IAFP

ILLINOIS FAMILY PHYSICIAN

VOLUME 62, ISSUE 6

November/December 2010

Published by the Illinois Academy of Family Physicians
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IN THIS ISSUE

MU!

No, it's not an abbreviation for a university beginning with the leader M. It's short for Meaningful Use, the standards that Medicare and Medicaid have established that will enable practices to earn incentive payments for transforming their practices and using electronic health records sooner than later.

The downside? If practices don't start working towards meaningful use, there are penalties in Medicare later, in the form of payment reductions. That's why IAFP has been an early advocate for electronic health records and for health information exchange. These two factors will help ensure smarter, safer, efficient quality care.

Who is eligible for Meaningful Use incentive payments? The criteria are based on the provider, not the practice. You are not eligible if you are in a hospital-based practice, or if you are a Medicare fee-for-service only provider.

While MU sounds scary on the surface, Illinois has the resources, personnel and federal funding to help primary care practices make the transformation and collect the incentives from Medicare and Medicaid that come from achieving Meaningful Use. The American Recovery and Reinvestment Act (ARRA) stimulus package includes financial incentives for healthcare providers that achieve meaningful use with an EHR.

First you need to decide which makes sense for your practice, pursuing Medicare or Medicaid incentives, because you can't do both! Most family physicians will need to examine their patient panel to determine which incentive program is the right choice for them. If you choose one and then decide later you are better off in the other incentive program, you may switch, but only one time.

Medicare incentive program
The maximum incentive payments for Medicare meaningful use is $44,000 if you begin by 2011 or 2012. Starting in 2013, the payment maximum drops and then no payments are made after calendar year (CY) 2015. There are bonuses for providers in Health Professional Shortage Areas (HPSAs), which can add another $2,400-$4,400 to that total. But you must meet the criteria by 2014 to receive any payments.

- In the first year, provider must report a 90-day period in the first year, and then report on the full 12 months in subsequent years.
- To meet certain objectives/measures, 80 percent of the provider's patients must have their records in the EHR.
- Providers must report on all 15 core objectives, and must choose 5 out of 10 measures from the menu of other options.
- Plus 6 clinical quality measures (CQM) – 3 core measures and 3 out of 38 optional menu choices.

Some other things to consider:
- If you practice at multiple sites, you would need to have an EHR at the location(s) that cover 50% or more of their total patient encounters.
- Your meaningful use measures would be based only on patients seen at locations with the certified EHR system.

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President's Message

Patrick Tranmer, MD

Still So Much To Be Done

It is with great pleasure that I have been able to serve as your President this past year. As I reflect on what we have done, I can see so much left to do. This is the wonderful thing about our organization and our specialty… there is always a need for our services and a mission for us to pursue. We are fortunate to have so many dedicated family physician volunteers and staff to meet those challenges; providing leadership and continuity as we go forward.

Health care reform changes are beginning. Young adults now have access to their parents' insurance plan; some preventive services are now covered without co-pays required. The fastest changes are happening in health information technology.

As you know, the clock is now ticking towards the electronic health records meaningful use program for Medicare and Medicaid. In just a few months, the first opportunities for physicians to earn incentive payments for achieving meaningful use standards will begin. This issue is dedicated to electronic health information. You'll find all the resources you need to make that important transformation happen and reap the rewards. In the member profile of Primary Care Associates, Dr. Brad Wainer advises that implementing an electronic health care record is a **six month process**. I urge you to use these final months of 2010 to prepare your practice for 2011 and beyond. Do your research and make your plans now.

Meanwhile, IAFP continues to harness the energy of our members through meaningful committee work. Established committees and the new ones of PCMH, EHR and Private Sector Advocacy worked together to handle current issues and develop working plans for our future.

Due to unforeseen developments, I was unfortunately not able to attend the AAFP Congress of Delegates in Denver last month. I did follow closely from home and saw some very lively discussion on our list serve about the events, conversations, and challenges ahead. Our delegates, alternate delegates, board members and other volunteers did an excellent job of representing our interests and promoting our resolutions.

Passage of health care reform legislation this year has engendered many challenges for family physicians ahead. Regardless how Election Day results affect you, IAFP will continue our efforts to improve the health care delivery model in America.

There has been a lot of discussion within the Academy and in the current press about accountable care organizations, or ACOs. If you haven't already, please review the AAFP Accountable Care Organization Task Force Report from October 2009 (http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/private/healthplans/payment/acos/acotfreport.Par.0001.File.tmp/AAFP-ACO-Report-NoRecs-20091010.pdf).

A recent article in the NEJM (see October 7, 2010 issue, "Becoming Accountable – Opportunities and Obstacles for ACOs, pp 1389 - 1391) provides further discussion of the challenges that lay ahead. Clearly primary care physicians and family physicians in particular, need to be a leading voice in the development of workable plans. As the AAFP final resolution on this topic notes, the AAFP has been asked by its membership to "take a leadership position in educating members in various practice settings about the formation of ACOs" and "encourage and facilitate strong family physician leadership in ACO development and governance."

The article that follows the NEJM article noted above reports on "Low-Cost Lessons from Grand Junction, Colorado" by Drs. Bodenheimer and West that details the success of such a family physician-led effort in this Colorado city and promotes seven interrelated features that made such a venture successful: "leadership by the primary care community; a payment system involving risk sharing by physicians; equalization of physician payment for the care of Medicare, Medicaid and privately insured patients; regionalization of services into an orderly system of primary, secondary, and tertiary care; limits on the supply of expensive resources, including specialists, beds, and equipment; payment of primary care physicians for hospital visits; and robust end-of-life care."

This encapsulates what many family physicians have heralded as essential elements of delivery reform. I am happy to see that in some places, our vision is becoming a reality. I can't help but wonder how such proposals would play in my own "back yard" in Chicago - and what I can do to help facilitate such a transformation.

Of course it won't be easy. Specialists and hospitals will not give up their

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IAFP News

(Cover story, continued from page 1)

- Beginning in 2015, all eligible professionals who do not meet meaningful use will be subject to payment reductions in Medicare schedule.

Medicaid Incentive Program
Medicaid eligible professionals are physicians, nurse practitioners, certified nurse-midwives, dentists and physicians assistants working in a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC) that is led by a physicians' assistant. The provider must also meet one of three patient volume thresholds

- Minimum of 30 percent Medicaid patient volume
- **Pediatricians only:** minimum 20% Medicaid patient volume
- Working in an FQHC or RHC only and have a minimum of 30% patient volume attributed to needy individuals. *CHIP, sliding scale or free care are only counted toward thresholds if employed at FQHC or RHC.*

Payments: The maximum incentives total $63,750 over six years, beginning in CY 2011 and running through 2021. There is no HPSA bonus under the Medicaid meaningful use program. In order to qualify, eligible providers must attest only in the first year of participation, reporting of specific measures is not needed.

Providers must attest they did one of the following in year 1 of their participation*

- Adopted – Acquired and Installed Evidence of installation prior to incentive
- Implemented – Commenced utilization of staff training, data entry of patient demographic information into EHR
- Upgraded – Expanded or upgraded to certified EHR technology or added new functionality to meet the definition of certified EHR technology

*Must be certified by ONC-HIT as an EHR technology capable of meeting meaningful use.

Now for the details of MU
There are three main components in Meaningful Use

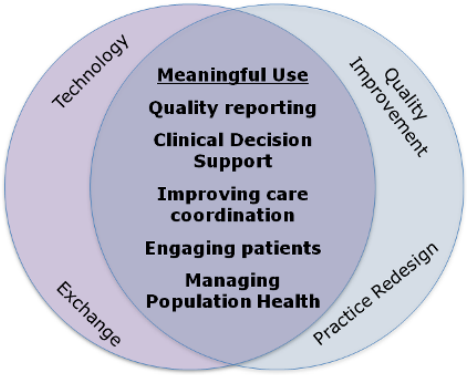
1. Use of certified EHR in a meaningful manner (e-prescribing, patient history, medication lists, etc.)
2. Use of certified EHR for electronic exchange of health information to improve the quality of care.
3. Use of certified EHR to submit clinical quality measures and other measures selected by the Secretary of Health and Human Services.

Not only do you need to be up to speed, so does your EHR system! The Office of the National Coordinator of HIT (ONC-HIT) has begun certifying EHR systems as meeting the criteria for meaningful use incentives. New products are added to the list as they are certified. You can find that list at http://www.onc-chpl.force.com/ehrcert

You must also get into the system. That means you need to register yourself on the EHR Incentive Program website. You will need your National Provider Identifier (NPI) and Taxpayer Identification Number. Once registered you can submit the requirements as you meet them to receive your payments. Registration should be available in January 2011 at www.cms.gov/EHRIncentivePrograms. Medicaid programs will be run by the states and providers will need their Medicaid specific details such as their patient volume, their licensure, whether they will Adopt, Implement or Upgrade to a Certified EHR technology.

Timeline for Medicare Incentive Payments

- Fall 2010 -Certification of EHR vendors began
- Jan. 2011 –Registration with CMS begins
- CY2011-2012 -Clinicians can report on using a certified EHR in a meaningful manner (must use a 90-day window in first payment year)
- April 2011 -Attestation of meaningful use begins
- May 2011 -CMS payments will begin



Don't go it alone! Get federally-funded help!

Illinois Health Information Technology Regional Extension Centers (IL-HITREC)
IL-HITREC provides general and technical assistance will be provided to all participating practices outside of the city of Chicago. IL-HITREC has four regional offices to serve as the hubs for their provider services

IL-HITREC is administered by Northern Illinois University with satellite delivery offices in DeKalb, Chicago, Peoria and Sauget. Below is a list of counties covered by the Illinois Regional Extension Center and each satellite office:
Northeast Satellite Office at Metropolitan Chicago Healthcare Council in Chicago: Cook, DuPage, Kankakee, Lake, and Will (excluding 606** zip codes)
Northwest Satellite Office at Northern Illinois University in DeKalb: Boone, Bureau, Carroll, DeKalb, Grundy, Jo Daviess, Henry, Kane, Kendall, LaSalle, Lee, McHenry, Ogle, Putnam, Rock Island, Stephenson, Whiteside, and Winnebago
Central Satellite Office at Quality Quest for Health of Illinois in Peoria: Adams, Brown, Cass, Champaign, Christian, Coles, DeWitt, Douglas, Edgar, Ford, Fulton, Hancock, Henderson, Iroquois, Knox, Livingston, Logan, Macon, Marshall, Mason, McDonough, McLean, Menard, Mercer, Morgan, Moultrie, Peoria, Piatt, Pike, Sangamon, Schuyler, Scott, Shelby, Stark, Tazewell, Vermillion, Warren, and Woodford
Southern Satellite Office at the Southern Illinois Healthcare Foundation in Sauget: Rest of the state.

For providers in the City of Chicago, turn to CHITREC
The Chicago Health Information Technology Regional Extension Center (CHITREC) is a partnership among Northwestern University, the Alliance of Chicago Community Health Services and more than 40 local and national collaborators focused on HIT adoption and use needs within the city of Chicago. CHITREC is a local service organization, specifically serving the 606xx zip code region in Chicago, and provides a range of services to primary care providers interested in achieving meaningful use of Electronic Health Records (EHR). As part of the American Recovery and Reinvestment Act, the **Office of National Coordinator** for

HIT has provided initial funding for the regional extension center with most of the funds allocated for direct assistance to providers.

CHITREC brings together resources and provides consultation, education and provisioning services to help primary care providers achieve meaningful use of EHRs. By understanding the technical and regulatory environment, CHITREC assesses individual and network needs and bridges the gaps by effectively directing appropriate resources.

How will the RECs assist providers in achieving meaningful use?
A customized roadmap will be developed for each participant based on the results of a readiness assessment that will be completed at the early stages of participation. Participants will receive tailored assistance for achieving meaningful use based on their assessment.

How do I participate in this program?
Please fill out the online Qualification Survey or download the Qualification Survey to verify eligibility and a representative will be in contact with you. If you have any questions contact us at info@ilhitrec.org or 815-753-1136.

View a video of an EHR visit in action:

http://www.youtube.com/tch?v=nCPGjUy25No

The final rules for Meaningful Use Public Comment period makes a difference

IAFP and AAFP were among the chorus of providers who submitted concerns, complaints and suggestions back to CMS during the 60-day comment period in response to the first draft of rules defining meaningful use standards.

As a result, CMS has two components comprised of 15 core requirements, plus a menu of ten, where you can pick your five options.

CORE

1. Use computerized order entry for medication orders.
2. Implement drug-drug, drug-allergy checks.
3. Generate and transmit permissible prescriptions electronically.
4. Record demographics.
5. Maintain an up-to-date problem list of current and active diagnoses.
6. Maintain active medication list.
7. Maintain active medication allergy list.
8. Record and chart changes in vital signs.
9. Record smoking status for patients 13 years old or older.
10. Implement one clinical decision support rule.
11. Report ambulatory quality measures to CMS or the States.
12. Provide patients with an electronic copy of their health information upon request.
13. Provide clinical summaries to patients for each office visit.
14. Capability to exchange key clinical information electronically among providers and patient authorized entities.
15. Protect electronic health information (privacy & security).

MENU, choose five of these ten

1. Implement drug-formulary checks.
2. Incorporate clinical lab-test results into certified EHR as structured data.
3. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.
4. Send reminders to patients per patient preference for preventive/follow-up care
5. Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, allergies)
6. Use certified EHR to identify patient-specific education resources and provide to patient if appropriate.
7. Perform medication reconciliation as relevant
8. Provide summary care record for transitions in care or referrals.
9. Capability to submit electronic data to immunization registries and actual submission.
10. Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission.

Other important changes since the first MU rules were issued in December 2009

- Thresholds reduced on many requirements (e.g., reduced from 80% down to 30-50% of patients)
- Administrative simplification delayed to Stage 2
- Recording advanced directives and providing patient educational materials added to "menu"

**Medicaid EHR incentives will be managed by states.*

View the entire Medicare payment charts at http://www.cms.gov/EHRIncentivePrograms/60_Medicare_Eligibile_Professional.asp#TopOfPage

Profile of an early EHR Practice

Primary Care Associates, Berwyn
www.pricare.org
5 Family Physicians, 1 Pediatrician and 20 Staff

IAFP spent some time with Brad Wainer, D.O. to talk about his group's journey with electronic health records five years ago. His practice will meet the Medicare and Medicaid Meaningful Use criteria in 2011.

Why did you make the switch five years ago?
First of all, it allowed us to communicate well between all the doctors. With six doctors here, we cover each others' patients during vacations, holidays and weekends. We found that the information in the written chart was not always very good. In addition we can access it from home. So when you're on call you can pull up any patient on the computer. Secondly, we were having a paper problem – as in the cost of the paper, cost of storage, and then the management of the paper! That addressed the patient safety and problems with lost charts, but it also saved the practice money.

Payment incentives;
We were getting more and more requests from insurance companies to do various surveys of our patients, such as diabetics, hypertensives, and immunization rates. And doing those audits in the paper world was very cumbersome and took a tremendous amount of time. It was just the tip of the iceberg. Physicians are being asked more and more to come up with this information and now we're being paid based upon that information.

What was the hardest part?
Understanding that these things are not "plug and play." You cannot just purchase a system today and use it tomorrow. We spent the better part of six months after we purchased our system just planning! I think that's the biggest disadvantage of the process.

Preparing your practice
We met weekly on a topic to explore a different workflow issue looking at our practice from "soup to nuts" and how each task would change in the new world with an EMR. You also have to assure your office staff that the computer is not going to replace them. I made a commitment to my staff that no one would be fired with this. Over five years we have reduced our staff by 4 full time equivalents, all through attrition. You also need to prepare for income loss due to a reduction in productivity during the transition - and set aside the cash ahead of time.

Preparing your patients
When we started, we actually introduced the patients to the computer. When I'd come in the room, I would show them the computer and explain to them how we use it and what the advantages are. And I try not to bury my face in the computer. Instead I try to pull them in, and show them something on the screen. I show them their cholesterol, or a series of their weights or blood pressure or a report of a procedure and patients like that a lot. I've had absolutely no pushback from patients. One of the things they love is that I can send my prescription electronically. It's also a great way to print up patient education on a topic and document that the patient received it.

The future of Electronic Health Exchange
I think right now we're a bunch of islands not at all electronically connected. So I have an electronic medical records system and another place has a system, but I still have to print and mail my pages to them, that's absurd. I think the future electronic exchange will make that process much smoother. I know it will get done, but I'm a little skeptical about when and where and how. In the future, I should be able to communicate with any other doctor, laboratory or other setting about a patient I am sending to them. Secondly, any time a patient of mine shows up and tells me he or she has seen another doctor or been in the hospital, I should be able to easily gather that information and it can't be difficult.

What we can do to help members?
First, explain to physicians that this is a hard process to go through. But at the end of the day, the work you put in at the beginning has a tremendous payoff at the end. It's as much about the time as it is about the money in this case. Second, I would advise them when they are looking for a system, to really narrow it down. Make a list of the five to 10 things you need the system to do for your practice and for you. Where do you want to accomplish things? Because it's hard to evaluate these systems unless you ask very specific questions.

I-CARE now compatible with electronic medical records

Looking for a way to improve immunization rates in your practice? Searching for an effective way to accurately track patient immunization records? I-CARE, Illinois Comprehensive Automated Immunization Registry Exchange can help your practice with all of the above! I-CARE saves time tracking and reporting immunizations providing practices a centralized place to track immunization records, print immunization records and school physical forms, generate reminder

letters for immunizations that are due and more. An additional benefit is that immunization data collected through I-CARE may help providers achieve minimum bonus payments of $20 per patient through Illinois Health Connect.

Additionally, in an effort to allow Electronic Medical/Health Records (EMR/EHR) to share immunization data with other systems such as I-CARE, the Illinois Department of Public Health (IDPH) has developed a standard to exchange data between incompatible systems. This international standard for exchanging health information is called Health Level Seven (HL7).

IDPH is implementing a HL7 data exchange between I-CARE and immunization providers in two phases:

- Phase 1: A one-way data transfer of unsolicited vaccine record updates to the statewide registry that will allow immunization providers using their own EMR system to send data to I-CARE. This phase is currently in-progress.
- Phase 2: A two-way data transfer of vaccine record queries and responses that will allow immunization providers using their own EMR system to query I-CARE for a patient's immunization records (not found in their own EMR system) and I-CARE will send the patient's immunization information back. (Phase 2 is expected to be completed in spring 2011)

If you are interested in testing I-CARE and EMR compatibility at your practice, contact Robin Holding at robin.holding@illinois.gov. For more information about I-CARE and the EMR/EHR compatibility process, click here to view the flyer. http://emr-icare_compatibility_flyerpdf.pdf

AAFP Congress of Delegates Report

IAFP was represented by our AAFP delegation at the 2010 AAFP Congress of Delegates in Denver:

- Delegates **Ellen Brull, MD** of Glenview and **Michael Temporal, MD** of Belleville.
- Alternate Delegates **Javette Orgain**, MD of Chicago and **Katie Miller, MD** of Decatur.
- IAFP board member **Ravi Grivois-Shah, MD** of Oak Park served as a delegate from the National Conference of Special Constituencies and member **Abbas Hyderi, MD** of Chicago was alternate delegate from the NCSC.

IAFP members at AAFP with U.S. Surgeon General Regina Benjamin, MD (center). From left to right: Katie Miller, MD; Ellen Brull, MD; Susan Nagele, MD; Javette Orgain, MD; Michael Temporal, MD and Carolyn Lopez, MD

IAFP Resolutions

Resolution 304 Recovery Audit Contractors – Congress of Delegates passed a substitute resolution adopted that calls for more member education. IAFP member **Tim Vega, MD** brought this issue to the IAFP to formulate the resolution that was submitted.

RESOLVED, That the American Academy of Family Physicians (AAFP) expand educational resources about Recovery Audit Contractors (RACs) and actively promote their availability to members.

Background: The reference committee did not believe it is appropriate for the AAFP to use its member dues to intervene on behalf of an individual practice undergoing a RAC audit and thus, was not supportive of a standing audit team paid for by the AAFP. The AAFP should also consider the incorporation of information about RAC audits in relevant coding and documentation CME activities in order to prevent the occurrence of an audit.

Resolution 509 Health Professionals from Other States Working at Free Clinics- Referred to the AAFP board of directors. IAFP past president **Ken Nelson, MD** brought this issue to IAFP which led to the final resolution submitted.

RESOLVED, That the American Academy of Family Physicians (AAFP) provide each constituent chapter with a template of a proposed state law that would provide licensing exemptions to out-of-state health care professionals who work in free clinics.

HELPFUL LINK for more information:
AAFP News Now coverage of 2010 Congress of Delegates
http://www.aafp.org/online/en/home/publications/news/news-now.html

Also at this meeting:

IAFP past-president **Lee Sacks, MD**, who is Executive Vice President and Chief Medical Officer for Advocate Health Care, received the 2010 AAFP Robert Graham Physician Executive of the Year Award. IAFP member **Susan Nagele, MD** accepted her 2009 AAFP Humanitarian of the Year Award. While maintaining her active IAFP membership, Dr. Nagele has been serving as a medical missionary in Kenya for over two decades. Last year, she was unable to accept her award at the AAFP meeting in Boston while she was home in Illinois recuperating from a very serious illness.

(continued on page 8)

(President's Message, continued from page 2)

influence so easily and a small city in the Colorado mountains is a far cry from the competitiveness and specialty-oriented system where I live. I must also mention the relative scarcity of younger family physicians and other primary care clinicians to help implement such changes and carry them forward. Decades of failure to address and strengthen the family physician workforce will compound our challenges ahead.

Still, we must address and manage this challenge going forward. Through the energy and enthusiasm of our members, IAFP can build a framework for these new health care delivery models that will improve patient access, care quality, and compensation for those at the heart of that care. I look forward to continuing to do my part in this effort, under the capable leadership of Dr. David Hagan, soon to be your new IAFP president. I wish all the best to him and all of us for a productive 2011.

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3 out of 13 National AAFP Pfizer Teacher Development Awards are Illinois FPs

The AAFP Foundation's Pfizer Teacher Development Awards Program recognizes outstanding, community-based family physicians that combine clinical practice with part-time teaching of family medicine. The award provides funding for each recipient to attend an activity of choice to further their professional development and teaching skills.

IAFP members captured three of the 13 awards

- Jennifer L. Rossato, D.O., a practicing family physician in Chicago and part-time instructor at the UIC/Illinois Masonic Family Medicine Residency Program.
- Umang Sharma, M.D, a practicing family physician in Chicago and a part-time instructor at the University of Chicago Department of Family Medicine.
- Daniel Wujek, M.D., a practicing family physician in Litchfield and a part-time instructor at Southern Illinois University Family and Community Medicine.

2010 ANNUAL MEETING

Connecting Our Family Medicine Future

December 3-5, 2010

Hilton St. Louis at the Ballpark

Room rate: $115 Cut-off is November 18th

Call 877-845-7354 or make your reservations online at http://www.hilton.com

Register Online at www.iafp.com or call 800-826-7944

Schedule:

See page 14 for CME details including the SAM half-day workshop on Friday morning

FRIDAY

Noon-1:00 p.m. Opening CME Session and lunch

1:15- 5:00 p.m. CME Programming

5:15-6:45 p.m. Committee Meetings Government Relations, Public Health, Private Sector Advocacy, Electronic Health Records, PCMH, CME and Family Medicine Educators

7:00-9:00 p.m. Reception Catch up with your family medicine friends – and make some new ones!

Foundation "FUN-draiser" Surprises in the Exhibit Hall

Check out this unique Foundation fundraiser where you can purchase tickets for mystery wine bottles and go home with a great surprise! If you would like to donate a prize (wine, tickets, vacation getaway, unique items,memorabilia, etc.) contact Desma Rozovics at drozovics@iafp.com).

Learning Labs: Sit down for some hands-on learning in the exhibit hall with Illinois Health Connect, Your Healthcare Plus and DocAssist. You can also get EHR "meaningful use" help from Southern Illinois Healthcare Foundation.

SATURDAY

9:00 a.m. – Noon CME Programming

11:00 a.m. - Noon IAFP Resident Meeting

What can IAFP do for you? Hosted by resident leaders Lareina Pedriquez, MD and Peggy Wang, MD

Noon – 1:30 p.m. AAFP Leader Presentation and lunch *Family Medicine and Health Care Reform* Presented by AAFP immediate past board chair Ted Epperly, MD

Presented by AAFP immediate past board chair Ted Epperly, MD

1:30 – 4:00 p.m. All Member Assembly

Results of the IAFP e-voting election will be announced. and resolutions will be considered.

6:00 p.m. IAFP Annual Awards Dinner - FREE for IAFP members. Guest fee is $35 per person

(Advanced registration is required for members and guests)

Family Physician of the Year – *Michael Brewer, MD of Springfield*

Family Medicine Teachers of the Year – *Abbas Hyderi, MD of Chicago and Christopher Guerrero, MD of Chicago*

President's Awards (3) – *Donald Lurye, MD; Yves-Mario Piverger, MD and Michael McRaith (Director, Illinois Department of Insurance)*

SUNDAY

8:00 a.m.-1:00p.m. IAFP Board of Directors meeting Members may attend if they register in advance by e-mail to vkeenan@iafp.com.

Government Relations

IAFP provides direction on reform implementation

States are grappling on how to best take the federal health care reform provisions and put them into practice as they take effect. Gov. Pat Quinn appointed a Health Care Reform Implementation Task Force, which is currently gathering input from around the state. IAFP recently provided live testimony at two hearings in Peoria and Carbondale.

IAFP New Physician Board Member Asim Jaffer, MD from the University of Illinois – Methodist Medical Center family medicine residency program in Peoria testified on Oct. 5th to address the following topics for the task force:

- Supply and demand of health care workers across the state
- Scope of practice
- Payment/reimbursement of providers

Scope of practice is the easiest one to address. Family physicians do it all in providing health care services in our state. But Jaffer took the opportunity to provide concrete steps for fixing payment and boosting the primary care workforce

Supply and demand of health care workers across the state
The supply and demand forecasts for primary care physicians currently paint a daunting picture. The U.S. Census report estimates a 36 percent increase in Americans over age 65 that will be on Medicare by the year 2025. At the same time, the Association of American Medical Colleges (AAMC) projects a physician shortfall of more than 130,000 physicians nationwide by 2025. The AAFP projects that Illinois will need an additional 1,000 family physicians more than our current level to meet demands for services that we will see by the year 2020. Basically we need to ramp up family physician production by **30 percent**.


IAFP New Physician Board Member Asim Jaffer, MD

This year, only 89 out of 1,184 - 8 percent - of Illinois allopathic medical graduates chose family medicine… continuing a poor trend dating back to the mid 1990s. "We are already near the end of the year 2010. Today's first-year medical student could be a practicing family physician by 2017," Jaffer told the committee. "So if we hope to shore up our supply of family physicians in 2020, we need to start moving those numbers up now."

Family physicians and internists have seen their annual income flatten out over the past ten years hovering just over $150,000, less than half of what many subspecialists are paid per year. Considering that medical school debt is the same regardless of your specialty, it's easy to see how a student would choose a subspecialty over primary care.

The Council on Graduate Medical Education (COGME) provides ongoing assessment of physician workforce trends and makes recommendations to the U.S. Secretary of Health and Human Services and committees of Congress. Dr. Russell Robertson, chair of the family medicine department at Northwestern University –Feinberg School of Medicine in Chicago chairs this council. Correcting the income disparity between primary care and subspecialty physicians is one of their recommendations. COGME's analysis concludes that boosting primary care incomes to at least **60 percent** of the equivalent subspecialty income would turn the tide back toward primary care.

Federal health care reform provides for some temporary increases in Medicare payment favorable to primary care. The federal reform bill also requires state Medicaid programs to match Medicare payment rates for physician services in 2013 and 2014. The federal government will provide the funds for states to make those increased payments. However there is no federal money for those increased Medicaid rates after 2014. It's critical that Illinois continue those higher rates for the providers who care for the millions of Medicaid patients in our state.

The public payers must set the standard in better payment models for primary care so that private payers can follow this lead. "We need everyone at the table moving our system toward one that pays for preventive care, coordination and quality rather than the current system that rewards procedures and perpetuates the income imbalance we see today," said Jaffer.

Link to Dr. Jaffer's complete testimony at: http://www.iafp.com/legislative/jaffertestimony.pdf

On October 20th, the task force moved to Carbondale, where they heard from IAFP Board member Dennon Davis, MD of West Frankfort. Davis is a family physician partner with Logan Primary Care in West Frankfort and medical director for the Franklin-Williamson bi-county health department.
He was was asked to provide insight on these topics:

- Payment system reforms
- Challenges of assuring primary care in rural areas

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- Fostering widespread adoption of electronic health records and participation in the State's upcoming health information exchange.

IAFP Board member
Dennon Davis, MD

Logan Primary Care has been using medical records for 10 years, making them among the first to go electronic. The program has enabled Davis to personally coordinate his patients care across multiple practice sites for LPC as well as nursing homes and other facilities. Yet now the practice is waiting for their vendor to get ONC certification for their product and then make the necessary upgrades to Logan Primary Care so that they will be eligible for meaningful use incentives. "Essentially our hands are tied for now," he said. Once their EHR company's product is certified, they must still wait to see if the practice will need to make any hardware or server changes for the transition. Other practices are in similar situations.

Getting practices in southern Illinois plugged in with electronic health records and integrated into the state's exchange will be challenging. IAFP is committed to assisting our members in accessing and maximizing the resources available through the HIT regional extension centers (REC) and federal incentive programs.

The EHR transition will come with a price tag that includes time, lost revenue and up-front costs to practices. Illinois must distribute Medicaid incentive payments as quickly as possible in 2011 – doing so will allow safety-net providers the resources to meet the meaningful use criteria. *Any delay in payments to the first providers will discourage other Medicaid providers from taking action if they fear that the payments will not be there when they need it.*

Payment reforms to boost the primary care physician workforce

In our current system, primary care is underpaid. We must reform *how* we pay providers, not just *how much* we pay for their services.

Davis used his time to discuss a **Blended Payment** model for Illinois. As the name suggests, a blended payment model combines different approaches.

- Standard fee-for-services provided in the practice.
- Care management fee which covers all the aspects of providing care to that patient outside of the exam room.
- "Pay for performance" When patients are healthier, their cost to the system goes down. By providing better care and reporting that information back, providers who are at the top of their field should be rewarded for that effort.

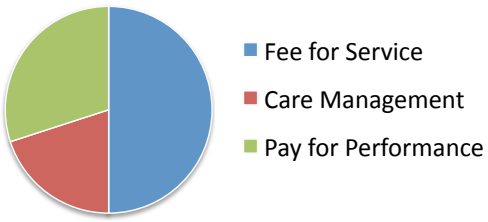
Illinois' Medicaid program already has some of these concepts in place. Many Medicaid patients now have medical homes, built through the Illinois Health Connect program. It's not a one-size fits all solution. While Illinois Health Connect has standard per member per month fees, the care management fee really needs to be determined based on the practice's patient panel – which is unique to the community and the demographics of the practice.

Because there are models in place already, these changes should be acceptable to all payers in the system. And we do need the payment system to be standard across all payers to ensure fairness for providers and patients.

The blended model needs the right mix of ingredients:

- 50 percent for the fee-for-service charges,
- 20 percent towards the care management fee
- 30 percent mix of the pay for performance measures.

Blended Payment Mix



To improve that care management fee proportion of the blended payment mix, a Medicare medical home pilot project suggests a three-tiered approach with a per-member-per month rate for complex patients, concurrent with the tier that the practice achieved in the patient centered medical home recognition by the National Committee on Quality Assurance. For practices that are not NCQA-recognized, a similar care management fee schedule for complex patients should reflect something close to those levels.

So what are the drawbacks? This blended model would still rely largely on the Resource Based Relative Value System for the fee for service portion of the payment formula, which still undervalues primary care services. And for Illinois and most states, the question remains "how are we going to pay for this?"

Link to Dr. Davis' full testimony at http://www.iafp.com/legislative/davis.pdf

Next up: IAFP board member Janet Albers, MD is scheduled to present at the task force's Nov. 16th meeting in Springfield.

Health Care Reform Check-up

Some reforms in the Patient Protection and Affordable Care Act have begun. Here is a short list of some changes since our last issue:

Effective September 23, 2010

- Adults up to age 26 can stay on parents' insurance plan
- Insurance companies may not rescind coverage for children, nor deny coverage for pre-existing conditions in children (Adult protections begin in 2014)
- No more lifetime $ limits on insurance coverage.
- Many preventive services (rated A and B by the USPSTF) must be completely covered by all new insurance plans.

Complete information is at www.healthcare.gov.

Here in Illinois

- Illinois offers health insurance plans for adults with pre-existing conditions who are currently denied coverage by private insurance. Premiums and deductibles apply. Illinois Launched their PXIP in late August. Learn more at http://insurance.illinois.gov/HealthInsurance/highriskpools.asp
- Health Care Reform Implementation Task Force is gathering input from around the state.

Classifieds

The University of Illinois at Chicago, Department of Family Medicine seeks a full-time non-tenure track clinical physician faculty. Responsibilities will encompass a full range of inpatient and outpatient services, with opportunities for predoctoral and residency teaching. Comprehensive benefits package and incentive plan included. Successful candidate must be ABFM certified; experienced in women's health, family planning, and obstetrics required. For fullest consideration, please respond by December 1, 2010. Interested individuals please forward letter of interest and CV to: Patrick Tranmer, MD, MPH, Head, Department of Family Medicine, UIC, 1919 W. Taylor St., MC 663, Chicago, IL 60612-7248 or electronically to tranmer@uic.edu. UIC is an AA/EOE.

Continuing Medical Education

Annual Meeting CME
Earn 7.0 credits over 2 days!

Friday- December 3rd 7:30 –11:30 a.m. ***SAM Workshop - Childhood Illness***

Facilitated by: Kyaw Naing, MD – Associate Professor, SIU School of Medicine Dept. of Family and Community Medicine and Sharon Smaga, MD – Assistant Director, SIU School of Medicine – Carbondale Family Medicine Residency Program.

Work on the Childhood Illness SAMs with your peers and get it done more efficiently! The IAFP half-day SAM Working Group offers a convenient and high-quality solution for your busy schedule to complete the American Board of Family Medicine (ABFM) Maintenance of Certification (MoC) Self Assessment Module (SAM). Facilitated by expert faculty, the workshop takes you through the 60 core competency questions to determine the correct answers. After the session, IAFP staff will report your answers to the ABFM.

LIMITED TO 20 PARTICIPANTS! Fee is $150
Separate online registration required – or e-mail Kate Valentine at kvalentine@iafp.com to register

FRIDAY, December 3rd

The Patient-Centered Medical Home: Redesigning Care and Workflow to Achieve Outstanding Results
Presented by Leonard Fromer, MD, FAAFP, ABFM
Assistant Clinical Professor, David Geffen School of Medicine at UCLA

Optimizing Preventive Services in the Medical Home
Presented by Margaret Kirkegaard, MD, MPH Medical Director, Illinois Health Connect and
Donald Lurye, MD, MMM, CPE – CEO, Elmhurst Clinic

The Continuing Evolution – Technology in the Medical Office
Presented by Stephanie Gonterman-Schulte, Humana

EHR to Meaningful Use
Presented by Roger Holloway, NIU (IL-HITREC); Fred D. Rachman, MD (CHITREC) and Steve Lawrence (Southern Illinois satellite office of IL-HITREC)

SATURDAY, December 4th

The Road to Transition: Roadmaps, Roadblocks and Roadside Assistance
Presented by Miriam Kalichman, MD - Child Development and Habilitation Clinic, University of Illinois at Chicago

The Care of Returning Service Members and Their Families: What Family Physicians Should Know
Presenter TBA

Lunch CME – Family Medicine and Health Reform
Presented by Ted Epperly, MD
Past President and Immediate Past Chairman of the Board, American Academy of Family Physicians
Program Director and CEO Family Medicine Residency of Idaho, Boise

View the entire CME course descriptions and learning objectives at http://www.iafp.com/calendar/AMbrochure.pdf
Application for CME credit has been filed with the American Academy of Family Physicians. Determination of credit is pending.

Meeting CME fees: $20 per day until Nov. 19 then $40 per day after Nov. 19
SAM Workshop requires separate registration and $150 fee
Register Online at www.iafp.com or call 800-826-7944

Calling all IAFP members and spouses!

Wine and Surprises "FUNdraiser" for the Foundation at the Annual Meeting

During breaks at the annual meeting get in on this unique fundraising fest of wine, friendship and fun, all to benefit the Family Health Foundation of Illinois. T'is the season to be joyous and generous!

Wine and Surprises Silent Auction
Friday and Saturday, December 3-4 in the Exhibit Hall
Hilton at the Ballpark – St. Louis

How the fundraiser will work: Attendees can buy mystery wine bottles and go home with a great surprise! Each surprise up for bidding will have a "hint" to help you decide if the prize is right for you! If you would like to donate a prize to the fundraiser (wine, gift baskets, event tickets, vacation getaway, memorabilia, etc.) contact Desma Rozovics ASAP - or should we say "STAT" - at drozovics@iafp.com.

The **Wine and Surprises** event is a non-profit fundraiser that will benefit the educational programs supported by the IAFP Foundation. The Foundation needs your help. Loss of state funding, coupled with declining member donations has put the Foundation's programs out of service. Those programs include: the Summer Externship program, Tar Wars, Resident programs and Family Medicine Interest Group support. By attending and supporting this event, you can help us rebuild the Foundation and sustain these important activities as we strive to enhance access to primary care for the people of Illinois.

If you're not coming to the Annual Meeting, you can still support family medicine's future. Please consider making a direct donation to the Foundation before the end of the year. Building up our Foundation from within now will help us attract outside funding tomorrow. You can find a donation form online at http://www.iafp.com/foundation/donorform.htm or contact the Foundation office at 800-826-7944 for more information.

Med students meet with family medicine
Illinois medical students gathered at the IAFP Family Medicine Fall Festival on October 16 in Oak Brook for a first-hand look at family medicine. Students visited with faculty and residents from nearly 30 programs from Illinois and beyond. Former IAFP Student President Carrie Holland, MD – now a faculty family physician at MacNeal family medicine residency program – presented a "Strolling Through the Match" presentation, much like the one she saw as a young student at Loyola.

Students and Residents got much-needed debt management input from our four-person panel including: Sgt. Don Wagman with US Medical Corps options, NHSC options from Patricia Johnson of the Health Resources and Services Administration (HRSA), financial planning pointers from Joe Khasho of Ameriprise Financial Services and a first-person guide to of financing a family medicine career from IAFP board member Renee Poole, MD.

ProAssurance Professional Liability Company presented a "Jeopardy!" edition of Insurance 101 which fostered some friendly competition among the attendees, along with some valuable education about the malpractice environment that they face in the near future.

UFE: Good Medicine for Family Medicine

A non-surgical alternative to hysterectomy *that can improve patient care and quality of life for your patients with fibroids*

A SAFE AND EFFECTIVE ALTERNATIVE FOR FIBROIDS

Uterine fibroid embolization (UFE), also known as uterine artery embolization, is a non-surgical treatment for symptomatic uterine fibroids performed by an interventional radiologist. Using a catheter and guidewire, the physician injects tiny microspheres into the vessels that feed the fibroids, blocking the blood supply, shrinking the fibroids, and relieving symptoms.

After the UFE procedure and appropriate case follow-up, your fibroid patient returns to you for continued care.

COMPARING UFE TO SURGICAL ALTERNATIVES

	UFE	Hysterectomy*
Procedure Time	Approximately 1 hour	A few hours
Hospital Stay	Usually 23 hours	1-3 days
Recovery Time	About 1 week	4-6 weeks
Anesthesia	Local/Conscious Sedation	General/Spinal/Epidural
Surgical Incision	No	Yes

* Laparoscopic surgery is less invasive; however, the overall majority of hysterectomies are still performed abdominally.

Take a Dose of GOOD Medicine

FOR MORE INFORMATION, to locate an experienced Interventional Radiologist (IR) in your local area and to order your free supply of patient pamphlets objectively discussing ALL fibroid treatment options call 866-275-7498.

BioSphere® Medical

ask4UFE.com®

David J. Hagan, MD
Gibson City Clinic
IAFP president-elect

Why family medicine?
I decided I wanted to be a doctor back when I was five or six years old. And back then the only doctor I knew was our GP – the family physician. As I went through school, I saw no reason to change. I flirted briefly with becoming a pediatrician, but realized that what I loved about pediatrics I could do as a family doc.

My IAFP activity
As a volunteer leader, I participate in as many meetings and conferences as I can. I'm also involved with the American Academy as I can. I really enjoy the Family Medicine Congressional Conference in D.C.

The Academy's best service or resource
I think the Academy's best resource is the staff who are there whenever you need anything.

How do you champion family medicine?
Probably the most important thing is making sure Gibson City Hospital stays family medicine friendly.

What would you do for a living if you weren't a doctor?
My backup plan for medical school, if I didn't get in, was to look for a program in biology with an emphasis on genetics. I always loved genetics as an undergrad. I also thought that once I stopped delivering babies I would go to law school. But I just stopped delivering a few years ago and I don't see myself going to law school at this point in my life.

How do you balance your career with your own well-being?
My family makes plans all the time for vacations. Often as soon as we finish one vacation, we're planning the next! In my practice situation, I'm basically a solo provider. My home phone number is published in the phone book and on the answering machine in the office. You make plans, carve out time and say "this is what we're going to do." I'm also very active in the community with the local Lions Club, and my wife and I are active with our congregation.

Something about you that would surprise us…
I am very active, but I do not own a set of golf clubs!
EDITOR'S NOTE: On Oct. 17, Dr. Hagan completed the Grand Rapids (Mich.) Marathon in 3:55:25. This was his second marathon and he hopes to qualify for the Boston marathon someday.

What are some challenges of private practice?
Fortunately our PHO at our hospital organized the transition to electronic medical records. As a solo doc without much computer knowledge, that would have been overwhelming for me, I wouldn't have been able to do that on my own and a significant expense. But doing it through the PHO made it relatively easy and relatively painless. Otherwise the toughest part is just the ridiculous amount of faxes that come across every day. All the forms and requests, the little minutiae that you deal with every day. I would say the "paperwork hassle" is awful.

Why is precepting medical students important to you?
For many reasons. First, it encourages young family doctors into the pipeline. I remember a girl several years ago who was a summer extern [at my practice]. It seemed to me that she was surprised to see how things are still done in my practice. She didn't think practicing medicine could be like that. She's now a family physician in a downstate rural community. It's also a recruiting tool. I've had a previous summer extern return to Gibson City to practice. My patients actually like having externs in the office and start asking the students questions about themselves! You can do well and have fun in family medicine, you can do a lot of good.

Members in the News

Congratulations to the family physicians that were honored with **Rural Physicians of Excellence Awards** from the Illinois Rural Health Association. The award honors rural physicians who go above and beyond the call of duty to provide health care to rural and underserved residents in Illinois. IAFP members **Jeffrey Parks, MD** of Herrin, **Ricardo Calderon, MD** of Peru, **Remi Satkauskas, MD** of Kewanee, **David Reese, MD** of Lanark and **Robert Ayers, MD** of Monmouth were among the ten who received their award at a reception in Springfield on September 15.

IAFP President **Patrick Tranmer, MD** penned a letter to the editor which ran in the September 3 *Chicago Sun-Times*, praising the newspaper's support of medical homes in a recent editorial about the University of Chicago's Urban Health Initiative that works to link ER patients to a primary care medical home in the community.

Michael Rakotz, MD of Highland Park was quoted in a September *North Shore Magazine* story about the importance of planning for a healthy breakfast in a healthy lifestyle.

Ronald Rembert, MD and long-time Summer Externship preceptor **Lisa Green, DO** are featured in *Chicago Tribune TribLocal* September 8th story about the Today Care program, which provides affordable primary care to the uninsured in Harvey, keeping the care in the community.

Paul Kinsinger, MD of Washington is featured in the September 30th *Pekin Times* for his "Piggy Paste" toenail treatment. The product has spread throughout the Pekin-Bloomington market and beyond via the web. In January, Kinsinger will pitch the Piggy Paste product on QVC, the home shopping network.

Jincy Joseph, MD of Carpentersville was featured in a Sept. 27th *American Medical News* article discussing how the nation's physicians are helping the 50.7 million uninsured in America access care. Joseph's practice offers $65 flat-fee visits for uninsured patients and discounted school and sports physicals.

Brian Knabe, MD was featured in the Oct. 6th *Rockford Register-Star* for recently earning two professional designations: one as Fellow of AAFP and also as a Certified Medical Planner (CMP) professional. The CMP program provides physician-focused financial planning and integrated medical practice management expertise. Knabe also holds a Certified Financial Planner designation.

Shaun Mathen, DO of Hampshire is quoted in an Oct. 15 *Chicago Tribune* article asking if prayer has a place in helping patients heal. Mathen says he feels that faith and prayer are important in the healing and recovery process.

John Dannenfeldt, MD of Moline is featured in the Oct 24th *Quad Cities Times* feature story on local physicians who are in excellent shape and set the example for their patients about physical activity and healthy lifestyles. Dannenfeldt has completed triathlons and Ironman competitions.

Neil Sharma, MD Chief resident at SIU-Carbondale family medicine residency program authored a guest column in the *Southern Illinoisan* to educate the community on the differences between colds and flu. and how to prevent and treat each one.

Board member **Alvia Siddiqi, MD** of Hoffman Estates is quoted in the Oct. 25th issue of *American Medical News* with her insights about keeping patients from using their cell phones during the office visit. Apparently it happens almost daily!

Kimberly Hanneken, MD of Decatur is featured in an Oct. 28th *Decatur Herald-Review* discussing the various types of headaches, how to prevent them and how to treat them.

Bob Farmer, MD of Belleville is featured in the Nov. 2 *Belleville News-Democrat* for his efforts to rally area doctors and lawyers to donate towards providing a tractor to refugee camp in Ghana to help them grow their own food.

Two Chicago area members were featured in a Nov. 3 *Chicago Tribune* story about the low numbers of U.S. medical students choosing primary care specialties. **Nina Vergari Rogers, MD** practices at Chicago Family Health Center on Chicago's south side and teaches at the University of Chicago – Pritzker School of Medicine. **Jim Winger, MD** practices at Loyola Center for Health in Maywood, and was inspired by two mentors he had at the University of Virginia's medical school.

Nathan Seaman, MD of Quincy is extensively quoted in a Nov. 7th *Quincy Herald-Whig* story about the obesity problem in Adams County. The obesity rates for adults and children age 10-17 are above national averages. Several county organizations are working with the Alliance for Building Community Health Leadership to reduce those rates well before 2020. Seaman talks about the various environmental factors in Adams County that contribute to unhealthy lifestyles and weight gain.

SIU-Carbondale Family Medicine Residency and **Rush Copley Family Medicine Residency** programs have received recognition from the National Committee for Quality Assurance (NCQA) for functioning as a medical home, reaching Level 1 designation. Congratulations to these programs and their fine family physicians for this achievement. The NCQA Patient-Centered Medical Home Program was developed to assess whether physician practices are functioning as medical homes and recognize them for these efforts. The program's standards emphasize the use of systematic, patient-centered, coordinated care that supports access, communication and patient involvement. The program reflects the input of the American College of Physicians (ACP), American

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News You Can Use

Free Resources for Families with Cancer

The American Cancer Society works with physicians and nursing staff to ease the stresses faced by patients and their loved ones.

A cancer diagnosis affects the entire family. Whether you're providing care directly for patients or treating loved ones who must struggle with the practical challenges of caring for someone with the disease, the American Cancer Society has free services that can help. Created in 2003, the Society's Patient Navigation Services™ network now serves patients and families in every Illinois community. This year alone, more than 30,000 patients received support ranging from free rides to treatment to peer counseling to help with financial concerns and more.

How it works

The Society operates in partnership with major cancer centers, hospitals and oncology clinics to address patient needs. At Illinois' largest cancer centers, full-time licensed social workers who are Society employees work closely with oncology staff, becoming an integral part of the medical team. And across the state, Society staff and volunteers are available at other major hospitals and cancer clinics to meet with patients and families referred by their physicians.

Face-to-face meetings are just one of the ways patients and families can receive support. The Society also operates a 24/7 cancer help line, 800.227.2345, and a Web site, www.IllinoisCancerHelp.org.

A patient-centered approach

No two families with cancer face exactly the same obstacles, so the Society navigator's first goal is to uncover concerns that can block patients from engaging fully in their own healing.

"Easing fears and solving day-to-day problems helps give patients and families more confidence, enabling them to work better with the oncology team," says Courtney Heiser, a Society representative who serves families at nine medical centers in central Illinois. "Patients tell me how grateful they are to have a real person to talk with, someone who understands the ups and downs of the journey they're on. I work with caregivers, too, and I find they need support just as urgently as cancer patients themselves."

Addressing critical needs

Society navigators offer caring support at a time when families feel overwhelmed with questions and concerns. Sometimes, the answer is as simple as a free ride to treatment. Bev, a Villa Park resident with breast cancer, had no idea how she would get to her medical appointments without a car or current driver's license. She and her husband are grateful for Krissy, a Society volunteer who has provided more than 200 round-trip rides between their home and the medical center, pharmacy and physician's offices.

Navigators also help patients overcome financial obstacles that can block the path to quality care. One father arrived at a Society support center in Chicago fearing for his 11-year-old son's life. He had lost his business, and along with it his family's health insurance. A navigator helped the family apply for state-sponsored coverage through the Illinois Kid Care program, and the boy soon entered treatment.

Filling gaps – and offering hope

Physicians and nurses who refer families to the Society's free program see tangible benefits. "The navigators play so many roles," says Dr. Elizabeth Marcus, a breast cancer specialist at John H. Stroger, Jr. Hospital in Chicago. "I can't say enough about the good these services do for my patients."

A full range of support

Having cancer is hard, but finding help isn't, thanks to the American Cancer Society's free support program. Patients and loved ones can benefit from:

- Free rides to and from cancer treatment
- Free wigs, hats, scarves and temporary prostheses
- Peer support programs staffed by cancer survivors
- Help with insurance and financial questions
- Free classes to help patients cope with side effects
- Links with additional community resources
- One-on-one counseling and support

The Society offers free Cancer Help Kits for all patients, providing a sturdy, easy-to-use file for medical records, prescriptions, printed information and more.

Stark Law: Term Definitions and Recent Changes Require Careful Consideration

By Kevin J. Ryan

Physicians who wish to enter into joint ventures or invest in health care services must evaluate such opportunities carefully, or risk serious consequences, including the possibility of losing Medicare payments. Physicians thoroughly review the physician self-referral law, commonly known as the "Stark law," before finalizing any relationship or investment. To best understand the Stark law, you must be aware of recent changes in the law, and understand the definitions of the specific terms used in its provisions.

As it currently stands, the Stark law provides the following: "Unless an exception applies, a physician is prohibited from making a referral to an entity for the furnishing of designated health services payable by Medicare if the physician or an immediate family member of the physician has a financial relationship with the entity," be it ownership, investment or a structured compensation arrangement.

What are Designated Health Services under the Stark law?

The designated health services (DHS) covered by the Stark law include clinical laboratory services; physical/occupational therapy services; radiology and imaging services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics and prosthetic devices; home health services and supplies; outpatient prescription drugs; and inpatient and outpatient hospital services.

Certain services are not considered DHS and fall outside of the Stark law regulations. These include ambulatory surgery center services reimbursed as part of the surgery center's composite rate. Lithotripsy services are also not considered to be DHS as a result of a court ruling.

Under the current Stark law definitions, a referral is considered to be a request for consultation with another physician, or any test or procedure that is ordered by, or on behalf of, a physician. But a referral for a DHS that is personally performed by that physician is not considered a referral by Stark law standards.

Recent changes in the law

On October1, 2009, a number of changes to the Stark law took effect that impacted the definitions of certain terms, as well as certain payment arrangements. Some of these changes had a profound effect on joint-venture activity among physicians, physician groups, hospitals and other providers.

First, the revised definition of "entity" now includes both the person that Medicare paid for the DHS and the "person or entity that has performed services that are billed as" DHS. This change expanded the entities that are subject to the Stark law, effectively prohibiting many situations where physicians and/or their groups provided services to hospitals or other providers "under arrangements." Because of the change in the definition of the term "entity," many joint ventures were restructured or terminated in the past year.

In addition, a "financial relationship" under the Stark law includes a direct or indirect ownership or investment interest in an entity. It also includes a compensation arrangement with an entity. Investments can be through debt, equity, corporations, limited liability companies, loans and other investment vehicles. Compensation arrangements are defined very broadly and can include any arrangement with a physician involving remuneration of any kind, including "any payment or other benefit that is made directly or indirectly, overtly, covertly, in cash or in kind."

The Stark law has also been revised to allow a physician to "stand in the shoes" of his or her physician organization in certain circumstances. In other words, according to the American Health Law Association, "the physician is deemed to have the same compensation arrangements (with the same parties and on the same terms) as the physician organization." As a result, an indirect relationship may become a direct relationship if a physician is determined to stand in the shoes of his or her physician organization.

Wide Reach

In addition to ownership, investment and physician compensation arrangements, even office space and equipment rentals are subject to the "financial relationship" provisions of the Stark law. The Centers for Medicare and Medicaid Services (CMS) made some further changes to the law in 2009 to create percentage-based payments for the rental of office space and equipment. CME cited concerns that such arrangements provide an incentive for the lessor to increase referrals for DHS to the lessee to potentially increase rental payments under the lease. Although CMS has not yet prohibited percentage-based agreements for non-professional services (such as management or billing services), the organization has stated that it will continue to monitor such arrangements.

Exceptions

As stated in the law, certain referrals are prohibited unless an exception applies. There are numerous exceptions, including general exceptions that apply

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to both ownership/investment interests and compensation arrangements, and specific exceptions that apply to either ownership/investment interests or compensation arrangements.

The most common general exceptions are the Physician Services Exception and the In-Office Ancillary Services Exception. In the Physician Services Exception, a physician can make a referral if the DHS is provided personally by another physician in the same group as the referring physician or under the supervision of another physician in the same group practice. Stark law provisions include a very specific definition of what constitutes a group practice.

The In-Office Ancillary Services Exception is also common. However, the service must meet certain criteria regarding the supervision of the service, the location where the service is provided, and billing for the service.

The Stark law permits only very limited exceptions for ownership and investment interests, most commonly the Publicly Traded Securities Exception and the Regulated Investment Company Exception. These exceptions allow physicians to refer patients to companies that are publicly traded and in which the physician has stock or mutual fund ownership. There are also exceptions for Whole Hospital Ownership and Rural Providers. In order to qualify for these narrow exceptions, referrals must meet very specific criteria.

There are also numerous exceptions for compensation arrangements. The most common are the Office Space and Equipment Rental Exception, the Bona Fide Employment Relationship Exception, and the Personal Services Arrangement Exception. These exceptions share many common elements:

- The agreement or relationship must be fair-market value and commercially reasonable.
- In many, but not all cases, the relationship or agreement must be in writing. Employment agreements are one of the few exceptions to this requirement because many physicians are hired by an employer without an employment agreement.
- Most of the compensation exceptions prohibit compensation based on the value or volume of services provided.
- In most cases the compensation must be set in advance and the agreement must have a term of at least one year.

Consequences of Non-Compliance

Under the Stark law, a referral that does not meet the criteria of an exception is strictly prohibited. If a physician's financial relationship does not meet an exception and the physician refers to a health care provider for a DHS, the health care provider may not bill Medicare or the patient for the services, and may face a fine of up to $15,000 for each violation. Violators may also be excluded from Medicare entirely.

The Stark law is a very complex law, and physicians need to understand its requirements and its exceptions. Before establishing a financial relationship with an entity, physicians should contact a health care attorney to ensure compliance.

Kevin J. Ryan, Chair of the Health Care Law group at Chicago-based Much Shelist*, concentrates his practice on legal and regulatory issues facing the health care industry. Kevin's clients include hospitals, nursing homes, surgery centers and physician groups, as well as other provider organizations and businesses. Kevin can be reached at 312-521-2429, or* kryan@muchshelist.com.

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Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP) and American Osteopathic Association (AOA) and others in extension of the Physician Practice Connections Program.

In Memoriam:

Alexander Z. Goldstein, MD, 85, of Edina, Minn., formerly of Harrisburg, passed away Sept. 28. He practiced family medicine in Rosiclare from 1955 to 1971 and in Harrisburg from 1971 to 2003. He and his wife, Anna, are both German concentration camp survivors who immigrated to the United States in 1951. Dr. Goldstein served on the clinical faculty of Southern Illinois School of Medicine in Carbondale.

L. Thomas Koritz, MD of Rochelle passed away on Nov. 5 at Memorial Hospital in Rockford. He practiced medicine as a family physician in Rochelle from 1953 to 1987, when he accepted a position as a clinical assistant professor of Family and Community Medicine, teaching students at the University of Illinois Rockford College of Medicine. In 1991, he was awarded the Raymond B. Allen Award for excellence in teaching, commonly referred to as the Golden Apple. For memorials, please consider the University of Illinois College of Medicine.

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