board chairman. “We offer the opportunity to participate in a value-based environment and grow competency in this arena, all with a low barrier to entry.”

SLPA participating physicians will be able to meet Medicare 2018 value-based requirements to qualify for more favorable reimbursement, Dr. Hardeman said.

Practices don’t have to change EHR systems to join SLPA, he added. SLPA is implementing a population health platform to aggregate and analyze patient data from various source systems.

Independent physicians offer a cost advantage. “Insurers have a real interest in working with independent physicians because of the value proposition,” he said, noting that outpatient surgery centers often are one-third the cost of going to the hospital.

continued on page 24
The Five Key Strategies for Survival

From payment and compliance challenges to measuring quality, how physicians can stay ahead in today’s environment

By Jerrie K. Weith, MBA, FMFMA, CMPE

Whether you are hospital-affiliated, employed in a system or academic medical center or independently practicing, you’ve felt the pinch. Declining reimbursement. New pressures on patients to directly pay you. Rising costs. Difficulty raising capital for investment. How did we get here? You’ve heard most of the reasons so we’ll only recap a few of the most pertinent:

- Patient engagement and preventive care. Patients are expected to be more attuned to their health, and be a proactive partner in staying healthy. Yet:
  - One in five adults smoke;
  - One in four eat less than the RDA for vegetables and fruits;
  - Two of three get too little exercise

There seems to be a disconnect between what is expected of you as a physician to provide excellent preventive care and the patient's impact on your efforts.

- Hospitals that employ physicians continue to lose an average minimum of $150,000 per year for at least the first three years. Unsustainable on an ongoing basis. Then after the first three years, the employment agreements are “re-negotiated” and physicians either stay and are disenfranchised, or leave to pursue other practice options.

- What will the ACA continue to bring us? As high-deductible plans are becoming the norm rather than the exception, your patients can’t afford to see you. They may not address a health issue as quickly if it’s out-of-pocket. Or they will see you but are unable to pay you. Or they see you, then discontinue their health insurance premiums. Either way, getting paid is getting tougher.

- The manner by which you are paid is chronically at risk. External parties determine what your services are worth in the marketplace, the mechanism by which you’ll be reimbursed for those services and when you’ll receive your payment.

- Regulatory rules and updates are over-arching. From requirements under HITECH for heightened HIPAA compliance, to ICD-10, to coding audits, it can be challenging to stay abreast of everything that can impact your practice.

- Technology has evolved into a major influence over every activity in your medical practice. A significant component of the growth in the use of EHR can be attributed to incentives that had been available for its meaningful adoption. However, as those standards become increasingly difficult to meet, will EHRs keep their recent historical pace of adoption?

What do these and so many other trends mean to your practice as a physician? Challenges. But with challenges come opportunities. No one can stay on top of every single trend in our industry, and not all trends are as important to one doctor as they may be to another. So the first step in surviving as a physician in our tumultuous industry is to identify those challenges that present the best opportunities for you to be successful, and capitalize on those opportunities.

Each of you comes from a different scenario, primary care vs. specialist; hospital-based vs. non-hospital-based; employed vs. independent. Regardless, there are five strategies you can deploy to be successful:

1. **Develop YOUR plan for success**
2. **Focus your practice on demonstrating quality patient care**
3. **Create financial viability**
4. **Manage your risk**
5. **Embrace technology as your practice’s foundation**

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**Jerrie Weith** is president and lead consultant with Healthcare Management Alternatives, Inc., a professional services firm devoted to the success of physician practices. She can be reached at jkweith@outlook.com, 618-779-5508, or www.hmai.cc.
Develop your plan for success.

This is the toughest of the strategies. Each of the other four strategies depend on what you decide here. Why is it the most difficult? It requires some soul-searching. You can’t plan for what you want to be and how you want to practice if you really don’t know what you want. Here are a few hints to get you started:

- Ask yourself where you want to be in five years. Do you want to stay independent? Are you employed and want to phase out your practice to take on administrative roles? Are you nearing retirement and working on an exit strategy? Until you answer this question, you can’t develop your plan to succeed.

- Once you’ve looked into the future and visualized what you want for yourself in five years, write it down. Sounds simple, but it can be hard. Writing it down is critical as it demonstrates commitment to your vision for yourself.

- Once you’ve documented what you want, set some goals. Set interim goals that support your five-year objective. For instance, you might say “I want to finish my executive MBA in 3 years” or “I want to return to independent practice within five years.”

- Just as with any type of goal-setting, involve anyone whose expertise you may need for meeting your goals. Don’t be timid about asking. Maybe your practice manager can help you develop a recruiting plan if your goal is to bring on a partner within the next four years.

- Each physician’s plan for success will be different, just as each physician’s personal objectives are different.

Focus your practice on demonstrating quality patient care.

It is aggravating when we hear that doctors need to begin providing quality patient care. How absurd. Quality patient care has been provided for many decades. What people are really saying is that they want doctors to be able to demonstrate they’re providing quality care. There are four basic guidelines in this regard:

- Provide medically necessary and quality care.
- Document the care you provided.
- Prove you provided quality care by using clinical protocols and evidence-based medicine.
- Communicate the provision of the care.

The first two guidelines are relatively simple. As physicians, you’ve been doing this your entire careers. You may need some pointers on the third and fourth.

When you’re proving you’re providing quality care, you can be faced with a major dilemma. Quality is still somewhat subjective. If you ask a patient, they’ll probably focus on whether or not their outcome was favorable or they were comfortable with the process. If you ask the payers to define quality care, they can’t; not as a unit. Each payer evaluates care using different metrics. What do you do?

- Learn the metrics of each of your major payers.
- Consider Patient-Centered Medical Home (primary care) or Patient-Centered Specialty Practice (specialists) designation as your mode of practice. The concepts focus on streamlined, effective, evidence-based medical protocols that are designed to support an environment of quality care with optimal patient satisfaction.
- Embrace active listening skills. These skills go a long way towards understanding your patients’ needs and your ability to communicate effectively with them.
- Consider patient satisfaction surveys, even if you’re not required to conduct them yet. This will certainly help you know how your patients feel about your care and your practice and can give you direction on improving the overall patient experience.
- If you don’t use an EHR yet, and you want to participate in the future incentive programs payers will undoubtedly be offering, now is the time to make your commitment. Unlike many consultants, I don’t believe that every doctor should have an EHR—it depends on what their purpose is in making the investment. But I do believe that it will be easier to communicate your quality results if you have an EHR.

Create financial viability.

Financial viability is basically determined by two things: your cash inflow and your outgoing expenses. Pretty simple, in concept. But when external parties determine your inflows, there’s a lot of opportunity for financial instability. What will improve your financial viability?

- Streamline your office. This doesn’t necessarily mean downsizing staff, but it does mean ensuring that you’re operating as a Highly Reliable Organization (HRO). An HRO has the right resource in the right place at the right time. No wasted effort, no wasted resources.
- Accelerate your revenue cycle. It’s a terrible waste of our health-care dollars to have claims written off because they’re untimely; patient A/R six months and older; charge lags due to incomplete documentation; manual processes instead of capitalizing on available technology.

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The Five Key Strategies for Survival  continued from page 17

- Align your compensation with the reality of our industry. If you’re in a group practice and haven’t revisited your compensation formula in the last five years, put it on your to-do list. Look at how the basic tenets of the formula will play out in a value-based-payment world.

Manage your risk.

In one of the most highly-regulated industries in our country, risk is everywhere you look. Often we think only of malpractice risk, but that’s only one type. Compliance, operational and financial risks are significant in the medical practice:

- Compliance risk.
  - Develop an internal compliance plan that fosters an environment in which all staff and providers acknowledge their role in having a compliant revenue cycle.
  - Implementation of ICD-10 has come and gone with relatively few major hiccups. But now the real work begins as you internally audit your coding against the denials and input from payers. This can be tedious but is certainly not only for compliance reasons, but for smooth cash flow.

- Operational risk such as Human Resources, HIPAA and OSHA.
  - An effective employee handbook with current job descriptions will go a long way to ensuring your HR compliance. But appropriately screening and recruiting staff, and following insurance and COBRA regulations are just two areas in HR in which you need to stay compliant.
  - HIPAA gets more challenging all the time. Make sure your manual and forms are current. Conduct annual training, security risk analysis and privacy risk analysis. If you are unfortunate enough to have a breach in privacy, act promptly.
  - OSHA is often overlooked or underestimated as to its importance, but it’s very important. This is the regulatory area that looks out for the well-being of your staff. Be sure you’re following all current regulations and conduct annual training as well as compliance audits.

- Financial risk can be devastating to the future of your practice if it isn’t managed. What is financial risk? It can be exposure to embezzlement. It can be payment and reimbursement risk, such as risk-based payer contracts. But most importantly to the future of all medical practices is the financial risk associated with value-based-payments (VBP) and bundled payments.

  - VBP and bundled payments require collaboration. Even if you are not a member of an ACO, these payment models will be replacing our fee-for-service models within the next five years.
  - Identify who your future partners could be in this new payment world. Begin to align yourself now. Learn your costs associated with care. That will help you determine the financial viability of a contract proposed to you.
  - Be proactive. Consider your options now and start working on your plan of action.

Embrace technology as your practice’s foundation.

Technology should not be deployed just because it’s the new great toy. But technology sufficient for you to manage your practice and your patients is necessary. Technology, used effectively, will give you an edge in your practice.

- Business operations such as patient registration, benefits verification, claims processing, payment monitoring, banking and payment processing, can all be accelerated with the right investment AND utilization technology.

- Clinical workflows can be made more efficient. Although EHRs have not been proven to improve production for providers, certain facets of the patient encounter can be enhanced and have been effective. For instance, e-prescribing and patient portals.

- Social media and electronic patient communication are not going away. We’re in a digital world. If they are done well, these tools can build patient volume as well as patient satisfaction.

Your approach to each of these five strategies will be unique to you. But the foundation of your approach will be pretty common to other doctors’ experience. Work with your internal team, doctors and management. Network with your colleagues. Seek the support of external advisors. Whatever you choose to do and however you choose to approach these opportunities, one thing is certain. You will have the greatest odds of success by taking the first step—developing your plan for success and documenting it.

INDEPENDENCE VS. EMPLOYMENT

December 2015 / January 2016
A Tale of Practice Transition
The Cast of Players in Practice Integration

By Julie Guethler, MGMA of Greater St. Louis

Our play opens at a specialty medical practice with three physicians and three nurse practitioners. The practice has been in business 40 years but, in recent years, due to changes in health care, trends in insurance and the impending retirement of some of the partners, it had become difficult to recruit physicians. Many young doctors coming out of school seemed to be more interested in lifestyle than owning a business. There was a loyal staff of 10 that had many years of experience—this would become an important factor in the success of the transition. A well-established team will continue to work together.

Fast forward to the next scene—a conference room at a local hospital medical group where, assembled for the first time, an implementation team of HR, IT, Finance, Credentialing, Billing Office, Marketing and a few others as well as the practice manager. The COO, serving in an interim capacity, had gathered the parties together in one room. The timeline was tight—three weeks. This group would meet weekly and assignments were given to each area of expertise.

In the third act, the transition of this practice into the health system occurred in the tight time frame established. The manager sometimes liked to joke that they “crash landed” into the system but, actually, things went remarkably smoothly. This is not to say that challenges did not present themselves along the way but there were a few things that helped the “relatively smooth” crash landing. Here are a few keys that you may look for if your practice becomes a sequel to this play:

**Town Hall Meetings**

Representatives from Administration made quarterly stops to the office to inform of upcoming changes to the organization. This was especially important as one of the things that had to be delayed was the connection to the information systems. The meetings always allowed plenty of time for staff questions. Staff began to feel that their input was important.

**Meetings/Huddles**

For the first year, the manager stepped up her meetings and included daily huddles. As there was a new reality for the staff—to be connected to a larger institution—more was more when it came to communication.

**EHR**

When the practice converted from their electronic health records to the health system’s EHR, there was plenty of support. Changing EHR systems in some cases can be more challenging than from paper to EHR. Plenty of IT staff was available for weeks as the practice worked through the small issues as well as the larger. An outside service was hired to move important documents from one system to the other.

**Flexibility/Fun/Food**

The practice remained as flexible as possible and tried not to make everything so serious. When in doubt, they would bring in some snacks and hunker down. The cast needed to be nourished during these long days of rehearsing for the big performance. These little things can mean a lot to staff.

**Critic’s View**

How will the audience respond to this play? Time will tell. Is your practice facing a major change in its story? Hopefully this tale will provide some insights as you work toward your happily ever after. Leadership from physicians and managers, working hand-in-hand with system administration, sets the tone for staff and directs the result to the one we all want—a successful, quality practice that cares for its patients.

*Julie Guethler is an experienced practice administrator, working with physicians in both the practice management and consulting sides of the industry. In addition, Julie will assume the role of president of MGMA of Greater St. Louis in 2016. She can be reached at 314-420-1067 or guethler@sbcglobal.net.*

**SLMMS has established a partnership with the Medical Group Management Association of Greater St. Louis (MGMA), including sharing information across publications, across websites, through organizational committees, and via joint educational programs. For more information on MGMA, visit www.mgmastl.org.**
The Good of Medicare

The year 2015 marks the 50th anniversary of Medicare. President Harry Truman first enunciated the need for health insurance for the elderly, and President John Kennedy was working on a plan before he was assassinated. Medicare was enacted in 1965 during the Lyndon Johnson administration. The bill was signed by Johnson in Independence, Mo., the home of Harry Truman who became the first person enrolled in Medicare.

I started practice in 1963, a year and a half before Medicare began. I recall a patient about 65 years old who came to my office with chest pain. I hospitalized him at a private hospital. He had a myocardial infarction from which he recovered. Several months later he again came to my office with complaints of chest pain. His major concern was not his chest pain but that he had run out of insurance and could not afford private hospitalization. I arranged for him to be admitted to St. Louis County Hospital. In those days when patients had no insurance, they were admitted to a ward service at St. Louis City Hospital or St. Louis County Hospital. Medicare was a godsend for patients like the one I just described.

For the first 20 to 25 years, Medicare worked well with regard to cost to the taxpayer and the quality of care rendered to patients. Journalist Steven Brill showed in a landmark Time magazine article how Medicare brought under control the main driver of high health-care costs—the hospitals.1 In contrast to private commercial health insurance companies, Medicare accomplished this feat with very low administrative costs.

Medicare Advantage

A revolutionary change in Medicare occurred in 1973 during the Nixon administration when the federally backed Health Maintenance Organization (HMO) Act was passed. This law provided grants and loans to HMOs and required employers with 25 or more employees to make available federally certified HMO options if they offered traditional health insurance to their employees.2

This law is, in my opinion, the primary cause of America’s problems with cost and quality in health care. The bill was supported by both Republicans and Democrats as a strategy to lower rising health-care costs. This was a cruel joke because health-care costs in the U.S. at that time were not out of control and were similar to costs in other Western industrialized democracies.

Although the ostensible reason for introducing HMOs into health care was to lower costs, the real reason was to increase corporate profits. This is borne out by an excerpt from the Nixon tapes in a transcript of a 1971 conversation between President Richard Nixon and his aide John D. Ehrlichman that ultimately led to the HMO act of 1973. There are some gaps in these tapes:

Nixon: “You know I’m not too keen on any of these damn medical programs.”

Ehrlichman: “Edgar Kaiser is running his Permanente deal for profit. And the reason that he can do it … I had Edgar Kaiser come in … talk to me about this and I went into it in some depth. All the incentives are toward less medical care, because … the less care they give them the more money they make”

Nixon: “Fine.”

Ehrlichman: “… and the incentives run the right way.”

Nixon: “Fine.”

Arthur Gale, MD, is a past president of SLMMS and frequent contributor to St. Louis Metropolitan Medicine and Missouri Medicine. His writings over the past five-plus years have been compiled into a new book, A Doctor’s Perspective on Medical Practice in the Twenty-First Century, available on Amazon.com. Dr. Gale can be reached at agalemd@yahoo.com.
This excerpt neatly sums up the purpose of HMOs from its earliest origins. Nixon told his friends who supported and initiated this law that they could make a lot of money from HMOs. And HMOs have lived up to this expectation in spades. It also explains why health-care costs are so much higher in the United States than in other industrialized nations. Health-care costs in the United States were about the same as other industrialized democracies until the 1980s. Then, managed care and HMOs took off and so did America’s health-care costs.

Figure 1 clearly documents this. Health-care per capita spending in the U.S. was about equal to other industrialized nations like Canada, the United Kingdom and Switzerland, etc., until about 1980. Then the graph shows a steep rise in health-care costs in the U.S. compared to other countries, which has persisted to the present day. This steep rise coincides with the advent and takeover of the U.S. health-care delivery system by commercial and Medicare managed care.

In the 1980s and 1990s corporate managed care stepped in and “fixed” a system that was not broken. In an Orwellian twist, Medicare policymakers now blame fee-for-service for the high cost of health care, despite the fact that standard Medicare—which is also known as Medicare Fee for Service (FFS)—annually costs the American taxpayer about $14 billion less than Medicare Advantage, Medicare’s managed care commercial private for-profit plan. It has been estimated that Medicare subsidies to Medicare managed care insurers over the past three decades have amounted to over $280 billion.

Consumers are only concerned about how much they pay out of pocket—not what it costs the government and ultimately the taxpayer. So they think that Medicare Advantage is a good deal. The big health insurance companies, like United Health Care and Humana, love Medicare Advantage because it is their most profitable product. Medicare Advantage is a prime example of corporate welfare.

### Accountable Care Organizations

Accountable Care Organizations (ACOs) are the newest government program designed to lower health-care costs under Medicare. The easiest way to understand ACOs is to acknowledge that they are just another form of HMO using capitation instead of fee-for-service. Under ACOs, doctors and hospitals will be financially rewarded if they meet certain goals or benchmarks. This is called “shared savings.”

The most controversial aspect of ACOs is that doctors will be at financial risk. Financial risk pits the financial incentives of doctors against the medical interests of patients. These perverse financial incentives were tried in the 1990s under the old gatekeeper HMOs. For the short time gatekeeper HMOs were in force, they did lower health-care costs. However, when the public found out what actually was going on with their health, i.e., doctors were padding their own pockets by denying needed care, their fury knew no bounds. This new form of rationing care won’t work because ultimately the public will find out what risk contracts really are, and again will reject them as they did with old gatekeeper HMOs.

### Quality of Care

What about the quality of care in Medicare today? The government through CMS is using its new toy, the electronic health record (EHR), to measure “quality” through the Physician Quality Reporting System (PQRS). This is being done in all three modes of health care delivery: fee-for-service, Medicare Advantage and Accountable Care Organizations. Supposedly by checking boxes on patients’ blood pressure, weight, exercise, cholesterol, etc., quality is improved. And doctors are rewarded financially if they check all the boxes correctly. It’s as if physicians were not discussing these issues with patients before these EHR metrics were introduced.

Quality of care should be equated with time spent with patients, not box checking. This is especially true with elderly patients with multisystem diseases who have many concerns and need time to express them.

### Medicare Part D

Medicare Part D is the Medicare drug program passed by Congress. It is an example of padding the bottom line of the pharmaceutical and insurance companies at the expense of Medicare beneficiaries and ultimately the taxpayer. Part D does not allow Medicare to directly negotiate drug prices with health plans as it does with the Veterans Administration. Veterans pay much less for pharmaceuticals than Medicare beneficiaries. Medicare members must pay a price for drugs that is a result of negotiations between drug companies and insurance plans, and as a result, the cost of drugs to a Medicare patient may be up to 80% more than what a veteran pays for the same drug.

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* 2012. Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers. Source: OECD Health Data 2013.

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Figure 1

Health Care Spending as a Percentage of GDP, 1980–2013

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<td>10.7%</td>
<td>10.2%</td>
<td>11.0%</td>
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continued on page 25
Students Present Speeches at MAC Luncheon

By Gill Waltman, SLMMS Alliance

The Alliance Voices of Excellence program for Loyola Academy of St. Louis culminated on Sept. 29 when 11 winners presented their speeches before a group of Alliance members and parents gathered for a luncheon at the downtown Missouri Athletic Club. In the program, students from the Jesuit middle school for boys wrote a five-paragraph essay and gave a speech on preventing violence in the community. Alliance members coached them in practicing their speeches. Recognition continued on Oct. 10 when the winners spoke before Alliance members at the North Central States conference.

North Central States Leadership Development Conference

MSMA Alliance President Sue Ann Greco and Kansas Alliance President Michelle Voth co-hosted about 30 Alliance members from North Central States at the Sheraton Clayton Plaza Hotel on Oct-9-11. Besides attending workshops, they toured Saint Louis University Medical School’s Health Resource Center. Located at 1408 N. Kingshighway, the clinic offers free primary care services in an academic environment.

SAVE Day

The 20th anniversary of “Stop America’s Violence Everywhere” (SAVE) was observed during October. Sandra Murdock conducted several Hands Are Not for Hitting programs at local schools.

Annual MSMA Alliance Fall Conference

MSMA Alliance members met in Columbia for the annual fall conference Oct. 20-21. Beth Dessem, executive director of the Missouri Court-Appointed Special Advocates Association, talked about CASA volunteers who advocate for abused and neglected children through local CASA organizations. Sue Ann Greco has been a CASA volunteer for five years; additional volunteers are needed around the state. Alliance members assembled fleece blankets for the children’s shelter at Rainbow House, the CASA program in Columbia.

R. Douglas Schwandt, campus police chief at the University of Missouri-Columbia, spoke on curbing campus sexual assault. Alcohol is almost always involved. He emphasized the need to encourage coeds to report assaults.

Thanks to Holiday Sharing Card Contributors

The following SLMS and Alliance members and friends contributed to the 2015 Holiday Sharing Card with donations to the American Medical Association Foundation and the Missouri State Medical Foundation.

- Sally and Erol Amon, MD
- Claire and Thomas Applewhite, MD
- Gregg Berdy, MD and Ranjan Malhotra, MD (Ophthalmology Associates)
- Millie and Grant Bever, MD
- Chris and George Bohigian, MD
- James Braibish and Diane Hamill, OD
- Rima and Edmond Cabbabe, MD
- Sophia Chung, MD, and John Holds, MD
- Pat and Jon Dehner, MD
- Sue Ann and Thomas Greco, MD
- Carrie Hruza, OD, and George Hruza, MD
- Sandra and Nathaniel Murdock, MD
- David and Jill Nowak
- Kelly and Timothy O’Leary, MD
- Jackie and George Paletta, MD
- David E. Perkins, MD
- Mrs. Jean Raybuck
- JoEllyn Ryall, MD
- Leena and Ravindra Shitut, MD
- Gill and Stephen Waltman, MD
- Mrs. Angela Zylka

Become an Alliance Member!

For membership information, contact Membership VP Angela Zylka, angelazylka@gmail.com.
Joseph J. Lauber, MD

Joseph J. Lauber, MD, board certified in family practice, died Sept. 20, 2015, at the age of 86. Born in Indianapolis, Dr. Lauber received his undergraduate degree from University of Notre Dame in 1951 and his medical degree from Saint Louis University School of Medicine in 1955. He served in the U.S. Army from 1957 to 1961.

Dr. Lauber was on staff at Mercy Hospital St. Louis and was the first chairman of the Department of Family Medicine. He created and headed the hospital’s family practice residency program.

In 1961, Dr. Lauber joined the St. Louis Metropolitan Medical Society and became a Life Member in 2001.

Dr. Lauber was preceded in death by his wife, Ellen Godfrey Lauber and two children, Bill Lauber and Terese Lauber.

SLMMS extends its condolences his children, Joe Lauber, Mary Lauber, Gerry Lauber, Cindy Guterriez and Louise Boyle; his 10 grandchildren and three great-grandchildren.

G. Russell AufderHeide, MD

G. Russell AufderHeide, MD, board certified in internal medicine, died Oct. 13, 2015, at the age of 97.

Born in St. Louis, Dr. AufderHeide received his undergraduate and medical degrees from Washington University. His internship was served at St. Luke’s Hospital. Dr. AufderHeide served in the U.S. Army as a battalion surgeon for the 273rd Field Artillery Battalion during WWII. He was severely wounded rescuing an injured soldier in Luxembourg in late 1944.

He was in private practice in north St. Louis for nearly 50 years and was on staff at St. Luke’s Hospital.

Dr. AufderHeide joined the St. Louis Metropolitan Medical Society as a resident in 1943.

He was preceded in death by his wife, Louise AufderHeide. SLMMS extends its condolences to his children; Janis AufderHeide, Joan AufderHeide and John AufderHeide, MD; his three grandchildren and two great grandchildren.

Robert Potashnick, MD

Robert Potashnick, MD, board certified in internal medicine with a specialty in cardiology, died Oct. 19, 2015, at the age of 101.

Born in St. Louis, Dr. Potashnick received his undergraduate and medical degrees from Saint Louis University. He completed his internship at St. Louis City Hospital and his residency at Robert Koch Hospital.

Dr. Potashnick served in the U.S. Army from 1943 through 1946.

Practicing internal medicine for over 50 years, he was on staff at the SSM Health Saint Louis University Hospital, SSM Health DePaul Hospital, Barnes-Jewish Hospital and SSM Health St. Mary’s Hospital. He was on the faculty of Saint Louis University School of Medicine.

Dr. Potashnick joined the St. Louis Metropolitan Medical Society as a resident in 1938. He became a Life Member at his retirement.

SLMMS extends its condolences to his wife, Myra Potashnick; his children; Pam Frank, Greg Potashnick, Suzanne Goldstein, Judith Bensinger Haynes, and Scott Bensinger; his six grandchildren and four great grandchildren. He was preceded in death by his first wife, Irma Potashnick.

Stuart Weiss, MD

Stuart Weiss, MD, board certified in neurology and pediatric neurology, died Oct. 27, 2015, at the age of 85.

Born in St. Louis, Dr. Weiss received his undergraduate and medical degrees from Washington University. He completed his internship at Barnes-Jewish Hospital and his residency at New York Neurological Institute.

He was professor of neurology at Washington University School of Medicine. He served on staff at Barnes-Jewish Hospital, St. Louis Children’s Hospital and St. Luke’s Hospital. He also served as a consultant to the Pediatrics Division at the former St. Louis City Hospital. He received awards including the School of Medicine’s Alumni Faculty Award and Barnes-Jewish Hospital’s Dr. Neville Grant Award for Clinical Excellence along with the Medical Staff Association Appreciation Award.

Dr. Weiss joined the St. Louis Metropolitan Medical Society as a resident in 1961, and became a Life Member at his retirement.

SLMMS extends its condolences to his wife, Marlita Wennerman Weiss; his children; Lori Weiss, MD, Michael Weiss, and Debra Weiss; and his five grandchildren.
Mercy Opens Virtual Care Center

Mercy calls its new Virtual Care Center in Chesterfield “the world’s first facility dedicated entirely to care outside its own walls.” Opened in October, the Virtual Care Center houses Mercy’s telemedicine programs including:

- **Mercy SafeWatch** – As the largest single-hub electronic intensive care unit (ICU) in the nation, its doctors and nurses monitor patients’ vital signs and provide a second set of eyes to bedside caregivers in 30 ICUs across five states.

- **Telesstroke** – Patients in community ERs with symptoms of a stroke can be seen immediately by a neurologist via telemedicine.

- **Virtual Hospitalists** – Seeing patients within the hospital around-the-clock using virtual care technology.

- **Home Monitoring** – Continuous monitoring for hundreds of chronically ill patients in their homes after hospitalization.

The exterior of the 125,000-square-foot, four-story building is visible at the southeast corner of Interstate 64 and Clarkson Road.

MD News

- **Richard L. Wahl, MD**, (SLMMS), the Elizabeth E. Mallinckrodt Professor and head of radiology at Washington University School of Medicine, has been elected to the National Academy of Medicine, formerly known as the Institute of Medicine. Dr. Wahl is among 70 new members and 10 international associates whose elections were announced in October. Members are selected based on their professional achievements and commitment to service.

Insurance Companies

- **Susan Tenney** has been named vice president of sales and marketing for MPM-PPIA, a physician-owned professional liability insurance company. Her experience in the industry spans more than 35 years, with 22 years of that in medical malpractice, working on both the provider and client sides. She directs MPM-PPIA’s statewide sales network and works directly with physicians and group managers to serve their needs for professional liability coverage.

Another organization that affords physicians the benefits of independence and a large system is Signature Medical Group, Inc. Signature has more than 130 physicians in 29 practices at 46 locations in St. Louis, Kansas City and other areas. Its physicians cover primary care and surgery plus a wide range of specialties including orthopedics, Ob/Gyn, urology and more.

While practices that join Signature retain their assets and their doctors become shareholders in Signature, their practice staff become Signature employees and participate in common benefits plans. Practices gain value from economies of scale and a common electronic health records system.

“We are responding to the change from volume to value,” said Jan Vest, Signature CEO. “We have the ability with analytics and managed care initiatives to help physician practices become more successful in managing value-based contracts.”

Signature is the only physician practice in the nation to be named a convener in the Medicare Bundled Payments for Care Improvement Model 2 initiative, he said. In this program, Signature is managing some 4,500 joint replacements each month around the country. In another population-management program, Signature has helped high-risk Medicaid mothers reduce pre-term delivery rates by 50 percent.

As patients deal with high-deductible insurance plans and narrow networks, Signature’s independent physicians present a cost advantage compared to hospitals, Vest said. “We are well-positioned to be the high-quality, more valuable choice to the patient.”

As physicians examine whether their paths are to employment, independence, or a large-group affiliation such as SLPA or Signature, the decision in the end is an individual one based on one’s personal circumstances and preferences.

Reference

None of this is likely to happen, at least in the near future, because our dysfunctional Congress is owned by the special interests who profit from maintaining the status quo. The non-partisan Congressional Budget Office (CBO) predicts that the Medicare Trust Fund will run out of money in 2030 or in about 15 years. A true financial crisis might force the government to make some of the necessary changes described above. Whether the government and the American people have the will to make these changes remains to be seen.

References
3. University of Virginia Miller Center, transcript of taped conversation between President Richard Nixon and John D. Ehrlichman that led to the HMO act of 1973, February 17, 1971, 5:26 p.m.-5:53 p.m.

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One of the coauthors of this giveaway bill was Rep. Billy Tauzin (R-La.) chairman of the House Commerce Committee. After the bill was passed, Tauzin quit Congress and took a job as chief lobbyist for Big Pharma at $2 million per year. The head of CMS (the Center for Medicare and Medicaid Services) at the time, Thomas Scully, later returned to the private sector and resumed his career as a health-care lobbyist. Medicare pays physicians directly. Why should the pharmaceutical companies be paid differently?

Conclusion

If the government through CMS was serious about lowering Medicare costs and improving quality, it would stop focusing on physicians and blaming fee-for-service for all of the ills of our health-care system. Instead of relying on gimmicks like Medicare Advantage and ACOs, it would eliminate them entirely. The government should also cut out the insurance company middle men in Medicare Part D and purchase drugs directly from the pharmaceutical industry for its Medicare beneficiaries. And of course the hospitals—the main driver of high health-care costs—must be reined in. As noted above by Brill, only Medicare has the power to lower out-of-control hospital charges.
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