President Kincer Q & A

PG 6
"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.

I selected ProAssurance because they stand behind my good medicine and understand my business decisions. In spite of the maelstrom of change, I am protected, respected, and heard.

I believe in fair treatment—and I get it.
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Back To School!

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.”

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What was one of the reasons you chose family medicine as a specialty?

I grew up in the backwoods of Kentucky in the Appalachian Mountains, where medical care was quite limited. The vast majority of the physicians were older general practitioners and later family physicians. My father had hemophilia A or factor VIII deficiency. In the 1960s when I was old enough to understand what was wrong with my father, there were no isolated treatments for the bleeding episodes that were so common. It was a way of life for us to be at our small hospital with my father getting whole-blood transfusions donated on the spot from friends and family. There were no ER physicians, so our family doctor was there with us, providing care and consoling us as my father faced numerous near-death GI bleeds. I remember our family physician telling us once that his hematocrit was 6 (not hemoglobin). That stuck in my head but did not mean anything to me at the time. When I was sick, I saw the same doctor, so I thought all doctors treated everything and everybody. Our family physician became our family friend as time passed, and he and my father started a local chapter of the National Hemophilia Foundation that brought much-needed attention to this common problem in eastern Kentucky. I saw how this physician treated patients of all ages, befriended his patients, became a vital part of the community and changed the lives of the people he encountered. Later, when I had the opportunity to attend medical school, I knew family practice was my destiny. The name was later changed to family medicine. To me, you cannot separate the bio from the psycho from the social part of medicine. It’s all or none — otherwise, you are not a complete physician.

As a residency director, what are some of the challenges you face training the youth of family medicine, and how is it different from your days as a resident?

Today’s residents are very tech-savvy. They grew up on computers, cell phones, Internet, texting, blogging and Facebooking. They prefer to communicate by text or email, and they enjoy learning via electronic media over lectures. They like predictable schedules and are focused more on preserving personal time while not allowing career to dominate their lives. They are group-oriented and thrive on praise and feedback. This should not be interpreted as being “bad.” They are much better than I am at pulling the newest information from the Internet and knowing the most up-to-date guidelines. They strive harder to help their patients meet these guidelines than I do. The one area that I find challenging for them is connecting with the patient behind the disease. They struggle more with face-to-face communication, and it can come across as lacking empathy. My biggest challenge is communicating with them in a meaningful fashion that lets them know that I care and, secondly, finding a way to teach them the finer art of practicing medicine, since they don’t like lectures. They are very intelligent and get bored easily with my long-winded explanations of disease processes, since they grew up playing on the computer, listening to music and texting all at the same time. We have completely revamped our learning methods to appeal to their learning styles by decreasing lectures and increasing group activities and self-directed learning modules. A final challenge that I face is getting my faculty to let go of the past teaching paradigm and embrace this new technology-driven learning.

Is there a particular patient encounter from your early career that you still reflect on today?

When I was a third-year medical student 27 years ago, I remem-
ber my patient Philip. He was a 40-some-year-old patient at the VA hospital in Lexington, Kentucky, with a dilated cardiomyopathy with an ejection fraction of around 10 percent. In those days, the medical student had to draw the blood, take the patient to X-ray, start our own IVs and insert Foley catheters. Philip was my patient for my entire one-month medicine rotation. I didn’t know very much medicine at all, and he knew it, but, even as sick as he was, he was interested in helping me learn as much as possible. He was very patient as I stuck him several times to get blood or start an IV. He shared his life with me and told me that he knew that he didn’t have long to live and that he was very scared. He taught me that caring for the patient was often more important than providing them care. Even after I moved on to a new rotation, I would go back and visit with him. Philip died from his illness while I was still a student. With his death, he even taught me that there is nothing wrong with physicians shedding some tears when your patient dies.

Where do you see family medicine in 10 years?

Family medicine is positioned to be the leader in the future of medicine. There is no new money in health care, and costs are escalating, hence money-shifting is a must. Numerous studies have shown that health care is better and expenditures are lower with more primary care physicians per populace. Moving health care from the most expensive venue into the least expensive must be a focus. Currently, the most expensive venue is hospital medicine, including ER visits, while the least expensive is the primary care office. Prevention, early diagnosis and treatment of chronic illness all occur at the primary care physician’s office. If this is not being done, the patients begin to utilize the ER as an urgent-care center, and, when their chronic illnesses are not addressed, they end up in the hospital with complications and end-stage processes driving up the cost of health care. This is the point in time where family physicians must get involved in the legislative process, driving health care change, since we have the greatest understanding of population medicine, prevention of disease and cost containment. This is easily the most influential time in the history of family medicine. If done right, family physicians will be the leaders in health care in 10 years.

What is the most rewarding aspect of being a family physician?

One word: influence. Let me walk you through my day today. I went to the nursing home at 7 a.m. to admit a patient with a dense stroke and spoke to the physical therapist, influencing the rehab and care of that patient and, hopefully, the day’s activities of the therapist. I then went to the office to see 17 patients before lunch with a third-year medical student in tow. I saw a long-term patient of mine in whom I diagnosed diabetes today and influenced his lifestyle change. I saw a female diabetic patient that had presented with vague fatigue and dyspnea several weeks ago and had a recent negative stress test yet underwent a cardiac cath and needed a stent. I looked at the medical student and said, “Never forget this moment; female diabetics do not have typical angina; don’t miss this.” Again, influence in education. Many more patient and student influential moments happened this morning. I had lunch with several of my residents and recounted stories of medical school and my residency, attempting to influence their outlooks on their own residencies. This afternoon, I met with several UAB medical students in the Rural Medicine Program and introduced them to our Academy, hopefully positively influencing their future in organized medicine. Lastly, as I’ve sat here tonight writing this article, I would hope that my writings have influenced many of you to practice family medicine, to love your patients, to teach medical students and residents, and to get involved in health care reform in a way that provides a great future for family medicine.

Dr. Kincer lives in Montgomery, Alabama, with his wife, Leigh, and their daughter, Abby, a first-year medical student at the University of South Alabama College of Medicine. Please join us in welcoming your 2013-2014 president, Tom Kincer, MD.
Alabama Medicaid Agency Moving Quickly to Comply with New RCO Law

After Gov. Robert Bentley signed a Medicaid reform bill into law, Medicaid staff, stakeholders and others are moving quickly to comply with the law by creating the legal and operational foundation upon which to build the new health care delivery system.

The first two challenges under the new law center on determination of actuarially sound districts and how to facilitate collaboration outlined in the law while remaining within state and federal law, according to State Health Officer Dr. Don Williamson, who is also leading the Medicaid transformation effort.

The proposed districts are based on several factors, according to Dr. Williamson. He explained that, in addition to being actuarially sound, the districts were drawn in an effort to honor existing referral patterns and, when possible, to keep various health systems together.

During the month of June, the Agency met with hospitals, physicians and other provider groups and worked with an actuarial consultant to propose districts for the planned regional care organizations. The map and the required state administrative code changes were submitted on June 28. Public input on the new map was received at a public hearing held on July 15, and additional comments were received by the Agency through August 2.

Acting Medicaid Commissioner Stephanie Azar noted that the Agency is on track to meet the law’s October 1, 2013, deadline to have the regional map finalized. Once the final rule is filed, it takes 35 days before the map is legally effective, she said.

At the same time, the Agency must develop the rules for collaboration, for governance and for what probationary or provisional certification of an RCO should entail, Dr. Williamson said.

“There is extensive language in the law about anti-trust, and the intent of the Legislature is to allow the creation of markets. Medicaid staff are working very, very hard now on anti-trust issues. They are looking at how other states have dealt with it, because it is a critical issue to get those rules out, because that is the next thing that has to happen,” he explained.

After that, the state will need to write rules around what constitutes a sufficient provider network, Dr. Williamson said. “We haven’t identified all the components we are looking for. Governance is one, but, beyond governance, I think it is incumbent that there is some evidence that an entity granted provisional certification is capable of putting together an adequate provider network, of being solvent and have necessary business back-office to manage capitation.”

Primary Care Physicians Receive More Than $8.8 Million Due to “Bump”

Approximately 2,100 Alabama primary care physicians who qualified for an enhanced federal payment rate known as the “bump” have received more than $8.8 million in additional reimbursement since the Alabama Medicaid received federal authorization on May 29.

The Agency began payment of the enhanced rate to qualified providers on June 8 and started reprocessing claims paid under the old rate in July so eligible providers could receive the difference for services provided since January. All reprocessing was expected to be completed by the end of September.

The increased reimbursement is the result of the Affordable Care Act, which required state Medicaid programs to increase or “bump” up payments to certain physicians for specified primary care services beginning January 1, 2013.

The Affordable Care Act requires states to pay 100 percent of the Medicare rate for 2013 and 2014 or, if higher, the Medicare rate for primary codes using the calendar year 2009 Medicare conversion factor. The increased payments — projected to be $39.6 million per year in Alabama — are funded entirely by the federal government for 2013 and 2014. However, the responsibility of maintaining the higher fees will fall to the state in 2015.

Eligible physicians include board-certified family medicine, pediatric medicine, general internal medicine and related specialties or eligible physicians who can verify that 60 percent or more of the Medicaid codes they billed in the previous year were primary care codes and certain codes associated with vaccine administration listed in the ACA. Health departments, federally qualified health centers (FQHCs) and rural health clinics are not eligible for the fee increase.
Armed with a new federally approved operating protocol for the state’s Money Follows the Person initiative, members of the Long Term Care Rebalancing Advisory Committee met July 16 to begin mapping out strategies to support the successful transition of up to 625 individuals over five years from an institutional setting to community living.

The first step will be the formation of subcommittees to address key issues, including outreach, housing and employment for participants who enroll in the program, according to MFP Project Director Ginger Wettingfeld. Committee work is expected to start in August. The Agency will also pursue development of a second Alabama Community Transition (ACT) waiver to enable Medicaid recipients with developmental disabilities or a mental-illness-related diagnosis to have the opportunity to move to the community as well. A timetable has not been established for this project.

“One of the greatest challenges for these recipients is finding safe, affordable and accessible housing,” she said. “In some cases, potential recipients could return to a family member’s home, but, for many, that is simply not feasible. With help from our stakeholders, we hope that communities throughout the state will respond by increasing the inventory of housing that meets the needs of those recipients so they can move safely to the community.”

Alabama is now one of 44 states with MFP initiatives, according to Wettingfeld. Alabama is eligible to receive up to $28 million in federal funds through 2016 in the form of an enhanced (84 percent federal/16 percent state) matching rate for MFP-related services and 100 percent funding for administrative costs. Grant funds will cover the upfront costs associated with transitioning each individual as well as administrative costs of operating the program and will be paid during the first year of each person’s transition.

The majority of the expenditures will go to provide home- and community-based services for Medicaid-eligible individuals who are elderly or have disabilities and who choose to transition from nursing facilities or a state-operated psychiatric hospital (only applies to recipients under 21 or over 65 for this type of facility). Most are expected to transition to one of Medicaid’s seven HCBS waiver programs or to a PACE program.

“Now that the federal government has approved our operational protocol, we are now ready to move forward toward our goal of providing greater choice to our recipients while maximizing Medicaid’s limited funds,” Wettingfield said.
Life Stages ’13 Meeting

This year’s meeting will be in the same format as the 2012 meeting. Day 1 (Saturday) will feature eight CME sessions, as listed below. Day 2 (Sunday) will offer a four-hour Self-Assessment Module (SAM) on heart failure. By the end of this session, you will have completed the 60-question Knowledge Assessment portion of this module. Twelve CME credits are awarded for successfully completing each Part II Module. Once you have completed the clinical simulation, the ABFM reports your credit to the AAFP’s Continuing Medical Education Records Department.

In an effort to “go green,” the AAFP will be uploading our syllabus to a protected website for our registered attendees. Each attendee will have the option of downloading to his or her computer/tablet or printing the syllabus and bringing a hard copy to the meeting.

2013 Alabama Academy of Family Physicians Fall Forum
December 14 and 15 • Embassy Suites Birmingham/Hoover

SATURDAY, DECEMBER 14
6:30-7:30 a.m. ........................ Registration, Pre-Function Area
6:30-7:30 a.m. .................. Continental Breakfast, Exhibit Area
7:30-8:30 a.m. ........................ Updates in Sports Medicine, Michael Goodlett, MD
8:30-9:30 a.m. ................ Update on Revised Beers Criteria, Marilyn Bulloch, MD
9:30-10 a.m. ................... Break to View Exhibits, Exhibit Hall
10-11 a.m. ........... Opioids in the PC Setting, Jerry Harrison, MD
11 a.m.-noon.............. Elevated Liver Enzymes/Hep-C, TBA
Noon-12:45 p.m. .................. Strolling Lunch, Exhibit Hall
12:45-1:45 p.m. ........................ ADD/ADHD, TBA
1:45-2:45 p.m. ........................ Menopause, TBA
2:45-3:15 p.m. ................ Break to View Exhibits, Exhibit Hall
3:15-4:15 p.m. ........................... Derm Update, TBA
4:15-5:15 p.m. ........................... Helping Patient/Family with End-of-Life Decisions, TBA
5:15 p.m. ........................ Adjourn

SUNDAY, DECEMBER 15
7-8 a.m. ........................ Continental Breakfast, Exhibit Hall
8-10 a.m. ........................ SAMs Session
10-10:30 a.m. .................. Break to View Exhibits, Exhibit Hall
10:30 a.m.-noon .................. SAMs Session

Registration Fees
Total conference registration (Days 1 and 2): $275  Day 1 only: $125  Day 2 only: $150

Make check payable to the Alabama Academy of Family Physicians, PO Box 1900, Montgomery, AL 36102-1900, or visit our website at www.alabamafamilyphysicians.org. You may also pay via credit card. If paying via credit card, please complete the following.

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Cardholder: _______________________________ E-mail address of credit cardholder: _______________________________
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Cancellation Policy: Refunds, less a $25 administrative fee, will be made upon request.

For more information, call Lynn Woodruff at:
334-954-2571 or 877-343-2237
334-954-2573 Fax
lynnafp@charter.net

NO REFUNDS AFTER November 15, 2013
Comprehensive Behavioral Intervention for Tics (CBIT) is a non-drug treatment with three important components:

- training the child to be more aware of tics
- training the child to use "competing" behavior when they feel the urge to tic and
- making changes to day to day activities in ways that can be helpful in reducing tics.

Our program consists of eight one-hour weekly sessions that focus on:

- identifying the frequency and severity of tics
- teaching alternate strategies to help the child manage the tic disorder with discretion and confidence and
- embedding the tic strategies or "competing responses" into everyday life.

An occupational therapy practitioner works with the child or youth to help limit the interruption of tics on health, well-being and development. Patients come from all over the country to participate in our program due to the limited availability of this therapy for children with Tourette syndrome or other tic disorders.

Contact Outpatient Scheduling at 205.638.7527
For more information, email Jan.Rowe@ChildrensAL.org

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ANNUAL MEETING RECAP

Dr. Kincer and our VIP American Academy Board Member Dr. Wanda Filer

Past president's breakfast

Dr. John Meigs and Dr. Wanda Filer

The Scope of Family Medicine
All four residency programs from Alabama attended.
A Note from the New Student President

I am very excited to serve as the new student president for the next year. Coming from a small town, I know the impact a family physician can make, not only in the office but also in the community as a whole. I believe this is one reason why family medicine is such an attractive specialty for future doctors in Alabama. It gives one the opportunity to truly make a difference in the lives of others. As the new student president, I hope to help show other medical students how great this specialty can be. Through opening the lines of communication between the physicians currently practicing and the student members of our organization, I believe we can create a strong presence in our schools and help spread our passion for family medicine. We are facing many challenges and opportunities as we see how medicine changes over the next few years. It is my hope to see us become more united across the state, bridging the gap between students and doctors, creating a more cohesive group for our members so we can work together to satisfy the future medical needs of our state.

Kaci Larsen
MD Candidate, UASOM Class of 2016
AAFP Student President
The Alabama Academy of Family Physicians will be hosting two events for our resident members in conjunction with our Life Stages ’13 Fall Forum meeting, which will be held December 14-15 at the Embassy Suites, Hoover, Alabama.

We will hold our fifth annual Poster Presentation program for our resident members on December 14. The selection of a topic is up to you. We will supply a mounting station for you to use to present your posters. Setup time will be from 7:30 until 8:30 a.m., and they will be located in the lobby outside the CME meeting rooms. During the lunch, we will encourage our attendees to visit the posters and discuss them with you. This is regarded as a scholarly activity by the Residency Review Commission.

Later on December 14, from 8:30 a.m. until 12:30 p.m., we will hold our annual “Starting Your Practice” seminar, full of information you need to know before going out on your own to establish your medical practice. We will present such topics as managing your money and basic finance information; selecting the right kind of practice for you (solo, group, employee, etc.); selecting insurance coverage (from medical liability to coverage for your building or employees health); avoiding licensure problems with the Board of Medical Examiners; dealing with all kinds of contracts; dealing with personnel and employee issues; and other things that will help you. Following the seminar will be the business meeting with the election of the 2013-2014 officers.

There is no cost to attend the seminar or to participate in the poster presentations, and we will even provide lunch and refreshment breaks. Please mark your calendar for December 14-15, 2013, and make plans to be with us.

We look forward to seeing you in Hoover.

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All resident-members of the Alabama Academy of Family Physicians are eligible to apply for the annual Stan Brasfield Memorial Scholarship. The family of the late Dr. Brasfield created the scholarship fund to honor his memory; it is to be given annually to a first- or second-year resident who meets certain criteria.

Dr. Brasfield, a Montgomery native, earned his medical degree in Alabama. He died at the untimely age of 33 while practicing in Florida. The scholarship is in the amount of $1,000. The criteria are as follows:

• The award will go to a first- or second-year Alabama family medicine resident who has demonstrated financial needs, as expressed in a short (one page or less) essay submitted by the applicant.
• The recipient will preferably be married and have an Alabama connection of some kind. Please tell us of any such connection.
• The deadline for receipt of essays will be Tuesday, December 31, 2013; send your essay to the attention of Chapter EVP Mr. Jeffrey Arrington at: alafamdoc@charter.net.

$1,000 Stan Brasfield, MD, Scholarship for Alabama AFP Residents Is Available

All resident-members of the Alabama Academy of Family Physicians are eligible to apply for the annual Stan Brasfield Memorial Scholarship. The family of the late Dr. Brasfield created the scholarship fund to honor his memory; it is to be given annually to a first- or second-year resident who meets certain criteria.

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Agency Employs Multiple Strategies to Save Money, Preserve Access

By employing a combination of financial, clinical and administrative strategies, Alabama Medicaid officials hope to cut approximately $11 million in state dollars from its pharmacy program in FY 2014 while still providing access to most critical medications for more than 600,000 Medicaid recipients who qualify for drug coverage each year.

The first cost-cutting measures were implemented July 1 and included reimbursement changes for compounded drugs, increased co-payments on drugs and a change to prevent stockpiling of medications via early refills. The three measures are estimated to save about $1 million in state funds during the 2014 fiscal year.

The next round of changes will start October 1 and include prescription-drug limits, a mandatory three-month supply for certain drugs used to treat selected chronic diseases and an end to coverage of over-the-counter drugs. Other measures set to begin on October 1 include a change to the Agency’s “lower-of” payment method and expanded efforts of the Agency’s Drug Utilization Review board. Together, they are projected to save $11.1 million during FY 2014.

One of the most visible changes will be the limit on prescription drugs for adults and a mandatory dispensing of a three-month supply of certain drugs. Recipients will be limited to a total of five drugs per month, four of which may be brand-name drugs. However, recipients who require anti-psychotic, anti-epileptic (seizure) and/or anti-retroviral (HIV/AIDS) drugs will be allowed to have up to five additional (10 total) brand-name or generic versions of these drugs. Additionally, the Agency is phasing in the drug limits to allow prescribers, pharmacists and recipients to find the best schedule for the recipient, according to Pharmacy Services Director Kelli Littlejohn, PharmD.

“While the prescription limit for adults may be challenging, the Agency is also implementing a mandatory three-month supply of certain medications for chronic disease states, such as hypertension, diabetes, depression, asthma, thyroid disease and high cholesterol, as well as contraceptives,” she said. “The three-month supply will only be applied to the recipient’s prescription limit during the month in which the drug is dispensed, however. Not only will this provide flexibility for the recipient, we also hope that this will benefit recipients who may now have transportation or other barriers to timely refills.”

Summary of Changes – Medicaid Pharmacy Program

- July 2013
  - Compounding changes
    - Compounding time no longer reimbursed
    - Most bulk products not covered for adults
    - Change in how claims for bulk powders are submitted
    - Maximum $200 payment for compounded products without prior approval
  - Increased co-payments for drugs based on drug cost
    - From 50 cents to $3 to 65 cents to $3.90
  - Edits to prevent stockpiling of drugs via early refills

- October 2013
  - Phase-in period for prescription drug limit for adults begins
  - Phase-in period for three-month supply for certain drugs begins
  - End coverage of OTC drugs for adults and children (insulin and nutritionals excluded)
  - Expansion of Agency’s Drug Utilization Review Board activities
  - Change to Agency’s “lower-of” reimbursement method so that wholesale acquisition cost (WAC) is changed from WAC+9 percent to WAC+0 percent

- January 2014
  - Prescription drug limit for adults goes into effect
    - Five total drugs per month, four of which may be brand-name drugs
    - Up to five additional (10 total) for brand-name and generic anti-psychotic, anti-epileptic (seizure) and/or anti-retroviral (HIV/AIDS) drugs
Congratulations to Tate Hinkle, MS4, at the University of Alabama School of Medicine Huntsville Campus for being elected as student board member of the American Academy of Family Physicians. Tate is a past president of the ALAFP student chapter and a Family Medicine Interest Group regional coordinator.

An excerpt from his campaign speech:

“Being involved with the leadership of the AAFP has been one of the best educational experiences of my career, and it’s something I want to continue to do. The mentorship and support from the AAFP has given me opportunities to learn and grow as a leader and future family doctor that I know will help me serve my patients, my community and family medicine in years to come.

“I challenge each of you to continue to be leaders at your schools, in your states, on the national level and, most importantly, among your peers and colleagues, because you understand where health care is going.”
New Residency Director Moving Program Forward

by Brett Bralley Jaillet

New Residency Director Richard Friend, MD, went through a bit of a transitional period when he first arrived at the University of Alabama College of Community Health Sciences in December. He spent half of his time at the college and half of his time wrapping up his tenure at Louisiana State University, where he not only served as the director of the Rural Family Medicine Residency in Bogalusa, which is part of the Louisiana State University system, but also was co-founder of the program.

But a busy back-and-forth schedule didn’t stop Friend from getting to know the residents, faculty members and staff members at the college while drafting a strategic plan to move its Tuscaloosa Family Medicine Residency — one of the oldest and largest of its kind in the country — forward, starting with an expansion from 36 to 44 resident slots.

“I think we have a real opportunity to become the preeminent family medicine residency in the country,” says Friend, now in Tuscaloosa full time. “A time of change can sometimes be an uncomfortable time for a lot of people, but I really enjoy these kinds of opportunities.”

Friend moved from Illinois to New Orleans as a child, and, though he wasn’t always sure what he wanted to do, part of the influence to become a physician came from his uncle, Herbert Rothschild, a noted pediatrician in New Orleans who was among the first in the country to use penicillin with children. Friend attended Tulane University and earned his bachelor’s degree in psychology. Shortly after he graduated, he went to medical school at LSU and specialized in family medicine during his residency in Shreveport.

“I like the idea of caring for the whole patient and the opportunity to make a difference in the lives of each patient,” Friend says. “I really enjoyed the variety of what I was learning [in medical school], and I didn’t want to stop doing any of the facets of what I had studied, so I just continued with family medicine.”

Friend’s devotion to rural family medicine can be seen throughout his career, from a private practice in Raceland, Louisiana, and then in Ocean Springs, Mississippi (though Hurricane Katrina quickly finished what he had started in Ocean Springs), to weekend nights spent in rural emergency rooms. Emergency medicine is one of his special interests, he says.

“It allows me to keep up my skills and take care of critically ill patients, and I hope to bring that portion of my experience to the curriculum for the residents,” he says.

Friend helped design, develop and implement the Rural Family Medicine Residency in Bogalusa in 2006, which is the largest of its kind in the LSU system. He served as the director from 2008 until this year, and he also secured the largest Title V11 grant in Louisiana in 2010 — a $3 million Affordable Care Act Primary Care Residency Expansion grant with a five-year budget to expand the program from 12 to 24 residents.

“That’s the kind of thing we need to do here,” he says. “We need to grow and produce more providers — and more quality providers — not just for the state but for the country.”

It’s that drive to see an increase in rural physicians, coupled with a passion for teaching, that fuels Friend’s love for working with residents.

“There’s always a need for more family doctors, from primary care to rural physicians,” he says. “The aging population, which includes aging physicians and practices, is really going to put a stress on the health care delivery in the next decade, so we have to turn out as many competent, well-trained rural family physicians as possible.”

Chief Resident Mark Christensen, MD, says he recognizes Friend’s drive to take the college’s Family Medicine Residency to the next level.

“In the short time I’ve come to know Dr. Friend, he has impressed me with his ability...”

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During the 2013 Legislative Session, one of the most dangerous pieces of legislation concerning physicians never made headlines outside of the Medical Association’s weekly legislative e-newsletter, Rotunda (MASA members only, Rotunda@masalink.org). Senate Bill 453, sponsored by Senate President Pro Tem Del Marsh (R-Anniston), was a total rewrite of the workers’ compensation system in Alabama, and, had it passed, it would have completely (and negatively) altered how injured workers are treated in Alabama.

SB 453 was a “wish-list bill” of workers’ comp insurance plans, which, in private circles, heralded the legislation as a profits windfall. How exactly? Well, largely by capping workers’ comp fee schedule payments to physicians at Blue Cross Blue Shield PMD plus 7.5 percent and annually recalibrating the fee schedule according to BCBS fees; if BCBS rates go down, so would the workers’ comp fee schedule payments to physicians at Blue Cross Blue Shield PMD which, in private circles, heralded the legislation as a profits windfall. How exactly? Well, largely by capping workers’ comp fee schedule payments to physicians at Blue Cross Blue Shield PMD plus 7.5 percent and annually recalibrating the fee schedule according to BCBS fees; if BCBS rates go down, so would the workers’ comp fee schedule under the proposed legislation. This was only the tip of the iceberg; to fully understand the issue, one must look under the surface.

In addition to establishing the basis for an initial fee schedule, the 1992 legislation also created a five-member Workers’ Compensation Medical Services Board. The board would consist of physicians, particularly those most capable of addressing the important issues of injured patients and their necessary care. These physicians are nominated by the Medical Association and tasked with establishing rules governing workers’ comp in Alabama. The board was also given the ability to approve an annual consumer price index (CPI) increase and set rates for new codes.

In 1992, MASA addressed this issue successfully on behalf of injured patients and the current system has worked for more than 20 years. MASA, workers’ comp insurers and plaintiff lawyers were all involved. The Medical Association defended physicians from attempts to reduce the fee schedule for this industry and jeopardize patient care and the same remains true today. The 1992 workers’ comp battle designed a law that created a one-time link to Blue Cross Blue Shield PMD payment rates plus 7.5 percent. This rate methodology was intended to create an initial baseline for a fee schedule, after which workers’ comp rates would forevermore be severed from any ties to BCBS. Existing law is clear.

In addition to slashing physician fees, SB 453 would have abolished the existing Workers’ Compensation Medical Services Board of five physicians and replaced it with a seven-member board of insurers and claims representatives. The new Board would have included only one physician, clearing the way for insurers to completely rewrite the rules on workers’ comp. Additional physician grievances included a clause preventing Alabama-licensed physicians from performing peer review, allowing only out-of-state physicians and, in many instances, nurses to review contested cases. MASA is prepared to discuss sensible changes to the workers’ comp system — modifications that focus on reducing administrative burdens and ensuring access to care for injured workers.

Plaintiff lawyers were involved deeply in 1992 and also in 2013, albeit in vastly different ways. In 1992, the plaintiff lawyers fought to defeat the legislation supported by the insurers. In 2013, however, from all indications, the two groups struck a deal behind closed doors to fill SB 453 with as many of the items on their wish lists as possible and to pass a bill over medicine’s objections and without any consideration for their injured employees. With those groups supporting the legislation, only MASA stood between them and disaster for physicians and injured workers.

MASA met with all stakeholders in good faith to try and address their concerns and guarantee injured workers access to the highest-quality care. When the committee of attorneys drafting the legislation released the bill, none of the Medical Association’s recommendations were accepted, forcing MASA to oppose the legislation. Several of MASA’s requests included standardizing the administrative process for workers’ comp, retaining the five-physician Workers’ Compensation Medical Services Board, ensuring proper peer review of disputed claims, ensuring timely payment of claims and ensuring adequate payment for services rendered. Drastically reducing the fee schedule discourages physicians from participating in the workers’ comp program, particularly when the administrative hurdles have increased and continue to grow more burdensome.

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HEALTHY TRUCK AND BUS DRIVERS MEAN SAFER HIGHWAYS

To ensure the nation’s commercial motor vehicle (CMV) drivers meet health standards, the U.S. Department of Transportation’s Federal Motor Carrier Safety Administration (FMCSA) has established requirements for health care professionals who perform or wish to perform physical qualification examinations for the drivers. And, while these requirements do not go into effect until May 2014, health care professionals must not wait until the last minute to become certified, as training is involved.

To be added to the FMCSA’s National Registry of Certified Medical Examiners, health care professionals must complete training and testing on the FMCSA’s physical qualifications standards and guidelines. Training will ensure medical examiners sufficiently understand how FMCSA medical regulations and related guidance apply to commercial drivers. Because information from crash investigations across the nation indicates that improper medical certification of CMV drivers with serious disqualifying medical conditions has directly contributed to crashes involving injuries and fatalities, the National Registry was created as a way to reduce those crashes and to enhance commercial driver health.

Once certified, medical examiners must comply with training, testing and FMCSA administrative requirements to maintain a listing on the National Registry; take refresher training every five years; and take the certification test every 10 years to maintain their certification.

For further information, please visit nationalregistry.fmcsa.dot.gov or call 617-494-3003.

“New Residency Director Moving Program Forward,” continued from page 18

to challenge the status quo and push the residency to be the best in the nation,” Christensen says. “His familiarity with all the facets of family medicine, combined with his willingness to teach inpatient and outpatient procedural skills, such as central lines and critical care, make him an asset to our program, which prides itself on the ability to train highly competent physicians to practice the entire scope of family medicine anywhere in rural Alabama and beyond.”

Now settling into the Tuscaloosa lifestyle, three of Friend’s four children have joined him, along with his wife, who has joined the faculty at UA’s Capstone College of Nursing.

“I feel like all the different roles I’ve held have really prepared me for this position and to help this institution move forward in a short period of time,” he says. “I’ve felt comfortable here from day one, and I feel like there is tremendous support here. [Residents] only get three years of training to prepare them for the rest of their career, so, if we can provide them with excellent training and be excellent role models and resources for the rest of their career, then I think we’ve done a good job.”

“New Residency Director Moving Program Forward,” continued from page 18

“Masala is prepared to discuss sensible changes to the workers’ comp system — modifications that focus on reducing administrative burdens and ensuring access to care for injured workers. Timely payment of claims and an insistence that disputed claims be reviewed and resolved quickly by licensed Alabama physicians are also paramount. Additionally, the existing Workers’ Compensation Medical Services Board should remain a board composed of physicians.

This issue is not going to disappear and is expected to return next legislative session (which begins January 14, 2014). For medicine to be successful in preventing undesirable changes to workers’ comp, all physicians must get involved. That means becoming a Masala member, checking each Friday’s Rotunda and participating in the Alabama Medical PAC (ALAPAC), which supports pro-medicine and pro-patient candidates for office. It also means speaking with your state senator and state representative about workers’ comp and other issues important to medicine, as these individuals will decide the fate of such legislation. By working together across every specialty, we can defeat dangerous legislation that impacts your practice and threatens patients.

“Injured Workers’ Access to Physicians Under Fire,” continued from page 19
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