WESTCHESTER PHYSICIAN

February 2014 **Volume 29, Issue 2**

PRESIDENT'S MESSAGE

SOCIAL INSURANCE

Don McCanne, MD, of Physicians for a National Health Program writes a daily health care policy update. He recently wrote an item titled "Social Insurance-What You Need To Know." You can read at (http://www.pnhp.org/news/2014/february/social-insurance-what-you-need-to-know) in which he reviewed, quoted, and commented on a scholarly text, "Social Insurance: America's Neglected Heritage and Contested Future," by Theodore R. Marmor, Jerry L. Lashaw and John Pakutka (http://www.cqpress.com/product/Social-Insurance-America-s-Neglected.html).

"Asking individuals, especially lower income individuals, to choose how much risk they can afford is a recipe for wide spread under-insurance."

The United States and other countries are defined in part by their approach to social insurance. America has evolved a complex approach to social insurance reflecting various political, ethical and historical influences. Nearly all of us face risks from six major threats and are in a position to benefit from social insurance put in place to protect us. These risks are: the threat of birth into a poor family; the threat of early death of a family breadwinner; the threat of ill-health; the threat of involuntary (un) employment-job lock; the treat of disability; and the threat of outliving one's savings. The policies that have been put in place to protect us, such as Medicare and Social Security, are very popular because nearly all of us both contribute and may potentially benefit. The Affordable Care Act has been enacted to extend protection against the threat of ill-health to many more millions of Americans in an affordable manner. Like earlier polices it has been shaped by the political, philosophical, and ethical influences present at its enactment. The result is a program that attempts to use market forces, means testing and separate risk pools to achieve its goal. However, healthcare economics with its emergencies and lack of control by consumers does not work the way it does for other consumer products.

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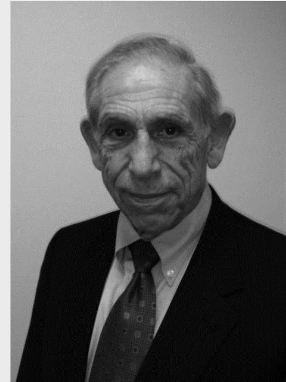

ROBERT G. LERNER, MD
President, WCMS

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UPCOMING EVENTS

CME Committee
Monday, March 3 at 5 PM

Board of Directors
Thursday, March 6 at 6 :30 PM

WESTCHESTER PHYSICIAN

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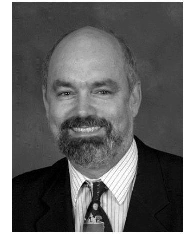
FROM THE EDITOR...

HOW I BECAME A DOCTOR: THE ABBREVIATED VERSION

PETER J. ACKER, MD



I have for the past few years become involved in doing interviews of medical school applicants on behalf of my alma mater: Sackler School of Medicine, the American program in Israel. I enjoy talking to these applicants and can feel the energy, desire, and angst that has gone into their quest. Many of the applicants appear quite qualified, with high GPA's, enviable MCAT scores, polished personal essays, and the requisite list of shadowing, research, mission trips, etc., that have become de rigueur for the modern medical school applicant. From time to time, however, I come across an applicant who has what I call a "redemption story," i.e., low grades in college, perhaps a period of desultory meanderings, and then seemingly out of nowhere, the desire to be a doctor inflames the individual. I must confess, my pulse quickens a bit when I see such an applicant and I counsel myself, be objective, because I can't help but identify with him or her.

I entered Oberlin college eons ago, with a more than respectable high school record and some unformed ambitions to do well and "make something of myself." That first year ended with the shootings at Kent State and I became embroiled in the politics of the time. It was a time of protests, questioning of authority, and a search for "relevance" that at the time did not include trying to get high grades. I dropped out midway and hitchhiked to Oregon where I lived with a group of like-minded young people. I gardened, learned to make compost, cheese, yogurt. I found a job as an aide in a nursery school. I did return to Oberlin to get my degree, but had no idea what direction to pursue. I spent several months traveling, first to California, then to Mexico and Central America and finally went to Nova Scotia where I rode a bike around it's perimeter and then settled down in Wolfville on the Bay of Fundy and found work as a harvester of strawberries on a farm. By the end of that summer, I was out of money and realized I needed to get a real job. Through a connection, I was able to find work as a tech in a toxicology lab in Cleveland.

That year in Cleveland was pretty dismal. I had a very unpleasant boss and I became increasingly gloomy about my prospects. Finally, I couldn't take it anymore and I quit and headed out to California, to Yosemite specifically where I spent six weeks hiking the back country. One night I was camping on top of a small flat topped mountain that was called Cloud's Rest. I was staring up at the sky and I was remembering the nursery school kids in Oregon and also a camp for autistic

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NEW YORK MEDICAL COLLEGE
A Member of the Touro College and University System

NEWS & NOTES

EDWARD C. HALPERIN, MD, MA
Chancellor & Chief Executive Officer

A CURIOUS DISCOVERY ON THE TOP OF A CABINET

In my previous column in this newsletter I told you about the discovery of a letter signed by Albert Einstein in one of the closets at the College. Last week I was visiting with one of the officers of the College in his office. He pointed out that stacked on his cabinet at the back of his office there were multiple framed letters, pictures, and certificates that he salvaged from the demolition of the interior of the College's new facility on Dana Road. The College has taken over this abandoned building and is converting it into a new disaster medicine center, simulation facility for standardized patient instruction (the use of actors to portray illness and robotic instructional mannequins), and our new biotechnology incubator.

The building had originally been used, prior to being acquired by the College, as a carcinogenesis and mutagenesis research laboratory of Dr. Ernst Ludwig Wynder, who died in 1999. When I toured it shortly after I arrived at the College, it was a mess: debris, old computer equipment, files, books, dead plants, and old laboratory equipment. Fortunately, much of the material of historical interest had been salvaged.

My colleague had five items that I have subsequently analyzed. Let me tell you about them:

There is a photograph of Dr. Ernst Ludwig Wynder and US Senator Edward Kennedy of Massachusetts inscribed by Kennedy to Wynder. Wynder gained fame as a medical student. In 1947, he began collaborating with the surgeon Evarts Ambrose Graham of Washington University in St. Louis. The previous summer he had conducted epidemiological studies of smoking behavior among 146 lung cancer patients in New York City. Graham and Wynder collected data on 604 patients with lung cancer. Departing from a tradition of using anecdotal evidence (e.g., clinical interviews) to develop explanations of disease causation, Wynder and Graham applied rudimentary statistical methods to their study. They divided patients into crude categories of "moderate" or "heavy" smokers, based on retrospective interviews of each patient's smoking behavior over a twenty-year period. The also measured and controlled for important confounding factors (e.g., age, types of tobacco use, inhalation level). Most importantly, with regard to an ability to demonstrate causation, Wynder and Graham also studied a control group of cancer-free individuals in hospitals. They systematically compared the lung cancer patients to the control group.

On May 27, 1950, the Journal of the American Medical Association published the resulting scientific report. They identified smoking as a significant risk factor for lung cancer, based on four findings: 1) Lung cancer was rare in non-smokers; 2) Among patients with lung cancer, cigarette use tended to be high; 3) Lung cancer incidence among men and women matched patterns of smoking behavior in

(continued on page 6)

SOCIAL INSURANCE *(continued from page 1)*

Asking individuals, especially lower income individuals, to choose how much risk they can afford is a recipe for wide spread under-insurance. I believe that these policies are likely to fail.

We have a long-standing tradition in America embraced both by progressives and conservatives that entitlement is based on contribution to market economy. This is not a “liberal” view. As Marmor, et al point out:

“That the reform of social insurance should be thought to be best accomplished by moving in the direction of market-like devices that shift risks onto individuals and families already buffeted by the staggering economic uncertainties of a rapidly globalizing economy, is, in our view, a serious mistake. ‘Modernization’ in this form misunderstands what social insurance is about.”

Our approach to social insurance defines American and I recommend this book to fully understand what it is and what physicians and all of us need to know. In that way we can contribute to the debate and design of better health care policies as knowledgeable physicians.

Lend your voice to the debate by joining and becoming active in the Westchester County Medical Society.

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MSSNY'S PHYSICIANS' CAPITAL FORUM
MONDAY MARCH 10, 2014
5:30—7:30 pm

MSSNY will host a Physicians' Capital Forum at the Albany Hilton and will webcast this event to physicians across New York State. You may connect through the following address*

http://www.webcastlive.com/clients/MSSNY/2014

Guest Speakers (Invited):

- **Donna Frescatore, Executive Director of the NYS Health Benefit Exchange**
- **Troy Oechsner, Special Assistant to the Superintendent, Department of Financial Services**
- **Legislative Panel: Senate Health Chair Kemp Hannon; Assembly Health Chair Richard Gottfried; and Assembly Insurance Chair Kevin Cahill.**

The WCMS will be offering the webcast live at their offices: 333 Westchester Ave., Suite LN01, White Plains, NY 10604. Please RSVP to Karen Foy at (914)967-9100 if you plan to attend. A light dinner will be served.

This link will not be active until the date/time of the program.

SEEKING JUDGES FOR WORLD CLASS SCIENCE FAIR

Professionals in all fields of science are needed to lend expertise in selecting the top regional high school science students from Westchester and Putnam counties at the Westchester Science & Engineering Fair on Saturday, March 15, 2014, 8 AM—3 PM, Sleepy Hollow High School.

Complimentary Lunch & Thank You Gift!

To Volunteer as a Judge:

Judge registration is online at: www.wesefreg.org/judges

For more information or questions: wesefjudges@gmail.com

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A TREASURE IN THE CLOSET *(continued from page 3)*

in men and women; and 4) "The enormous increase in the sale of cigarettes in this country approximately parallels the increase [lung cancer]." As further scientific evidence of smoking's role in causing lung cancer began to mount in the United States and Great Britain, Wynder and Graham investigated the biological plausibility of the association between smoking and lung disease. In 1950, they initiated a study of the impact of tars from tobacco smoke on mice. After a year of exposure to tar 44% of the mice developed cancers. Wynder also discovered specific carcinogens in tar (e.g., benzopyrenes, arsenic), but was unable to identify the contributions of these chemicals to cancer.

There is a black and white autographed photograph of Edmund Vincent Cowdry, Ph.D. His name is associated with "Cowdry bodies." These are eosinophilic nuclear inclusions composed of nucleic acid and protein seen in cells infected with Herpes simplex virus, Varicella-zoster virus and Cytomegalovirus.

Also discovered was a handwritten letter by Albert Bruce Sabin, MD. Sabin's life is most strongly associated with the conquest of polio. The Sabin vaccine consists of weakened forms of the viruses that cause polio. In 1955, Salk's "killed" vaccine was released for use. It was effective in preventing most of the complications of polio, but did not prevent the initial intestinal infection. The Sabin vaccine is easier to give than the earlier vaccine developed by Salk in 1954, and its effects last longer. In addition, those who received the Salk vaccine could pass on the polio virus. Sabin first tested his live attenuated oral vaccine at the Chillicothe Ohio Reformatory in late 1954. From 1956 to 1960, he worked with Russian colleagues to perfect the oral vaccine and prove its effectiveness and safety. The Sabin vaccine worked in the intestines to block the poliovirus from entering the bloodstream. It was in the intestines, Sabin had discovered, that the poliovirus multiplied and attached. Thus, the oral vaccine broke the chain of transmission of the virus and allowed for the possibility that polio could be eradicated.

A highly unusual item is a handwritten 1899 letter by Emil Adolf Behring, MD. Behring's most important researches were intimately bound up with the epoch-making work of Pasteur, Koch, Ehrlich, Löffler, Roux, Yersin, and others, which laid the foundation of our modern knowledge of the immunology of bacterial diseases. Behring is chiefly remembered for his work on diphtheria and on tuberculosis. In 1898, Behring and F. Wernicke had found that immunity to diphtheria could be produced by the injection into animals of diphtheria toxin neutralized by diphtheria antitoxin, and in 1907, Theobald Smith had suggested that such toxin-antitoxin mixtures might be used to immunize man against this disease. It was Behring, however, who announced, in 1913, his production of a mixture of this kind, and subsequent work which modified and refined the mixture originally produced by Behring and resulted in the modern methods of immunization which have largely eliminated diphtheria as a cause of disease in the developed world. Behring himself saw in his production of this toxin-antitoxin mixture the possibility of the final eradication of diphtheria; and he regarded this part of his efforts as the crowning success of his life's work. Behring was a 1901 recipient of the Nobel Prize in Medicine or Physiology-the first awarding of the prize.

Finally, there is a handwritten letter from John Enders. Enders was born in West Hartford, Connecticut in 1897. His father was CEO of the Hartford National Bank and left him a fortune of $19 million upon his death. Enders attended Yale University a short time before he joined the United

(continued on page 10)

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GUEST ARTICLE

THE ROLE OF CPH IN HELPING IMPARIED PHYSICIANS

TERRANCE M. BEDIENT, FACHE
VICE PRESIDENT AND DIRECTOR
COMMITTEE FOR PHYSICIANS HEALTH, MSSNY

The Committee for Physician Health (CPH) is one of the most valuable services provided by the Medical Society of the State of New York (MSSNY), but perhaps the least visible. CPH was formed by MSSNY to address the issue of physician impairment. In 1974, volunteer physicians began to provide informal assistance for colleagues who had substance abuse problems. At that time, a body of knowledge was emerging throughout the country which indicated that the most effective physician recovery programs operated in cooperation with physician licensure agencies. It became evident that the possibility of losing a license, even temporarily, was an important factor in motivating physicians to seek treatment. While licensure agencies were required to follow formal legal procedures in accordance with state laws and regulations, the medical societies could more rapidly assist physicians suffering from behavioral health disorders to obtain treatment, because they were not constrained by these legal requirements.

In 1980, legislation was enacted which enabled MSSNY to operate a physician committee whose intervention would remain confidential and whose purpose was to confront and refer physicians for treatment if they appeared to suffer from alcoholism, drug abuse, or mental illness. To fulfill this public health responsibility, MSSNY appointed a group of interested physicians to what ultimately became CPH.

With this legislation as the framework, CPH and the New York State Department of Health Office of Professional Medical Conduct (OPMC) agreed to work together more effectively to enhance the quality of treatment available for impaired physicians. At present, if a physician voluntarily seeks treatment through CPH, and OPMC has not been notified by hospitals or colleagues, the physician does not have to surrender his license. However, the physician must immediately stop practicing and enter treatment. CPH is obligated by law to preserve the confidentiality of the physician throughout the treatment process, if the physician cooperates with and makes progress in the treatment regimen. Further, OPMC will not be notified by CPH, unless the physician fails to cooperate with the program and/or monitoring. Immediate removal of a physician from practice until he/she is clinically cleared to return to practice safe and effective medicine quickly and effectively eliminates the potential risk of further patient harm.

If OPMC has received a report or complaint about a possibly impaired physicians, OPMC will promptly commence an investigation. In the absence of a finding of misconduct, OPMC typically encourages the physician to remain in CPH for appropriate treatment.

If OPMC discovers misconduct, including or due to impairment, the physician typically must surrender his/her license temporarily and complete treatment before being permitted to return to practice.

Finally, if the physician's impairment has caused patient harm in the hospital setting, OPMC must be notified by the hospital and OPMC will then take whatever action it deems appropriate with respect to the physician's license and any requirements for treatment and monitoring.

From its inception, CPH has monitored approximately 3,500 physicians. At any given point in time, CPH is monitoring approximately 500 physicians. In 75% of these cases, OPMC is never aware of the physician's involvement in the CPH program.

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THE ROLE OF CPH *(continued from page 8)*

Physicians may well be surprised and even troubled that CPH has a working relationship with OPMC. It is important to understand that it is this relationship which permits CPH to maintain its credibility and retain the legal authority to keep all of its files confidential. Throughout its decades of operation, CPH has been reviewed by the NYS Department of Health to determine whether it is effective in achieving the goals of its mission and whether it continues to work within the confines of the established legislative framework. These reviews have continuously confirmed that CPH has developed a strong and professionally managed program which is clinically sound and meets both the needs of the physicians it serves and the expectations of the DOH. When the state legislature has periodically reviewed the CPH program, it too has continued to legislatively authorize its continuation.

A key objective of CPH is to develop and present educational programs to the medical community, focusing on the signs and symptoms of impairment to promote early recognition and response. These programs also emphasize the significance of the impact of physician impairment on a broad range of individuals, from patients to families, staff, and others. They are aimed at encouraging medical professionals to take prompt action to prevent patient harm and to assist any physicians who appears to be potentially impaired to receive professional help. Each year, the CPH staff makes educational presentations to approximately 5,000 licensed physicians, residents, and medical students.

CPH accepts referrals from anyone interested in helping a colleague. The majority of referrals are received from senior administrators in hospitals or from members of physician practice groups. **A referral may be made simply by making a telephone call to 1-800-338-1833 or 1-518-436-4723. The source of the referral always remains confidential.**

Once a referral has been made, the next step is helping the physician to see the need and agree to immediately enter treatment. One of the most difficult responsibilities of being in management at a hospital or in a practice is the need to confront an impaired physician who appears to be suffering from a psychiatric or substance abuse disorder. Denial is very difficult to overcome. Because the clinical staff of CPH has such a high level of expertise in this area, CPH can coordinate most interventions and provide necessary support and valuable information to the participants.

Recovery from a chronic illness is a continuous process and not a single event. However, recovery must always begin with an accurate and thorough assessment of the needs of the individual and development of an individualized treatment regimen. If the physician has a chemical dependency, a CPH coordinated recovery often begins with inpatient treatment for 45-60 days. This is followed by outpatient treatment, which may continue for a year or longer. If the physician has a psychiatric disorder, appropriate inpatient and outpatient treatment are also provided, for whatever time period is determined to be medically necessary by the treating facility professionals or program.

According to the literature of addiction medicine, the probability of a full recovery for a typical patient entering treatment for substance abuse for the first time is less than 50%. Fortunately, because CPH has such an intense monitoring regimen, the probability of recovery for a typical physician involved in the CPH program for substance abuse is approximately 95%.

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HOW I BECAME A DOCTOR *(continued from page 2)*

children in Rhinebeck, NY where I had worked as a counselor, and the deep satisfaction that work had given me. Suddenly, like an epiphany, it came to me – I wanted to be a pediatrician.

I hitchhiked back East arriving in New York City and enrolled in the General Studies division of Columbia University. I was two weeks late, but threw myself into my studies in a way I never had before. I relied on the kindness of friends to put me up, before I found a series of sublets. I supported myself initially with taking care of a child while his parents worked and then as a lab tech in a transplant immunology lab at Mt Sinai Hospital.

Most of the schools I applied to turned me down flatly, but I did manage to get a few interviews, I think more out of the curiosity of the admissions officers (who is this guy?!). It wasn't just my checkered background, it was also because I was older which was uncommon back then. Columbia interviewed me and even put me on their waiting list, but I did not get accepted. I had the Sackler offer in my back pocket and had the hard choice to reapply or go ahead and start. In the end it was a blessing that I chose to not dally any longer and go to Israel. Not only did I have an amazing education and experience, but I also met my wife, Gila, there.

I don't recommend this particular path to medical school – it was fraught with angst. However, I will say that there are very few medical students who enjoyed the actual experience of medical school as much as I did. I was thrilled to be there and valued all I was learning to a much greater degree than if I had simply followed the traditional path. Also I believe my myriad experiences have had a decided impact on the kind of doctor I am today.

So, as I look up from the application on my lap and look at the young man before me, well not so young, thirtyish, who smiles at me and starts: " Listen, I know that my application is a bit unusual….." and I lean back to listen to his story, with a hint of a smile myself.

A TREASURE IN THE CLOSET *(continued from page 6)*

States Army Air Corps in 1918, as a flight instructor and a lieutenant. After returning from World War I, he graduated from Yale. He went into real estate in 1922, and tried several careers before choosing the biomedical field with a focus on infectious diseases, gaining a Ph.D. at Harvard in 1930. He later joined the faculty at Children's Hospital Boston.

In 1949, Enders, Thomas Huckle Weller, and Frederick Chapman Robbins reported successful in vitro culture of an animal virus—poliovirus. The three received the 1954 Novel Prize in Physiology or Medicine "for their discovery of the ability of poliomyelitis viruses to grow in cultures of various types of tissue."

In 1954, Enders and Peebles isolated measles virus from an 11-year-old boy, David Edmonston. In 1960, an Enders team began clinical trials. A year later reports appeared in the press pronouncing the measles vaccine effective. Refusing credit for only himself, Enders stress the collaborative nature of the effort. In 1963, Pfizer introduced a deactivated measles vaccine, and Merck & Co. introduced an attenuated measles vaccine. Enders died in 1985.

All of these items will find a home displayed on the walls of the College's Sunshine Cottage and Skyline buildings. Feel free to stop in and view them!

THE ROLE OF CPH *(continued from page 9)*

Physicians who have a diagnosis of chemical dependency are monitored for 5 years. Monitoring of a patient with a substance use disorder begins during inpatient treatment and continues throughout outpatient treatment. Those who have dual chemical and psychiatric dependency diagnoses must additionally be treated by a psychiatrist. Physicians are required to regularly submit urine specimens for toxicology testing to forensically corroborate their recovery. Those who have a substance abuse disorder must also regularly attend a mutual help meeting. Finally, every physician in the program who returns to the practice of medicine must have a work monitor to observe for signs of recovery or relapse.

If the physician's license has been temporarily surrendered, this includes advocating before governmental agencies, such as the NYS DOH and Board of Regents, as well as before hospital credential committees, group practices or partnerships, professional liability insurance companies, such as Medical Liability Mutual Insurance Company and others. Over the years, because of its successful treatment and monitoring programs, CPH has established credibility with many hospitals, practice groups, payer panels, and state agencies and has effectively assisted many physicians to successfully return to practice.

The stress of practicing medicine with all of its payment, staffing, regulatory, and liability issues has greatly increased over the past decade. As physicians and hospitals are being asked to do more with less, the financial, emotional, and professional pressures have continued to increase. Some physicians are more susceptible to stress which then manifests itself in the development of psychiatric or substance abuse disorders. Since this severely affects the physician's ability to practice in a safe and productive manner, CPH plays a critical role in the physician's future, particularly if CPH is able to intervene before either OPMC is involved or patient harm has occurred.

For many years, there has been a stigma associated with the treatment of psychiatric and substance abuse disorders. Frequently, fear of this stigma has prevented professionals from obtaining proper and timely treatment. This has often resulted in the increased clinical severity of the disorder, by the time if is finally recognized. This stigma is a significant barrier to the full engagement of the impaired medical professional treatment regimen. In order for treatment to be effective and the results maintained for life, this stigma and the fear with which it is associated must be overcome.

By endorsing and otherwise supporting the work of CPH, MSSNY has continued to reaffirm that having a chemical dependency or other psychiatric disorder does not need to end a physician's career. By arresting the progress of the physician's illness through the provision of effective treatment at an early state, active participation in the CPH program can prevent the ravages to health, family, and career that might otherwise ensue. Further, by preventing patient harm and avoiding the physician's loss of his/her medical license due to professional misconduct, the public is significantly benefited. Ongoing treatment and monitoring by CPH permits physicians to continue to be productive members of society and to safely practice medicine with appropriate skill after active treatment has been completed. However, because recovery is a life long process, CPH is there to continue to support the physician in maintaining his/her recovery.

MSSNY Legislative News

MSSNY SENDS LETTER EXPRESSING SUPPORT, BUT SOME CONCERNS, WITH NEW SGR PROPOSAL

This week MSSNY along with 8 other state medical societies sent a joint letter to key Congressional leaders expressing support for the latest SGR repeal proposal (H.R. 4015/S. 2000) before congress. The letter (which can be read at http://www.mssny.org/home/021214-Moe/Feb11-Revised-State-Coalition-Letter-Re-SGR-Reform.pdf) also reflected the fact that several concerns do remain with the proposal that, if this bill were to be enacted, we must continue to fight to address.

The letter followed a MSSNY survey sent asking physicians what MSSNY's position should be on H.R. 4015/S. 2000. Of the approximately 750 responses, about 65% said MSSNY should support; about 20% said MSSNY should oppose; and about 15% said MSSNY should neither support or oppose.

As reported last week, a bipartisan group of House and Senate lawmakers representing each House's fiscal committees announced a proposal to repeal and replace the Medicare SGR physician payment formula, provide modest payment increase and gradually implement a value-based payment system. However, it does not yet establish the "offsets" necessary to pay for the proposal, estimated to cost over $125 billion. The latest revised SGR proposal would:

- Repeal the SGR immediately, thereby eliminating the annual threat of 20+% Medicare physician payment cuts.
- Provide positive annual payment updates of 0.5% for five years, from 2014-2018; however, the bill would provide a zero percent update between 2019 and 2023.
- Create a Merit-Based Incentive Payment System (MIPS), which would consolidate the existing EHR meaningful use increase/penalty program PQRS program, and Value Based Modified into one quality program, which also incorporates clinical practice improvement activities. The program would require up or down Medicare physician payment adjustments starting in 2018, based upon composite "performance score" in these four performance categories.
- Impose negative payment adjustments on Medicare payment for physicians who fall below a performance threshold in the MIPS, capped at –4% in 2018, -5% in 2019, -7% in 2020, and -9% in 2021.
- Provide physicians with higher performance scores above the threshold with proportionately larger bonus payments up to 3x the annual cap for negative payment adjustments.
- Set an annual target for the HHS Secretary to identify "misvalued services" at 0.5% of the estimated amount of fee schedule expenditures from 2015-2018.
- Provide a 5% added incentive payment for physicians who participate in risk-based Alternative Payment Models. These physicians would also be exempted from the MIPS program.
- Provide $40 million in funding annually for technical assistance in the MIPS program or for participation in the APM program to small practices of 15 or fewer professionals.
- Require the creation of "appropriate use criteria" for advanced diagnostic imaging.
- Prohibit new liability causes of action based upon standards established in the ACA or Medicare.
- Permit physicians who opt-out of Medicare to engage in private contracting with their patients to no longer be required to renew their opt-out status every two years.

To read a more detailed summary of the proposal, including more information on the above, please go to:
http://origin.library.constantcontact.com/download/get/file/1115032643020-49/Section+by+Section+Summary.pdf

It is anticipated that many non-physician health care groups will oppose the proposal because of concerns that it may be paid for by cutting them. Physicians are urged to continue to call Senators Schumer and Gillibrand, as well as their respective member of Congress, in support of SGR repeal, by using the AMA's Grassroots Hotline at 1-800-833-6354.

MSSNY LEGISLATIVE NEWS

HHS URGED TO DELAY COST-PROHIBITIVE ICD-10 IMPLEMENTATION

The American Medical Association released a study this week that showed that new estimates of costs to implement the federally mandated ICD-10 code set by October 1, 2014, are in some cases nearly three times more than previously estimated. These figures were contained within a letter sent by the AMA to the US Department of Health and Human Services (HHS) Secretary Kathleen Sebelius urging her to reconsider the mandated transition to the new code set.

According to the report, costs associated with ICD-10 implementation include training, vendor and software upgrades, testing, and payment disruption. The report indicated that, 6 years ago, the estimated average ICD-10 implementation costs were $83,290 for small practices, $285,195 for medium-sized practices, and more than $2.7 million for large practices. However, the new study concluded that the estimated ranges were from $56,639 to $226,105 for small practices; $213,364 to $824,735 for medium-sized practices; and about $2 million to more than $8 million for large practices.

The release of the study received significant media attention. In response to the study, MSSNY President Dr. Sam Unterricht was quoted in the February 12th *Crain's Health Pulse* stating, "The study numbers seem accurate to me...This will hurt doctors and hospitals at a time when we are already overwhelmed and the only ones who are happy about this are the software and coding companies - they will make millions…The worst part is they are already well on their way to implementing ICD-11. Why not just wait until then?"

Preventing ICD-10 implementation is a high priority in the Federal Issues component of MSSNY's 2014 Legislative Program. Legislation (H.R. 1701/S. 972) has been introduced in Congress to prevent ICD-10 from being implemented.

WELCOME NEW MEMBERS

At the Board of Directors meetings held in January & February, the following were elected to membership in WCMS and the Academy:

Anurag Anand, MD
Internal Medicine
Thornwood

Obiageli Nweke-Chukumerije, MD
Pediatrics
New Rochelle

Cecile Fray, MD
Neurology
Ardsley

The following doctors were awarded Life Membership:

Arnold J. Hodas, MD
Member since 1961

David H.B. Sohn, MD
Member since 1979

WCMS Board Highlights — February 2014

At its meeting on February 6, 2014, the WCMS Board...

- Received the Report of the Executive Committee and the President, as presented by Thomas Lee, MD, Past President, on behalf of Robert Lerner, MD, President. Dr. Lee reported that the Executive Committee:
  - Reviewed and recommended Board adoption of the following policies to guide the Board and Staff in its deliberations: ***Conflict of Interest***; ***Non-Retaliation***; and ***Record Retention/ Document Destruction***. Dr. Lee commented that these policies are required now by all non-profit boards as a matter of due diligence and as part of the annual audit. ***The Board adopted these policies.***

- ***Approved the 2014 Budget*** as presented by Peter Liebert, MD, Chair, Budget and Finance Committee. Dr. Liebert and the Board thanked the Executive Director and staff for their continued efforts to streamline the budget and maximize both dues and non-dues revenue.

- Heard from Joseph Tartaglia, MD, President Westchester Academy of Medicine regarding the continued need for judges for the annual **Westchester Science and Engineering Fair, set for Saturday, March 15 at Sleepy Hollow High School in Tarrytown**. There will be several hundred science projects submitted by Westchester/Putnam county high school juniors and seniors as they seek to move on to national and international competition. There is a real need for physician judges, the commitment is only a half-day and it is a rewarding experience. ***See page 5 for details on how to register online.***

- ***Approved the Report of the Membership Committee*** welcoming one new member to the WCMS and Academy – Cecile Fray, MD, neurology, Ardsley, and two resident members.

- ***Approved nine (9) resolutions for submission to MSSNY and the 2014 House of Delegates proceedings.*** These resolutions were also supported by the others counties in the Ninth District Branch of MSSNY: Dutchess; Orange; Putnam and Rockland. These resolutions will be listed in the March issue of Westchester Physician.

- Heard from Dr. Thomas Lee, Legislative Committee Chair, reminding the Board of the following upcoming legislative activities to which ALL physicians are invited:

  - **MSSNY Capital Forum and Webcast** Monday, March 10 5:30-7:30pm (hosted by WCMS – for more information see page 5.)
  - **MSSNY Physician Advocacy Day** Tuesday, March 11 Albany

  Dr. Lee also discussed the recent Senate Hearing in Albany (January 27) at which he and several other physicians were able to convey to Senate Leadership the importance of preserving patient access to adequate out-of-network medical care. Dr. Lee also discussed the Governor's budget and distributed a copy of the MSSNY testimony submitted in response to the areas of the budget impacting health care delivery and public health.

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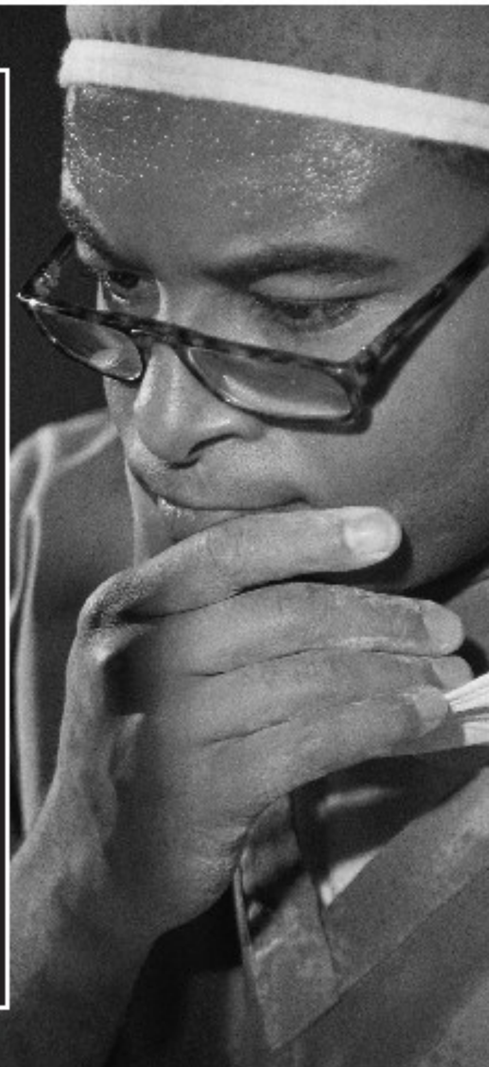

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