HEARTBEAT

THE BIMONTHLY NEWSLETTER OF THE ALASKA STATE MEDICAL ASSOCIATION December 2024

PRESIDENT'S COLUMN

I want to wish all of you a happy and healthy Holiday Season, while also recognizing that we may not all be enjoying good health, and that in our professional lives we often bear witness to illness, injury and great suffering.

Kristin Mitchell,

I've been following national conversations about physician burnout and the epidemic of loneliness and thinking about how we as professionals can maintain our own health and wellbeing while supporting those around us.

One of my strategies to address my own health and wellbeing is to disappear into a good book, and with that in mind, I look forward to the Booker Prize announcement every fall. This year the winner is a quick read, at about 200 pages. Orbital, by Samantha Harvey is set over one day on the international space station and contains this passage about the astronauts and cosmonaut looking at the earth below:

"Before long, for all of them, a desire takes hold. It's the desire — no, the need (fuelled by fervour) — to protect this huge yet tiny earth. The thing of such miraculous and bizarre loveliness. This thing that is, given the poor choice of alternatives, so unmistakably home. An unbounded place, a sus-

Mitchell Continued Page 3

Remember

Your medical license must be renewed before

December 31, 2024.

Renew online at my.alaska.gov

Also remember to renew your ASMA membership

Either pay from your emailed invoice or log in at asmadocs.org, go to Member Homepage, then My Profile and your invoice should be in the gray box.

Plan ahead for ASMA's Leadership Training Program in 2025

The Future Alaska Medical Leaders program (FAMLI) in partnership with the Physician Foundation is offering another leadership program in 2025. We can take up to 15 participants in the program. There are no fees for this program due to grant funding, but applicants must be current members of ASMA. Additionally, participants can earn up to 35 hours of CME for completing the program.

The program schedule is set for 2025. There will be an all-day, in-person beginning and ending session in Anchorage with the interim sessions via Zoom.

January 17 – Live Kick-off session in Anchorage – 9:30am-4:30pm
January 31 – Virtual - 8:00am-11am
February 14 - Virtual - 8:00am-11am
February 28 - Virtual - 8:00am-11am
March 21 - Virtual - 8:00am-11am
March 28 – Virtual 8:00am-11am
April 4 - Virtual 8:00am-11am
April 18 - Virtual 8:00am-1a1am
May 2 –Final in-person session and graduation in Anchorage – 8:30am-3:30pm

ASMA Website Info:

- For those that have not logged in yet, the site did not carry over your password. You **WILL** need to reset it in order to login.
- If you don't have an address in the "personal" field you will not receive mailings. Please login to update your profile.
- Physician images were **not** imported to the new site so please be sure you log in and upload a new photo for the OMD (Online Medical Directory).
- The system currently does not support Company Admin's uploading individual physician photos. You may email photos to Cjeanes@asmadocs.org, but please include the physician name and company so that we can be sure we're uploading to the proper profile.

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pended jewel so shockingly bright.…They're humans with a godly view and that's the blessing and also the curse."

As physicians, I think we too often have a high level view that is both a blessing and a curse.
Recent national trends suggest a loss of trust in experts and professionals, and I wanted to close with some data that gives me hope and confidence in our science-based profession:

A recent study in JAMA found that nearly 6 million cancer deaths were averted in the US over the past 45 years, and that 80 percent of the deaths averted were due to prevention and screening efforts. Kudos to everyone working in primary care and preventive health as well as those on the front lines of improving cancer treatments.

During the fall vaccination season, as I am encountering a new wave of vaccine hesitancy, I look back at the data from the WHO and am reminded that in 2021 alone, Covid-19 vaccines saved at least an estimated 14.4 million lives worldwide. The CDC estimates that last year's influenza vaccine prevented 6 million illnesses and 3,700 deaths.

I find professional meaning and renewal in the company of my colleagues who are working to improve health and healthcare in Alaska and the nation. I hope you all get some time away from work and find yourselves recharged and ready to continue the important work of medicine and advocacy in the year ahead. Please join us at ASMA and bring a colleague as we work on issues related to scope of practice for non-physicians, effects of repealing the 80th percentile rule, guaranteeing adequate insurance networks, and prior authorization reform.

Kristin Mitchell

References:

Physician Burnout - from Agency for Healthcare Research and Quality
https://www.ahrq.gov/prevention/clinician/ahrq-works/burnout/index.html

Epidemic of loneliness - Surgeon General Report 2023
https://www.hhs.gov/sites/default/files/surgeon-general-social-connection-advisory.pdf

Booker Prize winner 2024 Orbital by Samantha Harvey
https://thebookerprizes.com/the-booker-library/features/an-extract-from-orbital-by-samantha-harvey

Cancer Deaths Averted 1975-2020
https://jamanetwork.com/journals/jamaoncology/article-abstract/2827241?utm_source=substack&utm_medium=email

WHO advice on Covid Vaccines
https://www.who.int/emergencies/diseases/novel-coronavirus-2019/covid-19-vaccines/advice

MMWR on 2023-24 Influenza vaccine effectiveness
https://www.cdc.gov/mmwr/volumes/73/wr/mm7308a3.htm

The Physicians Foundation and Brandeis University Call for Applications from Leading Physicians for One-of-a-Kind Program to Transform the Future of Healthcare

The Physicians Foundation and Brandeis University are collaborating to launch The Physicians Foundation's Leadership Institute at Brandeis University. Twenty-five physicians will be selected to participate in this exclusive, one year hybrid training program to develop and sharpen leadership, policy and advocacy skills, address critical drivers of health, and promote physician well-being—all key to advancing effective healthcare delivery.

Participation in The Leadership Institute includes full coverage for tuition, travel and CME credits—an estimated value of up to $40,000. This prestigious, one-of-a-kind program is calling for physicians to apply by December 31.

"As our healthcare system continues to transform, it is imperative that we empower physicians to lead and drive solutions," said Gary Price, MD, president of The Physicians Foundation. "Physicians are not only the foundation of medicine, but also the architects of its future. By supporting their wellbeing and leadership, we help ensure that they can continue to provide high-quality, patient-centered care. Together, we can build a strong, sustainable healthcare system for physicians and their patients."

Why Apply?

The Leadership Institute is looking for dedicated physicians ready to step into leadership roles and shape the future of healthcare. This opportunity is limited to 25 participants, ensuring a highly focused and personalized experience. Key benefits include:

1. **Advance Knowledge and Skills:** Participants will gain crucial insights into national health policy, advocacy, leadership and management.
2. **Build Meaningful Connections:** The Leadership Institute offers the opportunity to collaborate and network with healthcare leaders from across the country, exchanging ideas and building partnerships that drive change.
3. **Reenergize Passion for Medicine:** The program will reignite participants' passion for medicine while empowering individuals to lead innovation and transformation in healthcare.

Innovate Solutions to Complex Problems: Physicians will acquire practical tools to tackle challenges in each of their healthcare institutions and develop strategies to enhance patient care and enhance operational efficiency.

"We are excited to collaborate with Brandeis University to launch this new program, designed to empower leaders with the transformative knowledge and skills they need," said Robert Seligson, CEO of The Physicians Foundation. "By combining our expertise, we are mixing academic insights with real-world applications to promote personal and professional growth amongst our participants. The Leadership Institute's training will equip our participants with the skills they need to not only excel in their careers but also make a real difference in communities and practices across the country, improving health outcomes along the way."

Curriculum Overview

With a hybrid format of in-person and online sessions from September 2025 – September 2026, physicians will gain essential insights into health policy and management while continuing to practice medicine.

The on-site residencies (five days each; beginning and end of program) and monthly one day, synchronous zoom class sessions will feature classes that address a broad range of management and health policy topics. Several core offerings that begin in the first residency will continue to be taught in the monthly online sessions and will conclude either during the year or in the second on-site residency at the end of the year-long program.

Highlights of the curriculum include:

1. **Tailored Studies:** Physicians will engage in case studies and simulations that reflect real-world challenges, and work on group projects to develop practical solutions.
2. **Focus on Health Policy and Connections:** Participants will also engage directly with leaders from specialty and state medical societies, national organizations and healthcare systems to collaborate on critical health policy issues and shape effective solutions.

Comprehensive Assessments and Incubators: Physicians will participate in The Physician Leaders' Innovation Incubator, working on a project designed to address complex problems in healthcare.

Apply for The Physicians Foundation's Leadership Institute at Brandeis University by December 31, 2024: https://physiciansfoundation.org/leadership-application-form/

Medical board business from the November board meeting

License renewal notices went out to all licensees to the preferred address (email or physical address), though some physicians have mentioned not receiving a notice. **Medical licenses must be renewed by December 31, 2024.**

Dr. Foland presented the issue of physicians under consent agreements and being monitored by the PHC are having difficulties getting hospital privileges and board certification. The board asked Dr. Foland and Ms. Ventgen to research with hospitals possible alternative language (currently these are listed as "probation") that would be acceptable to hospital credentialing committees.

Telehealth regulations within the medical board regulations are obsolete since statutory changes that were made in 2022 (following COVID). The board voted to eliminate the outdated language in 12. AAC 40.943 and tabled a decision on whether to adopt the 2022 FSMB guidelines on telemedicine until the next board meeting.

Dr. Nimmo provided an update and overview regarding the focus of and his participation in the Medical Spa Workgroup. He highlighted that this is a growing industry in Alaska and there are many individuals interested in these issues. A purpose of this work group is to put forth recommended statutes to the legislature. Services offered through this industry include IV Hydration (including the compounding of medications onsite in out-patient clinic settings), advanced aesthetic services such as chemical peels, laser treatment, Botox injections, and the use of designer drugs such as Ozempic or semaglutides. Some of the concerns raised are related to the delegation of duties to unlicensed personnel such as technicians and ethicians, and the lack of a physician or physician assistant being physically onsite, and the use of standing orders without a medical assessment of the patient. Related to this matter are board policies which were implemented many years ago and contain duplicative and contradictory guidelines to more newly adopted regulations which were implemented by the board in 2019. The conflicts between the policies and regulations were examined and several board members voiced support for repealing the old policies. On a motion made and approved by roll call vote, the Alaska State Medical Board repealed Board-issued guidelines pertaining to: Delegating Procedures to Non-physician personnel for Dermatological Procedures and Delegating to Medical Assistants.

Telehealth Services under the Medicare Physician Fee Schedule

(From CMS.gov)
Absent Congressional action, beginning January 1, 2025, the statutory limitations that were in place for Medicare telehealth services prior to the COVID-19 PHE will retake effect for most telehealth services. These include geographic and location restrictions on where the services are provided, and limitations on the scope of practitioners who can provide Medicare telehealth services. However, the final rule reflects CMS' goal to preserve some important, but limited, flexibilities in our authority, and expand the scope of and access to telehealth services where appropriate.

For CY 2025, we are finalizing our proposal to add several services to the Medicare Telehealth Services List, including caregiver training services on a provisional basis and PrEP counseling and safety planning interventions on a permanent basis. We are finalizing to continue the suspension of frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations for CY 2025.

We are finalizing that beginning January 1, 2025, an interactive telecommunications system may include two-way, real-time, audio-only communication technology for any Medicare telehealth service furnished to a beneficiary in their home, if the distant site physician or practitioner is technically capable of using an interactive telecommunications system, but the patient is not capable of, or does not consent to, the use of video technology.

We are finalizing that, through CY 2025, we will continue to permit distant site practitioners to use their currently enrolled practice locations instead of their home addresses when providing telehealth services from their home.

We are finalizing, for a certain subset of services that are required to be furnished under the direct supervision of a physician or other supervising practitioner, to permanently adopt a definition of direct supervision that allows the supervising physician or practitioner to provide such supervision via a virtual presence through real-time audio and visual interactive telecommunications. We are specifically finalizing to make permanent that the supervising physician or practitioner may provide such virtual direct supervision (1) for services furnished incident to a physician or other practitioner's professional service, when provided by auxiliary personnel employed by the billing physician or supervising practitioner and working under his or her direct supervision, and for which the underlying HCPCS code has been assigned a PC/TC indicator of "5" and services described by CPT code 99211, and (2) for office or other outpatient visits for the evaluation and management of an established patient who may not require the presence of a physician or other qualified health care professional. For all other services furnished incident that require the direct supervision of the physician or other supervising practitioner, we are finalizing to continue to permit direct supervision be provided through real-time audio and visual interactive telecommunications technology only through December 31, 2025.

We are finalizing a policy to continue to allow teaching physicians to have a virtual presence for purposes of billing for services furnished involving residents in all teaching settings, but only in clinical instances when the service is furnished virtually (for example, a three-way telehealth visit, with the patient, resident, and teaching physician in separate locations) through December 31, 2025. This virtual presence will continue to meet the requirement that the teaching physician be present for the key portion of the service.

More information relating to substance abuse care and prescribing.
https://www.dea.gov/sites/default/files/2024-11/HHS-DEA.pdf

And this view from the American Academy of Professional Coders:

- CMS acknowledges the CPT® Editorial Panel's decision to delete audio-only telephone services CPT® codes 99441-99443 for 2025. However, Medicare will **not** recognize 16 of the 17 telehealth CPT® codes (98000-98016) added for 2025; CPT® codes 98000-98015 will have an I *Invalid* status. Medicare will only pay separately for brief virtual check-in encounter CPT® code 98016 in lieu of HCPCS Level II code G2012, which CMS is deleting due to redundancy.
- Direct supervision through real-time audio and visual interactive telecommunications (not audio-only) will continue to be allowed on qualifying services.

Certain behavioral and mental health services will be permanently offered under telehealth for Medicare patients beginning Jan. 1, 2025. A link to CMS's List of Telehealth Services is in the Resources section, which you should reference (once the list is updated).

- Place of service (POS) codes will continue to have two telehealth designations:

O02 *Patient not in their home when telehealth services are rendered*; or

O10 *Patient in their home when telehealth services are rendered*. POS 10 will continue to be paid at the non-facility rate.

OCMS will continue to allow physicians to list their practice address, rather than their home address, when performing Medicare services via telehealth from their home.

OPre-pandemic geographic and location restrictions for telehealth (before March 1, 2020) are being reinstated. This means that unless a Medicare patient lives or is located in a health professional shortage area, a rural census track, or a county outside of the metropolitan statistical area at the time of service they will not be covered for telehealth services.

Teaching physicians may continue to have a virtual presence in all teaching settings, but only for Medicare telehealth services and just through Dec. 31, 2025.

Authoritative references are provided in the Resources section to allow you to source the information yourself.

Congress Could Change Everything

We still have until the end of 2024 for Congress to fix the geographical location issue for telehealth. But time is of the essence, or more than 85 percent of Medicare patients' telehealth encounters occurring after Jan. 1, 2025, could be invalid for payment.

The Telehealth Modernization Act 2024 is still sitting in Committee as of Sept. 18, 2024. Until Congress moves on this, medical practices and Medicare patients are in limbo as to where telehealth services will be covered in 2025. I urge you to contact your local representative to draw attention to this matter.

Resources
https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2025-medicare-physician-fee-schedule-final-rule
https://www.congress.gov/bill/117th-congress/house-bill/2617/text
https://aspr.hhs.gov/legal/PHE/Pages/covid19-11Jan23.aspx

Telehealth for Alaskans without Medicare

ASMA was instrumental in getting House Bill 265 passed last year

From AK Department of Health:
AS 47.05.270(a)(3) Expanding the use of telehealth for primary care, behavioral health, and urgent care.
The PHE ended May 2023, and the Office of Civil Rights and Centers for Medicare & Medicaid Services (CMS) established permanent telehealth guidance that would meet Health Insurance Portability and Accountability Act (HIPAA) compliance rules. In accordance with House Bill 265 that was signed into law on July 3, 2023, the Department adopted revised telehealth regulations on September 1, 2023, expanding both telehealth modalities and service types.
Telehealth is a method of delivering medical services using telecommunication technologies to extend patient care in place of in-person appointments. Telehealth is a Medicaid-covered modality. Medicaid pays enrolled providers for medical and behavioral health services delivered through telehealth modalities if the service is:
Identified as a covered service on the applicable fee schedule (see link below),
covered under traditional, non-telehealth modalities,
provided by a Medicaid-enrolled treating, consulting, presenting, or referring provider; and
appropriate to be provided via telehealth per the provider's standards of practice.

Services indicated on the Telehealth Fee Schedule are services that meet all four of the abovementioned components of coverage. Enrolled providers may request coverage of additional codes using the Request for New Consideration (medical/dental service) form.
A service delivered via telehealth is reimbursed at the same rate as a service delivered in-person. Alaska Medicaid covers the following telehealth modalities:
Synchronous (Live Interactive): Service delivery through a real-time, interactive two-way audio-video technology, or a two-way audio-only technology.
Asynchronous (Store and Forward): The transfer of recorded digital images, video, or sounds from one location to another to allow a consulting provider to obtain information, analyze it, and report back.
Patient-Initiated Online Digital Service (Synchronous or Asynchronous): Evaluation, assessment, and management services of an established patient through a secure platform such as an electronic record portal, secure electronic mail, or digital application.

While there may be increased utilization as access to services expands, telehealth services are reimbursed at the same rate as an in-person visit.

Please note that some State Medical Board regulations were made obsolete by HB 265. The State Medical Board is working to delete those obsolete regulations and bring others into alignment with HB 265.

The actual statutory language:
AK Stat § 08.02.130 (2023)
(a) A health care provider licensed in this state may provide health care services within the health care provider's authorized scope of practice to a patient in this state through telehealth without first conducting an in-person visit.
(b) A physician licensed in another state may provide health care services through telehealth to a patient located in the state as provided in this subsection, subject to the investigative and enforcement powers of the department under AS 08.01.087, and subject to disciplinary action by the State Medical Board under AS 08.64.333. The privilege to practice under this subsection extends only to
(1) ongoing treatment or follow-up care related to health care services previously provided by the physician to the patient and applies only if
(A) the physician and the patient have an established physician-patient relationship; and
(B) the physician has previously conducted an in-person visit with the patient; or
(2) a visit regarding a suspected or diagnosed life-threatening condition for which
(A) the patient has been referred to the physician licensed in another state by a physician licensed in this state and that referral has been documented by the referring physician; and
(B) the visit involves communication with the patient regarding diagnostic or treatment plan options or analysis of test results for the life-threatening condition.
(c) If a health care provider determines in the course of a telehealth encounter with a patient under this section that some or all of the encounter will extend beyond the health care provider's authorized scope of practice, the health care provider shall advise the patient that the health care provider is not authorized to provide some or all of the services to the patient, recommend that the patient contact an appropriate provider for the services the health care provider is not authorized to provide, and limit the encounter to only those services the health care provider is authorized to provide. The health care provider may not charge for any portion of an encounter that extends beyond the health care provider's authorized scope of practice.
(d) A fee for a service provided through telehealth under this section must be reasonable and consistent with the ordinary fee typically charged for that service and may not exceed the fee typically charged for that service.
(e) A physician, podiatrist, osteopath, or physician assistant licensed under AS 08.64 may prescribe, dispense, or administer through telehealth under this section a prescription for a controlled substance listed in AS 11.71.140 - 11.71.190 if the physician, podiatrist, osteopath, or physician assistant complies with state and federal law governing the prescription, dispensing, or administering of a controlled substance.

(f) An advanced practice registered nurse licensed under AS 08.68 may prescribe, dispense, or administer through telehealth under this section a prescription for a controlled substance listed in AS 11.71.140 - 11.71.190 if the advanced practice registered nurse complies with state and federal law governing the prescription, dispensing, or administering of a controlled substance.

(g) Except as authorized under (e) and (f) of this section, a health care provider licensed under this title may not prescribe, dispense, or administer through telehealth under this section a controlled substance listed in AS 11.71.140 - 11.71.190.

(h) A health care provider may not be required to document a barrier to an in-person visit to provide health care services through telehealth. The department or a board may not limit the physical setting from which a health care provider may provide health care services through telehealth.

(i) Nothing in this section requires the use of telehealth when a health care provider determines that providing health care services through telehealth is not appropriate or when a patient chooses not to receive health care services through telehealth.

AHHA 2025 Antimicrobial Stewardship Webinar Series

Online Event 12:00 PM – 1:00 PM

About the Event

This webinar series with Dr. Ben Westley will provide updated stewardship information targeted to physicians, pharmacists, infection preventionists, and other members of an antimicrobial stewardship team.

Information is geared specifically to the practice needs of Alaska providers and facilities and to provide support for complex clinical cases that have become more common due to antibiotic resistance.

The webinars are sponsored by the **Alaska Antimicrobial Stewardship Collaborative (A2SC)** and funded through the State of Alaska Department of Health. The A2SC is a partnership of hospitals, skilled nursing facilities, and other healthcare providers dedicated to developing innovative strategies to ensure appropriate antibiotic use.

Dr. Benjamin Westley is board certified in Pediatrics and Adult Infectious Diseases. He is a Fellow of the Infectious Diseases Society of America, and member of the HIV Medical Association. Dr. Westley is known across Alaska as a great resource in infectious disease.

SESSIONS & TOPICS:

By registering, you'll be signed up for all seven sessions of the webinar (dates and topics below). Recordings will be sent to everyone who registers.

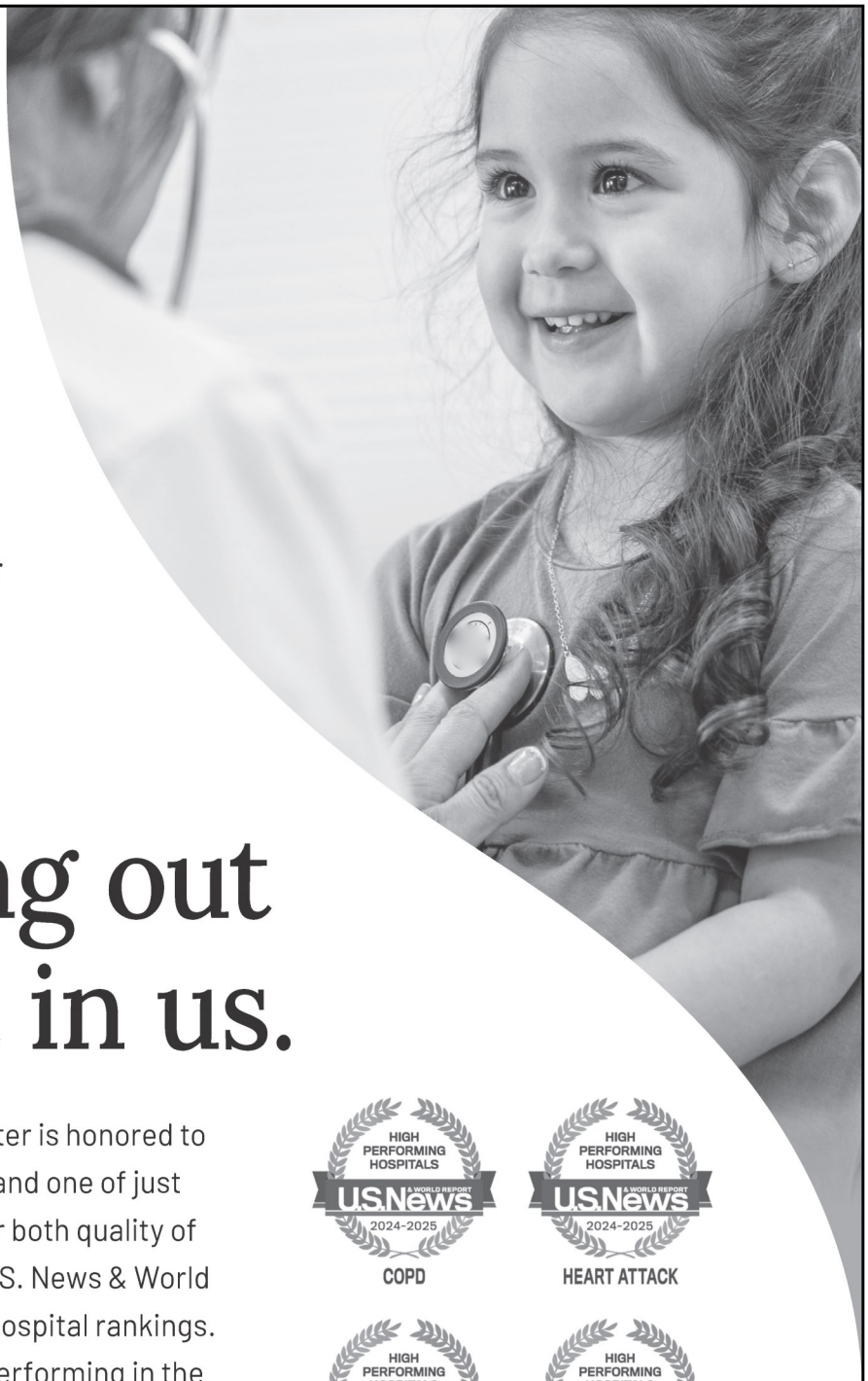
- Jan 22: Antimicrobial Stewardship in Action: Prospective Audit and Feedback
- Feb 5: Antimicrobial Stewardship and Respiratory Tract Infections
- Feb 12: Stewardship in Soft tissue and Skin Infections
- March 5: Stewardship in Urinary Tract Infections
- March 19: Stewardship in Intra-abdominal Infections
- April 2: Stewardship in Fever/Sepsis, Neutropenia, Osteoarticular Infection, and Endocarditis

April 16: Clostridium Difficile

Register at:

https://ashnha.zoom.us/meeting/register/tZcud-ytqDgpHt2b3b2nS2i4fFZEpVNJz20j#/registration

Please contact Debbie Lowenthal at dlowenthal@alaskahha.org if you have questions.



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HIGH PERFORMING HOSPITALS U.S.News & WORLD REPORT 2024-2025 COPD

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HIGH PERFORMING HOSPITALS U.S.News & WORLD REPORT 2024-2025 PNEUMONIA

HIGH PERFORMING HOSPITALS U.S.News & WORLD REPORT 2024-2025 STROKE

Alaska Supreme Court narrows the ability to sue based on informed consent

Proximate Cause Essential in Informed Consent Medical Malpractice Claims: Alaska Supreme Court Affirms Summary Judgment
Introduction
In the Supreme Court of Alaska case, **Kimberly Wallace Goodwin and Jonathon Goodwin v. Mat-Su Midwifery, Inc.**, the central issue revolves around a medical malpractice claim involving the death of a stillborn child, Jackson Wallace Goodwin. The plaintiffs, the Goodwins, sued the midwives for negligence and lack of informed consent, alleging that the midwives failed to adequately inform them of the risks associated with midwife-assisted delivery, particularly given Kimberly Goodwin's advanced maternal age and history of miscarriages. The Supreme Court affirmed the lower court's summary judgment in favor of the midwives, emphasizing the critical necessity of establishing proximate cause in informed consent claims.
Summary of the Judgment
The Superior Court of Alaska granted summary judgment in favor of Mat-Su Midwifery, Inc., determining that the Goodwins failed to provide sufficient evidence linking the midwives' care to the stillbirth of their child. The court upheld this ruling, emphasizing that in informed consent claims, plaintiffs must demonstrate two crucial elements of proximate cause:

- That the plaintiffs would not have consented to the specific treatment or course of care had they been properly informed of the associated risks.

That the treatment or course of care provided by the defendants actually caused the injury sustained.
Additionally, the court affirmed the award of enhanced attorney's fees against the Goodwins due to their "vexatious litigation conduct," which included prolonged delays and failure to comply with court orders.
Legal Reasoning
The court's legal reasoning revolves around the established elements required to succeed in an informed consent claim. It reiterates that plaintiffs must not only show that they would have chosen a different course of action had they been properly informed but also that the chosen course of care directly caused their injury. The Goodwins, in this case, failed to provide expert testimony that would counter the midwives' own expert evidence indicating that the stillbirth was due to an infection unrelated to the midwives' care.
Moreover, the court analyzed the Alaska statutes, particularly *AS 09.55.556(a)*, concluding that the statute does not override the common law requirement of medical causation in informed consent claims. Legislative history further supported this interpretation, indicating that the statute was intended to define informed consent without expanding liability beyond established norms.
Impact
This judgment has significant implications for future medical malpractice and informed consent cases in Alaska. It reinforces the stringent requirements plaintiffs must meet to establish causation, preventing the expansion of liability based solely on failure to obtain informed consent without clear evidence linking such failure to the plaintiff's injury. Additionally, the affirmation of enhanced attorney's fees for vexatious litigation serves as a deterrent against protracted and non-meritorious legal actions.
Complex Concepts Simplified
To better understand the judgment, it's essential to clarify some complex legal concepts:

- **Proximate Cause:** A legal concept that refers to the primary cause of an injury. In medical malpractice, it requires showing that the defendant's actions were a substantial factor in causing the plaintiff's harm.
- **Informed Consent:** A patient's right to be informed about the risks and alternatives of a medical procedure, ensuring they can make an educated decision about their care.
- **Summary Judgment:** A legal decision made by the court without a full trial when there's no dispute over the key facts of the case, allowing the court to decide based solely on legal arguments.
- **Medical Causation:** The necessity for plaintiffs to establish that a medical provider's actions directly caused the injury or harm they suffered.

Enhanced Attorney's Fees: Additional legal fees awarded to a party when the opposing party is found to have engaged in particularly obstructive or malicious litigation tactics.
Understanding these terms is crucial, as they form the backbone of the court's analysis and decision-making process in this case.
Conclusion
The Supreme Court of Alaska's decision in **Goodwin v. Mat-Su Midwifery** underscores the critical importance of establishing proximate cause in medical malpractice and informed consent claims. Plaintiffs must provide concrete evidence that not only did they act differently had they been informed but also that such alternative actions would have directly prevented their injuries. The affirmation of enhanced attorney's fees also highlights the judiciary's stance against litigants who engage in protracted and non-frivolous litigation.
This judgment serves as a pivotal reference for future cases, ensuring that medical providers are held accountable only when a clear and direct causal link exists between their actions and the harm incurred by patients. It also acts as a safeguard against the misuse of the legal system by those who may otherwise pursue baseless claims, thereby maintaining the integrity and efficiency of the judicial process in sensitive and complex medical malpractice cases.

HEALTH INSURER PROVIDER NETWORK STANDARDS

December 3, 2024

ISSUE:

Narrow (limited) health insurer provider networks create risk for patients and providers alike, especially in Alaska where the entire State is a federally designated healthcare professional shortage area. Provider network minimum standards provide protection to patients and preserve providers' ability to continue to practice.

BACKGROUND:

Limited provider networks are common in the Lower 48. Some include as few as 17% of the available providers in the market

The National Association of Insurance Commissioners, (the highly regarded national professional organization for Insurance Commissioners and regulators) has identified provider network minimum standards as the most important action a state can take to ensure a well-functioning health insurance and health care market.

Over 30 states and territories have adopted provider network minimums.

Alaska has a statute requiring an insurer to have an adequate network but there is no definition of "adequate".

Consumers cannot realistically determine if a network is "adequate". They frequently only discover it is not adequate when needing care for a serious illness or condition.

Providers excluded from networks risk financial insolvency, especially in a market dominated by one carrier.

Premera Blue Cross Blue Shield of Alaska leadership has publicly stated their desire to introduce narrow network options in Alaska with no coverage for out-of-network providers.

SOLUTION:

Establish provider network minimums under the existing statute to protect Alaskan patients and providers.

Widely used standards, such as time and distance, do not work in Alaska due to vast distances, small populations and limited numbers of providers

Minimum percentages of available providers is a simple standard which provides needed protections and is practical for Alaska. For example, to meet the standard an insurer must include the following percentages of qualified providers:

Anchorage - 85%, Mat-Su, Fairbanks, Kenai, Southeast – 90%, remainder of the state – 95%

All licensed acute care hospitals, skilled nursing facilities and behavioral health and substance abuse inpatient and outpatient facilities

All Tribal facilities and providers

Provisions included for health Insurers to meet the minimum standards by "deeming" a provider in-network where they have not yet achieved a contract, such as for a new carrier entering the market

BENEFITS:

Protects patients from unknowingly buying policies with inadequate networks

Protects providers at the bargaining table from undue leverage by health insurers

Provides definition of what is adequate, enabling enforcement of the existing statute

Alaska State Medical Association
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Anchorage, AK 99508-5334

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Physician Support Line
1 (888) 409-0141

Free and Confidential / No appointment necessary
Open 7 days a week / 8:00 am to 1:00 am Eastern time

(You are not establishing a doctor-patient relationship, thus this is not reportable as receiving therapy services. No need to report to your medical board.)

The Mission:

To offer free and confidential peer support to American physicians and medical students by creating a safe space to discuss immediate life stressors with volunteer psychiatrist colleagues who are uniquely trained in mental wellness and also have similar shared experiences of the profession.
The line is staffed by 800 volunteer psychiatrists helping our US physician colleagues and medical students navigate the many intersections