Reshaping Physician Income

The evolution to value-based reimbursement

Page 18

ACOs: A Report Card
Illinois Insurers Gain Clout
Getting on Top of Ebola
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FEATURES

18 Saying Goodbye to Fee for Service
A tsunami of forces is reshaping physician income, but none more than the evolution to value-based reimbursement
By Bruce Japsen

22 ACOs: How Are We Doing?
Depending on what you read and who you believe, ACOs are either meeting their objectives or failing miserably.
By Jim Watson

24 Medicaid Opportunities, Challenges and Changes The State of Illinois is on a roll moving patients into Medicaid managed care.
By Nicole Channel

PRESIDENT'S MESSAGE
2 Championing GME With Holiday Spirit
By Kenneth G. Busch, MD

OPINION
4 The Resolution Writing Process
By Zain Sayeed, Student

PRACTICE MANAGEMENT
6 Illinois Insurers Gain Clout; Patient Conflict Strategies; Is It Time to Assess Your Financial Policies?

PUBLIC HEALTH
10 Getting on Top of Ebola; Flu: What Docs Are Asking

LEGAL
14 Legal Preparedness and Ebola
By James G. Hodge, Jr., JD, LLM, Gregory Measer, and Asha M. Agrawal

16 POLST: Potential and Pitfalls
By Kerry R. Peck, JD, and Kyle T. Fahey, JD

MEMBER BENEFITS
26 Advocating for You
By Elizabeth Sidney

28 ISMS Update: Physicians Win Big in Midterms
By William A, McDade, MD, PhD

30 Calendar of Events / New Members

WHO'S WHO
32 It's All About Patients
Anthony J. Tedeschi, MD, a board-certified family physician and CEO at Weiss Memorial Hospital, takes the responsibility of ensuring patient health care quality and safety to heart—and it shows. By Cheryl England
MESSAGE FROM THE PRESIDENT

Championing GME with Holiday Spirit

The Chicago Medical Society is welcoming groups vital to medicine’s future this holiday season.

Among the guests bringing good cheer to our Annual Holiday Reception on Dec. 3: teaching faculty and residents, state lawmakers, aldermen and county officials. It’s one way we build bridges between partners.

New funding for graduate medical education has been one of our highest legislative priorities in the past few years. In countless ways, we have advocated for increases in the overall number of residency training positions to meet the nation’s projected health care needs.

We collaborate every December with the Illinois State Medical Society to co-host the Residency Program Directors meeting. The event features medical education leaders and experts who discuss the latest trends and issues in GME.

CMS’ co-sponsorship of the residency program directors gathering complements our many advocacy activities:

• Hosting five Chicago-area medical school deans for Rep. Aaron Schock’s presentation on GME funding issues. Congressman Schock is sponsor of HR 1201, “Training Tomorrow’s Doctors Today Act,” one of the three major bills under consideration by Congress to “uncap” the 94,000 resident financing limit.

• Orchestrating a letter campaign with Illinois’ eight medical school deans and our major medical societies. This joint letter to our state’s congressional delegation represents and reinforces the shared position of the medical community.

• Arranging for medical school deans to make house calls on Capitol Hill. Our team has included Dimitri Azar, MD, of the University of Illinois at Chicago; Linda Brubaker, MD, of Loyola University, Karen J. Nichols, DO, Midwestern University, and University of Chicago lobbyists.

• Close to home, meeting personally and regularly with members of Congress. Four U.S. House members signed on to Rep. Aaron Schock’s GME legislation, thanks to our concerted outreach (U.S. House Reps. Bill Foster; Mike Quigley; Jan Schakowsky; and Robin Kelly).

• Pursuing strategies to achieve GME reform. Outgoing lawmaker Rep. Peter Roskam encourages CMS’ involvement in the U.S. House’s “Doctors’ Caucus.” There is also a bipartisan Congressional Academic Medicine Caucus.

• Supporting medical students as they instituted their own letter-writing campaign to lawmakers. Burdened by debt and uncertain of their future, students speak from a unique perspective on the issue.

Two upcoming events will reinforce our physician workforce campaign, adding new momentum. Medical school deans will gather in December at Rush University Medical Center to discuss GME funding issues.

Another meeting, devoted to medical research funding, will take place on Northwestern University’s Chicago campus. CMS is co-hosting both events with U.S. Rep. Danny K. Davis. Congressman Davis represents the Illinois Medical District, an area dense with teaching institutions and hospitals. CMS’ goal is to provide Congressman Davis with input and education on the complexities of GME.

Let us celebrate our efforts and recommit to the future.

Kenneth G. Busch, MD
President, Chicago Medical Society
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The Resolution Writing Experience

Students can use this powerful tool to fight for positive change By Zain Sayeed

Whenever I mention resolution writing among fellow medical students, a stir of curiosity fills their minds. While trying to explain the pieces of a resolution, many of my colleagues get lost in my garble and nod politely. The ironic part of this is that I was exactly the same way when I first heard about resolution writing. After doing a bit of self-directed research I knew that this was something that would allow me to have an outlet to voice concerns. What I would later come to find is that resolution writing is the gold standard by which even senior physicians are shaping the future of health care. So let’s cut to the chase: what is a resolution?

A resolution is a written statement that requires research and a governing body to advocate for a chosen idea. Future decisions of an entire governing body, whether the American Medical Association, medical student sections, or a local medical society, are often guided by existing policy. Thus, a resolution potentially sets into place the guiding principles that will shape the future of health care. Sounds great: but how do we go about writing a resolution?

A solid resolution requires passion and a great idea. In order to come up with a resolution idea, I suggest having a brainstorming session with your peers. At the Chicago Medical School, I conducted a brainstorming meeting that was open to the entire school. A colleague, John Wahhab, and I thought of pursuing a measure to prohibit drivers and passengers from smoking in vehicles in which minors are present. At the time, John was a second-year student and boards were just around the corner, so I decided to take the lead, putting in extra work on research and writing, while John edited and guided me throughout the process. So other than an idea, what are the pieces that are incorporated into a resolution?

A resolution consists of two parts: whereas clauses and resolved clauses. The whereas clauses contain background information on an issue and outlines the need for a new policy or action. While writing my resolution I would take time out of my schedule to research and find proven evidence that reported the dangers of secondhand smoke on minors. Though this process is long and arduous, it undoubtedly bolsters a resolution.

Like any field of research, evidenced-based facts and statistics strengthen the final product. After gathering my resources, I began to write whereas clauses. I would write, reword, and use citations as needed. There is no correct, minimum, or required number of whereas clauses that a resolution requires. It’s all up to you, and how much you think it will take to convince your fellow students and physicians to support your resolution. But what about resolved clauses?

Perhaps the most important portion of the resolution, resolve clauses actually become part of the guiding principles of the governing body or organization. For me, this was the easiest part of writing, but as a writer it’s important to keep in mind that the resolve clauses get the most scrutiny from your peers. My suggestion is to keep them succinct.

Also bear in mind that your resolve statements may be amended by the governing body. Once your resolution is finished, you are able to present the resolution to your county or state medical societies, regional delegates, and ultimately to medical schools across the nation.

When I first wrote my resolution, I had no idea how much impact it could possibly have, or how many eyes would peruse the words I had written. I had no idea that I would have to defend my words amidst other medical students who came from across the nation to Chicago’s national convention. It was something that I was just doing because I was passionate about the topic, and had an urge to positively impact society.

The farther along I get in medical school, the more I am able to help younger students write their own resolutions and pursue activities in local medical societies. Perhaps the most inspiring part of this whole journey was the Chicago Medical Society Council meeting in September.

I saw senior physicians who use resolution writing principles to fight for positive change in the local Chicago community. So for those students who are still skeptical, who are still wondering what the point of these medical societies is and why they should join, I say, jump in and get involved. Try it out, chances are you’ll get a glimpse of what the future of health care holds. Who knows, you may be the person who is writing it.

In June 2014, the AMA adopted language supporting legislation that prohibits smoking while operating or riding in a vehicle that contains children.

For more information about writing a resolution, check out the AMA’s MSS for guidance at http://bit.ly/1tRv5RM or contact the Chicago Medical Society.

Zain Sayeed will graduate in 2016 from the Chicago Medical School of Rosalind Franklin University of Medicine and Science.
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Illinois Insurers Gain Clout

A few giant companies dominate the market

By Bruce Japsen

The clout of insurance companies is growing rapidly in Illinois, threatening competition and potentially squeezing patient choice of physicians, according to a new report issued by the American Medical Association (AMA). And Illinois is not alone. Across the country, mergers among health plans have put the control of who provides commercial insurance into the hands of fewer insurance executives. In addition, a single health insurance company has at least a 50% share of the market in 41% of metropolitan areas across the country, according to the AMA's report, “Competition in Health Insurance: A Comprehensive Study of U.S. Markets.” The study is based on 2012 data from commercial insurance enrollment in both fully insured plans and self-insured plans, the AMA said.

Physician groups locally and nationally say the report is evidence that consumer choice of doctors is threatened and could be contributing to higher health care costs for patients. The AMA said the report should raise antitrust concerns from legislators.

An Analysis of Insurance Company Control in Illinois

In Illinois, two insurance companies—Blue Cross and Blue Shield of Illinois and UnitedHealth Group—controlled 75% of the commercial insurance market, which is an increase from the AMA's analysis two years earlier when the two plans controlled 67% of the state's market.

In this year's analysis of the 2012 data, Blue Cross and Blue Shield of Illinois, a subsidiary of Health Care Service Corp., controls 61% of the commercial insurance market while UnitedHealth Group's United Healthcare of Illinois subsidiary controls 14% of the market. “In many Illinois cities, patients and the employers who provide coverage to workers are at a disadvantage due to limited health insurance options,” said William McDade, MD, a University of Chicago anesthesiologist and president of the Illinois State Medical Society. “When faced with limited competition, insurers have the opportunity to wield too much control, dictating premium expense and other aspects of patient care.”

In 8 of the 11 largest Illinois metropolitan areas, including the Chicago area, Blue Cross and Blue Shield of Illinois controls 50% or more of the market. The metropolitan area that includes Chicago, Naperville and Joliet was the least competitive market, with Blue Cross and Blue Shield of Illinois holding 68% of the insurance market.

From 2011 to 2012, Illinois experienced the “biggest drop” in competition, according to the AMA. The AMA also stated that Illinois is among 10 states that are considered the least competitive when it comes to commercial insurance.

The Increasing Clout of Insurers Troubles Physicians

This amount of control has medical professionals worried. “The dominant market power of big health insurers increases the risk of anti-competitive behavior that harms patients and physicians, and presents a significant barrier to the market success of smaller insurance rivals,” said AMA president Robert Wah, MD.

The increasing clout of a few insurance companies is something for physicians to take note of, particularly as more Americans gain commercial insurance coverage under the Affordable Care Act and private health insurers take on a greater role managing health benefits for those covered by the Medicaid program. Health insurance companies and employers that hire them to administer self-funded plans hold significant power over a patient's choice of medical care providers. Given that benefits provided under the health law are largely administered by commercial plans, the insurance industry's clout is only expected to increase in the future.

The Rise of Narrow Networks: Limiting Patient Choice?

To make plans operating on government-run exchanges more affordable, Blue Cross and Blue Shield of Illinois, UnitedHealth Group and others are offering more plans with narrow networks, which offer more limited choices of physicians and hospitals. Insurance companies say narrow networks allow them to more closely monitor quality providers. Doctors and hospitals who meet quality measures are more likely to be part of the narrow network, insurers say.

Physicians, however, say narrow networks are limiting patient choice and threatening access. “Health insurance companies have an obligation to build sufficient physician networks to ensure care delivery to their customers,” said Dr. McDade. “We are concerned that many insurers aren't meeting this obligation. Narrow networks may prohibit patients from seeing preferred physicians or require traveling greater distance when seeking care.”

For its part, Blue Cross and Blue Shield of Illinois, in response to the AMA market share study, said its large number of health plan members, which have ballooned to more than 8 million across the state, allows it to provide more choices and products that keep cost increases down.

“Blue Cross and Blue Shield of Illinois supports a competitive marketplace for health insurance,” a Blue Cross and Blue Shield of Illinois representative said in a statement to Chicago Medicine.

“Despite the strong local and national competition that we face, our members consistently choose Blue Cross and Blue Shield because of our product choices, the extensive provider networks we offer, along with our excellent customer service and commitment to helping them manage their health care choices and decisions,” a Blue Cross and Blue Shield of Illinois representative said. “Recent studies suggest our strong membership actually helps bring down the cost of medical care in the communities we serve, in contrast to the consolidation of providers in a market which is found to increase costs for consumers.”

Bruce Japsen is an independent health care journalist who writes for Forbes and contributes analysis to WBBM Newsradio and WTTW television in Chicago and Fox News Channel's Forbes on Fox. He can be reached at brucejapsen@gmail.com.
Patient Conflict Resolution Strategies

How to calm an angry patient  By Alina Mason

When a patient is angry and confrontational about a problem, our first instinct is to put up our shields and act defensive. Instead, we should take a breath, keep calm, and remember not to disagree, agree, or engage in argument. Following the pointers below will help you achieve an effective conflict resolution strategy.

1 Listen. Take the patient in an area where you can give him or her your full attention without any distractions, and just listen until the patient is done. In a conflict, managers should strive to understand their patient without trying to first be understood.

2 Apologize. Intuitively, we all know how to apologize. However, our method of apology is all too often assigning blame. Apologies should be sincere without shifting blame elsewhere. Telling a patient, “I am sorry we don’t have your results. The lab is always slow in processing them,” is not as effective as, “I am very sorry for the delay in getting your results. I will check with the lab and give you a call back in the next half hour.”

3 Show gratitude. A sympathetic and unbiased response to your patient’s emotional outpouring, even thanking the patient for coming to you with any problems or concerns helps calm a situation. Simply saying, “Thank you for bringing this matter to my attention” can go a long way towards diffusing a patient’s anger, which may lead to greater patient satisfaction.

4 Ask questions. Do not jump to conclusions. Review your patient’s problem or concern, to make sure you have a full understanding of what the patient’s perception is. Recapping in your own words will clarify any misunderstandings.

5 Make a decision. After you have a clear understanding of the concern, ask the patient what he or she believes is the best resolution. Come up with several possible solutions to the problem, while continuing to defer judgment. If the patient demands something that is clearly against practice policies, do not just tell patients that what they want is against the policy, but show them a written copy of the policy. At the end of the discussion, a plan or resolution should be decided upon.

6 Document and follow through. Any discussions with the patient should be documented along with the planned resolution. If the problem persists and could have an impact on other patients, be sure to put processes in place to drive improvement.

Finally, remember to approach every problem as a learning experience and means of improving your practice.

Alina Mason is chair of the CMS Practice Manager Section and executive director of Medical Arts Unlimited in Libertyville, Ill.
ANY PRACTICES are experiencing huge increases in outstanding patient balances. Insurers are placing more and more responsibility on the patient and paying less and less of the claims. Practices that have not yet updated their financial policies to meet the demands of the current health care system are seeing significant increases in aged patient account receivables. Front office operations assessments can help you identify areas in need of improvement. Changes can be enacted by simply tweaking a process or fully revamping a procedure.

Traditionally, attempting to collect unmet deductibles and coinsurance from patients was the responsibility of the billing office. But this process is expensive and ineffective in many instances. One area to review and move from billing into front office operations is the practice of estimating, communicating and collecting the patient’s financial responsibility.

Estimating Patient Responsibility: Tools and Tips
It is imperative for physician practices to review their financial policies to make sure that “patient responsibility” balances are collected at the front desk before services are rendered. Best performing practices not only collect co-pays and outstanding balances at the time of service, but they also use online tools to estimate patient responsibility on upcoming procedures.

Payer websites offer several tools to assist practices in determining a patient’s responsibility. While online, the front office enters patient plan information, CPT codes, and other vital information for the upcoming procedure. The system sends back the estimated allowable amount, the estimated insurance payment and the estimated patient responsibility, including unmet deductible amounts. Note: because accumulated deductible and maximum out-of-pocket amounts may change as additional claims are processed, the actual benefits will be determined once the claim is processed.

Best performers use this information to discuss estimated financial responsibilities with patients. Prior to the procedure, the patient is required to pay all or most of the estimated financial responsibility. Any credit balances created after claims have been processed should be immediately refunded to the patient.

Online estimator tools for registered site users include:
- Availity Web Portal
- Aetna
- BCBSIL
- CIGNA
- Humana
- Aetna
- CIGNA
- Humana
- UHC

Financial counselors are working with patients, in some cases, explaining the basics of how a claim is processed and how financial responsibility is determined based on the patient’s plan. In all cases, these financial counselors explain the estimated responsibility for upcoming procedures and what the patient is expected to pay prior to the service(s) being rendered.

You will need to check your contracts to make sure that you are allowed to collect from patients prior to claims processing. Many payer contracts have language that permits collection prior to claims processing or are simply silent on the topic.

Practices can no longer afford to rely only on back office efforts to collect from patients after services are rendered. As your practice shifts to front office operations processes, you will need to collect more from patients on the front end, and then your accounts receivable will begin to reflect real improvement.

Gail Wilkening is senior health care consultant with PBC Advisors, LLC, in Oak Brook. PBC Advisors provides business and management consulting and accounting services to physician practices. For more information, visit their website at www.pbcgroup.com.

“Practices can no longer afford to rely only on back office efforts to collect from patients after services are rendered.”

Your Practice Management Colleagues

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Westlake Hospital in Melrose Park got a chilling taste of treating a possible Ebola patient this past October. A young man walked into the ER saying he had been running a fever and had abdominal cramps. Following CDC guidelines to the hilt, registration knew immediately what questions to ask: Any recent travel? Out of this country? “Yes,” the young man said. He claimed he had been doing humanitarian work in Liberia. ER staff immediately gave him a mask to wear and moved him to a separate area. But not before several frightened patients started heading towards the exits. They were intercepted by Mike Ditoro, Westlake’s COO, who explained that this was only a drill; that the “Ebola man” was actually a pharmacy student who no one at the hospital knew, and he was hamming it up so Westlake could test its ability.

“The patients were happy and thankful for what we were doing, and returned to their seats,” Mr. Ditoro said. “We are going to have a continuous focus on these kinds of drills; it’s the only way we can stay safe.” Conceding that Ebola preparedness has cost a considerable amount of money, Mr. Ditoro said it is worth it. “This gives us a re-emphasis on appropriate procedures to keep us safe. It’s no distraction. Nothing is more important than the safety of our patients and caregivers.”

While Chicago hasn’t been visited by an Ebola patient, our local health care community has been working closely together to fine-tune procedures and protocols since the first U.S. Ebola case surfaced this past September in Dallas.

“This is a learning experience for all of us, and we have been very fortunate to have had the time to prepare over the last two months; the entire health care community has responded,” says Stephanie Black, MD, medical director of communicable disease for the Chicago Department of Public Health (CDPH). The department is overseeing a major, multi-pronged effort to deal safely with any Ebola situation that may hit Chicago.
Among the major players in this effort are four hospitals that have agreed to be part of the Ebola Response Network by volunteering to treat, and to take appropriate transfers of patients suspected or confirmed to have Ebola from other hospitals. The four institutions are Rush University Medical Center, University of Chicago Medical Center, Northwestern Memorial Hospital, and Ann and Robert H. Lurie Children’s Hospital. These institutions are working directly with CDPH. The department is:

- Acting as the liaison for the Centers for Disease Control, providing protocols, procedures and updates to all Chicago-area hospitals, in addition to the four network hospitals.
- Holding weekly teleconference calls with area hospitals, instructing them on how to transfer an Ebola patient to one of the four network hospitals.
- Encouraging hospitals to conduct Ebola drills.
- Making sure that hospitals have the proper Personal Protective Equipment (PPE) on hand.
- Going door-to-door to provide information about Ebola to outpatient clinics.
- Establishing protocols for tracing Ebola contacts and monitoring them, carefully following CDC guidelines. “We want protocols that protect the population, yet don’t discourage health care workers from participating in the care of Ebola patients,” Dr. Black said.

At Rush University Medical Center, infectious disease specialist Michael Lin, MD, concurs that all the hospitals are working together to share best practices. “If one hospital runs out of supplies, like PPE, the others are here to share,” he said. “Cooperation is possible because of leadership with CDPH, and from the Illinois Department of Public Health. They are really interacting with us and helping coordinate our efforts.” While Dr. Lin expressed his concern over the time involved for Ebola preparedness (“Everything I normally would be doing at the hospital was pushed aside”), he says the work was necessary.

Northwestern Memorial Hospital’s Robert Murphy, MD, director of the hospital’s Center for Global Health, said care providers spent three days just learning how to properly don and doff PPE appropriately, using the buddy system. “It’s very uncomfortable to wear, and we’ll still need to practice,” he said, “but Northwestern is adhering to the very clearly laid out procedures from the CDPH.” Dr. Murphy is hopeful for the future. “I worked in Nigeria for 15 years. They have been successfully handling the crisis there; we can handle it in the United States.” He also said the Ebola virus could likely be prevented by an immunogenic vaccine, which is being developed with the National Institutes of Health in conjunction with GlaxoSmithKline.

Speaking from one of the smaller hospitals about their Ebola preparedness, Vishnu Chundi, MD, says, “We have rapidly instituted recommendations from the CDPH.” Dr. Chundi, who is head of infection control at Westlake Hospital and West Suburban Medical Center in Oak Park, says his facilities are now fully prepared to screen and triage any suspected Ebola patient to an appropriate room so the rest of ER patients are safe. In addition, housekeeping staff and support personnel are undergoing training to avoid contamination.

“This is the first time Ebola has come to the Western world, but there was no big manual for it,” Dr. Chundi says. “We are getting on top of this and by the end of the day, we'll have gotten through it.” He says that it’s important for all physicians to keep on top of the Ebola issue to answer their patients’ questions, like, “Can I catch Ebola by riding on the bus or a plane?”

At the north side Chicago office of James McCreary, MD, staff asks any patient who is calling in for an appointment if they have been running a fever, and if they have traveled outside the country. Dr. McCreary’s office supervisor, Theresa Beyer, says they explain to all their patients why they are being screened before they come into the office. “They have been very respectful and understanding,” she says. The office is part of the Presence Health group, which provided its physicians a formal screening plan, as well as continuing Ebola email updates, along with a PPE kit. Ms. Beyer says her office is also in contact with CDPH.

“This is an ongoing effort,” says CDPH’s Dr. Stephanie Black. “Until we get source control in Africa, we need to be ready for cases here, and keep providing more education.”

Ebola Resource: The Chicago Department of Public Health

HEALTH CARE PROVIDERS who have general questions about Ebola guidance can call the CDPH Public Health Emergency Operations Center (PHEOC), 312-742-7921 or 312-742-0069. The PHEOC hotline operates during normal business hours, M-F 8:30 a.m. to 4:30 p.m. Staff at the PHEOC will route calls to the appropriate person to handle the request. If a provider is evaluating a patient outside of normal business hours and thinks the individual meets the criteria for possible symptoms of Ebola, the provider should call 311 and ask to speak with the Chicago Department of Public Health communicable disease physician on-call.
Flu: What Docs Are Asking

Answers to physicians’ flu-related questions

If quadrivalent vaccine has one additional strain, why isn’t it preferred over trivalent vaccines?
Traditionally experts have to choose between the two very different B viruses to include with the two A viruses based on which type of B virus is expected to predominate. This can be difficult to predict. The quadrivalent vaccine for 2013–14 included both B viruses. However, while quadrivalent vaccines may eventually replace trivalent vaccines, only a limited quantity of quadrivalent vaccine is anticipated to be available. Consequently, ACIP does not express a preference for use of one type of influenza vaccine over another type for persons for whom more than one type of vaccine is indicated and available.

Which influenza vaccines can we give to children?
Among the injectable inactivated influenza vaccines (IIV), only Fluzone (Sanofi) is approved by the FDA for use in children ages six through 35 months. However, there are several injectable influenza vaccines that can be given to children age three or older.

The nasal spray live attenuated influenza vaccine (LAIV, FluMist, MedImmune) is approved for healthy children age two years and older. When immediately available, LAIV is preferred for use in healthy children ages two through eight who do not have a contraindication or precaution to LAIV. ACIP states this preference because two studies have shown LAIV to be more effective than IIV in preventing influenza in this age group. However, both LAIV and IIV are safe and effective in this age group. If LAIV is not immediately available, IIV should be used. Vaccination should not be delayed in order to procure LAIV.

The pneumococcal conjugate vaccine (PCV13) package insert says that in adults, antibody responses to Prevnar 13 (Pfizer) were diminished when given with inactivated influenza vaccine. Does this mean we should not give PCV13 and influenza vaccine at the same visit?
No. The available data have been interpreted that any changes in antibody response to either vaccines’ components were clinically insignificant. If PCV13 and influenza vaccine are both indicated and recommended they should be administered at the same visit.

The Vaccine Information Statement for inactivated influenza vaccine states that you should not get the vaccine if you are severely allergic to antibiotics. Which antibiotics are they? The antibiotics, of which there are trace amounts in some influenza vaccines, are neomycin, gentamicin, and polymyxin B. You should check each product’s package insert information to see which, if any, antibiotics are listed.

How late in the season can I vaccinate patients?
Providers are encouraged to continue vaccinating patients throughout the influenza season, into the spring months. Because influenza occurs in many areas of the world during April through September, vaccine should be given to travelers who missed vaccination in the preceding fall and winter. Another late season use of vaccine is for children younger than age nine who needed two doses of vaccine but failed to get their second dose. For each of these situations, vaccine can be given through the month of June since most injectable influenza vaccine has a June 30 expiration date.

Providers are encouraged to continue vaccinating patients throughout the influenza season, into the spring months.
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“Shifts from conventional to crisis standards of care....do not lower the standard of care per se. Rather, they reflect an essential alteration in how care is administered to patients when resources are in short supply.”

Legal Preparedness and Ebola

Public health and policy considerations By James G. Hodge, Jr., JD, LLM, Gregory Measer, and Asha M. Agrawal

The threat of Ebola raises a number of unfamiliar issues. Core public health decisions vary across federal, state, and local jurisdictions. Difficult constitutional questions surface. The legal environment underlying national public health responses can change midstream. The following article discusses our top ten issues for health care providers and attorneys.

Emergency Declarations

Emergency legal preparedness issues related to emerging infectious diseases like Ebola are dynamic. Federal, state, and local governments have the capacity to respond to initial, select cases of Ebola through routine public health law powers. If cases mount or Ebola's spread becomes imminent, governments may increasingly declare formal states of “public health emergency” or more generalized states of “emergency” or “disaster.” The immediate effects of these declarations are profound. Resources can be quickly mobilized, public health powers may be expedited, and legal barriers may be waived temporarily. For example, during the H1N1 pandemic of 2009-2010, federal emergency declarations allowed for temporary waivers of the Emergency Medical Treatment and Active Labor Act. These and other legal variations for the duration of the emergency declaration literally “change the game” in how jurisdictions and health providers respond legally.

Duty to Treat

Despite availability of appropriate infection control protocols and equipment, treating Ebola patients creates a higher risk of exposure for health care workers and raises personal safety concerns that implicate ethical and legal duties to treat. Providing workers with adequate training, personal protective equipment (PPE) and supervision mitigates some of these concerns. Public health laws, disability protections, employment contracts, and medical licensure standards can mandate treatment of Ebola patients through legal recourse or sanctions. Though voluntarism among health care workers is preferable to imposing legal mandates, individuals may be pressed into action if cases of Ebola mount.

Testing and Screening

The duty to treat extends to most hospitals and their health care personnel under EMTALA. It requires hospital personnel to appropriately screen and stabilize patients “within the capability of the hospital’s emergency department” when patients present with emergency conditions. Issues arise when a hospital is not adequately equipped to safely treat Ebola patients. The Centers for Disease Control guidance instructs hospitals to immediately isolate patients with Ebola-like symptoms and a history of potential exposure, and to contact the local health department, yet offers few options for under-equipped institutions. Incorporating protocols and agreements for transfer to more specialized facilities under an Ebola response plan may reduce the possibility of EMTALA violations.

Contact Tracing and Privacy

Once Ebola patients are confirmed, thorough identification of their potential contacts is crucial to disease containment. Authorized by state or local public health laws, contact tracing involves notification and appropriate monitoring of potentially exposed individuals. Identifiable information about contacts is gathered directly by, or reported to, state or local health agents working closely with the CDC. Contacts are requested to self-monitor or take further steps depending on the degree of their potential exposure. Infringements on health information privacy interests under the HIPAA Privacy Rule or related state laws are unlikely given sufficient allowances for public health disclosures via the Rule. However, public health officials cannot disclose private information without public health justification.

Quarantine and Isolation

Public health powers to quarantine or isolate persons for conditions like Ebola are politically controversial and often misunderstood. Quarantine refers to the separation of persons suspected or known to be exposed to infectious diseases. Isolation entails the separation of persons who are known or suspected to be infected. The CDC has limited powers to quarantine or isolate persons traveling to the United States or across state lines. However, every state and some larger municipal governments can quarantine or isolate persons under varying laws, lending to debates over who sets the standards. No matter which level of government is involved, implementation entails significant due process protections, including adequate evidentiary proof, sufficient notice, right to a hearing and counsel, and assurances that medical and other needs of affected persons are met.

Travel Restrictions

Government restrictions on individual travel and movement implicate fundamental liberties, but these powers are vital to public health containment and often explicitly authorized by law. Federal regulations may limit persons with Ebola from traveling between states, although these powers
are rarely exercised by the CDC and have not been utilized to date for cases of Ebola. Instead, federal public health authorities tend to defer to states’ authority to restrict one’s travel for public health purposes. For example, after an initial delay, Texas public health authorities ultimately requested personnel who treated Thomas Eric Duncan to limit their travel during the period of their potential infectivity. Further, federal oversight of passport approval, immigration law, transportation regulations, and “Do Not Board” requirements may restrict the entry or exit of persons in and out of the United States. Still, federal officials are reluctant to completely prohibit travel to and from affected regions, opting instead for tighter screening protocols intended to protect the public’s health while allowing ongoing flow of aid.

Experimental Drugs
Considerable safety and ethical concerns surround experimental drugs in the treatment of Ebola. To date, the FDA has not approved widespread use of any vaccine or drug treatment for Ebola through its routine processes. However, the FDA has issued expedited approvals for emergency purposes (several Ebola diagnostic tests were authorized for field use pursuant to emergency use authorizations) or compassionate uses (limited supplies of ZMapp were administered to several U.S. patients with FDA approval). Difficult ethical considerations underlie the allocation of experimental drugs, which are often costly and limited in supply. Moreover, liability and safety concerns abound when dealing with drugs not yet clinically tested on humans.

Environmental Safety
Protection of health care workers, airline employees, and other individuals whose work carries a higher risk of exposure to Ebola necessitates specific considerations. Under federal law, employers have a duty to provide a safe workplace and comply with OSHA regulations, including those for PPE and respirator use. The CDC also issued comprehensive guidance for health care workers on appropriate PPE use and environmental infection control measures. Still, as demonstrated by two nurses in Dallas, employees and volunteers remain at some risk for Ebola infection. These risks may contribute to potential refusals to treat (despite duties to care) or entity liability for failure to properly assure the safety of patients or the workforce.

Crisis Standards of Care
Caring for a handful of Ebola patients nationally so far has required the efforts of hundreds of employees acting on their own volition, access to dedicated isolation facilities, and sufficient supplies. While there is no medical “magic bullet” for Ebola, routine administration of available medical treatments satisfies existing standards of care. This will change if the numbers of domestic Ebola cases spike. The Institute of Medicine described in 2012 how infectious conditions can necessitate shifts from conventional to crisis standards of care as resources like personnel, space, and medications become scarce. Shifts to crisis care does not lower the standard of care per se. Rather they reflect an essential alteration in how care is administered to patients when resources are in short supply. Corresponding legal shifts occur as well, altering the potential risks of liability related to triaging public health and medical services. For example, physicians’ acts or failures that may typically qualify as medical negligence in conventional standards of care may not constitute actionable negligence in crises when triaging patients is the premier objective.

Liability of Health Care Workers
Providers and entities on the frontline of emergency response to Ebola are routinely concerned about liability. The initial handling of cases of Ebola in Dallas and Newark have led to threats of litigation. Implementation of crisis care standards requires difficult life-and-death decisions on who gets tested, screened, and treated. Use of new or experimental treatments among patients implicates potential, unforeseen risks.

To counter the specter of liability, many levels of government provide specific immunities or other protections from acts of negligence among workers and volunteers. For example, federal and state volunteer protection acts insulated health care workers acting on their own volition in response to Hurricane Katrina in 2005. Some volunteer protections and other laws may even insulate hospitals or other entities from negligence claims. However, these protections often depend on declarations of emergency and typically do not apply to claims grounded in gross negligence, willful or criminal acts, or failure to plan.

Conclusion
The public health and medical challenges underlying Ebola in the United States are significant, but the nation is legally positioned to respond. Seeking precision in the interpretation of legal preparedness issues is not the goal given reasonable flexibilities among federal, state, and local governments. Rather, the objective is to recognize and respond to the inevitable shift in focus from the provision of routine medical services to essential public health services to control threats like Ebola.

James G. Hodge, Jr., is associate dean and professor of public health law and ethics, and director of the Public Health Law and Policy Program, Sandra Day O’Connor College of Law, Arizona State University. Gregory Measer and Asha M. Agrawal are JD candidates and senior legal researchers. The authors gratefully acknowledge the contributions of research assistant Matt Saria. For a list of references, please call 312-329-7335 or email esidney@cmsdocs.org.
POLST: Potential and Pitfalls

While these forms have the power to improve end-of-life care, like advance directives, they will only be effective to the extent patients and health care professionals utilize them properly. By Kerry R. Peck, JD, and Kyle T. Fahey, JD

PHYSICIAN ORDERS for Life-Sustaining Treatment (POLST) were first developed in Oregon to complement a patient’s advance directives and/or do not resuscitate orders (DNR), and to better adhere to the patient’s preferred amount of treatment in emergency end-of-life situations. Essentially, a POLST is a brightly colored form at the top of a patient’s medical chart, or carried with the patient if he or she is an outpatient, which serves as a medical order to any health care professional about treatments the patient should or should not receive in an emergency. Unlike an advance directive, a POLST form is an actual physician’s (or other recognized practitioner) order that medical personnel are required to follow. Unlike a DNR, POLST forms are tailored to a patient’s current medical condition and provide for the patient’s wishes with respect to treatments likely to be administered to a similar patient in an emergency, such as the administration of CPR, IVs, antibiotics, and/or intubation.

POLST programs were developed (and are continuing to be developed) to serve patients with grave illness and a limited prognosis, typically in the last year of life. Patients consult with their physician, discuss their prognosis and typical treatments administered to similar patients, and decide what they would and would not like to receive. After this discussion, the practitioner documents the patient’s directives on a POLST form signed by the patient or legal representative, the practitioner, and a witness.

While POLST forms are intended to fill the gaps left by advance directives and DNRs, their only recent implementation on a national scale leaves their efficacy unclear. As discussed below, some evidence exists that POLST forms can result in patient’s receiving care more consistent with their wishes; however, the various manner in which states have regulated them leave POLST forms vulnerable to many of the same criticisms of advance directives.

Creating A POLST

The formalities for creating POLST forms vary widely by jurisdiction, and it is imperative that practitioners are familiar with current requirements and keep their eye on growing trends. While all POLST forms require a health care professional to sign the form, jurisdictions vary on which professionals may do so. States such as California and New York allow only licensed physicians to sign the form. Other states, including Illinois, permit professionals such as nurse practitioners and physician assistants to complete the form. The growing trend is to allow other health care professionals authority to complete the form. More variations in requirements include whether a POLST form may be orally endorsed, whether health care surrogates can consent on behalf of a patient (and whether they must be a legally appointed surrogate), the consequences of a POLST conflicting with another advance directive, and whether health institutions must offer a POLST.

Potential Areas of Litigation

While there is some empirical evidence that the level of care selected in a patient’s POLST is directly correlated to whether the patient dies in the hospital, it remains too early to tell how effective POLST implementation will be.

“While there is some empirical evidence that the level of care selected in a patient’s POLST is directly correlated to whether the patient dies in the hospital, it remains too early to tell how effective POLST implementation will be.”

Working With the Bar

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respectively, died in the hospital. Comparatively, 34.2% of patients without a POLST died in the hospital. Thus, if one assumes that dying in or out of the hospital is representative of the degree of medical intervention one receives, then the study indicates that use of a POLST form correlates with a patient’s desired level of medical intervention.

Depending on how POLST forms are treated state by state, however, they could be subject to some of the same faults as advance directives. Two prominent critiques of advance directives are medical personnel’s lack of awareness of the directive and that those charged with following the patient’s wishes do not always comply with them. While POLST programs attempt to ameliorate such pitfalls by keeping the original POLST form with the patient and treating it as a direct order, questions remain whether such results will occur.

Emergency Personnel
First, the existence of a POLST form cannot guarantee that emergency personnel will be aware of it. Undoubtedly, at some point emergency responders, unaware of a POLST, will provide unwanted treatment. This begs the question whether emergency responders will have a duty to search for a POLST form and whether a failure to search could lead to liability if the patient receives unwanted treatment.

To account for this, many states are implementing electronic registration of the form. However, Oregon is the only state that currently mandates electronic registration. But electronic registration laws do not in and of themselves resolve the problem. For instance, California legislators recently proposed legislation mandating electronic registration. However, the bill was criticized because it was “not clear whether health care professionals and first responders, such as EMTs, will be required to access an online database prior to administering medical treatment...Arguably, this could create an extra, and potentially time consuming, step before an individual is provided life-saving treatment...Arguably, this could create an extra, and potentially time consuming, step before an individual is provided life-saving treatment...Arguably, this could create an extra, and potentially time consuming, step before an individual is provided life-saving treatment...

Treating Physician and Surrogate
Second, while POLST forms are medical orders, they may be easily supplanted, depending on how states regulate them. For example, in California the statutory authorization for POLST provides that “[a] health care provider shall treat an individual in accordance with a Physician Orders for Life Sustaining Treatment form” but also that “[a] physician may conduct an evaluation of the individual and, if possible, in consultation with the individual, or the individual’s legally recognized health care decision-maker, issue a new order consistent with the most current information about the individual’s health status and goals of care.” Thus, it clearly provides the treating physician and surrogate power to override the POLST in the event of incapacity. Moreover, the physician is required to consult with the patient or his/her surrogate only “if possible,” ostensibly granting authority to act against the orders of the POLST unilaterally.

Competing Laws
Additionally, competing statutory schemes may affect treatment of POLST forms across various jurisdictions. In In re Matter of Zornow, a New York court held that a POLST authorized by a 93-year-old woman’s co-guardians that refused all intubated feeding, was invalid pursuant to the Family Health Care Decisions Act. The Act provides that decision-making by health care surrogates should take into account the patient’s religious beliefs. The Court held that the patient, a Roman Catholic, would desire substantially more life-sustaining treatment than indicated by the POLST and therefore invalidated the blanket directive refusing artificial feeding. The decision indicates that statutory schemes governing a health care surrogate’s duties to a patient can limit the surrogate’s power to create a POLST on behalf of the incapacitated when evidence establishes the POLST is inconsistent with the patient’s own desires. While this may be beneficial, it leads to the central question raised in all advance directive litigation: “what medical treatment would this patient desire?”

Communication Still Critical
Due to their recent implementation, there is little developed case law on the subject of POLST programs, but Zornow is emblematic of the manner in which litigation of POLST programs could raise the same issues as advance directive litigation. While POLST forms have the power to provide substantial end-of-life benefits to patients, like advance directives, they will only be effective to the extent patients and health care professionals utilize them properly. Proper-end of-life planning requires ample communication between the patient, health care professionals, and all the patient’s loved ones. Without such communication, legal battles will likely revolve around family members’ disagreements about the proper care for their loved one, and litigation involving POLSTs will likely follow the same course as litigation of other advance directives.

Kerry R. Peck is managing partner in the law firm Peck Bloom, LLC. He specializes in the administration of trusts and estates. Kyle T. Fahey is an associate with the firm, specializing in trusts and probate litigation, as well as representing medical and financial institutions. For a list of references, please call 312-329-7335 or email esidney@cmsdocs.org.

“Undoubtedly, at some point emergency responders, unaware of a POLST, will provide unwanted treatment. This begs the questions whether emergency responders will have a duty to search for a POLST form and whether a failure to search could lead to liability if the patient receives unwanted treatment.”
Saying Goodbye to Fee for Service

As physicians take on more risk from new payment models that pay them to keep their patients healthy, compensation is only rising slightly across the board, particularly among specialists, as insurers put the brakes on certain tests and procedures and the economy is slow to recover. The United States health care system, driven by employer demands to keep costs low and new rules under the Affordable Care Act that require doctors to be more accountable, is keeping physician income to single digit growth rates, often below 4-5%. And in some cases, lucrative specialties are taking unprecedented hits to their income, with specialists on average seeing income rise below the overall rate of health spending growth.

This year’s survey from the Medical Group Management Association, the largest organization of doctor practices, said primary care physician pay, which has been rising faster than specialist income in recent years, rose 5.2% to $232,989 in 2013 from $220,942 in 2012. Meanwhile, specialist pay rose just 1.5% to $402,233 in 2013 from $396,233 in 2012. MGMA’s survey is a sampling of more than 4,100 medical groups representing more than 66,000 providers.

Changing Demands for Services

“We are seeing that demand has continued for primary care services and that it continues to be the primary driver,” Todd Evenson, vice president of consulting services and data solutions at MGMA, said of the compensation trends.

<table>
<thead>
<tr>
<th>Physician Compensation</th>
<th>2012</th>
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<tr>
<td>ALL PRIMARY CARE</td>
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<tr>
<td>ALL SPECIALISTS</td>
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<td>Reported median</td>
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<tr>
<td>Average quality</td>
<td>4.04%</td>
<td>5.7%*</td>
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<tr>
<td>percentage of compensation</td>
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*Non-ACO, Non-PCMH

EVEN AS PHYSICIANS
impacting physicians in an interview with Chicago Medicine. The specialist compensation increases aren’t keeping up with health spending rates in the U.S. that rose 3.6% in 2013 from 2012, according to the annual report released in September from the Office of Actuary in the Centers for Medicare and Medicaid Services.

Like much of health care, doctors were hit hard through the recession and a four-year period through last year when health spending was below 4%, the actuaries said. U.S. spending on physician and clinical services rose just 3% to $583.9 billion in 2013 from $565 billion in 2012, the CMS actuaries’ report said. “Underlying the spending growth is the lowest rate of price growth since 2002 (nearly zero percent),” actuary Andrea Sisko and colleagues from the federal CMS wrote in the October issue of the journal Health Affairs about physician and clinical services. “This is partly because of reductions in payments to Medicare providers resulting from the sequester and procedural payment changes.”

Payment changes coming from the private sector are also keeping physician compensation at or below health inflationary rates. Though most physicians are still practicing fee-for-service medicine, it’s something that is changing rather quickly. “The evolution from fee-for-service dynamics to value-based reimbursement will continue to impact growth rates,” Evenson said. “Groups are challenged to keep up with the changes occurring in health care. People continue to be concerned about the reimbursement side of the equation and it will be a challenge in upcoming years.”

To come with these trends, physicians continue to link—often through their group practice or hospital if they are employed—with accountable care organizations that link doctors, their practices and other providers of care under the same umbrella. The ACO shares in money that is saved from the costs of keeping patients healthy.

**Different Models**

Doctors are also forming other models. Primary care physicians in MGMA’s survey who indicated they were not part of an ACO or patient-centered medical home said that an average of 5.96% of their total compensation was based upon quality measures. Meanwhile, specialists told MGMA that an average of 5.7% of their total compensation was based on quality metrics of one variety or another.

But physician compensation analysts say the trend is no passing fad to pay providers based on the quality of care they provide or the health outcomes they are helping their patients achieve. “The new system under ACA aims to completely change what physician behavior is rewarded, which is a complicated process, as it involves influencing

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<td>163</td>
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**MGMA’s 2014 physician compensation and production survey** is based on 2013 data, representing 4,197 groups and 66,299 providers. Out of the physicians who report that greater than 0% of their compensation was attributed to value-based metrics, both primary care and specialty care physicians report an increase in the percentage of compensation based on quality compared to 2012. Specialty care physicians reporting on patient satisfaction as a percentage of their total compensation report an increase from 2012. The aforementioned physicians are not from an accountable care organization or patient-centered medical home.
physician behavior that has been entrenched for decades,” said Jim Stone, president of The Medicus Firm, a physician staffing and consulting firm, in a statement to Chicago Medicine.

Doctors seem to know a tsunami is coming. The Medicus Firm’s annual survey of doctors said their “most pressing concern” these days was about compensation and reimbursement. “There are so many forces, from all sides of the equation, that are pushing on physician income today, despite the fact that physician services are needed more than ever,” Stone said. “Not surprisingly, for physicians, their income consistently remains a primary concern regarding their career choices and professional future.”

There were 55% of physicians in practice who listed compensation as the most pressing concern in Medicus’ annual physician practice preference survey. Compensation and reimbursement ranked ahead of work-life balance and physician burnout among a list of pressing concerns. “High-volume admitters, high-volume surgeons, cardiologists, and other specialists have been coveted by hospital systems in years past,” Stone said. “The goal was to bring on busy providers, generating a lot of billings. Previously, physicians were compensated to do things to people, and the shift post-reform is to financially reward physicians not to do things to people.”

**But the Times Have Changed**

“This approach by ACOs is often compared by many to capitated care, in that health providers will be managing a defined amount of money over a large patient population,” Stone said. “Quality, not quantity, is the top priority and ultimate goal. The physicians who are able to make that transition from being volume-focused to quality-focused will be the ones earning the highest income.”

To be sure, insurance companies and government payers increasingly also want to pay via bundled payments to a doctor practice or clinic. In the area of cardiology, for example, the Centers for Medicare and Medicaid Services (CMS) have bundled together certain procedures into a single code where they used to allow billing for several. CMS is also increasing bundling of payment to other areas.

“A particular peripheral vascular (procedure) in the legs, for instance, historically was billed using up to four different codes and has now been bundled under just one,” said Joel Sauer, vice president of MedAxiom Consulting, a Neptune, Fla.-based company that works with cardiovascular practices and related programs across the United States. “As part of this bundling the total number of (relative value units) is also reduced, in some cases by as much as 20–30%,” Sauer added. “Thus, physicians doing the same number of everything [procedures] from one year to the next will see a reduction in their total RVUs, which in turn is the primary driver of their ultimate compensation.”

Bundled payment helped push cardiology income down in 2013 for the first time in five years, according to MedAxiom’s 2014 Provider Compensation & Productivity Report. MedAxiom’s compensation figures are based on data submitted last year by more than 130 cardiology programs representing more than 2,500 cardiologists. Overall, cardiology compensation dropped by nearly 8% in 2013 to $558,824, according to MedAxiom figures.

Sauer says the last five years have seen a steep decline in “prominent cardiology procedures,” such as catheterizations, percutaneous interventions such as balloon angioplasty and stents, nuclear testing and to a lesser extent, echocardiography. “At the same time, the stable of cardiologists in this country has remained quite steady which means the production per individual would mathematically come down,” Sauer said.

Like MGMA’s Evenson, Sauer sees a future where physicians are asked to do more to keep patients from becoming sick rather than being paid for tests and procedures once patients become ill. Private health plans, employers, government health programs like Medicare and insurers under the Affordable Care Act are moving away from fee-for-service payment to providers that critics say can lead to overuse and unnecessary treatments and procedures like invasive cardiology.

Increasingly, cardiology is treated like other specialized medical care in that the need for a test or procedure has to match up with evidenced-based guidelines. “A lot of the testing done in the past doesn’t provide value (so) anything we do to a patient has to add value,” Sauer said. “It’s all about value-based reimbursement. That’s not going to go away.”

Still, cardiologist income remains good with such medical professionals in the Midwest near the top of the pay scale at $559,000 while median income at the bottom in the Northeast was at $460,815. Physician staffing companies say the physician shortage should also protect income in the long run, particularly in the area of primary care. “As we’re going through this transition, employers are competing so fiercely for physician talent that they are offering more and more money in an effort to attract talent,” The Medicus Firm’s Stone said. “I guess the thinking is that it is better to have a physician we’re paying more than we can afford than to not have a physician at all.”

*Bruce Japsen is an independent journalist and contributing health care columnist to Forbes and author of the new book, “Inside Obamacare: The Fix for America’s Ailing Health Care System.” He is a regular analyst to Fox News Channel’s Forbes on Fox show, CBS-owned WBBM Newsradio 780 and 105.9 FM as well as WTTW’s Chicago Tonight public affairs program. He can be reached at brucejapsen@gmail.com.*
ACOs: How Are We Doing?

A new report from the federal CMS puts ACOs in a favorable light By Jim Watson

In September, the Centers for Medicare and Medicaid Services (CMS) released a report on the performance of Accountable Care Organizations (ACOs) and Medicare Shared Savings Programs (MSSPs). At the same time, a flurry of opinions and other reports came out stating that the CMS report did not highlight some of the more unfavorable aspects of these programs’ performance. Depending on what you read and who you believe, ACOs are either meeting their objectives or failing miserably.

Performance to Date

Last year, the ACOs had higher quality and better patient experience than published benchmarks. This year, the ACOs improved significantly for almost all the quality and patient experience measures. ACOs in the Pioneer ACO Model and MSSP also generated more than $372 million in total program savings for Medicare ACOs. At the same time, ACOs qualified for shared savings payments of $445 million. Even more encouraging news comes from preliminary quality and financial results from the second year of performance for 23 Pioneer ACOs and the first year of performance for 220 MSSPs. Other highlights from the CMS Fact Sheet on ACO Performance include:

- 53 MSSPs held spending $652 million below their targets and earned performance payments of more than $300 million as their share of program savings. One ACO in Track 2 overspent its target by $10 million and owed shared losses of $4 million. The Medicare Trust Fund will save about $345 million, including repayment of losses for one Track 2 ACO.
- An additional 52 ACOs reduced health care costs compared to their benchmark, but did not qualify for shared savings, since they did not meet the minimum savings threshold.
- MSSPs improved on 30 of 33 quality measures. Quality improvement was shown in such measures as patients’ ratings of clinicians’ communication, beneficiaries’ rating of their doctor, health care promotion and education, screening for tobacco use and cessation, and screening for high blood pressure.
- MSSPs achieved higher average performance rates on 17 of the 22 Group Practice Reporting Option Web Interface measures reported by other Medicare fee-for-service providers reporting through this system.
- In 2013 alone, more than 125,000 eligible professionals who were ACO providers or suppliers qualified for incentive payments for reporting their quality of care through the Physician Quality Reporting System (PQRS). These providers will also avoid the PQRS payment adjustment in 2015 because they demonstrated the ability to report quality measures through their ACO.

Pioneer ACOs showed these improvements:

Financial

- During the second performance year, Pioneer ACOs generated estimated total model savings of over $96 million and at the same time qualified for shared savings payments of $68 million. They saved the Medicare Trust Fund approximately $41 million. The total model savings and other financial results are subject to revision.
- Pioneer ACOs achieved lower per capita growth in spending for the Medicare program at 1.4%, which is about 0.45% lower than that of Medicare fee-for-service.
- Eleven Pioneer ACOs earned shared savings, three generated shared losses, and three elected to defer reconciliation until after the completion of performance year three.

Quality of Care and Patient Experience:

- The mean quality score among Pioneer ACOs increased by 19%, from 71.8% in 2012 to 85.2% in 2013.
- The organizations showed improvements in 28 of the 33 quality measures and experienced average improvements of 14.8% across all quality measures.
- The Pioneer ACOs improved the average performance score for patient and caregiver experience in six out of seven measures. This suggests that Medicare beneficiaries who obtain care from a provider participating in Pioneer ACOs report a positive patient and caregiver experience.

Some Argue the Picture Isn’t Rosy

The National Association of ACOs (NAACOS) reports that only 53 of the 220 ACO/MSSPs will receive payment and recoup some of their investment. NAACOS estimates that $1 billion has been spent on ACO development, with only $373 million in returns so far; 167 ACOs will receive no return on their investment.

Some argue that the Pioneer ACO program isn’t working: 10 have exited since the program began. The providers in the Pioneer program, chosen because of their relative maturity and presumed ability to handle risk, have not benefited from the program in the way they had hoped.

An example of this is Sharp HealthCare in San Diego, which recently dropped out of the Pioneer program. In its third-quarter financial report, Sharp leaders noted that they were at risk for making a
big payment to Medicare, despite the fact that they had cut readmission rates. Sharp executives said the deal wasn’t working out because CMS was setting standards on a national level rather than adapting to the markets in which Sharp operated. The Sharp HealthCare experience underscores a big problem with the core intent of ACOs: if even a high performer like Sharp risks having to pay millions back to Medicare, there’s something seriously wrong.

Other initial problems cited in ACO performance include start-up costs and operational challenges. The average cost to start an ACO is $2 million. Because of the slow build on return/lag on reconciliations, the average ACO will have to assume three years of operational costs before ($3.5 million average) it will see any cash flow from shared savings. Operational challenges include: Accessing CMS data/learning to use it; difficulty in meeting implementation schedules; slow/costly IT implementation; lack of skill sets among staff/leaders; translating data into actionable information for caregivers; and enrollee attribution and compliance challenges.

**Important Changes on the Way**

CMS seems to be aware of the challenges, and have proposed the following new rules to help create better success stories and address the critics.

**Additional Quality Improvement Reward:**

Revising quality scoring strategy to recognize and reward ACOs that make year-to-year improvements in quality performance scores on individual measures. ACOS would add a quality improvement measure that gives bonus points to each of the four quality measure domains based on improvement.

**Revisions to Quality Measure Benchmarks:**

Modifying benchmarking methodology to use flat percentages to establish the benchmark for a measure when the national fee-for-service data results in the 90th percentile being greater than or equal to 95%. This change is a response to feedback on “topped out” measures.

**Modifications to the Quality Measures that Make Up the Quality Reporting Standard:**

- Revisions to reflect up-to-date clinical guidelines and practice, reduce duplicative measures, increase focus on claims-based outcome measures, and reduce the ACO reporting burden.
- The proposed changes increase the number of measures calculated through claims and also decrease the number of measures reported by the ACO through the GPRO Web Interface.
- The total number of quality measures for quality reporting would increase from 33 to 37 measures under this proposal.
- Specifically, new measures would be added to focus on avoidable admissions for patients with multiple chronic conditions, heart failure and diabetes; depression remission; all cause readmissions to a skilled nursing facility; and stewardship of patient resources; the existing composite measures for diabetes and coronary artery disease would also be updated.

Additionally, CMS is seeking public comment on future quality measures that address areas such as: Gaps in measures and additional specific measures; measures for retirement (e.g., “topped out” measures); caregiver experience; alignment with the Value-Based Payment Modifier (VBM); care assessment in the frail elderly population; utilization; health outcomes; and public health.

NAACOS proposes additional program changes, based on its survey of ACOs currently in operation. These include: Changing the way patients are attributed to the ACO and bringing stability to the population the ACO serves; strengthening the relationship between Medicare beneficiaries and their ACO physician; improving the formula for risk-adjustment and setting of savings targets; accounting for the fact that in some communities the costs of care are well below the national average, and for them, it is even more difficult to achieve savings; improving the clinical and claims data ACOS receive to improve care; and recognizing that quality of care varies from community to community and allow regional differences and allow ACOs to receive savings/rewards if their overall quality of care is improved year over year.

**Moving Forward With Commitment**

Organizations across the country have spent significant time and money on ACOs, and other “accountable care” models. Increasingly, these organizations are asking themselves: Are we connecting the dots on cost, return, and value? Are all these things aligning (infrastructure, requirements to manage/comply, quality and performance metrics, and payer incentive/rewards)?

The latest reports on ACOs and other accountable care models offer two conclusions. First, depending on what you read and who you believe, ACO performance has been a mixed-bag. Second, CMS and the provider community seem to still support the concept, recognizing that changes need to be made to improve ACO performance and long-term success probability.

One central question remains, however. Can we rely on the federal government to continue its support across party lines for the next several years in order to sustain the commitment to ACO programs, which, regardless of what you read, can improve the cost and quality of care? If not, then what?

Jim Watson is a partner with PBC Advisors, LLC, in Oak Brook. PBC Advisors provides business and management consulting and accounting services to physician practices and hospital systems. For more information, visit their website at www.pbcgroup.com.

“CMS and the provider community seem to still support the concept, recognizing that changes need to be made to improve ACO performance and long-term success probability.”
Medicaid Opportunities, Challenges and Changes

The State of Illinois is on a roll moving patients into managed care By Nicole Channel

The State of Illinois is moving quickly to change the state Medicaid program. Here’s a quick summary of what you need to know.

1. As outlined in the ACA for 2013 and 2014, Medicaid reimbursement for primary care physicians (PCPs) has been increased to 100% of Medicare for E&M codes 99201 through 99449, as well as vaccine administration codes 90460, 90461, 90471, 90472, and 90473. In this instance, medical specialists are considered primary care physicians.

2. The ACA has also significantly expanded Medicaid eligibility to 138% of the federal poverty level, up from 100%. There are about 500,000 additional members in this program in 2014.

3. Illinois, like many states, is moving toward “managed Medicaid” programs. Legislation passed in 2011 mandated that by January 2015, at least 50% of all Medicaid enrollees must be enrolled in a “care coordination” plan. This has been happening in phases across the state:
   - Integrated Care Program (ICP): Formerly known as the program for the Aged, Blind & Disabled (approximately 160,000 patients), this program is being implemented across Illinois in 2014.
   - Family Health Plan (FHP): Formerly known as the Temporary Assistance for Needy Families (TANF), this is being implemented across Illinois in 2014 and is currently being implemented in the ten county metro Chicago area. There are about 2.3 million

<table>
<thead>
<tr>
<th>Specialty</th>
<th>CPT</th>
<th>Description</th>
<th>2014 IDPA</th>
<th>2014 Medicare Loc 16</th>
<th>2014 IDPA as % of 2014 Medicare Loc 16</th>
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<tr>
<td>Ortho</td>
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<td>Therapeutic procedures</td>
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<td>Care antepartum vag dlvr &amp; postpartum</td>
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<td>$1,693.90</td>
<td>$2,843.49</td>
<td>60%</td>
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</table>

* Facility rate used. ** IDPA fee includes: 13 antepartum visits (0502F), vaginal delivery (59410), postpartum exam (59430)
FHP Medicaid beneficiaries in Illinois. The state is moving this population via two primary care coordination models: Managed Care Organizations (MCOs)—eight to 12 will be available to enrollees—and Accountable Care Entities (ACEs). ACEs were created via Senate Bill 26 (the Medicaid Expansion Bill) passed in 2013. ACEs are essentially hospitals and health care systems that have banded together with their employed and affiliated physicians to manage a portion of the Medicaid population. Each ACE must accept a minimum of 40,000 Medicaid enrollees, and migrate to a risk contract within 36 months. In order for an ACE to renew its agreement after the initial three-year term, it must become an HMO or Managed Care Community Network (MCCN) and comply with all state insurance laws.

Additionally, the State of Illinois has partnered with the Centers for Medicare and Medicaid Services (CMS) for a demonstration project to better manage “dual-eligible” enrollees (patients eligible for both Medicare and Medicaid; approximately 261,000 in Illinois). Referred to as the Medicare Medicaid Alignment Initiative (MMAI), enrollees can voluntarily enroll in one of six new HMO options, or a Medicare Advantage (MA) health plan. Medicare remains primary, Medicaid remains secondary, with care coordinated and managed through MCO contracted networks.

Comparing Medicaid and Medicare
The snapshot table on page 24 compares Medicaid and Medicare reimbursement for various specialties based on the 2014 fee schedule. Now is a good time to carefully review how Medicaid is working for your practice, the implications of all these changes, and how your practice should approach Medicaid in the future. The Medicaid fee schedule is not consistent with Medicare overall and is generally (although not always) lower than Medicare’s fee schedule.

Rapid Movement
Patients covered by Medicare and Medicaid are rapidly moving to “managed care” networks and models. These market forces create new opportunities and challenges for physicians of all specialties in all parts of the state and nationally. It is important for physicians to understand these market transformations and the implications for their practices and patient referral sources. Physicians should carefully assess their opportunities and strategies (offensive and defensive) for participation (or non-participation) in these emerging provider networks and payer contracts.

Nicole Channel is a consultant with PBC Advisors, LLC, in Oak Brook. PBC provides business and management consulting and accounting services to physician practices. For more information, visit their website at www.pbcgroup.com.

“The State of Illinois has partnered with CMS for a demonstration project to better manage “dual-eligible” enrollees.”

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DocbookMD is a free benefit of your CMS membership. Learn more about the app at docbookmd.com.
This Section highlights the Chicago Medical Society’s ongoing conversations with local, state and national legislators. Coordinated by President Kenneth G. Busch, MD, our advocacy programs come in many formats and span the Chicago City Council to Washington’s Capitol Hill.

Mini-Internship Program
CMS works to educate policymakers and lawmakers on multiple fronts. One of the most popular methods is through the CMS Mini-internship Program, which matches physicians and legislators for a day of learning. By shadowing physicians as they make rounds, see patients in the clinic or perform surgery, lawmakers can observe the impact of their decisions on the practice of medicine. Mini-internships also provide physicians with input from other sectors concerned with health care.

The goal of every mini-internship is to educate participants on the realities of practicing medicine. Since September, CMS has hosted seven mini-internships, with two more scheduled in December. Here are highlights:

Advocate Christ Hospital
State Senator Bill Cunningham got to observe cardiothoracic surgery on Oct. 20, when Antone Tatooles, MD, inserted a mechanical heart into a patient. Dr. Tatooles used part of the day-long mini-internship to highlight the impact of the 30-day readmit penalty. Many patients readmitted to Advocate Christ Hospital have other co-morbidities, he explained to Senator Cunningham, and these conditions are often the reason for the patient’s readmission to the hospital.

The day concluded with Senator Cunningham calling the mini-internship an eye-opening experience. He asked if CMS would arrange for him to spend time in the hospital’s ER, where the state senator hopes to continue learning about health care delivery issues.
Westlake Hospital
State Rep. Kathleen Willis spent hours shadowing Jonnelle C. Sweetner, MD, learning about the hospital and the challenges it faces. The Oct. 22 mini-internship gave Dr. Sweetner the chance to share her experiences both as a hospitalist and as a private practice physician. The lawmaker also toured various departments and met several of Dr. Sweetner’s patients. In addition to meeting the executive leadership team, Representative Willis was part of a discussion on how the hospital recently conducted a drill to see if intake staff could identify and properly handle a mock Ebola patient.

Ingalls Memorial Hospital
State Senator Napoleon B. Harris accompanied James A. Wallace, MD, and met with patients at his private practice on Nov. 11. Dr. Wallace gave an overview of his practice, discussed issues that are prevalent in his South Side community and the insurance barriers to providing care. The day included talks with senior executive leadership about funding issues and their impact on community care.

Midwest Center for Women's Healthcare
State Rep. Laura Fine met with Cheryl E. Axelrod, MD, in her obstetrics and gynecology practice on Nov. 16. After giving an overview of her practice, Dr. Axelrod went on to describe the frustration of dealing with insurance companies and adapting to new systems. Representative Fine added her own personal experiences, and agreed that once a physician deems a treatment medically necessary, insurers should not deny claims.

Key Contacts Program
This new initiative complements the mini-internship format. Key contacts are individual physicians who work to establish a personal relationship with their legislative representatives. CMS provides support and training for program volunteers in all aspects of building and maintaining a relationship. Key contacts relay information about CMS’ position on specific bills, provide technical expertise, and report back to CMS. To date, 120 physician-members have signed on.

Networking Night a Hit with Students
The popular student social and networking event at Rock Bottom Brewery is a mainstay benefit that CMS regularly co-hosts with the Illinois State Medical Society. Students from the region’s seven teaching institutions last met on Sept. 5 to kick off the academic year. Another gathering is now in the works. Networking night encourages students to meet their peers at other medical schools and introduces them to the CMS leadership team. Over heavy appetizers and drinks, one lucky student always wins a raffle and goes home with a gift card. Student networking night also recruits new members and updates all participants on current CMS initiatives. Stay tuned for details on the next networking event.

Chicago Ald. Walter Burnett, Jr., (left) shadows ophthalmologist Philip B. Dray, MD, during a CMS mini-internship at John H. Stroger, Jr., Hospital of Cook County on Oct. 16. The alderman toured various hospital departments, including the intensive care unit, in addition to meeting the senior executive leadership. The hospital provides residents and physicians some of the best training opportunities in the nation because of the wide ranges of cases, Dr. Dray said. Stroger Hospital is often the first stop for foreign visitors arriving at O’Hare Airport with medical complaints.
Physicians Win Big in Midterms

Good news for medicine in all three branches of Illinois government

By William A. McDade, MD, PhD

The Midterm elections are over, and I’m happy to report that there is good news for physicians on all fronts.

Executive Branch
On Nov. 4, Illinois elected its first Republican governor in 12 years. I am pleased to say that the Illinois State Medical Society Political Action Committee (IMPAC) provided significant support for the governor-elect. The IMPAC Council believed that Illinois needs new leadership, and that Mr. Rauner has the skills to steer Illinois through this fiscal minefield.

IMPAC contributed $250,000 to his campaign. That’s a lot of money for IMPAC. In fact, it is roughly the amount IMPAC is able to raise over the course of 12 months. To be blunt, IMPAC contributions are down significantly in recent years.

The wise stewardship of the IMPAC Council was instrumental to our success in this election cycle, but to continue to be a significant player we’ll need to see increases in funds coming in from individual doctors, medical staffs and groups.

The governor himself is only the tip of the iceberg, however, and significant positive changes are ahead in other areas as well. Numerous state agencies deal with health care issues, and we are looking forward to much-improved relations between these agencies and the medical community. The effects of this shift will be far-reaching over the coming months and years.

Judicial Branch
Another successful candidate of great significance is one that didn’t appear on any of our ballots. Illinois’ Supreme Court Justices serve all of Illinois, but are elected by geographic district. Justice Lloyd Karmeier represents the 37 southernmost counties and faced a retention vote this year.

IMPAC heavily supported his initial election back in 2004 and again supported him for retention. Justice Karmeier’s election a decade ago was viewed by many as the catalyst for enacting tort reform in 2005. He was also one of the two justices who deemed the law constitutional, although unfortunately he was in the minority.

Justice Karmeier passed the threshold for retention by a razor thin margin of less than 1%. Judges need 60% and he garnered 60.6% at last count. This thin margin was due to a small handful of individual trial lawyers, who in the four weeks prior to this election dumped more than $2 million into a campaign urging voters not to retain Justice Karmeier.

IMPAC supported Justice Karmeier and sent “get out the vote” messages to the physicians in his district.

We are proud of IMPAC’s success in protecting a friend of medicine. That said, we must replenish our resources. The trial lawyer example I reference illustrates our challenge. In just one month, these trial lawyers raised ten times what IMPAC raises in a year! IMPAC contributions and ISMS membership statistics must reverse course if we are to continue effectively representing physician interests.

Legislative Branch
The Democrats maintain their veto-proof majorities in the Illinois House and Senate, but the bipartisan “medical majority” IMPAC has worked to build remains intact.

Our new governor and all other newly elected state lawmakers won’t be sworn in until next year, and we don’t know whether a “lame duck” session will be convened before then. In any case, we are already preparing for the 2015 legislative session to begin.

Our team is currently formulating our agenda, which is strongly influenced by the direction of our House of Delegates. We expect to contend with a medley of onerous bills, scope of practice encroachments, and attempts to legislate medicine.

Regulatory Wins
As a bonus, I’d like to say a few words about two regulatory wins that absolutely would not have occurred without ISMS. First, back in August, ISMS successfully convinced the Illinois Workers’ Compensation Commission to increase nonsurgical E&M code reimbursements by an average of 9.5%. Do you recall the last time any payer increased rates by 9.5%? Neither do I.

Second, as we understand it, ISMS is the first state ever to successfully lobby the AMA’s CPT Editorial Panel for a new code. Earlier this year, ISMS submitted a formal application and sent a team to urge the panel to create new codes for advance care planning counseling; the panel agreed, and recently added two new codes. Medicare didn’t include the codes in the 2015 fee schedule, but left the door open for paying for the codes in the future after vetting them through the public commenting process.

ISMS works hard every day, every year, to advocate for positive change and protect our members and our patients against bad medical policy. Thank you for your membership and support.

Dr. William McDade is the 171st president of the Illinois State Medical Society.
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TOPICS INCLUDE:

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- Regulations, specifically the regulatory exceptions, and the terms of the exceptions
- The source of interpretations of the Stark Law, including key cases and advisory opinions
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- A list of resources to further assist attorneys as they research and analyze Stark issues

This book is a must have for any individual working with healthcare entities needing a general introduction to the statute and regulations governing financial relationships between healthcare entities.

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MEMBER BENEFITS

Calendar of Events

DECEMBER
3 CMS Holiday Reception All members and guests of CMS are invited to mingle and enjoy holiday refreshments. 5:00-10:00 p.m.; Maggiano’s Banquets, 111 W. Grand Ave., Chicago. To RSVP, please contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

10 The Benefits of Transparency Software to Your Practice, Patients and Bottom Line (For all physicians and practice managers). As health care shifts toward consumer driven health plans, patients are taking on a greater share of their health care costs. Medical practices can benefit from recognizing that patients need information on both health care price and quality. Although information about quality has become more transparent, meaningful price information is still difficult to obtain. Medical practices that utilize price transparency software can better manage costs. In addition, price transparency helps patients make informed decisions based on value and assess their treatment options. 7:00-8:00 p.m.; Café la Cave, Des Plaines. One CME credit; No cost for CMS members and practice managers. For more information, please contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

12 Neurology, Neurosurgery and the Law This symposium is hosted by the Chicago Neurological Society 7:15 a.m.-12:50 p.m.; University of Chicago Gleacher Center, 450 N. Cityfront Plaza Dr., Chicago. Cost: $35 for CNS members who have paid their current dues for 2014; $135 for renewing and new CNS members; $175 for nonmembers; $75 for residents, nurses and physician assistants. Includes 4.25 Category 1 CME credit hours, continental breakfast, interactive lunch panel discussion, and refreshments. To register and pay, go to www.chicagoner2014.eventbrite.com. For more information or questions, please contact Paula at pwhisler@cmsdocs.org or call 312-329-7325.

17 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. 8:00-9:00 a.m. For information, please contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

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17 Meaningful Use Stage 2 and EHR Optimization (For all physicians and practice managers). The Centers for Medicare and Medicaid Services have implemented the requirements for Stage 2 of Meaningful Use. We will review the new Core and Menu measures and how they compare to Stage 1. We will also discuss how Meaningful Use Clinical Quality Measures will work in 2014. Meaningful Use Stage 2 is complicated. We will also discuss how others successfully optimized their EHR and improve EHR to see more patients in a shorter period of time. 9:30-11:30 a.m.; Maggiano’s, Chicago, IL. One CME credit; No cost for CMS members and practice managers. For information, please contact Lynn 312-670-2550, ext. 337; or ldefrance@cmsdocs.org.

JANUARY
14 CMS Executive Committee Meeting (See description above). 8:00-9:00 a.m. For information, please contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

15 Resolutions Reference Committee Meets six times a year to consider and make recommendations on member resolutions. 7:00-8:30 p.m. For information, please contact Liz 312-329-7335, or esidney@cmsdocs.org.

17 Meaningful Use Stage 2 and EHR Optimization (For all physicians and practice managers). The Centers for Medicare and Medicaid Services have implemented the requirements for Stage 2 of Meaningful Use. We will review the new Core and Menu measures and how they compare to Stage 1. We will also discuss how Meaningful Use Clinical Quality Measures will work in 2014. Meaningful Use Stage 2 is complicated. We will also discuss how others successfully optimized their EHR and improve EHR to see more patients in a shorter period of time. 9:30-11:30 a.m.; Maggiano’s, Chicago, IL. One CME credit; No cost for CMS members and practice managers. For information, please contact Lynn 312-670-2550, ext. 337; or ldefrance@cmsdocs.org.

21 Physician-Patient Communication 6:00-7:00 p.m.; Speaker: Vineet Arora, MD, Associate Professor, Director for GME Clinical Learning Environment Innovation, University of Chicago. Location: CMS Building, 33 W. Grand Ave., Chicago. One CME credit hour. For more information, please visit www.cmsdocs.org or contact Elvia 312-670-2550, ext. 338; or eme-drano@cmsdocs.org.

31 Polish American Medical Society 65th Annual Physicians’ Ball This event raises scholarship funds for medical students of Polish descent. Music will be provided by the folk-rock group Golec uOrkiestra. Ritz-Carlton, Chicago. For information, please call 773-775-7883 or go to www.zlpchicago.org.

FEBRUARY
10 Board of Trustees Meets every other month to make financial decisions on behalf of the Society. 5:00-6:00 p.m. (prior to the Council meeting); Maggiano’s Banquets Chicago, 111 W. Grand Ave. For information, contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

Welcome New Members!
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Anesthesiologist, board-eligible or board-certified, needed part-time for Family Planning Surgical Centers in Chicago, Northwest suburbs and West suburban Chicagoland area. Early morning to mid-afternoon hours; one to four days a week available. Please send resumes to administration@officegci.com or fax to 847-398-4585.

Ob-gyn physician wanted to perform surgeries, D & C, laparoscopic tubal sterilization, hysteroscopy and other gynecological procedures part-time in Family Planning Surgical Center in Chicago, Northwest suburbs and West suburban Chicagoland area. Travel between centers may be required. Must be within 50 miles of Chicagoland area. Please fax CV 847-398-4585 or administration@officegci.com.

Family physician/family practice physician needed in Arlington Heights. Looking for part-time/moonlighting. Board-certified family practice physicians with experience and familiarity with Pap smear exams and birth control, etc., and EMR proficient. Please fax resumes to 847-398-4585 or email to kimberleeo@officegci.com.

**Office/Building for Sale/Rent/Lease**

For sale: Medical office/urgent care building; 1650 Maple Ave., Lisle; 1,500-4,000 sq. ft. available; $19.50 per sq. ft. Single story, 20-30 car parking lot. Email vino878@aol.com. Fax: 847-398-4585 with serious inquiries.

For sale: Plastic surgery/pain management medical/office; 736 N. York Rd., Hinsdale. Building area (approx.) 3,200 sq. ft. Large operating room and recovery room. Single story, free standing building, ample parking. Asking $899,000. Email administration@officegci.com or vg1028@aol.com. Fax: 847-398-4585 with serious inquiries.

Gynecology practice for sale. Profitable newly established practice in Kane County, plus satellite office. EHR in place; newer equipment; $264,000 SDE in 2013 with 1,700 files. Contact Terry Flanagan terry@practicebrokers.com or 877-988-0911.

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It’s All About Patients

This busy hospital chief executive officer takes the responsibility of ensuring patient health care quality and safety to heart

By Cheryl England

Anthony Tedeschi, MD, started out as a family physician in his rural home town and now leads a team who cares for the health of thousands of patients at Weiss Memorial Hospital.

T’S ALL ABOUT the teamwork—or at least that’s what Anthony J. Tedeschi, MD, the chief executive officer at Weiss Memorial Hospital and chief medical officer for Tenet Healthcare Northeast Region-Chicago Market would tell you. “It’s a very exciting time in health care and I’m pleased to be part of the transformation,” he says. “It’s extremely fulfilling to be able to focus on redesigning health care by concentrating on improving quality and safety, as well as reducing cost—and to be able to do it as part of a team.”

Dr. Tedeschi grew up in the farming and mining community of West Frankfort, Ill., where he came to admire his family’s physician. After performing his residency in family practice at Lutheran General Hospital in Park Ridge, Dr. Tedeschi returned home to open a private practice. “I have always enjoyed everything about the practice of medicine and caring for patients and families,” he says. “I never thought of doing anything other than being a family physician.”

After three years, Dr. Tedeschi became a medical director at Stratford Immediate Care in Bloomingdale, where he had increasing levels of administrative responsibility. In 1996, he assumed a lead role developing CENTRA, a startup physician group that grew to have 100 physicians over the next five years. “I then moved to Central DuPage Hospital, serving in a senior administration role,” he says. “I needed to learn much about the business of health care so I went back to school to earn an MBA at Northwestern University.”

In 2004, Dr. Tedeschi launched a consulting firm, The Sibery Group, with two valued colleagues. The group focused on helping hospitals and physician groups improve performance in managing quality of care as well as costs. “I had a lot of great experiences in that journey,” he says. “Before my current position, I served at Cook County Health and Hospitals System where I was able to focus on strategically focusing the hospital system to better care for the community. I was fortunate to work with many wonderful people there.”

At Weiss, Dr. Tedeschi leads a team that is focused on quality and safety in health care, alongside operational efficiency. “I really enjoy partnering with other team members to provide the best care possible for patients,” he says. Last year Weiss was recognized by Tenet for clinical innovation, thanks to new concepts implemented to better manage patient flow. During Dr. Tedeschi’s time at Weiss, the hospital has received numerous awards in safety and quality, including becoming the first hospital in the Chicago area to receive the Gold Seal of Approval for Joint Replacement from the Joint Commission, and is one of only several hospitals in Chicago to be recognized in 2014 by The Joint Commission as a Top Performer in key quality measures.

Dr. Tedeschi also enjoys teaching and mentoring and that filters into his personal life as a baseball fan and coach. Dr. Tedeschi is married to DeeDee who he met in college. They have three sons, A.J., Joey and Tommy. As successful as Dr. Tedeschi has been so far, he still remembers the lessons he learned early on in West Frankfort. “As a practitioner, I experienced firsthand the disparities in health care between rural and urban areas,” he says. “It’s still extremely important to me to try to improve health care for patients no matter where they live.”

Dr. Tedeschi’s Career Highlights

WITH MORE THAN 20 years of operational and clinical leadership, Dr. Tedeschi has served extensively as a senior leader in a variety of physician organizations: as the interim co-CEO and president of CENTRA, a large suburban integrated delivery system, as the COO and CMO in two urban safety-net hospitals, leading organizational performance improvements; and as COO for the Cook County Health and Hospitals System where he was accountable for overseeing a large-scale performance turnaround. A board-certified family practice physician, Dr. Tedeschi is a clinical instructor at Northwestern.
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