Ranks of Family Medicine Grow for Fourth Consecutive Year

PG 11
“As physicians, we have so many unknowns coming our way...

One thing I am certain about is my malpractice protection.”

Medicine is feeling the effects of regulatory and legislative changes, increasing risk, and profitability demands—all contributing to an atmosphere of uncertainty and lack of control.

What we do control as physicians: our choice of a liability partner.

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To learn how we can help you lessen the uncertainties you face in medicine, scan the code with your smartphone camera.
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Attention Providers!

GET READY!

New immunization requirement for 6th grade entry

Beginning with the 2010-2011 school year, a dose of Tdap vaccine is required for Alabama students age 11 years or older, entering the 6th grade.

This requirement increases by one successive grade each year for the following 6 years to include sixth through twelfth grades, through the fall of 2016.

For the school year 2013-2014, all students in grades 6-9 not previously receiving Tdap at age 11 years or older are required to have a Tdap vaccination.

*For questions, please contact the Immunization Division at 1-800-469-4599.

ADPH.ORG
Mrs. K. is a 63-year-old divorced woman who runs a small alterations business. She was diagnosed with diabetes when she was in her 50s. She was told on many occasions that she had to take care of herself, but she didn’t go to the doctor regularly because she was too busy. She would call and get refills, would have them denied and go without for three to four months at a time. Her BMI was above 30 at the time of diagnosis and remained so. Her systolic blood pressure was always above 140 at the times of her visits, but she was frequently out of her meds. Last year, she developed chest pain. She also suffered greatly from heartburn, but these pains were different. For each of these episodes, she would be treated either in the emergency room or be hospitalized and had two heart catheterizations (the first demonstrated subacute blockage, and then her enzymes “bumped” with a severe angina episode). Her hospital bill for the past year was $800,000, of which her insurance company paid $350,000 to her physicians and to the hospital. Of that, the family doc received $300 (four office visits).

We all know this patient. We have all taken care of this patient. We shake our heads in the doctors’ lounge and ask, “How is health care reform going to fix this?”

Remember the Cuyahoga River in Cleveland? It was polluted for years, and no one thought much of it. Then it caught on fire, and people said, “Enough.” Fixing that problem took years and a concerted effort by many engaged people, including the industrial plants that were causing the pollution. For those of you who were with me watching Escape Fire in Tuscaloosa, our health care “river” is on fire, and we are being asked to participate in not only putting it out but in being a part of the solution. When asked, we have no choice but to say yes.

Our job will be, in part, to convince the patients that they have “skin in the game.” It begins when they come to their first visit. Our practice material should explain what primary care is, what a medical home is and how to access our services. Second, we will be asked to support our patients in self-care. We will need to identify and aggregate resources to help our patients combat their chronic illnesses. We will need to get good at counseling patients to make their own decisions about things such as advanced directives. Lastly, we are going to have to give our patients written information regarding their visits, probably including visit notes.

“But,” you say, “I’m already good at these things.” “Or,” you say, “I would be better at these things if I were paid more.” To this, I will say that being good requires demonstrating that you provide quality care. This will be measured, at least in part, by how well your patients do, and it is happening in other states. Being paid better will require that you do and document that you do these things well, and it is happening in other states. For those of you that are planning on helping clean the river in Alabama, the time to acquire and perfect this skill set is now. The Academy will begin offering, in addition to the usual offerings, educational activities focusing on the patient-centered medical home. Take advantage of these to hone your skills so that, when payment reform comes to Alabama, your patient’s story will be more like this:

When Mrs. K. and her husband divorced, it hit her pretty hard. She has been seeing her family physician regularly because of her family history of diabetes and persistently elevated fasting blood sugar. When her family doc’s office contacted her and had her come in for a preventive visit, she was found to have gained 30 pounds and had an elevated LDL. She was placed on a statin to control her cholesterol but, more importantly, was offered nutrition services and some support to help become more physically active. After losing 20 of those pounds, her blood sugar and cholesterol normalized, and she has been off all medication for a year. The office checks in on her every month or so by e-mail, because that is what she prefers. She attends about four group visits a year to help keep her mind on her diabetes and has her hemoglobin A1C done at that time, the results of which are available on her secure patient portal. Total health care costs for the year attributed to the patient were $120 (four group office visits). The office is paid for the visits and also is paid a chronic-care management fee and an annual bonus for the quality score. The practice received $1,200 for caring for Mrs. K., so well.


The Scope of Family Medicine

MEMBERS IN THE NEWS

The Alabama Chapter of the American Academy of Family Physicians proudly announces the candidacy of Dr. John Meigs Jr. for Speaker of the American Academy of Family Physicians.

The Medical Society and the Montgomery Family Medicine Residency Program are pleased to present Dr. Carlos Clark with the Outstanding Resident Award.

Following his graduation from UAB School of Natural Science and Mathematics in 1998, Carlos Clark worked as a Microsoft network engineer in Birmingham for nine years. Working closely with physicians, he helped to implement software and infrastructure maintenance on networks including the changeover from paper-based to electronic charting in medical facilities.

Carlos also worked as an emergency department technician in his hometown and in Birmingham while attending UAB. In 2006, married and with three young children, he entered medical school and began to fulfill his desire to become a physician. He graduated in 2010 with honors from St. Matthews School of Medicine. Simultaneously, he was enrolled and graduated from Davenport University in Grand Rapids, Michigan, with a master’s degree in business administration. His residency training is being completed at the Montgomery Family Medicine residency Program, where he was elected chief resident in 2012.

Upon completing his residency training in June of this year, Dr. Clark will join Southern Clinic in Dothan as a family physician, making a positive impact on his own hometown community.

In his spare time, you will find Dr. Clark running, biking and riding motorcycles. He also enjoys practicing martial arts and holds a first-degree black belt.

On January 25, 2013, the Department of Health and Human Services issued the HIPAA/HITECH Act Omnibus Final Rule (the “Final Rule”). The Final Rule is effective as of March 26, 2013. Covered entities are required to comply with most provisions of the Final Rule by September 23, 2013. HIPAA-covered entities and their business associates must prepare now for bringing their policies, forms and training materials into compliance.

The Final Rule has instituted changes to the business associate, including a new definition of business associate and subcontractor. In addition, the Final Rule revises the definition of “breach” and the standard for determining whether breach notification is required.

The Compliance Webinar session sponsored by the Alabama Academy of Family Physicians will cover how the new rules impact operations and will include revised policies and forms, including a revised Business Associate Agreement and training materials to bring into compliance HIPAA privacy and security programs.

The Webinar is only available to physician members of the AAFP and your practice managers. The cost is $75, and, upon completion of the session, you will receive a digital compliance manual for your practice. So mark your calendars today, and be looking for more information coming soon!

Let Us Help Your Practice Get Compliant!

Compliance Webinar, July 18 at 1:30 p.m. (CT)

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ALABAMA PROVIDERS USING MEDISYS COLLECT OVER $4 MILLION IN INCENTIVES
Collaboration Results in More Accurate Data, Streamlined Process

When studies confirmed that the Alabama Medicaid Agency and the Alabama Department of Human Resources shared many of the same clients, the two agencies joined forces to examine ways to save money and remove barriers to care by streamlining and simplifying Medicaid enrollment and renewals.

The resulting effort between the two state agencies now makes it possible for Medicaid to determine eligibility by using verified data supplied by DHR, according to Gretel Felton, director of technical support for Medicaid’s Beneficiary Services Division. Felton shared the state’s success in a webinar April 23 sponsored by the National Academy for State Health Policy (NASHP).

Dubbed “Express Lane Eligibility,” or ELE, the process now has resulted in determining eligibility for more than 350,000 Alabamians while maximizing the skills and time of eligibility workers.

“This change has had a huge administrative impact,” Felton said. “This means that we can dedicate more resources to work on other renewals and help with more complex cases that are not eligible for ELE.” Presently, children and women on Medicaid’s Plan First family-planning program are eligible to be renewed using the streamlined process, Felton said. States are currently authorized by the federal government to continue ELE through October 2014.

Moving away from a manual eligibility process to one that removes barriers for qualifying applicants and saves money for the state wasn’t easy or quick, but the result has been a win-win for all involved. The Agency first collaborated with the Alabama Department of Human Resources in 2009 when Medicaid-enrolled children receiving SNAP (food stamps) or TANF (cash assistance) benefits were renewed because the Medicaid income limits for children were the same or higher than the two DHR programs. In 2010, applications for children were added to the automated process, leaving Medicaid only responsible for checking citizenship through a matching process with the Social Security Administration in most cases. In February 2013, Medicaid implemented an automated renewal match with DHR. Now, instead of getting a packet of information that has to be mailed back in, each family receives a letter explaining that its case has been renewed using information from DHR or Medicaid records and that no further action is necessary. Now, approximately 44 percent of cases are automatically renewed through ELE each month.

Another benefit of the joint venture is improved accuracy of the information used to determine eligibility. “One of the things that made us want to do this was the potential impact on our error rate. What we have found is that, by using data from DHR (reported to that agency every six months), our data is more accurate,” she said.

It is the patients who benefit the most, however.

“Physicians have told us that this makes a tremendous difference in the continuity of health care by preventing lapses in coverage for patients who are eligible but have dropped off in the past because they moved or otherwise did not receive the mailed renewal packet,” Felton explained. “Because their income had not changed, we would ultimately end up putting them back on the system. This eliminates that problem.”

One-Time Grants to Accelerate One Health Record Adoption and Use

A new grant program for small rural hospitals and qualifying health care providers will soon be available to help accelerate adoption and use of One Health Record®, Alabama’s health information exchange.

The one-time grants are designed to help qualifying provider entities purchase federally certified products from “preferred” electronic health record (EHR) vendors. Participating vendors must agree to a fair and fixed price and will be asked to match the 25 percent of the system’s cost in in-kind services, according to Health IT Program Director Gary Parker. The remaining cost will be covered by federal grant funds.

“Many of these providers are interested in participating in a robust, interoperable health information exchange,” Parker said. “However, acquiring the necessary technology is a financial and logistical challenge for these organizations.”
CMS Approves “Health Homes” for Alabama Medicaid Networks

Care coordination for patients with high-cost, chronic health conditions has been the foundation for the early success of Alabama Medicaid’s four pilot Patient Care Networks (PCNs). Now, federal approval of a new “health home” program will provide extra funding and support needed to improve patients’ health outcomes while reducing overall expenditures to the state.

The Centers for Medicare and Medicaid Services (CMS) notified the Agency on April 9 that it had approved the Agency’s request to implement comprehensive care management in the four networks, also known as health homes. Federal approval will allow the state to draw down 90 percent federal matching funds for a two-year period between July 1, 2012, and June 30, 2014.

“We know that a relatively small number of our patients account for a significant percentage of the cost,” Medicaid Managed Care Division Director Nancy Headley said. “This is in part because a disproportionate share of the Alabama population is more likely to have chronic health conditions such as diabetes or heart disease. With the Health Homes program, we will be able to focus on the patients with these health conditions and work intensively with them to improve the quality of care they receive.”

Qualifying Medicaid participants must have two chronic health conditions or one chronic health condition and be at risk of developing another condition. Approved conditions include asthma, diabetes, heart disease, cardiovascular disease, chronic obstructive pulmonary disease, cancer, HIV, mental-health conditions, substance-abuse disorder and sickle-cell anemia, as well as transplant patients.

“This is particularly important for patients with mental-health conditions because they often have other chronic diseases that go untreated until their health situation becomes serious,” Headley said. “By identifying these patients and intervening with targeted case management, the quality of the health care they receive can be substantially improved.” The PCNs are now required to have a behavioral health nurse that will serve as a liaison between The Alabama Department of Mental Health and the primary care physician.

The program will also financially support the efforts of two other state agencies: The Alabama Department of Public Health, which will provide case management services, and the Alabama Department of Mental Health, which will provide targeted case management services. Physicians who oversee the medical care of participating patients will receive enhanced fees as well.

Patients will be identified monthly using claims data and referred for services. The effort also includes transitional care services so that patients are visited by a nurse prior to hospital discharge to help with medication reconciliation or other needs.

To qualify for these grants, the hospitals must have 60 or fewer beds, and all applicants need to be located in rural areas where larger hospitals are already connected or expect to be connected within six months. Grant application dates, details and forms are available on the project’s website at www.onehealthrecord.alabama.gov.

Parker emphasized that the success of the One Health Record® effort depends heavily on the ability of providers to connect and exchange information with regional referral hospitals and their medical staff specialists.

“By concentrating our efforts on those areas served by hospitals which have connected or will soon connect to One Health Record®, we hope to jumpstart regional network development and provide opportunities for all providers to benefit from this technology,” he said.
Medicaid Reform Legislation Passes, Now Goes to Gov. Bentley

Medicaid reform legislation that would ultimately restructure the state’s health care delivery system for low-income citizens won approval in the Alabama Senate on April 25 and in the House on May 7 and now goes to the governor for his signature. Senate Bill 340, sponsored by state Sen. Greg Reed, R-Jasper, was approved by the Senate 27-3. State Rep. Jim McClendon, R-Springville, sponsored similar legislation in the House.

The approved bill is based largely on the earlier recommendations of the Alabama Medicaid Advisory Commission which was appointed by Gov. Robert Bentley to improve Medicaid’s financial stability while also providing high-quality patient care. The commission recommended in January that Alabama 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 Alabama to provide that care.

In its current form, the bill would open the door to locally controlled managed care, according to State Health Officer Dr. Don Williamson, who chaired the Medicaid Advisory Commission and is leading the Medicaid transformation effort. The 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.

“It would let hospitals, doctors and other Alabama health providers form groups called regional care organizations that could sign contracts to provide medical care to Medicaid beneficiaries on the state’s behalf in return for negotiated payments per beneficiary,” he said. “If a regional care organization could provide care that met Medicaid’s quality standards for less money than it was getting from Medicaid, it would make money. If it couldn’t, it would lose money.”

Dr. Williamson emphasized that each regional organization would have an incentive to oversee and improve patient care to reduce costs: A patient who isn’t readmitted to the hospital because she had regular follow-up checks with her doctor likely is a less-costly patient and a healthier person.

“Sen. Reed and Rep. McClendon have worked long hours, talking with other lawmakers and with dozens of people representing hospitals, doctors, civic coalitions and other groups, in an effort to pass a law that would protect Medicaid patients, health care providers and Alabama taxpayers,” Dr. Williamson said. “Senate Bill 340 will do that. I want to thank them and Gov. Bentley for their leadership on this legislation. This legislation is the start of a journey which will result in Medicaid transformation in Alabama.”

“My Medicaid” Website Benefits Recipients, Applicants and Providers

Alabama Medicaid recipients who need to replace cards, update information or check benefit limits can now bypass telephone waiting queues and go online to quickly get the help they need.

Launched in February 2012, the user-friendly “My Medicaid” website has been visited by more than 28,000 Medicaid recipients, payees and sponsors, most requesting help with their cards or to make changes to their files. Other site features include the ability to change a Patient 1st doctor, to print out a temporary paper card or to track the status of a pending application.

The website is available on the Agency’s website at www.medicaid.alabama.gov under “Recipients” and may be accessed from any computer. Free table tents promoting the website are available by contacting Medicaid’s communications division at 334-353-4099.

The launch of the “My Medicaid” website for applicants and recipients was an important milestone in the Agency’s strategic plan to reduce costs and increase efficiency through innovation and technology...
Ranks of Family Medicine Residents Grow for Fourth Consecutive Year

Students Matching to Specialty Outnumber Total of 2012 Positions Offered

Medical-student interest in family medicine continued its growth this year, according to the 2013 National Residency Matching Program results released in March. This year, family medicine training programs attracted 2,938 students, compared to 2,611 in 2012. This year’s Match numbers are higher than the total 2,764 positions offered last year. This year’s “fill rate” also rose to 96 percent, up from the 2012 rate of 94.5 percent.

Known as the Match, the NRMP aligns graduating medical students with residency training programs in specialties they want to pursue. In this year’s Match, the total number of U.S. medical students choosing family medicine was 1,374 — up 39 from 2012.

This is the fourth consecutive year the number of medical students choosing family medicine has increased.

“Although we’re pleased with this year’s Match, the growth has slowed,” Jeffrey Cain, MD, president of the American Academy of Family Physicians, said. “If we’re going to successfully rebalance the health care workforce on primary care medicine, we need to build the number of U.S. medical-school graduates choosing family medicine. This means we must strongly advocate for health care education and workforce policies that foster interest in family medicine among U.S. medical students and continue support for programs such as the National Health Service Corps and primary care health professions grants under Title VII of the Public Health Services Act. Everyone should have a primary care physician in the patient-centered medical home.”

However, the trend does indicate students’ awareness of family physicians’ importance in patient care and a greater appreciation for the role they will play in a reformed health care system, according to Cain. The value of primary medical care has become much more apparent because health care reform has focused a bright light on the importance of primary care medicine and on new ways of providing that care — such as the patient-centered medical home.

“Students increasingly realize that family physicians can practice the kind of medicine they had envisioned when they decided to become a doctor,” Cain said. “They realize they can provide team-based, comprehensive care that is focused on the patient’s needs.”

Stan Kozakowski, MD, AAFP director of medical education, agreed. “We’ve reached out to students to make sure they understand the importance of primary care in today’s health care system and health care of the future,” he said. “Family medicine interest groups play an important role in introducing medical students to the professional challenges and satisfaction that come with being a family physician. This year, we added to that effort with a video geared specifically to medical students as they make their career choices.”

The video and FMIG programs emphasize that family medicine is a comprehensive specialty that cares for all ages and — in addition to providing preventive services and care for short-term illnesses — provides diagnosis and treatment for the medical cause of multiple, vague symptoms that develop in complex health conditions. Family physicians care for patients with serious conditions such as heart disease, chronic obstructive pulmonary disease, Parkinson’s disease, cancer, diabetes and multiple sclerosis. Data from the National Ambulatory Medical Care Survey show family physicians have more visits for circulatory problems (35 percent of visits) than cardiologists (19 percent) and nearly as many visits for musculoskeletal problems (27 percent) as orthopedic subspecialists (30 percent). More patients see family physicians for endocrine problems such as diabetes than they do other specialties or subspecialties.

Moreover, family physicians treat patients in hospital intensive care, cardiac-care and emergency departments, long-term care facilities, and hospice services.

“I’m pleased that students want to have the breadth and depth of training that will prepare them to provide such a full range of care to people of all ages,” Cain said. “As more young people choose family medicine, we can rebalance our physician workforce so that it meets the needs of America. And we’ll continue to work toward increasing the number of U.S. medical graduates who choose family medicine.”
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. Ad-
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: WHAT IS THE TIMELINE FOR IMPLEMENTATION OF THE TRANSFORMATION?
A: By October 1, 2013, Medicaid must have the care regions established. By October 1, 2014, an organization seeking to become an RCO must establish a governing board and structure approved by Medicaid. By April 1, 2015, an organization with probationary RCO status must demonstrate to Medicaid the ability to establish an adequate medical service delivery network. By October 1, 2015, an organization that has received probationary RCO status must demonstrate to Medicaid that it has met the solvency/financial requirements. By October 1, 2016, an organization with probationary RCO status must demonstrate to Medicaid that it is capable of providing services in the region pursuant to a risk contract. Nothing shall prevent an organization seeking Medicaid approval to operate as an RCO from meeting any of the aforementioned deadlines at an earlier date.

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.

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2013 Tar Wars® State Poster Contest Winner

Matthew Chapman, fifth grade
Collins Elementary School
Scottsboro, Alabama

Matthew will travel to Washington, D.C., this July 15-16 to compete in the national competition.