Alabama Gastroenterological Society
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Issue 61 | January 13, 2017

scope...

Book your room now for the AGS Annual Conference

AGS' 2017 Annual Conference is July 1-2 at the Hilton Sandestin. Rates begin at $299 per night and apply for two days before and two days after the conference, based on availability, so you can extend your stay and spend extra time with your family. **We expect the hotel to sell out before our room block expires.** **We strongly recommend booking your room early.** Call the Hilton Sandestin at (850) 267-9500 to reserve a room.

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Renew your membership for 2017!

Use the form on page 5 or renew and/or register for our annual conference online at www.tinyurl.com/AGS2017.

The following physicians have joined AGS in the first two weeks of 2017! We especially welcome all of our new members (marked with a star). Thank you for your support of AGS.

Vipul Thakorbhai Amin, MD, Etowah Gastroenterology Associates PC, Gadsden
Mark M. Anderson, MD, Capital City Gastroenterology PC, Montgomery
Cody B. Barnett, MD, Internal Medicine Center LLC, Mobile
Gregory L. Champion, MD, Gastroenterology Associates of North-Central Alabama PC, Birmingham
Stephen L. Coleman, MD, Eastern Shore Gastroenterology, PC, Fairhope
Jack Anthony Di Palma, MD, USA Division of Gastroenterology, Mobile
Susan Ellen Bonfili Fleet, MD, Internal Medicine Center LLC, Mobile
Miles E. Gresham, MD, Gastroenterology Associates of North-Central Alabama PC, Birmingham
Gerard D. Haggstrom, MD, Tennessee Valley Gastroenterology LLC, Florence
Colin Alexander Helman, MD, Gastroenterology Associates Central, Birmingham
Suresh Karne, MD, Huntsville Hospital Digestive Disease Center, Huntsville
★ **Kondal Kyanam, MD**, UAB, Vestavia
Donald W. Laney, MD, Pediatric Gastroenterology Associates PC, Huntsville
Randall D. McClellan, MD, Pediatric Gastroenterology Associates PC, Huntsville
Brendan Martin McGuire, MD, UAB Department of Medicine, Birmingham
★ **George A. Nelson IV, MD**, UAB Gastroenterology and Hepatology, Birmingham
Michael Palmer, MD, GI Associates of West Alabama, PC, Tuscaloosa
Robert A. Pendley, MD, Center for Colon & Digestive Disease PC, Huntsville
Bradley S. Rice, MD, Alabama Colon & Gastro PC, Huntsville
Michael Kevin Sanders, MD, Internal Medicine Center LLC, Mobile
★ **Viplove Senadhi, DO**, Greater Montgomery Patient Centered Gastroenterology and Hepatology, Montgomery

MOC: Time to Serve our Interests

Carol A. Burke, MD, FACG, ACG President

There is widespread dissatisfaction with the American Board of Internal Medicine MOC program within the gastroenterology community and among many other specialties within the "House of Medicine." The American College of Gastroenterology message to the ABIM is loud and clear: MOC in its current and proposed form places unreasonable burdens on participants in terms of unjustifiable cost and inconvenience, and detracts from patient care. Physicians should be held accountable as lifelong learners, not lifelong test takers.

The bioptic assessment of medical knowledge by a stressful, high stakes, secured recertification test whether it be at two, five or ten years, is no measure of the quality and effectiveness of the care we provide to our patients. Moreover, it does not reflect the process by which we obtain medical information to manage our patients. Increasingly, data show that providers frequently use point-of-service electronic resources to investigate differential diagnoses, optimal treatment and best practices strategies.

Consistently, diplomates advise me that many of the ABIM recertification questions continue to be irrelevant and do not reflect the common diseases and disorders we see day-to-day in our patients. The College has been hammering home this message to the ABIM for years.

Between the vexations of the EHRs, the demands of insurance companies, countless reporting requirements, and the swift transformation in payment models, the amount of time and money we are spending on regulatory and practice burdens accentuates the inappropriate demands imposed by the ABIM of maintaining Board certification.

ABIM: Talking, Not Listening

Unfortunately, in spite of consistent and widespread pressure, ABIM has not made meaningful changes to MOC. The College has participated in and facilitated opportunities for exchange with the ABIM, seemingly to no avail. Against the backdrop of increasingly negative perceptions of MOC, ABIM is still getting it wrong.

Diplomates who recently took the GI recertification exam were slammed with an additional 60 "beta" test questions sprinkled throughout the exam that would not count, increasing the exam from three to four booklets. The ABIM stunned recertifiers about three weeks before the exam to advise them to prepare for a 10 hour testing day.

To throw more salt on the wounds, the ABIM convened so-called "Listening Sessions" to open community dialogue between gastroenterologists and the ABIM regarding MOC. A few of these sessions were held at the recent ACG Annual Scientific Meeting in Las Vegas. I was informed by some session attendees that the sessions were not a dialogue, but were only meant to drive diplomates to choose their preference for either a two- or five-year, high stakes, secured MOC exam. They felt that ABIM only paid lip service to openness to discussion. It turns out that when ABIM claims they're listening to diplomates, they instead are doing most of the talking, without regard to serving the needs of their physician constituents.

The ABIM has not heard the message that patients and providers are married to a demonstration of physician competence easily shown by a commitment to lifelong learning, not lifelong testing. While the ABIM has the tools and capacity to innovate an educational, practical, and learner-centered assessment of physician knowledge and competence, it has demonstrated no ability to think outside of the box.

MOC – A Monopoly Position

ACG is committed to minimizing the negative impact of ABIM's monopoly position on MOC. As the sole arbiter of the requirements for recertification and the entity which also sets the price, ABIM is effectively behaving as a monopoly, while many physicians are a captive audience forced to comply and endure what ABIM requires.

The College is committed to doing all we can to fix the flawed MOC process, while at the same time pursuing alternatives – including alternative credentialing models in partnership with other organizations including our sister societies, the AASLD, AGA and ASGE.

This year, I created a Task Force on MOC chaired by Dr. Daniel J. Pambianco of Charlottesville, VA. The group is charged with expanding the College's efforts to make MOC easier to navigate for ACG members, collaborating with other like-minded specialties and societies to pressure the ABIM to understand our position, exploring alternative recertification strategies and ensuring all implications of any alternative to ABIM MOC are fully investigated.

Stranded Over the Barrel on MOC

While ACG fully recognizes that there are significant, fundamental problems with MOC, we acknowledge that there are many ACG members – particularly those who work in large hospitals or academic centers – for whom MOC is a condition of employment.

ABIM has these physicians stranded over a barrel. ABIM MOC is a requisite for participation in some insurance plans and to maintain hospital credentialing. Opting out of MOC is not a viable option if staff privileges are in jeopardy or if compulsory MOC is linked to licensure.

State Legislative Solutions

Recently Oklahoma passed a law (SB1148 signed by Oklahoma Governor Mary Fallin in April 2016) that would prohibit MOC participation as a requirement for contracts with insurance companies, physician employment agreements and hospital credentialing. We are aware of several states, including Arizona, Kentucky, Missouri, North Carolina and Michigan, which passed or are considering similar legislation. ACG supports bills at the state level that ensure that MOC requirements do not unduly interfere with contracting, employment or credentialing for physicians. At the same time, we will work to make sure that these efforts do not inadvertently undermine the ability to ensure that physicians doing endoscopic procedures are adequately trained – especially those who have not gone through GI training.

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Don't Surrender Docs... Let's Fight.

Niran Al-Agba, MD
Rebel.MD

Independent physicians are at the beginning of a challenging movement as we fight to stay relevant and solvent during the transition through "regulation without representation" in healthcare. In 1773, British Parliament passed the Tea Act with the objective to help the struggling British East India Company survive. Opposition to the Act resulted in the return of delivered tea back to Britain. Boston left the ships carrying tea in port and on December 16, 1773, colonists in disguise swarmed aboard three tea-laden ships and dumped their cargo into the harbor. It was the beginning of the Revolutionary War.

Physicians in private practice are facing a war of our own, and make no mistake; we are battling for our freedom and our livelihood. Insurance companies and government control of healthcare have become "regulation without representation." Lofty guidelines are imposed on us, while administrators, insurance executives, and policy consultants are wedged firmly between doctors and patients. However, when it comes to taking responsibility for a life, the physician stands alone. How dare we ask a fee-for-the-service we have rendered? That would be fiscally wasteful according to health policy pundits who know nothing of our service-oriented occupation, yet stand to make incredible salaries off of our work. This is my call to action.

Where is all the money going? CEO's of healthcare insurance companies make millions. High level CMS employees undoubtedly have higher incomes than primary care physicians. Where is the outcry from the media and public? The media, with reason, jumped all over Mylan when they started charging $600 for an EpiPen two-pack, but at least EpiPen provided a tangible product. These high paid middlemen? They are sucking the life out of patients and physicians without any demonstrable need or benefit.

The majority of physicians are beholden to third party payers, who decide what our work is worth, like modern day indentured servitude. Instead of having conversations with patients, our time is spent buried in absurd paperwork, endless forms, and questionnaires to accommodate federal requirements instituted by elected officials while industry insiders control the puppet strings. Physician lobbying groups, such as the American College of Physicians, keep telling us to "roll over and play dead" because they are profiting regardless.

While they may not be drinking tea, the business of healthcare is certainly having a party at the expense of physicians, patients, and taxpayers. It is time the party comes to an end. Physicians are being held accountable for outcomes yet have no influence on how we care for our patients in our own offices. Medicare beneficiaries are forbidden from entering private contracts with their long-term physicians (DPC); the only way out is for physicians to say no to Medicare and some private insurances.

Last year, a large insurance company and I did not see eye to eye. Family X already had two children for whom I provided medical care. Their newborn was assigned to an adult nephrologist two counties away by mistake (I hope), so it seemed reasonable to provide necessary primary care for their third child. This infant had a respiratory arrest at her two week appointment. I resuscitated the baby and paramedics transported the infant to the children's hospital for PICU care. Imagine my surprise 2 months later when a "take-back" was initiated on the payment for this patient encounter after initially being compensated. Dr. W in the appeal resolutions department told me to "lose his phone number"; he thought a few hundred dollars was too costly for saving a human life. Believe it or not, Dr. W was a pediatrician in private practice before "if you can't beat them, join them" took hold.

Ultimately, I had no choice but to bill the family for provided services (at a considerable discount) as cash pay, and they obliged. A threatening letter arrived a few days later from Mr. CEO that balance billing was illegal and there would be serious consequences if I insisted on any monetary payment for my work. This by definition is indentured servitude. Balance billing is charging a patient the difference between what health insurance reimburses and the provider charged. The fact I was not paid by his company nullifies his entire accusation.

I fired off a response humbly suggesting he focus more on placating his stockholders, while leaving the work of saving lives and being reimbursed for it, to me. Our practice cut ties with this company, notified patients it was no longer accepted in our practice, and most families changed their insurance plans. You would think my David and Goliath-esque tale ends here; however our local federally subsidized Community Health Center is the only place accepting this exchange plan (for reasons that should be obvious at this point.) There is no pediatrician available. The tables suddenly turned.

Local insurance representatives queried why patients were being turned away. Never having signed a contract, I made it abundantly clear they had no control over anything. If I did not receive back pay, there would be no further deliberations. The executive stopped by to clarify all 'take-backs' were being halted and prior ones would be reversed from over a year ago. When he inquired if I would reconsider accepting their patients, it dawned on me that physicians may hold more cards than we realize.

Health policy experts and insurance executives are NOT physicians and they require our expertise; they have not foreseen the complications that will arise when supply does not meet demand. Physicians are fed up with data collection requirements, cumbersome electronic record systems, and outcome measures that mean next to nothing. The time has come to throw proverbial tea chests into the Harbor. Our battle cry is "No Regulation without Representation." My practice is terminating another insurance contract this week. If we make smart business decisions, choke out insurance plans one at a time, and manage to survive long enough, we can win this war. Patients deserve better. Physicians deserve better.

Acquiescent physicians have already been driven out of private practice. Those who remain independent are smart, resilient, noncompliant, and resolute; we are devoted to our patients and know how to provide extraordinary care. My office is getting overwhelmed by patients clamoring for a living, breathing physician who listens, makes eye contact, and is not attached to a computer. We must never give up, we must continue to argue, irritate, and aggravate healthcare bureaucrats at every turn, like those brave individuals who boldly tossed tea into the Boston Harbor many years ago. Defiance will inspire progress. Do not surrender at any cost.

MOC continued from page 1

The ACG Board of Governors is active and engaged on state-level legislative solutions on MOC. As part of the great work initiated by Dr. Immanuel Ho as he ended his term as Chair of the Board of Governors and which is now being championed by Dr. Costas Kefalas as Chair and Dr. Douglas Adler as Vice Chair, a group of ACG Governors is energized and empowered to explore legislative action modeled on the successful state initiatives.

ACG - Making it Easier to Meet Your MOC Needs while Exploring Recertification Alternatives

As ACG pushes for meaningful MOC reform, the College feels a strong obligation to its more than 14,000 members to offer pathways in the interim to meet their MOC requirements while we pursue an "all options" strategy that includes developing and supporting alternatives to ABIM MOC.

This approach is not inconsistent, it's realistic. We cannot abandon our members for whom MOC is integral to their employment, licensure, credentialing or plan participation. ACG is working to make MOC meaningful, impactful, less expensive, and easy to navigate, while keeping ACG's MOC options free as a benefit of College membership. The College offers CME credit that also provides opportunities to earn ABIM MOC credit – at no cost. At the same time, we want to see what alternatives to MOC can work for the membership.

It is our mission to serve the needs of all of our members – including those who work in environments where they do not have a choice about whether or not to participate in MOC.

This is a complex issue. We are working to arrive at nuanced solutions that will reform Board recertification so it adds value to GI clinicians and quality care to our patients.

Vist AGS online at www.alagastro.org

BCBS announces pharmacy benefit changes

Blue Cross Blue Shield of Alabama

In January, Blue Cross and Blue Shield of Alabama (BCBS) implemented many changes to the pharmacy benefits for its health plans that may result in significant disruption for members. Patients may need to transfer their prescriptions to in-network pharmacies, however, pharmacies should be able to transfer most prescriptions for patients without the need for a new prescription. Also, since there are more formulary and drug copay tier options, some patients may ask to be prescribed covered alternatives.

Members who have prior authorizations for drugs that are not covered in 2017 will have a one-month grace period beyond the effective date of their new formularies.

Summary

- **Formularies (Drug Lists) and Drug Tiers**
  In 2017, BCBS will increase the number of drug copay tiers to accommodate benefit plans with up to six copay tiers.
- **Member Outreach**
  Members adversely impacted by any of these changes will receive letters to instruct them how to find in-network pharmacies through BCBS's Find a Doctor tool. Providers can view members' formulary and pharmacy network benefit information in ProviderAccess Eligibility and Benefits.
- **Drug Coverage Information**
  BCBS drug formulary information and patient specific coverage details are available in most EHR systems that have e-prescribing solutions. Formulary and coverage information such as tier level, prior authorization requirements, step therapy requirements, and quantity limits is provided to the EHR vendor through Surescripts. Many systems also offer solutions for identifying generic and therapeutic alternatives. Contact your EHR vendor for additional information regarding formulary and drug coverage services offered or search for software that has been certified by Surescripts for this service.
- **New Drug Coverage Lookup Tool**
  Providers who not have drug formulary information through their e-prescribing solution or if the solution doesn't work, Blue Cross will offer a new Drug Coverage Lookup tool in 2017 that enables providers to access the new formulary information from any mobile device or desktop computer. Sign in is not required. Simply enter the patient's contract number and the drug being prescribed. The tool returns coverage information for all patients on the contract as well as generic and brand alternatives, tier level, prior authorization requirements and quantity limits.

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Send article submissions and comments to Charlotte Morris at ***cmorris@alamedical.org*** *two weeks in advance. Scope is printed bimonthly. Comments and letters to the editor are welcome.*

Alabama Gastroenterological Society

2017 Membership Form

Please complete the following information.

One form per member. Blank forms are available at www.alagastro.org/joinAGS.

Name of Member: _____

Address: _____

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Phone Number: _____

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- Mail payment and updated contact information to: AGS | c\o Jennifer Hayes | P.O. Box 1900 | Montgomery, AL 36102-1900
- Watch your e-mail for ASG's bi-monthly newsletter, *Scope*.
- Make your plans to attend AGS's 2017 Annual Conference | July 1-2 | Hilton Sandestin

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THANK YOU FOR YOUR MEMBERSHIP!

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2017 ANNUAL CONFERENCE REGISTRATION FORM

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FEES (Before May 27 | After May 27 add $100)

❑ Physician Member $375
❑ Physician Non-Member $475
❑ Retiree - $150
❑ Associate Member $275
❑ Associate Non-Member $375
❑ Resident/Student - Free
❑ Practice Manager $150
❑ Spouse and guests are free

_____ Total number of adults attending dinner.

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ONLINE REGISTRATION

Go to ***www.tinyurl.com/AGS2017Conference*** to register online.

ACCOMMODATIONS

Call the Hilton Sandestin at (850) 267-9500 to reserve a room. Rates begin at $299 per night and apply for two days before and two days after the conference, based on availability. **We expect the hotel to sell out. Book your room early.**

If you have special needs or need assistance, please contact Jennifer Hayes, at (334) 954-2500 or ***JHayes@alamedical.org***.

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