Dr. Sam Unterricht & Dr. Donald Moore are among physicians worried they'll be "left holding the bag" by Obama's health plan - New York doctors are feeling queasy about ObamaCare — and many won't participate in the new national insurance program because they fear they'll go broke, The Post has learned. "ObamaCare is going to send me more patients to see and then cut the payments to provide the care — that's what's going to happen,” predicted Donald Moore, a primary-care doctor in Prospect Heights, Brooklyn. “I will not accept it.” Moore claims that President Obama made a big mistake by requiring uninsured residents to obtain medical coverage from for-profit insurers through the ObamaCare health exchanges instead of through public health programs like Medicaid. Under tremendous pressure to keep costs down and profits up, Moore said he’s concerned that commercial insurers will pay doctors less for patient visits and services than either Medicaid or Medicare. Many doctors, he argues, won’t be able to cover their costs with such skimpy fees. Mr. Moore scoffed, “Who’s going to sustain the losses? The insurance companies? It’s basically going to be a race to the bottom.” Despite a much publicized rollout, many other doctors said they haven't decided whether to become ObamaCare providers, because they haven't been notified by insurers or the state about reimbursement rates. “I have not spoken with anyone who has made a decision to participate in the exchanges. We simply don’t have any information about which we can make a decision,” said Dr. Paul Orloff, president of the New York County Medical Society. “We have no idea what the reimbursements will be or what the claims-form process will entail.” The Medical Society of New York State is conducting a survey of doctor concerns about the program and asking whether they will accept patients who buy policies. “There’s a real question about how many doctors will participate. Doctors are concerned about being left holding the bag,” said Sam Unterricht, an ophthalmologist and the president of the state medical society. The clumsy launch of ObamaCare in New York and elsewhere — with computer glitches and sketchy information — worries the medical community, he said. “It’s really shaky right now,” Unterricht said.

Spooked about the payments they'll receive under ObamaCare, other doctors said they've stopped hiring staff for their medical practices. “I’m apprehensive. I’m certainly not hiring anyone new,” said James Reilly, an obstetrician who has delivered 4,000 babies and heads the Richmond County Medical Society. We want to see the impact on the bottom line,” said Reilly, who has a 12-member staff and pays a hefty $200,000 annual medical-malpractice insurance premium. A spokesman for Emblem Health said a payment plan is in place for medical providers who are part of its ObamaCare plans. The state Health Department says more than 100,000 individuals have completed applications on the health-exchange Web site, healthbenefitexchange.ny.gov, and were deemed eligible for the new medical plans. The enrollment period for individuals in New York runs through March 31, and coverage begins as early as Jan. 1. Each insurer in the exchange offers different levels of coverage and deductibles — Platinum, Gold, Silver and Bronze
ObamaCare is making seniors sick

Elderly New Yorkers are in a panic after getting notices that insurance companies are booting their doctors from the Medicare Advantage program as a result of the shifting medical landscape under ObamaCare. That leaves patients with unenviable choices: keep the same insurance plan and find another doctor, pay out of pocket or look for another plan where their physician is a member.

New York State Medical Society President Sam Unterricht is demanding a congressional probe after learning that one health carrier alone, UnitedHealthcare, is terminating contracts with up to 2,100 doctors serving 8,000 Medicare Advantage patients in the New York metro region.

The are 2.6 million elderly New Yorkers who receive Medicare, the public heath-insurance program for the elderly. But one in three patients — nearly 900,000 — are enrolled in Advantage, Medicare HMOs run by private insurers.

Dr. Jonathan Leibowitz, who serves 30 patients under Medicare Advantage at his Brooklyn practice, said he was blindsided by UnitedHealthcare’s decision to give him the boot.

“A patient can’t see his doctor? What are they doing!” he asked.

UnitedHealthcare told Leibowitz that because of “significant changes and pressures in the health-care environment,” he’d be getting the ax on Jan. 1. Leibowitz’s patients are furious. Alfred Gargiulio, who has cerebral palsy with a seizure disorder, has been seeing Leibowitz since 1993. “Obama had said I could keep my doctor. Now they’re doing away with my doctor. They kicked him out! After 20 years, that’s not right. We love Dr. Leibowitz,” said Gargiulio.

Another patient, Wilma Streicher, 76, was equally baffled. “Of course I want to keep Dr. Leibowitz. I don’t see why they want to push him out,” she said.

Patients of other doctors faced the same dire situation. Lung-cancer patient Jeannette Campregon, 79, received a letter from EmblemHealth saying that her internist, George Ruggiero, was terminated from her VIP High Option Medicare Advantage network.

Emblem notified her she could stay in her current plan and choose another doctor, pick a different plan to keep her doctor or call a customer-service rep for help.

“I’m going absolutely nuts,” said Campregon, who got conflicting information from three different service reps. “I don’t want to change my doctor!”

Dr. Ruggiero said, “The people who lose out are the patients.” Federal funding to Medicare Advantage is being pared back by billions of dollars in coming years under the national Affordable Care Act. Obama said spending on the program was higher than regular Medicare and unsustainable.

UnitedHealthcare, in a statement, defended the doctor-roster cuts.

“The changes we are making will encourage higher-quality health-care coverage and help keep that coverage affordable for [patients],” said UHC spokeswoman Maria Gordon-Shydlo.

A spokesman for Emblem said the less than 1 percent of its physicians were being cut from Medicare Advantage.

An Empire Blue Cross-Blue Shield rep also said it booted “only 1 percent of doctors.”

“Those physicians were in certain specialties, including cardiology, ophthalmology and podiatry. This was done to ensure a more balanced network that would better contain cost for members,” said Empire spokeswoman Sally Kwskin.

An official with the state chapter of AARP said it’s monitoring the “horrible situation.”

AARP Associate Director Shaun Flynn said Medicare Advantage is a popular program but cautioned it’s privately run, and insurers — not patients — decide which doctors participate.

“It’s a case of buyer beware,” he said.
How to quickly "divorce" underperforming hires

Everyone knows that the average hiring process is less than perfect. In fact, most selection processes have high failure rates (i.e. even after months or even years of “assessment,” nearly 60 percent of the marriages in California end in divorce). So it shouldn’t be a surprise that as many as 46 percent of new hires fail within 18 months, according to Leadership IQ. Research also reveals that 61 percent of new hires are unhappy because they feel that they had been misled during the hiring process, according to Harris Interactive. The Recruiting Roundtable similarly reports that 50 percent of the hiring organizations or the new hires themselves regret the decisions they made. Shifting to non-exempt workers, research by Humetrics reveals that 50 percent of all hourly employees quit or are fired within their first six months. Given this high rate of mishires, it’s surprising that most corporations don’t even track mishires who must be terminated or encouraged to resign. Even fewer organizations have a formal “early release process,” like a no-fault divorce for identifying bad and frustrated hires and releasing them as soon as possible.

Why You Should Release Weak Hires and the Disgruntled as Soon as Possible

Some of the reasons why you should have a formal effort to release mishires include:

They are unlikely get better — one major network equipment company that thoroughly researched the issue determined that new hires who are still weak performers after six months on the job have an extremely small chance of ever getting better. If that rule holds for your corporation, it makes sense to cut your losses at the six-month point and move on.

They take up everyone’s time — weak hires may take up to 17 percent of the manager’s time that could be spent on employees who have a real chance for improving. They will also waste the resources of the training and performance management teams that will try in vain to get visa mishires up to speed.

Customers can tell — if these weak new hires have interactions with customers, their negative impacts after their first six months may equal or exceed their yearly salary.

They frustrate coworkers — coworkers can quickly get frustrated with having to constantly help new hires who never appear to “get it.” Keeping weak performers may also frustrate and drive your top performers into job search mode.

They delay the hiring of a quality replacement — keeping a weak performer eliminates the possibility of refilling the position with a top performer. In addition, if you put off the releasing of the weak new hire, you also delay the time until a replacement hire can be fully trained and at work meeting their minimum productivity levels.

They may “check out but never leave” — failing to release a weak hire may “doom” both the firm and the hiring manager to 10 to 20 years of weak performance. They unfortunately may stay “forever,” because their weak performance record will make it unlikely that they will ever be recruited away by another firm.

Approaches for the Quick Identification and Release of Weak New Hires

There are at least eight approaches that you should consider that facilitate the identification of weak new hires and their quick release. Those approaches include:

No-fault divorce after six months — Cisco once offered a “no-fault divorce” option that would still work today. Under the concept, managers could offer several months of pay and a good reference if their poor performers at the six-month point agreed to resign after being told there was an extremely low probability that they would succeed if they stayed on. If they refuse the offer and stay until their one-year evaluation and failed it, they would get no severance money and a bad reference. This gives them a powerful incentive to leave early. Incidentally, accepting the package means that they must sign away
their right to sue. Having the no-fault divorce as an option may also encourage wavering potential candidates to accept your companies’ offer, because they know up front that even if they fail in the job, they will have a palatable “out” available to them.

**Extended onboarding** — some firms use an extended onboarding process to better identify hiring mistakes. Facebook (six weeks) and Zappos (four weeks) use this intense onboarding process as a secondary assessment level. It has the advantage of giving much more time to accurately reveal not just her skills, but also their team and cultural fit.

**Pay them to leave after onboarding** — it may seem expensive to pay weak hires to leave. But if you calculate the damage that they can do, the idea turns out to have a high ROI. Zappos offers all new hires a $3,000 bonus to quit at the end of onboarding if they realize that this is not the job for them.

**Use initial training as a screening process** — if there is an extensive new hire training program, make it an “early mishire identification process.” HR must also learn how to statistically project the probability that the new hire will succeed/fail, based on their training scores. Those with a low likelihood of further improvement should be released immediately.

**Consider a more rigorous probation period** — almost all corporate “probation periods” are ineffective, because they are unstructured and they are supervised by managers who are naturally reluctant to fire someone who they just recently picked themselves. A more effective approach is to require managers to set periodic objective assessment points, with passing scores, and to report the subsequent rating of each new hire to HR. Human resources should also make managers aware of the low probability of success of a weak initial performer getting better and the economic costs of stretching out their release.

**Use a mentor** — some firms like Facebook provide every new hire with a mentor. That new hire mentor can be trained as an assessor, so that they can advise the new hire and the manager whenever they deem the new hire to be a lost cause.

**Allow the team to vote them out** — Whole Foods has a unique approach that allows team members to “vote” at the end of an assessment period on whether to make the new hire a permanent member of the team. Because there is a team-based performance reward, it makes sense to give team members a voice on whether to accept weak performers or “bad-fit” hires.

**Encourage the dissatisfied to leave quickly** — because 61 percent of new hires may be unhappy with their choice of a new job, it makes sense to take proactive action to encourage those who are dissatisfied (even if they are good performers) to quit even sooner than they would naturally. If you take the option of offering good performing new hires money to leave, you may be initially criticized but realize that you are also sending the message that the firm is “looking out for their interest.” and as a result, you may also create a long term “friend” of the company who may yield future business or referrals. The best way to identify dissatisfied new hires is to have an HR generalist or the recruiter who brought them in to assess whether their dissatisfaction will eventually impact their performance and teamwork.

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**LEADERSHIP**

*Think of others first*

This is the bedrock of becoming a leader people want to follow. Are you a serving leader or a self-serving leader? The people you lead know the difference. If it’s all about you, you’ll always struggle building follow ship. Rather than always seeking value from people, try adding value to people. We can all become leaders people want to follow. The journey begins in your heart.
The Plus Side of ICD-10
By Linda Smith, CPC, CPC-I, CEMC, CMSCS, CMBS

It’s a done deal; ICD-10 will be required on all claims with a date of service of October 1, 2014 and thereafter. Marilyn Tavenner, administrator of the Centers for Medicare & Medicaid Services (CMS) announced that there will be no delay to implementation for ICD-10. She has encouraged everyone in the industry to work diligently toward a successful transition. And as you are working diligently, keep in mind that there will be tremendous benefits to ICD-10.

• The added detail embedded with ICD-10 codes better inform health care providers of patient incidence and history, which improve the effectiveness of case management, care coordination and overall patient care.
• The breadth, granularity and specificity of codes will allow physicians to paint a clear picture, presenting a precise story of the patient’s health.
• Accurate coding will reduce the volume of payer-physician inquiries, delays in reimbursement and rejected claims due to ambiguity.
• Refined reimbursement models support equitable payment for more complex conditions.
• Updated terminology and disease classification will be consistent with current clinical practice and medical and technological advances.
• Increased flexibility for future updates to classify anatomic site, etiology and severity.
• More detailed data will help better analyze disease patterns and track and respond to public health outbreaks.

As a coding and billing trainer, I have had the opportunity to work with the new coding system for more than 2 years. Like many in my field, my first inclinations in making this very big change were that of frustration, apprehension and concern. It was hard to understand why we should have to go through this very large transition, with so much else going on in healthcare. But the reality of this positive side in using the new coding system set in as I began to learn about it. The more I explored the system, and started working with it, it became clearer and clearer as to how the transition to ICD-10 will incorporate the U.S., into a stronger international health care community that promotes improved patient outcomes, expanded research opportunities, lower health care costs and a healthier population overall. I am a believer in this new coding system and I can see the plus side to this transition. Will there be downsides to it also? Of course, but the long term benefits, will certainly outweigh the transitional pains. The transition will be a bump in the road if you plan accordingly and rely on your ancillary staff to facilitate the process. If you have certified coders on staff, they will require additional training, but 90% of what they need to know, they already know through their training and use of the ICD-9-CM coding system. As I work with coders and train them, they also see how this will impact them in a positive way. They now have codes for conditions that were never listed in ICD-9 due to the inability to expand the code set. They understand how the reporting of laterality will reduce the number of payer inquiries and rejections. And they are seeing that the new code system will allow them to report complexity in a way they weren’t able to previously. It’s time to embrace the new coding system and move forward. Embracing ICD-10 boils down to meticulous documentation and the solution is not to train physicians in ICD-10 coding but to show them the clinical documentation requirements that align with their specialty and are needed to be successful in transitioning to ICD-10.

Linda Smith is owner of MedOffice Resources and can be reached at lsmithmedoffice@aol.com

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For their Support & Sponsorship of our Legislative Healthcare Forum to be held on Friday, December 6, 2014
Medical Society of the State of New York

Just about half of New York State physicians surveyed said they are not accepting the insurance exchange plans under the Affordable Care Act, according to the Medical Society of the State of New York. In a survey of 409 physicians 44% said they are "not participating in any health insurance Exchange program" while 33% said they were "not sure". The survey did show a combined 21% are accepting at least one and up to more than five exchanges. Vice President of MSSNY, Morris Auster, said Wednesday the survey showed the confusion over the new law. "I think the issue is there are a lot of unknowns at this point," said Auster. Two big concerns physicians have with the new law are how they will be paid and how quickly they can provide care to their patients, Auster added. There is no clear answer as to how much money each insurance exchange would give to a doctor. "Doctors are like a small business, they rely on the money to keep the lights on to treat the patients," Auster said. Some insurance companies may also hold back authorization to a doctor, for longer periods of time, to allow certain treatments on a patient, Auster added. "So if a certain company is making that harder and harder that will make a physician less likely to want to participate with that company," said Auster. Dr. Mark Oldendorf of Oldendorf Medical Services says he understands where many physicians are coming from when they raise questions about the new law. "It is very unclear," Dr. Oldendorf said. "I have been trying for months to figure out which way we are going. Everyday has a little different twist on it".

A Heart-Healthy Diet: Should We Be Changing Our Recommendations?

Physicians and other healthcare professionals are invited to learn more about recent research findings on heart-healthy dietary guidance by visiting www.heart-healthynutrition.com. The site offers two newly released CME approved webinars approved for American Academy of Family Physicians prescribed credit. The credit may also be converted for use within the American Medical Association CME system through a reciprocal agreement between AAFP and AMA.

Based on research done at Pennsylvania State University and published in the American Journal of Clinical Nutrition, the BOLD Study (Beef in an Optimal Lean Diet) offers physicians new data and tools to utilize when working with patients following a heart-healthy diet and lifestyle. Improvements in dietary adherence as well as reduction of CVD risk factors when beef is included in a heart-healthy diet may be new concepts to many physicians. As a result, the presentations provide data and study results as well as practical information for patient education offering physician’s new tools to reduce CVD risk factors while helping patients achieve long-term dietary improvements. Viewers will find each hour-long webinar available at their convenience until February 2015. The web site offers slides plus video of the speaker, Dr. Michael Roussell. Extensive presentation notes and additional web-based resources for reference and further optional reading are also included. The application for CME credit is available on the web site; each participant will receive a certificate of participation. AAFP member’s participation will be reported to AAFP credit tracking.

Call for Nominations – anyone member wishing to serve as on the Comitia Minora (Board of Directors), please forward your name & contact information to the Office.

Bronx County Medical Society
Attention: Nominating Committee
3560 Netherland Avenue, Suite 2F
Bronx, NY 10463-1601
You can Fax: (718) 549-6681 or Email: bxcms@msn.com

Please do so prior to our January 21, 2014 Comitia Meeting – anyone wishing to run for Secretary & or Delegate, please forward a letter to the President stating your willingness to serve and the reason you would qualify for these position(s)
Women who follow good midlife diet linked to healthy aging

As a woman's metabolism slows with age, her body loses muscle and gains fat. A good midlife diet can help women stay healthy as they age, a new study finds.

NEW YORK - The way women eat in their late 50s and early 60s may have some connection to how well they age later on, according to a new study. Earlier studies examining the benefits of a healthy diet have typically focused on its link to specific diseases or death. The new report took a big-picture view of healthy aging in general.

Most health conditions develop slowly over many years. So it's important to look at people's disease risks over the course of their lives - not just in old age, Cecilia Samieri said. "Midlife exposures are thought to be a particularly relevant period," she told Reuters in an email. "For example, atherosclerosis in cardiac diseases (and) brain lesions in dementia, start in midlife."

Samieri is from the Research Center INSERM in Bordeaux, France. She worked on the study with researchers from Brigham and Women's Hospital and the Harvard School of Public Health in Boston. Their results were published in the Annals of Internal Medicine. The report included 10,670 women who were enrolled in the Nurses' Health Study, a large, long-term study that began in 1976. Women included in the new analysis were in their late 50s and early 60s and had no major chronic diseases in the mid-1980s. All participants filled out two diet questionnaires, one in 1984 and one in 1986. The researchers assigned women scores based on how closely their diets matched a general healthy eating index or a Mediterranean-style diet. Next, they followed the participants to see how well they aged through 2000, when women were in their 70s. The researchers defined "healthy aging" as having no major chronic diseases, physical impairment, mental health problems or trouble with thinking and memory. According to that definition, 1,171 women - or 11 percent - were healthy agers. The rest aged normally. General diet was measured on a scale from 0 (least healthy) to 110 (healthiest). Healthy agers had an average diet score of 53.2, compared to 50.6 among usual agers. The Mediterranean diet scale ranged from 0 to 9, with higher scores again reflecting healthier diets. Healthy agers scored an average of 4.5 on that scale, compared to 4.3 for usual agers. Compared with usual agers, healthy agers were also less likely to be obese or smoke and they exercised more in midlife. Fewer had high blood pressure and cholesterol.

Women with the highest diet scores were 34 percent to 46 percent more likely to have no chronic diseases or impairment in old age versus those with the worst diets, after other health-related factors were taken into account.

Still, the new study can't prove diet was responsible for healthy aging, researchers said. Although it included only women, Samieri said there is no reason to believe that similar associations shouldn't be observed among both genders. "We know that a balanced plant-based diet, one similar to the Mediterranean diet, the DASH diet, even MyPlate, can be heart healthy," Joan Salge Blake told Reuters. She is a spokeswoman for the Academy of Nutrition and Dietetics and was not involved in the new study. Heart disease is the No. 1 killer in America, and being overweight and obese can increase heart risks. "It's never too late to improve on your diet and lifestyle," Salge Blake said.

She suggested eating more whole grains, fruits and vegetables, low-fat dairy, meat and chicken and eating at least two servings of fatty fish per week.

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Hunger for wisdom:
Leaders are learners; no surprise here. There is a humility found in this trait. Leaders know they must keep learning and growing. Have you committed to a lifestyle of lifelong learning? What is your plan?

Accept responsibility:
The best leaders don't blame others. He or she is willing to accept the outcome and consequences of their actions and those we lead. Interestingly, leaders own negative outcomes and share, or even deflect, positive outcomes with others.

Respond with courage:
Courage is where intention moves into action. Virtually every decision a leader makes requires some level of courage — strategy decisions, calendar decisions, people decisions, expansions and budget decisions. Is there a decision you need to make today?
Please be mindful of two things -

1) Medicare patients are not eligible to purchase insurance through the NYS of Health Exchange.

2) If these disadvantaged Medicare patients do not select another Medicare Advantage plan during the open enrollment period (October through December 7, 2013), their coverage will default to traditional FFS Medicare. However, if they don't purchase a Medigap/Supplemental to Medicare plan and don't have retiree coverage through a former employer and don't purchase a Medicare Part D product for their prescription drugs, this population will have a great deal more out of pocket expenses to deal with in 2014.

Medicare Advantage Outreach and Education Bulletin

We want you to know about changes to our individual Medicare Advantage HMO and LPPO plan service areas. These changes will take effect Jan. 1, 2014. Some plan service areas will be eliminated or reduced. These service area changes do not impact your participation in the Medicare Advantage network.* Employer or union sponsored Medicare Advantage plan members are not affected by these changes. Empire Medicare Advantage member ID cards contain a CMS identifier in the lower right corner of the card. The number will be five characters (XXXXX) followed by three characters (XXX). The member is in an employer or union sponsored plan when the last three digits Start with an eight (8XX).

Empire will continue to offer Medicare Advantage HMO plans in Albany, Bronx, Kings, Nassau, New York, Putnam, Queens, Richmond, Rockland, Saratoga, Schenectady, Suffolk and Westchester counties. Empire will continue to offer Medicare Advantage LPPO plans in Albany, Bronx, Fulton, Kings, Nassau, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie and Suffolk counties. Specific plan changes by county are detailed below. We will no longer offer Empire MediBlue Select HMO plans in Dutchess, Nassau, Orange, Sullivan and Ulster counties. We will reduce the service area of Empire MediBlue Essential HMO plans in Albany, Dutchess, New York, Orange, Putnam, Schenectady and Sullivan counties.

We will reduce the service area of Empire MediBlue Freedom I LPPO plans in Columbia, Delaware, Greene, Montgomery, Warren and Washington counties. We will reduce the service area of Empire MediBlue Freedom II LPPO plans in Clinton, Columbia, Essex, Fulton, Montgomery, Rensselaer, Suffolk, Sullivan, Ulster, Warren and Washington counties. We will reduce the service area of Empire MediBlue Freedom III LPPO plans in Albany, Greene, King, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington counties.

As of Oct. 1, 2013, Empire will not market Medicare Supplement plans. Members that currently participate in one of Empire’s Medicare Supplemental plans will be able to retain their coverage.

Prior to Oct. 2, 2013, Medicare Advantage members affected by these changes will receive a letter from us that explains their Medicare coverage options. Members will continue to have coverage through their current plans until December 31, 2013. It’s important to note that members may have a different network of providers and/or different benefit structure when switching from previous plans.

We are working with Centers for Medicare & Medicaid Services (CMS) to help ensure our members understand options for continuing their Medicare health insurance coverage.

We understand our members may contact their doctors’ offices with questions about their plan when they receive this notification. Our customer service representatives are available to assist them with their concerns. Members may call the customer service telephone number in the letter they receive from us or they may contact our customer service through the number provided on the back of their member ID cards.

We are always evaluating our Medicare Advantage products to ensure that they meet our members’ needs for access, cost and quality.

If you have any questions, please contact your provider network manager.

* Providers who may receive termination notices for reasons other than service area reductions/eliminations are not impacted by this Notice.

Y0071_13_18026_I 09/03/2013
Services provided by Empire HealthChoice HMO, Inc. and/or Empire HealthChoice Assurance, Inc.,
It’s Time to Get Serious About Hepatitis C Virus (HCV) Screening

The CDC estimates that there are 17,000 new cases of HCV every year. Yet less than 1,000 new cases are actually diagnosed each year. Since most new cases are asymptomatic, acute Hepatitis C is usually not identified and is very under reported. While up to 15% of Acute Hepatitis C cases may resolve, about 85% develop chronic Hepatitis C infection. Of these, nearly 2/3 will develop chronic liver disease and up to 1/5 will develop cirrhosis over a period of 20-30 years. Perhaps 5% or more will die from consequences of chronic infection (e.g. liver cancer or cirrhosis). Chronic HCV infection is the most common reason for liver transplants in the U.S. The CDC estimates that over 15,000 deaths in 2007 were attributed to HCV. HCV is transmitted through exposures to infectious blood, from IDU (Intravenous Drug Use), receipt of donated blood products, organs, or shared medical equipment such as dialysis (particularly before testing became available in 1992), needle stick injuries, or birth to an HCV infected mother. While sexual contact or sharing personal items contaminated with blood are relatively inefficient means of transmission, they are means of spread that are a public health concern, particularly because one or even both partners may not know one is infected. About 1/3 IDUs under 30 have HCV, while older current and former IDUs have a much higher prevalence (70-90%). In addition, HCV is common in prisons with 1/3 having HCV. HCV rates are higher in African Americans compared to other ethnic groups. In addition, it’s estimated that 15-20% of persons with severe and persistent mental illnesses such as Bipolar Disorder and Schizophrenia or Schizoaffective Disorder are infected with HCV. Most importantly, most of the estimated 3.2 million people infected with HCV don’t know they are infected. Yet most patients who are at increased risk are never tested, perhaps because physicians don’t routinely ask or recommend testing, or perhaps because at risk patients are reluctant to admit and discuss risk factors. Recently, the CDC and Institute of Medicine both recommended one time screening of all baby boomers, those born between 1945 - 1965 because HCV infection is much higher in this group, and most don’t know they are infected. The Governor may sign a bill mandating that physicians and hospitals offer at least one time a screening test for HCV to this age group. While I do not personally support the mandate, I think I understand their concerns. It’s time for physicians to get past stereotypes and deal with HCV, an equal opportunity disease that has impacted all segments of society. Every patient over 15 years old, particularly those born 1945 -1965, should be asked about risk factors from any time in their lives. When in doubt, at least once, a screening test for HCV should be recommended. Good treatments are available and one or two additional options without the high risks of depression associated with Interferon are expected to be available in the next year or so. There are many good references available for physicians to become updated regarding HCV. Two good choices are: the Physicians Research Network at www.prn.org and the CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention at http://www.cdc.gov/nchhstp/ Whether or not the Governor signs the bill that mandates the offer of HCV testing to those, born 1945-1965, it’s time to step up to the plate. With proper screening, monitoring, treatment when needed, and counseling of all patients with HCV or at higher risk for HCV, we can make a huge difference in a short period of time.

Diabetes Update – http://www.usa.gov/

More than 8% of Americans have diabetes and about 35% of American adults have prediabetes. Prediabetes is a condition in which blood glucose levels are higher than normal. Without healthy lifestyle changes, those with prediabetes may develop diabetes. To protect your health, get information about: Risk Factors - Family history, blood pressure, and other factors can affect your chances of developing diabetes. Take a quick test to learn your level of risk. Prevention - The onset of Type 2 diabetes can sometimes be prevented or delayed through moderate weight loss, good nutrition, and exercise. How to Manage Diabetes - If you’ve been diagnosed with diabetes, learn how to stay healthy and keep the disease under control.
MSSNY Treasurer  
Charles Rothberg, MD

Whether one supports or disfavors the ACA, the insurance exchange has begun enrolling patients both for Obamacare subsidy and for health insurance coverage. Coverage purchased by December 15 will be effective January 1, 2014. New York State estimates that more than one million people will be newly insured due to the law. Thus, it is worth examining what this means to physicians.

Insofar as more people will have access to medical treatments, this is a good thing. This could result in lowering the amount of uncompensated care. But what impact will this change have on physicians and physician practices? Some background:

Public Exchanges:
It is important to understand that the word ‘exchange’ refers to the public exchanges created by the Affordable Care Act (ACA), which in New York will be run by the state. Individuals can compare coverage offered by seven competing private plans in Suffolk County. The plans must comport to a standard benefit package – which makes the comparison more straightforward. Plans will be offered in four varieties named ‘bronze’, ‘silver’, ‘gold’, and ‘platinum’. The plans will differ on the cost share experienced by the patient through deductibles and co-pays – 60% (bronze) to 90% (platinum). The plans will also differ in the provider network offered (three of the plans will utilize the Magnacare network, the others will be proprietary, but must fulfill New York insurance department rules on network adequacy). These plans satisfy the mandate to buy insurance under the law.

Individuals earning up to 138% of poverty (about $15,000/yr.) will be eligible to enroll in Medicaid. Those earning above 138% poverty up to 400% (almost $90k for a family of four) will be eligible for federal subsidy to offset premium on a sliding scale that limits premium to no more than 2 - 9.5% of income. The subsidy will take the form of reduced premium.

The subsidy will be based upon the ‘silver’ premium. But a consumer could instead apply this subsidy to purchase a less expensive plan (such as ‘bronze’) resulting in even lower premiums (in exchange for higher anticipated cost share).

Small Business Exchange (SHOP):
There will be three insurers offering plans on the small business exchange in Suffolk. Under the ACA small businesses of 25 or fewer employees (within certain payroll limits) have been eligible for tax credits to offset the employer share of the health premium. But beginning in 2014, to claim the credit, employers must purchase insurance on the SHOP.

Private Exchanges:
Some companies have been offering health insurance choices on a closed ‘marketplace’ established for their employees and retirees. Although the companies have been calling these venues ‘exchanges,’ they should not be confused with the public (ACA) exchanges. While they facilitate choice, these are not open to the general public, nor are they eligible for government subsidy. Ultimately, private exchanges may be a mechanism for companies to transition to defined contribution system of health care funding (analogous to a 401k for retirement).
So what’s the problem for physicians?

As an Employer:
If they offer a health plan, physicians should check with their current insurer to be sure that their current plan will be continued beyond the policy anniversary date.
Physicians may want to compare products offered on the exchange (especially for spouses) to what is available in the small group market. Be sure to factor in the value of government subsidy that may be available on the exchange.
Physicians may wish to compare products available on the SHOP, as these will still be eligible for premium tax credit while those on the small group market will not.

As a Provider:
Churn – this refers to folks whose income hovers near the 138% threshold and may switch from Medicaid and an exchange based private insurer during an episode of care. Rules, cost share and even networks that are incompatible may interfere with continuity during an episode of care.
Churn II – there is concern that employers may switch from the small group plans to the SHOP (to preserve their tax credit). This may result in physicians treating the same patients, but on a lower paying plan in 2014. Folks that are delinquent on premium – many folks on the exchange will be first time insureds. Some of these patients may be unaccustomed or unable to pay premiums regularly. The insurer won’t drop the beneficiary until premium is 90 days late, thus the provider may not know the insurance status of his patient.
Medicaid Parity – primary care physicians can treat Medicaid recipients at the same reimbursement rates as Medicare. The enhanced payment is retroactive to 2013. Normally I’d view this as good news, but this provision will sunset after just two years.
Workflow overload – physicians that accept these newly insured patients will be challenged by:
Volume of new patients. There will likely be ‘pent-up demand’ for physician services, especially at the beginning of the benefit year.
New patients unaccustomed to regular care

Issues of medical non-compliance
Issues of co-payments for services – these patients may be unprepared or unable to meet these demands

Fee schedules – I am not aware that these have been published, nor have I seen the network for several of the carriers. On one carrier’s website, a search for a physician in my specialty and zip code showed no providers over a 100 mile radius.

Network Adequacy – while the state regulates network adequacy from a patient perspective, physicians should be sure that the entities from which they get referrals and those to whom they refer are in a carrier’s network. Disruption of referral patterns can impact continuity of care and create workflow issues for which a physician should prepare.

The bottom line is this – it’s hard to ignore one million new patients. But, like any new rollout, physicians should examine the products. They should try to determine which products and which patients will likely make a good adjunct to their practice – and which ones won’t. They should be selective about which plans to accept and which ones not to. It is a marketplace after all.
Obamacare provision is causing 'sticker shock' for some

When setting premiums for next year, insurers baked in bigger-than-usual adjustments, driven in large part by a game-changing rule: They can no longer reject people with medical problems. Popular in consumer polls, the provision in the health law transforms the market for the estimated 14 million Americans who buy their own policies because they don’t get coverage through their jobs. Barred from denying coverage, insurers also can’t demand higher rates from unhealthy people and those deemed high risks because of conditions including obesity, high blood pressure or a previous cancer diagnosis. But the provision also adds costs. To a larger degree than other requirements of the law, it is fueling the “sticker shock” now being voiced by some consumers about premiums for new policies, say industry experts. In setting next year’s rates, insurers must factor in “assumptions about who will sign up, high users or healthy people,” said David Axene, a fellow of the Society of Actuaries. “You can imagine who most of the health plans thought would be predominantly signing up.” Regulatory filings and comments from insurers show they expect that accepting the sick as well as the healthy could raise their claims costs 5 percent to 50 percent or more next year. That “would be the largest single factor” at Blue Shield of California, accounting for about a 20 percent increase in expected claims costs, said Mike Beuoy, director, actuarial services. The focus on premiums has heightened recently, amid news reports about large numbers of individual policyholders nationwide who are learning that their current plans are being discontinued and they must choose a new policy.

To be sure, there are other factors affecting premium cost changes. For one, the law requires insurers include 10 benefits deemed essential by the law, including hospitalization, drugs, maternity care and mental health services, benefits not all plans sold to individuals currently include. Indeed, this is one of the major reasons insurers cite for discontinuing policies. Another provision caps consumers’ annual out-of-pocket costs to no more than $6,350 for individuals or $12,700 for families, which could add to premiums as well. Insurers must also charge men and women equally — and are limited to charging older Americans no more than three times what younger policyholders are charged, considerably less than they could before in many states. Altogether, those changes for some consumers may mean a sharp increase in premiums between their soon-to-be discontinued policies and new ones being offered them by insurers, even for similar plans. “I’m kind of shocked,” said Leo Lenaghan, who lives in the Chicago suburbs. The $336-a-month BlueCross Blue Shield policy for his wife and daughter, which had a $2,250 per person annual deductible, is being discontinued and the plan his insurer says is most similar to it in benefits will cost an additional $205 a month. It has a $3,000 per person deductible. “I guess we’re just going to have to suck it up.” Still, despite the factors that can drive up premiums — including medical inflation — not all consumers will see higher prices. Health law rules mean people who are older and sicker may see a drop from what they’re paying now. And about half of consumers who currently buy their own policies will be eligible for a subsidy to help offset the premium cost, according to a study released in August.

Blue Cross Blue Shield of Illinois would not comment specifically on Lenaghan’s situation, but spokeswoman Lauren Perlstein said the health law will “expand access to health care coverage for millions and may offer additional benefits for many [and] … the impact on premiums may vary widely.” The changes make the so-called individual market more comparable with the way insurers price and offer coverage to employers, where rules have long been in place barring them from rejecting employees with health conditions. Employer coverage also generally covered more benefits with lower deductibles and fewer restrictions than policies purchased by individuals, who sometimes did not realize the limits of their coverage. “We as consumers may not know just how lacking our current policies are because it seemed like a good value and we didn’t use it much,” said Michael Lujan, a health benefits consultant and former director of sales and marketing for Covered California, the state’s new online marketplace. The less their policies covered previously, the more consumers’ premiums are likely to rise, experts say. While adding some benefits only costs “pennies on the dollar,” said Georgetown University research professor Sabrina Corlette, others are more expensive. A Maryland Health Care Commission report from last year, for example, said the state’s requirement that insurers include maternity coverage added about 4 percent to the cost of a premium. The actuarial firm Milliman estimated that changes from the health law — including the take-all-applicants provision — could be expected to result in about a 14 percent increase to the average premium in California. On top of that, general medical inflation from 2013 to 2014 would add another 9 percent. Of all the factors, the biggest cited by Milliman was the guaranteed coverage provision. Actuaries say the impact of that provision on premiums is unlikely to recur in future years because insurers are factoring in this cost now, based on projections of the ratio of sick to healthy customers. “Once it’s built in, unless they were wrong, it won’t be repeated,” said Axene. But insurers’ estimates may be off. Troubles with the federal website and some state sites may discourage enrollment by younger or healthier people who see less incentive to buy coverage. “All insurers I talk with are absolutely terrified,” said Brian Haile, senior vice president, health care policy at tax preparation firm Jackson Hewitt. “They made assumptions about the number of young people entering the market … which may now be overly optimistic.” Brady Cass, president of Asuris Northwest Health in Washington state, said only time will tell. Asuris, a subsidiary of Regence BlueShield of Washington, estimated that the requirement they take all applicants will add about 8 percent to the cost of next year’s premiums. “Did we overshoot the runway or come up short? Only way to get there is to get to the end of runway and look back,” said Cass. “The hope is the actuary team has done a very good job at predicting the risk mix coming in.” If they underestimated, premiums might rise more in future years, he said. If they overshot, some consumers might see a rebate, as required by the health law. Asuris is getting a lot of calls from people wondering why, if they’re healthy, that they have to pay more to cover those who are not. “It’s the many helping the few,” he said, likening it to buying home owners insurance and paying in year after year, money that goes to help other people whose homes burn down. “That’s the concept of insurance, lots of people coming together to help those in time of need.”
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Timelines
8:00 AM - Registration/Breakfast & Sponsors/Exhibitors
9:00 AM – Introductions – Louis C. Rose, MD, Chairman Bronx County Medical Society’s Legislative Health Forum
9:10 AM – 12 Noon – Program

Special Guest Speakers
• The Honorable Justice Douglas E. McKeon
• Liz Dears, Esq. Senior Vice President for Legislative & Regulatory Affairs Medical Society of the State of New York
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• NYS Senator Jeffrey Klein
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Invited Special Guests
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