

Letters

Reaching a Medicare Breaking Point

I was reading your November-December 2007 issue. In the Letters to the Editor (p. 6), there is a letter by Frank R. Bacqué, MD, regarding the strain that the sustained growth rate formula is putting on our practices.

Your letter was interesting in response to his. I certainly agree that it would be surprising that more of us aren't writing about this. I personally have sent at least 10 letters to our Congress regarding the formula under which we are reimbursed and the fact that it must be changed.

I agree that we all went into medicine for the reward of helping patients in need. There is, however, a point that will soon be reached, when we will be unable to do that purely because of the overhead that is not going to go down. We are, in fact, small business people and when the income is less than the overhead, there is no question that we have to get out of that particular situation. I think this is an indication of the statement that I lose on every case, but I make it up in increasing the number of cases. There really comes a point when you can't increase the number of cases, not only surgical, but also seeing patients in the office.

There certainly is going to come a point, when in 2015, if they have reduced us by 40% by that time, we certainly will not be able to practice in the Medicare environment.

—John B. Fenning, MD
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Formularies, Consumerism, and Mid-Level Providers

As a rural family physician (FP) for 34 years working with a small rural Medicaid (and some Medicare Advantage [MA]) plan, I enjoy your

publication immensely and generally at least scan it cover to cover. I'm also convinced that quality should be the focus in medical care, but it must be affordable quality. If cost is not considered in the equation, we will continue to invest a greater percentage of our gross domestic product (GDP) in ineffective sickness care and fluff. I shy away from superlatives like "best care" in the absence of cost effectiveness. Its use can result in justifying huge marginal expenses for minimal increments in quality.

A good example of this is in formularies. Since long before managed care, I've tried to prescribe as I would hope that any physician would for one of my uninsured relatives of modest means. Our fairly limited Medicaid formulary nearly always suffices, and makes transition to second-line drugs easy. Rather than "a silo of drugs" chosen for their cost effectiveness, Congress has mandated an industry-created MA compendium, which must include as first line, numerous drugs of dubious "value" (that is, quality divided by cost). Rather than requesting that physicians first try more cost-effective drugs (that are likely to do the job equally well in 90%+ of the cases), plans must fill waves of prescriptions in the wake of either the latest drug rep's visit or more catchy direct-to-consumer (DTC) TV ads. I would suggest that when MA plans broaden their formularies, they do so primarily to attract uncritical patients in response to DTC ads. After all, they already have to pay for other equally expensive "me too" drugs, so it costs them little to pander.

This brings us to a major issue, consumerism. We should reject the appellation of "consumers of health care" in reference to our patients. Our professional expertise and caring is not a commodity. Health care bears no relationship to a "free market" and shouldn't. We have proved that buying more and more "health care" does not improve outcomes. Patient choice is an admirable goal, provided that patients understand and feel the costs of their choices. In the current state of affairs, the penalty is minimal for choosing a better advertised drug with no real advantage over a generic at a 10th of the cost. And how rational and well-informed are consumers who remain sedentary, often smoking, and in-

vest “healthcare” dollars in absurd breast augmentation, butt lifts, and Botox? Can doctors who help to create and perpetuate the demand for these limited-value services really “be trusted to do the right thing?” Are specialists who abhor patient contact and insist on bankers’ hours and multiples of the pay of lowly primary care physicians really not in it for the money?

And finally a word about mid-levels. I agree that they can provide about 70% of primary care provider (PCP) services. My experience suggests that many of them believe that figure is closer to 120%. They tend to treat conditions earlier and more expensively, often without appropriate indications or even a diagnosis in spite of extensive shotgun testing. Starting a second- or third-line drug on a patient with a single mild elevation of blood pressure or random blood sugar is not unusual. With a limited fund of knowledge, they often don’t suspect they are missing things. They appear to think little of patients referring to them as “doctor” and even less of correcting them. They save money only for their direct employers, who usually benefit as well from their indiscriminate testing. Most are caring and can spend more time with each patient than physicians. While they have a place in care delivery, we must never forget that a little knowledge is a dangerous thing.

—A Concerned Physician

Error in November/December Guidelines on Urinary Incontinence

I think there was an error on page 11 of the November/December issues of *MPM*. Oxybutynin prevents urge incontinence by relaxing detrusor muscles, not sphincter muscles.

—C. Parkman, MD

Dr. Parkman—Thanks so much for that fantastic pickup. We actually printed the guidelines exactly from the organization’s clinical practice guidelines, so we will be letting them know of the error as well. *MPM*

—Richard G. Stefanacci, DO, MGH,
MBA, AGSF, CMD
Editor-in-Chief
Medicare Patient Management

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