

## Ohio Supreme Court Issues Important Decision Affirming *Robinson v. Bates*

### AMCNO Submits Amicus Brief to Impact Decision

On May 4, 2009 the Ohio Supreme Court issued an Opinion in the case of *Jaques v. Manton*, 2010-Ohio-1838, and in so doing reaffirmed the viability of *Robinson v. Bates*, 2006-Ohio-6362.

Reminger was privileged to have participated in this case. Reminger attorneys Marty Galvin and Bill Meadows authored an Amicus Brief urging reversal for the AMCNO. The background and briefing done in this case was discussed extensively in articles that ran in the November/December and January/February AMCNO newsletters respectively. Both Reminger and the AMCNO were very pleased with the decision issued by the Ohio Supreme Court.

The essence of the Court's decision is that, at trial, where damages for personal injury are

sought, evidence may be admitted of both the amount billed to a plaintiff in medical charges and the amount actually paid. A plaintiff may still present evidence of the face amount of their medical bills, but defendants, in turn, may tell the jury what portion of the medical bills were written off by the health care provider. The Ohio Supreme Court stated that this result was mandated both by the common law collateral source rule, and by R.C. 2315.20, which was enacted after the cause of action in *Jaques* accrued. Two lower courts had held both that R.C. 2315.20 superseded

*Robinson v. Bates*, and that this statute prohibited juries from being informed that portions of medical bills introduced into evidence had been written off.

*(Continued on page 3)*



## AMCNO President Delivers Welcome Address at the Medical School Commencement Ceremony

Dr. Laura J. David, president of the Academy of Medicine of Cleveland & Northern Ohio (AMCNO), spoke at this year's Case Western Reserve University's School of Medicine commencement awards ceremony on behalf of the Academy of Medicine of Cleveland & Northern Ohio (AMCNO). The awards ceremony was held on Saturday, May 15th and included remarks by Dr. David to the students regarding the importance of becoming involved in the community and as a part of organized medicine. Dr. David was also present at the commencement ceremony the following day at Severance Hall. The commencement also included the graduating class of medical students from the Cleveland Clinic Lerner College of Medicine.

Several of the commencement awards were given out to students who have also received scholarships from the Academy of Medicine Education Foundation (AMEF). AMEF

scholarship recipients Patrick Elliott, Syed Mahmood and Jovana Martin were all inducted into the Alpha Omega Alpha Honor Medical *(Continued on page 4)*



Dr. David delivers her speech to the medical students in attendance at the welcome ceremony.

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## Ohio Supreme Court Issues Important Decision Affirming *Robinson v. Bates* AMCNO Submits Amicus Brief to Impact Decision (Continued from page 1)

The issue of whether write downs of medical bills are admissible came down to a dispute over the meaning of "reasonable value of medical care required to treat an injury." It is well-settled that in personal injury cases, an injured party is entitled to recover "necessary and reasonable expenses" arising from the injury. The question answered in *Robinson*, which was revisited, and ultimately reaffirmed in *Jaques*, is how to determine the reasonable value of the medical care.

The first option is to only admit evidence of the amount paid in settlement of the bills. The second option is to only admit evidence of the face value of the bills. The third option is to admit evidence of both the amount paid and the face value of medical bills, and then let juries sort it out. *Robinson*, and now *Jaques*, require application of the third option.

Generally, under the common law collateral source rule, a jury may not learn about a plaintiff's receipt of payment from a source other than the tortfeasor, so that a tortfeasor is not given an advantage from third party payments to the plaintiff. For example, if a person is injured in an accident and incurs \$1,000 in medical bills, which bills are covered by insurance, the collateral-source rule provides that the wrongdoer (the person who negligently operated his or her automobile) does not get the benefit of payment at the time that damages are decided. The question answered by the Ohio Supreme Court concerns how to handle situations where a portion of the medical bills incurred are not actually paid, usually because of a discount negotiated by a health care insurer.

After the *Robinson* decision was released, most observers considered this issue settled. Nevertheless, some trial lawyers soon began advancing an argument that the *Robinson* decision was flawed, and that it contained a fatal loophole which prevented it from being applied to all but a small number of cases. This argument suggested that because the statute governing the collateral-source rule, R.C. 2315.20, was amended after the *Robinson* decision was released, the decision would have no forward-going effect. This argument, which was essentially a distortion of an innocuous footnote contained in the *Robinson* opinion, had been accepted by numerous trial courts across the state.

The *Jaques* Court reasoned that:

"Because different insurance arrangements exist, the fairest approach is to make the defendant liable for the reasonable value of the plaintiff's medical treatment. Due to the realities of today's insurance and reimbursement system, in any given case, that determination is not necessarily the amount of the original bill or the amount paid."

The practical effect of this decision is that the Ohio Supreme Court has reaffirmed the viability of its prior ruling in *Robinson*, which should eliminate the problem of inconsistent application of the collateral-source rule by trial courts. Another effect is that jury verdicts will be fairer, less-inflated, and more consistent with a plaintiff's actual damages, rather than being based solely on an artificial damage figure.

Five Justices joined the majority opinion and one Justice dissented. The decision was reached after the late Chief Justice Thomas Moyer passed away so a total of only six Justices, rather than the usual seven, participated. A dissenting Opinion was authored by Justice Paul Pfeifer, which is a fairly customary role for him. Justice Pfeifer stated in his opinion that "[t]he statute at issue in this case is extraordinarily straightforward and the issue before us exceedingly simple." That is, Justice Pfeifer believed that since an insurance company has a contractual right of subrogation, evidence that an insurance company negotiated a write-off of medical bills is not admissible, period. This approach obviously ignores the fact that it is a plaintiff, and not a defendant, who customarily puts medical bills into evidence and at that point the issue becomes whether the jury should see the total amount billed or the amount actually paid or both.

Justice Judith Ann Lanzinger and Justice Maureen O'Connor, who each joined in the majority decision, will be on the ballot this November. Justice Lanzinger is running for re-election and Justice O'Connor is running for the position of Chief Justice\*.

The January/February article on this issue also contained a discussion of pending legislation, specifically House Bill 361 which was introduced on November 10, 2009. Under H.B. 361, if it eventually becomes law, evidence of write downs will again become inadmissible, and jury verdicts will again be

premised solely on artificially inflated medical bills, unbeknownst to jurors. H.B. 361 would also operate to extend this presumption of reasonableness to "any relevant portion" of a written bill or statement. On February 2, 2010, H.B. 361 was reported on by House Commercial and Civil Law Committee. There has been no activity on this Bill since that time. The AMCNO will continue to monitor the progress of this legislation and encourages its membership to make their views on this issue known. ■



Mr. Ed Taber, the Co-Chairman of the AMCNO Medical Legal Liaison Committee, spends a moment with Judge Fuerst.

Recently, representatives from the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) Medical Legal Liaison Committee met with Administrative and Presiding Judge Nancy Fuerst to discuss alternatives and improvements to the current tort reform system. This issue which has been at the forefront for the AMCNO is one that impacts the Northern Ohio region harder than most parts of the state. Our representatives discussed utilizing special courts similar to the commercial court docket program with specially trained judges for medical liability cases in Cuyahoga County. The AMCNO believes that this could bring speed and special judicial expertise to the medical liability cases in this region which could work to the benefit of all parties involved. While no commitments were made or changes considered at this time, the AMCNO Medical Legal Liaison Committee members have asked for input on initiatives that could improve or streamline outcomes for all parties in medical liability cases. The committee hopes to continue this dialogue in the coming months.

\*The AMCNO, through our PAC, the Northern Ohio Political Action Committee (NOMPAC) has endorsed Justice O'Connor for the position of Chief Justice as well as the re-election of Justice Lanzinger to the Ohio Supreme Court. More information on this race and legislative and judicial races from across Northern Ohio will be included in our 2010 Voting Guide.

# AMCNO COMMUNITY ACTIVITIES

## AMCNO President Delivers Welcome Address at the Medical School Commencement Ceremony (Continued from page 1)

Society at CWRU. In addition, Patrick Elliott received The James S. Winshall, M.D. '92 Memorial Award, presented to a student who has exhibited superlative clinical and interpersonal skills. Patrick also received the Janet S. and Thomas M. Daniel, M.D., Travel Fellowship along with Syed Mahmood, another AMEF scholarship recipient. AMEF scholarship recipient Marisa Quattrone received the Ohio Department of Aging Award for achievement in Geriatric Medicine, and Jovana Martin received the Daniel L. Sweeney Award in Family Medicine, an award sponsored by the Cleveland Clinic Medicine Institute given to a student who demonstrates excellence in Family Medicine. AMEF scholarship recipient Craig Jarrett received two awards — the Myron F. Kanter and Lawrence J. Kanter Endowment which is given to an outstanding senior specializing in cardiology and cardiovascular surgery and the Robert E. Hermann, M.D., Award in Surgery from the Cleveland Clinic.

Dr. David offered the graduates a "Welcome to the Profession" address which is read in part:

*Let me congratulate you on your many accomplishments and your graduation. For*



Dean Davis presents Craig Jarrett with the Kanter Endowment award (Mr. Jarrett was also an AMEF scholarship recipient in 2010).

*indeed, you have all demonstrated extraordinary dedication, discipline, drive and determination and you deserve every bit of high praise. Though many students complete graduate studies of one kind or another in this day and age, the demands of medical school are indeed singular. You've mastered legions of scientific facts, but have also been challenged to develop a kind of sixth sense known as clinical judgment.*

*It is within the circle of your classmates, and teachers and friends and family that these four years have passed. And it will be in the surrounding of future colleagues and*

*professionals and with their support and the sustenance of your family and friends that the next difficult steps in training and career development will be fostered. So, it is with a long-term view and recognition of the value of such relationships, and mentoring, and collaboration and cooperation that I encourage you to remain involved in organized medicine.*

*Please make your voices and your ideals known. Join your professional societies and specialty groups. Participate in community and local medical activities. Continue to volunteer, as I know many of you have done in medical school. Maintain a healthy private life, but never discount the value of the professional relationships that will also support your career and learning. And remember always, that the pursuit of the best science and practice of the fine art of medicine is indeed the most noble of all professions.*

The AMCNO and AMEF heartily congratulate all of the 2010 medical school graduates. The AMCNO has represented the physicians in this region for over 186 years and we were proud to be a participant in these events. ■

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## MedWorks Holds Its Second Mass Clinic AMCNO President and Other Members Volunteer

MedWorks, a Cleveland-based non-profit organization borne out of a high demand for health services for the uninsured and the underinsured, carried out its second mass clinic May 1-2, 2010. At their first clinic in July 2009, MedWorks provided more than 1500 different medical, vision and dental appointments to individuals in 15 Ohio counties and one in Pennsylvania. The May clinic served more than 700 patients who, collectively, had more than 2000 appointments and different services, an average of almost 3 services per individual.

Excluding women's health, almost 550 people received care by a primary care provider or specialist (including cardiologists, urologists, ENT specialists, podiatrists, rheumatologists, orthopedists, dermatologists, and others). Led by **Dr. Laura David, President of the Academy of Medicine of Cleveland & Northern Ohio**, the women's health department saw about 180 women and performed almost 150 pap tests and 60 mammograms. More than 350 people had vision screenings and approximately 300 of them either walked away with a free new pair of glasses or will be receiving a pair soon. Of those visiting the vision department, just over 20 were referred to St. Vincent Charity Hospital for follow-up care. Approximately 275 individuals saw a dentist and many of those had extractions. Just over 80 x-rays and EKGs were performed and the laboratory conducted 190 blood and urine tests. Radiology and lab results were reported within 20 minutes and doctors had an opportunity to review findings with patients. Just over 250 people were HIV tested and now know their HIV status.

MedWorks believes that follow-up care is the lynchpin to the entire operation and the key to a more healthy community. As a result, each person at the clinic met with a social worker just prior to discharge to discuss clinic findings, answer lingering questions, and begin to help patients connect with follow-up care. Individuals also spoke with organizations represented at a resource fair. Community health centers, hospital systems, disease specific organizations, behavioral health services and legal aid were made available to individuals. Representatives from hospital system financial assistance programs met with clinic patients to begin discussing eligibility criteria for charity care programs and the possibility that patients from the MedWorks clinic may qualify for assistance.

A preliminary report from the Cleveland Clinic indicates that they distributed folders with information to 75 patients. Twenty-five individuals have submitted financial assistance applications and, at initial glance, it appears as though all 25 will qualify for 100% charity care at the Clinic, if they choose that institution.



*Volunteers providing medical care at the MedWorks project spend a moment at the event. (left to right) Dr. Thomas Falcone, Dr. Lynn Pattimakiel, and AMCNO President Dr. Laura David.*

Similarly, the Ohio Benefit Bank met with almost 150 people during the weekend. Approximately 75% of those individuals are likely eligible for food stamps, energy assistance, medical premium benefits or prescription drug assistance.

Indeed, a few individuals have been taken under the wings of volunteer physicians and have begun to obtain services, including cancer-related treatments.

Of course, none of this care is possible without the in-kind support and amazing volunteer spirit that drives so many individuals in our lay and medical communities to give of their time. In all, more than 100 physicians, 20 dentists, 25 optometrists (and ophthalmologists), 160 nurses and physician's assistants, 60 social workers, 40 technicians, and 5 pharmacists participated over the two-day event. ■

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The Tax Increase Prevention and Reconciliation Act of 2005 (TIPRA) eliminates income limits and allows all taxpayers to convert traditional IRAs to Roth IRAs beginning in 2010.

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## Legislative Update

By Connor Patton, AMCNO Lobbyist

### Healthy Choices for Healthy Children Legislation Signed Into Law

A bi-partisan effort to decrease and prevent childhood obesity passed the Ohio General Assembly with the support of the Healthy Choices for Healthy Children coalition — with organizations represented from business, health care, education, child advocacy, fitness and nutrition. **The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) is an active participant in this coalition.**

The Healthy Choices for Healthy Children (SB 210) legislation was co-sponsored by Senator Kevin Coughlin (R-Cuyahoga Falls) and Senator Eric H. Kearney (D-Cincinnati) in the Ohio Senate. Representatives John Patrick Carney (D-Columbus) and Lynn Wachtmann (R-Napoleon) co-sponsored the bill in the Ohio House.

The bill will improve the nutritional value of foods offered during the regular and extended school day and raise the bar for physical education. The bill also provides for Body Mass Index (BMI) screenings upon school entry and in the 3rd, 5th and 9th grades and a pilot program for daily physical activity during the school day.

On May 18, the Ohio Senate passed the amended version of the bill, which included opt-out waivers for a requirement of 30 minutes of physical activity and BMI screenings for school districts demonstrating financial hardship. The Ohio House of Representatives passed an amended version of the Senate bill, creating a pilot program for districts to provide 30 minutes of daily physical activity in grades K-12. This amendment allows districts to opt in to a physical activity pilot program administered by the Ohio Department of Education. Districts participating in the pilot will be recognized on their district report card. The Senate concurred with the amended version of the bill and the legislation was signed by Governor Strickland.

### Medical Home Pilot Legislation Signed by the Governor

HB 198 — legislation strongly supported by the AMCNO — establishes the Medical Home Model Demonstration Project and provides for Choose Ohio First Scholarships to be awarded to medical students who agree to practice primary care. The bill creates a medical home pilot program that is focused on improving care and reducing costs. The legislation also extends the moratorium regarding hospital most favored nation clauses and updates laws regarding Medicaid payments for nursing home taxes.

### Physician Ranking Legislation Stalled in the Senate

HB 122 and SB 98, which are the physician ranking bills sponsored by AMCNO are still under review in the Ohio Senate. HB 122 passed in the Ohio House and the legislation has now had two hearings in the Ohio Senate Insurance and

Commerce and Labor committee. Over the past month the insurance carriers across the State have requested drastic changes to the legislation — changes that the AMCNO opposes at this time. The AMCNO and other interested parties will continue to work through the summer to discuss the suggested changes. The AMCNO plans to work to ensure that the changes do not change the intent of the legislation.

### Legislation Introduced Regarding Illegal Pain Clinics – Drug Abuse Task Force Continues Its Work

This spring an Ohio Prescription Drug Abuse Task Force was formed and began meeting to address the perceived epidemic that has been occurring in impoverished rural and urban areas of Ohio. Representatives from AMCNO have been participating in the task force. Legislation has now been introduced that would empower law enforcement to identify and prosecute offenders and crack down on illegal pain clinics.

The new legislation (HB 547) was introduced less than three weeks after the Task Force released its first set of recommendations.

The legislation would:

- Require the State Medical Board to adopt rules for when a physician is required to review information in the Ohio Automated Rx Reporting System, (OARRS) which would prevent patients from doctor shopping.
- Create a clear definition of a “pain management clinic” as a facility at which the majority of patients are treated for chronic pain with the use of a controlled narcotic substance.
- Establish strict guidelines for the operation of a pain management clinic, which would be adopted by the State Medical Board.
- Require those seeking licensure as a terminal distributor of dangerous drugs to meet additional requirements if the person works for a pain management clinic and require any person working for a pain management clinic to be licensed as a terminal distributor of dangerous drugs.

The AMCNO is reviewing this legislation at this time.

### Hospital Tax Issue Under Review

HB 497 – Hospital Assessments – would revise the law governing hospital assessments. HB 1, Ohio’s 2010-11 biennial budget, imposed a new tax on hospitals. As a result, Ohio hospitals are paying \$718 million in taxes, but the real cost is jobs lost. This new tax on Ohio hospitals could not come at a worse time for hospitals and the state’s economy. Hospitals pay the tax but there is a cost to all Ohioans — jobs have been and will continue to be lost. Half of Ohio’s hospitals have already laid off employees and many have canceled or delayed needed construction projects. Two-fifths have cut services and two-thirds are leaving vacancies unfilled. This legislation offers a solution to the problem and could reduce the hospital tax by \$150 million. The new hospital tax is levied against total hospital costs — including patient care costs for which hospitals are not reimbursed at all or are underpaid. The

legislation would revise the law governing hospital assessment by subtracting the costs of Medicare from the tax base, subtracting uncompensated care from the tax base and reducing the tax rate from 1.61% of costs to 1.5%. The AMCNO believes that if hospitals are taxed it impacts everyone affiliated with the hospital that provides patient care — including physicians, therefore **the AMCNO supports this legislation.**

*The 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. ■*

### Medicare Temporary Payment Fix is Not Enough – Tell Your Medicare Patients Their Choice of Physician Could be At Risk

As this issue went to press, the President had just signed legislation to offset the Medicare pay cut that went into effect June 1st. Physicians may now expect to see a 2.2% update in their Medicare payments through November 30, 2010. **This temporary fix is not enough.** The AMCNO has been lobbying Congress for many years asking for a permanent fix to this problem once and for all. Physicians across the region have contacted their Congressional representatives asking for a **permanent fix**. Yet every year our members are forced to face this same issue. At the June AMCNO board meeting it was determined that one way to keep the pressure on Congress to permanently fix this problem is to engage Medicare patients in the discussion. The AMCNO encourages our members to:

- Tell your Medicare patients to contact Congress and ask them to repeal the Medicare cuts formula — tell your patients how this has impacted you and your practice and tell them if this problem continues that their choice of physician could be at risk. Tell your Medicare patients that by repealing the SGR formula, Congress can avert these cuts. On average, legislation to repeal the SGR would prevent cuts of \$18,000 per year to each Ohio physician.
- Tell your Medicare patients that Ohio, at 15 percent, has an above-average proportion of Medicare patients and, at 18 practicing physicians per 1,000 beneficiaries, Ohio has a below-average ratio of physicians to Medicare beneficiaries, even before the cuts take effect.
- Tell your Medicare patients that 39 percent of Ohio’s practicing physicians are over 50, an age at which surveys have shown many physicians consider reducing their patient care activities. Today, about one out of four Medicare patients looking for a new primary care physician are having trouble finding one. Continued cuts in the program will only make matters worse.
- Tell your Medicare patients that Congress needs to fix this problem once and for all so seniors can be assured of continued access to care and choice of physician.

## Health Care Reform

### The Patient Protection and Affordable Care Act—Provisions Impacting the Practice of Medicine

In the last issue of the *Northern Ohio Physician* the AMCNO provided our members with an overview of some of the provisions contained in the \$938 billion Patient Protection and Affordable Care Act (the “Act”) – the health care reform law. The Act contains extensive legislation that will be implemented throughout the next decade and will have significance for businesses as well as physicians. In this issue we will be focusing on provisions in the bill that could impact physicians and their practice. Listed below are some of the major provisions that could impact you and your practice going forward.

Each of the following sections come directly from the new law. The headings are part of the law and the items listed under the headings are what the Act requires or directs under that provision. (Note: “Secretary” refers to the Secretary of the Department of Health and Human Services, and “CMS” refers to the Centers for Medicare and Medicaid Services).

#### Improving the Quality of Medicaid for Patients and Providers

- Directs the Secretary to: (1) identify and publish a recommended core set of adult health quality measures for Medicaid eligible adults; and (2) establish a Medicaid Quality Measurement Program.
- Requires the Secretary to identify current state practices that prohibit payment for health care-acquired conditions and to incorporate them, or elements of them, which are appropriate for application in regulations to the Medicaid program. Requires such regulations to prohibit payments to states for any amounts expended for providing medical assistance for specified health care-acquired conditions.
- Gives states the option to provide coordinated care through a health home for individuals with chronic conditions.
- Directs the Secretary to establish a demonstration project to evaluate the use of bundled payments for the provision of integrated care for a Medicaid beneficiary: (1) with respect to an episode of care that includes a hospitalization; and (2) for concurrent physicians services provided during a hospitalization.
- Requires the Secretary to establish a Medicaid Global Payment System Demonstration Project under which a participating state shall adjust payments made to an eligible safety net hospital or network from a fee-for-service payment structure to a global capitated payment model.
- Directs the Secretary to establish the Pediatric Accountable Care Organization Demonstration Project to authorize a participating state to allow pediatric medical providers meeting specified requirements to be recognized as an

accountable care organization for the purpose of receiving specified incentive payments.

#### Improving Quality and Efficiency of Health Care – Transforming the Health Care Delivery System – Linking Payment Outcomes

- Directs the Secretary to establish a hospital value-based purchasing program under which value-based incentive payments are made in a fiscal year to hospitals that meet specified performance standards for a certain performance period.
- Directs the Secretary to establish value-based purchasing demonstration programs for: (1) inpatient critical access hospital services; and (2) hospitals excluded from the program because of insufficient numbers of measures and cases.
- Extends through 2013 the authority for incentive payments under the physician quality reporting system. Prescribes an incentive (penalty) for providers who do not report quality measures satisfactorily, beginning in 2015.
- Requires the Secretary to integrate reporting on quality measures with reporting requirements for the meaningful use of electronic health records.
- Requires specified new types of reports and data analysis under the physician feedback program.
- Requires long-term care hospitals, inpatient rehabilitation hospitals, and hospices, starting in rate year 2014, to submit data on specified quality measures. Requires reduction of the annual update of entities which do not comply.
- Directs the Secretary, starting FY2014, to establish quality reporting programs for inpatient cancer hospitals exempt from the prospective payment system.
- Directs the Secretary to establish a value-based payment modifier, under the physician fee schedule, based upon the quality of care furnished compared to cost.
- Subjects hospitals to a penalty adjustment to hospital payments for high rates of hospital acquired conditions.

#### Encouraging Development of New Patient Care Models

- Creates within CMS a Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals.
- Directs the Secretary to establish a shared savings program that: (1) promotes accountability for a patient population; (2) coordinates items and services under Medicare parts A and B; and (3) encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.
- Directs the Secretary to establish a pilot program for integrated care (involving payment bundling) during an episode of care provided to an applicable beneficiary around a hospitalization in order to improve the coordination, quality, and efficiency of health care services.
- Directs the Secretary to conduct a demonstration program to test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams designed to reduce expenditures and improve health outcomes in the provision of items and services to applicable beneficiaries.
- Requires the Secretary to establish a hospital readmissions reduction program involving certain payment adjustments, effective for discharges on or after October 1, 2012, for certain potentially preventable Medicare inpatient hospital readmissions.
- Directs the Secretary to make available a program for hospitals with a high severity adjusted readmission rate to improve their readmission rates through the use of patient safety organizations.

#### Ensuring Beneficiary Access to Physician Care and Other Services

- Extends through calendar 2010 the floor on geographic indexing adjustments to the work portion of the physician fee schedule. Revises requirements for calculation of the practice expense portion of the geographic adjustment factor applied in a fee schedule area for services furnished in 2010 or 2011. Directs the Secretary to analyze current methods of establishing practice expense geographic adjustments and make appropriate further

(Continued on page 8)

## Health Care Reform

(Continued from page 7)

adjustments (a new methodology) to such adjustments for 2010 and subsequent years.

- Establishes an Independent Medicare Advisory Board to develop and submit detailed proposals to reduce the per capita rate of growth in Medicare spending to the President for Congress to consider. Establishes a consumer advisory council to advise the Board on the impact of payment policies under this title on consumers.

### Health Care Quality Improvements

- Amends the Public Health Service Act to direct the Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality (AHRQ) to conduct or support activities for best practices in the delivery of health care services and support research on the development of tools to facilitate adoption of best practices that improve the quality, safety, and efficiency of health care delivery services.
- Directs the Secretary to establish a program to provide grants to or enter into contracts with eligible entities to establish community-based interdisciplinary, interprofessional teams to support primary care practices, including obstetrics and gynecology practices, within the hospital service areas served by the eligible entities.

### Innovations in the Health Care Workforce

- Establishes a National Health Care Workforce Commission to: (1) review current and projected health care workforce supply and demand; and (2) make recommendations to Congress and the Administration concerning national health care workforce priorities, goals, and policies.
- Establishes a health care workforce development grant program.
- Requires the Secretary to establish the National Center for Health Care Workforce Analysis to provide for the development of information describing and analyzing the health care workforce and workforce related issues.

### Increasing the Supply of the Health Care Workforce

- Revises student loan repayment provisions related to the length of service requirement for the primary health care loan repayment program.
- Requires the Secretary to establish the Public Health Workforce Loan Repayment Program to assure an adequate supply of public health professionals to eliminate critical public health workforce shortages

in federal, state, local, and tribal public health agencies.

### Supporting the Existing Health Care Workforce

- Requires the Secretary, acting through the Director of AHRQ, to establish a Primary Care Extension Program to provide support and assistance to educate primary care providers about preventive medicine, health promotion, chronic disease management, mental and behavioral health services, and evidence-based and evidence-informed therapies and techniques.
- Requires the Secretary to award grants to states for the establishment of Primary Care Extension Program State Hubs to coordinate state health care functions with quality improvement organizations and area health education centers.

### Strengthening Primary Care and Other Workforce Improvements

- Requires Medicare incentive payments to: (1) primary care practitioners providing primary care services on or after January 1, 2011, and before January 1, 2016; and (2) general surgeons performing major surgical procedures on or after January 1, 2011, and before January 1, 2016, in a health professional shortage area.
- Reallocates unused residency positions to qualifying hospitals for primary care residents for purposes of payments to hospitals for graduate medical education costs.
- Revises provisions related to graduate medical education costs to count the time residents spend in nonprovider settings toward the full-time equivalency if the hospital incurs the costs of the stipends and fringe benefits of such residents during such time.
- Includes toward the determination of full-time equivalency for graduate medical education costs time spent by an intern or resident in an approved medical residency training program in a nonprovider setting that is primarily engaged in furnishing patient care in nonpatient care activities.
- Directs the Secretary, when a hospital with an approved medical residency program closes, to increase the resident limit for other hospitals based on proximity criteria.

### Physician Ownership and Other Transparency

- Prohibits physician-owned hospitals that do not have a provider agreement by August 1, 2010, to participate in Medicare. Allows their participation in Medicare under a rural provider and hospital exception to the ownership or investment prohibition if they meet certain requirements addressing conflict of

interest, bona fide investments, patient safety issues, and expansion limitations.

- Amends SSA title XI to require drug, device, biological and medical supply manufacturers to report to the Secretary transfers of value made to a physician, physician medical practice, a physician group practice, and/or teaching hospital, as well as information on any physician ownership or investment interest in the manufacturer. Provides penalties for noncompliance. Preempts duplicative state or local laws.
- Amends SSA title XVIII (Medicare), with respect to the Medicare in-office ancillary exception to the prohibition against physician self-referrals, to require a referring physician to inform the patient in writing that the patient may obtain a specified imaging service from a person other than the referring physician, a physician who is a member of the same group practice as the referring physician, or an individual directly supervised by the physician or by another physician in the group practice. Requires the referring physician also to provide the patient with a written list of suppliers who furnish such services in the area in which the patient resides.
- Amends SSA title XI to require prescription drug manufacturers and authorized distributors of record to report to the Secretary specified information pertaining to drug samples.

### Medicare, Medicaid, and CHIP Program Integrity Provisions

- Requires the Secretary to: (1) establish procedures for screening providers and suppliers participating in Medicare, Medicaid, and CHIP; and (2) determine the level of screening according to the risk of fraud, waste, and abuse with respect to each category of provider or supplier.
- Requires providers and suppliers applying for enrollment or revalidation of enrollment in Medicare, Medicaid, or CHIP to disclose current or previous affiliations with any provider or supplier that: (1) has uncollected debt; (2) has had its payments suspended; (3) has been excluded from participating in a federal health care program; or (4) has had billing privileges revoked. Authorizes the Secretary to deny enrollment in a program if these affiliations pose an undue risk to it.
- Requires providers and suppliers to establish a compliance program containing specified core elements.
- Directs the CMS Administrator to establish a process for making available to each state agency with responsibility for administering a state Medicaid plan or a child health plan under SSA title XXI the identity of any provider or supplier under

Medicare or CHIP who is terminated.

- Requires that overpayments be reported and returned within 60 days from the date the overpayment was identified or by the date a corresponding cost report was due, whichever is later.
- Directs the Secretary to issue a regulation requiring all Medicare, Medicaid, and CHIP providers to include their National Provider Identifier on enrollment applications.
- Authorizes the Secretary to exclude providers and suppliers participation in any federal health care program for providing false information on any application to enroll or participate.
- Subjects to civil monetary penalties excluded individuals who: (1) order or prescribe an item or service; (2) make false statements on applications or contracts to participate in a federal health care program; or (3) know of an overpayment and do not return it. Subjects the latter offense to civil monetary penalties of up to \$50,000 or triple the total amount of the claim involved.
- Authorizes the Secretary to suspend payments to a provider or supplier pending a fraud investigation.
- Requires the Secretary to furnish the National Practitioner Data Bank (NPDB) with all information reported to the national health care fraud and abuse data collection program on certain final adverse actions taken against health care providers, suppliers, and practitioners.
- Requires the Secretary to establish a process to terminate the Healthcare Integrity and Protection Databank (HIPDB) and ensure that the information formerly collected in it is transferred to the NPDB.
- Reduces from three years to one year after the date of service the maximum period for submission of Medicare claims.
- Requires the Secretary to establish a self-referral disclosure protocol to enable health care providers and suppliers to disclose actual or potential violations of the physician self-referral law.
- Authorizes the Secretary to reduce the amount due and owing for all violations of such law.
- Requires states to establish contracts with one or more Recovery Audit Contractors (RACs), which shall identify underpayments and overpayments and recoup overpayments made for services provided under state Medicaid plans as well as state plan waivers.

## Additional Medicaid Program Integrity Provisions

- Amends SSA title XIX (Medicaid) to require states to terminate individuals or entities (providers) from their Medicaid programs if they were terminated from Medicare or another state's Medicaid program.
- Requires Medicaid agencies to exclude individuals or entities from participating in Medicaid for a specified period of time if the entity or individual owns, controls, or manages an entity that: (1) has failed to repay overpayments during a specified period; (2) is suspended, excluded, or terminated from participation in any Medicaid program; or (3) is affiliated with an individual or entity that has been suspended, excluded, or terminated from Medicaid participation.
- Extends the period for states to recover overpayments from 60 days to one year after discovery of the overpayment. Declares that, when overpayments due to fraud are pending, state repayments of the federal portion of such overpayments shall not be due until 30 days after the date of the final administrative or judicial judgment on the matter.
- Requires state mechanized Medicaid claims processing and information retrieval systems to incorporate methodologies compatible with Medicare's National Correct Coding Initiative.

## Sense of the Senate Regarding Medical Malpractice

- Expresses the sense of the Senate that: (1) health reform presents an opportunity to address issues related to medical malpractice and medical liability insurance; (2) states should be encouraged to develop and test alternative models to the existing civil litigation system; and (3) Congress should consider state demonstration projects to evaluate such alternatives.

## Revenue Provisions

- Requires tax-exempt charitable hospitals to: (1) conduct a community health needs assessment every two years; (2) adopt a written financial assistance policy for patients who require financial assistance for hospital care; and (3) refrain from taking extraordinary collection actions against a patient until the hospital has made reasonable efforts to determine whether the patient is eligible for financial assistance. Imposes a penalty tax on hospitals who fail to comply with the requirements of this Act.
- Requires the Secretary of the Treasury to report to Congress on information with respect to private tax-exempt, taxable, and

government-owned hospitals regarding levels of charity care provided, bad debt expenses, unreimbursed costs, and costs for community benefit activities.

## Miscellaneous

- Requires the Secretary to: (1) develop a Physician Compare website with information on physicians enrolled in the Medicare program and other eligible professionals who participate in the Physician Quality Reporting Initiative; and (2) implement a plan to make information on physician performance public through Physician Compare, particularly quality and patient experience measures.
- Authorizes the Secretary to provide financial incentives to Medicare beneficiaries furnished services by high quality physicians.
- Directs the Secretary to make available to qualified entities standardized extracts of Medicare claims data for the evaluation of the performance of service providers and suppliers.
- Authorizes the Secretary to award demonstration grants to states for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations.
- Amends the Public Health Service Act to extend medical malpractice coverage to free clinics by deeming their officers, employees, board members, and contractors to be employees of the Public Health Service.

*Our organization and the physicians we serve recognize the need for health care reform and have long advocated for change in the health care delivery system. However, the proposal that has been signed into law does not address many issues that the AMCNO board felt should have been part of the legislation. For example, the legislation does not include changes to the Medicare SGR payment formula but it does create a new independent commission that could create more reductions in the Medicare physician payment system dependent upon how it operates in the future. The proposal also does not include measures to address medical liability reform. However, it does create a new health care entitlement program and expands an already underfunded Medicaid program. The AMCNO will continue to monitor the impact of this new law on physicians and their patients. (For more information on the AMCNO board policy on health care reform see the Northern Ohio Physician May/June issue). ■*

## House Calls in Primary Care

By Peter A. DeGolia, M.D., CMD

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### Case Study – Mr. C

Mr. C is an 86-year-old artist with progressive Parkinson's disease, myasthenia gravis on chronic steroids, hypertension, heart failure and chronic kidney disease. Over the past two years his general health was fragile but stable and he attended office visits approximately once every 4 months. An increasing amount of medical care coordination was performed over the telephone in collaboration with his wife and home health agencies. Office visits became increasingly more difficult to arrange because of the need for a caregiver to be in attendance at all times and his need for more specialized transport (rather than the family car). In the past six months his condition deteriorated to the point where transport into the office was no longer possible. The expense and human resources necessary to make office-based care possible became an unacceptable burden to patient, wife and other family members. As his physical condition deteriorated, his clinical needs increased. His primary care physician did not offer home visiting. The family arranged for physician home visiting as a better alternative to monitor heart failure and assess Mr. C's declining functional status. Visits were performed monthly with modification in diuretic use, bowel regimen, and home environment that resulted in improved quality of life.

This past month Mr. C developed an acute focal swelling of his right upper extremity with redness, warmth, and pain. An initial acute care evaluation backed by confirmatory ancillary studies supported a diagnosis of acute cellulitis. An oral antibiotic was started but his condition worsened over 48 hours. After a family meeting to discuss goals of care, Mr. C and his family decided that emergency department evaluation or hospitalization were not desirable. Following a discussion with his local pharmacist, IV Vancomycin was initiated and supervised by a local home health agency. Within 48 hours of starting the IV medication Mr. C's condition improved

remarkably. Close monitoring by the medical house calls team and home care nursing staff was maintained and led to a satisfactory outcome. While Mr. C's neurodegenerative condition continues, he receives all his medical and nursing care in his setting of choice — his home.

### The Demographic Tsunami

Medical care in the home is an overlooked but important and growing aspect of primary and comprehensive care. Every day in the United States 5,600 people turn 65 years old. Life expectancy is increasing — exemplified by a 274 percent growth in the "oldest old" (85 and over) between 1960 and 1995. It is predicted that by 2020 there will be a doubling of the frail, "home limited" older adults by over 2 million. Nearly 5.8 million community-dwelling seniors meet the Medicare definition of homebound for home health services that restricts a person's ability to leave their place of residence except with aid.

Even though older adults are covered by Medicare timely access to healthcare services remains a critical issue. A basic tenet of geriatric medicine is to maximize functional status and to identify problems early in order to minimize morbidity and limit the severity of illness. Transportation to and from the doctors' office for low mobility seniors is an access to care barrier. Often family members or neighbors must take off work and spend half-a-day taking the senior to an office appointment. Many older adults see more than one physician and require ancillary services and diagnostic tests which can add to transportation costs and scheduling problems. A fragmented healthcare system that focuses on acute and episodic care rather than chronic disease management with care coordination limits access to care and causes unmet health care needs as well. Higher emergency department utilization and prolonged hospital admissions are a consequence of this fragmented care delivery system. The top 5 percent of Medicare beneficiaries

account for 50% of all Medicare expenditures.

Medical house calls are a care delivery paradigm that has re-emerged over the past decade to address these issues. It involves primary medical care in the home and works collaboratively with other health care providers and community support systems to deliver comprehensive and coordinated care. Medical house calls should not be confused with Medicare or Medicaid designated Home Care services that provide nursing services to homebound older adults and are limited in duration and service by state, federal or payer rules and regulations.

### Physician House Calls Past and Present

Physician house calls were the standard of care through the mid-20th century. Changes in health care financing, lower transportation costs, and greater caregiver availability contributed to office-based and hospital-based care replacing physician home visiting. By 1980 house calls dropped to less than 1% of physician encounters. By the late 1990s, the shifting senior demographics, increasing cost of health care services, changing social dynamics limiting caregiver availability, advancements in the miniaturization of office-bound technology, and the growing acceptance and integration of non-physician providers ushered in a new era in house calls. Medicare supported these developments in 1998 when home care billing codes were established and reimbursement was increased by 50%. Medicare billed house call visits increased by over 68% between 1998 and 2007. Recently geriatricians demonstrated the greatest growth in annual house calls amongst physicians (92% increase compared to 41% for family practitioners and 59% for internists) but family physicians continue to make the most visits as a specialty.

These developments generated interest among hospitals and physicians to explore models related to house call visits for seniors. Such programs can further their mission of community service and function as a tool to manage the frail, chronically ill older adult. Additional benefits include capacity management and reduction in hospital average length of stay. Frail, medically complex patients and overwhelmed caregivers gain the advantage of enhanced care coordination and

substantially simplified service scheduling. This increases the quality of care and decreases patient and caregiver stress.

## The Home Visit

The home visit can offer many advantages to the frail older adult and their caregivers. Aside from providing continuous comprehensive care and extending care beyond what is provided by home health agencies, medical house calls facilitates a better understanding of the patient's and caregiver's situation. Physicians provide better coordination of care in conjunction with home health agencies. Indications for a medical house call include bedbound status, low mobility, acute illness, end-of-life care, difficulty transporting the patient, and persons with advanced dementia.

While house calls can improve access to comprehensive care, it is more than just "taking the office to the patient." The care paradigm is turned upside down with the physician as the guest in the patient's home. A house call visit is a visible sign of the physician's commitment to the patient and caregiver. This can lead to an improved therapeutic relationship between physician and patient/caregiver. A wealth of qualitative and quantitative information is gained that is not reliably obtained in the office setting. Examples include the direct evaluation of the physical environment monitoring for safety concerns such as risk factors for falls and the smell of gas; hoarding behavior suggesting cognitive problems; cognitive and functional capacity in the patient's every day setting; formal and informal caregiver support; review of all medications; food availability and type; and elder mistreatment.

The level of information gathered and the unique relationship dynamic contribute to enhanced medical decision-making and care plan development. One study observed that patients who had assessments both in the clinic and home, 95% had at least one problem that was identified only at the home visit. Of those issues identified at both visits, a large majority were significantly underestimated in the clinic-based assessment. Improved problem identification and assessment can influence decision making such as seeking community-based psychosocial support services or home-repair assistance. The home becomes the classroom with items such as prescriptions, the refrigerator, the kitchen cabinets and

even the stairs in the hallway serving as teaching aides. This aspect of the home visit has many advantages: integrates all parties into the care plan; promotes health literacy and patient/family self-management through customized education; and reduces stress.

The tools of the trade that the physician brings into the home are an important aspect of the home visit. Advances in portable technology make the physician's black bag a marvel of technological sophistication. Portable ECGs, pulse oximetry and Doppler devices are as common as a thermometer, scale, and stethoscope. Nearly all the diagnostic services that are offered in the office setting can be provided in the home.

The typical house call patient is not well-described. Medicare data suggests that the current health status of Medicare beneficiaries with five or more co-morbid conditions see on average 13 different physicians annually, account for 75% of all hospital admissions, account for 88% of all filled prescriptions, account for 72% of all physician office visits, and are 100 times more likely to have a preventable hospitalization than a senior with no chronic illnesses. In the University Hospital/Case House Calls program our typical patient is an 82 year old African American woman with 7 or more co-morbidities who takes 8 or more medications, was hospitalized at least once in the prior year and requires assistance in at least one Activity of Daily Living (ADL).

Most house call patients are seen by the medical provider every 4 to 12 weeks depending on the complexity of care and acuity. The medical visits for a new patient can exceed one hour, while visits with established patients are typically 30 to 45 minutes in duration. The average house call medical provider sees approximately 4 to 5 visits per half-day session compared to 2 or more times that volume in the office setting. Many house call programs also offer urgent care visits. These are mostly unscheduled home visits or, less frequently, telephone calls in response to an acute exacerbation of a chronic condition.

The process of billing for home visits has remained stable and straightforward since 1998 when Medicare created the CPT-4

codes and enhanced fees. Low turn over of the patient base, frequent telephone and in-person contact, a limited set of billing codes, and a common payer (for most) make billing and collections routine. Mounting pressure for accountability and value heightens the need for comprehensive documentation to explain the medical necessity of the visit and justify the level of visit intensity. Medical home visits are not held to the same definition of homebound status as home care skilled nursing and therapy services. These services require that the patient be "confined to his/her home...such that there exists a normal inability to leave home and, consequently, leaving home would require a considerable and taxing effort." For physician home services the Medicare "beneficiary does not need to be confined to the home." Medicare defines medical necessity for a physician visit as "the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member." Physician home visits must be "services or supplies that are needed for the diagnosis or treatment of your medical condition, meet the standards of good medical practice in the local area, and are not mainly for the convenience of [the patient] or your doctor." The house call provider should document why the home visit is made in lieu of an office visit ("hardship" or "undue burden" on patient or caregiver) and the medical necessity for the visit (for the diagnosis or management of a medical problem).

The work effort between home visits is a critical factor for success of house call programs. The general coordination of activities related to arranging medical consults or home nursing services, securing psychosocial support services, setting up home health diagnostic or therapeutic services, processing the paperwork and obtaining physician signatures to assure approval of these requests is a job equal in importance to the actual medical visits. Regular team meetings to discuss operational processes and challenging patient care issues are a necessity. They build camaraderie, ensure effective and timely communication, and gain insight from the perspectives brought by multiple disciplines.

These efforts represent another area of reimbursement related to the home visit:

*(Continued on page 12)*

## House Calls in Primary Care

(Continued from page 11)

care plan oversight (CPO). CPO allows a house call provider to bill for time spent coordinating care and services between home visits for patients who are either receiving skilled home care or enrolled in hospice. The house call provider must spend 30 minutes or more in a calendar month coordinating care, such as speaking with a home care nurse about the patient, signing orders, and/or reviewing ancillary study results. Documentation should detail the minutes spent on oversight work. Only one provider may bill CPO on a given patient in a given month. In addition, the provider must have seen the patient in-person within the preceding six months. A face-to-face encounter is not required for CPO billing.

## Back to the Future

The long-term sustainability of home-based comprehensive care faces several challenges, including supply of providers and reimbursement. It appears to be an effective tool to reduce utilization and costs for specific populations. The Independence at Home Act of 2009 was recently passed as part of the comprehensive health insurance reform legislation. Incorporating many of the principles of the patient-centered

medical home (PCMH), Independence at Home (IAH) is built on a foundation of primary care house calls and strives to promote coordination, collaboration, and accountability. IAH has highly specific patient-enrollment criteria, seeking the 5% to 10% of Medicare beneficiaries who account for 50% to 60% of all Medicare expenditures. At the core of IAH is the care organization that is responsible for delivering and coordinating the range of necessary health care and psychosocial support needs across all settings. Similar to PCMH, a range of services and infrastructure requirements must be met to ensure an organization can effectively meet this charge. The patient's home, rather than the physician's office, serves as the loci of care. This allows the IAH organization to leverage the capabilities and benefits of home-based care. As with many PCMH programs, it is proposed that the IAH organization would receive monthly care coordination fees for each enrolled patient, in addition to fee for service (FFS) payments for services rendered. This payment addresses the need for staff and infrastructure to serve this population, as well as provides the financial basis to sustain the practice. In return, the IAH organization must either achieve a 5% savings for Medicare relative to predicted costs for the

population served or repay the care coordination fee. This approach funds the IAH entirely from the savings produced. IAH organization retains 80 percent of any savings after the initial 5%.

## Conclusion

House calls have returned and the outcomes to date suggest that they are an effective tool to improve quality and reduce utilization for the chronically ill frail adult. As our society ages, and health care costs rise, low-cost services that help keep frail seniors living independently in our communities are in greater demand. The medical house call, especially as a component to the Patient Centered Medical Home, is a logical and achievable service that can benefit our frail home-limited seniors. A return to home-based primary care for appropriate populations offers a sustainable, long-term benefit to our patients and their families, family physicians, and our society.

**Editor's note:** The AMCNO welcomes article submissions from our members. The Northern Ohio Physician does not obtain medical reviews on articles submitted for publication.

AMCNO members interested in submitting an article for publication in the magazine may contact Ms. Danielle Gulden at the AMCNO offices at (216) 520-1000, ext. 102. ■

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## NORTHERN OHIO PHYSICIAN

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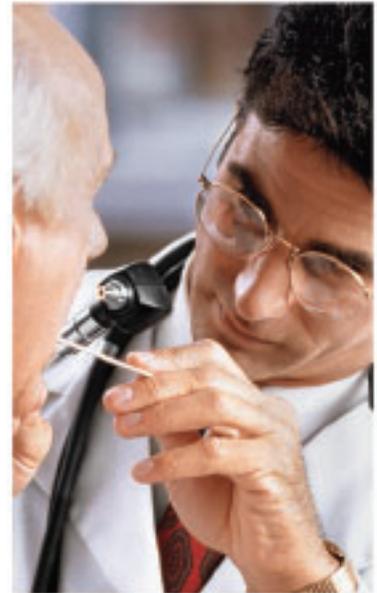
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## When does a Roth conversion make sense?

By: Philip Moshier, Sagemark Consulting

You'll likely hear a lot about Roth IRA conversions in the next few months. In 2010, the mandated income limits that preclude high earners from converting their traditional IRA accounts to the Roth are scheduled to be eliminated.

If you earn less than the income limits, you can make the switch anytime, but should you? The advantage is that the funds you've converted to the Roth will accumulate tax-free from that day on. That's a great benefit, of course, but it means you'll have to pay taxes on the assets at the time you make the switch. Of course, you may have smaller plan assets today than you did a year ago — meaning you'll pay less income tax.

Your financial planner can help you determine whether the conversion makes sense. Some issues you'll likely discuss are:

**Your income.** In 2009, you could convert to a Roth only if you had modified adjusted gross income (MAGI) of less than \$100,000 (the limit is the same for single and married filers). But in 2010 the income limit for conversions is eliminated, so additional individuals may convert. (You still must meet income-based eligibility requirements to make contributions to the Roth account.)

**The tax bill.** When you convert a traditional 401(k) or IRA to a Roth, you must pay income taxes on the amount you have converted (less the after-tax contributions) from non IRA funds to make this strategy work. If you don't have the funds on hand to pay that bill, you may want to consider taking a pass on making the switch. Taking money out of your IRA to pay the taxes doesn't make sense since the withdrawal for tax purposes will itself be taxed, and generally will incur a 10% early-withdrawal penalty if you're younger than 59. You will also have fewer assets invested than when you started the conversion.

Special rules in effect for 2010 provide some flexibility that may help you pay conversion taxes. For that year's conversions only, you can elect to recognize the income (50% each year) on your 2011 and 2012 tax returns, rather than taking the hit all at once.

Of course, if you expect to be in a substantially lower tax bracket when you begin withdrawing the funds, it will not make sense to pay the taxes now. You might be better off sticking with your current tax-deferred account.

**Your timeline.** In general, the longer you have until you need to withdraw the funds, the more you may benefit from a Roth's tax-free growth potential. That makes younger savers with a few decades before retirement prime candidates for the conversion. You have to hold a Roth IRA for five years and be at least age 59 for earnings withdrawals to be tax-free. Early withdrawals may be subject to penalties.

Conversely, you may decide not to convert if you expect to draw on your funds in the next few years. Your account is likely to be larger at that point, and you may be better off paying taxes on your withdrawals spread out over your retirement years than you would be taking a large tax hit all at once.

**Estate planning.** Unlike traditional IRAs and 401(k)s, Roth IRAs do not come saddled with required minimum distributions (RMDs) once you hit a certain age. The lack of RMDs means you can leave assets in the plan as long as you wish, potentially helping accumulate wealth, income tax-free, for your heirs. However, upon your death your beneficiaries will be required to take RMDs.

**Tax diversification.** Although no one knows what tax rates will be in the future, conventional wisdom suggests they may be going higher — a point in favor of making the conversion now. Holding both taxable and nontaxable accounts can help you prepare for any scenario.

*Philip Moshier, CFP®, CRPC® is a registered representative of Lincoln Financial Advisors Corp., a broker/dealer, member SIPC, and offers investment advisory service through Sagemark Consulting, a division of Lincoln Financial Advisors Corp., a registered investment advisor. ■*

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## AMCNO Hosts UnitedHealthcare's Cleveland Town Hall Meeting

On May 18th, the AMCNO welcomed an audience of physicians and office managers to the UnitedHealthcare's Cleveland Town Hall Meeting. Various speakers discussed UnitedHealthcare's (UHC) newest programs and recent changes developed to help physician practices achieve greater efficiency and patient satisfaction.



Practice managers from around the Northern Ohio region participated in the UnitedHealthcare Town Hall meeting at the AMCNO offices.

Sara Knipp, Market Manager of UHC's Medicare Solutions shared the newest information on UHC's Medicare plans. MedicareComplete and Evercare benefits, coverage, claim information, eligibility and new changes were broken down for the audience. Lisa Thompson, Account Manager of Healthways SilverSneakers Fitness Program, a free wellness program for any Medicare-eligible individuals, gave a brief overview of this important and beneficial program for older adults.

Other topics of interest discussed in this jam-packed seminar included: new ID cards, featured tools and webcasts on [UnitedHealthcareonline.com](http://UnitedHealthcareonline.com), and Question

& Answer sessions on radiology, cardiology and admission notification programs. The audience was particularly interested in the new UHC ID Cards. UnitedHealthcare is the first health company to use the national Workgroup for Electronic Data Interchange (WEDI) industry card standards. The new cards provide uniformity of information, appearance, and technology for commercial, Medicare and Medicaid ID cards. These new data standards mean physicians and care providers can read any carrier's ID card using a single card reader.

CareTracker had a representative on-site to demonstrate their new products. CareTracker is a fully integrated web-based program that supports both the clinical and administrative sides of a practice. CareTracker Practice Management (PM) enables physician practices to achieve greater efficiency by: streamlining front desk processes, optimizing first pass claims, monitoring provider contracts, reducing work on follow-up efforts and assessing and measuring staff provider performance.

If you were unable to attend this Town Hall Meeting, you can find information on all UHC Medicare programs and plans, as well as information on the UHC topics mentioned above at [www.unitedhealthcareonline.com](http://www.unitedhealthcareonline.com). ■



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## The National Practitioner Data Bank (NPDB) Is Not Just For Doctors Anymore: Section 1921 Enterprise-Wide Reporting Has Finally Arrived

The long-awaited expansion of the NPDB, to include adverse licensure actions on all licensed healthcare providers and entities, negative actions by peer review organizations, and private accreditation entities, means an increased opportunity and obligation to put the available data to good use.

On March 1, 2010 the NPDB, established by the *Healthcare Quality Improvement Act of 1986* (Title IV of Public Law 99-660), was expanded in scope through implementation of Section 1921 of the Social Security Act (“SSA”).

Section 1921 is not a new law; it was originally enacted by Congress as part of the *Medicare and Medicaid Patient and Program Protection Act of 1987*, and was intended to protect Social Security beneficiaries from unfit healthcare practitioners by authorizing the collection of adverse state licensure information. Section 1921 reporting was again expanded by the *Omnibus Budget Reconciliation Act of 1990*, Public Law 101-508. But remarkably, the Final Rule implementing Section 1921 was just published by the U.S. Department of Health & Human Services in the Federal Register on January 28, 2010.

### Impact of Section 1921

Section 1921 significantly expands the content of the NPDB by including certain adverse findings or actions from state licensure authorities, peer review organizations, and private accreditation organizations. Section 1921 also expands access to the enriched NPDB repository by granting new query rights to federal and state healthcare programs, Quality Improvement Organizations, State Medicaid fraud control units, and other law enforcement agencies.

### New Reporting Content

The most dramatic expansion of the NPDB is the inclusion of adverse actions by state licensing authorities against all healthcare providers (not just physicians and dentists) as well as healthcare organizations. Further, the reporting on these healthcare providers is not limited to actions based on professional competence and conduct. Rather, the reportable adverse licensure actions include the revocation, reprimand, censure, suspension, or probation of a license. Voluntary surrender of licenses after notification of an investigation must be reported, thus closing a loophole that has long stymied the effective surveillance of unfit practitioners. Referrals of practitioners for impairment monitoring or participation in a diversion program is not considered to be an adverse licensing action, and thus is not reportable.

Additionally, peer review organizations and private accrediting entities — two organizations that have not previously reported to the NPDB — are now required to do so. For purposes of Section 1921 reporting, the term “peer review organization” only includes stand-alone organizations and does not include the internal peer review committees of hospitals, professional societies, or other health care entities. HHS does not believe the new reporting rules are inconsistent with the Patient Safety Act, nor will they hamper PSO activities.

Reporting from private accreditation entities is limited to final actions that indicate a risk to patient safety or quality of health care services. Section 1921 does not require hospitals or other health care entities to self report accreditation recommendations.

The reporting of licensure actions and negative actions by peer review organizations and private accrediting entities must be submitted to the NPDB within 30 days following the action to be reported, and this reporting is retroactive to actions that occurred on or after January 1, 1992.

### New Access Rights

All current NPDB queriers will now have access to the expanded content of the NPDB and will automatically receive relevant Section 1921 information with each NPDB query. The new

rules also grant access, though limited to Section 1921 data, to agencies administering federal healthcare programs or their contractors, state agencies administering state healthcare programs, QIOs, State Medicaid fraud control units, the U.S. Comptroller General, and the U.S. Attorney General and other law enforcement. Each entity must certify its eligibility to the NPDB in order to report and/or query Section 1921 data. Section 1921 data is not available to the general public.

These NPDB changes are summarized below.

### With Change Comes Opportunity

With the influx of Section 1921 report data, the NPDB becomes a more valuable tool for hiring and credentialing enterprise-wide. Hospitals, nursing homes, and other healthcare organizations will now have access to state licensure taken against all healthcare practitioners, including podiatrists, pharmacists, physician assistants, nursing professionals, social workers, licensed therapists, and more. Thoughtful, consistent, and timely utilization of the NPDB resource can help organizations reduce the risk of negligent credentialing claims while enhancing patient safety.

In Ohio, as elsewhere, healthcare practitioners seek to expand the scope of their licensure (e.g., increased prescriptive authority for APNs), and some have come under increased reporting obligations to state licensing authorities (e.g., effective March 31, 2010, Ohio hospitals must now report disciplinary actions against radiologist assistants to the State Medical Board). The new reporting

*(Continued on page 17)*

### NPDB (Title IV) and Section 1921 Information

#### NPDB (Title IV)

- Medical malpractice payments (all healthcare practitioners)
- Adverse physician/dentist licensure actions (competence and conduct related)
- Adverse clinical privilege actions
- Adverse professional society membership actions
- DEA actions
- Medicare/Medicaid exclusions

#### Section 1921 (section 1921 only queriers receive this information)

- Any adverse licensure actions (all practitioners or entities – not limited to competence and conduct)
- Any negative action or finding by a State licensing or certification authority
- Peer review organization negative actions or findings against a healthcare practitioner or entity
- Private accreditation organization negative actions or findings against a healthcare practitioner or entity

Source: [www.npdb-hipdb.hrsa.gov](http://www.npdb-hipdb.hrsa.gov)

# PRACTICE MANAGEMENT ISSUES

mandates of Section 1921 will be an important complement to these movements.

One significant concern has emerged, however. Temporary nurse staffing agencies that clearly have a compelling interest in the efficient retrieval of nationwide licensing data for nurses on their rolls, do not have query rights to the NPDB and Section 1921 data (but may gain access if designated an agent of a provider).

Appealing as the new NPDB may be, querying entities must remember that the data coming out is only as accurate and meaningful as that which is reported in. The maxim “consider the source” also applies. Different states apply different standards for qualifying individuals to practice as well as for imposing discipline. Reports of adverse licensing actions warrant individualized weight and consideration. The NPDB cautions that information in the data banks should not be used as the sole source of verification of the professional credentials of a practitioner, provider, entity, or supplier. The NPDB should be used in addition to, not in lieu of, direct reference checks, criminal background checks, and other traditional HR screening strategies.

## Concluding Notes for Practitioners

Information reported in the NPDB, including Section 1921 reports, is considered confidential and may only be disclosed in accordance with NPDB regulations. The Office of the Inspector General has the authority to

| Summary of Changes to Reporting and Querying NPDB         |   |   |
|---|---|---|
| Entities  | Required to Report  | Entitled to Query                           |
| <b>Hospital, Nursing Homes, other healthcare entities</b> | Yes<br><br>(No change)  | Yes; now with access to §1921 information   |
| <b>State Licensing Boards</b>                             | <b>NEW</b> Report as to all licensed healthcare practitioners (not just doctors, DDS)<br><br>Report all adverse licensure actions (not just competence/conduct) | Yes; now with access to §1921 information   |
| <b>Private Accreditation Organizations</b>                | <b>NEW</b> Certain negative findings against healthcare entities  | No  |
| <b>Peer Review Organizations</b>                          | <b>NEW</b> Certain negative findings against healthcare providers   | No [unless a QIO]                           |
| <b>Law Enforcement Agencies</b>                           | No  | <b>NEW;</b> Yes; but only §1921 information |
| <b>Federal/State Healthcare Programs</b>                  | No  | <b>NEW;</b> Yes but only §1921 information  |
| <b>QIOs</b>   | No  | <b>NEW;</b> Yes but only §1921 information  |

impose civil monetary penalties on anyone who violates the confidentiality restrictions. Healthcare practitioners and entities may self-query the data bank at any time to request information about themselves (including Section 1921 information), by visiting the

datbank’s website at [www.npdb-hipdb.hrsa.gov](http://www.npdb-hipdb.hrsa.gov). Practitioners should use every opportunity to review their reports carefully, to correct errors or misstatements, as the impact of incorrect data can be severe. ■

## AMCNO Provides Membership Information and Exhibits at the Availity Cleveland Session

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) was pleased to participate as an exhibitor at a recent *Availity Health Information Network* seminar. AMCNO staff also had an opportunity to meet with attendees to share the benefits of AMCNO membership. The AMCNO, as part of the statewide initiative between America’s Health Insurance Plans (AHIP), and eight leading health plans in Ohio, encourages members to consider the Availity network. The Availity Ohio portal initiative is a collaborative effort between health plans, medical providers and professional associations to deliver immediate efficiencies and cost savings across the continuum of care. Health plans participating in the multi-payer portal include: Aetna, Anthem Blue Cross and Blue Shield, CIGNA, Humana, Kaiser Permanente, Medical Mutual of Ohio, UnitedHealthcare and WellCare Health Plans, Inc.

The Availity Ohio portal initiative offers health care providers real-time access to multiple payers through a single, secure Web portal which facilitates key office tasks. Using Availity can improve health care by 1) providing real-time information at the point of care, including CareCard — a card swipe option, saving time-intensive patient processing at check-in and check-out; 2) reducing costs by

eliminating health plan-specific administration and time spent calling multiple health plans and 3) increasing efficiencies through automation and simplification of routine office work such as authorizations and referrals, eligibility and benefits inquiry as well as claim status inquiry and claim reconciliation. Soon to be available is the *CareCost Estimator* which will allow physician offices to determine

patient financial responsibility in real-time, calculate the amount the patient owes instantly based on the primary diagnosis and procedures, the patient’s benefits, and the provider contractual allowances, however, this will be an estimate only; a claim must still be filed.

Physicians interested in using the portal should begin by registering for Availity at <http://www.availity.com/providers/registration-details/>. Upon completing and returning your signed application, Availity will send your login information to you within a few days. To “test drive” Availity and to see a demonstration of the portal, go to <http://www.availity.com/demo/>. No login is required. ■

The Academy of Medicine of Cleveland & Northern Ohio  
**THE VOICE OF NE OHIO PHYSICIANS FOR MORE THAN 186 YEARS**  
 AMCNO Working on Behalf of Our Members and their Patients

## LEGISLATIVE ACTIVITIES

- Spearheaded the passage in the Ohio House of HB 122 - legislation that would address the issue of physician ranking by insurance companies, and achieved the introduction of companion legislation in the Ohio Senate;
- Coordinated and participated in interested party meetings on the physician ranking legislation and on legislation related to scope of practice issues;
- Attained support for the physician ranking legislation from statewide associations and the Ohio Department of Insurance;
- Surveyed our members and sent detailed comments to Congress regarding the health care reform legislation and the impact on physicians and their patients.
- Met with Congressional leaders in an effort to voice AMCNO concerns with the health care reform legislation.
- Strongly opposed legislation to change the Ohio Revised Code to provide that, in actions for damages arising from personal injury or wrongful death evidence, certain charges and fees in a written bill are not reasonable.
- Participated in the Partnership to Fight Chronic Disease online video campaign aimed at Congressional leaders in Washington to voice support for health reform that prioritizes prevention and wellness.
- Met with the administrative law judge in Cuyahoga County to discuss the concept of special medical courts.
- Met with legislative leaders to continue strong working relationships for the AMCNO.
- Continued to advocate strongly for a permanent change to the Sustainable Growth Rate (SGR) formula used to calculate Medicare physician fees.
- Reviewed and took positions on over 100 healthcare related bills under review at the State legislature making our position known to the legislative sponsors and committee chairman – inclusive of written testimony – enhancing the AMCNO presence at the Statehouse.
- Continued our legislative forum concept – an opportunity for physicians at area hospitals to meet and greet legislators from their district and participate in legislative and health care reform events across the region.
- Met with lobbyists from the major institutions in Northern Ohio in an effort to dialogue on issues of importance to the physicians in our community.
- Participated in the Ohio Department of Insurance (ODI) Commission on Most Favored Nation Clauses in Healthcare Contracts committee.

## PRACTICE MANAGEMENT

- Provided timely information to our members on managed care issues and the yearly update on the fees to be charged for transfer of medical records.
- Supported a plan to launch a multi-payer portal project in Ohio to assess how best to offer physicians access to multiple insurers through the same channel of information exchange (i.e., web portals);
- Continued our active participation as a member of the UnitedHealthcare Physician Advisory Board voicing our concerns on various issues impacting physicians and their practice and became a participant on the UHC administrative advisory council for practice managers;
- Disseminated timely and topical news to practice managers through our publication Practice Management Matters.
- Provided our members with services designed to resolve insurance company disputes with third party payers in Northern Ohio.
- Provided a third party payor seminar for practice managers and physicians – an event created by the AMCNO now entering its twenty-eighth year.
- Provided members with updates on the delay of the Red Flag Rules and prepared information for compliance purposes for use by AMCNO members.

## COMMUNITY/PUBLIC HEALTH EFFORTS

- Actively participated in the Ohio Health Quality Improvement Summit convened by Governor Strickland to address health and wellness issues in the State of Ohio;
- Participated in meetings of the Ohio Health Care Coverage and Quality Council developed after the Governor's Summit;
- Became a founding member of the Cuyahoga Health Access Partnership (CHAP), a countywide health access partnership created to provide a coordinated system of access to care across all providers for the region's low income uninsured residents;
- Conducted our tenth annual successful Vote and Vaccinate event on Election Day offering flu and pneumonia vaccines through our community partnerships in underserved areas;
- Hosted the 25th annual Mini-Internship program that allows community members to shadow AMCNO physicians in their practice setting – this is the longest continuous program of its kind in the country;
- Participated in a Health Care Reform Forum coordinated by the AARP to provide seniors with insights on the impact of health care reform on physicians and their ability to care for their Medicare patients;
- Remained a strong advocate for the Partnership to Fight Chronic Disease – a national effort committed to improving health care policies through more effective prevention and management of chronic disease.
- Continued as an active participant in the Aligning Force for Quality Initiative in Northern Ohio (Better Health Greater Cleveland), a multi-stakeholder alliance committed to improving the quality of care for people with common chronic conditions;
- Participated in advocacy efforts with the Investing in Tobacco Free Youth Coalition to engage legislators in increasing other tobacco product taxes to decrease their use and enhance anti-smoking efforts;
- Provided timely articles and updates on Novel Influenza A (H1N1) Virus;
- Participated in the statewide release of a report produced by the Ohio Department of Insurance outlining a basic health plan for the uninsured;
- Provided volunteers and supported the MedWorks event in order to provide healthcare to the uninsured and underinsured population in

our area.

- Met with the American Medical Association (AMA) regarding quality improvement initiatives;
- Met with Mathematica to review and provide input on the Medicare Value Report Format.

## PUBLIC RELATIONS

- Conducted myriad exclusive interviews on the *Healthlines* radio program with physician members of the AMCNO.
- Participated in a media event launching the Cuyahoga Health Access Partnership (CHAP);
- Interviewed for an article in *Crain's* regarding Medicaid payment cuts;
- Provided detailed spotlight articles about area legislators in the Northern Ohio Physician magazine;
- Entered the 49th year of operation for the AMCNO Pollen Line – currently run and maintained by longstanding AMCNO members;

- Published numerous scientific and medical articles written by AMCNO members in the Northern Ohio Physician.
- Provided physician presenters through our Speakers Bureau to present on medically related topics to community organizations and schools.
- Participated in a media event announcing the regional extension centers in Ohio.

## FOUNDATION OUTREACH AND YOUNG PHYSICIAN ENGAGEMENT

- The Academy of Medicine Education Foundation (AMEF) awarded six \$5,000 scholarships to local third and fourth year medical school students.
- Presented a "Welcome to the Profession" address to the graduating class of Case Medical School and Cleveland Clinic Lerner College of Medicine;
- Financially supported the 8th Annual Consortium for Healthy & Immunized Communities Symposium providing immunization education;
- Participated in resident orientations across the region and greeted new medical students at their annual medical student picnic signing up all residents and students for AMCNO membership;
- Partnered with the William E. Lower Fund to present a seminar on Preparing for the Business Aspects of Medicine – a program designed for resident members and their spouses.

## PHYSICIAN EDUCATION OPPORTUNITIES

- Hosted topical sessions addressing medical legal issues such as current trends in HIPAA and privacy issues, recovery audit contractors, and meaningful use compliance;
- Coordinated with UnitedHealthcare to introduce a local, personalized provider advocate service to work with physicians and hospitals in Northern Ohio;
- Provided detailed information to our members on how to select an electronic health system and computer security issues;
- Prepared detailed information for our members on the Recovery Audit Contractors and how to prepare for an audit;
- Partnered with Tri-C to offer discounted practice management classes to physicians and practice managers.
- Provided timely information to our members on issues of importance to their practice such as the new IRS 990 form, contracting for electronic health records, medical licensure issues and much more.

## BOARD INITIATIVES/ADVOCACY

- Agreed to fund and file an amicus brief from the AMCNO on behalf of our members in the *Jaques v. Manton* case reviewed by the Ohio Supreme Court – a case that could have impacted the current tort reform law in Ohio by changing the application of the collateral source rule;
- Agreed to monetary support and submission of a letter to the Office of the National Coordinator in support of the region's Beacon Community proposal;
- Developed an AMCNO position statement on Health Care Reform for dissemination to the media, legislators and Congress;
- Agreed to work with the Ohio State Medical Board in reaching out to the Deans of medical schools in our region to increase awareness of the Board's "Partners in Professionalism" project;
- Nominated physician leaders to represent the AMCNO on committees formed as a part of the Ohio Health Information Partnership;
- Agreed to pursue a sponsorship of the PNC Healthcare practices concept;
- Agreed to monetary support of the Cuyahoga Health Access Project (CHAP);
- Alerted the Department of Health and Human Services regarding the need to include medical associations such as the AMCNO as an integral part of the regional extension center concept;
- Strongly supported the AMCNO joining the Healthy Choices for Healthy Children Statewide Coalition, an organization dedicated to decreasing and preventing childhood obesity in Ohio and supporting their efforts to pass legislation in Ohio to address the issue of childhood obesity.
- Supported and participated in the submission of a regional extension center (REC) proposal for the Northern Ohio region.
- Agreed to work as a stakeholder on the Case Western Reserve University School of Medicine Regional Extension Center project as part of the Ohio Health Information Partnership (OHIP), a program designed to lead the implementation of health information technology in Ohio.
- Agreed to sign onto an amicus brief asking the Ohio Supreme Court to block diversion of tobacco funds in order to utilize the funds for anti-smoking initiatives on behalf of patients;
- Continued to garner support from area physician groups to increase the AMCNO membership numbers to over 5,000 physicians from across the Northern Ohio region.
- Strongly supported statewide efforts to increase the tax on other tobacco products such as smokeless tobacco and small cigars as a member of the Investing in Tobacco Free Youth Coalition.
- Worked in conjunction with area institutions and developed a detailed response to the Centers for Medicare and Medicaid Services (CMS) regarding the meaningful use rules outlining four key areas of concern with the rules.

**Benefits of Membership in the AMCNO**

Renowned Physician Referral Service  
 Representation at the Statehouse through McDonald Hopkins, Co. LPA  
 Specialty Listing in *Member Directory & Community Resource Guide*  
 Practice Promotion via *Healthlines* radio program  
 Reimbursement Ombudsman  
 CME Seminars  
 Peer Review  
 Speaker's Bureau opportunities  
 Insurance/Financial Services  
 Weekly, quarterly and bimonthly publications offering healthcare news and practice guidance  
 Member Discounts including Worker's Comp, Practice Management Classes at Tri-C and so much more!

**Is YOUR Voice Being Heard?**

**Already an AMCNO member? Now is the time to renew your commitment to organized medicine that makes a real difference in your practice and our region. Look for a 2010 dues billing in your mail soon!**

**Not yet a Member? Now more than ever is the time to join the only regional medical association tirelessly working in the best interest of you — the NE Ohio physician. Call our membership department at (216) 520.1000 ext. 101 for details on all the benefits and services available exclusively to our members.**

## AMCNO Annual Meeting A Huge Success

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) held its Annual Meeting Dinner and Awards Presentation on Friday, April 23, at the Ritz Carlton in downtown Cleveland. One of the meeting highlights was the awarding of six medical student scholarships by the Academy of Medicine Education Foundation to local medical students.

The 2010 list of honorees was led by **Richard B. Fratianne, M.D.**, who received the Academy's most prestigious award, a Special Honor with Portrait, in recognition of his longstanding service to the medical community and to the AMCNO and its foundation, the Academy of Medicine Education Foundation. **John S. Collis, Jr., M.D.**, received the John H. Budd, M.D., Distinguished Membership Award for his work in the Greater Cleveland community and outstanding accomplishments in medical research and clinical practice. **Joseph F. Hahn, M.D., MBA**, was honored with the Charles L. Hudson, M.D., Distinguished Service Award in recognition of his dedicated service to the medical community, his exemplary achievements in the medical field, and support of group membership in The Academy of Medicine of Cleveland & Northern Ohio. The 2010 Clinician of the Year designation went to **Dale H. Cowan, M.D., J.D.**, recognizing his superb contributions in clinical medicine and service to his patients reflecting the highest ideals and ethics of the medical profession.

**Lawrence T. Kent, M.D.** received the Outstanding Service Award for his time and dedication to the AMCNO and in recognition of his work on behalf of the organization. The Academy's Special Honors Award was presented to **Pamela B. Davis, M.D., PhD**, for her notable commitment to the medical profession and her outstanding education and teaching career at Case Western Reserve University.

The Academy presented the **Honorable Barbara Boyd** with a Special Recognition Award for her distinguished legislative career and advocacy efforts on behalf of the health care community and the AMCNO. The Honorary Membership Award was presented to **Messrs. Bernie Rich and Jim Mathews**, in recognition of their longstanding collaboration and work with the AMCNO providing photography services at meetings, functions and events. **Edward E. Taber, Esq.** received the AMCNO Presidential Citation Award for his efforts as co-chair of the AMCNO Medical Legal Liaison Committee and for his service and commitment to the AMCNO. The



*Dr. Bacevice delivers his outgoing address to the annual meeting crowd.*



*The 2010 50 year awardees that attended the reception gather for a photo prior to the start of the meeting. (left to right) Dr. Harold Mars, Dr. Carl Groppe, Jr., Dr. Thomas Gretter, Dr. Julio Popovsky, Dr. Donald Herman, Dr. Thomas Markham and Dr. Young Kim.*



*The AMCNO past presidents in attendance for the evening posed for the camera prior to the festivities. (left to right standing – Dr. George Kikano, Dr. Howard Levine, Dr. Kevin Geraci, Dr. Victor Bello, Dr. Dale Cowan, Dr. Ronald Savrin. (Seated left to right) Dr. Donald Junglas, Dr. Richard Fratianne, Dr. George Leicht and Dr. Raymond Scheetz, Jr.*



*The 2010 annual meeting honorees shared a moment during the reception. (left to right) Dr. Richard Fratianne, Jim Mathews, Dr. John Collis, Jr., Dr. Dale Cowan, Dr. Pamela Davis, Representative Barbara Boyd, Dr. Lawrence Kent and Mr. Edward Taber.*

Academy of Medicine Education Foundation (AMEF) presented six local medical students with scholarships worth \$5,000 each at this year's AMCNO Annual Meeting. The scholarships were awarded to **Shamima Ahmed**, Northeastern Ohio Universities College of Medicine, **Timothy Anderson**, Case Western Reserve University School of Medicine, **Alexandria Howard**, Northeastern Ohio Universities College of Medicine, **Andrew Ibrahim**, Case Western Reserve University School of Medicine, **Craig Jarrett**, Cleveland Clinic Lerner College of Medicine, **Priya Malik**, Cleveland Clinic Lerner College of Medicine.

This was the fifth year scholarship monies were presented to recipients as part of the program at the AMCNO's Annual Meeting and Awards dinner, with students and their respective families in attendance.

And as always, physician members celebrating the fiftieth anniversary of their medical school



*The AMEF scholarship recipients gather at the podium with Dr. Victor Bello after receiving their \$5,000 scholarship award. (left to right) Craig Jarrett, Andrew Ibrahim, Dr. Bello, Alexandria Howard and Tim Anderson.*

graduation were honored during the program as well.

Following the awards ceremonies, outgoing president **Anthony E. Bacevice, Jr., M.D.**, passed the AMCNO gavel for the 2010-2011 year to **Laura J. David, M.D.** ■

# AMCNO ANNUAL MEETING

