

AMCNO Legislative Committee Welcomes Senator Coughlin

In February, the AMCNO Legislative Committee met with Senator Kevin Coughlin to learn more about the upcoming initiatives of his Senate Health Committee as well as to hear directly from Senator his thoughts on the landscape in Columbus since the election.

The Senator began his discussion with the committee by noting he was pleased that the AMCNO backed legislation introduced by Senator Coughlin (SB 88) calling for mandatory nonbinding arbitration did pass the Senate in the last General Assembly. Although the chairman on the House committee was interested in working with AMCNO and the Senator on the legislation, the trial bar became involved in the issue toward the end of the session and they

were able to effectively shut down the bill. Senator Coughlin is certain that no matter what the bill looks like in the future, the trial bar would not be in favor of it. Nonetheless, the Senator is reviewing the feasibility of reintroducing the bill in some format in this General Assembly. Senator Coughlin indicated to the committee that he had hoped that work could be done to get the bill referred to the Senate Health Committee if possible, since he is the chair of that committee.



Dr. John A. Bastulli, Vice President of Legislative Affairs spends a moment with Senator Coughlin prior to the legislative committee meeting in February.

However, at press time Senate Bill 59 — another bill calling for mandatory arbitration, which is also supported by the AMCNO — had been introduced by Senator Coughlin, but, the bill has been assigned to the Senate Insurance, Commerce and Labor Committee. *(Continued on page 2)*

NEO RHIO: Pioneering Health Information Exchange in Northeast Ohio

By Amy S. Leopard, Esq., Walter & Haverfield LLP

Northeast Ohio's national and international leadership position in health care has taken a major step forward with the adoption of a business plan to connect providers for the electronic exchange of health information. Multiple community-wide meetings have taken place to determine the level of community support and the feasibility of connecting and exchanging health information in the region.

After a year of detailed planning sessions, community stakeholders, including AMCNO, have developed consensus on a plan for creating an organization to serve as a neutral, trusted arbiter for the sustained development of the infrastructure and

protocols necessary for health information exchange. The new organization will be called NEO RHIO, short for the Northeast Ohio Regional Health Information Exchange Organization.

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LEGISLATIVE UPDATE

AMCNO Legislative Committee Welcomes Senator Coughlin (Continued from page 1)

As far as the landscape in Columbus is concerned, the Senator noted that the Governor has an override proof veto and it is likely that we will see more bipartisan discussion on issues. There are enough votes in the Senate to override a veto, but one would need seven votes in the House to achieve an override; therefore, prior to reaching the Governor for signature there will definitely have already been a lot of interaction on the bill at the legislature.

The Senator indicated that in Ohio they are getting a slow start on introducing legislation. If you look across the rest of the country one-third of the states will be through with their sessions by the time Ohio has introduced its first bill. This is due to the changes at the Statehouse as the Senate continues to negotiate with the House as to what the top 10 bills will be for this General Assembly.

On March 15th, Governor Strickland will unveil his proposed budget and until he does that there has been very little detail provided about his strategic plan. The Senator noted that there is definitely discussion at the Statehouse about health care and access to health care matters. All of the states, including Ohio, are beginning to look at Massachusetts, California and other states as well, to review what they are doing relative to the uninsured. However, the Senator cautioned that it will be important that a careful review be done of other legislative initiatives. He cited as an example, that when Governor Mitt Romney of Massachusetts made health insurance compulsory it sounded like a good idea at the time, but it is proving very difficult to enforce. In addition, everyone needs to remember that Massachusetts had federal dollars that were used to subsidize low-cost insurance for the uninsured in that state — and not every state has those federal dollars readily available.

As far as the Senate Health Committee goes, the Senator indicated that some of the issues coming forward are the standard of practice issue for pharmacists and what vaccines they can administer within the state, and the

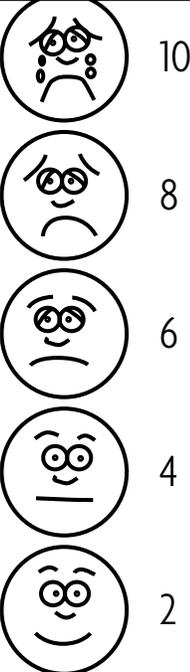


Mr. Ed Taber, a member of the AMCNO Medical Legal Liaison Committee, Dr. Ron Savrin, AMCNO past president, and Dr. James Sechler, AMCNO board member discuss legislative matters with Senator Coughlin.

HPV vaccine — many states have legislation to either mandate this vaccine or an opt-out provision and this will also be an issue that his committee will work on this session.

The AMCNO Legislative Committee plans to continue to work with Senator Coughlin on potential ADR legislation as well as other health care-related matters that come before his Senate Health Committee. Members who require additional information on the legislative initiatives of the AMCNO may contact Ms. Elayne R. Biddlestone, EVP/CEO at (216) 520-1000, ext. 100 or email her at ebiddlestone@amcnoma.org ■

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Michael Wise, Esq., AMCNO lobbyist

We have a new year, a new party in control of the Governor's office and a new General Assembly. Governor Ted Strickland wasted no time in asserting his new leadership as in his first week of office he vetoed legislation from the previous General Assembly. The Bill pertained to Ohio's Consumer Sales Act and also contained a provision regarding lead paint litigation. The new Ohio General Assembly that is now 20-13 Republican in the Senate and 53-46 Republican in the House could not muster the requisite 2/3rds majorities to override the veto. If it was not clear before, it is now — there is new aggressive leadership on the 30th floor of the Riffe Tower in Columbus.

Governor's Agenda

Strickland's policy agenda, termed "TurnAround Ohio" during the campaign, includes the following primary policy areas:

1. Increase access and funding for early care and education.
2. Create schools that work for every child by giving teachers the tools and technology they need to stimulate creative, problem-solving students to power Ohio's 21st century economy.
3. Dramatically increase the number of students in Ohio's colleges and universities by broadening access and ensuring that those who attend succeed and graduate with a degree that counts.
4. Focus on Ohio's strengths by building on Ohio's regional economies and globally competitive industries, spurring small and midsize business growth, supporting emerging entrepreneurs in our cities, fostering innovation and unleashing the potential of Ohio's great universities and investing in next-generation energy as a job source as well as a resource.
5. Provide all Ohioans the opportunities to attain skills for high-quality jobs. Include an effort to enroll an additional 230,000 Ohioans in college in the next 10 years and increasing graduation rates by 20%.
6. Stabilize health costs for government and businesses alike and advance the health of our citizens by increasing the number of Ohioans who have access to

affordable, high-quality healthcare, preventing illnesses and injury and focusing on community-based services for children, families, older adults and persons with disabilities.

7. Retain, create and attract jobs worthy of Ohio workers by focusing on industry sectors in which Ohio companies are growing, and which will spur our economy to generate wealth and prosperity for the future.
8. Restore transparency and accountability to the Bureau of Workers' Compensation.
9. Establishing the Ohio Government Accountability Plan to demonstrate how state government will live within its means and invest in what matters by focusing on core goals and directing the entire state government and budget toward meeting those goals.
10. The BroadbandOhio plan will power Ohio's economy and connect it to world markets. This effort will help in developing the jobs of the future by leveraging the state's investment in broadband infrastructure to create a competitive, well-connected economy in Ohio.

Each of these policy proposals will likely be reflected, to some degree, in the governor-elect's first State of the State Address in March as well as in the 2008-2009 Executive Budget proposal to be released by March 15, 2007.

The only major agenda item dealing with health care is number 6. Here, the Governor looks to stabilize health costs while also increasing access. This will be a tough challenge but perhaps there will be an opportunity for some type of ADR to positively impact costs.

Staffing Changes in Columbus

One of the Governor's key appointments as it pertains to the Academy of Medicine is the Director of the Department of Insurance. The Academy had a very strong relationship with Ann Womer-Benjamin. We met and conferenced with her often and her work on malpractice premiums provided a strong foundation for our mandatory arbitration bill. The new director is Mary Jo Hudson

and we have already reached out to her to arrange a meeting in the near future.

Director Hudson practiced law for eleven years, most recently with the Columbus offices of Bailey Cavaleri LLC, focusing on insurance regulation and liquidation law, and general corporate matters. Director Hudson also served as an attorney with the Ohio Department of Insurance and Office of the Ohio Insurance Liquidator. The AMCNO looks forward to working with her.

Gov. Strickland also appointed Alvin Jackson, MD, to replace Dr. Nick Baird, to lead the Ohio Department of Health recently. Dr. Jackson is the medical director of Community Health Services in Freemont, the clinic that launched his career in migrant health 15 years ago. Jackson, 56, also served as chief of staff at Memorial Hospital in Fremont from 2003 to 2005 and was a staff physician for the Sandusky County Health Dept. for more than a decade.

Helen Jones-Kelley was appointed director of the Ohio Department of Job and Family Services (ODJFS) by Gov. Ted Strickland effective January 8, 2007. As director, she oversees an agency of more than 4,000 full-time employees and an annual budget of more than \$17 billion. Previously, Jones-Kelley served as director of the Montgomery County Department of Job and Family Services after the Montgomery County departments of Job and Family Services and Children Services merged. She served as the executive director of the Montgomery County Children Services department since 1995. She is also a licensed attorney.

Legislative Changes

While there has been considerable change in Columbus, many good friends of the Academy remain, albeit in new positions. Senator Kevin Coughlin who sponsored our mandatory arbitration bill and successfully navigated it through the Senate in 2006, won his reelection. He will be the Chair of the important Senate Health Committee and he has agreed to once again sponsor the Arbitration Bill.

Senator Stivers returns as the Chair of the Senate Insurance Committee. He was very helpful with SB 88 and it is good to know that we have his support should our

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Legislation end up back in his Committee. Also, Senator Bill Harris returns as President of the Senate and Senator Harris was also a supporter of SB 88.

In the Ohio House, Cleveland-area Representative Matt Dolan will ascend to the chairmanship of the powerful House Finance Committee. Representative Dolan is well aware of our efforts with alternative dispute resolution and we look forward to working with him.

Three former long-time members of the House return, Representatives Batchelder, Wachtmann and Hottinger. All three of these members have a strong history of supporting tort reform initiatives. Representative Batchelder will chair the House Insurance Committee and Representative Hottinger will serve as vice chair of that committee. Representative Wachtmann will also serve on the Insurance Committee. Representative Wachtmann has also been appointed as vice chair of the House Health Committee.

Meeting with the new Attorney General

In February, AMCNO leadership met with Ohio Attorney General Marc Dann to discuss his agenda for the state and a future working relationship with the Academy of Medicine of Cleveland & Northern Ohio. Mr. Dann indicated he would be eager to meet further and discuss concerns of Northern Ohio physicians through the AMCNO leadership. A follow-up meeting is planned with Mr. Dann.

AMCNO Among Supporters of Limits to Jury Awards

On his last day in office, Attorney General Jim Petro asked the Ohio Supreme Court to uphold limits on jury awards in personal injury lawsuits. Now the job of defending the caps falls to new Attorney General Marc Dann — who voted against them in 2004. Pending before justices is a question of whether limits the General Assembly imposed on noneconomic and punitive damages are constitutional. Also under challenge: a section that permits the introduction of evidence of collateral benefits, money an injured person receives from insurance or other sources. Those provisions were contained in an overhaul of the personal injury lawsuit system (SB80, 125th General



AMCNO board member *Dr. John Clough* had an opportunity to meet personally with the new Attorney General Marc Dann at a recent event.

Assembly) enacted two years ago. The request to determine their constitutionality came from U.S. District Judge David Katz of Toledo. More than a dozen organizations have filed friend of the court briefs on behalf of plaintiffs and defendants in the case. The Academy of Medicine of Cleveland & Northern Ohio supports enactment of the limits and was listed as a member of the Ohio Alliance for Civil Justice (OACJ) on the amicus brief detailing such, in addition to such groups as the National Federation of Independent Business, the Ohio Association of Civil Trial Attorneys, the Ohio Hospital Association, the Product Liability Advisory Counsel, and the International Association of Defense Counsel.

Mandatory Arbitration Legislation

As far as our mandatory arbitration Bill goes, we are in discussions with Senator Coughlin regarding the future of this legislation. It is hoped that a bill will be introduced early in the session and then this will allow the full two years of the legislative session to obtain passage. The Academy has continued to work with the Legislative Service Commission ("LSC") and Senator Coughlin's office to improve the provisions of the Bill. Much of this work continues to focus on the timing of the arbitration process and the interplay with Civil Rule 10 pertaining to the Affidavit of Merit.

Ohio provides for a one year Statute of Limitations for Medical Malpractice claims. SB 88 provided for mandatory arbitration BEFORE the filing of a lawsuit. The plaintiff's bar wants to insure that a plaintiff does not lose the constitutionally protected right to file a lawsuit in court in the event that the arbitration concludes after the expiration of the statute of limitations. The defense

wants to reduce the cost of resolving these disputes. The solution that materialized was, that in lieu of a tolling provision, SB 88 contained a modification of the statute of limitations to provide a limited time period for a plaintiff to file a suit if the arbitration decision is rejected.

As far as the timing of the arbitration, SB 88 will balance the needs of both plaintiff and defendant to insure that cases are thoroughly and efficiently managed. One way that this will be accomplished will be by providing two separate frameworks; one for typical cases and another for complex cases. The intended result is a process that balances the right of a plaintiff to reach a jury while promoting a fair, efficient, and economical legal process.

Our Bill also had incorporated the provisions of Civil Rule 10. The Ohio Supreme Court has proposed changes to Rule 10 that will provide greater time flexibility to the plaintiff. The Academy discussed these changes with LSC and Senator Coughlin's office with the result being a new Bill draft that insures compliance with the spirit of Rule 10 while guarding the efficiencies of the mandatory arbitration process.

March 2007 through June 2007 will be very active in Columbus. My next article will report on the progress of our arbitration bill and also provide a summary of the proposed legislation that affects physicians. AMC/NOMA has a comprehensive tracking system of all health care related legislation in the General Assembly. If you are interested in receiving a copy of this document or if you have any questions about items included in this Legislative Update, please contact Elayne Biddlestone at (216) 520-1000. ■

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AMCNO Participates in HOPES Conference – Governor Strickland Provides Road Map on Access to Care

The Academy's Executive Vice President and CEO Elayne Biddlestone joined Gov. Ted Strickland along with executives from hospitals, insurance companies and other health advocacy groups for the *Post-Election Invitational Conference: Charting the Future of Health Care in Ohio* sponsored by the Center for Health Outcomes, Policy, and Evaluation Studies (HOPES) at Ohio State University. Governor Ted Strickland and former U.S. Senator John Breaux (D-La.), a national leader in health policy discussed the future of health care in Ohio. Former U.S. Senator John Glenn also attended and introduced Breaux.



Governor Strickland delivers his viewpoint on access to health care matters at the HOPES conference in January.

Both Strickland and Breaux described their ideas about the current health care issues facing the nation and Ohio. Strickland addressed many of the health care needs facing Ohioans, including the thousands of uninsured children, a shortage of nurses

statewide and little or no health coverage for many working Ohioans.

Governor Strickland indicated that there is a lack of investment in preventative care and this should be addressed in Ohio. He also

stated that the push for universal health insurance is back on the burner and he wants Ohio to be one of the states that is engaged and involved on addressing this issue. The Governor indicated that he has talked to Senator Voinovich about his federal bill that has bipartisan support which would allow states to be considered as "laboratories" and what can be done at the state level to expand high-quality health care (see AMCNO legislative committee report — page 3.) He indicated that he is aware that there is a growing awareness on the part of business, doctors, and hospitals and that it is time to take some action.

Strickland says he wants the state to take better advantage of federal health care money, making more citizens eligible. And, he does not oppose mandates on certain large business, such as Wal-Mart, to provide more extensive insurance to employees, while supporting a sliding-scale proposal for small businesses and the self-employed to afford coverage for their workforce.

Editor's note: Representatives from the HOPES at OSU have contacted the AMCNO and requested a follow-up meeting to look for avenues where the two groups might be able to work together on issues. The AMCNO physician leadership plans to set up a meeting in the near future. ■

The Health Partnership Act and the Health Partnership through Creative Federalism Act

This bill is meant to be a federal and state partnership approach to breaking the political logjam on covering the uninsured. The bill S. 325, is bipartisan legislation sponsored by Senator George Voinovich (R-OH), Senator Jeff Bingaman (D-NM), Rep. Tammy Baldwin (D-WI), Rep. Tom Price (R-GA) and Rep. John Tierney (D-MA.)

Summary: The conventional wisdom is that it is impossible to make any significant progress to help the uninsured in a polarized Congress. Meanwhile, the Census Bureau reports that the number of uninsured Americans has grown to over 45 million Americans.

The **Health Partnership Act** provides a path to move forward. These bills would:

- Break the Congressional logjam by allowing a diverse array of ideas to be tried in specific states.
- Test strategies that span the political spectrum to see which are most effective,

while protecting Americans already enrolled in programs.

- Expand health care coverage to Americans in need of health care.

Details: Congress would authorize grants to individual states, groups of states, or portions of states, to carry out any of a broad range of strategies to increase health care coverage. States desiring to participate in a health care expansion and improvement program would submit an application to a bipartisan "State Health Innovation Commission."

The Commission would consider applications that include a variety of approaches, such as tax credits, expansion of Medicaid or SCHIP, creation of pooling arrangements like the FEHBP, single payer systems, health savings accounts, or a combination of these or other options.

After reviewing the state proposals, the Commission would submit to Congress a slate of recommended state applications that represents a variety of approaches.

States receiving grants would be required to report on their progress. At the end of a five-year period, the Commission would be required to report to Congress whether the states are meeting the goals of the Act and recommend future action Congress should take regarding overall reform.

Editor's note: In February, the AMCNO Legislative Committee voted to support this legislation. The AMCNO plans to meet with the Senator in the near future on this and other related matters. ■

NEO RHIO (Continued from page 1)

Background

NorTech and OneCommunity provided primary operational support to convene the healthcare community in Northeast Ohio and support working groups to review and develop the operating, financial and marketing plan for a regional exchange. A task force to oversee the development of the business plan included stakeholder involvement from physicians, CIOs from area hospitals, local medical societies and hospital associations, health care quality improvement and advocacy representatives, and the payor community. Numerous individuals and stakeholder organizations donated time and funding.

Exchanging clinical information by definition involves physicians, and the Northeast Ohio medical community has been actively involved in the leadership and planning of this pioneering project. Dr. Brian Keaton, an emergency medicine physician from Akron who also is the President of the American College of Emergency Physicians, led the collaborative planning process to define the governance model, select the initial IT applications, and propose a business model for operations and ongoing funding. The task force overseeing the development of the business plan included representatives from the stakeholders outlined above.

The Organization

The business plan for NEO RHIO addresses key organizational and operational issues. NEO RHIO's mission will be to improve the quality, safety and efficiency of healthcare in Northeast Ohio through the use of information technology and the secure exchange of health information. NEO RHIO will be formed as a nonprofit organization and seek recognition as a 501(c)(3) tax-exempt entity.

The organization will establish a robust yet flexible governance structure that represents a broad spectrum of the community. The business plan calls for an initial board comprised of representatives from health care organizations, physician organizations, payors, employers, economic development organizations, quality and public health agencies and consumers.

Initial Projects

During the initial years, the NEO RHIO application strategy will focus primarily

on exchanging information among health systems, hospital-based physicians and a limited number of group practices. The projects are intended to be incremental with the initial pilot project to connect emergency departments (EDs) at participating hospitals. Pilot projects will produce knowledge, experience, infrastructure and trust for future exchange efforts. This incremental approach will allow NEO RHIO to build the infrastructure through grant funding, debt financing and initial membership dues.

The ED pilot project will permit authorized emergency department professionals to obtain past medical information about their patients from the data systems of other participating hospitals. Initially, authorized clinicians will be able to obtain and print information about a patient one hospital at a time. The goal is to provide physicians with timely information on pre-existing illnesses, medications, allergies and other factors that can be critical to ensuring patient safety and appropriate care.

The next phase of the project will locate and assemble a summary of information on a patient from multiple data sources on request. An information gateway/integrator will retrieve, standardize, and organize the medical information into a single electronic patient record summary. Initially, this information will be made available to emergency department clinicians, but will ultimately be useful for a wide range of health purposes. In the future, de-identified health information will be used to produce periodic biosurveillance reports. These reports will provide critical data to public health officials to help in the detection of disease outbreaks.

The ED pilot project was selected partly due to the demonstrated clinical / patient safety / quality / efficiency need for this service, but also because it will allow NEO RHIO to implement and test patient record locator and identity management infrastructure with a limited number of users while leveraging existing infrastructure in hospitals. The expected outcomes are that the information exchange will improve:

- Emergency department professionals' knowledge about each patient to improve diagnosis and treatment, reduce opportunities for error or injury, and reduce redundant costs.

- Public health authorities' ability to detect and manage outbreaks or mass casualty disasters.

Rules of Engagement

NEO RHIO participants will need to devote considerable time to establish appropriate rules of engagement. Designated workgroups will address state and federal healthcare and health information laws, especially the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") privacy and security rules governing healthcare providers and practitioners. Based on the data sharing contemplated from hospitals to clinicians located at other hospitals for treatment purposes, the ED pilot project represents the lawful sharing of protected health information among covered entities under the HIPAA treatment exception.

The adoption of HIPAA privacy and security standards serves as a starting point for creating and sustaining trust. NEO RHIO desires to be a trusted partner for health information exchange so that participants can exchange information without compromising the trust their patients have placed in them. The rights and responsibilities among participants will be established via agreement on how data providers and data recipients may use and disclose health information, who can and cannot access the information and for what purposes, the applicable security standards to ensure confidentiality and integrity, and related intellectual property, technology contracting and licensing issues.

The Future

The long-term plan of the NEO RHIO is to be financially self-sufficient and to expand to include primary care and specialty practices as well as ancillary health services providers as users and providers of information. The foundation established by these projects will create an infrastructure to address these information needs. Future NEO RHIO projects will address health care safety, economic efficiency, quality and public health by improving access to information when and where it is needed.

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Forming Physician Joint Ventures which Satisfy Federal Antitrust Law

Paul Edwards, Esq., McDonald Hopkins LLC

As hospitals and payors consolidate to obtain greater market power, physicians in various specialties such as pathology, urology, gastroenterology and dermatology, are doing the same. Short of a merger of existing practice groups, such consolidation, and the ability to lawfully negotiate price and price-related terms on a collective basis, may be achieved by either forming a new joint venture entity, or partially integrating existing practices without forming a new entity. However, before one would consummate any such consolidation, the antitrust implications, particularly if a large number of competitive physicians and/or groups are involved, would need to be considered. Because an antitrust analysis is fact-, circumstance- and data-dependent, a final, formal antitrust review typically is not feasible until the basic consolidation plan has been developed. As early as possible in the process, however, the potential parties should conduct a preliminary antitrust analysis in order to determine whether or not the general approach contemplated is likely to raise significant antitrust issues.

PROCESS

The first step is to establish a project core group of interested groups, with one or two representatives from each group. Generally, one would select the groups believed to be most critical to the success of the project, although this core group could later be expanded to representatives of each group that would ultimately be involved. Once a core group is formed, that group will need to identify the following:

- (a) the purposes, functions and authority of the core group;
- (b) the procedures for core group operation, including matters such as frequency of meetings and the mechanism for scheduling meetings and determining meeting agendas, methodology for communications within the core group, and rules for communications from the core group to participating groups and outside parties;
- (c) the source(s) of the resources necessary for core group functioning, such as how teleconferences will be paid for, secretarial assistance, and other items relative to the operation of the core group.

One of the first jobs for the core group would be to establish the initial parameters and objectives of the project. This would include a preliminary determination of the number of groups and physicians to be included, the criteria for group participation, a rough timetable for project consideration and completion, and the general goals for the project. With respect to this latter point, the core group should identify the perceived

advantages of a consolidation and also identify the potential disadvantages of or roadblocks to a consolidation. Typically, the perceived advantages of a consolidation include the following:

- (a) increased market position of the combined groups;
- (b) strengthening of negotiating position of the groups with hospitals and payors;
- (c) increased geographic diversity;
- (d) broadened access to subspecialty expertise;
- (e) economies of scale, particularly in the purchasing of insurance and supplies;
- (f) expanded access to capital;
- (g) ability to establish meaningful outreach or other operations; and
- (h) increased ability to recruit and retain physicians and other professionals.

The potential disadvantages would typically include:

- (a) the cost of establishing the entity;
- (b) at least some loss of autonomy for individual groups;
- (c) tying the business success of previously independent groups to each other; and
- (d) some loss of ability to adapt to local requirements.

Before undertaking the venture, the core group would want to achieve consensus on the perceived advantages and disadvantages, and a consensus that the perceived advantages outweigh the disadvantages. Moreover, the core group would want to achieve a preliminary consensus on the

form that the consolidation will take, and on the impact that the consolidation will have on the way that the constituent groups currently do things. Typically, in a consolidation there is some centralization of administration and compensation and benefit programs. In other words, very early on in the process, the core group needs to try to achieve consensus on the objectives, on the necessary structure to obtain those objectives and on the necessary consequences to the individual groups of such structure.

In determining the impact of the consolidation on individual groups, you must first start with determination of what it is you are trying to create. Are you trying to create a fully integrated model with centralized administration and common compensation and benefit programs or are you seeking to do something less than this? Please realize that from an antitrust standpoint, your ability to collectively negotiate will largely depend on how integrated you are.

Accordingly, a consolidated entity that is consolidated on paper only but in reality is a collection of independently practicing groups would likely not suffice for antitrust purposes. Financial integration is essential. Key issues that would need to be addressed include, but are not necessarily limited to, the following:

- (a) compensation and benefit program issues;
- (b) control and decision-making issues;
- (c) staff job security issues;
- (d) issues regarding admission of new physicians and termination of physicians; and
- (e) market and growth strategy issues.

Another important part of the process is considering the reaction of third parties to a consolidation. The two most important parties would be the groups' hospitals and managed care payors. With respect to hospitals, each group needs to assess whether its hospital(s) will support or oppose a consolidation. Each group should also review its hospital agreements to determine whether a hospital can "block" participation in the consolidation. Some hospital agreements permit termination by the hospital of the agreement upon the merger or other consolidation of the physician group.

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Forming Physician Joint Ventures which Satisfy Federal Antitrust Law (Continued from page 7)

Once you have reached a consensus on objective and structure, and the groups have accepted what this will mean in terms of their individual groups, it is appropriate to undertake a detailed antitrust review.

The antitrust analysis will take into account the number of groups involved, their geographic locations, the degree of competition among the groups, and the degree of integration within the entity, particularly financial integration.

If the antitrust analysis reveals that the desired approach is acceptable from an antitrust risk standpoint, then the core group would proceed to the next step. If the antitrust analysis indicates that it is not acceptable, the core group would need to alter the arrangement or abandon the venture. It is possible that the alteration required may be such that the constituent groups would no longer see a benefit to undertaking the project. However, it is possible that the proposal could be altered in a way to meet antitrust requirements and still represent a viable project for the parties.

Once a model is identified that passes antitrust muster, the core group would then begin to develop the detail for project implementation, typically through a representative committee. This would include the following:

- (a) Development of an implementation time line and project responsibilities document which identifies the timetable for the overall project, a timetable for its various components, and the party or parties responsible for completing each component;
- (b) Due diligence – the nature and extent of due diligence will depend, in part, on the type of consolidation involved. A true merger would involve a more extensive process than where a wholly new group is formed because the first approach would involve an assumption of historic liabilities and obligations. Even with a confidentiality and/or joint defense agreement, the sharing of fee-related data and payor/hospital contract terms and conditions may be limited somewhat due to antitrust considerations. Compilation of such information through a third party may be advisable

in the event that the project is not successfully concluded. Clearly, such information will need to be shared and determined jointly on a going forward basis in a consolidated entity;

- (c) Economic modeling;
- (d) Determination of legal entity type;
- (e) Preparation of all organizational documents;
- (f) Preparation of employment contracts and other service agreements;
- (g) Preparation of hospital and payor assignment documents;
- (h) Preparation of benefit plan documents;
- (i) Preparation of tax ID/provider number documentation;
- (j) CLIA and all other licensure-related work;
- (k) Selection of insurance and addressing individual group insurance issues, e.g., "tail" issues; and
- (l) Identification of need for capital to cover the transition period and the source(s) of such funding.

Once this stage is finished, actual implementation of the physician network joint venture would occur.

ANTITRUST ANALYSIS

The primary federal antitrust law guidance regarding both of these closely related structural alternatives has been provided by the Department of Justice ("DOJ") and the Federal Trade Commission ("FTC," and together with DOJ, the "Agencies") in Statement No. 8 of their Statements of Antitrust Enforcement Policy in Health Care (1996) ("Statement No. 8"). Statement No. 8 and two recent FTC advisory opinions provide significant guidance regarding the formation of physician network joint ventures which may lawfully negotiate price and price-related terms on a collective basis under federal antitrust law. Recent FTC Congressional testimony indicates that the FTC supports initiatives like these which enhance the quality of health care, reduce or control health care costs and help ensure the free flow of information in health care markets.

Statement No. 8 and Substantial Risk-Sharing. It is often said that agreements between or among competitors to fix prices or price-related terms are per se illegal, i.e., illegal on their face without the consideration of additional justifications. On the other extreme, under Statement No. 8, the Agencies, absent extraordinary circumstances, will not challenge a non-exclusive physician

network joint venture comprising 30% or less of the physicians in each physician specialty in the network with active hospital staff privileges who practice in the relevant geographic market and who share substantial financial risk. For exclusive physician networks, the membership threshold is reduced to 20%. The best source of reliable preliminary data with respect to the number of physicians within a given practice specialty and geographic market is the relevant state medical board. Exclusivity will be determined by the participants' conduct and activities, and not merely by the express terms of the agreement.

The safety zone provides examples of the sharing of substantial financial risks among members of a physician network joint venture, including in pertinent part where:

- the venture agrees to provide designated services or classes of services to a health plan for a predetermined percentage of premium or revenue from the plan;
- the venture creates significant financial incentives for its members as a group to achieve specified cost-containment goals, such as (i) withholding from all members a substantial amount of the compensation due to them, with distribution of that amount to members only if the cost-containment goals are met; or (ii) establishing overall cost or utilization targets for the network as a whole, with the network's physician participants subject to subsequent substantial financial rewards or penalties based on group performance in meeting the targets; or
- the venture agrees to provide a complex or extended course of treatment that requires the substantial coordination of care by physicians in different specialties, for a fixed, predetermined payment, where the costs of the course of treatment may vary greatly based on the patient's condition, treatment options or other factors.

Often these days, because most agreements with managed care plans in which the venture would enter would be fee-for-service contracts, as a practical matter it is unlikely that many ventures could use the first bullet to satisfy Statement No. 8's substantial risk-sharing requirement. Similarly, a venture's practical ability to use the approach outlined in the second bullet may also be suspect, since substantial cost or quality controls may not be realistic in a particular practice

specialty, such as pathology. This is because a pathologists' venture would have little or no control over the types and number of tests which it would be asked to perform. Accordingly, unless some innovative approach to the substantial risk-sharing requirement is identified, a joint venture entity which shares substantial financial risk may not be a feasible alternative for some individual practice specialties. For the third bullet to apply, various specialties must be involved in the joint venture.

Statement No. 8, the Rule of Reason and Integration. Statement No. 8 goes on to indicate that physician network joint ventures that do not involve the sharing of substantial financial risk may nevertheless involve sufficient integration to demonstrate that under the so-called "rule of reason," the venture is likely to produce significant efficiencies (as evidenced by implementation of an active and ongoing program to evaluate and modify practice patterns by the venture's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality), and the agreement to negotiate price and price-related terms is reasonably necessary to realize those efficiencies. These programs may include:

- establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care;
- selectively choosing network physicians who are likely to further these efficiency objectives; and
- the significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.

Application of the rule of reason can be complicated, and involves: (1) defining the relevant geographic and product/service markets; (2) evaluating the anticompetitive effects of the venture; (3) evaluating the procompetitive effects of the venture; and (4) evaluating the price, price-related and other collateral agreements. As part of step number 3, integration would be considered. Integration can take a number of forms, including governance, administrative, clinical and financial integration, and varies by degree. Clinical integration can include: common information technology; clinical protocols; care review based on protocols;

physician credentialing; case management; preauthorization of medical care; and review of hospital stays. However, as mentioned above, meaningful cost and quality controls may not be practical in this context for some practice specialties, and many ventures probably could not be selective regarding the physicians which would and would not be allowed to participate from among the existing physicians in each existing group. If adequate integration were nevertheless somehow determined to be feasible, joint contract negotiation could be reasonably necessary to achieve such integration because it may: help get sufficient active and ongoing physician participation; provide negotiating efficiencies; and prevent "free-riding" by group members.

Considering and contrasting the FTC's analyses in its MedSouth and SHO advisory opinions, discussed below, may help prospective participating groups identify potential means to achieve efficiency-enhancing integration, to the extent that such integration may be practical in the context of the delivery of particular physician services.

MedSouth. On February 19, 2002, the FTC issued its MedSouth advisory opinion on the proposed partial integration of a large number of physician practices and the resulting program's collective negotiation of rates with payers. MedSouth was a very large independent practice association ("IPA") in the South Denver/Arapahoe County area of Denver, Colorado, a for-profit corporation owned by the physician practices of its members. (About 100 primary care physicians supported on extensive referral network including 331 specialist physicians.) After the failure of its capitation contracts approach to integration, MedSouth was seeking assurance that its new proposed program was not per se illegal. The program had two major components: first, a Web-based electronic clinical data base for MedSouth physicians to access and share clinical information relating to their patients; and second, the adoption and implementation of clinical practice guidelines and performance goals relating to quality and the appropriate use of services provided by MedSouth physicians. All MedSouth physicians were to be contractually committed to these components. Although the MedSouth physicians had not agreed to share substantial financial risk, MedSouth proposed to collectively

negotiate rates with payors for its members, on a non-exclusive basis.

The FTC concluded that the proposed program was not per se illegal, and that the program "appears to be capable of creating substantial partial integration of the participating physician practices, and to have the potential to produce efficiencies in the form of higher quality or reduced costs..." Factual uncertainties about MedSouth's market power after implementation of the proposed program (MedSouth anticipated the loss of a substantial number of its members once the proposed program was implemented), the extent to which MedSouth's representation of its members in price negotiations would actually (as opposed to theoretically) be non-exclusive, and the extent to which anticipated efficiencies would actually be achieved, were resolved by the FTC using assumptions, with the following caveat:

If, however, MedSouth's member physicians are able to use collective power to force payers to contract with the network or to pay higher prices, then absent evidence that substantial efficiency benefits outweighed likely anticompetitive effects, we likely would recommend that the Commission bring an enforcement action.... This office will monitor MedSouth's operations and the behavior of its physician members for indications that the proposed conduct is resulting in significant anticompetitive effects.

Under this possible structural alternative, any similar venture is likely to be subject to similar factual uncertainties.

SHO. In another significant FTC advisory opinion on this topic, on March 28, 2006, the FTC denied favorable treatment to Suburban Health Organization, Inc. ("SHO"), which had proposed a program involving partial integration among 8 SHO member hospitals in Indianapolis, Indiana and surrounding counties, and 192 primary care physicians employed by those hospitals. Described as a "super-PHO" (physician-hospital organization), SHO proposed to adopt a "clinical integration program" which included medical management, quality management, practice support and physician incentive plan components. SHO also proposed to collectively and exclusively

(Continued on page 10)

Forming Physician Joint Ventures which Satisfy Federal Antitrust Law (Continued from page 9)

negotiate contracts with payors on behalf of its member hospitals, including uniform fees for the services of their 192 employed primary care physicians.

In *SHO*, the FTC described the applicable antitrust analysis as follows: first, consider whether the proposal “involves potentially efficiency-enhancing integration among the joint venture’s otherwise competing participants, and then evaluate whether the accompanying restraints are reasonably necessary — i.e., “ancillary” — to the achievement of the proposed program’s integrative efficiencies.” The proponent of the program must articulate a specific link between the challenged restraint and the purported justification in order for the analysis to proceed. If the restraints are determined to be ancillary, then the ultimate determination of the legality of the restraints “requires a weighing of the arrangement’s procompetitive and anticompetitive effects.”

The FTC was less than impressed with the degree of integration which could be expected through *SHO*’s proposed program, since in the FTC’s view the program: could be implemented by an individual hospital; relied on the individual hospitals to motivate its physicians, compensate them (except with regard to the limited bonus pool of up to 2.5% of a physician’s prior year’s compensation funded by the *SHO* hospitals and based upon overall group performance), and discipline chronically non-compliant physicians; and did not involve the collaborative provision of any physician services. Nevertheless, the FTC concluded that the degree of integration (the hallmark of which was said to be “interdependence”) “holds out some potential to improve the quality and efficiency of the participating physicians’ professional services.” Therefore, the competitive restraints which were part of *SHO*’s proposed program were not summarily condemned as naked price fixing or (in the case of the exclusive contracting restraint) an impermissible output restriction. However, the program’s limited nature and scope were viewed as significantly limiting the magnitude and range of its potential efficiencies.

In *SHO*, the FTC analyzed the uniform pricing restraint extensively. Among other

concerns, the FTC felt that there was no direct relationship between the restraint and the efficiencies, and that the proposed clinical integration program addressed only a limited subset of medical conditions which would be treated by the participating physicians, while the fees restraint covered all medical services performed by the employed primary care physicians. The FTC also rejected *SHO*’s argument that the program represented a “new product” which had to be separately and uniformly priced, distinguishing relevant U.S. Supreme Court case law on that topic and concluding, based on the legal standard from those cases as to when a new product would be involved, that the program “does not fundamentally alter the nature of the services provided to patients or to payors....” No new product was involved because each hospital would continue to bill separately for services actually provided by its physicians, and patients would not obtain access to prepaid, guaranteed, comprehensive services, or to a broader range of services and expertise, circumstances which were treated as potentially significant in *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982).

In holding that the fees restraint was not ancillary to the program’s putative efficiencies, the FTC also rejected *SHO*’s argument that the restraint was necessary to motivate the physicians to participate in the efficiency-enhancing aspects of the program. This rejection may be largely limited to *SHO*’s factual context, since according to the FTC, employed physicians do not need additional motivation to comply with their employer’s programs. Also, in *SHO* there was no showing that the uniform fees would actually motivate the physicians, because it was the hospitals which would directly benefit from the uniform fees, not the physicians. There were also less restrictive alternatives to achieve any necessary motivation, which could be implemented by individual hospitals without collective action.

Recent FTC Congressional Testimony. In recent testimony before Congress, the text of which was unanimously approved by the FTC, one of the FTC’s Deputy Directors recounted the Agency’s treatment of physician network joint ventures that involve significant potential for creating efficiencies through integration. Deputy Director Wales noted that developments in information technology, for example, present new

opportunities for efficiency-enhancing integration, and stated that “the FTC supports initiatives to enhance quality of care, reduce or control ever-escalating health care costs, and ensure the free flow of information in health care markets, because such initiatives benefit consumers.” He cited both *MedSouth* and *SHO* as providing detailed guidance about potentially pro-competitive forms of physician integration, and indicated that the FTC “currently is considering other requests for guidance regarding multi-provider arrangements involving clinical integration or other forms of collaboration.” Prepared Statement of the Federal Trade Commission on “Examining Competition in Group Health Care,” before the Committee of the Judiciary, United States Senate (September 6, 2006).

Conclusion. Accordingly, assuming putative physician network joint venturers attempt to identify practical efficiency-enhancing aspects of the proposed venture, new guidance may become available in the meantime to more fully inform those efforts. The provision of electronic clinical data, as in *MedSouth*, may be a feasible component upon which to build an integrated physician network joint venture. Another possible component may be the education of other physicians as to the nature and scope of available services. Also, the partial integration of proposed participants may produce: certain economies of scale; broadened access to subspecialty expertise; improved ability to establish meaningful outreach or other operations; increased ability to offer esoteric services; and improved recruiting capabilities. If so, the associated restraint of joint contract/fee negotiations should be found to be ancillary and therefore valid. Ideally, the putative participants in a physician network joint venture will focus on the pro-competitive benefits which their collaboration can create, and proactively identify innovative ways to obtain the necessary efficiencies.

Paul Edwards practices antitrust, franchising, securities and general corporate law as a partner in the Cleveland office of McDonald Hopkins LLC, a full-service law firm with offices in Columbus, Ohio, West Palm Beach, Florida, Detroit, Michigan and Chicago, Illinois. Mr. Edwards has been practicing antitrust law, with an emphasis on health care antitrust law, for over 15 years, and is a frequent speaker and author on health care antitrust law issues. ■

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AMCNO Pursues Anthem Audit issue

In a recent issue of this magazine, our members were provided with information regarding the audit process utilized by Anthem Blue Cross/Blue Shield.

Anthem has stated that these audits are based solely on correct coding and supporting documentation and in no way questions the level of care provided by the physician. Anthem has indicated that this is being done to ensure that the level of code billed is supported by appropriate documentation. However, there appears to be some question on the part of physicians undergoing these audits as to how Anthem reviews "risk." Some physicians have expressed concern that if the reviewers for Anthem merely assess the risk under medical decision making based on the eventual established diagnosis, it may not reflect the overall medical decision making work done for each patient.

The AMCNO managed care advocacy committee chairman and several physician leaders of the AMCNO recently met via conference call with the medical director of the Northern Ohio region for Anthem as well as the review company responsible for the audits.

Based upon our discussion, the AMCNO gleaned the following information from Anthem and HCS the company conducting the audits:

1. The Anthem audit process is not conducted directly by Anthem BC/BS; a paid contractor authorized by Anthem to perform the audits conducts the audits.
2. The audits are specific to level 4 and 5 E/M codes only.
3. Claims are obtained from throughout Ohio that contain level 4 and 5 codes and these are "data mined" and once all the codes are in hand then physicians are randomly selected from that pool — no physicians are "targeted."
4. Physicians that are audited are asked for 10 records and there is a detailed letter writing process utilized by the contractor when they are attempting to get a response from physicians targeted for an audit — resulting in a total of 75 days response time.
5. The basis of the process is to determine the correctness of the coding and how well the physicians understand the coding process — it is intended to be an educational audit not a punitive one.
6. Physicians involved in an audit may speak with personnel at HCS about the claims. Physicians may ask for a peer-to-peer conference and this will be provided if requested.
7. Physicians and their staff are directed on where to locate educational materials from various sources (other than Anthem BC/BS) about how to code correctly.
8. The Anthem BC/BS audit process will be expanded to include other physicians.
9. Once a physician has been randomly audited, he/she will be eligible for an ongoing audit approximately every six (6) months if, and only if, his/her accuracy rate is determined to be less than 80%. Otherwise, a physician can expect to be part of the audit cycle every 18 – 24 months.
10. Anthem BC/BS does not intend for this process to develop into a "compliance" program and they are not planning to use the data for network paring or a network management tool.
11. HCS representatives believe that this process is in keeping with the Center for Medicare and Medicaid Services (CMS) audit process.
12. There are no educational materials, discussion points outlining the audit process, or other background materials on this process available at this time through Anthem BC/BS publications, their Web site or other media provided by the insurer
13. The physician reviewer determines if there was a certain level of risk and during the peer-to-peer conference the physician can discuss this but the physician must prove the reason for the consideration of the risk level through documentation.

The AMCNO has sent a detailed letter to Anthem BC/BS regarding our concerns with the process. Overall, the AMCNO was of the opinion that the company should make the information outlined in the above points and the rationale for same readily available to physicians within their network. We suggested that Anthem BC/BS should publish what they consider correct coding criteria and procedures as well as providing links to Web sites and other materials and publications so that physicians and their office staff would have the tools and information needed to comply with Anthem programs.

In addition, the AMCNO strongly suggested that Anthem should publish verifiable, statistically significant data gleaned from their data mining and random audits so that physicians could become aware of what the issues are relative to coding. It was the opinion of

the AMCNO leadership that since Anthem BC/BS has indicated that their ultimate goal in this process is to educate physicians versus a punitive process than Anthem BC/BS should take the lead and provide that education to their network physicians.

a. **AMCNO Question:** *Why not provide the background and criteria utilized by Anthem to enable physicians and their staff to respond to these audits?*

Anthem's Response: Although Anthem currently provides key information outlining the background and criteria utilized in the audits, as documented in the overpayment notices and request for records notices, Anthem is also taking steps towards further enhancing all correspondence shared with physicians. Please see attached "Request for Records- Initial Letter" and "Overpayment Notice" templates for further reference on current language included for providers. Ideally, future correspondence will provide more information about the review program as well as a more detailed breakdown of the audit results. This information will be made available via written communication as well as electronically. Anthem also plans to provide ongoing information through Rapid Update communications.

b. **AMCNO Question:** *Why doesn't Anthem BC/BS provide a series of written articles and Web site updates outlining what Anthem perceives would achieve "correct" coding by physicians based upon the criteria you use for the audits and evaluations?*

Anthem's Response: As outlined in the current Overpayment Notice that is shared with all providers upon completion of the records review, the CMS 1995 and/or 1997 E & M guidelines, which ever is more favorable to the physician, are used when reviewing the documentation submitted by the physician in determining whether the documentation supports the code that was billed. The results provide a breakdown of each key component of the CMS E/M Guidelines and where documentation was insufficient. Anthem also plans to partner with Parses in providing additional educational resources and materials in the future via a series of free, Web-based video training modules to any Anthem physician that requests access. Information regarding how to request this access will be made available in an upcoming Rapid Update article.

In addition, Anthem published information regarding the Professional Coding Review Program in the Rapid Update communication dated August 27, 2003 and June 15, 2005. Rapid Updates are located on the

Anthem Web site at www.anthem.com. Although Anthem did not include the HCS Web site in the standard written communications, Anthem and HCS/Parses did direct physicians to the HCS Web site, www.hc-cs.com, via customer service inquiries, face to face audit/appeal meetings and conference calls to further discuss audit results. The HCS Web site provides several resources for coding education under their "LINKS" selection, including the link to the CMS 1995 and 1997 E/M Guidelines."

- c. **AMCNO Question:** *Is Anthem BC/BS performing the same level of audits on hospital and skilled nursing facilities or only targeting physician services — and why does Anthem only target the Level 4 and 5 codes?*

Anthem's Response: Anthem has a fiduciary responsibility to its members, employer groups, and the Blue Cross Blue Shield Association (BCBSA) to ensure correct coding and correct reimbursement across all specialty types and services. Anthem does not limit its audit scope to physician services only.

Incorrect coding of evaluation and management services continues to be an ongoing issue according to the Office of Inspector General (OIG) and CMS's Comprehensive Error Rate Testing (CERT) program. Results of recent reviews conducted on behalf of Anthem are consistent with the results seen by the OIG and the CERT program.

This program not only identifies and corrects services that have been over-coded, but also identifies and addresses services that have been under-coded based on the documentation provided by the physician.

- d. **AMCNO Question:** *Is it correct that, if requested, physicians can speak with a peer in the same specialty as part of the Anthem audit process and has this information been published to physicians in the Anthem network?*

Anthem's Response: A peer-to-peer conference is an additional service offered by Anthem, on a case-by-case basis, in an effort to provide a completely fair and objective assessment of the medical documentation provided by the physician. The vendor's medical director, on behalf of Anthem, conducts all peer-to-peer conferences unless otherwise specified. The medical director may or may not be of the same specialty.

Before requesting a peer-to-peer conference, the results of the initial review must first be appealed and the normal appeals process followed. If the physician

continues to disagree with the results of the appeal, a peer-to-peer conference may be requested. The physician's appeal rights and appeal instructions are outlined in the physician's results letter. **EDITOR'S NOTE:** *This particular issue had been of importance to many of our members. In the past, our members had been told that they would be able to have a peer-to-peer conference (i.e., a physician in the same specialty) on audit matters. This response from Anthem clarifies this point. The AMCNO will continue to dialogue with Anthem on this issue.*

- e. **AMCNO Question:** *If the physician can prove or provide data that clearly shows why a certain risk level should be applied has this ever changed the outcome of an audit?*

Anthem's Response: Yes. It would be appropriate to provide this information either during the appeal process or the peer-to-peer conference, if it was not provided with the initial medical records. Anthem is committed to a fair and objective review of all data and documentation on a case-by-case basis and therefore does not solely rely on the premise of "if it isn't documented, it didn't happen."

- f. **AMCNO Question:** *Has Anthem considered providing data on the results of the process and the findings as a result of the audit process?*

Anthem's Response: The result of each physician's audit is communicated to him/her upon completion of the initial review of medical records. A complete audit trail, which fully discloses the exact finding of the coding specialist, for each claim reviewed is also included with the results letter. Additionally, Anthem plans to communicate common findings amongst providers via the Rapid Update process on a regular basis in an effort to provide further education where appropriate.

Anthem BC/BS has indicated that they would be willing to continue to work with the AMCNO on this and other issues of importance to our members. If any of our members have comments or concerns regarding this issue, please contact Ms. Kris Snider at the AMCNO offices at (216) 520-1000, ext. 103 or email Kris at ksnider@amcnoma.org. ■

The Academy of Medicine of Cleveland and Northern Ohio (AMCNO) invites you to attend our 2007 Annual Meeting

Friday, April 27

Ritz-Carlton Cleveland
1515 West Third Street

6 p.m. Reception ∞ 7 p.m. Dinner
Black Tie Optional

Induction of the 2007-2008
AMCNO President

James S. Taylor, MD

Presentation of 50 Year Awardees and Academy of Medicine Education Foundation (AMEF) scholarships to medical students from CWRU School of Medicine, Cleveland Clinic Lerner College of Medicine and the Northeastern Ohio Universities College of Medicine.

AMCNO 2007 Honorees

William J. Reinhart, MD

John H. Budd MD Distinguished Membership Award

William H. Seitz, Jr., MD

Charles H. Hudson MD Distinguished Service Award

John D. Hines, MD

Clinician of the Year Award

Ronald A. Savrin, MD

Outstanding Service Award

Gary Y. DeNelsky, PhD

Patricia T. Horvath, RN

Special Recognition Award

Michael J. Jordan, Esq.

Presidential Citation Award

Please join us in congratulating our medical scholarship recipients and awardees on April 27th.

NPI Date is Fast Approaching!

On May 23, 2007, less than four months away, the National Provider Identifier (NPI) will change the health care industry. Physicians and other health care professionals must begin using this unique, all numeric, 10-position identifier when requesting reimbursement for health care services. The transition to NPI directly affects claims processing and payments for providers and impacts electronic transactions and paper claim transactions.

By acting now, your organization will be able to greet the transition to NPI feeling confident that you have tested their systems and will continue to operate with all the capability you have today.

NPI Checklist

Below is a checklist to assist you as you work toward NPI compliance:

✓ Apply for NPIs today.

If you have not already done so, contact the Centers for Medicare & Medicaid Services (CMS) today to apply for your NPI(s). The CMS Web site is <http://www.cms.hhs.gov/NationalProviderStand> or dial toll free at (800) 465-3203 to get started. Simply log onto the National Plan and Provider Enumeration System (NPPES) at www.nppes.cms.hhs.gov and apply online. Providers who have not completed this step put themselves at risk of not being able to complete the

full NPI transition with their health plans and electronic vendors — prompting disruptions in service and payments.

✓ Conduct a complete inventory and assessment of practice management systems.

Health care professionals need to evaluate practice management systems' software in anticipation of the NPI changes. With only a few months until the NPI implementation, providers, health plans and electronic vendors need ample time to successfully incorporate NPI changes.

✓ Ensure all vendors (such as medical supply companies, third-party billing agencies, laboratory services) who impact providers' practice management systems are also working toward becoming NPI compliant.

If you haven't already, have conversations with your electronic vendors to ensure these vendors will be compliant with the NPI requirements by May 23, 2007. It is critical that you coordinate any upgrades to your systems with your software vendors. The vendors' noncompliance could seriously impact your operations and hamper your ability to transition to NPI.

✓ Work with health insurance payers, software vendors, & clearinghouses to conduct NPI testing in a simulated NPI environment to ensure anticipated results are received.

If you have not applied for your National Provider Identifier, DO IT NOW. The process is not complicated. The paper application is six pages long including detailed instructions, the actual application is three pages of information you probably have readily available.

Important TIP: When applying for your NPI, CMS urges you to include ALL of your legacy identifiers, not only for Medicare but for all payors. If reporting a Medicaid number, include the associated state name. This information is critical for payors in the development of crosswalks to aid in the transition to the NPI.

Get It. Share It. Use It.

If you are a health care provider who bills for services, you probably need an NPI. If you bill Medicare for services, you definitely need an NPI! Getting an NPI is easy. Getting an NPI is free. The first step is to get your NPI. Once you obtain your NPI, it is estimated that it will take 120 days to do the remaining work to use it. This includes working on your internal billing systems, coordinating with billing services, vendors, and clearinghouses, testing with payers. As outlined in the Federal Regulation, (The Health Insurance Portability and Accountability Act of 1996 (HIPAA)) you must also share your NPI with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes. If you delay applying for your NPI, you risk your cash flow and that of your health care partners as well.

For many, there are several critical tasks yet to complete before the federally mandated implementation date of May 23, 2007. Will your office or facility be ready for NPI? The time to act is now. Please do not delay.

OSMB Unveils First Online License Application Form in U.S.

The State Medical Board of Ohio is the first Board in the country to employ the new online application process for medical and osteopathic physicians called the "Common License Application Form" or "CLAF." The CLAF will benefit physicians by reducing redundancy in filling out multiple application forms when applying for licensure in multiple states. For an introduction, complete instructions and detail of the new application process, visit <http://www.med.ohio.gov/pdf/Applications/mddoapp.pdf>. ■

AMCNO to partner with CMS on PQRI Learning Opportunity

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) in partnership with the Centers for Medicare and Medicaid Services (CMS) is pleased to bring to you the opportunity to learn more about the CMS Physician Quality Reporting Initiative (PQRI).

WHEN: Wednesday, April 11, 2007, 12 noon

TOPIC: Implementing the CMS Physician Quality Reporting Initiative: Capturing Clinical Quality to Gain Financial Reward.

PRESENTER: Dr. Susan Nedza, Office of Value-Based Purchasing, Centers for Medicare and Medicaid Services (CMS)

WHO SHOULD ATTEND? Physicians, office managers, hospital staff and insurance billers.

CMS will provide a call-in number and materials that will be posted on the AMCNO Web site. We will provide a call-in number and materials that you can post on your Web site or push out through email. Watch your mail and physician member emails for more details — or call the AMCNO to sign up to receive more information at (216) 520-1000, ext. 103.

AMCNO Leadership Meets with Center for Health System Change

On February 12, 2007, several physician members of the AMCNO met with interviewers from the Center for Health System Change to provide input into the latest Community Tracking Study for this community.

The Community Tracking Study is a national, longitudinal study of changes in local health care systems and the effects of those changes on people. The study is conducted by the Center for Studying Health System Change (HSC), a nonpartisan, research organization in Washington, DC, funded primarily by The Robert Wood Johnson Foundation. The goal of the research is to provide policy makers and private-sector decision makers with timely, objective information on how the U.S. health care system is changing and the policy implications of those changes.

Cleveland is one of twelve U.S. areas studied in-depth since 1996. Every two years, a team of researchers visits these communities to interview a wide variety of health system leaders to explore how the organization, financing and delivery of care have changed.

Key components of this interview surrounded such topics as:

What are the top three pressures physicians in this market face; to what to what extent has the site of care for any services such as diagnostic imaging or outpatient procedures shifted to physicians' offices or physician-owned ambulatory facilities in this market; to what extent have health plans incorporated any pay-for-performance-based (quality and/or efficiency) financial incentives into their contracts with providers in this market; and what efforts have there been in this market by hospitals, health plans, purchasers, and/or others to promote physician IT adoption over the past two years.

Interviewers from HSC met with many other hospital leaders and members of the health-care community as part of this interview process. A report will be published in the near future. ■

AMCNO Responds to article in *Plain Dealer* regarding Medicare payment cuts

A recent article in the *Plain Dealer* gave readers the impression that due to the fact that the Medicare pay cuts for doctors were rescinded that this was the proximate cause for the increase in monthly premiums — an issue that is certainly multifaceted. The AMCNO President, Dr. Paul Janicki sent a response (see pullout box) to this article providing the public with a glimpse at the real culprit — the SGR formula.

On Dec. 20, President Bush signed into law a tax, trade and health care bill (HR 6111) that included provisions to reverse a 5.1% reduction in Medicare physician reimbursements scheduled for 2007. The law maintains the current level of Medicare physician reimbursements in 2007 and provides a 1.5% increase in reimbursements to physicians who agree to report data on certain quality-of-care measures. It was reported that nearly 1 million patients and physicians contacted Congress to urge them to take action on this issue. The legislation also initiates a physician quality reporting program to begin in July 2007.

However, until a permanent solution to the flawed SGR formula is implemented, we will continue to monitor practice costs and the concerns of physicians relative to Medicare on behalf of our membership.

Senator George Voinovich was among 80 senators who signed a letter to the Senate leadership in support of erasing the cut and stated that fixing the problem should not be tied to a bill that Voinovich believed was "fiscally irresponsible and not a good use of taxpayer dollars." Senator Voinovich sent a response to Dr. Janicki's letter to the editor indicating that he "read with great interest" Dr. Janicki's letter in the *Plain Dealer*. The Senator agrees that Congress must deal with the flawed formula that determines physician payments under the Medicare program. The Senator continued by stating that "you and I both know that physicians are squeezed at both ends — while the cost of medical liability insurance continues to escalate. Medicare is not keeping up with the cost of care." AMCNO leadership is planning a follow-up meeting with the Senator to discuss this and other health care-related matters such as his Health Partnership Act (see page 5.) ■

THE PLAIN DEALER

Friday, December 29, 2006 | B8

LETTERS

Doctors, patients alarmed at Medicare's path

In response to the Dec. 17 article "Doctors' Medicare pay cuts killed; fund likely to shrink":

The public needs to understand that physician payment updates are driven by a flawed formula called the sustainable growth rate (SGR) — a formula that ties reimbursement changes to the gross domestic product. The underlying flaw of the SGR is the link between the performance of the overall economy and the actual cost of providing physician services.

Medicare physician reimbursements have not kept pace with the rising cost of providing care. Data from the Government Accounting Office show that between 1990 and 2006, the cost of operating a practice rose 40 percent, while Medicare payments increased only 19 percent.

Based upon the current payment formula, it is predicted that by 2015, Medicare physician payment rates could be cut by 37 percent. All patients will be adversely affected by these proposed payment changes because Medicaid and private insurers use Medicare rates as a resource for their reimbursement rates.

Congress must replace the SGR with a formula that allows for increases in the cost of practicing medicine, or physicians will be forced to reduce the number of Medicare patients in their practices.

PAUL C. JANICKI, M.D.
Cleveland

Janicki is president of the Academy of Medicine of Cleveland and Northern Ohio.

New Rules Relating to Prescribing to Persons Not Seen by the Physician

The Ohio State Medical Board has issued new rules on the subject of prescribing to persons not seen by the physician. These rules became effective in 2006 and violations can subject a physician to disciplinary action by the Medical Board.

Under the rules, with respect to a controlled substance, except in institutional settings, on-call situations, cross-coverage situations, situations involving new patients, protocol situations, situations involving nurses practicing in accordance with standard care arrangements, and hospice settings, a physician shall not prescribe, dispense, or otherwise provide, or cause to be provided, any controlled substance to a person who the physician has never personally physically examined and diagnosed.

With respect to a dangerous drug which is not a controlled substance, except in institutional settings, on-call situations, cross-coverage situations, situations involving new patients, protocol situations, situations involving nurses practicing in accordance with standard care arrangements, and hospice settings, a physician shall not prescribe, dispense, or otherwise provide, or cause to be provided, such a drug to a person who the physician has never personally physically examined and diagnosed, except in accordance with the following requirements:

- (1) The physician is providing care in consultation with another physician who has an ongoing professional relationship with the patient, and who has agreed to supervise the patient's use of the drug or drugs to be provided; and
- (2) The physician's care of the patient meets all applicable standards of care and all applicable statutory and regulatory requirements.

These rules do not apply to, or prohibit, the provision of drugs to a person who is admitted as an in-patient to, or as a resident of, an institutional facility. An "institutional facility" means a hospital, convalescent home, developmental facility, long-term care facility, nursing home, psychiatric facility, rehabilitation facility and mental retardation facility.

The above prohibitions do not apply to the provision of controlled substances or dangerous drugs by a physician to a person

who is a patient of a colleague of the physician, if they are provided pursuant to an on-call or cross-coverage arrangement between the physicians. The rule also does not apply to the provision of controlled substances or dangerous drugs by a physician to a person who the physician has accepted as a patient, if the physician has scheduled, or is in the process of scheduling an appointment to examine the patient, and the drugs are intended to be used pending that appointment.

The prohibitions also do not apply to the provision of controlled substances or dangerous drugs by emergency medical squad personnel, nurses, or other appropriately trained and licensed individuals in accordance with protocols approved by the Ohio State Board of Pharmacy nor by a nurse practicing in accordance with a standard care arrangement that meets the requirement of Ohio law and rules promulgated by the Ohio State Board of Nursing.

Lastly, the prohibitions do not prohibit the provision of controlled substances or dangerous drugs by a physician who is a medical director of a hospice program licensed under Ohio law to a patient who is enrolled in that hospice program. ■

New Hospital Requirements Affect Physicians

The Centers for Medicare & Medicaid Services (CMS) published a final rule revising requirements in the hospital conditions of participation for completion of history and physical examinations, authentication of verbal orders, securing medications, and completion of postanesthesia evaluations. The new rule, implemented Jan. 26, requires the following:

- **History and Physical (H&P) Examination:** This requirement expands the timeframe for completion of the H&P and expands the number of permissible professional categories of individuals who may perform the H&P.
 - (1) An H&P must be completed at least 30 days prior to or 24 hours after an admission, but before a surgical procedure;
 - (2) An H&P performed prior to admission does not need to be completed by a practitioner credentialed and privileged by the admitting hospital, but the practitioner must be qualified to perform H&Ps in accordance with state law and hospital policy. (CMS is staying out of the fight about which practitioners may perform H&Ps.);
 - (3) H&Ps performed prior to admission must be updated within 24 hours of admission prior to surgery;
- **Authentication of verbal orders:** This regulation requires that all orders, including verbal orders, **must be** dated, timed and authenticated by the prescribing practitioner with a temporary exception. For a five-year period, beginning with the date of publication of the final rule (Nov. 2006), the regulation requires that all orders, including verbal orders, must be dated, timed and authenticated promptly by the prescriber or another practitioner responsible for the care of the patient, even if the order did not originate with him or her.
 - (1) Hospitals still must prohibit the routine use of verbal orders;
 - (2) All orders, including verbal orders, must be dated, timed and authenticated by the ordering practitioner or for the next five years by another practitioner who is responsible for the care of the patient and is authorized to write orders by hospital policy/state law; and
 - (3) The timeframe for authentication of verbal orders is 48 hours. For the five-year period, verbal orders no longer need to be signed by the prescribing practitioner but can be authenticated by another practitioner responsible for the care of the patient.
- **Postanesthesia evaluation:** This requirement permits the postanesthesia evaluation for inpatients to be completed and documented by any individual qualified to administer anesthesia. ■

Welcome 2007 AMCNO Group Members

The Academy of Medicine Cleveland & Northern Ohio gratefully acknowledges the following for their support of organized medicine in our region through group membership:

Huron Hospital Group
Lakewood Hospital Group
Lutheran Hospital Group
Marymount Hospital Group
Parma Hospital Group
St. John West Shore Hospital Group

The AMCNO is pleased to have the support of these group members and hopes their commitment inspires other regional hospitals, groups and health professionals in Northern Ohio to facilitate our organization's mission to promote the practice of the highest quality of medicine. For more information on individual or group membership, contact Linda Hale at (216) 520-1000 ext. 101.



Laura David, MD, presents at a recent University Hospitals OB/GYN Faculty meeting on various AMCNO advocacy initiatives and the many benefits of membership for a hospital group with the only regional physician organization in Northern Ohio. If you would like the AMCNO Membership department to schedule a similar presentation to your medical staff, contact Linda Hale at (216) 520-1000 ext. 101.

The 4th Annual ACADEMY OF MEDICINE EDUCATION FOUNDATION MARISSA ROSE BIDDLESTONE MEMORIAL GOLF OUTING

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1-2-3 Best Ball Format
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Proceeds to benefit the Academy of Medicine Education Foundation, its local medical school scholarship programs and public health education initiatives in our region.

Call Linda Hale (216) 520-1000
to Register Today!

NEO RHIO (Continued from page 6)

NEO RHIO Goals

- make all necessary health care information available to patients and providers where it is needed, when it is needed
- provide a secure, confidential, patient-controlled environment for health information exchange
- provide opportunities for patients to more actively participate in their health care
- reduce duplicative testing, administrative burdens, and other barriers to cost-effective health care
- enable important public health functions including biosurveillance
- enable more effective disease prevention and chronic disease management
- enable health care research using de-identified data
- reduce disparities in health care
- provide transparency to enhance quality assessment and value comparison
- enhance the economic viability of the region

From the AMCNO Board of Directors:

The Board of Directors of the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) had the opportunity to review the NEO RHIO Business Plan at their meeting on January 23, 2007. Overall, the AMCNO board agreed that the business plan was very comprehensive and provided a thorough overview of the project. Based upon their review, the AMCNO Board voted to approve the NEO RHIO Business Plan provided that the following items were open for further discussion and action by the NEO RHIO:

1. The AMCNO board is of the opinion that the proposed annual fee structure and pricing for potential NEO RHIO membership should be reevaluated with broad-based input from physician practices in the community. The board agreed that the annual fee for individual practitioners appears high and there are no fees outlined for small physician groups. The NEO RHIO should convene groups of physicians that are practicing in the community to review and comment on the fee structure.
2. The AMCNO board realizes that the NEO RHIO project at this time is hospital-centric, however, it is the physicians and their team that provides the care in the hospitals that will be inputting and utilizing the data that will flow through the NEO RHIO process. We realize that the hospital CEOs will ultimately make the monetary decisions regarding participation in the NEO RHIO, and the hospital CIOs will evaluate the implementation strategies of the project, however, we believe that convening physician leadership is also of great importance. Meetings should be set up as soon as practicable with the hospital chiefs of staff and the emergency department leaders on an ongoing basis to review and evaluate the implementation of the NEO RHIO project.

The AMCNO stands ready to assist the NEO RHIO project staff in convening groups of physicians and physician leaders to further evaluate this project as it develops in our community. The AMCNO believes physician input is of paramount importance to the success of this project. ■

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Medical Records Fact Sheet Update Effective January 2007

Retention of Medical Records

Medical considerations are the key basis for deciding how long to retain medical records. Rules relating to the maintenance of patient records are to be found in the American Medical Association, Council on Ethical and Judicial Affairs, Code of Medical Ethics, Current Opinion **7.05**. Under Ohio Law (R.C. §**4731.22 (B)(18)**), violations of the AMA ethical rules can result in disciplinary action by the Ohio State Medical Board. Most states, including Ohio, do not have a general state law that requires records be kept for a minimum length of time. Ohio Revised Code §**2913.40 (D)** mandates the retention of records associated with Medicaid for a period of at least six (6) years after reimbursement for the claim is received by the physician. It is recommended that records relating to a Medicare patient be kept for at least six (6) years after the physician received payment for the service. Medicare's Conditions of Participation requires five (5) year retention. Managed care contracts should be consulted to see if they provide any specified period of retention of medical records. In all cases, medical records should be kept for the length of time of the statute of limitations for medical malpractice claims. Under Ohio Law an action for medical malpractice must be brought within one year after the cause of action "accrues" (R.C. §**2305.113**). However, there are various exceptions or special rules. For example, the statute of limitations in wrongful death cases is two years after the date of death. In the case of a minor, the statute of limitations does not begin to run until the minor has reached his or her 18th birthday. The statute can be "tolled" or otherwise extended in other situations, and the date on which a cause of action "accrues" can vary. As a practical matter, all of this makes it difficult to define the Ohio statute of limitations with absolute certainty. If you are discarding or destroying old records, patients should be given the opportunity to claim the records or have them sent to another physician. The AMCNO recommends that physicians keep medical records indefinitely, if feasible.

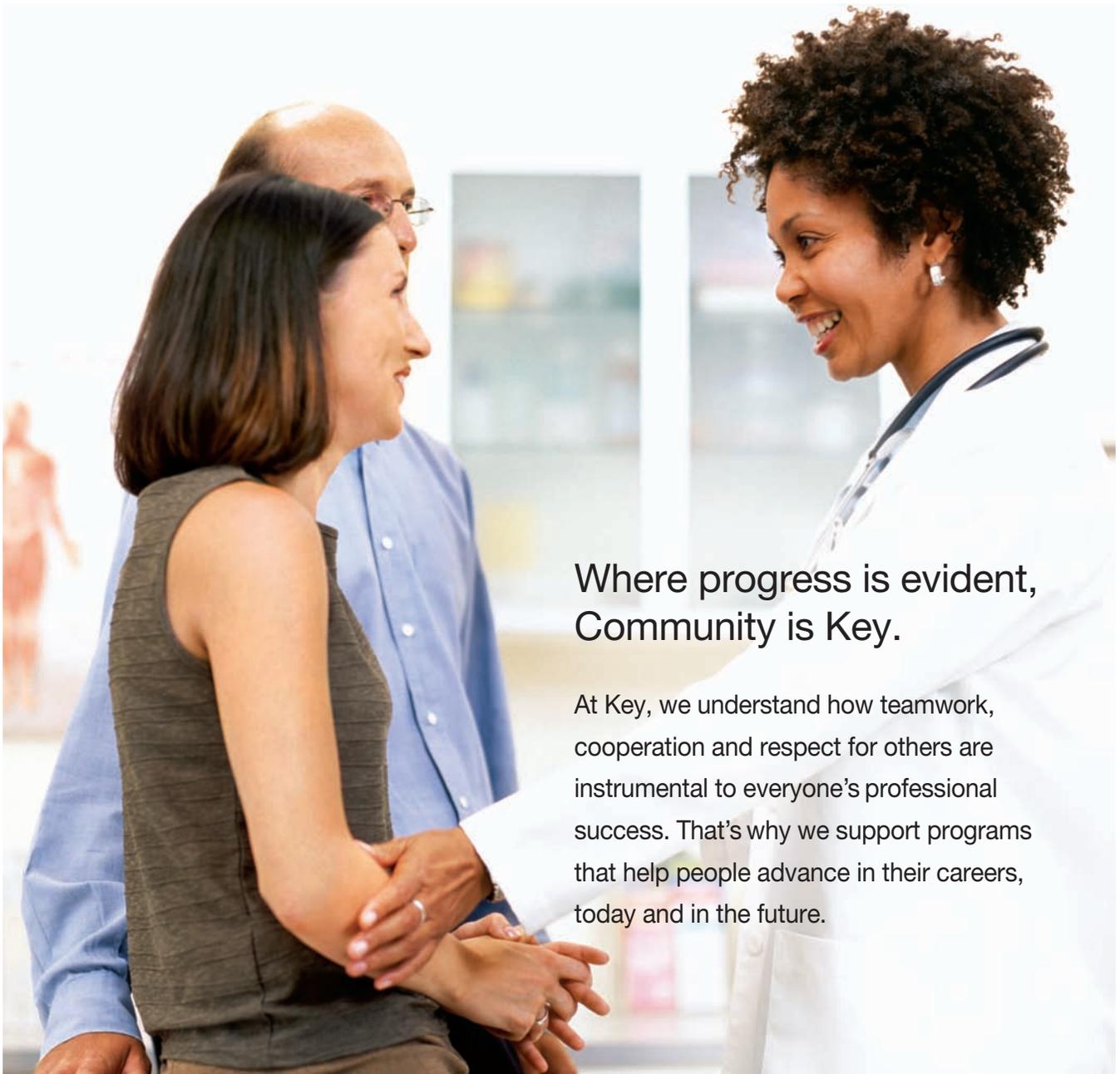
Update on Charging for Copies of Medical Records

A physician who treated a patient should not refuse for any reason to make records of that patient promptly available on request to another physician presently treating the patient, or, except in limited circumstances, refuse to make them available to the patient or a patient's representative (not an insurer). A written request signed by the patient or by what the law refers to, as a "personal representative or authorized person" is required. Ohio Revised Code §**3701.74** obligates a physician to permit a patient or a patient's representative to examine a copy of all of the medical record. An exception arises when a physician who has treated the patient determines for clearly stated treatment reasons that disclosure of the requested record is likely to have an adverse effect on the patient, in which case the physician is to provide the record to a physician chosen by the patient. Medical records should not be withheld because of an unpaid bill for medical services. Ohio law establishes the maximum fees that may be charged by health care provider or medical records company that receives a request for a copy of a patient's medical record. Ohio law provides for certain limited situations in which copies of records must be provided without charge, for example, where the records are necessary to support a claim by the patient for Social Security disability benefits. EFFECTIVE JANUARY 2007, the maximum fees that may be charged, are as set forth below.

- (1) The following maximum fee applies when the request comes from a patient or the patient's representative.
 - a) No records search fee is allowed;
 - b) **For data recorded on paper:** \$2.67 per page for the first ten pages; \$0.55 per page for pages 11 through 50; \$0.22 per page for pages 51 and higher
For data recorded other than on paper: \$1.82 per page
 - c) Actual cost of postage may also be charged

- (2) The following maximum applies when the request comes from a person or entity other than a patient or patient's representative.
 - a) A \$16.38 records search fee is allowed;
 - b) **For data recorded on paper:** \$1.08 per page for the first ten pages; \$0.55 per page for pages 11 through 50; \$0.22 per page for pages 51 and higher
For data recorded other than on paper: \$1.82 per page
 - c) The actual cost of postage may also be charged

Ohio Law requires the Director of Health to adjust the fee schedule annually, with the first adjustment to be not later than January 31, 2007, to reflect an increase or decrease in the Consumer Price Index over the previous 12-month period. If you have any questions regarding this fact sheet or other practice management issues, please contact the AMCNO at (216) 520-1000 ext 103.



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