WESTCHESTER PHYSICIAN

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Health Care Reform—*Opposing Views*

All the Health System Reform Plans are Under Attack - What Do We Do Now?

Robert Lerner, MD
WCMS Public Health Committee Chair

The Republicans are attacking the Affordable Care Act (ACA) and asking for its repeal. The Democrats are attacking the Republican "Roadmap for America's Future" put forth by Representative Paul Ryan (the Ryan Plan) as a plan to destroy Medicare and abandon the poor and elderly. Are they both so flawed and doomed to failure that we should seek a different way?

The first flaw that they have in common is that they rely on an insurance industry that has proved to be monopolistic, predatory and prone to frequent fraudulent practices. The medical profession has been fighting a losing battle with this insurance industry. The Congress has become dependent upon their campaign contributions for re-election and guidance in writing laws. It is naive to think that our individual patients will bring them under control by shrewd bargaining in the insurance market competition. It is also naive to believe that the proposed insurance exchanges will provide meaningful cost control as the number of companies decrease in mega-mergers.

Another flaw is how the proposals deal with "cherry picking". Part of the business model of the insurance industry is to insure healthy people who use less health care and leave the sicker ones to be paid for by taxpayers. The ACA bans exclusions for pre-existing conditions but proposes risk-adjustment strategies to deal with insurance company cherry-picking. The insurance companies have been very successful at preserving their profit with their own risk-adjustment strategies. The Ryan plan only requires that insurance be offered to everyone, not that it be affordable. *(continued on page 4)*

Health Care Reform: Let's Make Capitalism Work For Us

Joseph Tartaglia, MD, FACC
WCMS President

It is difficult to cut through the present rhetoric and partisan bickering to truly see the forest for the trees, but I will endeavor in this article to show why I am generally opposed to the current Affordable Health Care Act (ACA). Congressman Paul Ryan's GOP plan is an attempt to take Medicare back toward a capitalistic market driven system; whereas the ACA is moving us toward socialized medicine and all of its associated problems, delays, and layers of bureaucracy. If you want to see what the future of health care will be in America, just look at England. Democrats and Republicans agree that the current entitlement system is unsustainable, so both admit that budget cuts are inevitable. Harvard health care experts like Dr. Donald Berwick, who is also Administrator of the Centers for Medicare and Medicaid, had advised the then Democratic-controlled Congress to model health care reform after the National Health System (NHS) mainly because it is the least expensive of the European systems, only 11% of the GNP, unlike our current 17%. Most Americans say Medicare is worth the cost, but they mean the Medicare of today, which pays a fee that most doctors take, not the Medicare that it will become if the new law remains unchanged. The salvation of Medicare will be to re-engage the private sector for health care coverage, but it must be a competitive market place where insurance companies compete with each other for patients to drive down prices. A single payer system is not the answer.

Since President Obama stated in his national address that the entitlement programs of Medicare and Medicaid are largely responsible for the budget deficit (and not runaway spending by Congress), it seems ironic that his solution is to

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A Look Inside . . .

Mark Your Calendar

May 30, 2011
Memorial Day—OFFICE CLOSED

June 6, 2011
CME Committee Meeting—5:00 pm

June 9, 2011
WCMS/Academy Annual Meeting—6:00 pm
Knollwood Country Club, Elmsford

September 21, 2011
WCMS/Academy Golf Outing—11:00 am
Westchester Hills Golf Club, White Plains

**All meetings held at WCMS offices unless otherwise specified.*

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FROM THE EDITOR
Lost and Found

By Peter Acker, MD

It was the change in routine that led to my latest loss: my London Fog trench coat. I had agreed to interview medical school applicants for my alma mater and this entailed taking a train from Katonah into Grand Central each Monday, my day off from my suburban pediatric practice. Standing on the platform, briefcase in hand, wearing a suit and tie, my coat held tightly against my chest against the winter chill, surrounded by similarly attired men, I thought of my father. He did this for years, leaving our house in New Canaan before I was even close to waking and took the train into the city. I pretended, as I stood there, that I was a top executive, going into the city for some important meetings. The train arrived and I joined the silent throng entering the train and settled into a seat. The car quickly filled up as we stopped at Bedford Hills, Mount Kisco and all the other local stops until White Plains, when it became express to Grand Central. I read my copy of the Times, quickly catching on to the etiquette of quiet (punctuated by the occasional cell ring), carefully turning my pages without a rustle and without touching the person next to me. From Grand Central, I followed the crowd Northward on the platform and discovered for the first time that a series of tunnels leads to 48th and Madison. As I walked up Madison, I thought again of my father taking similar treks decades before to his office in Rockefeller Plaza.

My mother had died during my mid teens and my relationship with my father, somewhat formal in my early childhood, grew closer. A man of, at times, seemingly impenetrable reserve, he managed to convey love and tenderness through small gestures and a constancy of support. He possessed standards of a height to be almost insufferable, but was able to hold his tongue while I struggled through the temptations of the late sixties and early seventies. I called him once from a Texas roadside where I was stuck trying to hitch hike back from a trip to Mexico. His voice was even and contained only the slightest hint of recrimination as he asked where he could wire money for a bus ticket. Eventually I found my way, finishing medical school and a pediatric residency. It was only years later that I became aware of the magnitude of his angst about me during those years.

I swore to myself as a teenager, that I would never take any job that would require the arduous commute that I watched my father take. Yet now, I began to look forward to my Mondays, feeling a sense of importance as I waited on the platform, a sense of peace and strange collegiality while on the train. I felt close to my father, now deceased almost a decade, while walking up town, fingering my overcoat of a style that he would have worn.

Returning on the train, as we neared my station, my cell began to vibrate. It was my daughter Jess, with just the sort of call I used to make to my father. She had been driving and reached down to get a tissue, and was distracted just enough to cause her to veer off the road smashing in the passenger side door against a guard rail. I quickly learned that she was fine, but a bit upset. "Do you have your AAA card?" "Yes." "Call them. I'm almost home. I'll come to you. Are you sure you're all right?" "Yes, Dad, I'm fine." I became aware that the train had stopped. I grabbed my briefcase and sprinted off the train. As it pulled away, I realized that I had in my haste left my overcoat on the train.

I was afraid to tell my wife. I had a long habit of losing things, the product of a dreamy distractible nature, which to my father, a meticulously organized man, was a complete anathema. My wife, also organized, not only couldn't understand how I could be so forgetful, she had a particular attachment to objects. It was only after years of marriage that it occurred to me that she, as the daughter of a Holocaust survivor who had lost her parents and family home at the age of 14, felt a sense of panic whenever a household object disappeared. As I drove to my daughter, I cringed while thinking of the twin assaults on my wife's equanimity: a lost coat and a damaged car. I resolved to delay the coat revelation.

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All the Health System Reform Plans are Under Attack - What Do We Do Now? *(continued from page 1)*

Affordability is addressed by inadequate tax credits by both plans with the Ryan plan being much less generous. They both then claim that most Americans will be able to afford the insurance and the health care. It's the chronically and catastrophically ill who won't be able to afford it. But that is what insurance is supposed to be for.

The "individual mandate" of the ACA has been attacked as unconstitutional because it imposes a tax penalty if an individual does not buy insurance. The Ryan plan achieves the same end by denying the health care tax credit unless an individual buys health insurance. It sounds the same to me.

It has been proposed that individuals with "skin in the game" will provide some cost control. Both the ACA and the Ryan plan saddle patients with substantial personal financial costs just calculated differently and with a much greater personal burden for the Ryan plan. They then attempt to control costs in different ways. The Ryan plan controls the government portion of costs by pushing the bills onto the patient whether they can afford it or not. That doesn't control overall costs. That point has been recognized by the public and led to charges that the Ryan plan would destroy Medicare. The ACA proposes to control cost with an Independent Payment Advisory Board, much feared and despised by physicians, as well as drug companies and others now being paid by Medicare. This has led to charges of a government takeover of health care.

Of course the major difference is that the ACA looks to the federal government to guarantee affordable health care. The Ryan plan looks to an open market which unfortunately doesn't exist.

A properly designed single payer system eliminates for everyone financial hardship due to health care costs. Premiums are not a problem because the entire health care system is funded through equitable tax policies. Out-of-pocket spending is not a problem because first dollar coverage applies to all essential health care services and products.

There is another way that is called a Single Payer System. Let's all work to expose the deceptive rhetoric that the ACA or the Ryan plan have made health care affordable for almost everyone, when in fact, when you need health care, every last dime is squeezed out of you and that still isn't enough for up to one-fourth of us with significant health care needs. In the same breath, let's let the public know that there is a way we can do it - a single payer national health program. The State of Vermont has taken steps to develop a single payer system and the **Vermont Health Care for All** bill H.202, "an act relating to a universal and unified health system." passed the Senate on Tuesday April 26th. The Vermont Medical Society wanted a seat at the table and testified directly to lawmakers. Let's do the same here.

So finally, am I in favor of the ACA or the Ryan plan? I am glad that the ACA passed not because I am pleased with all of it. I am glad that an important change is being made to a currently unacceptable situation. There are now 52,000,000 uninsured Americans, many of them long-term unemployed, and at last count 45,000 die each year specifically because of being uninsured.♦

Health Care Reform: Let's Make Capitalism Work For Us

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expand the programs to the nation's 50 million uninsured, thereby virtually guaranteeing that the programs will become insolvent unless drastic cost reductions take place soon.

The ACA has many of the elements of the NHS written into it. The first was the single payer option which would have rendered private plans unable to compete with the government plan and was designed to get most of the nation onto a single payer system. It was defeated by the insurance lobby, via the Senate, and thus it merits no further discussion here.

The second element is the contentious Independent Payment Advisory Board (IPAB), termed "death panels," which have been modeled on Britain's National Institute for Health and Clinical Excellence or NICE board (rationing is always associated with terms like excellence and quality). In England, anything that costs more than $30,000 per year of life saved are not covered (a good example is Herceptin for Breast cancer). Although the American version is not allowed to ration care, raise taxes or the retirement age, over time it can only bring cost reductions by cutting payments to providers. It will reduce fee schedules and strain doctors and hospitals, only now it will be without Congressional oversight. Does anyone really think as spending grows beyond the point where we can't squeeze any more money from the providers that IPAB won't become NICE?

The third element of the ACA designed to convert us to the British system of National Health Care is the Accountable Care Organization (ACO). The NHS uses capitation to control cost through an army of general practitioners who serve as gatekeepers and work for regional hospital centers which are given annual budgets to ration care. This is similar to the ACO concept where doctors are being encouraged to form regional "entities" and combine with hospitals for bundled care where the doctors and hospitals will share bonuses with the government to cut costs and cut corners. Paying doctors and hospitals bonuses to give less care will lead to conflicts of interest. Worse yet, patients may not realize that they have a choice because they will not be informed. The ACO will be no more popular to the patient than the managed care capitation plans of the 90's.

I don't think the NHS is suited to a "free market loving" consumer nation like America, where patients expect the latest technology and the best treatment available without waiting. The GOP plan is an attempt to reverse the government takeover of healthcare and restore a more free enterprise system. The Ryan Plan aims to place the decisions of health care back in the hands of the doctor and patient. It creates a voucher system, adjusted to reflect medical inflation and pegged to income, with low income individuals getting greater payments. It funds Medical Savings Accounts (MSAs) for low income beneficiaries as a way to have them profit, instead of providers, from reducing health care costs. It allows the states greater flexibility to tailor Medicare to their specific needs. The proposal also provides a tax credit (up to $5,700 per family) to purchase coverage and keep it as patients change jobs. It forces insurance companies to reveal price and quality data to give transparency to consumers. It creates state based exchanges for affordable insurance without worry about pre-existing conditions. There is a provision to allow small businesses to purchase health plans together, encourages the adoption of health information technology, and assists states in establishing solutions to medical malpractice litigation. In England, any doctor who follows the NICE guidelines is immune from a lawsuit and, oddly enough, this is the only medical malpractice solution supported by the President in his last State of the Union address.

Ironically, as we fight to embrace a government controlled national health system, the Prime Minister of Britain, David Cameron, is attempting to introduce private competition to increase efficiency and allow doctors more control. Our system of health care is the most innovative and envied throughout the world and we built it with capitalism. It only began to fail as our government took over health care for the elderly and for the poor. These entitlement programs are bankrupting America and a national health system will bankrupt us further. Mr. Cameron is proposing to increase the retirement age to 66 and we should consider raising the Medicare eligibility age along with social security. When Medicare first began in 1965, the average life expectancy was 67 years; today it is 78. If

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WCMS/Academy Annual Meeting & Program
- Thursday, June 9, 2011 -
Knollwood Country Club

200 Knollwood Road Ext—Elmsford, NY 10523-2849

6:00 – Networking Reception
7:00 pm—Buffet Dinner & Program
8:00 pm—Keynote Speaker

KEYNOTE SPEAKER & WCMS & MSSNY Member

Congresswoman Nan Hayworth, MD

(Representing NY 19th Congressional District)

Remarks: *Joseph J. Tartaglia, MD, Outgoing WCMS President*
Abe Levy, MD, Incoming WCMS President

No Cost for Members; Spouses & Guests $25; Non-members $60
Please RSVP to Karen Foy, 914-967-9100, kfoy@wcms.org

Health Care Reform: Let's Make Capitalism Work For Us *(continued from page 5)*

Medicare had started today the age of eligibility would have been age 75. As seen with the airlines or the communications industry, breaking up the insurance monopoly is the only thing the government needs to do to put pressure on to drive prices downward. Yet, it is the only action that both the Democrats and the Republicans have failed to take. The flaw in Paul Ryan's plan is that the focus should be on the breakup of the insurance monopoly and not on radically changing Medicare to a voucher plan. I would have brought out softer proposals first like MSA's for Medicare as a pilot program to shift us gradually back toward competition, much the same way ACO's are a pilot program to shift us gradually toward socialized medicine. The American public needs to be eased into the concept. I agree with Dr. Lerner that increasing competition in the insurance industry is where the focus of this debate should be and is where there is common ground for reforms. But we need to reopen the door to private competition in this country. Capitalism, with proper government regulation, is a strong force that we can use to lower costs efficiently by motivating the patient to use resources wisely.♦

Newsletter Submissions

Members are encouraged to submit articles, letters to the editor, classified ads, members in the news, etc. for publication in the ***Westchester Physician.***

The deadline for the June 2011 issue is May 25th.

Please email your submissions for review to Brian Foy, Executive Director at ***bfoy@wcms.org***

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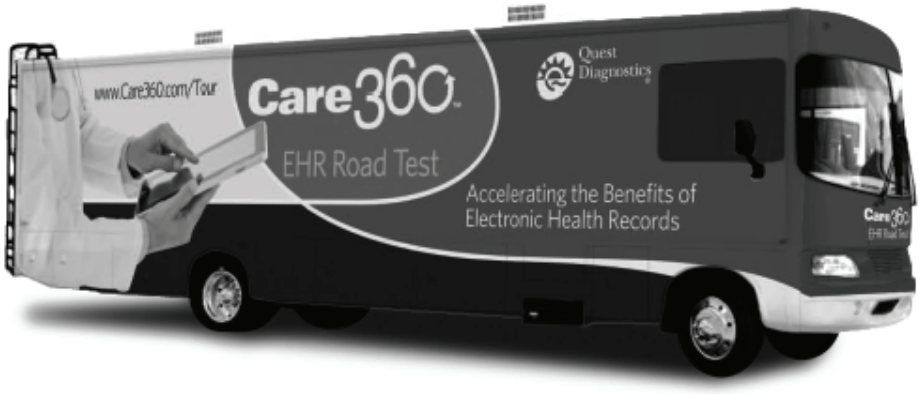

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New Officers Elected and New Policies Adopted at MSSNY's 205th House of Delegates

Following are a roster of new MSSNY officers, who were elected at MSSNY's 2011 House of Delegates meeting, held April 8-10, in Tarrytown, NY, along with highlights of some of the resolutions passed by the physician delegates from around the state who attended.

MSSNY's 2011-2012 Officers and their home NYS counties:

President – Paul A. Hamlin, MD, FCCP (Nassau)
President-Elect – Robert J. Hughes, MD, FACS (Saratoga)
Vice-President – Sam L. Unterricht, MD (Kings)
Secretary – Malcolm D. Reid, MD, MPP (New York)
Assistant Secretary – Joseph R. Maldonado, Jr., MD, MBA, DipEBHC (Oneida)
Treasurer – **Andrew Y. Kleinman, MD (Westchester)**
Assistant Treasurer – Charles Rothberg, MD (Suffolk)
Speaker – Jerome C. Cohen, MD, FACP (Broome)
Vice-Speaker – **Kira Geraci-Ciardullo, MD, MPH (Westchester)**
Chair, Board of Trustees (elected by Trustees) – Robert A. Scher, MD (Suffolk)

Highlights of MSSNY's New 2011 Policies:

- MSSNY will support legislation that would allow physicians to carry a first-tier of $500,000-$1.5 million worth of medical liability (ML) insurance and require a second tier of $1-3 million worth of ML insurance to be financed by a state insurance pool funded by a fee on every health insurance policy purchased in NYS. To insure survivability of such a fund, MSSNY will continue to support legislation for ML reforms including: a cap on non-economic damages, a no-fault system for claims involving neurologically impaired infants, medical expert witness reform and certificate of merit reform.
- MSSNY will support and advocate for legislation/regulation that will 1) prevent health insurance companies from selling policies that purport – but fail – to adequately provide out-of-network heath care benefits; and that will also 2) require insurers to base their out-of-network reimbursement methodology on true usual, customary and reasonable (UCR) charges such as the methodology being used by Fair Health to develop a new NYS-mandated UCR database to replace Ingenix.
- MSSNY should seek legislation, regulation or other means to require health insurance companies to provide a patient's in-network and out-of-network deductible information on a patient's insurance card as well as on the insurance company's website, and seek to assure that the information on the company's website be updated immediately when such information has changed.
- MSSNY will urge the AMA to seek an immediate delay of the penalty for non-compliance with e-prescribing (eRx), scheduled to go into effect in 2012, to allow physicians more time to explore available eRx options, weigh their alternatives and make conscious, educated decisions..
- MSSNY adopted policy recommending that hospitals that utilize voluntary physicians provide appropriate compensation for these services consistent with the advisory opinion issued by the Office of the Inspector General (OIG).
- MSSNY adopted as policy the statement that "restrictive covenants are unethical if they are excessive in geographic scope or duration in the circumstances presented; or if they fail to make reasonable accommodation of patients' choice of physician."
- In addition to its current policy supporting legislation to completely ban indoor tanning in NYS, pending such a ban, MSSNY will support legislation to bar anyone under the age of 18 years from indoor tanning without parental or legal guardian consent. MSSNY will also ask the AMA to urge the FDA to implement similar federal restrictions on indoor
- MSSNY will advocate for legislation requiring all high school students to attend a training course in CPR and the use of an automated external defibrillator (AED), using the course guidelines recommended by the American Heart Association and endorsed by the American Academy of Pediatrics.

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New Officers Elected and New Policies Adopted at MSSNY's 205th House of Delegates *(continued from page 8)*

- MSSNY will seek legislation that requires 1) young athletes suspected of having an acute traumatic brain injury, including concussion, to be removed from play/practice; and that requires 2) injured players to get written approval from a physician before returning to play/practice.
- In an effort to reduce overdose deaths, MSSNY will work with the NYS-DOH and specialty societies to expand Naloxone (which can reverse overdoses) programs as part of its overdose prevention programs.
- MSSNY will seek legislation that 1) permits physicians to report to the DMV patients whom the physician believes should not operate a motor vehicle and that 2) provides civil and criminal immunity for good-faith reporting.
- MSSNY will establish a database of physicians willing to mentor medical students, especially those of minority ethnicity, and make that database easily accessible to medical students who belong to MSSNY.
- MSSNY will support legislation that gives US medical students from LCME/COCA-accredited medical schools preference over students from international and dual-campus medical schools for clerkship rotations in NYS hospitals or affiliated clinics.
- MSSNY will work with NYS pharmacists and their professional organizations to help patients maintain the option of having their prescriptions dispensed at a local pharmacy and counseled face-to-face by their pharmacist.
- MSSNY will seek legislation that 1) only permits the title "physician" to be used by MDs and DOs and that 2) imposes penalties on those who mislead the public with the unauthorized use of the title.
- MSSNY should seek NYS Insurance Department regulations that require: 1) patients' health insurance cards to include [provide clearer information by including]: the payer's claim address, product line (Medicare, Medicaid, PPO, HMO, etc.), primary care physician, co-payments, deductible and/or co-insurance amounts, etc., and health plan's website; and regulations that require 2) the health plan's website to include a direct link to a webpage verifying this patient eligibility and financial responsibility information.. MSSNY should also seek swipe-card technology with verification.
- MSSNY should: 1) inform CMS that technical errors by NYS's Multi-Carrier System (MCS) are responsible for many Medicare claims errors; and 2) petition CMS to set up a dedicated unit or contact at the MCS to respond to – and resolve – erroneous claims denials reported by county, state and specialty medical societies.♦

FROM THE EDITOR—Lost and Found *(continued from page 3)*

Usually I shrugged off losses like this with an "it's only a material object." My daughter was surprised how calmly I assessed the damage. "Three to four thousand is my estimate. It's OK honey, it can be fixed." (I've become quite accurate at such estimations.) But the over coat bothered me. I mentioned it to one of my partners at work, an organized man, world wise to matters of the material world (I have, as a survival mechanism, managed to surround myself with organized people). "Call Metro-North Lost and Found." I was dubious that such an institution existed and, if it did, they would be able to find my coat. Still, I called and after a brief interlude on touch tone menus, a very pleasant man named Bob (my father's name!), took down all the information and promised that he would file a report and get in touch with me. I hung up, impressed with his cheerful efficiency, but still doubtful. Just hours later, I got an email. They had found a coat matching my description. I was advised to stop by Lost and Found at Grand Central.

I anxiously awaited the next Monday, each day preserving my secret from my wife. I arrived at Lost and Found and gave the person there my report number. He disappeared in the back for some minutes. A small line formed behind me. Then, he rounded into view. From a distance, it looked like my coat. As he got closer, I was certain. I felt a surge of joy, way out of proportion to the event at hand. I put it on, pulled close and began to walk up Madison. Found, indeed!♦

Inaugural Remarks of MSSNY President Paul Hamlin, MD

Paul A. Hamlin, MD, FCCP, a board certified specialist in pulmonary disease who practices in Lake Success, was elected President of MSSNY. Dr. Hamlin is a partner of Great Neck Medical Associates, a multi-specialty group in Lake Success. He has attending privileges at North Shore-Long Island Jewish Hospital in Manhasset and is a clinical assistant professor of medicine at New York University School of Medicine. Dr. Hamlin has been active in organized medicine's efforts to improve New York's healthcare environment for most of his career. He has served as both trustee and president of the Nassau Academy of Medicine, as well as president of his state district branch and the Nassau County Medical Society. Dr. Hamlin represented his county on MSSNY's Council for six years and has been part of NY's delegation to AMA meetings for five years.

Keep Government out of the Doctor-Patient Relationship

I would like to thank President Leah McCormack for her exceptional leadership, dedication and hard work on behalf of MSSNY. I would like to thank the Nassau County Medical Society, its Executive Board and the Nassau Delegation. I offer special thanks to Dr. Sam Gelfand and Dr. John Ostuni for their good counsel and guidance over these many years. Also, a special remembrance goes to my late friend and mentor, Dr. Sidney Mishkin, who urged me to become active in MSSNY many years ago.

The Prospective Trial

After finishing medical school and internship, I served in Vietnam. Upon returning from service in Vietnam, I completed my residency in internal medicine and subspecialty training and fellowship in pulmonary disease. During my pulmonary fellowship, I ran a 100-bed TB ward which was filled to capacity and had a waiting list. Only one year later, that facility was emptied and all the patients were moved to outpatient care. This was made possible because of multiple drug therapy for tuberculosis. This therapy was the result of what was one of the greatest advances in medicine of the twentieth century – the Prospective Trial.

The first prospective trial took place in the early and late 1950s, in New York State at Saranac Lake, and other TB centers – right here in New York. As you know, prospective trials are now common place and are responsible for the major advances in our treatment of lymphoma, leukemia, breast cancer, and many neoplasias, as well as hypertension, cardiovascular disease and HIV.

It is truly unfortunate that use of prospective trials was not utilized in the formation of a rational approach to health care delivery. With 50 states in which to run trials, we most certainly would have had a better and more cohesive health care system by now.

A Little History

I joined two internists in practice in 1974. Our practice grew rapidly to a multi-specialty group practice in Great Neck, Long Island. The group consisted of internal medicine, pulmonary medicine, cardiology, gastroenterology, and hematology and oncology specialists.

The advances in all aspects of medicine during this period have been truly remarkable and exponential. If a patient underwent cardiac bypass surgery in the 1970s or l980s, within five years, they were a redo or had expired. Today, procedures like bypass surgery are much more universally available and successful. Today, the United States five-year survival rate from cancer is 66%, which is the highest in the world. Through physician driven health care and prospective trials, we have added an extra decade to the American lifespan since I began practice.

When I was president of my county medical society, "Hillary Care" was being promulgated. At that time, all of Canada with its socialized health care system had three MRI machines. At the same time, just in my area of Nassau County, the five-mile stretch on Northern Boulevard between North Shore Hospital and St. Francis Hospital had about seven.

Government Should Not Practice Medicine

The message here is that government-controlled health care will involve rationing and decreased access to control cost. We cannot allow that to happen! I am proud to be a physician, as I'm sure you are, too. But I'm heartbroken and dismayed by what is happening to our profession. We must exercise our power. We must fight for our rights. And, we will fight for proper and cost effective health care, NOT government health care, but PHYSICIAN DRIVEN health care. *(continued on page 11)*

Inaugural Remarks of MSSNY President Paul Hamlin, MD

(continued from page 10)

One year ago this April, I had the privilege to accompany my son Paul to Salzburg, Austria where he was giving a series of lectures on adult non-Hodgkins Lymphoma. While there, I was reminded of the fact that after fifty years of socialized medicine in Eastern Europe, nothing in the way of new advances was produced. We cannot move in that direction with the ever increasing government control of medicine.

Sometime ago, I heard a lecture by a visiting professor at my hospital's grand rounds. The topic was "What is the Greatest Single Advance in All of Medicine?" The professor's observation was that "the history of the present illness," or in other words, the dialogue between the patient and the physician, was the greatest advance. Estimates are that a physician using diagnostic acumen and deductive reasoning along with the physical examination can accurately make a diagnosis in over 95% of cases and a differential diagnosis in up to 98% of all cases without ordering a single test.

Doctor/Patient Relationship

Today, the history of the present illness is under assault! You know too well that physicians are increasingly working in an environment of price controls, rising overhead, rising medical malpractice premiums, economic credentialing, reams of paperwork and administrative obligations, and cost shifting by both Medicare and the insurance industry.

Nurse practitioners and other physician extenders with their limited scope of training are trying to formulate the history of the present illness like a physician. Do you think they can do this successfully? I think not! We are witnessing the consolidation, the corporatization, and the generalized socialization of American medicine.

More and more physicians are abandoning private practice and consolidating into large groups of employed physicians, many in large hospital groups. My own practice, Great Neck Medical Associates, recently became a division of the North Shore University – Long Island Jewish Hospital system. Running a small group practice of eight physicians just simply became economically untenable.

Today, the average graduating physician has a student loan obligation of about $160,000. That's outrageous. It is a wonder why any physician would want to enter primary care, let alone many other specialties involving direct patient contact. In fact, less than 2% of them go into primary care and internal medicine. The future challenges to MSSNY are indeed formidable. All this is happening at a time of great social change in medicine.

What MSSNY Is Doing

We have an ever increasing crisis in medical liability and cost controls imposed on us by insurance companies and Medicare. We must curb the ugly trends and realities we are facing. So what are we doing?

- We must continue to lobby for tort reform, balanced billing and collective bargaining.
- We have to fight against scope of practice issues that are increasingly being pushed in the Albany legislature.
- MSSNY leadership is reaching out to the employed physicians and to those in transition from private practice to an employed position.

Recently, the consolidation of MSSNY's in-house council, Don Moy, with the law firm Kern, Augustine, Conroy and Schoppmann, will add a new dimension to MSSNY. Legal input and guidance will most definitely be needed as we enter into this new era of accountable care organizations and patient-centered physician homes, and a government review board (probably just new names for Gatekeeper and HMOs).

I look forward to the challenge. I am optimistic that MSSNY will strengthen and grow. MSSNY has been around for over two centuries and God willing, we will serve the physicians of New York State for centuries to come. We have only just begun. ♦

WCMS Board Highlights

At its meeting on April 14, 2011, the Board…

- Received a presentation from representatives of Citibank on *"Business Banking Solutions for Physicians,"* a comprehensive banking service package for physicians and their practices. Citibank has been supportive of the WCMS and its members in the past. Following the presentation, *the Board voted to approve Citibank as a Preferred Business Partner of the WCMS and will recommend its preferred banking services to the membership.*

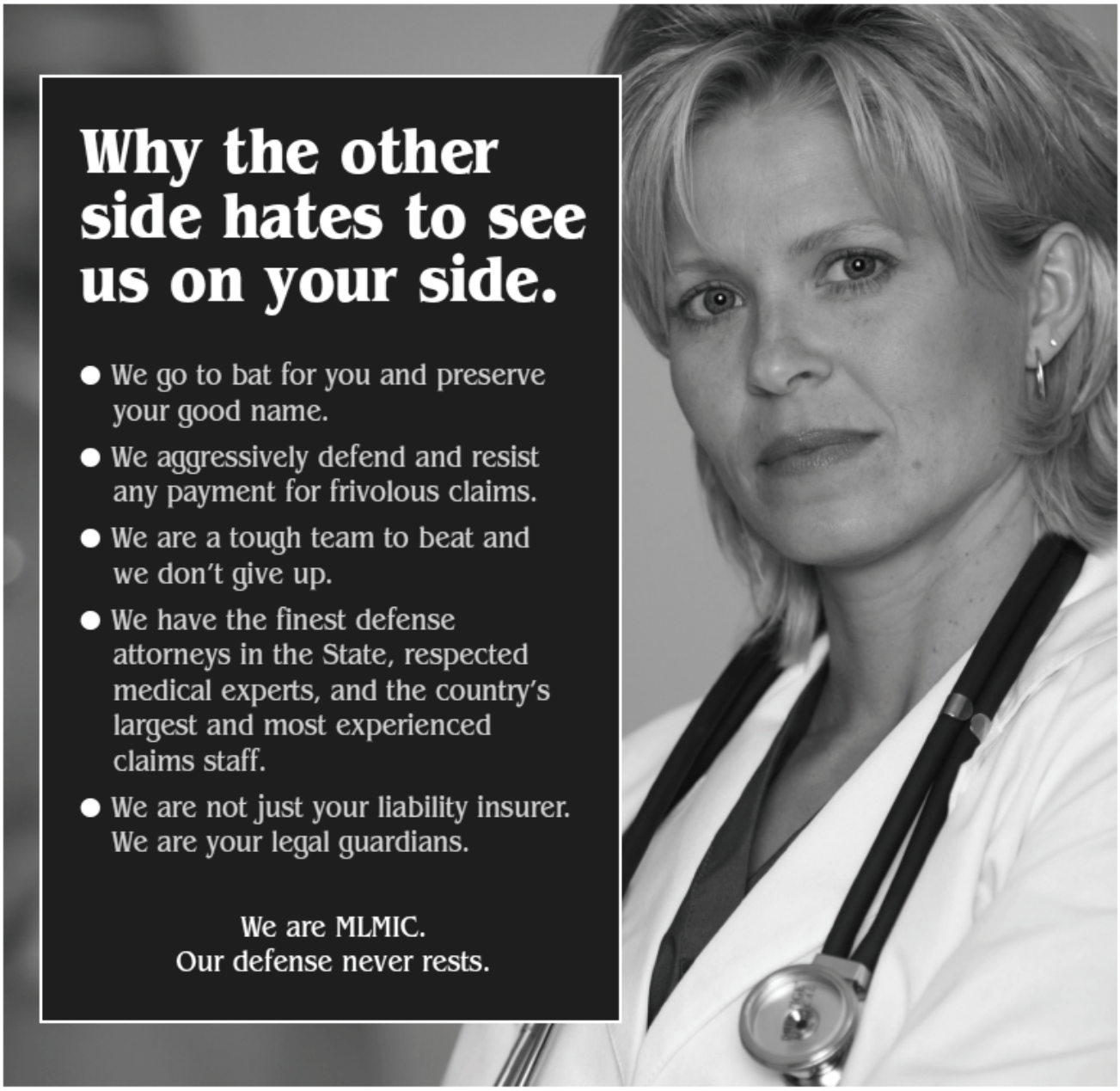
- **Welcomed Senator Greg Ball, who represents New York's 40th Senate District, including the northern parts of Westchester County.** Senator Ball briefly discussed the political climate in Albany and acknowledged the challenges facing physicians in accomplishing meaningful medical liability reform under current Assembly leadership. The Board advised Sen. Ball of the Society's three most important legislative priorities: resolving through legislation or regulation the action by insurers to cut out-of-network benefits to patients by tying physician reimbursement to Medicare benchmarks; achieving collective negotiation power for physicians with insurers; and securing meaningful medical liability reform to stabilize premiums and lower health care costs. The Senator asked for further information on the out-of-network problem and promised, as a member of the Senate majority and the Health Care Committee, to assist the medical community whenever possible.

- Heard from the President, Joseph Tartaglia, MD, who reminded the Board that the Nominating Committee must be appointed to develop the slate of officers/delegates for 2011-12. The Bylaws dictate the four immediate past presidents be on the committee, as a well as a member appointed by the Board and four members appointed by the president. The Board nominated Gino Bottino, MD, to represent the Board. Dr. Tartaglia appointed the following members: Howard Yudin, MD; Tancredi Abenavoli, MD; Luciano DeMarco, MD; and Roger Madris, MD. Finally, John Stangel, MD, immediate past president, will serve as chair, with the following past presidents also serving: Amy Newburger, MD; Alfred Tinger, MD; and Peter Rizzo, MD. The Committee will meet as soon as possible to develop and publish a slate 30 days prior to the WCMS/Academy Annual Meeting, June 9, 2011.

- Approved the Report of the Membership Committee welcoming ten (10) new members to the WCMS and Academy. The new members were published in the April edition of the Westchester Physician.

- Heard from Thomas Lee, MD, Chair Legislative Committee, regarding the activities and legislative visits associated with MSSNY Legislative Day, March 7-8, 2011. For the first time, MSSNY featured a webcast on March 7th and encouraged members to congregate at their county medical societies and watch MSSNY leadership pose member questions to key legislators. The evening session also featured remarks from the new State Commissioner of Health. On March 8th, a group of seven WCMS leaders travelled to Albany to meet with Westchester Assembly members Paulin, Castelli, and Abinanti, as well as Senator Ball. The WCMS Legislative Committee has also recently held local meetings with Assemblywoman Galef, Assemblymen Spano, Castelli, and Latimer, and Congresswoman Nan Hayworth, MD, a WCMS/MSSNY member. A meeting with Assemblyman Steve Katz, NY District 99, is planned for May 12. Dr. Lee mentioned that WCMS/MSSNY legislative priorities are addressed at all meetings.

- Heard from Brian Foy, Executive Director, regarding the MSSNY House of Delegates Meeting, April 8-10, 2011, at the Westchester Marriott, Tarrytown. A summary report focusing on WCMS Delegation activities was included in the April newsletter and further details will be included in the May issue.



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GUEST ARTICLE

ACOs: Organizations or Obfuscations?

By Joseph McNelis, MD
Vice President, WCMS

One of the mechanisms proposed as an important element of the Patient Protection and Affordable Care Act (PPACA) is the Accountable Care Organization (ACO). The ACO actually is in the process of being defined, as there are some anti-trust issues that need to be clarified. PPACA mandates that the federal government establish a Medicare shared-savings program by January, 2012. The ACO is a group of providers or network of groups which will be held 'accountable' for the quality, cost, and overall care of Medicare enrollees in a traditional fee-for-service program. If the ACO meets quality standards set by Medicare and does it at a lower cost than Medicare, the savings will be shared with the ACO. To this point, the quality measures have not been officially defined.

A demonstration project was recently completed by the Centers of Medicare and Medicaid Services that was a model for the ACO provisions. In the Medicare Physician Group Practice demonstration, ten large multi-specialty groups with various structures participated over a four year period. [1]

The ten large group practices, ranging from 232 to 1291 physicians, operated in various parts of the country. The individual physicians received their usual Medicare fee-for-service payments, but the group also was eligible for 80% of Medicare's performance payment. To generate performance payments, groups had to produce more than 2% savings of the target expenditures.

All ten groups met at least 29 of 32 quality goals, which were mostly related to coronary artery disease, diabetes mellitus, congestive heart failure, hypertension, and preventive care. Five groups produced Medicare savings of $38.7 million, earning performance payments of $31.7 million. One group, Wisconsin, generated more than half of the bonus dollars. Five groups received no bonus money, but were not penalized for missing target expenditures.

Donald Berwick, M.D., Administrator for CMS, described the savings in the demonstration project as "modest," but pointed out that the project helped to show several important factors: "an integrated organization that supports expending resources on programs to improve quality and reduce the provision of unnecessary services; dedicated physician leadership with a proven ability to motivate the implementation of quality-improvement programs; and a central role for health information technology in enabling the organization to manage population health and receive feedback at the point of care." [2]

The Government Accounting Office (GAO) has thrown some cold water on the projections as has the Congressional Budget Office (CBO). The GAO doubted whether practices of less than 200 physicians could absorb the start-up and annual operating costs necessary. The CBO projected only about $1.3 billion savings, although it admitted the figures were difficult to project.

Mark McClellan, former head of CMS in the Bush Administration, feels the ACO concept to be worthwhile, but that the process of implementation may make it unwieldy. "We need to be a lot faster," he said. Implementing an endeavor like this without having the participants understand the methods and aims likely would be an unworkable one. [3]

The key element in this system is savings generated from close patient monitoring through information technology, as indicated by Dr. Berwick. The startup and maintenance of such an endeavor are daunting for the small practice, as the GAO notes. The 'economies of scale' from the large practices spreads the costs over a large group.

(continued on page 15)

2011-2012 WCMS/ACADEMY Report of the Nominating Committee

The Nominating Committee of the Westchester County Medical Society and the Westchester Academy of Medicine met on Wednesday, May 4, 2011, at the Medical Society Offices and hereby nominates the following candidates for office **effective July 1, 2011:**

President-Elect
Joseph McNelis, MD

Vice President
Thomas Lee, MD

Treasurer
Robert Ciardullo, MD

Secretary
Robert Lerner, MD.

President – Academy of Medicine
Karen Gennaro, MD

Delegates to the MSSNY House of Delegates
(Four for two years; term ending 2013)
Andrew Kleinman, MD
Peter Liebert, MD
Louis McIntyre, MD
John Stangel, MD

Alternate Delegates to the MSSNY House of Delegates
(Four for two years; term ending 2013)
Robert Ciardullo, MD
Robert Soley, MD
Karen Gennaro, MD
Thomas Lee, MD

Note: Per the Bylaws, the current President-elect, Abe Levy, MD, automatically assumes the Office of President and the current President, Joseph Tartaglia, MD, assumes the Office of the Immediate Past President. Additionally, Gino Bottino, MD will be appointed to fill the unexpired term (2012) of Louis McIntyre, MD as Alternate Delegate.

Additional candidates may be nominated from the floor at the WCMS/WAM Annual Meeting, provided that each nomination is supported by a petition signed by at least 100 members, as specified in the Bylaws. **The final slate will be voted on at the June 9th Annual Meeting (see page 6).**

GUEST ARTICLE—ACOs: Organizations or Obfuscations?

(continued from page 14)

Keeping in close contact with the patient will need an added set of employees, which the large practice will provide in making the ACO model workable. Making an organization too large will produce negative economies of scale, so periodically streamlining the ACO may be needed. The overall implications for the small private practice are not promising with this.

Another concern with the ACO model is that organizations with close connections to hospitals did not fare well in the demonstration project. Negative externalities are much more involved in hospital care than private practice. The negative externalities of expensive procedures will be shifted in part onto the ACO, resulting in lower, if any, bonuses. The costs of ICU care are factors beyond the control of the ACO cost control mechanisms. The last days of life account for much of the increasing health care costs. The ACO model does little to "bend the curve" here. ♦

[1] Iglehart, John, "Assessing an ACO Prototype-Medicare Physician Group Practice Demonstration", *New England Journal of Medicine;* 2011:364:198-200.

[2] Berwick, Donald, "Launching Accountable Care Organization-The Proposed Role for Medicare Shared Savings Program", *New England Journal of Medicine;* March 31, 2011.

[3] Goozner, Merrill, "Mixed Signals on Medicare Pilot Savings Program", *The Fiscal Times*, October 28, 2010.

Legal Corner

Kern Augustine Conroy & Schoppmann, P.C.

Accountable Care Organization Rule Released

The long-awaited Accountable Care Organization (ACO) regulations have been published, implementing the Patient Protection & Affordable Care Act's mandate to HHS to establish, by January 2012, a shared savings program "to promote accountability for a patient population and coordinate services under [Medicare] parts A and B and encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery." The regulations address: eligibility, structure, and governance of ACO entities; beneficiary assignment and marketing parameters; quality measures; payment and sharing mechanisms; and compliance obligations. Other rulemaking and statements were concurrently issued regarding fraud and abuse, antitrust, and tax concerns related to ACOs. The rule and related materials can be accessed on the HHS dedicated website: ***http://www.cms.gov/sharedsavingsprogram/***. The regulations are under intense scrutiny from the health care community and HHS is seeking comment on numerous unresolved issues, one being how even large physician groups can invest the time and money (estimated in the proposal to be $1.75 million) for startup up and initial year operations. Comments on the ACO regulations and fraud and abuse waivers are due by June 6, 2011; comments on the antitrust and tax rulemaking are due by May 31, 2011. *A link to the AMA Summary of Proposed Rules and Policy Statements on Section 3022 of the Affordable Care Act, The Medicare Shared Savings/ACO Program can be found at www.thewestchesterphysician.com.*

Home Health/Hospice Face-to-Face Encounters

Effective April 1, 2011, home health agencies and hospices must have procedures in place to comply with new Medicare face-to-face encounter requirements for home health and hospice services. The rule requires the certifying physician to document that the physician, or a non-physician practitioner working with the physician, has seen the patient before certifying eligibility for home health services. It also requires a hospice physician or nurse practitioner to have a face-to-face encounter with a hospice patient prior to the patient's 180th-day recertification and each subsequent recertification.

Wage Theft Prevention Act Effective

New York's Wage Theft Prevention Act became effective on April 9, 2011. It requires employers, regardless of size, to provide new notices to employees regarding their rates of pay, allowances claimed as part of minimum wage, and the regular pay day, as well as certain identifying information about the employer. The notice must be issued at the time the employee is hired and annually thereafter, on or before February 1st of each year, and must be signed and dated by the employee. Additional new requirements relate to information that must be included in a statement provided with every wage payment. The notice, acknowledgment, and payroll records must be maintained by an employer for six years. The law carries significant penalties for violations. Information regarding the law, including templates for the required notices, is available at the New York State Department of Labor website: ***http://www.labor.ny.gov/workerprotection/laborstandards/workprot/lshmpg.shtm.***

WCMS Public Health Corner

HEALTH ADVISORY: TWO INFANT PERTUSSIS DEATHS IN NYS IN 2011

The New York State Department of Health (NYSDOH) is asking healthcare providers to consider pertussis, especially in young infants, when seeing patients with respiratory symptoms or clinically compatible illness, and to immediately report suspect cases to the local health department (LHD) and institute appropriate infection control measures.

- *Delays in recognition of pertussis in infants may contribute to adverse clinical outcomes.*
- *Delays in treatment before or after hospital admission may increase the risk of fatal illness.*

A reminder that Tdap is not just for mothers, it's for all family members and caregivers of the infant. Healthcare personnel who work in hospitals or ambulatory care settings and have direct patient contact should receive a single dose of Tdap as soon as feasible. Priority should be given to vaccination of healthcare personnel who have direct contact with infants 12 months of age and younger.

Infant Vaccine Recommendations

Unimmunized or incompletely immunized young infants are particularly vulnerable. The pertussis vaccination series can begin when an infant is 6 weeks of age. Infants, however, are not adequately protected by vaccination until the initial series of three shots is complete. All children should receive all age appropriate doses of pertussis containing vaccine.

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