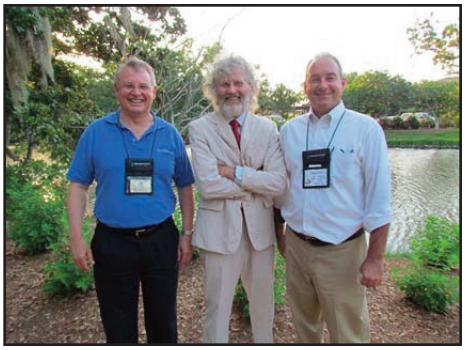
Alabama Chapter, American College of Surgeons Journal

July 2013

Alabama Chapter, ACS Annual Conference
June 13-15, 2013
The Grand Hotel, Marriott Resort, Golf Club and Spa



A quarterly publication of the Alabama Chapter of the American College of Surgeons

Letter from the President

**Mary Hawn, M.D.
Alabama Chapter,
American College of
Surgeons, President**

Dear Colleagues,

I am honored to serve as your president during the upcoming year. Our Chapter remains strong and we have many activities planned for the upcoming year. On behalf of the chapter, I would like to thank immediate past-president David McKinley for his hard work over the past year!

Our annual meeting at the Grand Hotel in Point Clear was replete with updates in clinical care and panel sessions on important policy changes coming our way. Several talks on state legislative issues stressed the importance of advocacy in ensuring the needs of our surgical patients are considered in policy development.

We encourage our members to participate in Lobby Day in Montgomery, the opening day of the Legislative Session as well as the evening of Governor Bentley's State of the State Address. This event will occur in February 2014 and we will keep you informed as we learn more about the event.

As your president, I will be attending the American College of Surgeons Leadership and Advocacy Summit will take place March 29-April 1 in Washington, DC. There will be opportunities to meet with members of Congress and mingle with American College of Surgeons Colleagues at receptions. The chapter has committed to sponsoring three members to attend the Summit this year. If you are interested, please contact Lisa Beard for more information.

In an effort to engage our trainees and young surgeons, we have appointed three resident members for two-year terms to the executive council of the Chapter. The resident members will work with chapter members to develop a career day program for trainees and students in the state. They will also attend the Leadership Summit in DC and plan a panel session for the 2014 meeting. I look forward to their active participation in our Chapter!

Last year, the Alabama Chapter of the ACS co-sponsored a reception at the ACS meeting in Chicago with the Departments of Surgery at UAB and USA. We look forward to continuing this tradition and hope you will stop by the reception on Monday, October 7th from 5-7pm. More details to follow.

Stay tuned to our newsletters and website for important updates on state legislative issues and activities of the chapter!

Best,
Mary Hawn, M.D., FACS
President, Alabama Chapter
American College of Surgeons

Alabama Chapter, ACS Annual Conference
The Grand Hotel, Marriott Resort, Golf Club and Spa

The Alabama and Mississippi Chapters of the American College of Surgeons held its annual conference June 13-15 at The Grand Hotel Marriott Resort in Point Clear, Alabama. Surgeons from both states gathered to hear panel discussions on topics such as: Inspiring Quality: Highest Standards; Diverticulosis/Diverticulitis; a Legislative Update, Lymphadenectomy; High Value Surgical Care and Foregut Pathology.

We were pleased to welcome John M. Daly, MD, FACS, Second Vice-President of the American College of Surgeons who gave an update from ACS. Poster Presentations were given by 10 residents from programs including: Baptist Health System, University of Alabama at Birmingham and University of South Alabama. The James G. Donald, II Memorial Residents Paper Award was given to: Yann-Leei Lee, MD for his presentation on Elevated mtDNA CAMPs are Linked to Outcome in the Severly Injured as well as Melissa L. Korb, MD for her presentation on Use of Optical Imaging to Improve the Surgical Resection of Breast Cancer. The William A. Maddox Cancer Award was given to Brett Broussard, MD for his presentation on Multi-targeted approaches in the treatment of Pancreatic Ductal Adenocarcinoma (PDAC). The Doyle Haynes Memorial Trauma Award was given to Christopher Richardson, MD for his presentation on Transesophageal Echocardiography may be Superior to Pulmonary Artery Catheterization in the Trauma/Burn Intensive Care Unit. Recognition was given to Dr. David McKinley, MD, FACS for his year of services as President of the Alabama Chapter.

We appreciate those who attended the conference and hope you will make plans to join us in 2014 at Sandestin Beach & Golf Resort, June 12-14.

Physician Payments Sunshine Act...Important Dates

In August, manufacturers of drugs, medical devices, and biological agents will begin tracking physician payments as required under the Physician Payments Sunshine Act. The law requires manufacturers to track certain payments to physicians and teaching hospitals and then report those outlays annually to the Centers for Medicare & Medicaid Services (CMS). Manufactures and group purchasing organizations also must report certain ownership interests of physicians and immediate family members. Physicians will be neither penalized nor required to take any action under this legislation. However, physicians will have the right to review and challenge their reports.

Important deadlines associated with tracking and reporting are as follows:

• August 1–December 31:
Manufacturers must begin tracking payments to physicians and physician ownership information.

• January 1, 2014:
Physicians will be able to register for a CMS online portal used to view reports.

• March 31, 2014:
Manufacturers will begin submitting reports to CMS.

• June, 2014:
CMS will provide physicians with access to their reports via the CMS portal. Physicians will be able to contact manufacturers through the portal to correct errors in the reports.

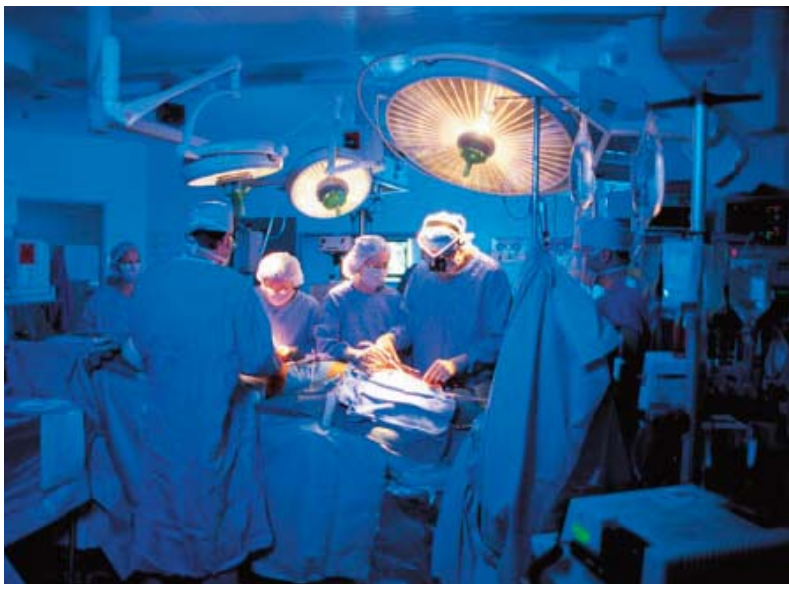
What surgeons can do now: (1) ensure that all financial disclosures and conflict of interests are current and regularly updated, and (2) if you have a National Provider Identifier (NPI), be sure that the information is up-to-date and the specialty designation is correct. Manufacturers will use the NPI, and other information to identify physicians. View the CMS fact sheet for additional information. Access the NPI enumerator database to check your NPI information.

ACS Continues Push to Reform the Medicare Physician Payment System

On July 11, the American College of Surgeons (ACS) responded to a second version of the House Energy and Commerce Committee's legislative draft proposal on reforming the Medicare physician payment system. This is the fifth response the ACS has sent to Congress this year concerning the Medicare physician payment system. The ACS also testified before Congress twice this year.

The proposal is legislative text that the Energy and Commerce Committee has drafted, which lays out the framework to scrap the existing sustainable growth rate (SGR) formula used to determine Medicare physician payment in favor of an improved fee-for-service system that would allow physicians to opt-out in favor of new ways of delivering care. The members of the committee and the College agree that repealing the SGR is the first step toward true payment reform.

Although the ACS appreciates the committee's efforts to craft the proposal, much work still must be done to develop a viable replacement for the SGR. The Energy and Commerce Health Subcommittee is expected to release a final draft of the plan in the coming days and then convene for a markup Monday, July 22. The College anticipates that a full committee markup will occur sometime before the August congressional recess.



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July 17, 2013

Mary T. Hawn, MD, FACS
President, Alabama ACS Chapter
University of Alabama
1530 3rd Ave South, KB428
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Dear Dr. Hawn:

Your Chapter's donation of $1,500.00 to the American College of Surgeons Foundation has come to our attention, and we wanted to thank you personally. This generous contribution will help the College to enhance key initiatives that provide fellowships/scholarships to promising young surgeons, improve surgical outcomes, and sponsor continuing education programs that ensure the expertise of our surgeons.

Over the years, your chapter's giving totals $19,000 and we hope that we may count on your chapter in the future. Similarly, we are so impressed that the individual members of your chapter contributed $4,540 in the past year – this, to us, signifies both affection and trust in what the College is trying to accomplish.

One of the ways the Foundation will strengthen the relationship is by keeping your Chapter informed on what we do – and why we do it. In addition to providing donor recognition, our electronic quarterly newsletter, *Philanthropy at Work,* which you will now receive, and our Annual Report give insight into how donor funds support the College's mission. You and your members can review archived copies of these publications at http://www.facs.org/acsfoundation/.

As the Co-Chairs of the Chapter and Affiliates Relations Committee it is our pleasure to promote philanthropy among our peers. If we can answer any questions you may have in this regard, please do not hesitate to contact us at any time.

Again, thank you for your generous and loyal support!

Best wishes,

Am so proud of the AL chapter!

Jon

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Practice Management Corner

Regional Care Organizations

Legislation passed by the 2013 Alabama Legislature calls for the state to be divided into regions and that a community-led network coordinate the health care of Medicaid patients in each region, with networks ultimately bearing the risks of contracting with the state of Alabama to provide that care.

The Alabama Medicaid Agency would have to draw regions by October 1, 2013, and regional care organizations would have to be ready to sign contracts no later than October 1, 2016.

In order to implement RCOs in Alabama, the federal government must approve an exception, or waiver, to the existing program. This will be done in the form of an 1115 Waiver.

RCO Timeline (Medicaid)

- 10/01/2013 – RCO regions established
- 10/01/2014 – RCO governing boards approved by Medicaid
- 04/01/2015 – RCO provider networks in place
- 10/01/2015 – RCO must meet solvency requirements
- 10/01/2016 – RCO accepts capitation payments from Medicaid

Planning Principles to be Included in Regulation (Medicaid)

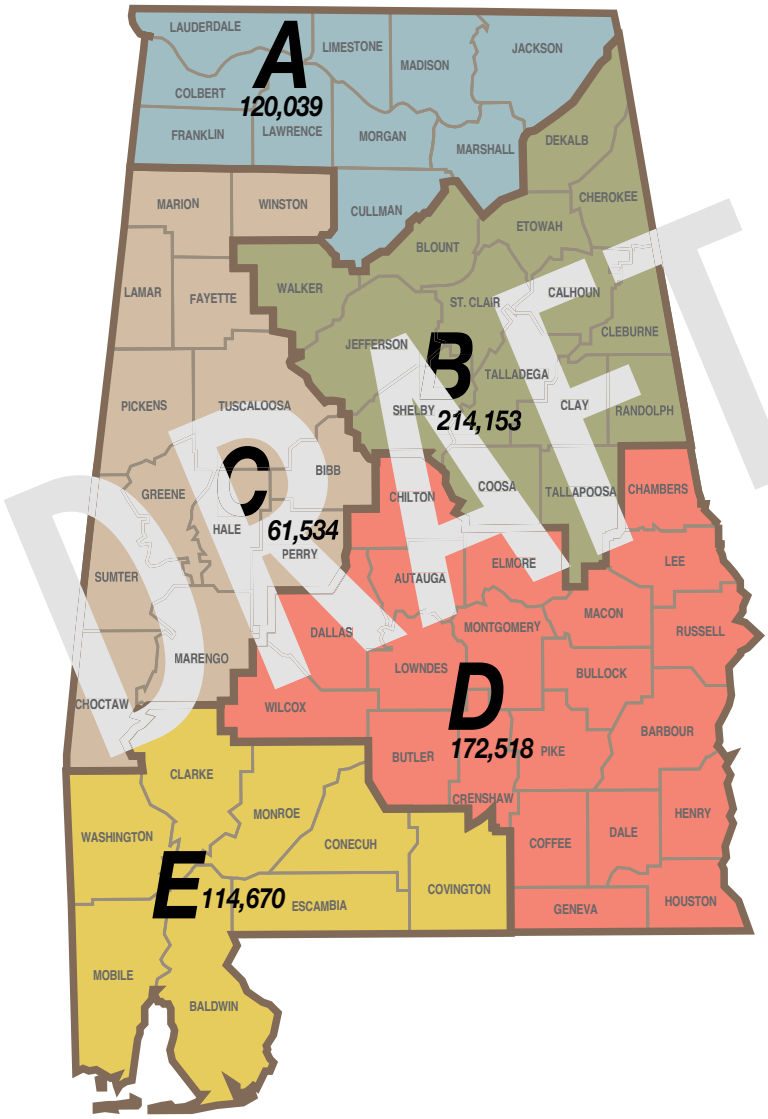
- One RCO per region.

- Member's residence determines RCO regional assignment for capitation.

- Any willing provider applies not only within region, but also across regional lines. For example, physicians and hospitals will be able to contract within their region as well as with adjacent regions.

- Medicaid will establish a floor for applicable provider payments for all regions, including out–of–region contracts.

5 REGIONS



FAQs on Medicaid "Transformation"

Alabama's Medicaid program is on its way to being fundamentally transformed from a fee-for-service model to managed care model of care delivery. But instead of contracting with commercial managed care organizations to deliver care to Medicaid beneficiaries, the state is allowing the creation of locally-run regional care organizations (RCOs) to coordinate care delivery.

While some things about the transformation are known and certain, many rules and regulations must still be drafted and adopted before the first patient is seen under the new delivery mechanism.

Below is a list of frequently asked questions on the legislation, SB 340, which is the vehicle that will enable the transformation of Alabama's Medicaid program.

Q: WHAT IS AN "RCO?"

A: RCO stands for "regional care organization," an organized group of physicians, hospitals and other providers of Medicaid services in a group of counties in the state. The organization could be a limited liability corporation or a for-profit or some other type organization but those participating in the organization will contract with the state to provide care to all Medicaid patients in that region. Each RCO contracting with Medicaid to deliver care in its respective region must be approved by the Medicaid Agency. Each RCO will provide services to Medicaid beneficiaries either through the RCO or through contracts with other entities. An RCO must contract with any physician, hospital or other provider willing to accept the payments and terms offered to comparable providers. Eventually, RCOs will become risk-bearing entities.

Medicaid will collect and publish information (unless protected by law) regarding quality, cost and outcomes for each RCO. RCOs must meet minimum solvency requirements for operation or submit proof of a bond guaranty in an equal amount of the solvency requirements to the Medicaid Agency as one of the requirements for approval as an RCO for a region. Each RCO will also have to issue periodic reports, financial and otherwise, to Medicaid. All data reported to Medicaid shall be consistent with HIPAA requirements. Medicaid will also conduct audits of each RCO at least every three years. At intervals, each RCO will be evaluated by Medicaid to determine whether the Agency will enter into a continuing contract for care delivery by that RCO for the region it serves.

Q: HOW WILL THESE "REGIONS" FOR CARE DELIVERY BE SET UP?

A: The state will be carved up into care regions, which Medicaid will ensure are actuarially sound. While it will be up to the Medicaid Agency to determine the number of regions and their geographic boundaries, the state will likely end up with between 5 and 10 regions. Each of these regions must be capable of supporting at least two RCOs that agree to provide a comprehensive package of Medicaid benefits to Medicaid beneficiaries in a defined region of the state. Medicaid beneficiaries will be assigned and enrolled to a care region by Medicaid and those falling within a region with two RCOs will be given a choice or assigned to one.

Q: HOW WILL THE RCOs BE PUT TOGETHER AND HOW WILL THEY OPERATE?

A: Physicians, hospitals and other entities providing health care services to Medicaid beneficiaries within each of the Medicaid actuarially-sound regions will have to come together and organize as RCOs, which are explicitly not considered insurance companies under the law. Each RCO shall have a medical director, who is a primary care physician, and a governing board of 20 members who fall into one of two categories: (1) 12 risk-bearing members, who contribute either capital, cash or other assets to the RCO, to include physicians or others providing health care services who agree to a capitated payment rate to treat beneficiaries; and, (2) 8 non-risk bearing members to include three primary care physicians, one optometrist, one pharmacist and three community representatives.

For those members in category (2), two of the primary care physicians shall be appointed by a caucus of county boards of health in the region while the third shall be from a Federally Qualified Health Center. These physicians and the optometrist and pharmacist serving on the board must work in the region served by the RCO and they can be neither risk-bearing participants in the RCO nor an employee of a risk-bearing participant but they can still contract with the RCO on a fee-for-service basis. The three community representatives in category (2) are a business person in the region and two representatives nominated from the region's citizens' advisory committee, made up of Medicaid beneficiaries and patient advocacy groups. No single type of health care service provider, whether physician or otherwise, may have a majority membership on the RCO board. Additionally, other safeguards exist to ensure physicians have a strong voice in decisions made by each RCO governing board.

FAQs on Medicaid "Transformation", continued

Q: CAN COMMERCIAL MANAGED CARE RUN ONE OF THESE REGIONS?

A: While an RCO may contract with an alternate care provider or commercial managed care company, only under certain limited circumstances may such an entity be allowed to fully manage delivery of health care services in a region. Those circumstances include the failure or termination of an RCO in the region; the lack of an RCO or any other organization in the region willing to accept management of care delivery for the region; and, the lack of any other established or probationary RCO elsewhere in the state willing to attempt establishing an RCO in the region in question. Any alternate care provider or commercial managed care company that contracts with Medicaid to provide health care services in a region shall be subject to the same network adequacy requirements as an RCO.

Q: IF WE'RE MOVING AWAY FROM FEE-FOR-SERVICE, HOW WILL PAYMENT RATES BE DETERMINED?

A: Medicaid will determine the capitated payment rate per-beneficiary to the RCOs. The governing board of each RCO will then determine how to apportion that payment amongst physicians and others providing health care services within the RCO, for both fee-for-service and at-risk contracts. Some physicians will elect to continue seeing Medicaid patients on a fee-for-service basis, such as those in category (2) of the RCO governing board. For those electing to enter into a "risk-reward" contract with an RCO, the "risk" is the capitated payment per beneficiary. If quality care is provided to patients for less than the capitated amount, those participating as at-risks physicians will share in the "reward" of those savings. This is the reason for the solvency requirements for each RCO - if the cost of care exceeds the capitated amount, the RCO's reserve can be accessed to cover the cost of that care. In Alabama's Medicaid "transformation," the financial risk of caring for patients shifts from the state to each RCO for the patients served in that region.

Q: ARE THERE ANTI-TRUST CONCERNS FOR PHYSICIANS?

A: The legislation specifically addresses that concern to provide safeguards for physicians. Because physicians, hospitals and others participating in the RCOs will be collectively negotiating and bargaining with one another to establish payment models for care delivery, the Medicaid Agency will play a direct supervisory role in that process to ensure protection from federal and state anti-trust laws. Physicians wishing to collectively participate will need to receive a certificate from the Medicaid Agency in order to collaborate with other entities, individuals or RCOs.

Q: HOW WILL QUALITY STANDARDS BE ESTABLISHED?

A: Medicaid will establish a Quality Assurance Committee appointed by the commissioner. At least 60 percent of those on the committee will be physicians who participate in one or more RCOs in the state. The committee will assess outcome and quality measures for all services provided to Medicaid beneficiaries and all measures must be consistent with state and federal quality guidelines.

Q: HOW WILL CLAIMS REJECTIONS AND GRIEVANCES BE HANDLED?

A: Medicaid will establish a timely procedure for wrongful denial of claims and develop rules for the appeals process for this and for addressing grievances of Medicaid beneficiaries. The first step for rectifying the purported wrongful denial of a claim will be an immediate appeal to the RCO's medical director, whose decision shall be binding on the RCO. If the physician or patient filing the initial appeal is dissatisfied with the medical director's decision, an appeal may be filed for a hearing before a peer review committee composed of three RCO-participating physicians of the same specialty practicing within the region. If the physician or patient filing the initial appeal is dissatisfied with the peer review committee's decision, an appeal may be filed with the Medicaid Agency. If the physician or patient filing the initial appeal is dissatisfied with the Medicaid Agency's decision, the physician or patient may file an appeal in circuit court.

Q: WILL THIS SOLVE THE PERPETUAL MEDICAID FUNDING CRISIS?

A: Unfortunately, no. The current Medicaid budget utilizes roughly 30 percent of the State General Fund, which also funds corrections and most non-education state spending. The current economic slump the state and nation are in has caused the Medicaid rolls in Alabama to increase by about 200,000 people since 2008 when the recession began. State lawmakers are hopeful the transformation from fee-for-service to RCO-run managed care will improve outcomes and reduce future growth in the General Fund budget.