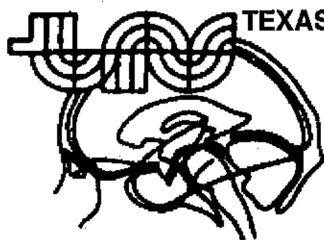

TEXAS NEUROLOGICAL SOCIETY

Broca's Area

The Voice of Texas Neurology

Fall 1995

Words from the President

Ernesto Infante, MD

I am most honored to serve this year as president of the Texas Neurological Society. In this time of change, our society can serve as a united voice for the neurologists in the state of Texas. Since our first organizational meeting in Houston, in May, 1974 with 24 Texas neurologists in attendance, we have grown to close to 300 members. During my tenure, I will try to continue to increase our membership and I encourage all current members to do the same.

An objective of our organization is to establish contacts among members and discuss issues related to our profession and to our specialty. I believe that *Broca's Area* can be used for this purpose. We all have to thank Tom Hutton for having started this publication and for his continued effort. I invite all members to submit their thoughts to the Journal in the form of articles, letters to the editor, etc.

Attendance at the Texas Neurological Society meetings held in conjunction with the Texas Medical Association annual meeting is another wonderful opportunity to meet colleagues from across the state and discuss issues and medical information of interest to us all. I personally find it most rewarding to get to know personally those neurologists with whom I had only shared correspondence in the past.

Another function of the TNS which has been most fruitful has been the excellent scientific programs held at our annual meetings. The quality of the presentations has been superior, updating different areas of neurology, and at the same time the addition of socioeconomic, practice and legislative issues has been most timely. Our meetings last for a day and a half and I am in favor of increasing it to two full days. Every year the program chairman has done a superb job. To make it easier, it would be helpful that from now on the year's chairman receive assistance from the previous two years chairmen.

We need to increase (continued page 2)

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Words from the President

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2the attendance at these excellent and informative meetings. I invite the members of the society to take an active role in this. Our next meeting in San Antonio will not coincide this time with the American Academy of Neurology and I believe this will help increase the attendance. From a historical viewpoint our first scientific meeting was held in San Antonio in May, 1975 thanks to the efforts at that time of Drs. Buell and Skaggs. This would be a wonderful opportunity to invite all of the previous presidents of the society to attend the meeting.

We also need to encourage the young neurologists in training to join this society and attend the meetings. In this regard, the young investigator award should help. I want to thank Dr. Homan for his excellent effort in putting it together.

In summary, there is much the Texas Neurological Society is currently doing and the future looks most promising. I encourage your input and participation in order to make the future of TNS even more successful.

TNS Young Investigator's Award Funded

DuPont Pharma has generously agreed to provide financial support towards the annual TNS Young Investigator's Award. The award is presented to a medical student, resident or fellow who has done outstanding research during the past year. The award is presented at the TNS annual meeting in May and will now be called the DuPont Pharma Young Investigator Award. The Texas Neurological Society gratefully acknowledges the support of Dupont Pharma for this award.

News of Members

Ninan T. Mathew, MD, Houston neurologist and Director of the Houston Headache Clinic was elected as Chairman of the Headache Section of the American Academy of Neurology. Dr. Mathew will serve a two year term as chairman.

Welcome to New TNS Members

The following were approved for membership in the Texas Neurological Society at the May, 1995, Annual Business Meeting.

Active Membership

Deborah T. Combs Cantrell, MD, Dallas
Walter G. Carr, MD, Denton
Lester B. Collins, MD, Tyler
Jack D. Gardner, MD, Dallas
Richard A. Hamer, MD, Rockwall
Brian Loftus, MD, Houston
Cherry Mathew, MD, Lufkin
William E. McIntosh, DO, Fort Worth
Richard Payne, MD, Houston
Haydee Rohaidy, MD, Amarillo
Robert G. Smith, MD, Houston
Azreena D. Thomas, MD, Houston

Associate Membership

Kristi J. Posey-Merkl, MD, Houston

Resident Membership

Nancy A. Allemier, DO, Houston
Jerry D. Boggs, MD, Lackland AFB
Lourdes M. Flanagan MD, Galveston
Randy C. Gardell MD, Galveston
Morris D. Groves, Jr., MD, Houston
William B. Lujan, MD, Lackland AFB
Vinaykumar K. Puduvalli, MD, Houston
Richard D. Tyler, MD, Galveston

EDITORIAL COMMENT

Patient Protection Act
A Postmortem

Tom Hutton, MD

Governor George W. Bush vetoed House Bill 2766, the Patient Protection Act, after overwhelming House and Senate support of the bill and after the close of the session so that no opportunity existed to seek an override of the veto. This bill was arguably the most feared by the managed care industry of any bill introduced in all the state legislatures this year. It is instructive for Texas Neurologists to understand the process and recognize the high stakes.

At the heart of the Patient Protection Act was a provision requiring that the criteria for selection of providers and the makeup of the plans' networks be disclosed to providers and enrollees. It also provided for more disclosure of benefits, provisions, restrictions, and limitations of managed care plans to prospective enrollees.

While these provisions appear reasonable, the managed care industry saw them as anathema. An incredible lobbying effort paid for by the Group Health Association of America descended upon Austin and culminated in Governor Bush's veto. While Governor Bush concluded that patients and doctors needed certain protections with the advent of managed care, he determined this could be accomplished better via insurance regulations.

Why would open and clear disclosure of managed care plans services and restrictions, and criteria for provided selection and network makeup be of such importance to predicate such an incredible lobbying effort? For managed care to be effective in reducing cost of health care and generating healthy profits, the industry desires arbitrariness in the provider selection process. While the managed care organization could easily negotiate a substantial discount with all providers, this is much less profitable than restricting the number of network providers. These providers initially feel fortunate to have been selected into the network; however, because they now depend on the managed care organization for access to their patients, they have no choice but to submit when further fee reductions and other restrictions are imosed upon their practices. In addition, limiting the network to a subset of available providers inevitably gives rise to animosity between network and out-of-network providers. The managed care industry counts on such antagonism and will play one group off against another to extract further fee concessions. Should fee concessions ultimately drive providers out of business, this is inconsequential to the managed care industry as it has convinced the public that too many specialists exist. The HMO industry is deliberately manipulating the public through advertising to decrease demand for specialists. Once this "surplus" is perceived to exist, then it becomes easier for managed care to exclude specialists from their networks and thus further reduce what they spend on physician services. A unified provider community could frustrate such predatory practices,and is feared by the managed care industry .

The managed care industry has data suggesting the American consumer of health care desires lower cost, access to providers and quality of care in that order. A study by Mathematica, Inc. in 1993 showed that Medicare actually spends 5.7% more with managed care than it would in direct fee-for-service reimbursements. A recent National Committee on Quality Assurance/Healthplan-Employer Data Information Set pilot project found a 22% annual turnover in managed care organizations with large numbers of abandoned patients and failure to demonstrate any measurable reduction in overall healthcare expenditures. This study implies that costs are merely being shifted. An additional concern was (continued page 9)

Medicare Reform: Conference Agreement

On the following pages you will find a side-by-side chart which compares the House and Senate Medicare Reform Legislation with the Conference report language. The chart reflects the provisions of the conference report as of November 16, 1995. The Conference report was presented to both houses of Congress and was voted on just before Thanksgiving. The Conference Report was accepted by the full House by a vote of 237 to 189 and by the Senate by a vote of 52 to 47 (after deleting CLIA and antitrust provisions). While this is not a full report, the following will give you the outcome with regard to the major issues.

The Medicare Choice program was adopted. The provider sponsored networks provision was approved with some modifications from the House provision. Federal standards would be developed for the approval of provider-sponsored networks but states would apply the standards. The antitrust protection included in the House bill for PSNs, whether Medicare contractors or not, was dropped because of the Byrd rule regarding provisions which do not have budget impact. **The Helms amendment on access to specialists was dropped.** There is a requirement in the final bill that an enrollee in a health plan must have access to appropriate providers including "credentialed specialists." There are in the final bill a number of other provisions regarding consumer protection, provider protection and quality assurance that have some positive impact regarding access to services and specialists.

With regard to the indirect medical education reductions, the Conference Report reduces the indirect medical education financing from the current 7.7% formula multiplier to 5% in 1999 through 2001. This is closer to the Senate provision than the House. The Conference agreement includes the basics of the House provision established the Medical Education Trust Fund. The Conference Agreement *drops* the House provision regarding reductions for the training of international medical graduates. The Conference Agreement modifies the House provision regarding the duration of training; the final agreement reduces the amount of payment from 50% to 25% of the average cost for residents who are trained in years after they become eligible for their initial boards. The House provision had eliminated all funding and current law allows 50% funding. The Conference Agreement limits payment in medical education to the number of first-year residents who were in first-year residency as of August 1, 1995. Specific reductions in payment apply only to those residency training programs who have a number of residents which are in excess of the number of first-year residents August 1, 1995.

The conference agreement basically includes the House provisions modifying Stark by reducing the designated health services to lab services, parenteral and enteral nutrition, physical therapy and radiology services including MRIs and CAT scans. The final provisions include all of the House provisions which relate to exceptions for shared facility services and services in communities where patients do not have access to alternative providers. All other House changes are included in the Conference Agreement,

The conference agreement does not include the House provisions which would have exempted physician office laboratories from CLIA. This and other provisions in the House bill were dropped in large part because of the Byrd rule. There will likely be an effort made to add to another bill the CLIA provisions and the antitrust protections which were dropped because of the Byrd rule.

The conference agreement reduces acute care hospital DRG payment by the amounts in the House bill which were the hospital market basket index (MBI) -2-5% for 1996 and -2% for 1997 through 2002. DRG exempt hospitals and units are reduced according to the Senate provision which cut the most deeply, and would reduce payments by the MBI -2.5% in 1996 through the year 2002. The update adjustment "would vary for hospitals above and below TEFRA limits." The update can be no less than 1.4% in 1996, 1.3 % in 1997, and 1.1% in the other years, however. This essentially reduces the impact of the MBI -2.5% since the current MBI is about 3%. The final language includes rebasing of long-term care hospitals according to the House provision. The final legislation eliminated the requirement for the Secretary to report in a prospective payment system for PPS-exempt hospitals.

The disproportionate share payment reductions follow the Senate provisions. *(cont. page 8)*

MEDICARE REFORM LEGISLATION

MAJOR ISSUE	MEDICARE PRESERVATION ACT (MPA) H.R. 2425 (10/17/95)	SENATE RECONCILIATION BILL S. 1357 (10/28/95)	CONFERENCE REPORT (11/16/95)
TRADITIONAL FFS MEDICARE			
Premiums	Maintains Part B. Premium at 31.5% of costs. Wile rise from $46.10 in 1995 to $90.20 in 2020. "Affluence testing" begins at $75,000 (ind), $125,000 (couples). Subsidy phased out at higher incomes.	Will rise from $53.00 in 1996 to $89.00 in 2002 Part B subsidy reduced for individual at $50,000; couples at $75,000; completely phased out at $100,000 (ind), and $150,000 (couples)	Part B Premium will rise from $53.70 in 1996 to $88.90 in 2002. Part B subsidy reduced for(ind) at $60,000; couples at $90,000; completely phased out at $110,000 (ind) and $150,000 (couples)
Co-pays/ Deductibles	No changes	Part B deductible raised to $150 as of 1/1/96 with programmed $10/yr annual increase through 2002.	No changes
Physician Updates/CF	MVPS abolished/replaced with sustainable growth rate based on new single CF updated annually, allowing for GDP+2% (after 1996), changes for inflation/enrollment. 1996 CF $35.42. Annual update limits: 93-103% of MEI '96-'97; lower limit of 92.25% in '98; 92% in '99. No behavioral offset.	MVPS abolished in favor of sustainable growth rate with single CF (set at $35.42 for 1996), with annual updates of GDP+2% beginning in 1996, limited to a range of 93%-103% of the MEI.	MVPS abolished in favor of sustainable growth rate with single CF (set at $35.42 for 1996), with annual updates of GDP+2% beginning in 1997, limited to a range of 93%-103% of the MEI.
Program Growth	For FFS Medicare program, bill sets "fail safe" overall Medicare benefit budgets for each of 7 years, which if triggered, apply categorically: inpatient hospital.; home health; extended care; hospice care; physician services; outpatient. hospital./ambulatory facility; DME; diagnostic tests; other services. HHS Sec. would change payment updates if services > designated spending growth targets. "Base closure" provisions, with expedited review, if President proposes changes. Establishes annual growth rates for each of 9 sectors for 7 yrs. If sec. determines FFS expenditures/sector: (1) > adjusted allotments for such sector, then allotment increased by amount of deficit. Sensitive to Medicare-Plus migration, but will never increase CF per se.	(Byrd Rule deletion: Budget Expenditure Limit Tool (BELT) provision would set annual Medicare spending limits for 1996-2002. CBO and OMB report to Congress on whether spending reductions necessary to reach BELT targets. President would issue order specifying % which when applied proportionately to all payments would bring previous or current year into compliance with BELT targets. Through expedited process, Congress would then be able to alter the way cuts are applied to various payments, but not overall amount. To delay or eliminate spending reductions, Congress would need 3/5ths support).	For FFS Medicare program, bill sets "fail safe" overall Medicare budgets for each of 7 yrs. beginning in 1996, which if triggered apply categorically for 9 sectors; inpatient hospital; home health; extended care; hospice care; physician services; outpatient. hospital/ambulatory facility; DME; diagnostic tests; other services. HHS Sec. would reduce prospective sector payment updates by 133% if projected total services exceed designated spending Growth targets and projected sector payments exceed growth target. Sec. may adjust payments for behavioral offset. "look back" adjustment beginning in 1998 would retrospectively spending for excess spending sectors if spending for total services and sector exceed targets.
MEDICARE-PLUS/CHOICE OPTIONS			
Plan Types	FFS; PSNs; MSA/catastrophic; POS plans with minimum payment levels for out-of-network; union; assoc. plans.	FFS; coordinated care, including PSN plans, along with mandatory offering of POS option when benefits and services limited; union or assn. plans (MSA/Catastrophic: Byrd deletion)	FFS; MSA/catastrophic; coordinated care, including PSN plans; union or association plans.

MAJOR ISSUE	MEDICARE PRESERVATION ACT (MPA) H.R. 2425 (10/17/95)	SENATE RECONCILIATION BILL S. 1357 (10/28/95)	CONFERENCE REPORT (11/16/95)
Premiums	Premiums "decoupled" from current FFS methodology and converted to budgeted contributions, annually determined. Premiums will be community adjusted rate, by age, disability, and other HHS-determined factors. Low utilization area rewards; initial $300/month floor	Premiums de-linked from current HMO payment methodology, and new 1996 base will be updated each year by per capita growth in GDP. HHS to conduct comp. bidding demo. project. Enrollees would add own funds to capitated amount for higher priced plans.	Premiums de-linked from current HMO payment methodology and will be updated annually by set % (1996 floor set at $300/month) Enrollees to add own funds to capitated amount for higher priced plans beyond required services. Premiums will be comm. adjusted rate, by age, disability, and other HHS-determined factors.
Rebates	Plans compete on adding benefits/lower copayments, not plan cost. Rebates can't be > value of Part B premium.	If Medicare payment exceeds cost of Medicare Choice plan, bene may receive 75% of excess as rebate. Excess could also go to MSA or supplemental coverage.	If Medicare payment exceeds cost of Medicare Choice plan, bene may receive 75% of excess as rebate. Excess could also go to MSA or supplemental coverage.
MSA	Government busy catastrophic policy and deposits excess contribution in MSA. Benes can use MSA funds to pay for any qualified medical expense. $10,000 deductible. Ability to move from MSA option to other Medicare Plus plans somewhat restricted.	(Byrded out: Government buys catastrophic policy and deposits excess Medicare payment amount in MSA. Benes can use MSA funds tax-free to pay for any qualified medical expenses; otherwise 10% penalty. Bene must provide 1 year notice to disenroll from MSAs with exceptions.)	Government buys catastrophic policy ($6000 deductible. for '97) and deposits excess Medicare payment amount in MSA. Bene must provide 1 year notice to disenroll from MSAs, with exceptions.
PPA/ Standards	Guaranteed info/disclosure/access for patients, confidentiality safeguards, access to ER services. For MDs: (1) Notice of participation rules; (2) written notice of adverse decision; (3) appeals process for adverse decision; (4) plans shall consult re med. policy, quality/credentialing & medical management. Physician indemnified from plan denial of medically necessary care.	Guaranteed info/disclosure/access, ER services for patients using prudent layperson standard, plus appeal rights. Enrollees receive "satisfaction" health outcomes, and disenrollment info for all plans. Choice of MDs, including out-of-network providers. If applicable, must be specified. Helms POS language.	Guaranteed info/disclosure/access for patients, confidentiality safeguards, access to ER services. (No prudent layperson def). For MDs: (1) Notice of participation rules; (2) written notice of adverse decision; (3) appeals process for adverse decision; (4) plans shall consult re med. policy, quality & medical management. Physician indemnified from plan denial of medically necessary care.
LIABILITY REFORM	Broad health care liability reforms, including $250,000 cap on non-economic damages. Applies to any health care liability action brought in any state or federal court, except for vaccines.	No provisions	No provisions.
PSNs/ ANTITRUST	For antitrust relief, DOJ/FTC to promulgate guidelines within 120 days, with case-by-case review under 'rule of reason". PSNs formed on standards set under expedited Neg. RM; NAIC will not set standards, nor will states without HHS approval. Modified cap/solvency standards possible. Expedited application review. PPA extended to PSNs.	No antitrust relief. PSN applications would first be through state; if denied or no action w/i 90 days, cert. could be sought through HHS, but HHS could act only where state stds. were unreasonable/ inconsistent with Fed. cert. stds. Ability to provide services/broad range of alt. means may be considered in developing solvency stds in expedited regulatory process. Fed cert good for only 36 mos. while state license sought, with 2002 sunset provision. Data collection program est'd. (Byrd out HHS partial capitation stds demo)	For antitrust relief, DOJ/FTC to promulgate guidelines within 120 days, with case-by-case review under 'rule of reason". NAIC will set standards (except for solvency) with HHS approval. Federal solvency standards by expedited Neg. RM. Expedited application review by HHS, with unlimited 36 month renewals where state fails to complete action or regulation is discriminatory.

MAJOR ISSUE	MEDICARE PRESERVATION ACT (MPA) H.R. 2425 (10/17/95)	SENATE RECONCILIATION BILL S. 1357 (10/28/95)	CONFERENCE REPORT (11/16/95)
FRAUD AND ABUSE	Patients empowered to detect/report, with financial rewards. Mandatory program exclusions for wide-ranging offenses, including excess charges and medically unnecessary services. Bounty system established. AG coordinates multi-agency task force. Doubled civil, new criminal penalties. Five HHS pilot projects.	HHS IG and AG coordinate fraud and abuse control program funded from HI trust fund funnel-through of civil and criminal penalties. Mandatory program exclusions for wide-ranging offenses, including excess charges and medically unnecessary services.	HHS IG and AG coordinate fraud and abuse control program, funded largely from HI trust fund funnel-through of civil and criminal penalties (bounty system). Mandatory program exclusions for wide-ranging offenses, including excess charges and medically unnecessary services. Patient incentive program fro reporting fraud. Creates fraud and abuse data collection program to record final adverse actions against providers.
REGULATORY RELIEF	Self referral: repeals compensation arrangement prohibition; reduces designated health services categories. Stark II can't be enforced until regulations promulgated. Repeals direct supervision/site of service requirement for in-office ancillary services. Creates shared facility/community need exceptions. CLIA: Physician office relief. Binding advance opinions on proposed or actual activities available from HHS Sec. (anti-kick law)	None specified.	Self referral: repeals compensation arrangement prohibition; reduces designated health services categories. Stark II can't be enforced until regulations promulgated. Repeals direct supervision/site of service requirement for in-office ancillary services. Creates shared facility/ community need exceptions. State law not pre-empted. Leaves in place reporting requirements. CLIA: Physician office relief.
WORKFORCE/ GME REFORM	New GME/teaching hospital trust fund. Caps FTE residents at 8/1/95 levels; non-US citizen phased reductions, except for resident aliens. $ follows services. Creates legislative committee on all-payer, IMGs, other issues. Non-MD post-graduate training programs would grow.	Includes MediChoice patients to determine DME and DSH payments; $1.2 billion added back to SFC bill that would have reduced IME to 4.5% by 1998 for each 10% increase in ratio of interns or residents to beds (principal effect felt beginning 1996).	7 year authorization: $13.5 billion to new GME/teaching hospital trust fund, including Medicare Plus incentive acct. with phased-in requirement for hospital stays paid through Medicare Plus plans. Caps FTE residents at 6195 levels, with some flexibility. Overall weighing factor reduced from 0.50 to 0/25 after first board cert. No IMG restrictions. IME levels slightly above Senate numbers. Teaching hospital must be part of consortium for $ follow services.
QUALITY	Beneficiaries given a Medicare Plus booklet describing approved plans available in area with quality inf.. Quality assurance program established. Booklet to include: (1) benefits and premium; (2) quality inf., including consumer satisfaction; and (3) rights and responsibilities of beneficiaries.	Annual accred. required for specified quality standards; allows for "deemed" status; required to have ongoing quality assurance program; required to contract with independent external quality organizations approved by HHS. Requirement for health plan standards. Establishes telemedicine demo projects with non-health care entities.	Annual accred. required for specified quality standards; allows for "deemed" status; required to have ongoing quality assurance program; required to contract with independent external quality organizations approved by HHS. Requirement for health plan standards.
PPRC/ ProPAC	Combined and will consider FFS payment policies and other Medicare Plus issues. New name: Medicare Payment Review Commission.	ProPAC directed to complete various annual assessments; annual rec. on Medicare Dependent hospitals. PPRC to submit annual rec on update	Combined and will consider FFS payment policies and other Medicare Plus issues. New name: Medicare Payment Review Commission.
CBO SAVINGS	Prelim: Part A: $132 billion; Part B: $137 billion; (Fail safe: $32.1 billion)	$270.1 billion over 7 years	Total: $270 billion over 7 years ($22.6 billion for physician services; $36.6 billion for fail safe)

Medicare Reform (continued from page 4)

The reductions would be 5% in 1996, an additional 5% in 1997, an additional 7.5% in 1998, an additional 7.5% in 1999, an additional 5% in 2000, and then would remain at this 30% level from 2001 through 2002. This level of cut is less than that of the House.

The conference agreement reduces capital payments for PPS-exempt hospitals by 10%, and otherwise follows the Senate provision which reduces capital for PPS hospitals by 15%.

The conference agreement includes the limitations on nonroutine ancillary services for skilled nursing facilities as included in the Senate bill. The conference agreement also includes the Senate requirement that there be a prospective payment system for skilled nursing facilities by fiscal year 1998. **A prospective payment system would involve "fixed payments for episodes of care."** All services would be included. Payment amounts would be required to take into account case mix, patient acuity, and other factors. Total payments under the new system could not exceed 90% of the amount that would have been paid for routine and nonroutine costs and capital expenditures which would have been paid under the current law.

The conference agreement includes a freeze on all DME updates through 2002 but allows, pursuant to the House provision, a 1% update annually for prosthetics and orthotics through the year 2002.

RBRVS updates are similar in both the House and Senate provisions, so the conference agreement includes no major variations from those provisions. The provisions would permit an update which would equal the medical economic index increase plus as much as 3% or minus as much as 7% depending upon whether expenditure targets were met or exceeded. The expenditure targets are based on factors which include the increase in the gross domestic product +2% as well as an MEI increase, and an increase factor related to enrollment in the program; the target rate of expenditure increase therefore might be about 8% a year.

This report of the Medicare Reform Legislation House/Senate Conference Agreement was prepared by Dick Verville, legislative counsel for the American Academy of Neurology and provided to TNS by Rosabel R. Young, MD, who sits on the AAN Legislative Affairs Committee.

Broca's Area

A periodic newsletter of the Texas Neurological Society

Editor: J. Thomas Hutton, MD, PhD
Associate Editor: Michael D. Merren, MD
Production Editor: Trudy Hutton, JD

Inquiries about this newsletter or about TNS in general are welcome at the following address:
Texas Neurological Society
401 West 15th Street
Austin, Texas 78701-1680
(512) 370-1532 Fax: (512) 370-1635

1995-96 Officers

President
Ernesto Infante, MD
6448 Fannin
Houston, Texas 77030
(713)-797-9191

President-Elect
J. Edward Garrison, MD
4647 Medical Drive
San Antonio, Texas 78284-3331
(210) 615-1300

Vice President
Richard Homan, MD
Department of Neurology
Texas Tech University Health Sciences Center
Lubbock, Texas 79430
(806) 743-2720

Secretary-Treasurer
Gage Van Horn, MD
6410 Fannin, #520
Houston, Texas 77030
(713) 794-5236

Member at Large
Robert W. Fayle, MD
6448 Fannin
Houston, Texas 77030
(713-797-9191

Immediate Past President
Blake B. O'Lavin, MD
3006 South Alameda
Corpus Christi, Texas 78404
(512) 883-1731

TEXAS NEUROLOGICAL SOCIETY

MEMBERSHIP APPLICATION

(Qualifications/Dues and Instructions Listed On Back of Application Form)

Name: ______________________________ **Spouse:** ______________
(last) (first) (middle)

Office Address: ______________________________

Home Address: ______________________________

Office Phone: ____________ **Home Phone:** ____________ **FAX:** ____________

Date of Birth: ________ **Place:** ______________________________

Type of Membership Requested: ACTIVE ☐ ASSOCIATE ☐ RESIDENT ☐

EDUCATION:

Academic: ______________________________ Name of University
Location Years Attended Degree Date

Medical: ______________________________ Name of University
Location Years Attended Degree Date

Internship: ______________________________ Name of Hospital
Location Dates

Residency: ______________________________ Name of Hospital
Location Dates Specialty

Post Graduate: ______________________________ Name of University
Location Dates Course of Study

License to practice medicine in Texas: Date ____________ License # ____________
Members must have permanent license Mo. Day Year

Certification by specialty board(s): ______________________________
Specialty Board Date Certified

____

Prior Medical Practice: ______________________________
Location Dates Specialty

Military Service: ______________________________
Branch of Service Rank Location Years

Organizations: Neurologic ______________________________

____

Names of two Active members of TNS who may be contacted by TNS as references:

(1) ______________________________

(2) ______________________________

I certify that the above information is correct, and hereby apply for membership in Texas Neurological Society.

______________________ ______________________

(Date) (Signed)

Membership Qualifications

Information below explaining categories of membership available by application is excerpted from the Bylaws. Membership shall be gained by submitting a completed application to Texas Neurological Society, 401 West 15th Street, Austin, Texas 78701-1680 for processing.

ACTIVE MEMBERSHIP (Dues: $75.00)

Active membership shall be open to any physician residing and licensed to practice in the State of Texas who shall be certified in Neurology by the American Board of Psychiatry and Neurology or have completed two or more years of Neurology Residency approved, for purposes of certification, by the American Board of Psychiatry and Neurology. Active membership may also be granted upon review and special permission by the Executive Board.

ASSOCIATE MEMBERSHIP (Dues: $15.00)

Associate membership shall be open to 1) physicians partially trained in and/or practicing clinical Neurology who are not eligible for Active membership, 2) physicians practicing in clinical fields related to Neurology, 3) persons including physicians and holders of an advanced degree practicing or engaged in non-clinical field relating to Neurology.

RESIDENT MEMBERSHIP (Dues: $00.00)

Resident membership shall be open to all residents in an approved Neurology Residency training program in the State of Texas. Application shall be made in the usual manner and shall be accompanied by proof that the applicant is in fact currently in such a training program as described above. Resident members may apply for elevation to Active status with the Society upon the completion of their training program and their meeting the requirements for Active membership. Resident status is discontinued after completion of the Residency, dismissal from the Residency training program, or changing to a Residency Program not located in the State of Texas. Resident members have no vote in Society matters and cannot hold Society office. Resident members are the invited guests of the Society to all Society functions including luncheon and dinner meetings at no cost to themselves.

Instructions To Applicant

(1) Please print or type, and answer all questions fully. A resumé or curriculum vitae may be submitted to supplement file, but not in lieu of completing form.

(2) Mail to **Texas Neurological Society, 401 West 15th Street, Austin, TX 78701-1680.**

(3) Enclose check payable to **Texas Neurological Society** with dues for appropriate category. Your check will be applied as payment for dues of the year in which your membership is approved. Acceptance of dues does not constitute acceptance of membership. Prepaid dues will be refunded if membership cannot be approved.

(4) The Texas Neurological Society ID# is 74-2073058.

(5) If you have any questions about the society or the application process, you may telephone the Administrative Director at 512/370-1532. Call this number also for assistance in selecting a sponsor.

(6) **Please complete the following for use in the TNS Membership Directory:**
Area of practice: ___ Adult and/or ___ Pediatrics
Please list areas of specialization (such as epilpsy, pain management, sleep, etc.) ____________________

FOR OFFICE USE:

Application Received: __________________ Check Amount: $ ____________
Membership Committee: ______________________ Executive Committee: ____________________
Approved as __________________ Member; Rejected _____; Deferred _____. Date: ______________

Editorial Comment

(continued from page 3)

that chronically ill persons, minorities, and the elderly were being systematically excluded from HMO enrollment. Numerous examples exist in which a patient or a provider is found to be a heavy user of service is simply disenrolled from a health plan. Needless to say, the Patient Protection Plan, which would allow such practices to be known by the consumer threatens the managed care industry in Texas.

The basic provisions of the Patient Protection Plan will likely be reintroduced at the next session of the legislature. The stakes for the managed care industry, for the patient and for the provider are high. Texas neurologists need to remain informed, express their opinions, communicate with their patients and become unified. By doing so good quality and cost effective neurological care will continue for all Texans.

TNS Membership Encouraged

The Texas Neurological Society encourages all Texas practicing neurologists, residents and fellows to join TNS. The Society provides an opportunity for Texas neurologists to work as one unit for the improvement of health care as it relates to neurology in our state. Membership also affords the opportunity to meet neurologists from all parts of the state and to participate in annual scientific sessions in which the latest developments in neurology are presented and discussed.

Membership categories and dues are Active Membership, $75 per year, Associate Membership, $15 per year, and Resident Physician Membership, dues exempt.

To learn more about membership categories, or to join TNS, fill out the enclosed membership application and mail to the TNS office at the address listed on the application.

Lisa Jackson Joins TNS as Executive Director

Lisa Jackson recently joined Texas Medical Association's Specialty Society Management Services as a specialty society manager. She will serve as the Executive Director for the Texas Neurological Society. In addition, she will manage the Texas Pain Society, Texas Society of Plastic Surgery, and Texas Radiological Society,

Ms Jackson holds a degree in Education from the University of Texas at Austin. She comes to SSMS from TMA's Practice Management Services, where she worked three years as a seminar coordinator responsible for handling all aspects of seminar management, including program development execution of promotional campaigns, coordination of meeting logistics, financial reporting and speaker arrangements

Before coming to TMA, Lisa worked in the office of now Speaker of the House Pete Laney, handling legislative research and constituent issues. Her strong legislative background coupled with her expertise in marketing and meeting management provides an excellent resource for the department and the associations she will manage.

This fall she joined the Texas Society of Association Executives and attend the TSAE Academy of Association Management as part of the career development program available to all specialty society managers.

Ms Jackson serves on various staff committees at TMA, in addition to serving as a volunteer for Meals on Wheels and Blue Santa. Outside of work. she enjoys spending time with her two daughters and husband.

Lisa is eager to work with TNS and assist with the society's upcoming projects. Feel free to contact her about any matters concerning TNS at 1-800-880-1300, ext.1532 or 512-370-1532

Broca's Area Receives Award

Broca's Area, the newsletter of the Texas Neurological Society received an honorable mention award in the 1995 American Association of Medical Society Executives Pinnacle of Success Awards Program. The newsletter won in the category for medical society newsletters under 500 in circulation.

Broca's Area was begun in 1993 as forum for Texas Neurologists to share their comments, concerns and knowledge about the practice of Neurology in Texas.

The editors invite your contributions to help enhance communication among neurologists in the state. Your original articles and letters relating to the practice of Neurology or to the Texas Neurological Society are most welcome. Send your submission to :

J. Thomas Hutton, MD, PhD
Editor, ***Broca's Area***
4102 24th Street, Suite 500
Lubbock, Texas 79410
806-796-7000
Fax 806-796-0689

Mark Your Calendars!
22nd Annual TNS Meeting Scheduled

The Texas Neurological Society Annual Meeting and Scientific Program will be held in conjunction with the Texas Medical Association's Annual Session again in 1996.

The 1996 meetings will be in San Antonio at the Convention Center on the Riverwalk Friday, May 10 and Saturday, May 11. As in past years, a dinner for TNS members and their guests will follow the meetings on Saturday evening.

The TNS meeting is planned so that it will be of interest to all members and everyone is encouraged to attend. Because the American Academy of Neurology meetings are scheduled for March in 1996, they should pose little conflict to Texas neurologists wanting to attend both meetings.

More information about the meeting will be sent after the first of the year. Watch the spring issue of *Broca's Area* for details.

Texas Neurological Society
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