

AMCNO Meets with State Medical Board Regarding Physician Ranking Legislation

Recently, representatives from the AMCNO met with the Executive Director and other members of the legal staff from the Ohio State Medical Board (OSMB) to discuss the physician ranking legislation spearheaded by the AMCNO.

The OSMB staff had questions regarding the intent of the legislation and how the information collected by the insurance companies would be utilized and published. The AMCNO explained our position and the reasons for introducing the physician ranking legislation pointing to other states that have passed a similar law as well as the review of this issue by the New York Attorney General. The AMCNO informed the OSMB staff that we plan to reintroduce the legislation in this General Assembly and we offered to provide additional information to the OSMB legislative committee or to their full board if necessary.

In follow-up, the AMCNO leadership and staff met with the OSMB legislative committee. At that meeting, members of the Board felt strongly that physicians shouldn't be ranked by the insurance industry due to the inherent conflict of interests and concerns over the methodology used; however, the AMCNO was able to provide information to the OSMB legislative committee that the best course may be to ensure that there is an evidence-based framework upon which this will take place. Therefore, the consensus of the OSMB was to accept the recommendation of their legislative committee and remain an



Dr. John Bastulli (right), Vice President of Legislative Affairs for the AMCNO spends a moment with the Executive Director of the Ohio State Medical Board, Mr. Rick Whitehouse.

interested party in this process. The AMCNO plans to work with the OSMB and other medical groups as this legislation moves forward in the General Assembly. ■

AMCNO Adopts Joint Principles of the Patient-Centered Medical Home

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) Board of Directors has voted to adopt the "Joint Principles of the Patient-Centered Medical Home," joining the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association in endorsing the principles. The principles include guidelines for the coordination of care to improve the patient-physician relationship, quality and safety, access to care, and the payment model for coordinated services.

The concept of the medical home has been around for some time. The American Academy of Pediatrics has advocated this model for decades for children with chronic

diseases, and it includes attributes of the "chronic care model" that encourages greater collaboration among physicians,
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BOARD ACTIVITIES

AMCNO Adopts Joint Principles of the Patient-Centered Medical Home (Continued from page 1)

hospitals and others for using cost-effective approaches to meet patients' overall needs.

As government and private payers use demonstration projects to test the medical home model for patients with multiple chronic conditions, it's important that incentives are provided to physicians who use the medical home model in their practices. Helping patients manage chronic conditions more effectively and efficiently will go a long way toward improving our nation's healthcare system.

"The use of a patient-centered medical home model can enhance the ability of physicians and other healthcare workers to provide coordinated care to their patients," said AMCNO President **Raymond J. Scheetz, Jr., MD**. "The AMCNO has been involved in discussions regarding this concept at both the local and state levels and we will continue to evaluate the impact of the medical home concept as it develops in our region."

This patient-centered medical home (PCMH) model of care starts with a patient having a personal relationship with a primary care physician, such as a family physician, where the physician takes care of the patient and coordinates all aspects of their healthcare in a system built around primary care.

The joint principles of the PCMH model adopted by American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and American Osteopathic Association as well as by the AMCNO are as follows:

Joint Principles for a Patient-Centered Medical Home:

Care Coordination

Each medical home patient has an ongoing relationship with a personal physician trained to provide first-contact, continuous and comprehensive care, coordinated across all elements of the U.S. health system.

Physician Pay

Medical home payments reflect the value of care-management work conducted by physicians and staff beyond face-to-face visits. Payment is available for use of health information technology as well as secure e-mail and telephone consultations. Doctors share in the savings from reduced hospitalizations. Additional payments are available for medical homes that achieve measurable and continuous quality improvements.

Quality and Safety

Medical homes seek optimal patient outcomes defined by a care-planning partnership among physicians, patients and their families. Doctors follow evidence-based medicine and actively seek patient feedback. An appropriate non-government entity certifies practices seeking to become medical homes.

Access

Enhanced patient access is available through open scheduling, expanded hours and new communication options among patients, their personal physicians and medical home staff.

To view the joint principles in their entirety go to: http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/jointprinciplespcmh0207.Par.0001.File.tmp/022107medicalhome.pdf. ■

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Friday, April 24, 2009

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The HB 125 Advisory Committee on Real-Time Adjudication and Eligibility Releases Their Final Report

In recent months, the AMCNO has been actively involved in an advisory committee set up by the Ohio Department of Insurance (ODI) under HB 125 to address the issue of standardizing communications between doctors and insurance companies in Ohio. HB 125 of the 127th Ohio General Assembly required the creation of an Advisory Committee on Eligibility and Real-Time Claim Adjudication.

The charge of the committee was to assess and provide recommendations to the General Assembly concerning standardizing the electronic communications for administrative functions within the healthcare sector in Ohio. The bill specifically directed the committee to consider interoperability standards that have been created by the Committee on Operating Rules for Information Exchange (CORE). In addition, the Advisory Committee was asked to advise the General Assembly regarding the adoption of certain data elements and whether certain technologies for eligibility verification should be recommended. The issue of when providers could rely on eligibility information provided by payors was another issue for review by the group.

The Committee focused on the issues involved in the exchange of eligibility information rather than real-time claim adjudication due to the fact that the current state of electronic communications in the healthcare sector was not ready for this type of focus.

At the outset, the committee heard presentations regarding CORE rules for electronic eligibility verification between providers and payors. Although the committee supported the work of CORE and recommended its adoption the committee did not unanimously agree if the CORE standards should be required by law or what timeline should be followed for their adoption. The committee identified barriers to the adoption of CORE certified eligibility verification technology such as the costs involved with system upgrades for both payors and providers, the time required to make these changes, the lack of a method for checking the eligibility of providers, and whether or not the eligibility information received electronically was reliable.

The committee was also unable to determine the extent of incorrect ineligibility information given to providers and what types of situations cause payments to providers to be denied after eligibility is confirmed. Therefore, the Advisory committee recommended as part of their report that additional data on eligibility denials and "take backs" be gathered in the future.

The Committee did agree that payors could take steps to provide eligibility information to providers that was more reliable and providers agreed that there were actions they could take to begin checking eligibility electronically on a regular basis. In order to promote the adoption of CORE rules, to continue the gathering of information on eligibility "take backs," to promote stakeholder adoption of best practices and to address the technical and other questions that might arise, the Advisory Committee also recommended its continued existence beyond January 2009.

The Advisory Committee reached unanimous agreement on several key points of interest to physicians including the following:

- Further analysis of broadband connectivity should be undertaken.
- Further investigations into alternative methods to provide electronic data interchange. Specifically attention should be given to exploration of established data networks (such as RHIOs).
- Gather additional data on eligibility denials and "take backs."
- Stakeholders should not be required to include data elements beyond those required by CORE for electronic eligibility and benefits verification.
- Specific information technology for personal identification such as smart card, magnetic strip or biometric technology was not recommended.
- Specific information technology to be used by providers to generate a request for eligibility was not recommended.

A majority of the committee agreed to the following recommendations:

- All the electronic administrative transactions related to healthcare insurance eligibility verification, must be CORE Phase I and Phase II compliant no later than three years after the deadline for ICD-10 compliance (**the AMCNO and other provider groups objected to this time frame, noting that this time frame was unreasonable**).

- Payments made for services rendered to ineligible employees and dependents should not be permitted to be "taken back" after one year from the date of original payment, if the provider confirmed eligibility electronically on the date of service and can demonstrate that eligibility was verified at the time services were rendered. (**The AMCNO and other provider groups pressed hard to reduce the "take back" provision from two years to one year, and our comments in the final report reflected a need for consideration of a further reduced time frame for "take backs" — not to exceed six months**).

The Advisory Committee also recommended several best practices for both payors and providers when applicable. The best practices for providers included the need to verify eligibility and insurance identification at the time of service and when scheduled, if feasible. The provider best practices also encourage providers to inquire about change in employment, coverage or dependent status at the time of service along with encouraging providers to arrange for payment by the patient if they believe they may not be eligible for coverage.

Some of the best practices for insurers outlined in the final report are as follows:

- Insurers should provide electronic access to patient eligibility information received from employers within two business days of receipt, if received electronically, and within five business days of receipt if received by another method of transmittal.
- Insurers should request employers to update eligibility information no less frequently than on the employer's payroll cycle or on a monthly basis;
- Insurers should request employers to update employee and dependent eligibility information as soon as possible following an employee or dependent's qualifying event.

The charge of the Committee required them to submit a report of their findings and recommendations for legislative action to the General Assembly. This article covers only a portion of the full report delivered by the Advisory Committee to the legislature. It is now up to them to determine the next steps based upon the findings of this final report. The report and the comments from committee members, inclusive of the comments sent in by the AMCNO, may be viewed on the Ohio Department of Insurance Web site at www.ohioinsurance.gov. ■

AMCNO Meets with Ohio Department of Insurance Regarding Prompt Pay and External Review Issues

Assists in Development of Toolkit for Consumers and Providers

The Ohio Department of Insurance (ODI) has continued to work with provider organizations on prompt pay and external review issues. The most recent meeting in January 2009 concerned transparency matters, specifically, the reporting of data collected by ODI to the public.

Consumer Complaints

The Consumer Services Division outlined how consumers could file a complaint with ODI noting that just over 42% of their total consumer complaints are healthcare-related — the others are for personal auto carrier complaints, home carrier complaints and life and annuity carrier complaints. The most common reasons for healthcare claim complaints by consumers were claim denials, claim settlement unsatisfactory offer, claim settlement payment delay, premium and rating, coverage questions, premium refunds due and other health reasons. ODI is currently in the process of updating their data collection system in their consumer services division and asked for input on what type of consumer complaint data would be most helpful for reporting purposes.

Physician Complaints

In addition, the ODI staff that handles provider complaints discussed upcoming changes to the OCHAMP provider complaint filing system which will allow ODI to capture complaint information in more detail. For example, the comments section on the complaint form filled out by providers is somewhat limited so the ODI is planning to expand that section for additional comments as well as building an alert into the provider complaint form so that providers know how much time they have to complete the form before they “time out” on the ODI Web site. In addition, a case number will appear on the ODI site once the complaint has been accepted and a copy of the email sent by ODI to the insurer will be sent to providers once the complaint has been filed and sent.

ODI staff also noted that although they do not have the ability on their Web site to accept mass complaints about an insurer,

providers can use the comments section to drill down on issues. So for example, a physician could file one complaint against an insurer and then indicate in the comments section that this complaint is only one of a large number of similar complaints the physician has against the company. A physician could also outline in the comments section if there are outstanding claim payments owed by a company which would add some additional information to each complaint filing.

Market Conduct Review

ODI staff from the market conduct division discussed changes to their upcoming prompt pay data call. This “prompt pay data call” had previously been conducted by ODI in the third quarter of each year. During this data call, ODI collected claims information for every single claim that a health insurance provider processed in that quarter and ODI conducted a review looking for violations of the Ohio prompt pay law. Some of the items reviewed by ODI were whether the claims were paid in 30 days, denied in 30 days, whether claims were paid beyond 30 days, if the claims were paid within 45 days, the limit of time for payment, whether there was any interest due on claims, etc.

In 2009, ODI plans to expand the prompt pay data call to give them more insight into these issues and they plan to ask the health insurance companies to provide their information by line of business — such as individual coverage or group coverage — to give ODI the opportunity to see if there is a trend on a specific line of business. The individual insurance information will not be made available to the public but if someone wanted the industry averages that can be provided. They do not collect data on self-insureds or Medicare Advantage plans.

External Review

ODI staff also provided information on the independent review process. The ODI staff stated that they are considering making de-identified outcome information available on their Web site that would include the results of the external reviews and could provide an analysis of a review decision inclusive of providing the clinical information used to make the decision on the claim, and the sources used to conduct the review and make a clinical decision. The group was of the opinion that this would be helpful and ODI staff indicated they would continue to review this concept along with the HIPAA issues and public record issues to determine how to proceed with this concept.

Toolkit Launched

One key point of interest mentioned at the meeting was the launch of an ODI toolkit to help Ohioans understand the process in which they can appeal a health coverage claim denial made by their insurer. The ODI is providing a link to the toolkit on their Web site. In addition, the AMCNO is also providing additional information to our members through our publications and email alerts.

The toolkit initiative — which includes helpful information for medical providers — was one of several topics to come from ongoing stakeholder meetings with representatives from the Department, insurance companies and associations, businesses, medical providers and consumer advocates. **The AMCNO has been an active participant in this process, inclusive of sending in changes to the toolkit prior to its publication and we are named as a contributor on the final publication.** The stakeholder group continues its work to improve the prompt pay process in which doctors are reimbursed by insurers and how consumers can more easily appeal certain health coverage claims denials, and in particular, through independent review organizations (IROs). To view the entire toolkit go to www.ohioinsurance.gov. ■

Ohio Department of Insurance (ODI) Joint Legislative Study Commission on Most Favored Nation Clauses in Healthcare Contracts Begins Its Deliberations

This commission was created as part of HB 125 which outlined the specific makeup of the group, with the Superintendent of the ODI serving as the Chairperson of the Commission.

The Commission is to study the following areas pertaining to healthcare contracts:

- The procompetitive and anticompetitive aspects of most favored nation clauses (MFNs)
- The impact of MFN clauses on healthcare costs and the availability of an accessibility to quality healthcare
- The costs associated with the enforcement of MFNs
- Other state laws and rules pertaining to MFN clauses in their healthcare contracts
- Matters determined by the ODI as relevant to the study of MFN clauses
- Any other matters that the Commission considers appropriate to determine the effectiveness of MFN clauses

The definition of a most favored nation clause under Sub. HB 125 is as follows:

1. Most favored nation clause means a provision in a healthcare contract that does any of the following:
 - a. Prohibits, or grants a contracting entity an option to prohibit the participating provider from contracting with another contracting entity to provide healthcare services at a lower price than the payment specified in the contract;
 - b. Requires, or grants a contracting entity an option to require, the participating provider to accept a lower payment in the event the participating provider agrees to provide healthcare services to any other contracting entity at a lower price;
 - c. Requires, or grants a contracting entity an option to require, termination or renegotiation of the existing healthcare contract in the event the participating provider agrees to provide healthcare services to any other contracting entity at a lower price;
 - d. Requires the participating provider to disclose the participating provider's contractual reimbursement rates with other contracting entities.

An amendment made to HB 125 in the last General Assembly replaced the original two year moratorium on the use of MFNs in physician contracts with a three year moratorium, resulting in the elimination of the one year gap which had been in effect under the original bill. This change in effect created a permanent prohibition on MFN clauses in physician contracts.

Due to this change in the bill language, the Commission is focusing on the use of MFN language in hospital contracts at this time because the bill did not apply to or prohibit the continued use of a most favored nation clause in a healthcare contract that is between a contracting entity and a hospital and that is in existence on the effective date of the Sub. HB 125; even if the contract is materially amended with respect to any provision of the healthcare contract other than the most favored nation clause during the two year period specified.

The Commission is to provide a preliminary report by March 2010 with the final report due in September 2010 unless it is extended. Members of the committee determined that for future meetings it might be helpful to obtain additional information on the use of MFNs in Ohio. It was decided that a survey should be developed and sent out to Ohio hospitals asking how many of them have MFN clauses in their contracts. In addition, another survey should be conducted with health insurers to find out if they use these clauses in their contracts with hospitals around the state. The ODI plans to work with the Ohio Hospital Association to collect the hospital information and ODI will conduct the insurer survey. Finally, ODI plans to contact other states that have already banned the use of the MFN clause in contracts to obtain additional information on what the impact has been when the MFNs clauses are removed from contracts. The AMCNO will continue to monitor the work of the Commission and provide updates to our membership. ■

It's Time For Your Portfolio Check-Up

In light of the recent market volatility, it may be a good time to let a professional review your current portfolio(s) and offer a second opinion. A professional opinion will offer you ideas on how to reallocate some of your portfolio and allow you to consider the addition of alternative investments to help remove some of the portfolio volatility. Second opinions are always helpful.

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Legislative Update

By: Michael Wise, AMCNO Lobbyist

We now begin the 128th General Assembly and there have been a lot of changes in Columbus since December. The people of the State of Ohio have a new Attorney General in Richard Cordray, the former State Treasurer from Columbus, a new Treasurer in Kevin Boyce, a former Columbus City Councilman, and a new Speaker of the Ohio House of Representatives in Armond Budish of Beachwood. Ohio also has seen a transition of the House of Representatives from a Republican Majority to a Democrat Majority for the first time in 15 years. The Democrats have a 53-46 edge in the House. Republicans still have a strong majority in the Senate with a 21-12 majority. Thanks to term limits, we now have 52 of the 133 members of the Ohio General Assembly in their first term. This makes for an interesting working dynamic between the Governor and the two legislative chambers — 13 members in the Ohio Senate and 39 members in the Ohio House of Representatives have no legislative experience at all.

In Northeast Ohio we will see five new members of the Ohio House of Representatives and two new members of the Ohio Senate. The new members to the Ohio House of Representatives include: Nan Baker (R-Westlake), Matt Patten (D-Strongsville), Mark Schneider (D-Mentor), Terry Boose (R-Norwalk), and Mike Moran (D-Hudson). Tom Patton (R-Strongsville) and Nina Turner (D-Cleveland), who finished the term for Lance Mason, are the new members of the Ohio Senate.

With the State of Ohio looking at a 7.3 billion dollar budget shortfall and the turnover in state government, the next five months will be quite challenging. The budget deliberations will be taking place through June 30, 2009 and Governor Strickland and the General Assembly will try to find creative ways to fill the gap and still increase the size of the budget by 4.4%. With Governor Strickland committed to not raising taxes, his administration must come up with some creative ways to reach the necessary means to operate state government and continue services to the people of Ohio.

The Strickland Administration outlined four budget priorities: education, healthcare, government efficiency, and jobs and economic development. A budget that does not contain tax increases does not mean it won't cost money. There are almost 1 billion dollars in new fees contained in the budget. The

Administration added that preservation of the safety net for social services is a "high priority" for the governor.

As with the first budget Strickland put together two years ago, this budget has many intermingled provisions that will make it difficult for legislators to alter one without significantly affecting other portions of the plan.

That includes a projection of \$1.5 billion in federal stimulus funds being used in FY10 and \$1.9 billion in FY11. Demonstrating just how imbedded those funds are, the Strickland Administration has said that if federal funds were not used, the following would occur:

- Cuts to subsidies at mental retardation/developmental disabilities, mental health, alcohol and drug addiction services.
- Cuts to Ohio Department of Job and Family Services operations.
- Cuts to public health and safety services in agriculture, health, DRC and youth services.
- Cuts to long-term care and Alzheimers' respite care.
- Cuts to provider rates and eligibility in Medicaid.
- Cuts to early care and education eligibility and provider rates.

However, with a budget that the governor estimated was \$7.3 billion short of continuation funding levels based on FY09, the federal funds provide only a part of the answer.

The Strickland Administration has highlighted other existing resources the budget leverages, adding to the complexity of the budget's structure. These include the following:

- Restructuring Ohio's general obligation debt. This will free up approximately \$400 million in General Revenue Funds through the issuance of new refunding bonds. It will also address Ohio's coming close to its indebtedness ceiling, which is occurring because of the decline in state revenues.
- State employee payroll reduction strategies. There will be pay reductions of 0 percent to 6 percent — changed from 3 to 5 percent — based on the amount earned. The intent is that this is applicable to all state employees in the executive branch, and that means, the governor and other cabinet officials will see the 6 percent reductions. In addition, state employees will be asked to pay more for vision, dental and life benefits. Both of

these changes are subject to the collective bargaining negotiations currently going on. According to the Office of Budget and Management (OBM), the state is requesting union concessions of an equivalent dollar amount in order to maintain a balanced budget. OBM has estimated this would save \$170 million to \$200 million per year.

- One-time cash transfers. These include the following:
 - Unclaimed funds – \$285 million over the biennium.
 - Budget Stabilization Fund – \$948 million in FY11.
 - Securities Lending – \$5 million in FY11.
 - Savings from consolidating backroom operations of occupational licensing and regulatory boards – \$30 million in FY11.
 - A loan from the School Facilities Commission of \$200 million in FY11.

It also includes increases in fees that will generate a total of \$892 million over the biennium through the institution of a hospital franchise fee and an increase in the existing franchise fees for nursing homes and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR), among other fee increases.

This approach is also used to move at least six agencies completely off General Revenue Fund funding, with approximately 120 fee changes bringing in an estimated \$236 million. The Strickland Administration also said all earmarks have been removed, but the Senate stated later last week that the budget will have earmarks.

Budget Contains Number of Healthcare Initiatives

After education reform, healthcare is a major priority of the governor's budget. The proposed budget "preserves Ohio's current Medicaid eligibility and services" through the use of federal stimulus funds; restructured fees and rates; policy changes affecting Medicaid managed care; and the transition to a price model for nursing homes in FY10 that was called for in House Bill 66 of the 126th General Assembly.

Among other healthcare provisions, the executive budget does the following:

- The planned expansion of eligibility for children to 300 percent of the federal poverty level is funded. [Ohio just received permission from the federal Centers for Medicare and Medicaid Services (CMS) in December to expand its program.]
- The Unified Long-Term Care budget to assure that Ohioans have access to a

broad range of long-term care choices in every community is implemented.

- The Certificate of Need policy is revised to supply nursing facility services in those areas of Ohio where capacity is needed.
- PASSPORT is fully funded to “prevent waiting lists for these community-based services.”
- Likewise, federal stimulus funds will be used for behavioral health programs: \$21.2 million in FY10 and \$5.2 million in FY11 “to offset subsidy reductions.
- The proposal implements a number of changes around the Medicaid managed care program which Medicaid Director John Corlett has said would include implementing a retrospective rather than prospective payment method, carving out the pharmacy component so that supplemental rebates can be taken advantage of, addressing hospitals’ involvement with managed care plans and revising the funding method. Director Corlett has also stated that under the Deficit Reduction Act, Ohio’s current funding method — a franchise fee — is no longer possible. This moves the funding to the sales and use tax — a component that is built back into the plans’ reimbursement.
- A number of taxes and fees are changed including implementing a hospital franchise fee and ICF/MR franchise fee for developmental centers and changing the nursing facility franchise fee.

Gov. Strickland’s budget would create a new Medicaid fee on hospitals that would be more than double the current assessment the facilities pay to subsidize care for the indigent and uninsured. The proposed new fee would total 1.27% of the industry’s total facility costs in FY 2010 and 1.37% in FY 2011, according to the Office of Budget and Management (OBM) analysis, which simply says it would be used to support the Medicaid program. The separate Hospital Care Assurance Program (HCAP) is currently 1% of Ohio hospitals’ total operating costs. The executive budget would make no major changes to that program. OBM estimates the fee would generate \$282.8 million in FY 2010 and \$315.6 million the following year. Inpatient and outpatient hospitals would receive a 5% reimbursement rate increase in FY 2010.

The AMCNO staff and lobbyists will continue to monitor the Ohio budget plan and provide key information, with an eye toward the health-related issues, back to our membership. ■

AMCNO Welcomes New Lobbyist

Connor P. Patton has joined the Columbus office of McDonald Hopkins LLC as Manager, Government Relations. He is a non-attorney professional. He will be working with the AMCNO along with Michael Wise, JD, on legislative issues of importance to physicians. Patton works within the McDonald Hopkins Government Relations Practice, a team of attorneys and other professionals who help clients navigate complex issues through the political environment. Patton has considerable experience as a campaign manager, most recently running a successful campaign for the Ohio House Democratic Caucus. Earlier, Patton was the legislative liaison for the Ohio Department of Administrative Services (DAS) under the Office of Governor Ted Strickland and the Office of Director Hugh Quill. Prior to joining the Strickland Administration, Patton was the campaign manager and legislative aide to State Representative Mike Foley, a former member of the House Leadership and Ranking Member of the House Ways and Means Committee. Patton received a B.A. in Political Science from Cleveland State University. He can be reached at (614) 458-0043 or cpatton@mcdonaldhopkins.com.

Legislator Spotlight



Armond D. Budish (D-Beachwood) is the Speaker of the House for the 128th Ohio General Assembly. He represents the 8th House District, which includes parts of the city of Cleveland and its eastern suburbs.

Speaker Budish obtained his bachelor’s degree from Swarthmore College near Philadelphia, PA, and then earned a Juris Doctor degree from New York University Law School. After clerking for a federal judge in Washington, D.C., he joined the law firm Hahn Loeser and Parks in Cleveland.

In 1993, he founded the law firm Budish, Solomon, Steiner, & Peck in Beachwood, OH, where he is currently a partner. Speaker Budish is also host of the television show *Golden Opportunities*, an informational program for seniors and their families, which can be seen Sundays on WKYC Channel 3 in Cleveland. He has written several books, including most recently, *Why Wills Won’t Work*. He has written articles for many national publications and, for a span of almost 25 years, penned a column entitled “You and the Law,” which was published by *The Cleveland Plain Dealer* and the *Columbus Dispatch*.

In 2006, after both his sons had left for college, Speaker Budish made the decision to run for public office. He was elected that year to the Ohio House of Representatives from the 8th District. His appointment as Ranking Minority Member of the Financial Institutions, Real Estate & Securities Committee enabled his extensive involvement in a number of important legislative issues, including payday lending reform. Having worked extensively with families struggling with healthcare and long-term care issues, he also took the lead on healthcare-related initiatives and served as a member of the Unified Long-Term Care Budget workgroup.

Armond Budish was elected to be Speaker of the House by his peers in January 2009. A true desire for cooperation and bipartisanship underpin the Speaker’s priorities for the House. To that end, he instituted a new rule aimed at removing partisanship from the Clerk’s office by requiring that the Clerk and Deputy Clerk be members of different political parties.

Speaker Budish’s top priorities for the 128th General Assembly are jobs, jobs and jobs. And education. To further the agenda and to help Ohio’s families meet their most pressing needs in these tough economic times, he has created several new committees, including Economic Development and Housing & Urban Revitalization.

Speaker Budish lives in Beachwood with his wife, Amy. They have two sons: Ryan, who is an attorney in Washington, D.C., and Daniel, who is earning his master’s degree in urban planning.

UnitedHealth Group and Aetna Agree to Settlements of Out-of-Network Reimbursement Rates

Rick Hindemand, Esq., an attorney with the Chicago offices of McDonald Hopkins, LLC

Readers may recall an article in a previous issue of the *Northern Ohio Physician* which discussed various enforcement activities and litigation directed toward providing relief for patients, physicians and other healthcare providers who have been frustrated by the low reimbursement levels paid by managed care plans for healthcare services performed on an out-of-network basis. Since that article was published, relief has arrived in the form of a flurry of settlement agreements.

During a three day period in mid-January, 2009, UnitedHealth Group Inc. (UnitedHealth) and Aetna entered into separate settlement agreements with New York's Attorney General Andrew Cuomo, putting to rest the Attorney General's investigation into their use of the Ingenix database to establish "usual, customary and reasonable" (UCR) reimbursement rates for out-of-network services, and UnitedHealth entered into a settlement agreement with the American Medical Association (AMA) and other plaintiffs to resolve a class action lawsuit filed in 2000.

New York Settlement

In February 2008, the New York Attorney General announced his intent to sue five UnitedHealth companies and investigate other prominent health insurance companies for defrauding consumers by underestimating the UCR charges, resulting in underpayments for out-of-network healthcare services and requiring patients to cover a higher share of the costs. On January 13, 2009, just eleven months later, the parties reached a settlement. The settlement provides

that UnitedHealth will pay \$50 million to finance the development of a new, independent database that will determine UCR reimbursement rates and will replace the Ingenix database formerly used by UnitedHealth and most other major health insurance companies. The settlement additionally requires the creation of an informational Web site that will educate healthcare consumers about market prices of medical services by displaying reimbursement rates and other healthcare-related information. Two days later, the Attorney General entered into a similar agreement with Aetna, which agreed to pay \$20 million for the new database. On February 2, 2009, the Attorney General announced that Aetna also agreed to pay more than \$5 million, plus interest and penalties, to reimburse out-of-network claims that were underpaid.

"We are committed to increasing the amount of useful information available in the healthcare marketplace so that people can make informed decisions, and this agreement is consistent with that approach and philosophy," said Thomas L.

Strickland, executive vice president and chief legal officer of UnitedHealth.

Class Action Settlement

In 2000, the AMA and other private plaintiffs filed a class action lawsuit against various UnitedHealth companies as well as MetLife and American Airlines challenging the calculation of UCR by Ingenix as flawed. Nearly a decade later, the parties reached a settlement establishing a \$350 million fund in which members of the plaintiff class will be eligible to receive compensation. This settlement is the largest monetary settlement of a class action lawsuit against a single healthcare insurer in the United States. While this agreement is a substantial accomplishment, the settlement agreement is nevertheless subject to court approval.

The Future of Reimbursement Rates for Out-Of-Network Care

These settlement agreements are huge milestones for healthcare providers, although the battle for appropriate out-of-network reimbursement is far from over. The success of these agreements is largely dependent on the creation of a practical alternative to the Ingenix database, court approval of the class action settlement agreement, and continuing diligence by all parties in implementing fair out-of-network reimbursement rates. ■

Physician Interaction With Pharmaceutical Companies: New Rules and Nationwide Trends

Edward E. Taber, Esq.; Jeffrey M. Whitesell, Esq.; Tucker Ellis & West LLP

Background

In the 1993 film *The Fugitive*, Harrison Ford plays the role of the handsome and eminently ethical surgeon Richard Kimble. Dr. Kimble is betrayed by a murderous plot engineered by a corrupt pharmaceutical company and a complicit physician. The pharmaceutical company has enticed Kimble's corrupt physician-colleague with lavish fishing trips and travel, leading to altered clinical study results designed to falsely promote a new and dangerous drug.

Wild and unrealistic as the Hollywood story line in *The Fugitive* is, it nonetheless symbolizes the extreme end of a growing public perception of "impropriety" in the relationship between healthcare professionals (HCPs) and pharmaceutical companies. These two groups are increasingly trying to address that perception of impropriety — in ways that will affect physicians immediately.

In reality, effective relationships between HCPs and pharmaceutical companies are essential to quality medical care. The HCPs provide necessary input to the companies regarding patient needs and clinical data, leading to the development of new and effective medications and devices. The pharmaceutical companies design and develop the products needed and then provide the HCPs with the most accurate, up-to-date information regarding the products. Patients benefit from this symbiotic relationship. However, over the past several years there has been growing public skepticism regarding the HCP-pharmaceutical company relationship. This negative perception has been fueled, in part, by the increasing cost of healthcare and certain high profile stories of alleged improprieties, including vast waves of lawsuits.

New trends — transparency and rebutting the appearance of impropriety

This "appearance of impropriety" has prompted new and revised guidelines and legislation intended to rebuild faith in the healthcare industry, eliminate the perceived and actual conflicts of interest and promote transparency in the relationships between HCPs and companies. This trend can be seen throughout the medical community — in the new PhRMA Code, in proposed federal laws, in new hospital guidelines and procedures, in medical society ethical standards, and in medical journals.

For example, one proposed federal bill, the Independent Drug Education and Outreach Act of 2008 (introduced July 31, 2008 by Sen. Herbert Kohl, D-WI and Sen. Richard Durbin, D-IL) seeks to eliminate pharmaceutical sales representative detailing altogether by establishing

a centralized, government operated program for distributing prescription drug information directly to HCPs.

A second piece of proposed federal legislation, the Physician Payments Sunshine Act of 2009 (introduced January 22, 2009 by Sen. Charles Grassley, R-IA and Sen. Herbert Kohl, D-WI) would require pharmaceutical companies to publicly disclose any payments to physicians (including gifts, honoraria, consulting fees and speaking fees) over a low threshold amount — perhaps \$25. This information would presumably be posted to a public Web site. At least one large pharmaceutical company, Pfizer, announced in early 2009 that it will begin to voluntarily publicize such payment information.

The American Medical Association has weighed in with implementation of the Prescribing Data Restriction Program. This program gives HCPs the option of whether or not to allow pharmaceutical sales representatives to have access to their prescribing data. This “physician choice” option is also built into the new PhRMA Code.

Another example is apparent to any physician reading their weekly medical journals. Most medical journals and publications now specifically require that all medically related article authors disclose the existence of any pertinent financial interest or other relationship with industry — within the text of the article.

The revised PhRMA Code

One significant effort to correct this “appearance of impropriety” has come from the pharmaceutical companies themselves. In July 2008, the Pharmaceutical Research and Manufacturers of America (PhRMA) released the updated *Code on Interactions with Healthcare Professionals*, superseding and building upon the 2002 version. PhRMA is a trade organization representing companies that develop and market new medications, primarily pharmaceutical and biotechnology companies. A copy of the revised PhRMA Code can be found on the PhRMA Web site (www.phrma.org).

The revised PhRMA Code became effective on January 1, 2009. Nearly every major pharmaceutical manufacturer has voluntarily signed off on this new Code, including Abbott, Bayer HealthCare Pharmaceuticals, Bristol-Myers Squibb Company, GlaxoSmithKline, Johnson & Johnson, Eli Lilly and Company, Merck & Co., Inc., Pfizer, Inc. and Wyeth. The changes to the PhRMA Code revolve around the related themes of (1) ensuring that interactions with HCPs are focused on providing scientific/educational information and supporting medical research; and (2) eliminating any appearance of impropriety.

What's new in the January 1, 2009 PhRMA Code?

Changes have been made to almost every aspect of the PhRMA Code, including substantially tighter restrictions on meals, gifts, entertainment, continuing medical education sponsorship, consulting, speaker training programs, relations with HCPs who are members of formulary or practice guideline committees, and the availability of prescribing practice statistics to pharmaceutical sales representatives (aka detail representatives). A helpful set of “Questions and Answers” are appended to the new Code, providing examples

of what is deemed permissible and not permissible in specific situations.

Gifts, meals, entertainment and travel

Under the revised PhRMA Code, there will generally be no more entertainment, *in-restaurant* meals, resort stays, travel, and promotional items like pens, pads and coffee mugs. Detail representatives may still provide occasional meals to medical offices, but the meals must be modest, they must be in-office or in-hospital, and they must be accompanied by a scientific and/or informational presentation. Meals with sales representatives cannot generally be offered *outside* of the office and cannot be part of any entertainment or recreational event. Free medication samples may still be provided to HCPs.

Detail representatives are also prohibited from giving away entertainment or recreational items (i.e., theater or sporting event tickets, sporting goods, vacations, etc.) to any HCP “who is not a salaried employee of the company,” because such items do not involve the exchange of medical or scientific information. Thus, even if a physician is acting as a consultant or speaker for a company, no tickets are permitted. This is also true for personal items such as music CDs, DVDs, flowers, cash or gift certificates. In fact, detail representatives cannot distribute any noneducational items to HCPs or to their staff, regardless of value. The only gift items that detail representatives may offer are those designed primarily for the education of patients or HCPs and are less than \$100 in value (i.e., an anatomical model). Any item that has independent value outside of the HCP's professional responsibilities would be considered inappropriate (i.e., a DVD player). Charitable contributions, such as a pharmaceutical company purchasing a foursome slot at a fundraising golf tournament, are also still permitted so long as the funds are paid to the charity rather than to individual HCPs. (See PhRMA Code Q & A No. 22).

CME — educational courses and meetings

The revised PhRMA Code provides limitations on CMEs and third-party conferences, and states that a company “should separate its CME grant-making functions from its sales and marketing departments” and “develop objective criteria for making CME grant decisions...” Thus, unless a physician is on the faculty, a company cannot offer to pay the physician's cost of travel, lodging or personal expenses for attending the program. The same is true for subsidies. The company likewise cannot provide any advice or guidance to a CME provider or medical conference sponsor regarding a program's content or faculty, even if the sponsor requests such guidance.

Consulting arrangements and agreements

The revised PhRMA Code recognizes that consulting agreements between HCPs and pharmaceutical companies allow the companies to obtain information and advice from medical experts, including insight on “the marketplace, products, therapeutic areas and the needs of patients.” However, the revised PhRMA Code establishes certain limitations on such consulting agreements, and if a physician's practice includes providing medical consultation to a company, the agreement will be affected. First, all such agreements must be based solely on the physician's medical expertise, reputation, knowledge. Also, a HCP-

consultant may receive reasonable compensation and reimbursement for reasonable travel, lodging and meal expenses so long as a legitimate consulting agreement is in place. However, this compensation must be both reasonable and based on fair market value, and any meetings must be held at a venue conducive to the consulting services and activities — no resorts allowed.

Speaker programs and training meetings

Regarding company speaker programs and speaker training meetings, the revised PhRMA Code recognizes that HCPs participate in such company-sponsored programs to help educate others about the risks, benefits and appropriate uses of the company's products. Thus, HCPs may still participate in these programs, but again there are additional limitations under the revised PhRMA Code. First, if the HCP intends to speak at any company-sponsored programs, the HCP must be chosen purely on merit. Also, the HCP can receive reasonable compensation for time and expenses only if the HCP is given extensive training on the company's products and the HCP has a legitimate consulting agreement in place. However, the compensation is now limited. Each company, individually and independently, must cap the total amount of annual compensation paid to an individual HCP for all speaking arrangements. In addition, the materials used during a company-sponsored program must identify the company and disclose that the HCP is presenting on behalf of the company.

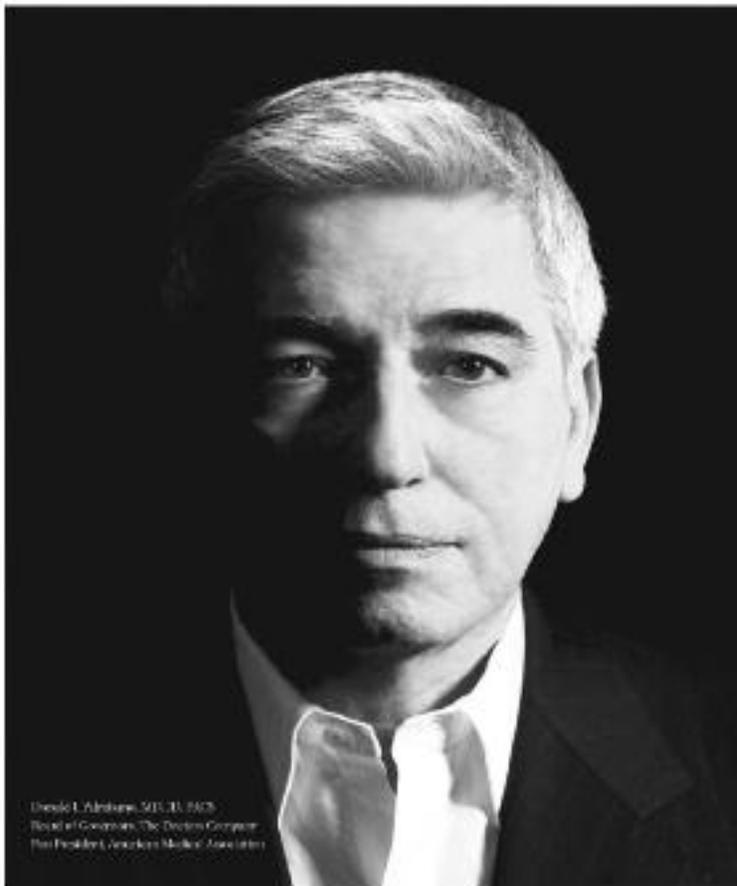
Formulary and practice guideline committee members

Interactions between companies and HCPs who serve on formulary or practice guideline committees are further regulated under the new PhRMA Code. Such HCPs can still simultaneously serve as a speaker or consultant for a company. However, the HCP must disclose to the committee the existence and nature of the relationship with the company. This obligation continues until two years after termination of the relationship with the company.

The new landscape — beyond PhRMA

The revised PhRMA Code is but one example of the active nationwide trend toward transparency and rooting out actual and/or perceived improprieties in the relationships between HCPs and industry. Similarly-themed codes and rules have been adopted and updated to incorporate these themes by a broad spectrum of entities in the medical field, from medical device manufacturers (through the Advanced Medical Technology Association), to the American Medical Association and specialty professional organizations, to hospitals and health systems nationwide, and of course to federal and state lawmaking bodies. Medical news headlines will undoubtedly be filled with additional rule changes, incorporating this trend, in the coming years. Ultimately, should these changes prove successful, Hollywood will have to look elsewhere for its story lines.

Edward Taber and Jeffrey Whitesell are attorneys with the Cleveland office of Tucker Ellis & West LLP, practicing in the Medical and Pharmaceutical Group. They can be reached at (216) 696-2365 or via the Web at www.tuckerellis.com. ■



Donald L. Andrews, MD, MBA, FACS
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New Challenges to Northeast Ohio: Reflections on Better Health, Greater Cleveland's Second Community Health Checkup

By: Randall Cebul, MD, Director, Better Health, Greater Cleveland

At the end of January, *Better Health, Greater Cleveland* published its second *Community Health Checkup*, again reporting the care and intermediate outcomes of adult patients with diabetes in the region (www.betterhealthcleveland.org). We reported on over 25,000 patients cared for by 322 primary care physicians at 42 practice sites, including 31 sites that also reported in our first *Checkup* last June. The availability of results over two year-long measurement periods enabled us to get a first look at *changes* in achievement over time in addition to the current achievement of practices on our nationally endorsed and locally vetted standards (Table 1).

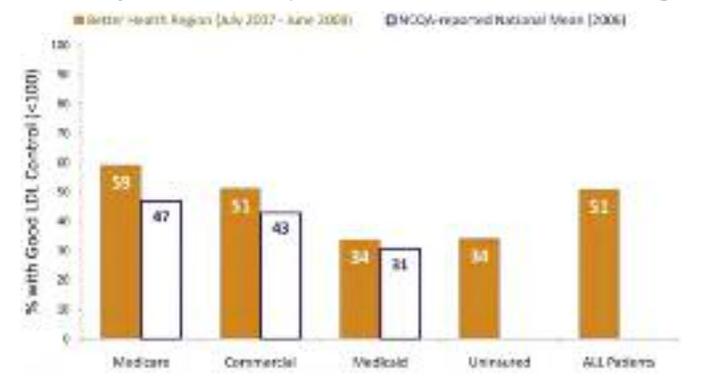
Table 1. *Better Health's* Individual and Composite Standards for Diabetes

CLINICAL OUTCOMES	CARE PROCESSES
5 standards of good control:	4 standards for good routine care:
<ul style="list-style-type: none"> • Blood Sugar (HbA1c < 8%) • Blood Pressure (< 140/80) • Cholesterol (LDL Cholesterol < 100) • Weight (Body Mass Index < 30) • Documented non-smoker 	<ul style="list-style-type: none"> • Blood sugar control test done • Screening or treating kidney problems • Annual eye exam • Pneumonia vaccine given
Composite Reported: Percentage of patients who met at least 4 standards	Composite Reported: Percentage of patients who met all 4 standards

Our recent *Checkup* was a mixed bag of results. On the positive side, we once again identified superior region-wide achievement as compared with HEDIS results from health plans nationwide (for example, see Figure 1). In

improvement efforts (for example, see Figure 3). We hope and expect that this cross-fertilization of best practices will accelerate region-wide improvement.

Figure 1. Greater Cleveland Region-wide Results Compared to Nationwide Health Plan Data: Percentage of Diabetics with LDL cholesterol Values < 100mg/dl. For complete comparisons on all of NCQA's Comprehensive Diabetes Care measures, download the Community Health Checkup at www.betterhealthcleveland.org.



addition, we identified widespread (if modest) improvements among those practices that reported in both periods (Figure 2). Finally, we have been able to find practices associated with exceptionally high achievement or improvement and incorporate the sharing of "best practices" in our quality

Figure 2. Results on Better Health's composite standards for care processes and outcomes for practices that reported in both Community Health Checkups.

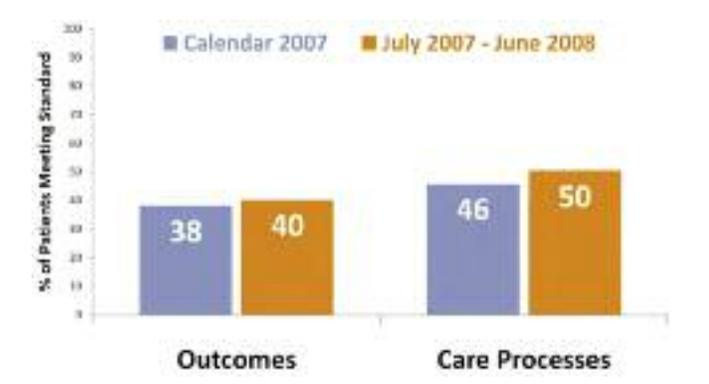
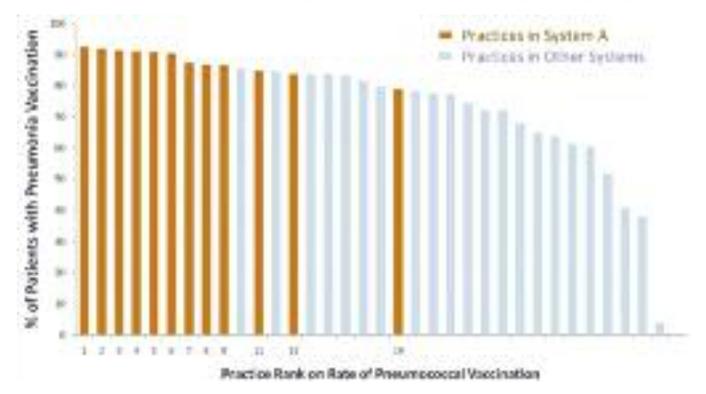


Figure 3. Pneumococcal Vaccination Rates for Diabetic Patients at Better Health's Partner Practices. Nine of the top 10 sites are practices in one healthcare system. What are they doing right?



We also identified challenges to the region. As in the first *Checkup*, we found continued disparities in achievement among our patients and practices with fewer resources. Achievement of our intermediate outcomes was lower among our minority patients and those who are poorer, less well-educated, and either uninsured or insured by Medicaid. In contrast to other subgroups, we also found no improvement in intermediate outcomes among the uninsured and those insured by Medicaid. Finally, we continued to see substantial differences in achievement between our 31 partner practices that use electronic medical records (EMRs) for reporting and the 11 practice sites that use paper-based records systems. While the paper-based practices in *Better Health* also care for disadvantaged populations, the absence of EMRs may make it more difficult for them to monitor and provide timely support for their patients in greatest need.

Additional challenges to *Greater Cleveland* came from New England, where faculty of the Dartmouth Atlas Project compared all 14 markets in the *Aligning Forces for Quality* initiative on important diabetes-relevant outcomes. Not *intermediate* outcomes, like glycemic or blood pressure control, but *real* outcomes, including amputations and potentially avoidable hospitalizations. In the "preventable Medicare hospitalizations" metric, Cleveland was dead last, having the highest rate among the 14 regions. For amputation rates among Medicare patients — including *all* Medicare enrollees in the region, and not just those cared for in Better

(Continued on page 14)

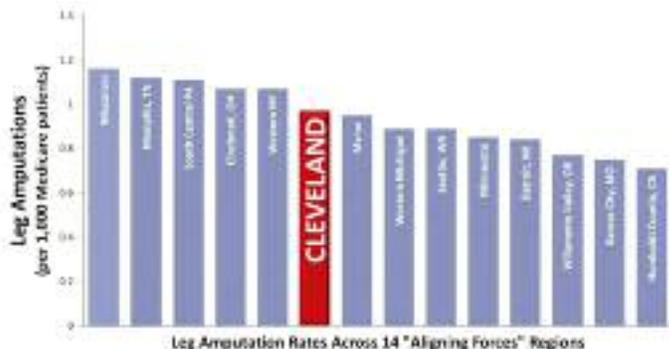
BHGC (Continued from page 13)

Health's partner practices — Greater Cleveland was no better than middle of the pack (Figure 4). Clearly, Greater Cleveland has room to improve.

The Dartmouth data challenge us to track and improve outcomes that are most important to both patients and payers. Hospitalizations for diabetic complications and for amputations represent unfortunate outcomes for patients, as well as high and potentially avoidable costs for healthcare payers. We are exploring ways in which we might capture these types of data across all patients and insurance categories. In addition, the Dartmouth data challenge us to extend our reach to healthcare systems and practices that are not currently involved in *Better Health*. We recognize that one barrier to participation is the absence of EMRs at smaller practices and those that are not affiliated with large health systems. At a recent *Better Health* Leadership Team retreat, we began the process of examining electronic registry systems that we might recommend to such practices that want to participate before they have fully functional EMR systems. If your practice is interested in becoming a partner in *Better Health*, be in touch with Carol Kaschube, Program Coordinator, at (216) 778-8024.

Editors Note: The AMCNO is a participant and partner in the BHGC Alliance. ■

Figure 4. Rates of Leg Amputations Among Medicare Patients in the 14 Regions that Collaborate in the *Aligning Forces for Quality* initiative. There is room to improve.



Data Source: Dartmouth Atlas Project.

Ohio Health Quality Improvement Summit (OHQIS) Releases Summary Report

More than 180 healthcare leaders from various organizations (inclusive of the AMCNO) attended the Ohio Health Quality Improvement Summit (OHQIS) held in Columbus at the end of 2008. The summit was the result of Ohio's participation in the Commonwealth Fund/AcademyHealth State Quality Improvement Initiative (SQII) with the goal of developing strategies and tactics to transform Ohio's healthcare sector into a high quality, cost-effective system that will optimize the health of all Ohioans.

The summit included presentations from nationally known speakers assessing the status of healthcare in Ohio and outlining national reform efforts underway in other states. The summit participants then worked in four focus groups instructed to identify four strategies with related tactics which they believed would have the potential for improving the quality of healthcare. Each group was also asked to address four cross-cutting concepts which affected all areas such as health disparities, health information technology, payment reform and workforce development.

Following the focus group meetings, the entire group reconvened and ranked 12 recommended strategies from the four focus groups in the following order of importance:

1. Advance a sustainable community specific Chronic Care Model with a prepared, proactive practice team and an informed activated patient that focuses on improved outcomes.
2. Promote a culture of physical and emotional health and wellness through lifestyle options that comprehensively address decreasing the prevalence of the most pressing population health issues: depression, obesity and tobacco use.
3. Transform healthcare delivery through patient-centered primary and preventative care.

4. Increase the percentage of Ohioans receiving the recommended primary and secondary preventative health services appropriate to an individual's age, gender and condition.
5. Reduce (eliminate) preventable error rates by improving communication during handoffs and transitions.
6. Decrease the non-value-added administration and transaction costs of financing and delivering healthcare.
7. Create an environment for patient-centered, informed decision-making around end-of-life care.
8. Utilize evidence-based medicine and management to reduce unnecessary and non-value-added care.
9. Prompt a system-wide culture of safety.

10. Reduce (eliminate) preventable healthcare associated infections.
11. Reduce (eliminate) preventable adverse drug reactions.
12. Prevent injuries with specific emphasis on fall related injuries, poisoning, youth injuries and motor vehicle injuries.

After ranking these strategies, the focus groups reconvened and developed tactics for the top strategies in their focus areas. The tactics were presented by each group to the entire conference on the last day of the summit. Following the close of the summit, an implementation team was formed to determine the next steps and compile information. Comments were then obtained from the summit attendees and a draft action plan will be developed and reviewed at a follow up meeting of the summit participants in the spring of 2009. The AMCNO will be sending representatives to this follow-up meeting to provide our input into this process.

The recommendations outlined in the summit are to serve as a framework for healthcare reform in Ohio, and it is not intended to be an all-inclusive action plan to transform Ohio's healthcare sector. The report released by the summit is meant to be an initial assessment. Full details outlining the summit and the materials used by the group can be obtained at <http://ohqis.pbwiki.com>. ■

In late January, **Dr. Raymond J. Scheetz, Jr., MD**, was honored to provide the keynote address and install the new officers of the association at the annual meeting of the Association of Philippine Physicians in Ohio.

Dr. Scheetz's remarks were centered on healthcare issues here in Ohio and the United States and the current activities of the AMCNO in this regard.



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AMCNO Completes Charity Care Survey

This survey was commissioned by the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) to gain a better understanding of the level of uncompensated care (i.e., charity care) by physicians to patients in the Northern Ohio region.

Of the physicians responding to the survey over sixty percent or half of the respondents indicated that they are currently providing care to the uninsured and over eighty percent indicated that they would treat a low-income patient who has insurance but could not afford a co-payment for care.

More than two-thirds of the respondents indicated that they would be willing to serve charity care patients if needed with a similar number indicating that they would be willing to provide additional uncompensated care to children and adults in their office or hospital clinic setting.

Respondents were also asked if they were currently seeing or were willing to see uncompensated care patients in a clinic setting and what were the top three features that would be most supportive of their volunteer work. The top three features chosen by the respondents were that the clinic would provide nursing and other support staff, the clinical would take care of all paperwork and that they would be covered by the clinic's malpractice insurance as a volunteer under state law.

In addition, respondents were asked that if they were providing uncompensated care to uninsured patients, would it be helpful to have standardized processes and resources in place and to identify the top three features that would be most important to them when providing charity care. The top three features were to have access to free or low-cost medical testing, a prescription benefit for the uninsured patient and a standard sliding scale fee.

About one-third of the respondents expressed an interest in providing charity care in our region and provided their contact information. The AMCNO plans to utilize this list when working with other organizations in the community on volunteer or other activities. Any physician member of the AMCNO interested in having their name included on our list of physicians willing to provide charity care in our community may contact Ms. Linda Hale at the AMCNO offices at (216) 520-1000, ext. 101. ■



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AMCNO Leadership Meets with Representatives of the Remote Area Medical Ohio Program ("RAM Ohio")

Recently, AMCNO leadership met with representatives of the Remote Area Medical Ohio Program ("RAM Ohio") to discuss their upcoming program. In May of 2009, the Remote Area Medical Ohio program ("RAM Ohio") will take place at the Cuyahoga County Fairgrounds (see the next page for additional information on the event). RAM Ohio is a health expedition to provide free healthcare services to the uninsured and underinsured. RAM Ohio is currently recruiting physicians, nurses, and other healthcare professionals to volunteer their services for the May 2009 event. Physicians may be familiar with the Remote Area Medical Foundation, a Tennessee entity that organizes volunteer healthcare domestically and internationally. The RAM Ohio event is modeled after the Tennessee Remote Area Medical Foundation.

Physicians that desire to participate in the event should be aware that even though the RAM Ohio event is providing volunteer services to patients, the set up of the event is such that it does not qualify for immunity under Ohio's charitable immunity law because the Statute grants immunity to individual physicians based on whether they satisfy the statutory requirements. (See the article below.) As noted above, the AMCNO has met with the organizers of RAM Ohio and we wanted to offer some additional information that may be of help to physicians that are considering participation in the event.

Are hospitals signing up their physicians to participate in RAM Ohio?

It is our understanding that the major hospital systems are recruiting physicians for this event and there are also discussions taking place

between RAM Ohio and other hospitals and private practices in the community regarding physician recruitment.

Is this event covered by a professional liability policy?

We have been informed by RAM Ohio that they are purchasing their own liability policy to cover all professionals participating in the event. For more information on this policy we suggest physicians contact RAM Ohio.

We also suggest that physicians check into their medical liability coverage with either their hospital if they get their coverage through a self-insured captive or with their own medical liability carrier before volunteering for this event.

Since retired physicians more than likely do not have a medical liability policy and they are not practicing medicine the AMCNO cautions these physicians to check carefully with RAM Ohio regarding how they could participate in this event and whether or not they are covered by the RAM Ohio policy since this does not qualify as a covered event under the Ohio charitable immunity laws.

How can I sign up for the event?

Several members of the AMCNO board of directors as well as many of our members from the Northern Ohio community are planning to participate in RAM Ohio. The decision to participate in this event is strictly voluntary and physicians who have additional questions should go to www.ramohio.org.

Editor's Note: *The AMCNO acknowledges that this event is only one of the options available to patients in the Northern Ohio region and we commend the physicians in our community that already provide care to the uninsured and underinsured in their practice, their hospital/group or in a clinic setting on a regular basis. ■*

Ohio Charitable Immunity Law

By: Elizabeth Sullivan, Esq., McDonald Hopkins, LLC

The Ohio Revised Code provides a heightened level of legal immunity to volunteer healthcare professionals, volunteer healthcare workers, nonprofit healthcare referral agencies and healthcare facilities that provide healthcare services to indigent and uninsured patients.

The Ohio Statute gives volunteer healthcare professionals, volunteer healthcare workers, nonprofit referral agencies and volunteer healthcare facilities immunity for services that they provide to indigent and uninsured patients (1). If the requirements set forth in the Statute are adhered to, the volunteer or volunteer organization will not be liable for tort or civil damages unless a volunteer's action or omission reaches the level of willful or wanton misconduct. The basic requirements of the Statute are that (i) the care provided is volunteer care and (ii) the recipient of the care is an indigent and uninsured individual as defined in the

Statute. Other requirements specific to physicians and volunteer healthcare facilities also apply.

For care to qualify as volunteer care, no remuneration may be accepted from any source for the care provided. "Indigent and uninsured" persons are individuals that: (i) have an income equal to or less than 200% of the current poverty line; (ii) are not eligible to receive medical assistance or disability assistance under any Ohio program or any other governmental healthcare program; and (iii) either are not covered under a health insurance policy or are

covered but the plan denies coverage, is insolvent or bankrupt.

The immunity will not apply to healthcare that is administered as part of a court-ordered community service arrangement (2), operations that require general anesthesia or are not typically performed in an office, any procedure that is beyond the scope of practice, education, training or competence of the healthcare professional, the delivery of a baby, or the performance of an abortion.

Under the Statute, the definition of "healthcare professional" includes physicians authorized to practice in Ohio. The Statute grants immunity to all physicians currently authorized to practice in the state of Ohio, including retired physicians that obtain a volunteer permit (3), and out of state physicians that obtain a special activity certificate (4). There is no requirement that the physician carry professional liability insurance (5).

CHARITY CARE ISSUES

For a healthcare professional to qualify for the immunity provided under the Statute, the healthcare professional must do three things in addition to meeting the basic requirements of providing volunteer care to an indigent and uninsured patient. These three requirements must be satisfied before the healthcare professional begins diagnosis or treatment.

The healthcare professional must (i) make a good faith determination that the patient is mentally capable of giving informed consent and is not subject to duress or undue influence; (ii) inform the patient that the effect of the Statute is that the patient will not be able to hold the healthcare professional liable for damages; and (iii) obtain a written waiver signed by the patient or another individual on behalf of and in the presence of the patient.

The written waiver must state that the patient is mentally competent to give informed consent, is not subject to duress or under undue influence, and the patient gives informed consent to the care provided. The written waiver must also clearly and in conspicuous type state that the person or individual who signs has full knowledge that the by giving the informed consent, a tort or civil claim cannot be instituted against the healthcare professional unless the action or omission constitutes willful or wanton misconduct. A physician or other healthcare professional that follows these requirements will fall under the protection of the provision, regardless of where the services are administered.

Healthcare facilities and other locations associated with healthcare volunteers must also satisfy additional requirements to gain statutory immunity for services rendered under the Statute. A healthcare facility is defined as a "hospital, clinic, ambulatory surgical facility, office of a healthcare professional or associated group of healthcare professionals, training institution for healthcare professionals, or any other place where medical dental, or other health-related diagnosis, care, or treatment is provided to a person." In addition to providing volunteer care to indigent and uninsured individuals, the healthcare facilities and other locations associated with volunteer care must also comply with the Ohio's nonprofit facility registration requirements (6).

Under Ohio law, nonprofit healthcare facilities operating in Ohio are required to register with the Ohio Department of

Health on January first of each year (7). The registration statute also requires all nonprofit healthcare facilities to keep records of all patients that receive diagnosis, treatment or care (8). It is important that entities comply with the registration requirements since office staff and other individuals providing volunteer services related to the entity but not directly related to a healthcare procedure are not otherwise granted immunity under the Statute.

Ohio law grants heightened immunity to volunteers and volunteer organizations that provide healthcare services to indigent and uninsured patients. For a physician to qualify for immunity under Ohio law, the physician must provide volunteer care to an individual that meets the statutory definition of indigent and uninsured, and before beginning diagnosis or treatment, the physician must determine the patient to be competent, inform the patient of the immunity granted under the provision, and obtain a written waiver subject to the requirements of the Statute. Retired physicians and out of state physicians may also qualify to provide volunteer care if they obtain a volunteer certificate or a special activities certificate from the Ohio Board of Medicine. To qualify for immunity, volunteer organizations that coordinate such treatments

must register their facilities with the Ohio Department of Health and keep records of the patients treated pursuant to Ohio's nonprofit facility registration requirements. ■

1. The Statute extends protection to healthcare workers such as medical technicians and medical assistants. Ohio Revised Code ("O.R.C.") § 2305.234(A)(6). Nonprofit healthcare organizations are defined as entities that are not operated for profit and refer patients to, or arrange for the provision of, health-related diagnosis, care or treatment by a healthcare professional or healthcare worker. O.R.C. § 2305.234(A)(8).
2. O.R.C. § 2951.02.
3. O.R.C. § 4731.295.
4. A special activity certificate for an out of state physician may be issued to a physician who holds a telemedicine certificate in Ohio or a physician that applies to the state medical board pursuant to O.R.C. § 4731.294.
5. The Statute does not address medical malpractice insurance. The Statute states that physicians without medical malpractice insurance are not required to follow the disclosure and waiver requirements imposed by the Ohio Revised Code when they comply with the requirements the Statute. This implies that physicians are not required to carry malpractice insurance to gain immunity. Although medical malpractice insurance is not necessary to be granted immunity under O.R.C. § 2305.234, physicians should check with their insurance carriers before providing volunteer care to determine whether their malpractice plan covers claims arising out of volunteer care, since this may impact their decision to provide such care.
6. O.R.C. § 3701.07.
7. *Id.*
8. Physicians providing healthcare services associated with a volunteer entity should determine if the entity is registered as a nonprofit healthcare facility and if the entity is complying with the record requirements of O.R.C. § 3701.071. While it does not impact the physician's immunity provided under O.R.C. § 2305.234, it is unclear whether a physician would be subject to disciplinary action if both the physician and the volunteer entity fail to retain a record of care provided through the volunteer entity.

COMMUNITY HEALTH COLLABORATIVE

RAM Ohio Health Expedition <http://www.ramohio.org>

Cuyahoga County Fairgrounds

Berea, Ohio

May 2 & 3, 2009

RAM Ohio is planning a Medical Brigades event for May 2 & 3, 2009 (6 am-6pm) at the Cuyahoga County Fairgrounds in Berea, Ohio. The event will provide totally FREE medical, dental and vision services to Ohio's uninsured and underinsured population.

They will have hundreds of volunteer doctors, dentists, optometrists and social workers. They have many collaborative partners, including the local free clinics, hospitals, universities, for-profits and non-profits. The long-term goal is to establish this program so that it is sustainable throughout the state.

NOW RECRUITING VOLUNTEERS:

General physicians, Specialists, Dermatologists, Nurses, Podiatrists, Pediatricians, OB/Gyns, Diabetic Specialists, Mammogram Techs, Pharmacists, Physical Therapists.

For more information or to volunteer contact kyan@ramohio.org



amcno

THE ACADEMY OF MEDICINE OF
CLEVELAND & NORTHERN OHIO

Medical Records Fact Sheet Update Effective January 2009

Retention of Medical Records

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

Update on Charging for Copies of Medical Records

A physician who treated a patient should not refuse for any reason to make records of that patient promptly available on request to another physician presently treating the patient, or, except in limited circumstances, refuse to make them available to the patient or a patient's representative (not an insurer). A written request signed by the patient or by what the law refers to, as a "personal representative or authorized person" is required. Ohio Revised Code §3701.74 obligates a physician to permit a patient or a patient's representative to examine a copy of all of the medical record. An exception arises when a physician who has treated the patient determines for clearly stated treatment reasons that disclosure of the requested record is likely to have an adverse effect on the patient, in which case the physician is to provide the record to a physician chosen by the patient. Medical records should not be withheld because of an unpaid bill for medical services. Ohio law establishes the maximum fees that may be charged by health care provider or medical records company that receives a request for a copy of a patient's medical record. Ohio law provides for certain limited situations in which copies of records must be provided without charge, for example, where the records are necessary to support a claim by the patient for Social Security disability benefits. EFFECTIVE JANUARY 2009, the maximum fees that may be charged, are as set forth below.

- (1) The following maximum fee applies when the request comes from a patient or the patient's representative.
 - a) No records search fee is allowed;
 - b) **For data recorded on paper:** \$2.84 per page for the first ten pages; \$0.59 per page for pages 11 through 50; \$0.24 per page for pages 51 and higher
For data recorded other than on paper: \$1.94 per page
 - c) Actual cost of postage may also be charged
- (2) The following maximum applies when the request comes from a person or entity other than a patient or patient's representative.
 - a) A \$17.48 records search fee is allowed;
 - b) **For data recorded on paper:** \$1.15 per page for the first ten pages; \$0.59 per page for pages 11 through 50; \$0.24 per page for pages 51 and higher
For data recorded other than on paper: \$1.94 per page
 - c) The actual cost of postage may also be charged

Ohio Law requires the Director of Health to adjust the fee schedule annually, with the adjustment to be not later than January 31st of each calendar year, to reflect an increase or decrease in the Consumer Price Index over the previous 12-month period. If you have any questions regarding this fact sheet or other practice management issues, please contact the AMCNO at (216) 520-1000 ext 102.

How to Manage Legal Issues

Impacting the Practice
Of Medicine

Wednesday, April 8, 2009 – Lakewood Country Club, or
Wednesday, April 15, 2009 – Mayfield Country Club
5:00 p.m. – 8:30 p.m.

Jointly sponsored by:



AEM
Academy of Medicine Education Foundation

Program Format

5:00 p.m. – 6:00 p.m. - Dinner

6:00 p.m. – 6:30 p.m.
Top Ten Medical Malpractice Issues That Lead to Malpractice Lawsuits (i.e. anonymous honor stories, lessons learned, and how to prevent such lawsuits).

Edward Taber, Esq.
Tucker, Ellis & West, LLP

6:30 p.m. – 7:00 p.m.
Apologizing to Patients for Complications and Medical Mistakes, the legalities involved and how to prepare for these situations.

Edward Taber, Esq.
Tucker, Ellis & West LLP

7:00 p.m. – 7:30 p.m.
eHR Adoption Issues and the HIT Stimulus Package, eHR License Agreements, and an Update on HIT Donation Rules

Amy Leopard, Esq.
Walter & Haverfield LLP

7:30 p.m. – 8:00 p.m.
The Impact of Never Events on Medical Claims

R. Mark Jones, Esq.
Cheryl O'Brien, Esq.
Roetzel & Andress, LPA

8:00 p.m. – 8:30 p.m.
Panel Discussion/Question and Answer

Call (216) 520-1000 for more information and to register by phone, or visit our Web Site at www.amcnoma.org

Meet the Presenters

EDWARD E. TABER is a partner in the Cleveland office of Tucker Ellis & West LLP. His focus is on litigation including medical malpractice, pharmaceutical litigation, products liability, business litigation, toxic tort and legal malpractice.

AMY S. LEOPARD is a partner at Walter & Haverfield LLP and a member of its management committee. She counsels physicians, group practices, and entrepreneurs on licensing, payment, regulatory and technology issues.

R. MARK JONES is a partner in the law office of Roetzel & Andress, LPA. Mr. Jones practices in both medical malpractice defense and civil litigation, focusing on representing hospitals and physicians in a variety of medical defense matters. Mr. Jones has handled more than 90 civil jury trials to verdict.

CHERYL O'BRIEN is a partner in the law office of Roetzel & Andress, LPA. Ms. O'Brien practices in the area of medical defense and civil litigation, focusing on hospital and medical defense claims. Her clients include local hospitals and physicians. Ms. O'Brien is a registered nurse with extensive experience in the areas of nursing home care, pediatrics, and pharmacology.

REGISTRATION FORM

I will attend the following session:

_____ **April 8, 2009**

Lakewood Country Club
2613 Bradley Road
Westlake, Ohio 44145

_____ **April 15, 2009**

Mayfield Country Club
1545 Sheridan Road
S. Euclid, Ohio 44121

Name _____

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FEES:
\$15.00 – Residents/Medical Students
\$35.00 – AMCNO Members
\$50.00 – Non-member Physicians/Staff

Return this form with your check made payable to The AMCNO and mail to:
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Independence, Ohio 44131
You may also fax back this form with a credit card payment. Fill in the information below and fax to (216) 520-0999.

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- # 2 Appropriate Insurance Coverage
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