How Much Is Your Practice Really Worth?

At some point, every practice undergoes physician transitions as physicians join, retire, merge and separate from groups. Advanced planning and communication can help facilitate the process. When physicians wait until the last minute, options are limited and decisions tend to be reactive to the market conditions. During the transition, patients may transfer their care to another physician that can result in the practice struggling to manage overhead expenses. On the other hand, a more proactive approach includes communicating with stakeholders early to manage transitions on a more appropriate schedule. A good transition plan indicates a well-run practice and is more attractive to potential suitors.

Many physicians want to know the value of their practice. The practice value is highest when the physician is working at full capacity, the building and equipment are in good condition, and technology investments are incorporated into the practice. The financial statements are more attractive when the physician is working at full capacity. A certified healthcare appraiser or accountant can help determine the value of the practice, but the appraised value is only as accurate as what the market will bear. The most common appraisals evaluate cash flow, tangible assets including the building and equipment, and comparable sales. Some valuations may include a single valuation approach and some use a combination of all three methods. The valuation method depends on the circumstance and the buyer. For example, a hospital valuation approach may be different than a private practice valuation if the hospital pays a market salary for the physician's integration. The more difficult and subjective approach to a practice valuation is the value of the intangible assets of the practice, also known as goodwill. Some examples of goodwill include reputation in the community, workforce in place, patient panel, and competition. Essentially, a new partner or purchaser of the practice has to determine if the expected earnings of the practice justify the buy-in or purchase amount or if it is more beneficial to set up a practice in another location. The Goodwill Registry is a national healthcare database that may be a useful comparison tool for determining the value of intangible assets.

Consider a solo physician who has practiced in a rural area for 30 years. The physician is near retirement and is reviewing options to sell the practice. The retiring physician has not invested in the practice nor facility in years, and the building and equipment are outdated. The cash flow might look attractive to a potential buyer, but the buyer would also have to consider the capital investment needed to update the practice. A prospective buyer has to determine the potential revenue stream of the practice or the goodwill value of the retiring physician's patient panel. A new physician moving to the area may find it more feasible to

set up a practice in a nearby location and incur the operating expense of starting a new practice rather than paying goodwill for the retiring physician's practice. Another variable for the retiring physician to consider is the storage and retrieval of patient medical records. The retiring physician might find it more beneficial to assign a lower goodwill value of the practice to transfer the medical records to a new physician to avoid the burden of storage and retrieval of medical record after retirement.

In another scenario, there is a four-physician practice in a metropolitan city. One physician is considering retirement within five years. If the group plans appropriately, they may be able to replace the retiring physician with a new physician so that the new physician has a stable patient panel and revenue stream. The retiring physician would sell his or her share of the partnership to the new physician, and the medical practice would continue. In this case, the new physician partner may invest in the assets of the partnership and be willing to pay some amount of goodwill for the established practice. In this case, the goodwill is the infrastructure of the group. The group has all of the business systems in place for a seamless transition. The goodwill value may be set as a percent of income, accounts receivable or compensation of the group. The incoming physician has to determine if the goodwill value is more or less reasonable than other options.

On the other end of the spectrum is the private practice group that makes the strategic decision to integrate with the hospital. The hospital is required to pay fair market value to comply with the Stark Regulations. Hospitals pay fair market value by providing a salary that is consistent with industry benchmarks, and they buy or lease the physician's building and equipment for the appraised value. It is very rare and highly unlikely that a hospital will pay for intangible assets or goodwill. In private practice, goodwill reflects the business infrastructure in place. When a private practice merges with a hospital, they integrate with the hospital's infrastructure. From the hospital perspective, the value in the integration is the physician's ability to serve the needs of the community. Some physicians considering retirement may find it beneficial to integrate with the hospital or health system for recruiting assistance or medical record transition. The physician near retirement has more leverage if he/she starts the discussions several years before retirement.

A practice transition includes many variables that need to consider. Timing, location, age of the practice, patient panel, recruiting and market conditions impact the valuation. To ease the stress of a future potential transition, physicians should include the topic in their ongoing strategic planning process. The discussions should include theoretical timeframes for physician departure, as well as ways to unwind the relationship. This helps to set expectations among the physicians in the group. It might be helpful to consult with hospitals or other providers within the community for recruiting assistance. State medical societies and residency programs may also be able to assist. If you start the process early, you may find the right physician to continue the care and service you expect for your patients and community. SVMIC is also a good resource to consult throughout the process of making decisions such as these. Our Medical Practice Services department is well equipped to assist with strategic planning, strategic discussions, and any other business-related issues. SVMIC does not provide practice valuations, but the Medical Practice

Services department can assist you with resources.

An Illusion of Communication

"The single biggest problem in communication is the illusion that it has taken place." - George Bernard Shaw

SVMIC has written articles and given seminars over the years about the importance of communication as it relates to providing medical care to patients. This article focuses on a case in which the breakdown in communication between physicians resulted in a medication loading dosage being continued inadvertently and is another reminder of how miscommunication between multiple physicians can result in harm to the patient.

Randy Richardson*, a 71-year-old male patient with multiple health issues, was admitted to the hospital for treatment of chest pain. Mr. Richardson had a medical history of obesity, sleep apnea, hypercholesterolemia, hyperthyroidism, arthritis, and ulcers, as well as a surgical history that included back surgery, thyroidectomy, and transcatheter intravascular stent placement. Dr. Samuel Carter, an interventional cardiologist, diagnosed Mr. Richardson with paroxysmal atrial fibrillation. Dr. Carter ordered nuclear stress testing, which was unremarkable, and transesophageal echocardiography (TEE), which demonstrated no evidence of atrial thrombus.

Dr. Carter initially planned a cardioversion at the time of the TEE, but Mr. Richardson had numerous episodes of paroxysmal atrial fibrillation with spontaneous conversion to normal sinus rhythm during the TEE. Because of Mr. Richardson's atrial fibrillation, Dr. Carter ordered intravenous Amiodarone, followed by oral Amiodarone, loading at 400 mg po tid. (Amiodarone is an antiarrhythmic agent that is often sold under the brand names of Cordarone and Pacerone.) Dr. Carter also prescribed Pradaxa 150 mg po bid as an anticoagulant agent. Mr. Richardson was discharged from the hospital by a hospitalist rather than by Dr. Carter. At discharge, the loading dosage of Amiodarone 400 mg po tid was continued with no recommended dosing reduction, with a scheduled follow up office visit four weeks later.

At the follow-up visit, Dr. Carter documented in his office note that Mr. Richardson was taking Amiodarone 200 mg po bid, when in fact Mr. Richardson was still taking the loading dosage of 400 mg po tid. The 200 mg po bid dosage is what Dr. Carter would have anticipated the discharge orders to contain, but he did not review the discharge summary and instead assumed the discharging physician had appropriately reduced the dosage. Mr. Richardson described symptoms of increasing shortness of breath and dizziness at that visit. Laboratory follow-up for Amiodarone toxicity was planned for three months later, with anticipated thyroid function tests, liver function tests, and pulmonary function tests at that time. Despite these new complaints, Dr. Carter did not review the dosage of the Amiodarone, nor did he otherwise review the dosage with Mr. Richardson.

Mr. Richardson had several office visits with various healthcare providers (who were not sued) over the next few months, with continuing complaints of weakness, dizziness, gait instability, and imbalance. During this time, his Amiodarone dosing continued at 400 mg po tid. This loading dosage of Amiodarone was eventually discontinued about four months after it began, having been discovered by another physician who saw Mr. Richardson for frequent falls and discussed the medications with Dr. Carter. Mr. Richardson was admitted to the hospital approximately ten days later with increasingly debilitating shortness of breath, weakness and tremor, and focal symptoms involving his right leg, with a CT scan showing a subacute left frontal cerebrovascular accident (CVA). Mr. Richardson was diagnosed with pneumonitis four days later. A wedge resection lung biopsy demonstrated necrotizing bronchopneumonia with diffuse alveolar damage. Mr. Richardson died a month later, and the autopsy found the cause of death to be necrotizing pneumonitis with multiple lung abscesses.

Mr. Richardson's estate filed suit against Dr. Carter, two other physicians who treated Mr. Richardson after his initial admission to the hospital, and the pharmacy that filled the prescriptions for the Amiodarone. It came as no surprise that Mr. Richardson's estate alleged that all of the symptoms that were present over the last few months culminating in the CVA and bronchopneumonia were caused by the improper dosage of Amiodarone. A normal dosing strategy for Amiodarone therapy typically begins with 400 mg po tid for one week, then 400 mg po bid for two weeks, then 200 mg daily thereafter. The patient usually returns to the clinic two to four weeks later on a dosage of 200 mg po bid, and further dosing changes are guided by patient response and tolerance thereafter.

The three physicians who were treating Mr. Richardson while he was in the hospital did not communicate with each other about the need to titrate the Amiodarone over time from a loading dosage to a maintenance dosage. During his deposition, the discharging physician testified that he was not aware of the dosage requirements of Amiodarone, as this is normally managed by the cardiologist. It is unclear why Dr. Carter's office note showed Mr. Richardson was on the maintenance dosage at his first office visit after discharge from the hospital, and it is unclear why the pharmacy continued to fill prescriptions for the loading dosage when the time period for titrating the loading dosage to the maintenance dosage had passed.

If the documentation and the communications between the three physicians had been better in this case, the overdosing of the Amiodarone and the subsequent harm to Mr. Richardson could have been avoided. There were several points during Mr. Richardson's care where better communication could have changed the outcome. This could have been accomplished by provider-to-provider verbal communication or more clear documentation of the Amiodarone dosage strategy in the medical record. This case shows that it is important for a physician to document future treatment plans, such as titrating medication, and communicating those plans with subsequent treating physicians. Also, as a physician downstream in the care, verification of the orders and medication dosages are important and help ensure that the communication between providers is complete. In this case, multiple assumptions without communication resulted in a case that could not be defended,

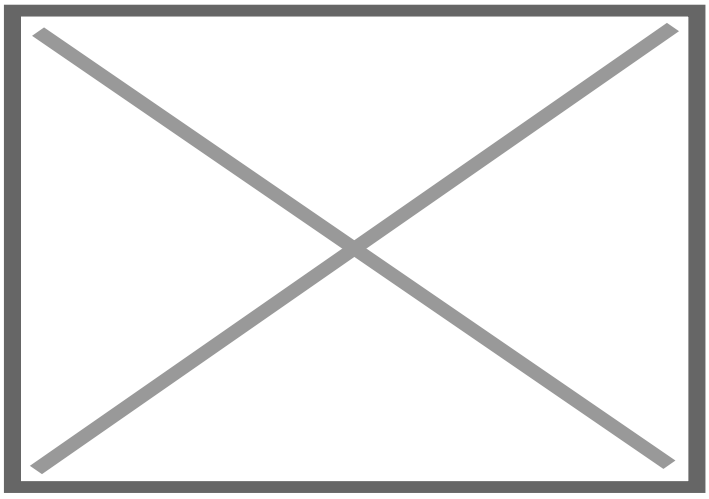
and the case was settled with contributions from all of the defendants.

* All names and identifying information have been changed

An Analysis of Oncology Closed Claims

Unexpected adverse outcomes can lead to allegations of medical malpractice; however, in the oncology specialty, many of the adverse outcomes are not unexpected. Nevertheless, the stressors of a lawsuit are devastating. Being aware of potential vulnerabilities can help reduce exposure. This article focuses on lessons learned from a review of closed claims with a loss paid on behalf of the SVMIC-insured oncologist.

A review of paid oncology claims from 2001-2016 revealed that, excluding errors in medical judgment, there were 3 basic areas that contributed to the determined indefensibility of the claims, as illustrated in the graph below.



MEDICATION/INFUSION ISSUES:

Across all specialties, SVMIC continues to see medication issues as a leading source of claims and this holds true for this particular specialty as well. Unique to oncology are the complex chemotherapy regimens where a miscalculation or medication error can be serious, as seen in the following two examples:

The first involved an infusion pump error in which the 5-FU ordered to be given over 46 hours was infused over an hour causing a loss of hearing, vision impairment, numbness in extremities, severe stomatitis and pain in a 69-year-old woman. The infusion company programmed the infusion pump erroneously, and the nurse failed to look at the pump screen to verify the correct dosage and rate before starting the pump. The plaintiff was successful in her allegations that the physician failed to provide proper oversight and training for his staff.

The second example involved a chemotherapy nurse who accidentally picked up the wrong syringe from under the protective hood and administered Vinblastine instead of 5-FU. The patient immediately developed light-headedness with tingling in the extremities and suffered long-term peripheral neuropathy. It was later discovered that another nurse had prepared the Vinblastine and set the unlabeled syringe down next to the 5-FU syringe.

DOCUMENTATION ISSUES:

Documentation issues were a factor in 36% of paid claims, with inadequate documentation as the key contributor to the indefensibility of the case. Maintaining a well-documented medical record, from both a patient care and a risk management standpoint, is crucial. It is impossible to document every event that occurs in the physician/patient interaction, but a few additional facts documented in the medical record can make cases appear quite differently to an outside observer. When a claimant presents a medical malpractice claim, the medical judgment of the provider is evaluated based upon the reasonableness of the decisions he/she made. It is critical that the important facts be documented; failure to include the rationale for medical decision making can hamper the defense. Inadequate documentation was a factor in the following two examples:

A 60-year-old patient with a known history of ovarian cancer was started on a chemotherapy protocol for suspected metastatic ovarian cancer. The diagnosis was made based on a CT scan that showed liver lesions with a CEA and CA 125 that were within the normal range. Following two rounds of chemotherapy, the patient self-referred to another oncologist who ruled out all signs of metastatic disease and maintained that the patient had been misdiagnosed. The patient filed a lawsuit alleging emotional injury due to the misdiagnosis as well as unnecessary treatments. In the lawsuit, the patient argued that further confirmatory tests (MRI, liver biopsy) were needed to confirm the presence of recurrence. Unfortunately, there was no documentation in the medical record to support the rationale for proceeding with treatment without confirmatory testing.

An oncologist treating a 56-year-old with hairy cell leukemia and known sulfa allergy allegedly failed to convey the risks/benefits/alternatives of using sulfamethaxazole as a critical support drug while the patient underwent a Leustatin® infusion. The patient suffered a severe allergic reaction and Stevens- Johnson syndrome ensued, followed by death. The oncologist did not think the patient had a true allergy but rather a sulfa intolerance issue, and, in his mind, the potential benefits of preventing pneumonia while the patient was

immunosuppressed outweighed the risks of administration. In his deposition, the oncologist testified that this discussion took place with the patient and her husband, but he failed to document it. That testimony allowed the plaintiff's attorney to postulate that, had the patient been aware of the risk, she would have likely declined the medication. Without the documentation, it became the husband's word against the physician's making the case less defensible.

COMMUNICATION ISSUES:

Effective communication is essential in establishing trust and building good patient rapport, which in turn plays a role in a patient's perception of the quality of care received and helps ensure compliance. Communication breakdowns occurred in 27% of the reviewed claims. The case below exemplifies a breakdown in communication further complicated by documentation issues.

A 61-year-old with lung cancer was admitted with fever, cough and weakness after a round of chemotherapy. The on-call physician rounded Saturday morning and made a brief note that the patient was complaining of a little shortness of breath but not in any distress. That evening and the following Sunday morning, the hospital nurses called regarding continued and increasing shortness of breath. The physician's triage nurse handled these calls. The patient coded the next day and died. An autopsy showed a pericardial effusion and cardiac tamponade. The lawsuit alleged that the oncologist missed an opportunity to save the life of the patient through earlier intervention and diagnosis of the pericardial effusion. The absence of a thoughtful physical exam during the Saturday morning rounds when the patient first complained of shortness of breath and the apparent lack of clear communication between the parties involved regarding the well-being of the patient painted the picture of a complacent physician who relied too heavily on his nurse. A complicating factor for the defense was that the oncologist dictated the discharge summary a week later and then subsequently dictated a more complete version (that appeared self-serving). The delayed dictation and attempt to embellish on the prior note were factors in the indefensibility of this case.

LESSONS LEARNED:

Chemotherapy administration:

- Stay abreast of the American Society of Clinical Oncology/Oncology Nursing Society Chemotherapy Administration Safety Standards.
- Be aware of the best practices and safety self-assessment for chemotherapy (oral and parenteral), available at Institute for Safe Medication Practices.
- Develop policies and procedures to ensure safe medication practices; reduce distractions in areas where chemotherapy is being prescribed and staff are preparing medications for administration:
    - Consistently apply the "five rights": right patient, right drug, right dose, right route, right time

- Maintain two-person verification of chemotherapy preparation and label chemotherapy agents immediately upon preparation
- To prevent administering a contraindicated medication, take a complete medication history, update it at each visit and prominently note allergies in the chart
- Have a comprehensive educational program for new staff administering chemotherapy, including a competency assessment at specified intervals and maintain documentation of such
- Maintain CPR certification for all clinical staff
- Have a written medical emergency plan and practice mock emergency drills

Documentation:

- Document the rationale for a treatment decision that may not be clear in the chart.
- Before beginning treatment, document your discussions with the patient about risk and benefits. Documentation should include:
  - the diagnosis and goals of therapy,
  - planned duration of the chemotherapy, drugs and schedule,
  - specific short- and long-term risks vs benefits,
  - address risk of no treatment, mention alternatives,
  - risks or symptoms that require notification and
  - emergency contact information, plan for monitoring and follow-up
- Include a family member in the consent discussion.
- Never alter a medical record. It will not only destroy your chances of prevailing in a lawsuit, but your professional liability coverage for the incident may be at risk.
- Do not be tempted to bolster your notes in an attempt to improve defensibility. Never amend the record without consulting first with SVMIC, especially if there has been an adverse outcome or you have received notice of a claim or lawsuit.
- Document any medical complications or unusual occurrences in an objective fashion and without reference to an incident report.
- Include specific clinical parameters in your orders that instruct when the physician should be notified.

Communication:

- Listen to patients who try to tell you when something does not feel right.
- Communicate relevant patient information in a timely and clear manner to the covering physician, especially information on patients with anticipated problems.
- Provide written and verbal instructions to the patient, including when to call the office and when to go to the ED and document this communication with the patient.
- Provide oversight to your phone call nurses and ensure they are well-trained on written advice parameters and can demonstrate competence.

Medicare Physician Fee Schedule 2018 Overview

Within just hours of the release of the Final Rule concerning the 2018 revisions to the Quality Payment Program (QPP) on November 2, the Centers for Medicare & Medicaid Services (CMS) published the ruling that governs the Medicare Physician Fee Schedule (PFS) for the coming year. Although overshadowed by the QPP announcement on the same day, the impact of the Medicare PFS Final Rule on physician reimbursement is arguably the more far-reaching of the two announcements. Let's break down the highlights of CMS' ruling.

First, the Medicare Access to Care and CHIP Reauthorization Act (MACRA) promised a 0.50% bump in reimbursement. While CMS granted that increase, its efforts to remain under a Congressionally imposed target for the recapture of mis-valued service codes, as well as to offset spending for new services, effectively whittled away a good portion of that amount. In the end, the PFS conversion factor for 2018 is $35.99, compared to 2017's $35.89.

Impacts on Specialties

As usual, there are winners and losers. Based on CMS' assessment of reimbursement changes included in the Final Rule, Allergy, Anesthesiology, Pathology, Urology, Otolaryngology, Oral/Maxillofacial Surgery, and Vascular Surgery will experience declines of 1% to 3%, while Cardiology, Dermatology, Infectious Disease, Radiation Oncology, Rheumatology, Podiatry, Psychiatry, and Plastic Surgery are projected to gain 1%.

Related to individual services, Primary Care performing behavioral health is a victor, with a payment increase resulting from an assessment of related office expenses. The set of care management codes introduced in 2017 – such as G0502 – migrate to permanent status by requiring the use of a CPT code. Primary Care Practitioners will also benefit from new prolonged services codes, G0513 and G0514. These new codes should be used when a clinician provides a prolonged (30-plus minutes) Medicare-covered preventive service.

VBPM Penalties Modified

Perhaps the biggest beneficiaries of the PFS Final Rule, however, are the physicians who were slated to be penalized via the Value-based Payment Modifier program. Except for those who had opted out of Medicare, all US-based health care professionals "participated" in the VBPM program, which piggy-backed on the Physician Quality Reporting System (PQRS). For those who did not report for PQRS, penalties for practices of 10 or more eligible clinicians were scheduled to be 4%, with smaller practices faced with a 2%

reduction. In the Final Rule, these automatic downward adjustments — that were being imposed in addition to the PQRS penalty of 2% — were changed to 2% and 1%, respectively. Even if the program determined you were “high” cost or “low” quality, all clinicians participating in reporting are being held harmless in 2018. In addition to reducing the penalties, the negative information won’t be reported to the public via Physician Compare. On the flip side, the maximum upward adjustments for high-quality, low-cost physicians were sliced to half of what CMS originally proposed.

Telehealth and Mobile Health

For nearly a decade, CMS has added CPT codes to the list of services that are covered for Medicare when provided via telehealth. This year is no different with the addition of new codes – such as G0506 (Care Planning for Chronic Care Management). Furthermore, CMS is eliminating the need to use the GT modifier for telehealth services, which was considered a duplicate effort as a result of the designated telehealth POS code, 02. This special POS code, which was introduced in 2017, will still be required.

Mobile health gets a huge boost from this Final Rule with CMS pledging to pay separately for CPT 99091.* Historically considered bundled, this code, which incorporates “remote patient monitoring,” is now valued at 1.1 work relative value units. CMS' policies for its use are: (1) the patient must be informed in writing, and the consent be documented in the patient’s record; (2) a face-to-face service must be provided to the patient within the previous year, at which time the remote monitoring is initiated; and (3) the service can only be billed once in a 30-day period.

Additional Impacts

Still unknown is the impact of the Final Rule on Oncology, Rheumatology and other specialties using biologics because CMS says it intends “to provide for the separate coding and payment for products approved under each individual abbreviated application, rather than grouping all biosimilars with a common reference product into codes.”

Those who provide advanced imaging services learn in the Final Rule that the Medicare Appropriate Use Criteria (AUC) Program for Advanced Diagnostic Imaging will begin with “educational and operations testing” in 2020. CMS provides a 24-month period for physicians to focus on the Quality Payment Program (QPP) before the AUC Program is launched.

CMS also provides a peek into comments based on its request to assess the evaluation and management (E/M) coding guidelines by referring to the differences between the 1995 and 1997 guidelines, as well as the impact of electronic health records, as among the several challenges that providers confront in appropriately using the set of codes. CMS will continue to accept comments; however, the agency also announced: “We are immediately focused on revision of the current E/M guidelines in order to reduce unnecessary administrative burden.” This statement would suggest there will be future changes, which will affect the vast majority of physicians and advanced practice providers.

All in all, 2018 will be another tumultuous year, yet this fact should come as no surprise in an ever-changing and challenging reimbursement environment.

**99091 is the collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time.*

It Takes a Village

Electronic Health Records offer the potential for vast improvement in continuity of care, legibility and accurate recordkeeping. However, to most practitioners, that goal seems light years away. This is due to many factors out of the user's control such as technology, design and integration issues. The good news is there are some ways the "end user" can help advance this goal. It's easy to learn just enough about the system to get by and to focus on the assigned task. But, with careful attention to your system's deficiencies and encouraging teamwork among your IT specialists and EHR vendor to address those issues, you will accomplish more, and impact other practices utilizing the same system. Evaluating the clinical decision support tools, standardizing the workflow, making appropriate modifications, and training and retraining to avoid perpetuating "user errors" passed down from others, are all ways to keep critical thinking and teamwork at the forefront.

The Physician Insurers Association of America's (PIAA) most recent review of EHR claims noted a rise in technology-related liability. "As EHR use is rising, so are MPL (medical professional liability) claims linked to the technology. As we continue to identify problems, we need to track the cause of those issues and share mitigation strategies," said PIAA's Vice President of Research & Risk Management P. Divya Parikh. "The goal remains to continually improve the safe use of EHRs and health IT. ONC's SAFER self-assessment Guides offer tools that users can utilize to help ensure continuous improvement in EHR systems so that perhaps eventually EHRs can offer the benefits of increased productivity and lower cost that have been promised."*

* The Office of the National Coordinator for Health IT (ONC) published Safety Assurance Factors for EHR Resilience (SAFER) Guides, which are available here.

CMS Unveils Numerous Changes to Quality Payment Program (QPP)

The number of clinicians required to heed Medicare's Quality Payment Program (QPP) next year and beyond got smaller, thanks to new language in the program's final rule for 2018. In issuing the rule on November 2, 2017, the Centers for Medicare & Medicaid Services (CMS) effectively raised the bar for physician participation to $90,000 in Medicare Part B total allowed charges or 200 Medicare patient encounters, removing an estimated 123,000 clinicians from the program. Eligible clinicians include physicians, as well as physician assistants, nurse practitioners, certified registered nurse anesthetists and clinical nurse specialists. If you are an eligible clinician by training and licensure, but fall below those thresholds, as of January 1, 2018, you no longer need to be concerned about the QPP.

For the thousands of clinicians whose annual Medicare charges or patient visits exceeds the new limits, there will still be a choice to make on which QPP track to embark: join an advanced alternate payment model (aAPM) or become an active participant in the Merit-based Incentive Payment Program (MIPS).

MIPS retains its four core components: quality, advancing care information (ACI), improvement activities and cost. Despite its earlier proposal to hold off scoring related to "cost" for another year, the CMS ruling establishes cost as a measure and gives it a 10% weighting. What's more, cost — calculated based on the Medicare Spending per Beneficiary (MSPB) and total per capita cost measure — will increase to a 30% weighting in MIPS for 2019 and beyond. In sum, for the 2018 calendar year, the measures and their relative contributions to eligible clinicians' MIPS scores will be: quality (50%); ACI (25%); improvement activities (15%); and cost (10%).

A ray of good news for some is that CMS will continue to allow practices to continue using their 2014-certified electronic health (EHR) systems although the program offers bonus points for reporting exclusively on the 2015 edition. That said, the total points required to avoid the penalty in 2018 climbs to 15, up from just three needed during the 2017 transition year. Other notable components of the final rule deal with:

Reporting mechanism. Practices may use only one mechanism - for example, EHR or registry - to report quality measures in 2018, a reversal of the flexibility hinted at when the rule was initially proposed. While acknowledging the need for flexibility in how quality measures are reported, CMS now says it will not offer this sought-after flexibility until 2019.

Reporting periods. Quality and cost measures must be reported for a period of 12 months in 2018, though the ACI and improvement activity categories remain at 90 days. It's worth noting here that several quality measures have "topped out," meaning one cannot score at the highest level in them even with perfect performance. The best response from clinicians may be to continue reviewing their quality measures each reporting year to determine which ones to submit to CMS. Although cost will be based on 12 months, it is a "behind-the-scenes" calculation made by CMS, thus not requiring any reporting.

Small practices. In 2018, practices with 15 or fewer clinicians receive an automatic bonus of five points towards their overall score, plus an automatic "base" three points per quality measure, regardless of data completeness. Small practices may also seek exemption from the ACI category in 2018 by submitting an application for this exception by the end of the calendar year.

Complex patients. Five bonus points are available for the "treatment of complex patients" in 2018. CMS will use both the dual eligibility ratio and the average Heierarchial Condition Categories (CMS-HCC) risk score in making this determination.

ASC physician exemption. The new rule gives physicians based at ambulatory surgical centers (ASCs) exemption from ACI, retroactive to the current (2017) reporting year. The exemption also extends to physicians practicing in off-campus-outpatient hospitals (Place of Service -19) as they are now assimilated into the "hospital-based physician" definition.

ACI measure excmptions. Another important ACI retroactive exemption goes to clinicians who write less than 100 permissible prescriptions: they are relieved of being measured in the e-prescribing category. Furthermore, clinicians who transfer patients to other settings or refer patients fewer than 100 times during the performance period will be excmpt from the health information exchange/summary of care measures. These exemptions apply to 2017 - and future years.

Improvement Activities. CMS adds 21 new improvement activities and makes changes to 27 previously adopted improvement activities; in total, 121 will be available in 2018.

Medical practices get some good news in the final rule with CMS now allowing virtual groups to form by joining with other practices in order to participate in MIPS. The final rule also addresses what happens when practices join an aAPM in the middle – or near the end – of the reporting year: the practice can be officially incorporated into the entity based on an alteration in CMS' look-back period, as long as the practice was able to participate for at least 60 continuous days during the performance period.

Of course, there's plenty more to peruse in the final rule which, despite CMS' pronouncements of greater flexibility, remains most certainly complex at 1,653 pages.

Here is the Final Rule for the Physician Fee Schedule (11/15)

Here is the Final Rule for the Quality Payment Program (11/16)

Is the Cloud Safe?

It seems that another cyber attack is in the news every week. Cyber criminals are trying to acquire personal information at an alarming rate, and the healthcare industry is a particular target. Patients' protected health information (PHI) often contains birthdates and social security numbers, and is in high demand by identity thieves. Many practices are utilizing cloud-based Electronic Health Records (EHR) and relying on the security provided by the vendor to protect their records. Unfortunately, cyber criminals continually work to crack the most sophisticated security, and PHI may be vulnerable if the vendor has a security breach.

Here are some real-life examples from SVMIC files:

- A practice was informed by a practice management software vendor that the vendor had sustained a ransomware attack. The practice could not use the software for about a week, causing a significant disruption of service.
- The IT Manager and HIPAA Security Officer at a medical practice were informed by its pharmaceutical software vendor that it had been attacked with ransomware. The practice discovered that they did not have a Business Associate Agreement.
- A medical practice was notified by their EHR vendor via a letter that the practice's EHR program "experienced unauthorized access to certain accounts on a specific group of data servers."
- A practice's medical records were frozen for 5 days. The practice uses a cloud-based service through a software vendor that had been subjected to a ransomware attack.
- A medical practice maintained all EHR on a cloud-based system. The vendor shut down access to their system due to a ransomware attack. The practice had no access to its EHR. The vendor advised that no PHI was compromised, but the practice was concerned about possible HIPAA breach and reporting obligations.

Utilizing a cloud services provider (CSP) for an EHR system does not relieve a medical practice from Health Insurance Portability and Accountability (HIPAA) compliance requirements and does not necessarily protect the medical practice if the vendor experiences a cybersecurity breach. A healthcare provider transmitting PHI electronically is considered a "covered entity" under HIPAA guidelines and is required to comply with the applicable provisions of the HIPAA rules. A practice's business associates are also required to be compliant with HIPAA regulations.

According to the Health and Human Services (HHS) website, the HIPAA Privacy, Security, and Breach Notification Rules establish guidelines for *PHI* when "created, received, maintained, or transmitted by a HIPAA-covered entity or business associate." HHS defines a "*business associate"* as "an entity or person, other than a member of the workforce of a

covered entity, that performs functions or activities on behalf of, or provides certain services to, a covered entity that involve creating, receiving, maintaining, or transmitting PHI."

Choosing the right cloud based EHR vendor is an important step in helping to keep electronic protected health information (ePHI) safe. In an article titled "10 Things to Look for in a Cloud Data Backup Service" the author, Sara Angeles, indicates there are several questions to ask when looking for a cloud-based vendor. In addition to regulatory compliance, learn how frequently the vendor backs up data. The more frequent, the better, especially when trying to recreate lost data. Find out where the information is stored – locally, off-site or both, and if the data is encrypted while being stored and while being sent to and from the server. Access to your medical records is critical; ask what measures the vendor takes to protect their servers as well as asking for their disaster recovery plan. The practice should be able to access the records offline if necessary in the event of a crisis, whether electronic or a natural disaster.

The HHS website recommends a Service Level Agreement (SLA) be used when a medical practice utilizes a CSP to create, receive, maintain, or transmit ePHI in order to process and/or store that ePHI. HHS indicates that an SLA "is commonly used to address more specific business expectations between the CSP and its customer, which also may be relevant to HIPAA compliance." HHS recommends that the SLAs contain provisions that address HIPAA concerns such as:

- System availability and reliability;
- Back-up and data recovery (e.g., as necessary to be able to respond to a ransomware attack or other emergency situation);
- Manner in which data will be returned to the customer after service use termination;
- Security responsibility; and
- Use, retention and disclosure limitations

The medical practice should ensure that the terms of the SLA do not prevent the entity from accessing its ePHI. You can find more information regarding guidelines and compliance at the Health and Human Services website.

Cyber criminals will not stop trying to access personal information, no matter where it is stored. Choosing a vendor that is compliant with regulations, employs security measures such as encryption and frequent backups, and provides an alternative access to records are ways to secure your patients' records when working with a cloud-based EHR vendor.

Your medical professional liability policy with SVMIC includes $50,000 of cybersecurity coverage to assist in mitigating the damages associated with a security breach. Through our partnership with NAS, higher limits are available for purchase at discounted premiums. The cost for additional coverage is based upon the limits chosen, group size and other factors. SVMIC and NAS have jointly implemented a web resource to offer cyber-specific support and risk management to policyholders. The website will offer an extensive collection of training material, sample policies, various risk management tools, and access

to webinars on timely topics. Expected to be available before the end of 2017, the new resource will be accessed on the SVMIC Cybersecurity Resource page.