LEE COUNTY MEDICAL SOCIETY INC.

Bulletin

Physicians Caring for our Community

Volume 35, Issue 3 | Editor: John W. Snead, M.D. | July 2011

Meetings and Events

FMA Annual Meeting July 28 – July 31, 2011 Disney's Contemporary Resort, Orlando, Florida

Board of Governors Meeting September 2011, TBA

General Membership Meeting September 15, 2011

Inserts:

- The Future of Healthcare/Julio Rodriguez, MD
- Potluck in Paradise
- EHR/Meaningful Use
- Office Space for Lease

Inside this issue:

President's Message

Trials and Tribulation of the Affordable Care Act - Medicaid

Shahid Sultan, M.D.

One of the salient features of the new Patient Protection and Affordable Care Act is to provide more individuals and families with affordable medical care. It is estimated that another 16 million people are slated to get Medicaid eligibility through this Act. This will make Medicaid, a federal-state program, responsible for more than one in four Americans health care needs.

Medicaid has become a vast enterprise that underscores the limits of what the states and the federal government can provide. Because of the recent downturn in the economy almost every state is struggling under widening budget deficits. For the State of Florida, 22% of its budget goes towards Medicaid and this percentage will further increase as new enrollees come on board in 2014. State spending on Medicaid is guided by the rules established by the federal government. Access to health care, at least to the same extent as the general population, was one of the promises of Medicaid legislation that has remained unfulfilled. In order to balance the budget, states have repeatedly cut physicians' payments, thereby essentially denying covered services to the recipients as many primary care physicians can no longer afford to accept Medicaid patients. The State of Florida is contemplating shifting all Medicaid enrollees to Medicaid HMOs, essentially washing their hands of the Medicaid recipients and letting the HMOs deny the services.

The Obama administration is aware of the situation and recently has proposed a rule to clarify the federal law governing Medicaid. It was published in the Federal Register on Friday, May 6th. It will make it more difficult for the states to cut payments to doctors and hospitals. This rule could also put pressure on the states to increase payment rates, which are typically lower than the Medicare or private insurance rates for the same service. In general states set Medicaid payment schedules within broad federal guidelines. The law has long said that states must enlist enough providers to make sure Medicaid recipients have access to care equivalent to other populations in the area. These rules have often been ignored and the states have decreased the payments to the doctors without ensuring the accessibility to medical care. Under the new rule states cannot decrease the payments unless they can show that the Medicaid recipients have "sufficient access" to care after the cuts. The states must also measure and document access to each covered benefit at least once every five years. In addition, the rule stipulates that states should compare payment rates with the amount paid by Medicare or commercial insurances with providers' cost or with their customary charges. Another important requirement will be to keep data on the number and percentage of doctors in the state accepting Medicaid enrollees. Data from such review will give a powerful tool to doctors, hospitals and nursing homes to fight cuts in the services without considering their effect on the patient population. Unfortunately for Floridians, the new rule does not apply to HMOs, but administration officials while explaining the new rule said that they are considering future proposals to guarantee access to care for Medicaid recipients in such plans as well.

Medicaid stands at a crossroads. With the number of Medicaid recipients increasing, coffers at the state and the federal level decreasing and the economy showing no sign of sustained recovery, both parties will have to tackle the difficult issue of a politically acceptable level of public support that the US government should provide to its citizens. Medicaid has many problems, low reimbursement rates being one of the most serious. But, numerous studies like RAND Health Insurance Experiment support the belief that basic public health insurance coverage improves health; therefore, instead of cutting the funding for Medicaid lawmakers should look for alternate sources to fund the program.

The choices will be difficult but the poorest and the most vulnerable should not be the ones bearing the brunt of these changes just because they don't belong to a group that has political clout.

LEE COUNTY MEDICAL SOCIETY BULLETIN
13770 Plantation Road Ste 1
Fort Myers, Florida 33912
Phone: (239) 936-1645
Fax: (239) 936-0533
E-Mail: awilke@lcmsfl.org
www.leecountymedicalsociety.org

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Lee County Medical Society Mission Statement & Disclosure Policy

The purpose of the LCMS is to unite the medical profession of Lee County, FL, into one compact organization; extend medical knowledge and advance medical science; elevate the standards of medical education; strive for the enactment, preservation and enforcement of just medical and public health laws; promote friendly relations among doctors of medicine and guard and foster their legitimate interests; enlighten and alert the public, and merit its respect and confidence.

All LCMS Board of Governors and Committee minutes are available for all members to review.

Membership News

New Office Address
Audrey Farahmand, MD
14090 Metropolis Avenue, Ste 102
Fort Myers, FL 33912
Phone: 239-332-2388

Nadia A. Kazim, MD, FACS
3501 Health Center Blvd Ste 2170
Bonita Springs, FL 34135
Phone: 239-494-4900

EFFECTIVE JULY 11, 2011 Southwest Florida Eye Care - **F. Rick Palmon, M.D.** and **Richard Glasser, M.D.** We are moving our Fort Myers location from 13670 Metropolis Ave. TO 6850 International Center Blvd, Fort Myers, FL 33912 the phone and fax number will be the same.

Moved out of area:
David Martin, MD

Resigned
Gregg Guffrey, MD
Thomas Johnson, MD
Robert Sharkey, MD
Tinerfe Tejera, MD

Retired
Congratulations to Richard DeIorio, MD on his retirement from active practice. Dr. DeIorio served as an orthopedic surgeon in lee County for over 33 years. He was in group practice with Orthopedic Associates of Cape coral.

New Members
Stefanie Colavito, MD - Hospitalist
Cogent Health Care

William M. Figlesthaler, MD - Urology
Specialists in Urology

Jeffrey Neale, MD - Colon/Rectal Surgery
The Colorectal Institute

Nagesh Ravipati, MD - Colon/Rectal Surgery
The Colorectal Institute

No Longer Members
Carole Barekman, MD
Juan C. Domingo, MD
Katie Drake, DO
Vidya Kini, MD
Avanee Master Lobo, MD
Harry Turner Jr, MD

Physicians in the News

Shahid Sultan, MD addressed the Greater Fort Myers Ministerial Association on Wednesday, April 27th. The talk was in reference to the state of medical care in the community and changes in health care and what could happen if funding is no longer funded by Congress.

LCMS Alliance Summer Kick Off!

As I Recall...

Roger D. Scott M.D.

Nurses Notes V

It was indeed a pleasant surprise for the Museum of Medical History when **Joyce Jackmann Brittan, R.N.** from Ocean City, Maryland appeared on March 4, 2011 bringing many desirable objects for the Museum collection. Joyce Jackmann (JJ for this article) was born and raised on Long Island, New York and was a Candy Striper (Or should it be Stripper?) at South Nassau Hospital before graduating from Oceanside High School in 1958. She then worked the summer lovingly as an aide in a local nursing home that convinced her to become a nurse so she entered the Southampton Hospital School of Nursing. During the three years of school she also worked at the Margaret Hague Maternity Hospital in Jersey City, NJ and Morrisania City Hospital in the Bronx for pediatrics and Brooklyn State Hospital for psychiatry. After graduation from Southampton in 1961, JJ loved working in the Delivery Room at Mercy Hospital in Rockville Centre, NY. Two years later she became a "Brittan" and a mother and moved to Setauket, NY where she continued nursing at Mather Memorial Delivery Room as well as a floating per diem RN for about seven years. JJ then worked in an OB/GYN office and ultimately became the office manager (The duties she describes sound as though it should have been a two-person job rather than for one!) until her retirement in November, 2005. (Incidentally the same time as I retired.) She is the only Legal Nurse Consultant that appears in my files. JJ is now a volunteer for the National Parks Service and also works as a Retired Nurse Volunteer "helping out any way we can" at Atlantic General Hospital (66 beds) in Berlin, Maryland along with Mary Buley, Marge Matturo, and Pam O'Dowd (all featured in this series of Nurses Notes). JJ brought too many contributions to list all, but especially important were her two highly starched nursing caps made from napkins (one folded and the other unfolded and flat), ribbons, pin, Nightingale lamp, student candleholder, photographs, and much literature as well as her mother-in-law's (Helen B. Weeks R.N) 1921 picture and her 1921 nursing pin from the Brooklyn Methodist Episcopal Hospital. We had a very nice visit and greatly appreciate the many new and variable items for the collection.

Marie Buley, R.N. is a graduate from Strong Memorial Hospital of the University of Rochester in upstate New York. She attended the University of Rochester from 1950 through 1955 to achieve a Bachelor of Science in Nursing in 1954 and a Registered Nurse (R.N.) in 1955. She states that at that time there was a three-year R.N. program and a 4 1/2 year BS, R.N. program. Over the last 50 years the program has changed significantly by dropping the diploma and BS programs, and adding the MS and PhD degrees in Nursing. She further states that she has been extremely proud of the fine education she received and also proud to be a nurse. She is now retired and lives in Ocean Pines, Maryland and is one of the Retired Nurse Volunteers. Marie donated a beautiful framed colored graduation portrait of herself in her uniform and cap.

Phyllis L. Brodsky, RNC, MS is now retired to Berlin Maryland but is working as a Substitute School Nurse for the Board of Education of Worchester County. She obtained her R.N. degree from the Albert Einstein Medical Center School of Nursing at Philadelphia in 1957, AA in Nursing from Montgomery College in Maryland in 1975, BSN University of Maryland School of Nursing in Baltimore in 1976 and at the same wonderful (my old school!) institution an MS in Nursing in 1979. Phyllis phenomenally had 49 years of nursing experience and nursing education for 22 years before retiring. Her expertise is in maternal and newborn nursing, and she has just recently completed a book on the history of childbirth. She continues to be active in the Maryland Nurses Association both as a planner and a presenter of continuing education. She has had several publications in journals, proceedings, and a chapter in a book. She has also written a book, *A Memoir of a Student Nurse or You Can Leave Any Time You Want,* that relates her humorous and poignant experiences along with some of her classmates as student nurses in the 1954-57 era. She sent the museum a copy of the book, which does provide an inspiring vision of the profession of nursing to anyone contemplating or recommending a nursing career (I read and agree.).

Barbara M. S. Rightmire, R.N. was born and raised in Lancaster, Pennsylvania. She attended Albright College, Reading, Pennsylvania from 1951 to 1957. She gained a BS in Nursing at the Reading School of Nursing 1953-1956 and a Registered Nurse from the Graduate Program at the University of Pennsylvania. Her nursing career covered Public Health Nursing and School Nurse in Allentown, Pennsylvania. She was Head Pediatric Nurse at Chilton Hospital, Pompton Plains, New Jersey and Psychiatric Nursing at Christian Health Care in Wycoff, New Jersey. Barbara then went private as Head R.N. for J. Duff Brown, M.D. and developed a complete in-house laboratory before retiring to Ocean Pines, Maryland. She was also a member of the Retired Nurses Volunteer Program at Atlantic General Hospital, volunteer for Court Appointed Special Advocate (CASA) for children who were in foster care following severe neglect or abuse, volunteer as well as chairman for the Nurturing Committee for Habitat for Humanity for several years. She has now relocated to Willow Valley Community is her old hometown of Lancaster, Pennsylvania.

Barbara contributed to the Museum her unusual gray wool, red lined nurses cape with four ornate gold buttons. It was manufactured by Marvin Neitzel Corporation (established in 1845) of Troy, New York, which supposedly manufactured capes in the Civil War for the Union Army. It does appear compatible with those capes.

Joyce Jacob, RN, BSN, PHN, CPNP, MaEd, President of the California Hospital School of Nursing Alumni Association had been very kind to donate a much longer than usual beautiful purplish blue (as my eye observed it) cape from the **C**alifornia **H**ospital **S**chool of **N**ursing to honor a very fine alumnus, Carol Rawl, R.N. (widow of Dr. J. Frank Rawl). Carol graduated there many years ago and married Frank, and they moved to Fort Myers about 1960. Thank you so much Joyce for your kindness.

The following quotation is extracted from **A Golden Look Back** by Jennifer Ruffner, Museum Curator for the University of Maryland School of Nursing on the occasion of its 120th anniversary (1889-2009). "An apprenticeship in nursing was offered in return for hard work, obedience, and loyalty." A 1902 graduate stated "immediately on entrance, we were placed on a ward or the halls and instructed by the Head Nurse of that department in answering bells, scrubbing macintoshes and woodwork, dusting, use of antiseptics, bed-making, carrying fresh water or cups of nourishment, bathing faces and hands of patients and straightening up rooms, making patients comfortable at night." As you have read these five issues of Nurses Notes you can see the remarkable changes in nursing that have occurred in the mid-20th century, and are changing greatly in this 21st century. In 1958, the nurses were NOT allowed to draw blood, start IVs, and many other things that they do routinely today.

<u>God Bless America & our protectors. Happy 4th.</u>

New Applicants

Robert P. Casola, DO — Dr. Casola received his DO degree from New York College of Osteopathic Medicine in Old Wesbury, NY in 1982. He completed his internship/residency at Doctors Hospital, Columbus, OH (1982-1987). Dr. Casola specializes in Wound Care and Hyperbaric Medicine. Dr. Casola is certified by the American Osteopathic Board of Orthopedic Surgery and is in group practice with Orthopedic Specialists of SWFL at 2531 Cleveland Ave, Fort Myers, FL 33901 - Tel: 239-334-7000.

Christopher A. Dawson, MD — Dr. Dawson received his MD degree from West Virginia University School of Medicine in 2005. He completed his internship at the University of Virginia Medical Center, Charlottesville, VA (2005-2006); residency/fellowship at Virginia Commonwealth University, Richmond, VA (2005-2010). Dr. Dawson specializes in Physical Medicine and Rehabilitation and is in group practice with Orthopedic Specialists of SWFL at 2531 Cleveland Ave, Fort Myers, FL 33901 - Tel: 239-334-7000.

Jon Kimball, MD — Dr. Kimball received his MD degree from University of North Carolina, Chapel Hill, NC in 2002. He completed his internship at University of Florida, Gainesville, FL (2002-2007); residency at Panoramo Orthopedics & Spine Ctr, Golden, CO (2007-2008) and fellowship at Ochsner Clinic, New Orleans, LA (2008-2011). Dr. Kimball is board certified by the American Board of Orthopedic Surgery in Orthopedics & Spine Surgery. He is in group practice with Joint Implant Surgeons, 2780 Cleveland Ave, Ste 709, Fort Myers, FL 33901 - Tel: 239-337-2003.

Freddy J. Montero, MD — Dr. Montero received his MD degree from New Jersey Medical School, Newark, NJ in 2004. He completed his internship at NJ Medical School, Newark, NJ (2004-2005); residency at Harvard Medical School, Brigham's & Women's Hospital, Boston, MA (2005-2008) and fellowship at Columbia University, New York, NY (2008-2011). Dr. Montero is board certified by the American Board of Obstetrics/Gynecology. He is in group practice with Maternal Fetal Medicine of SWFL, 9981 Health Park Circle #159, Fort Myers, FL 33908 - Tel: 239-481-5477.

Jason T. Nemitz, MD — Dr. Nemitz received his MD degree from Ohio State College of Medicine, Columbus, OH in 2005. He completed his internship/residency at Henry Ford Hospital, Detroit, MI (2005-2010) and fellowship at St. Joseph Mercy Oakland in Pontiac, MI (2010-2011). Dr. Nemitz specializes in Orthopedic Surgery/Foot & Ankle Surgery. He is in group practice with Orthopedic Specialists of SWFL at 2531 Cleveland Ave, Fort Myers, FL 33901 - Tel: 239-334-7000.

Steven Woodring, MD — Dr. Woodring received his DO degree from Atstill University, Kirkville College of Osteopathic Medicine, Kirksville, MO in 2003. He completed his internship at Cuyahoga Falls General Hospital, Cuyahoga Falls, OH (2003-2004) and residency at Case Western Reserve University, Metro Health Medical Center, Cleveland, OH (2004-2007). Dr. Woodring specializes in office-based anesthesia. He is in practice with Mobile Anesthesiologists of Florida, LLC, 3894 Mannix Dr, Naples, FL 34104 - Tel: 239-349-2604.

LCMS is saying Goodbye to one of their own! *After 14 years of dedicated service, Cynthia Greenfield, Admin Secretary has decided to become a stay at home mom to her son Landon Eli. She will be missed.*

Congratulations to Ashish Sharma, MD, FACS and Nadia, Kazim, MD, FACS on the birth of their baby girl, Ariana Sharma. Ariana was born on March 31, 2011 weighing 6 lbs. 7 ozs.

The LCMS would like to express their condolences to Shahid Sultan, MD - LCMS President and his family on the loss of his beloved mother.

"It's not only what we do, but also what we do not do, for which we are accountable."

Florida Board of Medicine Legislation

Effective July 1, 2011

We want to bring to your attention a number of bills that were passed during the 2011 Legislative Session that have been signed by Governor Scott and may affect your medical practice.

CS/CS/HB 155 Enrolled—Privacy of Firearm Owners

The provisions of this bill take effect upon becoming law, it creates the "medical privacy concerning firearms" law and establishes grounds for discipline for violation of certain provisions of the law. It prohibits a licensed health care practitioner or licensed health care facility from intentionally entering any disclosed information concerning firearm ownership into a patient's health record if the information is not relevant to the patient's medical care of safety, or the safety of others. Patients are permitted to decline to answer or provide any information concerning the ownership of a firearm and a decision not to answer does not alter existing law regarding a physician's authority to choose patients.

CS/CS/HB 935, 1st Engrossed/Enrolled- Health Care Price Transparency

This bill addressed posting, in the reception area of certain medical offices, urgent care centers, and clinics, a schedule of prices charged for the 50 most common services provided to an uninsured person paying by cash, check, credit card or debit card. The bill specifies the size of the posting and parameters for its contents. A primary care provider who publishes and maintains the schedule of charges is exempt from the professional license fee requirements for a single renewal period and continuing education requirements for a single 2-year period.

CS/CS/CS/HB 1319, Enrolled-Certificates, Licenses, Health Care Practioners

The bill authorizes the department to issue a temporary license to a health care practioner whose spouse is stationed in Florida on active duty with the Armed Forces if the applicant meets the eligibility requirements for a full license and is qualified to take the licensure

Continued on page 9

Meaningful Use: Fact Sheet for Physicians

If you need to have questions answered or help with EMR, you have to register with REC. See insert.

Meaningful Use

The Health Information Technology for Economic and Clinical Health (HITECH) act for 2009 provided for Medicare and Medicaid incentive payments to health care professionals and hospitals that adopt electronic health record (HER) technology and use it to achieve "meaningful use".

On July 13, 2010 the US Department of Health and Human Services (HHS) released standards that outline what goals physicians, hospitals and providers must meet in order to qualify for Medicare or Medicaid incentives and to be considered meaningful users of health information technology.* *(See Summary on next page)*

Meaningful user requirements will be phased in over three stages. Stage I (January 2011-2013) focuses on collecting data in coded formats; implementing clinical decision support tools; reporting clinical quality and public health data; and tracking conditions and coordinating care. Stages II and III are in development.

Inpatient and emergency room department physicians are not eligible for the Medicare incentive payments nor are the majority of inpatient physicians eligible for the Medicaid incentive payments.

Physicians can elect to participate in either the Medicare or the Medicaid incentive programs. They can make a one-time switch from one program to the other, after their initial choice.

Incentive Program: Medicaid

To be eligible for Medicaid incentive payments, estimated at $42,500 to $63,750 over six years, the provider must annually meet patient volume thresholds (20-30%, depending on practice and provider type) and demonstrate meaningful use. During the first year, a physician may qualify for an incentive payment by simply demonstrating that they have adopted, implements, or upgraded a certified EHR. In the second year they must demonstrate meaningful use, as defined by state and federal agencies, for a continuous 90-day reporting period to qualify for payment.

Incentive Program: Medicare

Eligible physicians can elect to participate in the Medicare incentive program. To qualify for payment in year one, practices must report on "meaningful use" for a continuous 90-day reporting period. In all subsequent years physicians must meet meaningful use objectives for a full year.

Physicians who demonstrate "meaningful use" will be eligible for reimbursement equal to 75% of their allowed Medicare Part B charges for covered professional services. For example, a physician with a total of $20,000 in allowed Medicare Part B charges in 2011 is eligible for $15,000; a physician with a total of $30,000 in allowed Medicare Part B charges in 2011 is eligible for the maximum amount - $18,000 (*not* $22,500.00). In 2015, payment penalties will be imposed on providers who are not using HER technology in a meaningful way.

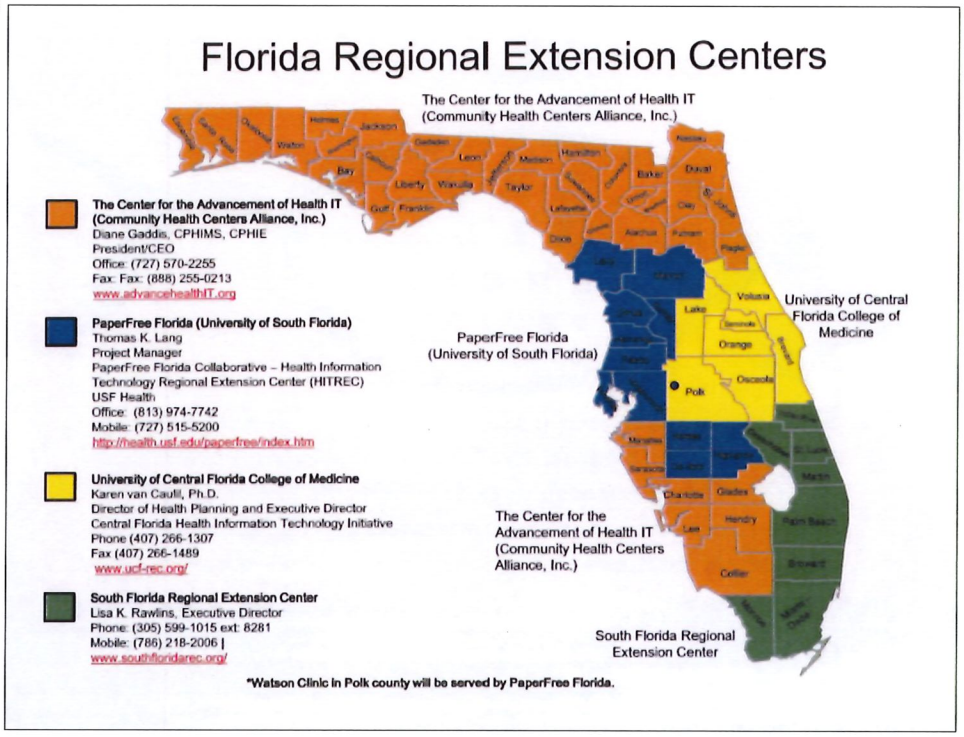
Extension Centers

Additionally, HHS established a nationwide network of Regional Extension Centers (RECs) to further assist primary care physicians in adopting and using certified HER technology in a meaningful way. Florida is divided into four regions. Primary care physicians, which include family and general practice, internal medicine, ob/gyn and pediatricians should contact the extension center to which their county is assigned.

First year provider meaningful user	Maximum amount eligible to receive per physician during calendar year						
	2011	2012	2013	2014	2015	2016	Total
2011	$18K	$12K	$8K	$4K	$2K	$0	$44K
2012		$18K	$12K	$8K	$4K	$2K	$44K
2013			$15K	$12K	$8K	$4K	$39K
2014				$12K	$8K	$4K	$24K
2015-2016					-1%	-2%	$0

Certified Systems

Physicians must also use certified HER technology to qualify for incentive payments. To assure providers that the EHR technology they adopt is certified and will support meaningful use, HHS established a temporary certification program for EHR technology. CMS has established a temporary certification program and anticipates the permanent certification program will be established by January 1, 2012.



Summary of Meaningful Use Objectives and Measures *

To qualify as a meaningful EHR user, physicians must meet all of the 15 core requirements and must meet five additional requirements or their choosing from the menu set.

Topics	Core requirements/measures of success – *Must meet requirements*
Demographics	Record patients' demographic data as structured data for more than 50% of patients (sex, race, ethnicity, DOB, preferred language)
Vital signs	Record vital signs as structured data for more than 50% of patients 2 years of age and older
Problem list	Record at least on current/active diagnoses in problem list as structured data for more than 80% of patients.
Medication list	Record at least one active medication as structured data in a medication list for more than 80% of patients
Allergies	Record at least one medication allergy as structured data in an active medication allergy list for more than 80% of patients.
Smoking status	Record smoking status as structured data for more than 50% of patients 13 years of age and older.
Communicate to patient clinical visit summaries	For patients requesting the information, provide clinical summaries (within 3 business days) for more than 50% of all office visits.
Communicate to patient test and diagnostic results	Provide copy of patient's health information (diagnostic test results, problem list, medication list, medication allergies) within 3 business days for more than 50% of all patients requesting the information.
E-prescribing	Generate and transit electronic prescribing for more than 40% of all permissible prescriptions using certified e-Rx technology.
Computer Provider Order Entry	For more than 30% of patients with at least one medication on their medication list, use Computer Provider Order Entry (CPOE) to order at least one medication.
Drug-drug &drug allergy interactions	Enable EHRs functionality to check for drug-drug and drug-allergy interactions for entire reporting period.
Health information exchange	Perform at least one test of the EHRs capacity to exchange information electronically with another provider or authorized entity.
Clinical decision support	Implement one clinical decision support rule and track compliance with the rule.
Security	Conduct or review a security risk analysis, implement updates, and correct security deficiencies.
Quality measurement	Provide clinical quality measure numerator and denominator data in aggregate to CMS or states through attestation. For 2012 electronically submit measures.

Additional Topics	Menu set/measures of success – Select five from menu set
Drug formulary	Access at least one internal or external drug formulary check system and implement for the entire reporting period.
Clinical laboratory test	Incorporate more than 40% of clinical laboratory test results into the EHR as structured data (positive/negative or numerical results).
Patient registries	Generate at least one list of patients with a specific condition for use in quality improvement, reduction of disparities, research, or outreach.
Patient education	Identify and provide at least 10% of patients with patient-specific education and resources.
Medication reconciliation	Perform medication reconciliation for more than 50% of transitions between care settings.
Care transitions	Provide a summary of care record for more than 50% of patients referred to or transitioned to another provider or setting.
Immunizations	Perform at least one test of immunization data submission and follow up submission to electronic immunization registry or database.
Public health surveillance	Perform at least one test of syndromic surveillance data submission and follow up submission to public health agency.
Patient reminders	Send reminders for follow up and preventive care to more than 20% of patients 65 years of age or older or 5 years of age and younger.
Patient electronic access	Provide more than 10% of patients who request it electronic access to their health information within 4 days of information being entered into the electronic health record.

Training Requirements for Physicians Practicing in Pain Management Clinics

Rule 64B8-9.0131 was filed for final adoption with the Secretary of State on April 27,2011 and became effective on May 17, 2011. The rule reads as follows:

64B8-9.0131 Training Requirements for Physicians Practicing in Pain Management Clinics.

Effective July 1, 2012, physicians who have not met the qualifications set forth in subsections (1) through (6), below, shall have successfully completed a pain medicine fellowship that is accredited by the Accreditation Council for Graduate Medical Education (ACGME) or a pain medicine residency that is accredited by ACGME. Prior to July 1, 2012, physicians prescribing or dispensing controlled substance medications in pain-management clinics registered pursuant to Section 458.3265, F.S., must meet one of the following qualifications:

(1) Board certification by a specialty board recognized by the American Board of Medical Specialties (ABMS) and holds a sub-specialty certification in pain medicine;

(2) Board certification in pain medicine by the American Board of Pain Medicine (ABPM);

(3) Successful completion of a pain medicine fellowship that is accredited by the Accreditation Council for Graduate Medical Education (ACGME) or a pain medicine residency that is accredited by the ACGME;

(4) (a) Successful completion of a residency program in physical medicine and rehabilitation, anesthesiology, neurology, neurosurgery, family practice, internal medicine, orthopedics or psychiatry approved by the ACGME; or

(b) Sub-specialty certification in hospice and palliative medicine or geriatric medicine recognized by ABMS;

(5) Current staff privileges at a Florida-licensed hospital to practice pain medicine or perform pain medicine procedures;

(6)Three (3) years of documented full-time practice, which is defined as an average of 20 hours per week each year, in pain-management and within six months of the effective date of this rule, attendance and successful completion of 40 hours of in-person, live-participatory AMA Category I CME courses in pain management that address all the following subject areas:

(a) The goals of treating both short term and ongoing pain treatment;

(b) Controlled substance prescribing rules, including controlled substances agreements;

(c) Drug screening or testing, including usefulness and limitations;

(d) The use of controlled substances in treating short-term and ongoing pain syndromes, including usefulness and limitations;

(e) Evidenced-based non-controlled pharmacological pain treatments;

(f) Evidenced-based non-pharmacological pain treatments;

(g) A complete pain medicine history and a physical examination;

(h) Appropriate progress note keeping;

(i) Comorbidities with pain disorders, including psychiatric and addictive disorders;

(j) Drug abuse and diversion, and prevention of same;

(k) Risk management; and

(l) Medical ethics.

In addition to the CME set forth in subsection (6) above, physicians must be able to document hospital privileges at a Florida-licensed hospital; practice under the direct supervision of a physician who is qualified in subsections (1) through (4) above; or have the practice reviewed by a Florida-licensed risk manager and document compliance with all recommendations of the risk management review.

(7) Upon completion of the 40 hours of CME set forth above, physicians qualifying under (6) above, must also document the completion of 15 hours of live lecture format, Category I CME in pain management for every year the physician is practicing pain management.

Rulemaking Authority 458.3265(4)(d) FS. Law Implemented 458.3265(4)(d) FS. History–New 5-17-11.

Pain Management Clinics Training Requirements Effective May 17, 2011

Legislation effective July 1, 2011

Cont'd

Examination. It also requires the applicant for a temporary license to pay for fingerprint processing for a criminal history check in addition to the application fee. It also names the temporary certificate for practice as a physician in areas of critical need the "Rear Admiral LeRoy Collins, Jr., Temporary Certificate for Practice in Areas of Critical Need."

It is imperative that you review each of these bills in their entirety to understand and comply with new provisions.

It is also important to note that there are other bills that may affect your medical practice than these noted here that were passed by the 2011 Legislature and some that are still awaiting Governor Scott's signature. Those bills have not been included. To access these laws and other information, please visit Florida Board of Medicine's website at: **http://www.doh.state.fl.us/mqa/medical/** or **http://www.flhealthsource.com**

Are You Already Exempt?

Centers for Medicare & Medicaid Services

Only certain physicians and other health professional are eligible to earn Medicare electronic prescribing bonuses. For those eligible, failure to e-prescribe in 2011 will trigger a 1% payment reduction in 2012, unless they also obtain special hardship waivers. Medicare defines and eligible professional as meeting all three of the following criteria.

- Is a physician, nurse or therapist with prescribing privileges as of June 30.
- Has at least 100 instances of eligible patients encounters for e-prescribing, such as an office evaluation and management visit, between Jan. 1 and June 30.
- Has at least 10% of total Medicare charges associated with eligible patients encounters.

Reprint from American Medical Association, American medical News, June 20, 2011 Vol. 54 number 12.

Cont'd on page 11

Skeptics question Florida's Medicaid plan

By Barbara Peters Smith

Many people questioned the fundamental premise of the Medicaid overhaul: that it would save millions of dollars annually. And they criticized the plan to shift elderly Medicaid recipients into the program, even though senior citizens were not included in a five-year test of the idea.

The 11th and final public hearing, held Friday in Fort Myers, was typical of those elsewhere in the state, with advocates for the poor, elderly and mentally ill joining health care professionals to inject economic and medical considerations into the politics behind the overhaul.

Mark Mazzeo, an elder law attorney from Venice, echoed speakers at every previous hearing in saying that, since the program to test the managed care concept excluded costly long-term care patients, the hoped-for savings could evaporate when they are enrolled statewide.

"This program may cost us more," he said. "We don't know the answer to that question. We simply don't have the data."

Sean Schwinghammer, executive director of the Florida Alliance of Home Care Services, said insurance companies promised legislators a 30 percent savings, but had no experience in providing elder care.

"They made a great claim that resonated throughout the committee meetings, and here we are today," he said. Providers who could not make money in the Broward County pilot project "cut and run," Schwinghammer added, and he is not impressed by lawmakers' assurances that the new statewide system would be different.

"Either of those options — tested and failed, or never tested — are unacceptable," he said. Lawmakers anxious to rein in Medicaid's rising strain on the state budget made reforming the joint state-federal program a priority in the spring legislative session.

The law placing some 3 million Medicaid beneficiaries into care plans is set to start taking effect in July 2012. That deadline depends on the federal government granting the state a waiver to expand the pilot project — so far confined to five counties — statewide, along with other changes lawmakers want to implement.

The law calls for long-term care patients to be enrolled first, with full statewide enrollment in private or hospital networks by October 2014.

Jim Nathan, president of Lee Memorial Health System, expressed doubt at the Fort Myers hearing that the Centers for Medicare and Medicaid Services will grant the waiver for such sweeping changes. The state plans to submit the waiver request by Aug. 1.

The lack of information on medical-loss ratios - the amount of Medicaid spending that would go directly to patient care under the reform - "is going to be a huge problem for the feds," Nathan said. "What we're doing is pretending that by reducing Medicaid reimbursement" to health care providers "by 12 percent and shuttling all these people into managed care that we'll save zillions," he said. But, he added, the costs of care would be forced on local communities. He said the portion of Lee Memorial's patients covered by private insurance is 21 percent, down from 35 percent in 2007.

Mazzeo and others criticized the so-called "granny-dumping" provision of the new law, which offers service providers incentives to discharge patients from long-term care facilities into the community. Several elder law attorneys and health care providers said sufficient community resources do not exist.

Florida Sen. Joe Negron, an architect of the new Medicaid plan, had urged Tea Party members this week to attend the last few hearings and counter the testimony heard at earlier sessions from many elder law attorneys. But there was no evidence of a Tea Party presence at Friday's hearing. One speaker, who identified herself as politically "to the right of the Tea Party," agreed with others that private managed care networks will not be able to meet the complex care needs of elderly patients.

The public can comment by email:

- cynthia.mann@cms.hhs.gov
- FLMedicaidManagedCare@ahca.myflorida.com
- by letter to: Centers for Medicare and Medicaid Services, Center for Medicaid and State Operations, 7500 Security Boulevard, Mail Stop S2-01-16, Baltimore, MD 21244-1850.

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"There is no deadline for public comment," said Melanie Brown-Woofter, of the Agency for Health Care Administration. If comments come after the state completes its waiver request, "we'll use those as we work toward an implementation plan."

The LCMS attended the Statewide Medicaid Managed Care Public Hearing held Friday June 17, 2011 in Fort Myers.

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Lee County Medical Society

13770 Plantation Road, Ste 1
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Fort Myers, FL 33906-0041

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