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AMCNO and Other State Organizations Continue Support of SB 59

Trial Lawyers Voice Opposition to the Bill

Representatives from the AMCNO, the Ohio Osteopathic Association (OOA), the Ohio Hospital Association (OHA) and the American College of Obstetricians and Gynecologists, Ohio Section, (Ohio ACOG) met with Senators Kevin Coughlin and Steve Stivers to discuss moving SB 59 through the Senate. Other organizations supporting SB 59 that were unable to send a representative to the meeting include the Ohio Podiatric Medical Association and the Ohio Orthopaedic Society.

Representatives from the Ohio Osteopathic Association and the AMCNO spend a moment with Senator Stivers after discussing SB 59 – l to r – Jon Wills, Executive Director of OOA, John Bastulli, MD, Senator Stivers and Laura David, MD.

Representatives from the groups expressed their viewpoint regarding the need for an alternative dispute resolution (ADR) concept as outlined in SB 59. Ohio ACOG indicated that OB/GYNs around the state continue to experience high medical liability rates and cited information from a recent statewide survey. OOA representatives noted that the legislation provides a viable alternative to the current system and that the bill has been changed to address procedural issues. AMCNO representatives continued to press for passage of the bill.

Senator Coughlin, the sponsor of SB 59, informed the group that he favors moving the bill out of the Senate committee and he expressed appreciation to the groups supporting the bill. Senator Stivers, chairman of the Senate Insurance, Commerce and Labor

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Physician Strategies To Manage "Most Favored Nation" Clauses In Payer Contracts

By Steven M. Harris, J.D.

Often, clients will contact me during payer contract negotiations with questions about contract clauses such as this one:

> Provider represents and warrants that it has not agreed to accept from any other payer a reimbursement rate that is less than what is offered by Payer under this contract. If Provider offers a better reimbursement rate to any other Payer, the Provider must provide prior written notice of such an offer to Payer and give Payer the option to accept the reduced reimbursement rate. Thereafter, at Payer's option, Payer may accept the reduced reimbursement rate or it may terminate the contract immediately upon written notice to Provider.

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Physician Strategies To Manage "Most Favored Nations" Clauses In Payer Contracts

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A contract clause like this is called most favored nation ("MFN") pricing. In a nutshell, it means, "Give me the lowest price you offer to my competitors." MFN clauses vary in scope and methodology, and in practical application, but in simplest terms, an MFN clause is an agreement between a healthcare provider and a payer to charge the payer no more than the lowest prices the provider charges any other payer. MFN clauses attempt to assure a payer that it will receive the benefit of any price concessions that a provider extends to other payers for services provided by the physician.

Large payers that command a substantial portion of the relevant market often use MFN clauses in their provider contracts. Large payers will often be able to persuade providers to agree to these contractual provisions depending upon the relative importance of the payer to the provider. Physicians should not assume, however, that MFN clauses are nonnegotiable. Having a strategy in place to address MFN clauses during contract negotiations with payers, and enlisting the assistance of an expert to implement that strategy, could have a real future financial benefit to providers. This article sets forth a strategy to address MFN clauses in payer contracts.

In advising my clients presented with MFN clauses during payer contract negotiations, I suggest and use the following multi-pronged strategy to eliminate MFN clauses or revise them to be more physician friendly.

- Is the Clause Legal? As a preliminary matter, determine the legality of MFN clauses in your state. Certain states have laws that prohibit or restrict the use of MFN clauses in payer contracts and other states have introduced such legislation. You should be able to obtain this information from your legal counsel or from your state's medical board, insurance commission or legislature. The leverage created by the suspect legality of an MFN clause in a particular jurisdiction may be used to negotiate with a payer to eliminate or revise the clause. Absent such a law, however, MFN clauses are not automatically legal or illegal. In the second half of the 1990s, the Department of Justice and Federal Trade Commission instituted several enforcement actions against the use of MFN clauses in contracts between payers and physicians. Concurrent with the federal government's enforcement actions, courts also began to view MFN clauses with increased skepticism. Since the late 1990s, however, there has been almost no activity by the federal agencies or the courts involving the use of MFN clauses in contracts between providers and payers.

- Confirm that Apples are Compared to Apples. Generally, an MFN clause should only be triggered by financial arrangements that favor substantially similar plans (e.g., the same type of plan, same patient demographics, same patient volume, and same geographic area). Accordingly, negotiate a clause that applies like products to like products for HMOs, PPOs, POS and FFS plans.

- Negotiate Exclusions to the Clause. If the clause cannot be deleted in its entirety, negotiate exclusions to the application of the MFN clause. Exclusions may be made for government programs (e.g., Medicaid and Medicare primary coverage patients, VA, workers' compensation, public health assistance, and non-managed care governmental programs); uninsured patients; employees, medical staff, volunteers and their dependents; outpatient services sold to physicians; other providers which are not HMO/HIC, PPOs, insurance companies, TPPs or administrators; and plans that are demographically or otherwise different from the plan to which the MFN clause applies.

- Negotiate a Provider Favorable Audit Provision. MFN clauses often contain a provision that permits the payer to audit the physician's financial records to confirm that a competing payer has not been offered a more favorable reimbursement rate. These audit provisions are often very payer-favorable. For example, while audits are generally performed by independent auditors, MFN provisions often provide that the auditor will be chosen solely by the payer. It is critical that the audit provisions provide for (i) provider control or share of control of the choice of the auditor; (ii) a comparison of like products to like products; (iii) a comparison of like payment methods to like payment methods; (d) a proper audit methodology; and (iv) audit appeal rights. Also, providers are generally required to pay for the audit. In virtually no other type of contract, however, would one party be responsible for paying the fees of an auditor selected by the other party.

In addition to advising clients on strategies to eliminate or revise MFN clauses in their payer contracts, I also suggest that all providers proactively resist the enforcement of MFN clauses in their states. This resistance has been successful in certain states and has been accomplished, in part, by providers taking the following actions:

- Support Legislative Action. Introduce or support state legislation to prohibit payers from using MFN clauses in contracts with providers. Providers have the right to advocate policies or positions to federal, state and local government bodies. To the extent such a campaign involves legitimate lobbying, litigation or complaints to government authorities, a physician's joint conduct with other physicians should be protected under federal doctrine. Consult with counsel, however, before taking any such action.

- Seek Department of Justice Involvement. In 2004, according to a DOJ spokesperson, the DOJ had begun investigating the use of MFN clauses in the insurance field. No further information, however, has been forthcoming. The DOJ's Health Care Task Force has also stated it will consider bringing an enforcement proceeding when a payer imposing an MFN provision on a provider constitutes a substantial share of the provider's income and has a significant share of the industry's market in relation to others. The success of a challenge under the federal antitrust laws against a payer will depend in large part on the determination of the payer's market power in the relevant geographic and product markets and the payer's specific conduct.

- Litigate the Issue. A provider subject to an MFN clause could seek a preemptive judgment in court that takes the position that the provision is unenforceable based on its illegality. Alternatively, a provider

could refuse to pay any recoupment amount allegedly due as a result of an alleged MFN violation. This course of action is risky. In response to a provider's refusal to pay the requested amount, a payer could sue to enforce the provision, or it could withhold amounts owed to the provider for future payments. In addition, a payer could refuse to enter into new agreements with the provider.

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Editor's Note: Currently in Ohio there is legislation under review — HB 125, that was meant to address the most favored nation clause along with other health care insurance-related matters. The AMCNO is somewhat concerned, however, that the legislation does not go far enough in that the insurance companies are not completely prohibited from using an all products clause, and that the bill does not completely prohibit insurers from including a most favored nation clause in contracts.

Instead, at the present time the latest version of the bill calls for a two-year moratorium on the usage of a most favored nation clause while a joint legislative review committee reviews the matter, and the bill would "restrict" the use of all products clauses.

Other states have already prohibited the use of such clauses and we feel that Ohio should follow suit. As noted in the article above, even the Department of Justice has begun to investigate the use of these clauses in the insurance field. These clauses are unfair and would never be allowed in other business practices.

The AMCNO would also have preferred that language were included in HB 125 that addressed the definition of what constitutes "medical necessity." Often insurance companies make decisions relative to medical necessity matters that are inappropriate and not in the best interest of patients.

Insurance companies routinely deny access to benefits guaranteed by their contracts, and this denial of payment for medical care can result in a patient receiving inadequate or delayed treatment. Physicians should be in control of what is deemed medically necessary for a patient — not an insurance company.

The AMCNO would favor inclusion of a definition of medical necessity in this legislation along with consideration of the legislature requesting that the Ohio Department of Insurance create a healthcare panel inclusive of physician representation that would review and comment on health insurance company practices. The AMCNO has articulated these concerns to the members of both the Ohio House and Senate that are reviewing this legislation. ■

AMCNO and Other State Organizations Continue Support of SB 59 *(Continued from page 1)*

Committee indicated that there is a need for the representatives of the supporting groups to reach out to specific members of his committee to discuss specific issues with the bill.

And, as expected, Ohio trial lawyers have finally testified in opposition to SB 59. After months of waiting and requesting testimony from the attorneys, the AMCNO was not surprised to hear that trial lawyers and trial advocates are of the opinion that the proposed pilot project would deny citizens living in selected counties a choice of mechanisms for resolving disputes, noting that the bill would require one form of dispute resolution to the exclusion of others. Testimony included comments that the bill included provisions which directly conflict with trial advocates who oppose "loser pay all" rules — claiming such rules function as a serious and substantial economic prohibition to a claimant's access to the civil justice system. Others stated that the arbitration process would result in such cases becoming more time consuming, and more expensive while claiming that in the past nonbinding arbitration did not reduce claims or cases that needed to be tried.

The witnesses opined that the bill made the right to trial by jury available only to wealthy patients and healthcare providers as a result of its bonding and "loser pays" provisions. Witnesses also stated that the pilot project arbitrarily subjects a patient to the virtual loss of the right to trial by jury depending on where the healthcare provider practices or lives in the state by barring the commencement of an action in the counties selected for the pilot without first proceeding through the arbitration process outlined in the bill. The AMCNO plans to discuss the testimony and the future of the legislation in this General Assembly with the bill's sponsor in the coming months. ■

Drs. John Bastulli and Dr. Laura David (pictured above with Senator Coughlin) along with other state association representatives discussed the need to continue to pursue SB 59 with Senator Coughlin.

The Ohio Bureau of Workers' Compensation: An Analysis of the Status Quo and a Proposal for Improvement (A Medical Perspective)

By William H. Seitz, Jr.

I. OVERVIEW AND HISTORY OF THE OHIO BUREAU OF WORKERS' COMPENSATION

Ohio, one of the nation's centers of manufacturing and commerce around which the Industrial Revolution was built, provided little protection for workers who sustained injuries in the work place at the turn of the twentieth century. Due to limited medical resources and access to care, injured workers frequently lost their ability to earn a living and became a burden rather than a source of productivity for the community. By the early 1900s, the groundswell of response to this situation and the social injustice that it represented increased.

In 1911, the Ohio General Assembly passed the state's first Workers' Compensation law. Participation by employers in the Workers' Compensation program was voluntary. The law created a state fund to compensate workers injured on the job. Through this process, the employer paid ninety percent and the employee paid ten percent of the proposed premium. However, because participation in the program was totally voluntary many employers declined to participate. Consequently, a 1913 amendment made the program compulsory for all employers. Provisions in the law mandated the use of the state insurance fund for claims by an injured worker. Alternatively, employers could be self-insured if they created their own fund that was deemed qualified to provide care for the number of workers they employed.

As the program grew over time, the Bureau of Workers' Compensation (BWC) developed into two divisions, an administrative arm and an insurance arm. The existing legislation provides that the Chief of the BWC, who is appointed by the Governor, oversees the system's administrative and insurance arm. On the other hand, the Industrial Commission has been the system's arm for claims adjudication. The three members of the Industrial Commission are appointees of the Governor and confirmed by the Ohio Senate, one member each representing labor, employers, and the public.

Just as the work place has increased in complexity since the inception of the BWC, so has the practice of medicine and the delivery of health care. Expanding the understanding of disease and the response of human physiology to disease has improved diagnostic skills. Technology and early intervention have reduced suffering and shortened disability. Streamlined, minimally invasive, and innovative treatment modalities have provided the source for successful treatment of many diseases and injuries with significant reduction of morbidity and rapid return to function. Unfortunately, the BWC "system" has become so mired in red tape through its rules and regulations and dozens of complex forms that it is often difficult for injured workers to take advantage of the improvements in medical care in a timely fashion, and the "system" itself has frequently proven to be an obstacle to providing care.

Moreover, the system has established an adversarial situation under which workers are pitted against their employers, and physicians frequently find themselves restricted in their ability to provide the needed care for their patients. This adversarial situation is not unique to Ohio. In fact, it is prevalent in most states. In reports published in peer-reviewed medical journals and presented at national scientific meetings considering outcomes of various medical treatment modalities, BWC patients are frequently factored out of the general pool of patients and considered a separate subgroup, because typically their outcomes are less successful than those of the general population. Why should this be? The answer lies in the system's inherent adversarial environment under which a worker injured on the job frequently has to fight to prove the injury was in fact job-related. In the current process, the employer, in an attempt to keep premium costs down, contests the worker's claim. The worker develops a sense of anger at the employer while attempting to prove her point. In the lengthy, expensive ensuing debate the worker feels that the employer and the "system" have wronged her, has further caused injury by delay, and as a result feels that she is owed compensation not only for the injury but for the aggravation, anxiety, and frustration involved. Once the worker begins to obtain benefits, the injured worker has lost a significant amount of loyalty to the employer and, therefore, has also lost incentive to return to the work place in a timely fashion.

The system also fosters incomplete diagnosis and treatment by accepting only the initial diagnosis at the patient's "point of entry," which is usually a corporate clinic or an emergency room. From this point forward, amending the diagnosis requires a special hearing. As a result, the insurance fund created to provide a resource and refuge for injured workers has substantially changed and no longer meets the goals and ideals for which it was created. Rather, the system fosters misdiagnosis, impedes ability to amend to include accurate diagnoses and delays prompt and appropriate care. From a physician's standpoint the system appears to be designed to delay treatment, escalate cost, and defer resources away from the injured worker and the health delivery system whose goal is to restore health. The result is a legal and bureaucratic entanglement in which it seems that a large percentage of the insurance dollar is spent on the system itself rather than on the injured worker.

A worker's compensation claim is frequently a nightmare for the patient (injured worker), the employer (insurance payor), and the physician (health care provider). Because of the wastefulness inherent in the system, the overall cost of providing workers' compensation care in the State of Ohio has increased dramatically and as a result has seen significant reductions in hospital reimbursement levels and patient benefits, such as prescription drug availability.

Physicians and attorneys must be advocates for their patients and clients. The current system is not addressing the needs of patients and clients; as a result, the system prolongs their suffering, effects their family's well being, and ultimately provides a disincentive for them not to return to the work place. The morass of paperwork, inability to

obtain timely authorization to treat, and the cost of personnel needed to address these issues disincentives physicians to treat these patients. Therefore, the State of Ohio must take steps to streamline its workers' compensation system.

II. RECOMMENDATIONS FOR REMEDYING THE WORKERS' COMPENSATION SYSTEM

Relatively straightforward revisions could be made to the rules that govern the BWC so that patients receive treatment sooner and employers have their employees returning to work more quickly. This section outlines some of those needed revisions.

A. Recommendation 1: Physicians Should Only Identify the Body Region of the Injury at the Initial Intake Point

When a patient is injured, there should be acknowledgement at the point of initial care by the plant physician, the emergency room physician, or the primary care physician that the patient has suffered an injury. The physician should identify the injury's body region, but at the initial generic intake point, the physician should not make a definitive final diagnosis. Then, that physician should initiate appropriate initial triage care and refer the injured worker to the most appropriate treating physician.

Implementing this recommendation would help remedy the situation faced by the laborer, and alleviate the situation where patients have to wait eight weeks to have their initial diagnosis amended, as the time-consuming hearings to change the initial diagnosis that caused the delay would no longer be required.

B. Recommendation 2: A Certification Process that Allows Amended Diagnoses Without Extensive Mandates

There should be a certification process across medical specialties under which recognized experts are deemed capable and proficient to make appropriate diagnoses, and amend those diagnoses as clinical information evolves and becomes clear, without a mandate to perform expensive tests or require independent medical examinations or hold hearings. Precedent for this exists on every hospital medical staff when physicians apply for specific privileges in that their education and training are documented, and the appropriate credentialing is granted based on specific credentialing criteria. Such credentialing could easily be applied to physicians in various specialties caring for injured workers. The BWC or some other entity could periodically audit physician performance by case review.

C. Recommendation 3: Test Guidelines that Establish Specific Diagnoses

A set of clinical as well as diagnostic test guidelines should be set up to establish specific diagnoses based on accepted medical practice. These guidelines should be flexible enough so that unnecessary medical test requirements, which cause extensive delays and expenditure of financial resources, are not necessary in all cases but may be obtained when necessary. Evidence based proactive principles and peer-review would then guide diagnosis and management.

D. Recommendation 4: Eliminate Reviews of the Bureau of Workers' Compensation's Certified Physicians' Diagnosis and Treatment Strategies

When diagnoses and treatment strategies are recommended by a physician certified in the management of BWC claims within a specific area of specialty that physician should be allowed to manage the injured worker's case without costly reviews by panels or physicians (frequently less expert in the field).

E. Recommendation 5: Notation on a Prescription Should Be Adequate to Obtain that Prescription

A notation on a prescription demonstrating a need for a specific drug or piece of equipment related to a patient's special needs should be adequate to obtain that prescription. Furthermore, fully reimbursed medication should not be limited to only "generic" prescriptions.

III. CONCLUSION: OHIO MUST STREAMLINE ITS WORKERS' COMPENSATION SYSTEM SO THAT PATIENTS RECEIVE TREATMENT AND RETURN TO WORK AS QUICKLY AS POSSIBLE

These changes would reduce the layers of bureaucracy that currently require hearing after hearing, review of voluminous documentation by multiple providers, and excessive financial expenditure. The resultant savings should reduce the overall cost and allow the health care dollars to be invested in an appropriate way enhancing the care of the patient by facilities and experts delivering medical care and rehabilitation. The system would then promote returning the injured worker to the work place more expeditiously, and ultimately save employers the excessive expense they now incur through their premiums. Most importantly, however, these changes would help the injured worker recover from his injury as quickly as possible.

Such a process would require a major overhaul of the BWC system and would also require legislative and executive support at the state level. It would require careful and combined oversight by the medical and legal professions whose charge is to protect, care for, and advocate for the people they serve. Nevertheless, Ohio has the opportunity to once again be on the cutting edge of reform. The "overhaul" of the BWC would not require major structural changes, but rather a thoughtful reorganization of policies. ■

References:

- Ohio State Senate laws – SB 127 (1911); Amended SB 48 (1913).
- Ohio Bureau of Workers' Compensation and the Industrial Commission of Ohio
- Ohio Revised Codes: 4121.121(A); 4121:3-18(A); 4121:3-18(A)(b); 4121.02(A); 4121.12(A);4123: 3-09;4123:6-04.3; and 4121:6-21(I).
- Ohio Administrative Code
- New York Workers' Compensation Law
- State of Ohio Industrial Commission Policy Statements and Guidelines; Burden of Proof
- Compensation, Ohio Bureau of Workers' Compensation Profile
- Ohio Revised Code Ann. 3705.351(A) and 4121.121(B)(13).

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Portions of this article were taken from an article authored by Dr. Seitz and printed in the *Journal of Law and Health* (Cleveland State University). Detailed footnotes were utilized in the original article. To obtain a copy of the original article (including case scenarios) contact the AMCNO offices at (216) 520-1000.

LEGISLATIVE UPDATE

By Michael Wise, JD, AMCNO Lobbyist
McDonald Hopkins, LLC

Executive Branch Issues

Ohio Department of Job and Family Services – Medicaid Reimbursement

Gov. Strickland has stopped plans to boost reimbursements for hospitals and clinics due to escalating Medicaid caseloads. Gov. Ted Strickland decided it would be prudent to delay the increased health care spending in light of the fact that Ohio's Medicaid caseload has increased steadily during each of the past three months. Gov. Strickland's executive budget allowed for a 3.2% increase in Medicaid reimbursements for hospitals and 3.0% for community providers, such as doctors' offices and clinics that participate in the Medicaid Managed Care program. The Ohio Department of Job and Family Services is of the opinion that implementing the increases as scheduled would have cost about $26 million for community providers and $24 million for hospitals. The Office of Budget and Management will evaluate caseload figures on a quarterly basis to determine whether the state can afford to implement increased Medicaid spending for hospitals, community providers, and dental services. House Finance & Appropriations Chairman Matt Dolan (R-Novelty) said the decision to stop the reimbursement rate increases was quite a surprise, given that Medicaid caseloads are close to projections offered during the conference committee stage of deliberations on the executive budget. Rather than going into effect in January as planned, the state will recalibrate Medicaid reimbursements in April, allowing hospitals to retain roughly a quarter of the estimated $13 million in payment reductions. Little more than a week after the administration moved to delay some Medicaid expansions, officials announced that other health care programs called for in the biennial budget would go into effect by late January. Stay tuned.

Ohio Department of Insurance

The Ohio Department of Insurance issued a press release to remind Ohioans that as of October 1, 2007, health benefit plans are to provide mental health benefits for biologically based mental illness. This change is pursuant to S.B. 116 (mental health parity legislation) that was effective March 30, 2007 and which became applicable to most health benefit plans on or after Oct. 1, 2007. "Ohioans who suffer from biologically-based mental illness finally have the security in knowing that their insurance will provide coverage on the same level as other health benefits," said Mary Jo Hudson, Director of the Ohio Department of Insurance. "We will monitor health plan product filings and the marketplace to ensure the appropriate products are being marketed and care is being provided as promised."

The law provides that individual and group health plans, including individual and group healthcare plans offered by Health Insuring Corporations (HICs), and public and private self-funded health benefit plans must provide benefits for the diagnosis and treatment of biologically based mental illnesses.

The mandated mental health benefits are subject to the same co-payments, deductibles, cost sharing requirements and managed care as the coverage for physical illnesses. As with traditional health benefit plans, employers and insurers may negotiate reimbursement rates and may establish networks with providers to deliver mental health services to the health plan's subscribers. Self-funded plans are included in the mandate, unless preempted by the federal Employee Retirement Income Security Act (ERISA). Biologically based mental illnesses are defined by the law as schizophrenia, schizoaffective disorder, major depressive order, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder.

Ohio State Medical Board

Also in the Agency area, the Ohio State Medical Board filed the Rules for physician assistants ("PAs"). These Rules became effective October 31, 2007. The Rules may be viewed at: http://www.registerofohio.state.oh.us.

Attorney General's Office

In December, the Ohio Attorney General held the first meeting of the Charitable Advisory Council. AG Jim Petro originally convened this Council and this was the first meeting held by Marc Dann. The AMCNO was in attendance to observe the meeting and AMCNO staff has talked with Marc Dann's office about an AMCNO representative serving on the Council. AG Dann is going to submit a new Rule to JCARR so that they can expand the group. The Council plans on discussing the following subjects in 2008: proper use of Charitable Trust Powers of the OAG, proper punishment of "cheaters," examination of conflicts of interests, examination of excessive compensation and travel reimbursements issues, and the community benefit reporting issue and determining how to work collaboratively regarding hospital accountability. The AMCNO plans to press for representation on the Council if possible. The next meeting is in January 2008.

Judicial Branch Issues

The Ohio Supreme Court has thrown out the state's largest medical malpractice award in Ohio and ordered a new trial because the judges found that the theatrics of the attorney for the brain-injured plaintiff, controversial Michigan attorney Geoffrey Fieger tainted the verdict. With a 6-1 decision, the Court negated the $30 million verdict in the case of 20-year-old Walter Hollins of Cleveland, brain-damaged at birth, saying the 2004 verdict was "given under the influence of passion or prejudice and tainted by misconduct of counsel." Hollins is a quadriplegic with a mental capacity of a one year old. In order to finance his future nursing care, he will have to present his case again at trial with a new lawyer.

Plans are underway to file motions for a new trial and to revoke Fieger's ability to practice law in Ohio. The Mt. Sinai Medical Center, Ronald Jordan, MD, and Northeast Ohio Neighborhood Health Services, Inc. had appealed a decision of the Cuyahoga County Court of Appeals that reversed the trial court's order awarding them a new trial and remanded the case to the trial court to consider motions for remittitur of damages and for prejudgment interest. The Supreme Court found that "where competent, credible evidence exists to support the trial court's finding of an excessive verdict given under passion or prejudice or misconduct of counsel, the order granting a new trial is not an abuse of discretion and should remain undisturbed."

Legislative Issues

SB 59 – Mandatory Arbitration

There is a summary elsewhere in this issue of our activity on this Bill outlining that the trial attorneys have come out full force against the Bill (see front page). Senator Coughlin is attempting to broker a compromise and we will be entering into that effort through the beginning of 2008. If the AMCNO must enter into another round of interested party meetings the outlook for passage of SB 59 in this General Assembly is remote.

House Bill 125 –
the Healthcare Simplification Act

As noted last issue, the Ohio House of Representatives passed, by a vote of 91-5, House Bill 125 – the Healthcare Simplification Act, which was supported by the Academy of Medicine of Cleveland & Northern Ohio, however, the AMCNO does believe that the bill as it is written needs further improvement.

The AMCNO lobbyists attended the interested party hearings on this legislation — a bill that was designed to provide remedies for many of the excessive administrative demands faced by doctors in their interactions with health plans. The intent of the bill was to implement reforms that would provide for ease in the health insurance contracting process, fairness in

Legislative Update

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contracting, a standardized credentialing process and Web-based eligibility verification.

However, after many hearings and interested party meetings, the bill has been changed radically. Of note, the language concerning insurance company usage of a most favored nation clause in insurance contacts was completely removed from the Bill in favor of a joint legislative committee to be formed to review this topic in the future. The 15-member Joint Legislative Study Commission on Most Favored Nation Clauses in Health Care Contracts is to be chaired by the Superintendent of Insurance and is charged with studying specified areas pertaining to most favored nation clauses in health care contracts, and requires the Commission to submit a final report of its findings and recommendations to the General Assembly. During the work of this Commission, there is a moratorium on most favored nation clauses (MFNs). (See lead article for more information on the onerous nature of MFNs and the AMCNO response to the legislature on the bill).

HB 149 – Optometry Bill

This Bill modifies the scope of practice of an optometrist holding a therapeutic pharmaceutical agents certificate or topical ocular pharmaceutical agents certificate. The Bill requires the State Board of Optometry to adopt rules governing the authority of optometrists to administer and prescribe controlled substances.

The AMCNO and the Ohio Ophthalmology Association initially opposed this bill due to the fact that it drastically changed the scope of practice of optometrists in the state. A number of amendments were added to HB 149 in committee to dramatically improve the Bill. Most important to the AMCNO was an amendment to require a prescription for cosmetic contact lens.

The cosmetic lens issue has been supported by the AMCNO for almost five years. A similar Bill passed the U.S. Congress in October of 2005 and President Bush signed it into law on November 9, 2005. The AMCNO was very supportive of the legislation and sent letters of support. AMCNO member Dr. Thomas L. Steinemann has lead this effort here in Ohio and at the federal level. The AMCNO is proud to have supported those efforts. Attorney General Marc Dann helped us here in Ohio as he called a news conference on the issue that was attended by the AMCNO. Marc's office asked courts in five counties to stop the sale of the decorative devices. With graphic photos of damaged eyes serving as a backdrop, Mr. Dann called it an excellent time to warn of the dangers of the lenses and said the state would take action to halt the illegal sale of cosmetic contacts without a prescription.

We are still less than halfway into a two-year legislative cycle yet, as you can see, there is considerable activity on the health care front in the General Assembly. 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. ■

On the National Legislative Front

At press time, Congress had finally passed a bill that would fix the 10.1% pay-cut for physician services in 2008. The bill replaces the cut with a 0.5% increase to the conversion factor. However, the pay-fix will expire in six months, and without another congressional intervention, the 10.1% cut could resurface in July 2008. The bill will replace the 10.1% cut with a 0.5% increase in physician payments next year. SCHIP, the state children's health insurance program, will be extended until early 2009. The president is expected to sign the new legislation. The bill will protect doctors from Medicare cuts until the end of June, when Congress will have to act again to stop the cut. Some of the available money in the Physician Assistance and Quality Initiative fund for 2008, used to pay the PQRI bonus, would be restricted by the bill in order to cover the pay-fix. The AMCNO will continue to monitor the Medicare pay-cut issue in 2008 and provide updates to our membership.

Center for Health Industry Solutions

Cuyahoga Community College

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Feb 5th – May 6th	AAPC Coding Certification for the Certified Professional Coder (CPC). Study for your Certification as a Certified Professional Coder (CPC) through our 81-hour Professional Medical Coding Curriculum. • Would you like to enter the growing field of professional medical coders? • Do you have professional coding experience but need certification? • Take this evening program to earn your professional coding certification and enhance your practice performance!	Tuesday and Thursday nights 6:00-9:00pm Corporate College - East 4400 Richmond Road Warrensville Hts., Ohio 44128 AMCNO Discount: $1650.00
Feb. 6th	Advanced ICD9-CM Coding Update $159	1pm-4:00pm
Feb. 6th	ICD-10: How Will It Affect Me? $159	9:30am-11:00am
Mar. 5th	Advanced CPT Coding Workshop $159	1pm-4:00pm
Apr. 2nd	Compliance Program Effectiveness $139	9am-12:00pm
Apr. 16th	Managed Care Updates $120	8am-11:00am
Apr. 16th	Appeals and Denials: A Panel Discussion for Coders $99	11:30am-1:30pm
Apr. 19th	CCS Exam Preparation $120	9am-2:15pm

To obtain your *AMCNO member discount promo code,*
Call Linda Hale at The Academy at (216) 520-1000.
Then, call Cuyahoga Community College to register at (216) 987-3075.

State Representative Tom Patton (R-18)

State Representative Tom Patton has served the residents of the 18th Ohio House District since 2003. The 18th District is comprised of Berea, North Royalton, Olmsted Falls, Olmsted Township and Strongsville, all within Cuyahoga County.

Representative Patton has a long history of service to Northeast Ohio. The son of a policeman, he attended Cleveland State University and eventually started a successful business, Cleveland Business Machines, with his brother. He also joined and later became the President of the Treasurer's and Ticket Sellers Local 756, a capacity he continues to serve in. Representative Patton has been very active in charitable and community causes throughout Northeast Ohio. He is a member of the Cleveland Police Historical Society, Holy Name Endowment Board, serves as Finance Chairman of St. Colman's Church and is a member of the Knights of Columbus. Representative Patton is the proud father of six children.

Unfortunately, Representative Patton's first extensive involvement with medicine came in 1982 when his wife, who was 29, became ill with and later died of cancer. Since that time, he has been an outspoken advocate for cancer research and a tireless champion of preventative medicine and programs in areas such as diabetes prevention. He is a co-Sponsor of HB 137 which would "amend sections 1739.05 and 1751.01 and to enact section 3923.71 of the Revised Code to require certain health care policies, contracts, agreements, and plans to provide benefits for equipment, supplies, and medication for the diagnosis, treatment, and management of diabetes and for diabetes self-management education."

Representative Patton is a member of the "Cancer Caucus," headed by Representative Jim Carmichael. This informal group of legislators meets periodically to discuss public health policy in relation to cancer treatment, research and funding.

Representative Patton co-Sponsored HB 119, the state operating budget for the 2008-2009 biennium. There were a number of important tax reforms, which will be beneficial to physicians and businesses. In addition, HB 119 increased the Medicaid reimbursement rate for physicians by 3% per year; increased eligibility for children services from 200% to 300% of poverty levels as well as increasing the eligibility for pregnant women from 150% to 200% of poverty. Representative Patton believes making more low-income families eligible for health care services is an important part of the prevention model.

Representative Patton is a co-Sponsor of HB 24 which passed the House and is awaiting approval in the Senate. HB 24 gives municipal corporations the option of allowing sole proprietors to take a municipal income tax deduction for amounts they pay for medical care insurance for themselves and their family members. It also gives municipal corporations the option of allowing individuals to take a municipal income tax deduction for cash contributions to health savings accounts. This is another important step in helping small business owners to be able to afford health care coverage.

Beyond working to make healthcare more affordable to Ohioans and making sure we keep the excellent physicians we have, Representative Tom Patton has spent the last four years working to improve Northeast Ohio's economy. It has always been his philosophy that a "rising tide floats all boats." As such, when a regional economy is performing well, the burden on safety net public services is lessened as per capita wealth and productivity increase. This translates into a lesser burden on the costs of healthcare for everyone, because physicians and hospitals are treating patients who can afford such services or have insurance for said services. The more paying consumers there are, the more the overall cost is fairly distributed, lowering the cost per paying consumer.

Representative Patton has made tax reform and higher educational development priorities while in the Ohio House. "We need to foster a tax climate that is beneficial to attracting businesses and creating jobs. Subsequently, we need a higher educational system that is producing the men and women who can fill the jobs we are trying to create. These issues are not mutually exclusive, but rather reliant upon one another," Patton said at a recent meeting with business owners and community leaders.

In 2008, Representative Patton will be seeking the Ohio Senate seat in the 24th district, currently held by Senator Bob Spada, who is term-limited. The 24th District covers a large part of suburban Cuyahoga County: Bay Village, Bentleyville, Berea, Brecksville, Broadview Heights, Chagrin Falls Village, Chagrin Falls Twp., Fairview Park, Glenwillow, Hunting Valley Village, Independence, Lyndhurst, Mayfield Heights (part), Moreland Hills, North Olmsted, North Royalton, Oakwood Village, Olmsted Falls, Olmsted Twp., Pepper Pike, Rocky River, Seven Hills, Solon, Strongsville, Valley View Village, Walton Hills and Westlake.

Representative Patton wants to bring his focus of economic and educational development, tax reform and making healthcare affordable and accessible, while protecting the rights and economic viability of physicians, to the Ohio Senate. Representative Patton welcomes your thoughts and opinions on any of the matters discussed at the Statehouse. Please feel free to contact him at (614) 466-4895, by email at district18@ohr.state.oh.us or by writing to: State Representative Tom Patton, 77 South High Street, District 18, Columbus, Ohio 43215. ■

Aligning Forces for Quality – The Northeast Ohio Collaborative (Aligning Forces NEO)

By Randall Cebul, M.D., Director

Health professionals strive to deliver the best possible care possible, yet a frustratingly high percentage of patients receive care that falls short of accepted standards and achieve sub-optimum outcomes.

Aligning Forces for Quality – The Northeast Ohio Collaborative (Aligning Forces NEO) is a multi-stakeholder alliance committed to improving the quality of care for people with common chronic conditions. Its focus on primary care in outpatient settings tackles improvement at the ground level, bringing a promise of better health for the chronically ill in Cuyahoga County and beyond.

Aligning Forces NEO was officially launched Feb. 1, 2007, when the Robert Wood Johnson Foundation (RWJF) selected Greater Cleveland as one of 14 communities to participate in a new national program, Aligning Forces for Quality – The Regional Market Project.

The alliance convenes providers, payers and patients to shape strategies using three building blocks to improve care and outcomes: Public reporting of nationally recognized performance measures at the practice-site level; provider education in quality improvement based on national models; and region-wide patient and community engagement to increase understanding of quality care and improve patients' self-care capabilities.

The ultimate goal of Aligning Forces NEO is improve outcomes for the chronically ill. Diabetes is the first condition that is being addressed. Hypertension, congestive heart failure, and coronary heart disease will be added in second year of reports.

"We know we can do better," said Randall Cebul, MD., director of Aligning Forces NEO.

Aligning Forces NEO Partners

As the Johnson Foundation grantee, the MetroHealth System forged partnerships with northeast Ohio's Health Action Council and The Center for Community Solutions to become founding members of Aligning Forces NEO, which formally incorporated in Ohio this past spring.

Cebul, a practicing internist at MetroHealth Medical Center and director of the Case Western Reserve University-MetroHealth Center for Health Care Research & Policy, began building Aligning Forces' broad-based coalition in the summer of 2006, at the time of the application to the Johnson Foundation.

The Collaborative includes participation of the primary care practices of the region's major health systems and all three Federally Qualified Health Centers, as well as representatives of virtually all regional health plans and public health agencies. The Health Action Council, an employers' health purchasing group, and its Plan Advisory Committee, represent interests of regional employers. Other partners include Ohio Medicaid; OneCommunity, a Cleveland-based information technology organization that connects public and nonprofit organizations to its fiber optic network; and NetWellness, an Ohio medical schools'-based consumer health information Web site.

More than 500 primary care physicians from eight health care organizations and 54 practice sites currently are part of the fledgling initiative. But plans are underway to ensure the alliance's sustainability and to expand physician participation and partnerships. In short, Aligning Forces NEO welcomes all comers committed to performance measurement and quality improvement.

The strategies

1. Performance Measurement & Public Reporting. The alliance is leveraging the electronic medical record capabilities of the region's health systems to measure and report on outpatient care for the targeted conditions across all payer sources and socioeconomic groups. Some practices — including all of the FQHCs, which principally care for Medicaid and uninsured patients in the region — are reporting data that they collect in patient registries.

   Practices are providing detailed data that are de-identified at the patient and physician levels. Public reports will include practice-level data stratified by insurance type (commercial, Medicare, Medicaid, uninsured). The first public reports will be published on the Web and in print every six months, starting next spring. Reports in the first year will cover diabetes measures; other conditions will be added in subsequent years.

   The objectives of the public reports are to focus providers' attention to nationally endorsed standards for high-quality care, as well as to activate patients and foster effective provider-patient partnerships in managing chronic conditions.

   "This is not a "bad apples" approach," said David Bronson, Director of Cleveland Clinic's Regional Medical Practices and Chair of Aligning Forces' Clinical Advisory Committee. "Our model encourages continuous improvement and addresses the important roles that patients have in their health care."

2. Quality Improvement Learning Collaborative: Teams from participating practices have joined the Aligning Forces NEO Learning Collaborative, an initiative that focuses on methods to continuously improve health care systems and outcomes for patients with chronic conditions. The Greater Cleveland collaborative is based on the Breakthrough Series model developed by the Institute for Healthcare Improvement (IHI) and the Chronic Care Model developed by Ed Wagner.

   In September, over 90 members of 21 practice teams from across the region convened at the Learning XChange in University Circle for the first in-person Learning Session. David Aron, a practicing endocrinologist and Associate Chief of Staff at the Louis Stokes VA Medical Center, leads the collaborative. "I've always dreamed of coordinating a region-wide Learning Collaborative," said Aron, who also leads the VA's Quality Scholars Program, "and the Aligning Forces initiative has been the perfect vehicle for improving care throughout Greater Cleveland."

3. Patient Activation. Because the best outcomes are more likely to occur when a motivated patient meets in partnership with her physician, Aligning Forces NEO is developing strategies to mobilize practices and to educate and activate patients in their own care.

(Continued on page 10)

Aligning Forces for Quality – The Northeast Ohio Collaborative (Aligning Forces NEO)

(Continued from page 9)

The overarching theme of the messages under development is the vital role of the patient-provider "team" in achieving the best outcomes for patients with chronic conditions. The alliance hopes to empower patients to ask their doctors questions, to arm them with the right questions, and to provide tools that will help their doctors to help them to manage their condition.

In the Planning Stages — Other Opportunities

Aligning Forces NEO has attracted both national as well as regional attention from potential partners in measuring and improving quality of care.

A Provider-Plan Partnership formed by Collaborative members is exploring ways to reduce duplication and maximize the benefit of plan-initiated disease management programs. A survey is under development that will allow the partnership to better understand current practices and problems in order to craft better solutions for participating practices and their patients.

Discussions are underway with the American Board of Internal Medicine to develop mechanisms that would enable participating internists to earn "Practice Improvement" credits towards maintaining their ABIM certification. "When the ABIM proposed this to us, I realized that this could add value to internists for participating in the collaborative," said Cebul, "and it also would represent a first-of-its-kind initiative by the Board."

Editor's Note: In November, the AMCNO board of directors agreed that the AMCNO should become an active participant in the AF4Q program, and the AMCNO has agreed to participate as a part of the AF4Q Leadership Team. The AMCNO representatives are to obtain and review additional information about the AF4Q program as it progresses and report back to the board and the AMCNO membership. Two AMCNO board members have agreed to participate as part of the Leadership Team. AMCNO Executive staff will monitor the group as well. Physicians interested on participating in the program should contact Diane Solov, Program Manager, Aligning Forces for Quality — the Northeast Ohio Collaborative, Center for Health Care Research and Policy MetroHealth Medical Center, (216) 778-8414. ■

Thinking About Retiring?

If you are considering retiring from your practice we need to hear from you. Why? Your benefits!

As a retired member you will continue to receive many of the benefits of membership, including dues-exempt membership at a "retired" status, access to staff, eligibility for AMCNO 50 year award, and your name in the AMCNO physician directory so you can stay in contact with your colleagues.

Here are some helpful hints:

- We can provide you with information that will be beneficial to you whether you are selling or closing a medical practice.
- Assist you with advertising in the *Northern Ohio Physician*
- It would also be very helpful for the AMCNO to know where your patient records are. We get many phone calls from patients trying to locate their medical records from a retired physician and can handle these inquiries for you.

Here are the options for retired membership:

- Your AMCNO dues must be current.
- If you retire before May 1, 2008, you pay no 2008 dues. You will have "retired" status.
- If you retire after May 1, 2008, you will need to pay your 2008 dues, then you will be dues exempt in 2009.

For more information about closing a practice contact Linda Hale in the Membership Department at (216) 520-1000 ext. 101.

NOT QUITE RETIRED BUT CUTTING BACK ON HOURS: AMCNO offers part-time membership to physicians 66+ years of age working less than 20 hours per week and less than 40 hours per week. For more information about part-time membership status, closing a practice, or retirement membership status, please contact Linda Hale at (216) 520-1000 ext. 101.■

Department of Health and Human Services Office of Attorney General Approves Hospital Proposal to Pay Physicians for Providing On-Call Emergency Coverage

In Advisory Opinion No. 07-10 issued September 20, 2007, the United States Department of Health and Human Services, Office of the Inspector General, ruled, in effect, that a proposal by a hospital to compensate independent physicians for providing on-call emergency coverage would not violate the Federal anti-kickback statute.

This Opinion was in response to a ruling request by an unnamed hospital. The hospital was a tax exempt medical center which operated an emergency department. Nearly 25% of the patients visiting the emergency department were uninsured, and approximately 10% of the uninsured patients who presented at the emergency department were subsequently admitted to the medical center for further care. The medical center had found that it was becoming increasingly difficult to provide physician care for various patients who presented at the emergency department, and that it frequently had to transfer patients to other medical facilities both for emergency treatment and necessary inpatient care.

In response to this situation, the medical center formed an ad hoc committee composed of Board members as well as leading staff and administration to study the problem and to make a recommendation. The arrangement that was ultimately developed provided that physicians on the medical staff in certain medical specialties would be offered the opportunity to provide emergency department on-call coverage, respond to patient's emergencies in the emergency department, and provide inpatient care for uninsured patients. All the physicians on the medical staff within the relevant specialties were offered the opportunity to contract for 2 year terms. The basic obligations under the contract included the following:

1. Equal participation within each specialty in an on-call rotation;

2. A commitment to provide inpatient care to any patients seen in the emergency department while on call;

3. A commitment to timely response to call from the emergency department, with monitoring by the medical center;

4. Cooperation with care management/risk management and quality initiatives; and

5. Documentation by the physician of services for all patients.

Under the contract, physicians participating were to be paid a per diem rate for each day spent on-call at the emergency department except for 1½ days per month that each physician was required to contribute without fee to the rotation schedule. The per diem rate was based on two factors: the physician's specialty, and whether call coverage was on a weekday or weekend. The difference in the per diem rates among specialties was based on the following factors:

1. Severity of the condition typically encountered by that specialty in treating a patient presenting in the emergency department.

2. Likelihood of having to respond when on-call at the emergency department;

3. Likelihood of having to respond to a request for inpatient consultative services for an uninsured patient when on-call; and

4. The degree of inpatient care typically required of the specialty for patients who initially present at the emergency department.

The medical center had engaged a consultant to conduct a study to determine that the per diem rates paid under the arrangement were fair market value, and to confirm that the rates were not, and would not be, something that would take into account the volume of referrals between the medical center and the physician. The OIG Opinion specifically did not address the accuracy of the fair market assessment contained in the consultant's report.

As is the case with OIG Opinions, Opinion 07-10 applies only to the requesting party based on the facts presented. The Opinion is limited to issues arising under the Federal antikickback statute. That being said, this opinion is good news for both hospitals and physicians in the guidance it provides.

However, there is a word of caution. While physicians who practice at hospitals which do not provide payment for on-call emergency department coverage are certainly free to raise this issue with hospitals, care should be exercised in the way in which a medical staff, or smaller groups of physicians, raise this issue. Concerted group activity in this area can give rise to antitrust issues. ■

John T. Mulligan
McDonald Hopkins LLC
600 Superior Avenue, E.
Suite 2100
Cleveland, Ohio 44114

AMCNO ACTIVITIES

New York Attorney General Signs Insurance Agreements

AMCNO Seeks Ohio Attorney General Comments

New York State Attorney General Andrew Cuomo (D) has signed onto an agreement with CIGNA, which will require CIGNA to provide its members with more information on how it ranks physicians. In August 2007, the New York AG warned Aetna and CIGNA that their physician ranking programs likely would confuse or mislead members because of problems with the information used to rank physicians. In addition, the New York AG had also asked UnitedHealth Group to cancel their launch of a similar program or face possible legal action. Under the agreement, Cigna will divide its preferred physician list into three lists — one that ranks by cost, one that ranks by quality and one that uses a combination of both measures. Cigna said that it always has used both cost and quality measures to rank physicians, but the insurer in the agreement pledged to make its ranking data more transparent to members. The agreement will require that CIGNA to report to the Attorney General every six months and that it use an outside monitor. Aetna has said it will work with the NY AG on the issue and UnitedHealth and other carriers in the state have indicated a willingness to discuss an agreement as well. At press time, the NY AG had also agreed to a similar agreement with Empire Blue Cross and Blue Shield and more than likely other carriers in the state of New York will follow.

Medical groups including the AMCNO have expressed concerns that doctor rankings can be confusing and could be used to steer patients to the least-expensive health care providers, rather than being based on quality. The AMCNO physician leadership has been reviewing this issue since the New York AG first issued the warnings to the insurance companies this summer to determine if this is a matter for review in Ohio. Physician ranking and rating is an issue of importance to our members based upon our recent membership survey. It will be important that the insurance companies are truly reviewing quality issues versus cost and claims data, and the data must be accurate with the ability of physicians to appeal their data.

Based upon the AMCNO review and discussion of the recent events in New York, the physician leadership of the AMCNO has requested the review of the Ohio Attorney General's office regarding the agreements reached in New York with the insurance companies. Although New York law clearly differs from the law in the state of Ohio, the AMCNO has asked for a meeting with the Ohio AG Marc Dann to discuss whether or not similar agreements and laws should be pursued in Ohio. The AMCNO physician leadership hopes to meet with the Ohio AG on this matter in the near future. ■

COLLEAGUES CORNER

Recognizing outstanding AMC/NOMA members for their honors, awards and achievements, in addition to their work spreading messages of health and wellness to the community.

AMCNO Past President George E. Kikano, MD, Receives Professorship

George E. Kikano, MD, Chairman of the Department of University Hospital Family Medicine, was recently given the Dorothy Jones Weatherhead Professorship of Medicine by Case Western Reserve University Board of Trustees. Kikano has received several awards for his professional achievements as a physician and medical educator. He has an extensive research resume and has published a number of peer-reviewed articles about medical management; disease prevention and health promotion and cardiovascular diseases.

Over 100 colleagues, administrators, friends, family and representatives from the AMCNO were on hand to witness the presentation to Dr. Kikano on Wednesday, November 28, 2007. The AMCNO offers our heartfelt congratulations to our past president.

AMCNO Past President Kevin T. Geraci, MD, Opens New Facility in Bainbridge

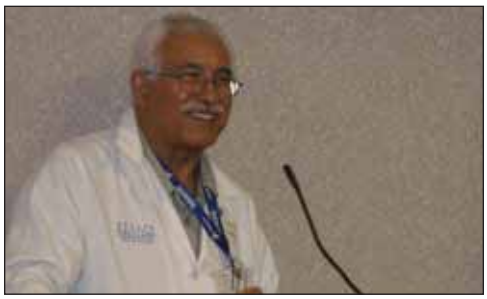
AMCNO Past President Dr. Kevin Geraci along with his partners and AMCNO members, Drs. R. Bruce Cameron, Michael Koehler, and Raymond Rozman, recently opened The Endoscopy Center at Bainbridge. Congratulations and best of luck to the group! ■

George Kikano, MD, (seated) surrounded by his family members at the presentation.

Two members of the group spend a moment with one of the guests at the opening – left to right – Michael Koehler, MD; Michael Nochomovitz, MD; and Kevin Geraci, MD.

All smiles about the new facility – left to right – AMCNO members R. Bruce Cameron, MD; Raymond Rozman, MD; Michael Koehler, MD; and Kevin Geraci, MD.

AMCNO and the William E. Lower Fund Team Up to Provide Practice Information to Residents



Dr. Victor Bello, AMCNO Membership Committee chairman and past president, welcomes participants.

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) presented our annual seminar, *Preparing for the Business Aspects of Practicing Medicine* on October 24th at the AMCNO offices. The agenda's content and speakers targeted specific issues that young physicians will face entering today's healthcare marketplace. Residents and spouses from several area hospitals were on hand to learn about employment contracts, liability coverage, asset management, estate planning, starting a practice, and tax concerns from a lineup of expert guest speakers. The seminar was co-sponsored by the AMCNO and the William E. Lower Fund. The AMCNO thanks speakers Michael Turney from Hilb, Rogal & Hobbs; Kristin Howard from McDonald Hopkins; Dave Downing from Sagemark Consulting; John Shelley, Esq. of Squires Sanders; and Dick Cause of Walthall, Drake and Wallace LLP who were on hand to share their expertise. ■

Kristin Howard from McDonald Hopkins LLP discusses employment agreements with the audience.

SAVE THE DATE

The Academy of Medicine Cleveland & Northern Ohio Membership Committee cordially invites physician members, residents, medical students and spouses to attend our 2008 wine tasting experience. This is the perfect opportunity for you to mingle with your colleagues.

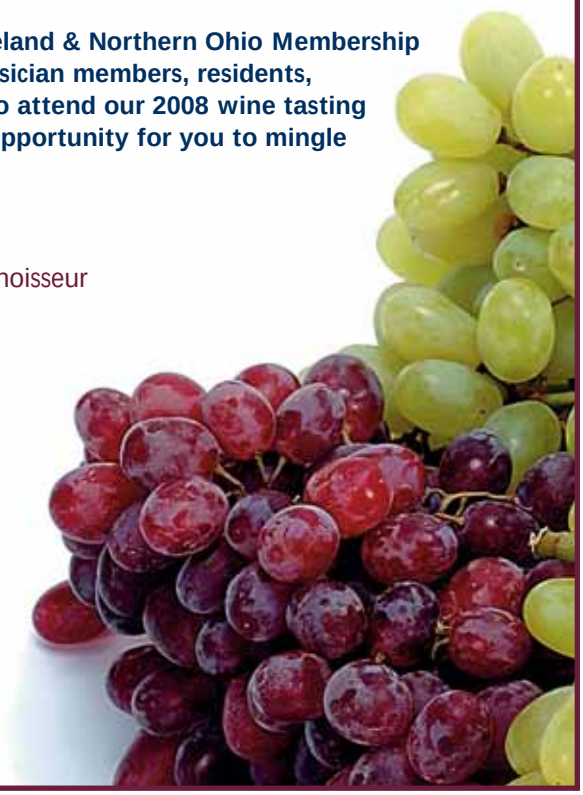
- Hors D'oeuvres
- A fine selection of wines
- Dialogue with a local wine connoisseur

LA CAVE DU VIN
2785 Euclid Heights Blvd.
Cleveland Heights, OH

Sunday, February 17, 2008
5:00 to 7:00 PM

COST:
$30 per members/spouses
$15 residents & medical students

RSVP by 02/11/08 to Linda Hale
PHONE (216) 520-1000 Ext. 101
FAX (216) 520-0999
MAIL 6100 Oak Tree Blvd., #440
Independence, OH 44131



Healthlines 2007

The Academy's Healthlines *radio program has provided medical information and the insight of our member physicians to listeners for more than 40 years. With hosts Ronald A. Savrin, MD, and Anthony Bacevice, MD,* Healthlines *is broadcast on WCLV 104.9FM at 5:45 p.m. every other Monday, Wednesday and Friday and is brought to the community by the Academy of Medicine Education Foundation (AMEF). Listed below are the featured physicians who aired on* Healthlines *in 2007.*

Thank you to the following interviewees that appeared on *Healthlines* in 2007:

Vasu Pandrangi, MD
Lawrence Bilfield, MD
Curtis Rimmerman, MD
George Coserieu, MD
Bernard Stulberg, MD
John Clough, MD
Bruce Agneberg, MD
Arthur Varner, MD
Elias Traboulsi, MD
K.V. Gopalakrishna, MD
Raymond Isakov, MD
Mark Stovsky, MD
Steven Bernard, MD
Laura David, MD
Holly Thacker, MD
Ayman Basali, MD
Daniel Geisler, MD
Katherine Lee, MD
Imad Najm, MD
William Seitz, Jr., MD
Ronald Krueger, MD
Jonathan Myles, MD
Daniel McLaughlin, MD
Stephen Flynn, MD
Bret Lashner, MD

Any physician member of the AMCNO may appear on the *Healthlines* radio program. If you are an AMCNO member and are interested in appearing on the program for 2008, please contact the AMCNO offices at (216) 520-1000 for more information. ■

Telephone Cents

By Kathy Spoon, On-Hold Marketing

You've spent money on the Yellow Pages, you've spent money on staff, and you've spent money on telephones. How can you maximize the return on your investment *and* increase patient satisfaction? Following are steps for you to consider:

Most patients "meet" your practice in three ways:
– through your telephones
– through your Web site
– through your front door

This article focuses on your phone system, and optimizing call-handling to provide personal, appropriate attention to the callers who need it. Why is this important? By saving staff time, you'll save money and gain practice efficiency — while showing your patients that you're concerned about their well-being.

Step 1 – Analysis
A staff analysis of inbound and outbound phone calls is necessary to identify where you can streamline. (Be sure to consider your satellite offices)! The analysis will yield data on peak call times, frequently asked questions, who handles which calls, what calls are placed, reason for call, and when/if outside lines are not available.

Implementation: Each Staff Member Keeps a One-Week Chart of Inbound/Outbound Calls:

The chart should include who handled/placed the call, the time of day, day of week, reason for call, able to handle, transferred to another staff person, put on hold, responded to voice mail, responded to phone message and room for notes.

Step 2 – Summarize Findings
You/Your Business Manager then compiles the findings for analysis. You'll want to chart the days and times of most frequent phone traffic, most frequent reasons for inbound/outbound calling, and how many staff layers (i.e., transfers to another person) / how much time did the calls require? Then, develop a flow chart of calls and the route they follow through your office.

Factors to Consider – Inbound Calls
What's Important #1 – Look at your staff costs; it's most cost-effective to have the majority of calls handled at lowest cost level.

What's Important #2 – Who are your inbound callers? Are they new patients or existing patients?

a) If they are new patients, they may be unhappy with their current physician, referred by another physician, new to the area, nervous, sick, or elderly. These callers present an opportunity to build your practice and should be handled as promptly, personally, and professionally as possible. They may have the Yellow Pages sitting in front of them!

b) If they are existing patients, look at the reason for their call, and assess the following Streamlining Tools in your practice:
– Could this question have been answered by brochures in the exam rooms? If so, send patients home with the brochures.
– Could this question have been answered by voice mail?
– Could this question have been answered by your Web site?

What's important #4 – Determine who you want handled by a live person immediately. Make sure your voice mail system is placed "behind" these calls in the flow chart.

What's Important #5 – Are many calls from referring physicians? Pharmacies? Labs? Drug Companies? You want to get these calls to the correct person quickly, without distracting the live person who is handling new patient calls.

What's Important #6 – Are expensive staff members being interrupted frequently to handle phone calls that could be consolidated into a time window each day?

What's Important #7 – Do you have a feedback loop to determine if your efforts are successful?
– Survey your existing patients by placing feedback forms and pens in the waiting room or exam rooms. Then adjust your phone/Web site/brochures as you determine appropriate.
– Conduct another phone analysis to determine if efforts are successful.

Factors to Consider: Outbound Calls
What's Important #1 – Was the call placed at a time convenient to staff?

What's Important #2 – Can they get an outside line? If not, can you predict when they can and cannot?

What's Important #3 – What is the financial return on the phone call; is it appropriate to be interrupted or should it be set aside?

Step 3: Application:
No two medical practices are alike. No phone vendors understand your practice as well as you and your staff do. Use these findings to make your phone system work for you — or to evaluate a new phone system.

Other tools: Pagers, cell phones, answering service? How are they being used? Could they be better used?

Training: Be sure your phone vendor trains your staff. Then be sure your staff is trained on how to handle phone calls,after all, they are representing YOU to the public. Have printed phone protocols readily available for new and temporary staff members.

Service: If your phone system is down or malfunctioning, it costs you money. Make sure you're comfortable that you'll receive service after the sale.

People are calling you…make the most of it!

Ms. Spoon managed Primary Care and Plastic Surgery Practices for 10 years before starting On-Hold Marketing in 1997. She works with practices throughout the country to help physicians market their practices through their telephones, Web sites, practice brochures, and On-Hold Messages.

AMCNO members are eligible for a 15% discount on On-Hold Marketing Services. For more information you may contact the AMCNO at (216) 520-1000, ext. 101. ■

Third-Party Payor Seminar Provides Worthwhile Updates

On Nov. 15, more than 50 practice managers, physician office staffers and others attended the Academy of Medicine of Cleveland & Northern Ohio's annual "Solving the Third-Party Payor Puzzle" seminar which provided reams of valuable information to attendees. Presenters included Ms. Vanessa Williams from PalmettoGBA, Ms. Cheryl Donahue from Anthem BC/BS, Ms. Diana Irvin from Medical Mutual of Ohio, Dr. Giesele Robinson Greene from UnitedHealth Care and Audrea Caeser from the Ohio Department of Jobs and Family Services (ODJFS). All of the presenters informed those gathered of the many changes in claims submission policy, and protocols for provider offices in dealing with payors from private and governmental agencies. Questions abounded throughout the day, as presenters and guests exchanged troubleshooting tips, helpful advice and an exhaustive list of technical and educational resources to better manage claims in the physician office setting.

The event was well-attended by AMCNO members and their office staff.

PalmettoGBA started the day by summarizing new Medicare initiative and program updates as well as providing a detailed overview of recent Medicare-related data. Ms. Williams also described the new tools available for use on the PalmettoGBA Web site. Topics covered included the 2008 Medicare Physician Fee Schedule which will become effective January 1, 2008. This rule includes changes for practice expenses, e-Prescribing, additional quality measures for use in the PQRI initiative and other revised methodologies. Ms. Williams also provided the groups with updates on the usage of the NPI number and how to look up modifiers and denial codes on the Web site.

The ODJFS presentation was divided into two parts — the first presentation covered the Bureau of Plan Operations expansion, the ODJFS implementation of the NPI number, policy updates, the Ohio Administrative Knowledge Systems, Medicaid paper billing and electronic data interchange adjustments. Also provides was detailed information on the ODJFS Web site and information on claims submission. The second presentation focused on the Medicaid Managed Care program by providing detailed information on covered families and children (CFC) and the aged, blind and disabled (ABD) programs.

The MMO presentation primarily focused on the Emdeon office. Attendees were provided with detailed information on how to register for Office and how to obtain online training for the service.

UnitedHealth Care focused a great deal of their presentation on how to navigate the UHC Web site for information. Of interest was the fact that UHC now has real-time claim adjudication available on their Web site. Also covered were new programs such as the advance notification and the radiology notification programs. Dr. Greene also briefly covered the UHC Vital Measures program which will combine a high deductible medical plan with a supplemental plan that provides an immediate cost savings for both employers and employees.

The final presenters from Anthem BC/BS provided background information on how Anthem is rolling out usage of the NPI, and an overview of Anthem products, the 2008 precertification list, the new Blue hospital/surgical plan, and finally their electronic network system solution.

The AMCNO is in discussions with both Aetna and CIGNA to provide presenters for the event next year. Watch for information on this AMCNO sponsored seminar in 2008. ■

Process to Resolve Medicaid Disputes Established by State – AMCNO Resources Also Available for Insurance Dispute Resolution

The Ohio Department of Job and Family Services has established a process to assist healthcare providers in pursuing unresolved concerns with Medicaid managed care plans. This process is to be used after exhausting the existing processes. If after utilizing the processes, providers can complete a complaint form at http://jfs.ohio.gov/ohp/bmhc/pro-man-care.stm. Once a provider has completed and submitted the form, ODJFS staff will work with the provider and the Medicaid managed care provider (MCP) to address the issues and ensure that the MCO is in compliance with their contract. MCPs have 15 days to respond to ODJFS. The only exception is if the complaint is related to a Medicaid consumer's access to care. Those issues require a two working day response time.

AMCNO members should remember that the AMCNO staff and physician leadership have developed working relationships with all of the third-party payors in our area and we meet or conference with them on a regular basis. The AMCNO will assist our members and their staff if they have complaints or problems with insurance companies. Our insurance complaint form is posted on our Web site at www.amcnoma.org or you may call the AMCNO at (216) 520-1000 for more information.

Cuyahoga County Board of Health Provides Information on CA-MRSA

Community-associated Methicillin resistant *Staphylococcus aureus* (CA-MRSA) was first reported in the United States in the early 1980s among intravenous drug users. In 2000, the Centers for Disease Control and Prevention (CDC) began investigating outbreaks of staphylococcal infections among inmates at correctional facilities in Mississippi, Georgia, and Texas. A new pulse-field gel electrophoresis (PFGE) pattern was found among MRSA isolates from all three correctional facilities, indicating that the same strain was causing infection in all three facilities. This strain type, called USA300, was subsequently isolated from children in Tennessee and Texas, sports participants, military recruits, and men who have sex with men. Results from a CDC-funded study conducted in 2004 showed that the USA300 MRSA strain was the most common cause of skin infections among patients treated at 11 emergency departments located across the United States.[1]

In March 2006 the CDC released guidelines for clinical management of MRSA in the community[2]. These guidelines are summarized below and can be found, in full, at the Cuyahoga County Board of Health Web site, www.ccbh.net.

1. MRSA should be considered in the differential diagnosis of skin and soft tissue infections (SSTIs) compatible with *S. aureus* infection. A presenting chief complaint of "spider bite" should raise suspicion of a *S. aureus* infection.

2. MRSA should be considered in the differential diagnosis of other syndromes compatible with *S. aureus* infection as well as some severe syndromes not typically associated with *S. aureus,* such as necrotizing fasciitis and purpura fulminans.

3. Clinicians are encouraged to collect specimens for culture and antimicrobial susceptibility testing from all patients with abscesses or purulent skin lesions.

4. Incision and drainage (I&D) constitutes a primary therapy for furuncles, other abscesses, and septic joints.

5. Empiric antimicrobial therapy may be administered in addition to I&D. Factors that may influence the clinical decision include: a) severity and rapidity of progression or presence of associated cellulitis, b) signs and symptoms of systemic illness, c) associated patient comorbidities or immune suppression, d) extremes of patient age, e) location of the abscess in an area that may be difficult to drain completely or that can be associated with septic phlebitis of major vessels, and f) lack of response to initial treatment with I&D alone. Refer to CDC guidance for discussion on recommended antimicrobial therapy.

6. Patients and caretakers should be instructed on methods to limit further spread of infection. Patients who cannot maintain adequate hygiene and keep the wound covered with clean, dry bandages should be excluded from activities where close contact with other individuals occurs, such as daycare or athletic practice, until their wounds are healed.

7. Data on the efficacy of decolonization of patients with MRSA infection and their close contacts is lacking. However, decolonization may be reasonable under the following conditions: a) an individual has multiple documented recurrences of MRSA infection or b) ongoing MRSA transmission is occurring in a well-defined, closely associated cohort. All members of a cohort that receive decolonization should do so simultaneously. Consultation with an infectious disease specialist may be helpful.

9. Clinicians should routinely ask about similar cases of SSTIs in household members and close contacts.

The Ohio Administrative Code 3701-3-02 requires that an outbreak or unusual incidences of staphylococcal skin infections be reported to the local health department. If you become aware or suspect an outbreak of MRSA, report it to your local health department. The 24/7 telephone number for central disease reporting in Cuyahoga County is (216) 201-2080. The Cuyahoga County Board of Health (CCBH) will investigate clusters of MRSA and provide guidance on prevention of transmission. In addition, the Ohio Department of Health will type isolate strains obtained from MRSA clusters to determine if the cluster is caused by the same strain. CCBH will facilitate the shipment of isolates to the Ohio Department of Health Laboratory. ■

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NORTHERN OHIO PHYSICIAN

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Consortium for Healthy Immunized Communities (CHIC) Hosts Statewide Conference in Cleveland

Vaccine financing and the complex vaccine schedule served as the main topics of discussion at this year's Consortium for Healthy & Immunized Communities (CHIC) conference held at the Ritz Carlton in Cleveland.

In 1985, the immunization schedule provided coverage against seven diseases: measles, mumps, rubella, diphtheria, tetanus, pertussis, and polio. Now, the schedule has been expanded to cover a total of 16 including: Hib, Hep A, Hep B, varicella, pneumococcal disease, influenza, meningitis, rotavirus, and HPV.

To increase compliance rates the Ohio American Pediatric Association is creating a new condensed immunization schedule, tentatively named the Ohio Timely Immunization Schedule (OTIS), to complete most childhood vaccinations during the first year of life.

The introduction of new vaccines has decreased morbidity and mortality in children while also creating challenges. Providers face caring for children without adequate coverage, expensive upfront costs, and flat reimbursement rates while vaccination costs more than four times as much in 2007 than in 2000.

"Providers have a real concern on how to provide services to the uninsured and underinsured," stated Cindy Modie, director of CHIC. "Vaccine financing and management of the increasingly expensive and constantly changing schedule are serious issues facing healthcare today. This conference served as a meeting of the minds for those directly involved."

Immunization of children in Ohio is difficult because of gaps created by a two-tier vaccination policy, according to Dr. Alan Hinman of The Task Force for Child Survival and Development. Children ineligible for the Vaccine for Children (VFC) program but without insurance for vaccines are often left without coverage. Those children are eligible for coverage through federally qualified health clinics (FQHC); however, there are only 13 FQHCs in Northern Ohio. Hinman also pointed to the recent President Bush veto of the expansion of the State Children's Health Insurance Program (SCHIP) as an additional barrier in providing immunizations.

Decreases in state funding for vaccine coverage will lead to additional hardship in 2008 according to Barbara Bradley, chief of Infectious Disease Control at the Ohio Department of Health. In 2008, $4.7 million in tobacco funds previously used to provide the vaccine to prevent pneumococcal disease in children will be unavailable.

A pediatrician from the Cleveland area stressed the importance of providers becoming involved in the solution to provide more children with immunizations, since approximately 80% of children receive vaccinations in private offices.

CHIC, a community collaborative in Northern Ohio focused on improving children's immunization status, has approximately 60 member organizations. About 220 physicians, nurses, and health department representatives attended this year's conference, the group's second statewide conference and seventh overall.

Meetings are held quarterly at the Women's Pavilion intersection of Lake and Belle Ave. in Lakewood. Membership is $25 annually.

To learn more or join CHIC visit www.chicohio.com or contact Cindy Modie at the Cuyahoga County Board of Health at (216) 201-2001 ext. 1310. ■

Romona Redding

Annual "Vote and Vaccinate" Program Promotes Wellness

The Academy of Medicine of Cleveland & Northern Ohio hosted its eighth annual "Vote & Vaccinate" program on Election Day, Nov. 6, 2007 in neighborhoods where influenza and pneumonia vaccination rates among senior citizens are reportedly low. The successful program provides the public with an opportunity to receive flu and/or pneumonia shots at area polling sites. It is a parallel program to voting and not connected in any way with the Board of Elections. The goal is to offer seniors these vaccinations conveniently at locations where they vote on Election Day. Proud sponsors of the annual program include the AMCNO, the Cleveland Dept. of Health, the Cuyahoga County Board of Health and Parma Community General Hospital. Our sincere appreciation to all the locations' staff and allied health professionals who helped make this worthwhile even possible, including those at Royal Redeemer Lutheran Church, Ridgewood United Methodist Church, Parma Heights Baptist Church, Pilgrim Congregational United Church of Christ, Normandy High School, Open Door Baptist Church and the Helen Brown Senior Center. The AMCNO received a request from a parish to conduct our "Vote and Vaccinate" program at their location next year and we will be contacting other area hospitals in the hope that we can gain additional participation in this worthwhile program. For more information on this or the many other public health outreach initiatives the AMCNO is involved with, contact (216) 520-1000. ■

A nurse from the Cuyahoga County Board of Health administers a flu shot to a resident from the Helen Brown Senior Center.

23rd Annual Mini-Internship Program Continues Tradition of Excellence

The Academy of Medicine of Cleveland & Northern Ohio was pleased to facilitate the 23rd Annual Mini-Internship Program Nov. 11 through Nov. 14, with both physicians and intern participants relating the many benefits of the two-day shadowing event. From office visits to surgery, trauma care to hospital rounds, interns experience a "Day in the Life" of local physicians, an unparalleled look at the practice of medicine in today's healthcare arena. The AMCNO expresses its sincerest appreciation to both the doctors and community members who committed their time and effort to make this very special program a true success. For more information on Mini-Internship opportunities, contact Linda Hale at (216) 520.1000 ext. 101.

Dr. Diane Butler and intern Steven Gardner discuss the day's events

"This opportunity was incredible, it made me see some things I need to change in my life."

Juan Lumpkin
PalmettoGBA

Ms. Gerber receives her certificate of participation in the program.

Mr. Gardner receives his certificate of participation in the program from AMCNO President Dr. James Taylor (right) and Dr. Seitz.

The 2007 interns pose with several of the physician participants – left to right – Dr. William Seitz, Jr., Dr. Matthew Levy, Juan Lumpkin of PalmettoGBA, Dr. Robert DeBernardo, Jackie Gerber from WCLV, Dr. Diane Butler, and Mr. Steven Gardner from the Cuyahoga County Bar Association.

"I was struck on how precise the surgeons were and the fact that so many procedures are done through such a small incision — it was a matchless opportunity."

Jacqueline Gerber
WCLV 104.9 FM

2007 Physician Participants

William Seitz, Jr., MD, Chairman
Laurence Bilfield, MD
Diane Butler, MD
Robert DeBernardo, MD
Mehrun Elyaderani, MD
Harry Hoyen, MD
Bram Kaufman, MD
Shashidhar Kusuma, MD
Matthew Levy, MD
Jon Meine, MD
Howard Nearman, MD
Mohammed Zahra, MD

2007 Program Interns

Steven L. Gardner, Esq., of McDonald Hopkins and President, Cuyahoga County Bar Association
Jacqueline Gerber of WCLV 104.9
Juan M. Lumpkin of PalmettoGBA

The 2007 interns receive congratulations from some of the 2007 physician participants in the program – left to right Dr. William Seitz, Jr., Dr. Diane Butler, Ms. Gerber, Dr. Matthew Levy, Juan Lumpkin, Dr. Mohammed Zahra, and Dr. Bram Kaufman.

"The degree of time spent with the patient and the evident caring that the physicians showed to their patients and family was overwhelming."

Steven Gardner, Esq.
Cuyahoga County Bar Association

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