

AMCNO keynotes nationally recognized City Club Forum

The Academy of Medicine of Cleveland was honored to have **Dr. John A. Bastulli**, AMCNO Vice President of Legislative Affairs invited as a keynote speaker at the City Club Forum on Wednesday, August 22nd. Dr. Bastulli was the featured speaker representing the viewpoint of organized medicine and physicians on the issue of tort reform and the need for a mandatory arbitration process in Ohio. Dr. Bastulli faced Peter Weinberger, Esq., in a debate where he was able to aptly provide the audience with concise information on the need for a change in the tort reform system.

Dr. Bastulli opened the forum by providing detailed information on SB 59, legislation sponsored by Senator Kevin Coughlin of Cuyahoga Falls and submitted on behalf of

the AMCNO, which would establish a pilot program that requires all cases of alleged medical negligence be submitted to
(Continued on page 3)



Dr. Bastulli delivers a key point during his address at the City Club.

AMCNO Physician representatives meet with Medicare Payment Advisory Commission

AMCNO board members Drs. James Taylor, Lawrence Kent, William Seitz, Jr., Paul Janicki, George Topalsky and Anthony Bacevice met with representatives from MEDPAC and Mathematica in July to discuss private payor plans usage of episode grouper (pay-for-performance) software as well as their interactions with and reactions from the physician community.



AMCNO physician representatives discuss key issues with MEDPAC and Mathematica staff.

The purpose of this meeting was to provide input into a study coordinated by Mathematica Policy Research. The final study will be provided to MedPAC — a congressional commission that advises Congress on Medicare payment issues. The Center for Medicare and Medicaid Services (CMS) is investigating

the use of episode grouper software in the future as part of the Medicare program. The study group has met with other physicians and hospitals around the nation and plans to prepare a report for Congress in the near future based upon these discussions.
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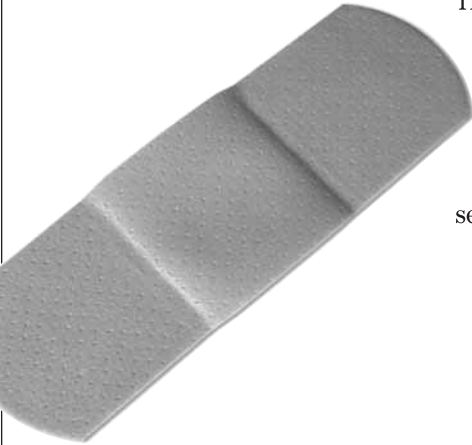
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AMCNO keynotes nationally recognized City Club Forum (Continued from page 1)

nonbinding arbitration. He noted that last year, a similar piece of legislation sponsored by Senator Coughlin, SB 88, passed the Ohio Senate late in the legislative year, but was not heard by the Ohio House prior to the legislature's recess.

Dr. Bastulli further noted that members of the Academy of Medicine of Cleveland and Northern Ohio (AMCNO) have made it clear that medical liability, the cost and availability of professional liability insurance and the fear of litigation remain their most pressing concerns and represents a significant threat to their ability to practice medicine and provide their patients with continued access to safe, cost-effective healthcare services. In addition, medical students who receive their education and training in Ohio are choosing not to train and/or practice here incident to our medical liability climate — which could result in a physician shortage in Ohio. There is no doubt that the primary reason for the continuing medical liability crisis is the cost of investigating, defending and settling claims brought against physicians and hospitals.

He informed the audience that the AMCNO is confident that SB 59 will reduce healthcare expenditures, stabilize the professional liability insurance market and help the current system to evolve to achieve three social goals: (1) to promote patient safety and quality outcomes;



Dr. George Topalsky, AMCNO board member, poses a question during the City Club debate.

(2) to compensate patients who are truly injured as a result of medical negligence in a fair, timely and equitable fashion; and (3) to extract corrective justice for all parties involved.

Dr. Bastulli outlined the intent of SB 59, which directs the head of the Ohio Department of Insurance (ODI) in collaboration with the Ohio Supreme Court, to establish a pilot program mandating arbitration for medical negligence claims in specific areas of the state. The intent of the pilot program is to determine the benefits of using arbitration in disputes. By structuring a required arbitration process that focuses on liability only — as outlined in SB 59, meritorious cases of any size are likely to be resolved and frivolous claims are less likely to be pursued. "SB 59 is legislation designed to preserve the rights of litigants, promote a more hospitable medical malpractice environment, foster patient safety initiatives and reduce healthcare expenditures," concluded Dr. Bastulli.

Following Dr. Bastulli's remarks Mr. Peter Weinberger spent the majority of his presentation blaming the medical liability problem on the medical malpractice insurance companies. He indicated that the passage of SB 281 in 2003 emasculated the rights of medical malpractice victims by placing caps on noneconomic damages of \$250,000 and that SB 59 would only create further obstacles for plaintiffs.

Questions from the audience were addressed both to Dr. Bastulli and Mr. Weinberger on a variety of issues, including whether or not the arbitration process in SB 59 differed from previous law in Ohio and whether it would add cost to the system. Dr. Bastulli readily responded to these queries by noting that the process outlined in SB 59 is a pilot program which would actually provide cost savings to the system because it is conducted pre-filing by a qualified panel conducting the arbitration, and the decisions are made only on the merit of the case.

A complete copy of this forum is accessible through the City Club Web site at www.cityclub.org. A copy of Dr. Bastulli's presentation is also available on the AMCNO Web site under the SB 59 information link at www.amcnoma.org. Specific questions or comments on this issue may be addressed to Elayne R. Biddlestone, executive vice president of the AMCNO at (216) 520-1000, extension 100 or at ebiddlestone@amcnoma.org ■

AMCNO Physician representatives meet with Medicare Payment Advisory Commission (Continued from page 1)

In response to questions regarding how quality information would be most useful to physicians, the group was of the opinion that at the very least the data should compare a doctor to a local peer group and a national benchmark. In addition, it was made clear that many physicians are already working with electronic health record systems and programs and there is a real concern as to whether or not the system is going to be compliant down the road — especially if CMS and the federal government start using new software — this issue must be addressed.

Concerns were raised that if CMS was to add yet another layer of work on physicians under Medicare rules to track data for quality reporting, and continue to cut physician pay and reimbursement it is not going to be workable.

It is a known fact that specialty societies and other national organizations are involved in setting parameters for these type of programs, yet not all carriers are using this information; rather they are developing different criteria and their own tracking mechanisms. If CMS and Medicare determine that they "must" implement a program then the parameters and measurements used should be based upon input from physicians and their specialty societies. In addition, there should be one set developed and utilized by all insurance companies if possible. There is still the medical liability cost factor to consider as well as the issue of how physicians are supposed to pay for the electronic health systems to implement these programs. The group also agreed that a big factor is patient accountability and noncompliance — patient behavior does play a role in utilization of services.

The takeaway message from the AMCNO physician leadership to MedPAC was that it will be important to inform physicians regarding:

parameters to be measured; what tools/software will be needed to provide the information on these measurements and will current systems be compliant; what will physicians need to document to comply; can the review program software be implemented in a pilot format reviewing only a select number of procedures; and in order to alleviate the need to comply with different review programs, Medicare should consider whether or not the parameters used should be applied uniformly across all other health insurance companies. Last, the group asked if there were plans to include a funding mechanism for this concept to ensure that additional costs would not be passed onto physicians.

The AMCNO is in contact with MedPAC staff and a copy of the report will be provided to the AMCNO.

Editor's Note: For more information on this meeting, please contact E.R. Biddlestone at the AMCNO offices. ■

AMCNO Representatives Participate on UnitedHealthCare Physician Advisory Committee

As a follow-up to the AMCNO board meeting with the new Northern Ohio Medical Director for UnitedHealthCare (UHC), the AMCNO was invited to send physician representatives and staff to the Physician Advisory Committee (PAC) meeting of UHC. In June, the PAC committee met to discuss the laboratory referral matter, the UHC Practice Rewards Program and the UHC radiology notification program.

UHC Lab Referral Issue

During the PAC meeting, UHC indicated that they plan to take action with respect to lab referrals only when physicians make continued, material use of nonparticipating laboratories and then only after discussions with those physicians. In addition, UHC indicated that to date no fines have been implemented. UHC also claims that they will not attempt to hold physicians accountable when their patients independently use out-of-network lab providers. The last item noted on this issue was that UHC subscribers will be receiving written notification in the mail in the near future about utilizing nonparticipating labs and the consequences for same, so physicians may expect to get questions from their patients. The AMCNO continued to advocate for our members by offering our opinion that physicians should not be subject to a change in rating or a penalty by an insurance company if the patient makes a decision to use a non-network lab. The AMCNO also questions the authority of UHC to require financial penalties against physicians as well as how these penalties would be applied.

AMCNO representatives noted that any letters sent out to UHC subscribers should also be sent out UHC contracted physicians as well — inclusive of detailed information as to where UHC subscribers and physicians could obtain the list of regional labs so that physician's staff can respond to any questions that may arise from the UHC members — since this could offset additional work on the part of the physicians if their patients ask questions. It should not be left up to the physicians to respond to questions from patients.

The AMCNO plans to continue to monitor this activity by UHC. If any member of the AMCNO has a concern about the lab protocol please contact us.

Practice Reward Program

The second topic of discussion, UHC's Premium Designation Program and Practice Rewards program has already been covered in this magazine (see July/August issue.) Of note, however, were comments made by physicians at the PAC meeting concerning the lack of information on the criteria used by UHC, the fact that information was not readily available about how the program functioned — specifically on the UHC Web site, and that physicians had to talk to the UHC medical directors to obtain information. The AMCNO responded to UHC by stating that there is a great deal of frustration on the part of physicians concerning ease in accessing information from the UHC on this program. We question whether data that would be a useful tool for physicians is available on the UHC Web site or whether certain data can only be obtained by contacting a medical director from UHC. The AMCNO has asked UHC to develop an informational piece outlining the details of what information is available on the UHC Web site inclusive of links as to where it can be viewed. In addition, the AMCNO has asked that UHC consider providing ongoing updates to physicians via email or other resources.

Radiology Notification Program

The PAC committee did not get a chance to cover the radiology program, however, AMCNO heard a presentation on this topic at our recent board meeting. UHC has noted that there has been an increase in imaging services and that 50 to 60% of the total amount spent is for "high-end" imaging, i.e., CT, MRI, Nuclear Medicine/Cardiology, PET, and Echocardiology. As the use of these modalities becomes more widespread, there are variations in the quality of the examinations, safety provisions, and appropriate utilization. UnitedHealthcare has developed their notification program to address these variations and to reduce duplication of services by developing guidelines based on evidence-based practices and physician guidance.

The program is two-pronged. Beginning March 1, 2008, all imaging facilities providing services to United Healthcare patients must

be accredited, or have applied for accreditation. This accreditation is based on guidelines recognized by the American College of Radiology (ACR), and/or the Intersocietal Accreditation Commission (IAC). All imaging facilities will be held liable, and cannot balance bill the patient.

The "notification" process represents the other prong of the imaging quality assurance program. With the exception of those physicians who are designated as Premium Q & E Providers, all physicians ordering "high-end" imaging must notify United Healthcare of their intent by phone, fax, or email, to receive a "notification" number. This should take a "short" time, but may take up to 24 hours if done by fax. In some cases, a peer review with a radiologist will be required. The time required for this peer review seems to average between three and four minutes, and if the peer review is not begun within 90 seconds, then the physician will be given a notification number, regardless. Since January, the use of the Web for these notifications has increased from 4% to 25%, and appears to expedite the process.

It was repeatedly emphasized that this is an attempt to use evidence-based clinical guidelines to support physicians in their decision-making process. Seventy percent of requests receive a notification number on the initial request, while 10 to 12% advance to a peer review with a radiologist, which may result in a more appropriate study, i.e., a MRI, instead of a CT scan, or vice versa. Regardless, if the physician feels strongly that a certain imaging study be performed, he will be given a notification number, and the study can then be performed.

Editor's Note: The AMCNO would like to hear from members if you have experienced problems concerning the radiology process or any other UHC program. Please send comments to ebiddlestone@amcnoma.org or contact her at AMCNO offices at (216) 520-1000, ext. 100.

Dr. Paul C. Janicki, Immediate Past President of the AMCNO and AMCNO representative to the UnitedHealthCare Physician Advisory Committee contributed to this article. ■

AMCNO REPRESENTATIVES MEET WITH DIRECTORS OF TWO STATE DEPARTMENTS TO DISCUSS ISSUES OF IMPORTANCE TO OUR MEMBERS

Meeting with the Ohio Department of Job and Family Services (ODJFS.)

A recent meeting with the ODJFS Director Helen Jones-Kelley was arranged by the AMCNO due to input we have received regarding the rollout of the Medicaid Managed Care plans. There are physicians in several areas of NE Ohio who want to continue to serve the uninsured, but they have become disenfranchised because of the way the Medicaid managed care plans were implemented and how contracts were obtained. Physicians who have treated Medicaid patients and have an established patient/physician relationship are now unable to treat these patients and obtain reimbursement because they are not under contract. This has resulted in Medicaid patients who are unable to return to their physician of choice due to plan enrollment. ODJFS concurred that unless the physician is a part of the provider network for that plan, or has prior authorization from the MCP to provide covered services, they will not be paid.

ODJFS stated that they are negotiating and establishing provider panels on a yearly basis through the contracted insurance companies. ODJFS reserves the right to request to set a cap on Medicaid members and a cap on the maximum amount of capacity that they will recognize for a primary care provider. In addition, there are levels set for the amount of hospitals and providers that have to be contracted with in a given geographic area based upon population size, utilization patterns and provider availability. There are only a certain ratio of enrollees allowed for a contracted MCP — and the managed care plans are instructed to monitor the physician practices — if a practice has over a certain number of enrollees there is a cutoff point. Therefore, physicians could be excluded from the panels.

The AMCNO asked ODJFS if they would consider surveying the Medicaid recipients in the state to ascertain their level of understanding of the program, whether or not they are able to see their physician of choice, what information they get from the plans, etc. ODJFS staff stated that they felt that it was “too early” in the process to ask the enrollees questions because the program had not had enough time to develop.



Following the Medicaid Managed Care discussion, Dr. John Bastulli (left), spent some time with Cristal Thomas (ODJFS), Director Jones-Kelley, and Jeff Jeney, CEO of Saint Vincent Charity Hospital.

AMCNO commented that this is the very population that the ODJFS needs to hear from the most and it seems that obtaining information directly from the participants in the plans is important. There is a need to see if patients are experiencing access/choice problems in a given area. The AMCNO letter to the Director pursued this request.

AMCNO asked if physicians were able to contact their former or current Medicaid patients prior to the next enrollment period in order to provide their patients with information on which managed care plans contract with the physician. This would allow patients to make an informed decision regarding plan enrollment. ODJFS stated that physicians are allowed to send a communication to their patients informing them of which panels they are currently on, however, physicians cannot encourage enrollment in a particular plan in any way. Therefore, if physicians have a roster of Medicaid patients who have been or are part of their practice they may wish to write a letter to these patients to let them know which Medicaid Managed Care plans they are enrolled with in their practice. Physicians should consider sending these letters far in advance of the October enrollment period.

MEETING WITH THE OHIO DEPARTMENT OF INSURANCE (ODI)

The AMCNO also met recently with Director Mary Jo Hudson, and her Policy and Legislation staff to obtain her opinion on SB 59 — the mandatory arbitration legislation. Discussion with the ODI Director centered on SB 59 — the mandatory arbitration legislation spearheaded by the AMCNO. SB 59 directs the head of the ODI in collaboration with the Ohio Supreme Court, to establish a pilot program mandating arbitration for medical negligence claims — inclusive of the ODI

choosing the counties for the pilot program based upon specific criteria and demographics. Director Hudson indicated that to date ODI have not taken any action on the bill however, the Legislative Service Commission (LSC) had asked ODI to submit a fiscal report regarding how the implementation of SB 59 would affect staffing at ODI, if any. ODI has estimated that in order to comply with the requests contained in SB 59 ODI would have to hire another attorney and at least one paralegal on the staff. Director Hudson asked if SB 59 contained a funding mechanism to implement the bill. AMCNO plans to follow up with the sponsor of the bill, Senator Coughlin to discuss inclusion of an amendment in the legislation to deal with the ODI funding request.

With regard to the medical liability insurance market, Director Hudson indicated that ODI is beginning to see a marked difference in rates. They are carefully reviewing the underwriting and rate-setting requirements of companies and rates seem to have stabilized, but more than likely they will not get down to their former level. ODI is required to provide closed claim data reports based upon information obtained from the insurance companies and ODI has just started this process so there are no real trends to show.

On the issue of the uninsured ODI informed the AMCNO that ODI is planning to conduct an actuarial study to review the alternatives for coverage reform. ODI plans to put together groups of stakeholders in the near future as this concept moves forward. AMCNO has been invited to participate as a part of the physician stakeholder group.

(Continued on page 16)



Dr. John Bastulli spends a moment with the Director of the Ohio Department of Insurance, Ms. Mary Jo Hudson.

BOARD ACTIVITIES

Medical Director of Ohio KePRO presents to AMCNO Board



Dr. Savrin makes a key point during his presentation to the AMCNO board of directors

At the June board meeting, Dr. Ronald A. Savrin, Medical Director of Ohio KePRO provided the AMCNO board members with a presentation on the current activities of KePRO. Ohio KePRO is a healthcare information company that is committed to continuous quality improvement in health care. As the Medicare Quality Improvement Organization (QIO) for Ohio, Ohio KePRO works on quality improvement initiatives in nursing homes, home health agencies, and physician practices for Medicare beneficiaries.

For hospitals, Ohio KePRO is working to reduce failure to provide patients with all inappropriate care for pneumonia, congestive heart failure and acute myocardial infarction. KePRO is also working to reduce failure to provide a surgical care improvement program (SCIP) in hospitals.

On the physician side, Ohio KePRO has worked with physician offices that have electronic medical records or are working to implement EMRs to assist them in the adoption of EMR, and increase the reporting data of these practices along with increasing the adoption of care management processes.

Dr. Savrin also provided the AMCNO board with background on the Health and Human Services Secretary Leavitt's report to Congress "Improving the Medicare Quality Improvement Organization

Program." This report set forth the goals of the Value Driven Healthcare/Value Based Purchasing program. This program, has become a guiding principle of a new initiative by HHS to improve healthcare quality and control healthcare costs. It is based on four defined cornerstones:

1. Connecting the system – identifying standards so that health information technology (HIT) systems can function on an interoperative basis and supporting electronic health records (EHRs).
2. Measuring and publishing quality data – identifying valid quality measures and defining benchmarks, using those measures to assess the quality of care delivered and reporting the results of those measurements publicly to all stakeholders.
3. Measuring a publishing price data – using an "Episodes of Care" model, reaching agreement on what procedures and services are appropriate, measuring both the cost and the price of those services, and reporting the results publicly to all stakeholders.

4. Creating positive incentives – to encourage all stakeholders to participate in arrangements that reward those who offer and those who purchase high-quality, competitively-priced health care.

Ohio KePRO has been designated a "Community Leader for Value-Driven Healthcare." Being designated as a Community Leader for Value-Driven Healthcare is a precursor to becoming a Value Exchange (VE). A Value Exchange is defined by HHS as an organization that has taken clear action in its community to convene industry stakeholders and advance the four cornerstones of Value Driven Health Care.

A key chartering term for the VE is that the VE must work directly with QIOs, medical specialty societies or associations and/or health plans. The AMCNO has notified Ohio KePRO that we are interested in working with KePRO on this initiative. Additional information on this project (if implemented) will be covered in future issues of the magazine. ■

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LEGISLATIVE ACTIVITIES

By Michael Wise, AMCNO lobbyist

STATEWIDE ACTIVITIES

My report in June focused on the Ohio budget and provided a historic overview of budget spending and trends. As I mentioned, Ohio has an annual budget that runs from July 1 to June 30. The budget was passed on June 27, 2007 and signed by Governor Strickland on June 30, 2007. The legislation contained significant provisions to expand access to health care for Ohio children. All children up to 300 percent of the federal poverty line will now have access to health-care through the State Children's Health Insurance Program. Also, families at incomes above 300 percent of poverty will be able to buy health coverage from the state for children with special needs that prevent them from qualifying for private insurance. This effort to improve access was bipartisan. Republican House member Jim Stewart introduced HB 6 early in this legislative session. HB 6 increased the income eligibility limit for the Children's Health Insurance Program Part II to three hundred per cent of the federal poverty guidelines. The Governor took that legislative language and expanded the provisions in HB 119, the Budget Bill. Both the Republican controlled House and the Republican controlled Senate supported the provisions, thus the inclusion in the final version.

The Governor's administration has been busy with other issues. Enforcement of Ohio's indoor smoking ban — which voters approved in November 2006, began recently. "We are pleased to clear the air in Ohio's public places, and protect Ohioans from the dangers of secondhand smoke," said Ohio Department of Health (ODH) Acting Director Anne R. Harnish. Businesses and places of employment were required to prohibit smoking, remove ashtrays and post no-smoking signs with the toll-free enforcement number — 1-866-559-6446 (OHIO) — beginning Dec. 7, 2006. ODH; however, was unable to levy fines until enforcement rules were in place. ODH wrote the enforcement rules in collaboration with an advisory committee made up of 34 representatives from 27 statewide organizations and in recognition of some 55,000 public comments received either in person at public hearings, in writing or via

telephone and email. Since the ban took effect, ODH has received more than 17,000 reports of alleged violations; these complaints resulted in informational letters reminding these entities of their threefold obligation under the law. Alleged violations are now forwarded to local health departments — ODH's designated enforcement agencies — which will then investigate complaints in their respective jurisdictions. No fines will be issued until local health departments conduct on-site investigations. Businesses cited under the law are subject to a warning letter for the first violation and fines of \$100 (second violation), \$500 (third), \$1,500 (fourth) and \$2,500 (fifth and subsequent violations). Individuals are subject to a warning letter for a first violation and \$100 fine for second and subsequent violations. Businesses and individuals cited under the law have the right to appeal.

Finally, as of April 2007 the ODH requires Ohio hospitals to report semiannual data with the ultimate goal of making this data available to all Ohioans. The Department is currently collecting six measures endorsed by the Joint Commission, the Centers for Medicare and Medicaid Services and the National Quality Forum regarding heart attacks, heart failure and pneumonia. In addition, the Department is collecting five Patient Safety Indicators created by the Agency for Healthcare Research and Quality regarding surgical procedures. The information reported by the hospitals is now available in at the following Web site: <http://www.odh.ohio.gov/healthStats/hlthserv/hospitaldata/hospperf.aspx>.

OHIO SUPREME COURT ACTIVITIES

In the Judicial branch, the Ohio Supreme Court continues to deliberate on the constitutionality of limits on noneconomic damage awards. The caps at issue are not for medical malpractice but most legal experts believe that the Court's ruling will have an impact on the similar caps in place for medical malpractice. The first major attack from the plaintiff's bar against recent reforms to Ohio's civil justice system came last June 2006 in the *Arbino v. Johnson & Johnson* case. Four questions were certified

from the U.S. District Court for the Northern District of Ohio to the Ohio Supreme Court. The Court was asked to rule on the constitutionality of three major provisions passed in 2004 in SB 80. The provisions include the caps enacted on punitive and noneconomic damages as well as the collateral source provisions. The Court heard oral arguments on May 1, 2007 with no decision yet. **AMCNO is a named entity in an Amicus Brief filed to support the constitutionality of the caps.**

LEGISLATIVE ACTIVITIES

In the Legislative branch, the Ohio House, Healthcare Access and Affordability Committee held a Cleveland hearing. At this hearing, our own **Dr. John Bastulli**, Vice President of Legislative Affairs of the AMCNO, testified. (see related story on page 8.) One of the points made by Dr. Bastulli is that there has been increased scrutiny regarding the amount of charity care provided by hospitals including discussions about favored tax exemptions given to hospitals and their nonprofit status. Hospitals run on razor-thin margins and can ill afford to pay more into the system. To ensure ongoing access to care across the state, it will be important to assess this issue in the future in the state of Ohio. The AMCNO is currently working on legislation in cooperation with the Center for Health Affairs ("CHA") to address the community benefit issue. Legislation has been drafted and is currently being reviewed by both CHA and the AMCNO. This Legislation may be ready for introduction this fall and if passed would provide needed predictability for Ohio hospitals as far as the issue of tax exempt status. If this issue is not addressed fairly in Ohio it could have far-reaching implications for our hospitals and the physicians practicing at these hospitals.

Both the House and the Senate have seen the introduction of a number of health care-related bills. AMCNO 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, please contact **Elayne Biddlestone** at (216) 520-1000. ■

LEGISLATIVE ACTIVITIES

AMCNO PROVIDES TESTIMONY TO THE HOUSE HEALTHCARE ACCESS AND AFFORDABILITY COMMITTEE

On July 30th, Dr. John Bastulli, Vice President of Legislative Affairs of the AMCNO, provided testimony on behalf of the AMCNO to the House Healthcare Access and Affordability and the Senate Health, Human Services and Aging Committees. The joint committee hearing was held in Cleveland and was the first in a series of statewide hearings where the committees plan to hear testimony from members of the public on various health care-related issues including current health care trends in various regions of the state, discussion on how health care needs change with age and how the health care system can adapt to these changes, and also proposals for viable health care reform.

The AMCNO testimony keyed in on specific points such as the fact that it is estimated 1.3 million Ohioans or approximately 12.3 percent live below the federal poverty level and the fact that the 46 million Americans who are uninsured are paying only five percent of the cost of their care; and that as a nation, we are getting older, heavier and sicker.

AMCNO testimony also noted that declining health status as a result of unhealthy lifestyle choices, contributes to the escalating rise in healthcare costs and that the American Medical Association estimates that 800 billion dollars a year is spent on healthcare services related to five conditions: obesity, tobacco use, sexually transmitted diseases, violence and teen pregnancies. Alcohol and drug abuse is prevalent in patients who present with sexually transmitted diseases, violence and teen pregnancy. The prevalence of obesity and diabetes has doubled over the last 25 years with an increase in diabetes- and obesity-related heart disease. In Ohio the numbers are alarming. 25 percent of the population smokes, 10 percent are obese and 10 percent suffer from diabetes. In order to control costs, reform must address certain unhealthy lifestyle choices. Dr. Bastulli noted that other individuals participating in this debate have stated that healthcare is a basic right and should be provided for all. However, there should be no individual right without individual responsibility.

The AMCNO testimony also noted the high costs of defensive medicine in this county — where it is estimated that the cost of defensive medicine is approximately 124 billion dollars a year, which amounts to 10 percent of the total increase in annual healthcare expenditures, which are presently 8.8 percent. Higher malpractice awards and premiums are associated with higher Medicare spending. In addition,



A capacity crowd was on hand at the joint hearing when Dr. Bastulli testified on behalf of the AMCNO.

medical students that receive their education and training in Ohio are choosing not to train and/or practice here incident to our medical liability climate — which could result in a physician shortage in Ohio.

Further testimony noted that physicians have to work with inefficient health system spending that does not add any value to patient care, such as excessive costs associated with dealing with the myriad insurance companies. The medical system has become more integrated and consolidated, with many physicians now in situations of employment, and negotiating contracts with large integrated health systems and managed care companies that hold the balance of power over patient care and workplace issues. Physicians may find it difficult to negotiate terms of their contracts or obtain information from the plans to assist them in their practice. And insurance companies are implementing pay-for-performance and practice reward programs with increased calls for “transparency” in the healthcare system. More than likely, in order to work within these systems, physicians will have to implement electronic health records in their practice. All of these activities add cost to the healthcare system and should be subject to cost-effective analysis to determine whether or not they actually add value to patient care.

AMCNO suggested several options for the committees to consider, such as was recently done in California — a survey of the uninsured to ascertain their coverage needs and what they would consider adequate and affordable. AMCNO also suggested that legislators should consider a minimum benefit package — one that provides universal coverage for basic, essential services but that focuses on early intervention and prevention. AMCNO also noted that adoption of SB 59 — the mandatory arbitration legislation — would help reduce healthcare expenditures and promote patient safety and quality outcomes. We also voiced

support for coverage expansion for preventive care, and the importance of reviewing the community benefit of hospitals. The AMCNO also pushed for funding at the state medical board level to allow the board to track specific physician demographics in order to focus on the future need for physicians in our state. Last, the AMCNO called for the establishment of a health insurance oversight/advisory committee made up of physicians to work under the auspices of the Ohio Department of Insurance in order to provide input on the manner in which these plans operate in and effort to monitor how these plans impact the practice of medicine from a cost perspective.

HOUSE HEALTHCARE ACCESS AND AFFORDABILITY COMMITTEE CHAIRMAN TO PROVIDE INSIGHT ON HEALTH CARE REFORM CONCEPTS ON THE AMCNO'S HEALTHLINES RADIO PROGRAM

State Representative Jim Raussen (R-Springdale) the Chairman of the Ohio House Health Care Access and Affordability Committee took time out of the Cleveland portion of the joint Ohio House and Senate Committees Health Care Access and Affordability Tour to complete an interview on the AMCNO's award-winning *Healthlines* radio program. The program was meant to provide the community with insight on the work of the committee to date. The committee has been hearing testimony since the beginning of 2007 from health care providers and the public on various health care-related issues including current health care trends in various regions of the state. The *Healthlines* program featuring Rep. Raussen is available as an audio stream at www.amcnoma.org.

For more information on the Healthlines radio program or to receive a copy of the AMCNO testimony provided at the Cleveland hearing, please contact our offices at (216) 520-1000, ext. 100. ■

LEGISLATIVE ACTIVITIES

AMCNO HOSTS LEGISLATIVE BREAKFAST AT PARMA COMMUNITY HOSPITAL

A key component of the AMCNO legislative agenda for 2007 is to coordinate meetings with hospitals/groups in the region. These meetings are to educate physicians and legislators on the ongoing impact of medical issues on access to care, physician practice, hospital care and reimbursement issues.

The breakfast format is not a fundraiser, rather an opportunity for physicians to meet with legislators from the hospital's district. Over the summer months, the AMCNO sponsored a Legislative Breakfast at Parma Hospital. The legislator in attendance for the Parma breakfast was Representative Tim DeGeeter (see a detailed article on Rep. DeGeeter on page 10.)

Dr. Bastulli, the AMCNO VP of Legislative Affairs provided the group with an overview of how the AMCNO legislative process functions as well as hitting upon key pieces of legislation on the AMCNO radar screen — with specific emphasis on the mandatory arbitration bill as well as the community benefit bill under review by the AMCNO along with the Center of Health Affairs.

A key item of discussion at the Parma breakfast was physician reimbursement and the impending Medicare payment cuts. Rep. DeGeeter noted that this was a federal issue, however, it was pointed out to him that it is important to note that most physician practices have contracts with private insurers who base their payment rates on the Medicare fee schedule. Therefore, another cut in Medicare payments in 2008 will mean a similar cut in reimbursement rates by other health insurers, further eroding the ability to provide medical care in Northeastern Ohio. Therefore, this issue is critical to continued medical access for his constituents in the community.

It was also noted that even if the Medicare physician payment cuts are avoided in 2008,

physicians still continue to experience problems with other health insurance plans. That is why the AMCNO is supporting both HB 125 and SB 127 — the Health Care Simplification Act — currently under review by the Ohio legislature. Rep. DeGeeter mentioned his co-sponsorship of the Health Care Simplification Act — legislation that is intended to reduce the burden upon physicians placed upon them by health care insurance companies. The bill would provide for transparency in insurance contracting, standardized credentialing for physicians, and Web-based eligibility and verification. Rep. DeGeeter was provided with a copy of the AMCNO support letter to Rep. Huffman regarding this legislation (see page 10.)

cannot recruit a new partner because no one will relocate to this area. Rep. DeGeeter was educated on the points contained in SB 59 and how the mandatory arbitration concept provided for in the bill is designed to provide for an alternative dispute resolution process that could help physicians deal with the medical liability issue in this region.

With regard to the community benefit issue, Rep. DeGeeter heard that this issue is of concern to both hospitals and physicians. The new Attorney General is planning to be very aggressive in this arena — asking hospitals to prove the amount of charity care they provide and scrutinizing their nonprofit status. The AMCNO will continue to work on this legislation



AMCNO Mike Wise (far right) provides the participants at the legislative breakfast with some key points regarding the legislative process.

With regard to the need for mandatory arbitration legislation such as the pilot program contained in SB 59, Rep. DeGeeter heard from the participants at the meeting that although health care is a major economic force in Northern Ohio, medical students and residents tend not to stay here to practice. In addition, it is becoming difficult to retain and recruit physicians in this area due to the medical liability climate. Northern Ohio continues to be a very hostile environment in which to practice medicine. Several examples were cited including an example where doctors

with the Center for Health Affairs to address this issue and we hope to garner support from both physicians and hospitals as it moves forward in the legislature.

The AMCNO is working to set up legislative breakfasts at area hospitals across the region. If you would like to attend the event or would like to set up a breakfast at your hospital, please email the AMCNO EVP/CEO at ebiddlestone@amcnoma.org ■

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LEGISLATOR SPOTLIGHT



Tim DeGeeter

Representative Timothy J. DeGeeter (D-Parma) serves as the State Representative for the 15th House District, which includes Brooklyn, Middleburg Heights, Parma and Linndale. He was appointed on December 2nd, 2003, and is serving his second full term in the House.

DeGeeter was adopted and raised near South Bend, Indiana. He attended Holy Cross Junior College in Notre Dame, Ind., and then transferred to John Carroll University, where he received his bachelor's degree in political science in 1991. He later earned a law degree from Cleveland Marshall College of Law.

While attending law school, Rep. DeGeeter was published in the *Journal of Law & Health*. His law review article, "The Politics of Reducing Tobacco Use Among Children & Adolescents: Why the FDA Cannot Regulate Tobacco and a Proposed Policy for States and Local Communities," received "The Best Note Award" for 1995-96.

Rep. DeGeeter's service to the law and the people of Ohio is extensive. He has worked as assistant Berea city prosecutor and as Avon Lake's assistant law director before opening a private law practice in 2000. Before his appointment to the Ohio House, Rep. DeGeeter served as Parma City Councilman for Ward 4 from 1998 to 2003.

DeGeeter currently serves on the Healthcare Access and Affordability, Public Utilities, and Civil and Commercial Law Committees. He is also the Ranking Minority Member on the Criminal Justice Committee.

As a co-sponsor of the Healthcare Simplification Act (HB 125*), Rep. DeGeeter realizes the importance of reducing red tape and duplicative paperwork. "Most people would agree that healthcare professionals should spend most of their time in patient and examination rooms. Doctors should focus on what they are trained to do, rather than dealing with unnecessary paperwork in their office."

Earlier this year, Rep. DeGeeter participated in the AMCNO legislative breakfast at the Parma Community Hospital. Health care professionals participated in a roundtable discussion on the importance of healthcare issues for Northeast Ohio. Included in discussion were ways to retain doctors in Ohio, as quality physicians do not stay in Ohio because of the medical liability issue. Health professionals discussed the importance of this issue for Northeast Ohio, as health care is a major economic force.

The Ohio House Healthcare Access and Affordability Committee, along with the Ohio Senate Health and Human Services and Aging Committee visited Middleburg Heights' Southwest General Health Center. As a member of this committee, DeGeeter reached out to people outside of Columbus to seek greater input on ways to establish healthcare reform efforts. The intent of the Committee was to hear:

- The current healthcare trends observed in Northeast Ohio;
- How a person's healthcare needs change as they age and how the healthcare system must adapt to these changing needs while ensuring quality and maximizing efficiency simultaneously; and
- How the current system can more easily adapt to current trends that focus on access, transparency, cost savings, improving efficiency and increasing healthy decisions.

"In the end, we should all strive for common ground for greater access to healthcare for all Ohioans," DeGeeter said. "We have a responsibility in our position as state lawmakers to help where we can when we can in keeping our citizens healthy." ■

HB 125 support letter from the AMCNO sent to Rep. Huffman and provided to Rep. DeGeeter at the AMCNO sponsored legislative breakfast



June 12, 2007

The Honorable Matt Huffman
Ohio House of Representatives
77 South High Street
Columbus, Ohio 43215-6111

Re: House Bill 125

Dear Representative Huffman:

I write on behalf of the Academy of Medicine of Cleveland & Northern Ohio (AMCNO). AMCNO represents 4,400 physicians in Northeastern Ohio, which constitutes a majority of the physicians in our area. The AMCNO is the predominant physician organization in our region and we speak for the physicians of Northeastern Ohio. AMCNO's legislative committee has reviewed HB 125—and we would like to offer our strong support for this Bill.

As physicians, we are acutely aware of the health plans that seek to undercut our ability to advocate for our patients. Physicians may find it difficult to negotiate terms of their contracts, such as the most favored nation clause, and as a result, plans present physicians with non-negotiable contract terms that a reasonable businessperson would never agree to. In this way, health plans are able to determine the kind of health care patients will receive.

The AMCNO has a longstanding history of supporting legislation that would eliminate the "red tape" that physicians encounter when dealing with health care insurance companies. In fact, the AMCNO spearheaded legislation in the past in Ohio that had intended to allow physicians to negotiate with health insurance companies.

Our proposed legislation would have allowed independent physicians and other health care providers to join together to negotiate non-fee-related contract terms with insurers, including, but not limited to: definition of medical necessity, utilization review criteria and procedures; preventive care and medical management policies; patient referral standards and procedures; drug formularies; quality assurance programs; liability issues; payment methods and timing; claim documentation requirements and administrative procedures; credentialing standards and procedures; dispute resolution mechanisms and all products clauses.

Although HB 125 differs somewhat from our previous legislation concept, it does provide for items that the AMCNO and our 4,400 physician members have advocated for in the past—such as standardized credentialing, prohibiting a health care contract from including certain provisions such as a "most favored nation clause," providing for appropriate dispute resolution, disclosure of payment methods/terms by insurance companies and transparency in health insurance contracting.

As a legislator, you may expect to hear negative testimony from insurance companies and their representatives regarding the provisions contained in HB 125. These representatives will tell you that the health insurance rules and regulations are necessary to control costs and that the very purpose of managed care is to control the "spiraling" cost of health care. Health insurance companies create roadblocks to care in the interest of controlling costs, and when physicians object to these roadblocks and red tape in the interest of quality of care we are accused of "protecting" our turf instead of what is the reality—we are protecting our patients. HB 125 provides physicians with some of the tools we need to reduce the administrative burden placed upon us by the health insurance company industry in Ohio. The AMCNO and our 4,400 physician members support the passage of HB 125.

AMCNO strongly supports passage of this legislation. If you have any questions, please contact me at the AMCNO offices at 216-520-1000, ext. 100 or our lobbyist, Mike Wise at McDonald Hopkins, 216-430-2034.

Sincerely,

John Bastulli M.D.

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President Bush Comments on Health Care-Related Issues on Recent Cleveland Visit

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) staff and several AMCNO members were on hand at the presidential forum held at the Intercontinental Hotel at the Cleveland Clinic campus in July. The Greater Cleveland Partnership sponsored the event.

Prior to the forum the President participated in four, hands-on demonstrations with surgeons and researchers at Cleveland Clinic. The demonstrations provided the President with the opportunity to learn about the latest in advanced medical technology and to understand how new technologies improve quality of life and save healthcare dollars. He received input on advances being made in heart, brain, and spine surgery and the minimally invasive treatment of aortic aneurysms.

During his remarks at the forum, President Bush pointed out the need to allow small companies and businesses to pool risk in order to provide for opportunities to reduce health care insurance costs. He also noted that he continues to believe in strong medical liability reform at the federal level — doctors are continuing to practice defensive medicine across the United States due to medical legal issues and there is a real need to address this issue. President Bush also noted that technology

is changing the way we live and this has to extend into the field of medicine — through the expanded use of electronic medical records. This would only serve to make health care more efficient and less costly. An individual should be able to access their medical records from any point in the system and from any locality.

The President stated that there must be more transparency in medicine — if you can find



AMCNO physician members were in attendance as part of the capacity crowd listening to the comments from the President.



President Bush makes a point regarding electronic health records during his stop in Cleveland.

out the fee you will have to pay to have other services rendered a consumer should be able to obtain the cost for a service in medicine. The President noted that as an alternative to the federalization of health care there has to be alternatives and incentives built into the system such as health savings accounts and other methodologies that will allow the consumer to make health care spending choices — but in order to have these choices the consumer will need to be able to access cost information.

The President remarked on the healthcare system in Cleveland noting “the citizens in Cleveland are fortunate to have such great medical care available to them in this community.” ■

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“Good Cause” Just Got Better (for Plaintiffs) – An Overview of the July 1, 2007

Amendments to Ohio Rule of Civil Procedure 10

Kristin K.C. Howard, Esq.
Matthew M. Nee, Esq.
McDonald Hopkins, LLC

The good news is that the hedge against baseless medical, dental, optometric, and chiropractic claims afforded by Ohio Rule of Civil Procedure 10 (“Civ.R. 10”) remains intact. Plaintiffs still must overcome their threshold burden of filing affidavits of merit to evidence breaches of applicable standards of care in all such cases where expert testimony is required. The bad news is that the threshold for showing “good cause” for extensions of time in which to file such affidavits has been considerably lowered.

On July 1, 2005, Ohio began mandating that malpractice plaintiffs file affidavits of merit along with their complaints, to weed-out insufficient claims (1). Upon “good cause” shown, courts were free to grant extensions of a “reasonable time” for plaintiffs to file their affidavits (2). Though Ohio’s courts rarely dealt with the new mandate (3), they were seemingly in accord that “good cause” was to be liberally applied and that complaints should not be readily dismissed even when an affidavit was lacking (4). Nonetheless, Ohio has amended Civ.R. 10 (effective July 1, 2007) “to clarify what constitutes ‘good cause’... and to define the effect of dismissal for failure to comply with the affidavit of merit requirement (5).”

Amended Civ.R. 10 retains its predecessor’s “reasonable time” and “good cause” language but loosely limits extensions to up to ninety days and states that courts must consider the following factors in their “good cause” analyses:

- (i) A description of any information necessary in order to obtain an affidavit of merit;
- (ii) Whether the information is in the possession or control of a defendant or third party;
- (iii) The scope and type of discovery necessary to obtain the information;
- (iv) What efforts, if any, were taken to obtain the information; and
- (v) Any other facts or circumstances relevant to the ability of the plaintiff to obtain an affidavit of merit (6).

Though the Staff Note purports that Civ.R. 10 was amended to “clarify what constitutes ‘good cause,’” courts need only “consider”

these factors and need not make any findings. Thus, what constitutes “good cause” is hardly clarified, and courts may continue to construe Civ.R. 10 as before.

Civ.R. 10 might not clarify what constitutes “good cause,” but its Staff Note is unequivocal. Though explanatory and not operational, the Staff Note leaves no doubt that showing “good cause” is a light burden. The Staff Note states, “It is intended that the granting of an extension of time to file an affidavit of merit should be liberally applied (7).” Moreover, the Staff Note provides that courts “must” grant extensions when:

[T]he plaintiff obtains counsel near the expiration of the statute of limitations, and counsel does not have sufficient time to identify a qualified health care provider...Similarly, the relevant medical records may not have been provided to the plaintiff in a timely fashion...Further, there may be situations where the medical records do not reveal the names of all of the potential defendants...The medical records might also fail to reveal how or whether medical providers who are identified in the records were involved in the care that led to the malpractice. *Under these and other circumstances not described here, the court must afford the plaintiff a reasonable period of time to submit an affidavit that satisfies the requirements set forth in the rule (8).*

Not only are extensions to file affidavits readily obtainable, but so are second chances to file sufficient affidavits. Civ.R. 10(D)(2)(e) provides, “If...an affidavit of merit is determined by the court to be defective..., the court shall grant the

plaintiff a reasonable time, not to exceed sixty days, to file an affidavit of merit intended to cure the defect (9).” No “good cause” showing is required.

In sum, though plaintiffs still must file affidavits of merit upon bringing medical, dental optometric, or chiropractic claims, plaintiffs now may rely on considerably greater grace should they fail to meet the requisites of Civ.R. 10. As usual when a new statute or rule becomes effective, it remains to be seen how attorneys and courts will react to their new mandates. What is clear, however, is that the threshold has been lowered and, for plaintiffs, good cause just got better.

Kristin K.C. Howard practices health care and general corporate law and routinely represents health care providers in all aspects of their practice management. Matthew M. Nee is a commercial litigator whose emphases include appellate practice. ■

1. Civ.R. 10, effective July 1, 2005.

2. Civ.R. 10 (D)(2)(b), effective July 1, 2005.

3. See *Fletcher v. University Hosps. of Cleveland*, Cuyahoga App. No. 88573, 2007-Ohio-2278, ¶ 1 (noting that the Court had “found no appellate cases construing Civ.R. 10(D)(2) or determining the proper procedure for ensuring compliance with it.”).

4. See *Teasdale v. Heck*, 2007 U.S. Dist. LEXIS 46673 (S.D. Ohio 2007), *8 (“[Ohio] state law teaches that the remedy for noncompliance [with Civ.R. 10 (D)(2)(b)] is not a dismissal for failure to state a claim...”; *Campbell v. Aeppli*, Muskingum App. Nos. CT06-0069 and CT06-0063, 2007-Ohio-3688, ¶153 (trial court erred by denying leave to amend complaint to include an affidavit of merit where “leave was requested in the early stages of the proceedings, and [sic: Appellees] would not have been prejudiced...”; *Ervin v. Cleveland Clinic Foundation*, Cuyahoga App. No. 88053, 2007-Ohio-818, ¶19 (trial court erred by not extending time to file affidavit of merit where plaintiff had received records “a mere 17 days from the...deadline.”); *Fletcher* at ¶19 (complaint that does not include an affidavit of merit does not fail to state a claim, and a defendant’s remedy is a motion for a more definite statement of the claims).

5. Civ.R. 10, Staff Note.

6. Civ.R. 10 (D)(2)(c).

7. Civ.R. 10, Staff Note.

8. Civ.R. 10, Staff Note.

9. Civ.R. 10 (D)(2)(e).



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AMCNO responds to CMS Proposed Rule – Physician payment and GPCI calculation at issue

On behalf of our membership, the AMCNO submitted comments to the Centers for Medicare and Medicaid Services (CMS) relative to the issue of the impending Medicare payment cuts for physicians. In addition, the AMCNO sent comments to CMS regarding the items contained in the proposed rule relative to the geographic practice cost indices (GPCI) utilized by Medicare.

The Medicare physician fee schedule adjusts physician fees for area differences in physicians' costs of operating a private medical practice. Three separate indices, known as geographic practice cost indices (GPCI) raise or lower Medicare fees in an area, depending on whether the area's physician practice costs are above or below the national average. These GPICs adjust physician fees for variations in physicians' costs of providing care in different geographic areas. The three GPICs correspond to the three components of a Medicare fee: physician work, practice expense, and malpractice expense.

At this time, CMS uses 89 physician payment localities among which fees are adjusted. CMS recognizes that changing demographics and local economic conditions may lead to increased variations in practice costs in certain payment locality boundaries. Currently, the state of Ohio is designated as a statewide locality. This designation was made with the support of the state medical association over ten years ago and over the strong objections of the AMCNO. The AMCNO objected due to the fact that a change to a statewide locality would impact payments to physicians in Northern Ohio since a statewide locality clearly would not accurately account for the variations in practice costs in certain localities.

In point of fact, a recent Government Accountability Office (GAO) report reviewing the geographic areas used to adjust physician payments for variation found that physicians in urban counties had the highest relative underpayment differences, whereas physicians in rural counties had the highest relative overpayment differences. In addition, CMS has not revised the geographic boundaries of the physician payment localities in over ten years, and CMS has indicated that the only mechanism the agency has set forth to modify the payment localities is for the state medical associations to petition for change by demonstrating that the change has the overwhelming support of the physician community. Unfortunately, as recently as this past year, the state medical association in Ohio has indicated that they cannot demonstrate statewide support for a change.

The AMCNO has written to CMS indicating that this mechanism for change in the payment localities seems biased since the state medical association does not represent all of the physicians in the state of Ohio. Our letter also notes that CMS has not required medical associations in the states that are now consolidated (like Ohio) to continue to demonstrate that there is "overwhelming" support from the physician community for a statewide payment locality.

As the regional organization representing physicians in Northern Ohio the AMCNO continues to advocate for a change in the payment localities utilized in Ohio. A copy of our letter to CMS has been sent to the Government Accounting Office and the Department of Health and Human Services. (see pullout box for complete copy of the AMCNO letter to CMS.) Any questions regarding this issue may be forwarded to E. Biddlestone at the AMCNO at (216) 520-1000, ext. 100. ■



August 14, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

Re: Proposed Rule CMS-1385-P

As Vice President of Legislative Affairs of the Academy of Medicine of Cleveland & Northern Ohio (AMCNO), an organization representing more than 4,400 physicians in Northeastern Ohio I am writing on behalf of the organization and the physicians we represent to comment on the Medicare Program; Revisions to payment policies under the physician fee schedule for calendar year 2008; proposed rule – CMS-1385-P.

Physician Payment Updates

Physician payment updates are driven by a flawed formula called the Sustainable Growth Rate (SGR). The underlying flaw of the SGR formula is the link between the performance of the overall economy and the actual cost of providing physician services. The medical needs of individual patients are not related to the overall economy.

By 2015, the 2006 Medicare Trustees report predicts that Medicare physician payment rates will be cut by 37% due to the flawed payment update formula, starting with a cut of nearly 5% in 2007. From 2007-2015, Medicare payments in Ohio will be cut by \$7.43 billion. In Ohio, the cuts over this period will average \$27,000 per year for each physician in the state. 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.

The AMCNO realizes that ultimately the administration and Congress will have to act in order to replace the SGR, however, CMS and its' administrators have the ability to review comments from physicians, physician organizations and other healthcare providers regarding the proposed payment and policy changes and try to find ways to improve physician payment without adding to overall Medicare costs.

Geographic Practice Cost Indices

It is our understanding that CMS adjusts Medicare physician fees for geographic differences in the costs of operating a medical practice. At this time, CMS uses 89 physician payment localities among which fees are adjusted. However, it is our belief that the boundaries of these payment localities do not accurately address variations in physicians' costs.

As noted in the proposed rule, CMS recognizes that changing demographics and local economic conditions may lead to increased variations in practice costs in certain payment locality boundaries. The AMCNO strongly believes that Medicare's geographic payment adjustment formula does not accurately reflect practice costs in Northern Ohio. Currently, the state of Ohio is designated as a statewide locality. This is problematic for our physician members practicing in Northern Ohio because CMS has not revised the geographic boundaries of the physician payment localities since the 1997 revision. Also, since that year, CMS has indicated that the only mechanism the agency has set forth to modify the payment localities is for the state medical associations to petition for change by demonstrating that the change has the overwhelming support of the physician community. This mechanism for change in the payment localities seems biased since the state medical association does not represent all of the physicians in the state of Ohio. In addition, CMS has not required medical associations in the states that are now consolidated to continue to demonstrate that there is "overwhelming" support from the physician community for a statewide payment locality.

A recent Government Accounting Office report (GAO-07-466 - Medicare Payment for Physician Services) indicated that more than half of the physician payment localities analyzed had at least one county within them with a large payment difference. We believe that the counties located in Northern Ohio should be reevaluated due to the fact that the urban area where our physician members are located would definitely qualify as an area receiving a "large payment difference" due to the statewide payment locality applied in Ohio.

As noted in the GAO report, "adjusting Medicare payments for the costs physicians incur operating a private medical practice in different parts of the country is important to ensure that Medicare accurately accounts for variations in physicians' costs of providing care, and that beneficiaries have sufficient access to physician care. Without a new approach to revising payment localities there will continue to be substantial cost variations among the localities." The AMCNO wholeheartedly concurs with this statement and we believe that a new approach must be implemented in Ohio to adequately reflect the differences across the state.

It is also the opinion of the AMCNO that CMS must find a new methodology for collecting and reviewing malpractice premium data from the states since there is verifiable data that the Northern Ohio area pays some of the highest medical liability rates in not only the state but the nation. While malpractice rates account for only a small portion of the GPCI calculation, this clearly has an impact on physicians in our area.

The CMS proposed rule lays out three options for a pilot program concept, which would be implemented in California with no plans to implement the program in any other state at this time. The AMCNO is of the opinion that option 3 as outlined in the proposed rule could, in fact, assist the physicians in Northern Ohio if this option were implemented in our state as well.

In fact, option 3 in the proposed rule appears to mirror one of the options suggested in the recent GAO report which calls for county-based geographic adjustment factor (GAF) ranges, which provides for a methodology which would result in Ohio becoming two separate localities, if it were implemented in our state.

However, the AMCNO would prefer the option outlined in the GAO report which calls for a metropolitan statistical area (MSA) iterative which would result in Ohio becoming five (5) separate localities an option which would clearly delineate the Northern Ohio area into two separate localities with the remaining three localities located in other parts of the state.

For the sake of our patients and profession, the members of the AMCNO ask that the proposed payment changes as well as the payment methodologies used by CMS be carefully reviewed and evaluated to assure fairness and accuracy. As it is, Medicare payments already lag behind increases in practice costs and unless the above referenced items in the proposed rule are adequately addressed additional problems will arise. The AMCNO believes that the CMS proposed payment and payment methodology changes for 2008 would adversely affect how Medicare patients will be cared for in the future.

If you have any questions regarding our comments please feel free to contact me through the AMCNO offices at 216-520-1000.

Sincerely,

John A. Bastulli, MD
Vice President of Legislative Affairs
The Academy of Medicine of Cleveland & Northern Ohio (AMCNO)

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Northeast Ohio e-Rx Study

Ronald A. Savrin, MD, MBA

Lucy Malakar, MA

Bonnie Hollopetter, LPN, CPHQ, CPEHR, CPHIT

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) requires that electronically transmitted prescriptions comply with final uniform standards to be promulgated no later than 2008. The Centers for Medicare & Medicaid Services (CMS) contracted with Ohio KePRO, Medicare's Quality Improvement Organization for Ohio, to conduct a special e-prescribing (e-Rx) study designed to assess certain aspects of e-Rx currently being considered for inclusion in the final e-Rx rules and to understand how e-Rx impacts workflow in small- and mid-sized community-based, primary care practices. University Hospital Medical Practices (UHMP) served as the primary study group as they had previously deployed an advanced e-Rx tool in most of their practices.

The study focused on 25 e-Rx UHMP primary care practices and 22 non-e-Rx practices in Northeast Ohio. Practices were matched for prevailing physician specialty. Site visits were conducted to complete data collection on practice culture, workflow, and efficiency and to identify issues critical to the adoption of e-Rx.

The vast majority of prescriptions (74%), as one might expect, were entered into the e-Rx system and transmitted by a non-physician. This practice, referred to as surrogate prescribing, ranged from a low of 57% in pediatric practices to a high of 82% in internal medicine practices. Consequently, medical assistants were strong proponents of e-Rx. Surprisingly, medical practices still received phone calls from patients and/or pharmacies stating that the prescription had not been received by the pharmacy despite the fact that electronic documentation correctly confirmed that the prescription had been properly transmitted and successfully received. The majority of this discordance was secondary to human factors at the pharmacy that could likely be ameliorated by appropriate training.

The acceptance and ready adoption of e-Rx by the UHMP practices was related to a number of factors that facilitated the change. Perhaps most importantly, the e-Rx application was integrated into the practice management system already in use. Importantly, there were minimal up-front costs associated with implementation. A personal digital assistant (PDA) for entering prescriptions into the e-Rx system could be purchased for \$350. Since the e-Rx application was Internet based there was no need to maintain or manage the software. As an incentive, physicians were offered a \$500 discount on professional liability insurance

premiums if they utilized the e-Rx system. The ready availability of medical assistants and other office staff to enter and transmit individual prescriptions also facilitated adoption.

Although it is commonly believed that e-renewals serve to drive adoption this relationship was not demonstrated in this study. Similarly, the concept that surrogate prescribing is a temporary bridge to direct physician e-Rx did not hold true in this investigation.

In the 47 practices studied in Northeast Ohio significant differences in workflow associated with medication renewals were noted between those practices that had adopted e-Rx and those that did not. As expected, practices using e-Rx used their e-Rx application, rather than telephone or fax, to send and receive prescriptions to and from pharmacies. Whereas practices without e-Rx relied more heavily on front-desk personnel those using e-Rx utilized medical assistants to process renewal requests. Although offices with e-Rx had 25% more incoming prescription related calls per physician per day, they had 58% fewer outgoing prescription-related calls.

There were a number of similarities between practices with and those without an e-Rx application. Both allowed established patients to request prescription renewals by contacting the practice directly and without the need for a new office visit. The most common form of internal communication for phoned-in renewal requests was a written note although if the renewal request was received by fax, the fax itself was used to communicate the request to the physician. These findings were the same whether or not the practice utilized

an e-Rx system. No statistically significant difference was noted in the number of prescription-related faxes between these two types of practices.

Perhaps most importantly, this study strongly suggested that the amount of time office staff devotes to prescription-related phone calls, especially with pharmacies, is decreased when using e-Rx.

John Kralewski, PhD, from the University of Minnesota's Department of Health Policy and Management, developed a survey tool used to assess practice culture. The survey measures nine domains of organizational culture including collegiality, emphasis on information, emphasis on quality, management style, cohesiveness, organizational trust, adaptiveness, physician autonomy, and the degree to which the practice is business-oriented. The survey was given to each clinical staff member and analysis of their responses indicate that practices utilizing e-Rx applications, as compared to those who do not use e-Rx, place a greater value on information, are more cohesive and more adaptive and emphasize the group over individual professionals

Health plan claims data, collected from 1/1/2004 to 6/30/2006, from several large health insurers in Northeast Ohio along with encounter data from the UHMP practice management system were used to detect adverse drug events (ADEs). Three categories of rules were used to trigger adverse drug events based on the type of data used: (1) drug only, (2) ICD 9 Codes, and (3) Drug Miscellaneous. Drug Only rules involve the use of medication data and National Drug Codes (e.g., identifying patients with "warfarin toxicity" by identifying patients taking both warfarin and phytonadione). ICD 9 Code rules use ICD 9 codes that describe "poisoning" (e.g. codes 960 to 980 indicate poisoning due to different drugs). Drug Miscellaneous rules are those that involve a medication and no other parameter, other than ICD-9 code (e.g., a patient over the age of 65 receiving a medication on the modified Beers list). Comparisons were made between those practices using and those practices not using e-Rx. Furthermore, the UHMP physician practices were analyzed to compare data prior to implementation of the e-Rx application with that following adoption of e-Rx. In all but one data set the rate of ADEs was statistically higher among the groups not

(Continued on page 16)

Insurance issues

(Continued from page 5)

AMCNO asked the ODI if they had any plans to survey the uninsured as a part of this study. AMCNO representatives pointed to a recent study completed in California. The California Healthcare Foundation Commission conducted a survey of uninsured patients at the federal poverty level of one to 300 percent to seek input on the health policy issues and coverage that would affect the uninsured. The data revealed that the uninsured placed a high priority on preventive care and establishing continuity with a small group of physicians in a medical home concept in order to reduce the need for emergency room visits. The survey also revealed the level of co-payments and premiums that would be acceptable to these individuals. ODI had not considered such a survey and they asked the AMCNO to send a copy of the survey results for their review.

AMCNO also queried the Director about the feasibility of establishing a health insurance industry oversight committee. The Director indicated that if such a committee were set up to rule on medically necessary issues and procedures that would take a whole new division and staff within ODI and it was not feasible from a cost perspective. However, the idea of a committee, which could include physicians, set up to advise and review issues relative to the health insurance companies might be feasible, but ODI would need more input on the concept. AMCNO plans to follow up with ODI on this issue in the near future. ■

Northeast Ohio e-Rx Study

(Continued from page 15)

using e-Rx. Similarly, the data also showed that UHMP practices had more ADEs before they began e-Rx, compared to the period following the e-Rx implementation. Since the vast majority of potential ADEs were identified by a specific ICD-9 code from administrative claims data and access to patient medical records was not available for study, we could not confirm whether or not an ADE actually occurred. A thorough study, with access to patient records is necessary to fully and accurately document the impact of e-Rx on adverse drug events.

Formulary compliance was examined using three months of health plan claims data from a single health insurer. Rates of formulary compliance were in excess of 90% regardless of practice type; and no statistically significant differences were found between practices using or not using e-Rx. This finding is to be expected in view of the fact that most formulary substitutions occur when the patient presents the prescription to the pharmacy. If the pharmacist notes that the prescribed drug is not on the patient's plan formulary, the pharmacist typically advises the patient and asks him to contact the physician or the pharmacy contacts the physician's office directly.

Ohio pharmacists are required to substitute generics for brand name drugs, when available, unless the prescription expressly indicates that substitution should not occur. Therefore we did not expect e-Rx to have a significant impact on generic substitution

rates. The results of data analysis on three months of health plan claims data (8/1/2006 through 10/31/2006) showed that the physicians not using e-Rx had a statistically significant higher proportion of generic prescriptions (56.2%) compared to the UHMP physicians (52.1%) who were using e-Rx. Review of 33 months (1/1/2004 – 9/30/2006) of Wolters Kluwer (WK) prescription claims showed that the generic prescribing rate was significantly higher for the physicians without e-Rx (50%) than for the those with e-Rx (44%). Since the "Dispense as Written" rates were identical between the practice types (1%) the difference in generic utilization rates may have been due, in part, to the fact that a higher percentage of patients (6%) in practices using e-Rx specifically requested a brand name drug as compared to those (4%) in practices not using e-Rx.

Although the practices using e-Rx had higher average cost per prescription, this difference existed before the majority of the UHMP practices had implemented e-Rx. The study was limited in that the prescription data could not be linked to medical claims data therefore we were unable to adjust for differences in patient severity or case mix. It is possible that cost differences were due to differences in patient health severity and/or health plan payer. A more controlled study is needed to accurately assess the impact of e-Rx on formulary compliance, generic utilization, and the average cost of prescriptions.

This study was part of the Centers for Medicare & Medicaid Services Special Study Pilot testing of Electronic Prescribing Standards, principle investigator Donald. P. Barich, MD (University Hospitals of Cleveland)

All material presented or referenced herein is intended for general informational purposes and is not intended to provide or replace the independent judgment of a qualified healthcare provider treating a particular patient. Ohio KePRO disclaims any representation or warranty with respect to any treatments or course of treatment based upon information provided. Publication No. 8041-OH-034-6/2007. This material was prepared by Ohio KePRO, the Medicare Quality Improvement Organization for Ohio, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. ■

The 23rd Annual Mini-Internship Program

The Academy of Medicine Cleveland & Northern Ohio is pleased to present our 23rd Annual Mini-Internship program Nov. 11 through the 14th. Designed to improve understanding and communication between the medical profession and those in the community who influence, establish, and report on healthcare policy in Northeastern Ohio. Interns have the opportunity to spend a half-day with four physicians, accompanying him or her through everything from office rounds to surgery.

The Mini-Internship is a two-way information exchange intended to broaden the perspectives of all participants. Through shared experiences, this project allows interns to witness firsthand the demands and rewards of the medical profession during a typical physician workday.

AMCNO Member: Are you interested in participating as faculty for this year's program? Do you know of a community member who would benefit from the program? If so, contact Linda Hale, (216) 520-1000 ext. 101, or email lhale@amcnoma.org for more information.

Steps to a Healthier Cleveland – Healthcare Provider Education

Casey Atkinson, R.D., L.D., Cuyahoga County Board of Health

Childhood obesity is a public health crisis. This growing epidemic makes headlines across the country, but locally, the figures are equally startling. A 2003 survey for the Child Family Health Service Community Health Indicators Project revealed that 35% of Cuyahoga County kindergartners were overweight or obese (1). The entire community carries the burden of this crisis — from families and schools to employers and the healthcare system itself. Physicians particularly are finding themselves on the frontline of this battle, often without the proper tools to win it. In fact, in another survey sent to local healthcare providers in 2003, nearly 43% of respondents reported a lack of training to adequately treat overweight pediatric patients (2).

Research shows that medical providers are among the most important health messengers and that patients are more likely to adopt new behaviors when instructed to do so by their health practitioners (3). In a 1995 study, physicians identified lack of time, patient non-compliance, inadequate teaching materials and lack of knowledge and training about counseling as important barriers to adequately addressing obesity with their patients (4).

Recognizing these challenges, Steps to a Healthier Cleveland has partnered with the Cuyahoga County Board of Health (CCBH) to develop an innovative and effective program that equips local healthcare providers with the best and most current tools available to prevent and manage childhood obesity and other related chronic diseases.

Steps to a Healthier Cleveland, a program of the Cleveland Department of Public Health, is a city-wide program designed to engage all Clevelanders to live longer, better and healthier lives. It is funded by the U.S. Department of Health and Human Services as part of Steps to a Healthier US. The Steps to a Healthier Cleveland (Steps) program encourages physical activity, healthy eating and tobacco-free choices. These efforts are intended to reduce the burden of diabetes, overweight/obesity and asthma in all of Cleveland's diverse neighborhoods. One of the cornerstones of Steps is its work to enhance the capacity of physicians and healthcare systems in Northeast Ohio to better support their patients in preventing and managing chronic disease.

The Steps CCBH "DIET" Program — "Dietitians Involved in Education & Training" — provides professional assistance for healthcare providers with children and weight management. The program targets physicians, residents, medical assistants, nurses, dietitians, social workers, community health workers and students. These healthcare professionals are provided a one-hour training session focusing on prevention and management of childhood obesity with a strong concentration on addressing the risk factors of poor nutrition and physical inactivity. The training sessions include the most current

best practices in assessment and the latest motivational interviewing techniques which can facilitate positive behavior modifications. The goal of the training is to assist healthcare providers in assessing their patients' readiness to adapt and self monitor realistic healthy lifestyle goals.

Often, the one-hour training is tailored to address the links between childhood obesity and diabetes. For these sessions, the Diabetes Association of Greater Cleveland partners with the "DIET" program to present on current diabetes guidelines, resources and educational materials.

All healthcare providers that complete the CCBH "DIET" training receive a unique complementary toolkit to take back to their practices. The toolkit was specifically designed to respond to local healthcare providers' identified need for easily accessible and culturally appropriate educational materials and evidence-based resources. The toolkit is continually updated and adapted to represent local needs and resources. It is organized according to Steps to a Healthier Cleveland's six focus areas: obesity, diabetes and asthma (chronic diseases), physical activity, nutrition and tobacco prevention and cessation (related risk factors). It is provided as a hard copy expandable file case and as a mini CD, and all of its contents are reproducible.

Among the tools provided in the kit are nutrition, physical activity and tobacco prescription pads. The pads feature easy-to-understand picture icons that healthcare providers can use to recommend healthy lifestyle practices to patients and their families.

Since 2004, Steps to a Healthier Cleveland has trained more than 330 healthcare providers through the CCBH "DIET" program and distributed 184 toolkits in the greater Cleveland area, well exceeding established program goals. The "DIET" program is now providing an additional service for healthcare providers and patients: waiting room bulletin boards with positive health messages to improve patient awareness.

For more information or to schedule a meeting to outline a tailored plan for your practice, please contact Casey Atkinson, R.D., L.D. at (216) 201-2001 ext. 1536 or catkinson@ccbh.net. To learn more about Steps to a Healthier Cleveland, please visit our site at www.clevelandhealth.org/steps or call (216) 664-STEP (7837). ■

1. Child Family Health Service Community Health Indicators project. (2003). This indicator was collected as part of an immunization assessment survey conducted through the Immunization Action Plan program administered through the Cuyahoga County Board of Health. Results available at: www.ccbh.net.
2. Atkinson C, Halko M. (2003). Childhood Obesity Survey of Healthcare Professionals in Cuyahoga County and administered through the Cuyahoga County Board of Health. Results available at: www.ccbh.net.
3. Logsdon DN, Lazaro CM, Meier RV. (1998). The feasibility of behavioral risk reduction in primary medical care. *Am J Prev Med*, 5(5), 249–256.
4. Kushner RF. (1995). Barriers to providing nutrition counseling by physicians: a survey of primary care practitioners. *Preventive Medicine*, 24:546–552.

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) was pleased to host the Steps to a Healthier Cleveland "Meet the Leadership Team — A Healthy Dialogue Community Consortium" on June 21, 2007. The lead agency of this project is the Cleveland Department of Public Health and the activities of the program are varied. In the health care field the focus of the program is on the DIET program and on collaborating with local health care systems to conduct provider education to highlight the benefits of incorporating healthy lifestyle counseling as a part of preventative care.

Note: The AMCNO is a community partner in this effort.



MEMBERSHIP ACTIVITIES

Resident Recruitment a Success



It was a busy summer both for new graduates beginning their residencies and The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) in one facet of its membership efforts by welcoming new physicians-in-training

into Northeast Ohio's professional medical society. In all, more than 384 new physicians joined the AMCNO as resident members this summer from the following institutions: Cleveland Clinic Foundation, Fairview Hospital, Huron Hospital, MetroHealth Medical Center, University Hospitals, St. John Westshore, St. Vincent Charity Hospital and South Pointe Hospital. AMCNO membership entitles these new physicians to many benefits including receiving weekly updates on all manner of health care related news as well as legislative and regulatory updates under review by the Ohio General Assembly and the United States Congress, legislative representation at the state house by AMCNO lobbyists, listing in the membership directory, seminars, publications and opportunities to serve on AMCNO committees and more. Welcome to all new resident members!

SAVE THE DATE!

PREPARING FOR THE BUSINESS ASPECTS OF PRACTICING MEDICINE

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) and the William E. Lower Fund are pleased to co-sponsor a free seminar for resident members (spouses are also welcome to attend).

Date:
October 24, 2007

Location:
The Academy of Medicine of Cleveland & Northern Ohio offices
6100 Oak Tree Blvd., Independence OH 44131,
Lower Level Meeting Room

Time:
5 PM

Speakers from McDonald Hopkins LLC, Squire, Sanders & Dempsey, Hilb Rogal & Hobbs, Sagemark Consulting and Walthall, Drake & Wallace LLP will enlighten residents on topics including: legal & other issues for new physicians joining a practice; estate planning for young physicians; disability issues-planning for your future; benefits available to physicians; as well as business & tax aspects of a medical practice.

NORTHERN OHIO PHYSICIAN

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FOUNDATION ACTIVITIES

The Academy of Medicine Education Foundation (AMEF) 2007 Golf Outing Is a Huge Success

Eighty golfers enjoyed the most perfect sunny day for golf one could imagine on Monday August 13th for the Academy of Medicine Education Foundation's (AMEF) fourth annual Marissa Rose Biddlestone Memorial golf outing. Foursomes competed in a shotgun start tournament that raised more than \$38,000 for AMEF. The funds will be utilized for medical student scholarships, annual CME seminars and the *Healthlines* radio program. 2007 scholarship recipients: Patrick Elliott – CWRU, Julie Eppich – CWRU, Joshua Nething – NEOUCOM, Jason Robertson – CC Lerner, Laura Sponseller – CWRU and Aaron Viny – CC Lerner joined the group for dinner.

First, second and third place foursomes were:

1st Place Team

Clinical Technology: Dennis Forchione, Jason Forchione, Kent Krafft, and Dominic Verrilli

2nd Place Team

Matthew Levy, MD, David Goss, T.J. Reagan, Eric Bram

3rd Place Team

Walter & Haverfield: John Giles, Jim Mackey, Tom O'Donnell, and Nick Zavarella

Prizes were also awarded for the following:

Closest to the pin – Mike Shaughnessy, MD, Greg Balogh, James Soltis (ForTec), Nick Zavarella (Walter & Haverfield)

Longest Drive – Dick Hollington (Sky Insurance), Dave Goss

Longest Putt Holed – Kathryn Sefcek (VNA)



Golfers await the shotgun start.



Event sponsor foursome representing Cleveland Anesthesia Group – left to right, Dr. John Bastulli, Rick Garcia, Mark Mingione and Dr. Irving Hirsch.



Event sponsor Medical Mutual foursome pose on the green.



Event Sponsor foursome representing The Endoscopy Center at Bainbridge left to right, Drs. Kevin Geraci, Raymond Rozman, Jr., Bruce Cameron and Mike Koehler.



Dr. Bastulli (left) with Kevin Ellison, from Kellison and Company, an event sponsor, after Mr. Ellison placed the top bid for an auction prize – a shirt signed by "Z" from the Cleveland Cavaliers.

A special thank you goes to all event, hole and hole-in-one sponsors who made the day possible:

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Reminger & Reminger
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Todd Associates
United Agencies
United HealthCare



Second place winners – Dr. Matt Levy, (far right) T.J. Reagan, Eric Bram and David Goss.



Third place winners – Event Sponsor foursome representing Walter and Haverfield.



Dr. Bill Seitz (second from left) and Dr. Joe Hahn (far right) pose with their foursome and caddy.



AMCNO EVP/CEO Elayne Biddlestone and a raffle winner share a laugh over one of the prizes – a White Hot putter complete with a "Little Stinker" club cover.

Get your clubs ready for next year's event — August 11, 2008 at Barrington Golf Club



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