



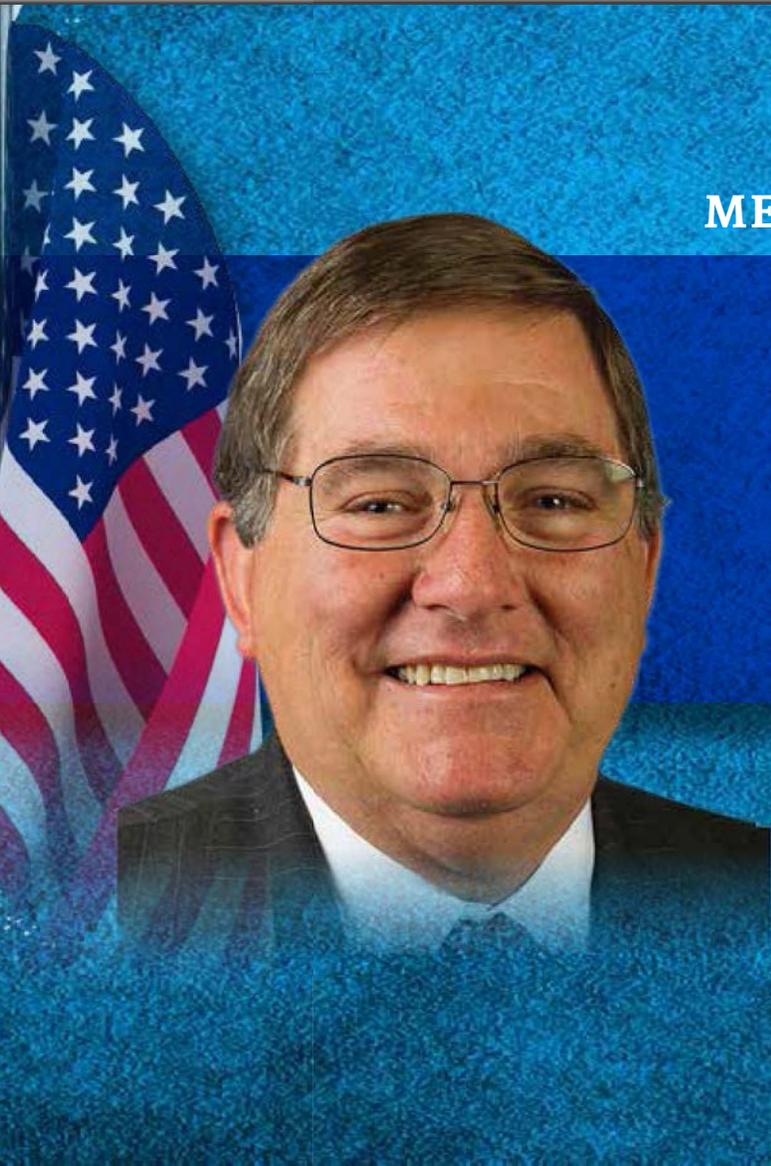
The Bulletin

For Members of the Medical Society, Counties of Erie and Chautauqua

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Dear Colleagues:

It is with deep sadness that we write to inform you Gregory T. Miller, Esq. has passed away.

As co-counsel to the Erie County Medical Society and the Eighth District Branch, MSSNY, Greg consistently worked with our leadership and administrative staff to foster greater collaboration between the legal and medical profession. Over the years he served on our Health Law committee and during this administrative year he served as its' co-chair, at the same time serving as President of the Bar Association of Erie County. He was instrumental in the development of programming under the banner of our "Breakfast at the Bar" series, and in the review and update of the "Legal Guidelines for the Medical Office". He will be deeply missed.

Our thoughts are with his wife Angela, son David and his family of colleagues and friends at this difficult time.

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The Bulletin

For Members of the Medical Society, Counties of Erie and Chautauqua

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Medical Society of the County of Erie
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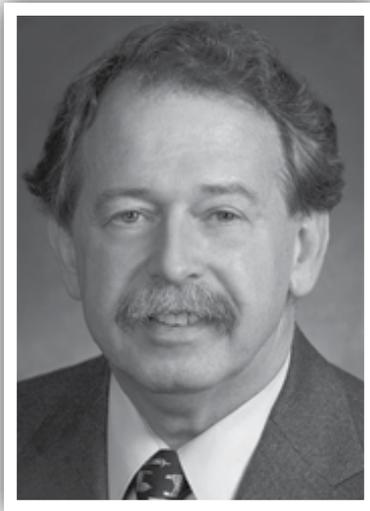
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A MESSAGE FROM THE PRESIDENT

Timothy F. Gabryel, M.D.

In our continuing efforts to keep our members aware of the changing landscape of health care, we are pleased to provide another series of articles on timely issues.

On January 1, 2017, Health Now initiated a capitated payment program for its primary care providers. While many of us have participated in capitation programs in the past, this plan is far more complicated. The Medical Society received calls from members and have met with concerned doctors and also with BCBS representatives. Dr. John Gillespie's article provides insight into this topic and raises some thoughtful questions to ponder.

We have all seen many changes in the structure of physician practices. Physicians leave groups with which they have long been associated, only to create new groups or accept employment with the health systems or other large physician entities. The legal issues, regulatory requirements and malpractice consequences of such changes can be substantial.

The Society has sponsored many educational activities on these topics and stands ready, as a resource for our members, who may have questions in these areas. If we do not have the answer, we generally can refer members to high quality individuals who are subject experts in the area of concern. A recent symposium was held on many of these topics and the late Gregory Miller, Esq. has ably summarized the events of the evening in his article in this issue.

Various healthcare cost containment initiatives and challenges are discussed in articles by Dr. Willie Underwood, Mona Chitre / Matthew Bartels, and Dawn Myszka, Esq. Please take the opportunity to review them.

While reading these articles you will appreciate how complex medicine can be. The Medical Society remains your reliable resource to help you with those and other matters that confront us in practicing medicine and caring for our patients.



A MESSAGE FROM THE EXECUTIVE DIRECTOR

Christine Ignaszak Nadolny

What have you done for me lately? Each time I am asked that question, I cringe. Why, you might ask? The answer is simple. If I don't name the one "benefit" that you are specifically looking for, I've just given you a reason why your membership and participation in the Medical Society is not worth the payment of your annual dues.

One of the most overlooked and undervalued benefits and, what I think is the best answer to the "what have you done for me lately" question is **ADVOCACY**. Over the past few months a number of your colleagues, acting as your advocate, met with the editorial board of the **BUFFALO NEWS**, Erie County District Attorney John Flynn and Acting US Attorney J. P. Kennedy. If you read the Buffalo News, or the **MSSNY ENews**, or the Member Connects Alerts, you know that your leadership is concerned about the possibility of the criminalization of medical practice. It was in those meetings that we received assurances that neither office had made any changes to the prosecution of physicians.

Across the State, your colleagues continue to and meet with State Senators and Assembly members to advocate for the passage of legislation which would provide comprehensive medical reform. NYS has the dubious distinction of being the worst state in which to practice medicine, according to an analysis from the website **WalletHub**. New York has the highest cost of malpractice liability in the nation by far! We continue to meet with legislators and urge that they reject any measures that would increase our liability exposure, such as: a change of New York's statute of limitations to a "date of discovery"; the expansion of

"wrongful death" damages to permit "pain and suffering"; the awarding of pre-judgment interest; and the elimination of statutory caps on attorney contingency fees. **MSSNY** continues to work to eliminate health disparities – assuring that all residents receive the best possible care. Their work addresses the need to secure reimbursement for language services for patients with limited English proficiency; how to attract a more diverse physician workforce and how to address the shortage of physicians in medically underserved areas. In this paragraph I've only pointed out a few issues that are of concern to every physician. A review of **MSSNY's LEGISLATIVE AGENDA** (<https://www.mssny.org/Documents/2017/Governmental%20Affairs/State/Leg%20Day/MSSNY2017LegislativeProgram.pdf?hkey=f00feb43-bf5c-4784-a908-ab59bf1bba57>) will provide you with a comprehensive listing of its advocacy platform for 2017.

But our advocacy doesn't stop there. Our offices (both at the local and state level) continue to identify issues that are of concern to both the physician and your staff. We continue to have educational programs (The Medical Record: Your Last Line of Defense), we are currently assisting a number of offices on issues related to audits, and are meeting with representatives of Blue Cross and Blue Shield regarding their recently introduced Best Practices program. Within the next few weeks, your elected representatives to the **MSSNY House of Delegates** will discuss, deliberate and vote on issues such as parity for telemedicine services, support for an increase in the cost for copying of medical records, developing

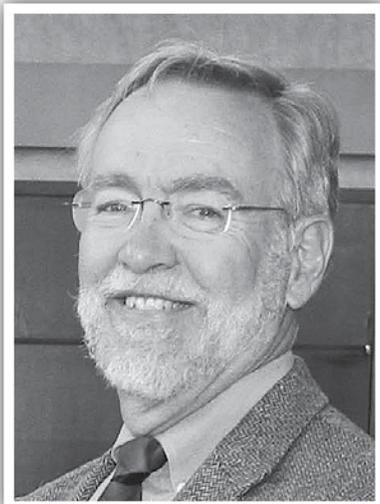
programs to address physician burnout and stress, and the disclosure of physician protected health information (PHI) on universal health care professional applications.

Effective Advocacy for any issue, on behalf of anyone or any organization does not come cheaply. There are a few options open to you. Membership in the Medical Society, participation on committees (both State and local), and attendance at Society sponsored programs and events are some of the avenues open to you. These are your opportunities to be your own, and your profession's advocate. If we become complacent – "I don't have the time", "it costs too much", "I'm not much good at talking to legislators," others (who may not be physicians) will ultimately make the decisions, and your voice will be lost. At some future date, will you look around and wonder who will then represent you?

Lastly, I would like to ask each of you to consider a contribution to the **MSSNY Political Action** committee. We need the dollars. Without money we are not at the table, when legislation or regulation which might threaten your profession is being introduced. All it takes is a contribution of, may I suggest, \$175 per year (or \$3.37 per week); or \$500 per year (\$9.62 per week)? Think about it. You may already be spending more than that at the local **Tim Hortons**, **Starbucks** each week....

Any questions, I'm only a phone call away. Cell phone is 716-316-0565.

Chris



CAPITATION

John Gillespie, M.D., Vice President

As payors in Buffalo, go to capitated arrangements to pay providers, this article is about some key points that primary care providers and their office/practice administrators should be aware of:

- **Attribution**
- **Coding**
- **Data that capitation was based upon**
- **Savings model**
- **How quickly are the databases updated**

Attribution – With capitated rates insurers typically pay providers a per member, per month (PMPM) rate for all the members assigned or attributed to them. Providers need to know the rules of how this is done. Is it based on claims from the primary care physician in the past 1, 2 or 3 years? Is it based on what the member indicates when they sign up? Any formula that is used should maximize the number of patients that a provider is responsible for and be explained, and in the contract the physician signs.

Coding – As providers move into capitated/ value based arrangements the documentation of the severity of illness of their patients is extremely important. The sicker their patient panels are, the higher their PMPM payments will be. It is in the best interest of providers to have as few “vehicles” to do this documentation as possible. For example, BCBS is using Vatica to do this. The perfect world would be to have one software program that all providers use to document the severity

of illness of their patients. The reality is to minimize the number of programs that one has to use to document severity. If the first insurer to adopt a capitation uses “X” program to do this, one would want those who follow to see the wisdom of using the same program with their providers. It should be clear in the coding agreement:

1. Who can fill out the information required?
2. What information can be extracted from the current EHR? Does your EHR work with Vatica and if so, how well? If not, then what? Will the payor support the process cost?
3. What is the payment you will receive for providing this information? Know that the insurer receives an increase in their payment from Medicare for the severity of the population they cover.
4. What is the frequency that this will be required? Yearly? Every 6 months?

The bottom line with coding is it benefits both the insurer and the provider to accurately document the severity of illness of the people they insure and care for. However, the provider is interested in the process being as simple as possible, since this takes time away from the direct care of the patient.

Data that is used to calculate the PMPM payments – Providers need to know what financial data is used, and the time period it covers, and how it is used to calculate the capitated payments. You need to know why this method was chosen and what are its pro’s and con’s. Are there built in trends, i.e. 2015 data was used. Is there a perceived increase built into the 2017 model? How are copays and deductibles accounted for in the total package? How will the different products be

constructed?

Providers, or their chosen representative, should be able to get this data and verify it and its findings.

Savings Model – Most capitated programs have the ability for providers to share savings with the insurer. In partial capitation the provider is responsible for the cost of care they provide. In full capitation the provider assumes responsibility for all the care the member receives. In full capitation, it is also essential that the primary care provider have the ability to assess the quality and cost effectiveness of specialists. Equally important to the specialist is confidence in the analytics that the severity of each case is reasonable. How the above savings in either plan are then allocated needs to be accurately described and understandable in the contract.

How quickly the data bases are updated? – Obviously a lot of work will go into proper attribution of members severity coding, understanding the financials of the agreement and how potential savings are shared. Equally important is how often the severity coding can change, how quickly patients move in and out of a provider’s base, how quality scores can affect the PMPM and when this occurs.

As we move into this new era of payment it is important that all of these issues be addressed by the insurer. The better the first major attempt is, the more likely is that subsequent insurers can be held to the same standard.



DON'T _____ ON ME AND TELL ME IT'S RAINING

By Willie Underwood, III, M.D., MSc., MPH

President Elect

Member, Council of Legislation of the American Medical Association

Since around 1985, the United States has led the world in healthcare cost as a percent of gross national product (17.6%) and average annual per person expense (around \$10,000/person). Increasingly, the burden of the cost of healthcare has shifted from the payors and employers to the beneficiaries and physicians. A major rationale stated by the GOP to repeal and replace the Affordable Care Act, is that patients' insurance premiums on the exchanges have become unaffordable for the average person and the cost of insurance has increased for everyone, whether on the exchange or not. Private insurance companies have shifted the cost of healthcare to the physicians through the creation of provider risk sharing products. Through these insurers risk sharing products, physicians have the potential to increase their revenue if they can control their beneficiary pool's healthcare spending. Theoretically, the plan is to have safe guards in place to assure that the cost reductions are not at the expense patient's quality of care and physicians receive higher revenue for managing the care of sicker patients.

As the burden of reducing healthcare cost rains down on physicians heads, the major question is how can physicians prevent from getting soaked by controlling healthcare cost? It sounds good when the media pundits state to increase health prevention, and reduce healthcare waste will reduce healthcare cost, but if this were that easy, it would already be done. What is unclear to me, is what makes anyone believe that physicians have a magic potion that will somehow make patients healthier or at least

reduce healthcare resource utilization to significantly dent the \$3.2 trillion annual U.S. healthcare expenditures? We may be able to reduce some healthcare overutilization, but this is impossible without things such as an interoperable electronic health record system that will allow physicians to see a patients records from other physicians and health systems and true medical tort reform that reduces defensive medicine.

Despite EHR being a mess and tort reform not on the agenda, healthcare scholars have proposed possible ways for physicians to reduce healthcare cost. The National Physicians Alliance (NPA) produced a list of ways that primary care physicians can reduce healthcare cost.¹ This list included but was not limited to the following recommendations:¹

"Physicians should not image the lumbar spine region of patients with lower back pain in the first six weeks unless certain red flags are present; antibiotics should not be prescribed for mild to moderate sinusitis unless symptoms persist more than seven days or worsen after initial improvement; and generic statins should be used when physicians initiate therapy to reduce LDL ("bad") cholesterol."

It has been suggested that the implementations of these recommendations by primary care physicians could save \$6.76 billion annually. Most of the savings, \$5.8 billion, would come from the use of generic statins.¹ It must be noted that preventive care costs money and this cost may produce a negative incentive that can result in physicians underutilizing preventive measures because the cost is attributed to their bottom line in short term. For example, it has been reported that the broad use of statins would cost \$85,000 to \$924,000 for every healthy year gained, depending

upon the patients' risk profile.²

It should be noted that physicians cannot force their patients to follow their recommendations or suggestions. Health or healthiness is a personal thing and there aren't any validated methods to motivate patients to be healthy. It has been reported that less than 3 percent of Americans meet the basic qualifications for a "healthy lifestyle."³ In this study 46.5 percent of participants got enough exercise, 37.9 percent had a healthy diet, but only 9.6 percent had what the study called "a normal body-fat percentage and just 2.7 percent of people met all four".³

As payors place more of the burden of reducing healthcare cost on the physician community, the greater the need for physicians to come together and redefine the discussion around healthcare reform. We have a golden opportunity to take a leadership role by meeting with stakeholders and creating strategic plans for improving the health and the healthcare of Erie County. Until then, keep dry because it is raining and it's not water.

1. Chris Fleming, Reducing Health Care Costs While Improving Care - Health Affairs Nov. 9, 2011. <http://healthaffairs.org/blog/2011/11/09/reducing-health-care-costs-while-improving-care/>

2. Steven Jacob, Healthcare in 2020 Where Uncertain Reform, Bad Habits, Too Few Doctors and Skyrocketing Costs are Taken Us. Chapter 11, pg. 145, 2012 Dorsam Publishing, USA.

3. Julie Beck, Less Than 3 Percent of Americans Live a 'Healthy Lifestyle'. The Atlantic. March 23, 2016. <https://www.theatlantic.com/health/archive/2016/03/less-than-3-percent-of-americans-live-a-healthy-lifestyle>.

MEDICAL CONSENTS FOR MINOR CHILDREN INVOLVED IN CUSTODY ORDERS

By Jesslyn Holbrook and Aven Rennie

Currently, New York State health care facilities and practitioners are facing a growing number of issues involving consent for health care for minor children involved in custody matters.

At an area hospital in which thousands of elective pediatric surgeries occur every year, the staff reports that between 300-400 procedures annually involve children subject to custody orders. The orders typically do not state that the custodian(s) are empowered to make medical decisions. At the same time, the children often have parents whose rights have not been terminated. Determining who may lawfully give informed consent for medical treatment in these cases can be difficult. In one case, a custody order appointed six joint custodians without identifying which custodian would make medical decisions. Even in cases with a single appointed custodian, however, New York law does not clearly provide that a custodian may consent to medical care, which is an issue that has been raised by experts in the field of non-parent care giving (see Gerard Wallace, "The Big Legal Picture: Grandparents Parenting Children: A New Family Paradigm," NYSBA Elder Law Attorney, Grandparents Rights News, Vol. 10, No. 3 at 12 (Summer 2000)).

The terms custody and guardianship are not statutorily defined. According to the Practice Commentaries of the Family Court Act, "the distinctions between custody and guardianship are elusive - and may be meaningless" (Sobie, Practice Commentaries, 2012, Family Court Act §661). Nevertheless, in some important respects, the law affords greater decision-making authority to guardians than it does to custodians.

Public Health Law §2504 refers to "parents" and "legal guardians" as persons authorized to consent to treatment of minors. Non-parent legal custodians are not listed as individuals with statutory authority to consent to such care (see also Public Health Law §18 [identifying a "qualified person" as a parent or legally-appointed guardian who may obtain clinical information about a patient]; Public Health Law §2994-



e [parent or guardian authorized to make decisions about life-sustaining treatment]).

In the absence of statutory authority, facilities and providers look to the contents of a custody order when determining whether a presenting party has authority to make medical decisions. Such authority is not routinely made part of custody orders, and medical professionals are tasked with the difficult job of determining which party in a custody matter, if any, has authority to consent to medical care. As today's families become increasingly more blended, the custody orders are more complex, involving mixtures of parents and non-parents, and differing rights afforded to different parties.

Complicating matters further, in 2008, New York State enacted section 657 of the Family Court Act, entitled "Certain Provisions Relating to the Guardianship and Custody of Children by Persons Who are Not the Parents of Such Children." It authorized a person possessing either an order of guardianship or custody of a minor child to enroll such child in the school district where they reside and in the guardian/custodian's employer-based health insurance. It was silent about consents for health care.

Then, in 2010, a third paragraph was added to Family Court Act §657. It provides:

Notwithstanding any other provision of law to the contrary, persons possessing a lawful order of guardianship of a child shall have the right and responsibility to make

decisions, including issuing any necessary consents, regarding the child's protection, education, care and control, health and medical needs, and the physical custody of the person of the child. . . . (§657 [c] [emphasis added]).

Notably, legal custodians are excluded from this third paragraph, which makes explicit the authority of a legal guardian to issue consents for medical care.

A review of the legislative history of the statute reveals that the goal was to eliminate confusion about the rights and responsibilities of guardians versus custodians.

The proposed legislation will clarify and harmonize [statutory] provisions regarding custody and guardianship of minors...The rights and responsibilities of a custodian or a guardian are not defined in current law. The lack of definition and seeming overlap between the meaning and effect of an application to be appointed a custodian or guardian of a child has caused confusion to parties, schools, health and medical services providers alike. Health insurance providers, school districts and medical providers have differing requirements regarding whether a non-parent must have custody or guardianship of a child to provide a child with health insurance, enroll a child in school or provide medical care and treatment. . . . (Bill Jacket, L 2008, ch 404 at 7 [emphasis added]).

Continued on page 9

Continued from page 8

It is unclear why, when given the opportunity in 2010, the Legislature made explicit the authority of legal guardians to issue consents for medical care, among other things, while not including legal custodians.

Although in practice it is not uncommon for medical providers to accept a custody order as sufficient for consent purposes, it may present a vulnerability for facilities and providers, who are necessarily concerned with obtaining proper informed medical consents. It should be noted that in emergency situations involving risk to life or health of the minor, such minor may be treated on an emergency basis without parental consent (see Public Health Law §2504 [4]). Thus, emergency care is not the focus of this discussion.

Many of the custody orders that health care facilities and practitioners are asked to interpret on a daily basis involve joint custody between a parent and a non-parent (such as a grandparent), or

sole custody to one or more non-parents. Absent a clear custody order, it appears that a parent retains superior authority to consent to treatment over a legal custodian. Clearly this has great potential to lead to unintended consequences. For instance, what if the parent is impaired or unavailable? What if a parent and non-parent disagree with the course of treatment?

Absent a legislative solution, it is recommended that legal practitioners involved in custody proceedings be mindful of the issues presented here, and include language in custody orders that would control in the event of a dispute. Although New York Court Form 10-2, which is an order following temporary removal of a child, contains a check box authorizing the temporary custodian to issue medical consents, New York Court Form GF-18, which is a general custody order, contains no such check boxes for legal custodians. The following suggested language may be incorporated into

custody orders:

Non-parent sole custodian:
[Custodian(s)] is/are authorized to give consent for medical, dental, health and hospital services on behalf of the minor child(ren).

Joint custodians (parent and non-parent): {Custodian(s)} shall have co-extensive authority with {parent(s)} to give consent for medical, dental, health and hospital services on behalf of the minor child(ren).

Including such language in court orders should simplify, clarify, and expedite consent issues for providers, hospitals, and facilities to the benefit of all parties involved.

The information and recommendations contained in this article have been reviewed and approved as best practices by Tina Hawthorne and Bernadette Hoppe, co-chairs of the BAEC's Practice and Procedure in Family Court Committee.



Welcome New Members!

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Mark Cohen, M.D., Pediatrics

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Frank, R. (2008, September 30). Wealthy Investors Stage Revolt Against Advisors. The Wall Street Journal. Retrieved January 13, 2014, from <http://blogs.wsj.com/wealth/2008/09/30/wealthy-investors-stage-revolt-against-advisors/>

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In Memoriam

David Albert, M.D.	12/20/2016
Robert Barone, M.D.	10/6/2016
George Barrios, M.D.	1/28/2017
Robert Baumler, M.D.	3/7/2017
Maurice Dewey, M.D.	1/16/2017
Svend Gothgen, M.D.	4/29/2017
Albert Kraus, M.D.	3/4/2017
Louis Lazar, M.D.	4/28/2017
Charles Massaro, M.D.	12/24/2016

Bulletin

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IT PAYS TO BELONG TO YOUR MEDICAL SOCIETY

By Kate Sellers, JD, CLU

Vice President, Charles J. Sellers & Co., Inc.

The Erie County Medical Society endorsed our family owned and operated agency on March 17, 1941. Decades ago, my grandfather came up with a saying that we still use today – “Membership Doesn’t Cost, It Pays,” to signify that the insurance savings for Medical Society members can offset, in whole or in part, Society dues.

A lot has changed since my grandfather’s time, including the increasing prevalence of employed physicians and a decrease in the number of independently owned physician practices. But the idea that “Membership Doesn’t Cost, It Pays” still holds true. Medical Society membership continues to benefit both independent and employed physicians. The insurance benefits we offer to members are just one way that membership can benefit physicians regardless of their practice setting.

The Medical Society endorsed disability insurance program we offer is one way that both employed physicians and physicians in private practice can benefit from membership. The program offers excellent coverage at premiums that are made more affordable by the Society’s group purchasing power. In speaking to hospital-employed physicians about their disability insurance protection, we sometimes hear that “the hospital takes care of that.” When we take a closer look at the insurance provided for the physician, however, we often learn that, while the hospital or other employer has provided some disability insurance for the physician, it isn’t enough protection. Some physicians have heard that the hospital’s disability insurance provides a percentage of income – typically, 60% – but some aren’t aware that these type of employer-based disability programs cap monthly payments. We’ve seen hospital plans that cap monthly payments at as little as \$5,000/month and at as much as \$15,000/month. This can leave many physicians underinsured. Your Medical

Society disability program is a cost-efficient way for an employed member physician to supplement employer-provided disability insurance. It also gives the physician a layer of disability coverage that he or she owns and controls, and can take with him or her if employment changes. This need for additional coverage is true of life insurance, as well.

Your Medical Society membership also provides you with access to a Travelers Insurance program that gives members a 5% discount on auto and a 7% discount on homeowners insurance. We’ve helped many physician members – both employed and independent physicians – save money on their personal insurance, and in the process, helped them put in place the higher liability limits that physicians, who are unfortunately targets for personal injury lawsuits, truly need.

The Erie County Medical Society and the Eighth District Branch also recently endorsed a Long Term Care insurance program with Mutual of Omaha, an AM Best A+ rated company. With this endorsement comes a 5% discount for members, on top of other discounts that may apply. This member benefit is important – most people will need some type of long term care services, whether home health care or facility care, as they get older. As the long term care insurance market has matured, premiums are now being set more accurately, and policies purchased now should not see the same type of premium increases that some older policy series have had. Long term care insurance is a great way to protect the assets you’ve worked so hard to accumulate, and premium payments and benefits receive favorable tax treatment.

There are many important reasons to belong to your Society – we see the insurance savings and assistance we can offer as an added bonus to membership. We are proud to support your Society, and we look forward to working with you and your fellow members for many years to come.



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LACK OF A HEALTH CARE PROXY LEAVES LOVED ONES GUESSING ABOUT YOUR END-OF-LIFE WISHES

Peter Kates
 Vice President Communications
 Univera Healthcare

Nearly nine out of 10 upstate New York adults are aware of the term, “health care proxy,” according to a new survey commissioned by Univera Healthcare. Among survey respondents who had heard the term, 89 percent know that it is a way to legally designate someone as your health care agent to represent you during a medical crisis if you can’t speak for yourself.

“Despite high awareness and knowledge of the health care proxy term, our survey also revealed that only about four out of 10 upstate New York adults have completed a health care proxy form,” said Patricia Bomba, M.D., Univera Healthcare vice president and medical director of Geriatrics. “That’s disappointing, because so many people have had the experience of making gut-wrenching health care decisions for loved ones who were unable to communicate.”

Univera’s online survey regarding end-of-life care was administered by the polling firm One Research. Two-thousand participants completed the survey. A county-level quota sampling method was used to ensure that it would be a representative sample of the region’s U.S. Census Bureau demographic profile.

According to Bomba, a health care proxy can make those decisions easier, and can help people avoid being faced with a situation like the Terri Schiavo case.

In 2005, the nation was transfixed by the family drama surrounding Terri Schiavo, a Florida woman at the center of a legal battle over the right to die. Schiavo was in an irreversible persistent vegetative state as a result of a cardiac arrest. Members of her family had differing views on what she would have wanted with regard to life-sustaining medical interventions. The various factions waged a highly publicized and prolonged series of legal challenges over who had the right to make health care decisions on Schiavo’s behalf.

“When you select a health care agent, ideally it’s a person who knows your values, beliefs and goals for medical care,” said Bomba. “Your health care agent should be able to step into your shoes and choose interventions based on what matters most to you, and not what they would want for themselves.”

Sharing your values, beliefs and goals for medical interventions and completing a health care proxy form are crucial to the advance care planning process. Filling out a health care proxy form legally documents your care wishes, and sharing your wishes ensures that your health care agent and other family members are aware of the proxy and its details.

Among those surveyed who had not completed a health care proxy, more than half also had not shared their wishes with family and others.

About a third of survey respondents see the need to fill out a healthy care proxy, but have not successfully completed a form. “Being aware, and understanding the value, of a health care proxy is important,” said Bomba, “but unless you take the time to fill out the form, your wishes may not be carried out.”

Univera found that knowledge of the health care proxy is lower in Central New York’s Southern Tier Region (Binghamton and Elmira) than in other parts of upstate New York.

Knowledge of Health Care Proxy, by region

Central New York Region.....	94 percent
Western New York Region.....	91 percent
Finger Lakes Region.....	89 percent
Utica/Rome/North Country Region	84 percent
Central New York’s Southern Tier Region	79 percent

Age was a factor when it came to knowledge of the “health care proxy” term: 98 percent of respondents age 65 and older reported knowing the term, compared to 61 percent of survey respondents in the 18- to 24-year-old age group.

“Having a health care proxy gives all parties involved in a medical crisis the peace of mind that comes from knowing the patient’s wishes,” said Bomba. “Everyone who is 18 years old and older should complete a health care proxy form and keep copies on file with their physicians, lawyers and loved ones.”

Other findings from the survey include:

- Health care proxy awareness and knowledge were significantly higher among women than men.
- Significantly more men than women feel that they have no need to fill out a health care proxy form.
- Respondents currently taking a prescription medication for a chronic condition had higher health care proxy awareness, knowledge and completion, compared with those not taking a prescription.

A free step-by-step booklet and discussion guide on advance care planning, including the health care proxy form, are available for download at compassionandsupport.org.

A link to Univera’s survey results is online at <http://tinyurl.com/kcfc5zt>.

WHAT CAN BE DONE ABOUT THE HIGH COST OF PRESCRIPTION DRUGS?

By Mona Chitre and Matthew Bartels

The cost of prescription drugs has been a focal point of health care in recent years. In the United States, the average price of brand-name drugs has increased 98.2 percent since 2011, according to Express Scripts, a pharmacy benefit management company that partners with health insurers such as Univera Healthcare.

Many prescription drugs sell for significantly less outside of our country than they do domestically. Unlike other countries, the U.S. permits drugmakers to set their own prices, with few restrictions and little transparency. The result of this hands-off approach, as illustrated in Express Scripts' exclusive Prescription Price Index, is rapid medication price inflation. One-third of branded products experienced 2015 price increases greater than 20 percent.

Members of Congress and others have raised concerns about the high prices of certain drugs and their impact on the Medicare Part D drug benefit, specifically catastrophic coverage. Part D beneficiaries enter catastrophic coverage when their out-of-pocket costs exceed a certain threshold, after which most pay a 5 percent co-insurance for drugs, while the federal government pays the vast majority of the remaining costs.

A January Department of Health and Human Services report shows that federal payments for Part D catastrophic coverage exceeded \$33 billion in 2015, more than triple the amount paid in 2010. Spending for high-priced specialty drugs – including expenditures for a class of medications known as biologics – significantly contributed to this growth.

Biologics are complex molecules that come from a variety of natural sources and are prescribed to treat cancer, rheumatoid arthritis, multiple sclerosis and other conditions. They can range in monthly cost from \$1,000 to more than



\$100,000, and that can add up to more than \$1 million per patient per year.

Biologics account for just 2 percent of prescriptions dispensed, but they make up more than 20 percent of all prescription drug spending.

Many biologics have lower-cost counterparts known as biosimilars, so named because they are comparable to an already approved biological product and have the same safety profile and clinical benefit. Biosimilars hadn't been available in the U.S. until the Affordable Care Act directed the Food and Drug Administration to speed their approval to promote competition and reduce costs. Patients in Europe and Asia long have used them to lower treatment costs by as much as 40 percent.

One study projects that the U.S. could save \$250 billion over 10 years if just 11 biosimilars were to enter the market. With more than 13,000 upstate New Yorkers suffering from multiple sclerosis, interest here in biosimilars is high.

While biosimilars and generics offer a way to reduce drug spending, drug companies have developed strategies to prevent or delay their arrival to market.

Drugmakers' tactics

"Pay to delay" is when brand-name drugmakers pay generic drugmakers to delay selling their lower-cost versions. Provigil is used to treat excessive sleepiness caused by narcolepsy and sleep apnea. Its annual sales exceed \$800 million. The Federal Trade Commission alleges that drugmaker Cephalon paid \$200 million to four generic drugmakers to not sell their versions for six years after Provigil's patent expired. Cephalon made an additional \$4 billion in sales, and the generic drugmakers earned more money than they would have from selling their versions.

"Picking the discount rack" is when drugmakers buy the rights to old, cheap medicines, which are the only treatments for serious diseases, and then hike the prices. An example of this is Daraprim, which is used to treat a parasitic infection that mainly threatens individuals who have weak immune systems. Turing Pharmaceuticals bought the U.S. rights to Daraprim and immediately raised the price from \$13.50 to \$750 per tablet. There are 25 million Daraprim users in the United States.

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Daraprim's patent expired decades ago, yet there's no generic version available. New York State Attorney General Eric Schneiderman is investigating whether Turing limited distribution of Daraprim to a small number of specialty pharmacies to prevent generic drugmakers from obtaining samples to use to create their own versions.

"New and improved" is when brand-name drugmakers limit access to a drug or pull it from the market just before its patent expires and replace it with a slightly modified version. An example of this is Namenda, which is used to treat Alzheimer's disease. This is drugmaker Actavis' top-selling drug, with annual sales of \$1.5 billion. The attorney general alleges that with its patent about to expire, Actavis limited distribution of Namenda to a single mail-order pharmacy and required doctors to submit a note stating that the drug was "medically necessary." The drugmaker then promoted its new extended-release version, called Namenda XR, which has patent protection until 2029.

Generics are essential

In 2005, 53 percent of prescriptions filled in upstate New York were filled with a generic drug. Recognizing an opportunity for savings, Univera launched a campaign to encourage people to talk to their doctors or pharmacists about lower-cost options.

Today, 85 percent of prescriptions filled in upstate are filled with a generic drug. Since our education effort began in 2005, upstate New Yorkers have saved more than \$1 billion by opting for generic versions of the brand-name drugs they've been prescribed.

Unfortunately, there is not always a generic version available, as is the case with insulin, an injectable drug for people who have diabetes.

Univera recently reported that diabetes medications increased in cost by an average of 42.6 percent from 2012 to 2015. By the end of 2016, the price increased again by an additional 18

percent.

It's no wonder that 50 percent of people with chronic conditions such as diabetes discontinue their medications within six months, according to the National Institutes of Health.

High costs deter patients

Medication adherence is the term used to describe the pill bottle label that instructs patients to take their medication as directed. The American Heart Association says that poor adherence annually takes the lives of 125,000 Americans and costs the health care system nearly \$300 billion a year in additional doctor visits, emergency department visits and hospitalizations.

People skip their medications for many reasons. For some, the barrier is cost. For others, getting to the pharmacy is the issue.

One study in the *Journal of Managed Care and Specialty Pharmacy* shows that Medicare Part D beneficiaries who receive medications for diabetes, hypertension or high blood pressure from a home delivery pharmacy are more likely to take their medication as directed than those who pick up their prescriptions from a retail pharmacy.

Educating the community

The World Health Organization notes that getting more patients to take their medications as directed may have a far greater impact on the health of the population than any improvement in specific medical treatments.

In 2014, Univera launched a community awareness effort to improve medication adherence. The centerpiece of the campaign is a stylized prescription pill bottle named TAD (Take As Directed). It appears as a superhero in ads, billboards and posters that convey simple messages about the importance of medication adherence.

What can be done?

Recently, the Centers for Medicare and Medicaid Services published information about certain drugs that

have had substantial price increases. It also asked the pharmaceutical industry to partner with the agency to find solutions that allow for both innovation and affordability. Moving forward, CMS will likely need to develop additional strategies, such as revising the law to allow the federal government to negotiate prices for certain drugs, to address the drug cost issue.

All health care stakeholders, insurers, pharmacists and providers bear a responsibility to assure that the medications patients need are readily available and easily affordable. Working together, caregivers can help those patients to become savvy health care consumers by encouraging them to:

- Shop around, because prices vary by pharmacy.
- Always ask whether a generic or lower-cost alternative is available.
- Use the cost-saving tools their insurer offers online.
- Consider subscribing to home delivery or obtaining a 90-day supply at retail for long-term medications used to treat chronic conditions.
- Review their health insurance company's drug formulary to become familiar with the various pricing tiers available.

Mona Chitre, Pharm.D., is chief pharmacy officer and vice president of medical operations and health innovations at Univera Healthcare. Matthew Bartels, M.D., is chief medical officer of health care improvement at Univera.



WRAP UP: THE LAST LINE OF DEFENSE, YOUR MEDICAL RECORD

Gregory T. Miller, Esq.

Shareholder, Roach Brown McCarthy & Gruber

On January 21, 2017, the Medical Society extended its longstanding collaboration with the Bar Association of Erie County when it put on an additional installment of its popular “Breakfast at the Bar” series at the Buffalo Club.

This presentation - entitled “The Last Line of Defense: Your Medical Record” - focused upon many topics which are pertinent to our members’s needs, and represented the culmination of months of hard work by the members of our Health Law Committee.

This program cast a wide net and focused on issues relating to the impact that the advent of the electronic medical record has had upon the everyday practice of medicine. While all of us are certainly well aware of the out-sized role that HIPAA plays in our practice, the focus of this presentation was upon the various and seemingly never-ending series of threats attendant to the practice of medicine in the digital age.

Broken into three parts, the seminar wrapped up with a panel discussion that was moderated by the co-chairs of the Health Law Committee, Dr. John Gillespie and Gregory Miller, Esq. The discussion addressed remaining issues, questions and concerns that were borne of the presentations prepared and given by Jennifer Scharf, Esq. and Caitlin O’Neil, Esq., Robert Vail, Kathleen Sellers, Esq., and Leah Ranke, Esq.

Ms. Scharf and Ms. O’Neil presented

on retention of the digital record, issues regarding denial of access to the medical record by patients and other interested parties, the rules regarding release of records and access to records, as well as providing an update on the regulations that surround the Privacy Rule components of HIPAA. Of particular interest to our members was the prime focus that is being placed on the manner in which a patient’s rights to his chart can be allowed, restricted, or enforced, especially as release of these records relate to the care and treatment provided to minors. Of even greater interest, however, was the myriad of ways in which social media platforms present ongoing and ever-changing challenges to the office’s duty to protect against the unintended dissemination of protected health information. As social media continues to explode in breadth and reach, all of our members need to be concerned with the increasing potentiality of violations of these regulations by fellow physicians, office staff, and other patients. A discussion of the development of best practices designed to limit the potential for a physician or her office to be guilty of such a violation was stressed, and strategies for coping with unintended breaches of privacy was discussed at length.

From there, Bob Vail, the Healthcare Information Security Officer from Erie County Medical Center Corporation took center stage, and described the anatomy of a ransomware attack and the impact that it can have on your office, your practice,

and your patients’s confidential personal and health information. To the uninitiated, ransomware is a type of malicious software whose defining characteristic is that it attempts to deny the user access to his or her own data by encrypting it with a key whose code is known only to the hacker. This individual then requires that the user pay a ransom (usually in Bitcoin) for the data to be released.

The hacker may then either release or not release the data, but in the interim, has already potentially sold the electronic protected health information and other confidential information to others on the dark web.

Because of the relative lack of sophistication of their computer systems and the trove of confidential personal information available on a provider’s system of a large number of people, the healthcare industry has been the subject of nearly nine out of every ten ransomware attacks as of 2015. On top of that, ransomware attacks experienced a 300% increase in volume between 2015 and 2016.

The important thing to note about ransomware is that with the prevalence of cloud computing, only a single point of entry into the system is needed in order to potentially compromise the entire patient database. Often delivered through spammed messages with an attachment that contains malware that itself connects to servers that download the ransomware onto the system, the attack can effect the

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entire network and prevent access to files or entire databases until the ransom is paid.

Based upon this, it is becoming an essential aspect of office- or hospital-based practice that each office ensure that steps are taken to protect the security of patient data. Failure to do so triggers reporting requirements of the breach, only opens your office up to HIPAA violations, and increases the risk of subsequent attacks on the system. More so than that, it is wise to remember that such attacks not only compromise the patient's information, it can also jeopardize patient care, and in extreme cases, patient health. Such attacks are often highly visible within the community and inevitably leads to financial loss to the practice and personal harm to your reputation.

There are, of course, steps that can be taken to limit susceptibility to the attack or its outcome. In this regard, best practices would include opening emails from known sources only, visiting only reliable websites, prohibiting downloading of software from the internet, ensuring timely non-cloud based backup of information, and hiring IT people who can anticipate, thwart, or respond to such attacks.

In the case of an attack that has been mounted against your office, it was explained to the audience that there several ways in

which you can limit the impact that such an attack can have upon your practice. For one, the audience learned that specialized insurance protection products exist to help defray the costs attendant to a data breach or a cyber attack and your office's recovery therefrom. In that regard, both Mr. Vail and Kate Sellers of the Sellers Insurance Agency provided information regarding the extent and type of coverage available to offices that have been the victims of such attacks.

Specialized insurance products provide coverage are available to provide assistance for everything from recovery costs from accidental destruction of data to the costs incurred by the practice for regulatory agency investigations occasioned by the data breach itself. Additional layers of coverage also exist to deal with business interruption, third party liability and first party costs attendant to managing the data breach itself. Moreover, the underwriting process itself can and often does highlight areas of potential susceptibility which provides you with valuable pre-breach information to assist in securing your network or computer systems from a breach in the first instance.

From there, the discussion turned toward strategies for effectively dealing with and combating regulatory agency investigations into your practice. This discussion, led by

Leah Ranke, Esq., focused upon strategies to deal with those who have a right to review your patient records. From a discussion of how to deal with payers who wish to audit your charts to regulatory or investigative agencies who can review your records for the purposes of determining civil compliance or evidence of criminal activity, participants were led through a series of vignettes that were designed to provide instruction on how to avoid the hidden pitfalls associated with these types of claims. More importantly still, the types of information needed to be disclosed in conjunction with each type of investigation was explained, as was a series of strategies designed to maximize the potential for a positive outcome from the audit process.

In that regard, the importance of reliable charting strategies, appropriate billing practices, and the role of the implementation of internal control measures was highlighted as a means to substantiate compliance with the rules and regulations imposed upon your practice in all settings. Through a combination of proper charting, appropriate billing practices and reasonably diligent oversight, it was demonstrated that most third party and regulatory compliance audits can be dealt with in a way that minimizes disruption to your practice and allows you to get back to the business of caring for your patients and their needs.

Based upon the extremely positive feedback we received from the attendees at this program, we would encourage all members of the society and their office staff to take part in the next installment of our series which will continue and extend our focus on legal issues pertaining to the medical record. As always, if there is any information that you would like to have be the subject of a presentation to the Medical Society, you are encouraged to contact us and make your opinions known.



LEGAL SERVICES FOR CANCER PATIENTS

By Dawn M. Myszka, Esq.

This article originally appeared in the November 2016 Neighborhood Legal Services Cancer Legal Services Program Newsletter (Vol. 74, p. 1), which is funded by a grant from the NYS Department of Health, Division Chronic Disease Prevention. It was also reprinted in the January 2017 issue of The Bulletin, the official publication of the Bar Association of Erie County. It is reprinted here with permission from Neighborhood Legal Services and the Bar Association of Erie County.

Through our Cancer Legal Services Program, Neighborhood Legal Services has helped many persons facing a diagnosis of cancer, and in some situations, their household members, with a wide array of legal matters. In addition to preparation of powers of attorney, wills, health care proxies, and other documents which may be vital when facing a serious, possibly fatal, illness, the Cancer Legal Services staff attorneys also assist with matters involving family law, Social Security (both SSD and SSI) and other issues.

Whether due to a cancer diagnosis or other illness, having a loved one taken to the hospital, or being taken yourself, is of course a frightening and confusing experience. It may seem as if innumerable forms are presented for signature at the same time as serious medical issues are being discussed. This column addresses a frequent scenario: the patient being placed under "observation status" with an incomplete understanding of the consequences such a designation brings.

OBSERVATION STATUS DURING A HOSPITAL STAY

What is "observation status"?

When you go into a hospital as a patient, you are assigned one of the following statuses:

- A) inpatient status
- B) observation status

You are considered "inpatient status" if you have severe problems that require technical, skilled care from medical providers.

You are considered to be under "observation status" if the doctors at the hospital are not sure exactly how sick you are so they place you "under observation" in the hospital. You transition to being an inpatient if you become sicker and require skilled medical care.

How do I know what status I have been assigned by the hospital?

You should not assume that just because you are in a regular hospital room or in a hospital bed rather than on a gurney that you are an inpatient, nor can you assume that if you have been in the hospital for a couple of days that you are now an inpatient. The only way to know is to ask the hospital and GET IT IN WRITING!

What is the difference between the two?

There is a major difference. Observation status patients are treated as outpatients. As an outpatient, your hospital bill will be covered under your Medicare Part B or the outpatient services part of your private health insurance policy rather than the Medicare Part A or hospitalization part of your private health insurance policy. Outpatient coverage costs more and has higher coinsurance amounts

than inpatient coverage.

Observation status may also cost you more if you need to go into a nursing home for rehab after your hospital stay. Why? Because Medicare usually pays for services such as physical therapy in a nursing home for a short period of time. You will only qualify for this benefit if you are an inpatient in a hospital for 3 days. If you are in a hospital in observation status for 3 days, then you won't qualify for Medicare to pay for physical therapy if you are transferred to a nursing home for rehab. You will have to pay for that cost out of your own pocket.

Why does this matter?

If you are an inpatient in a hospital and Medicare or your private health insurance later determines that you should have been placed under observation, it can refuse to pay for your entire hospital stay. When will you likely find this out from your insurance? Possibly weeks or months after your hospital stay.

If you are under observation status, you will still be hit financially as the cost of care for outpatient services is much higher than inpatient services.

What can I do?

New York State requires every general hospital to provide patients with both oral and written notice that the patient is under observation and is not admitted to the

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hospital. This notice must:

A) be provided to the patient within twenty-four (24) hours of being placed in observation status

B) contain language that observation status may affect the patient's insurance coverage and any subsequent discharge to a skilled nursing facility or home and community based care

C) advise the patient to contact his or her insurance carrier to better understand the implications of being placed in observation

D) be signed by the patient or the patient's legal representative acknowledging receipt of the notice

Once patients have been provided with this notice, they can seek to change their admission status with the hospital to inpatient status. Be aware, however, that your insurance company may refuse

to pay the hospital bill if it determines that you were incorrectly placed in inpatient status. In that case, you may want to ask for written specifics as to why the patient was placed in observation status rather than inpatient status. If you are too sick to do this yourself, this is where you can give permission to a friend or family member through a Power of Attorney to ask the hospital these questions and to get answers for you.

CANCER LEGAL SERVICES PROGRAM ELIGIBILITY

The Cancer Legal Services Program provides services free to financially eligible persons who reside in Erie and Niagara counties. Generally, NLS uses the Federal poverty guidelines to determine financial eligibility based on the number of persons in the household for most types of services. A sliding fee scale is available for

individuals who do not meet our income and resource guidelines. In addition, technical assistance, advice and referrals are available to individuals who reside in Allegany, Cattaraugus, Chautauqua, Chemung, Genesee, Livingston, Monroe, Ontario, Orleans, Schuyler, Seneca, Steuben, Wayne, Wyoming and Yates counties.

For more information, please contact our Cancer Services hotline at (716) 847-0650 and ask for extension 420.

Dawn M. Myszka is an elder law attorney in private practice as well as a part-time staff attorney at NLS under a grant from the NYS Department of Health.

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The Center for Elder Law & Justice in collaboration with Erie County Medical Center are excited to announce that they have formed a medical-legal partnership.

What is medical-legal partnership?

A medical-legal partnership (MLP) unites the healthcare community with a civil legal services agency under a common mission – to address and prevent health-harming social conditions for vulnerable patients and communities. MLP’s link lawyers, with doctors, nurses, social workers, and other clinical staff in order to help patients address underlying legal problems that harm their health. The MLP at ECMC is called the MedLaw Cancer Partnership of Western New York.

How will MedLaw help patients?

Legal issues can become a source of stress for patients, or may even become a barrier for patient’s to receive medical treatment. Studies have shown that patients who have received assistance with their legal issues have noted decreased stress and relief from the aggravation of fighting alone.

With that in mind, MedLaw has the goal to improve the health outcomes and quality of life for ECMC patients through the development of an on-site legal assistance center within the walls of ECMC. The legal assistance center will be staffed with an attorney from the Center for Elder Law & Justice, which will allow ECMC patients greater access to free legal services to address the root cause of their health-harming legal needs.

In addition to the legal assistance center, MedLaw will work alongside ECMC to provide joint trainings for hospital staff, and educational events on important legal topics for patients and the community.

What type of legal services are available through MedLaw?

MedLaw can address civil legal issues, including problems such as: access to state and federal public benefits, health insurance matters, family matters, safety and stability issues, housing and utilities issues, employment matters, planning for future decision making, and end-of-life planning.

Does MedLaw help with criminal cases or traffic tickets?

No, MedLaw cannot help with criminal matters or traffic tickets.

Who is eligible for legal services through MedLaw?

Any patient being treated for breast cancer, at risk of breast cancer, or being treated by the palliative care team at ECMC is eligible for referral to MedLaw. Preference will be given to low-income individuals.

How are patients referred to MedLaw?

Patients can be referred to MedLaw by any ECMC health care provider. The provider can contact MLP personnel by telephone at 716-853-3087 (ext. 250) or visit the clinic location on the 6th Floor of ECMC’s Main Building. Any patient referred to MedLaw should complete the “Authorization for Release of Limited Information” form.

For more information about MedLaw of Center for Elder Law & Justice, please visit www.elderjusticenyc.org or find us on Facebook!

The Medical Society would like to wish the following members a *Happy Birthday!*

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