CANS newsletter

President's Letter

Deborah C. Henry, CANS 2014 President and Associate Editor

As our newsletter goes to print, the Affordable Care Act is wrapping up its initial enrollment with its March 31st deadline. As of March 27th, over six million people have signed up for the inaugural program, and one million of those people are Californians. Fifty thousand California households began applying on this past Tuesday alone. This does not include the millions nationally that are now part of the expanded Medicaid program (source: *LA Times*, Friday, March 28, 2014)

I decided to try out the Covered California web site. There is a shop and compare tool that allows you to input your household income and household size, and it gives you your choices. I put in $22,000, which was my part time teaching salary, 2 for household (my son and I), a Los Angeles zip code and got directed only to Medi-Cal.

Next I inputted $60,000, my take home income my first year in private practice in Pasadena, and 2 for household and landed a qualification for Covered California. The visible choices of coverage are LA Care, Molina Healthcare, Anthem Blue Cross and Blue Shield in the Bronze level (covers about 60% of medical costs). I initially missed the arrows that don't appear unless you press "view details" that will then give you access to Kaiser and Health Net. Maximum out of pocket costs are over $12,000, not including the premiums that run between $421 (LA Covered) and $489 (Kaiser). I would receive a $96 monthly tax credit. The silver plans cover approximately 70% of medical costs with premiums ranging from $502 (Health Net) to $665 (Kaiser). I retain my $96 a month tax credit, and the maximal out of pocket costs remain the same. Urgent care's co-pay is $90 while specialty co-pay is $65. Gold and Platinum were not choices.

I then clicked on the "What do I get for my premium" section. This section discusses the "free" preventative health care services from a one-time screening of an abdominal aortic aneurysm if you are a male of "specified age" who has never smoked to diabetes type 2 screening if you have high blood pressure. Hmm, I thought obesity was a greater risk factor for Type 2 diabetes, but apparently if you are obese and of normal blood pressure, you would need to "pay" for diabetes type 2 screening.

Last, I tried an income of $100,000 a year. Here I receive no premium assistance, but may still enroll in Covered California for similar premiums and the option of health savings accounts.

Then I searched the Anthem Blue Cross site for available neurosurgeons taking traditional Blue Cross within a 10 mile radius of my house. The web site gave me 11 listings of neurological surgeons, but at least one was actually a neurologist. Next I tried to research physicians available through Covered California. This "plan" was not listed as an option. I searched the insurance basics on the site, and it appears that any health plan bought or changed after March 23, 2010 falls in the Covered California category. A plan from a date prior may be a grandfathered plan, but once one leaves that plan, one can never return.

Interesting how progress often complicates things that actually worked better when they were simpler. ❖

INSIDE THIS ISSUE:

EHRs get ranked—what's best for neurosurgeons?

Randall W. Smith, MD, Editor

Electronic Healthcare Record (EHR) systems have not been joyously employed by docs for any number of reasons but one of the biggest complaints has been the point-and-click, template-driven EHR systems that require intensive data entry, in part to satisfy the federal meaningful use requirements, which transforms docs into clerks, slows them down, and turns face time with the patient into screen time.

KLAS, an independent research firm in Utah, conducts over 1,900 healthcare provider interviews per month, working with over 4,500 hospitals and over 3,000 doctor's offices and clinics. Their Best of KLAS awards for 2013 in the 1 to 10 physician category was won by SRS EHR, a program that does not depend on a lot of mouse-clicking. EpicCare Ambulatory Electronic Medical Record from Epic repeated as number 1 among practices with 11 to 75 physicians and among those with more than 75 physicians.

SRS's program requires a fair amount of hard copy scanning but does allow for handwriting chart notes and physicians can dictate or use voice recognition for data entry. Filling in little boxes on the screen is kept to a minimum. Its software has evolved to the point of satisfying both stage 1 and stage 2 requirements of the federal meaningful use program. Roughly 80% of the 6000 clinicians who use the SRS program work in high-volume, high-revenue specialty practices that value speed.

By virtue of dominating the inpatient EHR market, Epic has become the leading vendor of EHRs for medium and large group practices. The reason? Hospitals are hiring physicians as fast as they can, and whether they like it or not, those physicians become users of Epic's ambulatory EHR for the sake of system integration. Epic's EHR has its pros and cons but nevertheless earns high marks from hospital-employed physicians in part because they don't have to pay for it.

Regarding the practice management software that physicians use to schedule patient visits, send out bills, and monitor collections, KLAS found that Athenahealth was on top in the categories of groups including 1 to 10 physicians and 11 to 75 physicians, whereas Epic prevailed as number 1 in groups with more than 75 physicians as well as the hospital market.

Based on the above, the KLAS rankings would suggest that neurosurgeons, who predominantly practice in groups of 1 to 10, should give SRS a close look for EHR and Athenahealth for practice management. ❖

CANS MISSION STATEMENT

'An organization of Neurosurgeons to promote the professional education and scientific achievement of surgeons and quality care for Californians'

DO YOU KNOW A NEUROSURGEON NEW TO CALIFORNIA?

TELL THEM ABOUT CANS AND DIRECT THEM TO THE CANS WEBSITE: WWW.CANS1.ORG! THERE IS A MEMBERSHIP APPLICATION ON THE SITE!

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Brain Waves

Deborah Henry, MD, Associate Editor

Insurance n: an arrangement by which a company gives customers financial protection against loss or harm, for example, theft or illness, in return for payment (premium). In the 1550's, insurance meant engagement to marry. The commercial use of the word dates to the 1650s. Insurance is derived from the word assurance, and its history goes back to the 3rd century BC with Chinese shipping and later the Code of Hammurabi to assure safe passage of caravans. The Romans joined burial clubs to help indemnify the costs of dying. The city of Genoa is home to the first insurance policy. Each person or group wrote their name and the amount of risk they wished to assume under the insurance proposal. Hence the term "underwriter" was born. Astronomer Edmund Halley created the first actuary table for life expectancy (1693). Halley joined together statistics of mortality rates with the idea of compound interest; however, he kept the rates the same despite the age of the individual. It took almost sixty years for Joseph Dobson to amend this formula. The first insurance company started in 1688 at Lloyd's coffee house in London. It is still in business: Lloyd's of London. As commerce grew throughout the next two centuries, insurance companies sprung up in colonial America. A large fire in New York (1835) and the great Chicago fire (1871), both where huge losses occurred, stressed the need for insurance companies to carry sufficient reserve funds.

Health insurance began in the 1850s as a type of accident insurance for railroad and steamboat travel. Modern type medical insurance plans arrived in the 1929 with the Baylor Plan. This plan, devised by Dr. Justin Ford Kimball of the Baylor University Hospital in Dallas, provided up to 21 days of medical services to teachers for a cost of 50 cents a month. The Great Depression saw an increase in hospital derived health plans partly to provide a steady income to the strapped hospital system. The American Hospital Association adopted the Blue Cross symbol in 1939 for plans that met their standards. In 1960, the plans of the AHA joined together to form the non-profit Blue Cross and as they were non-profit, they did not pay taxes and therefore were able to offer low premiums. The 1940s and 1950s saw a proliferation of employee-based health plans. On December 29, 1973, Richard Nixon signed the Health Maintenance Act that promotes the development of HMOs.

Blue Shield started as an insurance plan for the lumber and mining camps of the northwest in 1939. The blue shield logo began representing the plan in 1948. The two companies merged in 1982.

The non-profit nature of the companies changed with the Tax Reform Act of 1986 from a 501© (4) to a 501(m) with subsequent reduced taxation. In 1994, the companies become for-profit entities. In 1990, the average premium was around $1500. Twenty years later, that number is close to $5500. I wonder what it is going to be a year from now. ❖

Transitions in Neurosurgery

John Bonner, MD, Associate Editor

The trial attorneys are attempting to adjust the MICRA cap on non-economic damages (i.e., damages for pain and suffering). Recently, proponents of the Troy and Alana Pack Patient Safety Act submitted signatures to the Secretary of State in an attempt to qualify the proposition for the November ballot. In bringing this proposition, chief sponsor Bob Pack, who lost two children to a pharmaceutically-impaired driver, stated in a press release:

"For 37 years, injured patients in California have been denied access to justice and strong patient safety protections," said Pack, a technology executive and one of the pioneers of NetZero. "This ballot measure begins to even the balance of power for innocent patients who are victimized by medical negligence and protects against dangerous and drug-abusing doctors. It's a simple and reasonable step forward that the legislature should have taken decades ago."

According to the California State Legislative Analyst's Office, this measure will, if enacted:

*Raise the Cap on Noneconomic Damages for Medical Malpractice to reflect inflation(to $1.1 million dollars)
*Report Suspected Physician Drug or Alcohol Impairment or Failure to Follow Appropriate Standard of Care.
*Require Hospitals to Conduct Alcohol and Drug Testing on Physicians and refer the matter to the Attorney General's Health Quality Enforcement Section for investigation and enforcement.
*Require Health Care Practitioners and Pharmacists to Consult CURES prior to prescribing or dispensing certain drugs, such as OxyContin or Vicodin, to a patient.

The fiscal effects of this proposal, according to the LAO, could be significant. Specifically, "state and local government costs associated with higher net medical malpractice costs, likely at least in the low tens of millions of dollars annually, potentially ranging to over one hundred million dollars annually;" and "potential net state and local government costs associated with changes in the amount and types of health care services that, while highly uncertain, potentially range from minor to hundreds of millions of dollars annually."

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"If you like your doctor, you can keep your doctor," – how many times have we heard this refrain? Much press coverage has shown that this statement proved to be untrue because the Obamacare rollout made many private insurance companies drop coverage for enrollees, thus causing those with private insurance to lose their doctors. Yet, there has been relatively little coverage about how Covered California wrongly listed the names of numerous physicians as accepting Obamacare insurance. According to the Fresno Bee, many physicians in the San Joaquin Valley were wrongly listed on the Obamacare website as accepting patients who subscribed to Obamacare. Thus, many patients may have relied on the representation on the Covered California website that their physician was accepting Obamacare patients, only to find that their doctor was not accepting Obamacare insurance. In sum, many who purchased Obamacare health insurance may have done so under the belief that certain physicians would be available to treat them. These individuals, who have now enrolled in Obamacare, have found that some physicians do not accept Obamacare insurance, and thus, these individuals find that they do not have the physician choice they thought they would have. Covered California has since admitted its mistake and took such providers' names off the website. Nonetheless, it is unclear whether those who enrolled in Obamacare, under the impression that their providers were participating, will be able to find insurance elsewhere, or whether they are stuck with Obamacare and its limited physician pool.

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The Obamacare rollout will certainly affect the way medicine is practiced and also affect physician income. Obamacare reimbursement rates are considered too low for physicians to accept such insurance. Expanded patient caseload is not sufficient to expand income – certainly if good physician care is desired.
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CANS NEEDS SOME HELP!

Ken Blumenfeld, MD CANS Treasurer, is also the Chairman of the CMA Council on Legislation (COL). Ken was a longtime member of the council representing CANS but as Chair, can no longer represent CANS. Ken is looking for an interested CANS member to join him on the Council. The CMA COL formulates policy recommendations to the Board of Trustees regarding sponsored legislation or positions on anticipated major legislation affecting physicians. The council generally meets twice a year in person, with telephone conference calls, as needed, to address amended legislation. All council members must be CMA members.

Contact Ken at **kennethblumenfeld@mac.com** if you are interested in serving.

Tidbits from the Editor

Should the Sunshine Act Shine on You?

The Physician Payment Sunshine Act (PPSA) requires manufacturers of drugs, devices, biological and medical supplies to report to the CMS any payments or transfers of value worth more than $10 they make to physicians including those in fellowships as well as to teaching hospitals. There are no penalties for docs who receive such payments. The CMS plans to publish a list of who got what from whom on September 30th, 2014. There are some exclusions to what is reported including certified and accredited CME, buffet meals and snacks (which can't be monitored as going to a specific doc) at "large scale" events, product samples intended for patient use rather than for sale and dividends or other profit distributions due to ownership or investment interest in a publicly traded security or mutual fund. Group purchasing organizations (GPOs) must also report to the CMS regarding ownership interests that physicians or their immediate family members hold.

Manufacturers and GPOs begin submitting their reports to CMS on March 31st and in June-August CMS will activate a portal on their Web site that will allow docs access to the reports they plan to make about 2013 payments and docs will be able to contact the manufacturers/GPOs to correct errors or challenge the reports. Docs will have 60 days in the June-August epoch to resolve any disputes with manufacturers/GPOs and if resolution is not achieved and the manufacturer/GPO plans to stick by its original data, CMS will publish the manufacturers/GPOs original information anyway but flag it as disputed.

Since the manufacturer has to identify each doc on whom they plan to report by NPI number, you can anticipate a request for your NPI from the manufacturer which should attract your attention. The smart money suggests that each doc should register with the CMS for the online portal so you are ready to review the reports the manufacturers submit about you (go.cms.gov/openpayments) as well as signing up for the PPSA listserv to receive updates regarding the program.

Medicaid Business as Usual means more bad Business for Neurosurgeons

President Barack Obama's proposed budget for fiscal 2015 delighted champions of primary care because one proposal directly affects physician revenue: The White House wants to add 1 more year to a provision of the Affordable Care Act that raises Medicaid reimbursement to Medicare levels for evaluation and management services and for vaccination administration performed by primary care physicians. The act authorized this parity in Medicaid-Medicare pay for 2013 and 2014 to entice more clinicians to accept Medicaid patients, whose number would grow by the millions under the law. The president's budget not only would continue Medicaid-Medicare parity into 2015 but also would apply it to nurse practitioners and physician assistants. The cost, spread out over 10 years, would come to $5.4 billion.

All this is well and good for primaries but does nothing, as usual, to improve the pay scale for specialists treating Medicaid patients. In California, any neurosurgeon who operates on a Medicaid patient is doing pro bono work since the cost of delivering our care to such patients far exceeds what Medicaid pays. Little wonder so few specialists will accept such patients which in turn leads to major delays while the PCP tries to find a specialist who will see the patient. It is not surprising that a lot of these frustrated PCPs finally decide to send the patient to the ED where specialists have to respond. Another great use of the ED.

How long will it take for the Feds and the State to recognize that the patient care coin has two sides, primary care on one and specialist care on the other? Right now, flipping the Medicaid coin all too frequently comes up only primary care.

When is a Concussion a Concussion?

If you are a neurosurgeon who hasn't noted the intense national interest in sports concussion, you must be from another planet. Although there isn't any neurosurgical treatment for concussion, sports folk are moving toward using neurologists and neurosurgeons to do field evaluations of the potentially concussed athlete rather than relying on team trainers. During the last NFL season, the San Diego Chargers employed a neurosurgeon on the sidelines to check out these athletes and in addition, the NFL employed another neurosurgeon to video graphically oversee potential concussive injuries for both teams. Since most sideline neurosurgeons won't be working NFL games, the question arises as to what sideline tests a doc can employ at college, high school or Pop Warner type games that will best substantiate a concussion and thus allow removal of the athlete before more serious injury. Many teams can't afford to use the expensive ImPACT test used by the NFL.

Common sideline tests currently in use are the Standardized Assessment of Concussion (SAC) and Balance Error Scoring System (BESS) tests with those tests being performed pre-season on all players and then repeated if a concussion is suspected. A study done at the University of Florida by Laura Balcer, MD and UF team physician James Clugston, MD (to be reported at the American Academy of Neurology Meeting in Philadelphia in April) found that the SAC test identified 52% of concussions and the BESS test picked up 70%. When they added a vision-based test the concussion detection rate was 100%. The vision King-Devick test involves the reading of a series of numbers from index cards or an iPad screen, and it takes about 1 minute. Like the other tests, this is done at the start of the season as the baseline assessment. After injury the same test is conducted on the sideline and if the time taken is longer than at baseline, then concussion is diagnosed.

Since we neurosurgeons should be increasingly likely to be involved as team physicians for teams without a lot of money, it behooves us to have the team decide how concussions will be determined on the field and if they don't have an adopted protocol, then the doc should get them to officially in writing embrace the SAC, the BESS and the King-Devick tests. If you just apply your neurological exam skills on the sideline, some concussed athlete will convince you he/she is fine and you will send them back in to be concussed again and sustain real damage and get you into a lawsuit.

The Best Universities are just around the Corner

The Times Higher Education magazine of Great Britain, well known to us colonists, issued its annual World Reputation rankings of universities recently and declared Harvard, MIT and the University of Cambridge as the top three. Interestingly, it put Stanford in fourth place and UC Berkley in 5th while placing UCLA 9th, UCSF 31st, UCSD 36th and UCD 44th. Oxford was ranked 6th, Princeton 7th, University of Tokyo 8th, Yale 10th and Caltech 11th. USC was in a cluster from 61st to 70th. The rankings are based on opinion surveys by academics around the world, with special emphasis on the reputations of schools' research and teaching.

One might expect that the Times would be slightly biased in favor of old world institutions so it is meaningful that 8 of the top 11 schools are in the USA with 4 of those being in California. It would appear that our California kids have some pretty nice pretty local choices.

Neurosurgeon Salaries—but probably not in California

Physician staffing firm Jackson & Coker recently released a physician salary calculator, which provides hospital administrators and medical group managers with estimates of the fair market values of various physician compensation rates, as well as the revenue contributed by those specialties. The following pay data from 1,573 neurosurgeons created these figures:

Average annual compensation of full-time neurosurgeons

Salary: $690,548
Benefits: $138,110
Total compensation: $828,658
Salary per hour: $332
Hourly Benefits: $66
Total hourly compensation: $398
National average gross revenue per neurosurgeon: $2,632,463

This national average data looks good but the sun and surf of California usually reduces that number. Still, it's a beginning point if you are bargaining with a hospital or medical group. ❖

Thought for the Month

The trouble with unemployment is that the minute you wake up in the morning you're on the job--Slappy White.

Meetings of Interest for the next 12 months:

CSNS Meeting, April 4-5, 2014, San Francisco, CA
AANS/CNS Joint Pain Section Bi-Annual Meeting, April 4, 2014, San Francisco, CA
AANS: Annual Meeting, April 5-9, 2014, San Francisco, CA
Nsurg. Soc. of Amer: Ann. Mt., June 8-11, 2014, St.Andrews-by-the Sea, New Brunswk, Canada
Rocky Mountain Neurosurgical Society: Ann. Meeting, June 14-18, 2014, Victoria, B.C., Canada
New England Neurosurgical Society: Annual Meeting, June 26-28, 2014, Brewster, MA
Western Neurosurgical Society: Annual Meeting, August 16-19, 2014, Sun Valley, ID
CSNS Meeting, October 17-18, 2014, Boston, MA
Congress of Neurological Surgeons: Annual Meeting, October 18 - 22, 2014, Boston, MA
North American Spine Society: Annual Meeting, November 12-15, 2014, San Francisco, CA
AANS/CNS Joint Pediatric NS Section: Ann. Meeting, December 2-5, 2014, Amelia Island, FL
Cervical Spine Research Society: Ann. Meet., Dec 4-6, 2014, Hyatt Regency Grand Cypress, Orlando, FL
North American Neuromodulation Society: Ann. meeting, December 11-14, 2014, Las Vegas, NV
CANS Annual Meeting, January 16 – 18, 2015, Balboa Bay Resort, Newport Beach, CA
AANS/CNS Joint Cerebrovascular Section: Annual Meeting, 2015, TBA
Southern Neurosurgical Society: Annual Meeting, 2015, TBA
AANS/CNS Joint Spine Section: Annual Meeting, March 4-7, 2015, Phoenix, AZ

Any **CANS** member who is looking for a new associate/partner/PA/NP or who is looking for a position (all California neurosurgery residents are CANS members and get this newsletter) is free to submit a 150 word summary of a position available or of one's qualifications for a two month posting in this newsletter. Submit your text to the CANS office by E-mail (emily@cans1.org) or fax (916-457-8202)—Ed. ❖

The assistance of Emily Schile and Dr. Deborah Henry in the preparation of this newsletter is acknowledged and appreciated.

- To place a newsletter ad, contact the executive office for complete price list and details.
- Comments can be sent to the editor, Randall W. Smith, M.D., at rws-avopro@sbcglobal.net or to the CANS office emily@cans1.org.
- Past newsletter issues are available on the CANS website at www.cans1.org.
- If you do not wish to receive this newsletter in the future, please E-mail, phone or fax Emily Schile (emily@cans1.org, 916-457-2267 t, 916-457-8202 f) with the word "unsubscribe" in the subject line.

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