APPOINTMENT DISAPPOINTMENT
Why pediatrician Lisa Swanson, M.D., doesn’t see Medicaid patients
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BY JAY GREENE

Pediatrician Lisa Swanson, M.D., doesn’t accept Medicaid patients for one simple reason: Reimbursement rates don’t cover her costs.

“If I accepted even 10% Medicaid, I would have to close my office,” says Swanson, a solo practitioner in the Dallas suburb of Mesquite. “Pediatricians make very low margins. I am barely in business. … It breaks my heart I can’t treat Medicaid patients because I took care of them when I was a resident.”

Spencer Berthelsen, M.D., chairman of the 300-physician Kelsey-Seybold Medical Group, Houston, says the group limits Medicaid patients to two types: First, if they were existing patients before they became Medicaid-eligible; second, if a Kelsey-Seybold physician on call treats a patient in a hospital emergency department. The group doesn’t accept walk-in Medicaid patients because reimbursement rates are less than 50% of costs, Berthelsen says. Medicaid charges represent about 0.15%, or $500,000, of the group’s $340 million in gross annual charges.

“The Medicaid population has the real potential of having higher chronic illnesses. It is a very challenging socio-economic group,” Berthelsen says.

Despite increases nationally in Medicaid rates from 1998 to 2003, a growing percentage of physicians are declining to accept Medicaid patients or are limiting the number, according to a study released in August by the Center for Studying Health Care System Change.

Doctors cited low reimbursement, excessive administrative paperwork and bureaucratic hassles as reasons they avoid or restrict Medicaid, the center found.

In the last half of 2004 and first half of 2005, 14.6% of physicians reported receiving no Medicaid revenue, an increase compared with 12.9% during the same periods in 1996 and 1997. Moreover, 21% of physicians reported accepting no new Medicaid patients, up from 19.4% from the same periods in 1996 and 1997.

“The few physicians I know who accept Medicaid have huge volumes of patients—80 patients per day—and spend five minutes each with them,” Swanson says. “They don’t have time for preventive care or education. You need to spend time with patients, especially children and their parents.”

The center also found Medicaid patients are becoming concentrated in large medical groups, hospitals and community health centers. Solo practitioners like Swanson have the lowest Medicaid participation rates.

“I spend 15 to 30 minutes with each patient,” says Swanson, who employs two nurse practitioners. “I can’t afford to do that under Medicaid. Most patients understand (her decision not to accept Medicaid). Pediatricians are of two mindsets. I am of the business mindset that you don’t take anything below your costs.”

However, other physicians “harass us greatly because they believe it is our job as doctors to take care of all patients,” Swanson says.

Doug Curran, M.D., a family medicine physician with Lakeland
PHYSICIANS AND MEDICAID PATIENTS

Over the past decade, the percentage of doctors who don’t accept Medicaid patients or who have stopped accepting new Medicaid patients has increased slightly.

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<td>Accept all new patients</td>
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Source: Center for Studying Health System Change

Continued from p. 2

Medical Associates in Athens, Texas, says the 11-member group also limits its number of Medicaid patients based on available appointment slots, whether there’s an emergency and illness status. About 20% of the group’s patient mix is on Medicaid.

In 2003, Texas cut Medicaid rates 2.5%. As a result, less than 50% of Texas physicians participate in Medicaid, says Berthelsen, a member of the Texas Medical Association’s Council on Legislation. A recent association survey found that 38% of physicians accepted new Medicaid patients in 2006, down from 67% in 2000.

Curran, who also is president of the Texas Academy of Family Physicians, says the clinic loses $20 for every routine, moderate-complexity office visit.

“If we do additional ancillary work, that may help” stem financial losses, he says. “The bottom line is Medicaid is so inadequate that almost nobody can afford to do it.”

Of the 30 to 40 patients Curran sees every 12-hour day, he reserves five to seven slots for Medicaid patients. “Every physician has a different mix. Once we hit our limits, we don’t see (any more) Medicaid patients that day,” Curran says.

Uninsured illegal immigrants also are a problem for Texas physicians. For example, Curran conducted the interview with Modern Physician from 117-bed East Texas Medical Center, Athens, while waiting to deliver the baby of an illegal immigrant. “She will go on emergency Medicaid,” Curran says.

Expensive and time-consuming regulations also stifle Medicaid participation. “One issue is translators,” says Chip Cover, senior associate administrator with Nemours Children’s Clinic, a 130-physician pediatric group in Jacksonville, Fla. “Anyone who can’t speak (English) is eligible for that, and the doctor is required to pay for it.”

Translators cost Nemours $60 for a minimum of two hours. “We get paid $90 for a midlevel visit. Our costs exceed what we get for that visit,” Cover says.

In Washington state, Medicaid pays doctors less than 50% of Medicare rates, and onerous regulations place groups at unnecessary financial risk, says David Fitzgerald, chief executive officer of Proliance Surgeons, a 135-physician group practice based in Seattle. “It is like giving everyone a $10 bill for coming to the office,” he says.

In 2003, Proliance Surgeons stopped formally accepting Medicaid patients, but the surgeons continue to take Medicaid referrals on a case-by-case basis and write it off as charity care, Fitzgerald says. “We gave over $1.5 million in charity care in 2005,” Fitzgerald says. But “we continue to take heat from primary-care physicians when they need a specialist. They ask us why we don’t take Medicaid and ‘Could you please see this one patient for me?’ ”

While rising numbers of physicians decline Medicaid, the number of Medicaid recipients has exploded by 39% to 44.4 million in 2004 from 32 million in 1999, according to the CMS.

As Medicaid moves to cost-cutting managed-care models, the CMS reports Medicaid spending growth has declined from 12% per year from 2000 to 2002, while growth dropped to 7.2% from 2002 to 2005. It is projected to drop to 4.6% in 2006.

State Medicaid spending is similarly dropping. Sixteen states are projecting to have lower Medicaid expenditures in 2006 than the prior year, including California, Florida, Georgia, Maryland, Michigan, New Hampshire, Nevada, South Carolina, South Dakota, Texas and Wisconsin.

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In August, the Bush administration released its proposed 2007 budget that calls for the federal government to further curb Medicaid’s “excessive payments.” The Bush plan faces huge opposition across the political spectrum in Congress.

But the Kaiser Commission on Medicaid shows most Medicaid recipients have a greater percentage of chronic diseases and are hospitalized more often than the general population.

“They are sicker. … Our biggest issue is compliance,” says Nemours’ Cover. “We give them a prescription, and three weeks later they come back and haven’t filled it.” About 40% of Nemours’ patients are on Medicaid, he says.

Physician groups such as Nemours say they do not treat Medicaid patients differently to lower costs. But experts say physicians with large Medicaid practices are increasingly using such care-management techniques as primary-care case management, registries and preventive-care education to keep costs down.

“We tend to use nurse practitioners more in the Medicaid population because we find the Medicaid patients need more intervention than seeing the doctor,” Cover says.

Bob Kneeley, director of investor relations with Pediatrix Medical Group, says the group makes up for Medicaid losses by negotiating higher private-payer rates and by providing efficient and high-quality care.

Medicaid accounts for 27% of Pediatrix’s net revenue and 54% of its gross revenue. Pediatrix is an 875-member pediatric specialty group based in Sunrise, Fla., that contracts with 240 hospitals in 32 states.

“Anything we have done to improve care and outcomes really is focused on all our patients,” Kneeley says. “We have been able to identify best practices across our network, and that improves quality and holds costs down.”

Jay Greene is a former Modern Healthcare reporter and now a freelance healthcare writer based in St. Paul, Minn. Contact Greene at jaywriter@comcast.net
BY MATTHEW DOBIAS

The Institute of Medicine last month recommended that Congress step into the pay-for-performance fray by requiring the CMS to trim its physician payments to fund a much broader use of the measures.

Under the IOM’s recommendations, Congress would require Medicare to reduce its base payments or scheduled pay increases, and then pool that money to award providers demonstrating high-quality, patient-centered and efficient care. In its report, the IOM said it would let Congress determine by how much to decrease payments, but added it would have to be sufficient to create incentives large enough to goose doctors into action.

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But Robert Reischauer, president of the Urban Institute and a co-chairman on the IOM panel that steered the pay-for-performance recommendations, says there are many physician organizations that favor a rewards-based system.

“They have participated in a lot of nonprofit collectives where they have been able to generate performance measures,” Reischauer says. For the most part, he explains, the doctors will go along with a pay-for-performance program as long as it’s done right.

Wilson: Cuts alone would not provide incentive.
BY MARK TAYLOR

The battle over physician-owned specialty hospitals could grow even more contentious as healthcare’s biggest enforcement agency sets its sights on ensuring they offer quality care.

HHS Inspector General Daniel Levinson released the agency’s 2007 workplan in September, vowing to assess the CMS’ oversight of physician-owned specialty hospitals.

The agency will examine the CMS’ oversight “to ensure patient safety and quality of care at these hospitals,” the inspector general said in the 93-page workplan, and it will also scrutinize “policies relating to staffing requirements at these hospitals.”

The inspector general’s decision to include specialty hospitals as one of its priorities was in response to a request from Senate Finance Committee Chairman Chuck Grassley (R-Iowa) for tighter oversight of physician-owned hospitals, according to a spokesman from the inspector general’s office. The issue has grown in importance with the end in August of a two-year moratorium on Medicare certification of physician-owned hospitals (“Hospitals vow to fight on,” September 2006, p. 4).

Randy Fenninger, Washington lobbyist for the American Surgical Hospital Association, says he isn’t surprised by the inspector general’s interest. We presumed it was in the pipeline,” Fenninger says. “It’s nothing new. We’re happy to have them look at our quality. “We think we’ll do just fine, although, after we’ve been so analyzed” by the Government Accountability Office and the CMS, he says, “I’m not sure there’s much left for the inspector general to look at.”

But HHS’ move didn’t seem to please everyone. Chip Kahn, president of the Federation of American Hospitals, characterized the inspector general’s policing effort as “a day late and a dollar short.”

Kahn said HHS’ plan to tackle the specialty-hospital issue through its enforcement arm reflects the lack of commitment shown to the crisis caused by physician-owned specialty hospitals.
**Second CON a charm?**

Nemours, Jacksonville, Fla., filed a second certificate-of-need application in its effort to build a $260 million, 95-bed children’s hospital in Orlando, Fla. The Florida Agency for Health Care Administration, which rejected the first application, is expected to make a decision on the second CON by mid-December. Nemours is appealing the initial denial. Nemours says it adjusted its second CON application “to better explain our proposed children’s hospital and its benefits to the central Florida community.” Nemours, a pediatric specialty group, owns four specialty centers in Florida and Wilmington, Del., and 172-bed Alfred I. duPont Hospital for Children, Wilmington.

**Indiana docs get go-ahead**

A $20 million physician-owned hospital in Clarksville, Ind., received planning commission approval after a federal judge last year overturned a protective county law. Construction on the 60-bed Kentuckiana Medical Center, a general acute-care hospital, is expected to begin shortly. The for-profit hospital, owned by 25 physicians, is scheduled to open within two years. At least five Indiana counties had passed moratoriums or local certificate-of-need laws restricting hospital projects after physicians proposed building facilities that would compete with local hospitals. Federal judges struck down the laws last year.

**New head for clinic hospitals**

The Cleveland Clinic named Fred DeGrandis as president and chief executive officer of its eight regional hospitals, a leadership restructuring that consolidates oversight of the hospitals. DeGrandis, 56, will report to Cleveland Clinic President and CEO Toby Cosgrove, M.D. The clinic previously had divided the hospitals into eastern and western regions. DeGrandis was CEO of the three-hospital western region. The position held by Thomas Selden, who was head of the four-hospital eastern region, has been eliminated.

**Pediatrics settles billing case**

Pediatrix Medical Group, Sunrise, Fla., will pay $25.1 million to settle civil Medicaid fraud allegations that it upcoded claims for neonatal intensive-care services from 1996 until 1999. Pediatrix, which denied the allegations in the settlement, also signed a five-year corporate integrity agreement with HHS’ inspector general’s office. The publicly traded company provides services to hospital neonatal intensive-care units. The government alleges that as many as one-third of infants weren’t critically ill when admitted to the ICUs and about half of infants weren’t critically ill during subsequent treatment, although Pediatrix billed as if they were.

**Med school enrollment up**

First-year enrollment in U.S. medical schools edged up slightly—by

Continued on p. 8

With over 2,500 accredited organizations throughout the ambulatory community, the Accreditation Association for Ambulatory Health Care (AAAHC/Accreditation Association) is the leader in ambulatory health care. For over 25 years, the Accreditation Association has been using an educational, consultative and peer-based survey approach to help all types of ambulatory health care organizations provide the best possible care to their patients. Recognized by third party payors, medical societies, governmental agencies and the general public, AAAHC accreditation is a symbol that an organization is committed to excellence in quality health care.

To learn more about how the Accreditation Association for Ambulatory Health Care can put your organization on the path to quality health care, contact us at 847/853.6060 or info@aaahc.org, or visit www.aaahc.org.
2.2%—in 2006 for the second straight year, reaching an all-time high of 17,340, according to the Association of American Medical Colleges. The increase is a small step toward a long-term resolution of an expected future shortage of physicians, AAMC President Darrell Kirch, M.D., says. The AAMC, which represents all of the nation’s 125 accredited medical schools, has called for a 30% increase in medical school enrollment by 2015. Twenty-eight medical schools boosted first-year enrollment by 5% this fall. Kirch says the AAMC data also show greater student diversity.

Judge won’t dismiss hospital tax case
A U.S. District judge in Chicago refused to dismiss a lawsuit brought by the University of Chicago Hospitals seeking $5.5 million in employer tax refunds from the Internal Revenue Service. The judge is the third to refuse federal requests to dismiss lawsuits involving taxes paid for medical residents under the Federal Insurance Contributions Act. In July and August, federal courts refused to give summary judgments for cases involving 448-bed University Hospital, Cincinnati, and the Center for Family Medicine at the University of South Dakota, Sioux Falls. In all three cases, the hospitals contend that medical residents are students and exempt from FICA taxes.

Specialists see better pay in ’05
Median compensation for specialty physicians rose to $316,620 in 2005, a one-year increase of 6.6% and a 20.3% jump since 2001, according to an annual survey by the Medical Group Management Association. Primary-care physicians saw slightly slower compensation growth. Their median compensation hit $168,111 in 2005, a 3.9% increase from the previous year and a 12.8% rise since 2001. Doctors’ work volume as measured by gross charges also rose, a sign that physicians are boosting productivity, the MGMA says. From 2004 to 2005, specialists’ gross charges rose 6.5% and primary-care physicians’ gross charges increased 6.8%.

Docs sue to protect surgery center
Peoria (Ill.) Day Surgery Center accused 593-bed OSF St. Francis Medical Center of antitrust violations in a lawsuit filed in U.S. District Court, Peoria. The surgery center alleges that the Peoria-based hospital used boycotts, tying arrangements and exclusive contracting in an attempt to monopolize outpatient surgeries. The center performed about 4,770 surgeries in 2004, or about 14% of the market, according to the lawsuit. St. Francis and St. Francis’ ambulatory surgery center performed about 14,600 surgeries in 2004, or about 42% of the market, according to the lawsuit. A St. Francis spokesman says the hospital does not comment on pending litigation.
Pair Medicare pay freeze with comprehensive reform

It looks like averting a Medicare physician payment cut isn’t going to be the slam dunk it has been the past four years. This year’s reprieve is entangled in a web of congressional tactics, deficit politics and growing concerns that patients aren’t getting their money’s worth from doctors.

The hope is that everyone will come to their senses by averting the payment cut for 2007, but only in exchange for public reporting of quality data. Meanwhile, serious work should continue on refining pay-for-performance programs so they achieve the goal of cost-efficient care, as the Institute of Medicine recently recommended (See story, p. 5).

Current P4P projects focus on rewarding providers who already are high achievers. That needs to shift toward finding ways to reward across-the-board improvement in adhering to quality indicators and/or achieving better outcomes.

Furthermore, we need a system that pays primary-care physicians to spend more time with patients. Primary-care physicians need to be encouraged to prevent illnesses, find them earlier and manage them better when they do occur.

What is clear from the current CMS data on utilization is that the current physician payment formula is fatally flawed. Doctors frustrated with lagging payment updates have been treating Medicare patients like they are ATMs. Medicare expenditures for physicians’ services grew by 10% in 2005, but a study by the Center for Studying Health System Change found that private health insurance spending on physician services rose at a slower pace of 7% the same year. As work by the Dartmouth Atlas team and the RAND Corp. has found, all this greater spending actually leads to worse outcomes.

Based on the current formulas, replacing planned Medicare payment cuts of 5.1% in 2007 and a total of 37% through 2015 would cost tens of billions of dollars that we don’t have. Projected Part B spending is already outrunning targeted spending by $30 billion just over the next five years, the CMS says.

This seems like a critical juncture. Simply plowing ahead with a payment increase without a major restructuring of the way we pay for and provide care is lunacy at a time when deficits are set to explode again and the pressure on access to care couldn’t be greater.

LETTERS

We’re still here

Although it may seem odd, many of us at Loyola University Health System can’t help but smile when we see that our name has made it into a competing hospital’s marketing and advertising (September 2006, p. 1). When a doctor moves elsewhere, the physician’s new public relations team typically wastes little time in announcing that they’ve recruited a Loyola physician. After all, the Loyola name stands for quality, and that’s a good thing.

What is perplexing, however, is your implied assertion that the recruitment of three of our physicians has somehow crippled us.

First, the facts: Our lung transplant team has 40 members, not 12. The effect of three physicians leaving barely registered a blip as lung transplant volumes remained consistent in the weeks and months following the move. Have we lost our stars? Hardly. Our chairman of cardiovascular and thoracic surgery is Mamdouh Bakhos, M.D., the renowned surgeon whose first lung transplant at Loyola in 1988 was also the first in Illinois. Our newest recruit is Robert Love, M.D., one of the finest transplant surgeon-researchers in the nation. Love built the lung-transplant program at the University of Wisconsin. I, myself, have been a part of this program for 17 years.

However, perhaps too much value is placed on “star doctors” and not enough on the team that backs these doctors up. Our transplant team’s collaborative effort over the past two decades is what helped Loyola achieve its status as one of only seven in the nation to complete 500 lung transplants.

Charles Alex, M.D.
Medical director
Lung transplant program
Loyola University Health System
Maywood, Ill.

Wary of gain-sharing

You are spot-on with your concerns on gain-sharing as used in this manner (October 2006, p. 10). Financial incentives for providers in a pay-for-performance model must reward providers for higher-quality care. Anything else is tainted.

Jim Dempster
Executive director
MedEncentive
Oklahoma City

YOU STAND A CHANCE TO WIN

Win a $25 gift card!

Your opinion may be posted on modernphysician.com and in the next available letters section of Modern Physician. Please include your name, title, affiliation and location.
Hal Teitelbaum, M.D., is not interested in maintaining the status quo. As managing partner and founder of Crystal Run Healthcare, Middletown, N.Y., Teitelbaum started the multispecialty group in 1994 to combat the growing clout of managed-care organizations and to enable patients to receive the highest quality care.

This meant shaking up the system. “We saw increasing difficulties in providing high-quality care without controlling more of the system,” Teitelbaum says. “The whole reason for forming the practice was to gain control.” Teitelbaum also believes delivering optimal patient care means creating the best possible work environment for physicians and staff, and providing them with the most up-to-date information technology, clinical services and back-office business support.

But in the popular summer vacation area of the lower Catskill Mountains and mid-Hudson Valley, about 65 miles northwest of New York, Teitelbaum faced many obstacles in building the practice to 130 physicians in seven offices.

In June, Crystal Run’s physicians resigned from Catskill Regional’s medical staff, complaining to the state’s Department of Health about quality problems and alleging discriminatory medical staff bylaws. After the state cited the hospital in Harris for four quality violations in late September, the hospital’s president and chief executive officer, Arthur Brien, resigned.

In recognition of his business acumen and commitment to expanding patient access, the American College of Medical Practice Executives and the Medical Group Management Association have chosen Teitelbaum as their 2006 Physician Executive of the Year.

“He exemplifies the business orientation that we look for in physician leaders,” says William Jessee, MGMA president and CEO. “You see so many doctors who see something wrong in the industry and complain about it. He has done something about it.”

Born in Queens and raised on Long Island, Teitelbaum spent most summers until medical school in Sullivan County, where his grandparents owned and operated a bagel bakery. His father was an accountant who wanted Teitelbaum to join his practice. “I knew I wanted to be a physician since I was 5 years old. I had no doubt in my mind,” he says.

After his residency in internal medicine at New York Hospital-Cornell Medical Center and a fellowship in medical oncology at Memorial Sloan-Kettering Cancer Center in 1980, he joined the faculty of Albert Einstein College of Medicine. In 1982, Teitelbaum moved to Orange County, N.Y., where he met his wife, Jennifer. Along with partner Robert Dinsmore, Teitelbaum in 1994 laid the groundwork for Crystal Run by deciding to hire two oncologists and a cardiologist. Teitelbaum soon realized he needed more business skills, so in 1996 he enrolled at Columbia Business School. He earned an executive MBA in 1998.

In 2005, Teitelbaum was named the second most powerful individual in the Hudson Valley and Catskill region by the Times Herald-Record newspaper.

Jay Greene is a former Modern Healthcare reporter and now a freelance healthcare writer based in St. Paul, Minn. Contact Greene at jaywriter@comcast.net
Ethics elaborated

Confab takes on conflicts of interest

BY MARK TAYLOR

Conflicts of interest aren’t easy to resolve. That’s why they call them conflicts.

So the 200 ethics, compliance and conflict-of-interest officers attending the Cleveland Clinic’s Sept. 20 conference—A National Dialogue on Biomedical Conflicts of Interest and Innovation Management—heard many differing opinions and much public soul-searching about how to stimulate and support innovation in university research facilities and academic medical centers without surrendering ethical values.

They heard government regulators and grantmakers talk about new efforts to encourage transparency through disclosure—and what consequences face them if they fail to adopt those measures.

That’s becoming increasingly difficult given the many subtle and obvious temptations from pharmaceutical companies and devicemakers sponsoring or purchasing the fruits of that research. The conference brought together some of the top names in academia, research and business to grapple with issues researchers face daily.

Inventing the next breakthrough drug or miracle device has delivered wealth and prestige to individuals and universities, making reputations and attracting other bright minds, clinical studies and research grants from government agencies and the private sector. But in a few cases, ethical lapses and decision-making driven more by profit than by patient safety have cost lives, created negative press and brought shame, lawsuits and even criminal charges to the doorsteps of some of the best-regarded institutions in the country.

Philip Pizzo, M.D., dean of the Stanford University School of Medicine, says: “Some people will always do the right thing. Most need guideposts. But a handful will violate the law.”

He says Stanford officials know there will be conflicts of interest, but says leaders there help the faculty to manage those to support innovation. Pizzo says Stanford accomplishes that through extensive transactional and annual disclosure statements that include declaring financial interests, including more than $10,000 in equity in a private company.

“Our institution will divest an interest in any company doing clinical trials at Stanford,” Pizzo says. He says the free meals and gifts to physicians, researchers and staff create a “too close” intermingling of interests that could influence decisionmaking, and says Stanford has eliminated “all things that create confusion in the public mind and cost public trust ... breaking the shackles of marketing.”

Former Merck & Co. Chief Executive Officer Roy Vagelos, M.D., says those holding financial interests in a prospective product should not be allowed to conduct human research testing of those products. Vagelos says he tried but failed to get rid of the pharmaceutical sales representatives who market drugs to physicians, better known as “detailers.”

He says educating physicians about drugs is important to both manufacturers and physicians, but suggests a different environment, such as a conference, where doctors can learn without being pitched or bribed with gifts.

He says the drug companies don’t give away lunches and gifts out of pure generosity, but explains their studies tell them that the giveaways do influence physician prescribing behavior.

However, Thomas Stossel, M.D., an entrepreneur and Harvard University professor, says the disclosure requirements from universities and federal agencies are becoming onerous and intrusive. Stossel says the transparency movement discourages the best and the bright—those with expertise and connections—and intrusive. Stossel says the transparency movement discourages the best and the bright.

While Stossel is not alone in his opinions, the tone of the audience responses seemed to indicate a grudging acceptance of tougher rules and greater disclosure to rebuild and maintain public trust. “There’s a growing sentiment of distrust,” says former U.S. Attorney General Richard Thornburgh, or an erosion of public trust.

Thornburgh, a Pfizer board member, says if the biomedical establishment can’t regulate itself, “We can expect increasing government involvement. Appearance is everything. Vigilance requires attention to conflicts of interest on personal and institutional levels.”

CLICK to COMMENT

Your opinion may be posted on modernphysician.com and in the next available letters section of Modern Physician. Please include your name, title, affiliation and location.
**Reasons for limiting Medicaid patients**

Among the 22% of physicians who are limiting the number of new Medicaid patients they accept

**Major reasons**

- Low payment rates 63%
- Administrative problems 47%
- Payment delays 44%
- Difficulties making referrals to specialists 33%
- Missed appointments (or other noncompliance) 28%
- Difficulties in providing treatment 19%
- No Medicaid patients presenting themselves 6%
- Limiting all new patients/practice full* 6%
- Other reasons 3%
- High potential for lawsuits* 1%
- Group/hospital does not accept* 1%
- Difficult patients* 1%

* Volunteered

Source: Kaiser Family Foundation’s National Survey of Physicians, March 2002  
(Most recent data available)

**Physicians and Medicaid patients**

Percentage of physicians currently limiting the number of Medicaid patients they accept

- Yes, limiting 16%
- No current Medicaid patients 22%
- No, not limiting 62%

**The majority of physicians don't limit Medicaid patients; only one-third have a significant portion of Medicaid patients**

Among the 62% of physicians not limiting the number of Medicaid patients they see, the percentage of their patient mix who utilize Medicaid

- More than 20% 33%
- 1-5% of patients 24%
- 6-10% of patients 22%
- 11-20% of patients 21%

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ASSOCIATIONS
Rick Kellerman, M.D., a family physician from Wichita, Kan., is the new president of the 94,000-member American Academy of Family Physicians, the nation’s second-largest medical-specialty society. Kellerman, 52, took over the top post in September during the organization’s annual meeting. Kellerman is a private practitioner who also serves as a professor and chairman of the Department of Family and Community Medicine at the University of Kansas School of Medicine-Wichita. ... Steven Waldren, M.D., was promoted to director of the AAFP’s Center for Health Information Technology, replacing David Kibbe, M.D. Kibbe, 56, will work as an adviser to the center as needed, the AAFP says. Waldren, 33, served as co-chairman of the ASTM Continuity of Care Record Technical Committee and has worked on the compromise Continuity of Care Document standard, a joint development between ASTM International and Health Level 7.

GOVERNMENT
Former CMS Administrator Mark McClellan, M.D., will become a visiting senior fellow at the AEI-Brookings Joint Center for Regulatory Studies, where he will focus primarily on improvements to boost healthcare quality, affordability and innovation. McClellan, 43, announced his resignation from the CMS in September and left the agency last month. ... The Association of American Indian Physicians named Kelly Moore, M.D., the 2006 Indian Physician of the Year. Moore, 51, is a clinical consultant in the Indian Health Service Division of Diabetes Treatment and Prevention, Albuquerque, and serves as chairwoman of the American Indian and Alaskan Native Work Group of the National Diabetes Education Program.

HOSPITALS, SYSTEMS
Bernard Gawne, M.D., was named vice president and chief medical officer at SSM St. Mary’s Health Center, St. Louis. Gawne, 61, was the former CMO for the Provena Health Central Illinois Region. ... Brian Issell, M.D., was named vice president of clinical research at Scripps Health, San Diego. He will start his new job in December. Issell, 62, is the former director of the clinical-trials unit at the University of Hawaii’s Cancer Research Center. ... Barbara Paul, M.D., joined Community Health Systems, Brentwood, Tenn., in the new post of national medical adviser. She will provide consulting assistance to the quality- and resource-management team and the hospital system’s physician advisory groups. Most recently, Paul, 52, was senior vice president and CMO at Beverly Enterprises.

INSURERS

SUPPLIERS, VENDORS
Cardiac surgeon Michael Gallagher, M.D., was named medical director for eNotes Systems, a Pacific Palisades, Calif.-based developer and marketer of telemedicine products and services. Gallagher was also appointed chairman of the eNotes Systems medical advisory board. Previously, he served as vice chairman of the Cardiothoracic Surgical Section at Memorial Hermann Southwest Hospital in Houston and as a clinical assistant professor in the surgery department at the University of Texas (Houston) Medical School.