OCTOBER 2023

E-NEWSLETTER

MESSAGE FROM THE BOARD

To use the MGMA brand, the Pennsylvania MGMA (PA MGMA) has a State Affiliate agreement with National MGMA (MGMA). At the end of June, MGMA sent email communication to each state notifying state leaders of two new model agreements by which a state can become an affiliate and work with MGMA. The agreement chosen will be effective January 1, 2024, and replace our existing Affiliate Agreement.

The Pennsylvania MGMA Board of Directors has spent many hours diligently working to evaluate the proposed agreements, forming a task force to assess the impact on the PA MGMA, and meeting more often to engage in a dialogue on what's best for our association. The Pennsylvania MGMA Board of Directors is committed to ensure that any change will have a positive impact for our members.

Although state leaders from 41 states strongly advocated for more time to assess and implement the changes as proposed by MGMA, we were just notified that the timeline would remain the same without any extension granted. Within the next four to six weeks, additional meetings are scheduled both internally to the Pennsylvania MGMA and externally with other state leaders and MGMA staff.

I encourage you to register and participate in the PA MGMA Town Hall to be held on **Wednesday, October 4, 2023, at 3:30 PM ET,** via Zoom. We need and want your feedback and direction.

EVENTS

PA MGMA Town Hall
October 4 |
3:30 - 5:00 PM | Zoom

The Consummate Call Center: People, Process and Technology
October 20
12:30- 1:30 PM |
Webinar

Facts and Misconceptions of the Employee Retention Credit for Healthcare Organizations
November 17
12:30 - 1:30 PM | Zoom

View Events

Best,

Peter Constantinou
Executive Director

Shelley Rine, CPC, COPC
Chair

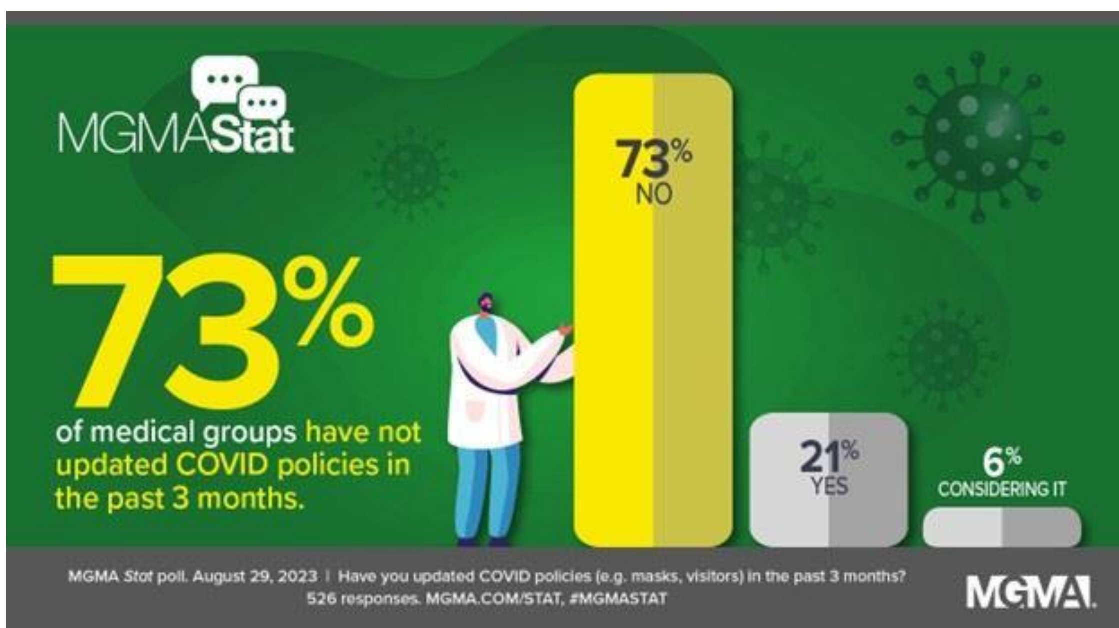
INDUSTRY NEWS

Medical groups prepare as a summer COVID mini-surge spills over into fall

Reprinted from MGMA Stat Article

While most medical groups haven't changed COVID-19 policies this summer, many are prepared to act on mask rules and more if a surge occurs this fall.

Labor Day unofficially marks the end of summer for many parts of the country, setting the stage for an uncertain autumn in which medical group practices contend with the triple threats of increased COVID-19, flu and RSV cases.



According to an Aug. 29, 2023, MGMA *Stat* poll, more than seven in 10 (73%) of medical groups report that they have not changed their policies around COVID-19 in the past three months. That's compared to about one in five (21%) medical groups that have updated policies at the same time, while another 6% report they are considering changes.

The poll had 526 applicable responses.

The lack of major changes on the policy side is not surprising, as new variants have only just emerged and case counts — for COVID-19 and Influenza A — have seen a rapid spike in numerous regions of the country. The Centers for Disease Control and Prevention (CDC) noted that hospitalizations and deaths tied to COVID-19 jumped 19% and 21%, respectively, last week, with more than half of U.S. states reporting a 20% or larger increase in COVID-19 hospitalizations week over week.

Mask rules: Some never changed

If COVID-19 case counts continue their upward trend, several practice leaders told MGMA that they are considering expanding the areas where masks are required within their facilities. Some are shifting to a uniform rule for staff to wear masks as a matter of public health and to preserve staffing levels amid ongoing difficulties recruiting and hiring.

While not as common, some respondents said they would consider requirements for staff and visitors to mask. Other practice leaders said they have never let their guard down against COVID-19.

“We have not ever stopped our COVID protocols for when patients are in the office,” one respondent told MGMA, who noted that the next steps for the group would be masking and distancing in staff-only areas, such as lunch/break room areas.

Vaccine education efforts to ramp up

Beyond those measures, one medical group leader said this fall would be an appropriate time to revisit the organization’s policies on vaccination requirements — with a new slate of COVID-19 vaccines designed for this year’s dominant strains of coronavirus, medical group leaders will be in a position to encourage patients and their staff to get shots for protection not just against COVID-19 but also the flu and possibly RSV.

However, there remains uncertainty over what vaccination campaigns might look like, as updated COVID-19 booster shots may not be available until late September.

Policies built to last

But the fact remains that a substantial number of medical groups either have not experienced COVID-19 case spikes in their area significant enough to trigger a change in how they operate, or the policies they have are designed to respond when stronger public health protections are necessary.

One practice leader said he hoped that changes won’t be necessary but that the organization has “instituted further cleaning protocols in patient rooms and lobbies” to mitigate potential exposure.

“We will make our decision based on surges and local market trends,” said another respondent to the new poll.

Practice leaders also expressed that they anticipate increased interest in telehealth for acute illness this fall as the combination of COVID-19, flu and RSV cases might spike patient demand.

INDUSTRY ARTICLES

You Can Help Improve the Medicare Physician Fee Schedule

By: Sandy Coffta, Vice President, Client Services

***Sandy Coffta** is the Vice President of Client Services at Healthcare Administrative Partners. Sandy oversees the team responsible for achieving and maintaining the company's consistently high retention and referral rates. She has over 20 years of experience in client relationship management, including reimbursement analysis, workflow optimization, and compliance education. She specializes in business intelligence and reporting development, is a subject matter expert in radiology practice billing, and has delivered presentations at several national and regional Radiology Business Management Association (RBMA) conferences. Sandy also serves on the RBMA Data Collection & Reporting Subcommittee.*

Sandy holds an M.A. in French Language and Literature from the State University of New York at Binghamton

Reimbursement under the Medicare Physician Fee Schedule (MPFS) has been consistently reduced for as many years as most of us can remember. Most recently, the

2023 payment rate was cut another 2.08% from the 2022 level, leaving the fee schedule 7.6% lower than it was in 1998 and 11.0% lower than it was in 2008.

The rates for radiology have essentially been cut by over 22% since 2001 when factoring both inflationary adjustments and recurring downward changes to the Conversion Factor. Estimates for many common radiology specific exams within diagnostic, ultrasound, DEXA, CT, and MRI modality-based procedures have experienced average Medicare reductions by 44% between 2011 and 2021. The last significant increase in the MPFS came in 2014 (+5.3%), but today's lower payment level has more than wiped out that increase (2023 is 5.4% lower than 2014). All the while, the cost of running a medical practice has not correspondingly decreased.

A bill recently introduced in Congress could help stave off this steady erosion of the Medicare payment level, which has implications not only for Medicare reimbursement but for any commercial payer that bases its payment rates on the MPFS. HR 2474, The Strengthening Medicare for Patients and Providers Act, would require an update to the MPFS conversion factor that is equal to the annual percentage increase in the Medicare Economic Index (MEI), beginning in 2024. This would replace the current "sustainable growth rate" formula that requires budget neutrality, which effectively eliminates the possibility for a fee schedule increase. The MEI is a rolling-four-quarter measure of real-world inflation, similar to the Consumer Price Index (CPI) with which most of us are familiar. The most recent MEI data shows a projected increase of 3.8% by the 4th quarter of 2023 over 2022 and a projected increase of 2.9% by the 4th quarter of 2024 over 2023.

The bill actually goes farther than a recommendation by the Medicare Payment Advisory Commission (MedPAC) in its 2023 Report to Congress, which unanimously recommended a 2024 increase to the MPFS by 50% of the MEI. MedPAC is an independent congressional agency established to advise the U.S. Congress on issues affecting the Medicare program. In addition to advising the Congress on payments to private health plans participating in Medicare and providers in Medicare's traditional fee-for-service program, MedPAC provides information on access to care, quality of care, and other issues affecting Medicare. The 2023 report also included a recommendation that Congress should enact a non-budget-neutral add-on payment, not subject to beneficiary cost sharing, of 15% for primary care and 5% for non-primary care physicians for services provided to low-income Medicare beneficiaries. This latter recommendation has not been taken up by Congress.

With a tangible piece of legislation pending, physicians can make their voices heard by contacting their representatives, and by encouraging others to do the same. HR 2474 was introduced on April 3, 2023, and already has 13 co-sponsors almost equally distributed on a bipartisan basis. This bodes well for its passage, and you can help. The Medical Group Management Association (MGMA) provides this helpful information for contacting legislators… share it with your colleagues and practice management staff. Everyone will benefit!

7 Essential Insights for Advancing Cybersecurity in Healthcare

By [Bill Sorenson, VP of Product, Netgain]

Bill leverages his 25 years of experience moving organizations to the cloud and leading businesses to secure environments as a senior technology leader. With a passion for cloud technology, Bill leads the product team in helping deliver robust, cost effective, and compliant solutions to the accounting and healthcare industries, allowing organizations to meet and exceed their goals. He is a national speaker on both cloud computing and cybersecurity to organizations working to align strategies to assist in growth and security.

Healthcare administrators play a crucial role in safeguarding patient information amidst the complexities of the industry. Although compliance is important, it should not be the sole driver of cybersecurity efforts. A multi-layered security approach is essential for healthcare organizations. Here are seven key insights that will help you strengthen your security strategy beyond mere compliance:

1. **Formulate Comprehensive Security Policies:** Develop clear guidelines and procedures that cover access control, risk management, data encryption, incident response, and disaster recovery. The key is not just creating these policies but consistently executing, evaluating, and refining them.
2. **Prioritize Identity and Access Management:** Upgrade your user credential and access management systems. In addition to traditional username-password combinations, embrace multi-factor authentication (MFA) and adhere to the principle of 'least privilege' to enhance security.
3. **Conduct Regular Audits and Vulnerability Assessments:** Perform routine audits to gain insights into system access and activities. Vulnerability assessments are crucial in identifying and addressing unmonitored security gaps, bolstering your defenses against potential cyber threats.
4. **Implement Data Encryption:** Make data encryption a standard practice for data at rest, in transit, and in use. To fortify network security, employ firewalls, intrusion detection systems, and frequent vulnerability assessments.
5. **Foster a Cybersecurity Culture:** Cultivate an organizational culture that prioritizes cybersecurity. Regular staff training, recognition for vigilant practices, and engagement will empower employees to become effective 'human firewalls.' Cybersecurity becomes everyone's responsibility, transcending IT's role.
6. **Develop Incident Response and Disaster Recovery Plans:** Prepare for cyber incidents by establishing effective incident response and disaster recovery plans. Being ready for contingencies helps mitigate damage, and regular drills and updates ensure the plans remain efficient.

7. **Engage with Industry Resources:** Collaborate with cybersecurity vendors, participate in healthcare information sharing centers, and align with national cybersecurity agencies. Leveraging industry resources will significantly enhance your security posture.

Cybersecurity is a continuous journey. Compliance serves as just one milestone along the way. If you seek a reliable partner on this journey, contact Netgain. We provide a proactive risk-centric approach to fortify your healthcare systems, making them more secure, resilient, and trustworthy, far beyond mere compliance.

Employment Agreements: the Physician-Employee's Perspective

By [Daniel Shay]

***Daniel F. Shay's** practice is restricted to health law and health care regulation focusing primarily on physician representation, fraud and abuse compliance, Medicare Part B reimbursement, and HIPAA compliance in the physician context.*

He has published on all of these topics both in the trade press and in major chapters the HEALTH LAW HANDBOOK. Mr. Shay received his Bachelor of Science degree cum laude in 2000 from Vanderbilt University and his juris doctorate degree from Emory University School of Law in 2003. Daniel is admitted to the Pennsylvania Bar, and is a member of the American Health Lawyers Association. He is a member of the Editorial Board for Compliance Today.

While not a universal truth, many physician-employees have formal employment agreements with their employers. Some agreements are barebones documents, while others are lengthy and detailed. This article explores three common contract provisions and the physician-employee's mindset relating to them: compensation, termination, and non-compete language.

Compensation

Most physician-employees prefer a fixed, predictable salary. Nevertheless, fixed salaries are increasingly giving way to models focused on productivity (e.g., wRVUs), sometimes including "at-risk" compensation, leading to certain common issues. First, when the contract begins with a fixed-rate and transitions to "at-risk" later, or when employees who have been working for the same employer on a fixed salary for years find themselves faced with new "at-risk" compensation terms when it comes time to renew the agreement, the employee may feel as if a part of their pay is now being taken; what was guaranteed is

now conditional. Even if the actual wRVU targets seem achievable based on past performance, employees recognize that circumstances may arise that reduce their productivity, and thus their pay. Unsurprisingly, they may complain about such terms, even if the employer offers the possibility of generous productivity-based bonuses (e.g., paying a fixed amount for each wRVU produced above a given threshold).

The method of at-risk compensation may also be an issue. For example, if the employee is paid on an estimated "draw," they may balk at the prospect of having to repay shortfalls if they fail to meet wRVU targets. Consider the impact of this approach, as opposed to adjusting compensation downward in future pay periods. While they will like neither approach, one is far less disruptive.

Termination

Many employment agreements include long lists of reasons for which an employer may terminate the agreement "for cause." The employee's breach of contract, loss of licensure, criminal conviction, violation of company policy, etc., may all lead to termination. However, most agreements do not allow the employee to terminate for cause, other than in the case of breach by the employer. These following reasons should be considered: the employer's bankruptcy, loss of license or certification necessary to continue operations, or other similar reasons.

Some employment agreements also allow only the employer to terminate without cause. Employees almost always object to this; they lose job security, but do not gain any flexibility in exchange. Employees know their lives may require them to leave employment and want the flexibility to change jobs without having to breach the contract or pay an attorney to write a settlement & release agreement. That said, the notice period for the employee to terminate without cause is typically longer than termination for breach, so the employer has time to find someone to replace the employee.

Non-competes

Physicians always ask about non-competes during contract reviews. Given their impact, it should be no surprise that most employed physicians strongly dislike such provisions. These terms can be especially problematic in the era of consolidation, where an employer's geographic footprint can grow as they expand facilities or buy new practices. They can place severe restrictions on a physician's ability to continue practicing in geographic areas where they may have built their life, purchased property, have children in school, etc.

Nevertheless, physicians will find it less objectionable if the non-compete only applies to locations where the physician actually worked (or within a small geographic radius of such locations) during the agreement, and if the non-compete will not apply if (1) the employer terminates without cause, or (2) the physician terminates for cause or breach.

Conclusions

Our firm has represented many physicians in contract negotiations. The issues discussed above are some of the most common points that physicians want addressed in any contract review. Many of these issues are driven by shifting attitudes towards the practice of medicine, and by the changing economics of the practice. As groups merge, as physicians' lives change, they want both predictability and flexibility. Stable compensation

is critical to them, as is the ability to exit the agreement on favorable terms. Employers should expect physicians to raise these issues, and others, in the course of contract negotiations. Forewarned is forearmed.

Health systems center clinicians in the C-suite

Reprinted from Becker's Hospital Review

When looking to fill top leadership posts, more health systems are turning to nurses and physicians.

At least 17 nurse leaders have been promoted to the CEO role in 2023. Nurses possess many useful skills for running a hospital: compassion, dedication and an in-depth understanding of how policies trickle down to affect caregivers and patients. This perspective is particularly vital during the nursing shortage, as RNs heighten demands on executives.

In fact, Cincinnati-based UC Health recently tweaked its leadership model to center nurses' perspectives. Each hospital will be led by a registered nurse, and existing chief administrative officers will be phased out.

Health systems are looking toward physicians for guidance, too. At least 14 have tapped physician leaders for the CEO role this year.

One system embracing physician leadership is Johnson City, Tenn.-based Ballad Health. In August, it appointed chief medical officers to several of its community hospitals in a move that ensures each of the 10 facilities in its Southern Region are represented by a physician leader.

"Chief medical officers are vital to our physician leadership teams, as these individuals are essential to developing a medical strategy to align with our goals and objectives as a healthcare system," said Lisa Carter, president of Ballad Health's Southern Region. "With a strong team of CMOs across our region, we are able to ensure a high standard of care in every patient care setting in the Ballad Health footprint, and elevating quality leaders will enable us to meet that goal."

WASHINGTON CONNECTION

Join PA MGMA for member benefits like exclusive access to the Washington Connection issued by National MGMA!

CALL FOR ARTICLES

We invite you to share your medical group management expertise and submit an article for the PA Pulse!

Here's what we need for your article's consideration:

- The article must be timely and relevant.
- It must be 750 words or less.
- Include full name, headshot, short bio, and link if applicable (LinkedIn or website).
- Email your article in original format (accessible web link or Word).

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