Macomb Medicus

Journal of the Macomb County Medical Society

July/August/September 2026 | Vol. 34 | No. 3

macombcms.org

Macomb
Medicus
Journal of the Macomb County Medical Society

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July/August/September 2026 | Vol. 34 | No. 3

In This Issue

Macomb Medicus Journal is published quarterly by the Macomb County Medical Society. Winter: Jan/Feb/Mar, Spring: Apr/May/Jun, Summer: Jul/ Aug/Sep, Fall: Oct/Nov/Dec. Subscription to the Macomb Medicus is included in the society's annual membership dues.

Address changes and all communications relative to articles and advertising in the Macomb Medicus should be addressed to: Editor, Macomb County Medical Society, P.O. Box 551, Lexington, Michigan 48450-0551 or email **HLeach@macombcms.org**.

All material for publication, including advertisements, must reach the Society office no later than the 10th (business) day of the month preceding the date of issue, e.g. December 10 for the Winter issue. Thank you.

A Message from the MCMS President

By: Lawrence F. Handler, MD
MCMS President

My best wishes to all of our members and families and hope you are taking advantage of our beautiful Michigan summer. On behalf of the Board of Directors, I want to thank each of you for your continued commitment and membership to the Macomb County Medical Society.

The Michigan State Medical Society House of Delegates recently approved a restructuring plan between the state organization and county medical societies. This action was precipitated from the long decline in membership, which has required the Michigan State Medical Society to reevaluate its organizational structure and long-term sustainability. Over the remainder of this year, county medical societies throughout Michigan will transition to operating as independent organizations while continuing to collaborate with the Michigan State Medical Society on issues of mutual interest.

Your Board of Directors has already begun this important work. We recently met to develop a comprehensive plan to ensure that our Society remains strong, financially sound, and well-positioned for the future. One of our highest priorities is conducting a thorough review of our current bylaws to determine whether they adequately support our continued operation as an independent county medical society. In the coming weeks, we will be interviewing legal counsel with expertise in nonprofit organizations to assist us with this process and to recommend any revisions to our bylaws and legal structure.

The Board also carefully reviewed our membership dues structure. Recognizing the importance of maintaining a vibrant and growing organization, **the Board unanimously approved a reduction from $260 to $100 in county dues for active membership beginning with the upcoming 2027 year**. We hope this reduction demonstrates our commitment to our members while removing financial barriers to participation.

Our goal is straightforward: to maintain the strong membership we currently enjoy while welcoming new physicians, residents, and medical students into our organization. A strong county medical society remains essential. It provides opportunities for professional networking, physician advocacy, leadership development, and collegial support.

While organizational structures may evolve, our mission remains unchanged. The Macomb County Medical Society will continue to advocate for physicians and our patients, promote professional excellence, and provide a unified voice for organized medicine within our community.

As these changes progress, we will keep you informed and seek your input whenever appropriate. Thank you for your continued membership, and your confidence in our Board. Together, I am confident we will successfully navigate this transition and emerge as an even stronger organization.

I wish you a safe, relaxing, and enjoyable summer. ✦

Macomb County Medical Society's Annual Meeting

Tuesday, October 13, 2026

Speaker to be annouced

Ike's Restaurant
Van Dyke just south of 17 Mile Rd.
in Sterling Heights

6 pm Cocktails ~ 6:30 pm Dinner ~ 7 pm Program

Free for MCMS Members
Join your colleagues for an evening of socializing and networking!

The SAVE DATE
10.13.2026

The Anatomy of a Smile: Leonardo da Vinci's Mona Lisa Through the Eyes of an Anatomist

By: Narendra Devisinh Gohel, MD
Editor, Macomb Medicus

"Anatomy is more than the study of the human body. It is the discipline of learning to see."

Introduction

For centuries, anatomy has been the cornerstone of medical education. Derived from the Greek word anatome, meaning "to cut up" or "to dissect," anatomy is the scientific study of the structure of living organisms, encompassing their organs, tissues, muscles, bones, nerves, and vascular systems. Since the Renaissance, generations of physicians have learned anatomy through cadaveric dissection—an experience often regarded as medicine's first encounter with the human body and, for many, its first lesson in humility.

Today, anatomy education is undergoing profound transformation. Three-dimensional imaging, virtual dissection tables, augmented reality, artificial intelligence, and sophisticated digital simulations are reshaping the way anatomy is taught. Some medical schools have substantially reduced cadaveric dissection, while a few have eliminated it from the core curriculum altogether, arguing that modern technologies can achieve comparable educational outcomes while overcoming limitations of cost, donor availability, and curricular time.

Whether cadaveric dissection should remain an essential component of medical education continues to generate thoughtful debate. Traditionalists emphasize that no digital simulation can fully replicate the tactile experience of human tissue or the appreciation of normal anatomical variation revealed through dissection. Others contend that emerging technologies provide efficient, reproducible, and clinically integrated methods of learning anatomy. The purpose of this essay is not to resolve that debate. Rather, it asks a different question.

What is anatomy ultimately meant to teach?

As medicine increasingly embraces digital technology, Leonardo da Vinci reminds us that anatomy is far more than the identification of muscles, nerves, and organs. At its heart, anatomy is the discipline of observation—the ability to see what others overlook and to recognize the subtle relationship between structure and function. Technology may transform how anatomy is taught, but it should never change what anatomy teaches us.

No individual exemplified this principle more completely than Leonardo da Vinci. Although remembered primarily as one of history's greatest artists, Leonardo considered himself first and foremost a student of nature. Painting, for him, was not merely an artistic pursuit but an extension of scientific inquiry. Every contour was grounded in anatomy, every shadow informed by optics, and every expression born from careful observation. Long before medicine, engineering, mathematics, and art evolved into separate disciplines, Leonardo pursued them as complementary paths toward a single objective: understanding nature through direct observation.

Perhaps nowhere is this union of science and art more beautifully expressed than in the Mona Lisa. For more than five centuries, her expression has captivated artists, physicians, neuroscientists, psychologists, and millions of museum visitors. Is she smiling? Is she contemplative? Does her expression change as we look at her? Countless explanations have been proposed. Yet the answer lies not only in artistic genius, but also in Leonardo's extraordinary understanding of anatomy and human vision.

Leonardo appreciated a principle that every anatomist eventually learns: what we perceive on the surface is determined by structures hidden beneath it. A barely perceptible contraction of a facial muscle, a slight change in the contour of the lips, or a delicate transition between light and shadow can transform an expression. Modern surgeons rely upon these subtleties during facial reconstruction. Neurologists detect disease through minute asymmetries of facial movement. Ophthalmologists recognize disorders from almost imperceptible changes around the eyes. More than five centuries earlier, Leonardo was already studying these relationships with remarkable precision.

Leonardo the Anatomist

His pursuit of anatomical knowledge was extraordinary, particularly considering the era in which he lived. Opportunities for human dissection were limited by legal, religious, and practical constraints. Nevertheless, Leonardo is believed to have dissected approximately thirty human cadavers during his lifetime. Working in hospitals and mortuaries, often by candlelight and racing against the inevitable decomposition of the body, he meticulously documented the architecture of the human form.

Unlike many anatomists of his time, Leonardo was not content simply to identify structures. He wanted to understand how

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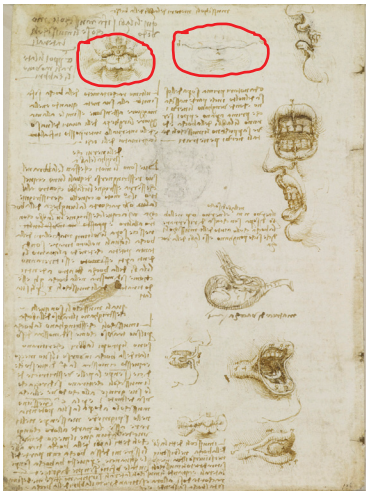
they functioned. He separated muscles layer by layer, traced tendons to their insertions, examined joints as mechanical levers, and followed nerves as far as contemporary knowledge permitted. His notebooks—filled with exquisitely detailed drawings accompanied by observations written in his characteristic mirror script—reveal an investigator driven by relentless curiosity rather than artistic ambition alone. Although his planned anatomical treatise was never published, many of his observations anticipated discoveries that would not be fully appreciated for centuries.

Among all regions of the body, none fascinated Leonardo more than the human face.

To him, the face was the body's most expressive anatomical landscape. Joy, sorrow, curiosity, serenity, fear, and compassion were communicated not by words but by the coordinated action of muscles lying beneath an extraordinarily thin layer of skin. Determined to understand this language, Leonardo undertook painstaking dissections of the head and neck, studying the muscles responsible for movement of the lips, cheeks, chin, and eyelids. His notebooks contain numerous studies of mouths in exaggerated expressions, revealing an anatomist attempting to understand not merely how the face was constructed, but how it communicated emotion.



One surviving notebook sheet beautifully illustrates this union of science and art. Left are careful anatomical studies of dissected lips and facial musculature; above them rests a lightly sketched smile drawn in black chalk. Few images better symbolize Leonardo's lifelong conviction that artistic expression begins with anatomical understanding. The anatomist and the artist were working simultaneously.

Leonardo approached the human body with two instruments—a scalpel and a paintbrush. One revealed structure; the other revealed beauty. Together, they produced one of history's greatest lessons in observation.

That lesson would ultimately find its fullest expression in the enigmatic smile of the Mona Lisa.

Constructing the World's Most Famous Smile

Anatomy was its blueprint.

His scalpel informed his paintbrush.

Unlike many Renaissance artists who relied primarily on visual appearance, Leonardo sought to understand the anatomical mechanisms responsible for facial expression. He believed that an artist could not faithfully portray emotion without first understanding the structures that created it. This conviction led him beyond the painter's studio and into the dissection room, where art and anatomy became inseparable.

Among Leonardo's most remarkable anatomical investigations were his studies of the human face. Through painstaking dissections of the head and neck, he examined the muscles that move the lips, cheeks, chin, and eyelids. His notebooks contain numerous drawings of mouths in exaggerated expressions, each attempting to isolate the contribution of individual muscles to the language of emotion. He recognized that a smile was not produced by a single muscle but by the coordinated action of many muscles working in harmony.

Modern anatomy confirms Leonardo's intuition. A smile results from the delicate interplay of several facial muscles, including the zygomaticus major, orbicularis oris, buccinator, and muscles that elevate and depress the lips and cheeks. Leonardo identified many of these structures centuries before modern anatomy assigned them their present names. More importantly, he understood that even the slightest variation in muscular contraction could transform the emotional meaning of a face.

His curiosity extended beyond muscles alone. Leonardo attempted to trace the nerves supplying the face, distinguishing those that originated within the brain from those arising from the spinal cord—an extraordinary undertaking long before the anatomy of the cranial nerves was fully understood. To him, anatomy was never simply a catalogue of structures; it was an attempt to understand how the human body created movement, expression, and ultimately emotion.

The lightly sketched smile introduced earlier offers a remarkable glimpse into Leonardo's method. Resting above his anatomical studies of the lips and facial musculature, it seems almost to emerge from the structures he had so carefully examined. The anatomy below informs the expression above—a visual bridge between dissection and creation. For Leonardo, understanding structure was not separate from creating beauty; it was the foundation upon which beauty was built.

Leonardo's investigations eventually extended beyond anatomy to another scientific discipline that fascinated him throughout his life—optics.

He understood that painting was not only about the object being observed but also about the eye that observes it. Years before the physiology of vision could be explained scientifically, Leonardo explored the behavior of light, shadow, perspective, and atmospheric haze, believing that an artist must paint the

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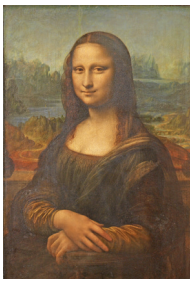
world as it is actually perceived rather than as it is intellectually described.

This philosophy culminated in one of his greatest artistic innovations: sfumato. Derived from the Italian word fumo, meaning "smoke," sfumato eliminates hard outlines by replacing them with almost imperceptible transitions between light and shadow. Forms dissolve gently into one another. Edges disappear. Shadows become soft. Flesh appears almost to breathe.

Modern scientific analyses have demonstrated just how meticulous this technique was. Using extraordinarily thin translucent glazes, often measuring only a few micrometers in thickness, Leonardo built the shadows of the Mona Lisa layer upon layer. Recent chemical studies have further shown that he experimented with an unusually opaque lead-white ground applied over a finely prepared poplar panel. Rather than using the more conventional mixture of gesso and chalk favored by many Renaissance painters, Leonardo prepared a luminous white foundation by dispersing heated lead oxide in his drying oil medium. Ambient light penetrates the translucent paint layers, reflects from this brilliant ground, and returns through successive glazes to the viewer's eye. The result is the extraordinary depth, softness, and inner luminosity that continue to distinguish the portrait more than five centuries later.

Yet the true genius of the Mona Lisa lies not only in pigments or brushwork, but in Leonardo's extraordinary understanding of visual perception.

Most viewers instinctively look directly at Lisa's mouth in an attempt to determine whether she is smiling. Ironically, this is precisely where the illusion begins.



The central retina, particularly the fovea, provides the high-acuity vision required to appreciate fine detail. When our gaze is fixed directly upon the corners of Lisa's mouth, we perceive the delicate contours of her lips and the subtle downward curvature at their edges. The smile appears restrained—perhaps even absent.

As our attention shifts toward her eyes, however, the mouth is no longer examined by central vision. Instead, it falls upon the peripheral retina, which is less sensitive to fine detail but remarkably responsive to broader patterns of light and shadow. Leonardo's sfumato now assumes control. The soft shadows surrounding the corners of the mouth merge imperceptibly with the cheeks, creating the compelling illusion that her lips have gently turned upward.

The smile appears.

Look directly at it again.

It quietly recedes.

Harvard neuroscientist Margaret Livingstone elegantly demonstrated that this phenomenon arises because the smile is carried predominantly by low spatial-frequency information—the blurred visual patterns processed more effectively by peripheral vision than by central vision. Leonardo, of course, knew nothing of retinal physiology or spatial-frequency analysis. Yet through relentless observation and experimentation, he intuitively exploited principles of visual perception that neuroscience would explain only five centuries later.

Giorgio Vasari, writing only decades after Leonardo's death, described the Mona Lisa's smile as being "more divine than human." He also recounted that Leonardo employed musicians, singers, and jesters to entertain Lisa Gherardini during the prolonged portrait sessions, hoping to preserve a natural, pleasant expression.

Whether every detail of Vasari's account is historically accurate remains uncertain. Yet the story reflects an essential truth: Leonardo was not attempting to paint a posed expression. He sought to capture life itself.

The resulting smile hovers delicately between movement and stillness, certainty and ambiguity. It seems almost alive, changing subtly as our eyes move across the portrait. More than five centuries after Leonardo laid down his brush, viewers continue to experience the same quiet illusion.

Leonardo did not merely paint a smile—he constructed one.

Seeing Anew

The mystery of the Mona Lisa extends beyond her smile. Physicians and art historians have long examined the portrait for subtle anatomical clues. Some have suggested that one pupil appears slightly larger than the other, raising the possibility of physiologic anisocoria, a benign finding present in many healthy individuals. Others have noted a faint yellowish discoloration near the medial aspect of the left eyelid that has been interpreted as xanthelasma. These observations are intriguing, but they remain speculative. Five centuries of aging, varnish, restoration, changing illumination, and photographic reproduction make retrospective diagnosis impossible. Their real significance lies elsewhere: Leonardo painted his subject with such astonishing realism that physicians still find themselves examining her as though she were a living patient.

Another enduring curiosity concerns Lisa's eyebrows and eyelashes. Today they appear almost absent, prompting generations of viewers to wonder whether Leonardo intentionally omitted them. Yet the Mona Lisa has undergone numerous cleaning and conservation interventions during the past five centuries. A major restoration in 1809 almost certainly altered the appearance of the paint surface, and some scholars have suggested that delicate superficial details may have been diminished during cleaning and revarnishing. In 2007, high-resolution multispectral imaging by the French engineer Pascal

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Cotte revealed faint evidence consistent with eyebrow hairs beneath later surface changes. Whether the eyebrows were originally more prominent may never be known with certainty. The episode reminds us that the painting we admire today has also acquired its own history.

Leonardo retained the Mona Lisa throughout the remainder of his life, continuing to refine it for many years rather than delivering it to its original patron. The portrait was, in many ways, a lifelong experiment—one in which anatomy, optics, chemistry, and artistic technique gradually merged into a single masterpiece.

Yet perhaps Leonardo's most remarkable anatomical insight is found not in the figure herself, but in the landscape that surrounds her.

Leonardo believed that the human body was the microcosm of the natural world, while the earth itself represented the macrocosm, both governed by the same universal principles. In his notebooks, rivers resemble veins carrying life through the landscape. Mountain ridges become the skeleton of the earth. Branching trees echo the vascular system, while winding roads suggest tendons connecting distant structures. The ceaseless flow of water mirrors the circulation of life itself. To Leonardo, anatomy was never confined to the human body; it was the underlying design of nature.

This philosophy quietly unfolds behind Lisa Gherardini. The landscape is far more than a decorative backdrop. Rivers, valleys, bridges, mountains, and winding paths seem to flow naturally into the figure, dissolving the boundary between humanity and nature. The portrait becomes something larger than the likeness of a Florentine woman. It becomes Leonardo's visual expression of the unity between the human body and the living earth. In the Mona Lisa, the macrocosm and the microcosm exist in perfect harmony.

The same philosophy is beautifully expressed in Leonardo's Vitruvian Man. Inspired by the writings of the Roman architect Vitruvius, Leonardo demonstrated that the human body could be understood through geometry, mathematics, and proportion. Remarkably, modern anthropometric studies have shown that many of his proportional relationships fall within approximately ten percent of contemporary measurements, underscoring the extraordinary accuracy of his observations. If the Vitruvian Man reveals Leonardo's understanding of the architecture of the human body, the Mona Lisa reveals his understanding of the architecture of human expression. Together, they represent two complementary masterpieces born from the same conviction: careful observation is the beginning of both science and art.

More than thirty years ago, I stood before the Mona Lisa in the Louvre Museum. Like millions of visitors, I admired the world's most famous painting. Yet I left without fully appreciating what I had seen. At that time, I viewed the portrait through the eyes of a tourist.

Today, after a lifetime in anatomy and surgery—and after exploring the remarkable science behind Leonardo's work—I know that I would stand before the painting very differently. I would spend less time searching for the famous smile and more time appreciating the countless anatomical observations, optical discoveries, and artistic innovations that made that smile possible. I would look beyond the face to the landscape, beyond the portrait to the philosophy, and beyond the painting to the extraordinary mind that united science and art with such effortless brilliance.

If, after reading this essay, the reader lingers a little longer before Leonardo's Mona Lisa, noticing details that once escaped attention, then it will have achieved its purpose. More importantly, if it also reminds physicians that careful observation remains one of medicine's greatest instruments, then Leonardo will have continued teaching anatomy more than five centuries after his death.

Leonardo did not ask us simply to look at a smile.

He taught us how to see one.

The next time you stand before Leonardo's Mona Lisa, you may still wonder whether she is smiling. But perhaps you will leave with a greater appreciation of something even more enduring—that anatomy, at its finest, teaches us not merely the structure of the human body, but the discipline of learning to see.

Anatomy is more than the study of the human body.

It is the discipline of learning to see. ✦

Editor's Note: The author gratefully acknowledges the assistance of ChatGPT (OpenAI) in organizing ideas, refining language, and editorial development during manuscript preparation.

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Health Department

MSU EXTENSION BRINGS TAI CHI TO ITS CLINTON TOWNSHIP OFFICE

This summer, Macomb County residents are invited to discover the many health benefits of **Tai Chi through a free Tai Chi for Arthritis and Falls Prevention** introductory series offered by **MSU Extension** at its Clinton Township office. This gentle, beginner-friendly program offers individuals of all ability levels the opportunity to explore a low-impact form of exercise.

Classes will take place on **Mondays from noon to 1 p.m., beginning June 15 and continuing through August 24, 2026**. Sessions will be held in the MSU Extension Assembly Rooms, located at 21885 Dunham Road in Clinton Township (please use Entrance "E"). There is no cost to attend; however, pre-registration is required.

Tai Chi is a slow, flowing practice that combines mindful movement, deep breathing, and focused attention. Participants may experience improved strength, balance, and posture, along with a reduced risk of falls. The program also supports overall well-being by promoting relaxation, reducing stress, and helping to connect mind, body, and spirit.

The class is led by instructor Jacqui Rabine, who will provide modifications to accommodate both seated and standing participants. Attendees are encouraged to dress comfortably, wear tennis shoes, and bring water.

To register or learn more, please call 586-469-7614 or email **rabineja@msu.edu**.

BATHING BEACH WATER MONITORING

The Macomb County Health Department monitors bathing beach water at Lake St. Clair Metropark Beach in Harrison Township, Walter & Mary Burke Park in New Baltimore, Memorial Park Beach in St. Clair Shores, Stony Creek Baypoint Beach in Washington Township, and Stony Creek Eastwood Beach in Shelby Township. Water testing is conducted to identify levels of E. coli bacteria. If sample bacteria levels exceed levels established in the Michigan Public Health Code, the beach will be closed to the public until bacteria levels fall to acceptable levels.

So if you're planning on going for a swim, **our website has information on current beach conditions**, sampling procedures, and historical beach testing data that you might find helpful.

MACOMB COMMUNITY ACTION (MCA)

For more than 60 years, Macomb Community Action has been dedicated to helping Macomb County residents achieve stability and improve their quality of life. Through a variety of programs and services, the organization provides critical support for individuals and families facing financial hardship, including housing and utility assistance, resources, early childhood education, transportation services, and financial empowerment programs.

Beyond providing essential services, Macomb Community Action serves as a strong advocate for residents throughout the county. By working closely with community partners, local leaders, and service organizations, they help identify community needs, connect residents to resources, and promote solutions that create lasting positive change.

Their continued commitment to advocacy, support, and empowerment makes a meaningful difference in the lives of thousands of Macomb County residents each year. We are proud to recognize Macomb Community Action for their ongoing efforts to strengthen our community and help residents build brighter futures.

For more information, please visit **Macomb Community Action** to learn more about their services and programs.

EMERGENCY PREPAREDNESS PLAN FOR MACOMB COUNTY BUSINESSES

If you own/operate a business, emergencies can have a devastating impact especially if you're not ready for them.

After a disaster, businesses are a lifeline for the community. We count on businesses small and large to get back up and running to support community resiliency, but over 60% of businesses say they don't have a comprehensive plan. Businesses and organizations can protect their employees and participate in community emergency response by becoming Closed POD partners and developing **Emergency Preparedness and Continuity of Operations Plans**.

In a public health emergency such as a bioterrorism event or pandemic flu, the Health Department is tasked with providing

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lifesaving antibiotics to the entire County population. We can work with you to build a plan that would help us quickly get prophylactic medication to your staff, their family members, and optionally, your customers/clients. This plan eliminates the need for you and your staff to go to a public Point of Dispensing (Open POD) site to receive this medication. Instead, your facility will be a private Point of Dispensing (Closed POD) site. You can help protect your workers, and ensure fewer disruptions to your business operations because staff know their families are taken care of.

We have worked with a number of private businesses, community organizations, and health care agencies to help them build their Closed POD Plans. To get started, follow the link below to register. A preparedness specialist will contact you to build the plan for your particular facility. There is no cost or obligation - we write the entire plan for you and handle all technical assistance. For more information contact **MCHD-EP@macombgov.org**

Closed POD Registration Form

THE MACOMB COUNTY HEALTH DEPARTMENT'S COMMUNICABLE DISEASE SURVEILLANCE PROGRAM

The Communicable Disease Surveillance Program helps protect the community by quickly identifying and responding to communicable diseases and outbreaks. Timely reporting from healthcare providers, schools, and childcare centers is essential to prevent the spread of illnesses such as chickenpox, Hepatitis A, measles, and rabies.

When a healthcare provider in Macomb County identifies a patient with any of the **reportable conditions**, they are required to report the diagnosis to Macomb County Health Department to help monitor the health of the community and provide preventive actions as necessary. The cooperation and prompt required reporting by physicians, laboratory scientists, infection preventionists, schools and other providers allows for timely action by local and state public health personnel. Some of the benefits of this teamwork include:

- Identification of outbreaks and epidemics
- Enabling preventive measures and/or education
- Successful targeting of prevention programs, identification of care needs, and efficient use of resources
- Evaluation of the success of long-term control efforts

For more information or to report a disease, contact the Communicable Disease Program at 586-783-8190 or email **diseasecontrol@macombgov.org**. ✦

Health and Community Services
Health Department

Macomb County Health Department
Reportable Diseases Summary

Diseases Reported in Macomb County Residents*

Cumulative total for previous years, year-to-date total for June 2026[b]

	2026	2025	2024	2023	2022
AMEBIASIS	0	0	0	0	0
BLASTOMYCOSIS	0	2	0	1	2
BOTULISM -FOODBORNE	1	0	0	0	0
BOTULISM -INFANT	0	0	0	0	0
BRUCELLOSIS	0	1	1	0	0
CAMPYLOBACTER	42	100	86	109	91
CHICKENPOX	18	27	32	37	29
CHLAMYDIA	1,288	2,564	2,855	3,074	3,105
COCCIDIOIDOMYCOSIS	3	2	4	4	1
CREUTZFELDT JAKOB	0	1	1	1	0
CRYPTOCOCCOSIS	0	0	0	0	0
CRYPTOSPORIDIOSIS	4	3	7	14	7
CYCLOSPORIASIS	37	1	0	2	1
DENGUE FEVER	0	0	1	0	0
DIPHTHERIA	0	0	0	0	0
EHRLICHIOSIS	0	1	1	0	0
ENCEPHALITIS PRIMARY	0	1	1	0	0
ENC POST OTHER	1	6	7	2	1
FLU-LIKE DISEASE	7,846	7,848	4,054	15,579	14,973
GIARDIASIS	9	22	19	26	16
GONORRHEA	380	864	970	1,065	970
GRANULOMA INGUINALE	0	0	0	0	0
GUILLAIN-BARRE SYN.	2	11	8	9	5
H. FLU INVASIVE DISEASE	10	11	30	17	16
HEMOLYTIC UREMIC SYN.	0	0	0	0	0
HEPATITIS A	3	0	1	3	1
HEPATITIS B (ACUTE)	1	7	8	7	5
HEP B (CHRONIC)	32	72	76	80	62
HEPATITIS C (ACUTE)	2	2	9	9	13
HEP C (CHRONIC)	65	135	223	199	198
HEPATITIS D	0	0	0	0	0
HEPATITIS E	0	0	0	0	0
HISTOPLASMOSIS	1	3	6	4	4
HIV^	26	42	48	51	56
INFLUENZA	3,090	8,005	4,846	3,523	5,558
KAWASAKI SYNDROME	0	1	6	11	5
LEGIONELLOSIS	15	38	44	60	36
LISTERIOSIS	3	3	0	0	2

	2026	2025	2024	2023	2022
LYME DISEASE	6	21	11	14	11
MALARIA	1	2	1	1	2
MEASLES	2	2	1	0	0
MENINGITIS VIRAL	4	16	15	12	26
MENINGITIS BACTERIAL/BACTEREMIA (EXCLUDING N. MENINGITIDIS	1	6	5	4	8
MENINGOCOCCAL DISEASE	0	1	1	1	0
MPOX	1	0	1	4	41
MULTISYSTEM INFLAM. SYND.	1	1	1	3	8
MUMPS	0	0	0	2	0
NOVEL CORONAVIRUS COVID19	3,094	9,380	16,162	26,232	123,251
PERTUSSIS	5	49	91	3	2
POLIO	0	0	0	0	0
PSITTACOSIS	0	0	0	0	0
Q FEVER	1	0	0	0	0
RABIES ANIMAL	0	2	0	13	1
RABIES HUMAN	0	0	0	0	0
REYE SYNDROME	0	0	0	0	0
ROCKY MNTN SPOTTED FVR	0	0	0	0	1
RUBELLA	0	0	0	0	0
SALMONELLOSIS	40	88	70	59	65
SHIGELLOSIS	6	15	18	9	18
STEC**	6	15	13	25	22
STREP DIS, INV, GRP A	55	64	67	63	30
STREP PNEUMO, INV + DR	35	72	61	56	61
SYPHILIS CONGENITAL	3	3	5	4	2
SYPHILIS	82	175	178	232	202
TETANUS	0	0	0	0	0
TOXIC SHOCK SYNDROME	0	0	0	0	1
TUBERCULOSIS	5	13	14	16	14
TULAREMIA	0	0	0	0	0
TYPHOID FEVER	1	3	0	2	1
VIBRIOSIS	1	2	1	2	0
VISA	1	0	0	0	0
VRSA	0	0	0	0	0
WEST NILE VIRUS	0	5	6	1	1
YELLOW FEVER	0	0	0	0	0
YERSINIA ENTERITIS	4	2	3	3	1
ZIKA	0	0	0	0	0

*Includes both Probable and Confirmed case reports.

**Shiga-toxin producing Escherichia coli per MDHHS; combo of E. coli & Shiga Toxin 1 or 2.

^ Previously reported as "AIDS".

[b] 2026 total is tentative at this time.

20-July-2026

MDHHS
Michigan Department of Health & Human Services

CYCLOSPORIASIS OUTBREAK IN SOUTHEAST MICHIGAN

Public Health Bulletin for Health Care Providers

The Michigan Department of Health and Human Services (MDHHS) continues to investigate an **outbreak of cyclosporiasis** with 9,253 cases reported as of July 27. While the investigation is ongoing, **current results point to lettuce or salad greens as a potential source for this outbreak**, although other food items cannot be completely ruled out. Previously outbreaks have been linked to fresh produce, such as: bagged salad mixes, cilantro, basil, raspberries, snow peas, and green onions (scallions). No specific type of produce, grower or supplier has been identified as the source.

Because this enteric illness can be protracted and relapse if untreated, provider awareness and timely clinical recognition are critical to managing the ongoing public health impacts.

MDHHS encourages health care providers to consider cyclosporiasis in patients with gastrointestinal symptoms:

- **Testing:** Standard microscopy methods such as modified acid-fast stain from concentrated specimen may have lower sensitivity due to low oocyst shedding. Molecular testing methods may be more sensitive. It is advised to contact the testing laboratory to ensure the stool order specifically targets Cyclospora. Do not rely on standard ova and parasite (O&P) test orders as Cyclospora may not be included.
- **Treatment:** Cyclosporiasis is self-limited in immunocompetent patients but can last weeks without treatment; treatment with Trimethoprim-sulfamethoxazole (TMPSMX) shortens illness duration substantially. Empiric treatment can be considered if testing is unavailable.
- **Reporting:** Confirmed cases should be reported to local health departments to assist in ongoing traceback investigations. If testing is not available, suspected cases should be reported.

MDHHS recommends the following safe practices for all individuals serving, preparing, or consuming lettuce and salad greens in **impacted counties**, including restaurants and commercial kitchens. Because this is an active and evolving situation, these recommendations may change as more information becomes available.

Focus on lettuce and salad greens

Given early information and the historical link between cyclospora and pre-packaged salad greens, MDHHS asks that you to provide your patients with the following lettuce-specific safety measures during this outbreak:

- Purchase whole heads: Buy whole heads of lettuce rather than pre-washed, bagged lettuce or pre-mixed salad kits.
- Discard outer layers: Before preparation, throw away the outer two to three layers of leaves.
- Wash inner leaves: Thoroughly wash the remaining inner leaves under clean running water.
- Prioritize cooking: For any greens that can be cooked, cooking to a temperature of at least 158 F (70 C) is the safest option, as the parasite is resistant to routine chemical disinfection and washing alone cannot guarantee its removal.

Epidemiology and Transmission

Cyclosporiasis is caused by the parasite Cyclospora cayetanensis. In the United States, infections are markedly seasonal with more than 90% of domestic cases occurring between May and August. Transmission occurs via the fecal-oral route through ingestion of contaminated food or water. Notably, direct person-to-person transmission is unlikely because the oocysts require days to weeks in the environment to become infectious.

Clinical Presentation

The incubation period averages approximately seven days with a range of two to 14+ days. Clinicians should maintain a high index of suspicion for patients presenting with:

- Watery diarrhea (median six stools/day).
- Anorexia, fatigue and significant weight loss (median ~3.6 kg).
- Abdominal cramping, bloating, nausea and low-grade fever.
- A "waxing and waning" course in which symptoms may appear to resolve before returning days later.

While generally not life-threatening, dehydration can cause severe illness, particularly in young children, the elderly and immunocompromised patients. In these populations, the illness can be protracted — lasting months if untreated — and may lead to rare extraintestinal complications like biliary disease (acalculous cholecystitis).

Diagnostic Considerations

Standard O&P examinations typically do not include testing for Cyclospora; **specific testing must be requested**.

- Molecular assays: PCR-based gastrointestinal multiplex panels, e.g., BioFire FilmArray, QIAstat-Dx, are preferred, offering ~95% sensitivity. Providers should verify that their laboratory's specific panel includes Cyclospora.
- Microscopy: If using microscopy, modified acid-fast staining is required. Because shedding can be intermittent and low-level, three stool specimens collected on subsequent days are recommended.

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Treatment Guidelines

Cyclosporiasis is highly treatable, with symptoms typically resolving within one to two days of starting the correct antibiotic. Empiric treatment can be considered if testing is unavailable.

- First-line treatment: Trimethoprim-sulfamethoxazole (TMP-SMX), such as one double-strength (DS) tablet twice daily for seven days.
- Immunocompromised patients: May require a more intensive regimen, e.g., TMPSMX DS four times daily for 10 days, and secondary prophylaxis to prevent frequent relapses.
- Sulfa-intolerant patients: Ciprofloxacin (500 mg twice daily for seven days) is an alternative, although it is less effective than TMP-SMX.

Additional Resources

- CDC: About Cyclosporiasis
- Cyclospora | FDA
- Preventing Foodborne Illness: Cyclospora cayetanensis
- Cyclospora Cayetanensis—Major Outbreaks from Ready to Eat Fresh Fruits and Vegetables - PMC
- Local Health Department Contact Information

MDHHS, GETSETUP CELEBRATE SIX-YEAR PARTNERSHIP

More than 2 Million Virtual Attendances for Older Michigan Residents

The Michigan Department of Health and Human Services (MDHHS) is celebrating its continued partnership with GetSetUp. Since 2020, the service has reached more than half a million older Michigan residents and surpassed 2 million virtual class attendances, spanning all 83 counties.

The collaboration continues to address some of the state's most pressing aging challenges – including digital literacy, social isolation, economic security and equitable access to health resources – through the power of peer-to-peer virtual learning.

The partnership reflects an enduring commitment to the goals of the Michigan State Plan on Aging, ensuring older adults have the tools, resources and community connections needed to age with dignity and independence. The strong attendance numbers reflect the depth of engagement across Michigan's urban centers, suburban communities and rural regions alike. From fitness and

mindfulness to fraud prevention and AI literacy, GetSetUp's curriculum has expanded each year to meet the evolving needs of older residents.

GetSetUp's sixth-year programming addresses the following topics:

- **Affordable housing and aging in place** – virtual classes on budgeting, mobility and home safety empower older adults to thrive independently.
- **Health and well-being** – mindfulness, fitness and chronic disease management classes support healthier, more active lifestyles.
- **Caregiver support** – sessions on dementia care, stress management and community resources provide meaningful guidance and relief.
- **Bridging the digital divide** – tech tutorials and state program resources ensure older adults know how and where to get help.
- **Social inclusion** – daily social sessions, from coffee chats to creative groups and interest circles, help learners build community and combat isolation.

This coming year, MDHHS and GetSetUp will offer new culturally inclusive programming, as well as expanded offerings in AI literacy, entrepreneurship and fraud prevention to address emerging needs.

GetSetUp partners with Area Agencies on Aging, Departments of Aging, MDHHS, Medicaid and Medicare Advantage plans to offer programming to millions of older adults. Classes are taught in English, Spanish, Hindi and Mandarin.

To learn more, visit GetSetUp and follow the program on LinkedIn. ✦

Macomb Medicus
Journal of the Macomb County Medical Society

SHARE YOUR NEWSWORTHY ITEMS!

Have you or a MCMS colleague been elected to a position *(specialty society, hospital, community based program, etc.)* or honored for your volunteer service within the community or abroad? Let us know. We would like to recognize MCMS members in the "Member News" section of the Medicus.

Contact Heidi Leach at HLeach@macombcms.org with newsworthy information.

Publication is subject to availability of space and the discretion of the Editor.

2026 Medical Records Access Act Fees

(In Accordance with the Consumer Price Index)

The Medical Records Access Act, Public Act 47 of 2004, MCL section 333.26269 (the Act) states that if a patient or a patient's authorized representative requests a copy of all or part of the patient's medical record, the health care provider, health facility, or medical records company to which the request is directed may charge the patient or the patient's authorized representative a fee. The Act requires the Department of Health and Human Services to adjust on an annual basis the fees prescribed by the Act by an amount determined by the state treasurer to reflect the cumulative annual percentage change in the Detroit consumer price index.

PLEASE NOTE: The Department's only involvement with the Act is to set the rate health care providers may charge for copies of records under the Act. The Department does not have the authority to make a health care provider give you copies of your health records. Additionally, the Department is not able to provide advice regarding the law.

In compliance with the Medical Records Access Act, I, Elizabeth Hertel, Director of the Michigan Department of Health and Human Services, recognize the State Treasurer's certification of the annual percentage increase in the Detroit Consumer Price Index for the 2026 calendar year. Accordingly, I have adjusted the fees by the cumulative annual percentage change as follows:

Year	Initial Fee	Per page for the first 20 pages	Per page from 21-50	Per page for pages 51+
CY 2026	$32.08	$1.60	$0.80	$0.32

NOTE: A 'patient', as defined by this rule, shall not be charged the initial fee for the patient's own medical record. However, a patient can be charged the other permitted fees (e.g., the per page fees).

Elizabeth Hertel, Director, MDHHS

Click here to see the complete Medical Records Access Act

Did you know:

- Physicians and health care providers cannot withhold requested records or portions of a record because a patient has an outstanding balance for services rendered.
- Upon sale, closure or retirement from practice you must inform the Michigan Department of Licensing and Regulatory Affairs – Bureau of Professional Licensing, in writing, of who will have custody of your medical records and how patients can request access to their records.

Additional Resources on Medical Records

- **AMA Code of Ethics, Opinion 3.3.1**
- **CMS Medical Record Maintenance & Access Requirements**
- **MSMS Medical Records Guide for Physicians**

Upcoming Changes to Your MCMS Membership

By: Heidi Leach
MCMS Executive Director

At the Michigan State Medical Society's April 18th House of Delegates, bylaws changes were passed allowing all members to join the Macomb County Medical Society or Michigan State Medical Society, without the mandate of dual membership in both organizations. Physicians can now choose which organization they would like to belong to: MCMS, MSMS, or both.

Previously all membership dues for both organizations were billed on a single invoice and paid to the Michigan State Medical Society. The state society would then distribute the county portion to the appropriate county society. To assist Macomb County while we transition away from the state society, MSMS will be collecting our dues for the 2027 billing year (which begins in August). **You will receive two separate invoices, one for Macomb County's dues and one for state society dues** (both will be paid to the Michigan State Medical Society) and you will have the option of paying one or both invoices.

For the 2027 transition year the Macomb County Medical Society has decided to significantly reduce our dues from $260 to $100 for Active and $20 for Residents making membership affordable for all physicians in Macomb County. Retired members and Students will remain dues exempt. We appreciate your membership and will continue to offer strong advocacy, educational and networking opportunities, and a local voice for physicians. ✦

The MCMS would like to wish the following members a very Happy Birthday!

JULY

Richard Arden, MD
Basivi Baddigam, MD
Mark Bergin, MD
William Carion, MD
Mariann Channell, MD
Michael Di Loreto, MD
James Dietz, MD
Lillman Dwarka, MD
Vasilios Gikas, DO
Thomas Graves, MD
John Guest, MD
Jareer Hmoud, MD
Mitchell Hollander, MD
Noori Ibrahim, MD
Carolann Kinner, DO
Linda Lu Kosal, DO
Vijaya Kotha, MD
George Kypros, MD
Rakesh Lattupalli, MD
Cheryl Lerchin, MD
Ronald Levin, MD
Richard Lubera, MD
Shyam Moudgil, MD
Anne Nachazel, MD
Parag Patel, MD
Swarn Rajpal, MD
Naveed Siddique, MD
Naysha Varghese, MD
Mary Veremis-Ley, DO

AUGUST

Fadi Al-Qas Hanna, MD
Jagatbhai Amin, MD
Ramon Aparece, MD
Allen Babcock, MD
Gerald Brueckner, MD
Ricardo Chalela, MD
Amnat Chandra, MD
Genevieve Crandall, MD
Stuart Gildenberg, MD
Tristan Guevara, DO
Dorothy Halperin, MD
Theresa Hsu, MD
Kenneth Ierardi, DO
Danilo Iglesias, MD
Joseph Kinzie, MD
Robert Lechy, MD
Vera Maranci, MD
Donald Muenk, MD
Ganga Nadarajah, MD
Pradeep Nagaraju, MD
Abimbola Osobamiro, MD
Chakradhar Reddy, MD
Renato Reyes, MD
Katie Rosen, DO
Andres Santiviago, MD
Gary Stencel, MD
Philip Tangalos, DO
Salvatore Ventimiglia, MD
Bhavana Vyas, MD
Jenny Yang, DO
Abdallah Zamaria, MD

SEPTEMBER

Paul Chuba, MD
Mark Decco, MD
Anu Duvoor, MD
Stephen Field, MD
Juan Frontera, MD
Narendra Gohel, MD
Brian Guz, MD
Derek Hill, DO
Jane Krasnick, MD
David Law, DO
Amar Majjhoo, MD
Gregory McIntosh, DO
Somsak Metriyakool, MD
Robert Mobley, MD
Eric Neisch, MD
Nwanneka Odumodu, MD
Ashok Reddy, MD
Akash Sheth, MD
Brian Stewart, DO
Alexander Tapper, MD
Steven Thibault, MD
Douglas Verrill, MD
John Vollmer, MD
Sanjay Vora, DO
Chad White, MD
Adli Yakan, MD

Michigan Awards Medicaid RAC Contract

The Michigan Department of Health and Human Services (MDHHS) posted a Medicaid Provider Letter on June 25, 2026, announcing that the Medicaid Recovery Audit Contractor (RAC) contract was awarded to Health Management Systems, Inc. (HMS). The contract runs through August 31, 2028, and will be overseen by the MDHHS Office of Inspector General.

The federal government requires states to have Medicaid RAC programs through which the contractors will audit claims. According to the 2026 Medicaid Provider **L 26-36 letter,** "HMS will approach the auditing of state provider services in two ways: automated and complex medical record reviews. Automated Reviews are audit algorithms that have gone through state specific billing and reimbursement analysis in which improper payments can be determined from claim data elements and well-established policy and rules. Complex Reviews are audit algorithms that have gone through state-specific billing and reimbursement analysis that cannot be automatically validated and require a medical record review conducted by qualified registered nurse reviewers, certified coding specialists, and physician peer review, as required."

Providers selected for an audit will receive a letter from HMS with detailed instructions and contact information. Once the review is completed, providers will be notified of the findings of these audits and will have an opportunity to provide documentation for reconsideration and/or appeal if they disagree with HMS' findings.

Any questions regarding this Medicaid Provider L letter should be directed to HMS Provider Services at (844) 364-6108. ✦

HENRY FORD HEALTH

Henry Ford Macomb Hospital

Free Opioid Overdose Reversing Kits Now Available Through Vending Machine at Henry Ford Macomb Hospital

Naloxone, a fast-acting medication used to reverse an opioid overdose, is now available for free to the public through a new vending machine in Henry Ford Macomb Hospital's Emergency Department.

The vending machine is in the front entrance of the Emergency Department for 24/7 access. Naloxone nasal spray kits can be retrieved by entering a two-digit number that corresponds to the selected item. The nasal spray can be easily administered by friends, family members or caregivers.

"Installing a Narcan dispensing device on campus is a meaningful investment in the health and safety of the community we are called to serve," said Emily Moorhead, president of Henry Ford Macomb Hospital. "Expanding immediate, stigma-free access to naloxone directly supports overdose prevention efforts and demonstrates Henry Ford Macomb's commitment to proactive, life-saving intervention."

The hospital obtained the vending machine through a grant from the Michigan Emergency Department Improvement Collaborative (MEDIC) and the Overdose Prevention Engagement Network (OPEN). To date, OPEN has implemented 63 naloxone vending machines and distribution boxes throughout Michigan.

$12 Million Grant will Advance Henry Ford Health's Suicide Prevention Model Across the U.S.

A $12 million philanthropic grant from Four Pines Fund will help expand Henry Ford Health's proven framework for reducing patient suicide attempts within health systems.

Suicide prevention experts will use the grant to expand and enhance access to effective suicide care across Henry Ford Health, Kaiser Permanente Colorado and HealthPartners in Minnesota, as well as establish a new suicide prevention center at Henry Ford Health.

Suicide remains a persistent public health challenge in the United States. According to the latest statistics from the Centers for Disease Control and Prevention, more than 49,000 people died by suicide in the U.S. in 2023 and 12.8 million seriously considered suicide.

Henry Ford Health pioneered a suicide prevention program known as the **Zero Suicide Model** more than 25 years ago and has since used it to identify patients in crisis and intervene early, leading to a dramatic reduction in suicides across its patient population. A **2025 study published in JAMA Network Open** showed that by adopting the ZS Model, health systems can reduce suicide rates among patients by 25% or more. Data shows more than 80% of people who die by suicide and more than 90% of people who attempt suicide visit a doctor's office in the months and weeks leading up to their death.

The Henry Ford Health approach starts with a suicide risk screening that patients fill out before they see their regular doctor. Providers immediately evaluate the survey; if a patient screens positive, they are further assessed for suicide risk. Those at elevated risk work with a specialized member of the care team to create a safety plan that covers who they can call if they're in distress, cognitive tools for reducing suicidal thoughts and what they can do to make their home environment safe. The patient is also referred to an outpatient behavioral health provider for psychotherapy focused on suicide prevention.

The $12 million gift from Four Pines Fund will support efforts to substantially expand services for patients at risk, including introducing more advanced and accessible safety planning support and virtual therapy for patients at mild-to-moderate suicide risk.

The gift will also help fund the establishment of an integrated suicide prevention center within Henry Ford Health that is designed for comprehensive suicide care, clinical innovation and provider training.

"This integrated center will be a place where our priorities for suicide prevention and care will sit front and center," said Dr. Deepak Prabhakar, chair of Psychiatry and Behavioral Medicine at Henry Ford Health. "As pioneers in suicide prevention, it's our responsibility to continue piloting novel solutions and developing education and training materials that help save the lives of people in our community and can be replicated across the country and around the globe."

Nearly Half of Henry Ford Health Hospitals Receive 'A' in Hospital Safety Grades

The Leapfrog Group's Spring 2026 Safety Grades have been released, and five Henry Ford Health hospitals were awarded 'A' grades in overall patient safety performance.

Three of the hospitals honored — Henry Ford Jackson Hospital, Henry Ford Providence Novi Hospital, and Henry Ford West Bloomfield Hospital — continued a streak of excellence for safe patient care. Henry Ford West Bloomfield earned an 'A' for the 10th straight period, Henry Ford Jackson for the fourth straight, and Henry Ford Providence Novi for the third straight period.

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Henry Ford Macomb Hospital and Henry Ford Providence Southfield Hospital were also cited by The Leapfrog Group for the highest honors in their Spring 2026 Safety Grades.

The three Oakland County 'A's for Henry Ford Health were the only ones in Michigan's second most-populated county. **Henry Ford Macomb was the only 'A' rating in Macomb County, the state's third most-populated county**.

Five Henry Ford Health hospitals receiving an 'A' grade represents a 25% improvement for the system since the previous cycle, when the system led the state with four 'A's.

"These safety grades reflect the unwavering commitment of our 50,000+ Henry Ford Health team members to do the right thing for every patient, every time," said Dr. Edward Pollak, Henry Ford Health's Chief Quality Officer. "Everyone can take pride in being part of such an incredible organization."

Grades are awarded each spring and fall to nearly 3,000 hospitals nationwide, based on evaluations by a national panel of patient safety experts. The panel uses up to 30 national performance measures from the Centers for Medicare & Medicaid Services (CMS), the Leapfrog Hospital Survey, and other supplemental data sources to determine each grade. ✦

McLaren

McLaren Macomb Hospital

McLaren Macomb Among First to Perform Complex Procedure to Treat Recurring Heart Disease

McLaren Macomb, part of statewide McLaren Health Care and the leading provider of cardiovascular care to its community, is among the first to perform a newly FDA-approved critical heart procedure using minimally invasive techniques to treat heart artery restenosis.

Stenosis is a narrowing of a coronary artery bringing blood to the heart resulting from a buildup of plaque. Restenosis occurs in patients who previously had an angioplasty or stent inserted to restore or enhance blood flow, though the artery has again narrowed and symptoms have returned.

Interventional cardiologist Dr. Blair DeYoung is among the first in the area to use a specialized high-pressure balloon catheter in coordination with the first FDA-approved drug-coated balloon designed to treat patients' in-stent restenosis.

Traditionally, restenosis requires additional stenting or open-heart surgery to restore blood flow, though this updated approach has demonstrated improvements to patients' outcomes.

"This approach of restoring patients' blood flow represents a meaningful advancement in the overall treatment of restenosis," Dr. DeYoung said. "Once the restenosis is confirmed, we are now able to improve patients' long-term outcomes while lessening their recovery time and getting back to their daily lives."

During the procedure, a catheter is inserted into the collapsed stent, and using the specialized, high-pressure balloon catheter, the artery is again opened and treated with a drug-coated balloon to reduce the chances of recurrent restenosis.

Caused by the buildup of scar tissue or plaque inside the stent, restenosis occurs in less than half of patients after being treated for their initial stenosis. Diabetes, high cholesterol, smoking, high blood pressure, and chronic kidney disease can all increase the risk of restenosis.

Symptoms of restenosis typically appear within three to six months following the stenosis treatment and mirror those of the initial symptoms, which include chest pain, fatigue, shortness of breath, and, in severe cases, heart attack.

McLaren Macomb Earns Successful Reverification, Maintains Level II Trauma Center Status

McLaren Macomb, part of statewide McLaren Health Care and operator of one of the county's busiest emergency departments, has maintained its Level II Trauma Center designation following a successful reverification survey from the American College of Surgeons.

Reverification recognizes the hospital's ability to continuously maintain the rigorous — through essential — standard of care required for timely trauma care. The designation was earned following a thorough onsite review of the hospital's clinical capabilities and processes by the ACS's Verification Committee.

Valid through April 2029, McLaren Macomb has maintained its designation as a Level II Trauma Center uninterrupted since 2014, when the hospital became the first in Macomb County to earn the advanced status.

"The requirements that must be fulfilled to remain a Level II Trauma Center are no small feat," said Tracey Franovich, McLaren Macomb President and CEO. "The reverification process is a testament to the extraordinary trauma team we are fortunate to have, who approach their incredible responsibility with

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commitment and compassion. With every reverification, our promise is renewed to be ever ready to provide the community with the potential lifesaving care they may need."

McLaren Macomb's commitment includes having trauma surgeons in-house 24 hours a day, seven days a week, allowing for patients to be examined immediately upon arrival, besting the national standard of being evaluated within 15 minutes.

Pink Out the Park Unites Thousands in Celebration of Strength and Survivorship

A spirit of courage and community filled the stands of Comerica Park during the 14th Annual Pink Out the Park. The Barbara Ann Karmanos Cancer Institute, McLaren Health Care and the Detroit Tigers welcomed thousands of fans as part of Strike Out Cancer Weekend. People gathered to honor the hundreds of individuals and families whose lives have been impacted by breast cancer.

The momentous evening started with the annual pre-game survivor parade. Hundreds of breast cancer survivors joined together on the baseball field as a powerful expression of unity and hope. This was a visual display of encouragement for the thousands of individuals diagnosed with breast cancer every year.

The evening's inspiration continued as Ralph Shaheen, a 1-and-a-half-year breast cancer survivor, stepped up to throw the ceremonial first pitch to Boris Pasche, M.D., Ph.D., FACP, president and CEO of the Barbara Ann Karmanos Cancer Institute. ✦

MSMS
MICHIGAN STATE MEDICAL SOCIETY

By: Daniel M. Ryan, MD, *MSMS Board Member*

REORGANIZATION UPDATE – ELIMINATION OF MANDATORY DUAL MEMBERSHIP BETWEEN MSMS AND COUNTY MEDICAL SOCIETIES

As a part of the Reorganization plan recently approved by the House of Delegates, mandatory membership in the Michigan State Medical Society (MSMS) and the county medical society has been eliminated. Physicians can choose to join MSMS, their county medical society or both.

MSMS has committed to billing for the counties through the 2027 dues cycle. The official turnover will take place on March 31, 2027, for 2028 dues. However, some counties are in the process of deciding whether to bill for themselves for 2027. That information will be shared with members prior to the August billing.

MSMS met with the County Presidents and staff on June 10, 2026, to review the transition plan. MSMS will meet with counties again on September 24, 2026, to provide a fall update on advocacy issues and upcoming activities. Additionally, the MSMS Foundation will be ready to accept grant applications to help assist counties with transition costs later this year.

MULTIPLAN LITIGATION UPDATE

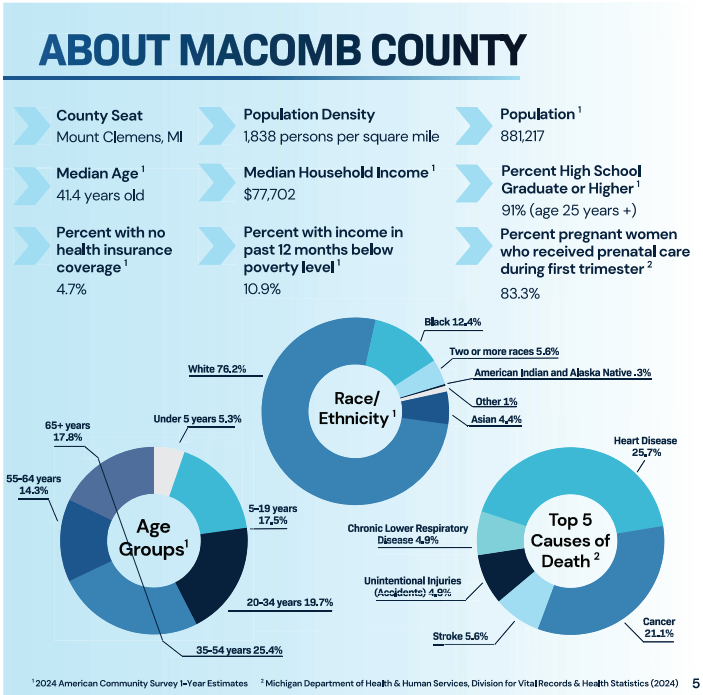
As has been reported, the Michigan State Medical Society (MSMS) is a plaintiff in the In re MultiPlan Health Insurance Provider Litigation, a federal antitrust case alleging that MultiPlan and major health insurers colluded to suppress out-of-network reimbursement rates paid to physicians and other providers. MSMS with other medical associations are seeking an immediate end to this anti-competitive conduct.

On June 24, 2026, Judge Matthew F. Kennelly of the U.S. District Court for the Northern District of Illinois denied the defendants' motion to amend their pleadings to assert an "unclean hands" defense. The defendants sought to allege that improper billing practices by the plaintiffs inflated the reimbursement amounts they bill to the payers and that the plaintiffs are barred from bringing antitrust claims as a result. The judge rejected the defendants' request, ruling that defenses like "unclean hands" cannot be used to hinder enforcement of federal antitrust law.

At the June 26, 2026, case management conference, Judge Kennelly granted a motion by several bellwether plaintiffs to name additional alleged co-conspirators as defendants. The parties and judge also discussed the ongoing exchange of evidence from the defendants and scheduling orders for upcoming deadlines, source code production, and trial dates.

The case remains in active discovery, with the 36 bellwether plaintiffs continuing to have their cases worked up for trial. However, any member who wants to file a case still can do so. Members who believe they've been impacted by MultiPlan's practices are encouraged to **contact an attorney at Napoli Law.**

For more information, contact Rebecca Blake at 517-336-5729 or **rblake@msms.org**. ✦



Upcoming Changes to BCBSM Incident-to Billing: What Every Practice Needs to Know

By: Etta Grandberry, MBA, MSA, CPC, CPB *Owner, Automated Medical Claims, Inc.*
www.automatedmedicalclaims.com

Over the past several weeks, I have spoken with several independent physician practices throughout Southeast Michigan. While practices appreciate receiving advance notice of these changes, many have expressed uncertainty regarding implementation timelines, enrollment requirements, staffing implications, and the potential financial impact of transitioning practitioners to direct billing.

The questions physicians are asking deserve thoughtful discussion and practical guidance.

WHY THIS MATTERS

For decades, the "incident-to" billing model has been a cornerstone of the independent practice workflow. It allowed physicians to extend their reach through mid-level providers: Physician Assistants (PAs) and Nurse Practitioners (NPs): while maintaining a unified billing structure under the physician's National Provider Identifier (NPI). However, Blue Cross Blue Shield of Michigan (BCBSM) is fundamentally restructuring this landscape.

Revenue loss often happens quietly. When policy shifts occur, they rarely announce themselves with a single catastrophic event. Instead, they manifest as incremental decreases in reimbursement, lost incentive payments, and administrative friction that slows the **revenue cycle**. For many independent practices, the shift away from incident-to billing may have meaningful financial and operational implications if not carefully planned. This is more than a coding change— it represents a shift in how services performed by advanced practice providers are reported, reimbursed, and incorporated into the overall revenue cycle.

WHAT IS CHANGING: PHASE 1

September 1, 2026 – February 28, 2027

The transition begins with a shift in reporting requirements and the immediate removal of financial incentives for specific claim types. During Phase 1, the primary focus is on identification and transparency.

- **Mandatory SA Modifier**: All claims for services delivered by a supervised clinician (PAs, NPs, or limited license clinicians) and billed incident-to a supervising physician must include the **SA modifier**. This modifier signals to the payer that while the physician is the billing entity, the service was physically performed by a mid-level provider.
- **Removal of Value-Based Reimbursement (VBR):** This is perhaps the most immediate financial impact for many high-performing practices. Claims submitted with the SA modifier will no longer qualify for **Value-Based Reimbursement (VBR)** or **Physician Group Incentive Program (PGIP)** incentives.

Practices that rely on these incentives to offset rising overhead costs will see a direct reduction in the net revenue for those specific services. During this six-month window, the base reimbursement remains at the physician's fee schedule, but the loss of the VBR "bump" starts the clock on the financial transition.

WHAT IS CHANGING: PHASE 2

March 1, 2027 – Onward

Phase 2 introduces the "hard" transition. At this stage, the administrative burden and the financial penalties for continuing the traditional incident-to model become more severe.

- **Direct NPI Billing Requirement:** BCBSM will require all clinicians who are eligible for direct participation: including NPs, PAs, and fully licensed mental health clinicians: to bill under their own individual NPI. This ends the practice of bundling these services under the physician's identifier for commercial plans.
- **The 80% Reimbursement Ceiling:** If an eligible provider continues to bill incident-to using the SA modifier instead of their own NPI after March 1, 2027, the reimbursement will be capped at **80% of the professional fee schedule allowed amount**.
- **Permanent Loss of VBR:** These incident-to claims will remain ineligible for any value-based incentives, creating a "double-hit" to the practice's bottom line: a 20% reduction in base pay and a 100% loss of incentive potential.

WHICH PRACTITIONERS ARE AFFECTED

The scope of this policy update is broad, affecting both advanced practice providers and those currently in the training pipeline.

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Understanding who falls into which category is essential for your **credentialing strategy**.

Eligible for Direct Enrollment:

- Nurse Practitioners (NPs)
- Physician Assistants (PAs)
- Fully licensed Mental Health Clinicians

These providers can and should: enroll directly with BCBSM. By joining the PGIP program under their own NPI, they can begin to earn their own VBR, which helps mitigate the financial shift from the physician's aggregate revenue.

Loss of Incident-to Eligibility in Office Settings: A critical and often overlooked aspect of Phase 2 is the status of trainees. After March 1, 2027, office-based incident-to billing will no longer be reimbursed for:

- Students and trainees
- Physicians in graduate medical education programs
- Limited Licensed Social Workers (LLMSW)
- Limited Licensed Professional Counselors (LLPC)
- Limited Licensed Marriage and Family Therapists (LLMFT)
- Provisional-license providers

These individuals may only continue incident-to billing in facility-based settings, such as psychiatric hospitals or FQHCs. For the independent private practice, this necessitates a significant reevaluation of how residents and trainees are integrated into the **patient care workflow**.

WHAT PHYSICIANS SHOULD BEGIN DOING NOW

Waiting until the end of 2026 to react is a high-risk strategy. Preparation should begin immediately to ensure a seamless transition and protect your **aging A/R** from preventable disruptions.

1. **Audit Your Provider Roster:** Identify every provider currently billing incident-to. Determine their licensure status and their current enrollment standing with BCBSM.
2. **Initiate Credentialing Immediately**: The credentialing process is notoriously slow. Ensure all eligible NPs and PAs begin their enrollment and CAQH attestation now to be ready for the February 28, 2027, deadline.
3. **Update EMR and Billing Systems:** Your systems must be capable of appending the SA modifier by September 1, 2026. Furthermore, you must prepare to map claims to the individual provider NPIs by the following March.
4. **Financial Impact Modeling:** Review your current volume of incident-to claims. Calculate the 20% reduction and the loss of VBR to understand the potential revenue gap. This data is vital for making informed staffing and operational decisions.
5. **Monitor Recoupments and Denials:** As these phases roll out, watch for retroactive disenrollments or unexpected denials. A proactive **denials and appeals management** process will be your best defense against system-wide errors.

QUESTIONS PRACTICES SHOULD BE ASKING

As we move toward these implementation dates, I encourage you to sit down with your leadership team and ask the following:

- "How much of our current revenue is derived from VBR on incident-to claims?"
- "Are our mid-level providers aware of their role in the PGIP program moving forward?"
- "Do we have a 90-day contingency plan for new hires moving from out-of-state or other practices?" (Note: BCBSM allows a 90-day transition window for these specific cases, though the 80% reimbursement rule still applies after March 1, 2027).
- "Is our front-office team trained to capture the correct provider information at the point of service?"

CLOSING THOUGHTS

The landscape of independent practice is shifting, and the "incident-to" model as we know it is evolving into a system that demands higher transparency and individual accountability. While change of this magnitude is understandably disturbing to the financial health of a practice, early education and strategic preparation are the tools that allow a physician to remain focused on clinical excellence.

Independent physician practices continue to face increasing administrative and reimbursement challenges. As these changes continue to evolve, ongoing communication among payers, medical societies, and physician practices will be essential to ensure providers have the information needed to prepare successfully. ✦

CMS Releases Proposed 2027 Medicare Physician Fee Schedule

The Centers for Medicare and Medicaid Services (CMS) released the proposed Physician Fee Schedule (PFS) Rule for 2027 on July 14, 2026. This announcement starts the clock for the submission of public comments on programmatic and reimbursement policies that affect physicians providing services to Medicare beneficiaries. The proposed Rule also includes proposed changes to the Merit-based Incentive Payment System (MIPS) and alternative payment model (APM) participation options and requirements for 2027.

A few notable proposals of concern include:

- Medicare payment updates that do not reflect the growth in physician practice costs.

Medicare Conversion Factor		Medicare Anesthesia Conversion Factor	
For APM* QPs**	For non-APM QPs	For APM QPs	For non-APM QPs
$33.1693 (-1.19%)	$32.8409 (-1.68%)	$20.4165 (-0.89%)	$20.2143 (-1.38%)

*Advanced Alternative Payment Models
**Qualified Participants

- Plan to sunset traditional MIPS reporting in 2029 and transition MIPS Value Pathways (MVPs), despite repeated concerns raised by physician organizations that MIPS is unduly burdensome; disproportionately harmful to small, rural, and independent practices; exacerbates health inequities; and is not aligned with meaningful clinical outcomes.
- Reducing payment when a separately identifiable E/M visit is furnished by the same physician (or a physician in the same practice) on the same day as a 0-, 10-, or 90-day global procedure.

Physicians are encouraged to share your comments with CMS. It is important to remember that CMS reviews all comments as they work to finalize the CY2027 PFS. Therefore, comments from physicians, state societies, the American Medical Association, and others can influence the outcome of the final Rule, which is typically released in November of each year. **Comments are due by September 14, 2026**, and can be submitted online at: https://www.regulations.gov/ (in commenting, please refer to file code CMS-1848-P).

Detailed information, links to resources, including an initial overview of the 1,600-page rule prepared by the AMA, are provided below. ✦

Resources:
AMA Alert: 07/14/2026
CMS Press Release
Physician Payment Schedule Fact Sheet
Medicare Shared Savings Program Fact Sheet
Quality Payment Program (QPP) Fact Sheet
Proposed Rule

Change of Address? Let Us Know!

Please contact Heidi Leach at HLeach@macombcms.org

CME Requirements for Licensure

Every three years physicians are required to complete the following continuing education for license renewal.

150 hr. Continuing Medical Education
75 hr. of which must be Category 1 CME credits for MDs
60 hr. of which must be Category 1 CME credits for DOs

3 hr. Pain & Symptom Management
with 1 hr. Controlled Substance Prescribing

1 hr. Medical Ethics

3 hr. Implicit Bias

Additional Requirements
One time – training for Identifying Human Trafficking Victims
One time – training for Opioids & Controlled Substances Awareness for Prescribers
One time – the Medication Access and Training Expansion (MATE) Act, requires DEA registered prescribers to have 8 hrs. training in opioid use disorders

CMS Releases 2024 Merit-Based Incentive Payment System Public use Data, Discontinues Publishing Quality Payment Program Experience Report

CMS recently published the 2024 Quality Payment Program (QPP) Public Use File (PUF). However, to the dismay of the AMA, CMS indicated it had discontinued publication of the QPP Experience Report, which is the companion report to the PUF and the main source of information released to the public regarding Merit-based Incentive Payment System (MIPS) and Alternative Payment System (APM) performance. The QPP Experience Report is also frequently utilized by the AMA and physician specialty societies to educate their members and inform policy discussion, as well as being the sole source of information measure stewards and developers receive from CMS regarding measure adoption and performance. Therefore, the AMA recently sent a letter to CMS urging them to release the report and prioritize the publication of more meaningful and accessible annual QPP reports.

Based on the AMA's analysis of the 2024 QPP PUF, 87% of the clinicians received a score higher than 75 in MIPS, which qualified them for a payment increase, while 7.6% received a score below 75 and qualified for a penalty, with the remaining 5.1% receiving a neutral score which will result in no adjustment in payment. 1.4% received the maximum penalty of -9%, while 6.4% received the maximum bonus of 1.05%. Once again, smaller practices were more likely to receive penalties, particularly the maximum penalty, than larger practices-typically due to non-reporting/submitting MIPS data to CMS.

This further highlights the need for Congress to support **HR 8622, Medicare Physician Data-Driven Performance Payment System (DPPS) Act of 2026**, which mandates that CMS fulfills its statutory obligations under MACRA to share more frequent data so physicians can leverage this data to implement changes that would improve patient care and use resources more efficiently. Failure by CMS to provide MIPS physicians with three quarters worth of data during the performance year results in physicians receiving the highest possible payment update.

OIG Reports Probe Medicare Advantage Prior Authorization Denials for Post-Acute Care

The U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) recently released two reports detailing serious issues with Medicare Advantage (MA) plans' prior authorization (PA) denials for post-acute care. These investigations reinforce longstanding AMA concerns about inappropriate MA PA denials for post-acute care admissions and the need for greater oversight of plans' utilization management practices. PA-related treatment barriers are particularly devastating for vulnerable patients seeking post-acute care, as delaying services such as rehabilitation and physical therapy can negatively impact long-term clinical and functional status.

The **first report** studied PAs for admissions to long-term care hospitals (LTCH) and inpatient rehabilitation facilities (IRF) in June 2024 and found that:

- The three largest MA organizations by enrollment (CVS Health, Humana, and UnitedHealthcare) denied care at higher rates than most other MA plans.
- These three plans denied over 70% and 50% of PAs for LTCH and IRF admissions, respectively.
- MA plans overturned 36% and 43% of LTCH and IRF PA denials on appeal, respectively.
- Overturn rates varied considerably, with some plans, such as CVS Health, overturning over 80% of IRF PA denials.

In a **companion report**, the OIG evaluated MA plans' PA decisions for skilled nursing facility (SNF) admissions in June 2024 and found that:

- The collective denial rate across plans was 12%.
- While only 18% of denials were appealed, MA plans overturned 95% of these denials—suggesting that MA plans regularly withhold medically necessary post-acute care.

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Both reports note the outsized role that naviHealth, a utilization management vendor, played in MA plans' denials of LTCH, IRF, and SNF care.

In both reports, the OIG recommended that the Centers for Medicare & Medicaid Services (CMS) evaluate the reasons for variation in denial and overturn rates between MA plans and take appropriate action. Importantly, the OIG also recommended that CMS collect service-level data regarding MA plans' PA programs, which reflects ongoing AMA advocacy calling for increased granularity in plans' publicly reported PA metrics. To learn more about the AMA's PA reform efforts, visit **FixPriorAuth.org**.

New AMA Patient Guide: New Medicaid Work and Community Engagement Rules Coming in 2027


AMA

New Medicaid Work & Community Engagement Rules Coming in 2027

Get Ready: If you or someone you know is covered by Medicaid, it is important to know about some program changes coming soon.

What is changing?

Starting January 1, 2027, people who are on Medicaid may have to prove they are working or doing other "community engagement" activities in order to keep their Medicaid coverage. This is a new reporting requirement, and it is sometimes called a "work requirement" even though not everyone will have to prove they are working.

If the new rules apply to you, you may notice changes to Medicaid applications and renewal forms, including new questions about work, income, caregiving responsibilities, or health conditions. You may receive more letters, texts, or online notices from Medicaid, and you may have short deadlines to respond. **Keeping your contact information up to date and responding on time is very important to keeping your coverage.**

Who is impacted by the new rules?

Certain people between the ages of 19 and 65 applying for or covered by Medicaid may be asked to **report on their work or community engagement activities to get or keep their Medicaid coverage.** However, several groups of people in this age group are exempt from the requirements (see below for more information about exemptions).

What information will I have to report?

If these new requirements apply to you, you may need to show that you are participating in at least 80 hours per month of certain activities. Working is one way to satisfy the new requirements, but it is not the only way.

Approved activities include:
- Working (full-time or part-time)
- Volunteering or doing community service
- Enrolled in school (full-time or part-time)
- Job training
- Earning at least $580 in income each month

Will I need to report my work & community engagement activities?

Many people will not have to meet these new work and community engagement requirements. These individuals are considered "exempt," which means they do not have to report work or community activities because they have a serious health condition, care for others, or face special life situations.

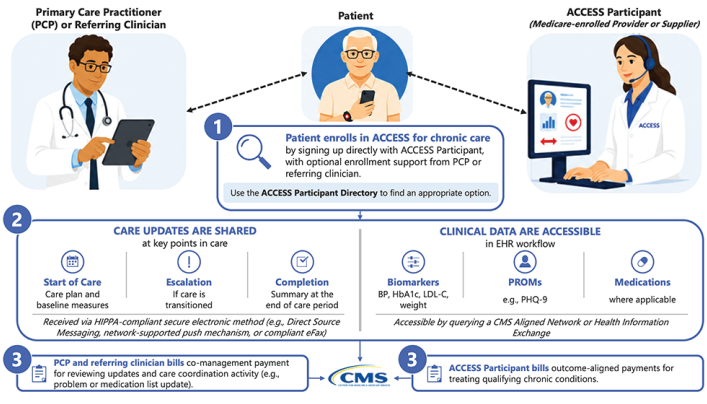
You might not have to report work or community engagement activity if you:

- Are under the age of 19 or over the age of 65
- Are blind or have a disability
- Are pregnant or were recently pregnant
- Are a parent, guardian, or caregiver of a child age 13 or younger
- Care for someone with a disability
- Are participating in a drug or alcohol treatment program
- Were in jail or prison within the past three months
- Have certain medical conditions (see more on the next page)

This is not an exhaustive list. Ask your doctor, clinic, or community provider for additional reasons you could be exempt.

To help patients understand the new Medicaid community engagement requirements, the AMA has developed a concise **patient guide (PDF)**. This resource explains exemptions, compliance requirements, and important steps patients should take to maintain coverage. Physicians and care teams are encouraged to share this guide widely with Medicaid patients to help ensure they are informed and prepared for upcoming changes. The **patient guide** is available on the **AMA website** alongside additional resources related to One Big Beautiful Bill Act implementation.

CMS Offers Dedicated Physician Resources on the ACCESS Model



Starting in July, the CMS Innovation Center's Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) model will test expanded provision of digital health tools to help manage prevalent chronic conditions for patients with traditional Medicare coverage. Organizations participating in ACCESS will provide technology-based services to Medicare patients with hypertension, prediabetes, chronic kidney disease, musculoskeletal pain, depression and other chronic conditions.

ACCESS organizations will receive modest monthly payments linked to improvements in specific patient health outcomes for these chronic conditions. Although each organization must have a physician clinical director, the only Medicare payments they can submit claims for are the ACCESS-specific monthly payments—they cannot submit claims for any individual services like visits, tests, or procedures to Medicare.

The AMA has heard from physicians with questions about the ACCESS model such as how to help their patients choose an ACCESS organization to help with their care, and what data and information they will receive from ACCESS participants about the services their patients are receiving. They also want to know what is expected of physicians who want to bill Medicare for "co-management" payments for physicians whose patients are receiving services from an ACCESS organization.

In response, **CMS has developed a dedicated webpage** specifically for physicians who have questions about ACCESS and whose patients may enroll with an ACCESS participating organization. According to CMS officials, this new resource is intended to answer many of the questions from physicians that the AMA has shared with the agency. It includes a link to a list of all the organizations accepted to participate in ACCESS and which chronic condition tracks they will offer, as well as how patients will enroll, samples of the information their physicians will receive and how to bill the co-management service.

Administration Releases Long-Awaited No Surprises Act Final Rule

On May 28, the Departments of Health and Humans Services, Labor and the Treasury ("the Departments") issued the Independent Dispute Resolution (IDR) Operations final rule. The corresponding proposed rule was published in November of 2023 and the AMA, like many other physician groups, submitted detailed comments in early 2024.

Broadly, the final rule can be considered positive for physicians and looks to streamline the dispute process and require more information to be provided to physicians. It increases the formality of the open negotiations process and reduces the costs of disputing a claim.

Specifically, and in line with many of the AMA's previous recommendations, the rule:

- Requires plans to use claim adjustment reason codes (CARC) and remittance advice remark codes (RARC), in both paper and electronic remittance advice to assist in clarifying eligibility
- Requires more information to be disclosed with the initial payment or notice of denial of payment

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- Streamlines the efficiency and increases the formality of the Open Negotiation process by requiring that the initiation and response take place via the federal IDR portal
- Requires plans and issuers to register in the federal IDR portal so that their information is available to physicians and other parties
- Allows for more flexibility in batching items or services into a single dispute, including extending the number of allowed line items from 25 to 50
- Reduces the administrative fee from $115 to $15
- Shortens the "cooling off period" from 90 to 30 days for batched claims

Unfortunately, the Departments did not fully address the range of concerns identified by many commentors with the 90-day cooling off period. Additionally, the Departments finalized a provision limiting batching to only those claims from the same self-funded payer rather than to all employers using the same third-party administrator. Unfortunately, they also did not extend batching allowances for different levels of evaluation and management services for emergency care.

Many of these new provisions will require further guidance from the Departments, potentially extending their implementation dates for months or even years. For example, guidance on the use of CARCs and RARCs is not expected for six months and with compliance requirements four months after that.

Fortunately, the reduced administrative fee took effect on June 11, and new requirements on information to be shared along with the QPA are effective 60 days after publication (Aug. 3).

Medicare Trustees Warn of Unsustainability of Medicare Physician Payment System

The Medicare Trustees released their **2026 report** and highlighted concerns about the future of Medicare physician payment updates, as they will be significantly below inflation as measured by the Medicare Economic Index (MEI). With no annual payment update to account for inflation in the costs of medical practice, physicians have seen their payments (when adjusted for inflation in practice costs) decline 33% from 2001 to 2026.

As they have in the past, the Trustees noted that, "absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term." They also pointed out that Medicare physician payment levels dropped from 82% of private rates in 2011 to 68% in 2024, and if current trends continue, will fall to only 23% of private rates by the end of the Trustees' 75-year projection period.

This report builds on similar repeated warnings from policymakers and the AMA that long-term access to care for seniors is threatened by Medicare's failure to keep up with the cost of practicing medicine. ✦

Macomb County Assistance Programs for Your Patients

In this tough economy many of your patients may be struggling to meet their basic needs as well as those of their families.

There are programs available to help. Below are some resources you can direct your patients to for assistance.

MACOMB COMMUNITY FOOD BANK
Provides immediate relief to those in need of food through a network of more than 55 pantry sites, hunger relief organizations, and the Fresh To You Mobile Pantry. The program supplies food at no cost to income eligible seniors and families with children throughout Macomb County. For more information visit the **Macomb Community Food Bank website** or call (586) 469-6004.

RENT AND MORTGAGE ASSISTANCE
Income-eligible Macomb County residents facing eviction, foreclosure, or homelessness may be assisted in resolving their emergency. Eligibility and guidelines will vary based on available programs. For more information contact your local **Community Action Center** at (586) 469-6964. For residents of Warren, Roseville, Eastpointe or Centerline call (586) 759-9150.

UTILITY ASSISTANCE - ELECTRICITY, GAS
Income eligible Macomb County residents facing utility shut off may be assisted in resolving their emergency. Utility assistance may be available for electric service, natural gas service, and deliverable fuels used to heat the home. Eligibility and guidelines will vary based on available programs. For more information contact your local **Community Action Center** at (586) 469-6964. For residents of Warren, Roseville, Eastpointe or Centerline call (586) 759-9150.

WATER RESIDENTIAL ASSISTANCE PROGRAM (WRAP)
Eligible households are offered credits on their water and sewer bills so that they pay no more than 3% of their household's annual income for up to two years. Eligible seniors and permanently disabled persons can obtain bill credit assistance without an expiration date.

To qualify for WRAP, households must be in a community in the service area, have a combined income at or below 200% of the federal poverty level, be primarily responsible for the water or sewer bill and have to reside in the home they rent or own. For more information and to apply visit the **Macomb Community Action's website** or call (586) 469-6464.

TRANSPORTATION ASSISTANCE
This department provides transportation to essential medical appointments and other specific locations for eligible Macomb County residents. For more information visit **Macomb Community Action's website** or call (586) 469-5225.

MYRIDE2 - CONNECTING SENIORS & ADULTS WITH DISABILITIES TO RIDES
AgeWays (formerly Area Agency on Aging) MyRide2 service can help find transportation options for seniors and adults with disabilities – helping them get to the store, to doctor's appointments, or out to visit friends and family. Myride2 is a transportation concierge service that arranges transportation from start to finish. There is no charge for arranging transportation through myride2, but there may be a cost for any transportation services they use. Payments are made directly to transportation providers. For more information visit **MyRide2 website** or call (855) 679-4332.

HOME INJURY PREVENTION
The Home Injury Prevention Program installs devices to ensure safety and prevent falls in the homes of eligible Macomb County seniors. A home assessment determines which safety devices will be installed. Services are free but contributions are appreciated. For more information visit **Macomb Community Action's website** or call (586) 469-6329.

HOUSING REHABILITATION
The Housing Rehabilitation Program provides assistance to eligible homeowners to repair their homes to achieve decent, safe and sanitary housing. Assistance is provided in the form of a no-interest loan. For more information visit **Macomb Community Action's website** or call (586) 466-6256.

WEATHERIZATION ASSISTANCE
The Weatherization Assistance Program performs the installation of energy efficient items to conserve energy in Macomb County homes. These improvements reduce energy use and can save an average of 30% on heat and utility bills. A home energy audit determines which items will be installed. Services are free for income-eligible residents. For more information visit **Macomb Community Action's website** or call (586) 469-6329.

WARMING & COOLING CENTERS
There are places across Macomb County where individuals can find respite from the extreme heat and cold. For a full list visit **Macomb Community Action's website**.

DIRECT CARE PROGRAMS – TO HELP SENIORS STAY LIVING AT HOME
Home care services help seniors and people with disabilities continue to live safely in a home setting. These services provide assistance with daily activities a senior might have trouble doing for themselves – things like bathing, dressing, meal preparation or housekeeping.

AgeWays (formerly the Area Agency on Aging) has several programs that offer direct care for Southeast Michigan families. For more information visit the **AgeWays website** or call (800) 852-7795.

PROGRAMS OFFERED SPECIFICALLY FOR SENIOR THROUGH MACOMB COUNTY SENIOR SERVICES
The following programs are offered to Macomb County residents age 60 or older. For more information on any of these services visit the Macomb County Senior Services website or call (586) 469-5228.

ADULT DAY CENTER
Provides daytime assistance for aging adults in need of structured activities, exercise, and supervision. The credentialed center can provide caregivers with a needed break while giving older adults a chance to socialize with their peers and remedy the isolation and loneliness many experience. For more information call (586) 469-5580.

FRIENDLY CALLER
Program volunteers reach out over the phone to connect with seniors interested in a friendly social conversation. It's an informal social call that can last anywhere from 10 minutes to 30 minutes depending on interest and natural flow of conversation.

HANDY HELPERS
Provides assistance with household maintenance tasks such as replacing light bulbs or faucets, washing windows and walls, repairing furniture, pest control, yard clean up, leaf raking, weatherizing, and more.

RESOURCE ADVOCACY
Provides consultation for seniors to assess needs, recommend services and assist with tax credits, Medicare Part D enrollment, Medicaid application process, community resources, and more.

NUTRITION ASSISTANCE

DINING SENIOR STYLE
A daily lunch program for seniors at 24 locations throughout Macomb County. Seniors are provided a well-balanced meal while also socializing with their peers.

MEALS ON WHEELS
Delivers a ready to eat meal to homebound residents no longer able to leave their homes on a regular basis without assistance or able to prepare meals.

ENSURE PLUS PROGRAM
Meals on Wheels offers cans of Ensure Plus as a supplement for Macomb County's most vulnerable homebound seniors with a prescription from their physician for Ensure Plus.

HOLIDAY MEALS ON WHEELS
Holiday meals are available for seniors who would be otherwise home alone on the holiday. A special hot lunch is freshly prepared that day, including many traditional favorites. Meal delivery is available for Easter, Thanksgiving, and Christmas.

SENIOR PROJECT FRESH COUPONS
Offers income-eligible seniors the chance to purchase fresh produce such as carrots, tomatoes, melon, and even honey. Seniors who participate will receive a $20 coupon book to use at local farmers' markets and stands.

2026 Macomb County Legislator Contact Guide

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Thomas Kuhn (R), District 57
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House – Appropriations Subcommittee LARA, Insurance & Financial Services
Donavan McKinney (D), District 14 – Vice Chair

House – Appropriations Subcommittee Public Health
Tom Kuhn (R), District 57 - Vice Chair

House – Appropriations Subcommittee Medcaid & Behavioral Health
Tom Kuhn (R), District 57

House – Families & Veterans
Doug Wozniak (R), District 59
Mai Xiong, (D), District 13

House – Health Policy
Alicia St. Germaine (R), District 62

House – Insurance
Joseph Aragona (R), District 60

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Senate – Health Policy
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Veronica Klinefelt (D), District 11
Michael Webber (R), District 9
Paul Wojno (D), District 10

Senate – Regulatory Affairs
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