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"Dr. Keller Goes to Washington"

Michael B. Keller, MD, President

As part of our never-ending mission to heal the sick, Kathy Lindquist-Kleissler, Denver Medical Society's Executive Director, and I ventured to Washington D.C. in early March to attend the American Medical Association's National Advocacy Conference. In this case, the sick patient is our Federal Government, whose symptoms include, among many, a seemingly complete inability to fix a healthcare system spiraling into inevitable implosion.

Now normally, we only have patient care privileges here in Denver, but on this occasion, we were asked by the AMA, along with our colleagues from the Colorado Medical Society and other Colorado component medical societies to consult on two specific problems.

First, we were asked to urge Congress to pass a permanent legislative solution to the Sustainable Growth Rate (SGR) formula used to determine physician payment rates for Medicare. As a reminder, the SGR is the economic formula adopted in 1997 which, in a highly complex (and tragically flawed) fashion, ties physician payments for Medicare to economic growth. For practically the past 10 years, the SGR formula has threatened annually to decrease physician payments and Congress has adopted short-term fixes to avoid this problem. Not unexpectedly, these short-term fixes haven't solved anything. In fact, they've added a few hundred billion dollars to the problem and continue to put our nation's most vulnerable patients at risk of not having physicians who can afford to care for them. Ironically, on the day we arrived in Washington, March 1st, the SGR adjustment was set to go into effect, resulting in a staggering 21% decrease in physician payments.

Brendan Devine, Legislative Director for Rep. Diana DeGette, and Michael Keller, DMS President

Second, but probably not less significant, the AMA asked us to lobby on behalf of healthcare reform, touting some of the adopted principles of the AMA and attempting to cure (or at least discharge into rehabilitation) the "trainwreck" that is the U.S. healthcare system. Now, I could go into some detail on these signs and symptoms, but suffice to say that it would be much easier to list those organ systems still working rather than those that are in some degree of failure.

As often happens in these consults, when we arrived, we found the patient to be much sicker than anticipated. With this being an election year, fiercely partisan politics, political and media grandstanding, and legislative delay tactics seemed to be more important than genuine problem-solving. Indeed, "catatonic" may have been an adequate description of our patient since Congress seemed ill-prepared to forcefully move on any type of permanent fix to the SGR much less comprehensive healthcare reform.

Fortunately, on March 1, the Center for Medicare and Medicaid Services acted to delay the payment reduction by 10 days in order to give Congress more time to act (because 10 years wasn't quite long enough.) This acted sort of like a shot of Decadron to keep the

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patient from dwindling for a few days. At this point, the Senate was prepared, once again, to delay the SGR payment reduction for 30 more days, but Senator Jim Bunning (R-KY) objected, which halted the whole process. Seemed he wanted a way to pay for this budgetary allowance (shouldn't he understand how Washington works after all this time?)

Anyway, despite this setback, our Colorado contingent continued to diligently care for the patient, now intubated and sedated but at least with a pain response. We visited the offices of our two senators, Mark Udall and Michael Bennett, and of congresswoman Diana Degette, all of whom agreed that the SGR needed a permanent fix but weren't exactly sure how or when it would happen. We even stopped off at Senator Bunning's office to express Colorado physicians' displeasure and received a quick scowl from the receptionist (now that's democracy!). Ultimately, Senator Bunning was placated by his colleagues and the measure passed. Fittingly, the SGR was set to go into effect again on April Fool's Day, but the Senate has subsequently passed a resolution deferring this until October 1, 2010.

Jacob Swanton, Legislative Assistant to Sen. Mark Udall, and Dr. Keller

So, our working diagnosis regarding the SGR issue: Hearing loss, severe and paralysis. How else can you explain the ignoring of 10 years of physician and patient pleas to fix a system that threatens to leave our seniors and sickest patients without a system to care for them? I would express some optimism for a more permanent solution around the October deadline, but it is time for mid-term elections and our legislators may have other priorities.

We did also attempt to address comprehensive healthcare reform ("Oh by the way, Senators, our current system of healthcare, which is the largest part of our economy, is unsustainable.") Suffice to say that partisan politics seems to be getting in the way of meaningful reform here. The Senate doesn't trust the House. The House doesn't trust the Senate and neither party wants to play nicely with one another. Meanwhile, costs of care continue to spiral out of control, access is dismal especially as the economy and jobs suffer and our healthcare quality parameters remind us that, for this kind of money, we ought to be getting a better product. On this point, we tried to reiterate that, when a disaster is coming, doing nothing isn't a very good option and for us, would violate our Hippocratic Oath. I'm not sure what oath our legislators have taken.

So our second working diagnosis for the sick patient: multi-organ, multi-system failure which may ultimately require a brain transplant or at least an extensive lobotomy to successfully treat.

Now, don't think that we went at this herculean effort alone. The AMA called in its own set of specialists: Political author and columnist Stuart Rothenberg, U.S. Surgeon General Regina Benjamin, M.D., Secretary of Health and Human Services Kathleen Sebelius, nationally syndicated columnist Kathleen Parker and a host of other Washington pundits were there to help consult on the patient. Unfortunately, although thoroughly entertaining, their consult notes proved to reinforce what we saw play out in the halls of Congress. (I understand that the patient assessment is multi-organ failure, it was your plan that I was interested in.) When we asked for tips and suggestions, not much advice was offered.

Anyway, since the patient was stable, we did periodically take in some cool museums and funky restaurants. Washington's still a fun town, but like any good doctors, our thoughts often turned to our terribly ill patient. We left business cards, documents and articles for our legislators which supported our positions regarding systemwide reform. But before we returned to beautiful Colorado, and feeling that those efforts probably wouldn't be enough, we visited Capitol Hill one last time and did the least that we could for our bloated and dysfunctional patient: we ordered daily Fleets enemas and a psych consult. Results are pending.

***Denver Medical Bulletin**: Michael B. Keller, MD, DMS President and Publisher / Randall M. Clark, MD, Chair of the Board / Naomi M. Fieman, MD, President Elect / Lucy W. Loomis, MD, Treasurer / Kathy Lindquist-Kleissler, Executive Director / Barbara Kamerling, Program Director. The **Bulletin** is the official publication of the Denver Medical Society, established April 11, 1871, as the first medical society in the Rocky Mountain West. Published articles represent the opinions of the authors and do not necessarily represent the official policy of the Denver Medical Society. All correspondence concerning editorial content, news items, advertising and subscriptions should be sent to: The Editor, **Denver Medical Bulletin**, 1850 Williams Street, Denver, CO 80218. Phone (303) 377-1850. Fax (303) 331-9839. Web www.denvermedsociety.org. Email: dms@denvermedsociety.org. Postmaster: Send address changes to 1850 Williams Street.*

Denver Medical Society Young Physicians

Mark Your Calendars!

Thursday, May 13, 2010 **Maggiano's - 500 16th Street, Denver**

"Getting by with a Little Help from Your Friends"

facilitated by

Michael B. Keller, MD, and Aaron Burrows, MD
(by Young Physicians for Young Physicians)

Join with your Young Physician Colleagues as we navigate the crazy world of healthcare. Bring a problem or issue that you are facing in your own practice. Share your experiences and gain from others. The idea is to facilitate give and take as well as problem solve.

You are welcome to bring a guest.

6:00 PM Cocktails and hors d'oeuvres; 7:00 PM Dinner begins; 7:30 PM Program starts

Wednesday, September 22, 2010 **– location to be determined**

"Marketing and Growing Your Practice – Part II"

presented by

Marcia Brauchler, MPH

You were so impressed by Marcia's first presentation that you asked that she come back in a year to see whether you have implemented a marketing strategy and how well it has worked for you. Well, the year will be up in September, and she's wants to know how well you are doing. Of course if you haven't gotten around to it, it's not too late. To obtain the most current insights, Marcia will be informally surveying some of the practices she works with to see what has worked for them. Remember, the name of the game is success!

Programs generously sponsored by THE DOCTORS COMPANY

Frequently Asked Questions about Health System Reform Legislation (H.R. 3590)

American Medical Association, March 19, 2010

This summary, from the AMA, was prepared prior to final passage of the Patient Protection and Affordable Care Act and the companion reconciliation bill. In coming months DMS will provide ongoing updates as more is clarified and understood about the impact of this legislation.

Does the legislation fulfill the AMA's essential elements for health system reform?

Five of the seven American Medical Association (AMA) essential elements for health system reform are substantially achieved in the legislation. Health insurance coverage is significantly expanded; pre-existing condition limitations are removed and other health insurance market reforms are implemented; the patient-physician relationship is protected; investments and incentives are provided for quality improvement, prevention and wellness initiatives; and insurance claims processing is streamlined and standardized to eliminate unnecessary costs and administrative burdens. The Administration and congressional leaders remain committed to permanent repeal of the Medicare Sustainable Growth Rate (SGR) formula. In addition, the Administration already has initiated a medical liability reform alternative grant program.

Will the legislation truly expand health insurance coverage to the uninsured?

According to the Congressional Budget Office (CBO), the legislation expands coverage to an additional 32 million persons by 2019, a 59% reduction in the number of uninsured. Independent estimates from RAND and The Lewin Group also forecast a similarly sized reduction. Expanding Medicaid eligibility to all individuals under age 65 (including childless adults) up to 133% of the federal poverty level (FPL), and providing refundable and advanceable "premium" credits to individuals and families up to 400% of FPL ($88,200 per year for a family of four) for the purchase of private health insurance are the two key factors that allow for this expansion. CBO estimates that employer-provided coverage will decrease by only 4 million, or 2%. RAND's estimate for employer-provided coverage is a 6 million increase. The legislation also would provide dependent coverage for children up to age 26 under all individual and group policies. Long-standing AMA policy supports providing low-income individuals and families with refundable and advanceable tax credits for the purchase of health insurance, creating national standards of uniform Medicaid eligibility for all persons below the poverty level, and extending coverage for dependent adult children on their family policies.

Will Medicaid expansion place further financial burden on the states and on physician practices?

Many state governments are struggling to balance their budgets due to the lingering effects of the recession. However, the legislation provides 100% federal funding for the expansion of Medicaid coverage to all individuals under age 65 with incomes up to 133% of FPL from 2014 to 2016, 95% in 2017, 94% in 2018, 93% in 2019, and 90% thereafter. The AMA has long supported the creation of national standards of uniform eligibility for all persons below the poverty level. CBO projects that 16 million currently uninsured Americans will become covered under Medicaid and the Children's Health Insurance Program by 2019, as a result of the legislation. In addition, the legislation requires that Medicaid payment rates to primary care physicians providing primary care services be no less than 100% of Medicare payment rates for 2013 and 2014, and provides 100% federal funding for the incremental costs to states of meeting this requirement.

Will Americans be required to have health insurance under the legislation?

Americans who have affordable options for health care coverage but who choose to remain uninsured are required to pay a penalty to offset the cost of their health care. The penalty is a flat tax in the amount of $95 in 2014, $325 in 2015, and $695 in 2016, or as an alternative, as a percent of income in the amount of 1% in 2014, 2% in 2015, and 2.5% for 2016. After 2016, the penalty will increase annually by the cost-of-living adjustment. As previously noted, affordability is addressed by providing tax credits for the purchase of health insurance for individuals and families earning up to 400% of FPL. There are important exemptions to the "individual responsibility" requirement for dependents, non-citizens and those who express objections on religious grounds. These provisions are consistent with longstanding AMA policy on the issue of greater individual responsibility. The AMA supports a requirement that individuals and families earning more than 500% of FPL ($110,250 per year for a family of four) obtain coverage for catastrophic health care and evidence-based preventive health care, using the tax structure to achieve compliance. The AMA supports a similar requirement for those earning less than 500% of FPL, upon enactment of premium subsidies such as those in the legislation, that make coverage affordable at lower income levels.

How does the legislation help those who are uninsured and have been unable to obtain health insurance coverage because of their health or because of affordability?

The legislation contains key provisions to ensure that people who have had trouble getting health insurance coverage in the past—either by being priced out of the market or because they are "uninsurable" at any price—have more health insurance options. Consistent with AMA policy opposing pre-existing condition exclusions, and supporting modified community rating and guaranteed issue in the context of an individual mandate, insurance companies will no longer be able to deny coverage based on pre-existing conditions, and premiums will no longer be allowed to be based on gender and health status. The affordability of health insurance coverage is addressed in a manner that is consistent with AMA policy: Individuals and families with incomes up to 400% of FPL would be eligible for assistance in the form of refundable, advanceable, and sliding-scale premium credits, as well as

cost-sharing subsidies.

How does the legislation help insured Americans keep their health insurance coverage?
The health insurance coverage of individuals and families who are already insured will also be protected. Insurers will no longer be able to drop coverage if policyholders actually get sick, and once insured, individuals and families will be guaranteed renewal of their health insurance policies, which is consistent with AMA policies supporting guaranteed renewability and ending the arbitrary rescission of health insurance policies.

Will health insurance premiums rise due to the legislation?
Health insurance premiums will not rise for most people. CBO predicts that premiums in the large group market (nearly 70% of the non-elderly covered population) would fall 0 to 3% in 2019 compared to current law. Premiums in the small group market (13% of those with insurance coverage) may fall—CBO predicts a change from -2% to + 1% compared to current law. Only premiums in the nongroup market (17% of those with insurance coverage) are expected to rise compared to current law. CBO predicts that premiums in the nongroup market will increase 10 to 13%. It should be noted, however, that while premiums will likely rise modestly in the nongroup market, those purchasing such policies will be gaining richer benefits. CBO also has indicated that 57% of the nongroup enrollees will likely receive a subsidy that would make their actual contribution 56 to 59% lower than what they would pay under current law.

Does the legislation expand the role of government into the practice of medicine with respect to implementing payment changes, determining quality and dictating standards of care?
Physicians will continue to exercise considerable control over the practice of medicine and the care that they provide to their patients. Nonetheless, several provisions in the legislation remain troubling, such as value index adjustments to individual physician payments based on cost and quality outcomes, potential penalties on physicians who do not successfully participate in the Physician Quality Reporting Initiative (PQRI), and public reporting of physician claims data to develop performance reports. The legislation contains some safeguards related to these provisions and the AMA will work aggressively for additional safeguards in subsequent correction bills. PQRI penalties for physicians that do not meet reporting criteria, and the value index adjustments to individual physician payment are not scheduled to be implemented until 2015. The legislation also calls for improving payment accuracy by identifying and addressing misvaluations within the Medicare physician payment schedule. The language clearly allows the Secretary of Health and Human Services (HHS) to rely on existing processes to address coding revisions and relative valuation of physician services, leaving the CPT Editorial Panel and the AMA/Specialty Society RVS Update Committee (RUC) in place to represent organized medicine. Representatives of the Centers for Medicare and Medicaid Services have stated clearly that the agency has no intention of creating a separate committee or review panel.

What is the impact of creating an Independent Payment Advisory Board (IPAB)?
The legislation will establish a target for overall Medicare spending growth and an Independent Payment Advisory Board (IPAB) that would develop proposals to cut Medicare spending if the target rate of growth is exceeded. The Secretary of HHS will be required to implement the IPAB's proposals unless the statutory process is overridden by new legislation. CBO projects that IPAB cuts would total $13 billion over 10 years. The AMA strongly opposes any provisions that would empower an independent commission to mandate payment cuts for physicians, who are already subject to an expenditure target, and any other payment reductions under the Medicare physician payment system. The Administration and congressional leaders have reaffirmed their commitment to address AMA issues of "double jeopardy," projection errors and appropriate spending increases (e.g., H1N1) in subsequent correction bills.

Does the legislation ban physician-owned hospitals?
The legislation would ban new physician-owned hospitals and restrict existing facilities, unless they were the primary provider of Medicaid services. The AMA strenuously opposed this provision in the legislation and repeatedly advocated that physician-owned hospitals have achieved the highest quality scores in some markets and have been shown to provide more net community benefits through uncompensated care and taxes than not-for-profit competitors as a share of total revenues.

Does the legislation include proven medical liability reforms?
The legislation establishes a competitive grant program for states to develop, implement and evaluate innovative medical malpractice reforms. This is in addition to the $25 million medical liability reform alternative grant program that the Administration initiated in September 2009, which is being implemented by the Agency for Healthcare Research and Quality (AHRQ). The AMA will continue to advocate for proven liability reforms at the federal level, such as a cap on noneconomic damages. The AMA worked aggressively to ensure that liability reform provisions were included in health system reform legislation, and the Administration's effort to stimulate innovation at the state level represents tremendous progress in an area where previous administrations have failed to propose even incremental changes.

Is antitrust relief for physicians included in the legislation?
Antitrust relief for physicians is not included in the legislation. Nonetheless, there appears to be growing recognition that antitrust relief is needed to enable physicians and other health care professionals to effectively negotiate with health plans without fear of violating antitrust laws. Physicians should be allowed to negotiate contract terms that increase patient choice and improve quality of care. Patients and their physicians should make informed decisions about their health care needs, not insurers. The AMA is advancing this objective through dialogue with the Federal Trade Commission and

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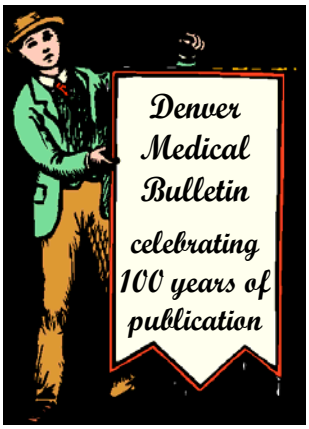

An excerpt from the
Denver Medical Bulletin
September 30, 1911

CULTURES IN SUSPICIOUS THROATS

It is the duty of the physician who suspects diphtheria to take a very thorough culture; the patient's throat should be exposed to a good light, head thrown backward, tongue depressed, and see that the swab comes in contact with all the surface of the throat and especially well down into the larynx; do not take a culture within a period of 2 hours after using any antiseptic gargle or spray. If the patient is suffering from a nasal discharge, then we should use another swab to take a culture of the nose. If the patient is under 10 years of age, I would advise the administration of at least 30,000 units of antitoxin before leaving the house, as it requires at least 12 hours to grow his culture before the bacteriologist is able to make his report. If the report should be negative, we have only caused the patient a small expense, and in the event it should prove to be positive, we have given him the assistance he so badly needs. In a number of instances, to my personal knowledge, the delay in the administration of antitoxin has been the cause of death. I have conversed with the attending physicians in these cases, and I receive almost always the same reply: "The family is too poor to buy the antitoxin." or "They would not permit the use of it." No one is too poor to be denied the use of antitoxin, and for the enlightenment of some of my fellow practitioners, I will inform them that the Cutter Laboratory of Berkeley, California will gladly furnish the antitoxin to all poor people free of cost, and their product can be obtained at the Cunningham pharmacy.

While in California during the month of July, I had the pleasure of visiting this laboratory, and took up the question of antitoxin for the poor people, and the vice president of the company assured me that they would be pleased to furnish antitoxin as heretofore stated.

If the attending physician suspects diphtheria and the parents refuse to have the antitoxin injected, it would be wiser to resign from the case than to permit the family to pass on your judgment in the matter.

If is for us to always bear in mind that antitoxin does not repair the damage which has already accrued, but if the case is not moribund, it will stop the disease where it finds it.

The common mistake in the administration of antitoxin is the injection of too small a dose, or giving one or two doses and expecting that to cure a severe case. When you write a prescription for almost any trouble you have your directions to read, "Every four hours" or "three times a day," etc. Why? Because you know that the action of this or that drug should be repeated in order to obtain the effect. Then repeat your antitoxin every 4, 8 or 12 hours as is necessary for the welfare of your patient. Large doses of antitoxin, and if necessary, frequently repeated, save the lives of our little patients, and we are in the life-saving business.

—F. R. COFFMAN

Health System Reform FAQs

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the Department of Justice to modify enforcement policies through regulatory processes.

How will the legislation benefit physicians and their practices?

The legislation contains a number of provisions that, in combination, clearly benefit physicians and their practices. Recent AMA estimates suggest that physicians provided $24 billion in charity care in 2008, much of it to their uninsured patients. The financial impact this has on physicians' practices is particularly acute when private and public payments are declining or flat, and physicians are less able to cover the cost of treating uninsured patients with revenue from insured patients. Expanded health insurance coverage to the uninsured, which the CBO has estimated will increase to 32 million more insured Americans by 2019, would help with the problem of uncompensated care. In addition, the time and cost burden of physicians' interactions with health plans remains large. Estimates from 2006 suggest that physicians spend three hours per week, their nursing staff spend 19 hours and their administrative staff spend 36 hours per week interacting with health plans. In total, the annual time cost of these activities is more than $68,000 per physician. Many of the administrative simplification provisions in the legislation would reduce these costs.

SPANISH FOR THE MEDICAL PROFESSION

Two Scholarships Left!

Friday, May 21—Monday, May 24, 2010

Denver Medical Society, 1850 Williams Street, Denver

The Denver Medical Society is offering a four-day intensive, total-immersion learning experience in conversational and medical Spanish for physicians, nurses, PAs, NPs and other medical staff. This is the fourteenth offering of this highly popular class conducted by Rios Associates, although the first to cover four days.

It's longer! It offers a ton of CMEs! But you have to plan now.

The cost of the class is $499 for DMS members, $599 for non-members, including text book, a corresponding set of 10 CDs and 43 CME credits through ACEP, AAFP or AANP or 43 CMEs through the AMA! To register, complete the coupon below and include payment. All payments will be held until 15 people have registered. If we are unable to enroll 15 participants, all checks will be returned and credit card information will be destroyed. No cancellations after April 30, 2010. Call 303-377-1850 or email dms@denvermedsociety.org for additional information.

******COPIC is offering a limited number of $250 scholarships for COPIC/DMS members who have not participated in this offer previously, on a first come-first served basis. Don't delay.***

Enroll me in *Spanish for the Medical Profession* course offered May 21-May 24, 2010.

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