Lee County Medical Society

January 2008
Volume 31, Issue 7

Bulletin

Editor: Mary C. Blue, M.D.

January Meeting

Special Speaker:
Karl Altenburger, MD
FMA President

Installation of Officers

January 17, 2008
Royal Palm Yacht Club
2360 West First Street
Downtown Fort Myers

Reservations:
LCMS, PO Box 60041
Fort Myers, FL 33906
Tel: 936-1645 **Fax**: 936-0533

Inserts

- January General Membership Meeting Notice
- 2008 Committees
- AMA National Health Policy
- Opportunity to Immunize
- Business Management Services of Florida Ad

Inside this issue:

President's Message

2008 – Time to Fix the Sustained Growth Rate

Dean Traiger, M.D.

A new year brings hope of a fresh start, a better life than the year before and for confidence in the future. Unfortunately, our friends in Washington, DC must not agree.

Medicare will ring in the New Year in 2008 by reducing physician reimbursement by 10%. Sadly this is on top of a system in which Medicare payments to physicians only cover about 65 percent of the actual cost of providing patient services.

Medicare payments to physicians are modified annually using the sustainable growth rate (SGR) formula. The SGR links physician payment updates to the gross domestic product (GDP). However, fluctuations in general economic conditions as measured by GDP have very little relationship to the cost of providing patient services.

The SGR formula was designed to control utilization by reducing physician fees. Primary utilization drivers, however, are new or improved technologies, more services provided due to the aging of the population, greater beneficiary awareness of treatment options, and a shift from inpatient to outpatient care. Physicians control none of these factors.

Without long-term congressional action, the SGR will mandate more fee cuts for the foreseeable future. In July 2007, the U.S. Centers for Medicare and Medicaid Services issued a proposed rule to cut payments by nearly 10 percent effective in 2008, and payments are expected to drop by more than 40 percent by 2015.

Medicare Advantage plans received a fee hike of more than 7 percent in 2007, while hospitals and nursing homes got increases of 3 percent or more. Physicians got no increase in either 2006 or 2007.

In the past, only quick congressional fixes averted these cuts. Again this year we are all awaiting Congress to give us another year's respite, however this is not guaranteed. As it was explained to me by one of our congressmen in the House of Representatives, the temporary fix is accomplished literally by borrowing from Peter to pay Paul and the total cost for a long-term solution increases yearly. As a result, the cost for a meaningful fix is so inflated at this point, that none of the legislators want to tackle the problem; so instead they band-aid it and hope that someone else will fix it next year.

Congress must either find surplus funds or cut the budgets of existing programs to balance the increased cost of Medicare services; otherwise, the fee schedule will go through as planned.

Representatives of the AMA and American College of Physicians called upon legislators to "step in to replace the cut with payment increases that keep up with medical practice costs," and warned that if the fee schedule goes through, 60% of physicians will be forced to accept fewer Medicare patients. Among the suggestions is to use the $54 billion in excess payments to private Medicare health plans to offset the cut.

While physicians are committed to providing quality health care to America's seniors, current Medicare fee trends make it financially impossible for many physicians to do so. Failure to fix the SGR will harm seniors' access to health care as physicians are forced to limit their Medicare patient volume or drop out of the program. We need to continue to push for meaningful reform and ask for the Congress to make this part of their New Years' resolutions:

- Act immediately to increase Medicare physician fees to a level that is adequate to cover the average cost of providing services.
- The flawed SGR formula should be eliminated.
- Congress should implement an annual update that considers all legislative, regulatory, and economic forces that increase physicians' operating costs.

The only way to ensure that this goal comes to realization is by voicing your concerns to your representatives in Congress. In addition, ask your family and relatives to join your voice and finally ask your patients to add their voice as well. More information on this can be found on the American Medical Association's website at: http://www.ama-assn.org/ama/pub/category/13409.html.

See Page 7 for action information.

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The editors welcome contributions from members. Opinions expressed in the Bulletin are those of the individual authors and do not necessarily reflect policies of the Society. Advertisements do not imply sponsorship by or endorsement of Lee County Medical Society.

PRINTERS
Insta Print

Membership Activity

New Address

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Resigned
Scott Fields, M.D.

Moved out of Area
Susanna Beshai, M.D.
Tong Duong, M.D.

Retired

Stuart Levy, M.D. has retired from active practice. Dr. Levy has been a member of the Lee County Medical Society since 1982. He was a physician with Physicians Primary Care SWFL.

Robert Pascotto, M.D. has retired from active practice. Dr. Pascotto has been a member of the Lee County Medical Society since 1975. He was a physician with Gulf Coast Thoracic Surgery.

Lee County Medical Society & Alliance Holiday Party

The Lee County Medical Society and Alliance Annual Holiday Party was held on December 3, 2007 at the beautiful Veranda Restaurant. The Holiday Party was sponsored by Ironstone Bank. Two baskets were raffled by the Alliance to raise funds for the Alliance Foundation and $765 was raised this year. Ironstone Bank provided the Alliance with an amazing basket that Mrs. Betty Rubenstein won, a second basket assembled by the Alliance was won by Dr. Paul Tritel.

Please join us for our installation of officers at 6:30 p.m on January 17, 2008 the Royal Palm Yacht Club . The FMA President, Karl Altenburger, M.D. will be our special speaker.

Our sponsor Ironstone Bank: David Tucker, Joe Mulino Jr, Hope Connell (President, Ironstone), Pam Blackwell, Debbie Apercino, Edward Lick

Dr. James and Mrs. Betty Rubenstein. Betty Rubenstein won the Ironstone Bank gift basket.

Dr. Paul Tritel and Ms. Beverly Rashide. Dr. Tritel was a basket winner.

President, Dr. Dean and Mrs. Tami Traiger

As I Recall...

Roger D. Scott, M.D.

Fiery Serpents

Upon graduating from medical school in 1951, I became entitled to attach an emblem on the license plate of my car revealing my status as a physician. It was confusing as to whether a staff of Aesculapius or a caduceus was proper as various readings (remember this was before computers) suggested using one or the other. I had gathered some knowledge from a book but today one may find much information on ye old network (especially @drblayney.com) and some of this information is abstracted in this article. Of course the emblem of medicine is important as it extends to the entire profession and well beyond simply the license plate of the car, and it granted certain privileges such as no speeding or parking tickets, parking in unauthorized spots and other privileges of respect. We would even stop and help an injured person or give aid to anyone.

The staff of Aesculapius (Roman Latin) or Asklepios (spelling for benefit of Drs. George Kalemeris and P.J. Tsakalakis & other Greeks) consists of a rough stick (staff) upon which a single snake is entwined. It is sometimes difficult to differentiate between mythology and history, but it is thought that Aesculapius was a worshipped Grecian physician probably around 1200 BC. It has been theorized that the single serpent wound around the staff represents the filarial (guinea, fiery serpent) worm that caused Filariasis then and still exists. This worm's life cycle is amazing as it can grow to 3 feet in length and eventually winds up in the subcutaneous tissue. The ancient physicians removed the worm by incising the skin ahead of the worm's path, and the physician wound the worm around a stick until the entire serpent was removed. This was a common infection, and it is believed that physicians advertised their services by displaying a sign with the worm (snake) on a stick. Aesculapius had three daughters whose names are associated with today's medicine: Meditria (medicine), Hygenia (hygiene), & Panacea (panacea). The staff of Aesculapius is sometimes referred to as a caduceus, but it is not for there is a true Roman (Latin) caduceus (kerykerion -- it's all Greek to me PJ and George), which appears as a greater & elaborate symbol to represent the medical profession. The mythological Roman Mercury's (Greek Hermes) winged – topped staff is entwined with two snakes (Some in mythology say these are copulating snakes that were separated by Hermes sticking his staff between them!). Mythology states that Greek Hermes (Roman Mercury) invented the lyre by making holes in a tortoise shell and threading nine linen cords through them. He then traded the lyre to Apollo and received the caduceus in exchange. It was thought that Mercury presided over everything that required skill and dexterity. One of Mercury' s functions was to conduct the souls of the dead from the upper to the lower regions, but he always carried the caduceus with the serpents as symbols of life. The Bible in Numbers 21:8 states, "And the Lord said unto Moses, make thee a fiery serpent, and set it upon a pole and it shall come to pass, that everyone that is bitten, when he look upon it, shall live."

Many ancients favored the staff of Aesculapius as the medical symbol; however, from the early 16th century onwards both were used by printers to denote pharmacopoeias and physicians, which leads us to a state of confusion as to the true medical emblem. So with this background can you tell if the winged staff of Mercury or the staff of Aesculapius is the true medical emblem? It has been said that the ill-informed considered both the staff of Aesculapius and the caduceus to be the same, but the United States Army in 1902 adopted for its Medical Department Mercury's caduceus to replace its original insignia of a cross. It is believed that this action greatly influenced the concept that the caduceus was truly the symbol for Medicine and represents wisdom, eloquence and communication (much better than focusing on the snake)! (We in the USAF Medical Corps were not allowed to wear an emblem in the 1950's.) Anyone in the military injured in combat receives the Purple Heart but an additional beautiful badge is awarded only to members of all medical services who were assigned to medical units of company or smaller sizes engaged in active ground combat since December 1941. The badge consists of a horizontal stretcher crossed by a caduceus surmounted at the top by a Greek cross and on and over an elliptical oak wreath with stars added to indicate subsequent awards. (I never knew this emblem existed until this research.) This is very similar in manner to the paratroopers jump badge.

Dr. Walter Friedlander in his 1992 *The Golden Wand of Medicine: A History of the Caduceus Symbol in Medicine* surveyed 242 logos of American health organizations and found professional associations used the staff of Aesculapius (62%) while commercial organizations were more likely to use the caduceus (76%). Only 37% of hospitals used an Asclepian staff and 63% use the caduceus.

I am pleased to report that our Medical Society in 1958 properly used the staff of Aesculapius on its beautiful car emblem and also "LEE, CHARLOTTE, COLLIER, HENDRY CO.MED.SOC.FLA." in a golden circle surrounding a green cross centered with the staff and M.D. within a crimson circle.

Please be aware that there are several different ways of spelling Aesculapius and there are many mutant forms of both the staff and the caduceus.

This has all been "Greek" to me, but I hope that this has solved the problem for you.

Here's the answer to my 1951 problem. The round staff -- caduceus emblems could not be attached to my license plate because they were attached at the upper portion and partly blocked the opening to my trunk and; therefore I found a plain stainless steel shield with only "M.D." in bronze that I drilled two holes in and attached it to the side of the license plate. This one was used on my car from 1951 until the emblem of pride became the mark for suit, I guess in the 1970's, but I still wear a "staff" in my coat lapel.

EMBLEMS ATTACHED TO CAR LICENSE PLATES 1958

Caduceus

Staff of Aesculapius

Lee County Medical Society Alliance

Mary Macchiaroli and Jennifer Kim, Co-Presidents

As we look to 2008, we begin the process of selecting the next slate of officers for the 2008-2009 leadership of the Lee County Medical Society Alliance and Foundation. The Nominating Committee will be working over the next few months to identify potential leaders to fill the roles of President, President-Elect, Vice President, Treasurer, Recording Secretary, Corresponding Secretary, and Parliamentarian. Together, these positions make up the Executive Board of the Alliance. Additionally, there are many committee and event chair positions available. Everyone who has been a member of the Alliance for at least a year is eligible to serve in any position.

The President (co-presidents in our case) is responsible for the overall leadership of the Alliance throughout the year. We plan the monthly board meetings and general membership meetings, including location, agenda, and content. We send notices of meetings to our members. We work with the board and committee chairs to plan special and charitable events throughout the year. We also guide the content of the newsletter. The time commitment involved in being president adds up to about 10 to 15 hours a month, for one person. As co-presidents, we divide that time commitment between us.

The role President-Elect is primarily to attend the monthly board meetings and events and plan for the coming year. The American Medical Association Alliance offers a leadership training program in Chicago every fall to help Presidents-Elect plan for their year as president. The time commitment involved in the role of President-Elect is no more than five hours per month.

The Vice President serves as the right hand to the President, and, in her or his stead in the event the President cannot attend an event. The VP attends the monthly board meetings and other events and meetings throughout the year. The monthly time commitment for the Vice President is probably no more than two to five hours a month.

The Treasurer serves the very important role of managing the budget and finances of the both the Alliance and the Foundation. The treasurer attends the monthly board meetings and presents the budgets to the board members. The monthly time commitment for the Treasurer is about ten to fifteen hours per month.

Recording Secretary attends the monthly board meetings and records and then disseminates the minutes of the proceedings. The minutes reflect the topics discussed, detail any votes taken and note who was in attendance at each meeting. The time commitment for the Recording Secretary is about three to four hours per month.

The Corresponding Secretary picks up the Alliance mail each week at the PO Box and disseminates it to the appropriate person. The time commitment for the Corresponding Secretary is approximately two to five hours per month.

The Parliamentarian attends every meeting of the Alliance to ensure that they are conducted according to Robert's Rules of Order. A solid knowledge of parliamentary procedure is an important prerequisite for this job.

In addition to the above positions, there are opportunities to chair and serve on various committees, such as Membership, Welcome Brunch, Newsletter, Potluck in Paradise, and Medi-bags, to name a few. The chairs work hard to plan the events and fulfill the purpose of their committees and events. The time commitments vary depending on how many people help on a task.

The purpose of all this is to let you know that we need your help to fill the available positions. Please encourage your spouse or step up yourself and volunteer to take on a role in next year's leadership of the Alliance. The rewards are many—from great networking opportunities to just plain fun and camaraderie. Please contact a member of our Nominating Committee, Michele Tyson, Jodi Johnson and Elaine Green if you or someone you know has any questions or would consider volunteering for a position. We need your help!!

Dear Members:

We wish to thank you for your assistance and your continued commitment to your profession. We would like to thank your staffs for all the support they have given to the Medical Society office and all the assistance they have provided and continue to provide.

We ask for your continued support in 2008 and wish you a happy and prosperous New Year.

Sincerely,
Lee County Medical Society Board of Governors and Staff

Flu Shots Can Be Given Through out Flu Season

The Adult Flu Coalition of SWFL met on Wednesday, November 5th to discuss the needs of our Community during Flu Season. At this meeting, the Advisory Committee on Immunization Practices (ACIP) guidelines were reviewed. The ACIP emphasizes that immunization providers should offer influenza vaccine and schedule immunization clinics throughout the influenza season. Logistically, it is challenging to immunize everyone who should be vaccinated in the current 2 to 3 months vaccination window (Sept-Nov); the vaccination period must expand. Some of the topics discussed:

Demand

- Health-care provider recommendations are a key driver in creating consumer demand for influenza vaccine.
- Direct-to-consumer campaigns aim to increase consumer awareness about the value of influenza vaccination and the importance of immunization throughout the season

Supply

- Supply is no longer a barrier to influenza immunization
- Between 150 and 200 million doses are anticipated in the next few years

Opportunity

- Access to unimmunized high-risk patients exists throughout the entire immunization season
- Health-care providers need to be more proactive as patient awareness and interest decline later in the season.

Note: See Influenza Insert

United Way 211 Can Help You Help Your Patients

Louise Hawthorne

Many people seen in your practice have social service needs beyond the medical services that your practice provides. This could be an elderly person who needs respite because of an ill spouse, a family who needs food, or a child who needs physical therapy. United Way 211 can help.

United Way 211 is a service that provides information and referral to health and social service agencies within Lee, Hendry and Glades Counties. People in need call our easy to remember, three-digit number at any time during the day or night. Callers will be connected to an information and referral specialist who can help guide them through the maze of social service organizations and refer them to the appropriate program to help with their problem. Our service is available in English and Spanish. A community resource directory is available, or you can visit our website and view 750 community resources at **www.unitedwaylee.org**.

Detailed information regarding our service is available including posters and cards for patients and staff. We would appreciate your assistance by sharing this information with them. We look forward to working in conjunction with the local physicians and medical providers to help the residents of our community.

Please call Linda Pankow at 239-433-3900 ext 240 or e-mail her at linda@unitedwaylee.org if you have any questions or would like 211 materials for your office.

Louise Hawthorne , United Way Lee County Campaign/Communications Manager

Keep Yourself Out of Trouble

- When prescribing medications for family, friends and other physicians document, document, document.
- Clear handwriting so the pharmacist does not give your patient the wrong medication or wrong dosage.
- Make sure you have all of your CME to renew your medical license, if not this can be costly.
- Advise staff not to speak about one patient in front of another patient.
- Keep it professional—don't down talk a physician in front of a patient.

Medicare Cuts

Ray Kordonowy MD, LCMS Member and Private Practice Physician

Recently I attended the FMA sponsored Medicare Summit Meeting. The President Elect for the National AMA was also in attendance and gave an initial analysis of the situation as well as proposed some fixes. There was no media coverage of this summit. Approximately 35 physicians from across our state attended this meeting. I was one of several who provided testimony to our Federal Representatives (none of whom actually attended the meeting) via their respective secretaries who came to the meeting. I feel the fact that no actual representatives attended this conference indicates the apathy our government is showing regarding any empathy toward our profession and to the Medicare program.

My testimony consisted of outlining the revenues obtained in 2006 for my Group's 16,900 Medicare visits that we provided. I also revealed the overhead of our Private Practice using only our core staff, building and equipment (which includes electronic records and excluded ancillary expenses). The overhead exceeded revenues generated for physician E&M services before Physician salaries were dispensed! The fact that our business model provides ancillary services is why we are able to maintain profitability. I explained to those in attendance that it is not a coincidence that there are very few Primary Care Physicians in private practice given the meager payments provided for physician office evaluations. I envision serious physician shortages for the foreseeable future due to this present capped revenue economy that the Medicare program is using. The interesting perception of recent increased student applications for Medical School will rapidly be dismantled once the students learn that the present payer system does not follow a free economy. Their attempt to meet increased physician demand will not be met by increased payment for their services.

Following the meeting, our group then did a proforma of next year's printed 10% cuts for physician services. The level of distress we experienced can't even begin to be described. The proposed payments for 2007 are shocking when placed in black and white on a spreadsheet for our various coded services. I in no way can see how this can be tolerated. Our 2007 overhead of approximately 85% will become 95% unless something gives. What makes this even harder to stomach is to know that the CMS formula calls for continuing such cuts for at least an additional 4 years.

I suspect physicians and patients are going to actually listen to our politician's rhetoric about nationalized (socialized) healthcare due to the horrendous future outlook of the present payment system. I would remind our members that such an idiotic proposal as Universal/ Socialized Healthcare is only a magnified and accelerated model for the present stranglehold we are experiencing under Medicare's present payment structure.

What we really need is a free market economy for our services. I would remind you that Dentistry and Veterinary Medicine are doing very well (thank you) with a real world economy. Why we want to be the patsy and agree to basically accept a communistic approach to our labor force, intellect and compassion I cannot understand.

The AMA did propose that we immediately be allowed to balance bill (which was how it was prior to the 1997 Omnibus Healthcare Act). The AMA also proposed that Medicare patients have a "swipe card" which would immediately provide direct payment to a physician's bank account upon providing service. This proposal is much like present prescription cards provided by insurance plans. At any local pharmacy confirmation of a patient's participation in a prescription plan is made upon swiping the card. Using computer software program, a clearinghouse arranges payment to the pharmacist for a portion of the prescription cost and the patient then provides their portion to cover the rest. Both of the above mentioned proposals would immediately solve several present concerns. I am afraid such a practical approach will be snubbed because it would take some of the power and control away from the social engineers, health consultants and lobbyists that presently exist based upon the premise that they know better how to provide healthcare than we physicians.

To follow the Medicare dilemma further I would like to make some further observations and opinions. This past week my group began to consider our options. We are facing the probability of a major overhaul in how we presently run our practice. The discussion of Par, Nonpar and Opting out of Medicare is part of our analysis. I learned that we have to inform our government if we wish to change our Participation status no later than December 30th of this year. This highlights the amount of control this program is under. The government gets to tell you a few weeks in advance that they are planning to gut your revenues. The providers have to decide under duress whether they want to upset their patients and staff with a Nonpar status change within a few weeks of learning this horrible news (in order to be allowed to charge a net 1% loss of last year's fee schedule mind you). The fact that this rule exists is what allows our Government to see (by the number of status changes that occur prior to January one, 2008) how serious we physician's are when we say we can't tolerate these cuts. I suspect even my group will not find the will to change our status by the appointed date. Armed with this information, the government will believe that we are all willing to go along with the cuts as outlined. The need to legislate any change or even any band-aid will not be appreciated by the government because very few of us will have changed our status by December 30th.

I have stated this before and will repeat it now. The real power is in our hands. When and how we exercise this power is up to us. The subspecialist who provides procedures may not appreciate the severity of cutting physician E & M payment as acutely as someone in my field. This doesn't change the fact that we are all part of one profession. We need to support each other collectively in order to maintain our autonomy to practice good medicine based upon our understanding of healthcare delivery. We should not allow non physicians to convince us that we are doing a bad job (which is what this pay for performance hogwash is about) and that we are somehow the ones' who have to sacrifice our incomes in order to offset the increased cost of providing healthcare. You and I have very little to do with actual cost of care and dollar utilization (remember my opinion article in 2005 in this same newspaper) in healthcare.

If physician's feel the response to the cuts is to hire more ancillary staff to increase patient visits remember that this treadmill running with ongoing cuts is planned for an additional 4 years. Also remember that you are now competing with a labor market that includes retail pharmacies and wholesalers (such as CVS and Wal-Mart) who are now hiring ARNPs to man their retail "clinics". Also remember as we hire more extenders we are in essence telling the payers, retailers and Medicare that our services and expertise can be easily replaced by such extender staff. I personally believe there is a difference in quality and that we should be supporting our profession more rigorously, not watering down the quality of healthcare with less supervision and less trained clinicians.

How Can Your Patients Help With Medicare Cuts?

Cut this out and handout copies to your patients...

Medicare Talking Points

Severe Medicare cuts in 2008 and beyond threaten your family's access to doctors. Here's how:

- In an AMA survey, more than half of all doctors said a Medicare cut will **force them to decrease or stop seeing new patients and to discontinue nursing home visits**.
- A majority of doctors in rural communities said they would no longer be able to conduct important outreach services due to nine years of projected cuts in this same survey.
- Nearly three out of four doctors said the Medicare cuts will **force them to delay purchasing critical new medical equipment.**
- Also, nearly 65% of doctors reported that the Medicare cuts will force them to delay purchase of new health care technology.
- It's gotten harder for doctors to refer patients to certain medical and surgical specialists, and that **many seniors now have to travel further for needed medical care**.

Americans deserve better. We are asking the U.S. House and Senate to permanently reform Medicare and stop future cuts -- but Congress won't act until you do!

Sen. Mel Martinez – 317 Hart Senate Ofc Bldg, Washington, DC 20510 – (202) 224-3041 - (202) 228-5171 FAX
Sen. Bill Nelson – 716 Hart Senate Office Bldg, Washington, DC 20510 – (888) 671-4091 - (202) 228-2183 FAX
Rep. Connie Mack – 317 Cannon House Ofc Bldg., Washington, DC 20515-0913 – (202) 225-2536 - (202) 226-0439 FAX

Visit the AMA Patient Action Network at patientsactionnetwork.og

Universal Coverage

AAPS News

While many are preoccupied with fighting the Single-Payer bogeyman—which is not too likely at the present time in the United States—the real threat is unopposed, writes Greg Sandlen of Consumers for Health Care Choices. That is mandatory insurance coverage for all Americans.

"Universal coverage" is the stated goal of the AMA as well as most presidential candidates. An "there is no voluntary path to universal coverage," writes George Halvorson, the chairman and CEO of Kaiser Foundation Health Plan and former CEO of Health Partners of Minneapolis.

The American model will probably be different from the British or Canadian. "Government-controlled public/private arrangements in which federal subsidies are used to justify the federal government regulation and controlling everything, but leaving the financial risk to private parties...are the risk in…all the proposals coming from Democratic candidates for president," writes AAPS member Richard B. Warner, MD, immediate past president of the Kansas Medical Society.

There's a $2.5 trillion pie to divvy up, and stake holders are gathering: The American Hospital Association, America's health Insurance Plans, Service Employees International Union, Phrma, the Business Roundtable—and the AMA.

The Pieces are Already in Place

Eight developments "finally make health care reform possible," state Holvorson in his book Health Care Reform Now! - a must-read, according to Rep. Pete Stark (D-CA) and Alain Enthoven. The first is the "common provider number," the NPI, which makes I possible to "track individual provider performance using available electronic data bases." (He ignores HIPAA-noncovered entities). Other essentials include interoperable computer databases; the government's willingness to make its Medicare data on provider performance available to the public; and lawmakers' readiness for reform.

Comepteint Behemoths (A.D.A. "Managed Competition")

Once all that data is available, plans can compete on the bases of performance. Since individual consumers are unlikely to make care giver selection decisions well, and will not have the market clout to "transform any single multimillion-dollar revenue provider of care into a more accountable vendor," Halvorson writes, "we need to hire a vendor to set up and administer those market forces," using both wholesale and retail purchasing leverage: an infrastructure vendor (IV).

Six-Sigma Goals

Companies like General Electric, which has "world-class reengineering capabilities," set Six-Sigma quality standards for themselves. These allow only 3.4 defects per million opportunities. The best score among all health plans in the country for breast cancer screening compliance is 88.6%, a mediocre tow –sigma level. Only with extensive and 100% complete data collection– impossible without universal coverage –can we hold providers accountable to a six-sigma standard of compliance with best practices. And to find out what the best practices are, "we" need to hire someone to do the "keeping up" work, as no mere physician can possibly read all relevant studies.

Already, of the chronic-disease patients who incur most medical costs in America, "we know exactly what care they need." Patients with congestive heart failure, asthma, diabetes, coronary artery disease and depression need to have their lab tests and take their medicine. And they need to make lifestyle changes (the IV will therefore assign patients a case manager and care team): "Raw potential positive impact of patients giving up cigarettes , losing weight and exercising regularly are massive." If we could achieve those goals, "Medicare funding would disappear as an issue," Halvorsen thinks.

Since America still has some independent physicians, the IV needs to create the functional equivalent of vertically integrated care: ":virtually linked" care to overcome endemic care linkage deficiencies (CLDs).

Buyers

Employers will continue to be major buyers, and they'll be purchasing benefit delivery packages and a health reform agenda from IVs. They will also be paying for population health improvement and provider performance management. IVs will have "negotiated prices with each care provider," and will have patients "appropriately incented and supported to make the right decisions about coverage, care systems, caregivers, and care." Only "higher income" (>300% of federal poverty level) working people would buy coverage directly and be forced to buy a $10,000-deductible plan from the government if they didn't attach proof of insurance to their IRS form 1040. Taxpayers, of course, would be buyers for others without employer-owned coverage. A new program called HealthPrime would use Medicaid's infrastructure for those not qualified for Medicaid. The problem with just expanding Medicaid is getting enough providers to sign up.

The cost shift from the uninsured could be ended. (There apparently is no cost shift from Medicare or Medicaid.) A health care sales tax and/or an in-lieu tax on employers who don't provide insurance would provide any needed extra money in case the cost savings were insufficient.

Universal Control

It is essential for everyone, including noncitizen residents (and all "providers"), to be in the system to eliminate health disparities, to know every needed service that a patient is not receiving, and to achieve health solidarity as a core value.

Letter To Dr. Michael D. Maves, AMA EVP

Dear Dr. Maves:

I want to thank you for taking the time to speak with me about the "campaign for the uninsured". First, I want to make it clear that I believe that health insurance is a good thing so long as we are talking about insurance, an actuarial bet. That said, I walked into the AMA HOD last Saturday and, as usual, read all the signage and I was shocked.

First, one in seven is NOT accurate. Many of those uninsured are 1) not citizens 2) uninsured by Choice or 3) uninsured only intermittently. The signage reads (to me) that if a patient doesn't have insurance they might as well not even seek care because a physician's door is shut. That is a bad message. A mammogram runs about $80 and during breast cancer month can be free .... A patient DOES NOT need insurance to seek MD advice. A patient DOES NOT need insurance to get a mammogram. Your message is misguided.

Access to care is NOT about insurance. Again, I am not suggesting that patients not insure but I am suggesting that the insurance industry is the problem. P4P and government programs that assume that all patients are the same are expensive and not at all what we are about. They are about paper work and government mandates.. not about care. Health care is about what happens between 4 walls and a closed door and access to care is about my asking "how can I help you?"

That may seem overly simple but it is what the profession of medicine is about. I believe that the message you hoped to deliver was that you wanted to help provide an environment where a patient can find affordable health care... not affordable health insurance. Insurance is NO guarantee of care and it might be obstructive.

Surely, the business of medicine is complex and burdensome and I would suggest that most of that is because of insurance and the government. I would only expect that any campaign to engage in more of a "bad" thing cannot be good. Let's work together to educate our patients about the REAL cost of care. I invite you to visit the website http:www.healthylongbeach.org. The site is almost complete. We are in the process of getting the physicians and hospitals as well as the surgery centers and the imaging centers registered but all have agreed to post their retail prices. That's transparency and that information should be available to patients all over the country. I believe that we can change the face of medicine by being the spokespersons for healthcare transparency.

Consider the message that I hope you heard from the HOD. We are tired of being the slaves of government and insurance. Doctors desperately want to get back to the business of caring ...I believe that the AMA should be spending time talking about the patient-doctor relationship and how our doors are open. Efforts should be made to enable us to directly contract with patients outside of the traditional insurance. We should be engaging the presidential candidates and finding the best candidates who will engage OUR message. WE are the profession and our patients need us to put care first before the authorization and the begging. How demeaning ...This is the time to "just say no... no.... no" to P4P, unnecessary regulation, more authorizations... and the AMA should be leading the chorus.

Please give serious consideration to ending this bad campaign. To date, I have not found anyone who finds it productive. Let's work together to deliver the message that we REALLY want our patients to hear…

"Hi Mrs. Smith .. My name is Dr. Jones... How may I help you today?"

NOT "Hi Mrs. Smith... My name is Dr. Jones... What kind of insurance do you have?

I am going to continue to wake up every morning knowing that I am in the privileged position of being a doctor who can make my patients' day better..... I hope the AMA can somehow translate that message into healthcare reform ….

Thanks for listening…
Marcy Zwelling, MD
Private Medical Services

This letter is shared with you to create discussion on healthcare for our patients. You can give your feedback to Dr. Zwelling who is setting up a website to share with the world.

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Anti Mark Up Regs Hit Group Practices Hard

Jeffrey Cohen, Esq.

Some of the biggest regulatory changes in many years will smash group practices' ability to provide diagnostic services to their patients. The Anti Mark Up Regulations will cause groups to rethink their arrangements with Independent Diagnostic Testing Facilities ("IDTFs") and will prevent groups from adding to the purchased cost of both the technical and professional components of diagnostic tests. With a beginning effective date of January 1, 2008, the new regs can be expected to cause group practices to rethink their arrangements with providers of technical components and physicians who interpret them.

IDTF Issues

These changes will hit groups that time share or block lease IDTF equipment, space and/or technicians. Under the new rule, IDTFs may not sublease their equipment, space. Simply put, that spells the end of time share arrangements, whereby groups used IDTF space and equipment on a part-time basis to provide diagnostic services like MRIs and CTs to group patients. There is a one year phase-in for existing part time lease arrangements, but the anti mark up provisions may cause groups and IDTFs to end their arrangements much more quickly. Mobile IDTFs, like mobile ultrasound or EKG providers, are not affected by the prohibition, although the anti mark up provisions may mean that fewer mobile IDTF part time arrangements remain in place.

Anti Mark Up

The anti mark up provisions of the new rules will have even broader impact. Medicare currently prohibits a technical component ("TC") of certain tests being marked up when they are billed by some entity other than the entity that provided the service. The concept has been broadened by the reg to apply to all diagnostic tests and to the professional component ("PC") as well.

The TC anti mark up provision applies with respect to any **diagnostic test** that is **ordered by a billing physician** if the TC is purchased or if it is performed somewhere other than the office of the billing physician. The term "office" means "space where the physician...regularly furnishes patient care." The regs expand on that to state that it is the location where "the physician organization provides substantially the full range of patient care services that the physician organization generally provides." A centralized building (for all the group's performance of diagnostic tests) does NOT satisfy the requirement that it be performed in the physician's office. The site of service is a key determinant of whether or not the anti mark up provisions apply.

The anti mark up provisions also applies to the PC of diagnostic tests ordered by the billing physician. If the PC is purchased or the PC is not performed in the billing physician's office, it may not be marked up. The issue of whether the professional person doing the PC is part-time or full-time, an employee or independent contractor are irrelevant, for purposes of the anti mark up provisions.

In short, if the PC or the TC was purchased, the anti mark up provisions apply. If the PC or the TC was not performed in the office of the ordering physician who will bill for the test, then the anti mark up provisions apply.

Tests

Based on the foregoing, physicians should ask:

1. Is a diagnostic test involved? If so, then the regs apply;
2. Is the physician ordering the diagnostic test also the billing physician? If so, then the regs apply;
3. Is the test being performed in the billing physician's office? If so, then the mark up restriction do not apply to the TC unless the TC is purchased by the physician;
4. Was the PC performed in the office of the ordering/billing physician? If so, then the anti mark up prohibitions do not apply unless the PC was purchased;

Examples

The regs provide numerous examples of how they apply. For instance:

1. In a urology practice that contracts with a leasing company for a technician and a pathologist for testing on prostate samples, where all the work is done in a centralized building where the urologists do not treat patients, the anti mark up provisions apply to both the TC and the PC because neither of the services were done in the group's office.
2. A physician in a group practice orders a diagnostic test and a part time employee technician of the group performs the test in the group's office. An independent contractor physician who has reassigned to the group his right to bill and receive payment for the services performs his/her service in the group's office. The mark up prohibitions do not apply to the PC or the TC because (1) they were done in the group's office, and (2) the PC was not purchased from the physician.
3. A group practice purchases the TC and PC of a diagnostic test and wants to bill Medicare for the test. The regs prohibit it because both components were purchased in the event a component is purchased, the location where it was performed does not matter.

The Future

Judging from comments by the authors of the new rules, there are more restrictions on the horizon, including those may affect per click (use) lease fees and percentage based compensation arrangements. As a result of the new regs, physicians will have to rethink (1) part-time lease arrangements with IDTFs and (2) marking up any diagnostic test.

Mr. Cohen is a shareholder in the Delray Beach law firm of Strawn, Monaghan & Cohen, P.A. He is Board Certified by the Florida Bar as a specialist in Health Law. Mr. Cohen may be reached by calling (561) 278-9400.

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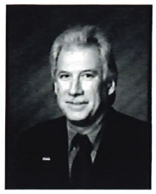

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