

Quarterly Newsletter

American Osteopathic Colleges of Ophthalmology and Otolaryngology-Head and Neck Surgery - Spring 2011, Vol. 46 No. 2



PRESIDENT'S MESSAGE

Kirk W. Steehler, DO

Greetings from your Executive Board of Governors. The Board is preparing for a transition to new President. I am very excited about the leadership of the Board of Governors. There is a diversity of personalities and geographic location. Elections will be completed within the next week.

It is going to be a spectacular meeting in Tucson. I expect it to be one of our most successful ever at every level of measurement. I will look forward to seeing all of you there.

I will mention one very special thing that I would rather say now, instead of at the meeting. Many of you remember my mother from the Mid-Year Meetings and ACA. She befriended Dr. Charlie Schrimpf for one person and she loved our Osteopathic profession. When my father died, she was very lonely and I knew she absolutely loved to go with my father to his General Surgery Conventions. Bringing her to these meetings while she could get around well was a delight to her. I know this is a personal story in our *Quarterly Newsletter*, but I must tell this story. After I became President of the Board of our College, my mother who was too sick to attend the meeting, wanted to know all about what happened. She asked me about some of the people she met at past meetings and I told her about them. I then showed her the medal you receive from becoming President of the Board and she asked me if she could see it. I brought it to her and she immediately put it on. She wouldn't take it off and was so excited to show everyone who came over to see her. She wore it constantly for about few weeks and never really did give it back to me. She passed away a couple of weeks later. I can't tell you how proud she made me feel for what I had considered a recognition for a job well done. After seeing her wear it, she made me feel like a king. She made me feel so proud of my accomplishment.

I just have to tell everyone that she taught me a great lesson as she had always done throughout her life. We need to slow down a little and recognize our accomplishments and successes. When we care for our patients and things go well we need to appreciate our success. We must feel a full measure of success and accomplishment for what we really do for others as physicians, at least once in awhile. Be happy and know you are important as Osteopathic Physicians. Don't let any political situation or financial burden of the many unfunded mandates pressed on us, ruin all of the fun of what we do as doctors. When you see me wearing my medal at our Ceremonial Dinner, please know how proud I am to wear it.

Warm Regards,

Kirk W. Steehler, DO

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Residency Alumni Events during May 2011 ACA

ATTENTION ALUMNI EVENT ORGANIZERS

Most residency alumni events are held on Friday evening, May 6th, during the Annual Clinical Assembly. If you would like to publish a residency alumni event notice on the "Events Bulletin Board" during the ACA, please email your articles to info@aocoohns.org.

10th Mid-Year Seminar

The AOCOO-HNS Foundation is holding the 2011 Mid-Year Seminar at the Detroit Westin Metropolitan Airport Hotel, August 27-28.

DON'T FORGET TO VOTE FOR 2011 BOARD MEMBERS BY MARCH 25TH.

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Views and opinions expressed in the *AOCOO-HNS Quarterly Report* are not necessarily endorsed by the American Osteopathic Colleges of Ophthalmology and Otolaryngology-Head and Neck Surgery.

Quarterly Report Schedule

SUMMER: copy deadline May 15th
mailing June 15th
FALL: copy deadline August 15th
mailing September 15th
WINTER: copy deadline November 15th
mailing December 15th
SPRING: copy deadline February 15th
mailing March 15th



Report from the Director of Educational Affairs

Alvin D. Dubin, DO

Professionalism--

The medical profession is beset with many problems today: How to survive the many real threats to financial security, how to comply with the increasing demands of insurance and government requirements, the increasing time demands, and how to continue to deliver quality patient care, to name just a few.

This is certainly the time to assess our role and responsibilities in order to continue to do no harm to our patients or ourselves. It would be also time to once again review and understand clearly our basic core values- professionalism, ethical dictates, and standards of care.

The following is an excerpt from the Foundation of the American Board of Internal Medicine, March 20, 2009. I believe it clearly states a physician's responsibilities and goals, as well as helping to educate our patients:

Professionalism is the basis of medicine's contract with society. It demands placing the interests of patients above those of the physician, setting and maintaining standards of competence and integrity, and providing expert advice to society on matters of health. The principles and responsibilities of medical professionalism must be clearly understood by both the profession and society. Essential to this contract is public trust in physicians, which depends on the integrity of both individual physicians and the whole profession.

At present, the medical profession is confronted by an explosion of technology, changing market forces, problems in health care delivery, bioterrorism, and globalization. As a result, physicians find it increasingly difficult to meet their responsibilities to patients and society. In these circumstances, reaffirming the fundamental and universal principles and values of medical professionalism, which remain ideals to be pursued by all physicians, becomes all the more important.

The medical profession everywhere is embedded in diverse cultures and national traditions, but its members share the role of the healer, which has roots extending back to Hippocrates. Indeed, the medical profession must contend with complicated political, legal, and market forces. Moreover, there are wide variations in medical delivery and practice through which any general principles may be expressed in both complex and subtle ways. Despite these differences, common themes emerge and form the basis of this charter in the form of three fundamental principles and as a set of definitive professional responsibilities.

Fundamental Principles

Principle of primacy of patient welfare. The principle is based on a dedication to serving the interest of the patient. Altruism contributes to the trust that is central to the physician-patient relationship. Market forces, societal pressures, and administrative exigencies must not

compromise this principle.

Principle of patient autonomy. Physicians must have respect for patient autonomy. Physicians must be honest with their patients and empower them to make informed decisions about their treatment. Patients' decisions about their care must be paramount, as long as those decisions are in keeping with ethical practice and do not lead to demands for inappropriate care. **Principle of social justice.** The medical profession must promote justice in the health care system, including the fair distribution of health care resources. Physicians should work actively to eliminate discrimination in health care, whether based on race, gender, socioeconomic status, ethnicity, religion, or any other social category.

A Set of Professional Responsibilities

Commitment to professional competence. Physicians must be committed to lifelong learning and be responsible for maintaining the medical knowledge and clinical and team skills necessary for the provision of quality care. More broadly, the profession as a whole must strive to see that all of its members are competent and must ensure that appropriate mechanisms are available for physicians to accomplish this goal.

Commitment to honesty with patients. Physicians must ensure that patients are completely and honestly informed before the patient has consented to treatment and after treatment has occurred. This expectation does not mean that patients should be involved in every minute decision about medical care; rather, they must be empowered to decide on the course of therapy.

Physicians should also acknowledge that in health care, medical errors that injure patients do sometimes occur. Whenever patients are injured as a consequence of medical care, patients should be informed promptly because failure to do so seriously compromises patient and societal trust. Reporting and analyzing medical mistakes provide the basis for appropriate prevention and improvement strategies and for appropriate compensation to injured parties.

Commitment to patient confidentiality. Earning the trust and confidence of patients requires that appropriate confidentiality safeguards be applied to disclosure of patient information. This commitment extends to discussions with persons acting on a patient's behalf when obtaining the patient's own consent is not feasible. Fulfilling the commitment to confidentiality is more pressing now than ever before, given the widespread use of electronic information systems for compiling patient data and an increasing availability of genetic information. Physicians recognize, however, that their commitment to patient confidentiality must occasionally yield to overriding considerations in the public interest (for example, when patients endanger others).

Commitment to maintaining appropriate relations with patients. Given the inherent vulnerability and dependency of patients, certain relationships between physicians and patients must be avoided. In particular, physicians should never exploit patients for any sexual advantage, personal financial gain, or other private purpose.

Commitment to improving quality of care. Physicians must be dedicated to continuous improvement in the quality of health care. This commitment entails not only maintaining clinical competence but also working collaboratively with other professionals to reduce medical error, increase patient safety, minimize overuse of health care resources, and optimize the outcomes of care.

Physicians must actively participate in the development of better measures of quality of care and the application of quality measures to assess routinely the performance of all individuals, institutions, and systems responsible for health care delivery. Physicians, both individually and through their professional associations, must take responsibility for assisting in the creation and implementation of mechanisms designed to encourage continuous improvement in the quality of care.

Commitment to improving access to care. Medical professionalism demands that the objective of all health care systems be the availability of a uniform and adequate standard of care. Physicians must individually and collectively strive to reduce barriers to equitable health care. Within each system, the physician should work to eliminate barriers to access based on education, laws, finances, geography, and social discrimination. A commitment to equity entails the promotion of public health and preventive medicine, as well as public advocacy on the part of each physician, without concern for the self-interest of the physician or the profession.

Commitment to a just distribution of finite resources. While meeting the needs of individual patients, physicians are required to provide health care that is based on the wise and cost-effective management of limited clinical resources. They should be committed to working with other physicians, hospitals, and payers to develop guidelines for cost effective care. The physician's professional responsibility for appropriate allocation of resources requires scrupulous avoidance of superfluous tests and procedures. The provision of unnecessary services not only exposes one's patients to avoidable harm and expense but also diminishes the resources available for others.

Commitment to scientific knowledge. Much of medicine's contract with society is based on the integrity and appropriate use of scientific knowledge and technology. Physicians have a duty to uphold scientific standards, to promote research, and to create new knowledge and ensure its appropriate use. The profession is responsible for the integrity of this knowledge, which is based on scientific evidence and physician experience.

Commitment to maintaining trust by managing conflicts of interest. Medical professionals and their organizations have many opportunities to compromise their professional responsibilities by pursuing private gain or personal advantage. Such compromises are especially threatening in the pursuit of personal or organizational interactions with for-profit industries, including medical equipment manufacturers, insurance companies, and pharmaceutical firms. Physicians have an obligation to recognize, disclose to the general public, and deal with conflicts of interest that arise in the course of their professional duties and activities. Relationships between industry and opinion leaders should be disclosed, especially when the latter determine the criteria for conducting and reporting clinical trials, writing editorials or therapeutic guidelines, or serving as editors of scientific journals.

Commitment to professional responsibilities. As members of a profession, physicians are expected to work collaboratively to maximize patient care, be respectful of one another, and participate in the processes of self regulation, including remediation and discipline of members who have failed to meet professional standards. The profession should also define and organize the educational and standard-setting process for current and future members. Physicians have both individual and collective obligations to participate in these processes. These obligations include engaging in internal assessment and accepting external scrutiny of all aspects of their professional performance.

Summary

The practice of medicine in the modern era is beset with unprecedented challenges in virtually all cultures and societies. These challenges center on increasing disparities among the legitimate needs of patients, the available resources to meet those needs, the increasing dependence on market forces to transform health care systems, and the temptation for physicians to forsake their traditional commitment to the primacy of patients' interests. To maintain the fidelity of medicine's social contract during this turbulent time, we believe that physicians must reaffirm their active dedication to the principles of professionalism, which entails not only their personal commitment to the welfare of their patients but also collective efforts to improve the health care system for the welfare of society. This Charter on Medical Professionalism is intended to encourage such dedication and to promote an action agenda for the profession of medicine that is universal in scope and purpose.

Member News

John R. Alway, DO

At the recent Grandview Medical Center/Ohio University Education Graduation ceremony Dr. John R. Alway was presented with the Legacy Award in recognition of his contributions to medical education. The award recognizes faculty who through teaching and mentoring have created a legacy that has changed those residents and students whose lives they have touched.

Brian Bearie, DO

Dr. Brian Donald Bearie, aged 50, left us too soon on Tuesday, March 8, 2011. He was preceded in death by his parents, Donald and Beverly Bearie. He is survived by his wife, Anne Wallace; children, Nicole (Keith) Westerfield, D.J. Bearie, Bradley Bearie; their mother, Lisa Bearie, and many friends, professional colleagues and his entire staff. He was an undergraduate of the University of Michigan, attended Michigan State University Medical School and did his fellowship in Denver, CO. He opened his practice, the Grand Rapids Eye Institute, as the medical director in 2000.

He was a caring, wonderful father, loving and devoted husband who enjoyed boating and scuba diving. He will be greatly missed. Memorial contributions may be made to the local Lions Organization.

Report from the Bureau of Federal Health Programs Meeting on January 21, 2011

By Paul Imber, DO

The Bureau of Federal Health Programs is the arm of the AOA that coordinates the interaction and information flow between the AOA and the federal organizations involved in health and medical education policy and rules and regulations, including CMS. Three times a year, the Bureau reaches out to the AOA's membership with meetings open to constituent organizations (like the AOCOO-HNS) to educate, inform, and engage in dialogue on issues relevant to osteopathic physicians. For many years the AOCOO-HNS has been privileged to have Dr. Wayne Bizer give of his time, knowledge and energies to represent us at these meetings. Dr. Bizer has always given engaging, thoughtful and insightful reports from each Bureau meeting, that, if compiled in their entirety, might be partially (although certainly unintentionally) responsible for the deforestation of several wooded acres. I can only hope to be equally informative and challenging.

The Bureau meeting is an all day event, with several special speakers, usually of considerable import, and reports from various divisions of the AOA with content apropos to the focus of the meeting. The speakers this meeting included Bruce Reed, Executive Director of the Presidential created National Commission on Fiscal Responsibility and Reform (and now the new Chief of Staff to Vice-President Joseph Biden), and Peter Budetti, MD, Deputy Administrator for the CMS Program for Integrity and Fraud Initiatives (the CMS police!). Also, Shawn Martin of the AOA staff gave his presentation (soon to be delivered to the AOA Board of Trustees) on the "Future of Medicare Reimbursement." The division reports will be summarized as well.

NATIONAL COMMISSION ON FISCAL RESPONSIBILITY

Bruce Reed was given a most thankless, yet ultimately challenging task of directing a bipartisan Congressional commission (House and Senate) whose membership was appointed by President Barak Obama, and whose mission was to address the nation's fiscal challenges. It was charged with identifying policies to the President that would improve the fiscal situation in the medium term, and to achieve fiscal sustainability over the long run. The Commission "shall propose recommendations designed to balance the budget, excluding interest payments on debt, by 2015. In addition the Commission shall propose recommendations that meaningfully improve the long-run fiscal outlook, including challenges to address the growth of entitlement spending and the gap between the projected revenues and expenditures of the Federal Government." The Commission completed its task the end of 2010, and submitted final documents. The scope was global, including tax codes, and Section III focused on Health Care Savings. For a recommendation to be carried forward, an agreement of 14 of 18 members was required. I will summarize what I believe are the most poignant components reported.

Reform of the Medicare Sustainable Growth Rate- It is estimated that repeal of the SGR formula and freezing physician payments would cost \$267 billion from 2012 to 2020 relative to current law. In the near term, it is recommended that the future reductions be replaced with a freeze through 2013 and a one percent cut in 2014. For the medium term the Commission recommends CMS to develop an improved formula that encourages coordination of care across multiple providers and settings, and pays doctors based on quality instead of quantity of services. If the new formula is not established by 2015, the SGR formula would be reinstated with 2014 as the base year.

Medicare Savings

Increase government authority and funding to reduce Medicare fraud. The Commission recommends increasing the ability of CMS to combat waste, fraud, and abuse by providing the agency with additional statutory authority and increased resources.

Reform Medicare cost-sharing rules. Because costs sharing of the current Medicare benefits are low, the

structure encourages over-utilization of services. The Commission recommends establishing a single combined annual deductible of \$550 for both Part A and Part B Medicare, along with a 20% uniform coinsurance on health spending above the deductible. There would also be catastrophic protection, with coinsurance reduced to 5% after costs exceed \$5,500 and capping total cost sharing at \$7,500.

Restrict first dollar coverage of Medicare supplemental insurance. The goal would be to prohibit Medigap plans from covering the first \$500 of an enrollee's cost sharing obligation and limit coverage to 50% of Medicare cost sharing. Similar treatment is recommended for TRICARE for Life, Medigap for military retirees, as well as federal and private employer retirees.

Reduce excess payments to hospitals for medical education. The Commission recommends bring GME payments in line with the actual cost of medical education by limiting hospitals' direct GME payments to 120% of the national average salary paid to residents in 2010, adjusted forward by CPI, and reducing the IME adjustment from 5.5% to 2.2%, more accurately reflecting the true indirect costs.

Medicaid Savings

Place dual eligible in Medicaid managed care. There are 9 million low income recipients of both Medicare and Medicaid. This yields confusion and poor coordination, with possible duplication in payment and administration. The recommendation is made to have these beneficiaries under the direct care of Medicaid and its' established managed care programs. Medicare would continue to pay its' share, reimbursing Medicaid. Medicaid has a larger system of managed care than does Medicare, providing better care coordination and administration.

Medical Malpractice Reform

Tort reform. Experts agree that the current tort system leads to increased health costs. This is true because of both the direct costs (professional liability insurance) and indirect costs (over utilization of defensive medicine). The Commission recommends an aggressive set of reforms to the tort system.

1. Modifying the "collateral source" rule to allow outside sources of income collected as a result of injury (e.g. Worker's comp and other insurance benefits) to be considered in deciding awards.
2. Imposing a statute of limitations- 1 to 3 years- on medical malpractice lawsuits.
3. Replacing joint-and-several liability with a fair-share rule, under which a defendant would be liable only for the percentage of the final award that was equal to his share of responsibility.
4. Create special "health courts" for medical liability lawsuits.
5. Allow "safe haven" rules for providers who follow best practices of care.
6. Many Commission members believe that there should be statutory caps on punitive and non-economic damages, and the Commission recommends Congress consider caps and evaluate the impact.

Implement and Expand Payment Reform Pilots-

The Commission recommends CMS aggressively conduct the pilot programs required in the Affordable Care Act. These would include the reforms of bundling for post acute care services, pay for performances, bundled payments and ACO's. CMS should also ensure that the private sector is an active partner in the research and design of payment reforms. Pilot programs that succeed in controlling costs should be expanded as rapidly as is feasible.

Eliminate Provider Carve-Outs from IPAB

The ACA established the Independent Payment Advisory Board to recommend changes in Medicare payment policies. The law exempts certain provider groups- hospitals- from any short term changes from IPAB's authority. The Commission recommends eliminating these carve-outs.

The scope of the Commission's charge, and the "everything is on the table" approach, led to a comprehensive, "everybody takes a hit", list of recommendations with few sacred cows. Keep in mind that 14 of 18 bipartisan Commission members had to agree on each of these recommendations. While it is unlikely all of these recommendations will be followed, you can rest assured that many will be seen in some form in the near future.

CMS PROGRAM FOR INTEGRITY AND FRAUD INITIATIVES

Peter Budetti, MD is a pediatrician by training and prior practice, who now is the Deputy Administrator of this coordinated Program. His charge is to develop, implement and coordinate all integrity and fraud investigations for

all federal healthcare payment programs under the CMS oversight. Basically, he is the Inspector General for CMS. He desire is to modify and adjust the system used in the past. He intends to use technology to prevent medically unnecessary services, evaluate enrollment and credentialing fraud, and identify medical identity theft (estimated to be 3% of all identity theft in the US). Interestingly, he focused most of his discussion on the non-physician community.

The recent CMS initiatives were based on a “pay and chase” model, and now he desires a “prevent and detect” model. Recent CMS initiatives were “one size fits all”, and now will be a risk based approach. Recent initiatives were a legacy process with inwardly focused communication, and now will be innovative with transparency and accountability. Recent initiatives were a government cultured stand alone program, and now will be engaging the private sector in partnership with a coordinated and integrated PI program. Who can argue with that?

Dr. Budetti emphasized that the Program recognizes that Integrity is a spectrum with gradation from errors- to waste -to abuse- to fraud. They will be targeting areas of high abuse, both by provider type and geographic location. The Program for Integrity and Fraud Initiatives will have –

1. A limited focus on physicians.
2. A moderate focus on suppliers.
3. A high focus on residential care and home health.

The hope is that information technology will provide crossover data bases to identify “players” who infiltrate the CMS system under a variety of names and services, but have the same individuals as controlling principles. Apparently, the “bad guys” tend to dip into the well over and over, and under different provider names and services, but within the same geographic regions and same owner names. The RAC’s will also be expanding their focus to include Medicaid and Part C and D Medicare. Many of the past RAC audits are being overturned, and CMS is now taking a softer approach to physician audits for errors and waste. However, it will now be required that all providers must have a compliance program. Of course the content of this program is yet to be defined, but now would be a good time to begin the groundwork.

Is this the new kinder and gentler CMS, or will I awaken to find ruby slippers on my feet? If Dr Bendetti can keep his job while he enforces his objectives, physicians can practice medicine with little fear of untoward oversight. Of course, this assumes that physician infractions are unintentional errors which can be mitigated with EHR and education, and low on the fraud spectrum.

FUTURE OF MEDICARE PHYSICIAN PAYMENT

Shawn Martin, Director of the AOA Government Relations Team, has been a student of the evolution of the healthcare delivery system in our country. He has developed this presentation for the AOA Board of Trustees next month, and previewed it with our Bureau meeting.

Currently our system reimburses physicians for E&M and procedural based services, with all providers paid at the same rate- why are we paid with the same fee schedule? Currently, we are all paid on a volume driven model which is episode based. This structure is unpredictable with some important services (such as wellness and prevention and patient education) not considered reimbursable, with payment variable by payer, site of service and geography. Payment is only made for face to face interactions, and duplicative services are provided by different physicians for the same patient.

The new model for healthcare delivery will promote quality, with an advanced process of coordination and healthcare information technology leading to improved outcomes. The future of reimbursement may be varied, based on the provider specialty. Some specialists and subspecialists may continue to be paid on a fee for service basis due to low volumes and limited focus of patient care. Others may find a blended payment structure, with some fee for service and some global payments, such as the ACO or Medical Home Model for some aspects of patient care and fee for service for carve outs. Some doctors, perhaps the primary care physicians, may have bundled payments which are a modified capitation model. Finally, quality based and global payments may be in all of our futures, the HMO with a hospital and complete outpatient services with payment being resource based with shared savings and multiple doctors’ bundled payments- capitation. The future will undoubtedly bring the Patient Medical Home. The advantages will be flexibility, higher payments for select patients, coordination of care. This should lead to improved population health and pay doctors adequately.

The systematic challenges for the future system are the current lack of information to analyze performance, the cost of implementation and administration (including HIT), staff training, and the lack of control of patients’ behavior. There are many legal roadblocks to this “new world”. Many laws have been written to restrict the very

explicit integration being recommended. It is currently illegal to be paid to reduce care, to be paid for referral, for hospitals to pay doctors who are not employee contracted. Not to mention the myriad of Stark violations. Also, most physicians would find themselves with multiple contracts from a variety of insurers.

In anticipation, physicians need to prepare for these inevitable changes. We need to have the HIT to support compliance and collect and analyze data. We need to be able to implement a quality improvement program and practice transformation. We must have influence and control over the expenditures of our partners and ourselves. We must have practice models that are flexible and adroit, able to bend with the breezes but withstand the force of the strong winds.

AOA REPORTS

I will summarize several dozen pages of information into their salient points.

1. ICD10 will be implemented October 1, 2013. It will be here sooner than you think. Prepare now, do an impact assessment and be prepared to use the updated transmission format 5010 instead of 4010. As of January 1, 2012 all electronic claims must be using version 5010, as 4010 will not be recognized.
2. Medicare fee schedule has had a temporary fix for 2011, with fees fixed at 1% above 2010.
3. Medical Homes are being tested as Multi-Payer Advanced Primary Care Practice Demonstration in 8 states; including Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan, and Minnesota. This demonstration will eventually impact 1,200 medical homes serving almost 1 million Medicare beneficiaries.
4. E- Prescribing is a requirement for 2011. Those doctors not e-prescribing will have 1% reduction in 2012 and 1.5% in 2013. Having an HER incentive will not exempt the non-compliant e-prescriber from the reduction.
5. The PECOS database does not work as currently structured. It will be revamped from the ground up, and no claims are being rejected based on PECOS non-compliance.
6. The HER Incentive Program is getting very complex- no such thing as a free lunch. The definitions of meaningful use are currently being translated from government- speak to English, and hopefully we will be able to make this transition and have at least some of the costs covered by this incentive program. For more information- <http://www.cms.gov/EHRIncentiveprograms/>
7. FTC Red Flag Rule for physicians is dead! The Congress passed a clarification Act which ensures the small medical practices do not face undue regulatory burden associated with the Red Flag Rule.
8. Health Care Repeal is unlikely to occur. But now is the time to get some of the components of the ACA adjusted.
9. Section 5503 of the ACA establishes a resident redistribution pool whereby 65% of unused resident slots are pooled for redistribution to certain hospitals based on specific criteria and a detailed application process.
10. There are some resident cap reductions and increases that will be assessed based on the “reference resident level” vs. the FTE limit. It’s complicated and can be found in the Federal Register published November 24, 2010.
11. The AOA has launched the OGME Development Initiative to assist non teaching hospitals interested in starting OGME programs. If you or your hospital is interested contact Dr. Carlo DiMarco for more information- this is his baby!

As Health Costs Soar, Massachusetts Seeks Solution

Sunday, March 6, 2011

By Christine Vestal—Stateline.org

WASHINGTON — One of the most familiar criticisms of the new national health-care law is that it does little to contain costs. And that’s true: The primary goal is to provide universal access to health insurance. Cost controls are supposed to come later.

“Later” has arrived now for Massachusetts’ statewide plan, enacted in 2006 and similar in many ways to the federal one. Some 98 percent of all adults and nearly 100 percent of all children are covered, but costs have spiraled

out of control. Massachusetts spends 40 percent of its budget on health care, and median-income families are expected to spend one-third of their paychecks on health care by 2016.

Now, after five years, Massachusetts is getting very serious about the cost problem. Democratic Gov. Deval Patrick has proposed a sweeping bill designed to rein in health-care expenses that are among the highest in the country.

“Massachusetts led the nation on health-care reform,” Patrick boasted the day he unveiled the bill, “and is poised to lead again on health-care cost containment.”

Patrick said he understands why his predecessors “decided to put cost control off to another day — because if you think access was hard, wait until you take on cost control.”

Patrick’s bill encourages voluntary adoption of medical pricing practices that stress quality of care over the number of procedures performed. But at its heart are strict price restrictions on hospitals and other medical providers. The health industry does not like those. Although it has pledged cooperation with the governor on the cost-control problem, passage of the legislation is far from assured.

Any meaningful reform would have to do two things at once, says health-care policy expert Robert Berenson, of the Urban Institute. It’s important to move to a more cost-effective payment model, he says, but the savings won’t get passed along to consumers unless the state restrains the fees doctors and hospitals are able to negotiate.

“Everyone has a big stake in making this work,” Berenson adds. “If it doesn’t, the whole thing could fall apart.” In addition to cost increases because of new technologies and disease treatments, a major cause of what experts call “market failure” in the Massachusetts and U.S. health-care industries is the ability of prestigious hospitals and large medical practices to command just about any price they want from insurers. The same is true for hospitals in some monopoly markets in rural areas.

“It’s very hard to sell an insurance policy in the Boston area, for example, if your network doesn’t include Mass General, Children’s Hospital and Brigham and Women’s,” says David Shore, an independent insurance broker. “Price reforms won’t work unless we address the issue of market clout.”

Last year, Massachusetts Attorney General Martha Coakley used her office’s subpoena power to do just that. An investigation of otherwise confidential contracts between medical providers and insurers found wide disparities in price among providers working in the same geographic areas and offering the same types of services. According to Coakley’s report, price variations correlated to “market leverage,” not quality of care or the nature of the population served. The U.S. Department of Justice also investigated possible antitrust violations by Partners HealthCare, the parent of Massachusetts General Hospital and Brigham and Women’s Hospital.

Meanwhile, Patrick raised the ire of the health-care industry — the largest component of the state’s economy — when he directed insurance regulators to reject 235 out of 274 proposed increases in health-insurance premiums, which averaged 8 percent to 32 percent more than the previous year. Insurance companies sued the state because they said they had binding contracts with medical providers that required them to raise rates. The case was settled out of court with insurers agreeing to accept lower rates temporarily.

If enacted, Patrick’s plan would give the state more authority to reject insurance increases based on existing medical contracts and would provide incentives for doctors and hospitals to base their fees on quality of care. The state could reject rates if they exceed the increase in the state’s gross domestic product or total medical expenses in the region. Medical providers that move from a fee-for-service system to an alternative payment structure aimed at improved efficiency and patient care would be given favorable consideration.

Partners HealthCare, owner of Massachusetts General, issued a short statement agreeing to work with the governor to “craft real solutions when it comes to health-care affordability.” Dr. Alice Coombs, president of the Massachusetts Medical Society, also agreed to work with the Patrick administration but cautioned that a “one-size-fits-all solution would be a mistake right now, when the landscape of health care is changing so rapidly.” Consumer advocate Amy Whitcomb Slemmer, executive director of Health Care for All, is confident that significant cost controls will be enacted. “Political interests,” she says, “have really aligned in deciding that the status quo is not sustainable.”

Ophthalmology Opportunities

COLORADO

- Established Ridgway, CO integrative medical clinic seeks doctors/practitioners to compliment our coalition of independent professionals offering comprehensive, personalized, holistic healthcare. Stellar reputation, spectacular setting, superb quality of life—973-626-9877.

CONNECTICUT

- Excellent opportunity available for Spring/Summer 2011 for the BC/BE fellowship trained glaucoma specialist with leadership qualities. Well established, successful ophthalmology practice with multiple offices and optical departments. Retiring partner in seven-person group with very active surgical and medical practice with a large proportion of glaucoma patients. Partnership track with excellent income potential. New state-of-the-art facilities and equipment. Associated with ASC and Hospital. The best that New England has to offer for lifestyle PLUS less than 2 hours from NYC or Boston. Please email CV to dls2003stephens@yahoo.com.

KENTUCKY

- Excellent opportunity to join a solo ophthalmologist desiring to slow down. Opportunity for partnership after one year. Competitive salary and benefit package. Brand new office equipment. New office building. Associate with optometrist. New hospital with state-of-the-art outpatient surgery. Call Dr. Kay Hazelett 606-424-8721.

FLORIDA

- Multi-specialty practice in South Florida looking for a full-time cornea/general surgeon. Well-established practice with multiple locations in Dade and Broward Counties with top-notch equipment and staff. Competitive 401K plan with employer match and healthcare benefits. South Florida offers a high quality of living with ample recreational activities and great weather. Interested individuals should fax a CV and cover letter to 305-442-1498 or email to eyesecdoc@gmail.com.

NEVADA

- Established otolaryngology/ophthalmology practice seeking BC/BE ophthalmologist to compliment group. The practice has three state-of-the-art offices in Henderson and Southwest Las Vegas Valley. All offices are located in community-oriented, high profile areas with one of the offices adjacent to the Seven Hills Surgery Center, and the new Southwest office located next to the new Southern Hills Hospital. Practice partnership and ASC opportunities available. Contact Judy Duncan at jduncan@nvayepa.com or 702-492-6928.

OHIO

- Excellent anterior segment/glaucoma surgeon needed for group practice in Maumee, OH. Practice in a new state-of-the-art facility and ambulatory surgery center with all amenities. Salary plus incentive with buy-in after two years. Send CV to Ronald M. Kendrick, DO, 3509 Briarfield Blvd., Maumee, OH 43537. Phone 1-800-782-9214, FAX 419-865-3451.

WEST VIRGINIA

- Glaucoma specialist wanted. Join a team of two ophthalmologists and one optometrist bringing high quality care to southern West Virginia. Best equipment available. Starting salary up to \$250,000.00. Shape your own practice, but surgical opportunities are limited only by your skills. Contact mkrasnow@marshall.edu or call Bettie Chapman at 304-697-0393.

WASHINGTON

- OPH wanted in beautiful Washington state. Opportunity for someone interested in aggressively expanding a practice, or someone interested in working half-time and sharing the practice. A new DO medical school is being built in Yakima. There is opportunity for any level of participation. Hospital-owned ASC with all new equipment. Call Dr. Leo Figgs at 509-952-8545.

Ophthalmology Fellowship MARYLAND

- NRI fellowship program at the National Retina Institute offering hands-on opportunities to hone diagnostic and surgical

skills as a vitreoretinal specialist with a large patient base in the Baltimore-Washington-Virginia area. Contact Ruth Zeller via rzeller@bmgmri.com or call 443-921-4154.

OHIO

- Refractive fellowship position available, LASIK Plus, Cincinnati, OH. Contact Vincent Marino, DO at 513-652-9585 or email marino@fuse.net.

NEW LOCATION

- University Eye Surgeons has moved: 5187 US Rt. 60, Suite 6, Huntington, WV 25705—304-691-8800. Have 10,000 sq. ft. including two surgery suites, 11 exam lanes and the most up-to-date technology. The staff includes three ophthalmologists and one optometrist. Dr. Parveen Nagra is subspecialty trained in cornea, and Dr. Krasnow is fellowship trained in glaucoma. University Eye Surgeons is a division of Marshall University School of Medicine. Students are welcome to rotate in this facility.

Otolaryngology Opportunities

ALASKA

- ENT wanted. Kenai Peninsula, SW of Anchorage. Excellent salary and benefits. Call or email: James Zirul, DO, 220 Spur View Drive, Kenai, AK 99611 at 907-283-5400 or email jzirul@acsalaska.net.

ARIZONA

- 320 days of sunshine per year! Become part of a busy, expanding otolaryngology/head and neck/facial plastic surgery practice with full audiology services in the metropolitan Phoenix area. Seeking a BC/BE associate with early partnership opportunity to join our successful team. Competitive salary and benefits. Attractive lifestyle. Please contact Dr. David Mendelson at 480-894-5550 or fax CV to 480-894-9469 or send email to info@entsoa.com.

CALIFORNIA

- Santa Barbara, CA—Unique opportunity in private practice for well-trained BE/BC physician in general otolaryngology or subspecialty in this premier coastal community, north of Los Angeles. Office is fully equipped. Includes audiology, sounds booths and HAD department. Adjacent to Outpatient Surgi-Center and area's major hospital. For more information contact: Joseph Di Bartolomeo, MD, 2420 Castillo Street, Santa Barbara, CA, (805) 563-1111, fax (805) 563-2277, email: earfdn@aol.com.

COLORADO

- Dr. Patrick Henderson is looking for an otolaryngologist to join established practice in beautiful Montrose, CO. Small and growing community at the base of San Juan Mountain Range. Within one hour drive of Telluride Ski Resort, hiking, trophy fishing, mountain biking, and camping facilities. Town of Montrose is in the top ten growing communities in the nation with abundant sunshine for the outdoor enthusiast. Call office at 970-249-6968 or email coentpc@frontier.net.

- Established Ridgway, CO integrative medical clinic seeks doctors/practitioners to compliment our coalition of independent professionals offering comprehensive, personalized, holistic healthcare. Stellar reputation, spectacular setting, superb quality of life—973-626-9877.

FLORIDA

- Central Florida otolaryngology group is recruiting BC/BE otolaryngologist to join rapidly expanding practice. Two clinic sites, Leesburg and The Villages, and our main OR site has accreditation from AAAASF. We have four BC ENT physicians, one of which is BC in facial plastic & reconstructive surgery. We have an allergy department, complete audiology services with two doctors of audiology and a BC hearing aid specialist on staff, plus electronic medical records. We offer good schools with a suburban lifestyle in beautiful Lake County. Excellent salary with partnership anticipated. Contact info: michelle.lakeent@earthlink.net or call 352-728-2404.

- ENT job opportunity located in Ocala, FL, one hour north of Orlando. Practice is looking

for BC/BE general ENT/facial plastic surgeon to join group of three general ENTs. Contact Dr. Scott Nadenik at cellular 352-274-1570.

- Sunshine, beaches, boating, and a GREAT opportunity. Busy solo ENT looking for a BC/BE ENT to join state-of-the-art practice. EMR, CT scanner, audiology/sound booths and fully-equipped Med-Spa already established. Fast track partnership available. Competitive salary + bonuses + benefits package. New graduates welcomed. Please send CV to toddparnes@gmail.com.

GEORGIA

- General ENT needed in Atlanta. Immediate opening or 2010 position. Private practice in two-person group. Full benefit package. ER call 1:5 weeks. Fax resume to Hailey McIntyre at 678-838-7454.

MASSACHUSETTS

- Work in the heart of beautiful New England. Extremely busy practice in north central Massachusetts seeking associate. Currently one physician doing all aspects of general ENT. Shared call with three others. Community hospitals. This is an excellent opportunity in proximity to mountains, beaches, and Boston. Contact Dr. Daniel Ervin at (978) 874-7368.

MICHIGAN

- Northwest Michigan practice opportunity. A busy two-physician practice seeking BC/BE ENT to join practice affiliated with two community-based hospitals. For further information, contact Andrew Mendians, DO at 231-843-6557 or mendians@voyager.net.
- Wanted: ENT associate to join busy two-office practice with 1:6 call. Unique opportunity for new graduate to work into a busy practice with fast track to partnership. In mid-Michigan with easy access to northern Michigan outdoor activities. Contact R. Borenitsch, DO at rborenitsch@hotmail.com.
- Detroit Medical Center is looking for a general otolaryngologist. Large referral base, major urban academic medical center, new residency program for support. If interested, please contact Dr. David N. Madgy at 313-745-5402.
- Wanted ENT associate to join busy 2 man practice in the Warren and Mount Clemens area. Residency program for support. If interested, please contact Dr. Michael Shrbirn or secretary Angie at 856-463-5831.

OHIO

- Seeking an otolaryngologist for position/ownership in an established practice located in Troy, OH. The practice has a well-established facial plastics base. The practice has been in this location 20+ years. If interested, please contact Deborah or Georgia at 937-335-7278 or fax to 937-335-1783.
- ENT BC/BE needed in Newark, OH thirty minutes east of Columbus. Need an additional solo practice physician, 167 hospital undergoing continual upgrading. Additional information can be obtained by calling Michael Ehler at 740-788-6010.
- Fabulous opportunity. 36-year-old otolaryngology practice in Stark County, OH offering excellent salary benefit. Office fully equipped for allergy and audiology. If interested, please contact Dr. George Vogelgesang at 330-837-3559 or email drgwv@hotmail.com.
- Excellent opportunity to become part of a thriving ENT practice in Cincinnati. Seeking BC/BE associate to join busy practice. Exceptional earning potential and early partnership opportunity. Large referral base. Two base offices with two satellites. Office fully equipped and two full-time audiologists on staff. Contact Beth Sears at 513-891-8700 or email bsears@montgomeryent.com.
- Excellent opportunity in the friendly Midwest for a BC/BE otolaryngologist. Immediate opportunity for a well-established, thriving two-physician MD/DO practice. Full scope of general ENT and hearing aid dispensing. Extraordinary benefits package, highly competitive salary, early partnership opportunity, ASC ownership available, income is unlimited. Email CV to Karen Brown at Karen.brown@khnw.net or call 800-891-0102. Or contact Gordon Katz, DO at 937-416-1806.

OKLAHOMA

- ENT attending physicians needed. Sign on bonus, salary income guarantee, one hospital coverage, working with Oklahoma State University Medical Center residents. Please call for details: Dr. Sammy Worrall at 918-527-4673; Dr. Minda Bull at 918-361-4877; Dr. Richard Huffaker at 918-408-5194.

PENNSYLVANIA

- Suburban Philadelphia. Four-physician otolaryngology practice looking for highly motivated ENT. Practice includes all phases of otolaryngology, head and neck surgery, otology and allergy. Competitive salary, bonus and benefits, partnership track. Contact Benjamin Chack, DO at 215-280-6993.

- Premier Southeastern PA private practice of 4 physicians and 2 PAs seeking BC/BE otolaryngologist starting in 2010. Attractive salary and benefits package, early partnership opportunity and generous loan repayment offered. Comprehensive range of ENT-head and neck surgical services, separate allergy suite, 4 office locations, speech therapy, specialty audiologic testing and hearing aid dispensing distinguish our practice in the community. Please direct your letter of interest and CV to: practice.mgr@earthlink.net.

WASHINGTON

- Practice opportunity in the beautiful Northwest. Seeking associate in general ENT and proficiency/interest in FPS, otology and allergy desirable. New osteopathic medical school opened in fall 2008 with op. for ENT academic position in addition to private practice. Merged two separate ENT groups in 2008 to form a single group in that serves 300K regional patient draw with a current ENT manpower shortage. Strong and respected DO community, two hospitals and two ASCs. Contact: Palmer Wright, DO, 3999 Englewood Ave. #201, Yakima, WA 98902 at 509-453-5300 or email palmer@yvn.com.

NEED MEDICAL DIRECTOR

- Specialty medical clinic in Southlake (Trophy Club), TX is seeking a compassionate board certified otolaryngologist to serve as the clinic's medical director. This is an excellent opportunity to practice and represent an innovative vision of patient advocacy in one of Texas' premier communities. The position offers competitive salary plus performance incentive, \$300,000+ annual income potential, no call, no weekends, full benefits package, excellent hours to ensure quality of life for you and your family, specialty care practice, focus on patient care, state-of-the-art equipment and facility, verifiable need. Interested candidates should call Steve Orlando at 512-351-4747 or send your CV via fax to 512-338-0083 or via email to steve@neurosensorycenters.com.

Otolaryngology Fellowships FLORIDA

- One-year clinical fellowship in otology-neuro-otology starting July 1, 2011 at the Ear Research Foundation/Silverstein Institute, Sarasota, FL. Hands-on surgery, research and patient care including chronic ear cases and surgeries, otosclerosis surgery, Meniere's disease, minimally invasive surgery, cochlear implants, implantable hearing devices, and acoustic tumors. Large temporal bone lab and medical library. Contact Herbert Silverstein, MD at jmoss@earsinus.com.

MICHIGAN

- Training program in otolaryngic allergy as a one-year continuous, or two-to-three-year interrupted, program at St. John Oakland Hospital in Madison Heights, MI under the direction of Donald M. Rothen, DO. This program became effective July 1, 2001 and is approved by the AOA for three positions. To be eligible, the candidate must be certified in otolaryngology. For further information, please contact Dr. Rothen at 248-541-0100 or email rochenph@hotmail.com.
- Pediatric otolaryngology fellowship available July 2008 at Children's Hospital of Michigan in Detroit, MI. Please contact Dr. Michael Hauptert or Dr. David Madgy at 313-745-5402.