Medical liability coverage that always goes the extra mile.

ISMIE.

When it comes to providing the best medical liability insurance for your group, ISMIE is with you for the long run. ISMIE’s group 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 will be there for them every step of the way. That’s the ISMIE difference.

Protecting the practice of medicine since 1976.

If you want to experience the extra mile that ISMIE goes for its policyholders, 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 Creating the Medical School of the Future
The AMA and medical schools work to shift GME to today’s patient needs.
By Bruce Japsen

18 MACRA: Implications for Physician Agreements
There will be winners and losers as the new payment system takes hold.
By Mark C. Herbers

22 A New Era for Medicaid Managed Care
Physicians may deal with more complexities but the state says more innovation as well.
By Bruce Japsen

PRESIDENT’S MESSAGE
2 Doctor Ownership Shift Signals Need for Education
By Clarence W. Brown, Jr., MD

PRACTICE MANAGEMENT
4 Second Opinion: Good Service; Cardiac Care Bundled Payments; 2017 Licensure Renewal Update

PUBLIC HEALTH
7 Fighting Opioid Abuse in Chicago; Hepatitis C: The Silent Epidemic; Chicago Wins National Award for Health Policies

LEGAL
10 Medical Malpractice and Tort Reform Environment
By Robert James Cimasi, MHA, and Todd A. Zigrang, MBA, MHA

13 Nuances in Leave Time Law
By Ryan A. Haas, Esq., and Kimberly T. Boike, Esq.

MEMBER BENEFITS
24 Resolutions Hit the Ground Running

27 Your Voice Counts!

28 Committees: At Work for You

30 Calendar of Events

31 New Members

31 Classifieds

WHO’S WHO
32 Promoting Access to Family Medicine
During his 30 years at the University of Illinois at Chicago, Patrick Tranmer, MD, MPH, has accomplished a great deal whether in clinical work as a family physician, teaching or administration. One of his longest-term positions as head of the department of family medicine allowed him and his team to build the department into a world renowned department.
A new report from the American Medical Association shows less than half of physicians now have an ownership stake in their own practices and an unprecedented number of doctors are now employees.

The AMA's analysis on practice arrangements shows the share of patient care physicians with an ownership stake in their practices has dropped below 50% for the first time, falling to 47% last year, compared to 53% in 2012.

This trend has escalated as physicians sell their practices to larger health systems or young doctors coming out of residency decide they cannot afford to start their own practice. As a result, more physicians are becoming employees of hospitals, of larger practices or of healthcare companies.

The share of employed physicians rose to 47% in 2016 from 41.8% in 2012. And for younger doctors, it’s even less likely they will work for themselves, given that 65% of physicians under age 40 worked as employees in 2016. This is a continuing and significant drop from 2012 when just about half or 51% of doctors under the age of 40 were employees.

Such employment shifts are not something to be ignored. When you work for someone else or don’t have an ownership stake, it changes your beliefs in how you practice medicine.

What we don’t know is how the shift in workforce will impact patient care and continuity of care. One school of thought is that doctors could become less productive; indeed, myriad studies over the years show this is likely to occur.

Yet the Chicago Medical Society is not standing by, waiting passively. Our legislative priorities—such as working to ensure physicians have access to their patients by making sure lawmakers and policymakers address network adequacy—are critical.

Physicians who become employees could lose some autonomy and voice depending on their employer. As health insurers increasingly shift away from fee-for-service medicine to value-based models that reward quality and measure doctors, physicians could end up as winners or as losers. Employed physicians would have less control over their ability to remain employed if they didn’t score well, for example.

Ultimately, it’s about outcomes and providing the best care. Employers will want physicians to outperform the metrics. And if doctors don’t, there could be problems down the road. The move to value-based care is still in the early stages but it is moving quickly, particularly in the commercial sector, but also on the federal level with coming quality measures under the Medicare Access and CHIP Reauthorization Act of 2015, also known as MACRA.

As employment and payment models evolve, we are proceeding with our goals to educate one another and work together on advocacy through collaboration.

Please share your thoughts with the Chicago Medical Society so we can pursue these shared goals and better represent you.
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
Second Opinion: Good Service

Quality patient care is much more than having good outcomes at an acceptable cost
By Susan Reynolds, MD, PhD

I did get my questions answered when I finally saw him, but before that I felt like the office was an orthopedic mill. The waiting room was small and not well lit with no outside lighting. The chairs were crowded very close together in spite of people having to maneuver with casts, crutches, and canes. The receptionist called me “Susan.” I signed some forms electronically, found an open chair, and waited, and waited, and waited...55 minutes until a medical assistant called “Susan” and escorted me back to a room. And again, I waited until the orthopedic fellow came in and went through my history. It was another 20 minutes until I saw the surgeon I knew. He explained the procedure in detail, then sent me to sign out at a desk that was empty, in a waiting room that was very dimly lit and empty. I had to call out to get someone to show up with the instructions to take home.

Office Setup and Staff
Although I had confidence in the surgeon, and he took time to go through everything with me, I had a bad feeling about the office setup and the staff.

AFTER THREE arthroscopic surgeries on my left knee and multiple knee injections to keep me on the tennis court, my rheumatologist said it was time for a total knee replacement. So I searched the web to find the top knee replacement specialist in the area. Two orthopedists got top scores for all of the Los Angeles area, and one of them was someone I had known since residency. And I made an appointment to see him, knowing he would answer all my questions.

“Although I had confidence in the surgeon, and he took time to go through everything with me, I had a bad feeling about the office setup and the staff.”

Small Things Make a Patient Feel Human
In my view, service matters a great deal! It only takes a small effort to make a big difference in the patient experience. Of course the surgeon needs to be an excellent communicator, explain the procedure and its risks, and listen to the patient’s concerns. It’s the small things that can add up to truly great service, like seating arrangements, appropriate wait times, keeping the patient informed, properly addressing the patient by name, even offering something to drink. Those details can make a patient feel human, not like just another “knee.”
The new proposed Episode Payment Models (EPM) focuses on cardiac care (bypass surgery and heart attacks). This is the second major push by the Centers for Medicare and Medicaid Services (CMS) to mandate bundled payments. Hospitals are being encouraged to prepare now for episode-based care delivery no matter which markets are selected for the Cardiac EPM.

“We think it’s important to keep pushing forward on delivery system reform,” said Dr. Patrick Conway, acting principal deputy administrator and chief medical officer for CMS. It is the goal of CMS to have 50% of traditional Medicare payments flowing through alternative payment models by 2018. As for the Cardiac EPM, hospitalizations for heart attacks for more than 200,000 beneficiaries cost Medicare over $6 billion in 2014. Yet for every treatment, the cost could vary by as much as 50%, the CMS said.

Additionally, the cardiac mandates may qualify physicians towards Advanced Alternative Payment Models (APMs) credit. This, too, hints at CMS’ intention to roll out more Episode Payment Models over time.

**The Components of the Proposed EPM Model**

Three major components make up the mandatory EPM proposal. These are:

1. **Cardiac Bundles.** Inpatient admissions will be paid under a bundled payment for Acute Myocardial Infarction (AMI) episodes and Coronary Artery Bypass Graft (CABG) episodes for the next five years and includes:
   - Episode length: 90 days post-discharge.
   - Mandated markets: 98 random markets.
   - Downside risks and gains: phased in over time and maxed out at 20% in the final years.
   - Target price: weighted to hospitals’ historical performance in year 1 and transitioned to one regional price in year 5.
   - Quality and patient satisfaction scores influence financial gain or downside risk.

2. **Cardiac Rehabilitation (CR) Incentives.** CMS will incentivize cardiac rehabilitation services utilization post-discharge within the 90-day episode:
   - First 11 CR services post-discharge from CABG or AMI admission: $25.
   - Remaining CR services in 90-day episode: $175.

3. **Comprehensive Care for Joint Replacement (CJR) Addition:** surgery for hip fractures was added to the current CJR mandate and will only immediately impact those hospitals in CJR mandated regions.

“Although a cardiac episode bundle presents very different challenges than a joint replacement, the way to approach the episode care redesign, standardization, and monitoring process is very similar.”

As expected, the proposed cardiac bundles are designed with very similar objectives as the CJR bundles. This includes:

- Reduce unnecessary use such as readmissions.
- Incentivize discharge placement to the appropriate care setting.
- Promote care coordination across providers.
- Improve quality through care model design and standardization.

**A Suggested Approach for Cardiac Episode Care**

Although a cardiac episode bundle presents very different challenges than a joint replacement bundle, the way to approach the episode care redesign, standardization, and monitoring process is very similar between both bundles. Start developing teams across the pre-acute, inpatient, and post-acute settings to standardize processes as well as developing teams dedicated to reporting and monitoring of outcomes and engagement of the patient across the entire episode.

Industry sources examined 2013-2014 data from the CMS under the proposed EPM. They found that 85% of hospitals would not have gains or losses exceeding $500,000 per year. However, 15%

---

### Reducing Spending

<table>
<thead>
<tr>
<th>Category</th>
<th>Costs Related to IP Stay</th>
<th>Readmissions Costs</th>
<th>Suggested Approach to Reduce Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMI</td>
<td>35%</td>
<td>22%</td>
<td>Establish an effective care continuum to prevent readmissions.</td>
</tr>
<tr>
<td>CABG</td>
<td>60-70%</td>
<td>6%</td>
<td>Most patients discharged to a SNF; develop post-acute protocols and preferred partners. Medical Device utilization.</td>
</tr>
</tbody>
</table>
of hospitals could experience significant penalties. Hospitals with higher cardiac care spending are more likely to struggle to meet CMS targets. The breakdown on how spending disbursement for each cardiac service can suggest an approach to reduce spending is shown in the table on page 5 entitled “Reducing Spending.”

Unlike the elective joint replacement patient, this cardiac episode population has greater co-existing chronic conditions and will naturally have more unplanned services and complications, which make achieving success more unpredictable. Successfully engaging patients by identifying tools and programs to assist them with adherence to treatments and medication management, compliance with cardiac rehabilitative regimens, and dietary and nutrition goal adherence could make the difference.

**How it Would Work: A Hospital Example**

Consider hospitals in model years four and five of the EPM in a region where Medicare historically spent an average of $50,000 for each coronary bypass surgery patient, taking into account the costs of surgery as well as all related care provided in the 90 days after the patient’s hospital discharge. Target prices would reflect the average historical pricing minus the discount rate based on quality performance and improvement.

Hospital A is performing at the highest overall level on quality measures and its discount rate is 1.5% for the episode. As a result, its quality-adjusted target price for bypass surgery is $49,250 (or $50,000 minus the discount of $750). By taking measures to avoid readmissions and other unnecessary costs, Hospital A is able to reduce average total hospitalization and related 90-day post-discharge costs for bypass surgery patients to $48,000. Hospital A would be paid average savings of $1,250 per patient.

Hospital B in the same region also reduces its average costs to $48,000 per patient. However, it achieves only acceptable overall performance on quality measures. Its discount rate is 3% and its quality-adjusted target price is $48,500 (or $50,000 minus the discount of $1,500). Hospital B would be paid an average savings of only $500 per patient.

Hospitals should begin to prepare now for cardiac care bundled payments. The program will start July 1, 2017.

Cathryn Johnson is a senior healthcare consultant with PBC Advisors, LLC, in Oak Brook. PBC provides business and management consulting and accounting services to physician practices, medical groups and hospital systems. For more information, visit www.pbcgroup.com.

---

**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
Fighting Opioid Abuse in Chicago

Senator Durbin’s letter to stakeholders in the war on opioid abuse is only part of the story

As part of the ongoing war against opioid abuse, U.S. Senators Dick Durbin (D-IL), Sherrod Brown (D-OH), Angus King (I-ME), Amy Klobuchar (D-MN), and Tammy Duckworth (D-IL) sent letters in mid-May urging the U.S. Drug Enforcement Administration (DEA), the Centers for Medicare and Medicaid Services (CMS), and commercial insurers to use public data to improve oversight of opioid prescribing practices and hold doctors accountable for overprescribing dangerous and addictive painkillers. The Medicare Part D Opioid Prescribing Mapping Tool, developed by CMS, provides localized data on Medicare Part D opioid prescription claims across the United States. The senators believe it could be used to identify hotspots and prevent overprescribing and diversion.

Senators Durbin and Duckworth also sent letters to Health Care Services Corporation (the parent company of Blue Cross and Blue Shield of Illinois), the Illinois State Medical Society, the Illinois Medical Licensing Board, and the Illinois Board of Dentistry asking how they have used the mapping tool to protect Illinoisans from the growing opioid epidemic. The number of people dying from opioid overdoses is on the rise, with one of the biggest increases being seen in Illinois. The Centers for Disease Control and Prevention (CDC) reported that the opioid-related death rate in Illinois rose 120% from 2014 to 2015. Specifically in Cook County, the biggest increase has been in fentanyl-related deaths. According to the Cook County Medical Examiner, there were 20 fentanyl-related deaths in 2014. In 2016, there were approximately 400.

According to the National Institute on Drug Abuse, the number of opioid prescriptions in the United States has risen dramatically from approximately 76 million in 1991 to more than 245 million in 2014. And, the United States is by far the largest consumer of these drugs — accounting for almost 100% of the world total consumption of hydrocodone and 81% of oxycodone. The increased frequency with which prescription opioids have been prescribed in recent years has played a major factor in our nation’s escalating heroin epidemic, including an alarming increase in opioid-related emergency room visits, opioid-related treatment admissions for abuse, and opioid-related overdose deaths. Between 2002 and 2013, the rate of heroin-related overdose deaths nearly quadrupled, with more than 8,200 people dying from heroin in 2013. According to the federal government's National Survey on Drug Use and Health, four out of five current heroin users report that their opioid use began with prescription opioids.

New and Innovative Programs

The letters were part of a multi-pronged approach by numerous groups to combat the growing threat. “Any successful anti-drug strategy involves three equal parts—prevention and education, treatment and enforcement,” says Special Agent-in-Charge Dennis Wichern of the Chicago Field Division of the Drug Enforcement Administration. “Senator Durbin and his peers wrote the letter as part of our strategy to improve provider awareness and their knowledge of safeguards such as how to write the correct prescription.”

While the education and prevention component includes a wide variety of programs, one is a newly designed DEA class for providers entitled “Prescription Drug Updates and Medical Provider Safeguards.” The one-hour class provides information on drug trends, safeguards for physicians and updates on opioid abuse and offers CME and GME credits. Contact Dan Gillen at Dan.j.Gillen@usdoj.gov to find out about upcoming classes. Wichern also cites the Robert Crown Center for Health Education in Hinsdale as having an excellent heroin prevention program to help keep children from even trying their first dose.

When it comes to enforcement, clearly the DEA is targeting drug gangs and cartels. The Agency has also made sure that “take back drug” boxes are available 24 hours a day, 7 days a week in law enforcement departments in the Chicago area so that patients can safely and securely dispose of drugs they no longer need.

Treatment, too, is an area that concerned citizens are targeting. Numerous groups including physicians, law enforcement and politicians are joining forces to increase the availability of Naloxone. Illinois passed Lali’s Law in 2015, allowing the drug to be sold without a prescription in pharmacies. By late 2016, more than 500 Walgreens locations had begun selling the drug with sales at CVS and Jewel-Osco locations quickly following.

Wichern also notes that innovative new programs are constantly being introduced. A program called “A Way Out” that was started in Lake County but is also now offered in Cook County is available 24/7 for anyone who seeks treatment. “The program provides a window of opportunity for anyone who has hit rock bottom and doesn’t know where to go,” says Wichern. “Patients go into a participating law enforcement agency, which will connect them with the appropriate treatment program—without fear of facing charges.” The program is often called the “angel” program because of the many devoted volunteers who sit with program participants while treatment arrangements are being made. And that’s certainly a heavenly deal for patients.
Hepatitis C: The Silent Epidemic

HHS releases updated roadmap for addressing viral hepatitis in the United States
By Jim Lando, MD, MPH, Corinna Dan, RN, MPH, Jessica A. Clark, RN, MPH, and Lesley J. Craig, MPH

AN ESTIMATED 3.5 million Americans are living with chronic hepatitis C virus (HCV). And most people who are chronically infected do not have symptoms and only about one-half are aware of their infection. In 2012, HCV-related deaths surpassed deaths from all other 60 reportable infectious diseases combined. Almost three-fourths of individuals with chronic HCV infections are baby boomers—people born from 1945 to 1965. Most were infected years ago, and present few ongoing risks for exposure or transmission to others. However, late diagnoses and missed treatment opportunities have resulted in this population experiencing the nation’s highest HCV-related death rates.

New HCV infections are on the rise in the U.S., with a 250% increase in incidence between 2010 and 2014. The rise in acute HCV infections is largely fueled by the opioid epidemic and associated injection drug use; increases disproportionately affect non-urban whites. The greatest increases in acute HCV cases have been among individuals aged 20-39. In Illinois in 2015, the rate of acute HCV cases (0.2/100,000 population) was lower than the national average (0.7/100,000 population), but it is difficult to know the true incidence due to profound underreporting. In fact, it is estimated that every reported case of acute HCV represents 14 actual cases.

Both the Centers for Disease Control and Prevention (CDC) and the independent U.S. Preventive Services Task Force (USPSTF) recommend screening for HCV in persons at high risk for infection, as well as one-time screening for HCV infection in baby boomers.

“Within clinical settings, there are missed opportunities for risk assessment, prevention counseling, testing, diagnosis, and treatment.”

Recent advances have led to the availability of highly effective treatments that can cure 90% of people, if the drugs are taken as prescribed. These effective oral therapies, which have fewer side effects than those previously available, can be given safely to people with most other chronic health conditions, and generally require only two to three months of treatment.

The physician-developed HCV guidelines (www.hcvguidelines.org) from the American Association for the Study of Liver Diseases and Infectious Diseases Society of America, state: “...from a medical standpoint, data continue to accumulate that demonstrate the many benefits, within the liver and extrahepatic, that accompany HCV eradication. Therefore, the panel continues to recommend treatment for all patients with chronic HCV infection, except those with short life expectancies that cannot be remediated by treating HCV, by transplantation, or by other directed therapy.”

Earlier this year, the U.S. Department of Health and Human Services (HHS) released the “National Viral Hepatitis Action Plan, 2017-2020” (Action Plan) which outlines strategies to fight viral hepatitis. Developed by the HHS Office of HIV/AIDS and Infectious Disease Policy, in collaboration with more than 20 federal entities, and with input from a variety of sectors, it establishes four major goals to reach by 2020:

- Prevent new viral hepatitis infections.
- Reduce deaths and improve the health of people living with viral hepatitis.
- Reduce viral hepatitis health disparities.
- Coordinate, monitor, and report on implementation of viral hepatitis activities.

The Action Plan details several challenges to tackling this immense problem. There is a major data gap, so healthcare providers often do not know HCV’s impact on their communities. Within clinical settings, there are missed opportunities for risk assessment, prevention counseling, testing, diagnosis, and treatment. Additionally, low public awareness, coupled with low perceived risk of acquiring HCV, leads to late diagnosis and treatment, transmission of HCV, and continued stigma.

The high treatment cost may prevent HCV-infected individuals from receiving care, as does stigma, which often leads individuals to avoid testing and treatment for fear of disclosing their status and subsequent discrimination. Despite these barriers, testing is critical—providers can educate HCV-infected patients on how to prevent transmission to others and talk to them about refraining from alcohol. Heavy alcohol intake contributes to HCV-associated liver disease.

Healthcare providers can play a significant role in achieving these goals by:

- Sharing this article with colleagues to increase awareness.
- Implementing screening practices aligned with the CDC and USPSTF recommendations.
- Using the new oral therapies that allow patients to experience the benefits of viral eradication and avoid liver disease and liver cancer.
- Integrating viral hepatitis services in settings where people at high risk for HCV receive other services, such as substance misuse treatment, primary care, HIV care, and mental health.

To learn more and access the Action Plan, visit: www.hhs.gov/hepatitis.

Jim Lando, MD, MPH, is an Assistant Surgeon General/Rear Admiral, U.S. Public Health Service and Regional Health Administrator at the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Health—Region V (IL, IN, MI, MN, OH, WI). Corinna Dan, RN, MPH is the Viral Hepatitis Policy Advisor in the Office of HIV/AIDS and Infectious Disease Policy at HHS. Contact them by emailing Lesley.Craig@hhs.gov.
Chicago Wins National Award for Health Policies

Chicago has been awarded a Gold Medal from CityHealth for the city’s work in developing and implementing policies that have been shown to improve health. CityHealth is an initiative by the de Beaumont Foundation, a group dedicated to transforming public health in the United States. The award comes during CityHealth’s first ever assessment of how the country’s top 40 cities fare when it comes to policies that can make real, lasting impacts in people’s everyday quality of life. Cities could receive gold, silver or bronze awards—or no award at all—based on how they fared in nine policy areas such as paid sick leave and alcohol sales control.

Only five cities out of the 40 received a Gold Award and Chicago was the only one in the Midwest region to do so. Other cities receiving the Gold Award included Boston, Los Angeles, New York and Washington, DC. CityHealth specifically recognized Chicago’s efforts to make quality pre-kindergarten universal for all children, the passage of the city’s first paid sick leave law, implementation of policies to promote walking and biking, and raising the age for purchasing tobacco products to 21.

“We have enjoyed tremendous success since launching Healthy Chicago 2.0, from raising the purchasing age of tobacco to 21 to increasing vaccination rates among young people,” said Chicago Department of Public Health (CDPH) Commissioner Julie Morita, MD, “CDPH and our partners stand ready to work with Mayor Emanuel and residents across Chicago to pursue policies that will help our children.”

In addition, Mayor Emanuel announced a series of town hall meetings as the next step forward in identifying innovative solutions that will further improve the health and well-being of Chicago’s youth. “Chicago is leading the nation when it comes to passing innovative policies to improve our health, as this gold medal and our recent successes show,” Mayor Emanuel said. “But even with these successes, there is more that we can do, especially in communities facing the greatest health challenges. I am asking CDPH and our community partners to work together to identify concrete, evidence-based policy proposals that will help even more young people grow into healthy adults.”

Five town hall meetings will be held from June to August to gather feedback from content experts and Chicago residents, including Chicago’s African American and Latino communities, which often face greater health disparities. The first meeting will be in conjunction with the monthly Chicago Board of Health meeting on June 21. Following the town hall meetings, CDPH will release a comprehensive report detailing the feedback from participants and policy recommendations.

The town halls will focus on five key areas surrounding youth health: improving homes, empowering parents, promoting vaccines, reducing obesity and mitigating trauma. This aligns with the recent Healthy Kids Spotlight report from CDPH showing that even though there has been progress in each key area, significant health disparities remain. The town halls will be held in various areas of the city. For more information, visit www.cityofchicago.org.

Online CME Now Available 24/7

- Medical Cannabis in Illinois: Legal Impact on Physicians
- Dealing with Difficult Patients
- Vendor Relationships: What Physicians Need to Know
- And many others

Whatever your health care practice, or even if you are a young professional entering the field, you need ongoing education to gain valuable insight and strategies. These CME and CLE webinars are held in conjunction with the American Bar Association. So, they are also invaluable for health care attorneys, whether new to the legal field or longtime practitioners. Offered exclusively by The Chicago Medical Society. Your resource for high-quality education.

Bundle options available at a discount for a limited time

For more information or to register please visit: http://cmsdocs.inreachce.com

For registration questions and online assistance, call the customer support line 877-880-1335. For other questions, contact the Chicago Medical Society’s Education Department 312-670-2550 ext. 338, or email: rburns@cmsdocs.org or fax to: 312-670-3646.
Medical Malpractice and Tort Reform Environment

The Protecting Access to Care Act of 2017 seeks a non-economic damages cap of $250,000 and signals the intent of the Republican-controlled Congress to push for federal tort reform. By Robert James Cimasi, MHA, and Todd A. Zigrang, MBA, MHA

Since the inauguration of President Donald Trump in January 2017, and with Republicans controlling Congress and the White House, the issue of tort reform has received heightened attention at the federal level. Industry commentators have noted that federal bills related to tort reform may have an increased probability of passage. A consideration of the current medical malpractice environment may serve to frame this highly political issue within context. This article presents a brief review of the significant elements of the tort reform debate, including the comparatively slower than expected growth in medical errors, the concentration of medical malpractice lawsuits and litigation within a subset of physicians, and the nature and extent of tort reform efforts at both the state and federal levels.

Significant increases in the volume of procedures performed by physicians over the past half century have contributed, in part, to the increase in both the risk of harm to patients and the liability exposure for physicians through medical errors, or deviations from the norms of clinical care. Since the 1999 Institute of Medicine (IOM) report that estimated that 44,000-98,000 patients died each year due to an adverse event, of which 58% were preventable (directly tied to medical error), numerous studies have concluded that the prevalence of fatal medical errors may be far greater than previously estimated. A 2011 study published in Health Affairs found that deaths stemming from adverse medical events could range as high as 400,000 per year. Additionally, a 2016 study published in BMJ by researchers from Johns Hopkins University estimated that 251,000 U.S. deaths occur annually due to medical errors, making medical errors the third-leading cause of death in the U.S.

Payout Trends

Despite increased risk exposure, the total amount and rate of indemnity payouts (damages awarded to injured parties from defendants) for instances of medical malpractice have decreased over the past 20 years. According to National Practitioner Data Bank (NPDB) data analyzed by professional liability insurer Diederich Healthcare, the total amount of damages payouts in instances of medical malpractice in the U.S. fell nearly $1 billion over the past decade, from approximately $4.8 billion in 2003 to $3.84 billion in 2016. The 2016 data reflect a decrease of 2.54% from 2015 levels, and serve as the first decline in medical malpractice payouts since 2012, which, at approximately $3.6 billion, marked the figure’s lowest level since 2003. Similarly, a separate analysis of NPDB data published by JAMA Internal Medicine found that “the rate of claims paid on behalf of all physicians declined by 55.7% from 1992 to 2014.”

The decline in both the total amount and rate of medical malpractice damages payouts may be attributable to depressed claims frequency, the rate at which insureds request protection from their insurer for actions covered under their insurance policy. According to the 2016 Annual Rate Survey Issue published by Medical Liability Monitor, claim frequency levels are at “historic lows [with] little-to-no evidence of a significant upward trend in the near future.” Although physicians infrequently pay damages awards themselves, it remains unclear whether the depressed claims frequency actually reflects decreased numbers of medical malpractice lawsuits. However, this decreased claim frequency may be attributable to the efforts by states over the past 40 years to limit noneconomic damages for this type of litigation, which may, in part, disincentivize plaintiff attorneys, who work on a contingency fee basis, from assuming the risk of representing a client in a case that will only result in a certain (capped) amount of damages.

Premium Decreases

Additionally, average professional liability insurance premiums for physicians have decreased over a similar timeframe. Data compiled from Medical Liability Monitor’s Annual Rate Survey Issue indicates that average professional liability insurance premiums for the general surgery, internal medicine, and obstetrics and gynecology specialties have decreased each year from 2005 to 2014, and have remained relatively flat from 2015 to 2016, as illustrated in Exhibit 1.

Exhibit 2 on page 12 shows that the average medical malpractice payout amounts for internal medicine and obstetrics and gynecology have decreased during the 2003 to 2008 period while payout amounts for general surgery has increased slightly during the same period. Payouts for obstetrics and gynecology showed a dramatically sharp decline during the period.

Average Rate by Period

- General Surgery
- Internal Medicine
- OB/GYN

Dollar Amount

- $200,000
- $275,000
- $350,000
- $425,000
- $500,000
Tread carefully when handling requests for leave from employees
By Ryan A. Haas, Esq., and Kimberly T. Boike, Esq.

EMPLOYERS, including medical practices and hospitals, must be aware of nuances in the laws allowing employees to take family and medical leave. New laws have been adopted starting on July 1, 2017, requiring employers to offer paid sick leave to employees in Chicago and Cook County. These laws add requirements to the existing rules under the federal Family and Medical Leave Act (FMLA). The myriad of regulations covered employers must follow range from accurately determining how to process an employee’s request for leave to deciding what is required of the employer when an employee returns from leave. Two particularly tricky issues for employers involve requests for intermittent leave and requests for leave that are unforeseeable.

The FMLA entitles a qualified employee to a total of up to 12 work weeks of unpaid leave during any 12-month period. The following must be met:

• The birth of a son or daughter of the employee and the care of such son or daughter.
• The placement of a son or daughter with the employee for adoption or foster care.
• The care of a spouse, son, daughter or parent of the employee with a serious health condition.
• A serious health condition of the employee that makes the employee unable to perform the essential functions of his or her positions.

To qualify for FMLA, the employee must have been employed for an accumulated total of 12 months and must have worked a minimum of 1,250 hours during the 12-month period before the date leave begins. An employer may request medical certification for FMLA leave.

Upon return from FMLA leave, an employee must be placed in the same position or an “equivalent position with equivalent benefits, pay, status, and other terms and conditions of employment.” The FMLA prohibits an employer from interfering with an employee’s exercise of his or her FMLA rights or retaliating against an employee for taking qualified leave under the FMLA.

Intermittent Leave
The FMLA allows a qualified employee to use leave intermittently or as part of a reduced work schedule. Intermittent leave can create difficult decisions for an employer. For instance, in a recent case, Hansen v. Fincantieri Marine Corp., an employee with debilitating depression was approved for intermittent FMLA leave based on a certification from his doctor that he could experience “about four episodes” requiring leave “every six months.” After the employee’s eighth episode in two months, the employer sent a letter directly to the employee’s doctor asking him to confirm his initial medical certification. After the doctor confirmed, the employer found that the employee’s absences exceeded the doctor’s original estimate, denied his request for additional leave and terminated the employee for too many absences.

The employee sued alleging claims of interference and retaliation. In siding with the employee, the court held that medical certification forms are merely estimates and do not establish a hard limit on the frequency and duration of intermittent leave under the FMLA. The court explained that “an estimate, by definition, is not exact and cannot be treated as a certain and precise schedule.” By terminating the employee, the employer violated the FMLA.

Unforeseeable Leave
Some additional thorny issues arise when determining an employee’s rights when the leave is deemed “unforeseeable.” For instance, in another recent case, the court held that a former employee of a nursing home did not give up her FMLA rights despite not providing an anticipated return to work date from leave because her leave was unforeseeable.

In Gienapp v. Harbor Crest, the employee submitted a request for FMLA to her employer without identifying an anticipated date she would return to work. The employer later received a doctor’s note stating uncertainty as to when the employee would be returning to work. Rather than treat the leave as “unforeseeable” and keep the employee’s position open, the employer took the note to mean that the employee would not be returning before the 12-work weeks she was entitled to under the FMLA and hired a replacement. When the employee attempted to return to work prior to the 12 weeks, she was told she no longer had a job.

The employee sued. The court held that the employer may have violated the FMLA because the employee’s leave was “unforeseeable” and she was not required to provide a firm return date when she requested the leave. The court also found that the employer failed to properly follow up with the employee and violated her FMLA rights by not returning her to an equivalent position.

Employers should tread carefully when handling requests for leave from employees. Any doubts about leave requests or reinstatement rights should be discussed with an employment attorney.

Kimberly T. Boike, Esq., (kboike@chuhak.com)
practices healthcare law at Chuhak & Tecson, PC.
Ryan A. Haas, Esq., (rhaas@chuhak.com) practices employment law affecting healthcare providers.
In this special section, two physician-turned-lawmakers share their opinions about healthcare delivery and the work that awaits the 115th Congress.
CREATING THE MEDICAL SCHOOL OF THE FUTURE

The AMA and medical schools work to shift GME to today’s patient needs

By Bruce Japsen

As fee-for-service medicine gives way to value-based care that measures physicians on everything from patient experience in the waiting room to quality and safety, medical schools are changing how they educate doctors to meet medicine’s new demands. It’s what a growing number of medical educators are calling the creation of the “medical school of the future.”

Pushed on a national level by the American Medical Association (AMA) and the Association of American Medical Colleges (AAMC), medical schools and teaching hospitals are creating new curricula, residency programs and patient-centered courses in hopes of preparing tomorrow’s physicians for the increasingly complex healthcare system. The AMA’s effort is known as the “Accelerating Change in Medical Education Consortium.” Its membership has tripled to 32 medical schools in just the last three years, adding several participants in the last year including the University of Chicago’s Pritzker School of Medicine.

New Curriculum Concepts

“While medical schools have typically done an excellent job training students on the scientific underpinning of disease, it is equally critical for physicians of the future to be equipped to function in the healthcare system so they can ensure the best care for their patients,” says Vineet Arora, MD, assistant dean for scholarship and discovery at the University of Chicago. “This is the area we are hoping to address.”

The Accelerating Change in Medical Education initiative began in 2013, providing $11 million in grants to fund innovations at 11 medical schools. Since then, the effort has continued with an additional 21 schools including the University of Chicago earning grants in 2015. “Our goal is to enable all medical schools across the country, not just those working with the AMA’s consortium, to access this innovative work and the consortium’s expertise to make sure their students become physicians who understand how patients receive and access care in today’s healthcare systems,” said Susan Skochelak, MD, group vice president for medical education at the AMA.

The University of Chicago’s grant was used to launch the “VISTA” Curriculum, which Dr. Arora said “aims to empower our medical students to effectively advocate for their patients in areas such as value, improvement, safety and teamwork through a combination of active learning experiences, including simulation, and use of mobile technology.”

Graduate medical education programs and the educators involved want to make sure physicians are trained so the residency and classroom experience reflect the needs of today’s patients. That means medical educators are teaching students to be more focused on patient outcomes and quality in an era where physicians are being measured by health insurers, employers and patients.

The first class of medical students who enrolled this past year in the University of Chicago’s new curriculum learned how value-based care and its team-based approach can work to improve patient care. These are concepts educators say aren’t generally taught during medical school.

First- and second-year medical students at the University of Chicago shadow nurses and learn how to work in teams that include a variety of caregivers they might not interact with until they’re in practice. “Our ultimate goal is to create physicians who are better able to function in our evolving healthcare delivery system,” Dr. Arora said.

Navigating Value-Based Care

Government and private insurers increasingly emphasize the importance and need for physicians to take on new roles as quarterbacks who manage the medical care needs of patient populations through accountable care organizations or other alternative payment models. The Centers for
Medicare and Medicaid Services (CMS) is shifting 50% of all Medicare payments to alternative models by 2018 and commercial insurers are shifting even more dollars toward these new models. Aetna, for example, has committed to putting 75% of its business into “value-based payment arrangements by 2020,” the insurer said.

Physicians will also be faced with quality measures from the Medicare Access and CHIP Reauthorization Act of 2015 known as “MACRA,” which bring together three existing reporting programs: the physician quality reporting system; the value-based payment modifier; and meaningful use. ACOs and other entities like patient-centered medical homes take responsibility for keeping patients out of the hospital and emergency room and helping patients manage their conditions by getting them to take their medications appropriately and coming back for needed appointments. The AMA’s policy emphasizes the physician should be leading the team.

With the quarterback role in mind, medical schools are educating doctors on how to be better navigators for their patients. Penn State College of Medicine, for instance, three years ago launched a new “Systems Navigation Curriculum” with the help of a $1 million AMA grant. The Penn State program embeds first-year medical students through central Pennsylvania to make sure students learn “health systems science” on top of the traditional basic and clinical sciences.

AMA Chief Executive Officer James Madara, MD, a longtime former medical school dean and educator, said such new courses are needed to get students and residents out in the field because so much of medical training historically has been hospital-based even though most care is provided in outpatient settings, particularly for Americans suffering chronic conditions.

“We know that the way health care is being delivered is changing, but until now those changes have not been widely incorporated into the way we teach our physicians,” Dr. Madara says. “Our medical schools are very good at preparing students for the basic and clinical sciences that are paramount to providing care to patients, but what is largely missing is how to deliver that care in a complex health system.”

Some medical schools are creating new degrees as part of their efforts to transform a curriculum. Brown University, which also received $1 million in AMA grant money, created a Primary Care-Population Medicine degree. The Brown program awards graduates Doctor of Medicine and Master of Science in Population Medicine degrees as part of a four-year degree.

Both Brown and Penn State use the AMA’s new “Health Systems Science” textbook launched in late 2016 as part of the Accelerating Change in Medical Education initiative. “We collaborated with the nation’s leading medical schools to develop a formalized strategy and textbook that can be used by all medical schools to ensure that physicians in training can learn how to deliver care that meets the needs of patients in modern health systems,” Dr. Madara said.

As one example, the Penn State program includes a course known as “Foundations of Patient-Centered Care” that consists of three components: communication and clinical interviewing; physical examination and integration; and application and advancement teaching sessions, the university’s curriculum says. The Foundations course spans the first 19 months of the student’s medical school experience.

AAMC Adds Momentum

The AMA’s effort is endorsed by the Association of American Medical Colleges, which says it is also developing new ways to educate aspiring physicians and teaching faculty on the latest innovations in value-based care. “Our member medical schools and teaching hospitals are advancing innovations in medical education every day, from advancements in curricula to simulation technology to moving training for tomorrow’s doctors outside the classroom,” Alison Whelan, MD, chief medical education officer of the Association of American Medical Colleges, said in a statement to Chicago Medicine.

The AAMC says it has launched initiatives known as “Core Entrustable Professional Activities for Entering Residency” and “Education in Pediatrics Across the Continuum” that move “beyond more traditional assessment to create innovative approaches,” Dr. Whelan said.

Dr. Whelan said the AAMC’s efforts are designed to “better evaluate the readiness of physicians-in-training as they progress to the next phase of training and into independent practice.” Another AAMC program, Teaching for Quality, is a faculty development program designed to integrate quality and patient safety into traditional teaching and medical practice.

“Through our regional and national meetings, webinars, and online educational resources, the AAMC plays a key role in the dissemination of medical education innovations by providing opportunities for medical educators to present new results of education initiatives,” Dr. Whelan said. “The sharing of best practices at our meetings is a critical component to advancing medical education nationally.”

Bruce Japsen is a healthcare journalist, speaker, and author who writes for Forbes. He is the author of the book, “Inside Obamacare: The Fix for America’s Ailing Health Care System” and is an analyst on health, business and political topics for WBBM Newsradio and WTTW television’s Chicago Tonight and Fox News Forbes on Fox. He can be reached at brucejapsen@gmail.com.
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 Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) creates powerful incentives for all physicians with more than 100 Medicare patients to report quality measures, improving care measures and advancing care measures, or face a 4% fee reduction. The reporting requirements will be a new cost—one small practices will struggle to implement. Some may “go it alone” and others may finally join a group or become employed. Independent contractor hospital-based professional groups may have to gain the cooperation of their hospital client to assist with collecting, compiling and reporting some of the measures. Large specialty groups will want to develop automated collection tools while small groups may need to contract this service to an outside party. During 2017, data will need to be collected initially for a 90-day continuous period; subsequent periods may require full 12-month periods of data submission. As clinicians become more informed about MACRA, and the new costs for data submission, hospitals and larger groups can expect independent physicians, small group practices and hospital-based groups to approach them for help.

The Centers for Medicare and Medicaid Services (CMS) announced in October 2016 the final MACRA rule and transitional policies. This announcement softened language previously released in May 2016 and April 2015 and responded to thousands of comments received from concerned physicians, healthcare organizations, and elected officials.

Overview of MACRA
MACRA implements the Merit-based Incentive Payment System (MIPS) and replaces three current programs set to expire in 2018: the physician quality reporting system (PQRS), the value-based modifier program (VBMP), and the Meaningful Use of electronic health records. Licensed Medicare physicians who elect to submit measures of patient quality outcomes from their practices for a continuous 90-day period in 2017 are eligible for incentive payment adjustments to their Medicare claims in FY 2019. CMS will review the submitted data, generate a score, and award an incentive payment. MIPS incentive payments vary by year (see Table 1) and exceptional performers may be eligible for an additional positive payment adjustment.

CMS is requiring clinicians to report data in CY 2017 as a basis for making incentive compensation adjustments to program claims in FY 2019. Clinicians choosing to not participate in MIPS will receive no score and will be subject to a 4% reduction in their program claim payments in FY 2019.

Eligible clinicians have three ways to submit data to MIPS in 2017. Clinicians can choose to report to MIPS for a full 90-day period or, ideally, the full year, and maximize the their chances to qualify for a positive adjustment. In addition, MIPS-eligible clinicians who are exceptional performers in MIPS, as shown by the practice information they submit, are eligible for an additional positive adjustment for each year of the first six years of the program.

Clinicians can choose to report to MIPS for a time period of less than the 2017 full performance period, but at a minimum of the full 90-day period and report more than one quality measure, more than one improvement activity, or more than the required measures in the advancing care information performance category in order to avoid a negative MIPS payment adjustment and to possibly receive a positive MIPS payment adjustment.

Clinicians can choose to report one measure in the quality performance category; one activity in the improvement activities category, or report the required measures of the advancing care information category, and thus avoid a negative MIPS payment adjustment. If MIPS-eligible clinicians choose to not report even one measure or activity, they will receive the full negative 4% adjustment.

MIPS-eligible clinicians may be approved to participate in Advanced APMs, and if they receive a sufficient portion of their Medicare payments or see a sufficient portion of their Medicare patients through the Advanced APM, they will qualify for a 5% bonus incentive payment in 2019.

For full participation in MIPS, and to achieve the highest possible final scores, MIPS-eligible clinicians are encouraged to submit measures and activities in all three integrated performance categories: quality, improvement activities, and advancing care information. For full participation in the quality performance category, clinicians will report on six quality measures, or one specialty-specific or subspecialty-specific measure set. For full participation in the advancing care information performance category, MIPS-eligible clinicians will report on five required measures. For full

Table 1: MIPS Incentive Compensation Range

<table>
<thead>
<tr>
<th>CY</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incentive/Penalty</td>
<td>+/- 4%</td>
<td>+/- 5%</td>
<td>+/- 6%</td>
<td>+/- 7%</td>
</tr>
</tbody>
</table>
participation in the improvement activities performance category, clinicians can engage in up to four activities, rather than the proposed six activities, to earn the highest possible score of 40.

MACRA also provides for “virtual groups,” defined as solo and small practices that join together for reporting purposes. CMS is not implementing virtual groups for CY 2017. Solo and small practices that choose to submit data may seek to join larger groups; seek employment with a hospital or health system; or obtain a third-party vendor to assist with the submission of their data. Those close to retirement may elect to not participate; others may decide after assessing costs vs. the incentive benefit.

Submission Associated Costs
CMS estimated the impact by clinical specialty utilizing 2014 data as a surrogate for 2017 performance. Its analysis identified the number of clinicians, their allowed Part B charges and the estimated percent of clinicians who would have a negative adjustment to their payment rates (see Table 3). A number of clinical specialties frequently contract with hospital providers as independent contractors, through coverage agreements or employment agreements.

Some clinicians in each specialty shown in Table 3 are expected to see negative adjustments under MACRA. Some specialties such as dentistry have little activity outside of their office practice. General practice, psychiatry, plastic surgery, physical medicine, allergy/immunology and oral/maxillofacial surgery are specialties that often have on-call and coverage agreements with hospitals. Activities associated with their services rendered in the hospital/clinic setting may require coordination with the hospital/clinic for data collection. Clinical nurse specialists and nurse anesthetists are commonly employed by hospitals. Data collection and submission for these clinicians will require new processes by their employer(s). CMS also reported the expected impact of implementing MACRA by size of clinical practice (see Table 4). Groups of less than 10 clinicians are most at risk for negative adjustments and are estimated by CMS to bear more than 70% of the total aggregate negative adjustment payments—$579 million of aggregate negative adjustments.

Table 3: CMS Projection of MACRA Impact by Clinical Specialty

<table>
<thead>
<tr>
<th>Provider Type</th>
<th># Clinicians</th>
<th>Allowed Charges</th>
<th>% with Negative Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Practice</td>
<td>3,598</td>
<td>$273</td>
<td>69.40%</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>20,854</td>
<td>$1,143</td>
<td>68.80%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>3,691</td>
<td>$287</td>
<td>65.40%</td>
</tr>
<tr>
<td>Physical Medicine</td>
<td>7,295</td>
<td>$918</td>
<td>57.90%</td>
</tr>
<tr>
<td>Allergy/Immunology</td>
<td>3,031</td>
<td>$199</td>
<td>57.10%</td>
</tr>
<tr>
<td>Oral/Maxillofacial Surgery</td>
<td>200</td>
<td>$7</td>
<td>55.00%</td>
</tr>
<tr>
<td>Hospital Based Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiology</td>
<td>34,998</td>
<td>$4,165</td>
<td>49.20%</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>34,233</td>
<td>$1,904</td>
<td>47.40%</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>41,728</td>
<td>$2,626</td>
<td>35.40%</td>
</tr>
<tr>
<td>Pathology</td>
<td>7,302</td>
<td>$593</td>
<td>43.30%</td>
</tr>
<tr>
<td>Internal Medicine (includes Hospitalists and Intensivists)</td>
<td>89,257</td>
<td>$9,327</td>
<td>40.30%</td>
</tr>
</tbody>
</table>
compared to $105 million of aggregate positive adjustments. Larger group practices are expected to be more favorably impacted—$539 million aggregate positive adjustments compared to $57 million aggregate negative adjustments.

A recent study reported that based on a survey of 523 non-pediatric specialty physicians, “nearly three-quarters (71%) say they would accept value-based payment models, mostly shared savings, for a five percent guaranteed increase in payment.” This suggests many clinicians serving the Medicare population will want to evaluate their participation in MIPS.

Practice Examples

For a solo physician who collects annually ~$200,000 from Medicare for patient services (Part B allowed charges), the certainty of a 4% reduction in CY 2019, if the physician elects to not submit any data, would result in an $8,000 reduction in revenues. The trade-off for this physician is the cost of reporting to Medicare in 2017 and 2018 to participate in a potential 0-4% increase in payment.” This suggests many clinicians serving the Medicare population will want to evaluate their participation in MIPS.

Table 4: MACRA’s Projected Impact by Practice Size

<table>
<thead>
<tr>
<th>Practice Size</th>
<th>Eligible Clinicians #</th>
<th>Eligible Clinicians %</th>
<th>Part B Allowed Charges ($ MM)</th>
<th>% Eligible with Payment Adjustment Negative</th>
<th>% Eligible with Payment Adjustment Positive</th>
<th>Aggregate Adjustment ($ MM) Negative</th>
<th>%</th>
<th>Aggregate Adjustment ($ MM) Positive</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solo</td>
<td>102,788</td>
<td>13.5%</td>
<td>$12,458</td>
<td>87.0%</td>
<td>12.9%</td>
<td>($300)</td>
<td>36.1%</td>
<td>$105</td>
<td>7.9%</td>
</tr>
<tr>
<td>2-9</td>
<td>123,695</td>
<td>16.2%</td>
<td>$18,697</td>
<td>69.9%</td>
<td>29.8%</td>
<td>($279)</td>
<td>33.5%</td>
<td>$295</td>
<td>22.1%</td>
</tr>
<tr>
<td>10-24</td>
<td>81,207</td>
<td>10.8%</td>
<td>$9,934</td>
<td>59.4%</td>
<td>40.3%</td>
<td>($101)</td>
<td>12.1%</td>
<td>$164</td>
<td>12.3%</td>
</tr>
<tr>
<td>25-99</td>
<td>147,976</td>
<td>19.4%</td>
<td>$12,868</td>
<td>44.9%</td>
<td>54.5%</td>
<td>($95)</td>
<td>11.4%</td>
<td>$230</td>
<td>17.3%</td>
</tr>
<tr>
<td>100+</td>
<td>305,676</td>
<td>40.1%</td>
<td>$18,648</td>
<td>18.3%</td>
<td>81.3%</td>
<td>($57)</td>
<td>6.9%</td>
<td>$539</td>
<td>40.4%</td>
</tr>
<tr>
<td>Total</td>
<td>761,342</td>
<td>100.0%</td>
<td>$72,606</td>
<td>45.5%</td>
<td>54.1%</td>
<td>($833)</td>
<td>100.0%</td>
<td>$1,333</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

A three-person group with similar performance statistics (three physicians each generating $200,000 of Part B Medicare allowable charges) may achieve some economies of scale in collecting and reporting practice data. CMS’ estimate of an annual cost of $24,000 would approximate $6,000 per quarter per physician or $18,000. Assuming a small economy of scale, Table 7 assumes this three-person group can collect and report 90 days of data for a total cost of $15,000 in 2017 and that the reporting requirements for FY 2018 thru FY 2023 remain at a single 90-consecutive day period, the investment “pays off” in FY 2022 if the full 4% incentive is earned.

It is important to note the cost associated with collection, compiling and reporting required to avoid the 4% penalty. The physician or group could expend the investment to report and not qualify for the full 4% incentive. This group would spend $90,000 over six years to potentially receive $96,000 of MIPS; a 3% earned incentive would approximate a cumulative loss of $15,000. If this group elected to not participate, and their Medicare business remained steady, the group could expect to have their payments adjusted downward each year as shown in Table 1—a revenue shortfall of $121,540 compared to an “investment” of $90,000 for a positive cost/benefit of $31,640 if the 4% MIPS incentive is earned. A 3% incentive would result in a

Table 6: Solo Practice Primary Care Example

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment</td>
<td>($6,000)</td>
<td>($6,000)</td>
<td>($6,000)</td>
<td>($6,000)</td>
<td>($6,000)</td>
<td>($6,000)</td>
<td>($6,000)</td>
</tr>
<tr>
<td>Incentive Earned</td>
<td>$8,000</td>
<td>$8,000</td>
<td>$8,000</td>
<td>$8,000</td>
<td>$8,000</td>
<td>$8,000</td>
<td>$8,000</td>
</tr>
<tr>
<td>Cumulative Impact</td>
<td>($6,000)</td>
<td>($12,000)</td>
<td>($10,000)</td>
<td>($8,000)</td>
<td>($6,000)</td>
<td>($4,000)</td>
<td>($2,000)</td>
</tr>
</tbody>
</table>
Table 7: Three Person Primary Care Practice
$600,000 of Annual Part B Allowable Charges

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment</td>
<td>($15,000)</td>
<td>($15,000)</td>
<td>($15,000)</td>
<td>($15,000)</td>
<td>($15,000)</td>
<td>($15,000)</td>
<td>($15,000)</td>
</tr>
<tr>
<td>Incentive Earned</td>
<td>$24,000</td>
<td>$24,000</td>
<td>$24,000</td>
<td>$24,000</td>
<td>$24,000</td>
<td>$6,000</td>
<td>$15,000</td>
</tr>
<tr>
<td>Cumulative Impact</td>
<td>($15,000)</td>
<td>($30,000)</td>
<td>($21,000)</td>
<td>($12,000)</td>
<td>($3,000)</td>
<td>$6,000</td>
<td>$15,000</td>
</tr>
</tbody>
</table>

negative cost/benefit of $18,000.

Small groups of less than 25 clinicians, and solo practices may seek assistance with the reporting requirements from an ACO, a larger physician group, or a hospital provider. Any such assistance will have to comply with the Stark laws and be provided at fair market rates.

Provider Agreements
Provider contracts with physicians typically take one of four basic forms. These forms are:

- **Hospital-based professional (HBP) services.** Common features include an independent contractor with exclusivity for the contract term who may have a supplemental fee arrangement to cover services provided to self-pay/charity patients.
- **Employment agreement.** Often these are for primary care physicians with office-based practices.
- **Medical directorship.** Physicians provide administrative services oversight to support medical services in a facility including the medical executive committee functions.
- **Physician coverage.** Typically these are for specialty physicians who treat patients who have no identified physician and require treatment while in a facility.

The MACRA reporting requirements and the changes in compensation beginning with CY 2019 may stimulate discussions between the parties as contracts are reviewed or renewed.

Hospital Based Services
The HBP physician or group's ability to report data for eligibility in the MIPS program necessitates the cooperation of the provider facility. Other measures may require a change in the contract terms during any measurement period. For example, one measurement period requires the availability 24/7 of MIPS-eligible physicians. To achieve this measure, coverage requirements between the physicians and provider may need to change or be augmented. The hospital with professional service agreements for these HBP services should prepare for the group(s) to initiate discussions about “being made whole.” For example, if the impact in 2019 is a 4% reduction in their professional fees, the group will likely want to discuss some stipend arrangement to make up for the shortfall. Also, if the data is submitted with the assistance of the provider hospital/clinic, and the MIPS incentive earned is less than expected by physicians, it is likely that discussions will ensue between the parties to adjust current agreements. Existing agreements may not contain language regarding responsibility for collection and submission of quality data to regulatory agencies.

Employment Agreements
The receipt of incentive compensation in CY 2019 and after may enter the conversation with employed clinicians, especially if some portion of the total compensation includes a factor for collections. The hospital/clinic employer will likely be responsible for the collection and submission of data to participate in MIPS. The “pass through” of MIPS incentive earnings to the employed clinician will likely be a point of discussion. Independent solo or small group practices may be more open to employment arrangements with a hospital provider in order to participate in MIPS without the investment to collect and report data.

Medical Directorship Agreements
The existing agreements between clinicians and hospitals/clinics/providers may not contain language addressing the responsibilities for development of systems and processes to collect and report quality measures for participation in the MIPS program. These agreements may require amendment to incorporate these responsibilities (and adjust the compensation).

Physician Coverage Agreements
These agreements are generally straightforward and involve compensation for coverage of the clinician’s specialty to the broader medical staff and emergency department patient demands. The existing agreements may not contain language addressing the responsibilities for collecting and providing clinician data reports of quality measures supporting the clinician’s participation in the MIPS program. These agreements may require amendment to incorporate these responsibilities (and adjust the compensation).

MACRA establishes a “pay for performance” formula. CMS is allowing clinicians to ramp up to the ultimate goal of full-year reporting and publishing clinician practice behaviors. Clinicians who want to avoid a 4% annual reduction in Medicare Part B fees will likely seek partners to bear this cost. New performance management programs will require a close review of existing agreements.

**“It is important to note the cost associated with collection, compiling and reporting (the investment) required to avoid the 4% penalty. The physician or group could expend the investment to report and not qualify for the full 4% incentive.”**

Mark C. Herbers is director of the Chicago office of AlixPartners, LLP, an international business advisory firm. Contact him at mherbers@alixpartners.com.
A New Era for Medicaid Managed Care

Physicians may deal with more complexities but state says it’s more innovation
By Bruce Japsen

Illinois is joining a national push by states further away from fee-for-service Medicaid as private insurance companies largely take over managing medical care for what has become the largest health insurance program in the country. For physicians, it could mean additional layers of complexities from new managed-care rules. But Illinois state Medicaid administrators say physicians will find opportunities to innovate and experiment with ways to improve care coordination and gain financial rewards.

“For physicians, there are positives and negatives. They should be prepared for Medicaid managed-care as it mimics the overall shift away from fee-for-service medicine.”

Gov. Bruce Rauner has announced plans to move more than 80% of the state’s 3.1 million Medicaid beneficiaries into private health insurance plans in a move that will touch most physicians in Illinois and Cook County that care for low-income patients covered by the program.

“Transforming Illinois’ health and human services allows us to deliver better care to our most vulnerable residents more efficiently,” Rauner said in announcing the shift to more Medicaid managed care. “The steps we are taking will allow us to improve the way we offer Medicaid services, fulfilling our promise to care for millions of Illinois residents, while better serving taxpayers.”

The move is the latest in a national trend that Illinois is joining. Managed-care plans are taking on an unprecedented role in providing health coverage to poor Americans, in part due to more states like Illinois opting to go along with the Affordable Care Act’s Medicaid expansion.

But states including Illinois are also generally moving to Medicaid managed care to deal with budget issues. And Illinois’ are notorious with the state debt at billions of dollars and legislators and the governor battling to get it under control. “There is a belief that there is more fiscal predictability when you move to Medicaid managed care,” says Ari Gottlieb, a director with PricewaterhouseCooper’s Health Strategy Practice. “When you put someone in managed care, you are going to be spending less because you are actually managing the care.”

Three in Four Medicaid Patients in Private Plans

The potential promise of managed care has led to three in four Medicaid beneficiaries now enrolled in a managed-care plan. PricewaterhouseCoopers (PwC) said 73% of Medicaid beneficiaries across the country—or 54.7 million of the 75.2 million Americans covered by covered by Medicaid are enrolled in private plans that contract with the Medicaid program.

Illinois will be adding hundreds of thousands of new Medicaid beneficiaries to the national managed-care figures when it is extended to all 102 counties effective in January 2018 from just 30 counties under the current program. Illinois began the transition to managed-care in 2011 and state lawmakers escalated that shift when they required at least 50% of Medicaid beneficiaries to be in a private plan by 2015.

For physicians, there are positives and negatives. They should be prepared for Medicaid managed-care as it mimics the overall shift away from fee-for-service medicine. “There are going to be the kind of mechanisms in (Medicaid managed-care) that physicians are used to in private commercial insurance and Medicare advantage,” PwC’s Gottlieb said.

To be sure, the Rauner administration says the shift is designed to move from paying providers for “value rather than volume” that is common under fee-for-service. This means providers will begin to adhere to more measures and care coordination with payments geared toward encouraging prevention and offering services that are “evidence-based and data driven,” the Rauner administration said in announcing the so-called “Medicaid managed-care reboot.”

“Providers are going to have to contend with managed-care processes that are more complex rather than fee-for-service when they just treat and bill,” PwC’s Gottlieb said. When providers sign contracts, they should pay close attention just as they would when signing contracts with commercial insurers, Gottlieb advises.

Network Adequacy Woven into Medicaid Managed Care

Felicia Norwood, director of Illinois Department of Healthcare and Family Services, said there will ultimately be fewer managed-care plans managing Medicaid in Illinois, which should lead to a less
complicated system. When Rauner came into office, the state was “contracting with 30 different entities” to provide Medicaid benefits, but has whittled that to 12 plans, Norwood said. By Jan. 1, 2018, there will be “up to seven.”

Illinois is seeking three to five proposals to contract with Medicaid statewide. In addition, the state is seeking bids for a “Cook County only option” for up to two plans, Norwood said. Bids are due May 15 and Norwood hopes to have plans selected by the end of June. “It is very hard for anyone to manage effectively when contracting with over 30 entities and have the kind of outcomes you are trying to achieve and care you are trying to coordinate,” Norwood said.

The Rauner administration is dangling a larger number of Medicaid patients before health plans that failed in a six-county region around Springfield this year. Doctors and hospitals complained about Molina Healthcare, which was the only insurer in a six-county region, saying it was slow-credentialing providers and fell behind when it came to paying claims. The Rauner administration had to shift more than 25,000 Medicaid beneficiaries back to fee-for-service because Molina’s problems led to a lack of providers in its networks. The state said the managed care “reboot” will go a long way toward making sure incoming health plans have adequate providers in their networks and a better system. “In the case of Molina, we essentially ended up with a situation where we had no choice,” Norwood said. “The RFP gives us some choice statewide.”

But physicians worry that fewer plans will lead to narrow networks and strategies that limit Medicaid patients’ choice of providers. That has been a trend with commercial carriers and the exemption of Medicaid plans from network adequacy isn’t addressed in Illinois House Bill 311 (HB311), which covers the commercial PPO insurance market and its “network adequacy.”

But Norwood said Illinois Medicaid’s request for proposals from insurance companies requires health plans to demonstrate network adequacy. That should put at least some concerns of physicians at ease…

Norwood sees positives for physicians, patients and taxpayers. “To truly succeed, there must be a greater focus on the beneficiaries that encourage and reward innovation, outcomes and excellence,” Norwood said. For example, other states that have handed off more of their Medicaid membership to private managed-care plans have introduced new rewards and outcomes measures that reward doctors. When private health insurers are involved, it’s easier for providers to group together.

The momentum is leading medical care providers to integrate end-of-life care and advanced directives into their ACOs, which gather doctors and other caregivers under one umbrella and are paid by Medicare and private insurers to treat groups of patients. If the ACO reduces costs while improving quality, the providers keep some of the savings. That is different than payment today that encourages excessive treatment by paying by procedure. “It’s easier to enter into risk-sharing,” PwC’s Gottlieb said. “Plans are going to be more willing to experiment and try different things than a state would. If you have some things that you are doing like telehealth, for example, the private plan might be willing to work with you.”

While physicians worry that new health plan measures will wreak havoc on doctor practices and cause additional layers of bureaucracy, Norwood said any measures used by Medicaid plans should already be familiar to them. “All states are working off similar measures,” Norwood said, citing HEDIS as one example. “(The measures) should be based on what are already being used by commercial plans and in Medicare Advantage.”

Bruce Japsen is a health care journalist, speaker, author and regular contributor to Chicago Medicine who also writes for Forbes. He is a regular analyst on health, business and political topics to WBBM Newsradio and WTTW television’s Chicago Tonight program and Fox News Channel’s Forbes on Fox. He can be reached at brucejapsen@gmail.com.
OUR CHICAGO Medical Society made a proud showing at the 2017 Illinois State Medical Society House of Delegates, demonstrating the value of membership. Through our resolutions process CMS not only advances key reforms on your behalf in the ISMS House, but we also create a vehicle for physician-members who desire an active and personal role in shaping agendas, from policy to legislation.

This year’s annual meeting, held on April 21-23, saw a strong lineup of CMS proposals go on to win approval by the House, clearing the way for legislative advocacy in Springfield or for in-depth study of complex issues prior to formulating a plan for implementation. CMS delegates also heard progress reports on their efforts of years past, such as CMS proposals to address gun violence and to expand leadership opportunities for trainees and students within ISMS.

In today’s evolving practice environment and healthcare system, you can count on CMS to keep the needs and concerns of physicians front and center. Our position is that affordable, accessible health insurance coverage go hand-in-hand with regulatory and financial relief for our members. Here’s a recap of CMS resolutions activity from Oak Brook, site of the 2017 House meeting.

Elimination of Medical Center Restrictive Covenant and Non-compete Clauses

By Jerrold B. Leikin, MD, and Scott M. Leikin, DO

Medical center employment contracts impose an undue hardship on hospital-based specialists. A big issue today, these restrictive covenant clauses limit physicians who don’t even have their own patients such as emergency medicine, hospitalist medicine, pathology, radiology, and anesthesia. Taking aim against this practice, the Chicago Medical Society adopted new policy to abolish post-employment non-compete clauses from any medical center corporation contract unless the physician owns equity in the practice.

Now CMS is urging ISMS to adopt the same policy and to support or introduce legislation that eliminates the enforceability of these clauses and covenants from medical center employment contracts when the physician has no equity in the practice. The legislation also would ban the use of such clauses in medical center physician contracts.

Due to the complexity and merits of restrictive covenants for different types of physician work environments, ISMS voted to study the measure in-depth.

Referred for Study and Report Back

Employed Physicians Bill of Rights

By Jerrold B. Leikin, MD, Susan Acuna, MD, Brad L. Epstein, MD, Patrick Para, DO, and Andrew Ward, MD

This multipronged Chicago Medical Society and Kane County Medical Society resolution calls for
MEMBER BENEFITS

ISMS to champion an “Employed Physicians Bill of Rights.” As such, ISMS will support or introduce legislation modeled after principles laid out in the resolution, which would establish a legal basis for employed physicians’ contract provisions with healthcare corporations. These provisions address physician compensation; academic freedom; peer review of clinical activity; data entry, coding and management of electronic medical record systems; activities outside of defined employed time boundaries; and conflict of interest disclosures.

Adopted

Firearm Sales Legislation
By Kathy Tynus, MD
In 2016, the Chicago Medical Society urged ISMS to support criminal background checks for all gun sales, public, private and Internet-based. Under this amended resolution, ISMS will support legislation that would restrict the sale of assault weapons with large-capacity magazines of 10 rounds or greater for civilian use.

Adopted as Amended

Over-the-Counter Contraceptive Drug Access
By James Curry, Medical Student
Back in 2016, the Chicago Medical Society requested that ISMS research and develop policy for equitable access to OTC contraceptives, including those recommended for OTC sale. Other provisions in the resolution prohibit cost-sharing obstacles to OTC contraceptive access, and full coverage of all contraception without regard to prescription or OTC utilization, since all contraception is essential preventive health care.

ISMS will advocate for simpler FDA OTC drug approval applications and registration, as well as regulations that promote access to sufficient varieties of OTC contraception in the marketplace, and further advocate for legislation and regulation to improve OTC contraceptive drug access and quality.

The measure now moves on to the AMA House of Delegates for similar policy and action.

Adopted

Perioperative Do Not Resuscitate Orders
By Barbara Jericho, MD
Under this Chicago Medical Society initiative, ISMS policy will support the “required reconsideration” of a patient’s existing advance directives in the perioperative period, prior to a procedure or surgery and the administration of anesthesia. ISMS will educate its members on the importance of perioperative review of patients’ do-not-resuscitate advance directives.

Adopted as Amended

Inappropriate Requests for DEA Numbers
By Howard Axe, MD
In response to companies requesting physicians to provide a DEA number for reasons that do not involve a prescription for controlled substances, this resolution from the Chicago Medical Society calls upon ISMS and AMA to collect information on how often and under what circumstances physicians receive these requests. The resolution also directs both ISMS and AMA to seek legislation that would penalize companies making such inappropriate requests.

Adopted

Advanced Care Planning Codes
By Howard Axe, MD
Both the Chicago Medical Society and ISMS were instrumental in the enactment of new codes for advanced care planning that reimburse physicians for time spent discussing end-of-life care with patients.

Now, under this new CMS resolution, ISMS and AMA will take steps to assess the degree to which Advanced Care Planning Codes 99497 and 99498 have been used since then, with the goal of studying the barriers to advanced care planning by physicians and patients. In addition, the measure would enable use of these codes over multiple clinical visits to satisfy the time requirements, given the complexity of these discussions and the number of clinical staff involved as well as family members of the patient.

Adopted

Opposing Attorney Presence and/or Recording of IMEs
By Jerrold B. Leikin, MD
A measure from the Chicago Medical Society proposes a feasibility study of state and federal policy that would prohibit the recording, videotaping, or the presence of court reporters or opposing attorneys during the independent medical exam as a condition for medical opinions being allowed in court.

The resolution would encourage legislation to prohibit courts from compelling or permitting these activities. Finally, it would add such policy to the 7th Edition of the AMA’s Guides to the

Dr. Clarence Brown, president of CMS, joins colleague Dr. Amy Derick, a delegate from the Chicago area. Both physicians are dermatologists and proud members of organized medicine.
Acceptance of Hospital-Based Serum Alcohol Results in Litigation

By Jerrold B. Leikin, MD

This Chicago Medical Society resolution requests ISMS to seek legislation so that courts accept the validity of test results without further physician or other expert testimony. According to the measure, there is no clinical difference (and minimal analytical difference) between a hospital-based serum alcohol test and whole blood alcohol concentration. Courts should adjudicate as such, and not interpret hospital-based alcohol testing as “speculative” and not bar such testing. Finally, the resolution says hospital-based alcohol concentrations should be admissible as evidence of intoxication even without other evidence.

Adopted

Improving the Insurance Appeals Process

By A. Jay Chauhan, DO

This Chicago Medical Society resolution would require insurance companies to state the criteria by which a prior authorization assessment is denied and to provide in the initial denial letter to the patient and physician the criteria for approval. CMS’ directive calls for ISMS to work with interested parties and their representatives with the goal of requiring insurance companies to provide this information.

Adopted

Pronunciation of Pharmaceutical Names

By B.H. Gerald Rogers, MD

As the number of complicated brand and generic names for drugs multiply, so does the challenge of referring to them accurately in a discussion with colleagues and patients. That’s why the Chicago Medical Society is requesting ISMS and the AMA to adopt policy that AMA-sponsored medical journals develop means to convey the proper pronunciation of all new pharmaceutical names.

Adopted as Amended

Voting Privileges for Trainees and Medical Students

By Kathy Tynus, MD

In 2016, the Chicago Medical Society asked ISMS to increase opportunities for students and trainees within the fold of organized medicine. Following months of study, ISMS opted to approve additional medical student and resident physician voting delegates within the House of Delegates. These additional delegates will accrue to the ISMS Medical Student Section and ISMS Resident and Fellow Section, respectively. The allocation methodology allows for one delegate for each 75 members in the Resident and Fellow Section, and one for a major fraction thereof, as determined by ISMS membership rolls on Dec. 31 of the preceding year. The Medical Student Section is entitled to send one delegate per each Illinois medical school campus.

Substitute Adopted

Protecting Medical Trainees from Hazardous Exposures

By A. Jay Chauhan, DO

ISMS voted to study in-depth a Chicago Medical Society resolution that seeks the voluntary education of students, residents, physicians and surgeons about their occupational exposure to harmful substances.

The measure encourages giving trainees the option of excusing themselves from exposure to hazardous materials without negatively impacting their standing in a training program.

Trainees who may be pregnant would have the ability to excuse themselves from exposure to Methylmethacrylate without harming their standing.

Referred for Decision

“Stop the Bleed” Campaign

By Raj B. Lal, MD

This important public health initiative from the Chicago Medical Society calls upon ISMS and AMA to actively promote the education of physicians, other professionals and the public through a “Stop the Bleed” campaign that prepares bystanders to save lives by rendering first aid (hand pressure, tourniquets, hemostatic pressure and gauze bandages) prior to the arrival of first-responders. Locally, CMS will bring this effort to the Chicago City Council.

Adopted

The 2018 House of Delegates is slated for April 20-22.
Your Voice Counts!
Opportunities abound for physicians who want to be part of advocacy process

Some of the most important work that the Chicago Medical Society (CMS) does for its members, no matter their specialty or practice mode (solo, small or large group, or hospital-based) comes in the form of legislative advocacy. But CMS can’t do this in a vacuum—we need your input. All members have plenty of opportunities to make their voices count, and watch their dues dollars at work. Your involvement can be as simple as writing a resolution, giving testimony, joining a committee, representing your district, or just listening in.

Policymaking is our Governing Council’s most critical function. It is members like you who supply the substance of resolutions and make the vital contacts with legislators and key decision-makers to explain—and defend—policies that are good for physicians and their patients. Your efforts, combined with those of CMS, can defeat legislation that is detrimental—sometimes highly so—to the practice of medicine.

Changes to CMS’ Bylaws over the years have enabled more members of Chicago’s diverse physician community to participate in our Governing Council. Hospital medical staffs and groups once considered affiliated or associated now have the opportunity to influence CMS’ future. The resolutions process was also streamlined so that every member may sponsor resolutions on issues affecting their professional needs and interests. CMS’ committees work with the Council to study and recommend action. The electronic meeting format expedites these functions.

While CMS offers myriad ways to get involved, authoring resolutions is something physicians can easily do. We urge you to be part of the action, putting your membership to work. It’s never been more important than now.

Resolutions: Make your Voice Heard
After reading highlights of the 2017 ISMS House of Delegates (see pages 24-27), you may notice the number of resolutions emanating from CMS. These resolutions outline a problem and desired solution, often providing guidance to lawmakers, or directing your medical societies to act on particular issues. A resolution allows rank-and-file members to shape the agenda of CMS, ISMS and the AMA.

Many public health laws and physician protections in Illinois are the direct result of resolutions from grassroots physicians.

Key Contacts Program
Physicians rightly expect their medical associations to represent their interests. But when it comes to advocating on their behalf, grassroots members share the responsibility. Leaders of an organization can advocate only with the membership, not for them as they sit on the sidelines and wait for the desired action. A medical society is only effective in the legislative arena if its members are fully engaged participants. A disconnect on their part will sink the most agile, well-run and well-funded advocacy program.

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

Specific duties of a Key Contact include periodically communicating CMS’ views on specific legislation or other advocacy activities, as well as CMS events and goals to legislators. Volunteers also may interact with legislative staff and report on their efforts to the CMS Districts and leadership. The information exchange keeps volunteers up to date on issues within their communities.

Physicians who personally know a legislator are encouraged to build on their acquaintance or relationship with the legislator. The greater our access, the more opportunities to communicate our needs and influence healthcare policy. Key Contacts can approach legislators through less formal routes, particularly if the lawmaker lives in the same community as the Key Contact, frequents the same clubs, civic organizations, or religious institutions, is an alumnus of the same school or university, or has received the CMS member’s personal support in previous elections to office.

Whatever the relationship, we encourage members to stay in touch with their local elected representatives, so they remain active and aware of issues affecting their profession. CMS’ ability to influence healthcare policy depends on a cadre of Key Contacts. We encourage you to sign up now. To learn more, please call 312-670-2550.

The Importance of Your Involvement
We can’t stress enough how important your involvement is in keeping good legislation on track and bad legislation shelved. We’ve never met a physician who did not have an opinion on some health care issue of importance and ideas for how to make the system work better for the profession of medicine and the patients who depend on a just health care system. We urge you to get involved today. We are here to help you with any questions or training you may need to get started.
IN THIS MOMENTOUS time for health care, the Chicago Medical Society encourages you to seize the opportunity for advancing physician-led reforms. You can begin this critical work by serving on a CMS committee. Appointments to CMS committees take place each spring. Committees lay the groundwork for successful legislative advocacy, by anticipating and responding to trends and issues.

Regardless of your practice type, age, or specialty, policymaking is the open to everyone. Your involvement can be active participation or simply listening and learning. Committees study issues brought by other members, leadership, or legislators. As a committee member, you'll hear testimony, shape resolutions, and have ample opportunity to share your opinions. The electronic meeting format expedites committee discussion thus saving you valuable telephone time or travel time.

On the following pages, you'll see the wide variety of avenues for students, residents, and physicians to make their voices count, and put their dues dollars to work. You'll also see information on how to sign up for a committee in the sidebar “How to Join a CMS Committee” on the next page. For more details, or more information on how to sign up for a committee, please call 312-670-2550, or send an email to Ruby at rbahena@cmsdocs.org.

Academic Physicians
Formed to improve CMS’ representation of physicians involved in academic medicine, this committee addresses the unique regulatory and financial issues that affect academic physicians, and provides a forum to discuss them. The committee is responsible for researching the feasibility of policies, activities and services to best serve the needs and interests of academic physicians.

NOTABLE WORK: ADVOCATING FOR NEW INVESTMENT IN MEDICAL RESEARCH

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

NOTABLE WORK: LAUNCHING THE NETWORK ADEQUACY AND TRANSPARENCY BILL, NOW IN THE GENERAL ASSEMBLY

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

NOTABLE WORK: INVESTIGATING HOSPITAL CHARGES FOR UNINSURED PATIENTS, AUTOMATED FAX REFILL REQUESTS

Public Health
Purpose: Reviews and responds to requests for advice, opinion, or program approval directed to CMS by any health department, municipal health committee, or public health body in Cook County. In addition to drafting resolutions, the committee studies local health issues and initiates contact with groups on matters of concern to medicine.

NOTABLE WORK: ADVANCING POLICIES ON GUN VIOLENCE, CHILDREN’S TOYS AND HEARING SAFETY, HAZARDOUS MATERIALS, OPIOID EDUCATION

Resolutions Reference
Purpose: Reviews new policy and action resolutions from members and the leadership; holds hearings on those resolutions, and makes recommendations to the Council.

NOTABLE WORK: RECOMMENDING POLICY AND LEGISLATION

Medical Staff Leadership
This council was formed in response to the growing demands on medical staff leadership, and is designed to address their needs and interests, as well as the unique issues affecting medical staffs and hospitals. The council is composed of medical staff presidents, presidents-elect, secretaries, and representatives of the American Medical Association’s Organized Medical Staff Section. The services offered include: quarterly meetings to discuss issues affecting hospitals; the development of educational programs; the preparation of newsletters to inform staff of important medical, legal, and legislative updates; and research on topics of interest or concern.

Employed Physicians
This committee was formed to address the
MEMBER BENEFITS

concerns of employed physicians through education and advocacy. Efforts in this area include educational programs on employment contracting, employee rights, and benefit resources.

Women Physicians Forum
The forum looks at the unique needs and interests of women physicians in Cook County. As the local counterpart of the Illinois State Medical Society’s (ISMS) Women Physicians Forum, the group is structured to focus on three key areas of particular interest to women physicians: (1) representing and advocating on behalf of women physicians; (2) networking; and (3) offering services specific to women physicians. The Women Physicians Forums of CMS and ISMS provide the means for a strong representative voice on behalf of the growing number of women in medicine.

Young Physicians
This group was formed to assist new physicians in their transition from training to a professional career. A young physician is defined as a doctor younger than 40 years of age or a physician within the first eight years of professional practice following residency and fellowship training. This resource helps facilitate the transition process and provides networking, educational and mentoring opportunities.

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

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

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

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

Membership/IMG
Purpose: Develops strategic plans for the ongoing recruitment and retention of members, including residents and students; reviews all applications for new membership, status change requests, dues waivers and transfers, and reports its recommendations to the Council; reviews physicians who have resigned or forfeited their membership and wish to be reinstated; supports measures to encourage complete integration of IMGs into American medical practice; represents the issues of concern to IMGs in CMS and the IMG community.

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

Subcommittee on Joint Sponsorship
Purpose: Helps plan CME activities and provides detailed review of all applications received from related organizations for joint sponsorship of activities; advises the full CME Committee on trends, concerns, and requirements; assures that CMS activities and joint sponsorship programs are in full compliance with the Essential Areas and Standards for Commercial Support of the Accreditation Council for Continuing Medical Education (ACCME).

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

How to Join a CMS Committee

EACH YEAR the Chicago Medical Society appoints members to its various committees. All physicians are encouraged to become active participants in the Society by volunteering for any committee they wish. To sign up, please send us an email, fax, or letter listing the following information: Name, address, city, state, zip code, email address, phone and fax numbers. Be sure to indicate which committee(s) you wish to serve on. Fax: 312-670-3646, or email: rbahena@cmsdocs.org. Or go to our website: www.cmsdocs.org.
Calendar of Events

**JUNE**

7-8 The 70th Annual Conference “Survival Guide: Emerging Issues in Healthcare, What to Expect and How to Prepare” Hosted by the American Bar Association’s Health Law Section and the Chicago Medical Society, this unique educational event offers attorneys, physicians, and their administrative partners access to national speakers. They will provide critical information on issues affecting employer and hospital relationships, business and industry responses to payer consolidation and market control. Experts will share everyday “survival” techniques for hospital and private practice settings.

InterContinental Chicago, 505 N. Michigan Ave., Chicago. To register or for more information, contact Candace 312-670-2550, or visit www.cmsdocs.org.

10-14 AMA House of Delegates and Annual Meeting CMS actively participates in the American Medical Association’s policymaking meetings, advocating for both members and their patients. Resolutions adopted at the CMS governing Council frequently advance to the Illinois State Medical Society, where they are implemented, before ultimately reaching the AMA. CMS delegates to the AMA may submit a resolution directly to the AMA House for consideration and support. Physicians are encouraged to exercise this outstanding membership privilege, ensuring that their voice is heard at the highest levels of organized medicine and well beyond. Hyatt Regency Hotel, Chicago. For more information, please go to www.ama-assn.org.

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

17 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.

**JULY**

13-16 Headache Update (Presented by the Diamond Headache Clinic Research & Educational Foundation & the Diamond Inpatient Headache Unit at Presence Saint Joseph Hospital), Disney’s Grand Floridian Resort & Spa; Walt Disney World Resort; 4401 Floridian Way; Lake Buena Vista, Fla. Call 312-867-9104 or visit: www.dhc-fdn.org/events.

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

**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, contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

11-14 AMA Interim House of Delegates Meeting CMS actively participates in the American Medical Association’s policymaking meetings. Resolutions adopted at the CMS Governing Council frequently advance to the national stage at the AMA. Hawaii Convention Center, Hilton Hawaiian Village Waikiki Beach Resort, Honolulu, Hawaii.
Welcome, New Members!
The Chicago Medical Society greets its newest members. We are now 32 voices stronger!

Student District
Alex Anderson
Zachary A. Bahr
Kellie E. Barsotti
Marcel Bertsch-Gout
Ritika Dhawan
Jianbing Leng
Raqayyah A. Malik
Sean McClellan
Karan Nijhawan
Neha Reddy
James M. Roemer
Gabriel M. Siegel
David B. Sutherland
Ray W. Urban
Joshua Verson

Mindy C. Colgrove, MD
Birju Patel, MD
Brigitte Sallee, MD
Sahar Rabiei-Samani, MD

District 3
Janet V. Starck, MD

Practice Administrators
Jean M. Barcarella
Bridget Daniel
Joan King
Denise T. Lemanski
Helena Z. McDermott
Joyce McDevitt
Becky Pietkin
Cheryl A. Scalaletta
Verndale Sheldou
Maura C. Thiele

Resident District
Ahmad Agha, MD
Justin Bloomberg, DO

Personnel Wanted
Family Planning Center in Chicago is looking for ob-gyn or family medicine physician to see patients three to five days a week part-time. Please email us your CV or contact us at waclinic@yahoo.com or call 773-725-4232.

- 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
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.

Equipment for Sale/Rent
New or refurbished medical equipment for all specialties—AEDs, exam tables, power exam tables, vital sign monitoring, EKGs, patient monitors, defibrillators, stretchers, anesthesia machines, EtCO2 monitors and more. We buy used equipment. Financing available. MESA Medical, Inc. Call 800-989-4909 or email: james@mesasales.com.

Business Services
APEX Design Build—Contact our team for design, architecture, and construction of medical practices. We are the turn-key resource that creates a seamless build-out process. Let us conduct a complimentary analysis of your real estate before buying or leasing, to avoid future challenges. Contact: www.apexdesignbuild.com or 847-737-7573.

Physicians’ Attorney—experienced and affordable physicians’ legal services including practice purchases; sales and formations; partnership and associate contracts; collections; licensing problems; credentialing; estate planning; and real estate. Initial consultation without charge. Representing practitioners since 1980. Steven H. Jesser 847-424-0200; 800-424-0060; or 847-212-5620 (mobile); 2700 Patriot Blvd., Suite 250, Glenview, IL 60026-8021; sjj@sjesser.com; www.sjesser.com.
Promoting Access to Family Medicine

This long-term UIC physician and his team have grown the department significantly, thus improving patient access

By Cheryl England

When he first started his career at the University of Illinois at Chicago in 1987 after receiving his medical degree from the University of Iowa College of Medicine, Patrick Tranmer, MD, MPH, didn’t realize that 30 years later he’d still be enjoying his tenure there. Today, this accomplished physician serves as an associate dean for clinical affairs for the UIC College of Medicine, operations director for managed care for UI Health, and executive director of the UI Physicians Group. Fondly remembering how he arrived at UI, Dr. Tranmer says, “I had a friend who was starting the family medicine department at UIC who recruited me. I’ve always liked Chicago a lot so it was not a difficult decision to join.”

Although Dr. Tranmer has held a variety of positions at UIC, one of his longest-term positions was as the head of the department of family medicine, a position that he held for a total of 12 years, including two years as the interim head. During his tenure, he and his team built the department significantly. “We were able to establish a strong residency program in family medicine, starting with four residents and growing to eight.” he says. “It’s now a very highly sought after residency program. We also obtained a clerkship for students in their third year. And we’ve managed to establish a large clinical presence—we now have approximately 40,000 patient visits per year.”

Dr. Tranmer has also had a long history of teaching experience. “I’ve always been interested in teaching,” he says. “After my first year as a medical student, I was eager to help other students learn about anatomy. I wanted to get better at the practice of teaching and, fortunately, UI has given me that opportunity.”

And, although Dr. Tranmer practices general family medicine, he has a special interest in HIV and chronic diseases. In fact, Dr. Tranmer currently serves as the principal investigator for the Midwest AIDS Training and Education Center located at UIC. “When I first came to UI, it was the beginning of the HIV epidemic and I had patients who needed care for the condition,” he says. “So I learned about it and have kept up the interest.

As for his focus on chronic disease management, Dr. Tranmer explains quite simply: “I’ve been in practice for so long that as I’ve gotten older, my patients have gotten older with me.” He laughs, “I guess that’s good!”

But of all the things he’s done, Dr. Tranmer is most proud of building a family medicine department at UIC that has top-notch faculty who are committed to caring for the underserved as well for patients who have challenges getting quality care in an urban environment. It’s a cause that Dr. Tranmer believes passionately in. “These days I try to facilitate communication with different people in different departments to promote best practices and improve the efficiency of care. “The whole idea,” he continues, “is to make sure that people have access to quality healthcare when they need it.”

NO STRANGER to awards, Dr. Tranmer recently received the UIC Dean’s Award for Excellence in Healthcare Leadership. He’s also been named one of the Best Doctors in America numerous times over the years. Prior to joining UIC, Dr. Tranmer was a family physician with the Muscatine Health Center in Muscatine, IA, as well as a member of the medical staff at Muscatine General Hospital. This board-certified physician received his MPH from UIC in 1990. He has held a wide variety of high-profile teaching positions and is a frequent speaker and author.
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.

Want to reduce risk?  ProAssurance.com/Seminars

CMS Insurance Agency, Inc.
For more information, please
call our staff at 312.670.2550.

Healthcare Liability Insurance & Risk Resource Services
ProAssurance Group is rated A+ (Superior) by A.M. Best.
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