The Year in Review

2013 saw a progression of changes in the health care delivery system—and your Society was there to fight for your interests.

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The Perfect Storm for Health IT in 2014
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2013 has come and gone in what seemed like a blink of the eye. But with unprecedented shifts in health care delivery underway, the Chicago Medical Society and the Illinois State Medical Society were in the trenches, fighting for you and your patients. Here’s our recap of the milestones of 2013. By CMS Staff

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Occupational medicine expert, Peter Orris, MD, specializes in environmental toxins that can bedevil general practitioners. And he does so with the belief that everyone has equal rights when it comes to health care. By Cheryl England
A Balanced Budget

In 2013, the Chicago Medical Society (CMS) Board of Trustees set three distinct and somewhat contradictory administrative goals: increase membership, lower dues, and maintain a balanced budget. Prior reports have focused on membership and dues, and this report will explore the budget.

The Great Recession wreaked havoc on CMS finances. From 2005-2009, CMS experienced a deficit for five consecutive years, amounting to a cumulative loss of $1.49 million. Since then, CMS has reversed this trend and made $264,000 between 2010—2012.

To erase the budget deficit, there has been a significant decrease in expenses. The Society cut back on non-essential spending, including the Holiday Reception and the Annual Dinner. Several contracts, including building maintenance, were renegotiated on more favorable terms. Electronic communication with members and on-line meetings generated significant savings.

Since 1995 the number of CMS employees slowly decreased from 45 to 15. This net decrease was entirely through attrition and not layoffs. A wage freeze, which has been in place since 2008, is to be lifted in 2014.

When one examines the Society’s economic turn-around, it is interesting to note that the improved financial performance is almost entirely on the expense side. Dues revenue has not increased during this period. However, CMS has profited from non-dues revenue sources. Non-dues revenue has had a tarnished reputation since the AMA/Sunbeam debacle in 1998. Any non-dues revenue source for CMS is carefully evaluated to assure the endeavor is consistent with the core values of the Society.

The CMS building has provided an excellent source of non-dues revenue for the organization. Purchased in 1979 for $1.8 million, the Grand Avenue property was appraised last spring for over $6 million. The building’s 47,000 rentable square feet, which includes a portion of the basement, are fully rented. The free cash generated to the Society totaled about $133,350 for 2012, and the profitability is expected to increase as leases mature.

The CMS Insurance Agency is also a significant source of non-dues revenue for the Society. Specifically, 2012 showed profitability of $53,934. This continued performance is particularly impressive given the increased competitiveness of the insurance industry. As the core business of small physician groups contracted, the Insurance Agency has come up with creative ways to market to larger groups, such as the Risk Purchasing Group for Children’s Memorial Hospital physicians.

Despite the financial improvements, there are also continuing challenges. The move to electronic communication has generated significant financial savings. However, the one remaining print communication, Chicago Medicine, which was redesigned two years ago, remains quite expensive. CMS continues to sell advertising to help defray the cost, and will now contract that work out in the hope of obtaining additional advertising revenue.

The past few years have seen a welcome paradigm shift, a shift in the way CMS leadership views the budget. There is no longer the hope for, but the expectation of, a balanced budget, and that expectation continues to be realized.

Robert W. Panton, MD
President, Chicago Medical Society
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Spotlight on GME Advocacy
Anticipating workforce shortages, CMS fights for new Medicare-sponsored residencies

IN A HARD-HITTING letter campaign, the Chicago Medical Society urged Illinois lawmakers to support bills in Congress that would lift the 1997 cap on Medicare-funded graduate medical education (GME) slots and add 15,000 new residency positions over the course of three years. The joint correspondence was signed by leaders of eight teaching institutions in Illinois, as well as prominent medical society leaders such as Steven M. Malkin, MD, chairman of the Illinois State Medical Society (ISMS) Board. Impossible to ignore, this detailed and compelling document arrived in the mailboxes of every Illinois Congressional Delegation member.

CMS President Robert W. Panton, MD, orchestrated the campaign, which began last fall. The following medical schools signed on—the University of Illinois at Chicago College of Medicine, Southern Illinois University School of Medicine, Midwestern University—Chicago College of Osteopathic Medicine, University of Chicago Pritzker School of Medicine, Loyola University Stritch School of Medicine, Rush Medical College, Northwestern University Feinberg School of Medicine, and Rosalind Franklin University of Medicine and Science—the Chicago Medical School. Together, our state’s teaching institutions graduate more than 2,000 physicians each year. Indeed, the University of Illinois at College of Medicine is the largest medical school in the United States, with 1,351 medical students at four different campuses.

Of course, the letter campaign continues to be reinforced by in-person visits with influential Illinois legislators in Washington, DC, or in their Chicago offices, by Drs. Panton and Dimitri Azar, dean of the UIC College of Medicine.

GME advocacy is just one more example of the power physicians wield when speaking with a unified voice through their Chicago Medical Society and Illinois State Medical Society.

For your own talking points on these issues, look no farther than the letter on the opposite page.
December 2013

Dear Illinois Congressional Delegation:

Illinois’ medical school deans and major medical societies urge you to support proposed legislation that would increase the number of Medicare-sponsored GME (graduate medical education) positions.

Three major bills in Congress would increase the GME cap: HR 1180, HR 1201, and S 577. All three bills are supported by the AAMC (Association of American Medical Colleges). Each of the bills calls for an increase of 15,000 Medicare-funded GME positions on top of the current 94,000 positions. In addition, each of the bills supports residency positions in shortage specialties, including primary care. The bills require a GAO report on the strategies to increase the number of health professionals from rural, lower-income, and under-represented minority communities.

The Balanced Budget Act of 1997 capped the number of sponsored residency positions at 94,000, with a current annual cost of about $9.5 billion. Since 1997, the U.S. population has increased by more than 50 million. Moreover, as the population continues to age, the number of Americans age 65 and older is expected to increase by 36% over the next decade.

To meet the increasing demand for medical services, the number of U.S. medical student graduates has also increased commensurately. The AAMC reports that the number of first-year medical students was 16,488 in 2002, with an expected increase to 21,376 by 2016.

Despite the fact that the number of medical student graduates has increased, the number of Medicare-funded residency positions has remained flat since 1997. As a result, the number of graduates of U.S. medical and osteopathic schools will soon exceed the number of sponsored residency positions.

Many residents train at teaching hospitals, where they provide much-needed care to the poor and elderly. Teaching hospitals account for 28% of all Medicaid admissions, and are reported to provide 40% of all charity care in the U.S. at a cost of $8.4 billion annually. In addition, 37,000 medical residents receive all or part of their training at VA hospitals, providing health care to active soldiers and veterans.

Each of the three bills before Congress increases the number of sponsored residency positions by 15,000, adding to the current 94,000. We believe that each of these measures could significantly ameliorate the shortage of residency positions. An increase in the number of Medicare-funded residency positions would train sufficient numbers of physicians to care for our increasing and increasingly aging population.

Again, Illinois’ medical schools and major medical societies urge your support for HR 1180, HR 1201, and S 577.

Sincerely,

Dimitri T. Azar, MD, MPH
Dean, College of Medicine
University of Illinois at Chicago

Kenneth G. Busch, MD
Chairman of the Board
Chicago Medical Society

J. Kevin Dorsey, MD, PhD
Dean and Provost, Southern Illinois University School of Medicine

William A. McDade, MD, PhD
Deputy Provost for Research and Minority Issues, University of Chicago

Karen J. Nichols, DO
Dean, Midwestern University
Chicago College of Osteopathic Medicine

Kenneth S. Polonsky, MD
Dean of the Division of Biological Sciences and the Pritzker School of Medicine

Linda Brubaker, MD, MS, FACS, FACOG
Dean, Loyola University
Stritch School of Medicine

Thomas A. Deutsch, MD
Dean, Rush Medical College

Steven M. Malkin, MD
Chairman of the Board
Illinois State Medical Society

Eric G. Neilson, MD
Dean, Northwestern University
Feinberg School of Medicine

Robert Panton
President
Chicago Medical Society

Russell Robertson, MD
Former Dean, Chicago Medical School—Rosalind Franklin University of Medicine and Science
Conducting a Security Risk Analysis

To comply with meaningful use requirements, you must meet security guidelines

By AAPC

**ONE OF THE MOST important considerations in using an electronic health record (EHR) is ensuring your patients' health information is protected and secure.** If your practice is participating in Stage 1 or Stage 2 of the Medicare and Medicaid EHR Incentive Programs, you must conduct security risk analyses of your practice to meet meaningful use requirements.

The Office of the National Coordinator’s (ONC) “Guide to Privacy and Security of Health Information,” suggests ways your practice can comply with meaningful use security requirements, as outlined in core measure 15.

According to the ONC, a high-level security risk analysis process involves:

- Reviewing existing security of protected health information (PHI)
- Identifying threats and vulnerabilities
- Assessing risks for likelihood and impact of a security breach
- Mitigating security risks
- Monitoring results

There isn’t, however, a specific risk analysis method you must follow.

To help organizations identify and implement the most effective and appropriate safeguards to secure e-PHI, the Office for Civil Rights (OCR) developed “Guidance on Risk Analysis Requirements of the Security Rule,” which can be found on the U.S. Department of Health and Human Services website.

Note that even if your practice isn’t participating in an EHR incentive program, you're not off the hook. The HIPAA Security Rule requires all covered entities to conduct risk analyses of their electronic PHI.

For complete information on ensuring the privacy and security of your organization’s e-PHI, the following resources will help boost your confidence:

- OCR’s “Guidance on Risk Analysis”
- [www.healthit.gov](http://www.healthit.gov)
- HHS’ Health IT Privacy and Security Resources ([www.hhs.gov](http://www.hhs.gov))

The AAPC is the nation's largest training and credentialing organization for the business of medicine.

You can find them at [www.aapc.com](http://www.aapc.com).

Learning to Meditate Effectively

Your questions answered confidentially

By Daniel H. Angres, MD

**The Chicago Medical Society’s new Physician Wellness Committee helps members cope with stress or deal with impairment issues, including substance abuse. Committee members come from all disciplines but have experience either professionally or personally with wellness issues. Confidential questions addressed to the Committee will be answered privately. Questions with broad appeal may be published in Chicago Medicine, omitting the author’s name.**

**Q:** I try to meditate but I either get really tired or my mind races. I can only last about a minute. Any suggestions?

**A:** People may complain about getting tired or having mind “racing” sensations when they first try to meditate. Sometimes gentle music or guided meditations will help. Brain wave entrainment (BWE) with or without binaural beats is frequently used to aid meditation. BWE is basically a method of synchronizing various brain waves. It is thought that BWE works because its rhythmic pulses are able to attract the brain’s neural firing rhythms into its own rhythmic train of influence. With binaural beats, the right and left olivary nuclei (the audio-processing centers in the two hemispheres of the brain) work together to detect the phase difference between the two audio inputs. With BWE using binaural beats, the effect is greatly enhanced.

Many helpful commercial CDs are available. Go to YouTube and enter brain wave entrainment or binaural beats and sample what is out there. On iTunes, check out Jeffery Thompson or Technomind. Experiment to find what works for you.

*Dr. Angres is medical director of Presence Behavioral Health. Inquiries about the CMS Physician Wellness Committee or confidential questions should be sent to Dr. Angres at dangres@presencehealth.org.*
Ten Questions to Evaluate Your Billing Vendor

Make sure your practice gets the high-quality service you are paying for By Alina Mason

Financial success does not depend only on your physicians’ expertise. An effective and well-trained billing vendor is crucial to revenue flow. Whether you are evaluating your own billing vendor or looking to make a change, here are important questions to ask.

1. How many of your clients share my specialty? Coding and billing is a complicated process with lots of rules that pertain to each specialty. Determine if your billing vendor has other clients in your specialty. If you are the only client, consider looking at other vendors who are familiar with the type of services you provide. Their knowledge of what you do will drive your practice's success.

2. Will you be working on your practice management software (PMS) or on our own software? Determine if your billing vendor will use its PMS or work with your own. Most EMR software has a practice management component already built in. If the vendor is working on your software, you will have to decide who will cover the cost of the clearing house and if there are any other fees you are picking up. If your billing vendor will be using its PMS, you will need to establish guidelines in your contract to ensure you have the rights to your billing data and reports.

3. Are periodic audits performed? It is important to audit claims periodically to catch any over- or under-coding. The billing vendor should be able to perform quarterly audits of at least ten charts. The vendor should serve as an educational guide for physicians on any coding errors that are found.

4. How many certified coders are on staff? Determine how many certified coders are on staff, and ask if they will be handling your account. Many billing vendors will have a couple of certified coders on hand, but hire other staff members to handle physician accounts. It is important to know who will be working on your claims, and know the level of training they have received.

5. What is the workload of the staff on your account? Determine how many accounts the staff member assigned to you is responsible for. This will give you a clear idea of whether your account is given the proper amount of attention. If the staff member is responsible for five other physician accounts, minor errors can be easily overlooked.

6. How often are claims submitted? The frequency of claim submittals will determine your revenue flow. Claims can be submitted daily, weekly, or biweekly. Establish set guidelines for when claims should be submitted to streamline your revenue flow.

7. How are rejections and denials handled? The handling of rejections and denials will have a significant impact on future claims. Having the knowledge of what triggers mistakes with various insurance companies will set your practice on a path to improvement. If rejected and denied claims are written off without a second glance, you lose an opportunity for revenue growth.

8. How often are patient statements submitted? In the current economy, patients have a greater responsibility for their statement balance. The sooner they receive their statements the sooner your practice will get paid for services rendered. Patient statements should go out at least once a month, but ideally on a weekly basis.

9. Who will be responsible for handling patients’ billing questions and concerns? Once patients receive their statement, it is important to determine if the billing vendor will answer standard patient questions about deductibles, copays, and coinsurance. If all calls are simply routed to your practice, be prepared to have staff trained in answering billing questions.

10. What type of reports do you provide? On a monthly basis, your billing vendor should provide you with a set of standard financial reports that include billable services, payments, adjustments, and accounts receivable. Find out if the billing vendor can provide you with customizable reports, which can potentially give you valuable information about denied claims, procedural codes, and various insurance companies.

Evaluating your billing vendor by asking these simple ten questions will help you determine whether your practice is getting the quality of service you are paying for. Billing vendors who are knowledgeable, efficient, and accurate will help you maintain a financially successful practice.

Alina Mason is chair of the CMS Practice Manager Section and executive director of Medical Arts Unlimited in Libertyville, Ill.
Perfect Storm for Health IT in 2014
The conditions are right for merging meaningful use and EHRs
By Janet Baxter, MBA, RHIA, and Abel Kho, MD, MS

Health IT workers have a crowded calendar as many initiatives come together in 2014, impacting everyone using an electronic health record (EHR). Luckily, with a little extra effort, you can stay on track this year.

ICD-10
The change to ICD-10 will affect your staff far beyond coding. Starting Oct. 1, 2014, the Centers for Medicare and Medicaid Services (CMS) and most other U.S. payers will require diagnostic codes to use ICD-10.

“Although implementation might create challenges, the 2014 technology brings improvement.”

ICD-10

Current codes should be reviewed; can you list your 25 most common codes and how they will map to ICD-10? Most ICD-9 codes will map to several possible ICD-10 codes. Additional information must be documented to substantiate the selection of the specific code.

For example, musculoskeletal diagnoses will see the numbers of codes increase drastically. Specific site, type of injury and laterality, will test the coder’s knowledge of anatomy. Each code reflects a particular point in the episode of care (initial, subsequent or sequela). Obstetric documentation requires the trimester of pregnancy. The specifics must be documented in the patient’s record.

Most providers will need new software, which should be tested with each payer. Some experts predict the changes will slow October payments, severely affecting cash flow. Small practices will want to run reports to study their most common codes and to identify all the people in the practice who may participate in documentation of diagnoses to determine who needs what kind of training.

Meaningful Use and Certified EHRs
Starting in 2014, you must use certified 2014 EHR technology to attest for Stage 1 or Stage 2. This will mean a system upgrade for most users and new workflows for the entire staff. Once changes are made, all users should be trained on the new workflows to maximize meaningful use, regardless of stage. This may seem like a lot of work, but it will maximize the benefits of the new technology and build good work habits.

Although implementation might create challenges, the 2014 technology brings improvement. It reflects what the industry has learned and moves us down the road toward using and exchanging structured data. It encourages patients and families to be engaged in their own care. Those of you who have attested in prior years will recognize the benefits of having the attestation reports submitted directly from your EHR. Starting in 2014, all attestation reports must come directly from the EHR, without using custom reports or a data warehouse. Those tools can be used for additional reporting and data analysis.

Changes to Meaningful Use
New 2014 Meaningful Use measures for all users can be met by adding patient portals. Patients must be able to view, download and transmit their own health information. This functionality allows patients to securely see test results, scheduled appointments, and notes from providers.

To gain the benefits of the portal, staff, providers and patients should be trained. Managing the new patient communications will require new workflows, with thought to screening and routing messages. Each person in the process should be working at the top of their capabilities and license. Doctors should not attend to trivial tasks such as moving junk emails to the spam folder; they should just communicate on clinical matters.

If you had a successful test with the Illinois Comprehensive Automated Immunization Registry Exchange (I-CARE), ongoing data transmissions are expected. Additional public health reporting is expected to be available in Illinois soon.

In 2014, all users will attest to Meaningful Use for a three-month period. Some users will be at Stage 2 and many practices will have providers in both stages. This requires careful tracking to be sure you are running the correct reports for each provider. Also note that eligible providers who are not meaningful users by Oct. 1, 2014, will see a reduction in Medicare reimbursements starting in 2015.

Stage 2 Meaningful Use
Providers who have achieved Meaningful Use for two or three years will meet Stage 2 in 2014. There are increased thresholds for some measures, such as demographics and smoking status. At least five clinical decision support rules must be implemented and clinical visit summaries must be given for 50% of visits within one day. Using the portal to distribute the summaries can minimize the need to print the summaries for each patient.

Stage 2 providers might be doing some of the new measures already. Computerized physician order entry (CPOE) reporting now includes orders for lab and radiology. Lab results will feed to the EHR as structured data. If that’s not happening already, your IT team or vendor may need to set up interfaces with your laboratory provider. Other measures for Stage 2 may be new to your organization, such as using the EHR for patient engagement and sharing information when patients see more than one provider.

You can get help understanding and meeting the new requirements from your EHR vendor, CMS (www.cms.gov), the Electronic Health Record Medicaid Incentive Payment Program (www2.illinois/hfs) under the medical providers section, and CHITREC.

Janet Baxter is the Meaningful Use program manager at the Alliance of Chicago. She works with community health centers in ten states. Dr. Kho is an internist and co-executive director of the Chicago Health IT Regional Extension Center (CHITREC). CHITREC (www.chitrec.org) assists providers in achieving Meaningful Use of electronic health records.
Compliance Deadlines for Doctors

Four key items for your “to do” list

By Professional Business Consultants

1 Physicians who are participating in the Medicare EHR Incentive Program have until Feb. 28, 2014, to attest to meaningful use of their EHR to receive the 2013 payment year incentive. Medicare penalties begin in 2015 for physicians and other providers who are not meaningful users of EHR technology. You must successfully attest by 11:59 p.m. Eastern Standard Time.

2 On Oct. 1, 2014, all services and discharges must be coded using the ICD-10 code set. ICD-9 diagnosis codes cannot be used for services provided on or after Oct. 1, and claims that do not use ICD-10 diagnosis codes cannot be processed for reimbursement. The necessary system and workflow changes need to be in place by the compliance date in order for you to send and receive the ICD-10 codes. But only half of health providers have conducted impact assessments and even fewer have begun testing. Key areas to focus on include training and education, payer collaboration, cross-mapping solutions, vendor readiness, systems remediation, as well as dual coding.

3 Watch for revalidation letter requests from your Medicare contractor. You have 60 days from the date on the request to submit the revalidation. The Internet-based Provider Enrollment, Chain and Ownership System (PECOS) can be used in lieu of the Medicare enrollment application (i.e., paper CMS-855). This revalidation effort applies only to those providers who were enrolled prior to March 25, 2011. You must wait to submit the revalidation only after being asked by your MAC to do so. Revalidation notices are mailed to the provider’s primary payments address and to the correspondence address. Not receiving the revalidation request is not a valid reason for not completing the CMS 855 application. Be sure to periodically check the CMS website to find out if your revalidation request has been sent. To access PECOS, you must have an active National Provider Identifier (NPI) and a web user account established in NPPES. Physicians and non-physician practitioners will access PECOS with the same User ID and password they use for NPPES.

4 July 31, 2014, is the license renewal deadline for Illinois physicians. If you haven’t taken the required 150 hours of continuing medical education, check out the Chicago Medical Society’s Calendar of Events page on 28 for upcoming CME programs. The Illinois Department of Financial and Professional Regulation will send automatic renewal notices to all physicians prior to the license expiration. IDFPR also conducts random audits of physicians for compliance with the CME requirements. Hours earned should consist of formal educational programs (40%) and a combination of formal and informal education (60%).

Professional Business Consultants, Inc. (PBC) is a practice management consulting firm in Oak Brook that specializes in health care. For more information on PBC, visit www.pbcgroup.com.

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Do-It-Yourself Valuations

When and how to determine fair market value without an outside appraiser

By Albert “Chip” Hutzler, JD, MBA, CVA

The sheer volume of transactions that invoke federal health care laws is staggering. Couple that with the fact that health care law requires remuneration in those transactions to be consistent with “fair market value” (FMV). As a result, a logistical problem arises: how does one accurately and consistently determine FMV? Further complicating the picture is that determining FMV is anything but intuitive and straightforward. To get a sense of how difficult FMV can be to determine in the context of IRS and Stark definitions, just take a look at the BVR/AHLA Guide to Healthcare Industry Compensation and Valuation, a 947-page textbook edited by Timothy Smith and Mark O. Dietrich (2012). At larger health care entities, such as hospitals or pharmaceutical and device companies, much of the work is handled internally out of sheer necessity. Read on to discover the challenges and best practices for do-it-yourself (DIY) valuations that are simply an unavoidable fact of life.

Far From a Walk in the Park

Determining FMV is no picnic, and any guidance provided by the government is limited and somewhat vague and disjointed. The key passages of the Stark regulations and associated commentary intentionally define FMV differently than the IRS does in its version of the FMV standard. On the one hand, the guidance suggests that parties may use “any reasonable method” to determine FMV. On the other hand, though, the commentary indicates that FMV is defined in a way that limits the use of traditional methods in the IRS context. Furthermore, in the Stark commentary the Centers for Medicare and Medicaid Services (CMS) made it clear that DIY valuations are allowed, stating:

“We agree that there is no requirement that parties use an independent valuation consultant for any given arrangement when other appropriate valuation methods are available. However, while internally generated surveys can be appropriate as a method of establishing fair market value in some circumstances, due to their susceptibility to manipulation and absent independent verification, such surveys do not have strong evidentiary value and, therefore, may be subject to more intensive scrutiny than an independent survey.”

Therefore, while the government’s guidance indicates a preference for independent third-party appraisals, whenever possible, CMS recognizes that it is not feasible to require independent appraisals in all cases. Simply put, CMS no doubt recognizes that too many transactions are subject to the FMV requirement for the federal agency to insist that all valuations be conducted by an independent third party. That said, a frequent remedy in settlements and corporate integrity agreements has been to require the settling party to obtain outside valuations for a subset of its riskier transactions during an agreed-upon time period.

When Do-It-Yourself Appraisals Are Sufficient

While health law regulatory guidance clearly allows DIY valuations, it is not entirely clear when DIY valuations are sufficient as opposed to independent third-party appraisals. Certainly the fact that DIY appraisals are allowed at all suggests the government felt that in some circumstances, a DIY appraisal would be sufficient. The key passage from the commentary above suggests that the government is concerned about bias, manipulation, rigor and consistency of internal valuations versus independent ones.

Thus, the parties’ decision about which transactions to value internally and which to value externally should be based on the risk of those factors (internal bias, rigor, etc.) as well as the relative risk of exposure to health care liability. For example, some transactions are riskier than others simply because their characteristics alone may suggest inducement, whether inducement exists or not, such as those with high dollar remuneration or those with physicians who are large referral sources rather than occasional referral sources. It’s important to note that some transactions may seem simple to value but may actually be quite risky due solely to the substantial referrals between the parties. Furthermore, entities that receive referrals from physicians face substantially greater penalties and financial risk under the Stark law (because they file Medicare claims for “designated health services” or DHS), and are likely to need the extra protection of an external appraisal than physicians.

Best Practices for Do-It-Yourself Valuations

For an entity that decides to conduct a DIY valuation, the local hardware store carries prefabricated parts and tools. However, the entity can take steps to help ensure it gets the most protection possible against potential liability, despite the inherent risks of the DIY approach. Here are ten best practices:

1. **Use A Consistent Method.** Using the same approach in a regular and consistent manner to value recurring, similar transactions is one of the best ways to demonstrate to regulators and prosecutors that a valuation was free from bias and
manipulation. However, as a practical matter, this can be difficult, when you consider that FMV is often diametrically opposed to the underlying missions and objectives of the parties. Most physicians and DHS entities exist primarily to provide health care services (and products) to their patients, customers, and communities, and in the case of for-profit entities, they all have the additional primary objective of turning profits for their shareholders. The parties will often face pressure to stray from a consistent approach to meet key objectives. Having the right compliance process in place to avoid this temptation and remain consistent in the valuation approach is sometimes a formidable challenge.

2 Use Multiple Valuation Approaches. In general valuation theory, the use of multiple valuation approaches is preferred because it mitigates the drawbacks of each individual approach. IRS Revenue Ruling 59-60 describes the three major approaches to valuation—cost, income, and market—and suggests that whenever possible, all three should be considered when determining FMV. The multiple valuation approach is similar to the theory of diversifying one’s investment portfolio, where the diversity of investments mitigates the unique risk of each individual investment, leaving the portfolio subject primarily to the overall market risk. The Stark law recognizes that it is not always possible or practical to use certain approaches, but considering multiple approaches is always a prudent practice, even if ultimately only one approach is carried out.

3 Use Multiple Objective Surveys. The government has indicated that using “multiple, objective, independently published” physician salary surveys is a “prudent practice.” However, many organizations have a tendency to gravitate toward one physician salary survey in particular, most often the Medical Group Management Association (MGMA) survey. While MGMA is considered by many the gold standard of physician salary surveys with the best and most extensive data and reporting, the MGMA survey does have certain drawbacks. They include: lack of a random sample, and therefore representation, since responses are voluntary and may indicate bias; relative lack of localized data; danger that productivity ratios can be misinterpreted due to how they are calculated; and limited data on certain metrics, such as benefits or hours worked. Similar to multiple valuation approaches, using multiple surveys mitigates the drawbacks of each individual survey.

4 Avoid Cherry Picking Survey Data. The surveys slice and dice the data in numerous ways, including regional and state data, size or type of practice. Parties should avoid the temptation to focus solely on data tables that support a particular result or position. Using a table only when it shows the highest value, and avoiding it when is has lower values than other tables is dangerous. A consistent approach is the best practice, with recognition that sometimes the tables used will have values that are higher or lower than other tables, and sometimes they are unable to support a proposed transaction.

5 Beware of Productivity Ratios in Survey Data. Certain surveys report “productivity ratios” or “conversion rates” such as compensation per work-relative-value-unit (wRVU) rates or compensation to collections ratios. These ratios are tempting to use in setting productivity-based compensation rates. While productivity-based compensation is popular and is generally a fair and reasonable structure, the conversion rates reported in surveys can be highly misleading. It is important to know that the surveys calculate rates from the compensation and productivity data, and that the relationship between productivity and compensation is not a linear correlation. That is to say, the surveys clearly warn that, as productivity increases, compensation increases, but compensation per unit of productivity actually decreases. This behavior holds for all specialties over the last four years that data has been available. The phenomenon likely has multiple causes but it is important that DIY valuations recognize this fact when using productivity ratio data.

6 Beware of Anecdotal Data and Strategic Value. Parties will often wonder why FMV is not simply what the physician right down the street is getting paid, but even assuming that anecdotal information is reliably reported (which often it is not), the use of anecdotal data is particularly dangerous. First, the parties down the street may have very different circumstances (e.g., terms, conditions, payer mix, etc.), making an accurate comparison challenging, at best. Further, anecdotal information typically represents a transaction between parties in a position to refer to one another, and this is generally considered tainted data under the Stark FMV definition. There is no guarantee that the compensation rate down the street is consistent with FMV or was even analyzed at all. Just because a nearby doctor gets paid at a particular rate in another deal does not necessarily make it FMV for the subject transaction.

Similarly, FMV is a hypothetical standard that specifically excludes notions of “strategic value” or “investment value.” The parties will often want to consider the unique value they bring to the table (which can include referrals, but also other synergies such as proximity, shared knowledge of their particular market and situation, or shared vendor relationships). While those unique elements might otherwise have significant value to the parties, they cannot be considered in determining FMV for transactions subject to health care law, and thus, cannot be included in the remuneration paid under
Avoid Valuations Based on “Opportunity Cost” Calculations. The government has indicated that compensation based on a theory of “lost opportunity” is potentially problematic. Physicians will often argue that certain activities, such as call coverage or medical directorships, take up valuable time, which they otherwise could have used to perform procedures or patient care services. However, the government strongly disfavors payments based on mere speculation of what a physician will do or could have done in the same time. Thus, it seems you would need evidence that those activities were actually displaced, or that the physician actually lost business. In practice, when a doctor agrees to perform a new task (e.g., a medical directorship), and has no material loss in patient volume or revenue as a result, a claim of “lost opportunity” will likely be met with skepticism. Frankly, because of the government’s suspicion of payments based on mere speculation of lost business, even a legitimate argument of lost business is likely subject to heavy government scrutiny.

Beware of Circular Databases. Some services exist where FMV is determined by soliciting rates from subscribers to the service and then regurgitating that data back to the subscribers to help them determine FMV. While unrelated transactions may be in the database, the existence of user-provided transactions is dangerous, because it can lead to self-fulfilling results, which can cause rates to be determined in a circular fashion, with ever-escalating rates being labeled as FMV. FMV generally should not be based on what an entity has already agreed to with other parties. This can have dangerous consequences. While the major salary surveys are also at risk for this kind of effect, it is far less prevalent, given their larger sample size and ability to mitigate the impact of any one survey by consideration of other surveys.

Avoid Rewarding Internal Valuators Based on Deal Success or Related Profits. This concept may seem obvious at first glance, but in practice, it is often hard for internal personnel to avoid feeling pressure to get deals done (especially at for-profit entities). Thus, it is critical for DIY valuations to be free from financial incentives that might suggest analysts were compensated based on the success of deals or related profits, including, ancillary revenue. When added to the concerns the government already has about DIY valuations versus outside analysis, even the mere perception of profit or deal-triggered financial incentives forvaluators would undermine the credibility of a DIY valuation.

Have the Valuation Framework Reviewed by an Independent Third Party. Depending on an organization’s particular needs, it may be wise to engage a third-party appraiser to evaluate an internal framework that is used consistently for analysis of multiple recurring arrangements. This is frequently seen with larger entities that have many similar transactions, such as call coverage, medical directorships, and hospital-based subsidy arrangements. The third party is not assessing the reasonableness or accuracy of specific facts or circumstances that are associated with an internal analysis. Rather, the third-party valuator will test the framework extensively, and provide an opinion that states, in essence, that while it is not analyzing any transaction directly, the internal framework is expected to yield results that are consistent with FMV if used correctly. The relative cost is small for the likely significant extra protection.

Balancing Risk with Rewards

While DIY valuations are generally riskier than external assessments, they are a necessary fact of life at many health care organizations. Nevertheless, through a number of important steps parties can mitigate the relative risk of DIY appraisals, thereby reducing the risk of a health care law violation. Some of the recommended steps are easier than others to implement in practice, but all are worth considering, given the associated exposure.

Albert ‘Chip’ D. Hutzler, JD, MBA, CVA, is a partner at HealthCare Appraisers in Delray Beach, Fla.
The Cost of Health Insurance

Debate over Grassley and Vitter amendments illuminates issues  
By Stephen Angelette, JD

The Impact of the cost disparity between employer-sponsored group health insurance and individual policies has never been more apparent than in the recent legislative battles over government-sponsored insurance for members of Congress and their staff. It all started in the Patient Protection and Affordable Care Act (ACA) negotiations. Senator Chuck Grassley (R-Iowa) proposed an amendment removing all members of Congress and their staff from the Federal Employee Health Benefits (FEHB) program and forcing them into the newly formed insurance exchanges. As Senator Grassley explained in 2009: “[t]he exchange…is designed to give participants the same kind of choices and options for health care coverage as federal employees. My interest in having members of Congress participate in the exchange is consistent with my long-held view that Congress should live under the same laws it passes for the rest of the country.” Surprisingly, an amendment “meant to embarrass Democrats” was accepted in principle by “too clever-by-half” democratic lawmakers and was incorporated into the ACA.

Employer Contribution Maintained

A few months later, the Office of Personnel Management (OPM) stated that members of Congress and staff would still qualify for employer contributions. The OPM acknowledged that the provision requiring members of Congress and staff to join the exchanges included the phrase “notwithstanding any other provision of the law.” However, the employer contribution was not eliminated. The OPM noted that the definition of “health benefit plans” is very broadly defined. Therefore, the current law, even as amended, requires Congress to maintain the employer contribution for all health benefit plans fitting within the definition set forth in [5 U.S.C.] 8901(6). This includes a group insurance policy or contract; medical or hospital service agreement; membership or subscription contract; or similar group arrangement that provides, pays, or reimburses expenses for health services. Thus, the federal government is allowed to contribute the same amount to exchange plans as it now spends (75% of premiums).

The Vitter Amendment

The OPM interpretation was unsatisfactory to some congressmen, who felt that the amendment had been stripped of its primary purpose. During a floor debate in late 2013, Senator David Vitter (R-La.) proposed another amendment that would remove ACA subsidies described by the OPM and re-establish the Grassley Amendment as he [Vitter] originally interpreted it. Rep. Michael McCaul (R-Texas) submitted a companion bill in the House. The “Vitter Amendment” reads that, “No government contribution… shall be provided on behalf of an individual who is a member of Congress, a congressional staff member, the president, the vice president, or a political appointee for coverage.”

Through political maneuvering, the Vitter amendment was eventually narrowed to include only members of Congress, the president, vice president, and cabinet officers. Congressional staff would still receive subsidies to help pay the monthly premiums after they enroll in state insurance exchanges. Democrats have repeatedly blocked Senator Vitter’s attempts to call for a vote on his amendment.

It is interesting to consider how Senator Vitter’s amendment would affect the original law, and what the law itself illuminates to mainstream America. The exchanges were intended for uninsured people who couldn’t get health insurance through their employer or qualify for Medicaid. But as the high cost to staffers became apparent to Congress, the momentum to force them into the exchanges dissipated. Many felt that junior staff members were being “sacrificed” for political gambit. The Congressional Management Foundation’s staff survey had also suggested that 63% of junior staff were considering leaving their jobs because of low pay and long hours before the amendments. Congress did not want to risk a mutiny.

Those with access to employer-sponsored health insurance meeting minimum coverage requirements or with incomes above a certain level may still purchase insurance on the exchanges—but without a subsidy and with after-tax income. Using the Kaiser Family Foundation subsidy calculator, a congressional staffer in a family of four with a combined income above $95,000 would pay on average $800 monthly for exchange insurance. This number is drastically reduced by employer sponsorship.

The New State of Health Insurance

Senator Grassley noted that his intent all along was for Congress to participate in the exchanges with their federal employer subsidy, and for Congress to go through the same red tape as every other citizen. He has given us an instructive example of the cost disparities between employer-sponsored insurance and out-of-pocket individual policies, and the vital importance of employer sponsorship to most Americans. The rollercoaster of opinions on these amendments show that both Congress and the public are coming to understand the new state of health insurance in America.

Stephen Angelette, JD, is an associate in the Baton Rouge office of Breazeale, Sachse & Wilson, LLP, practicing in the area of health care law.  

“Congress should live under the same laws it passes for the rest of the country.”
PUBLIC HEALTH

How You Age May Depend on What You Eat

Overall diet in mid-life may predict future aging phenotypes

By Neelum T. Aggarwal, MD

MULTIPLE initiatives from the City of Chicago's Healthy Chicago programs, to Building a Healthier Chicago's F.I.T City, to Food Day/Eat Real Chicago, encourage healthy eating and nutrition. Now this message is reinforced by a study that examined the role of diet/nutrition in the overall health of a large group of community-dwelling individuals.

Traditionally, medical literature has focused on analyzing dietary patterns and their potential impact on individual age-related diseases—cognitive decline, dementia, cardiovascular disease, stroke, and metabolic conditions such as diabetes. However, little has been reported on the effect of diet on overall health—considering the incidence of all these conditions simultaneously. A recent paper by Akbaraly and colleagues in the American Journal of Medicine examined diet from a holistic approach, using data from a well-established longitudinal study in the United Kingdom, often referred to as the Whitehall group.

The Whitehall group is a cohort study of people ages 35-55 who worked in 20 civil service departments at the time of baseline evaluation. A screening phase took place between 1985-1988 with over 10,000 people, and was comprised of a clinical examination and self-administered questionnaire. In Phase 3 of the study (between 1991-1993), a nutrition survey was given to participants. For this paper, only those age 60 by the end of 2007-2009 and with no history of stroke, myocardial infarction, or cancer, were included.

The food questionnaire administered during the study consisted of 127 food items and the selected food items/category was converted to daily intake. The groups were then broken into two categories: Western-type diet (fried or processed food, red meat, pies, and high-fat dairy products) or healthy foods (high intake of fruits, vegetables and fish).

Four aging outcomes were considered for this study: (1) ideal aging; (2) non-fatal cardiovascular disease at follow-up; (3) cardiovascular death; and (4) non-cardiovascular death. Criteria for ideal aging (age 60 or older at the last follow-up examination) included: being alive; having no chronic diseases (such as coronary heart disease), stroke, cancer or diabetes; absence of mental health problems; and good cardio-metabolic, respiratory, musculoskeletal, and cognitive functioning.

Over the 16-year-period, 12.7% of the cohort developed non-fatal cardiovascular disease; 2.8% died from cardiovascular disease; and 7.3% died from non-cardiovascular causes. The remaining 73.2% followed a natural aging course. Diet data was examined based on two types of patterns—healthy foods and Western diets. Higher scores on the Western diet were associated with higher odds of cardiovascular and non-cardiovascular mortality (OR= 1.53 and 1.36) in adjusted models. People in the highest tertile of the Western dietary pattern, compared to the lowest tertile, were more likely to have poorer musculoskeletal and cognitive functioning. There was no association noted between the Western diet and indicators of cardio-metabolic and respiratory functioning and mental health.

Interestingly, the healthy food dietary pattern did not demonstrate any significant associations with the four aging outcomes, contrary to the literature, which has demonstrated the protective effect of vegetarian diets or of those low in meat to health outcomes. This result, however, should be interpreted cautiously, since in this cohort there were very few non-meat eaters and the study did not attempt to classify whether participants were vegetarians.

Nevertheless, this study provided a model for examining how multiple aging phenotypes could be analyzed simultaneously in a cohort to inform patterns associated with dietary intake and habits. In addition, the study also reinforced recommendations of other studies, namely, that avoiding a Western diet could improve the chance of reaching old age free of chronic disease in addition to remaining highly functional.

Dr. Aggarwal is the chair of the F.I.T. City Initiative and board member of Building a Healthier Chicago (www.healthierchicago.org).

Keep Your Vaccines Safe

THE CHICAGO VACCINES for Children (VFC) program is recruiting clinics to participate in the data logger pilot project. Data logger thermometers continuously monitor and record temperatures every 15 minutes in vaccine storage units, including during closed office hours and power failures. The data loggers indicate when temperatures have been out of range and for how long. This information will help the program determine if vaccines can be used safely. The Joint Commission is now requiring this type of temperature recording within all accredited facilities. If your practice is interested in receiving a data logger and training, please contact Marcia Levin, VFC Program Manager, by email at Marcia.levin@cityofchicago.org.

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For preteen girls and boys, the human papillomavirus (HPV) vaccine offers the best protection against HPV-related cancers in later years. And physicians can greatly influence a parent’s decision when it comes to giving a child the HPV vaccine. Indeed, the lack of a recommendation is one of the top reasons parents report for not having their children vaccinated, according to the 2012 National Immunization Survey-Teen (NIS-Teen).

Parents said they trust their child’s physician and would agree to the HPV vaccine series as long as the doctor recommended it. Studies also have shown that providers give weaker recommendations for HPV vaccination than for other routine vaccinations for adolescents. Because parents may have questions about the HPV vaccine before agreeing to the series, and physicians should take the time to listen and to answer their questions.

To increase coverage levels among local adolescents, the Chicago Department of Public Health (CDPH) announced plans to train 200 medical providers and to coordinate a patient reminder system using electronic immunization records, according to a January 22 statement. A citywide public education campaign aimed at adolescents and their parents is being funded through a grant from the Centers for Disease Control and Prevention (CDC).

The CDPH reports that 38% of female adolescents (ages 13-15) in Chicago have received all three doses of the HPV vaccine. The national coverage level for the same group is only 28%. The CDC recommends vaccines for all U.S. adolescents age 11 and older.

The CDPH advises doctors to recommend the vaccine in the same manner they recommend other vaccines, including Tdap and MCV4. For tips and timesaving advice on talking to parents about the HPV vaccine, go to the CDC website at www.cdc.gov/vaccines.

Top 5 Reasons for Not Vaccinating

The second most cited reason by parents who opted to not vaccinate their daughter during 2013 was that they did not receive a recommendation from a physician. The most frequently cited reason was that the parents did not know much about HPV or HPV vaccine, and so felt it was not needed.

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Keeping the Flu at Bay
Lurie Children’s Hospital takes the lead in keeping viral infections away  By Cheryl England

WHEN Kathleen Seerup, RN, and her team at Lurie Children’s Hospital noticed an increase in kids’ respiratory viral infections, she investigated. Sure enough, the numbers proved her right—the Centers for Disease Control and Prevention (CDC) showed an uptick in flu-related diseases year after year. In record time, Seerup, who is the administrator for critical care services at the hospital, pulled together a team to fight back. It only took Seerup 30 days to get approval for a plan. After a round of benchmarking and presentations to hospital staff, the care-giving team adopted new policies in December 2013 to take effect the next month.

The policies determine who can visit children during the flu season, which is anticipated to last until approximately April 30. A maximum of two healthy adults who are immediate family members or designated caregivers, siblings who are at least age 14 and are supervised by an adult, and healthy clergy members are allowed to visit as they normally would.

The policies also exclude anyone with cold or flu symptoms such as a runny nose or cough. “We support the family and the child to the best of our ability,” she says. For example, if a parent of a hospitalized child is not feeling well but refuses to go home, the staff will require the parent to wear a mask and to stay in the room with the child. The staff will also make special accommodations for family to visit on a child’s birthday, for example, or if the child is in the hospital long-term or is being breastfeed.

The hospital works to inform parents and visitors, explaining the policies to them. Posters in the entry areas stress the importance of staying away from the hospital when not feeling well. Staff routinely asks visitors how they feel physically that day. Overall, the policies have been well-received. “You obviously can’t please everyone,” says Seerup, “but the families who have children here for the long term do appreciate it and thank us.”

CDC Health Advisory to Clinicians
2013-2014 influenza-related illness may disproportionately affect young people

The pH1N1 virus has emerged as the predominant flu strain in the United States, and the Centers for Disease Control and Prevention (CDC) has received a number of reports of severe respiratory illness among young and middle-aged adults who are infected by the influenza A (H1N1) pdm09 (pH1N1) virus. In a Dec. 24 health advisory to clinicians, the CDC noted multiple pH1N1-associated hospitalizations, including many requiring intensive care unit admission, and some fatalities.

Low vaccination rates among young adults have experts concerned because the trend suggests they are at greater risk. Among adults ages 18-64, slightly more than one-third got a flu shot for the 2012-2013 season, a new analysis by the Trust for America’s Health reports. Only 56.6% of children ages six months to 17 years were vaccinated, the report found.

The 2009 pH1N1 virus caused the swine flu pandemic, resulting in more illness in children and young adults, compared to older adults, although severe illness was seen in all age groups. Older adults are thought to have some cross-reactive immunity due to prior infection with antigenically related pH1N1 viruses. The 2009 pandemic was also notable for reports of severe illness among pregnant women infected with pH1N1 and for adverse neonatal outcomes.

The most common underlying medical conditions among adults were obesity, metabolic disorders, cardiovascular disease, and asthma. In children, the most reported underlying conditions were asthma, obesity, neurologic disorders, chronic lung disease (excluding asthma), and cardiovascular disease. Although most people with severe illness had risk factors for influenza-associated complications, some did not. The CDC has not detected any significant changes in pH1N1 viruses that would suggest increased virulence or transmissibility.

Antiviral treatment with oseltamivir or zanamivir is recommended as early as possible for patients with confirmed or suspected influenza who have severe, complicated, or progressive illness; who require hospitalization; or who are at greater risk for serious influenza-related complications.

As in recent past seasons, high levels of resistance to the adamantanes (amantadine and rimantadine) continue to persist among 2009 H1N1 and influenza A (H3N2) viruses. Adamantanes are not effective against influenza B viruses and are not recommended for use this season.
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Making their rounds on Capitol Hill to increase the ranks of graduating physicians are, from left: John Pyatt, director of federal relations, University of Illinois; Dr. Dimitri Aazar, dean, University of Illinois at Chicago College of Medicine; and Dr. Robert W. Panton, president, Chicago Medical Society.
Year in Review

2013 saw a progression of changes in the health care delivery system. CMS was there to fight for your interests.

By CMS Staff

It was the best of times, it was the worst of times. While 2013 didn't quite compare to the hyperbole in the opening line of Charles Dickens’ *A Tale of Two Cities*, it was certainly a year of upheaval and uncertainty for the medical profession. While not in full swing, the Patient Protection and Affordable Care Act (ACA) moved closer to full implementation. Physicians prepared for new patient care models, and braced themselves for more regulation and bureaucracy, frustrating reimbursement schemes, and the ever-present creep of scope of practice threats and more.

The ACA split the physician community. Many independent Chicago Medical Society (CMS) physicians say they worry about their survival amid the explosive growth of super groups. Mergers and consolidations continue apace. Though some lawmakers hope to repeal the ACA, the law is already having a profound impact on the health care landscape.

Americans were stunned by insurer cancellation notices and the higher than anticipated cost of insurance exchange policies. For those with employer-based insurance, the exchanges spell the end of the traditional defined insurance benefit, as companies move toward defined contributions, in which workers are given a set amount to purchase insurance on the exchange. This means patients assume greater financial responsibility for their own care.

In these tumultuous times, organized medicine remains a steadying force. Your CMS is at the forefront, advocating for the needs of physicians and patients. Our advocacy is grounded in the principle that physicians drive high-quality care and make the choices about care as leaders of the health care team. Since our founding in 1850, we have fought for core principles: educating physicians and safeguarding public health.

We are proud to be your voice for physician advocacy and patient care. Your leadership works to improve the practice climate for physicians through legislation and public policies that give all physicians, regardless of their specialty, the ability to provide high-quality medical care and improve the health of patients.

Protecting GME

CMS has made itself a formidable physician and patient advocate, and we have taken new strides on another front: protecting graduate medical education. The fight to increase the cap on Medicare-funded graduate medical education (GME) slots extends our reach well beyond CMS’ traditional constituency, to residency program directors and DIOs.

Back in July, CMS President Robert Panton, MD, and the Dean of the UIC College of Medicine, Dimitri Azar, MD, headed off to Washington, DC, to meet with key legislators about several bills that aimed to increase the cap on Medicare-funded residency slots by 15,000. The team spent time with Senator Richard Durbin and Rep. Aaron Schock (R-Ill.) as well as other influential members of the House Ways and Means Committee, which oversees Medicare and Medicaid. During the meetings, Dr. Azar was quick to hit on the main issue: under the 1997 residency cap, the U.S. will be short by more than 100,000 needed physicians in 2020.

After the meetings, Dr. Panton spearheaded a letter campaign to all members of the Illinois Congressional Delegation highlighting the importance of raising the caps. (See “Spotlight on GME Advocacy” on page 4 of this issue.) Not only did the letter campaign reinforce the message, it also served to unite the deans and key leaders of Illinois’ eight medical schools.

“CMS has made itself a formidable physician and patient advocate, and we have taken new strides on another front: protecting graduate medical education.”

Workforce Issues

CMS was also honored to serve on Senator Durbin’s Workforce Issues panel, joining officials from the American Medical Association, American Hospital Association, and American Academy of Craniofacial Pain. The Senator asked for new ideas on how to rapidly train and increase the number of primary care physicians. CMS gave input on the factors that shape a medical student’s choice of specialty. Students’ goals change in medical school as they amass debt and look toward an uncertain economy. Those who considered a career in primary care may decide on dermatology or surgery instead. CMS said that workload and lifestyle preferences influence students’ decisions also.

CMS physicians also explained how dismal reimbursement and the high cost of malpractice insurance continue to squeeze the medical profession. With the added cost of adopting EHRs and other technology, solo and independent physicians are merging to form “super groups,” which in turn contract with hospitals. Others are giving up their practices for hospital employment. Outpatient hospital-owned facilities jack up the cost of services. The “facility fee” is an added burden on patients while also driving up health care costs.

Evaluating MOC, MOL Requirements

A little closer to home, CMS voted to oppose the misuse of costly and time-consuming recertification and relicensure testing modules by hospitals and insurers to restrict medical staff
membership or plan participation. Maintenance of certification (MOC) is a process developed by physician specialty boards to evaluate physicians’ skills and abilities. Participation in an MOC program requires continual participation in activities that demonstrate professionalism, commitment to lifelong learning, periodic completion of closed-book examinations, assessment of practice performance, and demonstrated improvement in performance. The ACA tied the Physician Quality Reporting Initiative and Medicare payments to MOC. In addition, many hospitals, health systems, insurance plans and new payment and delivery models now also require specialty board certification by physicians to participate in these systems.

Maintenance of licensure (MOL) is a process by which licensed physicians provide evidence that they are participating in continuous professional development as a condition of license renewal. The Federation of State Medical Boards (FSMB) is working with individual state medical boards to develop a MOL system. Nine state medical boards are currently participating in pilot projects to test implementation of MOL. In Illinois, the only professional development required of physicians is completion of 150 hours of continuing medical education during the three-year license period. At this time, the IDFPR is not taking immediate steps to implement MOL in Illinois.

At this time, the American Medical Association (AMA) is undertaking a study of the impact of MOL and MOC requirements on the physician workforce, physician practice costs, patient outcomes, patient safety and patient access. The study will look at the examination processes of the American Board of Medical Specialties (ABMS), the American Osteopathic Association and the FSMB. CMS has officially stepped up to support this work.

Legal Education
Partnering with the legal community, CMS offered a new learning venue. For the third year, CMS teamed with the American Bar Association's Health Law Section to host the Physicians Legal Issues Conference in June. The event was especially pertinent in 2013 given the huge shifts in health care delivery due to the Affordable Care Act. Key topics included accountable care organizations (ACOs), physician employment, medical staff bylaws issues, reimbursement, electronic health records, fraud and abuse, and social media policies. A special presentation reviewed the U.S. Supreme Court case Fisher vs. the University of Texas, which challenged affirmative action, and could ultimately harm minority health research and access to care in underserved communities.

Residency Program Directors
Near the end of the year, the Illinois State Medical Society (ISMS) and CMS hosted the annual Midwest Residency Program Directors Meeting in Oak Brook. Expert panelists discussed the rapid evolution of GME. One presentation focused on approaches to dealing with disruptive behavior in the hospital setting, with speakers representing the regulatory, institutional and clinical points of view. Another presentation focused on the ongoing implementation of the Next Accreditation System (NAS) and what steps institutions should take in transitioning to the new system. Finally, University of Chicago physicians spoke about the impact of the internal medicine residency program’s expansion into social media, with helpful pointers on avoiding pitfalls.

Educat ing Local Legislators

**The Well-Known Aphorism**

*“All politics is local,”* underscores the importance of grassroots communication in the legislative process. Each month CMS hosts conversations with lawmakers to advance key health initiatives while strengthening our presence in the City Council and State Legislature.

CMS has regular conversations with:

**House Majority Leader**

Rep. Barbara Flynn Currie

Subjects discussed: Scope of practice, medical liability reform, Medicaid expansion, Medical Practice Act, and tele-health expansion.

**State Senate President**

John Cullerton

Subjects discussed:
The Affordable Care Act, accountable care organizations, the state insurance exchange, and Medicaid expansion.

**State Rep. Sarah Feigenholtz**

Subjects discussed:
Physician workforce issues, scope of practice, working with CMS and ISMS, participating in the CMS Mini-internship program, CPR training by CMS.


Subjects discussed: Support for GME funding, adding more residency slots, eliminating the SGR.

**U.S. Rep. Mike Quigley**

Subjects discussed:
An overview of how bills are funded

**State Senator Kwame Raoul**

Subjects discussed:
Youth violence prevention, and health insurance exchanges. We thanked him for voting “no” on the psychology prescribing bill.

**State Senator Mattie Hunter**

Subjects discussed: Adverse effects on physicians under the ACA, growth of physician super groups, reimbursement, Medicaid expansion, and restricting primary care physicians to only one ACO.

CMS repeatedly asks lawmakers why the Medicaid pay increase to primary care physicians is not permanent. We say that removing the incentive to care for this patient population after a few years is counterproductive.

**State Senator Heather Steans**

Subjects discussed:
Adverse effects on physicians under the ACA, growth of physician super groups, reimbursement, Medicaid expansion, and restricting primary care physicians to only one ACO.
Year in Review

SGR Advocacy
The trip to Washington, DC, in support of lifting the Medicare-funded GME cap was certainly not the only advocacy to come out of CMS. Other trips to Capitol Hill included talks with key legislators to warn of the significant harm from Medicare payment cuts due to the flawed sustainable growth rate (SGR) formula. Congress is finally zeroing in on a long-term fix for the SGR by passing a short-term bridge that will allow lawmakers to focus on accomplishing a permanent solution in early 2014.

Shaping Public Health
Your CMS also screened and recommended candidates for the Cook County Health and Hospitals Systems (CCHHS) Board. The nominating committee is made up of individuals representing health, minority and patient advocacy organizations as well as civic, financial, public policy, hospital and physician advocacy groups like CMS. The nominating committee presents names to Cook County Board President Toni Preckwinkle. CMS has served on this committee since 2008 to ensure that Chicagoans have access to a strong public health system.

Preventing Scope of Practice Intrusions
CMS works through the Illinois State Medical Society to influence legislation at the state level. In the past year, a number of dangerous bills tried to expand non-physicians’ scope through legislation, rather than additional education and training. Our organizations are adamant that health care teams be physician-led to ensure continuity of care, data sharing, and common decision-making. Here’s a recap of misguided proposals that our organizations beat back in 2013.

- **Psychologist Prescribing Privileges.** ISMS and the Illinois Psychiatric Society stopped a bill that would have given psychologists the authority to prescribe psychotropic drugs with only minimal pharmacology coursework. SB 2187 and HB 3074 would have granted clinical psychologists who have their doctorate in psychology and complete a master’s program in psychopharmacology the authority to prescribe and dispense drugs used in the treatment of mental, emotional, and psychological disorders. The bills also would have required prescribing psychologists to maintain a collaborative agreement with any type of physician. The agreement language was misleading and failed to require that any collaboration be with an Illinois physician who provides mental health services.

- **Naturopathic Physicians.** Your societies didn’t stop there. We prevented the licensure of “naturopathic physicians” as health care professionals. These individuals want to offer homeopathy, herbal therapy and other services, but they are not trained to diagnose or treat disease. SB 1168 would have provided for the regulation of naturopathic physicians through licensure by the IDFPR. Naturopaths are neither trained nor capable of diagnosing and treating physical ailments. ISMS opposed this legislation and the bill was never called for a vote.

- **Colon Hydrotherapists.** Similarly, we prevented licensure of colon hydrotherapists as health care professionals. HB 3368 and SB 1651 would have licensed colon hydrotherapists as health care professionals. ISMS opposed these bills because there is little to no science that supports this therapy as medically beneficial. Both bills failed to advance.

- **Advanced Practice Nurses.** Amended a bill that would expand advanced practice nurses’ authority, successfully maintaining the team approach and protecting collaborative agreements. SB 73 and HB 1052 would have allowed all types of APNs to provide medical care completely independent of physicians. ISMS successfully amended HB 1052 with language retaining the collaborative agreement between a physician and an APN while easing some of the current restrictions. The ISMS language clarifies that a written collaborative agreement outside of an employment
arrangement may not restrict APNs from contracting with Medicaid, Medicare or other health plans, nor limit geographic practice locations. The ISMS language further clarifies that the agreement may include services the collaborating physician may provide, but chooses not to. And finally, the amendment states that APNs may provide primary health care services such as health screenings, histories and physicals, women’s health exams and school physicals as part of their routine practice or on a volunteer basis. There are no changes to prescribing or to anesthesia services. In the end, SB 73 was never called for a vote.

HB 1052, as amended, passed both houses and awaits further action by the Governor.

- **Home Health Services.** Amended a bill (HB 2839) that would have allowed physician assistants to prescribe home health services. ISMS amended the bill to state that the definition of “home health services” be limited to services provided under a plan of treatment prescribed by a physician, a physician assistant who has been authorized by a physician to prescribe those services, or an APN with a collaborating agreement with a physician who delegates that authority. The bill passed both houses and awaits further action by the Governor.

- **Certified Professional Midwives.** Prevented licensure of “certified professional midwives” as health care professionals. HB 2685 and HB 1194 would have provided for the licensure of “certified professional midwives” (CPMs) by the IDFPR. These midwives are significantly different from certified nurse midwives—CPMs have little to no medical education. Another bill, HB 3636, would have provided for licensure of direct entry midwives. ISMS opposed all of these bills. As a result, HB 2685 failed in the House Health Care Licenses Committee and HB 1194 was never assigned to committee. HB 3636 remains in the House Rules Committee.

- **Contact Lenses.** Prevented the dispensing of contact lenses by anyone other than a licensed optometrist, licensed pharmacist, or a physician licensed to practice medicine in all of its branches in SB 2218. Senate Amendment 1, which was adopted, clarified that “contact lenses” include, but are not limited to, contact lenses with prescriptive power and decorative and plano power contact lenses. It also clarified that “direct supervision” means that the optometrist is responsible for training the person assisting the optometrist in the dispensing or sale of contact lenses, but does not mean that the optometrist must be present in the facility where he or she practices under a license or ancillary registration at the time the contacts are dispensed or sold. ISMS supported SB 2218, which passed both houses and awaits further action by the Governor.

- **Dentists.** Prevented dentists from administering vaccinations after they complete “appropriate training” on how to address contraindications and adverse reactions. ISMS strongly opposed this legislation, SB 1217. The requirement for additional training was deemed inadequate and would not protect patients, especially those who suffer from chronic illnesses, experience allergic reactions or those who are on other drugs that may negatively interact with an immunization. There was also concern about dentists’ ability to actually implement a program for which they have little to no experience, including the vaccine schedule, its administration, handling and storage. ISMS questioned the Illinois State Dental Society on how dentists would retain documentation and communicate with the patient’s primary care provider, and how they would bill for these services. General dentists do not enroll in Medicare, nor do they participate in most health plans. Because of ISMS’ opposition, the language permitting dentists to provide immunizations was removed and replaced with language making minor changes to the Dental Practice Act.

ISMS President-elect William McDade, MD, testifies on behalf of his resolution at the AMA House of Delegates. The measure, which was first adopted by CMS, calls upon the AMA to educate medical providers on caring for victims of human trafficking.
Public Health Advocacy

CMS made huge strides last year in the area of public health. Dangers to minors abounded in the form of energy drinks and tanning beds, not to mention electronic cigarettes and the debate over their safety and utility. The controversy will surely continue into 2014. Here are highlights from last year.

• Energy Drinks. In what turned out to be an exciting year for public health initiatives, Chicago made national headlines for Ald. Edward Burke’s campaign to ban the sale of energy drinks. And CMS was right there with him. Alderman Burke, City Finance Committee chairman, and Ald. George Cardenas, City Health Committee chairman, invited CMS to testify at City Hall. Then-CMS President Howard Axe, MD, explained that these products contain nearly 3.5 times the caffeine per ounce of regular soda, with some packing up to 500 mg of caffeine. He also stated that energy drinks may contain ingredients whose combinations and additive impacts are not well understood. Squaring off against CMS and the two aldermen were dozens of industry-hired medical experts and lawyers for the American and Illinois Beverage Associations. While the future of the proposed ordinance in Chicago is still uncertain, the campaign reinforced other efforts. The AMA jumped onto the bandwagon announcing its support for a ban on the sale of energy drinks to anyone under 18. And, during a visit to Washington, DC, CMS member physicians encouraged lawmakers to support regulatory action against energy drinks, noting that a recent Department of Health and Human Services report showed that emergency room visits related to energy drinks doubled from 10,000 to 20,000 between 2007 and 2011. Senator Richard Durbin apparently agreed with CMS and shared copies of his correspondence with the FDA on the dangers of energy drinks. Currently, the FDA is investigating a series of adverse event reports, including deaths, linked to energy drink consumption.

• Indoor Tanning. In another fight to protect our nation’s youth, a CMS resolution spurred legislation in both Cook County and the State of Illinois that prevents minors from using indoor tanning facilities even if accompanied by a parent. HB 188 and SB 2244 amend the Tanning Facility Permit Act and prohibit tanning facilities from allowing anyone under age 18 to use tanning equipment or a device defined as equipment that emits ultraviolet (UV) radiation used for tanning of the skin, such as a sunlamp, tanning booth, or tanning bed that emits electromagnetic radiation with wavelengths in the air between 200 and 400 nanometers. ISMS supported both bills. HB 188 passed both houses and awaits further action by the Governor.

• Electronic Cigarettes. Both CMS and ISMS supported SB 1756, which amends the Prevention of Tobacco Use by Minors and the Sale and Distribution of Tobacco Products Act and prohibits the sale of electronic cigarettes to anyone under age 18. The bill passed both houses and awaits further action by the Governor.

• Telemedicine. CMS and ISMS supported both SB 1422 and SB 2366, which would require health insurance plans to provide coverage for telemedicine services. SB 2366 specifically states that an entity subject to the provision concerning tele-health will provide coverage under a health insurance policy or contract for health care services appropriately delivered through tele-health; that the entity may not exclude from coverage a health care service solely because it is provided through tele-health and is not provided through an in-person consultation or contact between a health care provider and a patient; and that the entity will not require an in-person contact to occur between a health care provider and a patient before payment.
“In a big step forward for patients—and a perfect example of how effective a resolution can be—the AMA adopted a CMS measure to reclassify obesity as a chronic disease state.”

including people with handicaps or disabilities.

- **Nutrition Guidelines for Food Pantries.** CMS approved a measure to encourage food banks and food pantries to develop statewide nutritional guidelines for the items they dispense. State agencies and other organizations impacted by the obesity crisis should assist with developing these guidelines. Nutritious foods, especially fresh fruits and vegetables, are sorely missing in these facilities due largely to the lack of refrigeration and stringent food safety guidelines. The resolution also directs the ISMS and AMA to work toward statewide and national nutritional guidelines for food banks and food pantries.

- **CPR Training.** CMS will train state and local legislators in basic CPR in sessions to be held in Chicago and Springfield. In the past two years, CMS has instructed hundreds of doctors, allied health professionals, and the public on CPR. Not only that, CMS encouraged the City Council to implement a hands-only CPR campaign in Chicago and Governor Quinn signed a statewide CPR and AED awareness week proclamation.

**Resolutions to Protect Patient Care**

This year, many strides on behalf of patients came in the form of resolutions submitted by CMS members, which were then forwarded to the ISMS and AMA for implementation and legislative advocacy. CMS physicians play a prominent role at the annual ISMS House of Delegates, the legislative body for both our organizations. Resolutions allow members to shape the destiny of ISMS and to shape the evolution of medical practice and public health.

- **Reclassifying Obesity as a Disease.** In a big step forward for patients—and a perfect example of how effective a resolution can be—the AMA adopted a CMS measure to reclassify obesity as a chronic disease state, a step that builds momentum for Medicare and insurers to cover the cost of weight-loss counseling and treatment. Classifying obesity as a disease encourages increased research funding into obesity prevention and treatment strategies, including the biologic, environmental and genetic factors contributing to unhealthy weight. The CMS proposal launched an in-depth AMA study and captured attention on Capitol Hill. Only a day after its approval, lawmakers introduced bipartisan legislation in the House and Senate titled “The Treat and Reduce Obesity Act,” which would require Medicare to cover obesity treatments.

- **Human Trafficking.** Similarly, a CMS resolution to educate medical providers on how to care for victims of human trafficking informed new AMA policy. The measure directs the AMA to raise awareness about human trafficking. As such, the AMA now informs physicians of resources to aid them in identifying and serving victims, including hotlines, assessment tools, online training, and links to local resources across the country. The AMA also now encourages its member groups and sections, as well as the federation of medicine, to raise awareness and offer relevant resources.

- **Medication Management.** CMS called for legislation permitting nursing staff to administer and manage medications for residents in assisted and sheltered living, and in dementia care facilities. The language directs the ISMS to work with the Illinois Department of Aging, Illinois Department of Public Health, Illinois Medical Directors Association, Illinois Geriatrics Society, Illinois Healthcare Association, and others, to create statewide policy.

- **Patient Transfers.** A measure was passed encouraging an orderly, seamless process for medication ordering and administration during patient transitions to a nursing home or other facility from the hospital with follow-up by the receiving facility. The resolution resulted in an expansion of existing ISMS policy.

- **DNR Choices.** A CMS measure advanced a resolution to protect a patient’s end-of-life DNR choices. The measure calls for legislation that would prohibit anyone other than the patient or health-care surrogate or decision-maker from altering a DNR order already established by the patient. The Illinois Department of Public Health (IDPH) Uniform DNR Advance Directive, also known as the Physician Order for Life-Sustaining Treatment (POLST), is a signed medical order that travels with the patient to assure the patient’s treatment preferences are honored across settings of care. CMS encourages advanced care planning and advance directives in particular.

**In the End**

The evolving health care delivery landscape and initial throes of the Patient Protection and Affordable Care Act made everyone from medical providers to patients both hopeful and apprehensive. CMS and ISMS rose to the challenge, educating members on the new reform law, while advocating for their interests and those of patients. We look forward to 2014 when, working together as medical providers and health care advocates, we continue to represent Cook County physicians and improve the lives of millions of patients.
Benefits and Services

As a Member of CMS, you have a wealth of programs and opportunities at your disposal, many of which can save you precious time and money. Our educational programs will keep you informed of key issues in health care delivery. We offer discounts and assistance in a wide range of areas, including reimbursement issues. In addition, through CMS you can get involved in legislative advocacy at the county, state, and national levels. Here are a few highlights:

Key Contact Program
CMS makes it easy for members to commit themselves to the advocacy process. Through our Key Contacts program, CMS encourages and trains volunteers to form meaningful connections with their lawmaker or candidates running for office. The program is flexible, accommodating physicians’ busy schedules.

The Key Contact communicates CMS’ views on legislation or advocacy activities, as well as CMS events and goals. Volunteers also may interact with legislative staff and report on their efforts to the CMS Districts and leadership. The information exchange allows members to remain active and to exert influence on the legislative process.

Legislative Internships
The CMS internship program matches physicians for a day with an elected official while they make daily rounds, perform surgery, or care for patients in the clinic or hospital. The goal is to show legislators firsthand the complexities and hassles a practicing physician encounters each day. Many legislators have said they come away with a new appreciation and respect for the practice of medicine. Not only do they witness the impact of legislation on physicians and health care delivery, but physicians acquaint themselves with the responsibilities of legislators, and how to communicate their needs to them. The Mini-internship program also shows lawmakers and civic leaders that CMS is a valuable source of information and guidance on health policy issues, which they should use in their deliberations.

Physician Wellness
With health care delivery placing ever greater demands on physicians, 87% report moderate to severe levels of stress and burnout. Stress and burnout can lead to substance abuse, depression, anxiety and suicide. CMS now offers a solid infrastructure of wellness resources for those who want help coping with the new environment. Each issue of Chicago Medicine features a physician wellness column authored by Daniel Angres, MD, medical director of Presence Behavioral Health Addiction Services, and adjunct associate professor of psychiatry at Northwestern University’s Feinberg School of Medicine. CMS has also formed a Physician Wellness Committee, chaired by Dr. Angres, to help members access services and support.

Grassroots Advocacy Center
This CMS website’s advocacy center informs members of new and pending legislation, encouraging them to engage with their congressional representatives. The site lists contact information, links, sample letters, and guidance on communicating effectively with legislators.

CMS Career Center and Job Board
In our changing practice landscape, where 49% of residents and 65% of established physicians are joining hospital-owned practices, CMS can expand your employment reach. Our online Career Center & Job Board connects medical professionals of all types with employers nationwide. Job seekers can post and view hundreds of positions at leading institutions and groups.

The site’s services include career coaching, advice on preparing a CV and interviewing, and a content library. When you open an account, you can store your CV and search-alerts in one place and sign up for special alerts when a new job matches your search criteria. Easy-to-use tools make searches more organized and efficient.

Recruiters can also find qualified candidates across a range of specialties and locations. We help large health systems, private practices, government agencies, and academic medical centers find physicians and other key staff with the right credentials and experience. With the click of a button, this website brings job seekers and recruiters together.

DocBookMD
This physicians-only iPhone and Android app allows doctors to send HIPAA-compliant text messages and photos; assign an urgency setting to outgoing text messages; search for local pharmacies; and search for local county medical societies. Message content can include patient information, such as diagnoses, test results, or medical histories. Physicians can add a high-resolution image of an EKG, an x-ray, lab report, or anything that can be photographed with an iPhone to the message. CMS offers the DocBookMD app exclusively to members at no charge. Only CMS members can access DocBookMD in Cook County.

Partnership with the Legal Community
This mutually beneficial relationship with the American Bar Association’s Health Law Section brings the medical and legal professions together around shared professional and personal interests. The massive shifts in the heavily regulated health care system mean that doctor-lawyer alliances are crucial to steering the course and protecting physicians’ rights and interests. Our collaboration with the ABA paved the way for educational programming, attorney-written articles in Chicago Medicine, and other joint projects.

Practice Manager Section
CMS’ Practice Manager Section is our first non-physician membership category. Formed exclusively for practice managers, the section fosters a strong working environment built on education and teamwork. Practice managers will find in-depth resources to guide them on practice development and expansion, cost-containment, research, and patient education. Through our forums, blogs, and networking events, practice managers enjoy increased access to colleagues and expert opinions. Membership in this section allows you to structure CMS programs and services according to your professional needs and interests, while advancing your practice’s financial health.
How to Write a Resolution

RESOLUTIONS SHOULD describe a problem and propose a solution. They have two essential parts: the “whereas” clauses, or rationale and supporting information; and the “resolves,” or the action thus recommended. The resolve(s) must specify one of three recommendations: ask for change in CMS or ISMS policy; or request action that does not create policy; or request a public statement without requiring action or policy change. If a resolution makes all three recommendations, the author should include three separate resolves within the resolution. In other words, a policy resolve and directive should not be combined in a single resolve.

Because they are the only portion of the resolution that is adopted, the resolves should make sense on their own without references to external documents, policies, or standards of other organizations unless those documents are incorporated into the resolution. Resolutions that are clearly and concisely written have the best chance of being adopted. Resolution sponsors are strongly encouraged to provide testimony before a reference committee, either in person or over the phone.

Previous CMS/ISMS/AMA policy or directives on the issue presented in the resolution should be researched prior to submission. CMS staff can provide assistance. For information on submitting a resolution to CMS, please contact esidney@cmsdocs.org or call 312-329-7335.

Annual ISMS House of Delegates Meets

This is your opportunity to voice your opinion and to help shape the future of health care

Physicians from across the state converge in Oak Brook each year to set ISMS’ policy and legislative agendas. The CMS delegation brings resolutions on behalf of all Cook County physicians.

All Chicago Medical Society (CMS) members have the power to shape the direction of the Illinois State Medical Society (ISMS) and physician-friendly legislation in the state’s General Assembly. The time commitment is minimal. Your participation can be as simple as submitting a resolution to CMS or volunteering as a CMS delegate to ISMS’ annual meeting April 25-27 in Oak Brook.

Every member is welcome to submit resolutions to CMS, thereby furthering the objectives of their profession. Deadline for submission to ISMS is March 11.

Many CMS physicians have seen their resolutions form the basis of advocacy and legislation at the state and national levels. Recent examples include measures to promote antibiotic research and development, through the GAIN Act, to require insurers to pay for obesity counseling, to set certification requirements for staff working in dementia care units, and to ban smoking in cars when children are present. Both ISMS and AMA advanced a CMS measure to fight Medicare’s proposed rule on returning and reporting overpayments.

ISMS’ House of Delegates is the state’s most powerful forum for advocating on behalf of the medical profession and patients. Once measures are adopted, ISMS springs into action, relaying the will of its members to legislators, payers, governmental agencies, and various health organizations. The State Society also launches resolutions forward to the American Medical Association for implementation in the U.S. Congress.

CMS physicians who want to observe the policymaking process firsthand may represent their county medical society as a delegate to the ISMS House meeting. Delegates receive an honorarium for attending. CMS arranges all accommodations at the Oak Brook Hills Marriott Resort, site of the House meeting.

For more information on serving as a CMS delegate, please call Ruby at 312-670-2550 or email her at rbahena@cmsdocs.org.
COMMITTEES are the backbone of the Chicago Medical Society (CMS). They allow members to request the formal study of specific issues in medicine, and ensure that a reviewing body will give direction to the organization. As the origin of new policies and legislative initiatives, committees are open to all members.

CMS understands the time constraints on physicians, and so offers members the option of virtual meetings and online discussion forums.

Bylaws/Policy Review
Reviews suggested changes to the Bylaws and recommends amendments to the Council when appropriate; reviews Council actions and statements in the CMS Policy Manual for appropriateness and timeliness.

Communications/Technology
Monitors the world of technology, and informs and educates members on the use of computer and technology applications in the clinical setting and for personal use.

Continuing Medical Education
Ensures that CMS is in compliance with the Essential Areas and Standards for Commercial Support (SCS) of the Accreditation Council for Continuing Medical Education (ACCME); initiates, implements and evaluates CME programs; and assists related groups in structuring CME programs under joint sponsorships.

Credentials/Elections
Determines the number of voting members present during Council meetings, announces quorums, acts as tellers, and takes charge of all general elections.

Health Care Economics
Monitors local managed care trends, health delivery service and quality; advises CMS of significant trends; reviews the actions of the professional liability insurance industry; informs CMS about health planning in Chicago and Suburban Cook County; evaluates the effects of physician reimbursement and medical policies proposed by the federal government and third-party payers.

Long-Range Planning
Ensures that CMS has a well-conceived five-year strategic plan that includes an analysis of the Society’s trends, strengths and weaknesses and the environment of medicine, and prescribes action to position CMS for the future.

Membership/IMG
Develops strategic plans for ongoing recruitment and retention; reviews new member applications, status change requests, dues waivers and transfers, and makes recommendations to the Council; reviews reinstatement requests from physicians who have resigned or forfeited their membership; supports measures to encourage full integration of IMGs into American medical practice; and represents issues of concern to IMGs.

Senior Physicians Group
Provides a vehicle for senior physicians to support CMS through outreach, education, and mentoring.

Subcommittee on Joint Sponsorship
Helps plan CME activities and reviews all joint sponsorship applications from related organizations; advises the full CME Committee on trends, concerns, and requirements; assures that CMS activities and joint sponsorship programs are in full compliance with the ACCME’s Essential Areas and SCS.

Physician Advocacy
Represents and protects the rights, responsibilities, and interests of physicians in all practice modes (solo, group, employed, and academic); in all hospital medical staff issues (self-governance, credentialing, medical policy development, peer review, patient advocacy, and quality of care); and resolves complaints, or conflicts involving members of a medical staff or structured medical entity.

Public Health
Reviews and responds to requests for advice, opinion, or program approval directed to CMS by any health department, municipal health committee, or public health body in Cook County. Also initiates contact with such groups when directed by the CMS President, Executive Committee or Council, on matters of concern to organized medicine.

Resolutions Reference
Receives all resolutions referred by the Council; holds hearings on those resolutions, and reports recommendations to the Council.

How to Join a CMS Committee
All physicians are encouraged to volunteer for any committee they wish. To sign up, please send an email, fax, or letter listing the following information: Name, address, city, state, zip code, email address, phone and fax number. Be sure to indicate which committee(s) you wish to serve on. Our fax number is (312) 670-3646 and our email is rbahena@cmsdocs.org. To download a form, please go to our website at www.cmsdocs.org.

“We understand the time constraints on physicians, and so offer members the option of virtual meetings and online discussion forums.”

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Illinois Seeks Medicaid Transformation

With thousands of new Medicaid enrollees expected in 2014 and beyond, will fundamental changes sought by the state be a boon or a bust?

BY NOW, most Illinois physicians are accustomed to talk of changes in the Medicaid program. Enrollment in the program has nearly doubled in the past decade, and is set to surge this year as the Affordable Care Act’s expansion of Medicaid kicks in. Soon, over three million Illinois residents will depend on the program.

Meanwhile, Medicaid reimbursements to physicians and health care facilities in many cases do not even cover the cost of providing care, and serious questions remain about what this significant increase in enrollment may do to payment cycles and our state’s already-stretched budget. These problems have led to some very big-picture discussions of how to rebuild Illinois’ troubled Medicaid model.

Federal law may provide an opening for much-needed change. Section 1115 of the Social Security Act gives the Secretary of Health and Human Services (HHS) authority to approve experimental, pilot, or demonstration projects (through a process known as a “Section 1115 Waiver”) that give states additional flexibility to redesign and improve their Medicaid programs in ways that are not otherwise allowed under federal law. Waivers issued under this section have been in use for decades, including in Illinois, but now that the federally funded expansion of our state’s Medicaid program has taken effect, they are in the spotlight again.

The Illinois Department of Healthcare and Family Services (IDHFS) has released a draft waiver application that consolidates Illinois’ existing Section 1115 waivers and outlines a broad vision for restructuring our state’s Medicaid program. It includes significant changes to how physicians and institutions are paid, a wide range of public health efforts, and funds for training community health workers to help address many of the root causes of poor health in our state.

Physicians concerned with taking a holistic approach to the well-being of their patients may well applaud the goals of this proposal. Caution is warranted, however, as the draft application is relatively short on details for many of its components.

The positive elements within the plan include new Graduate Medical Education funding through Medicaid; loan forgiveness for physicians willing to practice in underserved areas; and pilot programs to reduce over-utilization of ERs as primary points of care. These provisions, if they are designed and implemented well, have the potential to make a significant impact in Illinois’ physician workforce and in the health of Medicaid patients around the state.

However, while the plan purports to expand and improve care to vulnerable populations in a more efficient and coordinated manner, the Illinois State Medical Society (ISMS) has concerns or questions about several elements in the plan. These include:

- **Workforce.** The plan appears to expand the scope of practice for some allied health professionals, and includes the creation of newly certified “Community Health Workers.”

- **Managed Care.** The rush to modify payment models and align them with improved outcomes, all within an increasingly capitated system, is accelerated by this proposal.

- **Access to Care.** ISMS has serious concerns about a lack of provider capacity consistent with the state’s desire for care coordination.

As always, ISMS will maintain a balanced position, working with the state to strengthen the positive elements while also expressing our concerns. We have submitted testimony aimed at helping address our concerns, and we are hopeful that many of our questions will be answered as more details are released. The final waiver application is expected to be submitted by the governor to the Centers for Medicare and Medicaid sometime in February.
5% Discount After Five Years
Loyal members get a break

WHILE LOYALTY is said to be its own reward, the Chicago Medical Society (CMS) recognizes outstanding physicians for their contributions in a variety of areas. Be sure to nominate a deserving colleague today. Nominees must be members of CMS and nominations must be received by May 1. Recipients will be announced at the June 3, 2014, Annual Dinner and Meeting. Award descriptions and nomination instructions follow.

HENRIETTA HERBOLSHIMEYER, MD, Annual Public Service Award
This award recognizes physicians for outstanding contributions in the local community or government. (Contributions need not be health-related.) The award communicates to the City of Chicago and Cook County the important work of physicians, while encouraging CMS members to participate in community or civic affairs. Honorees must be CMS members, and are selected on the basis of their community service. Past presidents of CMS are not eligible until five years after their term of office has ended.

Physician of the Year Award
This award recognizes local physicians for recent contributions or achievements in the field of medicine, as clinicians, researchers, educators, or leaders. Recipients are honored for improving the lives of patients locally, nationally, or throughout the world, as well as for their service on behalf of the medical profession.

Outstanding Student/Resident/Fellow of the Year Award
This award recognizes young members who are most likely to become well-rounded outstanding physicians or clinicians. Recipients are honored for their compassion toward patients, professional behavior, clinical and academic excellence, and service to their medical organizations and or community. The award recognizes medical residents and fellows who go above and beyond their duties, serving as role models to those they lead and educate, while exhibiting overall achievement in their field, clinical promise, innovation skills, and commitment to the medical profession and or community.

Lifetime Achievement Award
This award recognizes physicians for their distinguished careers in medicine. It honors recipients for their sustained commitment and contributions to patient care, for example, as clinicians, educators, researchers, humanitarians, or thought leaders. The award also recognizes physicians’ contributions to their profession.

Please check the CMS website (www.cmsdocs.org) or call Elvia Medrano, 312-670-2550 for instructions on nominating a physician, student, resident, or fellow for an award.

Nominate a Colleague
CMS’ annual awards recognize physician members for outstanding achievements and service

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Calendar of Events

MARCH

5 ICD-10 CM: Preparing for a Successful Implementation
Intended for all physicians, practice managers, physician executive staff, and medical office staff. Successfully transitioning to ICD-10 CM by Oct. 1, 2014, will require careful planning and coordination of resources. Many provider and health plan databases and applications will be affected—every application where diagnosis or procedure codes are captured, stored, analyzed or reported. There are significant impacts to physician practices. Participants will learn to describe key elements required of a successful transition plan; make recommendations for each of the four phases of implementation: planning, impact analysis, implementation, and post-implementation; and understand the code structure, format and basic conventions of ICD-10-CM diagnosis coding and their impact. Speaker: Nelly Leon-Chisen, RHIA, Director, Coding and Classification, American Hospital Association, Chicago. Registration/breakfast: 8:30-9:00 a.m.; presentation: 9:00 a.m.-12:30 p.m.; Hilton Oak Lawn, 9333 S. Cicero Ave., Oak Lawn; 3.5 CME credits; $59 per person for CMS members; $159 for non-members/staff. Register online at: www.cmsdocs.org or contact Elvia at emedrano@cmsdocs.org or 312-670-2550, ext. 338.

6 Public Health Committee General Meeting This meeting is intended for all committee members, but is open to interested CMS members as well. 7:30-8:30 a.m.; Conference Call. To RSVP, please contact Meredith 312-670-2550, ext. 326; or oney@cmsdocs.org.

28 OSHA Training Intended for physicians, physician assistants, nurses, practice managers, and dental professionals who risk potential exposure to bloodborne pathogens. Participants will learn to: implement a training program for health care employees who may be exposed to bloodborne pathogens; identify appropriate personal protective equipment (PPE); develop an emergency response plan; create a written exposure control plan for health care workers assigned as first-aid providers; and develop a strategy to prevent the spread of pandemic flu within the practice. Speaker: Sukhvir Kaur, Compliance Assistance Specialist. 10:00-12:00 noon; DoubleTree by Hilton-Oak Brook, 1909 Spring Rd., Oak Brook; 2.0 credits; $99 per person for CMS members/staff; $139 for non-members/staff. To RSVP, register online at: www.cmsdocs.org or please contact Elvia at emedrano@cmsdocs.org or 312-670-2550, ext. 338.

16 CMS Executive Committee Meeting Meets once a month to plan Council meeting agendas; conduct business between quarterly Council meetings; and coordinate Council and Board functions. 8:00-8:00-9:00 a.m.; Maggiano’s Banquets, 111 W. Grand Ave., Chicago. For questions, please contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

25-27 ISMS Annual House of Delegates Meeting The policymaking body of the Illinois State Medical Society meets at the Oak Brook Hills Marriott Resort, 3500 Midwest Road, Oak Brook. For more information, please contact www.hod@isms.org or call 312-853-4745 or 800-782-4767, ext. 4745.

30 OSHA Training Intended for physicians, physician assistants, nurses, practice managers, and dental professionals who risk potential exposure to bloodborne pathogens. Participants will learn to: implement a training program for health care employees who may be exposed to bloodborne pathogens; identify appropriate personal protective equipment (PPE); develop an emergency response plan; create a written exposure control plan for health care workers assigned as first-aid providers; and develop a strategy to prevent the spread of pandemic flu within the practice. Speaker: Sukhvir Kaur, Compliance Assistance Specialist. 10:00-12:00 p.m.; Chicago Medical Society Bldg., 33 W. Grand Ave., Third Floor, Chicago; 2.0 credits; $99 per person for CMS members/staff; $139 for non-members/staff. Register online at: www.cmsdocs.org or please contact Elvia at emedrano@cmsdocs.org or 312-670-2550, ext. 338.
Personnel Wanted

Visiting physician service in south suburb seeks physician for 10-15 hours per week for administrative duties. Primary responsibilities include review of (physician, nurse-practitioner, or physician assistant) medical histories and physical exams; reports of eligibility; plans of care; pharmacy/lab documentation and orders; and insurance-related forms presented for health care delivery. Other supervisory functions with mid-level providers may be required as needed. Compensation rate is negotiable. Please contact Dr. Bola Ayeni at 708-898-2700 for further details.

Office/Building for Sale/Rent/Lease

Oak Forest medical office for rent. Will build to suit up to 5,000 sq. ft. of prime Twin Lakes office. Near Oak Forest Hospital of Cook County and Fresenius Medical Care Center. Elevator building with wheelchair access ramp. Up to three months free rent. Ideal for new graduate, specialist, satellite, or main office. Contact Peter at mrcholdingsllc@gmail.com or 312-288-1877 or http://twinlakesoffice.webs.com.

Medical building for lease at 1650 Maple Ave., Lisle, Ill. 60515; 2,000-4,000 square feet available @ $19.50 per sq. ft. Contact: Email administration@officegci.com or fax 847-398-4585 with serious inquiries.

Business Services

K M Medical Billing, Inc. servicing most specialties including ancillaries since 1997. Call 773-324-0119 or kathybridges@kmmedicalbilling.com or KMmedicalbilling.com.

Physicians’ Attorney—experienced and affordable physicians’ legal services including practice purchases; sales and formations; partnership and associate contracts; collections; licensing problems; credentialing; estate planning; and real estate. Initial consultation without charge. Representing practitioners since 1980. Steven H. Jesser 847-424-0200; 800-424-0060; or 847-212-5620 (mobile); 5250 Old Orchard Rd., Suite 300, Skokie, Ill. 60077-4462; shj@sjesser.com; www.sjesser.com.
FAST-TALKING and passionate, Peter Orris, MD, MPH, an occupational medicine specialist, is a true child of the 60s. A 1975 graduate of Rosalind Franklin University—Chicago Medical School, Dr. Orris knew early on that he wanted to serve people at the low end of the U.S. economic spectrum. At the same time, he was heavily involved in the Civil Rights movement.

During his second year in medical school, Dr. Orris discovered that while larger companies had medical departments, workers could not find physicians in their communities who could tell them what the impact of a chemical exposure was on their health. “As students we met workers who couldn’t find independent medical advice about workplace exposure or workers compensation injuries,” he says. “Our response was usually, ‘I don’t know but I’ll look it up.’” He continues, “That’s when it struck me. Much of primary care becomes routine. But with some 80,000 chemicals out there, and more being added yearly, occupational medicine would never become old.”

After 35 years of general internal medicine at Cook County Hospital, Dr. Orris now serves as chief of service for occupational and environmental medicine at the University of Illinois Hospital and Health Sciences System and continues to teach in the Department of Preventive Medicine at Northwestern University’s Feinberg School of Medicine. He is a professor of internal and preventive medicine at Rush Medical College and volunteers at the occupational medicine clinic at Stroger Hospital of Cook County. He says, “The service is the clinical and consulting arm where we provide assessments of environmental and occupational toxicology issues.”

The department provides consultations to patients, physicians, companies, unions, government agencies, and attorneys. “We often are particularly helpful,” Dr. Orris says, “when a primary care physician is faced with a patient who has odd symptoms and complaints of environmental exposure. Due to lack of time for research and often difficulty in defining the syndrome and existence of multiple causes, the result of the interaction is not satisfying for the patient or the clinician.”

True to form, Dr. Orris is also passionate about bringing sustainable practices to health care. He currently serves as chair of the Research Collaborative of Health Care without Harm, a group of organizations and institutions from 75 to 80 countries committed to sustainability in health care. “We’ve done well over the last several years,” he says. “For example, there are no more mercury thermometers available in the U.S. We’re also trying to convince our colleagues to mitigate climate change by moving away from fossil fuels.”

In 1989, he was the author of a New England Journal of Medicine article that stimulated the creation of PNHP, a physicians’ single payer advocacy group, which still attracts much of his passion today. Dr. Orris credits the Affordable Care Act for taking a step toward improving health care access for everyone. “The biggest contribution from the government in the ACA,” he says, “is the underlying belief that everyone is entitled to health care.”

IN ADDITION to his 35 years at Cook County Hospital, including a stint as president of the medical staff, Dr. Orris has been medical director of occupational and corporate health at Mount Sinai and Northwest Community Hospitals, and Midwest medical officer for the National Institute for Occupational Safety and Health. He currently sits on the Illinois’ State Board of Health, and the Health Professionals Advisory Board of the U.S./Canadian International Joint Commission. He was recently elected to the Social Service Honor Roll of the Yale University School of Public Health, received the Chicago Medical School Distinguished Alumnus of 2011 award, and has been a fellow of the Institute of Medicine in Chicago. He is on the Board of Physicians for Social Responsibility of Chicago, a member of the AMA, president of District 6 of CMS, and a delegate to ISMS. He has authored many articles and governmental reports on occupational and environmental medicine.
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† This Guarantee covers ICD-10-CM codes and does not cover the ICD-10-PCS code set. Eligibility for the cash advance is limited to independent practices that (i) are live on athenahealth’s athenaOne services, or on our athenaCollector, athenaCommunicator and athenaClinicals services, by June 30, 2014; (ii) have an overall average days in accounts receivable (DAR) of more than 60 days in regard to transactions occurring on or after October 1, 2014; (iii) have Client-responsible DAR of seven days or less for such month; and (iv) are not in breach of the athenahealth Master Services Agreement; provided, however, that the total aggregate amount of cash advances made by athenahealth to its clients will not exceed $50 million dollars in the aggregate and cash advances made to each practice will be capped based on the number of MDs and mid-level providers in such practice. Additional terms and conditions apply; please see your sales representative for more information.

†† If you don’t receive the Federal Stimulus reimbursement dollars for the first year you qualify, we will credit you 100% of your EHR service fees for up to six months until you do. This offer applies to HITECH Act reimbursement payments only. Additional terms, conditions, and limitations apply.