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CHICAGO MEDICAL SOCIETY
THE MEDICAL SOCIETY OF COOK COUNTY
Newsletter, 2011, Vol. 114, No. 5

Special feature: ACO's--Death knell of private practice, or tremendous opportunity for physicians? See page 13

PRESIDENT'S MESSAGE

Providing value during tough times

Thomas M. Anderson, MD, was installed as President of the Chicago Medical Society for 2011-2012. Inaugural coverage begins on page 4.

Greetings to all members of the Chicago Medical Society. I am honored to represent you in these uncertain times as we try to focus on caring for patients – the noble task that called us into the profession and for which we are best trained.

By now, those of us in active practice have likely received postcards from the Illinois Department of Financial and Professional Regulation. We are invited under veiled threat of action against our licenses to practice medicine, to review and approve our online physician profiles. That is a legislative spinoff of last year's Illinois Supreme Court decision that declared the state law establishing limits on non-economic damages in liability lawsuits as unconstitutional.

There have been other legislative disappointments; limits on private insurance company payments to out-of-network physicians for services rendered and revisions to the workers' compensation law, including a physician fee schedule reduction. We even hear rumblings of an increase in professional license fees as well as shortening of the three-year cycle covered by each renewal.

Going forward, under my presidency, CMS will focus on issues that bring our members value. We will work to revitalize the CMS blog so ably pioneered by Dr. William Werner during his presidency.

We ask that you let us know which advocacy issues are most important to you. Please tell us how

(continues on page 2)

Inside

PRESIDENT'S MESSAGE *(continued from first page)*

New CMS President Dr. Thomas M. Anderson addresses guests at the Annual Dinner on July 13 in Oak Brook, with newly installed Council Chairman Dr. Robert W. Panton, and Secretary Dr. Kenneth G. Busch on the dais.

directly your practice has been affected by the legislative and judicial changes I mentioned earlier, and which education topics would be most helpful to you. We need to hear from those of you who don't understand what the Patient Protection and Affordable Health Care Act is all about. And from those of you who think that accountable care organizations are part of your future.

While we cannot promise to surmount all the challenges, we would like to know where CMS members want our efforts to be focused.

Please take a few minutes from your busy schedule to let us know what's on your mind **(cmspresident@cmsdocs.org).**

I look forward to serving you.

Thomas M. Anderson, MD
President,
Chicago Medical Society

NEWS FOR CHICAGO PHYSICIANS

chicago medicine
CHICAGO MEDICAL SOCIETY
THE MEDICAL SOCIETY OF COOK COUNTY

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Liz Sidney, *Co-Editor/Editorial*
Scott Warner, *Co-Editor/Production*

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Adapting to a changing landscape: theme of CMS annual dinner

Outgoing CMS President Dr. David A. Loiterman (*left*), hands the baton of leadership to incoming President Dr. Thomas M. Anderson.

TO OFFER GREATER VALUE DURING TOUGH economic times, CMS is exploring ways to expand its presence in both education and advocacy, stated incoming President Thomas M. Anderson, MD, in his inaugural address before members and guests at the Society's annual dinner meeting on July 13.

In becoming CMS' 163rd president, Dr. Anderson, a diagnostic radiologist, reflected on changes in medical practice, from the era of his great uncle and father, both doctors, to the present, which includes Dr. Anderson's daughter and her husband, both physicians, who want a radically different lifestyle.

CMS is adapting to changing attitudes and economic conditions with flexible and more frequent clinical conferences and course offerings, both in-person and electronic, as well as partnerships with other groups, to deliver timely, original, high-quality CME. As the medical profession enters the post-PPACA era, members can also access sessions on practice management topics, legal, regulatory, and legislative issues.

Dr. Anderson, a Harvard Medical School graduate and former department chairman at Mercy Hospital, said that CMS will advocate for changes articulated by ISMS to preserve physician practice priorities and to address issues that hamper physician practice such as medical liability reform.

Bringing CMS fully into the electronic meeting age with online Council discussions is another of Dr. Anderson's goals. Those who are unable to attend may access deliberations online. He hopes that electronic meetings will increase participation.

Dr. Anderson also said he is committed to building on recent membership gains and achievements in the public health arena initiated under outgoing President David A. Loiterman, MD, such as the governor's proclamation declaring June 1-7 CPR and AED awareness week, changes to the Good Samaritan Act, and programs to educate and encourage bystanders to give CPR to sudden cardiac arrest victims.

In his farewell address, Dr. Loiterman thanked Society leaders for their collegiality and cooperation, and welcomed each new officer and trustee (see listing on page 6). He gave special recognition to colleague, Vemuri S. Murthy, MD, chairman and founder of Project SMILE, the coalition promoting hands-only CPR and AEDs. CMS was also active in the Building a Healthier Chicago coalition, working to combat the city's rising obesity rates.

The wealth of new programs and activities un-

CMS Past Presidents, Drs. Steven M. Malkin (*left*), and M. LeRoy Sprang, and CMS Trustee Dr. Adrienne L. Fregia listen to Dr. Anderson's inaugural address.

(continues on page 6)

Ashish Chopra, M.D. Gastroenterology,
Cathy Lomelino McAfee, M.D. Internal Medicine,
Grant Su, M.D. FASOPRS Ophthalmology

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derway at CMS are cause for optimism.

"It's not the strongest who survive, but those who adapt to change," Dr. Loiterman concluded.

This year's annual meeting took place in a new venue—DoubleTree by Hilton Hotel in Oak Brook—and immediately followed the quarterly policy-making Council meeting. Other meeting highlights included a recognition ceremony for 50-year members of CMS/ISMS. (Council meeting coverage will be presented in the next issue of *Chicago Medicine*.)

ISMS President Dr. Wayne V. Polek sits with Dr. Kathy M. Tynus, newly appointed Vice Chairman of the CMS Council, during the CMS inaugural ceremonies.

Background: CMS President Thomas M. Anderson, MD

Dr. Anderson

DR. ANDERSON IS BOARD-CERTIFIED IN DIAGNOSTIC RADIOLOGY and nuclear medicine. He is on staff at Mercy Hospital and Medical Center, where he chaired the Department of Radiology for 20 years and is now a consulting radiologist. He is also a senior attending for Radiological Physicians, Ltd., in Chicago. On the academic side, Dr. Anderson is a clinical assistant professor of diagnostic radiology at the University of Illinois at Chicago, where he has received a resident Teacher of the Year award for each of the past three years.

A graduate of Harvard Medical School, Dr. Anderson completed his internship and residency at the University of Chicago Hospitals. He served his fellowship at both the U of C and Michael Reese Hospitals. He holds subspecialty certification in pediatric radiology and neuroradiology. Dr. Anderson is a diplomate of the National Board of Medical Examiners, American Board of Nuclear Medicine, and a fellow of the American College of Radiology.

A CMS member since 1972, Dr. Anderson served as a councilor from the Chicago Radiological Society (1993-2005) before completing four terms as CMS treasurer and one year as president-elect. His past service includes chairing multiple committees: Budget, Investment, Resolutions Reference, and Credentials/Elections. Other committee assignments included: Healthcare Economics, Nominating, Bylaws/Policy, Election, Task Force on Professional Liability Insurance, and Building. Dr. Anderson continues to serve on the Long-Range Planning Committee, Committee on Committees, and Continuing Medical Education Committee. As CMS president, he is a member of the Board of Trustees and Editorial Advisory Staff. He is a current delegate to ISMS.

New officers and trustees inducted

Thomas M. Anderson, MD, *President*
Howard Axe, MD, *President-elect, Chairman of the Board*
Kenneth G. Busch, MD, *Secretary*
Philip B. Dray, MD, *Treasurer*
Robert W. Panton, MD, *Chairman of the Council*
Kathy M. Tynus, MD, *Vice Chairman of the Council*
David A. Loiterman, MD, *Immediate Past President*

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Josh Williams, *Student*

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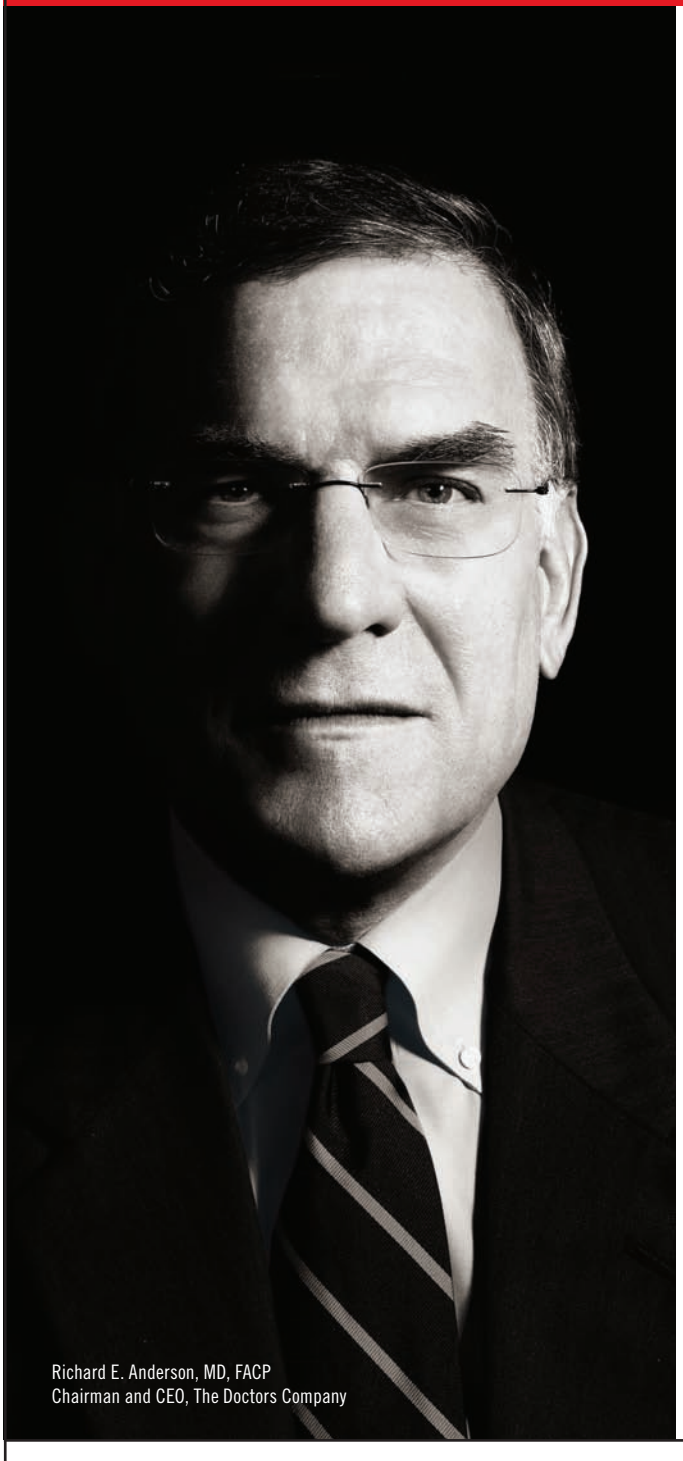

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New law encourages bystanders to give CPR aid

LEADERS OF A CARDIAC ARREST RESUSCITAtion coalition praised Gov. Pat Quinn's signing of an amendment to the Illinois Good Samaritan Act (HB 1549) on July 18.

The Act, which took effect immediately, makes it easier for bystanders to provide lifesaving emergency CPR to victims of sudden cardiac arrest outside the hospital setting.

The bill signing, at Northwestern University's Center for Simulation Technology and Immersive Learning, is the crowning achievement of a coalition led by Northwestern-based CCARES (Chicago Cardiac Arrest Resuscitation Education Service).

Earlier this year, at the Coalition's urging, Gov. Quinn signed a proclamation designating June 1-7 CPR and AED Awareness Week in Illinois.

Gov. Quinn was flanked by George Chiampas, DO, Co-director of CCARES, and Vemuri S. Murthy, MD, chairman of proejct SMILE, an initiative to promote hands-only CPR throughout Illinois.

Dr. George T. Chiampas, co-director of Chicago Cardiac Arrest Resuscitation Education Service, welcomes Gov. Quinn to a bill signing to help boost hands-only CPR.

Before he introduced the governor to a crowd of coalition partners, Dr. Chiampas, read a statement from his co-director colleague, Amer Z. Aldeen, MD, describing the work of the organization. "We at CCARES thank the legislators of the state of Illinois for submitting this crucial piece of legislation for the Governor's approval," Dr. Chiampas said.

Coalition partners include: The Chicago Medical Society, American Heart Association, Chicago Fire Department, Chicago Police Department, and American Red Cross.

The American Heart Association has produced a powerpoint slide demonstration of the hands-only technique, along with a video, and comprehensive website resources, for organizations and individuals.

The Chicago City Council is also getting involved. Working with city aldermen, the Coalition is finalizing plans to train aldermen on hands-only CPR and AED usage.

Under the Act, Good Samaritans need only be trained in CPR rather than undergo certification. Training may include a four-hour course in a training center or a 20-minute training video at home, office, or in a classroom. The law protects bystanders against civil damages provided the person acted in good faith, complied with generally recognized standards, and provided services without compensation.

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Dr. Murthy honored for resuscitation science

In recognition of his outstanding contributions to promoting resuscitation science, Vemuri S. Murthy MD (*shown here with Gov. Pat Quinn at Northwestern University on July 18*), was named a 2011 Champion of Global Health by the Global Health Consortium. Dr. Murthy's work extends to India as well as Illinois. Dr. Murthy, who is Chairman of the Department of Anesthesiology at Vanguard West Suburban Medical Center, is also Chairman of project SMILE, an initiative to promote Hands Only CPR throughout Illinois. Dr. Murthy will be honored at a Global Health Consortium Dinner on Sept. 24 in Elmhurst. ***For information, go to www.Globalhealthchampions.org***

CALLING ALL DOCS: PROJECT SMILE WANTS YOU!

Volunteers needed for CPR and AED awareness campaign

Following Gov. Pat Quinn's signing of a crucial amendment to the Illinois Good Samaritan Act, the governor was joined by health care leaders, *from left*: Dr John Vozenilek, director of the Northwestern University Simulation and Immersive Learning Lab; Dr. George Chiampas, assistant professor in the Department of Emergency Medicine at NU; Gov. Quinn; Dr. Amer Aldeen, assistant professor in the Department of Emergency Medicine at NU; and Dr. James Adams, chairman and professor in the Department of Emergency Medicine at NU.

VOLUNTEERS ARE NEEDED FOR PROJECT SMILE community presentations throughout Illinois. The 30-minute presentations are designed to boost survival rates for victims of sudden cardiac arrest outside the hospital setting.

Medical students, residents, and physicians are encouraged to apply.

All approved applicants will receive training in the Project SMILE (Saving More Illinois Lives through Education) format before giving "hands-only" CPR and AED demonstrations to the public.

The goal is to teach all Illinois residents the skills to assist in emergency situations before medical personnel arrive on the scene.

Renewed interest in CPR and AEDs followed a report by the American Heart Association in 2008, stating that "hands-only" CPR is as effective as conventional CPR, or mouth-to-mouth resuscitation. Chest compressions are easier to administer, eliminating the threat of germs and disease, said the AHA.

SMILE Chairman Vemuri S. Murthy, MD, has already given presentations in hospitals, places of religious worship and public libraries.Dr. Murthy said he is scheduling more presentations for the future.

Locally, the Chicago City Council invited CCARES and CMS to demonstrate hands-only CPR and AEDs before aldermen this fall.

Project SMILE volunteer requirements

Volunteer medical professionals are needed to promote CPR and AED community awareness in Illinois

Physicians, residents, medical students, paramedics, firefighters, and anyone with a provider card in basic life support training from the American Heart Association or Red Cross is encouraged to apply.

Teaching skills and a commitment to the Project SMILE Coalition campaign are essential.

All volunteers are required to receive training in the Project SMILE technique, either privately or through public classes taught by coalition instructors. Volunteers will be proided with the presentation material.

In recognition of their contributions, volunteers will be honored at the CMS quarterly Council Meeting or Annual Dinner Meeting. All programs are centrally coordinated by a CMS staff person.

For information on volunteering, please call Ashley Robbins at (312) 670-2550, ext. 326; or email: arobbins@cmsdocs.org

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ACOs -- Death knell of private practice or big opportunity for physicians?

By Gary Baldwin

The shift to accountable care organizations—a model of care delivery called for in the new health care reform legislation—evokes the story of the blind men describing an elephant. Depending on who is talking, ACOs are:

1. A health care delivery model that is doomed to fail, at least at the federal level;

2. The industry's last, best hope to rein in unsustainably rising costs;

3. The death knell of independent private practices; or

4. A tremendous opportunity for physicians to re-establish themselves as the leaders when it comes to care delivery.

In sum, there is widespread disagreement, if not outright confusion, over what "accountable care" really means. At its core, an ACO shifts reimbursement away from productivity to quality. Rather than reward physicians and hospitals for how much they do, the model rewards them for how well they do it. The model envisions replacing the current norm of fragmented, uncoordinated care with information technology-enabled organizations that communicate care plans, incorporate evidence-based medicine into treatment decisions, and do an overall better job of taking care of patients. Avoiding unnecessary hospitalizations, readmissions and testing is the goal. That is why many in the industry liken the ACO to the unicorn: everybody believes in them, but nobody has ever seen one.

Among physicians, skepticism about the concept—or the federal version at least—runs rampant. During his farewell keynote address to the Medical Group Management Association last year, MGMA president William Jessee, MD, quipped that ACO actually stands for "any consultant's opportunity." There's no arguing that, given the rapid appearance of attorneys, practice management advisers, and other assorted experts ready to offer their services.

At the same time, few, if any physicians challenge the fundamental goal of the ACO: to reduce health care costs and improve care. That's because the U.S. now confronts unsustainable increases in the cost of care. The runaway costs are felt most significantly at the federal level, where Medicare outlays are spiraling—largely due to expanding costs for chronic conditions, an increasingly sick and aging population, and lack of coordination across the spectrum of settings where patients receive care. Commercial payers, too, confront rising costs, which is why many of them—including Blue Cross Blue Shield of Illinois—are crafting their own private sector versions of an ACO at the state and local level. Driving regional cooperation among physicians, hospitals and commercial payers may be the most significant—if unintended—byproduct of the federal action

Rising costs drove the ACO model at the federal level. Medicare spending has doubled in the last decade, with a relatively small proportion of patients accounting for the majority of the spending. "Volume is the driver, not payments to physicians and hospitals," says Ronald Klar, MD, who spoke at World Congress Leadership Summit on ACOs last spring in Vienna, VA. Klar, now a consultant, led ACO-like efforts at George Washington Uni-

Understanding the federal ACO program—mandated by law to begin in January 2012—is no easy task. Its complexity is so daunting that the AMA urged the federal government to issue an "interim final rule" to give the industry time to digest any changes before acting on the partnership opportunity with the Centers for Medicare and Medicaid Services.

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The ACO model does underscore the important role of physicians, which is why some observers describe the idea as a tremendous opportunity for them. The proposed program specifies high degrees of physician participation in both clinical and administrative decision-making.

versity Medical Faculty Associates. He also advised the Centers for Medicare and Medicaid Services (CMS) in the creation of the federal model.

Proposed rules (which ran 128 pages, single-spaced) for the program's "shared savings" model were issued by CMS in early April—and were greeted by widespread disenchantment during the comment period. Multiple organizations—including the American Medical Association, the American Hospital Association, and MGMA—submitted their objections. In the case of the AMA, the comments letter ran 31 pages (available at the AMA website).

Understanding the federal ACO program—mandated by law to begin in January 2012—is no easy task. Its complexity is so daunting that the AMA urged the federal government to issue an "interim final rule" to give the industry time to digest any changes before acting on the partnership opportunity with CMS. Speaker after speaker at the World Congress dismissed as unworkable the proposed federal model—which would return "shared savings" from care cost reductions (which the government estimates would hit $500 million annually) to those who make it happen, namely those organizations willing to meet federal criteria for participation and whose costs of care prove lower than national benchmarks. At the same time, ACOs would face financial penalties for not meeting certain financial benchmarks, a so-called "two-sided risk" model that the AMA hopes will be softened. "We believe an option allowing ACOs to receive shared savings, without the down-side risk, will encourage participation," wrote then-AMA Executive Vice President Michael Maves, MD, in the organization's June 3 comments letter.

Despite the potential financial rewards, some organizations are already saying "no thanks." Douglas Wood, MD, chairman of Mayo Clinic's policy and research division, told the Minneapolis Star Tribune that the proposed program would interfere with the way it runs its Medicare operations, which treat about 400,000 patients annually. Federal officials, including CMS Administrator Don Berwick, MD, have taken the barrage of criticism in stride. Berwick is widely credited as being the godfather of the program. Speaking at a federal listening session on ACOs last fall, Berwick described the program as "a new and better way to organize care. It's not the status quo repackaged."

The ACO model does underscore the important role of physicians, which is why some observers describe the idea as a tremendous opportunity for them. The proposed program specifies high degrees of physician participation in both clinical and administrative decision-making.

Physicians, or networks of physicians, are eligible to launch an ACO under the proposed rule. Any ACO would need to commit to a three-year engagement in the effort, meeting detailed criteria for a management structure that includes maintaining physician leadership, demonstrating "patient-centeredness," and incorporating evidence-based clinical guidelines into the mix. "It's not a low bar to become an ACO," noted health law attorney Doug Hastings, who spoke at the Health Care Financial Management Association's annual conference in late June.

Must be "meaningful users"

Industry objections to the program run the gamut from the practical to the philosophical. Speaking before the American Bar Association's health law conference in mid-June, AMA President Cecil Wilson, MD, noted, for example, that the rule's requirements for the use of information technology are unrealistic. Stipulations under the proposed rule require half of participating primary care physicians to be "meaningful users" of electronic health records by the second year in the program. A meaningful user is one who uses certified EHR technology and meets various reporting criteria established by the government, and is thus eligible for incentive payments. It's part of a federal effort to help defray the cost of purchasing EHR technology among under-automated group practices.

The EHR requirement was among several issues

Dr. Wilson raised at the Chicago conference. He acknowledged that the ACO concept has potential to improve care and lower costs. However, the ACO rule is laden with problems that would, in effect, block widespread participation. Among them are the "retrospective attribution" provisions of the program, in which patients participating in the Medicare payment model would be identified only after the fact. In essence, ACOs would be on the hook for delivering quality care to patients, but would not know their identities until after any savings were distributed. In the shared savings ACO model, Medicare would return a portion of any savings from reduced costs to providers, while simultaneously exposing providers to a certain amount of risk for delivering quality outcomes.

Let patients know they're in program

Even participants in early government test runs of the ACO model challenge the retrospective attribution model. Nicholas Wolter, MD, serves as CEO of the Billings (Mont.) Clinic, a 241-physician multi-specialty group. The clinic is part of an integrated delivery system and participated in an ACO demonstration. Wolter said at the HFMA conference that any ACO effort would have a better shot of success if patients were identified in advance as participants—and knew they were in the program. "If patients feel like they are part of something, you will have higher success."

Another common criticism of the ACO revolves around expense. The cost of entry to the federal ACO program—a number that is in dispute—would effectively block physician practices from launching an ACO, noted David Hilgers, a partner in Brown McCarroll, an Austin, Texas-based health law firm who spoke at the ABA event. "ACOs are too complicated and not going to work for doctors," he said.

For one thing, physician groups are strapped for capital, he said. That is a major hurdle for them in acquiring the kind of EHR technology that is instrumental to the care coordination required to make an ACO work.

In its comments letter, the AHA also seized on the cost issue. The organization estimates that start-up costs for establishing an ACO are much higher than CMS projections. "The per-organization investment required to put in place and sustain the elements necessary for success is considerably higher—$11.6 to $26.1 million—than the $1.8 million estimated by CMS in its proposed rule for start-up and one year of operating expenses," according to the AHA. Much of the start-up cost is attributed to expensive information systems needed to document care, monitor patient progress, streamline communications across specialties and generate the necessary quality reports required by Medicare. Some 65 quality metrics are identified in the ACO proposal, a number that critics say is far too high, but that advocates say represent the breadth of what is needed.

RESOURCE

The AMA has published a guide, "ACOs, CO-OPs and other Options," which explains participation in accountable care organizations and related models under the health care reform act. To access, go to:
http://www.ama-assn.org/ama/pub/advocacy/current-topics-advocacy/private-sector-advocacy/accountable-care-organizations.page

Despite all the misgivings around the federal ACO program, a number of regional efforts are materializing. In Chicago, Advocate Health Care has an ACO venture with Blue Cross Blue Shield of Illinois underway. "We looked at federal health reform, the pressures on the market place, and the need to control costs," says Lee Sacks, MD, Advocate's chief medical officer, in an interview. "We mutually agreed we needed to change the trend in health care costs." As part of the deal, Advocate will rejoin Blue Cross' lower cost HMO, known as Blue Advantage. "Our interest is to provide only necessary care and to be efficient," Sacks says.

In the arrangement, Blue Cross will reward Advocate if it can demonstrate lower costs than its peer group in Illinois. Dr. Sacks declined to speculate about the potential financial return for Advocate, but noted that the amount spent by the payer on its HMO and PPO patients is substantial, some $1 billion annually. Advocate will focus on a select group of high-risk patients, such as those with diabetes and congestive heart failure, attempting to better coordinate care and do aggressive monitoring of these patients. To assist, Advocate is hiring 66 outpatient care managers, Sacks notes.

Advocate physicians will receive a share of distributed savings based on upholding various quality

(continues on page 16)

metrics, such as prescribing lower cost generic drugs. An electronic health record is not required to participate at the group practice level. Advocate does have a disease management registry, which tracks key indicators of chronic disease management and is accessible by all physicians. In addition, Advocate is beefing up its predictive analytics capabilities to help identify patients at elevated risk for hospitalization. In all, Advocate is spending some $25 million annually to support the ACO effort. "Care coordination can have a big impact," Dr. Sacks says.

Gary Baldwin is former editor of Chicago Medicine. He now serves as editorial director of Health Data Management, a monthly trade magazine covering information technology and related issues.

Anti-Trust Conundrum

FOR THE ACO MODEL TO WORK, FORMERLY INDEPENDENT ORGANIZATIONS SUCH AS hospitals, physician groups, and medical suppliers will have to work in close unison, sharing information, coordinating referrals, agreeing to more cost-effective purchasing arrangements, and maintaining tight integration of clinical services. Joint ventures will be the norm. But with consolidations and cooperation comes the specter of market dominance. Thus, the government is relaxing earlier regulations that sought to prevent health delivery monopolies and inappropriate practices that worked against competition. "Anti-kickback laws evolved during the era of fee-for-service, and information sharing was feared," says health care attorney Doug Hastings, chair of Epstein, Becker, & Green, who spoke at the Health Care Financial Management Association's annual conference in late June. "Now accountable care organizations depend on information sharing. A rethink is going on."

Recognizing the need for more relaxed anti-trust laws, the Department of Justice issued guidelines in mid-April that highlight new policies that will apply to ACOs. Terrell Isselhard, principal at Chuhak & Tecson, a Chicago-based health law firm, says the DOJ is "caught in a box. It doesn't want anyone with such control over the patient base that they can dictate fees and drive costs even higher than what

(continues on page 17)

UNDERSTANDING ACOs *(continued)*

they should be. But the DOJ is willing to give some leeway to ACOs as long as they accomplish what Medicare wants."

According to the DOJ, an ACO will fall into a "safe zone" of protected activity if its combined share of the market is less than 30% of services rendered within an area defined by the zip codes of participating patients. ACOs that fall into a 30-50% market share will undergo a perfunctory DOJ review, Isselhard says, while those over 50% must do extensive reporting to qualify.

In a large metropolitan area like Chicago with a large patient base, physician groups would most likely fall into the safe zone, Isselhard says. The catch could come for physicians who join an ACO that is launched by a health system that would ultimately encompass a much larger base of patients. "The ACO creates incentives for bigger health systems to continue to integrate physicians," Isselhard says. "The hospital would have to make sure it is not getting into a trick bag with some violation."

ABA program explores practice landscape, post-PPACA

WHAT WILL THE PHYSICIAN PRACTICE landscape look like under the Patient Protection and Affordable Care Act?

Both physicians and their legal counsel wanted answers and more during a health law seminar hosted by the American Bar Association at Loyola University Chicago School of Law, June 15-17. A variety of sessions and panels addressed expectations, strategies, and tools physicians will need to succeed in this new world.

A conference highlight was the session, "Just a Tweet, Click, or blog Away from Trouble." Covering the legal implications of physicians using social media and telemedicine prescribing in their practices, the session answered myriad questions.

Other sessions discussed:

- Practice options, both traditional and innovative, and their associated pros and cons.
- Short- and long-term implications of the health care reform law and related government strategies.
- The physician practice footprint, specialty centers of excellence, primary care concierge practices, and coordinated medical care.
- OIG initiatives all physicians and counsel should know.
- Recent civil enforcement actions and settlements involving physicians and hospitals.
- The "elusive" steps in making repayments within 60 days of the date the overpayment is identified.
- Building and ensuring an effective physician-specific compliance program.
- The quality movement from the physician's post-PPACA perspective.

Donald Palmisano, Jr., executive director of the Medical Association of Georgia, and Almeta Cooper, associate general counsel at the Ohio State University Medical Center, discuss legal issues surrounding telemedicine and social media in medical practice. They spoke during a recent ABA health law seminar at Loyola University Chicago School of Law.

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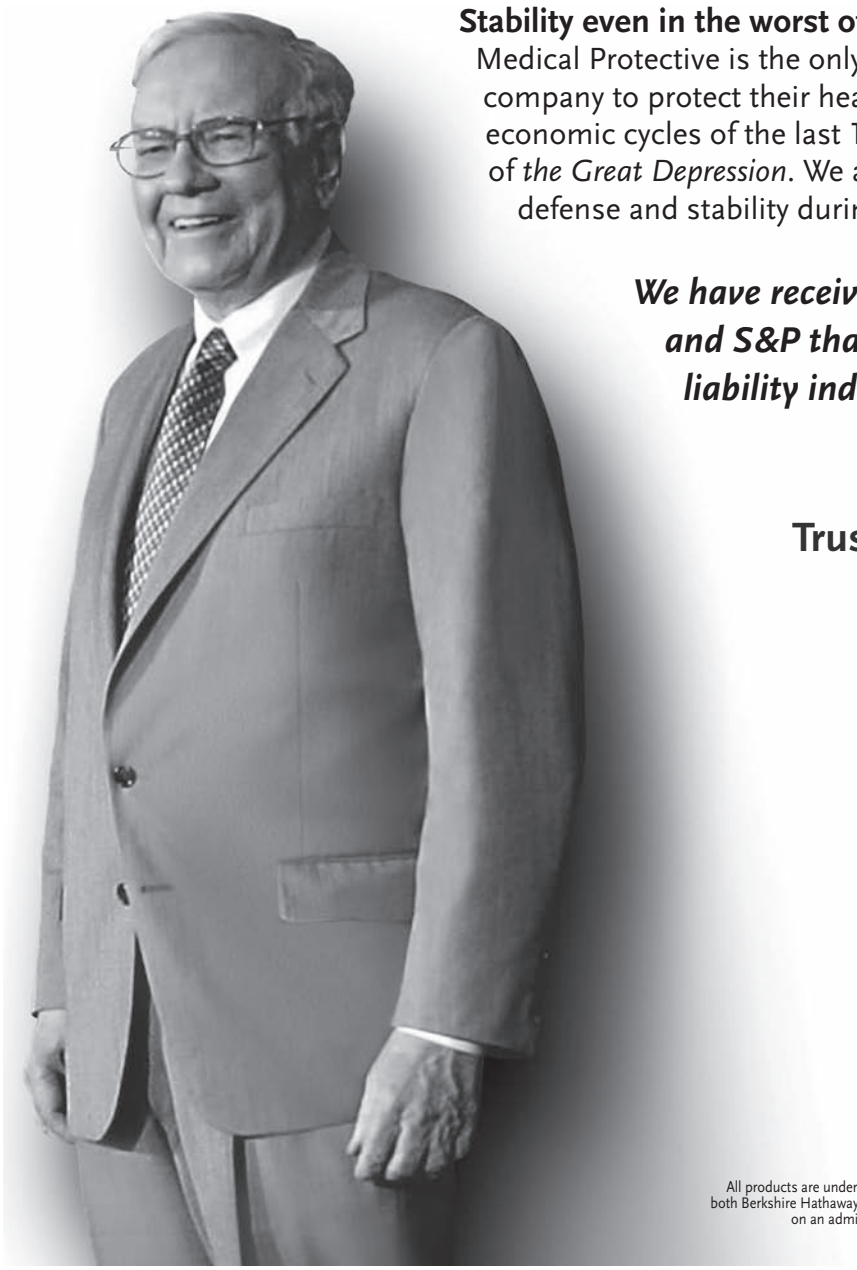

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LEARNING OBJECTIVES: 1) Implement a training program for healthcare employees who may be exposed to blood-borne pathogens. 2) Identify appropriate personal protective equipment (PPE). 3) Develop an emergency response plan. 4) Create a written exposure control plan for healthcare workers assigned as first-aid providers. 5) Develop a strategy to prevent the spread of pandemic flu within a practice.

2011 WORKSHOPS:

☐ **Wednesday, Sept. 21:** Embassy Suites (Downtown Chicago) 10 a.m. to 12N

☐ **Wednesday, Oct. 19:** Advocate Christ Medical Center (Oak Lawn, IL) 2 p.m. to 4 p.m.

☐ **Friday, Oct. 21:** Doubletree Hotel-Chicago (Oak Brook, IL) 9:30 a.m. to 11:30 a.m.

☐ **Friday, Nov. 4:** Advocate Lutheran General Hospital (Park Ridge, IL) 2 p.m. to 4 p.m.

SPEAKER: Sukhvir Kaur, MPH, Compliance Assistance Specialist, OSHA-Chicago North Office. *Ms. Kaur has disclosed that she has no relevant financial relationships with commercial interests.*

The following planning members of the Chicago Medical Society's CME Subcommittee on Joint Sponsorship and staff have disclosed the following: Vickie Becker, MD, Chairman, Roger L. Rodrigues, MD, Planning Member, Bapu P. Arekapudi, MD, Planning Member, Marella L. Hanumadass, MD, Planning Member, Vijay Yeldandi, MD, Course Director, and Cecilia Merino, Director of Education, have no relevant financial relationships with commercial interests.

ACCREDITATION AND DESIGNATION STATEMENTS:

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME). The Chicago Medical Society is accredited by the ACCME to provide continuing medical education for physicians.

The Chicago Medical Society designates this educational activity for a maximum of 2.0 ***AMA PRA Category 1 Credits™.*** Physicians should only claim credit commensurate with the extent of their participation in the activity.

REGISTRATION: Register Online at www.cmsdocs.org or
contact Elvia Medrano at (312) 670-2550, ext. 338, or emedrano@cmsdocs.org

DR. YESH NAVALGUND / *OWNER*
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ISMS UPDATE

Veto Session and *Medical Practice Act* battle are approaching

ISMS' LEGISLATIVE AFFAIRS TEAM WAS HARD at work earlier this year during the Illinois General Assembly's 2011 session. Attempts by the nurses' lobby to gain independent practice and prescriptive authority for APNs, and by the midwives' lobby to license direct-entry midwives, were unsuccessful thanks to ISMS lobbying. Sex offenders are no longer permitted to hold medical licenses. Also due to ISMS' sustained efforts, reasonable time limits on insurance company recoupments were instituted and state employees will soon have the option to open Health Savings Accounts. **Information on all these initiatives, and the current status of every other legislative issue on which ISMS is active, may be found in our 2011 End-of-Session Legislative Report, available on the Legislative Action Hub at www.isms.org.**

Another fight is coming, however, and we will need your help soon. The Illinois General Assembly will meet for its annual "veto session" over several days in October and November. During this time Illinois' *Medical Practice Act* will be renewed, and ISMS will be fighting hard to prevent changes that may harm physicians or patients.

The renewal of the *Medical Practice Act* is of great significance. **For a primer on the *Act* and its importance, visit the Legislative Action Hub on www.isms.org.** Even though the legislature must renew it – if it failed to do so, anyone could practice medicine in Illinois without restriction, regardless of training or licensure – there are myriad opportunities for competing interests to attempt to change it in the process. Proposals that have been raised this year include shortening the physician license renewal period and doubling physician licensure fees, both of which would greatly increase financial burdens on physicians. Adding insult to injury, lawmakers have repeatedly raided the Medical Disciplinary Fund, into which our licensure fees go, leaving little hope that increased fees would actually be used for their stated purpose. Finally, legislative leaders may attempt to renew the Act for only one or two years, forcing us to fight these battles all over again very soon.

ISMS stands opposed to such harmful changes, and we will be asking you to call your lawmakers as the veto session gets underway. We will be there to make sure they hear our message, but the voices of their constituents are always heard the loudest.

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