GRASS-ROOTS PRESSURE PAYS OFF

Your Society is the Catalyst for Critical Network Adequacy Legislation that Protects Physicians and Patients
The key to the best medical liability insurance coverage for your group.

ISMIE.

It’s no secret that ISMIE is the best company to provide for your group’s medical liability insurance needs. Our policyholders and their professional risk managers expect a lot from their medical liability insurance company: flexible coverage, proactive claims strategies, excellent service, and hands-on risk management. They know that ISMIE is all of those things and we have a key understanding of the challenges our policyholders face due to a shifting healthcare environment.

Protecting the practice of medicine since 1976.

If you want the key to the best medical liability coverage for your group, contact our professional underwriting staff at 800-782-4767, ext. 3350 or e-mail us at underwriting@ismie.com. Visit our website at www.ismie.com.
FEATURES

14 Grassroots Pressure Pays Off
Your Chicago Medical Society is the catalyst for critical network adequacy and transparency legislation to protect physicians and patients that is now awaiting the governor’s signature.

20 The Better Care Reconciliation Act
Explaining the most significant changes in the Senate bill to repeal and replace Obamacare.
By Sidney Welch, Esq., and Peter Critikos

24 Survey: Physician Attitudes Shift toward Single Payer
A special Chicago Medical Society poll adds the voice of physicians to the health care debate.

PRESIDENT’S MESSAGE
2 CMS Successful in Advocacy
By Clarence W. Brown, Jr., MD

OPINION
4 Take Repeal Off the Table
By U.S. Senator Richard Durbin

PRACTICE MANAGEMENT
6 How to Check Your MIPS Participation Status; Reforming Medical Liability in Illinois; The Rapid Evolution of Managed Care Plans; eClinicalWorks Case Raises New Questions

PUBLIC HEALTH
11 The Rise of Diabetes in Children and Adolescents; Protecting the Public at the National Level

MEMBER BENEFITS
28 AMA: Health Reform at a Crossroads

30 Calendar of Events
31 New Members
31 Classifieds

WHO’S WHO
32 A Rare Breed of Physician
As a practicing internal medicine physician and owner of her own private practice—Quality Primary Care in Chicago—Niva Lubin-Johnson, MD, is a rare breed. After 25 years as a practicing physician, Dr. Lubin-Johnson still finds her greatest joy in taking care of her patients and in giving back to the community and to the practice of medicine.
CMS Successful in Advocacy

WHEN FRUSTRATED physicians heard from their patients that the state’s largest health insurance company—Blue Cross and Blue Shield of Illinois—was restricting doctor choices by ending a popular statewide PPO plan, your Chicago Medical Society set in motion a plan to help.

And after a year of debate with legislators in a deeply divided political climate in Springfield, physicians can lay claim to bipartisan legislative achievement following the Illinois legislature’s passage of the Network Adequacy and Transparency Act (NAT Act). The bill, expected to soon be signed into law by Gov. Bruce Rauner, comes after a year of collaboration and cooperation on advocacy from physicians to help their patients have adequate provider choices.

But the NAT Act is perhaps more so a victory for physicians as new models from government and private insurers attempt to take not only control of provider networks that limit choices, but threaten physician compensation and the practice of medicine. When private insurers gain more control of your patients’ benefits, that means the likelihood is greater that performance measures will increase and there is potential for winners and losers among physicians. As one example, physicians should be leery of Medicare Advantage because it hands off administration of benefits for seniors to private insurers that control choice of providers and how physician compensation will be measured against quality, health outcomes and performance measures.

Through advocacy on issues like network adequacy, we at CMS are helping physicians because insurers are setting up tiers in their networks based on quality and performance data. The NAT Act ensures, among other things, adequate lists of physicians so patients know who is in the network and who is not. Often directories are unreliable so the NAT Act helps protect patients from charges that are incurred if the insurer claims the provider isn’t in-network and the patient is hit with a higher charge. The legislation helps give the patient better information.

Already, we know that insurance companies that have survived losses and remain on public marketplaces under the Affordable Care Act have done so by restricting patient choice as Illinois Blue Cross has done with a more restrictive plan that has replaced the PPO. In some cases, these plans say they will remain offered under the ACA because they’ve scaled back choice of PPOs in favor of narrow network plans like HMOs and exclusive provider organizations, or “EPOs.” And this narrow network strategy is also poised to gain momentum beyond states and commercial insurance under ACA and into Medicare. Nationally, there is more talk of privatizing Medicare under the Republican-led Congress and that will put even more provider networks at risk for change.

All of this means our work at CMS is only beginning. But what started with physicians bringing the Illinois Blue Cross PPO issue to our attention shouldn’t end there. We found success.

We will continue to advocate in Springfield and Washington for provisions and legislation that protect patients and their physicians. At the end of the day, it’s about the outcomes and providing the best care. Please share your thoughts so we can pursue these shared goals and better represent you.

Clarence W. Brown, Jr., MD
President, Chicago Medical Society
Tirelessly defending the practice of GOOD MEDICINE.

We’re taking the mal out of malpractice insurance.
By constantly looking ahead, we help our members anticipate issues before they can become problems. And should frivolous claims ever threaten their good name, we fight to win—both in and out of the courtroom. It’s a strategy made for your success that delivers malpractice insurance without the mal. See how at thedoctors.com
“According to the CBO, the AHCA would throw 23 million people off health insurance over the next decade (including an estimated one million Illinoisans).”

The AHCA is opposed by every major medical and patient advocacy organization—from the American Medical Association to the American Association of Retired Persons, from the American Hospital Association to the American Lung Association, from the American Nurses Association to the American Heart Association, from the American Academy of Family Physicians to the American Diabetes Association, from the American Academy of Pediatrics to the March of Dimes—and yet, it passed by a vote of 217 to 213.

Not a single Democratic House Member voted for the legislation. The bill is strongly opposed by the Illinois Health and Hospital Association—which estimates that the legislation would result in 60,000 job losses in our state alone.

There are many problematic provisions contained within the House-passed bill, but the dramatic changes to the Medicaid program are especially worrisome. By effectively terminating the ACA’s Medicaid expansion—which has benefitted 650,000 Illinoisans—and converting the entire program into a “block grant” or “per-capita cap” system, the AHCA would slash $834 billion in federal Medicaid funding. Illinois would lose approximately $40 billion in federal funding over the next decade. Given the ongoing budget crisis we face in Springfield, there is no way to downplay the impact that cuts of this magnitude would have on our state. Even Republican Governor Rauner announced his opposition to the House action, after it passed.

Would our state further cut Medicaid reimbursement to providers? Would Illinois restrict Medicaid eligibility and create waiting lists for those in need? Would health services—such as mental health, substance abuse, or maternity and newborn care—be deemed too expensive for the state to cover anymore? Would Illinois schools—half of which offer special education services thanks to Medicaid funding—be forced to cut back on services available to help our state’s most vulnerable children?

There are so many questions but here is something we do know: Under the AHCA, uncompensated care costs for hospitals would increase next year by $347 million in Illinois. Hospitals and health systems are already owed $2 billion by the state in outstanding Medicaid reimbursements, but under the House-passed bill, the state would have to increase its Medicaid spending five-fold just to maintain the status quo. It would be an understatement to say that the Governor would have some tough decisions to make.

The AHCA would also undermine protections for people with pre-existing conditions. Today, 130 million Americans—including 5.5 million in Illinois—have a condition that insurers would classify as a “pre-existing condition”—everything from asthma to allergies, arthritis to breast cancer, heart disease to sickle cell anemia, diabetes to obesity. Thanks to the ACA, insurers can no longer reject, drop, or charge people more because of pre-existing conditions. However, the AHCA ends this protection by allowing states to opt out of protections for pre-existing conditions. Not to mention that it allows states and insurers to opt out of covering essential health benefits, everything from hospitalizations and prescription drugs to substance abuse treatment and maternity care. In those states, the CBO estimates “out-of-pocket spending on maternity care and mental health and substance abuse services could increase by thousands of dollars in a given year.”

Knowing that ending protections for pre-existing conditions would be politically unpopular, House Republicans tried to answer this significant shortcoming by throwing in at the last moment an extra $8 billion over ten years for states to create “high-risk pools”—the idea being that states could dump people with pre-existing conditions into a separate insurance market and receive federal funds to help cover the costs. Sadly, this is nothing
more than a fig leaf, as the bill underfunds these “high-risk pools” by $200 billion, according to estimates. Many states, including Illinois, have tried “high-risk pools” in the past. The vast majority have failed due to lack of funds.

The AHCA would impose an “age-tax” on older Americans aged 50 to 64, who would get hit twice: higher premiums and less help paying them. Under current law, insurers can only charge older consumers three times as much as younger people. The AHCA would allow insurers to charge five times as much, or more. It would also slash the ACA’s tax credits, which currently help 94,000 Illinoisans aged 50 to 64 purchase insurance in the individual market. For example, today under the Affordable Care Act, a 64-year-old making $26,500 annually pays an average of $1,700 for their premium. Under the AHCA, that senior would have to pay $16,100.

The bill would also cut off funding for Planned Parenthood health centers (jeopardizing care for 2.5 million patients a year, including 60,000 Illinoisans) and slash funding for the Centers for Disease Control and Prevention. And, in the midst of the ongoing opioid crisis that we face in Illinois and around the country, the bill would allow insurers to refuse coverage of mental illness and substance abuse treatment.

Now, this disastrous bill has come to the United States Senate. Rather than moving this legislation—which would impact one-sixth of our nation’s economy—through the traditional committee process, Senate Republicans have crafted their bill behind closed doors. There have been no hearings, no public input, and no amendments, and the American public will have little time to review the bill before the Senators will vote on it. This secretive process stands in stark contrast to the thorough committee process, 161 Republican amendments that were adopted, and 25-consecutive day period of open debate during consideration of the Patient Protection and Affordable Care Act.

“The AHCA would impose an “age-tax” on older Americans aged 50 to 64, who would get hit twice: higher premiums and less help paying them.”

I have long said that improvements can, and should, be made to the ACA. For many people, insurance is still far too expensive. For many communities, choice is far too limited. For so many people, provider networks are unfairly limited and they are unable to see the doctors of their choice. These are things we can and should improve: we could create a Medicare-like plan to compete alongside private insurers in areas where choice is limited; we could improve subsidies to help people afford insurance; and we could finally do something about the high cost of prescription drugs. It is my hope that Senate Republicans sit down with Senate Democrats to chart a responsible bipartisan path forward that improves access to care and reduces costs.

Richard J. Durbin, is the senior U.S. Senator from Illinois.

Update: Senate Health Care Bill

ON JUNE 22, THE PUBLIC got its first glimpse of Senate Republicans’ proposal to repeal the Affordable Care Act. Upon its release, U.S. Senator Richard Durbin called the Better Care Reconciliation Act a repackaging of the House legislation, which passed May 4.

Since then, the CBO estimate said that 22 million Americans could lose health insurance coverage under the plan.

The original draft, opposed by both moderate and conservative Senate caucus members, prompted Republican Leader Mitch McConnell to pull the bill. He continues to work on amendments to make it more palatable to conference colleagues. As this magazine went to press, these changes could include preserving some of the ACA taxes on the wealthy, providing more financial help to low-income people buy insurance, and spending billions more on treating opioid addiction. Other possible changes would allow consumers to use pre-tax income to pay for insurance premiums and for the sale of cheap, deregulated insurance as long as ACA-compliant plans are sold.

Still, some Republican senators said they were worried about harming people with pre-existing conditions and cuts to Medicaid. Others said the bill did not go far enough in repealing Obamacare.

In a floor speech, Senator Durbin highlighted what the bill could mean to the State of Illinois.

“The Republican bill would cut Medicaid dramatically and then keep cutting—a 35% cut over the next 20 years, with devastating impacts on hospitals and clinics and many other facilities,” Durbin warned.

By 2020 average premiums in the individual market would increase by 76%, he said. One million Illinois residents could lose their health insurance.

The measure needs 51 votes to pass the Senate. Although there are 52 Republicans in the chamber, three defections would doom its passage.
How to Check Your MIPS Participation Status

Resources for clinicians from the Centers for Medicare and Medicaid Services
By Sidney Welch, Esq., Cybil Roehrenbeck, Esq., Bruce Johnson, Esq., and Neal Shah, Esq.

UNDER THE Medicare-Based Incentive Payment System (MIPS), starting in 2019, participating clinicians can earn a bonus or penalty of up to 4% of their reimbursement for services provided in 2017. This bonus/penalty is based on success/failure in four performance categories: quality; resource use; clinical practice improvement; and “advancing care information” through use of health information technology, formerly known as “meaningful use.” Part of the confusion for providers has centered around determining who is a participating clinician and who is not. Generally, participating clinicians include physicians; physician assistants; nurse practitioners; clinical nurse specialists; and certified nurse practitioners who:

• Bill Medicare Part B more than $30,000 a year
AND
• See more than 100 Medicare patients a year.

What’s the Quality Payment Program and Should I Participate?

THE MERIT-BASED Incentive Payment System (MIPS) is an important part of the new Quality Payment Program. Designed to improve Medicare, the Quality Payment Program replaces the Sustainable Growth Rate formula, which threatened clinicians participating in Medicare with potential payment cuts for 13 years. This program combines and streamlines many existing Medicare quality programs.

The Quality Payment Program aims to keep patients at the center of health care while paying clinicians based on their performance. It also works to improve care delivery by supporting and rewarding clinicians who:

1. Find new ways to engage patients, families, and caregivers; and
2. Improve care coordination and population health management.

Here are eight ways to know if you’re included in the Quality Payment Program:

1. You visit qpp.cms.gov, click on the MIPS Participation Look-up Tool, and use your National Provider Identifier (NPI) to check your status. Also, you may have recently gotten a letter from your Medicare Administrative Contractor (MAC) that tells if you’re included in MIPS. Your practice should have received a letter that includes the MIPS participation status of each clinician associated with the practice’s Taxpayer Identification Number (TIN).

2. You’re a physician (includes doctors of medicine and doctors of osteopathy, which includes osteopathic practitioners; physician assistant; nurse practitioner; clinical nurse specialist; certified registered nurse anesthetist; or a group including such clinicians.

3. You’re a MIPS eligible clinician who bills $30,000 or more in Medicare Part B allowed charges a year AND provides care to more than 100 Part B-enrolled Medicare beneficiaries a year. You’re MIPS eligible if you did both and you are part of MIPS for the 2017 transition year. In other words, you go beyond the “low-volume threshold.” CMS determined billing and patient volume by using claims data from Sept. 1, 2015, through Aug. 31, 2016. CMS will identify additional low-volume clinicians using claims data from Sept. 1, 2016, through Aug. 31, 2017.

4. You’re not new to Medicare in 2017. If you’re new in 2017, you’re not part of MIPS.

5. Your practice tells you the group you’re a part of is participating. Each practice should let its clinicians know their MIPS status. If you practice under more than one TIN, you’ll hear about your status for each TIN. Your status can be different across TINs. For example, you might be part of two practices with different TINs. Your Medicare billing and patient count might be more than the low-volume threshold at one practice, but not at the other practice.

6. Your practice chooses to participate in MIPS as a group. If your group does choose to participate, you’ll be assessed and scored as a group.

7. You didn’t participate sufficiently in Advanced Alternative Payment Models (APMs) and become a Qualifying APM Participant (QP). If you did, you’re exempt from participating in MIPS. If you’re in an Advanced APM and become a Partial QP, you may choose whether to report on MIPS measures and activities, be scored using the APM scoring standard, and be subject to a MIPS payment adjustment. Partial QPs can choose not to participate in MIPS, but they must still meet the participation requirements of their APMs.

8. You want to participate. Even if you don’t have to participate in the MIPS program you can still choose to participate. If you do, you won’t be subject to MIPS payment adjustments.

The Quality Payment Program offer free resources to help. Visit the official federal CMS website at qpp.cms.gov. Or email qpp@cms.hhs.gov, or call 1-866-288-8292 (toll-free).
Reforming Medical Liability in Illinois

New legislation aims to end medical lawsuit abuse

The Protecting Access to Care Act (HR 1215) was introduced on Feb. 24 by Rep. Steve King (R - Iowa), and is a much-needed medical liability reform bill that includes proven, effective reforms that Illinois doctors and patients have sought for many years. The bill is fully supported by the Chicago Medical Society and the Illinois State Medical Society among numerous other medical groups.

The bill, now that it has passed the House, has been received in the Senate, where it was referred to the Committee on the Judiciary. The bill establishes provisions governing health care lawsuits where coverage for the care was provided or subsidized by the federal government, including through a subsidy or tax benefit. Essentially, H.R. 1215 limits non-economic damages to $250,000 and also sets limits on attorney contingency fees. The bill does not preempt certain state laws and federal vaccine injury laws and rules.

The Congressional Budget Office (CBO) has determined that HR 1215 would cut federal healthcare spending by $44 billion over 10 years and reduce the deficit by $50 billion over the same period of time. Previously, Illinois enacted legislation that included reasonable caps on non-economic damages, but the state supreme court overturned the law. In all likelihood, federal legislation is the only chance for medical liability reform for Illinois doctors. Be sure to let U.S. Senator Dick Durbin know that you support this important legislation!
The Rapid Evolution of Managed Care Plans

From narrow networks to tiered networks to micro networks, the landscape is changing

By Jim Watson

NOT SO long ago, handling managed care agreements in a physician practice was as easy as understanding the difference between HMO and PPO products. There were no Medicare or Medicaid health plans until the mid-2000s, and there were no Marketplace products until 2014. Things were relatively simple back then.

But in the last five years, there has been an explosion in the number and complexity of health plans, across the spectrum of commercial, governmental and individual products. This has created enormous strain on the operations of physician practices and other health care providers, in both front-end and back-end functions. It is not uncommon for a physician practice to add a devoted full-time employee to manage the complexity of these growing payor contract portfolios.

Emerging complexities in handling that managed care contract portfolio include: the growing popularity of narrow networks, tiered networks, micro networks, and carve-out networks. Here is a summary of what these networks look like, and why they are growing in popularity among employers and consumers.

Narrow Networks

Narrow networks are health insurance plans that place limits on the doctors and hospitals available to subscribers. According to consulting firm McKinsey and Co., nearly 70% of all ACA plan networks are narrow or ultra-narrow, meaning they include 25% or less of the physicians in the area. These networks:

- Remove “high-cost” (high-rate) providers, lower premiums and may also facilitate the exit of high-cost members who seek to stay with their providers via other MCOs.
- Include “traditional” narrow network products: Blue Advantage HMO, Blue Choice PPO, United Healthcare Compass.
- Include “new” narrow network models. Narrow networks align Clinically Integrated Networks (CINs)—which are touted to represent the best care model—with insurance products. Examples include BlueCare Direct and United Healthcare Charter.

Tiered Networks

Tiered networks give patients financial incentives for choosing more cost-effective doctors and hospitals. These networks:

- Allow access to higher cost/rate providers (designated to Tier 2 and Tier 3 status), but incentivizes members to use lower cost Tier 1 providers. The rates paid are the same, but patient out-of-pocket expense differentials between the three tiers can be dramatic.
- Are a popular model for hospital employee benefits plans, incentivizing employees to use “home” hospitals and physicians at lower out-of-pocket cost.
- Land of Lincoln Health (LLH) was a pioneer in offering three tier network products via their “Private Label” products with many of the larger health systems in Chicago.

Micro Networks

Micro-networks are healthcare systems that have organized to create high quality physician networks that rely upon the support of health plan services companies to provide robust, targeted access to care. The concept revolves around channeling health plan members toward specific providers by incenting them financially. These networks:

- Employer-specific networks created by insurers specifically for larger employers. These networks typically include “tiers.”
- In 2017, BCBSIL introduced Blue Focus Care, an eight hospital HMO network centered in Cook County for City of Chicago employees.

Carve-Out Networks

Carve-out networks offer medical services that are separated from a contract and paid under a different arrangement... These networks typically carve out:

- Behavioral Health: Dating back to the 1990s, many larger insurers and large employers would “carve out” behavioral health coverage to another vendor who sets up a provider network separate from the insurer to manage behavioral health services.
- Ancillary Services: Increasingly, large insurers are creating carve-out networks to focus on high-cost, highly used ancillary services in an effort to better manage cost, quality and access. Examples of these services include outpatient diagnostic imaging, physical therapy, and home care.
- Centers of Excellence: Payors continue to innovate in care delivery by directing certain procedures to centers of excellence that provide higher quality at lower cost for procedures like joint replacement, cardiac surgery, and transplants.

“In the last five years, there has been an explosion in the number and complexity of health plans, across the spectrum of commercial, governmental and individual products.”

Positioning Your Practice

So what can you do to best position your practice in these evolving insurer network configurations, and how can you best manage your managed care contract portfolio? Here are recommendations and tips:

1. Know your contract affiliation options and maximize those affiliations (direct contracts and contracts through local IPAs, PHOs, and CINs).
2. Understand the rules and requirements of the IPA/PHO/
CIN affiliations.
3. Know what products are tied to what rates.
4. For tiered networks, know what tier you are in and why.
5. Confirm eligibility and benefits for each patient to ensure that you are “in network” for services. It is clear that even though you may have a contract with any given insurer, you may not be in network for all services and all products offered by any given insurer.
6. Create a managed care contract grid detailing each insurer and its products, your participation status and any special rules for each insurer and each product offered by each insurer.
7. Know your cost, quality and service metrics through the eyes of the MCOs. Understand the metrics that are most relevant to your practice and the network contract that you participate through.
8. Stay on top of any quality incentive reports sent to you that affect your incentive payment or how your scores are publicly reported.
9. Know your numbers and do the math. Look at denials that affect your contract yield. Create models of proposals. MCO math and provider math often differ because of underlying data sets, timeframes, systems and methodologies.

Moreover, it is important to take a global view of how you approach managed care contracting. Use the following two strategies:

1. Understand your practice’s competitive position in the market.
   - This will drive your ability to negotiate agreements and assess your attractiveness to payors and networks.
   - Know how your MCO contract affiliations are held (directly or via an IPA/PHO/CIN).
   - Effectively manage your MCO contract portfolio.
   - Know your options and how to maximize contract rates.
   - Consider your options in IPA, PHO, CIN, ACO participation, and the importance of participation in these networks and products in aligning with your referral base.
2. Align with a CIN whenever possible.
   - CINs have the best contracts and are evolving quickly.
   - They are often the core of narrow networks.
   - They are quickly evolving into provider sponsored health plans (PSHPs).
   - Being outside the CIN means being outside the referral streams.
   - Health system CINs are aligning with health system-based ACOs (Medicare and commercial models).

Managed care plans now represent a significant portion of your entire patient population including employer-based plans, Medicare plans, Medicaid plans, and individual plans. Payors will continue to get creative and health plan products will continue to evolve, driven by employer and consumer demand. Understanding this market dynamic and its impact on your medical practice is important to your continued success.

Jim Watson is a partner at PBC Advisors, LLC, in Oak Brook. The company provides business and management consulting and accounting services to physician practices and hospital systems. For more information, visit www.pbcgroup.com.
Case Raises New EHR Questions

Settlement brings up questions about how EHRs should be certified and monitored

By Clay J. Countryman, Esq.

On May 31, 2017, the U.S. Department of Justice (DOJ) announced that eClinicalWorks (ECW) agreed to pay a $155 million settlement and enter a corporate integrity agreement with the OIG to resolve allegations that ECW caused its health care provider customers to submit false Medicare and Medicaid claims for meaningful use payments in violation of the False Claims Act (FCA). Under the corporate integrity agreement, ECW agreed to strict compliance and reporting obligations and to provide the latest version of its EHR software to current customers free of charge.

The settlement by eClinicalWorks raises questions about how EHRs should be certified and monitored. Physicians may need to assess how the settlement will affect their ability to retain previously received meaningful use payments.

“Customers ‘unknowingly’ submitted false attestations, reasonably believing that eClinicalWorks’ EHR software was properly certified. The False Claims Act requires the government to establish that false claims were submitted knowingly.”

Complaint Allegations

The DOJ alleged that ECW caused its customers to receive unearned EHR incentive payments by submitting false attestations of meaningful use of CEHRT. Based on the complaint, it appears the DOJ did not pursue ECW’s physician practice customers for the unearned incentive payments, in part, because ECW’s customers “unknowingly” submitted false attestations, reasonably believing that ECW’s EHR software was properly certified. The FCA requires the government to establish that false claims were submitted knowingly.

DOJ also alleged that ECW paid kickbacks to influential customers to induce them to recommend ECW’s EHR software in violation of the Anti-Kickback Statute. DOJ alleged that ECW paid the purported kickbacks through a referral program, site visit program, and a reference program. According to the complaint, under the referral program, ECW paid customers up to $500 for each provider they referred who executed a contract with ECW, with payments totaling almost $144,000. Under the site visit program, ECW paid customers to host prospective customers; payments varied based on the number hosted and whether the prospect licensed the software. Under the reference program, ECW paid customers as much as $250 to serve as references and speak to prospects.

The OIG has long taken a position that marketing payments could technically implicate the Anti-Kickback Statute, but also recognizes that payment for marketing services are common and unavoidable without banning marketing activities entirely. OIG advisory opinions set forth a multi-factored facts-and-circumstances analysis for distinguishing between proper and improper marketing activities outside the Anti-Kickback Statute Safe Harbors.

The five-year corporate integrity agreement (CIA) that ECW entered includes several requirements not usually included in CIs. Some are:

- Free upgrades. ECW must provide the latest version of the its EHR software to current customers at no charge.
- Free data transfer. ECW must transfer an existing customer’s data without penalties or service charges to the customer or the customer’s designated successor vendor.
- Quality assurance program. ECW must establish a program with “professionally recognized software development, quality assurance, and risk management standards and practices appropriate to the nature and purposes of EHR systems.” ECW also must proactively monitor information about potential software defects, usability problems and other issues that may impact patient safety or EHR certification.

The settlement by eClinicalWorks raises questions about how EHRs should be certified and monitored. Physicians may need to assess how the settlement will affect their ability to retain previously received meaningful use payments.

Clay J. Countryman is a partner with Breazeale, Sachse & Wilson, L.L.P in Baton Rouge, La. Contact him at: Clay.Countryman@bswllp.com.
The Rise of Diabetes in Children and Adolescents

Early education and prevention key to reducing risk and adverse outcomes

By Anna Gonzales, MPH, Jessica A. Clark, RN, MPH, and Lesley J. Craig, MPH

Diabetes has long been recognized as a major public health issue, but the impact of this chronic disease is increasing among America’s youth. A recent study in the New England Journal of Medicine found the incidence rates of both type 1 and type 2 diabetes rose significantly among American youth from 2002-2012, particularly among certain racial and ethnic minority groups. During this period, although type 1 diabetes is most common in non-Hispanic whites, annual rates of increase in type 1 diabetes were much higher among Hispanic youth (4.2%) than among other racial and ethnic groups, including Asians or Pacific Islanders (3.7%), non-Hispanic blacks (2.2%), non-Hispanic whites (1.2%), and Native Americans (0.4%). For type 2 diabetes, annual rates of increase were highest among Native Americans (8.9%) and Asians or Pacific Islanders (8.5%), followed by non-Hispanic blacks (6.3%) and Hispanics (3.1%), but increases were low among non-Hispanic whites (0.6%).

A combination of genetic, environmental, and behavioral factors contributes to diabetes onset; these factors may lead to variations in incidence among different racial and ethnic groups. Studies also have shown vast differences between racial and ethnic groups in the methods of treatment, clinical outcomes, and barriers to quality care—including cost, not having a regular health care provider, and lack of contextual care.

Disparities in Mortality

A recent Morbidity and Mortality Weekly Report stated that despite increases in diabetes incidence and prevalence among children and adolescents from 2000 to 2014, there was an overall decrease in the number of deaths from diabetes among this age group. However, significant racial and ethnic disparities in diabetes mortality exist; from the years 2012 to 2014, the diabetes mortality rate (for types 1 and 2) among non-Hispanic blacks was more than twice that of non-Hispanic whites and Hispanics (at 2.04 per 1 million population, compared to 0.92 and 0.61 respectively). The underlying reasons for differences in diabetes mortality rates may be complex, but possible explanations include disparities in access to diabetes care, health services, and education about self- and parent/caregiver-management of diabetes.

Prevention of Adverse Outcomes

Research has shown that a large percentage of youth with diabetes have poor glycemic control, which can increase the risk of adverse outcomes, including micro- and macrovascular complications. Youth with diabetes also are more likely to experience major depressive episodes compared to those without diabetes. If the rising trend in diabetes (both type 1 and type 2) cases continues, a growing proportion of U.S. children and adolescents will be impacted. Effective treatment is proven to prevent diabetes complications, and measures initiated by providers are essential to mitigating associated health risks among this group.

Measures to reduce the risk of diabetes-related adverse outcomes in youth include:

- Educate patients early about symptoms of diabetes.
- Coach patients to maintain glycemic control.
- Promote behavioral change (among patients diagnosed with type 2 diabetes).
- Ensure early treatment of diabetic ketoacidosis (in patients diagnosed with type 1 diabetes).
- Many online tools exist to assist providers and patients in effective diagnosis and management of diabetes, including:

  - The National Institute of Diabetes and Digestive and Kidney Diseases has developed tools for people diagnosed with types 1 and 2 diabetes and their caregivers, with a section devoted to youth. This resource also includes tools for providers, and can be found at www.niddk.nih.gov/health-information/diabetes.
  - The U.S. Centers for Disease Control and Prevention developed a National Diabetes Prevention Program, which includes resources for health professionals. View the Program at www.cdc.gov/diabetes/prevention/index.html.

Anna Gonzales, MPH, is a Captain in the U.S. Public Health Service and Acting Regional Health Administrator at the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Health—Region 5 (IL, IN, MI, MN, OH, WI). Contact us by emailing Lesley.Craig@hhs.gov.
Protecting the Public at the National Level

New policies adopted at the AMA’s House of Delegates meeting

At the Annual American Medical Association (AMA) House of Delegates held in Chicago on June 10-14, the AMA debated numerous public health proposals, including some that had their origin at the Chicago Medical Society and the Illinois State Medical Society. (For general highlights of the AMA meeting, please see “AMA: Health Reform at a Crossroads” on page 28). Here is a summary of new public health measures emerging from the annual conference. The descriptions are adapted from the online AMA Wire.

Reducing Consumption of Sugar-Sweetened Beverages
Evidence has consistently shown a link between consumption of sugar-sweetened beverages (SSBs) and an increase in type 2 diabetes and coronary heart disease. As a result, the AMA adopted policy as part of a comprehensive report on SSBs, aimed at reducing the amount of sugar Americans consume. New policy supports evidence-based strategies to reduce the consumption of SSBs, including excise taxes on them, removing options to purchase SSBs in primary and secondary schools, the use of warning labels to inform consumers about the health consequences of SSB consumption, and the use of plain packaging.

The AMA policy also urges continued research into other strategies that may be effective in limiting SSB consumption, such as controlling portion sizes, limiting options to purchase or access SSBs in early childcare settings, workplaces, and public venues, and changes to the agricultural subsidies system. Under the new policy AMA also encourages hospitals and medical facilities to offer healthier beverages for purchase in place of SSBs. Additionally, the policy calls for these facilities to make calorie counts visible next to the price of beverages sold in their vending machines. Physicians are also encouraged to counsel their patients about the health consequences of SSB consumption and importance of replacing SSBs with healthier beverage choices.

Evidence-based Vaccine Policy
The AMA adopted policies aimed at protecting children’s health by addressing vaccine policy. In recognition that vaccinations are safe and effective, and that their benefits far outweigh any risks, the AMA adopted policy that supports the rigorous scientific process of the Advisory Committee on Immunization Practices as well as its development of recommended immunization schedules for the nation; recognizes the substantial body of scientific evidence that has disproven a link between vaccines and autism; and opposes the creation of a new federal commission on vaccine safety whose task is to study an association between autism and vaccines.

Preventing Myopia
According to research cited in an HOD resolution, myopia is “the leading cause of visual impairment globally.” The resolution also stated that nearsightedness might “lead to lower quality of life, financial burden, retinal detachment and macular degeneration” in children. To help prevent myopia onset and progression in school children and adolescents, delegates adopted policy supporting efforts aimed at encouraging children to spend more time outside participating in various outdoor activities instead of remaining indoors. The new policy would also promote other activities that have been shown to reduce the onset of myopia in children and adolescents.

Resolution for Action on Lead Sources
Lead in domestic water remains a problem in many communities across the United States. According to an HOD resolution, 4.9% of children in Flint, Michigan, “were found to have lead poisoning in 2015.” Even if many communities have not experienced the same devastation as Flint, lead pipes remain in dozens of communities around the country, according to data cited in the resolution.

Testimony in support of this resolution said the focus should include multiple possible sources of lead poisoning, not just in water sources. Delegates adopted policy to support requiring “an environmental assessment of dwellings, residential buildings or child-care facilities following the notification that a child occupant or frequent inhabitant has a confirmed elevated blood lead level.” This complete environmental assessment will help determine the potential source of lead poisoning in those children,

The National Spotlight

Resolutions describe a problem and propose a solution. If you would like to see your resolution debated on the national stage where it will have the most impact, at the American Medical Association’s House of Delegates, now is the time to get started.

Any Chicago Medical Society member can author a resolution on an issue of wide concern to physicians. Once vetted by CMS, most resolutions move on for debate at the ISMS House of Delegates, which meets every April, and then to the AMA House of Delegates, which meets twice a year, in June and in November. During both the ISMS and AMA meetings, assigned reference committees hear testimony and suggest improvements. At the final stage, often on the House floor, delegates vote to pass, or amend, or refer a resolution for study.

The resolutions you see here had humble beginnings with a single member at a local medical society putting a proposal in writing. Be sure to participate in this important process now!
whether through the testing of the water supply or another origin.

**Laundry Packets’ Hidden Dangers**

In 2015, the Detergent Poisoning and Child Safety Act was introduced to require the U.S. Consumer Product Safety Commission to set mandatory safety standards for liquid laundry packets to prevent ocular burns in children. The AMA supported the legislation. This new resolution, offered by the American Academy of Ophthalmology, argued that a voluntary American Society for Testing and Materials “standard neither requires a reformulation of liquid laundry packets to make them less caustic to children, nor do they require changes in color and design to make them less attractive to children.” To ensure the voluntary ASTM standard adequately protects children from injury, such as ocular burns, the HOD directed AMA to “encourage the Consumer Product Safety Commission, in conjunction with the American Association of Poison Control Centers, to study the impact of ASTM’s standard that is currently in place.”

**Classifying Infertility as a Disease**

Delegates voted in support of WHO’s designation of infertility as a disease state with multiple etiologies requiring a range of interventions to advance fertility treatment and prevention. The declaration could have a broad impact on how patients, insurers and society at large view infertility. Infertility affects 15% of couples and is recognized as a complex disease by WHO and ASRM. Some of the largest health insurance companies in the U.S., including Cigna, Optum Health and Aetna, cover some treatments. However, not all insurance companies cover treatment. Delegates offered unanimous testimony supportive of this resolution, with an emphasis on how this classification would promote insurance coverage and payment.

**Prenatal Supplementation**

A resolution adopted by the AMA supports evidence-based amounts of choline in all prenatal vitamins. Adequate levels of choline—an important nutrient that helps a baby’s brain and spinal cord to develop properly—are necessary to maintain normal pregnancy including neural development of the fetus and reducing the incidence of birth defects. Inadequate choline levels during pregnancy are thought to negatively affect cognitive development. Neural tube and hippocampus development also are dependent on adequate choline intake. Prenatal vitamins only contain 0–55 mg of choline, leaving the majority of pregnant and lactating women without enough dietary choline to protect the health and development of their babies, according to data cited in a resolution adopted by the HOD.

**Improved Coverage of Preventative Care**

The HOD took several actions aimed at improving research on and payment for preventive care. Newly adopted policies encourage expert committees making preventive-services recommendations to follow transparent, evidence-based processes, encourage comparative-effectiveness research on secondary prevention and advocate that all payers be required to provide first-dollar coverage of routine preventive pediatric care.

Delegates also voted to support requiring Medicare to waive coinsurance for colorectal screening and any interventions required during the procedure, such as polyp removal, and support removing insurance barriers to securing coverage for HIV pre-exposure prophylaxis (PrEP).

More than 100 tests and treatments are paid for without cost-sharing as directed by the Affordable Care Act based on the recommendations of the expert committees, the AMA report says. The HOD adopted new policy asking these expert committees to develop evidence reviews with enough specificity to inform cost-effectiveness analysis, work together to identify preventive services that are not cost-effective and consider development of recommendations for secondary prevention.

**Pain Care**

The HOD took actions aimed at improving pain care while expanding access to buprenorphine for patients with opioid-use disorder and encouraging the safe storage and disposal of controlled substances. A resolution presented by the American Academy of Pain Medicine to ensure that pain care gets the attention it deserves amid the vital effort to address the opioid epidemic, resulted in delegates directing the AMA to convene a task force from organized medicine to:

- Discuss medicine’s response to the public health crisis of undertreated and mistreated pain
- Explore and make recommendations for augmenting medical education designed to educate healthcare providers on how to help patients suffering from pain with evidence-based treatment options.
- Discuss strategies that may prevent or mitigate acute pain, educate physicians about these strategies, and suggest research to study if these strategies prevent the development of chronic pain.

**Laundry Packets’ Hidden Dangers**

In 2015, the Detergent Poisoning and Child Safety Act was introduced to require the U.S. Consumer Product Safety Commission to set mandatory safety standards for liquid laundry packets to prevent ocular burns in children. The AMA supported the legislation.

This new resolution, offered by the American Academy of Ophthalmology, argued that a voluntary American Society for Testing and Materials “standard neither requires a reformulation of liquid laundry packets to make them less caustic to children, nor do they require changes in color and design to make them less attractive to children.” To ensure the voluntary ASTM standard adequately protects children from injury, such as ocular burns, the HOD directed AMA to “encourage the Consumer Product Safety Commission, in conjunction with the American Association of Poison Control Centers, to study the impact of ASTM’s standard that is currently in place.”

**Classifying Infertility as a Disease**

Delegates voted in support of WHO’s designation of infertility as a disease state with multiple etiologies requiring a range of interventions to advance fertility treatment and prevention. The declaration could have a broad impact on how patients, insurers and society at large view infertility. Infertility affects 15% of couples and is recognized as a complex disease by WHO and ASRM. Some of the largest health insurance companies in the U.S., including Cigna, Optum Health and Aetna, cover some treatments. However, not all insurance companies cover treatment. Delegates offered unanimous testimony supportive of this resolution, with an emphasis on how this classification would promote insurance coverage and payment.

**Prenatal Supplementation**

A resolution adopted by the AMA supports evidence-based amounts of choline in all prenatal vitamins. Adequate levels of choline—an important nutrient that helps a baby’s brain and spinal cord to develop properly—are necessary to maintain normal pregnancy including neural development of the fetus and reducing the incidence of birth defects. Inadequate choline levels during pregnancy are thought to negatively affect cognitive development. Neural tube and hippocampus development also are dependent on adequate choline intake. Prenatal vitamins only contain 0–55 mg of choline, leaving the majority of pregnant and lactating women without enough dietary choline to protect the health and development of their babies, according to data cited in a resolution adopted by the HOD.

**Improved Coverage of Preventative Care**

The HOD took several actions aimed at improving research on and payment for preventive care. Newly adopted policies encourage expert committees making preventive-services recommendations to follow transparent, evidence-based processes, encourage comparative-effectiveness research on secondary prevention and advocate that all payers be required to provide first-dollar coverage of routine preventive pediatric care.

Delegates also voted to support requiring Medicare to waive coinsurance for colorectal screening and any interventions required during the procedure, such as polyp removal, and support removing insurance barriers to securing coverage for HIV pre-exposure prophylaxis (PrEP).

More than 100 tests and treatments are paid for without cost-sharing as directed by the Affordable Care Act based on the recommendations of the expert committees, the AMA report says. The HOD adopted new policy asking these expert committees to develop evidence reviews with enough specificity to inform cost-effectiveness analysis, work together to identify preventive services that are not cost-effective and consider development of recommendations for secondary prevention.

**Pain Care**

The HOD took actions aimed at improving pain care while expanding access to buprenorphine for patients with opioid-use disorder and encouraging the safe storage and disposal of controlled substances. A resolution presented by the American Academy of Pain Medicine to ensure that pain care gets the attention it deserves amid the vital effort to address the opioid epidemic, resulted in delegates directing the AMA to convene a task force from organized medicine to:

- Discuss medicine’s response to the public health crisis of undertreated and mistreated pain
- Explore and make recommendations for augmenting medical education designed to educate healthcare providers on how to help patients suffering from pain with evidence-based treatment options.
- Discuss strategies that may prevent or mitigate acute pain, educate physicians about these strategies, and suggest research to study if these strategies prevent the development of chronic pain.
THE RECENT passage of HB 311, known as the Network Adequacy and Transparency Act (the NAT Act), marks the culmination of a two-year odyssey launched by the Chicago Medical Society. Passed with bipartisan support, HB 311 creates protections set forth by CMS that will benefit patients who purchase state-regulated health insurance plans, and the physicians who care for them. “We’re very grateful to Illinois lawmakers who helped us advance this critical legislation,” CMS President Clarence Brown, MD, said after the House passed the bill on June 24. “On both sides of the aisle, House and Senate members joined as co-sponsors, to address an issue that we can all agree on—the well-being of patients.”

Dr. Brown praised the leadership of State Rep. Gregory Harris (D-Chicago), Rep. Chad Hays (R-Catlin), State Sen. Linda Holmes (D-Aurora) and State Sen. Sue Rezin (R-Morris), all of whom paved the way for the bill’s passage. Rep. Chad Hays was the leading Republican sponsor of HB 311.

“The health insurance issues we face here in East Central Illinois are very real,” Rep. Hays said. “It is not unusual for patients to drive an hour or longer to an appointment, and I hear all too often from constituents who believe they are scheduling appointments with ‘in-network’ physicians and specialists only to learn when they arrive for an appointment that the professional is no longer on their insurance plan. The provisions in HB 311 will go far in establishing new standards to protect consumers.”

An Odyssey Begins
Physicians familiar with Chicago Medicine magazine may recall the origin of this effort under Immediate Past President Kathy Tynus, MD. Dr. Tynus, an internal medicine specialist and educator, took office in June 2015, and throughout her term gave regular updates on the initiative.

CMS was aware early on of worrisome developments in the Affordable Care Act’s (ACA) insurance marketplace. By 2015, Illinois patients who bought marketplace insurance were facing drastic reductions in choice of hospitals and doctors. And the trend was not just limited to the ACA marketplace but also to products sold outside the ACA insurance marketplace.

For patients with highly complex medical needs, where continuity of care is most critical, many physicians worried that these shifts could have catastrophic results. And the process for patient and physician appeals to insurance companies can be complex, inefficient and lacking in transparency, causing delays in care or payment, Dr. Tynus pointed out.

Another worrisome feature—reports of unsuspecting patients, through no fault of their own, getting hit with penalties for out-of-network care. These surprise medical bills, often for emergency care, stoked outrage and controversy.

Not long into Dr. Tynus’ presidency, the state’s largest insurer announced it would be withdrawing its broad PPO plan from the insurance exchange’s individual market as of Jan. 1, 2016. While this was major news, capturing media attention, other narrow network plans were entering the Illinois market. Alarmed physicians brought their concerns to the Chicago Medical Society. It was clear to all that narrowing and tiering of plans in the Chicago area and Illinois could have a profound impact, on physicians and their patients.

Now the Chicago Medical Society had its work cut out.

Under Dr. Tynus, a network adequacy taskforce was appointed to study the shrinkage of health plan networks, as well as the turmoil in the insurance marketplace. The taskforce got reinforcement from CMS’ Healthcare Economics Committee, in addition to stakeholder input from various sectors and specialty societies. By year-end, a multi-pronged strategy was taking shape at CMS.

Talking to Insurance Companies
Amid dire reports of some insured patients losing access to covered care at the major academic tertiary hospitals, CMS decided to initiate talks with insurance officials. These meetings shed some light on the challenges faced by insurers. According to one insurance executive, many newly ACA insured individuals had gone for years without care because of pre-existing conditions or unaffordability. As a group, these patients were sicker and older, and, as a result, drove up costs far higher than estimated. At the same time, healthy young people who were needed to balance the actuarial pool of insured patients opted to pay a penalty rather than buy marketplace insurance. Last but not least, the loss of risk corridor adjustment
GRASSROOTS PRESSURE PAYS OFF

NAT Act Highlights

YOUR CHICAGO Medical Society was the catalyst for vital legislation drafted by the Illinois State Medical Society and now awaiting the governor’s signature.

The Network Adequacy and Transparency Act (the NAT Act) contains provisions set forth by a CMS taskforce, which in 2015 began investigating the emergence of narrow and tiered plans in Illinois. Once the CMS taskforce developed its response plan, a set of recommendations, they were submitted to ISMS for prompt action.

Following its analysis, ISMS incorporated the CMS provisions into its draft bill that was introduced in spring 2016. The ISMS-drafted legislation won overwhelming support from lawmakers, physicians, and patients.

Illinois’ new NAT Act:

- Provides the Illinois Department of Insurance a framework to ensure that patients have access (close proximity) to necessary health care professionals, including specialists and appropriate health care facilities.
- Requires health plans to maintain up-to-date provider directories. Reliance on inaccurate provider directories was a concern voiced by physicians. Now, health insurance plans must notify patients in a timely fashion if a physician or hospital is dropped from a network, to help patients avoid surprise out-of-network charges.
- Obligates physicians to notify affected patients if they choose to leave a network as a result of non-renewal or plan termination.
- Requires in-network facilities to provide disclosures to patients advising them that some care may be delivered by out-of-network providers.
- Prevents patient care disruptions due to changes in health insurance networks. A patient’s physician may be dropped from the network, but patients with complex conditions will be able to stay with their physician long enough to make a smooth transition at no additional cost.

Prior to the bill’s passing, ISMS and the Illinois Health and Hospital Association negotiated several amendments. One change allows network plans to consider the use of telemedicine to partially meet network adequacy requirements. Also, the departure of a physician or hospital provider from a network plan will not be considered a “qualifying event” that would allow the patient to change insurance plans. The bill also clarifies that network adequacy standards apply only to the lowest cost-sharing tiers provided in individual plans (not group plans). Finally, the “effective date” of the legislation, for all plans offered for coverage is on or after Jan. 1, 2019.
CMS also looked to the National Association of Insurance Commissioners. Back in 2015, as the NAIC revised its draft Managed Care Plan Network Adequacy Model Act, the AMA and dozens of other groups urged commissioners to incorporate several features above and beyond the draft revisions. In a letter to the commissioners, the groups called for: active approval of networks prior to products going to market; the use of quantitative measures to determine network adequacy; and regulation of tiered networks to prevent discriminatory network design.

“We believe state legislatures and Insurance Commissioners will be better equipped to establish reasonable, meaningful standards for network adequacy, while still allowing for market flexibility and choice,” the letter said. In addition, the AMA’s suite of model legislation directly addresses network issues and improved access to care for patients. CMS opted to include several of the AMA models in its proposal.

**To the Illinois State Medical Society**

Once the taskforce made its recommendations, the Chicago Medical Society drafted a network adequacy and transparency proposal, and fired it off to the Illinois State Medical Society. Dr. Tynus urged the ISMS Board to give it prompt review. The proposal, presented as a resolution, set forth network adequacy provisions, as developed by the taskforce. The ISMS Board, then chaired by Paul DeHaan, MD, was urged to draft a bill for introduction in the General Assembly in spring 2016. Dr. Tynus stressed she was working outside the usual process. Unlike the typical resolution to the ISMS House of Delegates, there was no time for this one to wind slowly through. “We believe the problem is too critical for delay, and have opted to forgo the traditional path of introducing a resolution to the April House of Delegates,” Dr. Tynus wrote to Dr. DeHaan. Soon, in a matter of days, Dr. Tynus was already giving in-person testimony to ISMS.

**Network Adequacy and Surprise Medical Bill Resolution**

The CMS proposal recommends adoption of the AMA principles for network adequacy rules along with other model acts developed by the AMA. Here is what the Chicago Medical Society requested of ISMS:

1. Create network adequacy rules, modeled on those proposed by the American Medical Association.
2. Mandate adequate network directories, modeled on the AMA Model Bill entitled “Meaningful Access to Accurate Provider Directories.” – This Act requires insurers to provide accurate provider directories that are updated in a timely manner. Such directories are essential to patients when

**Where Hope and Healing Meet**

Shriners Hospitals for Children — Chicago, offers a broad pediatric plastic surgery service for patients with congenital, developmental and acquired deformities of the face, jaw, head and ears. In addition to surgical services, specialty clinics including our head shape and Ear Well™ programs bring hope to parents by providing non-invasive interventions that can offer dramatic results.

The hopes of families are met in our other areas of expertise as well. For over 90 years, parents and children with orthopaedic conditions, spinal cord injury, and rehabilitation needs have seen their hopes realized right under our roof — by physicians, nurses, and specialists using the latest technology, innovative research, and a collaborative, family-centered approach. It’s how the 22 Shriners Hospital locations provided care to over 121,000 children last year alone.

**Do You Know a Child Who Needs Expert Specialty Care?**

For a consultation, or to refer a patient, call:
Shriners Hospitals for Children — Chicago
773-385-KIDS (5437)
2211 N. Oak Park Ave., Chicago, IL 60707

facebook.com/shrinerschicago  twitter.com/shrinerschicago  shrinerschicago.org

---

GRASSROOTS PRESSURE PAYS OFF
AMA Passes New Network Adequacy Measures

AT ITS JUNE 2017 meeting, the American Medical Association approved new measures to prevent disruptions in care for patients in active courses of treatment, especially for new enrollees in a health plan. The policy came out of a Council on Medical Service report, which said patients “should also have the opportunity to receive continued transitional care from their treating out-of-network physicians and hospitals at in-network cost-sharing levels.”

AMA policy already supports giving patients the opportunity for continued transitional care from physicians who leave their health plan networks or whose health plan contracts are terminated without cause.

“Moving forward, the AMA should continue to provide assistance upon request to state medical associations in support of state legislative and regulatory efforts ... to ensure continuity of care protections for patients in an active course of treatment—both for existing and new health plan enrollees,” the Council wrote.

In addition, delegates approved resolutions on access to out-of-network care. Among the resolutions was an effort by hospital-based physicians and several state medical societies to hold patients harmless from costs associated with unanticipated out-of-network care and ensure incentives for insurers to contract with physicians through fair payments. Proponents said new AMA policy should address the causes of unanticipated out-of-network care as well, including inadequate networks and gaps in insurance coverage.

Under one final measure, the AMA voted to support the following:

- Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.
- Insurers must be transparent and proactive in informing enrollees about all deductibles, co-payments and other out-of-pocket costs that enrollees may incur.

- The AMA should develop model state legislation to address coverage and payment for out-of-network care.
- Out of network coverage should be established using geographic data from a benchmarking database that is independently recognized, transparent, verifiable and maintained by a non-profit organization that is not affiliated with an insurer, municipal cooperative health benefit plan or health management organization.

Early in 2017, the AMA said at least 25 state medical societies anticipate proposals to address out-of-network billing this year, specifically in the hospital-based setting. And in almost as many states, proposals could be introduced to address the adequacy of these networks to offer access to network providers.
Communication saves lives. Just ask Dr. Singh.

When Pamela felt a flutter in her chest and feared she might faint, she went straight to the ER. Emergency physician Dr. Singh discovered a suspicious finding on Pamela’s EKG, and sent an image of the recording to the on-call cardiologist via DocbookMD. The cardiologist quickly confirmed SVT, a condition requiring immediate medical intervention. The potentially life-threatening episode was resolved within minutes—rather than hours—and Pamela was safely discharged home. All thanks to some quick thinking and the secure mobile app, DocbookMD.

DocbookMD is a free benefit of your CMS membership. Learn more about the app at docbookmd.com.
The Better Care Reconciliation Act

Explaining the most significant changes in the Senate bill to repeal and replace Obamacare

By Sidney Welch, Esq., and Peter Critikos

On June 22, 2017, the U.S. Senate unveiled a draft version of its highly anticipated healthcare reform bill dubbed the Better Care Reconciliation Act (BCRA). Like the House of Representative’s American Health Care Act (AHCA), the BCRA represents Republican-led efforts to “repeal and replace” the Patient Protection and Affordable Care Act (ACA) enacted during the Obama administration. While the Senate’s bill leaves many of the ACA’s provisions intact, it limits their effectiveness by significantly decreasing federal funding. The Senate has not yet mustered sufficient support to pass the BCRA, due in part to public dissatisfaction stemming from a Congressional Budget Office (CBO) report issued on June 26, 2017.

The CBO’s comprehensive analysis found that the BCRA would reduce the cumulative federal deficit by $321,000,000,000 between 2017 and 2026, but would also leave 22 million Americans uninsured by 2026. Consequently, Senate leadership has delayed voting until after the July 4 recess. Whether the BCRA will ultimately become law (at least in its current form) is uncertain. Nevertheless, its enormous ramifications for the healthcare landscape necessitate careful study. Below we outline significant changes.

Insurance Market

The BCRA outlines several changes to the insurance market including subsidies, mandates, interim relief for States, tax repeal, health savings accounts and defunding of Planned Parenthood. Details on each of these areas are outlined below.

Insurance Subsidies

As the law stands, applicable taxpayers with incomes between 0-400% of the federal poverty level qualify to receive a tax credit to subsidize the cost of their health insurance premiums. Starting in 2020, premium tax credits will be tied to age, geography, and income for individuals who earn between 0-350% of the federal poverty level. States can design their Medicaid plans to cover individuals who fall outside of this spectrum. Additionally, tax credits under the BCRA would be benchmarked to a less generous plan than the silver plans offered under the ACA. The silver plans under the ACA have an actuarial value of 70%, meaning enrollees pay for an average of 30% of their health care expenses.

Under the BCRA, individuals receiving a tax credit must enroll in a plan with a 58% actuarial value, meaning they will pay an average of 42% of their health care expenses.

Individual and Employer Mandates

The BCRA would effectively repeal the ACA’s individual and employer mandates by eliminating the penalties for not acquiring minimum essential coverage (individual mandate) or for not offering adequate minimum essential coverage to full-time employees (employer mandate).

Interim Relief

The BCRA would establish a “short-term” fund to help States transition into the post-ACA regime. For each calendar year 2018 and 2019, the CMS Administrator would disperse $15 billion among the States to provide financial subsidies to insurance providers to help stabilize insurance premiums and “to promote state health insurance market participation and choice in plans offered in the individual market.” The money allocated to the fund would decrease to $10 billion for calendar years 2020 and 2021. Additionally, the BCRA would create a similar “long-term” fund through calendar year 2026. Money allocated to this fund would range between $4 billion and $14 billion annually and (in addition to the purpose cited for the short-term fund) would be used to provide financial assistance to help high-risk individuals enroll in a health insurance plan in the individual market; to provide payments to health care providers for the provision of health care services; and to provide subsidies to help reduce out-of-pocket costs for enrollees in the individual market.

Tax Repeal

The BCRA would repeal or reduce many of the taxes implemented by the ACA at various intervals, including: the net investment tax, the prescription medicine tax, the over-the-counter medicine tax, the medical device excise tax, the chronic care tax, and the tanning tax. Taxes on distributions to health savings accounts (HSAs) not used for qualified medical expenses would decrease from 20% to 10%, and taxes on distributions to Archer HSAs would decrease from 20% to 15%. The BCRA would also lift the $2,500 contribution limitation to health savings accounts (HSAs) not used for qualified medical expenses would decrease from 20% to 10%, and taxes on distributions to Archer HSAs would decrease from 20% to 15%. The BCRA would also lift the $2,500 contribution limitation on flexible savings accounts. Additionally, it would delay the Medicare tax increase for high-income earners until 2022 and the Cadillac Tax for high-cost employer sponsored plans until 2026.

Health Savings Accounts (HSAs)

In addition to the HSA tax reductions, the BCRA would increase the HSA annual contribution limits for self-only and family coverage to match the out-of-pocket limits for HSA-qualified high deductible health plans (HDHPs). As a result, individuals filing single
could contribute annual amounts of up to $6,500, and those with family coverage could contribute up to $13,100. The BCRA would also allow spouses, irrespective of the HSA owner, to make catch-up contributions to the same HSA. Finally, for eligible medical expenses, “as long as the HSA is established within 60 days of the date of coverage under the eligible high deductible health plan begins, any medical expenses incurred after the coverage date of the high deductible plan will be considered eligible medical expenses regardless that the expenses may be incurred prior to the establishment of the HSA.”

Defunding of Planned Parenthood and Similar Entities
For a one-year period, States cannot disburse federal funding to “prohibited entities,” defined as: (1) a not-for-profit entity; (2) described as an essential community provider primarily engaged in family planning services, reproductive health, and related medical care; (3) providing abortions in cases that do not meet the Hyde amendment exception for federal payment; and (4) that received more than $350 million in Medicaid expenditures (both federal and state) in FY2014.

Medicaid Provisions
The BCRA outlines several changes to Medicaid provisions including presumptive eligibility, phase-out federal funding for Medicaid expansion, DSH-funding for non-expansion States, retroactive eligibility, safety net funding for non-expansion States, and more. Details are outlined below.

Presumptive Eligibility
Effective Jan. 1, 2020, hospitals will no longer have the option to offer presumptive eligibility to the Medicaid expansion population.

Phase-Out Federal Funding for Medicaid Expansion
The BCRA would retain the ACA adult expansion category as optional. However, beginning Jan. 1, 2020, the BCRA would gradually eliminate the enhanced federal funding for expansion states. By 2023, federal funding would only be available at the State’s normal matching rate. The Senate bill would also sunset the essential health benefits standards after Dec. 31, 2019, leaving states free to tailor coverage requirements for the expansion population.

DSH-funding for Non-Expansion States
To “restore fairness in DSH allotments,” the BCRA would: (1) waive scheduled DSH payment reductions in non-expansion states, and (2) increase DSH allotments in FY2020 for non-expansion states whose per capita FY2016 Medicaid DSH allotment amount was below the national average per capita FY2016 Medicaid DSH allotment amount. Presumably, all non-expansion states would have a per capita FY2016 Medicaid DSH allotment below the national average. Expansion States would not receive any reprieve from pending DSH payment cuts under the BCRA. The draft is unclear as to whether an expansion state could become a non-expansion state to qualify for these benefits.

Retroactive Eligibility
The BCRA would reduce retroactive eligibility for Medicaid coverage from three months to one.

Safety Net Funding for Non-Expansion States
The BCRA would allow non-expansion states to adjust payment amounts for safety net providers so long as the payment adjustment does not exceed the provider’s costs in furnishing health care services to its indigent, uninsured patients. Additionally, the federal medical assistance percentage applicable to the payment adjustments would increase to 100% in FY2018 through FY2021 and 95% in FY2022 with an annual cap of $2,000,000,000. Each non-expansion state’s annual allotment would be determined according to the number of individuals in the state with income below 138% of the federal poverty line in 2015 relative to total number of individuals with income below 138% of federal poverty line for all the non-expansion states in 2015.

Eligibility Redeterminations
The Senate draft incentivize States to conduct Medicaid eligibility redeterminations for program enrollees at least once every 6 months by offering as consideration a 5% increase in its federal matching percentage for administrative activities.

Optional Work Requirement
The BCRA would permit states to impose a work requirement as a condition of Medicaid eligibility for nonelderly, non-pregnant, nondisabled enrollees. States would receive a 5 percentage point increase in their federal match for administrative activities for implementing this provision.

Provider Taxes
The Senate draft would gradually decrease the Medicaid provider tax threshold from the current rate of 6% to 5% by 2025.

Per Capita Cap Model
Under the BCRA, States would receive federal funding for their Medicaid programs through a per capita cap model starting in FY2020. Each state would select 8 consecutive quarters between FY2014 and the third quarter of FY2017 (subject to modification by the Secretary of Health and Human Services (HHS)) to serve as a base period to set targeted spending for each Medicaid enrollment category. The state’s targeted spending amounts would increase annually by the applicable annual inflation factor. For fiscal years after 2024, the annual inflation factor would drop to the consumer price index for all urban consumers.

“While the Senate bill leaves many of the ACA’s provisions intact, it limits their effectiveness by significantly decreasing federal funding.”
In calculating the cap amounts, the BCRA would exempt certain state expenditures including DSH-payments, non-supplemental payments, and safety-net provider payment adjustments in non-expansion state as well as certain population groups such as CHIP enrollees, Indian Health Services beneficiaries, eligible individuals with breast or cervical cancer, partial benefit enrollees, and blind or disabled children aged 18 or younger.

If a state has excess aggregate medical expenditures for a fiscal year, the federal government can recoup the excess amount by lowering subsequent payments in the next fiscal year. Additionally, the Senate bill would impose a penalty on states with DSH allotments 6 times the national average as of FY2016 that also require political subdivisions to contribute to State Medicaid funding. To “promote program equity,” the BCRA also imposes a 2% downward adjustment in federal payments for states (certain “low density” population states excluded) whose per capita spending in a fiscal year exceeds the national mean by 25% or more.

Block Grant Option
Beginning in FY2020, states may forego federal funding through the per capita cap model if the HHS Secretary approves a State's application to start a Medicaid Flexibility Program. Before the Secretary could approve an application, the State would need to make it publically available for a 30-day notice and comment period. Following approval, States would receive a block fund (a predetermined fixed amount of federal funding) to cover health expenses for non-elderly, nondisabled, non-expansion adults.

For the first fiscal year a state has a Medicaid Flexibility Program, the block fund amount would equal the State's federal average medical assistance matching percentage for that year multiplied by the product of the target per capita medical assistance expenditures for the non-elderly, nondisabled, non-expansion adult enrollees and the number non-elderly, nondisabled, non-expansion adult enrollees in the category for the following fiscal year by the percentage increase in the state population over that one-year span. For subsequent years, States' block grant amount would equal the amount from the previous fiscal year increased by an annual inflation adjustment factor.

States can obtain “rollover funds” if the state satisfies a maintenance of effort requirement and also retains the Medicaid Flexibility Program in the following fiscal year. States that fail to meet the maintenance of effort requirement would suffer a reduction in their block grant amounts for the next fiscal year. States that elect to receive federal funding through a Medicaid Flexibility Program would commit to at least one program period (five consecutive fiscal years), though states may terminate the program if the Secretary approves a transition plan.

Under a Medicaid Flexibility Program, States would still provide assistance to mandatory category enrollees. Additionally, the BCRA identifies mandatory services the funds would have to cover, including inpatient and outpatient hospital services, nursing facility services, family planning services and supplies, nurse midwifery services, and certified pediatric and family nurse practitioner services, among others. States would have the option to cover additional services.

Medicaid and CHIP Quality Bonuses
In FY2023 through FY2026, States that are able to satisfy a set of child and adult quality measures while also spending lower-than-expected aggregate Medicaid expenditures during an annual performance period would receive a bonus payment in the form of additional federal funding. The quality bonus payment allotments for all states would total $8,000,000,000 for the four-year period.

Grandfathering Certain Medicaid Waivers
The BCRA would allow states operating “grandfathered managed care waivers” to continue to furnish services under the waiver so long as the terms and conditions of the waiver are not modified. The relevant provision defines “grandfathered managed care waivers” as “a waiver or experimental, pilot or demonstration project relating to a state's authority to implement a managed care delivery system, which (1) has been approved by the HHS Secretary under SSA Section 1915(b), SSA Section 1115(a)(1), or SSA Section 1932, as of Jan. 1, 2017; and (2) has been renewed by the HHS Secretary at least once.”

Miscellaneous
The BCRA also includes three special changes that are outside of the insurance market and Medicaid. These three are:

Opioid Crisis
The Senate bill would appropriate $2 billion for FY2018 to the HHS Secretary to assist states in combating the opioid crisis. Funds would be available until expended.

Community Health Center Program
The BCRA would provide an additional $433 million in FY2017 to the Community Health Center Fund.

Age Variation in Insurance Premiums
Starting in FY2019, the BCRA would establish an age rating ratio of 5:1 for adults. As such, health insurers could charge a 64-year-old individual as much as five times the premium they would charge a 21-year-old individual for the same plan. Under the ACA, the rating ratio is set at 3:1.

Sidney Welch, Esq., practices in the Atlanta office of Polsinelli, a firm with 20 offices nationwide; Peter Critikos is a third-year law student at Emory University School of Law, also in Atlanta.
UNDERSTAND the new model of ACOs

This book is intended for individuals involved in the formation, maintenance, or deconstruction of a physician-owned ACO. Real-life applications involving physician-owned ACOs are used to educate the reader, as the authors leverage their vast experience as lawyers and physicians in creating ACOs.

ACOs pose difficult issues because of their accountability for the quality, cost, and overall care of Medicare beneficiaries. The ABCs of ACOs encapsulates the most applicable knowledge available on how these healthcare organizations will work within a model of payment and care that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients.

This book provides an understanding of both the one-sided (sharing savings, but not losses, for the entire term of the first agreement); and two-sided CMS models (sharing both savings and losses for the entire term of the agreement); and the payment models (capitation, fee-for-service with asymmetric or symmetric shared savings).

CHAPTERS INCLUDE:

- ARRA/HITECH/HIPAA and the Business Associate Agreement
- Federal and State “Fraud and Abuse” Laws and Medical Ethics
- Antitrust Matters
- ACOs and Respondeat Superior
- Impact on Bundle Payments and Value-Based Purchasing

2014, 129 pages, 6” x 9”
By Raymund C. King, Martin R. Merritt, John Okray and Rachel V. Rose
$79.95 / $65.95 for ABA Health Law Section Members

Go to www.shopABA.org to order, or phone 1-800-285-2221
Survey: Physician Attitudes Shift to Single Payer

Poll adds voice of physicians to health care debate

MID THE GROWING uncertainty surrounding health care reform, the Chicago Medical Society recently polled both members and non-members for their views on different health care policies and payment models. Of the 5,451 physicians contacted via email, 1,060 participated in the optional survey, which consisted of nine questions. All the respondents practice in Cook County and adjacent “collar counties.” Survey data was collected March 31, 2017, through May 26, 2017.

The survey was conducted at the request of the CMS Governing Council, by a specially appointed presidential ad hoc committee. All results reflect the opinions of the physicians who chose to participate, not the policies of the Chicago Medical Society. The data is being reviewed by several CMS committees, which will make recommendations to the Council.

Unfavorable View of AHCA

Nearly four in five physicians (77%) who responded to the Chicago Medical Society survey (1,060) said they are opposed to the American Health Care Act (AHCA), which passed last May in the U.S. House of Representatives. As the U.S. Senate considers the health care reform bill, an increasing number of physicians say they support a single-payer “Medicare-for-All” form of health insurance.

The AHCA, which would roll back the Medicaid expansion in 31 states, including Illinois, was viewed positively by just 23.4% of physicians who said they have a “generally favorable” view of the legislation, while 77% of respondents in Cook and its Illinois collar counties said they have a “generally unfavorable” view of the legislation.

Physicians voice support for single payer and also express support for the Affordable Care Act (ACA) with some fixes. In the Chicago Medical Society survey, Chicago-area respondents had a “generally favorable” view of the ACA, at 62.7%, and even more, or 66.8%, had a “generally favorable” view of a single-payer financing health care system. Given a choice between single payer, an improved ACA, and the AHCA, Chicago physicians favored a single payer approach by 2 to 1 over the ACA, and by 3 to 1 over the AHCA.

Chicago-area physicians’ more positive views of single-payer financing comes as attitudes shift on the issue. Not long ago, the California Senate approved a “Medicare for all-type/single payer bill.”

Physicians Split on Private Insurer Role

Physicians are divided on whether the private insurance industry should play a role in the future delivery of medical care, the Chicago Medical Society analysis shows. Of those surveyed, 50.3% either “disagree somewhat” (24.8%) or “disagree strongly” (25.5%) with private insurance companies continuing their role in the U.S. health care system, while 49.7% either “strongly agree” or “agree somewhat” that private insurers should be involved. In other highlights:

- 87.6% of physicians think “basic health care should be available to all individuals as part of the social contract, a right similar to basic education, police and fire protection.”
- 59.5% of physicians “agree strongly” (15.2%) or “agree somewhat” (44.3%) that people currently have access to the medical care that they need.

The authors suggest that future studies include a larger number of physicians practicing in rural or less populated areas throughout the state. Expanding future surveys to include other states and enlarging the participant pool to include all medical professionals could also provide valuable insight.

The poll comes as policymakers and Congress are considering reforms to the U.S. health care system, which were debated and discussed by physicians in Chicago during the American Medical Association’s meeting June 10-14.
Respondent Demographics: Primary Practice Location

- Rural: 2.30%
- Urban: 64.51%
- Suburban: 33.19%

Respondent Demographics: Political Party Affiliation

- Independent
- Republican
- Democrat
- Other
Respondent Demographics: Primary Specialty

Which of the following structures would offer the best health care to the greatest number of people for a given amount of funding? (n=714)

Occupational medicine, pathology, and family practice subspecialty had responses under 2%.

American Health Care Act (AHCA) 18.49%
Affordable Care Act (ACA) 25.91%
Single Payer 55.60%
Which of the following structures would you prefer for health care system financing?

**Repeal of Affordable Care Act**
- Generally Unfavorable: 76.61%
- Generally Favorable: 23.39%

**Repeal and replace ACA with American Health Care Act**
- Generally Unfavorable: 37.29%
- Generally Favorable: 62.71%

**Affordable Care Act**
- Generally Unfavorable: 33.24%
- Generally Favorable: 66.76%

**Single Payer**
- Generally Unfavorable: 0%
- Generally Favorable: 100%
AMA: Health Reform at the Crossroads

While Congress considers legislation, CMS moves new policies and protections across the finish line at House of Delegates

As U.S. Senate Republicans met to fashion their own bill to repeal the Affordable Care Act, the Chicago Medical Society was hard at work advancing physician-led reforms through the American Medical Association’s House of Delegates. The annual meeting saw CMS joining nearly 200 state and medical specialty groups in Chicago on June 10-14.

Not only did the Chicago Medical Society author several public health measures but CMS also gave testimony in support of new policies to reduce costly, complex regulations on medical practice. Chicago physicians also got an inside view of the national policy and political issues at play.

Throughout the health system reform debate, the AMA has offered health reform objectives to guide Capitol Hill discussions. The AMA strongly urged Senators to adopt a different course than the House-passed legislation known as the Better Health Care Act, which the AMA said violates the precept of *Primum non nocere*. Under the House legislation, 23 million people could lose insurance coverage, according to the CBO estimate.

Both the House and Senate employ the reconciliation process by which budgetary issues can be settled with a simple majority vote instead of a 60-vote Senate majority. It’s a Byzantine process that does not allow for inclusion of all the AMA policies and principles, AMA Senior Vice President of Advocacy Richard Deem told delegates during one session.

AMA objectives state that reforms should not result in individuals with health insurance losing access to affordable, quality coverage. This stance has also said that Medicaid, CHIP and other safety net programs should be adequately funded; and that key market reforms, such as pre-existing conditions, be maintained.

At the June meeting, delegates opposed proposals to convert the Medicaid program into a predetermined formula based on per-capita-caps or block grants. These caps would make it difficult for states to respond to unanticipated costs or public health epidemics, such as the opioid abuse crisis.

The AMA also said that middle- and low-income patients could struggle due to reduced insurance subsidies and the increased likelihood of waivers of important protections such as required benefits, actuarial value standards, and out-of-pocket spending limits.

Below are key highlights from the annual HOD meeting.

**Public Option**

Amid health system reform debate, the AMA voted to explore the feasibility of a public option “as part of a pluralistic health care delivery system.” Delegates who voted to add a public option to the menu of insurance plans clarified that their goal was universal coverage, not single-payer, and not a mandate.

The public option would create a government health plan that would compete with private health plans in the marketplace. The AMA opposed this idea when it emerged as an issue in the 2009 debate over the legislation that became the Affordable Care Act.

**Medicare Payment and RAC Audit Reform**

This resolution directs the AMA to pursue legislation or regulation so that post-payment audits are conducted fairly. The AMA will also seek a mechanism by which prepayment and post-payment audit denials can be resolved via phone or other electronic means. In addition, the audit process should give far more weight to the treating physician’s determination of medical necessity, the AMA said.

**Medicare’s Appropriate Use Criteria**

This resolution directs the AMA to continue to advocate for a delay in the effective date of the Medicare AUC Program until the Centers for Medicare and Medicaid Services can adequately address technical and workflow challenges with implementation and interaction between the Quality Payment Program and use of advanced diagnostic imaging AUC.

**MACRA**

The AMA will advocate for appropriate scoring adjustments for physicians treating high-risk beneficiaries in MACRA and urge the federal CMS to continue to study whether MACRA creates disincentives for physicians to provide care to sicker patients.

**Maintenance of Certification**

The AMA will advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for MOC Part IV.
New language also directs the AMA to recognize that life-long learning for a physician is best achieved by ongoing participation in a program of high-quality continuing medical education appropriate to that physician's medical practice as determined by the relevant specialty society.

**New Psychoactive Substances**
The AMA voted to support multifaceted, multiagency approaches to combat new psychoactive substances (NPS). These steps include increased surveillance and early warning systems, funding for federal and state agencies, and continuing medical education for physicians. The emergence of NPS products in recent years poses unknown dangers and potentially high death tolls.

Many NPS products are unregulated and often marketed to young people as bath salts, plant food or incense, and some may include variations of fentanyl. Drug traffickers continue to find ways to circumvent federal drug laws by making slight alterations to the chemical structure of their products and designing new synthetic drugs.

AMA delegates voted also the Synthetic Drug Control Act of 2017 (HR 1732) a bill that would require the U.S. attorney general to classify as Schedule I about 250 new synthetic substances identified by the DEA since 2012.

**Retail Health Clinics**
New AMA policy says that any individual, company or other entity that establishes or operates retail health clinics should follow specific guidelines. For example, clinics must help patients who do not have a PCP to identify one in the community; use electronic health records to transfer the patient’s medical records to the PCP and other providers with the patient’s consent; produce patient visit summaries for transfer to other physicians and providers in a meaningful format; work with PCPs and medical homes to support continuity of care and follow-up care; should not expand their scope of services beyond minor acute illnesses; and finally, list their services and the qualifications of their professionals before providing care.

**Drug Price Controls**
The AMA adopted new policy calling on pharmaceutical companies to list the suggested retail prices of drugs in direct-to-consumer ads, and to urge federal regulators to include that requirement. One study found a 34% increase in prices for prescription drugs advertised directly to consumers. For other medications, the increase was 5%.

New AMA policy also addresses the sudden increase in the cost of naloxone. The AMA voted to increase awareness after several makers of naloxone sought the help of physicians, community groups and elected officials to raise awareness and insurance coverage of naloxone.

However, these same makers then suddenly and significantly boosted the cost of the drug after public policy changes increased access to naloxone, the AMA said. The AMA also said it will support legislative, regulatory and advocacy efforts to improve access to affordable naloxone.

**Gun Policy**
The AMA voted to amend two policies to eliminate the usage of the phrase “gun control.”

The original resolution, which came from the Illinois delegation, asked the AMA to use the phrase “gun violence mitigation” in lieu of “gun control” when referencing gun violence reduction laws and legislation or related efforts.

“Removing politically charged language from gun violence discussions will allow for a better-defined focus on reasonable solutions to this public health crisis,” the delegation wrote. The term “gun control” connotes to some individuals the restriction of Second Amendment rights. Yet the medical community's interest in firearm policy primarily concerns the prevention of death and injury.

The AMA Interim Meeting is scheduled for Nov. 11-14, 2017, at the Hawaii Convention Center, Hilton Hawaiian Village Waikiki Beach Resort, Honolulu. For information, visit https://www.ama-assn.org. Members of the Illinois delegation to the AMA House of Delegates influence policy through their participation on reference committees. Chicago physicians joined nearly 200 state and specialty associations at the June 10-14 meeting.
Calendar of Events

AUGUST

19 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. 8:30-9:00 a.m. CMS Building, 33 W. Grand Ave., Chicago. For information, contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

19 CMS Board of Trustees Meeting
Meets every other month to make financial decisions on behalf of the Society. 9:00 – 11:00 a.m. CMS Building, 33 W. Grand Ave., Chicago. For information, contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

SEPTEMBER

12 CMS Council/Annual Dinner
The Society’s governing body meets four times a year to conduct business on behalf of the Society. Following the Council meeting, CMS will install the 2017-2018 leadership team and present awards to outstanding physician members. 6:00-9:00 p.m., Maggiano’s Banquets Chicago, 111 W. Grand Ave. To RSVP, please contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

16 The Polish-American Medical Society Annual Physician Ball
The Ritz-Carlton Chicago, Time TBD.

20 CMS Executive Committee Meeting
Meets every other month to make financial decisions on behalf of the Society. 9:00 – 11:00 a.m. CMS Building, 33 W. Grand Ave., Chicago. For information, contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

OCTOBER

21 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. 8:30-9:00 a.m. CMS Building, 33 W. Grand Ave., Chicago. For information, contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

21 CMS Board of Trustees Meeting
Meets every other month to make financial decisions on behalf of the Society. 9:00 – 11:00 a.m. CMS Building, 33 W. Grand Ave., Chicago. For information, contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

NOVEMBER

7 CMS Council Meeting
The Society’s governing body meets four times a year to conduct business on behalf of the Society. The policymaking Council considers all matters brought by officers, trustees, committees, councilors, or other CMS members. 6:00-9:00 p.m., Maggiano’s Banquets Chicago, 111 W. Grand Ave. To RSVP, please contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

11-14 AMA Interim House of Delegates Meeting
Hawaii Convention Center, Hilton Hawaiian Village Waikiki Beach Resort, Honolulu, Hawaii.

16 CMS Executive Committee Meeting
Meets once a month to plan Council meeting agendas; conduct business between quarterly Council meetings; and coordinate Council and Board functions. 8:30-9:00 a.m. CMS Building, 33 W. Grand Ave., Chicago. For information, contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

14 CMS Holiday Reception
Place and time TBD.

16 CMS Board of Trustees Meeting
Meets every other month to make financial decisions on behalf of the Society. 9:00 – 11:00 a.m. CMS Building, 33 W. Grand Ave., Chicago. For information, contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

DECEMBER

14 CMS Holiday Reception
Place and time TBD.

16 CMS Executive Committee Meeting
Meets once a month to plan Council meeting agendas; conduct business between quarterly Council meetings; and coordinate Council and Board functions. 8:30-9:00 a.m. CMS Building, 33 W. Grand Ave., Chicago. For information, contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

16 CMS Board of Trustees Meeting
Meets every other month to make financial decisions on behalf of the Society. 9:00 – 11:00 a.m. CMS Building, 33 W. Grand Ave., Chicago. For information, contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

Working With the Bar

THE CHICAGO Medical Society and the American Bar Association have established a formal relationship to address medical-legal issues affecting CMS members and their practices. This legal section is sponsored by the Health Law Section of the American Bar Association.

For CMS members this means that you get monthly articles from legal experts who specialize in health law. The articles will focus on subjects of current interest to the medical profession as well as new laws and regulations as they are implemented. The authors will vary every month in order to bring you the best information possible from the attorney who specializes in the subject matter.

If you have a particular question or would like more information on a subject, please send us your suggestions. You can send an email to Elizabeth at esidney@cmsdocs.org.
Personnel Wanted

- Anesthesiologist for D & C
- Ob-Gyn for D & C and Tubal Sterilization
- Urology primarily for Vasectomy
- Family Medicine Physician for D & C and Birth Control

Family Planning and Birth Control Centers, 1-3 days per week in Wood Dale, Downers Grove, Glen Ellyn and Chicago (Motor Row District). Please send CV and salary requirements by fax to 847-398-4585 or send CV via email to administration@officegci.com and vino878@aol.com.

Practice for Sublease

15-year-old family and pediatric group practice in a very busy, high-traffic area of Lombard, IL. Fully equipped with modern exam rooms. Practice is turnkey operation, functioning clientele. Doctor will stay a few months to introduce. Please call 773-895-4647 or email limramedical@gmail.com.

For sublease: fully equipped medical office available in the prime location of Chicago Loop. Available on Tuesday, Wednesday and/or Thursday, two or three days optional. Flat rate of $3000.00 for three days, includes CAM and real estate taxes. Call 708-957-7432 or email: cscale@associatedallergists.net.

Business Services

Physicians’ Attorney—experienced and affordable physicians’ legal services including practice purchases; sales and formuations; partnership and associate contracts; collections; licensing problems; credentialing; estate planning; and real estate. Initial consultation without charge. Representing practitioners since 1980. Steven H. Jesser 847-424-0200; 800-424-0060; or 847-424-0200 (mobile); 2700 Patriot Blvd., Suite 250, Glenview, IL 60026-8021; shj@sjesser.com; www.sjesser.com.
A Rare Breed of Physician

Practicing physician and private practice owner spends the majority of her time helping patients and giving back to her profession

By Cheryl England

A PRACTICING internal medicine physician and owner of her own private practice—Quality Primary Care in Chicago—Niva Lubin-Johnson, MD, is a rare breed. She started out at Creighton University in Omaha, NE, with the idea of becoming a biology major and following a pre-med program. “In the end, I earned my BS in pharmacy,” she says. “I had thought about opening my own pharmacy but the ease of doing that was changing—and not for the better.”

As a result, Dr. Lubin-Johnson attended Southern Illinois University School of Medicine to earn her MD in 1984. After her residency at St. Joseph Hospital in Chicago and a two-year stint working at HMOs, Dr. Lubin-Johnson jumped feet first into starting her own practice. “I had always had an interest in business,” she says. “At Creighton, I took six of seven courses required for a certificate of business before the school stopped the program. And through the years I’ve continued taking courses in the business of medicine.”

Although Dr. Lubin-Johnson finds running her own private practice a challenge these days due to the rapid changes in health care delivery, she wouldn’t opt to work any other way. “I like being my own boss,” she says. “Plus, I have been able to hire the equivalent of 2.25 employees. I consider that a small contribution to the community.”

Dr. Lubin-Johnson is also unusual in that, despite running her own practice, she is still able to devote 90% of her work day to seeing patients—a fact that she partially credits to electronic health records. “EHRs give me the ability to do many things outside of office hours,” she says. “I can do things such as order prescription refills and sign off on labs and x-rays without cutting into my patient time.”

Her reward for spending off-hours on patient details is the joy she gets from taking care of her patients. “Sometimes I am even able to help with issues outside of direct health care,” she says. “For example, senior patients sometimes need help to make sure they get the care they need,” she says.

“They may need help getting to appointments or getting medications. They may need help keeping the family informed and involved in their health care.”

Dr. Lubin-Johnson doesn’t take her 25 years as a successful practicing physician for granted either. As a way of giving back, she is actively involved in numerous professional societies such as the Chicago Medical Society, the American Medical Association, and the Illinois State Medical Society among others, holding key positions in most of them. One of her most treasured positions was as Chair of the American Medical Association’s Minority Affairs Section Governing Council for two years running. “I’ve been blessed in so many ways,” she says. “The Chair is an elective process. I’ve put in work but it’s an incredible honor to have your peers think enough of you to elect you to such an important position. I have a lot to be grateful for!” She was also elected to serve on the AMA Women Physicians Section Governing Council for a two-year term beginning in June 2017.

Dr. Lubin-Johnson’s Career Highlights

Dr. Lubin-Johnson has been a clinical instructor at the University of Illinois and a senior attending physician at Mercy Hospital and Medical Center and Advocate Trinity Hospital. She has also served as a physician advisor and currently serves as a medical consultant. She has held a wide variety of leadership positions including president of the Cook County Physicians Association, president of the Prairie State Medical Society, chair of the National Medical Association board of trustees, and chair of the board of trustees of Chicago State University among others.
Keeping the game fair...

...so you’re not fair game.

Your Illinois medicine
is getting hit from all angles.

You need to stay focused and on point—
confident in your coverage.

Get help protecting your practice,
with resources that make important
decisions easier.
Experts & Advocates in Liability Protection

For Illinois practitioners, we’re experts and advocates in medical liability insurance. Our licensed staff provides answers and support, while our agency sponsors the legislative advocacy and educational programs of the Chicago Medical Society.

We’re run by physicians for physicians, and you’ll appreciate the difference true professionalism can make.

CMS Insurance
A SUBSIDIARY OF CHICAGO MEDICAL SOCIETY

FOR MORE INFORMATION, PLEASE CALL US AT 312.670.2550 OR VISIT US ONLINE AT www.cms-ins.com