Private Equity: A New Vista for Physician Organizations

Investment in Ancillary Providers

VBC Update

Insurance Market Stabilizes

Health Insurers Turn Losses into Gains, But Will Improving Profits Be Good for Physicians?
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FEATURES

18 Individual Insurance Market Stabilizes Ahead of Trump Changes
A slowly improving insurance market, with increased profits, should be good news for physicians, but it comes with narrowing networks and rate increases.
By Bruce Japsen

22 New Officers Speak Out
Your Chicago Medical Society leadership voices opinions on key issues.

PRESIDENT’S MESSAGE
2 Be it Resolved...
By Vemuri S. Murthy, MD

PRACTICE MANAGEMENT
3 VBC Programs: An Update; 2018 Quality Payment Program Final Rule

PUBLIC HEALTH
6 Helping Youth Thrive: Addressing Childhood Obesity; Managing Physician Burnout

LEGAL
8 Private Equity: New Vistas for Physician Organizations
By Andrew Demetriou, Esq.

15 Private Investment Equity in Ancillary Healthcare Providers
By Patrick Souter, Esq.

MEMBER BENEFITS
26 Serve Your Profession

28 Nominate a Colleague for a CMS Award!

29 CMS Gives at Gala

30 Calendar of Events

31 Classifieds

WHO’S WHO
32 A Passion for Population Health
Heading up the Chicago Department of Public Health is a massive challenge, but Julie Morita, MD, chief executive of the department, has spent a lifetime preparing—and she is well-equipped to handle any public health issue that comes her way.
Be it Resolved...

As we head into 2018, the Chicago Medical Society wishes you a Happy New Year.

This is a time when some of us resolve to adopt a healthier lifestyle. I ask you to consider a different kind of resolve, one that shapes our legislative agenda.

Here’s what you can do: draft a resolution for our Feb. 6, 2018, Council meeting. These are simple statements of need that outline a problem and desired solution; they may request action of lawmakers or direct your medical societies to advocate on specific issues, or to create new policy. There’s no shortage of professional, regulatory and patient care issues on which we physicians have opinions. So please send us your burning issues and recommendations.

Your Chicago Medical Society functions as a grassroots launch pad for legislative proposals in Illinois; measures that pass through our Council go on to the House of Delegates of the Illinois State Medical Society. Ultimately, the process allows rank and file members to shape the agenda of ISMS and the American Medical Association.

The ISMS House of Delegates meets on April 20-22.

As the leading source of resolutions to ISMS, we rely on members like you to supply the substance.

I believe every member has this responsibility.

When the Chicago Medical Society represents your interests before local government bodies as well as members of the Illinois General Assembly and U.S. House and Senate, your ideas, as set forth in a resolution, are what guide us.

For 2018, physicians can also resolve to serve on a committee, or serve as a delegate to the House of Delegates, or cultivate a working relationship with their local elected representative. Please check the back section of this magazine issue for opportunities to make your voice count. You can even nominate a colleague for an award.

The Chicago Delegation to the House of Delegates carries with it the responsibility of representing the physicians of Cook County and provides an opportunity to influence the policies of organized medicine. As a delegate, you'll testify on behalf of Chicago resolutions and weigh in on resolutions from other Illinois counties.

All this leads us back to the CMS resolutions process. Many public health laws and physician protections in Illinois are the direct result of resolutions from grassroots members. Every year, these initiatives originating at CMS inform new policies and advocacy efforts by ISMS and AMA. In fact, Illinois’ new Network Adequacy and Transparency Act had its start at CMS. It was signed into law in 2017.

If you are new to the resolution-writing process, CMS leadership would be happy to guide you on using this powerful advocacy tool effectively. And now is the time to get started. Please submit your resolution by Feb. 1, 2018, for consideration.

Vemuri S. Murthy, MD
President, Chicago Medical Society
VBC Programs: An Update

The current state of value-based care and how it will affect you

By Jim Watson

VALUE-BASED care and value-based contracting (VBC) programs were introduced by the Centers for Medicare and Medicaid Services as part of the Affordable Care Act in 2009, but their origins are rooted in the pay-for-performance (P4P) programs the commercial insurance industry introduced in the 1990s. Today, the U.S. healthcare system is all about VBC. While VBC programs vary, they are all centered around a common idea: rewarding healthcare providers with incentive payments for the quality of care they give to Medicare patients. These programs are part of a larger quality strategy to provide better care for individuals, better health for populations and lower cost.

VBC has also taken hold in commercial and Medicaid programs. As reported by Forbes in its April 2017 edition, Anthem Blue Cross now estimates that 60% of its healthcare spending is in VBC programs. All major health insurers in Illinois have VBC components in their standard physician and hospital agreements. Most state Medicaid programs have migrated to managed care models, including Illinois, where there are VBC components in all MCO agreements with the state. Typical incentive measures include: HEDIS measures (such as breast cancer screening), non-HEDIS measures (such as medication adherence), re-admission measures, cost measures, and care gap measures.

It’s important to understand the following key points as they relate to VBC programs:

- Direct/individual participation or participation via a “network.” Unlike Medicare, where PQRS/MIPS incentives are calculated on an individual basis via Medicare participation, many commercial VBC models are held through networks such as clinically integrated networks, physician hospital organizations, and independent physician associations that you must join to access the patient population and incentive program. These networks are well-suited for “population health management” initiatives that are increasingly popular with insurers.
- Members can be “enrolled” with you or “attributed” to you. The old P4P models primarily centered around HMO contracts, under which patients enroll in a PCP. More contemporary VBC models also have programs based on PPO products, where patients are attributed to you based on claims data.
- Upside risk and downside risk. Most commercial and Medicare Advantage agreements held via networks offer significantly greater rewards to participating physicians, but they also pose greater levels of delegated risk. Often, the first couple years of an agreement has “upside risk” where you or the network only earns bonuses and is not subject to reimbursement reductions or other losses. Increasingly, these agreements move to “downside” risk in later years or upon renewal such that you are exposed to reimbursement reductions and can be held liable for losses on the population.
  - Delegated vs. non-delegated VBC contracts. Insurers prefer to work through larger networks for PHM and VBC models for a variety of reasons. But most important, they want to ensure proper provider engagement. Providers have “more skin in the game” when there is some level of risk in their MCO agreements. In a delegated model, the MCO delegates medical management, claims and other administrative functions to the network. In non-delegated models the MCO retains these functions, and allocates percentages of the premium to different risk pools such as hospital services, physician services, or ancillary services and pays claims from these pools. Pool surpluses are shared with the network, as are pool deficits.
  - Medicare providers should pay attention to the Value Modifier, MIPS, and MACRA since these will affect reimbursement. Over time these metrics will become mainstream in commercial and other payor types.

When joining a network, be sure to understand your options and the important baseline facts about each network. For example, what MCO contracts does the network hold, and what support does the network provide for earning VBC incentives? What are the administrative requirements?

Stay informed and stay connected. Medical societies, conferences, and webinars provide great networking opportunities to hear about the latest market trends and to learn best practices.

Finally, be sure to engage in VBC incentives because an increasing percentage of your total compensation will come from VBCs; your performance will make you attractive (or not attractive) to networks that hold the larger, high-value VBCs; and your performance scores (cost and quality) are publicly reported and available to current and future patients.

Jim Watson is a partner with PBC Advisors, LLC, in Oak Brook. PBC provides business and management consulting and accounting services to physician practices, medical groups and hospital systems. For more information, visit www.pbcgroup.com.
ONE YEAR AGO, the Centers for Medicare and Medicaid Services (CMS) issued the first Quality Payment Program (QPP) final rule. Since then, the American Medical Association, with input from the Chicago Medical Society, has advocated for improvements to the program and engaged with the Administration. As a result, a number of policies that were proposed for the 2018 performance year and now finalized are based on our recommendations. Although the Administration reversed a few positive proposals that were in its proposed rule, and which AMA and CMS supported, it did finalize several important policy changes, including ones to help physicians in small practices. The final rule’s impact analysis projects that 97% of eligible clinicians will avoid a penalty in 2020 based on their QPP participation in 2018.

Below are some of the highlights from the AMA’s initial read of the proposed rule. A “thumbs up” reflects policies that address concerns raised by the AMA. You’ll also find “thumbs down” and “neutral thumb” policies.

### Additional Accommodations for Small Practices

#### Expands the low-volume threshold to 
$90,000 or less in Medicare Part B allowed charges or 200 or fewer Medicare Part B patients (previous threshold was $30,000 in allowed charges or 100 patients)—CMS estimates that only 37% of clinicians who bill Medicare will be subject to MIPS.

#### Creates virtual groups to assist small practices.

#### Adds 5 bonus points to the final MIPS scores for practices of 15 or fewer clinicians.

#### Favorable scoring under the quality category—minimum of three points for reporting on a quality measure regardless if it meets data completeness and practices of 15 or fewer clinicians are exempt from the All-Cause Readmission measure.

#### Adds a hardship exception from the Advancing Care Information (previously Meaningful Use) category for practices of 15 or fewer clinicians.

### General MIPS Policies

#### Includes an automatic extreme and uncontrollable circumstance hardship exemption for physicians affected by recent hurricanes and wildfires.

#### Adds up to 5 bonus points to the final MIPS score for clinicians who treat complex patients (CMS had proposed up to 3 bonus points).

#### Begins measuring improvement in the quality and cost performance categories in 2018.

#### Sets the 2018 performance threshold at 15 points and maintains the exceptional performance threshold at 70 points.

#### Delays implementation of the facility based measurement option in the quality and cost performance categories until 2019.

#### Includes Part B drug costs in MIPS payment adjustment.

The AMA is pressing Congress to clarify that drug reimbursement should not be subject to MIPS payment adjustments.

### Advancing Care Information

#### Allows the use of 2014 edition certified electronic health records technology (CEHRT) past 2017—CMS will not mandate that physicians update their EHRs in 2018.

#### Increases opportunities for bonus percentage points.

#### Finalizes exclusions for e-prescribing and health information exchange measures.

#### Permits physicians to continue to report on Modified Stage 2 measures in 2018 instead of new Stage 3 measures.

The AMA will continue to seek more flexible ACI measures.

### Quality

#### No additional cross-cutting measure requirements added in 2018.

#### Maintains CAHPS for MIPS as optional.

#### New and modified specialty measure sets for the 2018 performance period, including the removal of cross-cutting measures from most specialty sets.

#### Decreases the quality performance category weight to 50% in 2018 (due to the cost category weight increasing to 10% as opposed to the proposed 0%).

#### Maintains the number of quality measures a physician must report for full participation in the quality performance category. (AMA asked for fewer quality measures in 2018).

#### Proposes a phased-in approach to identify and remove topped out measures. However, CMS increased the maximum points a physician can earn on topped out measures from 6 points to 7.

#### Increases the reporting threshold on quality measures from 50% to 60% of applicable patients in 2018.

The AMA will continue to urge CMS to retain topped out measures, but if the agency insists on periodically removing them it should implement a more systematic and evidence-based process.

### Cost Category

#### Replaces its proposal to weight costs at zero
in the 2018 performance/2020 payment year with a 10% cost weight (the cost weight would rise to 30% in 2019/2121).

- Cost scores will be based on two AMA-opposed carry-over measures from the value-based payment modifier—total per patient cost and total spending around a hospital admission.
- Ten previously-finalized episode-based cost measures will be replaced in the future with measures developed with more input from clinical experts and stakeholders.

The AMA had supported CMS’ decision to keep costs at zero next year and urged CMS to keep this weight for several more years and will continue to urge CMS and Congress to limit the weight of this category.

**Improvement Activities**

- CMS continues to allow physicians to report on IAs through simple attestation.
- Creates stability in program requirements by not changing the number of IAs physicians must report.
- Broadens existing IAs and develops new IAs, including activities related to diabetes prevention programs and the use of digital health tools.
- Increases the number of IAs eligible for the ACI bonus.

The AMA will continue to work with CMS to increase the number of IAs available to physicians and strive to align IA with the other performance categories.

**Alternative Payment Models**

- The revenue standard for more than nominal financial risk remains at 8% of revenues for 2 additional years.
- The lower financial risk standard for medical homes, which ranges from 2.5% to 5% of revenues, will be phased in more gradually.
- Other Payer APMs will also have access to the 8% of revenues standard for more than nominal risk.
- Participants in the first round of the medical home model currently recognized as an Advanced APM, Comprehensive Primary Care Plus (CPC+), will have access to the lower nominal risk standard that applies to medical homes even if they have more than 50 clinicians.
- CMS will develop a demonstration project to test the effects of allowing credit for participation in Medicare Advantage APMs starting in 2018.
- CMS anticipates that the second round of CPC+ and the start of the Track 1+ ACO model will increase opportunities for physicians to participate in Advanced APMs.

The AMA also welcomed a separate Request for Information that CMS issued on a new direction for the Center for Medicare and Medicaid Innovation to increase opportunities for APM participation.

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Helping Youth Thrive: Addressing Childhood Obesity

Screening and intensive behavioral interventions for obesity in children and adolescents can lead to improvements in weight status.

By Anna Gonzales, MPH, and Lesley J. Craig, MPH

For a number of years, public health officials have identified childhood obesity as a major health challenge. Obesity can lead to health conditions that have a negative impact on quality and length of life, in addition to increasing health care costs. Obesity also significantly impacts our national security. In fact, nearly 1 in 4 young adults are too heavy to serve in the military; the Department of Defense's annual expenditure on obesity-related healthcare for current and former service members and their families, as well as the replacement of unfit personnel, amounts to $1.5 billion.

Both the U.S. Department of Health and Human Services (HHS) and the Chicago Department of Public Health (CDPH) have established as key priorities the goal of reducing childhood obesity. On a national level, obesity affects about 12.7 million children and adolescents in the U.S. (2011-2014) with higher rates among African Americans and Latinos. From 2011-2014, the prevalence of obesity was 20.5% in 12- to 19-year-olds, 17.5% in 6- to 11-year-olds, and 8.9% among 2- to 5-year-olds.

Clinical screening, diagnosis, counseling, and referral are key to reducing and preventing childhood obesity. The U.S. Preventive Services Task Force (USPSTF) has found that screening and intensive behavioral interventions for obesity in children and adolescents age 6 years and older can lead to improvements in weight status.

Clinical Recommendations

The Centers for Disease Control and Prevention (CDC) defines obesity in children as an age- and sex-specific body mass index (BMI) in the 95th percentile or greater. BMI measurement is the recommended screening test for obesity. The USPSTF recommends that “clinicians screen for obesity in children and adolescents six years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status.”

There are many tools to help clinicians provide useful information and counseling to young people and families affected by obesity. For example:

- ChooseMyPlate.gov emphasizes the importance of making healthy food and beverage choices from all five food groups, including fruits, vegetables, grains, protein, and dairy to ensure that patients are getting the nutrients they need for a healthy eating plan. It provides daily recommendations of amounts to eat from each food group based on calorie needs that are estimated based on age, sex, and level of physical activity. General recommendations are given for each food group for 2- to 3-year-olds, 4- to 8-year-olds, 9- to 13-year-olds, and 14- to 18-year-olds (children 9 and older are further divided into amounts for girls and boys), based on less than 30 minutes per day of moderate physical activity. By filling in specific child information, clinicians or parents can use the MyPlate Checklist Calculator to tailor plans.

- Physical Activity Guidelines for Americans (PAG) recommends that children and adolescents (ages 6 to 17) get 60 minutes or more of physical activity daily. An updated edition of the guidelines is scheduled for release in late 2018.

Local and National Goals

Healthy Chicago 2.0, a citywide plan that provides more than 200 action steps to improve health equity, selected “Reducing Obesity” as one of five key areas to improve the health and well-being of children. Similarly, the HHS Healthy People 2020, the nation’s health improvement priorities, established goals and objectives within the topic areas of nutrition and weight status, physical activity, early and middle childhood, and adolescent health that all address the reduction of obesity and chronic disease, and the promotion of health and quality of life.

HHS is currently reviewing its obesity-related programs. In the HHS Office of the Assistant Secretary for Health (OASH) Region 5 office, we have established a prevention collaborative that includes a childhood obesity subcommittee that brings together federal agencies and other partners to coordinate and collaborate. The subcommittee identifies and shares successful practices and systems that address childhood obesity from conception to young adulthood. HHS is identifying ways to encourage new generations to eat better and exercise more—cutting our rates of obesity will improve health and reduce costs.

If you are actively engaged in preventing and managing childhood obesity, please share your story with us. Contact our subcommittee lead, Lesley Craig at Lesley.Craig@hhs.gov.

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.
Independent practitioners can make positive changes in their lives and practices

By Susan Sirota, MD

EXPERTS SAY that about one in three physicians will experience burnout at some point in their career. Most cases are not caused by bad experiences with patients or patient communications. Rather, burnout is due largely to overwhelming administrative and clerical responsibilities as well as inefficient work processes that are interfering with our focus on our patients.

Given this growing epidemic, it’s critical to assess what it means for us. Consider how much we physicians have invested in becoming good doctors. We spent significant amounts of time, money and effort because we are committed to this path. And now, after years of practice and so heavily investing in our work and our patients, we must not only recognize burnout, but more important, make changes so we can return to enjoying the practice of medicine.

Understanding the Need for Change

There are three components to physician burnout: lack of energy both emotionally and physically, feelings of cynicism, and a low sense of personal achievement. Anyone suffering from extreme exhaustion simply can’t perform at their best. Physicians who suffer from these feelings aren’t going to be able to form a strong relationship with their patients, and eventually the overall care will decline.

Years ago, we trained to be physicians, not business owners. Fortunately, for more recently trained doctors, universities are recognizing changes in healthcare and its landscape, and are responding by offering alternative educational tracks such as business and healthcare policy. This shift in education presents a notable advantage for our younger colleagues.

But for independent physicians with plenty of years left to practice medicine, how do we maintain a workplace where physician wellness prevails?

Finding the Right Balance

Like everyone else, we need to set goals. Perhaps we can’t change the direction of healthcare, but we do have the power to change how we approach our work as a whole.

Independent physicians can start by taking a mental inventory of their work and consider what responsibilities they enjoy most. These responsibilities are often addressed by one of three approaches: 1) focusing more on the business side of your practice; 2) dedicating more time to practicing medicine than running your business; or 3) deciding you want to do both equally.

The key to success is finding the right balance, one that enables you and your practice to thrive.

Once you’ve reflected on your responsibilities and set your goals, you can assess how you are going to achieve them and who is going to help manage each of the responsibilities. To do this, you need to evaluate which aspects are weighing you and your practice down and look at some of the demands outside of caring for patients.

For me, in addition to caring for patients, my partners and I were juggling everything else that comes along with owning a business. This included HR, operations, business development and revenue cycle management, to name a few. We realized we needed to develop a plan and delegate responsibilities to alleviate some of these burdens.

It is extremely difficult to find one person with a broad enough skill set to manage all the business functions successfully. Hiring outside experts to assist with practice management can be highly effective in preventing the kind of exhaustion to which we are all susceptible, and in promoting the success of your practice.

For us, it made sense to outsource our revenue cycle management. Our internal billing team was excellent, in fact, it was so good that not only did we outsource, but we also formed a billing company, separating it from the practice completely. And we did this with an important goal in mind: to help other independent physicians successfully navigate the tedious, time-consuming, complicated, and exhausting realm of revenue cycle management that can contribute to physician burnout.

Prioritizing Wellness

As physicians, we focus on the care of our patients and their health. We must do the same for ourselves. Though difficult, recognizing the signs of burnout is an important first step. Setting goals to strike a healthy balance comes next. This balance is very individualized. For some, it might be outsourcing internal processes that are inefficient or ineffective, and put your practice at financial risk. For others, it might mean internal changes.

Whatever your solution, it must start with thorough self-reflection. Prioritizing physician wellness will be better for you, your practice and your patients.

Dr. Susan Sirota has been a practicing pediatric physician for over 20 years. In 1993, she founded Pediatric Partners practices in Highland Park and Vernon Hills, which later merged with eight other practices to form PediaTrust, LLC. She also serves as the chair of the PediaTrust Board of Managers.

Dr. Sirota is an assistant professor in clinical pediatrics at Northwestern University Feinberg School of Medicine.
New Vistas for Physician Organizations

Private equity firms offer access to capital and new opportunities for physicians and groups but not without challenges and some disruption By Andrew Demetriou, Esq.

In the past few years, the market for the delivery of physician services has seen a class of new investor entrants—private equity firms have become active acquirers of physician groups and practice assets, providing an alternative to hospital-physician organizations and the traditional growth of physician groups through small acquisitions. For those of us with longer memories, this trend has some parallels to the physician practice management company (PPM) saga of the 1990s, but given the profound changes in reimbursement ushered in by the Patient Protection and Affordable Care Act, the development of enhanced technology (such as electronic medical records) to support physician practices and the availability of advanced data analytic techniques to model and modify physician practice behavior, the transactions which are occurring in the current environment are markedly different from those of a generation ago.

“Over the longer term, compensation arrangements will be subject to contractual adjustments, and this will be tested against the parties’ expectations.”

In addition, the profile of physician practices has changed significantly. A large percentage of physicians are now employed by hospital-based systems or large groups affiliated with such systems (such as medical foundations), eliminating the needs for capital and infrastructure support that drove physicians to seek refuge with PPMs in the 1990s. In addition, after a period in which some physician organizations, principally large independent practice associations (IPAs), collapsed due to their inability to deliver value to their physician members, large multi-specialty groups are reasserting themselves in the marketplace, and this is creating pressure on solo and small practices which are unable to adapt to required technological innovations, the shift to value-based purchasing for physician services and the re-emergence of risk-based compensation systems in markets which abandoned such systems in the past.

Many of the current models for large physician organizations are showing signs of instability. Physician-hospital affiliation models created years ago and modeled on the then current, primarily fee-for-service reimbursement models have not shown the ability to adapt to changing circumstances and shifts in the means by which medical services are being delivered, including the emphasis on population health management. While large physician organizations have more capital resources than their smaller peers, their ability to continue to grow and remain relevant players in the marketplace is fundamentally constrained by laws which restrict ownership and limit physician organizations from assuming risk for the services of other providers. As a consequence they are seeking new sources of capital (other than hospital systems) and partners that can provide the means to expand service offerings and support practice improvement initiatives.

This article provides an introduction to private equity (PE) firms which are entering the market to acquire physician and ancillary services provider organizations, explore the nature of the deals being proposed to physician organizations and identify a number of important considerations and common deal terms which characterize PE transactions with physician organizations, reflecting the expectations and investment perspective of these firms. While much of the discussion will focus on acquisitions of physician organizations or practice assets, it is equally applicable to joint venture transactions to create new organizations to be engaged in risk contracting or population health management.

Enter the PE Firms

PE firms have appeared in the fractured marketplace described above, presenting an alternative for physicians and groups. These organizations have raised large pools of capital for investment in physician services and allied businesses, lured by the $600 billion marketplace, and their investments in provider services in recent years are substantial.

Many of the PE firms are market sector agnostic, for example, physician services as opposed to diagnostic services; they are focused on deals promising absolute financial return to their investors and healthcare investments in general have provided better returns over the past few years than comparable investments in other industry sectors. In addition, they may lack a meaningful pedigree in the delivery of healthcare services, which on the one hand means they may be naïve as to the environment in which physician organizations operate, but also that they are not limited in their imagination by traditional tropes and are not burdened by regulatory constraints which affect hospitals. Since they are not providers of care they are willing to be more concrete in their support for clinical independence of their physician partners, within the confines of financial performance parameters established in their models.

As noted, private equity investors are primarily motivated by absolute return on invested capital.
The managers of these funds rely on outside investors for capital and are aggressive users of debt to magnify their returns. Since they typically are compensated based on a formula that includes a two percent annual return, based on invested funds and 20 percent of gains on the disposition of investments, they must achieve significant returns to satisfy the expectations of their investors and this fuels an appetite for debt, particularly in the current low interest rate environment. In addition, the managers enhance returns by rotation of their investments, typically within time horizons of five to seven years.

This is a stark contrast to hospital-physician deals which, in the author’s experience, are typically premised on extremely long partnership periods (20 years or more) and means that physicians involved in PE deals need to be prepared for prospective change in their PE partners relatively frequently. A benefit for physicians in these deals is that they are offered an equity upside from future transactions (which is generally not available in hospital deals), and if the PE firm offers a significant increase in scale by rolling up a number of specialty practices, prospective gains which are substantially higher than the physicians would realize from the sale of just their practices.

The need for returns influences the types of deals that are attractive to PE investors. They tend to be interested in practices which are readily scalable due to similar services offerings, those which make use of relatively capital-intensive technology (ophthalmology practices which use lasers and dermatology practices offering Mohs surgery), and those for which they forecast stable to increasing levels of reimbursement in the investment horizon. They are also interested in reimbursement schemes (such as managed Medicaid) in which there is opportunity in managing risk through improved practice performance, even if the reimbursement rates are below those offered for private pay or Medicare services. As a consequence, the targets for their acquisitions may vary from year to year.

**Preliminary Considerations**

PE firms may approach what they believe to be an attractive group without regard to existing relationships or commitments the group may have. If the physician group is already party to a management or services arrangement with a hospital or system, its leadership must consider the degree to which it has freedom to discuss a potential transaction with a third party. It may be that the physician group is only bound to joint contracting in a limited sphere of payment arrangements, leaving it with the right to pursue other opportunities on its own initiative.

The group may have certain exit rights from its current arrangement, or believe that its hospital partner has not fulfilled its obligations with respect to investment in practice assets, management infrastructure or negotiation of managed care arrangements. Before initiating discussions with a PE firm, the group must carefully explore the extent of its commitments and devise a strategy, including communication and transition plans that will permit it to seek a new partner. In addition, knowledge of its obligations may inform the negotiation of terms with a PE firm that will include funds to exercise buyout or other rights necessary to terminate its contracts and move on to a new relationship.

“While the PE firm may offer the physicians parity in board representation, it may insist on tie-break rights on key issues that affect financial performance and provide only limited ‘reserved powers’ to the physician representatives.”

Unlike negotiations with hospitals over joint ventures or affiliations, in which physicians and groups often enter based on significant historic relationships, preliminary meetings with a PE firm must be approached with regard to the firm’s expectations and experience. The PE firm may bring some expertise from other transactions into the discussions, but it will not have the same orientation toward delivery of care as would a hospital or another provider group. Rather, the PE firm will be much more focused on financial aspects of a transaction, since it does not directly benefit from clinical integration—unless it is acquiring multiple practices in a specialty area and is looking to gain market share for competitive and contracting purposes.

The ability of the group to demonstrate predictable future earnings will be an important consideration, both in determining price and in evaluating the feasibility of financing the transaction. Since most physician groups distribute substantially all of their earnings to their owners and do not have audited financials, physicians who negotiate with a PE firm must be prepared to see their financials “reconstructed” (with caps on physician income) to reflect profitability at the entity level—either the group itself, in states where that is permitted, or through a management enterprise jointly owned by the physicians and the PE firm.

In addition, the PE firm will expect to have an outside accounting firm perform what is called a “quality of earnings” or QoE, analysis to test the historical accounting practices of the group and develop a forecast of likely future earnings. It may also retain a consulting firm that can provide an assessment of prospective changes in federal or state law and policy that will affect reimbursement for the group’s services in the future. Finally, the PE firm may have certain baseline expectations concerning physician work commitments and revenue generation to support its financial models and the capital structure of the deal.
The PE firm will want to enter into a non-disclosure agreement very promptly and get authority to do preliminary financial testing to determine whether a deal makes sense without being committed to complete the transaction. To get there it may issue a preliminary “expression of interest” with a proposed purchase price and other key terms. It is important for the group to understand that such a document is not binding, and will be highly qualified, leaving the PE firm with substantial opportunity to renegotiate terms or walk away from the deal.

The Letter of Intent
After the PE firm has conducted its preliminary investigation, it will make a decision on whether to present a letter of intent (LOI) for the acquisition. While the LOI will be characterized as “non-binding,” unlike the expression of interest the LOI will include relatively definitive terms, including price and structure of a proposed transaction as well as a requirement that the group negotiate exclusively with the PE firm. In addition, the LOI will set out more detailed requirements for due diligence, conditions precedent to the obligations to complete the transaction and termination rights.

It is important that the group be well advised on what are typical (or in the jargon of dealmakers, “market”) terms in the LOI, to avoid a situation in which the group is tied up negotiating an inferior transaction and unable to seek better terms. In one case with which the author is familiar, the PE firm’s LOI was exclusive for a set period of time, but did not include a right of the group to terminate, creating an ambiguous situation where, several months after the LOI was signed, it was not at all clear whether the PE firm was intent on proceeding, but the group was at potential risk for entertaining other offers.

“The ability of the group to demonstrate predictable future earnings will be an important consideration, both in determining price and in evaluating the feasibility of financing the transaction.”

In some instances, the group may wish to propose a “fiduciary out” term, which allows the group to terminate negotiations during an exclusivity period if it receives an unsolicited offer that it deems superior to the pending offer from the PE firm. The rationale is that the board of the group cannot truly exercise its fiduciary duty to the owners of the group if it cannot seek the best price and terms for a deal. If the PE firm is amenable to such a provision, it will typically require either the ability to match the other offer or to receive a “break up” fee (which may be two to five percent of the value of the transaction), to compensate it for the time and expense associated with its investigation of the deal. These types of protections for the PE bidder will tend to discourage competing offers from being made at all, and the group should not seek a fiduciary out unless it is reasonably sure that competitors are likely to approach it without being invited to submit a bid.

As noted, the LOI is still non-binding, except for provisions related to confidentiality of information exchanged, the obligation to negotiate in good faith toward definitive agreements, termination rights, and in some cases remedies for a breach of the LOI. As a result, it is important that the group have a sense of whether the PE firm is truly serious about the deal or is just kicking the tires. In many instances it is useful to perform “reverse due diligence” on the PE firm to learn about its track record in closing deals and possibly to interview physicians with whom the PE firm has worked in the past.

As important as the terms of the deal are going in, it may be far more important for the group to have an understanding of how it may be treated by the PE firm after the closing—for example, will the PE firm be faithful to key understandings or does it say whatever is necessary to get the deal signed and then become a bad partner? Will it respect bargains about governance and truly involve the group in key decisions or just pursue its own agenda? Will it be committed to making the partnership successful, or will its attention be focused on the next deal? The answers to these types of questions should play an important role in proceeding with a PE firm.

Deal Artifacts
Traditional hospital-physician affiliation models involve the acquisition of practice assets coupled with a long-term provider agreement, the purpose for which is to bond the physician group to the hospital or health system. Physicians will realize some gain on the initial sale and benefit (it is hoped) from a compensation package which will afford some protection from market pressures and alliance with a provider system that remains relevant to payors in the future.

In the case of non-profit hospitals and health systems there are regulatory limits (such as the Anti-Kickback and Stark laws) on the amounts that can be paid to acquire assets and in compensation going forward, in addition to charitable trust concerns and the inability to afford physicians a continuing equity role in the enterprise. For-profit hospitals do not face the latter constraints and can create true joint ventures with physician equity participation, but must still contend with patient referral concerns and fair market value considerations in structuring the financial relationship with physicians.

In contrast, PE firms do not typically face these types of hurdles. Since they are not providers, and generally are focusing on a relatively narrow silo
of services, they are usually not concerned with anti-kickback issues with respect to the acquisition of assets or compensation to physicians, although they are disciplined by (some would say) the harsher mistress of financial performance. Rather than being unable or unwilling to offer an equity upside to physicians, PE firms typically require that sellers retain 20 percent of the equity in the acquisition vehicle, so that the physicians have “skin in the game” and to reduce capital investment in the acquisition phase.

Physicians need to be concerned about two issues in this regard—the first being what rights they may have to sell the 20 percent “strip” in the future, and second, ensuring that it represents a meaningful stake in the future if the PE-backed enterprise grows. Typically, the physicians will be required to sell their interest into a transaction the PE firm negotiates, a so-called “drag along” obligation, and may be able to participate electively in a potential sale, a “tag along” right, but they typically do not have the right to require the PE firm to buy them out in the future or to sell their equity to a third party.

In addition, an important point of negotiation is the equity rights the physicians will have, if any, in a parent entity which owns the practice acquisition vehicle. Having a right to convert subsidiary equity into parent equity more closely aligns the physicians with the ultimate financial interests of the PE firm, rather than potentially being limited to owning a piece of an entity that serves their practice alone, or a small universe of local practices, and consequently may reduce the risk of holding the equity investment over the longer term. Conversion rights, if offered at all, will be heavily negotiated by the PE firm, since granting them to physicians prospectively dilutes returns for the PE sponsor and its investors.

Depending on the relative sophistication of the physician group and its financial history, there may be significant negotiation about how the purchase price is to be paid. PE firms may try to set a high price to attract interest from the physicians, but minimize front-end capital outlays by making certain elements of the purchase price contingent, whether on post-closing adjustments based on audits of profits or working capital, or through “earnout” arrangements where additional payments are tied to attainment of financial performance targets by the management vehicle after closing.

These bits of financial engineering can have significant implications for the actual proceeds physicians can expect to receive in a transaction, as well as the value of the equity interest they retain. In a more perverse situation, the physicians may discover that they are ultimately paying themselves by providing all of the financial returns that generate future contingent payments. It is important that the group have counsel and other advisors who are familiar with these types of arrangements and can analyze the risk and reward associated with different payment models.

Physicians also need to be aware that PE firms will be more aggressive than hospitals in implementing IT systems and financial reporting infrastructure, and are more likely to require changes from the platforms the physicians may be using with hospitals. Often the PE firm will see such systems as drivers of profitability through decreasing operational costs. On a related note, the PE firm will be focused intently on revenue enhancement through careful attention to coding for services, prompt billing and aggressive collection practices, and this can be disruptive to physicians, as it represents changes in the way they have typically conducted their business. There will likely be a loss of collegiality and understanding of certain practices which are viewed by the PE firm as inefficient.

“Traditional hospital-physician transactions are often idiosyncratic, with terms negotiated to suit the particular local situation and influenced by personal relationships between the principals.”

In addition, in situations where the basic agreement anticipates management of the physician group or a complex contracting strategy, the PE firm will insist on a fairly iron-clad long-term provider agreement. Unlike the rationale for such arrangements with hospitals—insuring long term loyalty—the PE firm is seeking to lock in a revenue stream that will facilitate the sale of the enterprise in a relatively short time frame. Consequently, financial terms in the provider agreement need to be reasonably acceptable into the future and include downside protection against changing reimbursement patterns, since physicians will not have a right to terminate, say in the event of a sale of the management enterprise or a financial restructuring by the PE firm.

Not surprisingly, termination rights are also heavily negotiated. The PE firm will want exits in situations where its financial projections are upset by material changes in regulations or reimbursement rules or where the physicians fail to meet basic productivity targets. They will resist termination rights in favor of physicians and groups in situations where the PE firm has failed to achieve market share or growth targets. Rights to terminate for breach will be very limited. Neither side should be looking for, or expect, a near term exit. In addition, the deal terms need to address the disposition of assets in the management enterprise on termination.

Unlike the typical hospital-physician relationship, in which physician practice assets have little value to the hospital, the PE firm may have
a strong interest in certain assets that support its management of other groups, and the physicians need to contemplate how they might replace the systems for maintaining medical records and which support billing and financial reporting in the event that the PE firm is unwilling to sell them to the physician group on termination.

Another important consideration is governance rights. While the PE firm may offer the physicians parity in board representation, it may insist on tie-break rights on key issues that affect financial performance and provide only limited “reserved powers” to the physician representatives on the board. In addition, managers appointed by the PE firm will typically have fairly broad discretion in business operations.

“While deals with PE firms may be superficially attractive to certain physicians, completion of deals can be quite challenging given the ways in which the expectations of PE firms differ from well-trod ground that underlies the provider deals negotiated in the past.”

The physicians should expect control over clinical matters, but even in this area, the PE firm may want a voice in clinical decisions that affect revenues and profitability, to the extent this is not limited by laws governing the professional practice of medicine. In addition, as is the case with equity interests, the physicians need to appreciate whether their governance rights are limited to the subsidiary which acquired their practice or includes representation in a parent entity, which may be charged with making decisions that affect the subsidiary based on regional, or even national, considerations.

Finally, the parties need to consider the issues of capital investment. Physician groups are chronically short of capital and one factor that PE firms emphasize in pitching for deals is their ability to provide resources for better practice support. The key question is whether the PE firm will deliver on its promises and meet the expectations of the physician group, which may also turn on a meeting of the parties’ minds about common expectations.

Physicians should expect that future capital decisions by the PE firm will be based on fairly hard-edged financial metrics and need to become familiar with terms like “hurdle rates” for investments. This is in stark contrast to historical relationships they might have with a hospital, where the hospital may be motivated to make capital investments for political or other non-financial reasons.

**The Transaction Process**

Traditional hospital-physician transactions are often idiosyncratic, with terms negotiated to suit the particular local situation and influenced by personal relationships between the principals. In many cases the parties may even choose common legal counsel in an effort to save expense and limit contentious negotiation. In contrast, physicians should expect the PE acquirer to come to the table armed with very specific transactional norms in mind and detailed reasoning behind its negotiation strategies. It may demand use of its form deal documents and entertain only limited changes.

Physicians are advised to retain knowledgeable transaction advisors, both to assess the reasonableness of proposed terms and provide a context for the group to appreciate the consequences of the transaction as well as to negotiate favorable terms based on prior experience. Legal counsel can play a valuable role in shaping physician expectations concerning the outcome of negotiations as well as helping the group deal with transactional customs such as disclosures and due diligence investigation, which form the basis for representations the group will need to make in definitive agreements.

The decision to enter into a purchase contract dramatically increases the liability of the parties; they are no longer in a situation in which they can easily walk away from the deal without consequence. The purchase agreement is a binding contract and must be treated with seriousness, as it contains all of the specific terms of the transaction. A discussion of the key elements common to these documents follows.

Representations and warranties will comprise a substantial share of the base acquisition or joint venture documentation, and physicians must appreciate subtleties in what they are promising about the
business being sold. Breach of representations and warranties implicates contractual remedies, so it is very customary to negotiate limitations on the extent of representations, for example, the extent the representation is based on the actual knowledge of key physicians in the group (rather than being absolute) or limited to matters that are “material” (those for which a misrepresentation would have a substantial impact on the acquired practice). In addition, there are customarily time limits on the duration of the representations, after which the acquiring entity has assumed the risks of a state of affairs inconsistent with the representation. In this area it is also important to have advisors with experience in negotiating representations and prepared to propose customary limitations to protect the physicians’ interests.

The representations generally tie into provisions which require the physicians to indemnify the acquiring firm if certain events occur after the closing. The indemnity language may require that the physicians actually assume the defense of the acquisition entity or, alternatively, pay for any expenses or damages incurred. The obligations may also be affected by the availability of insurance to cover losses, obviating the need for indemnification by the selling physician organization. As with the representations, it is important for the physicians to understand customary terms for indemnification, for example capping exposure to a percentage of the purchase price, or requiring that the damages exceed a negotiated threshold before the obligation is triggered. It is also important that there be time limits on the assertion of any claim for indemnity to provide certainty as to the extent to which the physicians may be exposed.

The purchase agreement may also contain specific promises concerning matters to be addressed by one or both parties as conditions precedent to closing, in situations where there is a gap period between signing the purchase agreement and the closing date. These “covenants” can include securing governmental or third-party consents where required to complete the deal; addressing employment matters, such as assisting the purchaser in hiring key personnel or transitioning employee benefit plans; restrictions on the pre-closing conduct of the business; protection of the confidentiality of deal terms; and limits on the ability of the selling physicians to compete with the acquiring entity in certain lines of business in the future.

Finally, the purchase agreement will contain certain terms that are described as “boiler plate” and which seldom attract attention from businesspeople negotiating a deal, as they address somewhat mundane issues such as governing law and whether singular terms refer to the plural as well. Nonetheless, some of these often-neglected provisions can become significant to the parties in the future—for example, the right of the PE firm to assign its interests to another entity or the manner in which disputes between the parties are to be resolved. Competent advisors will recognize the importance of such terms and at the least focus the attention of the physicians on the potential consequences of certain choices.

**The Aftermath**

Once the transaction is closed, the parties must now accommodate themselves to coexistence based on the terms of the agreements they have negotiated. Early decisions on the conduct of the business will test whether the governance arrangements mirror the expectations of both sides and provide for a solid working relationship. As the management of the new enterprise begins to dig into operational details it may discover problems which implicate the accuracy of representations, such as the existence of an undisclosed claim or non-compliance with a key license, and the parties must determine how to address the situation—either by working cooperatively to solve the problem or seeking recourse to the contractual terms they have negotiated. It is perhaps only at this time that the physicians may appreciate the importance of the representations and covenants they agreed to. Operational decisions that may be left to management under the key agreements can be escalated to the governing board if, for example, physicians become dissatisfied with policies concerning support personnel, creating tension concerning the appropriate roles of management and the board.

“Physicians should expect that future capital decisions by the PE firm will be based on fairly hard-edged financial metrics and need to become familiar with terms like ‘hurdle rates’ for investments.”

Over the longer term, compensation arrangements will be subject to contractual adjustments, and this will be tested against the parties’ expectations. Physicians may become dissatisfied and seek to leave the group, creating potential issues with exit strategies and possibly with maintaining sufficient practice revenues to support the management structure. At some point the PE firm will reach the point at which it seeks to roll over its investment to raise cash for distribution to its investors, or to find new acquisition targets with better returns, but keep the physician group bound to provider or other agreements to assure that it has a salable asset. This will prompt discussions with the physician owners concerning the future course of the business, including the willingness of the physicians to work with a potential new partner or alternatively to exercise rights to reacquire the business. While these issues should properly be addressed in the negotiation of the purchase agreements, even the best advisors have limited foresight as to issues that may emerge, particularly if the PE firm is inexperienced in
operating the business or the physicians were not well advised on their undertakings.

The transactional documents may also contemplate a potential breakup of the deal in certain events—for example, if the entity is unable to meet agreed upon targets for revenues or profitability, or changes in law or regulation jeopardize the viability of the organization. Some recent transactions involve the creation of joint venture entities that will be risk bearing organizations, contracting with health plans to provide a wide range of services for a global capitation payment. This is an area in which state laws in many instances are undeveloped or developing, and the transaction structure chosen by the parties may not be in compliance with changing requirements.

Changes in law may require additional capital commitments or expenses associated with licensure, which were not contemplated by the parties and may be beyond their capabilities. Negotiation of exit provisions is often difficult and distasteful to the parties; who wants to contemplate divorce on the precipice of marriage? Nonetheless, having certain plans against future events built into the relationship at the outset may create a basis for resolution and the avoidance of disputes. The working relationship between the parties may be critical in how they address unforeseen circumstances that force reconsideration of the basic deal.

**Conclusion**

The recent interest of PE firms in acquiring provider organizations creates new opportunities for physicians and introduces an element of disruption into the traditional relationships between physicians and hospitals. The access to capital and ability to innovate afforded by PE firms may create new models for service delivery that better address the reimbursement profiles of the future, with increasing bundles, value-based payments and true risk arrangements. While deals with PE firms may be superficially attractive to certain physicians, completion of deals can be quite challenging given the ways in which the expectations of PE firms differ from well-trod ground that underlies the provider deals negotiated in the past. It is important that physician organizations take the time to understand the new players in the market and seek out counsel and other advisors who can evaluate and document potential deals.

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Private Equity Investment in Ancillary Healthcare Providers

Significant investment continues to flow to certain niche ancillary providers

By Patrick Souter, Esq.

The U.S. healthcare system has recently experienced events that would ordinarily cause those considering private equity investments in the industry to be hesitant to do so. A new Administration, uncertainty regarding the status of the Patient Protection and Affordable Care Act (PPACA), consolidation in the provider and payor world and changes in reimbursement would seem to all be material in making investments in the healthcare sector. However, these considerations, which may be red flags to some, appear to be opportunities to others. While there has been a slight drop-off in healthcare merger and acquisition activity, private equity investment in the healthcare sector continues to be significant across areas of the spectrum. This activity is not limited to hospitals and physician practices. Significant investment continues to flow into ancillary providers. These ancillary providers supplement the care provided by hospitals and physician practices or provide products or services utilized by those providing direct patient care. For purposes of this review, all such ancillary providers are considered ancillary healthcare providers.

Why Does Private Equity View Healthcare Investment Favorably?

Despite the uncertainties tied to the healthcare industry, the total value of private equity investment in 2016 reached its highest level since 2007. Investors continue to view the healthcare industry as a safe haven from economic volatility. The value of disclosed transactions involving private equity was $36.4 billion on a global basis. This investment activity was across all major sectors of the healthcare industry, with significant activity involving those referred to as “healthcare-light companies.”

This classification encompasses those in the healthcare industry that are usually not directly impacted by changes in reimbursement. This industry positioning allows for those entities to benefit from market forces, causing growth in healthcare without being detrimentally impacted by some of the regulatory risk. Many types of ancillary providers fit within that category.

North America healthcare investment experienced a tumultuous 2016 in light of the competition for choice asset targets, political uncertainty and aggressive valuations but still witnessed a total deal value of $28.4 billion. The focus away from those companies overly affected by regulatory and reimbursement concerns fueled much of this activity. Interestingly, nine of the top ten healthcare deals globally involved U.S. assets with 40% of those transactions involving European buyers.

Niche Ancillary Provider Investment Areas

The healthcare industry has certain niche ancillary providers that are of particular interest to the private investment community. These ancillary providers include healthcare IT and electronic health record (EHR) vendors, laboratories, behavioral health, urgent care, revenue cycle management, and management companies offering business services to dental and anesthesia providers. The reason these areas are of heightened interest is three-fold. First, some ancillary provider segments of the marketplace are experiencing high profits which are not expected to last for a significant period due to pending regulatory or payor action or market saturation. Second, the products and services of these ancillary providers may be in high demand in patient care, so profits are reasonable and explainable. Third, these providers often offer profitable ancillary products or services to a primary business line such as laboratory services in a physician office.

Those ancillary providers who have seen significant investor interest but which have recently experienced less activity include medical devices, ambulatory surgery centers and specialty pharmacies. While these three areas still maintain solid returns, each has issues that may make them less attractive than the other highlighted ancillary providers. These concerns do not necessarily mean that any of the three would not be an attractive industry for investment purposes. Rather, market attention has simply shifted to new areas that appear to have greater potential from a financial aspect or in light of market conditions dictated by the government or payors.

Digital Health

The healthcare IT and EHR space, or what is recently been referred to as the “Digital Health” space, has seen the market mature where the number of market participants has narrowed significantly. This reduction in providers fosters incentivizing those remaining to outpace competition by creating and offering advances in technology. The result of such activity makes for an attractive market. Also, the various governmental
and payor efforts to create and utilize common information platforms in the delivery of care will continue to create a market for these products and the underlying support services they have to offer. Significant private equity transactions in the second quarter of 2017 include Modernizing Medicine, which provides EHRs for specialists; it raised $231 million, increasing its total funding to $318 million.

**Laboratories**

Laboratories continue to be appealing to investors, since their services are necessary in the delivery of care by hospitals and medical practices and are a basic component in the national effort to provide preventive care and coordinate care among providers. There have been several recent highly publicized private equity transactions in the laboratory area. However, there has been significant enforcement activity involving fraudulent billing, unneeded services performed and kickback schemes between laboratories and other providers.

“In These ancillary providers include healthcare IT and electronic health record (EHR) vendors, laboratories, behavioral health, urgent care, revenue cycle management, and management companies offering business services to dental and anesthesia providers.”

In addition, laboratories that utilize management and distribution companies to create a financial arrangement with a referral source rather than the provider having an investment in the laboratory may be subject to additional regulatory scrutiny. The laboratory will establish a management or distribution company and will offer providers, commonly those who refer business to the laboratory, the opportunity to invest in the company. The general concept of a management or distribution company may fit within certain safeguards and be lawful, but the use of this business model has pushed the boundaries. For instance, a laboratory may pay the management or distribution company for questionably needed services or amounts that may exceed fair market value for services performed. There are also instances where the laboratory has established multiple management or distribution companies and offered investment opportunities to small groups of physicians. The company will then provide management and distribution services related to the laboratory’s business associated with the investors. However, this type of arrangement usually reveals no business purpose for a laboratory to have multiple management companies performing the same service and the investor physicians commonly receive distributions that may be similar to their referral patterns. The Department of Health and Human Services’ Office of Inspector General (OIG) remains sensitive to management arrangements that involve companies with physician investors that are providing products and services to ancillary providers that the physician investor may refer to and in turn benefit from the management fees derived from such referrals.

**Behavioral Health**

Behavioral health and substance abuse treatment operations have seen a significant increase in investor attention. The attractiveness of this ancillary area is due to the increased demand for their services in conjunction with limitations on the ability of payors to utilize more onerous standards when determining reimbursement for such services than those used for pure medical services. Additionally, governmental regulation requiring behavioral health payor coverage and significant revenue and profit margins are other driving forces that have caused this area to be appealing for the past five years. Indications are that such drivers will continue to create a positive effect on this segment’s outlook.

**Urgent Care**

The urgent care market encompasses more than just neighborhood urgent care centers. Investments in this area include CVS’ Minute Clinic, freestanding emergency departments and specialty urgent care, such as orthopedic-specific urgent care facilities. Since 2008, approximately $3 billion has been invested in this industry with speculation of continued activity in this area occurring through 2019 and beyond. A recent transaction involving the majority acquisition by a private equity firm of a majority stake in the 68-unit CityMD urgent care chain is an example of such activity.

**Revenue Cycle Management**

One may not believe that revenue cycle management (RCM) providers are ancillary providers in the healthcare world. However, the core business of these providers pertains to the fundamental issue encountered by all healthcare providers: efficient tracking, billing and collecting of revenue. RCM is more than just billing and collecting services. It may be as complex as the administrative department of an enterprise that handles all financial aspects of operations, performs analytics and offers revenue solutions, or as simple as providing software that may be used to perform such functions. With the variety of RCM services, its market is expected to grow at a 26.5 percent compounded growth rate through 2018. Private equity has been instrumental in expanding RCM operations through internal growth as well as acquisitions of smaller targets to shore up end-to-end RCM service offerings.
Practice Management

Practice management companies, such as in dentistry and anesthesia, have been attractive to private equity groups. Similar to RCM providers, these companies provide a valuable tool in navigating the business aspects of healthcare. From the mid-2000s to 2015, more than 25 private equity firms committed significant investment in dental practice management companies, with some of the larger companies in this space achieving annual revenues in excess of $100 million. Similar projected growth continues to make this an appealing ancillary provider even in spite of a 2013 Senate committee investigation that concluded some dental practices should be excluded from Medicaid due to questionable practices. Recently a private equity group committed $25 million to fund the organization of a dental practice management start-up.

Anesthesia practice management companies have exploded onto the market in the past few years, and private equity has taken notice. Anesthesia practice management services allow for platforms that are scalable without the need to incur high cost since anesthesia services are primarily located at facilities such as hospitals and surgery centers. It is not a capital-intensive venture to expand anesthesia operations because they generally do not require significant space, equipment or staffing. This allows for a much more profitable type of medical practice that will in turn generate revenue for the management company.

Why Has Private Equity Increased Its Focus on Ancillary Providers?

There are several reasons why ancillary providers have experienced increased investment activity by private equity compared to physician practices. First, hospital acquisition of physician practices has increased, so physician practices do not necessarily need to seek private equity to fund aspects of the practice. Rather, the health systems may acquire a physician practice and provide the funding necessary to expand it and its capabilities, a function ordinarily served by private equity. Second, the prohibition against the corporate practice of medicine doctrine restricts private equity from investing in physician practices. In those states that follow this doctrine, it limits the ability of a private equity firm to invest in physician practices since a non-licensed person would be an owner in or control a medical practice. Finally, ancillary providers have experienced substantial revenue growth due to PPACA’s expansion of the need for such services through incentivizing preventive medicine and quality of care measures that rely upon ancillary providers and their services.

The availability of capital from private equity has been of significant value in the various ancillary markets. The opportunity for increased access to funding allows local or regional providers to expand the markets where they offer services. It may also provide funding for new equipment or personnel or the ability to move into other complementary ancillary services. By providing avenues for funding, private equity enables the ancillary providers to be more independent and not reliant on health systems as a funding source by being acquired or entering joint venture arrangements. Ultimately, new sources of capital that ancillary providers may access have been a “win-win-win” for all involved. It allows the ancillary provider a different source of capital from that it has traditionally utilized through health systems and physicians. The private equity firms are able to invest in healthcare and obtain significant positive return on investment through a focused healthcare vehicle. Non-ancillary providers and their patients have additional, and more advanced, opportunities from those ancillary providers that have expanded their operations, either through geographic footprint or services offered, which may lead to better care.

"Private equity investment in ancillary healthcare entities will continue to thrive even with the uncertainty in the U.S. healthcare system."

Conclusion

Private equity investment in ancillary healthcare entities will continue to thrive even with the uncertainty in the U.S. healthcare system. Ancillary providers that have made a niche in the industry addressing product and service lines necessary to comply with governmental and payor requirements are popular investment vehicles since they are needed by those who provide medical services. Those that provide value-added services, especially without incurring significant cost in doing so, have been particularly attractive to private equity. Many of these ancillary providers were spawned out of the need to bring additional expertise to the healthcare provider in the delivery of care. Continued evolution of further ancillary providers that identify additional niches will be those whom private equity will continue to seek out for investment purposes.

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A slowly improving individual insurance market should be good news for physicians and their patients, thanks to increasing profits of health plans selling Obamacare policies under the Affordable Care Act. Still, physicians will find they are less likely to see as many of their services covered for patients out-of-network as health insurers emphasize narrow networks.

And should health insurance companies take advantage of an executive order by President Donald Trump that would open the market to cheaper plans, regulations could make it easier for patients to see the doctor they want though higher deductibles could limit the ability of patients to seek care. “It’s good that these plans are doing better as it can have the impact of offering more stable markets, which hopefully means more stable (provider) networks,” said Cheryl Larson, vice president, Midwest Business Group on Health, which represents some of the Chicago area’s largest employer purchasers of healthcare. “But it’s important for patients that the right elements are in place for the best care at the best price.”

To be sure, health insurance company earnings reports and a November analysis by Fitch Ratings show the financial performance of insurance companies improving “significantly.” In Illinois, in particular, the parent of Blue Cross and Blue Shield of Illinois has gone from a loss to earning more than $1 billion in the first half of this year.

Improving health insurer finances is critical to the future of individual coverage, also known as Obamacare, which is offered under the ACA because Blue Cross and Blue Shield plans tend to dominate individual markets like Illinois. “Premium rate increases, operational changes that tightened enrollment and underwriting practices on marketplaces established by the Affordable Care Act (ACA), lower than anticipated utilization trends and 2017’s temporary suspension of the ACA’s health insurer fee contributed to the improvement,” said Mark Rouck, senior director at Fitch Ratings.

Some see the lower utilization as a sign that patients could be avoiding care due to high deductibles. But insurers say they are more effectively managing these newly insured patients than in the first three years of Obamacare coverage.

From 2014 to 2016, which were the first three years coverage was available on exchanges under the ACA, insurers lost money because they were unable to manage the costs of sick patients signing up for coverage.

Individual Insurance Market Stabilizes Ahead of Trump Changes

But doctor networks narrow as insurers raise rates and increase profits

By Bruce Japsen

Aetna CEO Mark Bertolini said that any new association health individual plans wouldn’t be available to the public until 2019. “We have to get the executive order to regulation before we can understand what the rules are.”
MARKET STABILITY

up for coverage. Such losses triggered decisions by Aetna, Humana and UnitedHealth Group to leave scores of public exchanges including Cook County and the entire state of Illinois.

But Blue Cross and Blue Shield of Illinois, which is owned by Health Care Service Corp., has turned the early years of losses into profits in 2017 after raising rates and also narrowing its provider networks. The Illinois Blues no longer offers its statewide preferred provider organization (PPO) on the public exchange and is offering narrow network plans such as Blue Direct, which limit most provider choices to doctors and hospitals in the Advocate Health Care System.

Cheryl Larson, vice president, Midwest Business Group on Health, said an improving individual insurance market should be good news for physicians and their patients, especially if markets become more stable and the right elements are in place for patients.

Illinois Blue Cross’ $1 Billion Profit
The narrowing of health plan networks helped Illinois Blue Cross parent Health Care Service Corp. turn a six-figure loss into a seven-figure gain. The story was similar for other Blue Cross and Blue Shield plans across the country as more turned to narrow network plans like health maintenance organizations (HMOs) and exclusive provider organizations (EPOs). “The aggregate first-half 2017 underwriting gain of the 34 Blue Cross Blue Shield companies included in the report was $5.1 billion greater than the prior-year period as premium growth exceeded benefit growth by roughly $2.3 billion and administrative expenses declined on an absolute basis by roughly $2.8 billion,” Fitch said in its November 6 report.

Health Care Service Corp. made $1.15 billion in the first half of this year after losing $159 million in the first half of 2016. In addition to Blue Cross and Blue Shield of Illinois, Health Care Service Corp. offers plans in Illinois, Texas, Oklahoma, New Mexico and Montana. Though the Fitch report didn’t state specific profits or losses for each plan, Blue Cross of Illinois figured prominently because it’s the largest of the five in terms of enrollees.

“Analysts say the improving profits will be good for physicians when it comes time to negotiate reimbursement rates with health plans.”

The future to offering a financially stable individual insurance product means moving away from fee-for-service medicine to value-based models that reward physicians based on the quality of care provided to patients, say insurers offering Obamacare in Illinois. “Part of financial stability comes from continuously improving and coordinating care, which benefits physicians, insurers and members,” Illinois Blue Cross spokesman Greg Thompson said in a statement to Chicago Medicine. “When we are able to know these members consistently over time (as BCBS plan members), we are all better able to work closely with doctors and other health care partners to create networks with the right balance of cost and quality for our members and best use of insights and tools available to help improve outcomes.”

The story is similar for other health insurance companies that still sell Obamacare policies in Illinois. Cigna CEO David Cordani said during the company’s third-quarter earnings call in November that the insurer expects 2017 individual “results to be slightly profitable.” Illinois is one of six states where Cigna is continuing to sell Obamacare policies in 2018.

Cordani said Cigna has been successful managing costs in its health plans in part by using narrow networks and a value-based approach that shifts contracts with physicians away from fee-for-service medicine that bases payment on volume of care delivered. “The push for value is as intense as it has ever been,” Cordani said.

In Cigna’s third quarter, the “total commercial medical care ratio was 78.6%, which “reflects strong performance and effective medical cost management in both our employer and individual books of business,” executives said. Cigna’s rivals, particularly in the individual business, are seeing ratios higher than 80%, which means they are spending far more of the premium on medical costs and related claims. The inability to manage costs figured in decisions by Aetna, Humana, UnitedHealth Group and others to scale back their
Cigna CEO David Cordani said the company has been successful in managing costs in its health plans in part by using narrow networks and a value-based approach that shifts contracts with physicians away from fee-for-service medicine that bases payment on volume of care delivered.

Obamacare individual offerings in Illinois and across the United States.

Analysts say the improving profits will be good for physicians when it comes time to negotiate reimbursement rates with health plans, which will have better news to tell their brokers, employers and individual customers. “If an insurance carrier is able to make a profit in the individual market, that’s probably good news for the employer group plans in their book of business,” said Beth Umland, director of research for the employee benefits consultancy Mercer. “Not only does it take pressure off group plans as a source of revenue to make up shortfalls, but it means the company has more money to invest in programs to drive quality and efficiency.”

“The AMA approved new policy that opposes removal of any categories from the essential health benefits package offered under the ACA.”

So far, health insurance companies are taking a wait-and-see approach to new rules the Trump administration is proposing to ease regulations for sales of individual insurance policies via executive order. In October, Trump directed federal agencies to establish rules that would allow “association health plans,” sales of health insurance across state lines, and is open to allowing states to skirt some rules under the ACA.

But such rules have yet to be published nor had they been communicated to insurance companies as of December 1. Thus, any new individual plans outside of those offered this year under the ACA wouldn’t be available to the public until 2019. “We have to get the executive order to regulation before we can understand what the rules are,” Aetna CEO Mark Bertolini said on the company’s third quarter earnings call last month.

Doctors Oppose Effort to Gut ACA’s “Essential Health Benefits”

Meanwhile, some are interpreting Trump’s executive order as the administration being open to waivers that would allow states to cover fewer services or skirt the EHB provisions. In Illinois, there is no indication yet that any insurers would lobby for waivers to allow them to cover fewer services for Obamacare policies. But organized medicine is opposed to any “weakening or removing any” of the categories of essential health benefits (EHBs) under the ACA.

The ACA doesn’t allow for insurers to carve out certain things that might historically have allowed a health plan to price a product lower, which is something that Republicans and the Trump administration say they want to allow. Illinois, for example, has had a requirement for certain maternity care coverage that became required for all plans operating on the exchanges when ACA was enacted.

A report released at the interim American Medical Association House of Delegates meeting last November said the most likely essential health benefits that states would eliminate if allowed to do so would include “maternity care; mental health and substance abuse benefits; rehabilitative and habilitative services; certain pediatric services, including oral and vision care; and prescription drugs.” But the AMA approved new policy that opposes removal of any categories from the essential health benefits package offered under the ACA. “Most costs associated with EHB requirements are attributable to such services as hospital inpatient and outpatient care, physician services, and prescription drugs,” AMA President Dr. David O. Barbe, said. “These services are fundamental components of health insurance coverage. Removing any categories from the EHB requirements, or allowing waivers of such requirements, could make individuals vulnerable to significant out-of-pocket expenses, or hinder patient access to necessary services.”

Bruce Japsen is a health care journalist, speaker, author and regular contributor to Chicago Medicine who also writes for Forbes and The Motley Fool. He’s a regular analyst on WBBM Newsradio and WTTW television’s Chicago Tonight program and Fox News Channel’s Forbes on Fox. He can be reached at brucejapsen@gmail.com.
Newly elected CMS leaders voice their opinions on key issues
By Cheryl England

ACK IN September, the Chicago Medical Society’s new leaders took charge. Several such as Vemuri Murthy, MD, and A. Jay Chauhan, DO, were already officers. Others such as Victor Romano, MD, are new to the elected leadership. Here we have a conversation with some of the leaders including President Vemuri Murthy, MD; Secretary A. Jay Chauhan, DO; Chair of the Council Christine Bishof, MD; and Vice Chair of the Council Victor Romano, MD. Here’s what they have to say about key issues in healthcare today.

Most everyone agrees that Obamacare has flaws. In a repeal and replace scenario, what would you like to see happen?

Dr. Murthy: We really need to understand that the state of U.S. healthcare is nebulous. Because we, as physicians, care for patients on a daily basis, we need to be able to sit down at the same table as policymakers and go through each and every point of policy including funding, basic healthcare and working conditions. It’s a very difficult goal, but we need to look at the whole picture, not just a few pieces. Medical societies need to be taken seriously because our members are the providers of healthcare.

Dr. Bishof: Unfortunately, the system has become so complex and dysfunctional after the advent of Obamacare, I’m not sure it can be fixed without a complete repeal. The intent of Obamacare was good, but its implementation was poor. While promising to cover essential health benefits, many people are left with outrageous premiums and no meaningful access to care due to extremely narrow networks. I think this can only be fixed with a total restructuring of the insurance market with all the stakeholders at the table. We need to get back to the basics and get insurance (public and private) out of the exam room. Healthcare is about healing and the patient-doctor relationship, not EHRs, billing, the two-midnight rule, prior authorizations, and unproven metrics masquerading as indicators of quality care.

Dr. Chauhan: Frankly, the ship needs to be righted. Those who promulgated the ACA rightfully acknowledged that the law was imperfect and required adjustments during and after its implementation. If a new piece of legislation is created, I am under the impression that there would be preservation or parallel features in the “replacement.” Therefore, it seems like the discussion regarding repeal versus replacement is semantic, or you can call it brinksmanship (depending upon your point of view), and unfortunately, it is drawing energy away from fixing the healthcare system in a material way.

Dr. Romano: The big problem with Obamacare is that healthy people pay into the system and end up taking care of the people who do not buy insurance but get care anyway. For example, I took care of a 35-year-old patient who fell down stairs and broke his tibia. Of course, we are going to take care of him, but he had gone 10 years without paying into the system. Even before Obamacare, people without insurance were responsible for paying their bills, but they went bankrupt, so they couldn’t pay anyway. This needs to be fixed.

What do you think of the trend toward value-based care?

Dr. Bishof: Value-based care is a great idea in theory. In an attempt to get away from paying more for doing more, it is supposed to put the focus on decreasing cost and utilization while improving care. However, I think the direct benefactors are the insurance companies, not the patients.

Dr. Chauhan: Like my fellow physicians and surgeons, I have always been mindful of practicing medicine in the most economical fashion: looking for generic alternatives, encouraging patients to align themselves with preventative healthcare behaviors, providing educational resources for patients, and filtering new therapeutics for efficacy and value. The value-based shift in healthcare requires greater patient volume, adds layers of paperwork, increases challenges for physicians and complexity for patients. It does not appear to mitigate increases in pharmaceutical pricing, nor does it address the ever-growing frequency of medication shortages. It will result in higher insurance deductibles, continued liability concerns, and it complicates the healthcare insurance labyrinth. This all makes me ask: a value-based system for whom?

Dr. Romano: I think it’s a good program, but it has problems, too. For example, there is no incentive...
LEFT TO RIGHT FROM TOP: Drs. Clarence W. Brown, Jr., immediate past president; A. Jay Chauhan, secretary; Tariq Butt, treasurer; Vemuri S. Murthy, president; Victor M. Romano, Council vice chair; Christine P. Bishop, Council chair; and Dimitri T. Azar, president-elect.
for a physician to avoid surgery if possible.

What words of wisdom can you give to new medical graduates?

Dr. Chauhan: An individual seeking a career in medicine should consider the length and arduous nature of training; this does not simply refer to time invested. Even though hours for residents have been reduced from the not-so-uncommon 110 hours per week that were required of us, what has not changed is the nature of caring for the critically ill and its emotional toll. Additionally, the cost of completing 11 to 13-plus years of training amortized over 30-plus years of practicing medicine should be considered as well as the encroachment of paraprofessionals. Specifically, I would recommend to new graduates what I recommend to those entering medical school: namely, to minimize expenses and maintain frugality while maintaining a good life-family-work balance. The former prevents financial stress and the latter helps prevent burnout. For recent grads, I would also add that once your loans are paid off, begin saving for your retirement in the same manner.

Dr. Bishof: I always tell new graduates to have a back-up plan. As more physicians become employed, they are losing some of their autonomy and may be left without a job on short notice due to contract issues. I suggest having privileges at more than one hospital, just in case a working relationship goes sour.

Dr. Romano: There are a lot of problems in medicine today, but it is still the best profession around. I would advise medical graduates to always remember why they went into medicine in the first place, especially when things get tough.

Dr. Murthy: Physicians need to stay on top of changes and be able to adapt because the healthcare system is in a state of flux.

What do you think is the next big breakthrough in medical technology will be?

Dr. Bishof: I think personalized treatment protocols, those that are developed based on the genes of individual patients, are the next great frontier in medicine.

Dr. Chauhan: I completely agree.

Dr. Murthy: Not only is genetic therapy a game-changer but robotic procedures, precision-guided cancer treatment and telemedicine provide breakthroughs in each specialty.

Dr. Romano: Communication keeps getting better.

In the old days, if we found an uncommon problem we had to look it up in medical books or go to the library. Now we can do things such as send x-rays to another physician anywhere in the world and get instant feedback on the problem.

What do you think is the most positive trend in U.S. healthcare today?

Dr. Chauhan: The continued gratification we physicians feel in being able to help patients in need.

Dr. Murthy: And that our patients still get quality care despite obstacles in the healthcare system.

Dr. Romano: Because people are more informed now, thanks to being able to do research online, they don’t just take what we say for granted. I find that if a patient is better educated, then he or she is more likely to follow my advice.

What do you think is the biggest threat to quality healthcare today?

Dr. Bishof: The lack of interoperability and the fragmentation of our healthcare system leads to an unconscionable amount of waste and adversely affects the health of our patients and our ability to care for them.

Dr. Chauhan: Pandemic or natural disaster.

Dr. Murthy: Definitely, the high cost of healthcare. The cost of drugs keeps escalating and the cost of health insurance is astronomical. Because of high deductibles, many patients are more conservative about getting care even when they do need it.

What is the biggest change in the practice of medicine since you graduated from medical school?

Dr. Bishof: The movement of physicians from solo and small group practice to large group practice and hospital system employment.

Dr. Chauhan: The current shift in the healthcare delivery system.

Dr. Murthy: On the positive side, the average lifespan and quality of life has improved. On the negative side, physicians have less control over providing quality care.

As the population ages and as disasters (both natural and human-induced) occur seemingly more frequently, what additional stresses does this place on physicians and the medical system?
Dr. Romano: For disasters, we need to get better at knowing how to handle them and what to do. For aging, we need to work out better preventative medicine programs. Another thing that is a big problem is end-of-life care. We now take extraordinary measures to keep very ill patients alive. In the United States, average per capita medical spending in the last 12 months of life is $80,000—substantially higher than in comparable developed nations. The U.S. healthcare system needs to find lower-intensity options for patients with advanced illness at the end of life while providing adequate care and pain relief, and to address the needs of caregivers—many of whom are unpaid family members.

Dr. Bishof: More and more patients are living longer, despite dealing with multiple complicated medical problems. Hospitalizations, procedures and medications are expensive and we’re under constant pressure to reduce costs and utilization while improving patient health and outcomes. To optimize their health, patients require highly coordinated care, by physicians, nurses, social workers, dieticians and more, but our fragmented system simply isn’t up to speed on incentivizing or paying for this kind of care.

Dr. Chauhan: There are limited resources in the new value-based system, with razor-thin margins and little room for error in the current healthcare delivery paradigm. Ironically, this limits capacity that would otherwise be beneficial in crises situations. Additionally, if we are experiencing shortages in medications during “normal” conditions, it seems inconceivable that demand could be met under more “stress-test” situations.

What do you think the Chicago Medical Society’s greatest contribution to medicine has been?

Dr. Murthy: On both local and national levels, CMS has been a leader in healthcare advocacy, empowering physicians to provide high-quality care and providing networking opportunities for physicians.

Dr. Chauhan: CMS provides a voice for physicians and their patients.

Why is organized medicine relevant today?

Dr. Bishof: Organized medicine is more relevant today than ever. The practice of medicine is changing at breakneck speed and more complex than ever. Physicians need the Medical Society to continue to advocate for them and their patients as reimbursement rules, licensing and certification, and scope-of-practice issues become ever more complex.

Dr. Murthy: Organized medicine is the only route left for average physicians to voice their concerns and for them to affect both local and national policies.

Dr. Chauhan: Organized medicine provides an important resource and voice for physicians and their patients. Frankly, I do not see any other organization that promotes the ability of physicians to practice medicine in the best interest of their patients. Certainly, the stronger organized medicine is, the more capable it can be in protecting the patient-physician relationship from incursions.

Dr. Romano: It is extremely important to get the voice of physicians heard. Lobbyist groups control Congress now. Lobbyist lawyers pick up congressmen at the airport, take them to dinner, take their kids to a baseball game—they see congressmen all the time and get their attention, whereas physicians go to see their congressmen maybe only once a year. We need to group together to be more powerful.

What do you look forward to the most in your upcoming year as a CMS officer?

Dr. Bishof: I look forward to continuing the longstanding tradition of advocating for all physicians and patients in Cook County. I hope to inspire members to become more involved and non-members to join.

Dr. Chauhan: I plan to continue my efforts in promoting physicians as leaders in healthcare, preserving the sanctity of the physician-patient relationship, maintaining channels of communication with policymakers to assist in the crafting of legislation that could impact patient care and physicians’ ability to practice and deliver genuine quality care, helping to develop physician strategies to curb the impact of the opioid crisis, and promoting physician health.

Dr. Romano: I look forward to learning more about the inner workings of CMS and figuring out how I can best help the practice of medicine.

Dr. Murthy: Recruiting new members and retaining current members for one. I also welcome input from other members of our leadership team. And, of course, I look forward to tackling local and national issues such as gun violence, the opioid crisis, and physician burnout both within our Medical Society and in working with local and national lawmakers and other societies such as the Illinois State Medical Society and the American Medical Association. CMS is one of the oldest and largest county medical societies in the U.S. It has withstood the test of time and it will continue to support physicians in Cook County.
Serve Your Profession
A healthy legislative agenda depends on committees that study issues and recommend change at the local, state and national levels.

Do you have ideas for legislation to improve medical practice or healthcare delivery? Here’s where you begin: join a Chicago Medical Society committee. Whatever your practice type, age, or specialty, CMS has a committee waiting for you. As the backbone of our organization, committees anticipate and respond to trends and issues, and they are open to all members. The time commitment is minimal, thanks to our electronic meeting format.

Flexible Participation
Your participation can be active or just learning and listening. Committees study issues brought by other members, leadership, or outside organizations. You’ll hear testimony, shape resolutions, and have ample opportunity to share your opinions.

This page describes all the CMS committees on which students, residents, and physicians can make their voices count, and watch their dues dollars at work. For information, or to sign up for a committee, please call 312-670-2550, or email rbahena@cmsdocs.org.

Academic Physicians Committee
Purpose: Addresses the unique regulatory and financial issues that affect academic physicians, and it provides a forum to discuss them. The committee is responsible for researching the feasibility of policies, activities and services to best serve the needs and interests of academic physicians.

Health Care Economics Committee
Purpose: Monitors local managed care trends, healthcare delivery service and quality; advises CMS of significant trends; reviews the actions of the professional liability insurance industry; informs CMS about health planning in Chicago and Suburban Cook County; evaluates the effects of reimbursement policies on physicians.

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

Public Health Committee
Purpose: In addition to drafting resolutions, this committee studies public health issues and initiates contact with relevant groups. The committee also reviews and responds to requests for advice, opinion, or program approval from any health department, municipal health committee, or public health body in Cook County.

Resolutions Reference Committee
Purpose: Studies member resolutions, holds hearings on those resolutions, reviews current CMS policy and potential new policies and directives; makes recommendations to the Council.

Council on Medical Staff Leadership
Purpose: Addresses the needs and interests of medical staff leadership, as well as the unique issues affecting medical staffs and hospitals. Services include: arranging quarterly meetings; developing educational programs; preparing newsletters to update staff on medical, legal, and legislative topics; and researching areas of interest or concern.

Employed Physicians Committee
Purpose: Addresses the concerns of employed physicians through education and advocacy. Efforts in this area include programs on employment contracting, employee rights, and benefit resources.

Women Physicians Forum
Purpose: Provides for the unique needs and interests of women physicians. As the local counterpart of the Illinois State Medical Society’s (ISMS) Women Physicians Forum, the group focuses on: (1) representing and advocating on behalf of women physicians; (2) networking; and (3) offering services specific to women physicians.

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

**Communications/Technology Committee**

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

**Bylaws/Policy Review Committee**

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

**Continuing Medical Education Committee**

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

**Long-Range Planning Committee**

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

**Membership/IMG Committee**

**Purpose:** Develops strategic plans for the recruitment and retention of members, including residents and students; reviews new membership applications, status change requests, dues waivers and transfers, and makes recommendations to the Council; reviews reinstatement requests from physicians who have resigned or forfeited their membership; supports measures to integrate IMGs into American medical practice; represents issues of concern to IMGs.

**Senior Physicians Group**

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

**Subcommittee on Joint Sponsorship**

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

**Credentials/Elections Committee**

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

Remember: grassroots committees make your profession and your Medical Society stronger.

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**Call for Resolutions**

**IF COMMITTEES** form the Society’s backbone, resolutions provide the lifeblood. CMS is the starting point for county, state, and national efforts, laying the all-important groundwork for legislative activity in Springfield and Washington. Not only do resolutions provide specific guidance to lawmakers, they direct your medical societies to act on particular issues. Resolutions give rank-and-file members a direct hand in shaping the policy platform from which the Chicago Medical Society, the Illinois State Medical Society, and the American Medical Association approach government agencies and elected leaders. Illinois’ new Network Adequacy and Transparency law had its start at CMS. Without CMS, Illinois would lack other public health laws and physician protections. Our state’s prominence at AMA meetings would diminish. All resolutions to CMS receive prompt consideration. A committee studies issues and works with the sponsor in order to recommend the best course of action.

Here’s a sampling of recent CMS resolutions:

- Network Adequacy and Transparency
- Prescription Drug Price Gouging Relief
- Physician Payment Model Survey
- Opioid Education
- Medical Necessity Determinations
- Provider Shield Act
- Reimbursement for Prior Authorization
- Improving the Insurance Appeals Process
- Inappropriate Requests for DEA Numbers
- Obesity as a Chronic Disease State
- Headphone Distraction Awareness

If you are new to the resolution-writing process, then the CMS leadership is happy to mentor you on using this powerful advocacy tool effectively. To learn more about the process, please call 312-670-2550.
Nominate a Colleague for a CMS Award!

Every year, at the Chicago Medical Society’s Annual Dinner and Meeting, member physicians receive prestigious awards from their peers. Below are descriptions of the award categories. Nominees must be members of CMS and nominations must be received by June 1.

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

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

Outstanding Student of the Year Award
One award recognizes medical students who are most likely to become well-rounded outstanding physicians or clinicians. Recipients are honored for compassion toward patients, professional behavior, clinical and academic excellence, and service to their medical organizations and or community.

Resident/Fellow of the Year Award
This award recognizes medical residents and fellows who go above and beyond their duties, serving as role models to those they lead and educate, while exhibiting overall achievement in their field, clinical promise, innovation skills, and commitment to the medical profession and or community.

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

Nomination Information
To nominate a physician, please provide the following information in its entirety:

Biographical Data
Provide an updated curriculum vitae, or a sheet giving in 300 words or less the date and place of birth, education, pertinent professional information, and, if desired, family information.

Photograph
All nominations should be accompanied by a glossy black and white, head-and-shoulders photo of the nominee.

Nomination Rationale
List the reasons why you are nominating this physician for an award. Please list specific dates, offices held, projects, accomplishments, and so forth.

Who Can Submit Nominations?
Everyone is encouraged to submit nominations. In the past, a number of nominations have come from the general public. Other nominations have been made by civic groups, hospitals, public officials, friends, medical colleagues, CMS Districts, and medical specialty groups.

There are many good physicians. Please keep in mind that these awards are not only for excellence as a physician, but also for the many things a physician has accomplished in addition to his or her professional medical work. Nominations may be made by letter, fax, or email.

Where to Send Nominations
To check on a physician’s membership status, please call Ruby at 312-670-2550, ext. 344; or email rbahena@cmsdocs.org.

Nominations should be sent to the Chicago Medical Society, 515 N. Dearborn St., Chicago, IL 60654, Attn: Ruby, or emailed to rbahena@cmsdocs.org, or faxed to 312-670-3646, Attn: Ruby.
MEMBER BENEFITS

R. VEMURI Murthy presented several awards on behalf of the Chicago Medical Society during the Annual Gala Banquet of the Indian American Medical Association in Illinois, held on Nov. 18. As CMS President, Dr. Murthy recognized IAMA-IL’s new affiliation with the Medical Society’s community CPR project. He singled out both the IAMA leadership and its Outgoing President Dr. Tapas Dasgupta. The gala event installed Incoming President Dr. Srinivas Reddy.

IAMA-IL recently joined with the CMS-led Community CPR Initiative, also known as Project SMILE (Saving More Illinois Lives through Education). For years Dr. Murthy has been on a mission to bring community-based CPR to all parts of the world. In his comments, Dr. Murthy noted that through educational programs and charitable events, IAMA-IL continues to flow into the mainstream of organized medicine.

With nearly 500 in attendance, special guests included Dr. Nestor A. Ramirez, president of the Illinois State Medical Society, and U.S. Congressman Raja Krishnamoorthi. The IAMA held its gathering in Rolling Meadows at the Meadows Club.

CMS President Dr. Murthy (at left) presents an award to Dr. Tapas Dasgupta, outgoing president of the Indian American Medical Association in Illinois, during IAMA’s Annual Gala Banquet on Nov. 18. The award recognizes Dr. Dasgupta and IAMA for collaborating with CMS on the Community CPR Project. Dr. Radhika Chimata (far right), a medical resident at Rush University, sang the National Anthem, before nearly 500 members and guests.

U.S. Congressman Raja Krishnamoorthi learned to administer CPR when the CMS-led project visited his Chicago office in 2017. He is shown below speaking at the IAMA Gala Banquet.
Online CME Now Available 24/7

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

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**JANUARY**

**23 Resolutions Reference Committee Meeting**
Hears testimony and makes recommendations on members’ resolutions. These resolutions often lay the legislative groundwork for new laws at the local, state, and national levels. 7:00-8:00 p.m. For information, contact Liz, 312-670-2550, ext. 335 or esidney@cmsdocs.org.

**24 CMS Executive Committee Meeting** Meets once a month to plan Council meeting agendas; conduct business between quarterly Council meetings. 8:00-9:00 p.m. For information, contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

**FEBRUARY**

**6 CMS Council Meeting** The Society’s governing body meets four times a year to set a legislative agenda as well as conduct business on behalf of the Society. 7:00-9:00 p.m., Maggiano’s Banquets, 111 W. Grand Ave. To RSVP, contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

**12-14 AMA National Advocacy Conference CMS** meets with Congressional leadership in Washington and advocates on health care issues at this annual event. Grand Hyatt, Washington, DC. For information, go to: www.ama-assn.org.

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

**MARCH**

**21 CMS Executive Committee Meeting** Meets once a month to plan Council meeting agendas; conduct business between quarterly Council meetings. 8:00-9:00 a.m. 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.

**14 MAPS Annual Scientific Meeting 2018**
Register for the Midwestern Association of Plastic Surgeons Annual meeting at: midwestplasticsurgeons.org.

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

**20-22 ISMS House of Delegates Meeting**
CMS participates in the Illinois State Medical Society’s Annual Meeting. Hilton Oak Brook Hills Resort and Conference Center; 3500 Midwest Road, Oak Brook. For more information, go to: www.isms.org.
Personnel Wanted

- Anesthesiologist for D & C
- Ob-Gyn for D & C and Tubal Sterilization
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Welcome, New Members!
The Chicago Medical Society greets its newest members. We are now 9 voices stronger!

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- Anna A. Melio
- Tammy Hua
- Edleda James
- Osarigmen Osakhuwuomwan

District 5
- Sreenivas Reddy, MD

District 8
- Irfan Alhayani, MD
- Neil D. Ybanez, MD

Resident District
- Phyo Thazin Myint, MD
- Carlen Yuen, MD
When it comes to public health, Julie Morita, MD, is all business—and rightly so. As the chief executive of the Chicago Department of Public Health for the past three years, Dr. Morita is currently most passionate about expanding the focus of the department to include social determinants of health to having healthier communities. “To make a true difference,” she says, “we must be extremely focused on leveraging all of our existing resources.”

And it’s just this leveraging of resources that Dr. Morita has done during her 18 years in the department. “Over time, I’ve had the opportunity to lead a number of initiatives requiring collaboration between internal and external partners,” she says. “For example, during the terrible 2009-2010 flu outbreak, we had to leverage citywide resources to distribute nearly one million doses of vaccine in Chicago to minimize the impact of the outbreak. The same has been true in preventing meningitis outbreaks and in preparing for the potential introduction of the Ebola virus.” She continues, “In the case of Ebola, we established a network of hospitals that could provide care for patients suspected of being infected with Ebola. Fortunately, we did not have an outbreak, but if we had, we would have been ready.”

In fact, it is the wide range of potential things to do each day in her position that makes Dr. Morita thrive. “I love it when people ask me what I do each day,” she says. “It varies widely. My job consists of developing new public awareness campaigns to improve influenza vaccine acceptance, identifying ways to more efficiently eliminate lead hazards in homes, working to promote local policies that positively impact public health—including raising the age of tobacco purchase to 21 years—and thinking creatively about how we can collaborate across city agencies and city partners to make Chicago healthier.”

Although Dr. Morita started out as a pediatrician in Tucson, Arizona, she says the move to public health was a natural step for her. “Pediatricians focus on prevention,” she says. “We help prevent injuries by promoting the proper use of car seats, and promote vaccinations to prevent serious infections.”

Her first step into public health was in a position as an epidemic intelligence service officer at the Centers for Disease Control and Prevention (CDC) where she participated in several outbreak investigations, acquired analytic skills and had exposure to national policy development including the fortification of cereal with folic acid to help pregnant women from having children afflicted by spina bifida.

“I really enjoyed my time at the CDC, learning about policies, systems and programs that affect the whole U.S. population,” she says. “But Chicago is my home and I really wanted to come back. So, 19 years ago, I joined CDPH as the medical director for their immunization program—a natural fit for me. Being appointed as commissioner 15 years later by Mayor Rahm Emanuel was truly an honor and an incredible opportunity to work on a wider range of health issues including social and structural factors that affect health.”

**WHO’S WHO**

**A Passion for Population Health**

Heading up the CDPH is a big challenge, but one that this physician is more than ready to meet

By Cheryl England

Dr. Julie Morita, chief executive of the Chicago Department of Public Health, is passionate about public health in all forms.
healthy vitals

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