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FEATURES

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In the latest round of large-scale mergers and acquisitions, CVS is buying Aetna while Advocate is merging with Aurora Health Care, Wisconsin’s largest system. Could this mean even less autonomy for physicians? By Bruce Japsen

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Lee Francis, MD, MPH, president and CEO of Erie Family Health Centers, runs the day-to-day operations of this federally qualified healthcare center with its 13 locations and multitude of services. He’s passionate about his position because the centers provide top quality healthcare to every patient regardless of their ability to pay—a feat that is central to his core belief that healthcare is a right, not a privilege.
Advocating on the Hill

**OUR CHICAGO** Medical Society was back in Washington Feb. 12-14 to engage lawmakers in one-on-one conversations about physician priorities and the future of healthcare delivery. Our national Capitol Hill advocacy reinforces CMS’ year-round work with local governmental bodies.

Prior to our visit, I invited you, our members, to share with me specific concerns the CMS leadership should address on your behalf with Congress. My thanks to all who responded. The outpouring of feedback—from physicians of all ages and specialties and practice types, as well as students—helped us fine tune and focus our message. CMS came armed with fresh data, statistics and real-life examples.

Here is what you asked us to address: administrative burden and burnout; insurance preauthorization and narrowing of networks; prescription drug price gouging and PBM oversight; physician workforce and GME funding; higher payment for primary care and generalists; tort reform and defensive medicine; coverage for non-pharmacologic pain control; and mental healthcare funding.

Some of you said the time had come for single payer healthcare, or an expanded and improved Medicare-for-All. Poor reimbursement by Medicare and Medicaid always ranks near the top of your concerns. Members also cited low pay for cognitive knowledge and for medical doctors who take thorough histories and physical exams, and spend time counseling patients. Some of you said Medicare Advantage plans create confusion because they don’t always provide coverage identical to Medicare. Also, insurers engage in take-backs for patients seen one year ago because the doctor is “not in network.” You also pointed to problems with Medicaid Managed Care. These plans change often, forcing patients to switch. Yet patients often miss the letter informing them of changes or lack the ability to respond appropriately. Not a small logistical problem.

All your concerns above were folded into our packed Washington agenda. Prior to meeting with lawmakers, we always plan and establish clear goals. Our team strives to engage personally with each member of the Cook County Congressional Delegation, as well as Illinois’ own U.S. Senators Durbin and Duckworth. We also allot time to renew our relationships with influential legislators from other states, such as our colleagues in the Congressional Doctors Caucus.

Old-fashioned one-on-one advocacy, where you shake a lawmaker’s hand and look them in the eye, is critical to advancing physicians’ priorities. Given legislators’ busy schedules and competing interests, we physicians must make our message clearly, simply and early. Legislators want to hear how issues impact patients, their constituents. They also listen more attentively when physicians present a solid, unified front.

With attempts to repeal the Affordable Care Act behind us, the coming year promises more turbulence. How will elected leaders restore stability to the individual insurance market, balance safety net and public health funding with a massive tax cut? On the bright side, Congress and the Administration appear open to easing the administrative and regulatory burden on physicians, thanks to our advocacy.

Whatever direction and shape federal healthcare reform ultimately takes, physicians must be at the vanguard, not in the rear, or left behind. We are facing a defining moment in our nation’s history, and we must speak up for our patients and our profession.

Vemuri S. Murthy, MD
President, Chicago Medical Society
Physicians Help Communities Prosper

A new study shows the positive economic impact of physicians on communities

In small towns and big cities across America, physicians care for the sick and prevent illness. They are also creators of economic health, benefitting communities directly and indirectly. Now, a new report quantifies that impact, showing that physicians generate more jobs, higher wages and benefits, and tax revenue compared to other select industries. Physicians also support industries indirectly.

The American Medical Association hired IQVIA to conduct the analysis, which is the latest research effort showing the value of physicians to the economy. The AMA said the findings are important for policymakers and legislators, and it encourages members to share them with elected leaders.

Using the AMA Masterfile, the analysis was limited to 755,802 (73.9%) post-residency physicians whose major activity is the provision of patient care. “Physician” is defined as someone with a medical or osteopathic degree, office-based or hospital-based, employed as well as independent.

Economic Barometers

Direct physician impact is the value of four "vital" economic barometers: output, jobs, wages and benefits, and state and local tax revenue. Indirect impact includes the same barometers, but the values are generated by industries that are supported by physicians.

The total national impact is the sum of both direct and indirect economic impacts. State-level direct impacts are added up to calculate the total direct impact. While indirect impacts within a state are limited to effects within its borders, the report notes that these indirect economic effects often reach into neighboring states. For this reason, the total national economic impact is larger than the sum of the total state economic impact.

In 2015, physicians supported $559.6B in direct wages and benefits in aggregate across all states. The total amount of wages and benefits supported by patient care physicians at the national level was $1,044.9B (including the indirect wages and benefits supported by the industry), or an average of $1,417,958 per physician. At the state level, physicians supported a median of $8.9B and a mean of $16.7B in wages and benefits.

Physician economic impact varies across states and is dependent upon the number of physicians in each state as well as other factors, such as the general economy and the healthcare environment in particular. National health expenditures grew 5.8% in 2015 and accounted for 17.8% of GDP. Physician and clinical services expenditures grew 6.3% in 2015, an acceleration from growth of 4.8% in 2014, and the first time since 2005 that the growth rate exceeded 6.0%. Healthcare spending accounted for 17.2% of GDP in 2012.

MDs and Jobs

In aggregate across all states, the number of jobs directly created by patient care physicians (including the number of physicians themselves) was 3,545,399. The total number of jobs supported by patient care physicians at the national level was 12,575,602; the average physician supported 17.07 jobs in the economy. At the state level, physicians supported a median of 115,752 and a mean of 182,370 jobs. In aggregate across all states, physicians generated $821.6B in direct output in 2015. At the national level, patient care physicians generated $2.3T in total output, or an average of $3,166,901 per physician. At the state level, physicians generated a median of $18.9B and a mean of $32.8B in total output.

MDs v. Other Industries

The analysis compares physician economic impact to several industries (legal services, higher education, nursing and community care facilities, and home health). Physicians supported higher total wages and benefits than other comparable industries except for the legal services industry in the District of Columbia. At the national level, physicians supported $1,044.9B in wages and benefits, compared to $94.9B for home health and to $254.5B for legal services. Nationwide, physicians also supported 12,575,602 total jobs. Across the other industries, total jobs ranged from 2,629,559 for home health to 4,432,916 for nursing and community care facilities.

Illinois-at-a-Glance

For Illinois, which has 30,258 physicians providing patient care, the total economic output comes to $73.2B, creating 396,856 total jobs, with total wages and benefits of $34.8B, and generating $3B in local and state tax revenue. The average total taxes per physician are $99,967.

Other industries lagged on jobs, with higher education, 121,211; nursing and community health facilities, 166,726; legal services, 163,750; and home health, 82,625 jobs. To read the complete study, visit the AMA website at www.ama-assn.org.

In a separate 2016 survey, the AMA found the single specialty group accounted for the largest share of physicians (42.8%), while 24.6% practiced in multi-specialty groups, 16.5% in solo practice and 7.4% in direct hospital employment. Movement toward hospital-owned practices and direct employment by a hospital appear to have slowed since 2014.
Physician Manpower Utilization

What does the expanding role of non-physician providers mean for the medical profession?

By Todd A. Zigrang, MBA, MHA, and Jessica L. Bailey-Wheaton, Esq.

“One of the primary concerns about the increasing use and autonomy of non-physician providers is whether the care provided is as safe and efficient as care provided by physicians.”

Concerns Related to the availability and adequacy of the physician workforce have been debated in the healthcare industry for decades. Although often centered on physician supply and demand, these discussions realize the multifactorial nature of patient utilization of the physician workforce for providing care within the current healthcare delivery system. As stated in a 2002 Health Affairs editorial, “... a larger health care workforce has hardly been synonymous with a better one.” In this article, the current status of the physician workforce, and how the use of non-physician providers (NPPs) could potentially affect future physician utilization, will be discussed.

Healthcare workforce planning has become much more complex than a simple numbers game related to supply and demand, due not only to budget constraints, but also to the changing healthcare environment. Planning now requires that both cyclical factors, such as short-term changes in economic cycles and the current healthcare environment, and structural factors, such as long-term population and disease trends and healthcare infrastructure, be addressed. Additionally, traditional models often evaluated providers within separate “silos,” meaning physicians and nurses. More recent models have begun to consider the “plasticity” of healthcare workers, both in terms of horizontal integration among different physician specialties. For example, the provision of obstetrics care by both physicians trained in obstetrics-gynecology and in family practice, and, more recently, vertical integration, the sharing of tasks across different occupational groups such as physicians and NPPs.

The Current Healthcare Workforce

Recent studies by the Association of American Medical Colleges (AAMC) and the Health Resources and Services Administration (HRSA) have both predicted that physician demand is, and will continue to, grow faster than supply, leading to a future shortfall of total physicians. The AAMC has estimated that by 2030, there will be a total physician shortage of 40,800 to 104,900 physicians.

Trends in Physician Supply. As of 2016, there were approximately 272 active physicians, 92 active primary care physicians, and 7.8 active general surgeons per 100,000 population in the U.S. This might be considered adequate if the workforce were appropriately distributed; however, estimated shortages in physician supply fluctuate based on geographic area. As of December 2017, HRSA identified 7,118 health professional shortage areas (HPSA) in primary care. A number of provisions in the 2010 Patient Protection and Affordable Care Act (ACA) have attempted to address this disproportionality by providing funds to under-represented minorities from rural areas to pursue careers in healthcare (in the hope they might return to these locations to practice); supporting physician recruitment and retention in underserved areas; and encouraging medical students to pursue focused training and experience in rural and urban HPSAs.

There is also growing concern about the number of active physicians nearing retirement age, particularly with the aging baby boomer population. As of 2016, more than 30% of physicians were over the age of 60. Compounding this concern, data have shown that physicians under age 35 are working approximately 13% fewer hours than their older colleagues. These trends, in addition to the stagnant number of new physicians entering the workforce due to the cap on graduate medical education (GME) funding by Medicare, further curtail the supply of physician services.

Trends in Physician Demand. The primary driver of increasing healthcare demand continues to be the growth and aging of the general population. While the U.S. population is projected to grow 12% from 2015 to 2030, the percentage of the population aged 65 and older is projected to grow by 55%. Given that the elderly population comprises only 14% of the total population, but accounts for more than 30% of inpatient procedures and diagnostic treatments, the demand on the healthcare workforce is predicted to concurrently increase with the aging of the population. Additionally, the expansion of health insurance coverage under the ACA, which has increased the number of insured non-elderly people by approximately 19 million from 2010 to 2015, has amplified the demand for physician services. Although the non-partisan Congressional Budget Office has estimated that the number of uninsured will rise due to the recent repeal of financial penalties related to the individual mandate, it is unknown how this repeal will impact physician demand estimates.

Utilization of NPPs

The expansion of NPP services has been viewed as a strategy to improve access to care, contain healthcare costs, and relieve anticipated physician shortages. Since the concept of nurse practitioners (NP) was first introduced in the 1960s, the role has evolved and is now part of the larger umbrella term of NPPs, otherwise known as mid-level providers; advanced practice registered nurses (APRN); or advanced practice providers. Examples of NPP roles include: physician assistants (PA); certified registered nurse anesthetists (CRNA); and certified
nurse midwives (CNM). Most recently, in 2017, Missouri became the first state to create a new NPP role—the assistant physician (AP)—for those individuals who have completed medical school but not a post-graduate residency program.

The role of the NPP was originally created to expand a primary care physician’s workload capacity and allow more patients to access primary care services, particularly in underserved or rural areas. Additionally, health systems could (ideally) improve access to primary care by relieving physicians from performing many basic and necessary, but time consuming, tasks common within primary care, including counseling on lifestyle issues and management of routine screening and preventive care. Delegating these tasks could reduce costs to health systems while allowing nurses opportunities for advancement and increasing the quality of patient care.

In recent years, the role of NPPs within the healthcare industry has expanded. There has been much debate about the appropriate scope of care, including NPP's autonomy to prescribe and supervise services. This scope varies considerably by title, state legislation, and even institutional policy. One of the primary concerns about the increasing use and autonomy of NPPs is whether the care provided is as safe and efficient as care provided by physicians. Multiple studies have addressed this issue, particularly in the realm of primary care, and found that nurse-led care is equivalent to physician care with regard to patient clinical outcomes, safety, and satisfaction.

Estimates predict that the growth rates of NPPs will outpace that of physicians in the coming years. From 2015 to 2030, the projected physician-to-PA ratio is expected to fall from approximately 7:1 to 4:1, and the physician-to-APRN ratio from approximately 4:1 to 2:1. This will impact multiple medical specialties, but most significantly those of anesthesiology; obstetrics and gynecology; and primary care. Data have shown that NPs are more likely than physicians to pursue primary care. For instance, a 2013 Health Affairs study showed that NPs practicing in states with fewer restrictive regulations were 2.5 times more likely to provide primary care to Medicare patients than their counterparts in the most restrictive states.

**What This Means for Physicians**

Job openings for NPPs are growing at an annual rate of approximately 160%, and it appears unlikely that the growth in the healthcare market for NPPs will decrease any time soon. While physician organizations have historically voiced unease about the potential supplanting of physicians with NPPs, thus far, NPPs have served an important role in caring for underserved communities with unmet needs, and in the future, NPPs likely will be needed to offset the increasing demand for healthcare services, as evidenced by the ongoing (and growing) physician shortage.

The rising number of retail clinics (often staffed by NPPs), and increased utilization of NPPs in general, are expected to supplement unmet demand for physician services, especially in primary care. A growing number of hospitals and health systems are developing partnerships with retail clinics to increase their patient outreach and provide care for many routine medical situations. The NPPs staffing those clinics may be able to unburden physicians, who can delegate the more routine medical treatments to NPPs and focus on higher acuity patients. Further, physicians are being sought out to serve in managerial positions for hospitals, health systems, and commercial payors (medical and service line directors, executive leadership), and to provide clinical input for the purposes of evidence-based medicine in this era of value-based, quality-driven reimbursement.

It has also been shown that physician practices that utilize NPPs typically perform better financially and have higher physician compensation. This may be due in part to increased practice efficiency, allowing physicians to concentrate on more complex patients or procedures. In addition, NPPs who are directly supervised by physicians can bill for 100% (as incident-to billing) of the physician fee schedule, while unsupervised NPPs are typically reimbursed at only 85%, thereby directly increasing practice revenue. As such, it appears that NPP utilization has the ability to augment a physician’s practice without supplanting physician services.

**Future Workforce Planning Efforts**

Of the myriad factors that affect physician workforce planning, the utilization of NPPs remains a valid strategy to positively impact both the supply and demand of healthcare practitioners within the ever-changing healthcare environment. In particular, given the aging of the baby boomer population and an increased focus on the management of chronic diseases (an area in which NPPs have been shown to be effective providers), NPPs have the potential to greatly alleviate the growing demands on the physician workforce. Challenges remain as to NPP scope of practice, as well as the impact on patient care and costs that require continued assessment and evaluation. Notwithstanding this uncertainty, NPPs will likely serve an important role in the healthcare delivery system going forward, providing an already stretched physician workforce the availability to care for higher acuity patients and the time to assume a leadership role and take a meaningful seat at the table in directing the future of the U.S. healthcare delivery system.

“Physician practices that utilize NPPs typically perform better financially and have higher physician compensation. This may be due in part to increased practice efficiency, allowing physicians to concentrate on more complex patients or procedures.”

Todd A Zigrang, MBA, MHA, is president of Health Capital Consultants, a company based in St. Louis, where he focuses on the areas of valuation and financial analysis for hospitals, physician practices, and other healthcare enterprises. Jessica Bailey-Wheaton, Esq., is vice president and general counsel for HCC.
THE FOLLOWING update was prepared by the American Medical Association. AMA advocacy with the Centers for Medicare and Medicaid Services (CMS) was critical to achieving many adjustments. Below are some of the highlights of the AMA’s advocacy work.

Physician Payment Update and Misvalued Codes Target
The update to payments under the PFS in 2018 will be +0.31%. This reflects the 0.5% update factor established under the Medicare Access and CHIP Reauthorization Act (MACRA), minus 0.09%, due to the misvalued codes target recapture amount, required under the Achieving Better Life Experience (ABLE) Act of 2014. The conversion factor was reduced by an additional 0.10% to offset spending on newly covered services, include new coverage of prolonged preventive medicine services (G0513 and G0514) and remote monitoring (CPT 99091). CMS finalized a 2018 conversion factor of 35.9996 (2017 conversion factor was 35.89). The Medicare anesthesia conversion factor for 2018 is 22.1887.

Physician Work and Practice Expense
CMS finalized valuation for individual services in 2018 consistent with recommendations of the AMA/Specialty Society RVS Update Committee (RUC). The RUC recommendations for 2018 included resource estimates for new/revised CPT codes and services identified as potentially misvalued. To date, the RUC’s efforts to address misvaluations have resulted in $5 billion in annual redistributions.

In response to an AMA House of Delegates request and RUC recommendations, the federal CMS has published relative values for several non-covered/bundled physician services, including inter-professional consultations.

Professional Liability Insurance
CMS did not finalize its proposal to use updated premium data in computing the professional liability insurance relative values. CMS will work to address the premium data shortcomings identified by the AMA and RUC prior to updating this information in 2020. CMS did finalize its proposal to utilize the RUC and specialty recommendations for specialties expected to have low volume codes, a change long advocated by the RUC.

The Physician Quality Reporting System (PQRS) and Meaningful Use (MU) Quality Reporting
The AMA and other members of the Federation urged CMS to revise CY2016 PQRS and MU quality reporting requirements to only require physicians to report six measures with no domain or cross-cutting measure requirements. CMS finalized this change which aligns the CY 2016 PQRS and MU quality reporting requirements with the new quality reporting requirements for physicians under the Merit-Based Incentive Payment System (MIPS). CMS estimates that this change will result in approximately $22 million in reduced penalties for physicians. To further align with the MIPS requirements, CMS finalized making the CAHPS for PQRS survey optional under GPRO for practices of 100 or more eligible clinicians in 2016.

Value Modifier (VM)
CMS finalized several changes to better align the VM program with the MIPS program. These changes include:

• Holding all groups and solo practitioners who met 2016 PQRS reporting requirements harmless from any negative VM payment adjustments in 2018.
• Halving penalties for those who did not meet PQRS requirements to -2% for groups with 10 or more eligible professionals, and to -1% for smaller groups and solo practitioners.
• Reducing the maximum upward payment adjustment to two times an adjustment factor that is set at the rate needed to keep penalties and bonuses budget neutral.
• Dropping its earlier proposal to publicly report 2016 value modifier data on its Physician Compare web site.

Patient Relationship Categories
MACRA directed CMS to create new patient relationship codes that physicians would be required to report on claims starting in 2018 for the purposes of determining which physician would be held accountable for a patient’s cost of care. CMS finalized the use of Level II Healthcare Common Procedure Coding System (HCPCS) modifiers as the patient relationship codes. The HCPCS modifiers may be voluntarily reported beginning Jan. 1, 2018. CMS notes that by allowing for a voluntary approach to reporting, it will gain information about patient relationship codes and allow for education and outreach to physicians on the use of the codes.

Diabetes Prevention Program (DPP)
Addressing pre-diabetes is one of the AMA’s strategic focus areas, so AMA is strongly supportive of CMS moving forward with the Medicare DPP. CMS finalized a maximum payment per beneficiary of $670 (a decrease from $810 in the proposed rule) over three years for the set of MDPP core and maintenance services. CMS also revised the payment amount to shift a higher percent to the core service period (especially the first six months of the MDPP services period) from what it had previously proposed.

CMS also finalized a two-year time limit on Medicare coverage for ongoing maintenance sessions, specifically finalizing that after year one, suppliers of MDPP would have to offer one year of ongoing maintenance sessions to beneficiaries who continue to meet attendance and weight loss goals. CMS also finalized that a diabetes diagnosis exclusion only applies as of the date of attendance at the first core session.

For more information, see Chicago Medicine’s Fall 2017 issue featuring the AMA’s annual advocacy efforts.
CMS finalized a delay of the start date of the MDPP for three months until April 1, 2018, noting it believes the 90-day period will allow eligible organizations adequate time to enroll in Medicare as MDPP suppliers. CMS also finalized the establishment of new HCPCS G-codes for reporting MDPP services.

**Virtual DPP**
CMS stated in the proposed rule that expansion of the MDPP benefit to virtual services could not be considered because it was not a modality evaluated in the original MDPP demonstration. The AMA urged CMS to expand MDPP to include virtual services in the expansion. Instead, CMS indicated that virtual MDPP would only be considered as part of a future demonstration.

**Digital Medicine**
CMS finalized a number of proposed expansions of telehealth and remote patient monitoring services coverage. The AMA strongly supported expanded coverage of both, and the expanded coverage of remote patient monitoring is not subject to the same geographic and originating site restrictions as Medicare telehealth services. This represents a seminal decision by CMS to expand coverage of remote patient monitoring services in the Medicare program. Further, CMS welcomed the development of new remote patient monitoring codes by the CPT Editorial Panel that will be ready for consideration in the 2019 Medicare proposed PFS. In addition, CMS has extended support for digital medicine to MIPS, so now physicians can get credit in the MIPS Improvement Activity category and be reimbursed for using digital medicine.

**Remote Patient Monitoring**
CMS finalized coverage of remote patient monitoring services by unbundling and activating CPT code 99091 (collection and interpretation of physiologic data) for separate payment under Medicare for 2018 as a short-term measure until new CPT codes have been valued and considered as part of the Medicare 2019 Physician Fee Schedule. CMS specified that 99091 requires a minimum of 30 minutes of time in a 30-day period. CMS will utilize the RVUs ($59) for CPT code 99091. CMS noted that separate payment for this code will not mitigate the need for coding revisions. Until the new CPT codes are considered through future rulemaking, CMS will apply some of the current requirements regarding chronic care management services including advance beneficiary consent, a face-to-face with the billing practitioner for new patients, and those who have not seen their practitioner one year prior to billing the code, for example.

**Appropriate Use Criteria (AUC)**
The Protecting Access to Medicare Act (PAMA) of 2014 required CMS to create a program that effective Jan. 1, 2017, would have denied payment for advanced imaging services unless the physician ordering the service had consulted AUC. In response to advocacy by the AMA and other members of the Federation, CMS previously delayed implementation until 2018. In this final rule, CMS again responded positively to advocacy by the AMA and other physician organizations and finalized a further delay of the AUC program until Jan. 1, 2020. In 2020, the program will begin with an educational and operations testing period, during which CMS will pay claims for advanced diagnostic imaging services regardless of whether they correctly contain information on the required AUC consultation. CMS is also implementing a voluntary reporting period beginning July 2018 through 2019.

**Biosimilars**
As recommended by the AMA, CMS reversed previous proposed policy on coding and payment for biosimilars and will now provide for separate coding and payment for each approved biosimilar product. Previous policy would have grouped all biosimilars for a single originator product into a single HCPCS code and payment amount. CMS noted that most commenters believed that the previous proposed policy of including all grouping biosimilars into the same code/payment would decrease incentives for biosimilar development and limit provider choices. The agency noted it supports a healthy biosimilar marketplace that promotes innovation, competition, and options for providers and patients.

**Data Collection and Pricing for Clinical Laboratory Testing**
CMS requested feedback on the experience of clinical laboratories that were required to submit information on private payer payments as part of the data collection and pricing exercise mandated by PAMA. The AMA submitted comments expressing strong concern that the data collection process was flawed and urging CMS to initiate a market segment survey to ascertain whether the rates were accurate. Throughout the regulatory process, the AMA raised tremendous concern about the impact of this policy on physician office labs. Due to statutory constraints, CMS declined in the final rule to modify the effective date and the rates.

**Payment Rates under the Medicare PFS for Nonexcepted Items and Services Furnished by Nonexcepted Off-Campus Provider-Based Departments (PBDs) of a Hospital**
Last year CMS finalized a PFS payment rate for nonexcepted off-campus PBD services of 50% of OPPS payment. In the final 2018 PFS, CMS reduced the current payment rates to 40% of the OPPS payment.

**Evaluation and Management (E/M) Documentation Guidelines**
In the 2018 proposed rule, CMS asked for comments on revisions to the E/M documentation guidelines that would reduce administrative burden to physicians. CMS relayed that commenters did not agree on how the current standards should be changed, and different specialties expressed different challenges and recommendations regarding the guidelines. However, the agency also noted that it continues to believe revised documentation guidelines could reduce clinical burden, and it is considering the best approach for collaboration to develop and implement potential changes going forward.

**Medicare Shared Savings Program (MSSP)**
CMS finalized its proposal to reduce the document submission requirements for the MSSP initial application by eliminating the requirement to submit supporting documents or narratives unless CMS requests the materials. CMS also finalized
changes to the Skilled Nursing Facility (SNF) three-day waiver application procedures to reduce documentation submission requirements.

CMS also finalized reducing the burden placed on ACOs that include Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) by treating a service reported on an RHC or FQHC institutional claim as a primary care service furnished by a primary care physician for purposes of assignment methodology. In addition, CMS finalized its proposal to revise the definition of primary care services to include three additional Chronic Care Management codes and four Behavioral Health Integration (BHI) codes.

Highlights of the 2018 ASC/OPPS Final Rule
Below are highlights of this Final Rule:

OAS CAHPS Measures
CMS finalized its proposal to delay the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey measures beginning with the calendar year 2020 payment period. The AMA supports the delay of the OAS CAHPS survey measures.

Medicare Part B Laboratory Date of Service (DOS) Policy
After advocacy from AMA and other stakeholders, CMS finalized a new exception to the laboratory DOS policy which permits laboratories to bill Medicare directly for advanced diagnostic laboratory tests (ADLTs) and molecular pathology tests excluded from OPPS packaging policy if the specimen was collected from a hospital outpatient during a hospital outpatient encounter and was performed following the patients discharge from the hospital outpatient department.

340B Drug Pricing
CMS finalized reducing the payment rate for separately payable drugs and biologicals under the 340B program from Average Sales Price (ASP) plus 6% to ASP minus 22.5%. Rural sole community hospitals, children’s hospitals and PPS-exempt cancer hospitals are excluded from this payment adjustment in 2018. CMS also established two modifiers to identify whether a drug billed under the OPPS was purchased under the 340B program, one for hospitals subject to the payment adjustment and one for hospitals not subject to the payment adjustment. CMS says it may revisit the 340B payment policy in CY 2019 rulemaking.

Medicare Site of Service Price Transparency
The 21st Century Cures Act required that the Secretary make publicly available the estimated payment amount for an item or service under either the OPPS or ASC payment system for an appropriate number of items and services. CMS plans to establish the searchable website in early 2018. Further details regarding the website will be issued through sub-regulatory guidance.

ASC Payment Reform
CMS did not make any changes to the ASC payment update methodology, but stated that given supporting alternative update methodologies, such as the hospital market basket, and given its interest in site neutrality and the efficiency of care, it intends to explore this issue further. 
Effects of the 2018 Medicare Physician Fee Schedule

The Final Rule has been released By Nicole Channell

THE CENTERS for Medicare and Medicaid Services (CMS) released the 2018 Final Physician Fee Schedule effective Jan. 1, 2018. CMS has set the conversion factor (CF) for 2017 at $35.9996. This includes the 0.5% update as required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). However, this 0.5% is decreased by 0.19% due to not reaching the 0.5% target for net adjustment to mis-valued codes in 2018.

Impact of Final Rule by Specialty

Here is a snapshot of the combined estimated impact (work, MP and PE, RVU changes) for select specialties from CMS. The impact illustrated here reflects only the change in RVUs. It does not include the conversion factor (CF) calculation for 2017.

- Cardiac Surgery: 0%
- Dermatology: 1%
- Orthopedic Surgery: 0%
- Otolaryngology: -2%
- Rheumatology: 1%
- Urology: -2%

The Final Rule also contains policy updates on the following programs that are either already present and/or coming in the near term:

- Addition of codes to the list of Telehealth Services.
- Finalizing Care Management Codes in 2018 that are currently listed as “G” codes.
- Rural Health Clinic (RHC) and Federally Qualified Health Centers (FQHC) to receive payment for Care Coordination Services, Behavioral Health Integration Services and Psychiatric Collaborative Care Model Services.
- Establishes the new Medicare Diabetes Prevention Program, which begins April 1.
- Clarification of Medicare Shared Savings Program (MSSP) and Value Modifier updates.

Nicole Channell is a senior healthcare consultant at PBC Advisors, LLC, in Oak Brook. The company provides business and management consulting and accounting services to physician practices. For more information, visit www.pbcgroup.com.

Reimbursement Examples

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<td>43239</td>
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<td>Endoscopy</td>
<td>$370.46</td>
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<td>59400</td>
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<td>59510</td>
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<td>Cesarean Section</td>
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<td>70450</td>
<td>26</td>
<td>CT - Head</td>
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<tr>
<td>71010*</td>
<td>26</td>
<td>Chest X-ray</td>
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<td>Surgical Path - Level IV</td>
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<tr>
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<tr>
<td>G9202*</td>
<td>26</td>
<td>Screening Mammogram</td>
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<td>$40.03</td>
<td>0.80%</td>
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</table>

*71010 replaced by 71045 in 2018
THE 2017-2018 flu season is shaping up to be one of the worst in recent history. According to the Centers for Disease Control and Prevention (CDC), as of early February—the midpoint of flu season—nearly 60 hospitalizations for influenza occurred per 100,000 people in the United States. In contrast, at the peak of the 2014-15 season, one of the two most severe seasons in the last 15 years or so, 29.9 people out of every 100,000 were hospitalized for the flu.

The highest hospitalization rate during this influenza season is among people 65 years and older (263.6 per 100,000), followed by adults aged 50-64 years (63.1 per 100,000), and younger children aged 0-4 years (40.0 per 100,000). During most seasons, adults 65 years and older have the highest hospitalization rates, followed by children 0-4 years. This year, hospitalization rates are tracking higher than in any year since the CDC began monitoring that metric in 2010.

In addition, as of early February, the flu had caused a total of 63 pediatric deaths. The CDC has tracked pediatric deaths from influenza since 2004, and they’ve ranged from 37 to 171 during regular seasons; the highest was during the 2009 pandemic, when 358 pediatric deaths were reported. “We are receiving a volume of calls about the flu that we haven’t experienced in about ten years,” says Deborah Gulson, MD, a pediatrician at PediaTrust’s Lake Shore Pediatrics location. “The number of parents asking for flu services for their children is actually exceeding our capacity.”

**Most Frequent Strains**

The most frequently identified influenza virus subtype reported by public health laboratories to the CDC was influenza A(H3N2) virus. During the week ending Feb. 3, there were 1,453 influenza-positive tests reported. Of those, 73.3% (1,065) were influenza A viruses and 26.7% (388) were influenza B viruses. Of the 978 influenza A viruses that were subtyped, 85.3% (834) were H3N2 viruses and 14.7% (144) were (H1N1)pdm09 viruses. From Oct. 1 (when monitoring for this flu season began) through mid-January, more than 60,000 samples testing positive for influenza were reported.

“H3 and H2 strains of influenza are especially virulent,” says Dr. Gulson. “They have a history of causing severe symptoms and this particular H3N2 strain is causing more severe symptoms such as fevers and inflammation in airways. And, this strain has mutated since the vaccine for it was created, which is something influenza is very good at doing.” The flu vaccine is less effective against H3 viruses, which tend to cause more serious flu cases than other strains, according to the CDC.

**The Flu in Chicago and Illinois**

In Chicago, as of early February, the number of reported influenza-associated ICU hospitalizations had surpassed the total number of reported ICU hospitalizations for any season since 2010-2011. Since Oct. 1, 2017, 323 influenza-associated ICU hospitalizations had been reported; 297 were positive for influenza A, with 92 cases being the H3N2 strain, 13 cases being the H1N1 strain, and 192 cases consisting of an unknown subtype. Twenty-six cases were positive for influenza B. The median age of reported cases was 62 years. Two pediatric deaths were reported including one ICU hospitalization.

The number of influenza cases across the state of Illinois prompted state health officials in late December to recommend that hospitals limit visitors and put precautions into place aimed at preventing and controlling further spread of the flu. The precautions include restricting hospital visits for anyone younger than 18, limiting the number of visitors to two per patient, promoting hand washing and assessing visitors for symptoms of acute respiratory illness. Visitors who show signs of the flu should be asked to leave the facility or at the very least wear a sanitary mask.

Cook County public health officials have also instituted a screening policy at their hospitals to cut the risk of transmission to already ill people. Visitors are being screened for flu-like symptoms before being allowed to see patients. Children under 12 won’t be allowed to visit patients at Stroger or Provident Hospitals at all.

**CDC Recommendations**

The CDC continues to recommend the influenza vaccination for all persons 6 months of age and older as flu viruses are likely to continue circulating for weeks, and there is an increasing proportion of influenza B, H1N1, and H3N2 viruses being detected.

In addition, in the context of widespread influenza activity, the CDC is reminding clinicians and the public about the importance of prompt treatment with antiviral medications in people who are severely ill and people at high risk of serious flu complications who develop flu symptoms.

“As physicians, we have to just keep our chin up and work longer hours to get through the influenza season,” says Dr. Gulson. “And we don’t mind. Our ability to help others is our privilege.”

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By Cheryl England

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Getting Patient Consent for a Flu Shot Reminder

Be sure to cover your bases when sending out flu shot reminders to your patients

By Sarah R. Anchors, Esq.

Many medical offices and wellness clinics send out flu shot reminders to their patients. But have those patients consented to receive those reminder text messages or robocalls? Yes, under certain circumstances, said the U.S. Second Circuit Court of Appeals in Latner v. Mount Sinai Health Sys., Inc., No. 17-99-cv (2d Cir. Jan. 3, 2018). This ruling is notable because it is the first appellate court decision on the “health care exception” to the Telephone Consumer Protection Act (TCPA), articulated by the Federal Communications Commission in 2012. And it is good news for the medical offices sending those reminder messages—the ruling interprets the exception broadly.

About the Telephone Consumer Protection Act

The TCPA requires businesses to have “prior express consent” to use automatic dialers and prerecorded messages for calls and text messages to consumers’ cell phones, and to use prerecorded messages for calls to residential landlines. Generally, that consent is when the consumer gives a business the telephone number in connection with a transaction that is related to the purpose of the robocall/prerecorded message. If those robocalls/text messages are telemarketing or introduce an advertisement, then the business has to go a step further. It must have the recipient’s prior express written consent, given with certain disclosures. The TCPA carries statutory damages of $500–$1,500 per violation, and is a frequent basis for class-action claims.

The 2012 Health Care Exception, and the 2015 Health Care Treatment Exemption

The 2012 health care exception to the Telephone Consumer Protection Act states that calls and texts that are: (a) by or on behalf of a covered entity or business associate, as defined by HIPAA; and (b) for a health care treatment purpose; are not considered telemarketing. Giving a healthcare provider a telephone number is sufficient consent to send messages under the health care exception, the FCC said. In 2015, the FCC announced a “health care treatment exemption,” so the sender needs no consent to send the message, under certain additional circumstances (including that the call and/or text is free to the recipient).

The Second Circuit Speaks

Latner involved the 2012 health care exception. Mr. Latner gave his cell phone number as his contact on a new patient form, and consented to Mt. Sinai using his health information “for payment, treatment and hospital operations purposes.” He also received privacy notices that said his information could be used “to recommend possible treatment alternatives or health-related benefits and services.” Mr. Latner declined immunizations during his November 2011 appointment, and then in November 2014, received a text message reminding him it was flu season and encouraging him to call the Mt. Sinai facility to schedule a flu shot. This reminder was sent to all active clinic patients who had been seen within the previous three years.

The Second Circuit affirmed that the health care exception applied. The reminder was intended as a direct or recommended alternative treatment, and to communicate health-care related information rather than to offer property, goods, or services. It did not matter to the Second Circuit that it had been three years since Mr. Latner had last been to Mt. Sinai’s facility, or that he refused the flu shot in 2011. Mr. Latner’s provision of his cell phone number on the new patient form, and the policies provided to him about using his health information to recommend treatment were sufficient prior express consent for the flu shot reminder.

We can expect to hear more from the Second Circuit on this topic as oral argument is scheduled in another flu-shot reminder case, Zani v. Rite Aid Headquarters Corp., next month. The trial court in Zani focused on the reminder being an individualized offer of health care treatment because it was only sent to those who had received flu shot in the prior flu season.

What This Means to You and Your Practice

Covered entities and business associates should confirm the consent they have from patients before using robocalls or mass text messages to remind patients to come in for a flu shot.

“Covered entities and business associates should confirm the consent they have from patients before using robocalls or mass text messages to remind patients to come in for a flu shot.”

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Addressing Boys’ and Men’s Mental Health
Peer pressure and loss of close male friendships contribute to “crisis of connection”
By Anna Gonzales, MPH, Anthony Harden, and Lesley J. Craig, MPH

In Illinois, rates of attempted suicide among male high school students are higher than their female counterparts’ and the national figures for high school males.”

More than 40 million Americans struggle with mental illness each year, according to the Substance Abuse and Mental Health Services Administration (SAMHSA). With treatment and support, people can get better and many can recover completely. Yet many go undiagnosed, do not seek care, or lack access to services. This is often the case with boys and men.

While the National Survey on Drug Use and Health reports that 21.2% of women and 14.3% of men experienced mental illness in 2015, the National Institutes of Health reports that men may be less willing to talk about their feelings or seek help. And some men with depression mask their emotions and appear angry or aggressive, while many women express sadness, a more common symptom of depression. Symptoms may also manifest as physical issues, such as racing heart, consistent headache, or issues with digestion.

Untreated mental illness can make men more vulnerable to substance misuse, employment issues, homelessness, and incarceration. Boys are more likely to experience negative repercussions such as disruption to their school performance, harm to relationships, and suicide.

Suicide is the 10th leading cause of death nationally, accounting for more than twice the number of homicides in the U.S. Suicide is the second leading cause of death for 15- to 24-year-olds. As of 2013, children ages 10 to 14 were more likely to die from suicide than in a motor vehicle accident.

In Illinois, rates of attempted suicide among male high school students are higher than their female counterparts’ and the national figures for male high school students—10% of Illinois high school males reported they attempted suicide one or more times in the past year, compared to 9% reported by Illinois high school females and 6% reported by high school males nationally.

Research demonstrates that adolescents with close friendships are less prone to mental illness, while those without close friendships have an increased risk for many negative outcomes, including suicide and drug use. Dr. Niobe Way, a professor of developmental psychology at New York University, has interviewed hundreds of adolescent boys over the past 25 years about friendships. Her longitudinal research finds that boys, in early and middle adolescence, often have close male friendships and explicitly link these relationships to their mental health. Yet by late adolescence, boys discuss losing close male friendships and reveal feelings of loneliness and isolation. Boys report this is due to feeling pressure to “man up” and fear that having or expressing interest in close male friendships will make them look “ girly” or “gay” (direct quotes from boys in the study). To better understand this “crisis of connection,” the U.S. Department of Health and Human Services Office of Adolescent Health, the federal Interagency Working Group on Youth Programs, and Dr. Way developed a video and two discussion guides (Youth.gov).

While fostering positive relationships with adolescents is important, early warning signs of problems may be present even in very young children and often meet clinical criteria for a diagnosable condition. In fact, half of all mental health disorders manifest before age 14, and three-quarters begin before age 24.

The U.S. Preventive Services Task Force (USPSTF) recommends screening adolescents in five areas related to mental health, including alcohol use, child maltreatment, depression, illicit drug use, and suicide risk. Screening for major depressive disorder should occur in adolescents aged 12 to 18 years.

The USPSTF recommends screening all adults for depression, including pregnant and postpartum women. It is important to note that the USPSTF “Grade B” recommendations state that screening should be done with “adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.” Despite these screening recommendations, in 2016, just 43% of adults with any mental illness received mental health services and only 31% of adolescents (ages 12-17) received treatment. Adolescent boys are less likely to receive mental health services than adolescent girls.

Effective treatments exist, varying by mental health disorder and individual, and may involve a combination of psychotherapy and medication.

The SAMHSA-HRSA Center for Integrated Health Solutions provides training, technical assistance, and guidance to behavioral health organizations and health centers, as well as primary care organizations, to promote the integration of services, whether individuals are seen in behavioral health or primary care settings. Learn more at www.integration.samhsa.gov.

Health care providers and their patients can also find information at MentalHealth.gov, which provides one-stop access to U.S. government mental health resources and guidance.

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

When handling requests, employers should heed Court decisions and their implications
By Ryan A. Haas, Esq., and Kimberly T. Boike, Esq.

Medical Practices face challenges when handling employee requests for temporary disabilities. The Americans with Disabilities Act (ADA) requires employers to engage in an interactive process to accommodate an employee’s disability so the worker can perform the essential job function. The Family and Medical Leave Act (FMLA) requires employers to allow employees to take medical leave for a qualifying medical condition. These requirements apply equally to an employee who suffers impairments related to a pregnancy.

Impairments Under the ADA
In 2008, the ADA was amended to make it much easier for an employee to demonstrate that a medical condition is a covered disability. Thus, impairments resulting from pregnancy, such as gestational diabetes or preeclampsia, may qualify as disabilities under the ADA.

An employee who is temporarily unable to perform her job due to a medical condition related to pregnancy or childbirth must be treated in the same way as any other temporarily disabled employee. Thus, an employer must offer a reasonable accommodation. This can take the form of temporary leave, light duty or modification that enables an employee to perform her job due to a disability related to pregnancy. An accommodation must be provided unless it would result in significant difficulty or expense to the employee.

Leave Under the FMLA
Practices with 50 or more employees may also need to comply with the FMLA when a pregnant employee seeks leave for a serious health condition. The FMLA entitles eligible employees with up to 12 weeks of unpaid leave in a 12-month period.

The FMLA provides that employees seek leave 30 days in advance if the leave is foreseeable. In addition, employees should provide an anticipated return to work date when feasible. However, pregnant employees who develop complications often require leave that is not foreseeable and often are not certain of a return to work date.

The Seventh Circuit Court has held that the employer violated the FMLA when it hired a replacement because the employee’s leave was “unforeseeable.”

Protections Under the PDA
The Pregnancy Discrimination Act of 1978 (PDA) creates further protections. The Act forbids discrimination based on pregnancy related to any aspect of employment, including hiring, firing, compensation, job assignment, promotion, or a fringe benefit, such as leave policies and health insurance.

In a Supreme Court decision, Young v. United Parcel Service, the court held that an employer may be required to provide a reasonable accommodation to pregnant workers if it accommodates non-pregnant employees with similar requests. This is in addition to ADA accommodations for medical conditions arising from pregnancy.

The Supreme Court’s recent decision involved the denial of light duty work to a UPS driver. As an employee she was expected to lift packages of up to 70 pounds. But after the employee became pregnant, her doctor advised lifting no more than 20 pounds early in her pregnancy and 10 pounds after 20 weeks. UPS denied the request for light duty, and the employee was forced to take leave without pay. She sued UPS alleging its conduct violated the PDA because UPS had accommodated other non-pregnant workers with lifting restrictions.

Rejecting UPS’ argument that the PDA simply prohibits discrimination based on pregnancy and does not require accommodations, the court held the Act requires pregnant employees to be treated the same way as other employees who are “similar in their ability or inability to work.” Thus, a denial of an accommodation to a pregnant employee that is offered to other similarly situated non-pregnant employees may violate the PDA.

This decision has obvious implications for medical practices who require staff to perform physically taxing work. As such, employers must follow the Supreme Court’s guidance when a pregnant employee requests an accommodation.

Kimberly T. Boike, Esq., and Ryan A. Haas, Esq., practice at the Chicago office of Chuhak & Tecson, PC. Kimberly T. Boike, Esq., is a principal, and practices healthcare law. Ryan A. Haas, Esq., is a principal and general counsel and practices employment law affecting healthcare providers.
ON OCT. 26, 2017, after weeks of internal deliberations, President Donald Trump directed Acting Secretary of Health and Human Services (HHS) Eric Hargan to declare a national state of public health emergency (PHE) in response to the escalating opioid epidemic. In so doing, the President classified the opioid epidemic as the deadliest PHE to ever be so designated since the nomenclature originated in 2001. Over the last two decades, overuse and abuse of prescription and illicit opioids have contributed to rampant morbidity and mortality across the country. Since 1999 over 600,000 deaths among all ages, sexes, races, and classes are attributable to opioid abuse. Solutions to this “Medusa of epidemics” are not easy, quick, or cheap. Absent enhanced and innovative public health interventions funded by a sizable infusion of resources, hundreds of thousands more may die by 2020.

Like opioid-related declarations issued already by a half-dozen states and multiple tribal governments and localities, the federal PHE declaration is a purposeful step. Alongside other interventions, it legally authorizes federal, state, tribal, and local authorities to allocate existing personnel and resources toward opioid prevention efforts, waives some key legal inhibitions, ramps up critical public health surveillance, and facilitates greater coordination across federal agencies.

Still, HHS’ declaration has generated considerable controversy. Some favor classifying the opioid epidemic as a PHE, but wish President Trump would have declared a full-blown national emergency to free up more resources. Others seriously question the utility of labeling a long-term, complex epidemic of opioid abuse as an emergency at all. They assert that PHEs are typically reserved for rapidly-escalating infectious disease threats or quick responses to humanitarian disasters. Debating the utility of a PHE declaration in response to the opioid epidemic, however, is misplaced for several reasons: (1) PHEs have been declared in response to threats far less serious than the opioid epidemic; (2) while a PHE declaration may not solve the crisis, it can diminish its impacts; and (3) innovations undertaken during a PHE can become standard practice post emergency. The primary question is not whether the opioid epidemic qualifies as a PHE, but rather what other conditions might also constitute PHEs going forward. This article suggests a series of criteria designed to better clarify PHEs for the future.

Legal Scope and Range of Public Health Emergencies

The terrorist attacks of Sept. 11, 2001, and ensuing anthrax exposures prompted public health law scholars at Johns Hopkins and Georgetown Universities to develop model legislation for state and local officials to rapidly respond to emergency events. The resulting Model State Emergency Health Powers Act (MSEHPA), disseminated in December 2001, has been adopted by legislatures and agencies in almost all states as well as the District of Columbia, and used to declare PHEs in response to acts of bioterrorism, emerging infectious diseases, or other threats posing a “high probability” of deaths, disabilities, or exposures to harm-causing agents.

As illustrated in Table 1, PHEs have been declared under diverse circumstances necessitating a heightened legal response to protect the public’s health. Multiple PHEs have been issued to curb the spread of highly contagious, sometimes fatal diseases such as H1N1 (2009), Ebola virus (2014), and Zika virus (2016) through strengthened medical countermeasures and enhanced authorizations of social distancing efforts. Humanitarian disasters, including Hurricanes Katrina (2005), Sandy (2009), and Harvey (2017) have sparked numerous other emergency declarations, allowing redirection of government funds and personnel to bolster local response efforts in devastated and overwhelmed regions.

Government officials have increasingly issued PHEs for events or conditions less sudden and severe than deadly outbreaks or humanitarian disasters. For example, PHEs of limited scope have been declared for food insecurity in Hawaii County (2012), seasonal influenza in New York (2013), and homelessness in Seattle (2015). Though dissimilar in origin and trajectory, these conditions mirror traditional emergencies in their need for additional funding, medical countermeasures, and skilled personnel to curb imminent and preventable threats to morbidity and mortality. Interventions proving successful during declared emergencies,
such as allowing pharmacists to administer flu vaccines, can be incorporated long-term through routine public health practice.

**Qualifying the Opioid Epidemic as a Public Health Emergency**

Like a deadly infectious disease outbreak, recent mortality related to opioid misuse surpasses historically low rates. Since 2010, annual opioid overdose deaths more than quadrupled, reaching 64,000 deaths in 2016 (and far exceeding comparable rates from motor vehicle crashes and gun violence over the same period). Despite emerging policies to control opioid prescribing, overdose mortalities continue to rise. This is due in part to increased trafficking of cheaper, illicit, and highly potent heroin and synthetic opioids such as fentanyl. These drugs are flooding the nation almost like agents of bioterrorism. Public health repercussions of the opioid epidemic are extensive. Heightened transmission rates of HIV and hepatitis C, for example, are attributable to unsafe opioid injection practices. Overwhelmed localities are in dire need of state and federal assistance to address preventable morbidity and mortality through additional funding, resources, and healthcare and addiction treatment personnel.

Six states and several tribes preceded HHS in declaring opioid emergencies to expedite essential interventions. These include enhanced data collection efforts in Arizona, naloxone standing orders in Alaska, and major funds devoted to drug addiction treatment and prevention in Maryland. In directing HHS to declare a nationwide PHE on Oct. 26, 2017, President Trump promised increased Medicaid coverage for addiction treatment as well as actions against prescription drug companies and illicit drug traffickers. In its final report on Nov. 1, 2017, the President’s Commission on Combating Drug Addiction and the Opioid Crisis further recommended increasing the affordability and accessibility of naloxone and additional criminal justice interventions such as drug court programs.

**Clarifying the Criteria for Future Public Health Emergencies**

The opioid epidemic inarguably constitutes a national PHE consistent with model legal approaches and prior applications. However, its classification within the spectrum of PHEs necessitates clarification to better distinguish other types of multifarious health threats. In 2017, for example, 30 million Americans will likely abuse alcohol. Millions will die of heart disease, cancers, stroke, and Alzheimer’s disease. Thirteen million American children will suffer food insecurity. Nearly that many kids face obesity. These and other serious conditions present real risks to human health, but classifying them as PHEs may: (1) embroil legal and political controversies surrounding their legitimacy; (2) exhaust emergency resources; and (3) lead to unwarranted exercises of authority. How can PHE declarations be qualified to avoid these outcomes? Table 2 presents a series of criteria that can be used collectively to distinguish PHEs from non-emergencies.

Urgency may be the most persistent commonality characterizing PHEs. Rapid deployment of countermeasures against slowly developing conditions like obesity or heart disease may be disfavored over incremental interventions. In the context of the opioid crisis, however, expanding naloxone access could curb on average 100 overdose deaths each day. Unremitting patterns of escalation absent rapid intervention may further qualify a PHE, although some declarations may hinge on the imminent potential to cause widespread harm. Under either circumstance, severe risk to morbidity and mortality lays the groundwork for a PHE declaration. When Connecticut’s Governor Dannell Malloy declared a PHE for Ebola virus in 2014, the imminence of Ebola to impact local populations, combined with severity (a high
risk of death for exposed persons), spurred the ramped-up response despite no reported cases in the state.

PHE declarations are less contentious when their classification is limited in scope to definitive populations or locations afflicted by the threat. PHEs may also be justified by the commitment of interventions with known or predicted effectiveness to address the emergency. A national PHE allows the U.S. Food and Drug Administration (FDA) to issue an Emergency Use Authorization for an unapproved drug, device, or intervention if anticipated benefits determinedly outweigh the risks of the condition left untreated.

Aside from efficacy, PHE interventions must also be ethical. Unleashing a series of powers to address a perceived or known public health threat is untenable if those efforts are impractical, underfunded, or disproportionately encroaching on individual or community rights. Declaring PHEs to implement efficacious, legal, and ethical interventions augments public trust and confidence in public health authority.

By law, the national opioid PHE lasts 90 days (absent reauthorization). Temporary efforts made possible by declarations should hold promise to diminish or control the suspected or known threat. Limiting the duration of PHEs allows for strategic funneling of resources without disinheritting other public health priorities. Resolving emergencies like the opioid epidemic entails a coupling of immediate actions and long-term reforms. Interventions demonstrating efficacy during a PHE can be incorporated later into routine public health practice. Calls for the FDA to convert naloxone from a prescription to over-the-counter drug during the opioid emergency, for example, may result in a permanent reclassification if the drug is demonstrated safe and effective.

**Conclusion**

HHS’ declaration of the national opioid PHE reflects a modern trend of utilizing emergency efforts to address a broad range of calamitous conditions. While there are no set rules guiding determinations of PHEs, re-examining criteria for their declarations is critical to meaningfully respond to future emergency-level crises. The factors presented above help identify conditions where a PHE declaration is legally warranted. As public health threats evolve, emergency authority must adapt as well to protect and promote population-level health.

[This article is based in part on the following publication: James G. Hodge, Jr., Sarah A. Wetter, Danielle Chronister, Alexandra Hess & Jennifer Piatt, Redefining Public Health Emergencies: The Opioid Epidemic, 58 Jurimetrics J. (December 2017)].

The authors are affiliated with the Center for Public Health Law and Policy, Network for Public Health Law—Western Region Office, Sandra Day O’Connor College of Law, Arizona State University (ASU). Sarah Wetter, Esq., is a research scholar and staff attorney (sarah.wetter@asu.edu); James G. Hodge, Jr., Esq., LLM, (james.hodge.1@asu.edu) is a professor of public health law and ethics, he is director of the Center for Public Health Law and Policy. Danielle Chronister and Alexandra Hess are JD candidates (2018) and senior legal researchers.

### Table 2: Criteria Underlying PHE Declarations

<table>
<thead>
<tr>
<th>Criteria</th>
<th>A PHE May Be Justified...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgency</td>
<td>when preventable morbidity or mortality due to a public health threat is likely to continue unabated absent more substantial interventions</td>
</tr>
<tr>
<td>Escalation</td>
<td>when the ascendency of a public health condition leads to morbidity and mortality rates surpassing historic lows</td>
</tr>
<tr>
<td>Imminence</td>
<td>to prevent a potential threat (prospective release of a bioterrorism agent) from developing into a mega-threat</td>
</tr>
<tr>
<td>Severity</td>
<td>in response to potential or actual impacts presenting serious or irreversible public health risks for affected populations</td>
</tr>
<tr>
<td>Scope</td>
<td>if public health threats may significantly impact subgroups (infants, elderly) or smaller regions or locations (daycare centers, schools, hospitals)</td>
</tr>
<tr>
<td>Interventions</td>
<td>to authorize interventions, including removal of legal obstacles, that may obviate negative public health repercussions</td>
</tr>
<tr>
<td>Efficacy</td>
<td>to facilitate proven, otherwise unavailable measures known to effectively address similar threats</td>
</tr>
<tr>
<td>Ethicality</td>
<td>in furtherance of efficacious interventions that may be ethically questionable outside an emergency</td>
</tr>
<tr>
<td>Duration</td>
<td>where emergency measures of limited duration can lead to the termination, diminishment, or control of the public health threat</td>
</tr>
<tr>
<td>Incorporation</td>
<td>to promote positive reforms of routine interventions through demonstrated successes of emergency measures</td>
</tr>
</tbody>
</table>
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.
obody is immune to the magnetic
draw of text messaging as an immediate and efficient means of communication. Providers in healthcare settings
are no exception—anything that can streamline the process and free up precious time is appealing. One can easily see the practical benefits of texting by providers, both with each other and with patients. Text messages can be sent and received almost instantaneously, which means that important patient data can be communicated, accessed, and reviewed quickly. However, there are risks—some obvious (such as security of protected health information (PHI) and some more obscure (such as complying with regulatory or accreditation requirements). The purpose of this article is to outline the primary legal and accreditation hurdles and identify the current limitations of texting in a healthcare environment. Recent guidance from the Centers for Medicare and Medicaid Services (CMS) has clarified two important points for providers who participate in Medicare: (1) texting of orders is not permitted regardless of the platform used; and (2) texting of other health care information is permitted over a secure platform.

HIPAA
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rule requires covered entities (including providers) and their business associates to implement technical security measures to guard against unauthorized access to electronic PHI that is being transmitted over an electronic communications network. Texting poses a new challenge to providers who have been working to achieve Security Rule compliance in other contexts, such as with the electronic medical record. HIPAA does not explicitly prohibit texting of PHI but imposes certain security parameters in order to do so in a compliant manner.

Under the Security Rule, providers must implement a mechanism to encrypt PHI if possible. Encryption is an “addressable” requirement under HIPAA, which means that if an entity concludes that it is not reasonable and appropriate to implement encryption software in its environment, the entity must document the reasons for that determination and implement an alternative security measure to accomplish the same purpose. Given that encryption technology has become readily accessible and available, it is difficult to take the position, even for small providers, that it is not reasonable and appropriate. In short, unless there is a very good reason not to, providers should encrypt electronic PHI in all circumstances, including texting.

Texting should not even be considered unless the texting platform is secured in all aspects (hardware, software, network, storage, and other components). A standard text message containing PHI that is sent from an unencrypted phone and without a secure texting platform is definitely not compliant with the Security Rule. Moreover, if the mobile device is lost, stolen, or hacked, the messages on that device could be easily accessible to unauthorized individuals if not encrypted and secured. Such access compromises patient privacy and could have damaging consequences to patients (identity theft). Unauthorized access could also have significant consequences for the provider. In February 2017, the Office for Civil Rights (OCR) announced a HIPAA civil monetary penalty against Children’s Medical Center of Dallas based on an impermissible disclosure of unsecured ePHI stemming from, among other compliance issues, the loss of an unencrypted BlackBerry device. Children’s Medical Center of Dallas paid $3.2 million in civil monetary penalties as a result of the incident and its non-compliance.

The HIPAA Security Rule also requires certain measures for access control (unique user identification, emergency access procedure, automatic logoff) and integrity (implementing policies, procedures, and technological strategies to ensure that ePHI is not improperly altered or destroyed) which could affect texting.

The Joint Commission/CMS
For entities regulated by CMS, recent guidance clarifies that texting orders is not permitted under any circumstances. This guidance, issued on Dec. 28, 2017, brings a conclusion to some vacillation on the issue by CMS and The Joint Commission (which accredits numerous providers and works in conjunction with CMS). The primary concerns
previously expressed about texting orders centered around the lack of the ability to clarify the content of the order and the manual burden on nurses to transcribe the texts into the medical record. CMS further stated that Computerized Provider Order Entry is the preferred method of order entry.

CMS also clarified in the guidance, citing certain rules, that texting other health care information is acceptable if the platform is secure. While most providers assumed this to be the case as technology has developed, CMS eliminated any doubt with the recent guidance.

The American Medical Association
The AMA policy on electronic communication with patients generally supports the use of email and text messaging in the practice of medicine, although notes several compliance as well as related ethical concerns. For example, provider-patient relationships should not be established through email or texting. Even after the relationship is established, providers should obtain patient consent prior to initiating clinical conversations by electronic communication. Moreover, the AMA maintains that the content of the communications must always be professional and should not cross over to non-clinical personal matters. This balancing act becomes even more complicated when family members are involved. While it may be ethical and legal to discuss a patient’s care with a family member if authorized, communicating electronically with family can open another can of worms and is best avoided.

General Risks
In addition to the regulatory risks, using texting for clinical purposes opens providers up to distraction, particularly if the device is also used for personal purposes. There are readily available horror stories of providers distracted by a text, who then failed to enter an order or otherwise failed to complete the clinical task at hand. There is also a risk that providers using text messages may not enter them into the medical record, rendering the record incomplete and inaccurate and potentially leading to adverse patient safety events or medical malpractice claims. Moreover, the language of the text is not always what the sender intended, and does not always go to the intended recipient. In the medical context, these common texting experiences could be disastrous.

Practical Solutions
Texting in the clinical context can be useful but has numerous risks. To navigate those risks, providers and others should consider taking the following steps:

• Encrypt all mobile devices that are used to transmit clinical information.
• Ensure that texts are sent over a secure platform provided by a vendor who understands its obligations as a business associate under the HIPAA Security Rule as well as the practical parameters for designing the platform to be compliant with all HIPAA Security Rule requirements.
• Double up—require a username and password to use the secure platform.
• Do not permit texting of orders under any circumstances.
• Adopt a remote wiping system that can be used should the mobile device holding clinical texts be lost or stolen.
• Specify a process for all employees/workforce members to immediately notify the Security Officer of lost or stolen mobile devices.

“Unless there is a very good reason not to, providers should encrypt electronic PHI in all circumstances, including texting.”

• Do not allow concurrent personal use of devices that are used to text clinical information. In other words, a separate device should be used for work than the one used for personal purposes.
• Adopt a robust, complete texting policy that incorporates these suggestions and addresses all of the risks identified above before allowing any texting of clinical information. For entities participating in Medicare, CMS’ recent guidance explicitly states that providers must implement processes/procedures to routinely assess the security and integrity of texting systems and platforms being used.
• Train all workforce on the texting policy and enforce it rigorously.

Conclusion
In summary, the risk management and legal parameters that will ultimately govern the use of text messaging to communicate PHI have not yet caught up to the current state of technology. This is a familiar concept in health care law. For example, consider the many state medical records laws that assume paper records, e.g. requiring “legible handwriting.” With texting, we expect that within the next few years the multiple regulatory and guiding agencies (CMS, OCR, the AMA, TJC, etc.) will be under pressure to put forth practical guidance. Until then, the parameters and suggestions outlined in this article should help organizations remain compliant.

Sarah Coyne, Esq., is a partner in the health law group at Quarles & Brady LLP, Madison, Wisc. She may be reached at sarah.coyne@quarles.com. Rachel Weiss is an associate in the health law group at Quarles & Brady LLP. She may be reached at rachel.weiss@quarles.com.
Physicians will face more reimbursement pressure, quality measures and a loss of control in how they treat patients in the future, thanks to hospital systems consolidating with everything from drugstore chains to insurance companies. In the last three months alone, an unprecedented variety of large mergers have begun to change the healthcare landscape across the United States and in Chicago. CVS Health, a chain of 9,700 pharmacies and more than 1,100 walk-in clinics staffed by nurse-practitioners, is buying Aetna, the nation’s third-largest health insurer, for $69 billion. Aetna has more than 22 million customers including several hundred thousand patients in the Chicago area. “These mergers of provider-provider, insurer-provider, etcetera, mean less autonomy for doctors,” said Jim Unland, president of the Health Capital Group and a law professor at the Loyola University’s Beazley Institute for Health Law and Policy.

Closer to home in the Chicago area, Advocate Health Care, which is already Illinois’ largest health system, is going to merge with Aurora Health Care, which is the largest healthcare system in Wisconsin. And two giant national Catholic healthcare systems—Dignity Health and Catholic Health Initiatives—are merging and relocating their headquarters from the West Coast to Chicago, a beachhead for future expansion and potential network if they aren’t part of a larger organization, analysts say. Even hospital systems like Advocate with a dozen or more networks if they aren’t part of a larger organization, analysts say. Even before the Aetna deal, CVS was moving to reach that doctors and hospitals will need to compete with, analysts say. Even before the Aetna deal, CVS was moving to meet patients in locations doctors are not. CVS’ more than 9,600 retail pharmacy locations include the more than 1,600 Target pharmacies that were converted to CVS last year.

Providers Face More Risk-Based Reimbursement

For physicians, the consolidation means they will be part of larger organizations with physicians seeing less control over the relationship they have with their payer. Increasingly, doctors and their medical groups are finding themselves shut out of provider networks if they aren’t part of a larger organization, analysts say. Even hospital systems like Advocate with a dozen or more hospitals are feeling the need to grow via consolidation.

Much of the consolidation is brought on by the shift from fee-for-service medicine that allows physicians to bill for each and every procedure to value-based care that reimburses providers based on quality measures and health outcomes of their patients. Providers are facing more bundled payments and related risk-based reimbursement contracts.

In announcing their merger, Aetna and CVS executives say they will do all they can to make sure their patients are seen in lower cost settings that don’t always mean a physician’s office. Aetna and CVS executives say they will be escalating their push to measure doctors and hospitals via quality and performance scores.

“Our current system of fragmented care has made some strides to control cost, but more is needed to truly impact the trajectory of healthcare spending,” CVS Health Chairman and Chief Executive Officer Larry Merlo said on a conference call with analysts in December to discuss the merger. “And through our integrated healthcare management and delivery platform, we will be able to better coordinate care, eliminate waste and unnecessary spending, and drive efficiencies throughout the entire healthcare system. This will not only lead to better care for patients, but also lower costs for payers.”

Through the Aetna merger, which is expected to close in the second half of this year, CVS will have an even bigger geographic reach that doctors and hospitals will need to compete with, analysts say. Even before the Aetna deal, CVS was moving to meet patients in locations doctors are not. “We’ll become a leader in driving further adoption of value-based care models through our combined assets, promoting our lower cost sites of care, eliminating unnecessary spending and enhancing our clinical programs,” Merlo added. “By integrating data across our enterprise assets and through the use of predictive analytics, we will create targeted interactions with patients to promote healthy behaviors and drive adherence. And this will further improve the quality of care for patients, while also resulting in healthier outcomes.”

The closer ties between CVS and Aetna and other conglomerates are triggering more consolidation among hospital systems as well as large medical groups. Some see CVS and Aetna mimicking the provider strategy of UnitedHealth Group, the nation’s largest health insurance company, which owns Optum, which is also expanding by buying doctor practices, urgent care

More Business to Nurse Practitioners and Pharmacists

CVS has increasingly been lobbying to allow nurse-practitioners and pharmacists to do more like administer vaccinations beyond just seasonal flu shots. But CVS and Aetna aren’t stopping at the retail clinics that some see as already chipping away at physician services and the market share of medical groups and hospital-based clinics.

CVS plans to expand services in its pharmacies and retail clinics, and begin to deliver care to patients’ and customers’ homes as a way to capture patients in lower cost settings and save premium dollars paid by Aetna clients, employers and those covered by Medicare and Medicaid. “We see the healthcare marketplace evolving into a more value-based system where premium is placed on the efficiency with which care is delivered,” CEO Merlo said.

“Increasingly, doctors and their medical groups are finding themselves shut out of provider networks if they aren’t part of a larger organization.”

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centers and other outpatient care facilities. In December, for example, Optum said it would pay nearly $5 billion for DaVita Medical Group and its clinics and urgent care centers that treat 1.7 million patients annually in one-half dozen states.

Regional and local health systems generally led by hospitals say they see the need to consolidate to gain economies of scale as pressure builds from insurers to push more care out of the hospital and into lower cost centers. That means specialists, in particular, could lose patients in the hospital to other facilities.

**Big Economies of Scale Good for Technology and Innovation**

Already, the large for-profit hospital operator Tenet Healthcare is exiting the Chicago area and this past fall announced plans to sell MacNeal Hospital, one of its flagship inpatient facilities in the western suburbs to Loyola Medicine, which is part of the large Catholic-owned Trinity Health. Michigan-based Trinity has more than 90 hospitals in 22 states while Tenet says it doesn’t have the market share in the Chicago area to effectively compete. “Bringing MacNeal into the Loyola system allows us to expand our delivery system, add more providers and deliver exceptional care to a greater number of residents close to their homes,” Loyola University Health System CEO Larry Goldberg said.

Executives at Advocate and Aurora say they need to merge in order to capture more patients and combine resources to develop new and better information systems and technology. Chicago’s Advocate and Milwaukee’s Aurora will operate 27 hospitals and more than 500 sites of care, including clinics, health centers and doctors’ offices and treat more than 3 million people annually.

“By joining forces we will be able to expand our network to scale innovation and create a destination in the Midwest for patients...”

“Regional and local health systems generally led by hospitals say they see the need to consolidate to gain economies of scale as pressure builds from insurers to push more care out of the hospital and into lower cost centers.”
and the talented clinicians who care for them,” Advocate Chief Executive Officer Jim Skogsbergh said.

Aurora said it was drawn to Advocate in part because of its push into value-based care. For example, Advocate operates one of the Chicago area’s first accountable care organizations.

The providers in an ACO are responsible for managing the care of the health plan enrollees and are financially rewarded for working together to improve quality and rein in costs. In these models, doctors and hospitals take on more risk so that they can streamline the care, and eliminate bureaucratic inefficiencies. “Advocate has a well-deserved reputation as a national leader in population health and their value-based approach has led to better outcomes and more affordable healthcare,” said Aurora Health Care Board Chair Joanne Disch. “We share a bold vision for the future as we create a consumer-centric system to improve the quality of life for the diverse communities we serve.”

Geographic Expansion and Pricing Power
The Aurora merger is different than Advocate’s failed effort last year to buy NorthShore University HealthSystem. The Advocate-NorthShore deal came apart after a federal judge ruled the deal would eventually lead to higher medical prices for consumers. This time, Advocate is merging with a health system that isn’t a competitor and essentially serves a different market. Thus, Advocate hopes to escape antitrust scrutiny this time.

“The idea of an autonomous doctor is like vinyl records. We are going to just have them in museums.”

Critics of the Advocate-NorthShore deal say consumers could also be harmed if the combined system gains more leverage against insurance companies to raise prices. “Even though they are not direct competitors, these geographic expansion mergers lead to greater pricing power,” said David Balto, a former Federal Trade Commission lawyer who is director of the Coalition to Protect Patient Choice, which worked with doctor and hospital groups to fight Aetna’s acquisition of Humana.

Balto said physicians are destined to lose autonomy no matter what deals occur in their markets. “The idea of an autonomous doctor is like vinyl records,” Balto said. “We are going to just have them in museums. None of this bodes well for the autonomous doctor.”

And it doesn’t appear that the consolidation will ebb anytime soon, according to Skokie-based consulting firm Kaufman Hall. The number of hospital mergers and acquisitions through the third quarter of 2017 was already ahead of the 2016 pace and those figures didn’t include the Advocate-Aurora deal to create the nation’s 10th-largest healthcare system. Kaufman Hall predicts even more consolidation in 2018. Says Kaufman Hall Chairman Ken Kaufman: “You can’t be too big to compete in today’s developing healthcare market.”

Bruce Japsen is a healthcare journalist, speaker, and regular contributor to Chicago Medicine who also writes for Forbes. He is also an 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” business news show. He can be reached at brucejapsen@gmail.com.
MEMBER BENEFITS

Holiday Camaraderie

LEFT: Drs. Clarence Brown and Kathy Tynus, CMS past presidents; Dr. Srinivas Reddy, IAMAIL president; Dr. Nestor Ramirez, ISMS president; Dr. Vemuri Murthy, CMS president; Dr. Scott Cooper, ISMS past president; and Lynda Ramirez.

LEFT: Dr. Tariq Butt, CMS treasurer; Keith Kudla, CEO, Family Health Network; Faisal Niaz Tirmizi, Pakistan Consulate General; Dr. David Banayan RIGHT: A pianist adds to the elegant “old world” setting of the Standard Club of Chicago.
NEARLY 150 CAME to enjoy an evening of good fare and fellowship at the Chicago Medical Society's annual Holiday Reception. This festive occasion is a way for CMS to thank hardworking physicians and other professionals who support the Medical Society all year long. For newcomers, it is also a friendly welcome to CMS.

At this year's event, held at the Standard Club of Chicago, the larger community of medical residents, physicians, hospital administrators, legislators and attorneys enjoyed mingling in an elegant “old world” setting with live piano music. Many physicians say they find the relaxed atmosphere conducive to informal conversation about healthcare issues in Illinois. The CMS Holiday Reception took place on Dec. 7.
Advocacy: What’s Coming in 2018?

AMA releases state legislative and regulatory priorities and announces top issues

“THe AMERICAN Medical Association (AMA) Advocacy Resource Center recently shared the results of its annual state legislative and regulatory priorities survey. The survey is distributed to state and national medical specialty societies and asks a range of questions to identify trends for the upcoming 2018 state legislative sessions. With responses from more than 70 state and specialty societies, the survey provides a clear picture of the top issues facing organized medicine at the state level.

Much like 2017 and recent years, state and specialty societies put team-based care, scope of practice, prescription drug misuse and treatment issues at the top of their priority lists. Insurance network-related issues and Medicaid also were cited as top priorities for 2018 along with public health advocacy, prior authorization and step therapy. Maintenance of certification was ranked high by many societies while medical liability reform and telemedicine also remain top priorities for many medical societies.

Insurer Issues

With increasing concentration in markets, payers continue to create short-sighted policies, the AMA reported. Not only do these policies undermine physicians’ ability to practice medicine, but they also overlook the well-being of patients, in addition to creating waste in the system.

The AMA is pursuing state legislative campaigns to address insurer practices and to enact new rules. That means advocating so that regulators support and enforce strong policy, as your Chicago Medical Society did by launching Illinois’ new Network Adequacy and Transparency Act. The legislation went into effect Sept. 15, 2017.

Prior Authorization

A burden for physician practices and patients, prior authorization costs time and money and may also negatively impact patient outcomes when treatment is delayed. It is increasingly inefficient and lacking in transparency. Care delays associated with getting pre-approval are so widespread that 90% of physicians say the process does indeed delay care. Another 44% say that prior authorization often or always delays care, as opposed to 46% who say it sometimes does, and only 9% who report never or rarely. AMA is working to address prior authorization and step therapy through state legislation.

At the national level, AMA is advocating with organizations like the NCOIL and NAIC for regulation of utilization management programs and entities. The AMA is also working to eliminate prior authorization requirements in alternative payment models (APMs) involving financial risk for physicians. Grassroots websites of the AMA aim to increase awareness of the issue for patients and physicians.

The following five areas offer opportunities for improvement in prior authorization programs and processes which, once implemented, can achieve meaningful reform. They come from a consensus statement issued by the AMA, American Hospital Association, America’s Health Insurance Plans (AHIP), Medical Group Management Association (MGMA), Blue Cross Blue Shield Association, and American Pharmacists Association.

- Selective Application of Prior Authorization.
- Prior Authorization Program Review and Volume Adjustment.
- Transparency and Communication Regarding Prior Authorization.
- Continuity of Patient Care. Continuity of patient care is vitally important for patients undergoing an active course of treatment when there is a formulary or treatment coverage.
- Automation to Improve Transparency and Efficiency.

Regulatory Relief

Administrative tasks exact a huge toll on physician well-being. For every hour spent with patients, physicians spend two hours on complying with regulations. The result is reduced patient access to care and increased costs to the system. Burnout can be the end result.

The AMA is working to eliminate, streamline, align and simplify the many federal rules and regulations imposed on physicians. Additional work includes improving the usability of electronic health records, making practice data available to physicians and holding vendors accountable for their products. Last but not least, AMA is creating clear and concise educational resources for physicians to improve their understanding of issues relevant to their practice, such as cybersecurity.

Anti-Trust

AMA continues to offer state medical associations assistance in managing the ramifications of the U.S. Supreme Court’s decision in North Carolina Dental Board of Examiners v. FTC, holding that state occupational licensing boards are not immune from antitrust liability unless they are actively supervised by the state. In 2017, the Advocacy Resource Center developed a model state bill designed to provide antitrust immunity to physicians serving on medical licensing boards and to thereby encourage them to take the initiative and
to make the hard decisions in scope of practice and other matters necessary for protecting public health and safety. State medical associations are encouraged to introduce this critical legislation.

In 2018, look for AMA to continue fighting the anticompetitive mergers of health insurers. This advocacy follows the successful campaign against the Anthem/CIGNA and Aetna/Humana mergers. Blocking these mergers were monumental wins. AMA’s leadership collaborated with 17 state medical associations and national groups to persuade the U.S. Department of Justice (DOJ) and state attorney generals to challenge those health insurer mega mergers. Had the mergers gone through, the end result would be steep premium increases and reduced health plan quality. For physicians, the consolidation would lead to lower reimbursements.

**Drug Pricing Transparency**
The cost of prescription medication increases year after year due to an opaque system that prioritizes company profits over patient health. AMA is urging state medical associations to advance AMA model legislation to increase transparency on payers, pharmacy benefit managers, and pharmaceutical manufacturers. Your Chicago Medical Society has taken the lead also, with testimony on behalf of a City Ordinance to require drug makers to justify steep price increases. Also, CMS is backing a bill in the U.S. Senate introduced by Senator Durbin.

**Telemedicine**
Digital health technology is changing the way physicians practice medicine and is improving public health. AMA is taking a multi-pronged approach:

- Modernizing state medical practice acts to lay the groundwork for adoption of telemedicine.
- Promoting model legislation to ensure physicians are paid for the care they provide via telemedicine.
- Facilitating license portability through support of the Interstate Medical Licensure Compact.

**End the Opioid Epidemic**
To end the opioid epidemic, patients need increased access to multidisciplinary pain care, as well as treatment for substance use disorders. Here’s what the AMA is doing about it:

- Advocating to end prior authorization for medication-assisted treatment.
- Working with payers to remove barriers to multidisciplinary pain care.
- Providing physicians with specialty-specific educational resources on safe opioid prescribing and treatment.
- Advocating for expanding access and coverage for treatment of substance use disorder.

**Scope of Practice**
Patient health and well-being are threatened when health care practitioners are allowed to practice beyond their education, training or experience. Here’s what the AMA is doing:

- Harnessing the power of organized medicine through the Scope of Practice Partnership.
- Developing new advocacy tools and resources to deploy in state legislatures.
- Compiling research on non-physician education, training and quality of care.
- Giving grants to state medical associations to support scope of practice advocacy efforts.

**Medicare Payment Reform**
Many of the significant changes in physician payment systems hold the promise to provide better support for coordinated, high-quality care. Here’s what AMA is doing so that Medicare and other insurers achieve that promise:

- Advocating for payment system changes that support improvements in care rather than simply add new administrative burdens.
- Working to simplify administrative requirements in payment models to improve professional satisfaction.
- Expanding payment model options for physicians in all specialties.
- Developing simple, straightforward educational material to help physicians succeed under new payment models.

**Access to Coverage**
AMA is working to preserve certain gains made by the Affordable Care Act, in coverage and the ban on pre-existing condition exclusions. Other advocacy is directed at:

- Stabilizing the individual insurance market and improving the affordability of premiums and copayments.
- Maintaining the strength of safety net programs like Medicaid and the Children’s Health Insurance Program (CHIP).
- Ensuring adequate state and federal funding for Medicaid and ensuring physician payment rates are sufficient to ensure meaningful access to care.
- Medicaid expansion to cover the uninsured.

**New Model State Bills**
The AMA has drafted model legislation to address a number of issues, which states are being urged to implement. Examples include: Acts to Increase Drug Cost Transparency and Protect Patients from Surprise Drug Cost Increases; Transparency in Electronic Health Record Systems; Hospital Self-Referral Disclosure and Communications; Medical Licensing Board Activities; Phantom Damages Elimination; and Right to Treat. 

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**MEMBER BENEFITS**

*IF YOU HAVE* concerns or suggestions about the future of health care delivery, now is the time to exercise your membership privilege and turn your opinions into policy or legislation. The Chicago Medical Society wants your input and your valuable contribution!

Please volunteer as a delegate to the 2018 Illinois State Medical Society's Annual House of Delegates meeting. The HOD is the legislative body for CMS and ISMS. It meets once a year to establish policy and set legislative objectives on key issues, ranging from scope-of-practice and reimbursement reform, to public health and graduate medical education.

As a delegate, you will have the opportunity to shape legislation in both the Illinois General Assembly and the U.S. Congress.

This year's HOD meets Friday, April 20, through Sunday, April 22, in Oak Brook, at the Hilton Oak Brook Hills Resort & Conference Center, 3500 Midwest Road.

**Resolutions Spark New Laws in Illinois**

Back in 2016, your Chicago Medical Society crafted a proposal to mandate insurance network adequacy and transparency in Illinois. This successful effort, which was adopted by the HOD, directed ISMS to draft a bill and then introduce it in Springfield. The rest is history. Governor Rauner signed the legislation into law in 2017. Now, all health plans sold in the state of Illinois must adhere to new standards. The law protects both physicians and patients.

**Choice of Dates**

While times are subject to change, below are the dates on which members are needed to volunteer. You can choose to serve one day, or two days, or all three. On Sunday, the HOD adjourns by 12:00 noon.

- Friday, April 20
- Saturday, April 21
- Sunday, April 22 (Half-day)

To learn more, or to sign up, please contact Ruby at rbahena@cmsdocs.org or fax 312-670-3646. You may also call in your availability: 312-670-2550, ext. 344.
Physicians bring economic health to our nation’s communities.

Beyond their role in safeguarding the health of our communities, physicians in the U.S. are a major driver of the national economy, spurring economic growth and creating jobs across all industries.

Physicians hire locally, buy locally and support local economies. Through the creation of jobs with strong wages and benefits paid to workers across the country, physicians empower a high-quality, sustainable workforce that generates state and local tax revenue for community investments. Physicians’ economic output—the value of the goods and services provided—helps other businesses grow through their own purchasing and through the purchasing of their employees. Each dollar in direct output applied to physician services supports $2.84 in economic activity nationally, and physician-driven economic activity is greater than legal services, home health care, higher education, and nursing home and residential care.

View the 2018 American Medical Association Economic Impact Study to learn more about the contributions physicians make to the health of the nation’s economy at PhysiciansEconomicImpact.org.

VITAL SIGNS: THE ECONOMIC IMPACT OF PHYSICIANS NATIONALLY

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1. The national economic impact of physicians (QuintilesIMS, December 2017).
Calendar of Events

FEBRUARY
12-14 AMA National Advocacy Conference Grand Hyatt; Washington, DC. CMS meets with Congress and advocates on healthcare issues at this annual event. For information, 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. 8:00-9:00 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.

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

MARCH
6 Deadline for Submission of Resolutions to the Illinois State Medical Society House of Delegates.

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

APRIL
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. Date and Time: TBD. For information, contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

CMS Board of Trustees Meeting Meets every other month to make financial decisions on behalf of the Society. Date and Time: TBD.

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

JUNE
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Salute to Research

LEFT: Dr. Anil Gulati, associate professor at the Chicago College of Pharmacology at Midwestern University, stands with guest speakers Dr. Matthias Barton, professor of cardiology at the University of Zurich, and CMS President Dr. Vemuri Murthy, who spoke before students on Annual Research Day, Jan. 26, 2018.
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LEE FRANCIS, MD, MPH, president and CEO of Erie Family Health Centers, holds the large responsibility of running the day-to-day operations of this federally qualified healthcare center with its 13 locations and multitude of services in Cook and Lake Counties. When you talk to Dr. Francis about his position, he is quick to relay how proud he is of the fact that Erie provides top quality health care to every patient regardless of their insurance status or their ability to pay. “I’m very passionate about the idea that healthcare is a right, rather than a privilege,” he says.

Dr. Francis received his MD from the University of Illinois College of Medicine at Chicago in 1988 followed by an internal medicine-primary care residency at Cook County Hospital (now John H. Stroger, Jr., Hospital). While spending a few years as the assistant director of the primary care internal medicine residency program at Cook County Hospital, Dr. Francis also landed a clinical position as a staff internist at Erie in 1991—and he hasn’t left the group since then. “I’ve always found that internal medicine provides a great opportunity to offer quality health care to the underserved population, especially adults who have complex cases,” he says. “And I loved my initial exposure to community health centers during my residency.”

During the ten years that Dr. Francis worked as an internist at Erie, he got an intense primer on challenging health care issues since the HIV epidemic was at its height. In addition, he honed his teaching skills during that time as teaching attending at Northwestern Memorial and Cook County Hospitals. “It was during that time that I decided I needed to learn a new language about healthcare so that I could address a larger patient population,” he says. “So I received my MPH in epidemiology at the University of Illinois School of Public Health.”

A typical internist, says Dr. Francis, serves about 1500 to 2000 patients in their panel. In his current position, however, Dr. Francis is responsible overall for the care of approximately 72,000 patients who make up about 300,000 patient visits a year. And Dr. Francis and his team have largely been responsible for those high numbers. During his first promotion at Erie to medical director, the team more than doubled the number of patients seen at Erie. Since becoming president and CEO in 2007, the number has doubled again.

His other major growth accomplishments as president have been to add five new community health center sites, make significant renovations to older sites and add GME teaching slots for family medicine and other residents. He has also worked hard to maintain relationships with Erie’s nine hospital partners. “I’m very grateful for these partners,” he says. “I’m very concerned about the continuum of care between our primary care services and hospitals.”

Dr. Francis still also spends about 17% of his time caring for patients. “Continuing clinical work helps me to become a better manager and to provide better health care for patients since it keeps me on the front lines of health care from both perspectives,” he says. But he’s quick to point out that Erie’s successes have not been all because of him. “I’m really proud of the care our staff delivers. I really depend heavily on them to accomplish our goals of top-notch health care. I wouldn’t be here without them.”

Dr. Francis’ Career Highlights

ASIDE FROM his duties at Erie, Dr. Francis also teaches ethics to medical students as an assistant professor of clinical medicine at the Feinberg School of Medicine. He is also active on several boards for community health and public service organizations. He has won numerous awards including intern of the year and resident of the year at Cook County and has been honored as a fellow at the American College of Physicians. He is also a nationally ranked U.S. Masters Swimmer.
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